Medicaid Managed Care Program (STAR) and Children’s Health Insurance Program (CHIP) Claims Billing and Authorization Training Provider Training
Agenda

- Claims and Billing
- Physician and Mid-Level Billing
- Ancillary Billing
- Medical Management Overview
- Value Added Services (VAS)
- Additional Information
- Magellan Behavioral Health
Claims and Billing
Eligibility Verification for STAR and CHIP

- Providers must verify eligibility before each service

- Ways to verify STAR and CHIP member eligibility
  - Call the BCBSTX Customer Service Center:
    - 877-560-8055
    - Customer Care Representative
    - Interactive Voice Response automated telephone response system
  - Use the State’s Automated Inquiry System (AIS) for STAR (not CHIP)
    - 800-925-9126
  - www.availity.com
  - www.passporthealth.com
Eligibility Verification for STAR and CHIP

Medicaid eligibility and Claim Status Inquiries (DOS 12/1/2015 and later)
- Payer ID HCSVC
- Alpha prefix + 9 digit Medicaid ID
- There must not be an “X” following the plan prefix: results in member/claim not found
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 or stolen
- Blue Cross and Blue Shield of Texas member identification card

CHIP members only receive BCBSTX member 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: <SBSR_ID>
Medicaid ID Number: <MEME_MEDCD_NO>

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

BlueCross BlueShield of Texas
Your Health Plan. Your Choice.

Texas STAR

pcp: <PCP_NAME>
<PCP_PHONE>

BlueCross BlueShield of Texas

Customer Care/Atención al Cliente
(Medical/Prescription Drug/Vision)
24 hours 7 days a week
TTY: 1-888-657-6061
TTY: 711

Behavioral Health Services Hotline/Behavioral Health Lines Direct Care Services
24 hours 7 days a week
TTY: 1-800-327-7899
TTY: 1-800-735-2988

bcbsinx.com

For emergency care received outside of Texas:
Hospital and physicians should file claims to the local BCBS Plan
Card Issued <DT>
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> |
| Phone: | <PCP_PHONE> |

| Office Visit/Visitas al consultorio: | <$XX> |
| Non-Emergency ER/No emergencias en la ER: | <$XX> |
| Hospital per admit/hospital admiten: | |
| Emergency Room/Emergencia en la ER: | |
| Pharmacy (Brand)/farmacia (marca): | |
| Pharmacy (Generic)/farmacia (generico): | |
Examples of BCBSTX identification cards

- CHIP Perinate
  - Member Name: <F_NAME_M_INIT_L_NAME> Alpha Prefix: ZGE
  - Subscriber ID: <SBS_B_ID> CHIP ID No.: <CHIP ID No.>
  - Effective Date: <EFF DT>
  - Rx Group No.: <Rx Group>
  - PCP: N/A
  - PBM: PRIME
  - CHIP Perinate alpha prefix: ZGE

- CHIP Perinate NB
  - Member Name: <F_NAME_M_INIT_L_NAME>
  - Alpha Prefix: ZGE
  - Subscriber ID: <SBS_B_ID>
  - CHIP ID No.: <CHIP ID No.>
  - PCP: <PCP_NAME>
  - PCP PHONE: N/A
  - Rx Group No.: <Rx Group>
  - Rx BIN: 011552
  - Rx PCN: TXC Aid
  - PBM: PRIME

For CHIP Perinate new patients, no co-payment on cost sharing for covered services.

- Blue Cross Blue Shield of Texas
  - Member Name: <F_NAME_M_INIT_L_NAME>
  - Alpha Prefix: ZGE
  - Subscriber ID: <SBS_B_ID>
  - CHIP ID No.: <CHIP ID No.>
  - Effective Date: <EFF DT>
  - Rx Group No.: <Rx Group>
  - PCP: N/A
  - PBM: PRIME

bcbx.com/Medicaid

For emergency care received outside of Texas, patients and physicians should file claims to the local BCBS plan.
Attestation

- Claims billed with unattested NPI’s will deny (STAR only)

- Attest (register and report) NPI with Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com
Claims Coding

> Coding (in most cases) 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”.

> Claims editing software from McKesson: ClaimsXten Rules available @ http://bcbstx.com/pdf/cxten_rules.pdf

> CMS Medically Unlikely Edits (MUE) and National Correct Coding Initiative (NCCI) edits located @ www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/
National Drug Code (NDC) required for all provider-administered medications

- Includes: Intrauterine devices, hormone patches, vaginal rings, sub dermal implants, and intrauterine copper devices
- Exceptions: Vaccines from TVFC program, DME, Limited Home Health Supplies (LHHS), and Radiopharmaceuticals

“How to Submit Claims for Physician Administered Drugs” resource guide located at
http://www.bcbstx.com/provider/medicaid/submitting_ndc_claims.html

Conversion from 10 digits to 11 digits

- Submitting Paper Claims
- Submitting Electronic Claims

If NDC information is missing or the NDC is not valid for the corresponding HCPCS code, BCBSTX will deny entire claim for failing to comply with Clean Claim Standards
National Drug Code (NDC) Coding

- N4 qualifier
- 11-digits, no hyphens
- Unit of Measurement qualifier
- Quantity administered
- Example:

```
N4 qualifier    Unit of Measurement qualifier
11-digit NDC, no hyphens
```

```
N 4 1 2 3 4 5 6 7 8 9 0 1  U  N 1 2 3 4 . 5 6 7
```

Unused spaces for the quantity should be left blank

Numeric quantity administered. Include decimal.
Referral Process/NPI Requirement

- PCP’s and Specialist may refer members to other in-network Specialist
- Record of Referral to Specialty Care
- Claim will deny that do not include the referring provider’s NPI on the claim
- “Claims Billing Requirements for Primary Care Physicians and Specialists to Reminder”
Referral Process

- Referring Provider NPI can be obtained from provider’s office or from the NPI Registry website @ https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

- Referrals made by an FQHC or RHC
  - Individual or Group NPI may be used

- Referring Provider Requirements
  - 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
  - Loop 2310A for EDI
PCP types that do not require a referring provider

Services that do not require NPI when billing
- Services from OB/GYN's
- Services from Indian Health Providers
- Urgent Care Center Services
- Health Department Services
- Anesthesia Services
- Ambulance Services
- Emergency Services
- Family Planning Services
- Health Education
- Inpatient Services
- Immunizations and Administrations
- STD/HIV Services – Testing and Treatment
- ECI – Early Childhood Intervention
- Chiropractic
Submitting Claims

- Timely filing limit is 95 calendar days from the date of service
- Electronic
  - New payer ID 66001: BCBSTX STAR and CHIP Medicaid
  - Only for Dates of Service on and after 12/1/2015
  - Consult with your clearinghouse to verify the new payer ID they have assigned to this new BCBSTX payer: BCBSTX STAR and CHIP Medicaid
- Mail 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

- Alpha + 9 digit Medicaid number
  - EX: ZGT123456789

- Ensure Member’s name and date of birth is correct prior to submission

- “X” prefix
  - Do not include the “X”
  - Only valid for claims with DOS prior to 12/1/2015
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 by WLP until July 1, 2016
  - Effective July 2, 2016 all correspondence and claims will be handled by BCBSTX/TMG
Third Party Liability (TPL) or Coordination of Benefits (COB)
- If the claim has TPL or COB or requires submission to a third party before submitting to BCBSTX, the filing limit starts from the date on the notice from the third party.

BCBSTX must receive COB claims within 95 days from the date on the other carrier’s RA or denial letter

Claim should be submitted on paper with TPL or COB attached
- Third party Remittance Advice (RA)
- Third party letter explaining the denial of coverage or reimbursement
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 clean 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)
Claim Status Inquiry and Follow-Up

Claim status Inquiry
- [www.availity.com](http://www.availity.com)
- Customer Service @ 877-560-8055
- Initiate follow-up action if no response after 30 business days
- Check [www.availity.com](http://www.availity.com) or IVR for disposition
- Provide a copy of the original claim submission and all supporting documents to the Claims address

Claim Status Inquiry Payer ID HCSVC

The Customer Service Representative will perform the following functions:
- Research the status of the claim
- Advise of necessary follow-up action, if any
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](http://www.bcbstx.com/provider/network/medicaid.html)
- [www.availity.com](http://www.availity.com)

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

Email appeal: GPDTXMedicaidAG@bcbsnm.com

www.availity.com
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 @ 1-800-746-4614 with questions or to enroll
Physician and Mid-Level Billing
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
Submitting Electronic Claims

- Submit electronic professional claims in 837P format
- Texas Provider Identifier (TPI) 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
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
Frew v. Janek Consent Decree and Corrective Actions

Class action lawsuit that alleged Texas Medicaid failed to ensure children access to EPSDT (TX Health Steps) services

Some of the Requirements
- TX Health Steps Benefits
- Medical Checkup Periodicity Schedule
- Immunization Schedule
- Missed Appointment Referrals
- Children of Migrant Farmworkers Accelerated Services
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
  - Providers must use modifier 25 to describe the circumstances in which an acute care visit was provided at the same time as a Texas Health Steps visit
  - 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” on Texas Health Steps claims
  - EP1 field 11 (Benefit Code is not required for CHIP preventive claims)
    - Z00121 or Z00129
    - Z23 for Immunizations
Texas Health Steps (TH Steps) – Timely Checkups

- Newly enrolled children on STAR should be seen within 90 days of joining the plan for a timely Texas Health Steps Checkup
- Roster List of Members provided Monthly
- Existing Members birth through 35 months should receive TH Steps Checkup within 60 days beyond the periodic due date based on the Member’s birth date
- Existing Members three years and older is due annually, considered timely if TH Steps Checkup occurs no later than 364 calendar days after the child’s birthday
Texas Health Steps (TH Steps) – Timely Checkups

- Providers should bill as an exception to periodicity
- Exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup
- Modifier 32 Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier “-32” to the basic procedure or service
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)
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
Texas Health Steps Continued

- **Texas Vaccines for Children (TVFC)**
  - Providers who administer vaccines to children 0 – 18 years of age may enroll
  - Providers who administer vaccines to children 0 – 18 years of age must be enrolled in Texas Health Steps
  - To enroll visit TMHP website
  - BCBSTX will only reimburse the administration fee for any vaccine available through the TVFC program
  - Only time a provider is reimburses for use of private stock is when TVFC posts no stock currently available message on website
  - Claim should be billed with U1 to indicate private stock
  - Bill with the appropriate vaccine and administration codes
STAR Delivery codes should be billed with the appropriate CPT codes

- 59409 = Vaginal Delivery only
- 59612 = Vaginal Delivery only, after previous cesarean delivery
- 59514 = C-Section only
- 59620 = C-Section only, following attempted vaginal delivery after previous cesarean delivery
- 59430-TH = Postpartum Care after discharge for STAR claim only
CHIP Perinate Mother’s are entitled to a maximum of 2 postpartum visit

CHIP Perinate Mother’s eligibility terms at the end of the month the baby was born

If a Provider checks benefits after the month of the baby’s birth, they will be advised the CHIP Perinate mother is not eligible

To be reimbursed for the postpartum visits, following these billing guidelines….
BILLING OB/GYN CLAIMS

CHIP Delivery codes should be billed with the appropriate CPT codes:

- 59410 = Vaginal Delivery only (including postpartum)
- 59515 = Cesarean Delivery only (including postpartum care)
- 59614 = Vaginal Delivery only, after previous cesarean delivery (including postpartum care)
- 59622 = C-Section 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.
The following modifiers must be included for all deliveries:

- U1-Medically necessary delivery prior to 39 weeks of gestation*
  - STAR claims must include a medically necessary diagnosis from the list of approved diagnosis
- 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 Maternity Claims (Cont’d)

- BCBSTX reimburses only one delivery or cesarean procedure per Member in a seven-month period
- Reimbursement includes multiple births
- Delivering physicians who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery
- Itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Laboratory (including pregnancy test) and radiology services provided during pregnancy must be billed separately and received within 95 days from the date of service.
- Use modifier TH, obstetrical treatment or service, prenatal or postpartum, with all antepartum codes.
If a Member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.

If high risk, the high risk diagnosis must be documented on the claim form.

Global codes cannot be used for billing BCBSTX.
**Billing Maternity Claims (Cont’d)**

- 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 along with diagnosis code O09211 and the NDC

- When submitting claims for the trademarked drug (Makena), use the following code:
  - J1725-U1 with the NDC

*TMHP Provider Manual 8.2.39.4*
Sterilization

- Use the CMS-1500 claim form and follow appropriate coding guidelines. Attach a copy of the completed Sterilization Consent Form. The Sterilization consent form is available at www.tmhp.com.

- Claims will deny if the Sterilization consent form is not included with the claim.
Billing for Initial Health Assessment (IHA)

- PCP’s function as the “medical home” or “patient advocate” and is responsible for Member access to care

- Strongly recommend an IHA be conducted within 90 days from Members date of enrollment with BCBSTX

- IHA consists of a complete history and physical

- Use diagnosis codes:
  - Z00121 or Z00129 for children (newborn to 18 years of age)
  - Z0000 for adults (19 years and older)
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
- Include copy of W-9 with first time submissions
Ancillary Billing
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
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
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
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.
- Initial visits do not require Prior Authorization.
- Additional services and re-evaluations require authorization 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
Medical Management Overview
Customer Service

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

▶ Customer Service Phone Numbers
  – Member: 888-657-6061
  – Provider: 877-560-8055
  – TTY: 711

▶ Available Monday through Friday from 8 a.m. to 8 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: **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
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?
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)
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**

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* 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 Dispute Resolution 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 [http://www.bcbstx.com/provider/medicaid/forms.html](http://www.bcbstx.com/provider/medicaid/forms.html)
Prior Authorization

- New Texas Department of Insurance (TDI) Standard Prior Authorization Request Form for Health Care Services

- The provider completes the form and faxes it to the Intake Department at:
  - 855-653-8129
Submitting an Appeal

Submit an appeal to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
P O Box 27838
Albuquerque, NM 87125-7838
Prior Authorization

- Submittal of Medical Records not accepted in Place or Prior Authorization
- Include Prior Authorization Number on Claim for faster processing
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

- Call 877-560-8055
The provider website contains resources such as:

- Access to list of Services Requiring Prior Authorization
- Access to view Clinical Guidelines
- Access to many other very helpful resources and forms

Log on @ [http://www.bcbstx.com/provider/medicaid/index.html](http://www.bcbstx.com/provider/medicaid/index.html)
Value Added Services (VAS) Overview
Value Added Services (VAS) Overview

- Infant Safety Car Seats
- Free Pregnancy Classes
- Home Wellness Visits (for mom and baby post delivery)
- Breast Feeding Coaching
- Austin Farmers Market Vouchers (fresh fruit and vegetables)
- Dental Services for Pregnant Adult Members
- Non Emergency Medical Transportation (NEMT)
Value Added Services (VAS) Overview

- Lodging and Food coverage (for out of area NEMT travel)
- Sports and Camp Physicals
- Enhanced Eyewear Frames for kids
- 24/7 Nurse Hotline
- Multilingual glucometers for STAR members
- Safety booster seats for kids
- Safety helmets for kids
Value Added Services (VAS)

- Free Diaper Bag with New Baby Item Gifts
- Hands Free Breast Pumping Bra Gift for mothers who are breastfeeding
- Well Child Check Incentives
  - Eligible to request $50 gift card
- Prenatal and Post Partum STAR member Incentives
  - Prenatal - eligible to receive $25 gift card
  - Post Partum – eligible to receive a $50 gift card
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/mailing 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)
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 the Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions (FAQ) on www.tmhp.com.
Magellan Behavioral Health Overview
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

- Precertification 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](http://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
Don’t forget!

Due to a new federal mandate, all Texas Medicaid providers must periodically revalidate their enrollment in Texas Medicaid. Providers enrolled before January 1, 2013, must re-enroll by March 24, 2016. To simplify this process, the Provider Enrollment Portal has been updated with new features. For additional guidance please visit the TMHP Provider Re-enrollment page.

For help, call TMHP at 800-925-9126.

Deadline extended to Sept 25, 2016
Questions?
Thank you for your time!

Please complete the training evaluation form.