BlueCross BlueShield of Texas

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Claims Billing Provider Training STAR, STAR Kids, and CHIP

Revised 03222023

SKSCP-9038-0822

Agenda

1. Claims and Billing
2. Provider Onboarding/File Maintenance
3. Claims Requirements
4. Physician and Mid-Level Billing
5. Texas Health Steps (THSteps) Billing
6. Children and Pregnant Women (CPW)
7. OB/GYN Billing
8. Ancillary Billing
9. Medical Management Overview
10. Magellan Behavioral Health
11. Therapy Billing
12. Provider Relations Information
13. Questions

BlueCross BlueShield of Texas

Claims and Billing

Eligibility Verification

Our providers must verify eligibility before each service.

Contact Customer Service for eligibility verification:

STAR/CHIP:
1-877-560-8055

STAR Kids:
1-877-784-6802

Use the State's Automated Inquiry System (AIS) for

STAR and STAR Kids:

1-800-925-9126

Utilize online resources:

www.tmhp.com

www.availity.com

CHIP Members receive a card:

- Blue Cross and Blue Shield of Texas member identification card
- They do not receive a State issued Medicaid identification card.

STAR and STAR Kids members will receive two identification cards upon enrollment:

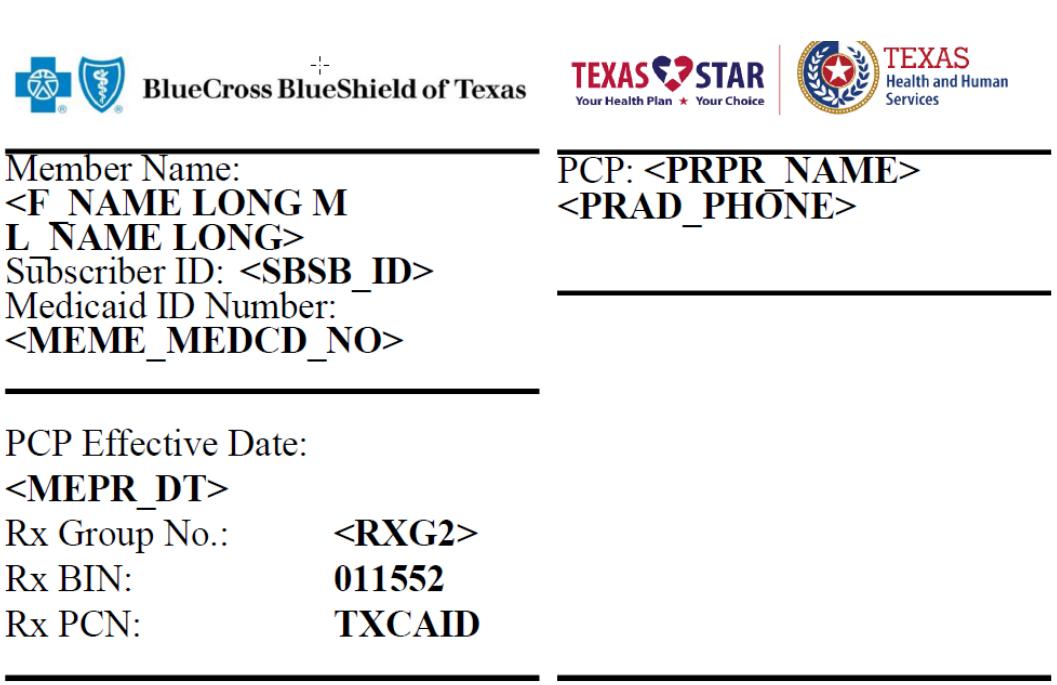
- State issued Medicaid card (Your Texas Medicaid Benefit Card)
- Blue Cross and Blue Shield of Texas Member Identification card

Blue Cross and Blue Shield of Texas identification cards will be re-issued if/when:

- The member changes his/her address
- The member changes his/her PCP
- Upon Request
- At Membership renewal

Sample Member Identification Cards

STAR



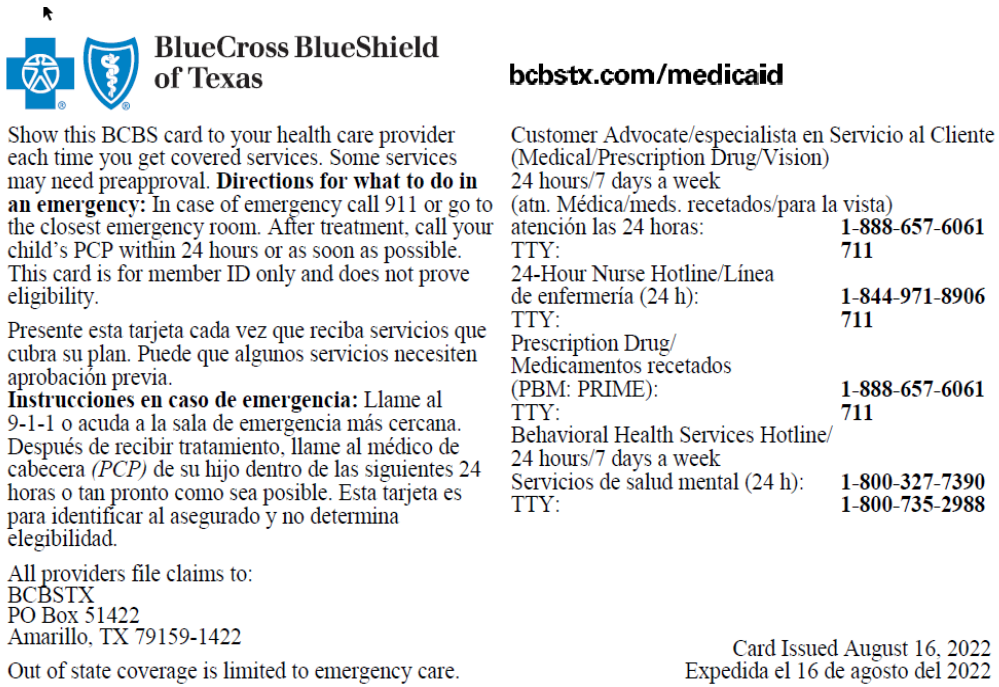
BlueCross BlueShield of Texas

TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Member Name:
<F_NAME LONG M L_NAME LONG>
Subscriber ID: **<SBSB_ID>**
Medicaid ID Number:
<MEME_MEDCD_NO>

PCP: **<PRPR_NAME>**
<PRAD_PHONE>

PCP Effective Date:
<MEPR_DT>
Rx Group No.: **<RXG2>**
Rx BIN: **011552**
Rx PCN: **TXCAID**



BlueCross BlueShield of Texas

bcbstx.com/medicaid

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.

Presente esta tarjeta cada vez que reciba servicios que cubra su plan. Puede que algunos servicios necesiten aprobación previa.
Instrucciones en caso de emergencia: Llame al 9-1-1 o acuda a la sala de emergencia más cercana. Después de recibir tratamiento, llame al médico de cabecera *(PCP)* de su hijo dentro de las siguientes 24 horas o tan pronto como sea posible. Esta tarjeta es para identificar al asegurado y no determina elegibilidad.

All providers file claims to:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

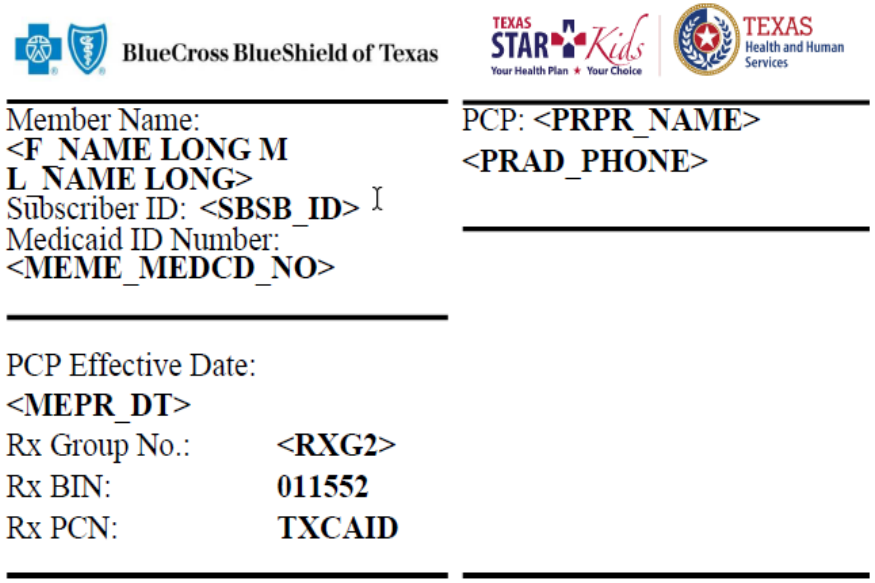
Out of state coverage is limited to emergency care.

Customer Advocate/especialista en Servicio al Cliente (Medical/Prescription Drug/Vision)
24 hours/7 days a week
(atn. Médica/meds. recetados/para la vista)
atención las 24 horas: **1-888-657-6061**
TTY: **711**
24-Hour Nurse Hotline/Línea de enfermería (24 h): **1-844-971-8906**
TTY: **711**
Prescription Drug/ Medicamentos recetados (PBM: PRIME): **1-888-657-6061**
TTY: **711**
Behavioral Health Services Hotline/
24 hours/7 days a week
Servicios de salud mental (24 h): **1-800-327-7390**
TTY: **1-800-735-2988**

Card Issued August 16, 2022
Expedida el 16 de agosto del 2022

Sample Member Identification Cards

STAR Kids



BlueCross BlueShield of Texas

TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Member Name:
<F_NAME LONG M
L_NAME LONG>
Subscriber ID: **<SBSB_ID>**
Medicaid ID Number:
<MEME_MEDCD_NO>

PCP: **<PRPR_NAME>**
<PRAD_PHONE>

PCP Effective Date:
<MEPR_DT>
Rx Group No.: **<RXG2>**
Rx BIN: **011552**
Rx PCN: **TXCAID**

BlueCross BlueShield of Texas

bcbstx.com/starkids

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BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

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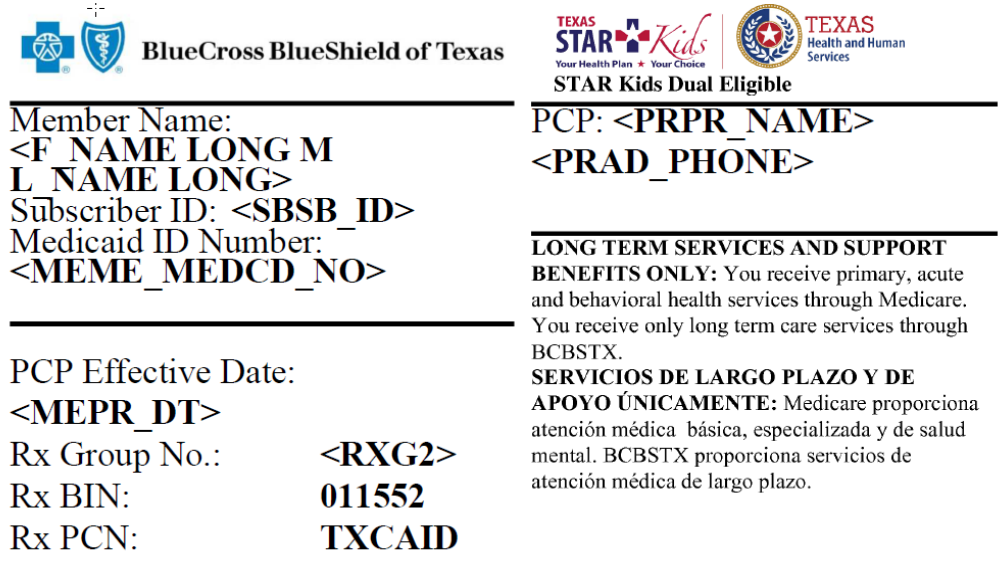
Customer Advocate/especialista en Servicio al Cliente
(Medical/Prescription Drug/Vision)
24 hours/7 days a week
(atn. Médica/meds. recetados/para la vista)
atención las 24 horas: **1-877-688-1811**
TTY: **711**
24-Hour Nurse Hotline/Línea
de enfermería (24 h): **1-855-802-4614**
TTY: **711**
Prescription Drug/
Medicamentos recetados
(PBM: PRIME): **1-877-688-1811**
TTY: **711**
Behavioral Health Services Hotline/
24 hours/7 days a week
Servicios de salud mental (24 h): **1-800-424-0384**
TTY: **1-800-625-2883**
Service Coordination/
Servicio de coordinación: **1-877-301-4394**
TTY: **711**

Card Issued August 16, 2022
Expedida el 16 de agosto del 2022

STAR Kids Dual Eligible



BlueCross BlueShield of Texas

TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services
STAR Kids Dual Eligible

Member Name:
<F_NAME LONG M
L_NAME LONG>
Subscriber ID: **<SBSB_ID>**
Medicaid ID Number:
<MEME_MEDCD_NO>

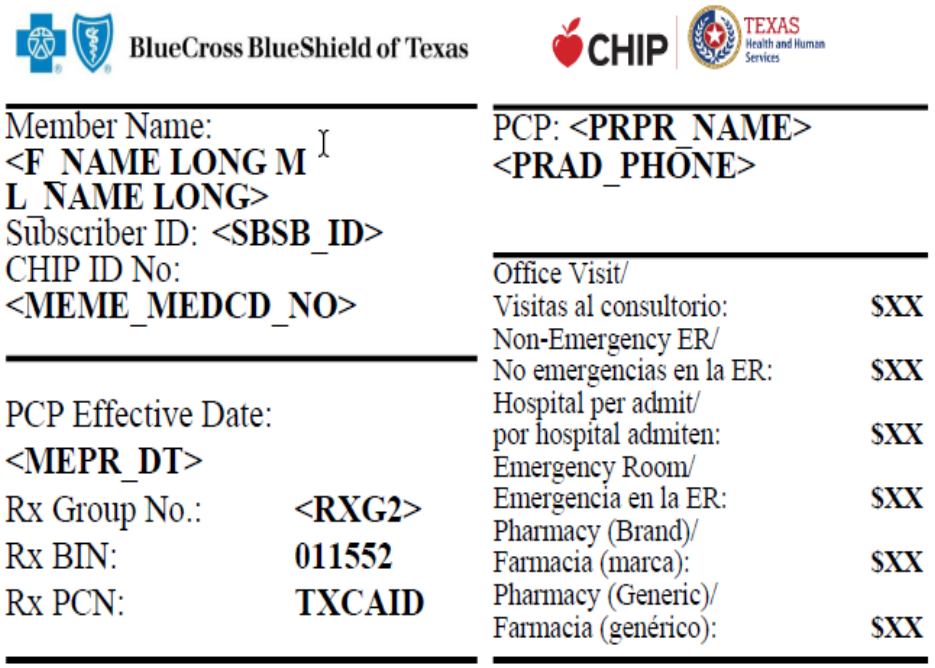
PCP: **<PRPR_NAME>**
<PRAD_PHONE>

PCP Effective Date:
<MEPR_DT>
Rx Group No.: **<RXG2>**
Rx BIN: **011552**
Rx PCN: **TXCAID**

LONG TERM SERVICES AND SUPPORT BENEFITS ONLY: You receive primary, acute and behavioral health services through Medicare. You receive only long term care services through BCBSTX.
SERVICIOS DE LARGO PLAZO Y DE APOYO ÚNICAMENTE: Medicare proporciona atención médica básica, especializada y de salud mental. BCBSTX proporciona servicios de atención médica de largo plazo.

Sample Member Identification Cards

CHIP



BlueCross BlueShield of Texas

CHIP TEXAS Health and Human Services

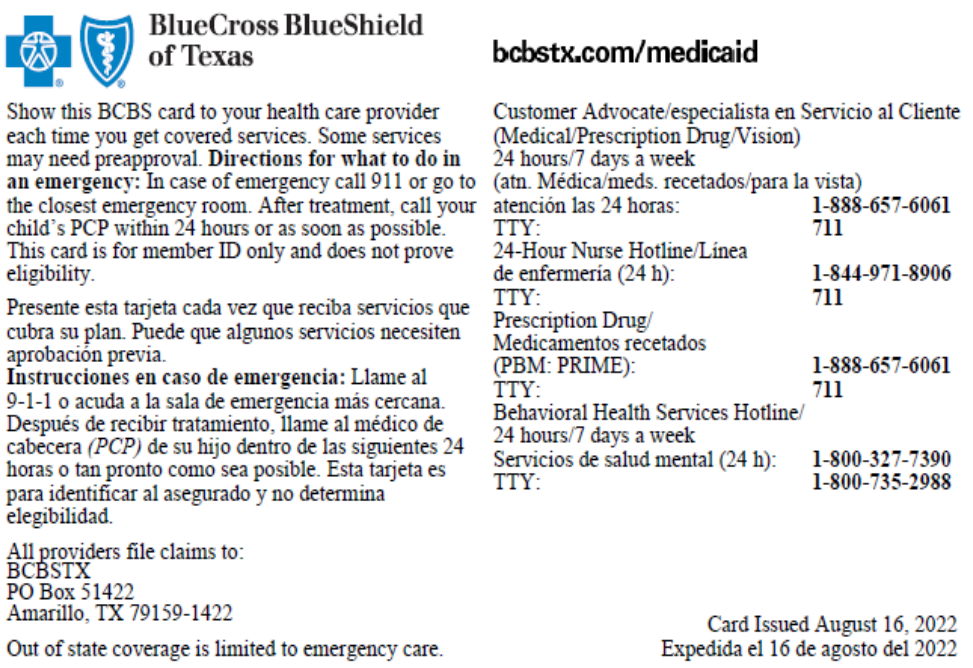
Member Name:
<F_NAME LONG M L_NAME LONG>
Subscriber ID: **<SBSB_ID>**
CHIP ID No:
<MEME_MEDCD_NO>

PCP Effective Date:
<MEPR_DT>

Rx Group No.:	**<RXG2>**
Rx BIN:	**011552**
Rx PCN:	**TXCAID**

PCP: **<PRPR_NAME>**
<PRAD_PHONE>

Office Visit/ Visitas al consultorio:	**$XX**
Non-Emergency ER/ No emergencias en la ER:	**$XX**
Hospital per admit/ por hospital admiten:	**$XX**
Emergency Room/ Emergencia en la ER:	**$XX**
Pharmacy (Brand)/ Farmacia (marca):	**$XX**
Pharmacy (Generic)/ Farmacia (genérico):	**$XX**



BlueCross BlueShield of Texas

bcbstx.com/medicaid

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All providers file claims to:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

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Customer Advocate/especialista en Servicio al Cliente (Medical/Prescription Drug/Vision)
24 hours/7 days a week
(atn. Médica/meds. recetados/para la vista)

atención las 24 horas:	**1-888-657-6061**
TTY:	**711**
24-Hour Nurse Hotline/Línea de enfermería (24 h):	**1-844-971-8906**
TTY:	**711**
Prescription Drug/ Medicamentos recetados (PBM: PRIME):	**1-888-657-6061**
TTY:	**711**
Behavioral Health Services Hotline/ 24 hours/7 days a week Servicios de salud mental (24 h):	**1-800-327-7390**
TTY:	**1-800-735-2988**

Card Issued August 16, 2022
Expedida el 16 de agosto del 2022

Sample Member Identification Cards

CHIP Perinate

BlueCross BlueShield of Texas

CHIP Perinate

Member Name:
<F_NAME LONG M_INIT L_NAME LONG>
Subscriber ID: **<SBSB_ID>**
CHIP ID No:
<MEME_MEDCD_NO>

PCP: **N/A**
N/A

Effective Date:
<MEIA_REQ_DT>
Rx Group No.: **<RXG2>**
Rx BIN: **011552**
Rx PCN: **TXCAID**

CHIP Perinate Newborn

BlueCross BlueShield of Texas

CHIP Perinate NB

Member Name:
<F_NAME LONG M_INIT L_NAME LONG>
Subscriber ID: **<SBSB_ID>**
CHIP ID No:
<MEME_MEDCD_NO>

PCP: **<PRPR_NAME>**
<PRAD_PHONE>

PCP Effective Date:
<MEPR_DT>
Rx Group No.: **<RXG2>**
Rx BIN: **011552**
Rx PCN: **TXCAID**

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

Servicios incluidos en la cobertura CHIP Perinate para recién nacidos no requieren copagos ni gastos

BlueCross BlueShield of Texas

bcbstx.com/medicaid

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Customer Advocate/especialista en Servicio al Cliente (Medical/Prescription Drug/Vision):
24 hours/7 days a week
(atn. Médica/meds. recetados/para la vista)
atención las 24 horas: **1-888-657-6061**
TTY: **711**
24-Hour Nurse Hotline/Línea de enfermería (24 h): **1-844-971-8906**
TTY: **711**
Prescription Drug/ Medicamentos recetados **1-888-657-6061**
TTY: **711**
Behavioral Health Services Hotline/
24 hours/7 days a week
Servicios de salud mental (24 h): **1-800-327-7390**
TTY: **1-800-735-2988**

Hospital Facility Billing:
TMHP
P.O. Box 200555
Austin, TX 78720-0555

Professional/Other Services Billing:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

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BlueCross BlueShield of Texas

Provider Onboarding/ File Maintenance

Attestation and Provider File Maintenance

- Claims will deny if provider has an unattested National Provider Identifier (NPI)
- Provider can check or apply for Attestation with Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com
- Providers must revalidate or re-enroll with TMHP to avoid termination. Blue Cross and Blue Shield of Texas (BCBSTX) must be notified by the provider for any demographic changes.
- Notify BCBSTX online at bcbstx.com for any demographic changes including:
  - Address
  - Phone number
  - Fax number

Importance of Correct Demographic Information

- Updated provider demographic information is necessary for accurate provider directories, online provider information, and to ensure clean claim payments.
- Providers are required to notify BCBSTX of any changes to their: address, telephone number, group affiliation and/or any other material facts, to the following entities:
  - BCBSTX via: bcbstx.com - Demographic Change Form
  - Texas Medicaid and Health Care Partnership (TMHP) – via the Provider Information Change form at www.tmhp.com
- Claims payment will be delayed if the following information is incorrect:
  - Demographics – billing/mailing address (STAR, CHIP, and STAR Kids)
  - Attestation of Tax Identifier Number (TIN)/rendering and billing numbers for acute care (STAR and STAR Kids)

BlueCross BlueShield of Texas

Claims Requirements

Fraud, Waste or Abuse

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care provider or a person getting Medicaid benefits is doing something wrong. Doing something wrong could be fraud, waste or abuse, which is against the law.

Examples of Fraud, Waste and Abuse:

- A health care professional getting paid for services that weren't given or needed
- Altering medical records
- Use of unlicensed staff
- Drug diversion (e.g., dispensing controlled substances with no legitimate medical purpose)
- Kickbacks and bribery
- Providing unnecessary services to members.

To report fraud, waste, or abuse, choose one of the following:

•Call the Office of Inspector General (OIG) Hotline at **1-800-436-6184**
•Report Waste, Abuse and Fraud online ; or
•You can report directly to your health plan:
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, Texas 75266-9506

Claims Coding

- Coding (in most cases) will mirror the Texas Medicaid and Healthcare Partnership (TMHP) guidelines found in the most current Texas Medicaid Provider Procedures Manual (TMPPM).
- Access the current procedures manual at www.TMHP.com, click on "Medicaid Provider Manual."
- Claims editing software may be updated periodically. BCBSTX will give providers advance notice of any new edits being applied that are expected to result in material changes.
- Centers for Medicare and Medicaid Services (CMS) Medically Unlikely Edits (MUE) and National Correct Coding Initiative (NCCI) edits located at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/
- Access the Vendor Drug Program for formulary search: www.txvendordrug.com/formulary/formulary-search

National Drug Code (NDC) Coding

- National Drug Code (NDC) required for all provider-administered medications
  - Includes: Intrauterine devices, hormone patches, vaginal rings, subdermal implants, and intrauterine copper devices
  - Exceptions: Vaccines from Texas Vaccines for Children Program (TVFC), Durable Medical Equipment (DME), Limited Home Health Supplies (LHHS), and Radiopharmaceuticals

- *"How to Submit Claims for Physician Administered Drugs"* located at http://www.bcbstx.com/provider/medicaid/submitting_ndc_claims.html

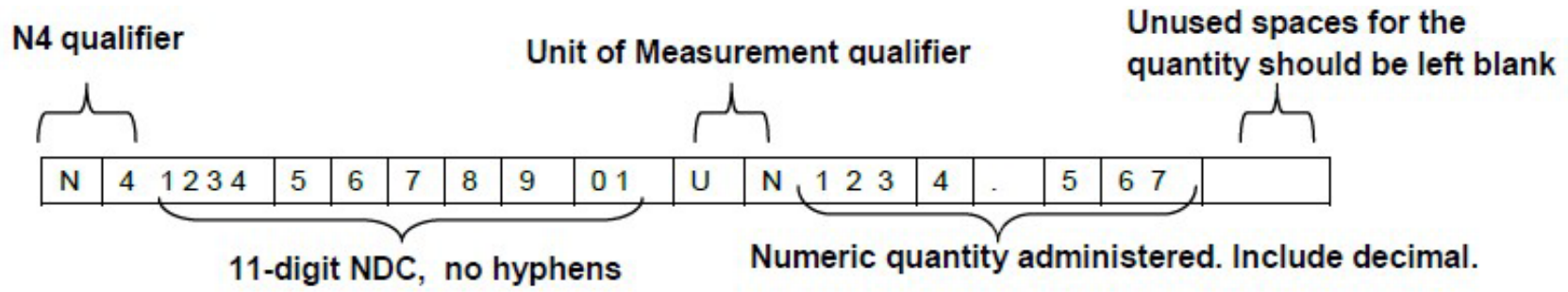
- Conversion from 10 digits to 11 digits
  - Submitting Paper Claims
  - Submitting Electronic Claims

- If NDC information is missing or the NDC is not valid for the corresponding Healthcare Common Procedure Coding System (HCPCS) code, BCBSTX will deny the 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:



Taxonomy Requirement

- Taxonomy code submitted *must match* the one submitted and approved by the State Medicaid Agency for the submitted National Provider Identifier (NPI)/Atypical Provider Identifier (API)/Tax ID.

- Confirm taxonomy and resubmit any rejected claims.

BCBSTX Medicaid STAR/CHIP & STAR Kids Claim Requirements	Electronic Claims	CMS-1500 Claim Form	UB-04 Form Locator
Billing Provider Taxonomy Code – required on all claims	2000A, PRV03	Box 33b w/ ZZ qualifier preceding the taxonomy code	Box 81cc A w/ B3 qualifier
Rendering Provider Taxonomy Code – required on Professional claims when Rendering Provider information is submitted at the claim and/or service line level	2310B, PRV03 (claim level) 2420A, PRV03 (service line level)	Box 24J shaded area w/ ZZ qualifier in Box 24I	N/A
Attending Provider Taxonomy Code - required on Inpatient Institutional claims	2310A, PRV03	N/A	Box 76 w/ B3 qualifier

Claims P.O. Box Requirements

Rejected for the below reasons must be resubmitted with the necessary information

BCBSTX Medicaid STAR/CHIP & STAR Kids Claim Requirements	Electronic Claims	CMS-1500 Claim Form	UB-04 Form Locator
Atypical Providers – If NPI is not submitted, provider must submit their assigned API number	Billing Provider Secondary Identification Loop 2010BB, REF01 (G2 qualifier) 2010BB, REF02 (API Number)	Box 19 w/G2 qualifier followed by API Number	Box 57 w/G2 qualifier followed by API Number
Billing Provider NPI – required on all claims (excluding Atypical Providers)	2010AA, NM109	Box 33a	Box 56
Rendering Provider NPI – required on Professional claims when the Rendering Provider is different from the Billing Provider	2310B, NM109 (claim level) 2420A, NM109 (service line level)	Box 24J Unshaded area	N/A
Attending Provider NPI – required on Inpatient Institutional claims	2310A, NM109	N/A	Box 76
Billing Provider Address – required on all claims. Should contain the physical address, not a P.O. Box or Lock Box	2010AA, N301/N302	Box 33	Box 1

Submitting Claims
Road to get claims paid quickly:
Benefits of Electronic Data Interchange (EDI) and Claims Portals

Timely Filing Limit: 95 calendar days from the date of service or per provider agreement or contract

- **Convenient expedited claims processing**
- **Able to confirm, correct errors, and resubmit batch status electronically**
- **Portals/EDI Vendors**
- **TMHP Claims Portal**
- **Availity® Essentials**
- **HIPAA compliant and meet federal requirements**

Paper Claims Submission

- Paper Claims
- Professional = CMS – 1500
- Institutional = CMS – 1450
- **Paper Claims Address**:
  Blue Cross and Blue Shield of Texas
  P.O. Box 51422
  Amarillo, TX 79159-1422

Electronic Claim Submission

- Electronic Data Interchange (EDI)
- Electronic Payor ID: 66001

Electronic Claim Submission via Availity Provider Portal

Availity Provider Portal

Availity's Claim Submission tool allows providers to quickly submit electronic Professional (ANSI 837P) and facility, or Institutional (ANSI 837I) claims or encounters to Blue Cross and Blue Shield of Texas (BCBSTX), at no cost. Use this online tool to submit a single claim or add to batch and send multiple claims to BCBSTX at the same time. Once submitted, you can confirm BCBSTX's receipt of the claim(s) and check claim status in real-time, all within the Availity Portal.

You must be registered with Availity to use the Claim Submission tool for electronic professional. You can sign up today at Availity, at no charge. For registration assistance, call Availity Client Services at **1-800-282-4548.** This Availity Portal option does not require the use of a separate clearinghouse or practice management system.

How to access and use Availity's Claim Submission tool:

1.Log in to Availity
2. Select **Claims & Payments** from the navigation menu
3.Select **Professional Claim** or **Facility Claim**
4.Within the tool, select your **Organization, Transaction Type and Payer**
5.Complete the required fields
For additional details, refer to the **Electronic Professional Claim Submission User Guide**

Claims Status Tool via Availity Provider Portal

Availity Provider Portal

The Availity Claim Status Tool is the recommended electronic method for providers to acquire detailed claim status for claims processed by Blue Cross and Blue Shield of Texas (BCBSTX) for the following members:

Government Programs –including Texas Medicaid Providers can improve their accounts receivable and increase administrative efficiencies by utilizing the Claim Status tool to check status online for all your BCBSTX patients. Results are available in real-time and provide more detailed information than the HIPAA-standard claim status (276/277 transaction).

Quick Reference for Availity's Claim Status Tool:

Quick Reference:
→ Refer to page 7 to view claim status results for government programs claims
→ Refer to page 8 and 9 to view basic HIPAA-standard claim status results (276/277 transaction)

For additional details, refer to the **Electronic Professional Claim Status User Guide**

ERA/EFT

- Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

  - The EFT option allows claims payments from BCBSTX to be deposited into a designated bank account.
  - ERA delivery allows providers to receive claim payment and remittance details from BCBSTX. Providers can receive these remittance advices through their preferred clearinghouse or software vendor.
  - Use Availity® Essentials to enroll for EFT and ERA delivery from BCBSTX. Learn how to enroll by referring to the EFT & ERA Enrollment User Guide.
  - Questions? Email our Electronic Commerce Services at ecommerceservices@bcbstx.com.

Submitting Claims

Third Party Liability (TPL) 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
- Claims should be submitted on paper with TPL or COB attached:
  - Third Party Remittance Advice (RA)
  - Third party letter explaining the denial or coverage or reimbursement
  - THSteps claims are not required to be billed to other insurance (OI). We pay these as primary.

Claims Information

- 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 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)

Submitting Claims cont.

Claims Status Inquiry and Follow up

- Claim Status Inquiry:
  www.availity.com or IVR for disposition
  Claim Status Tool.pdf
  - **Medicaid (STAR)/CHIP** Customer Service **1-877-560-8055**
  - **STAR Kids** Customer Service **1-877-784-6802**
  - Initiate follow-up action if no response after 30 business days
  - 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 rep will perform the following:
  - Research the status of the claim
  - Advise of necessary follow-up action if any

Claims Forms On Medicaid Website

www.bcbstx.com/provider/medicaid/forms.html

- Provider Appeal Request Form
- Reconsideration Request Form
- Claims Status Request Form
- DME Request for Claims Status
- DME Review Request Form

Forms Submission and Process

- Complete the appropriate fields (*) on the forms
- Submit the claim form via email:
  TexasMedicaidNetworkDepartment@bcbstx.com

- Claim Forms Review Process:
  - Leadership reviews each claim form
  - Assigned and researched by staff
  - Denial reason is researched:
    - Educates how to correct the claim
    - Submits claim for reprocessing

Submitting Appeals

Filing a Standard Appeal:

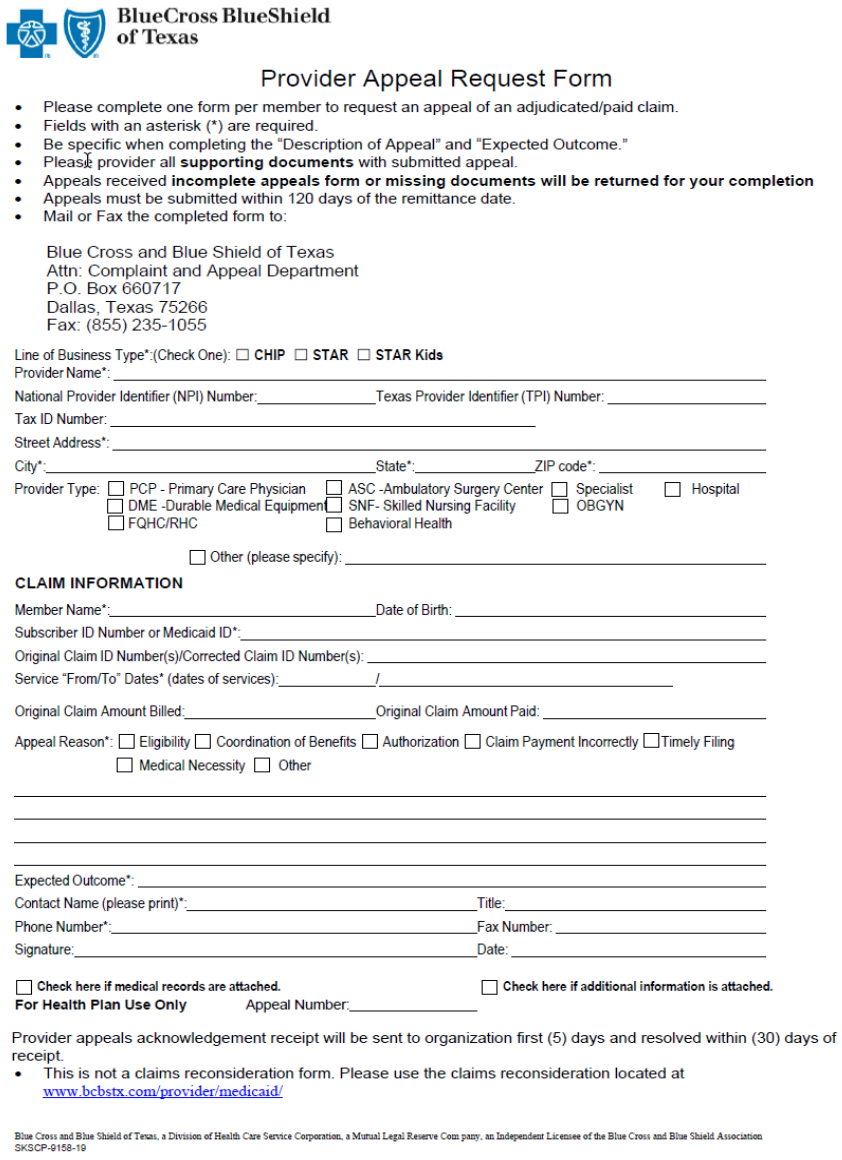
An Appeal is defined as a request for review of an action or adverse determination, which is any denial, reduction, or termination of benefits in whole or in part.

Within **60 Calendar** days of the notice date on an action letter advising of the adverse determination, a Member or Provider may file an appeal.

Appeals and Resolved Dates:
Within **5 Business** days Acknowledgement letter sent to providers
Within **30 Calendar** days (standard appeal) unless extension is needed
Within **72 hours** (emergency appeals)
Within **1 working day** (if a request for continued stay)

Submit an Appeal, State Fair Hearing or External Medical Review request by calling:
A Customer Advocate at **1-888-657-6061 (711)** as first option
A Member Advocate at **1-877-375-9097 (711)**

Provider Appeal Request Form



BlueCross BlueShield of Texas

Provider Appeal Request Form

- Please complete one form per member to request an appeal of an adjudicated/paid claim.
- Fields with an asterisk (*) are required.
- Be specific when completing the "Description of Appeal" and "Expected Outcome."
- Please provider all **supporting documents** with submitted appeal.
- Appeals received **incomplete appeals form or missing documents will be returned for your completion**
- Appeals must be submitted within 120 days of the remittance date.
- Mail or Fax the completed form to:

Blue Cross and Blue Shield of Texas
Attn: Complaint and Appeal Department
P.O. Box 660717
Dallas, Texas 75266
Fax: (855) 235-1055

Line of Business Type*:(Check One): ☐ **CHIP** ☐ **STAR** ☐ **STAR Kids**
Provider Name*: _____
National Provider Identifier (NPI) Number:_____Texas Provider Identifier (TPI) Number: _____
Tax ID Number: _____
Street Address*: _____
City*:_____State*:_____ZIP code*: _____
Provider Type: ☐ PCP - Primary Care Physician ☐ ASC -Ambulatory Surgery Center ☐ Specialist ☐ Hospital ☐ DME -Durable Medical Equipment ☐ SNF- Skilled Nursing Facility ☐ OBGYN ☐ FQHC/RHC ☐ Behavioral Health

☐ Other (please specify): _____

CLAIM INFORMATION

Member Name*:_____Date of Birth: _____
Subscriber ID Number or Medicaid ID*:_____
Original Claim ID Number(s)/Corrected Claim ID Number(s): _____
Service "From/To" Dates* (dates of services):_____/_____
Original Claim Amount Billed:_____Original Claim Amount Paid: _____
Appeal Reason*: ☐ Eligibility ☐ Coordination of Benefits ☐ Authorization ☐ Claim Payment Incorrectly ☐ Timely Filing ☐ Medical Necessity ☐ Other

_____
_____
_____
_____

Expected Outcome*: _____
Contact Name (please print)*:_____Title:_____
Phone Number*:_____Fax Number: _____
Signature:_____Date: _____

☐ **Check here if medical records are attached.** ☐ **Check here if additional information is attached.**
For Health Plan Use Only Appeal Number:_____

Provider appeals acknowledgement receipt will be sent to organization first (5) days and resolved within (30) days of receipt.

- This is not a claims reconsideration form. Please use the claims reconsideration located at www.bcbstx.com/provider/medicaid/

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Com pany, an Independent Licensee of the Blue Cross and Blue Shield Association
SKSCP-9158-19

Submitting Claims Reconsideration

Claims reconsideration is review of a claim for payment reconsideration. Claims are either rejected at the EDI gateway, or the claims is adjudicated in our claim system for payment reconsideration.

Provider or authorized representative can file a claims reconsideration.

Deadlines:
95 days from initial timely filing
120-day claims reconsideration deadline from date of first denial

What must be included with submission
Certain claims must be sent with accompanying documentation for a claim to be reconsidered:
•Reconsideration Request Form
•Primary Insurance EOB
•Sterilization forms
•Invoice/MSRP
•Itemized bill
•Unlisted procedure code/procedure code documentation
•Medical records related to a claim denial

Email completed form and all attachments to:
Blue Cross and Blue Shield of Texas
Claims Reconsiderations
Texas Medicaid Network Department
Email: TexasMedicaidNetworkDepartment@bcbstx.com

Claims Reconsideration Request Form

BlueCross BlueShield of Texas

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:
- Primary insurance EOB
- Invoice/MSRP
- Itemized bill (when required)
- Unlisted procedure code/ procedure code documentation
- Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- Claim was denied for no authorization, but authorization number _____ was obtained.
- Claim was denied due to lack of Texas Provider Medicaid enrollment. The TPI is: _____
- Claim was not paid per contracted rate with BCBSTX. My contracted rate with BCBSTX is _____ the terms of my contract with BCBSTX Plans. Please explain and advise of your payment expectation/amount:
  _____
  _____
- Claim was denied due to member ineligible however, member was effective for date of service rendered ____
  _____
  _____
- Other. Please explain.
  _____
  _____
  _____
- ☒ **Check box if this Reconsideration Request is for multiple claims.** Please attach a separate list if more than one claim number and/or member ID is related to this reconsideration request.

Provider Name	Provider Tax ID
Provider NPI	Original Payment Received
BCBSTX Claim Number*	Dates of Service*
Member Name*	Member ID*

Email completed forms and all attachments to:

Blue Cross and Blue Shield of Texas
Claims Reconsiderations
Texas Medicaid Network Department
Email: TexasMedicaidNetworkDepartment@bcbstx.com.

Contact name & number of person responsible for reconsideration _____ ___

BCBSTX

Submitting Fair Hearing

State Fair Hearings and External Medical Reviews:
A STAR or STAR Kids member who is not satisfied with the decision made on the appeal can request a State Fair Hearing with or without an External Medical Review. A request must be submitted within 120 days from the notice of adverse determination (CHIP members can request an IRO).
Appeals, State Fair Hearings and External Medical Review request forms can be submitted to: Blue Cross and Blue Shield of Texas Attention: Appeal Department P.O. Box 660717 Dallas, TX 75266-0717 Fax: **1-855-235-1055** Email: **GPDTXMedicaidAG@bcbsnm.com**.
Find plan specific complaints, appeals, State Fair Hearing and External Medical Review forms at the respective member site. **www.bcbstx.com/starkids** **www.bcbstx.com/chip** **www.bcbstx.com/star**

Submitting a Member Complaint

A Complaint is defined as any expression of dissatisfaction about any matter related to BCBSTX except for an action or an adverse determination (i.e., any denial, reduction, or termination of benefits in whole or in part denial of services).

A member or provider or authorized representative can file a complaint.

A complaint can be **filed anytime**.

Within 30 Calendar days of receipt of complaint, it must be resolved.

Note: If the member is a minor or incapacitated, the parent, guardian, conservator, relative or other designee of the member, as appropriate, may submit the complaint.

Ways to Submit Complaints:
Call a Customer Advocate at
1- 888-657-6061 STAR and CHIP
1-877-688-1811 STAR Kids
submit in writing to:

Call a BCBSTX Member Advocate toll free at 1-877-375-9097 (711).

Return the **Complaints form** to:
Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Dept.
P.O. Box 660717
Dallas, TX 75266-0717
Fax: 1-855-235-1055

Call the Managed Care Help Line: 1-866-566-8989 (toll free).

Texas Health and Human Services Commission
Office of the Ombudsman,
MC H-700
P.O. Box 13247
Austin, TX 78711-3247
Fax: 1-888-780-8099 (toll-free)

Note: For more information on how a member can submit a complaint:
HHSC Member Complaints

Submitting a Provider Complaint

Physician and other professional provider complaints and appeals are classified into categories for processing by BCBSTX as follows:

Complaints relating to the operations of BCBSTX.

Physician and other professional provider appeals related to Adverse Determinations.

Physician and other professional provider appeals of non-medical necessity claims determinations.

Ways to Submit Complaints:
Calling Customer Service at
1- 877-560-8055 STAR and CHIP
1-877-784-6802 STAR Kids
submit in writing to:

Texas Health and Human Services Commission Provider Complaints
Health Plan Operations, H320
P.O. Box 85200
Austin, TX 78708

Complaints may also be emailed to:
HPM_complaints@hhsc.state.tx

CHIP care providers:
Texas Department of Insurance (TDI)
Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149104
Austin, TX 78714 -9104
Complaints may also be emailed
ConsumerProtection@tdi.state.tx.us

BlueCross BlueShield of Texas

Physician and Mid-Level Billing

Type of Billed Services

- CMS-1500 Professional Services
  - Physician and Mid-level services
  - Specific Ancillary Services
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Audiology
    - Ambulance
    - Free Standing ASCs
    - Durable Medical Equipment
    - Dietician

Submit Electronic and Paper Claims

- 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 claims
  - Rendering NPI field 24J and Billing NPI field 33a*

- Electronic claims
  - 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**

BlueCross BlueShield of Texas

Texas Health Steps

Frew et al vs. Traylor et al
Consent Decree and Corrective Actions

- Class action lawsuit that alleged Texas Medicaid failed to ensure children access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) through Texas Health Steps (THSteps) services.
- Some of the Requirements:
  - TX Health Steps Benefits
  - Medical Checkup Periodicity Schedule
  - Immunization Schedule
  - Texas Health Steps Provider Outreach Referral Form (website: https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/forms)
    - Scheduling a follow-up visit
    - Rescheduling a missed appointment
    - Scheduling transportation to an appointment
    - With other outreach services
  - Children of traveling farm workers

Texas Health Steps (THSteps)

- THSteps is a program that includes both preventive and comprehensive care services.
- For preventive, use the following guidelines: For acute care services and THSteps and CHIP preventive visits performed on the same day:
  - Claims must be billed separately
  - Modifier 25 to describe the circumstances in which an acute care visit was provided at the same time as a Texas Health Steps visit
  - Modifier 25 must be billed on the acute care visit and not the THSteps 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 11c (Benefit Code is not required for CHIP preventive claims)
- Texas Health Steps Quick Reference Guide (www.tmhp.com/programs/thsteps)
  - Diagnosis codes: Z0000, Z0001, Z00110, Z0011, Z00121, Z00129
  - Diagnosis code: Z23 for Immunizations

Texas Health Steps (THSteps) 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 a THSteps Checkup within 60 days beyond the periodic due date based on the Member's birth date
- Existing Members ages three years and older are due annually, considered timely if THSteps Checkup occurs no later than 364 calendar days after the child's birthday
- 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

Texas Health Steps (THSteps)
Mental Health Screening Procedure Codes

Mental Health Screening in adolescents two codes:

- 96160
- 96161

Required once for all clients ages 12-18

Only one procedure code reimbursed per client per calendar year

Postpartum Depression Screening:

- G8431
- G8510

Only one procedure reimbursed per client

Texas Health Steps (THSteps), 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 (Care Coordination provided by BCBSTX Effective 6/27/2022)

Texas Health Steps (THSteps) Benefit Code

- Benefit Code is an additional data element used to identify various state programs
- Claims will deny if Benefit Code is not included
- For CHIP, STAR and STAR Kids use the appropriate Benefit Code:
  - HCFA-1500 paper claim: box 11
  - Electronic claims: SRB Loop 2000B, SBR03 qualifier field
- Providers who participate in the following programs will use the associated Benefit Code when submitting claims
  - EC1-Early Childhood Intervention Providers (ECI)
  - EP1-Texas Health Steps Medical Provider

Texas Health Steps (THSteps)

- 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 the TMHP website: https://www.dshs.texas.gov/immunize/tvfc/default.shtm
  - BCBSTX will only reimburse the administration fee for any vaccine available through the TVFC program
  - Only time a provider is reimbursed 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

BlueCross BlueShield of Texas

Children and Pregnant Women (CPW) Billing

Children and Pregnant Women (CPW)

CPW Contracted Case Managers will not require authorizations for procedure code G9012 and the following modifiers used for all CPW services. Modifiers are used to identify which service component is provided. Please refer to the table below for coding requirements:

Service	Coding Requirements
Comprehensive Visit (in person)	G9012 with modifiers U2 and Modifier U5
Comprehensive Visit (synchronous audio-visual)	G9012 with modifiers U2, U5, and 95
Follow-up visit (in person)	G9012 with modifiers U5 and modifier TS
Follow -up visit (synchronous audio-visuals)	G9012 with modifiers U5, TS, and 95
Follow-up visit telephone (audio-only)	G9012 with modifiers TS and 93
Reminder: Billable services are defined in program rule 25 TAC 27.11.	

BlueCross BlueShield of Texas

OB/GYN Billing

Billing OB/GYN Claims

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

59409	• Vaginal Delivery only
59410	• Vaginal Delivery only (including postpartum)
59612	• Vaginal Delivery only, after previous cesarean delivery
59514	• C-Section only
59515	• Cesarean Delivery only (including postpartum care)
59614	• Vaginal Delivery only, after previous cesarean delivery (including postpartum care)
59620	• C-Section only, following attempted vaginal delivery after previous cesarean delivery
59622	• C-Section only, following attempted vaginal delivery after previous cesarean delivery (including postpartum care)
59430	• Vaginal Delivery, Antepartum and Postpartum Care

Billing OB/GYN Claims
CHIP Perinate

- CHIP Perinate Mothers are entitled to a maximum of 2 postpartum visits.
- CHIP Perinate Mothers' 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 Maternity Claims

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 diagnoses	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 tests) 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.

Billing Maternity Claims (Cont'd)

- If a member is admitted to the hospital during 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 OB/GYN 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.

- Limited to a maximum of 21 doses per pregnancy

- When submitting claims use the following code:
  - J1725 U1 with NDC – Compounded Version
  - J1725 with NDC – Trademarked Version (Makena)
  - Diagnosis Codes: O09211, O09212, O09213, O09219

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/resources/forms.
- Claims will deny if the Sterilization consent form is not included with the claim.

BlueCross BlueShield of Texas

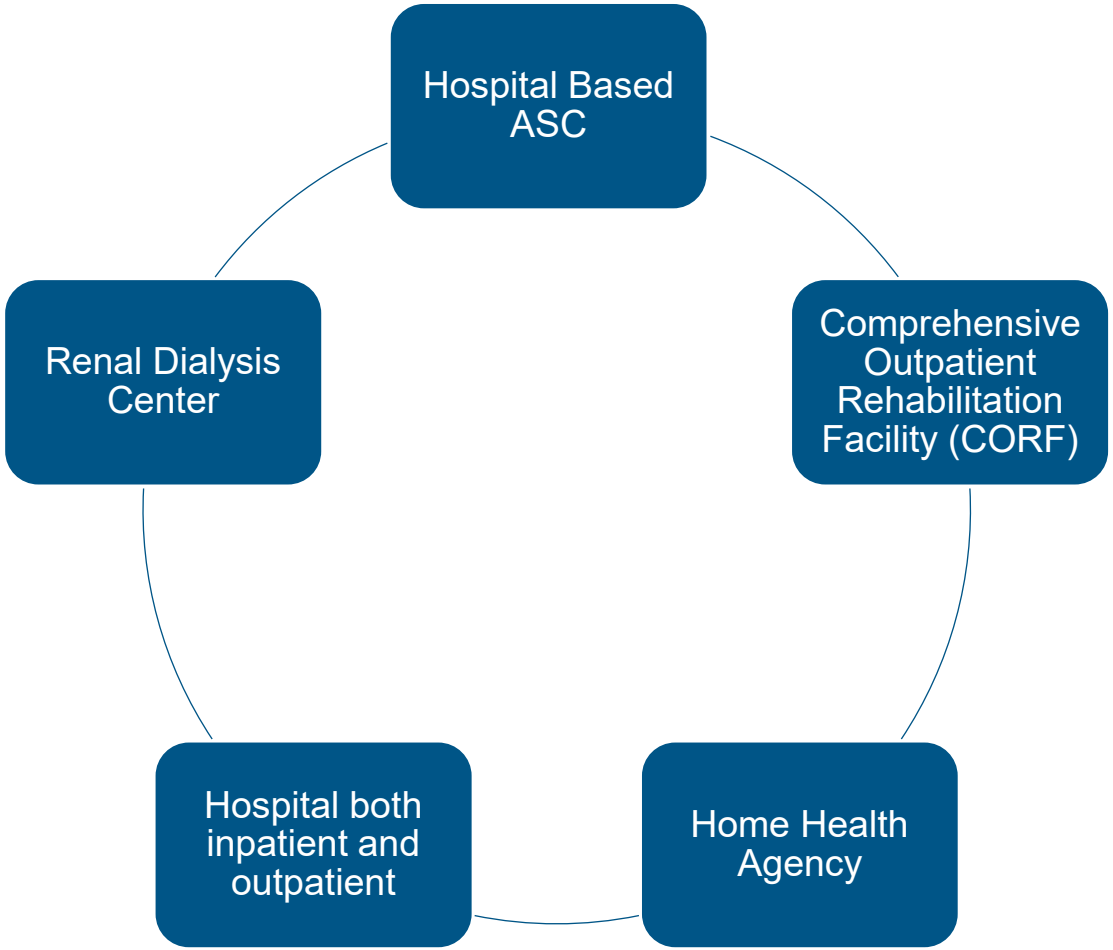
Ancillary Services

Ancillary Services

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

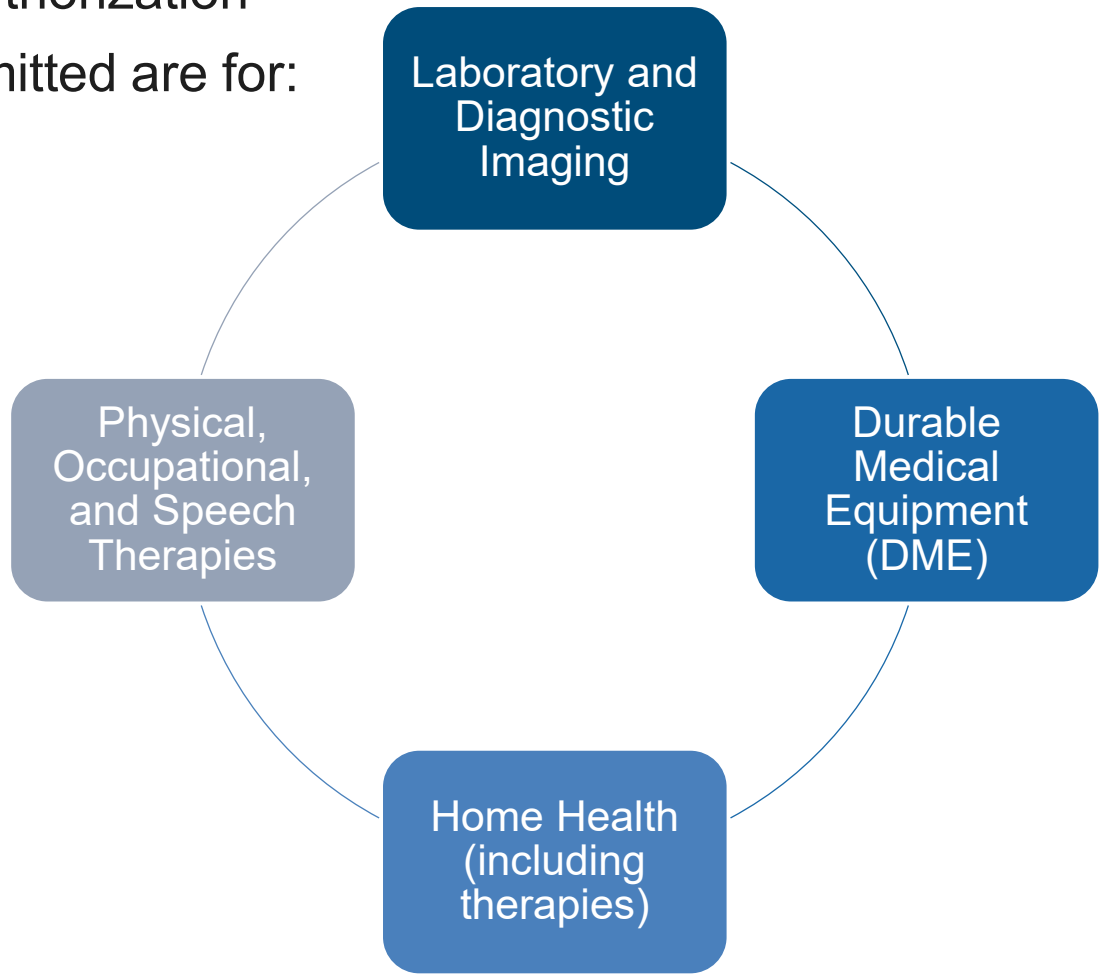
Ancillary Services Cont'd

Providers who will use CMS-1450 (UB-04) include:



Ancillary Services Cont'd

- In general, no additional documentation or attachments are required for services that do not require prior authorization
- Most Ancillary claims submitted are for:



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, STAR Kids and CHIP 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 supply invoices for Average Wholesale Price (AWP)/ Manufacture Suggested Retail Price (MSRP) pricing

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)
- Additional modifiers should also be billed with the Therapy Codes UB/U5 to denote the provider type billing service.

Ancillary Services – PT/OT/SP Therapies

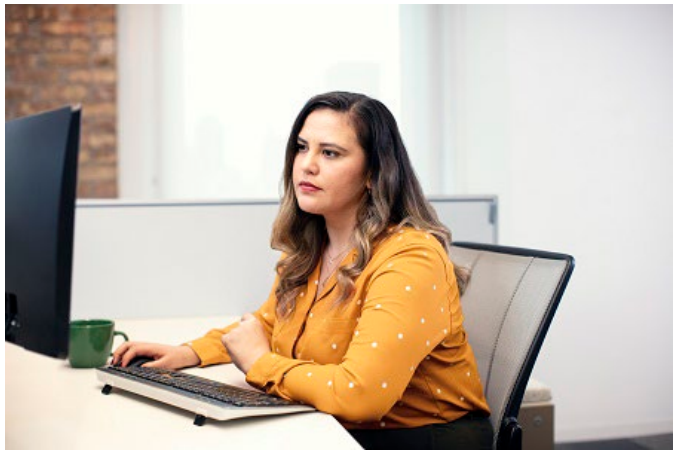
- Independent/ group therapists providing PT/OT/SP services in an office, clinic setting, or outpatient setting must bill on a CMS-1500 form
- Initial visits do not require prior authorization
- Additional services and re-evaluations require authorization, and the authorization number must be included 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

BlueCross BlueShield of Texas

Medical Management Overview

Utilization Management

BCBSTX Utilization Management (UM) Team collaborates with providers to promote and document the appropriate use of health care resources.



Utilization Management takes a multidisciplinary approach to help provide access to health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria and the community standards of care.

Authorization is based on medical necessity and will be contingent upon eligibility and benefits. It is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications with the exception of Texas Health Steps Service for children from birth through 20 years of age. For these services, medical necessity is based on the clinical documentation received by the utilization management department when requesting a prior authorization.

Providers may call Utilization Management toll-free for **STAR and CHIP** at **1-877-560-8055 and STAR Kids at 1-877-784-6802** with questions and/or requests, including requests for urgent/expedited prior authorization and urgent concurrent/continued stay review. An on-call nurse will provide assistance with any urgent after hours needs.

Utilization Management attempts to return calls the same day they are received during normal business hours. Calls received after normal business hours will be returned the next business day. All routine requests will be responded to within **24 hours**.

Providers may fax Utilization Management for **STAR and CHIP** to **1-855-653-8129 and STAR Kids to 1-866-644-5456** with requests for urgent/expedited and non-urgent prior authorization and concurrent/continued stay review. Faxes are accepted during normal business hours as well as after hours. Faxes received after hours will be processed the **next business day**.

Eligibility verification, benefits, and network information may be available after normal business hours at **www.availity.com**.

Services Not Requiring a Prior Authorization

In-Network services not requiring a prior authorization

- Diagnosis and treatment of sexually transmitted diseases
- Testing for the Human Immunodeficiency Virus (HIV)
- Family Planning services to prevent or delay pregnancy
- Behavioral Health Outpatient Services
- Annual Well Women exam
- Prenatal services
- Texas Health Steps
- **Additional Services may apply**

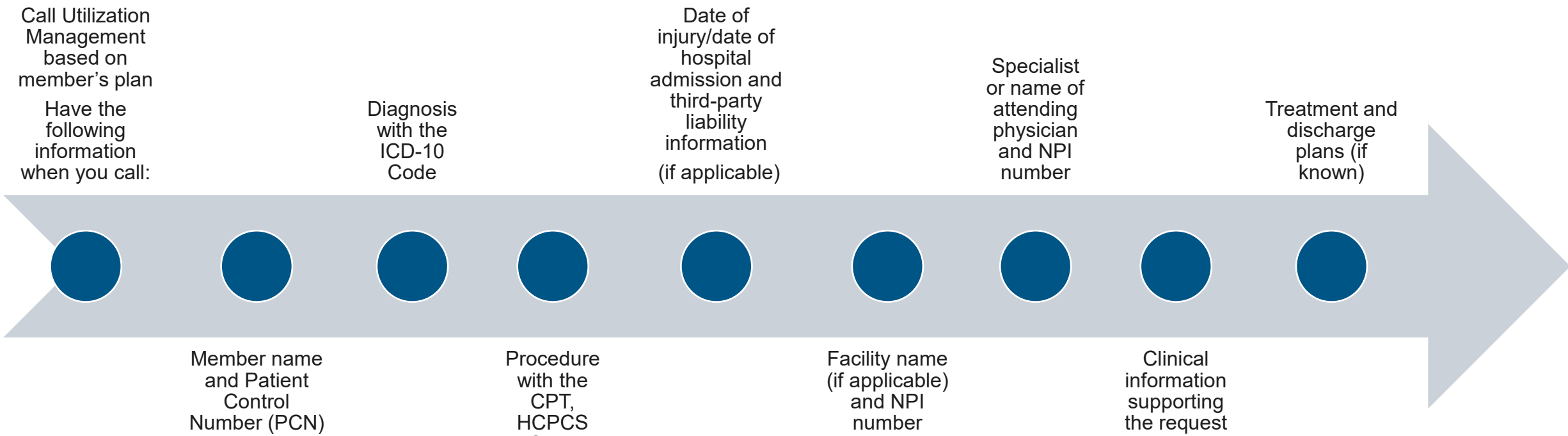
eviCore healthcare (eviCore)® Prior Authorizations

Using eviCore

Providers initiate prior authorization for certain services through our BCBSTX partner eviCore.	24/7 Availability to submit prior authorizations request and check status via online	To register and receive training using eviCore, please contact your BCBSTX Provider Representative.	Prior Authorization Call Center: 7:00am- 7:00pm M-F, **1-855-252-1117** Website: www.evicore.com Web Based Services: portal.support@evicore.com **1-800-646-0418 Option 2** Client Providers Operations: clientservices@evicore.com	Providers seeking Prior Authorizations for the following types of services will be required to use eviCore: 1. Radiology 2. Medical Oncology 3. Molecular Genetics 4. Musculoskeletal (OT, PT, ST, Chiro, Joint, and Pain) 5. Radiation Therapy 6. Sleep 7. Specialty Drug

Note: eviCore does not process claims.

Submitting a Prior Authorizataion



Time Frames:

24 Hours

Concurrent Stay requests (when a member is currently in a hospital bed)

3 Business Days

Prior authorization routine requests (before outpatient service has been provided)

1 Hour

Urgent prior authorization requests are initiated before outpatient services have been provided and are reviewed within this time frame.*

Phone Numbers:

- STAR/CHIP: **1-877-560-8055**
- STAR Kids: **1-877-784-6802**

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

Note: BCBSTX Prior Authorization form or the Standard Authorization form must be included with submission.

BlueCross BlueShield of Texas

Magellan Behavioral Health Overview

Magellan Care Management Center

Member and provider hotlines:

STAR/CHIP: 1-800-327-7390 (including after hours support)

STAR Kids: 1-800-424-0324 (including after hours support)

- Authorizations
- Assistance with discharge planning
- Claims inquiries
- Effective 6/27/2022 – Care Coordination handled by BCBSTX

Magellan Member and Provider Support Available

Provider relations support through Provider Services Line (PSL) and through Texas based Field Network Provider Relations Team

- PSL **1-800-788-4005**

Online resources available
www.magellanprovider.com

- Includes member and provider education materials

Provider Responsibilities for Behavioral Health

Precertification is required for mental health and substance abuse services for STAR, STAR Kids 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

Contact Magellan if during the course of treatment, you determine that services other than those authorized are required

Provide Magellan with a thorough assessment of the member

Submitting Claims for Behavioral Health

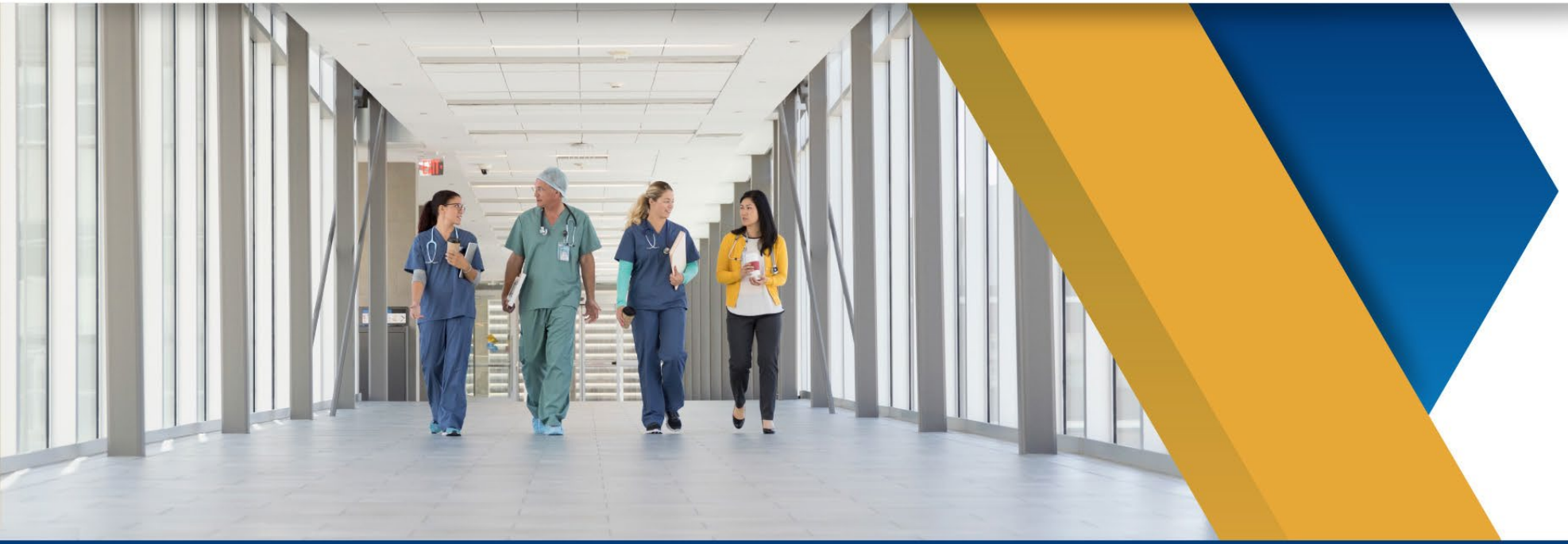
Electronic Claims submission via www.magellanprovider.com or through a clearinghouse

When submitting claims electronically, use submitter ID #01260

Mailing Claims:

Magellan's Claims Address
Magellan Health Services
Attn: Claims
P.O. Box 2154
Maryland Heights, MO 63043

BlueCross BlueShield of Texas



Therapy Billing

Claim Form Requirements

- CMS-1500 Claim Form:
  - Individual Therapy Providers and Non-Outpatient Rehabilitation Facilities (ORF)/Comprehensive Outpatient Rehabilitation Facilities (CORF)Therapy Clinics
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy

- CMS-1450 (UB-04) Claim Form:
    - Outpatient Hospital Therapy Clinics
    - Comprehensive Outpatient Rehabilitation Facilities (CORF)
    - Outpatient Rehabilitation Facilities
    - Home Health Agencies

Therapy Policy and Billing Guidelines

- Medicaid reimbursement provided for therapy services:
- The Physical Therapy, Occupational Therapy, and Speech Therapy Handbooks are currently published on the TMHP website www.tmhp.com and contains information regarding benefit limits, therapy policies and guidelines.
- Accepted coding principles followed
- Additional information and resources located in Blue Cross and Blue Shield of Texas Medicaid (STAR), CHIP and Star Kids Provider Manual www.bcbstx.com/provider/medicaid/education-and-reference/education-reference

Taxonomy Requirement

- Taxonomy Code submitted must match the one submitted and attested by the State Medicaid Agency for the submitted National Provider Identifier (NPI)/ Atypical Provider Identifier (API)
- Confirm taxonomy and resubmit any rejected claims
- Solo providers must use rendering NPI and taxonomy in both box 24J and 33a

Common Denial Reasons

- Provider sanction status
- Missing or invalid modifier
- Incorrect place of service and modifier placement for Telehealth Claims
- Missing or invalid authorization
- Invalid Diagnosis Code

Provider Relations Representative

- Education and Training
- Assistance with problem claim resolution and locate forms on our website:
  - Claims Resolutions forms: www.bcbstx.com/provider/medicaid/forms.html
- Assistance with provider attestation issues
- Answer questions regarding program guidelines and claims filing

- Contact:
  - Call 1-855-212-1615
  - Email: TexasMedicaidNetworkDepartment@bcbstx.com.
  - Website: www.bcbstx.com/provider/medicaid/network-participation/network-participation

Disclaimers

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