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

- History
- Customer Service Overview
- Claims and Billing Overview
- Ancillary Billing
- Medical Management Overview
- Authorization Process
- Provider Resources
- Case Management Referral Process
History
Blue Cross and Blue Shield Texas strives to make the right connections between members, providers, and the community for our Medicaid (STAR) and CHIP members’ better health.

- Develop strong collaborative relationships with our provider/partners
- 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 is one of the plans selected to administer the Medicaid (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
Customer Service
Customer Call Center

- 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

<table>
<thead>
<tr>
<th>Inquiries</th>
<th>Web Portal</th>
<th>Customer Call Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Verification</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Claims Inquiries</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Benefit Verification</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Primary Care Physician Assistance</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Interpreter/Hearing Impaired Services</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
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
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
  - 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
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
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 Effective Date: <EFF DT>
Rx Group No.: <RX_GROUP2>
Rx BIN: 011552
Rx PCN: TXCAID
PBM: PRIME

PCP: <PCP_NAME> <PCP_PHONE>

bcbsTX.com

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

24-Hour Nurse Line/Línea de ayuda de enfermería
disponible las 24 horas:
TTY: 1-844-971-8906
711

Prescription Drug/Medicamentos Recetados:
TTY: 1-888-657-6061
711

Behavioral Health Services Hotline/
Behavioral Health Line Direct Care Services:
24 hours/7 days a week
TTY: 1-800-327-7899
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>
Examples of BCBSTX identification cards

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

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>

CHIP alpha prefix: ZGC
Examples of BCBSTX identification cards

CHIP Perinate

Member Name: <F_NAME M_INIT L_NAME>
Alpha Prefix: ZGE
Subscriber ID: <SSBI_ID>
CHIP ID No: <CHIP ID No.>

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

PBP/NA

CHIP Perinate NB

For CHIP Perinate newbook with co-payment on cost-sharing for covered services

Member Name: <F_NAME M_INIT L_NAME>
Alpha Prefix: ZGE
Subscriber ID: <SSBI_ID>
CHIP ID No: <CHIP ID No.>

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

PBP/NA

bcbs.com/Medicaid

Customer Care Association of Clients
Alphabetical Prescription Drug list
24 hours/7 days a week
1-844-657-0601

Prescription Drug
MedICATION: ZGE
toll free: 1-844-657-0601

Behavioral Health Services
Toll free: 1-855-227-7298

Provider Directory
Toll free: 1-844-657-0601

Hospitals Facility Billing
1-800-822-3285

For emergency care received outside of Texas, hospital and physicians should file claim to the local BCBS plan.

CHIP Perinate alpha prefix: ZGE
Claims and Billing Overview
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”.

- National Drug Code (NDC)* for physician-administered prescription drugs.
Type of Billed Services

- **CMS-1500 Professional 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
  - 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

- 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
Submitting Claims

- Ensure Member’s date of birth is correct prior to submission
  - DOB is included in the pre-adjudication membership validation process

- Duplicate Claim Identification
  - Duplicate claim identification is included in the pre-adjudication process
  - Rejected with message: “Duplicate of Previously processed 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)
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)

- 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](mailto:GPDTXMedicaidAG@bcbsnm.com)

**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 advices through their clearinghouse. Enrollment is required
- Contact EDI Services at 1-800-746-4614 with questions or to enroll
- [http://www.bcbstx.com/provider/claims/era.html](http://www.bcbstx.com/provider/claims/era.html)
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
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
- Pharmacies with DME
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.
- Use miscellaneous codes (such as E1399) when a HCPCS code does not exist.
- Attach manufacturer’s invoice if using a miscellaneous code.
- Catalog pages are not acceptable as a manufacturer’s invoice.
- Sales tax must be billed separately from the service code (do not include in the rental or purchase amount charged).
- L9999 is used to bill sales tax.
Ancillary Services

- Provider must reduce, cancel, or stop delivery at the Member’s or the Member’s authorized representative’s written or oral request. The Provider must maintain records documenting the request.

- For automated refill orders for covered Products
  - Provider must confirm with the member that a refill or new prescription received directly from the physician should be delivered
  - Provider must complete a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Texas Administrative Code §291.34
  - Member or Member’s LAR must have the option to withdraw from an automated refill delivery program
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)
Independent/group therapists providing PT/OT/SP services in an office, clinic setting, or outpatient setting must bill on a CMS-1500 form.

Initial evaluation does not require Prior Authorization.

Prior Authorization is required for continued services and re-evaluations.

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](http://www.TMHP.com)
Ancillary Services – Cancellation of Product Orders

- Provider must reduce, cancel, or stop delivery at the Member’s or the Member’s authorized representative’s written or oral request. The Provider must maintain records documenting the request.

- For automated refill orders for covered Products
  - Provider must confirm with the member that a refill or new prescription received directly from the physician should be delivered
  - Provider must complete a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Texas Administrative Code §291.34
  - Member or Member’s LAR must have the option to withdraw from an automated refill delivery program
Medical Management Overview
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
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?

To access a list of services that require a prior authorization go to the Medicaid Provider Website at http://www.bcbstx.com/provider/medicaid/forms.html (under Prior Authorization Forms)
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 calendar days**
  - Urgent* requests: within **72 hours**

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

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

- If the request meets criteria, then the nurse will authorize the request
- Nurses review for medical necessity only, and never initiate denial
- If the request does not appear to meet criteria the nurse refers the request to a Peer Clinical Reviewer (PCR) – a.k.a. Physician Reviewer
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](http://www.bcbstx.com/provider/network/medicaid.html)
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
Single Case Agreements

Utilization Management (UM) staff utilize the BCBSTX Network Department to assist with single case agreements for out-of-network contract negotiations.
Retrospective Requests

- The service has already been performed
- Prior Authorization Required on all claims
- Submittal of Medical Records are not accepted in place of Prior Authorization
- No longer accept and review medical records attached to claims in place of required Prior Authorization (PA)
- Claims received for a service requiring PA with medical records attached in place of the required PA, will be denied due to lack of Prior Authorization
Provider Website

➤ The provider website contains resources such as:
  ➤ Access to list of Services Requiring Prior Authorization
  ➤ Access to view Clinical Practice Tools
  ➤ Access to the most current Quick Reference Guide
  ➤ Access to many other very helpful resources and forms

➤ Log on at
  ➤ www.bcbstx.com/provider/network/medicaid.html
Case Management
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.
Referrals to Case Management

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

- By calling Blue Cross and Blue Shield of Texas Case Management
  - 877-560-8055
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 Mid March 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.
Questions?
Thank you for your time!
We look forward to working with you!

Please complete the training evaluation form.