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

Ancillary Provider Training

2012 Provider Training
Agenda

- History
- Customer Service Overview
- Claims and Billing Overview
- Ancillary Billing
- Medical Management Overview
- Authorization Process
- Provider Resources
- Case Management Referral Process
Blue Cross and Blue Shield of Texas (BCBSTX) knows health care coverage in Texas; we invented it. We’re Texas born and bred, and this is the only place we do business. Our mission since our founding more than 80 years ago has been to provide financially sound health care coverage to as many Texans as possible.

Effective March 1, 2012, Blue Cross and Blue Shield Texas will participate in the State of Texas Access Reform (STAR) and Children’s Health Insurance Program (CHIP) programs.

Blue Cross and Blue Shield Texas will strive to make the right connections between members, providers, and the community for our 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 was selected as one of the plans to administer the STAR and CHIP programs for the Texas Health and Human Services Commission (HHSC) in the Travis Service Area
- Other health plans serving in the area include:
  - Sendero Health Plans
  - Seton
  - Superior (Centene) HealthPlan Network
  - Amerigroup-STAR Plus ONLY
  - United Healthcare-STAR Plus ONLY
Travis Service Area

Eight Counties:

- Travis
- Bastrop
- Burnet
- Caldwell
- Fayette
- Hays
- Lee
- Williamson
Leverage our proven health insurance experience - over 80 years - to deliver exemplary quality services to Medicaid and CHIP members and providers.

Selected WellPoint to provide a variety of administrative services to support BCBSTX Travis Service area programs including Pharmacy Benefits Administration via Express Scripts, Inc.

WellPoint brings proven call center capacity, processing technology, full process operations and health, disease and care management programs.

BCBSTX and WellPoint have a long history of working together on a national basis.
Customer Service
Committed to providing excellent service to members and providers

- **Telephone support**
  - Provider: 1-888-292-4487
  - Member: 1-888-292-4480
  - TTY: 1-888-292-4485
  - Monday to Friday
  - 7 a.m. to 6 p.m. CT

- **Web Support at**
  - [www.availity.com](http://www.availity.com)

- **Information and Forms can be found at:**

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*Available through www.availity.com
24/7 Nurse Line

- Information line staffed by registered nurses
  - 1-877-351-8392
  - 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
To Better Serve Our Members and Providers

Members

- Interpreter services at all points of contact
- Interactive Voice Recognition System to quickly identify member language and access an interpreter for the call
- Bilingual documents (English/Spanish) required for all member materials; additional languages as needed

Providers

- Web-based information will be available soon regarding cultural differences and access to interpreter services at: www.bcbstx.com/provider/network/medicaid.html*
  - Cultural Competency Toolkit that covers many topics such as communication styles, health care tradition, cultural beliefs
  - Employee Language Skills Self-Assessment Tool
  - Interpreter Services
  - Interpreter Services Desktop Reference

* Website functionality coming soon
Providers should verify eligibility before each service

Ways to verify STAR and CHIP member eligibility

- Register with Availity at www.availity.com
- Use the State’s Automated Inquiry System (AIS)- for STAR (not CHIP)
  - 1-800-925-9126
- Call the BCBSTX Customer Care Center:
  - Provider: 1-888-292-4487
    - Live person
    - Interactive Voice Response automated telephone response system
- Call the 24/7 Nurse Line after-hours
  - 1-877-351-8392
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
Examples of BCBSTX identification cards
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.

  - Provides a list of NDCs assigned to HCPCS procedure codes.
  - May not contain a complete listing of all NDCs for any given procedure code.
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 or as stated in your provider contract
  - Electronic Submission
    - The BCBSTX required payer identification number is 84980
    - Web submission through Availity
    - TMHP Claim Portal – STAR Claims ONLY

- Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
  - The EFT option allows claims payments to be deposited directly into a previously selected bank account
  - Providers can choose to receive ERAs and will receive these advises through their clearinghouse. Enrollment is required
  - Contact EDI Services at 1-800-746-4614 with questions or to enroll
Submitting Claims Continued

- Bill with the Medicaid/CHIP identification number, (field 1a). The BCBSTX alpha administrative code (X) and the BlueCard alpha prefixes are not required but will allow for more efficient processing, especially in retrieving member eligibility information (270/271 transactions) and claims status information (276/277 transactions). If you are utilizing the State portal only use the Medicaid/CHIP identification Number
  - STAR: ZGTX Medicaid ID number
  - CHIP: ZGCX CHIP ID number
  - CHIP Perinate: ZGEX CHIP Perinate ID number

- Submit paper claims to:
  Blue Cross and Blue Shield of Texas
  ATTN: Claims
  PO Box 684787
  Austin, TX 78768-4787
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).
Provider Appeals

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

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

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

- When will the appeal be resolved?
  - Within **30 calendar days** (**standard claim appeals**) unless there is a need for more time.
  - Within **3 business days** (**expedited UM authorization appeals**) for STAR.
  - Within **1 working day** (**expedited UM authorization appeals**) for CHIP.
Submit an appeal to:

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

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

- Submit request in writing to:
  
  Blue Cross and Blue Shield of Texas
  Attn: Complaints and Appeals Department
  PO Box 684249
  Austin, TX 78768
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 Billing
Providers who will use CMS-1450 (UB-04) include:

- Hospital Based ASC
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Home Health Agency
- Hospital - both inpatient and outpatient
- Renal Dialysis Center
Ancillary Services Continued

- In general, no additional documentation or attachments are required for services that do not require prior authorization.

- The majority of Ancillary claims submitted are for:
  - Laboratory and Diagnostic Imaging
  - Durable Medical Equipment (DME)
  - Home Health (including therapies)
  - Physical, Occupational, and Speech Therapies
  - 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
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 - Home Health

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

- Independent/group therapists providing PT/OT/SP services in an office, clinic setting, or outpatient setting must bill on a CMS-1500 form.

- Prior Authorization will be required for these services, and the authorization number must be included on the claim form.

- Please refer to the Texas Medicaid and Healthcare Partnership for a listing of all applicable coding and limitations.

- Billing information will be found in the Texas Medicaid Provider Procedures Manual on the TMHP website.
  - [www.TMHP.com](http://www.TMHP.com)
Ancillary Services – Pharmacy with DME

- Durable Medical Equipment is a medical benefit that should be billed to BCBSTX not Express Scripts
- Must bill Durable Medical Equipment on a CMS-1500 form
- A prescription is required and a Plan of Care must be included in order to be reimbursed
- Prior Authorization may be required. If required, the authorization number must be included on the claim form
- Prior Authorization is not needed for glucose testing supplies*, ostomy supplies, diabetic supplies, nebulizers and inhalers**, catheters and related supplies (this is not an all inclusive list).
- Additional information can be found in the Texas Medicaid Provider Procedures Manual on the TMHP website
  - [www.TMHP.com](http://www.TMHP.com)

*with limitations  **the medicine required is a pharmacy benefit; the machine is a DME benefit
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: 1-855-879-7178
- Intake fax number: 1-855-879-7180
- Intake fax number for concurrent review: 1-855-723-5102
Intake Department Continued

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

- What service is being requested?
- When is the service scheduled?
- What is the clinical justification?

To access a list of services that require a prior authorization go to the Medicaid Provider Website at www.bcbstx.com/provider/network/medicaid.html (under Medicaid (STAR) and CHIP Preauthorization Information)

To request a copy of Medical Policies and/or UM Clinical Guidelines used to review for medical necessity, call Utilization Management at 855-879-7178 CT, 8AM to 5PM CT, M-F
Please have the following information available when calling the Intake Department at **1-855-879-7178**

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

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

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

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

- Nurses utilize Clinical Guidelines, Medical Policies, Milliman Guidelines, and plan benefits to determine whether or not coverage of a request can be approved
  - If the request meets criteria, then the nurse will authorize the request
  - Nurses review for medical necessity only, and never initiate denial
  - If the request does not appear to meet criteria the nurse refers the request to a Peer Clinical Reviewer (PCR) – a.k.a. Physician Reviewer
Physician Review

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

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

- If denied by the PCR, the UM staff will notify the provider’s office of the denial. Providers have the right to:
  - Request a peer-to-peer discussion with the reviewing physician
    - 1-877-496-0071
  - Appeal the decision
    - Submit an appeal in writing using the Provider Dispute Resolution Form within 120 calendar days from receipt of the Remittance Advice (RA) or notice of action letter.
    - The Provider Dispute Resolution Request Form is located at [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html) (under Medicaid (STAR) and CHIP Forms).
Submitting an Appeal

Submit an appeal to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 684249
Austin, TX 78768
Out-of-Network Contracts

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

- The service has already been performed - medical record documentation needs to be submitted with the claim.
- A UM case will not be started if a retrospective case is called into the Intake Department.
- The Post Service Clinical Claims Review Unit (PSCCR) reviews retrospective cases.
The provider website contains resources such as:
- Access to list of services requiring Prior Authorization
- Access to Prior Authorization Information
- 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
Prior Authorization Information

Contains a list of 13 procedure specific pre-service forms

Request for Preservice Review Form can be found at
  - [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html) (under Medicaid (STAR) and CHIP Preauthorization Requirements)

The provider completes the form and faxes it to the Intake Department at:
  - 1-855-879-7180

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

The authorization list is available online at [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html) (under Medicaid (STAR) and CHIP Preauthorization Requirements)
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.
Providers, nurses, social workers and members, or their representative, may refer members to Case Management in one of two ways:

- Call 1-855-879-7178
- Fax a completed Case Management Referral Form to 1-866-333-4827
  - A Case Manager will respond to the requestor within three business days

The Case Management Referral Form is located at

- [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html) (under Medicaid (STAR) and CHIP Forms)
Texas Case Management Example

A 49 year old, 88 pound woman in end-stage Chronic Obstructive Pulmonary Disease (COPD). Member was referred to CM from a post-discharge call screening following an admission for COPD exacerbation. Co-morbidity of throat cancer which had been diagnosed and treated earlier in the year with chemotherapy and radiation therapy.

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

Please complete and fax the training evaluation form.