Medicaid (STAR), STAR Kids and (CHIP) Claims Billing and Authorization Provider Training
Agenda

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

- Providers must verify eligibility before each service
- Ways to verify STAR, STAR Kids and CHIP member eligibility
  - Call BCBSTX Customer Service Center:
    - **STAR and CHIP:** 877-560-8055
    - **STAR Kids:** 877-784-6802
      - Customer Care Representative
      - Interactive Voice Response automated telephone response system
  - State’s Automated Inquiry System (AIS)- STAR and STAR Kids (not CHIP)
    - 800-925-9126
  - www.availability.com
  - www.passporthealth.com
STAR and STAR Kids members receive two identification cards upon enrollment:

- State issued Medicaid identification card (*Your Texas Medicaid Benefit Card*); this is a permanent card and may be replaced if lost or stolen
- Blue Cross and Blue Shield of Texas member identification card

CHIP members only receive BCBSTX member identification card

Identification cards will be re-issued

- If the member changes his/her address
- If the member changes his/her Primary Care Physician (PCP)
  - The member may change his/her PCP at any time and the change is effective the day of request
- Upon member request
- At membership renewal
Sample Member Identification Cards

STAR Alpha Prefix: ZGT

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

PCP: <PCP_NAME>
PCP PHONE: <PCP_PHONE>

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

BlueCross BlueShield of Texas

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.

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

Claims: PO Box 51422
Amarillo, TX 79119-1422

bcbs.tx.com

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

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

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

Behavioral Health Services Hotline/Behavioral Health Lines Directas:
24 hours/7 days a week
TTY: 1-800-327-7890
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>
Sample Member Identification Cards

STAR Kids alpha prefix: WZG

Member Name: <F_NAMEM_INITL_NAME>
AlphaPrefix: WZG
Subscriber ID: <SBSB_ID>
Medicaid ID Number: <MEME_MEDCD_NO>

PCP: <PCP_NAME>  <PCP_PHONE>

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

Member Name: <F_NAMEM_INITL_NAME>
Alpha Prefix: WZG
Subscriber ID: <SBSB_ID>
Medicaid ID Number: <MEME_MEDCD_NO>

PCP: <PCP_NAME>  <PCP_PHONE>

PCP Effective Date: <EFFDT>
Rx Group No.: <RxGroup2>
Rx BIN: 011552
Rx PCN: TXCAID
PBM: PRIME

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 A LARGO PLAZO Y SERVICIOS DE APOYO ÚNICAMENTE: Usted recibe servicios de atención médica básica, especializada y de salud mental a través de Medicare. Usted solamente recibe los servicios de atención médica a largo plazo a través de BCBSTX.
CHIP Perinate Alpha Prefix: ZGE

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

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

CHIP Perinate

BlueCross BlueShield of Texas

P.C.P./N/A
N/A

bcbx.com/Medicaid

Customer Care/Avance al Cliente
(telefónico 24 horas/7 días a la semana)
1-844-457-4661
TDD 711

Regional Nurse Line/Linea de enfermería regional disponible 24 horas
711

Prescripción Farmacéutica/Prescripción Farmacéutica Regional
TDD 711

Regional Health Services/Robocall
711

Hospital Facility Billing/Tributos de Hospital
800-366-1491

Amtrak, 713-652-4102
Card Issued: <DT>

CHIP Perinate

BlueCross BlueShield of Texas

P.C.P./N/A
N/A

bcbx.com/Medicaid

Customer Care/Avance al Cliente
(telefónico 24 horas/7 días a la semana)
1-844-457-4661
TDD 711

Regional Nurse Line/Linea de enfermería regional disponible 24 horas
711

Prescripción Farmacéutica/Prescripción Farmacéutica Regional
TDD 711

Regional Health Services/Robocall
711

Hospital Facility Billing/Tributos de Hospital
800-366-1491

Amtrak, 713-652-4102
Card Issued: <DT>

Sample Member Identification Cards

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

For emergency care received outside of Texas: Hospital and physicians should file claims in the local BCBS plan.
Attestation

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

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

- Coding (in most cases) will mirror TMHP (Texas Medicaid and Healthcare Partnership) guidelines found in the most current Texas Medicaid Provider Procedures Manual.

- Access the current procedures manual at www.TMHP.com, click on “providers” and then click on “Reference Material”.

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

- CMS Medically Unlikely Edits (MUE) and National Correct Coding Initiative (NCCI) edits located @ www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/
National Drug Code (NDC) Coding

- National Drug Code (NDC) required for all provider-administered medications
  - Includes: Intrauterine devices, hormone patches, vaginal rings, sub dermal implants, and intrauterine copper devices
  - Exceptions: Vaccines from TVFC program, DME, Limited Home Health Supplies (LHHS), and Radiopharmaceuticals

- “How to Submit Claims for Physician Administered Drugs” located at [http://www.bcbstx.com/provider/medicaid/submitting_ndc_claims.html](http://www.bcbstx.com/provider/medicaid/submitting_ndc_claims.html)

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

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

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

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

11-digit NDC, no hyphens

Numeric quantity administered. Include decimal.

Unused spaces for the quantity should be left blank
**Taxonomy Requirement**

- Taxonomy code submitted *must match* the one submitted and approved by the State Medicaid Agency for the submitted NPI / API.
- Confirm taxonomy and resubmit any rejected claims

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

<table>
<thead>
<tr>
<th>Atypical Providers – If NPI is not submitted, provider must submit their assigned API number</th>
<th>Electronic Claims</th>
<th>CMS-1500 Claim Form</th>
<th>UB-04 Form Locator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider Secondary Identification Loop 2010BB, REF01 (G2 qualifier) 2010BB, REF02 (API Number)</td>
<td>Box 19 w/G2 qualifier followed by API Number</td>
<td>Box 57 w/G2 qualifier followed by API Number</td>
<td></td>
</tr>
</tbody>
</table>

| 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 PO Box or Lock Box | 2010AA, N301/N302 | Box 33 | Box 1 |

- Rejected for the above reasons must be resubmitted with the necessary information
Submitting Claims

- Timely filing limit is 95 calendar days from the date of service
- Electronic
  - Payer ID 66001
  - Consult with your clearinghouse to verify the payer ID
- 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
  - WZG: STAR Kids
  - ZGC: CHIP
  - ZGE: CHIP Perinate

- Alpha + 9 digit Medicaid number (preferred)

EX: ZGT123456789

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

- Resubmit corrected claims electronically
  - Payer ID 66001
  - CLM05-3 segment should indicate claims is a voided/corrected claim
- Mail corrected claims to mailing address:
  Blue Cross and Blue Shield of Texas
  PO Box 51422
  Amarillo, TX 79159-1422
Third Party Liability (TPL) or Coordination of Benefits (COB)
- If the claim has TPL or COB or requires submission to a third party before submitting to BCBSTX, the filing limit starts from the date on the notice from the third party.

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

Claim should be submitted on paper with TPL or COB attached
- Third party Remittance Advice (RA)
- Third party letter explaining the denial of coverage or reimbursement
Submitting Claims Continued

- Providers are prohibited from balance-billing CHIP or STAR Medicaid members for covered services

- Claim Filing With Wrong Plan - if you file with the wrong plan and can provide documentation, you have 95 days from the date of the other carrier’s denial letter or Remittance Advice to resubmit for adjudication

- Claim Payment - your clean claim will be adjudicated within 30 days from date of receipt. If not, interest will be paid at 1.5% per month (18% per annum)
Claim Status Inquiry and Follow-Up

Claim status Inquiry
- [www.availity.com](http://www.availity.com)
- Medicaid (STAR) Customer Service @ 877-560-8055
- STAR Kids Customer Service @ 877-784-6802
- Initiate follow-up action if no response after 30 business days
- Check [www.availity.com](http://www.availity.com) or IVR for disposition
- Provide a copy of the original claim submission and all supporting documents to the Claims address

Claim Status Inquiry Payer ID HCSVC

The Customer Service Representative will perform the following functions:
- Research the status of the claim
- Advise of necessary follow-up action, if any
Provider Appeals

_PROVIDERS CAN APPEAL BLUE CROSS AND BLUE SHIELD OF TEXAS’S DENIAL OF A SERVICE OR DENIAL OF PAYMENT_

.Submit an appeal in writing using the Provider Appeal Request Form

- Submit within **120 calendar days** from receipt of the Remittance Advice (RA) or notice of action letter
- **Medicaid STAR and CHIP Provider Dispute Resolution Request**
- **STAR Kids Provider Dispute Resolution Request**
- [www.availity.com](http://www.availity.com)

**WHEN WILL THE APPEAL BE RESOLVED?**

- Within **30 calendar days** (standard appeals) unless there is a need for more time
- Within **3 business days** (expedited appeals) for STAR
- Within **1 working day** (expedited appeals) for CHIP
Submitting An Appeal

> **Mail:**

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 27838
Albuquerque, NM 87125-7838

> **Fax:** 855-235-1055

> **Email appeal:** [GPDTXMedicaidAG@bcbsnm.com](mailto:GPDTXMedicaidAG@bcbsnm.com)

> [www.availity.com](http://www.availity.com)
Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

- The EFT option allows claims payments to be deposited directly into a previously selected bank account.
- Providers can choose to receive ERAs and will receive these advises through their clearinghouse. Enrollment is required.
- Contact EDI Services @ 1-800-746-4614 with questions or to enroll
Type of Billed Services

- CMS-1500 Professional Services
  - Physician and Midlevel services
  - Specific Ancillary Services
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Audiology
    - Ambulance
    - Free Standing ASCs
    - Durable Medical Equipment
    - Dietician
Submitting Electronic Claims

- Texas Provider Identifier (TPI) is not required and may delay adjudication of your claim

- Must utilize your National Provider Identifier (NPI) number when billing
  - Paper
    - Rendering NPI field 24J and Billing NPI field 33a*
  - Electronic
    - Rendering NPI Loop 2310B, NM109 qualifier field
    - Billing NPI Loop 2010AA, NM109 qualifier field

*Solo providers must use rendering NPI in both 24J and 33a
Benefit Code

- Benefit Code is an additional data element used to identify state programs.
- Claims may reject if Benefit Code is not included.
- Use the appropriate Benefit Code in Box 11 for STAR and STAR Kids on paper claims and SRB Loop 2000B, SBR03 qualifier field on electronic claims.
- Providers who participate in the following programs will use the associated Benefit Code when submitting claims:
  - CCP- Comprehensive Care Program (CCP)
  - EC1- Early Childhood Intervention Providers (ECI)
  - EP1- Texas Health Steps Medical Provider.
Class action lawsuit that alleged Texas Medicaid failed to ensure children access to EPSDT (TX Health Steps) services

Some of the Requirements
- TX Health Steps Benefits
- Medical Checkup Periodicity Schedule
- Immunization Schedule
- Texas Health Steps Provider Outreach Referral Form (located on DSHS website: https://www.dshs.texas.gov/thsteps/ POR.shtm)
  - Scheduling a follow up visit
  - Rescheduling a Missed Appointment
  - Scheduling transportation to an appointment
  - With other outreach services
- Children of Migrant Farmworkers Accelerated Services
THSteps is a program that includes both preventive and comprehensive care services.

For preventive, use the following guidelines:
- 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.
- Rendering NPI number is not required for THSteps check-ups.
- Billing primary coverage is not required for THSteps and CHIP preventive claims.
- Include Benefit Code “EP1” on Texas Health Steps claims.
- EP1 field 11 (Benefit Code is not required for CHIP preventive claims).

Texas Health Steps Quick Reference Guide (www.TMHP.com)
- Z00110, Z0011, Z00129, Z00121, Z0000, Z0001
- Z23 for Immunizations.
Texas Health Steps (TH Steps) – Timely Checkups

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

- Providers should bill as an exception to periodicity.
- Exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup.
- Modifier 32 Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier “-32” to the basic procedure or service.
Texas Health Steps: Mental Health Screening Procedure Code 99420

- Effective January 1, 2017 Code 99420 discontinued
- Replaced by two new codes
  - 96160
  - 96161
- Required once for all clients 12 - 18
- Only one procedure code may be reimbursed per client per lifetime
- Not reimbursed for the same clinic for any date of service
- Must be submitted with the same date of service by the same provider as procedure code 99384, 99385, 99394, or 99395
Texas Health Steps Continued

Comprehensive Care Program services include services such as:

- Medical supplies and Durable Medical Equipment (Pharmacy may provide these services)
- Therapies
- Outpatient Rehabilitation
- Private Duty Nursing
- Mental Services (provided by Magellan)
Comprehensive Care Program services billing guidelines are:

- Provider must use Rendering NPI Box 24j (if applicable)
- Provider must use Billing NPI in Box 33a
- Must include Benefit Code CCP
- Claims may reject if Benefit Code is not included
- Use the appropriate Benefit Code in Box 11 or 11c for STAR on paper claims and SRB Loop 2000B on electronic claims
Texas Vaccines for Children (TVFC)

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

- STAR Delivery codes should be billed with the appropriate CPT codes
  - 59409 = Vaginal Delivery only
  - 59612 = Vaginal Delivery only, after previous cesarean delivery
  - 59514 = C-Section only
  - 59620 = C-Section only, following attempted vaginal delivery after previous cesarean delivery
  - 59430-TH = Postpartum Care after discharge for STAR claim only (1 Postpartum Visit)
CHIP Perinate Mother’s are entitled to a maximum of 2 postpartum visit

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

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

To be reimbursed for the postpartum visits, following these billing guidelines.....
Billing OB/GYN Claims

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

- U1-Medically necessary delivery prior to 39 weeks of gestation*
  - STAR claims must include a medically necessary diagnosis from the list of approved diagnosis
- U2-Delivery at 39 weeks of gestation or later*
- U3-Non-medically necessary delivery prior to 39 weeks of gestation*

Payments made for non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria, will be subject to recoupment. Recoupment may apply to both physician services and hospital fees.
BCBSTX reimburses only one delivery or cesarean procedure per Member in a seven-month period.

Reimbursement includes multiple births.

Delivering physicians who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery.

Itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.

Laboratory (including pregnancy test) and radiology services provided during pregnancy must be billed separately and received within 95 days from the date of service.

Use modifier TH, obstetrical treatment or service, prenatal or postpartum, with all antepartum codes.
Billing Maternity Claims (Cont’d)

- If a Member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If high risk, the high risk diagnosis must be documented on the claim form.
- Global codes **cannot** be used for billing BCBSTX.
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](http://www.tmhp.com).

- Claims will deny if the Sterilization consent form is not included with the claim.
Billing Sports Physicals
Value Added Service for STAR and CHIP

- Complete the Sports and Camp Physical Reimbursement form
  - Education & Reference, Forms, Other
  - $25.00 reimbursement
  - Submit form within 95 days of date of service
  - Include copy of W-9 with first time submissions
Ancillary Billing
Ancillary Services

Providers who will use CMS-1500 include:

- Ambulance
- Freestanding Ambulatory Surgical Center (ASC)
- Early Childhood Intervention providers
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Durable Medical Equipment (DME)
- Laboratory
- Physical, Occupational, and Speech Therapists
- Podiatry
- Radiology
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
Ancillary Services - Lab and Radiology

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

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

- Home Health Agencies bill on a CMS-1450 (UB-04) with the exception of DME

- DME provided during a Home Health visit must be billed on a CMS-1500

- Home Health services include:
  - Skilled Nursing
  - Home Health Aides
  - Home Health Physical and Occupational Therapy (Modifier GP for Physical Therapy (PT) and GO for Occupational Therapy (OT) must be billed for these services)
Ancillary Services - PT/OT/SP Therapies

- Independent/group therapists providing PT/OT/SP services in an office, clinic setting, or outpatient setting must bill on a CMS-1500 form.
- Initial visits do not require Prior Authorization.
- Additional services and re-evaluations require authorization and the authorization number must be included on the claim form.
- Please refer to the Texas Medicaid and Healthcare Partnership for a listing of all applicable coding and limitations.
- Billing information will be found in the Texas Medicaid Provider Procedures Manual on the TMHP website.  
  - www.TMHP.com
Medical Management Overview
Customer Service

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

- Customer Service Phone Numbers
  - Member Medicaid STAR and CHIP: 888-657-6061
  - Member STAR Kids: 877-688-1811
  - Provider Medicaid STAR and CHIP: 877-560-8055
  - Provider STAR Kids: 877-784-6802
  - TTY: 711

- Available Monday through Friday from 8 a.m. to 8 p.m. CT
Post Stabilization Care

- For stabilized members
  - Require notification of admission for post stabilization care
  - Within 1 business day following treatment of an emergency condition
  - Failure to timely notify and obtain pre-approval may result in denial of claim
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
  - *Medicaid STAR and CHIP*
    - *Intake phone number: 877-560-8055*
    - *Intake fax number: 855-653-8129*
  
  - *STAR Kids*
    - *Intake phone number: 877-784-6802*
    - *Intake fax number: 866-644-5456*
Intake Department Continued

- Prior authorization and/or continued stay review phone calls and fax requests from providers
- Phone calls regarding overall questions and/or case status inquiries
- Notification of delivery processing and tracking via phone calls and fax
- Assembly and indexing of incoming faxes
- Out-of-network claims processing
Important Utilization Management Questions

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?
Calling the Intake Department

Please have the following information available when calling the Intake Department:

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

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

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

---

* 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 Dispute Resolution Form within 120 calendar days from receipt of the Remittance Advice (RA) or notice of action letter
  - The Provider Appeal Request Form is located at [http://www.bcbstx.com/provider/medicaid/forms.html](http://www.bcbstx.com/provider/medicaid/forms.html)
Prior Authorization

- Department of Insurance (TDI) Standard Prior Authorization Request Form for Health Care Services
- Request for Prior Authorization Form
  - Medicaid (STAR) and CHIP Fax: 855-653-8129
  - STAR Kids Fax: 866-644-5456
Submitting an Appeal

Submit an appeal to:

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

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

Continuity of Care
- Allow for the lesser of the authorization period:
  - 180 days with no prior authorization required for existing delivery of service
  - End of pre-existing authorization period

First 12 months post implementation
- Members can continue to see Medicaid enrolled, out of network Providers, in or out of the service delivery area for Medicaid covered services

Prior authorization for non-emergency services is required in order to ensure smooth claims processing
- BCBSTX will work with Providers to obtain the prior authorization
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

- Medicaid STAR and CHIP: 877-560-8055
- STAR Kids: 877-784-6802
Provider Website

The provider website contains resources such as:
- Access to list of Services Requiring Prior Authorization
- Access to view Clinical Guidelines
- Access to many other very helpful resources and forms

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

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

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

- Free Diaper Bag with New Baby Item Gifts
- Hands Free Breast Pumping Bra Gift for mothers who are breastfeeding
- Well Child Check Incentives
  - Eligible to request $50 gift card
- Prenatal and Post Partum STAR member Incentives
  - Prenatal - eligible to receive $25 gift card
  - Post Partum – eligible to receive a $50 gift card
STAR Kids
Value Added Services (VAS)

- Enhanced Eyewear
- Extra Help for Parents: Respite Care for Parents/LAR
- Incentive Gift Card for Attending Parent/LAR Peer to Peer Orientation and Resource Meeting
- Hippotherapy or Therapeutic Riding Services
- In-Home Delivery Meal Services
- Non-emergency transport services
- Recreational Safety Helmet
- Texas Health Steps Checkup Incentive
BCBSTX Additional Information
Importance of Correct Demographic Information

- Accurate provider demographic information is necessary for accurate provider directories, online provider information, and to ensure clean claim payments.

- **Providers are required to provide notice of any changes to their address, telephone number, group affiliation, and/or any other material facts**, to the following entities:
  - BCBSTX- via the *Provider Data Update Notification Form*
  - Health and Human Services Commission’s administrative services contractor
  - Texas Medicaid and HealthCare Partnership (TMHP)- via the *Provider Information Change Form* available at [www.tmhp.com](http://www.tmhp.com)

- Claims payment will be delayed if the following information is incorrect:
  - Demographics- billing/mailing address (STAR, STAR Kids and CHIP)
  - Attestation of TIN/rendering and billing numbers for acute care (STAR and STAR Kids)
  - Attestation of TIN/rendering and billing numbers for Texas Health Steps (STAR and STAR Kids)
Member and provider hotline 1-800-327-7390

- Authorizations
- Coordination of Care
- Assistance with discharge planning
- Claims inquiries
24/7/365 Member and Provider Support Available

- After-hours support provided to members and providers by calling 1-800-327-7390

- Provider relations support through Provider Services Line (PSL) and through Texas based Field Network Provider Relations Team
  - PSL 1-800-788-4005
  - Texas Field Network Team 1-800-430-0535, option #4

- Online resources available through www.magellanprovider.com
  - Includes member and provider education materials
Provider Responsibilities

- Precertification is required for mental health and substance abuse services for both STAR, 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
  - Provide Magellan with a thorough assessment of the member
  - Contact Magellan if during the course of treatment you determine that services other than those authorized are required
Submitting Claims

- **Electronic Claims submission** via [www.magellanprovider.com](http://www.magellanprovider.com) or through a clearinghouse

- When submitting claims electronically, use submitter ID # 01260
Website Features

- [www.magellanprovider.com](http://www.magellanprovider.com)
- Web site demonstration on home page
- Online provider orientation program
- *Provider Focus* behavioral health newsletter
- Electronic claims submission information
- HIPAA billing code set guides
- MNC and CPGs
- Clinical and administrative forms
- Cultural competency resources
- Demos of all our online tools/applications: go to Education/Online Training
- Behavioral health information for members
Questions?
Thank you for your time!

Please complete the training evaluation form.