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

Comprehensive Overview

Provider Training
Welcome to Blue Cross and Blue Shield Texas Medicaid Training
Program Introduction
Customer Service
Member Enrollment and Eligibility
Member Benefits and Services
Claims and Billing
Medical Management
Complaints and Appeals
Quality Management
Magellan (Behavioral Health) Services
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.

Blue Cross and Blue Shield Texas will continue to develop relationships between members, providers, and the community for our STAR and CHIP members’ better health.

- 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
Customer Service
Customer Service

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>
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<tr>
<td>Eligibility Verification</td>
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<td>Interpreter/Hearing Impaired Services</td>
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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
Member Enrollment and Eligibility
Enrollment

- HHSC delegates to its enrollment broker, Maximus, the responsibility to educate STAR and CHIP eligibles about their health plan options.

- Eligible STAR and CHIP individuals and families are asked to select an HMO and an in-network Primary Care Physician (PCP) upon enrollment:
  - State assigns member to a STAR plan if information is not received within 45 calendar days; this is called default.
  - CHIP eligibles must enroll in a CHIP HMO within 90 days or the member becomes ineligible:
    - CHIP eligibles do not default into a medical plan.
    - CHIP Perinate is a subset of CHIP (limited benefits apply to expectant mother).
  - CHIP Perinate Newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment.
Eligibility Verification for STAR and CHIP

- Providers must verify eligibility before each service
- Ways to verify STAR and CHIP member eligibility
  - Call the BCBSTX Customer Service Center:
    - 877-560-8055
    - Customer Care Representative
    - Interactive Voice Response automated telephone response system
  - Use the State’s Automated Inquiry System (AIS)- for STAR (not CHIP)
    - 800-925-9126
    - [www.availity.com](http://www.availity.com)
    - [www.passporthealth.com](http://www.passporthealth.com)
Medicaid eligibility and Claim Status Inquiries (DOS 12/1/2015 and later)

- Payer ID HCSVC
- Alpha prefix + 9 digit Medicaid ID
- There must not be an “X” following the plan prefix: results in member/claim not found
STAR and CHIP 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
  - 9 digit Medicaid ID

Identification cards will be re-issued

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

#### Examples of BCBSTX identification cards

**STAR alpha prefix:** ZGT

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>PCP: <code>&lt;PCP_NAME&gt;</code></th>
</tr>
</thead>
<tbody>
<tr>
<td><code>&lt;F_NAME M_INIT L_NAME&gt;</code></td>
<td><code>&lt;PCP_PHONE&gt;</code></td>
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<tr>
<td>Alpha Prefix:</td>
<td></td>
</tr>
<tr>
<td>ZGT</td>
<td></td>
</tr>
<tr>
<td>Subscriber ID:</td>
<td></td>
</tr>
<tr>
<td><code>&lt;SBSB_ID&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Medicaid ID Number:</td>
<td></td>
</tr>
<tr>
<td><code>&lt;MEME_MEDCD_NO&gt;</code></td>
<td></td>
</tr>
<tr>
<td>PCP Effective Date:</td>
<td><code>&lt;EFF_DT&gt;</code></td>
</tr>
<tr>
<td>Rx Group No.:</td>
<td><code>&lt;RX_GROUP2&gt;</code></td>
</tr>
<tr>
<td>Rx BIN:</td>
<td>011552</td>
</tr>
<tr>
<td>Rx PCN:</td>
<td>TXCAID</td>
</tr>
<tr>
<td>PBM:</td>
<td>PRIME</td>
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**BlueCross BlueShield of Texas**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company. An Independent Licensee of the Blue Cross and Blue Shield Association.

**Texas STAR**

Your Health Plan  Your Choice

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**bcbstx.com**

Customer Care / Atención al Cliente

<table>
<thead>
<tr>
<th>Service / Servicio</th>
<th>Number</th>
<th>Extension</th>
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<tr>
<td>Medical/Prescription Drug/Visa</td>
<td>1-888-657-6061</td>
<td>711</td>
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<tr>
<td>24 Hour Nurse Line</td>
<td>1-844-971-8906</td>
<td>711</td>
</tr>
<tr>
<td>Prescription Drug / Medicamentos Recetados</td>
<td>1-888-657-6061</td>
<td>711</td>
</tr>
<tr>
<td>Behavioral Health Services Hotline</td>
<td>1-800-327-7809</td>
<td>1-800-735-2988</td>
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</table>

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

**Card Issued:** <DT>
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<th>&lt;F_NAME M_INIT L_NAME&gt;</th>
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<th>Office Visit/Visitas al consultorio:</th>
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<td>Non-Emergency ER/No emergencias en la ER:</td>
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<tr>
<td>Emergency Room/Emergencia en la ER:</td>
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<td>Pharmacy (Brand)/farcia (marca):</td>
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<tr>
<td>Pharmacy (Generic)/farcia (generico):</td>
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Examples of BCBSTX identification cards

CHIP Perinate alpha prefix: ZGE
Member Benefits and Services
STAR Covered Benefits

Some of the benefits include:

- Well-child exams and preventive health services, and screening for behavioral health problems and mental health disorders
- Physician office visits, inpatient and outpatient services
- Durable Medical Equipment and Supplies
- Chiropractic Services
- Emergency Services
- Family Planning Services (any Medicaid provider in or out of network)
- Prenatal vitamins – with prescription
- Transplants
- Vision Plan by Davis Vision
- Behavioral Health by Magellan Health Services
- Pharmacy benefits administered by Prime Therapeutics
CHIP Covered Benefits

Some of the benefits include:
- Well-child exams and preventive health services, and screening for behavioral health problems and mental health disorders
- Physician office visits, inpatient and outpatient services
- Durable Medical Equipment
- Transplants
- Chiropractic Services
- Prenatal vitamins – with prescription
- Vision Plan by Davis Vision
- Behavioral Health by Magellan
- Pharmacy benefits administered by Prime Therapeutics
CHIP Perinate Covered Benefits

For Mothers that do not qualify for Medicaid, their unborn baby may qualify for perinatal care as a CHIP Perinate member.

Some of the benefits include:
- Prenatal care through delivery
- Medically necessary physician office visits
- Some inpatient and outpatient services
- Prenatal vitamins – with prescription
- Laboratory, x-rays and ultrasounds
STAR and CHIP members may self-refer for the following services:

- Diagnosis and treatment of sexually transmitted diseases
- Testing for the Human Immunodeficiency Virus (HIV)
- Family planning services to prevent or delay pregnancy (STAR Only)
- Annual Well Woman exam (in-network only)
- Prenatal services/obstetric care (in-network only)
- Behavioral Health Services (Magellan Network)
- Early Childhood Intervention (ECI)
- Chiropractor
Pharmacy Services

- Pharmacy benefits are administered by Prime Therapeutics
  - Provider Customer Service:
    - **CHIP Pharmacy Help Desk:** 855-457-0403
    - **STAR Pharmacy Help Desk:** 855-457-0405
      - Call for 72 hour emergency supplies while waiting for prior authorization approval
  - Prior authorization:
    - **STAR & CHIP** 855-457-0407
  - Prior authorization fax:
    - **STAR & CHIP** 877-243-6930
      - Prior authorization requests will be addressed within **24** business hours

- Benefit Identification Number (BIN): 011552
- PCN: TXCAID
Pharmacy Services Continued

- The Formulary and clinical edits will mirror Texas Vendor Drug Program
  - www.txvendordrug.com*

- For STAR only, Over The Counter (OTC) items are included if on the Formulary and require a prescription to be processed for reimbursement. Not covered for CHIP/CHIP Perinate
  - Infertility, erectile dysfunction, cosmetic and hair growth products are excluded from this benefit (OTC and contraceptives for contraception are also excluded for CHIP)
  - Diabetic monitors/devices, office based injectables, and nutritional/enteral formulas are available and should be billed to the medical benefit

* Smart Phones on www.epocrates.com
STAR members have no copay; CHIP members’ copay depends on the family’s Federal Poverty Level
  - CHIP Perinate unborn children will have prescription coverage with no copay
  - CHIP Perinate newborns will have prescription coverage with no copay

BlueCross BlueShield of Texas offers e-prescribing abilities through Surescripts for providers to:
  - Verify client eligibility
  - Review medication history
  - Review formulary information

For additional information visit the website www.txvendordrug.com
All STAR and CHIP members must select a Dental DMO and a main dentist

Dental Services are provided by one of the following vendors

- DentaQuest
  - **STAR** 800-516-0165
  - **CHIP** 800-508-6775

- Managed Care of North America Dental (MCNA)
  - **STAR** and **CHIP** 800-494-6262
STAR Medical Transportation Program

The Medical Transportation Program (MTP) is provided by Texas Health and Human Services Commission (HHSC).

STAR members can receive transportation assistance to get to and from a provider, dentist, hospital or drug store. HHSC will do one of the following:

- Pay for a bus ride or ride sharing service
- Pay a friend or relative by the mile for the round trip
- Provide gas money directly to the member/parent/guardian

If a member has to travel out of town for services, HHSC may pay for lodging and meals for the member and the member’s parent/guardian.
Co-payments apply from $0 to $100 depending on Federal Poverty Levels (FPL) and type of service.

Co-payment amount is found on the member’s identification card.

Once cost-sharing limit is reached the member must call the enrollment broker, Maximus, to report that they met their max.

BCBSTX will receive updated files from Maximus reflecting co-payment maximum reached.

- An identification card will be re-issued to show that co-payments do not apply.
PCPs and Specialists must make appointments for Members from the time of request as follows:

- **General Appointment Scheduling**
  - Emergency examinations: immediate access during office hours
  - Urgent examinations: within 24 hours of request
  - Non-urgent, routine, primary care examinations: within 14 days of request
  - Specialty care examinations, within 30 days of request
Medical Appointment Standards

Services for Members under the Age of 21 Years

- Initial health assessments:
  - Within 14 days of enrollment for newborns
  - Within 60 days of enrollment for other eligible child Members
- Preventive care visits: according to the American Academy of Pediatrics (AAP) periodicity schedule found within the Preventive Health Guidelines (PHG)

Services for Members 21 Years of Age and Older

- Preventive care visit within 90 days
Prenatal and Postpartum Visits

- First and second trimesters: Within 14 days of request
- Third trimester: Within five days of request or immediately if an emergency
- High-risk pregnancy: Within five days of request or immediately if an emergency
- Postpartum: Between 28 and 56 days after delivery
After Hours Standards

After Hours

- Members have access to quality, comprehensive healthcare services 24 hours a day, 7 days a week
- Members can call their PCP with a request for medical assessment after PCP normal hours
- PCP must have an after-hour system

Unacceptable After-Hours Coverage

- Only answered during office hours
- Recording instructing patients to leave a message
- Recording directs patients to the emergency room of any services needed
- Returning after-hour calls over 30 minutes after call received
Early Childhood Intervention (ECI)

- Identify and refer children up to 35 months of age suspected of having a developmental disability or delay or of at risk of delay to ECI for screening and assessment
- As soon as possible but no longer than seven days after identification
Claims and Billing Overview
Attestation

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

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

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

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

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

- 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

Unused spaces for the quantity should be left blank

Numeric quantity administered. Include decimal.
National Drug Code (NDC) Coding

Electronically Submitted Claim Requirements
- Loop 2410 Line 02, providers must enter NDC qualifier N4
- Loop 2410 Line 03, providers must enter NDC
- Loop 2410 CPT04, providers must enter quantity billed
- Loop 2410 CPT05, providers must enter measurement code
- Loop 2410 REF01, providers must enter prescription number
- Loop 2410 REF02, providers must enter prescription number or sequence number
NDC requirements includes long acting reversible contraceptives

- Intrauterine devices (IUDs)
- Hormone patches
- Vaginal rings
- Sub dermal implants
- Intrauterine Copper devices
Long Acting Reversible Contraceptives

▷ LARC pharmacy benefit
  - Available at a limited number of specialty pharmacies
  - Listed on the Vendor Drug Program website
  - Prescribe and obtain LARC will be able to return unused and unopened LARC products to the manufacture’s third-party processing Questions – contact TMHP @ 1-800-925-9126
  - Remains a medical benefit

▷ Participating pharmacies:
  - Prime Therapeutics
  - CVS Caremark
  - Walgreens
Referral Process/NPI Requirement

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

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

- Referring Provider Requirements
  - The referring provider’s name will be captured in Box 17 on the CMS-1500
  - The referring provider’s NPI will be captured in Box 17b on the CMS-1500
Referral Process/NPI Requirement

PCP types that do not require a referring provider
- Family Practitioner
- General Practitioner
- Internal Medicine
- Nurse Practitioner
- OB/GYN
- Physicians Assistant
Services that do not require NPI when billing

- Services from OB/GYN’s
- Services from Indian Health Providers
- Urgent Care Center Services
- Health Department Services
- Anesthesia Services
- Ambulance Services
- Emergency Services
- Family Planning Services
- Health Education
- Inpatient Services
- Immunizations and Administrations
- STD/HIV Services – Testing and Treatment
- Early Childhood Intervention (ECI)
- Chiropractor
Submitting Claims

- Timely filing limit is 95 calendar days from the date of service
- Electronic Submission – Claims Payer ID
  - 66001
- Submit 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

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

- “X” prefix
  - Do not include the “X”
  - Only valid for claims with DOS prior to 12/1/2015
Corrected Claims

- Resubmit corrected claims electronically
  - Payer ID 66001
  - CLM05-3 segment should indicate claim is a corrected claim (applies to corrected claims with a DOS 12/1/2015 and later)
Overpayment Recovery

- Provider discovers overpayment

- Mail a check and a copy of the remit
  - Blue Cross Blue Shield of Texas
    Attn: Overpayment Recovery
    P O Box 51422
    Amarillo, TX 79159-1422
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)
Submitting 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 on paper claims and SRB Loop 2000B, SBR03 qualifier field on electronic claims.
- Providers who participate in the following programs must use the associated Benefit Code when submitting claims:
  - CCP - Comprehensive Care Program (CCP)
  - ECI - Early Childhood Intervention Providers (ECI)
  - EP1 - Texas Health Steps Medical Provider
Frew v. Janek Consent Decree and Corrective Actions

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

- Some of the Requirements
  - TX Health Steps Benefits
  - Medical Checkup Periodicity Schedule
  - Immunization Schedule
  - Missed Appointment Referrals
  - Children of Migrant Farmworkers Accelerated Services
Texas Health Steps (THSteps)

THSteps is a program that includes both preventive and comprehensive care services

For preventive, use the following guidelines

- You can bill for acute care services and THSteps and CHIP preventive visits performed on the same day
- Claims must be billed separately
- Providers must use modifier 25 to describe the circumstances in which an acute care visit was provided at the same time as a Texas Health Steps visit
- Rendering NPI number is not required for THSteps check-ups
- Billing primary coverage is not required for THSteps and CHIP preventive claims
- Include Benefit Code “EP1” on Texas Health Steps claims
- EP1 field 11 (Benefit Code is not required for CHIP preventive claims)
- Z00121 or Z00129
- Z23 for Immunizations
Texas Health Steps (TH Steps) – Timely Checkups

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

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

Comprehensive Care Program services billing guidelines:

- 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 for STAR on paper claims and SRB Loop 2000B on electronic claims
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

➤ Use appropriate CPT/HCPCS and diagnosis codes when billing
  - “Evaluation and Management” codes 99201 – 99215*
Billing OB/GYN Claims

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

- U1 - Medically necessary delivery prior to 39 weeks of gestation
  
  For all Medicaid (STAR) claims submitted with the U1 Modifier, **we will require diagnosis codes to support medical necessity. Any claims billed without one of the approved diagnosis code (any position) will be denied.** List of approved diagnosis codes: [http://www.bcbstx.com/provider/medicaid/claims.html](http://www.bcbstx.com/provider/medicaid/claims.html), Related Resources

- 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.
17P (Alpha Hydroxyprogesterone Caproate) is a Texas Medicaid Benefit for pregnant clients who have a history of preterm delivery before 37 weeks of gestation.*

Prior Authorization is required for both the compounded and the trademarked drug

When submitting claims for the compounded drug, use the following code:
- J1725-TH along with diagnosis code O09211 and the NDC

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

A Newborn child may be eligible for Medicaid for up to 1 year if:
- The child’s mother received Medicaid at the time of the child’s birth.
- The child’s mother is eligible for Medicaid or would be eligible if pregnant.
- The child resides in Texas.

If the Newborn is eligible for Medicaid coverage:
- Providers must not require a deposit from the guardian for newborn care.
- Hospital or birthing center must report the birth to HHSC eligibility Services at the time of the child’s birth.

Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn client’s Medicaid number.
Circumcisions performed on Members more than 1 year old require authorization
Billing Sports Physicals
Value Added Service

Complete the Sports and Camp Physical Reimbursement form
- Education & Reference, Forms, Other
- $25.00 reimbursement
- Submit form within 95 days of date of service
- Include copy of W-9 with first time submissions
Attention Deficit Hyperactivity Disorder (ADHD) follow-up visits

- PCP’s may be reimbursed for ADHD follow-up visits consistent with Medical policy
- Bill with appropriate procedure code and diagnosis applicable to each follow-up visit
- Providers should offer clinically appropriate services and bill according to the payable procedure codes on TMHP online fee lookup
- See handout for examples of procedure codes that can be billed for follow-up visits after prescribing ADHD medications
Claim Status Inquiry and Follow-Up

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

Claim Status Inquiry Payer ID HCSVC

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

- Submit an appeal 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 [http://www.bcbstx.com/provider/medicaid/forms.html](http://www.bcbstx.com/provider/medicaid/forms.html)
  - 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

**Electronic appeal:** GPDTXMedicaidAG@bcbsnm.com

**Availity.com**
Submitting An Appeal

Provider appeals include, but are not limited to:

- Payer allowance
- Medical policy or medical necessity
- Incorrect payment/coding rules applied

Provider appeals are not considered:

- Corrected claim
- General inquiry/question
- Claim denials needing additional information
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
Federally Qualified Health Center/
Rural Health Center
FQHC/RHC Covered Services

**FQHC Covered services include:**
- General medical services
- Adult preventive services
- Case management
- Family planning
- Mental health
- Texas Health Steps
- Vision

**RHC Covered services include:**
- General medical services
- Family Planning
- Texas Health Steps
FQHC/RHC Overview

- Members will be enrolled to the FQHC at the Tax Identification Number (TIN) level
- FQHC/RHC will be paid their assigned encounter rate for services
- All services provided that are incident to the encounter should be included in the total charge for the encounter and not billed as a separate service
- FQHC/RHC must bill procedure code T1015
FQHC/RHC Billing Claim Forms

FQHC Claim form
- CMS-1500 paper claim form - Preferred claim submission method
- ANSI ASC X12 837P 5010A electronic specifications
- CMS-1450 (UB-04) - Note: Must use CMS-1500 when billing THSteps
- ANSI ASC X12 837I 5010A format

RHC Claim form
- CMS-1500 paper claim form - Preferred claim submission method
- ANSI ASC X12 837P 5010A electronic specifications
- CMS-1450 (UB-04) - Note: Must use CMS-1500 when billing THSteps
- ANSI ASC X12 837I 5010A format

Rendering NPI number is not required. May cause claim delays or denials if included with claim submission (Paper - Box 24j on CMS-1500, Electronic - Rendering NPI Loop 2310B, NM109 qualifier field)
FQHC and RHC - services provided by a health care professional require one of the following modifiers:

- AH - Indicate services performed by a clinical psychologist
- AJ - Indicate services performed by a clinical social worker
- AM - Indicate services performed by a physician or team member
- EP - THSteps services
- FP - Family Planning Services
- GY - Gynecological Services
- SA - Indicate services were performed by an Advanced Practice Nurse (APN) or Certified Nurse Midwife (CNM) rendering services in collaboration with a physician
- TH - Obstetric Services
- TU - After-hours Care
Ancillary Billing
Providers who will use CMS-1500 include:
- Ambulance
- Freestanding Ambulatory Surgical Center (ASC)
- Early Childhood Intervention providers
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Durable Medical Equipment (DME)
- Laboratory
- Physical, Occupational, and Speech Therapists
- Podiatry
- Radiology
Providers who will use CMS-1450 (UB-04) include:

- Hospital Based ASC
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Home Health Agency
- Hospital - both inpatient and outpatient
- Renal Dialysis Center
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.
  - Use miscellaneous codes (such as E1399) when a HCPCS code does not exist.
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 can be found in the Texas Medicaid Provider Procedures Manual on the TMHP website.
  - [www.tmhp.com](http://www.tmhp.com)
Medical Management
Dedicated Staff To Support Programs

- Medical Director- Jerald Zarin, M.D.

- Physician Advisors

- Registered Nurses with expertise in:
  - Utilization Management
  - Case Management
  - Quality Management
Intake Department

- Assists providers in determining if an authorization is required, create cases, and forwards cases to nurses for review as needed

- Utilization requests are initiated by the providers by either phone or fax to the Intake Department
  - Intake phone number: 877-560-8055
  - Intake fax number: 855-653-8129
Intake Department (cont’d)

- 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
Prior Authorization Review Process

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
Utilization Management Prior Authorization Review

- All services provided by out of network providers, except emergency care and family planning, and some services rendered by in network providers require prior authorization;

- Prior Authorization requests are reviewed for:
  - Member eligibility
  - Appropriate level of care
  - Benefit coverage
  - Medical necessity

- Examples of services requiring prior authorization review include, but are not limited to:
  - All inpatient admissions (except routine deliveries)
  - Durable Medical Equipment
  - Select procedures performed (outpatient and ambulatory surgical services)
    - MRI’s and CT Scans

- List of Services Requiring Prior Authorization is posted on the BCBSTX website

- New list effective January 1, 2016
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
Physician Review

- The Peer Clinical Reviewer (PCR) reviews the cases that are not able to be approved by the nurse.
- Only a physician can deny service for lack of medical necessity.
- If denied by the PCR, the UM staff will notify the provider’s office of the denial. Providers have the right to:
  - Request a peer-to-peer discussion with the reviewing physician
  - Appeal the decision
    - Submit an appeal in writing using the Provider 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 [http://www.bcbstx.com/provider/medicaid/forms.html](http://www.bcbstx.com/provider/medicaid/forms.html)
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

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.
Medically complex patients with Special Healthcare Needs (HIV/AIDS, Transplants)

Chronic long-term conditions (diabetes, asthma, hemophilia, sickle cell)

Patients with frequent emergency room visits or hospital admissions

High risk pregnancies
Referrals to Case Management

Providers, nurses, social workers and members or their representative will be able to refer members to Case Management:

- By calling Blue Cross and Blue Shield of Texas Case Management
  - 877-560-8055
Providers must report suspicion of abuse, neglect, and exploitation in any of the following situations to the Department of Family and Protective Services (DFPS):

- An adult who is elderly or who has a disability
- An adult who is elderly or who has a disability and is receiving services from:
  - A facility (a mental health facility operated by the Department of State Health Services; a facility licensed under Chapter 252, Health and Safety Code; a program providing services to that person by contract with a mental health facility operated by the Department of State Health Services, a state supported living center or the ICF-IID component of the Rio Grande State Center; a program providing services to that person by contract with a state supported living center or the ICF-IID component of the Rio Grande Center
  - A community center, local mental health authority, and local intellectual and developmental disability authority;
  - A person who contracts with a health and human services agency or managed care organization to provide home and community-based services;
  - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - A managed care organization
  - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
  - An employee, fiscal agent, case manager, or service coordinator of an individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code
Abuse, Neglect and Exploitation (ANE)

A child who is receiving services from:

- A mental health facility operated by the Department of State Health Services;
- A facility licensed under Chapter 252, Health and Safety Code;
- A community center, a local mental health authority, or a local intellectual and developmental disability authority; or
- A program providing services to that person by contract with a mental health facility operated by the Department of State Health Services, a community center, a local mental health authority, or a local intellectual and developmental disability authority;
- A state supported living center or a local ICF-IID component of the Rio Grande State Center;
- A program providing services to that person by contract with a state supported living center of the ICF-IID component of the Rio Grande Center; or
- An officer, employee, agent, contractor, or subcontractor of a home and community support services agency (HCSSA) licensed under Chapter 142, Health and Safety Code
Report suspicion of abuse or neglect of a child to DFPS.

- Contact DFPS
  - Call 1-800-252-5400
  - Online in non-emergency situations @ www.txabusehotline.org

Report to DADS if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegations to DFPS;
- Adult day care centers; or
- Licensed adult foster care providers

Contact DADS:
- Call 1-800-647-7418
If unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS

- Contact Local Law Enforcement

Failure to Report or False Reporting

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE.
- Everyone has an obligation to report ANE against a child, an adult that is elderly, or an adult with a disability to DFPS.
  - Includes ANE committed by: family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.
Quality Management
Blue Cross and Blue Shield of Texas’s Quality Assurance and Performance Program includes

- Continuously identify, measure, assess and promote improvement of quality outcomes
- Evaluate performance and effectiveness in meeting the needs and expectations of our internal and external customers
- Promote processes that reduce medical errors and improve patient safety
- Promote high quality of care and service and effective utilization of service
- Provide training and feedback to participating providers on program requirements
Ensuring Quality Through Medical Records and Facility Site Reviews

The provider is responsible for:

- Partnering to ensure timely and quality service to members; initial health exam for new members within 90 days of the member’s effective date
- Cooperating with Medical Record Review and HEDIS data collection; we will make every effort to make this convenient
- Participating in Access to Care Appointment and Availability Surveys
- Participating in orientations and ongoing provider training
Children of Migrant Farm Workers (CMFW)

- **Challenges Members Encounter:**
  - Inability to secure a “Medical Home”
  - Increased E.R. Utilization Rates

- **Blue Cross and Blue Shield of Texas** has teamed with the National Center for Farmworker Health to help us identify and service our CMFW population to facilitate coordination of service benefits under the Texas Health Steps umbrella. The Patient Navigators help us identify and service the migrant population. Patient Navigators:
  - Assist members with finding PCPs.
  - Reach out to our members by making “Welcome Calls” and follow-up with home visits to families who are unable to be reached telephonically.
  - Connect families to outside community resources such as food banks, utility assistance and more.

- **What you can do to help:**
  - Refer families to our Member Advocates at **877-560-8055**; they can coordinate with FQHCs in other states
Complaints and Appeals
Providers may submit complaints relating to the operations of the plan

- Providers may file written complaints involving dissatisfaction or concerns about another physician or provider, the operation of the health plan, or a member, that are not related to a claim determination or Adverse Determination.

Complaints are required to include

- Provider’s name
- Date of the incident
- Description of the incident

Requests for additional information

- Blue Cross and Blue Shield of Texas may request additional information or medical records related to the complaint, and providers are expected to comply with the request within 10 calendar days.

Timeframes

- An acknowledgement letter is sent within five business days of receipt of the complaint.
- A resolution letter is sent within 30 calendar days of receipt of the complaint.
Submitting A Provider Complaint

Submit a complaint to:

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

Fax: 855-235-1055

Electronic: GPDTXMedicaidAG@bcbsnm.com
Value Added Services (VAS)
*Value Added Services (VAS) Overview

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

*Limitations apply.
Value Added Services (VAS) Overview

- Lodging and Food coverage (for out of area NEMT travel)
- Sports and Camp Physicals
- Enhanced Eyewear Frames
- 24/7 Nurse Hotline
- Multilingual glucometers for STAR members
- Children’s booster seats
- Recreational safety helmets
- Breast Pumps for CHIP Perinate Members
Value Added Services (VAS)

- Free Diaper Bag with New Baby Item Gifts
- Hands Free Breast Pumping Bra Gift for mothers who are breastfeeding
- Well Child Check Incentives
  - Eligible to request $50 gift card
- Prenatal and Post Partum STAR member Incentives
  - Prenatal - eligible to receive $25 gift card
  - Post Partum – eligible to receive a $50 gift card
Importance of Correct Demographic Information

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

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

- Claims payment will be delayed if the following information is incorrect:
  - Demographics- billing/mailing address (for STAR and CHIP)
  - Attestation of TIN/rendering and billing numbers for acute care (for STAR)
  - Attestation of TIN/rendering and billing numbers for Texas Health Steps (for STAR)
Provider Training Tools

Provider Manual:
- Search capability
- Links between subjects
- Links to forms

Internet Site
- website www.bcbstx.com/provider/network/medicaid.html
Texas Medicaid Providers
Re-Enrollment Process

In compliance with Title 42 Code of Federal Regulations (CFR) CFR §455.414, Medicaid providers are required to revalidate their enrollment information.

Revalidation of enrollment information will require existing Medicaid providers to re-enroll by submitting a new enrollment application.

The federal government requires each Texas Medicaid provider to complete the re-enrollment process by September 25, 2016.

Re-enrollment is the submission of a new Texas Medicaid provider enrollment application, all additional documentation and application fee, if required, to continue the participation in Texas Medicaid.

For more information refer to the Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions (FAQ) on www.tmhp.com.
Don’t forget to Re-enroll in Texas Medicaid

- Due to a new federal mandate, all Texas Medicaid providers must periodically revalidate their enrollment in Texas Medicaid. Providers enrolled before January 1, 2013, must re-enroll by September 25, 2016. To simplify this process, the Provider Enrollment Portal has been updated with new features.

- For additional guidance please visit the TMHP Provider Re-enrollment page.

- For help re-enrolling, contact
  - A TMHP provider enrollment representative @ 800-925-9126, Option 2
  - Town hall meetings
Member and provider hotline 1-800-327-7390
- Authorizations
- Coordination of Care
- Assistance with discharge planning
- Claims inquiries
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](http://www.magellanprovider.com)
- Includes member and provider education materials
Provider Responsibilities

Prior Authorization is required for mental health and substance abuse services for both STAR and CHIP

- Direct referral – no PCP referral required to access mental health and substance abuse services
- Mental health and substance abuse providers contact Magellan for initial authorization except in an emergency
- Contact Magellan as soon as possible following the delivery of emergency service to coordinate care and discharge planning
- Provide Magellan with a thorough assessment of the member
- Contact Magellan if during the course of treatment you determine that services other than those authorized are required
Submitting Claims

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

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

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

We look forward to working with you!

Please complete and fax the training evaluation form.