BlueCross BlueShield of Texas

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

Claims Billing Provider Training STAR, STAR Kids, and CHIP.

Revised 07142021

Agenda

- Claims and Billing
- Physician and Mid-Level Billing
- Texas Health Steps (THSteps) Billing
- OB/GYN Billing
- Ancillary Billing
- Medical Management Overview
- Magellan Behavioral Health
- Therapy Billing
- Provider Relations Information
- Questions

BlueCross BlueShield of Texas

Claims and Billing

Eligibility Verification

Our providers must verify eligibility before each service.

Contact Customer Service for eligibility verification:

STAR/CHIP: 1-877-560-8055

STAR Kids: 1-877-784-6802

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

STAR and STAR Kids

1-800-925-9126

Utilize online resources:

www.tmhp.com

www.availity.com

CHIP Members receive a card:

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

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

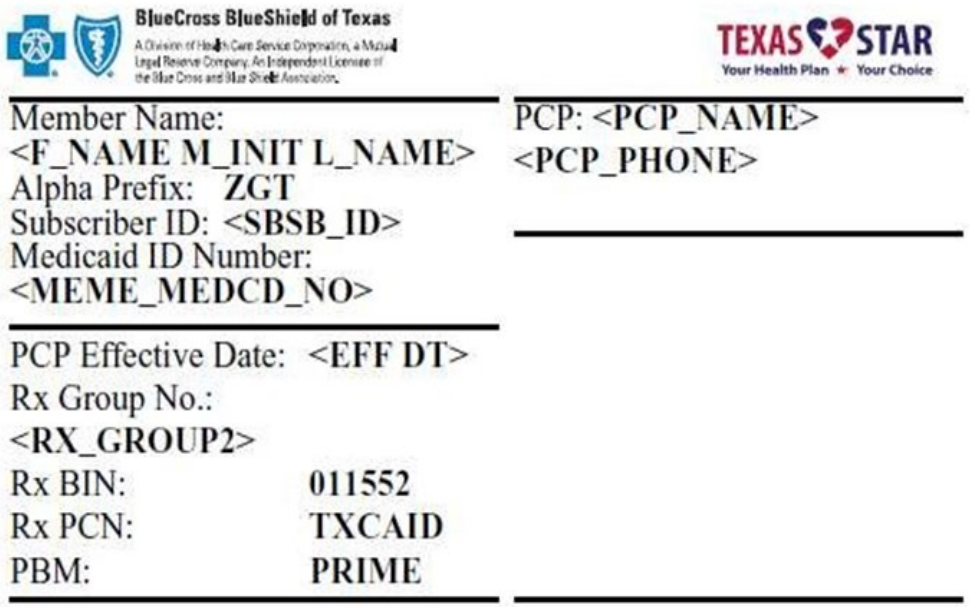
- State issued Medicaid card (Your Texas Medicaid Benefit Card)
- Blue Cross and Blue Shield of Texas Member Identification card

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

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

Sample Member Identification Cards

STAR Three-Character Prefix: ZGT



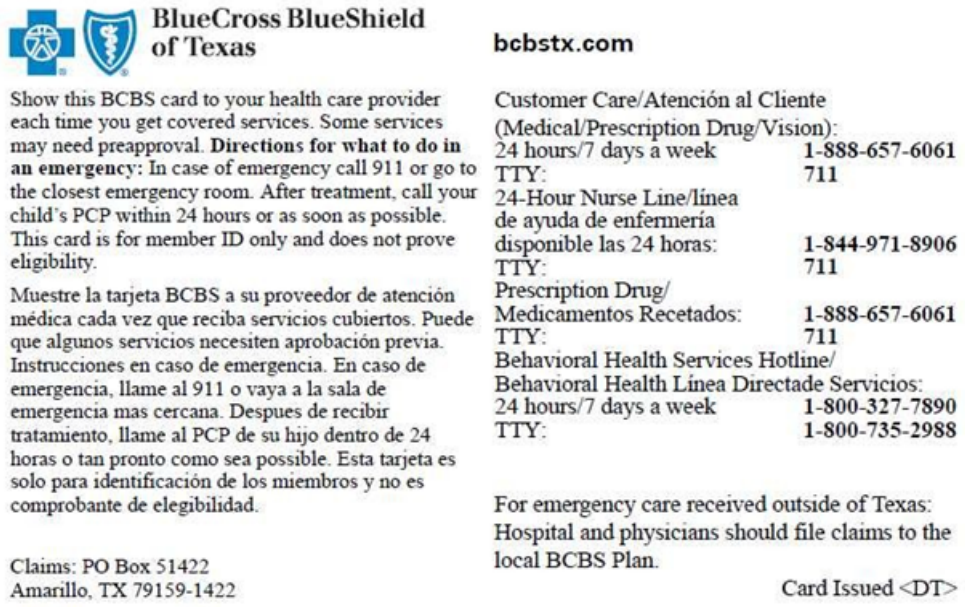
BlueCross BlueShield of Texas
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company. An Independent Licensee of the Blue Cross and Blue Shield Association.

TEXAS STAR
Your Health Plan ★ Your Choice

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



BlueCross BlueShield of Texas

bcbstx.com

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.

Muestre 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 mas cercana. Despues de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea possible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.

Claims: PO Box 51422
Amarillo, TX 79159-1422

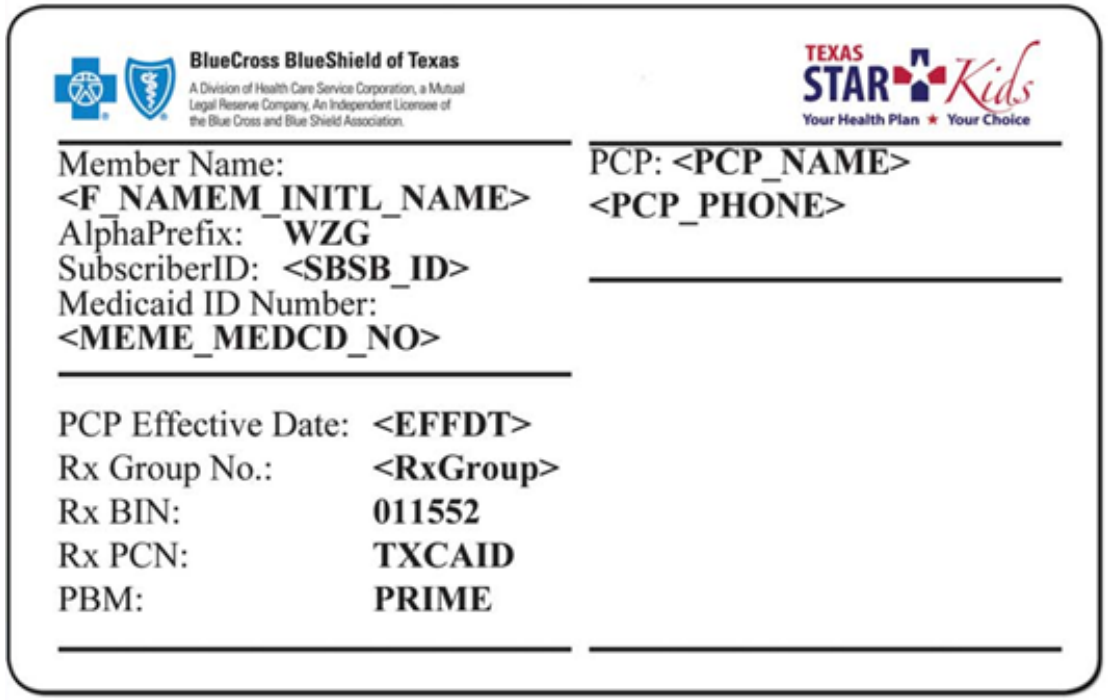
Customer Care/Atención al Cliente
(Medical/Prescription Drug/Vision):
24 hours/7 days a week 1-888-657-6061
TTY: 711
24-Hour Nurse Line/línea
de ayuda de enfermería
disponible las 24 horas: 1-844-971-8906
TTY: 711
Prescription Drug/
Medicamentos Recetados: 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/
Behavioral Health Línea Directade Servicios:
24 hours/7 days a week 1-800-327-7890
TTY: 1-800-735-2988

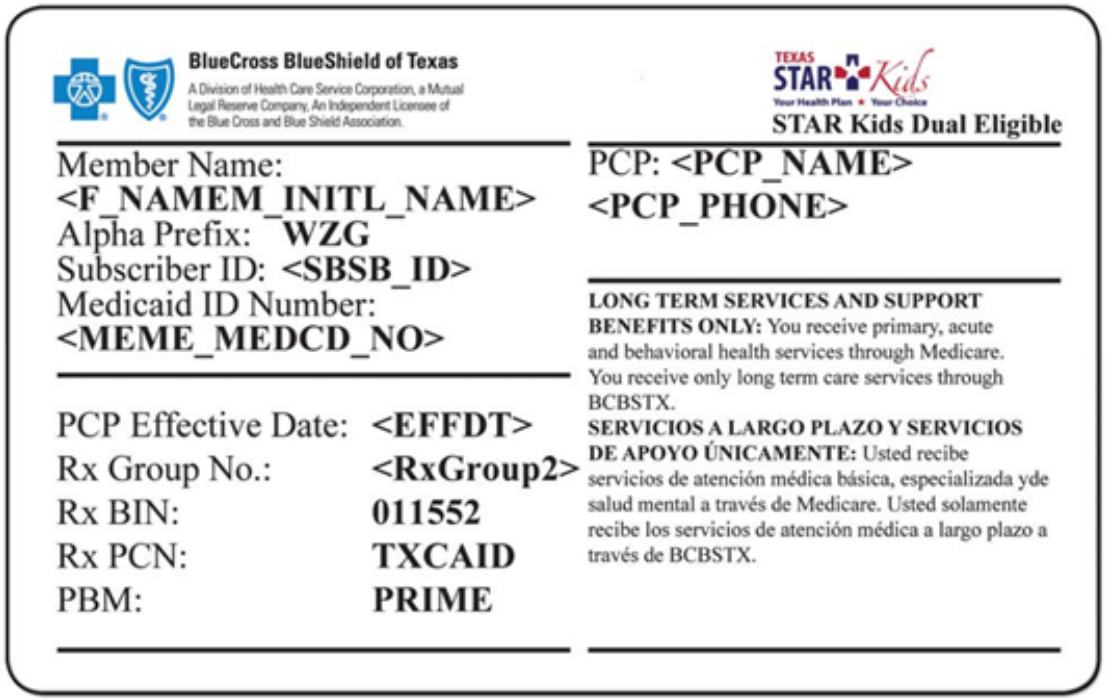
For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS Plan.

Card Issued <DT>

Sample Member Identification Cards

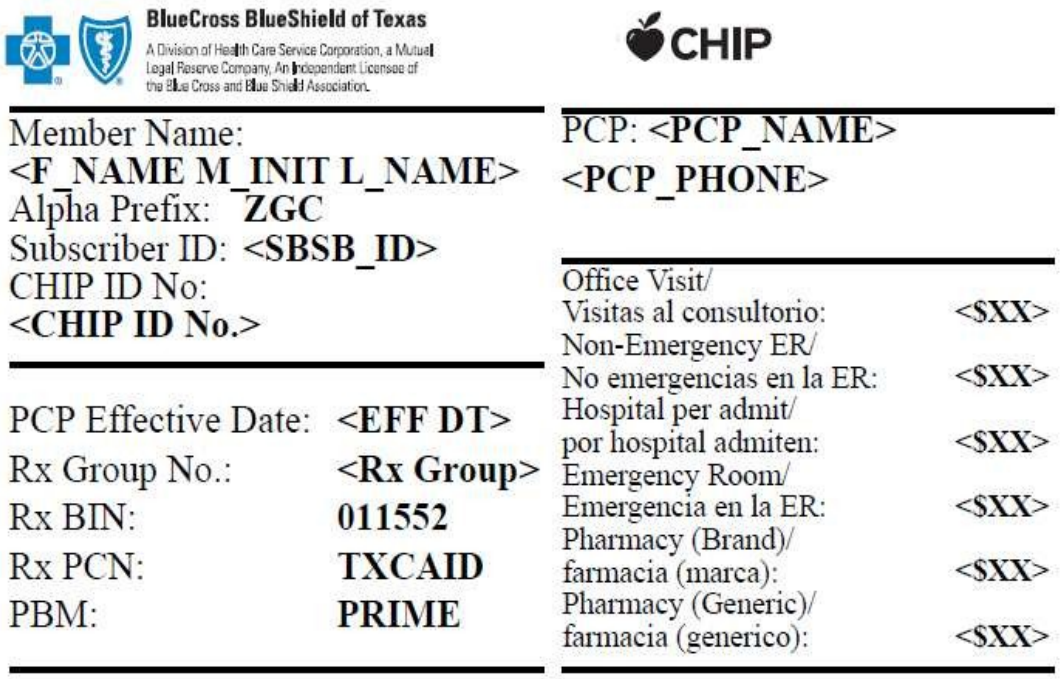
STAR Kids Three-Character Prefix: WZG





Sample Member Identification Cards

CHIP Three-Character Prefix: ZGC



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CHIP

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

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

PCP: <PCP_NAME>
<PCP_PHONE>

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

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Amarillo, TX 79159-1422

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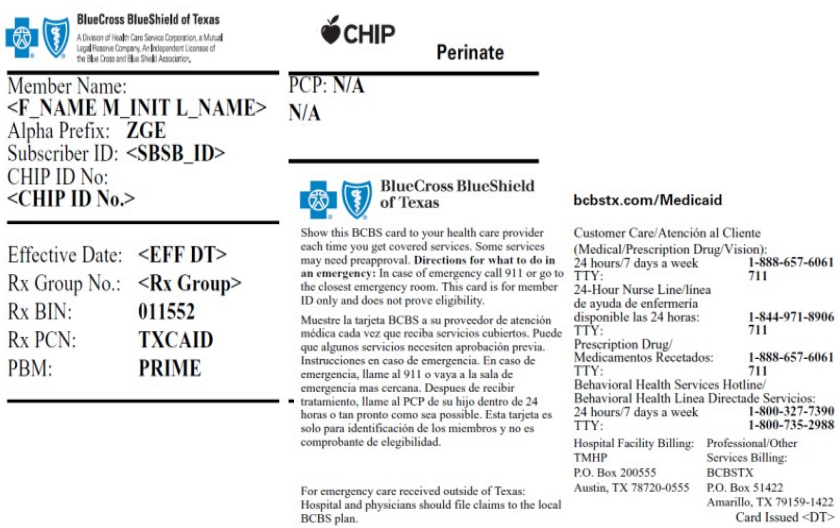
(Medical/Prescription Drug/Vision):
24 hours/7 days a week 1-888-657-6061
TTY: 711
24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: 1-844-971-8906
TTY: 711
Prescription Drug/ Medicamentos Recetados: 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/
Behavioral Health Linea Directade Servicios:
24 hours/7 days a week 1-800-327-7890
TTY: 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

CHIP Perinate Three-Character Prefix: ZGE



BlueCross BlueShield of Texas
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CHIP Perinate

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

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

PCP: N/A
N/A

BlueCross BlueShield of Texas

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

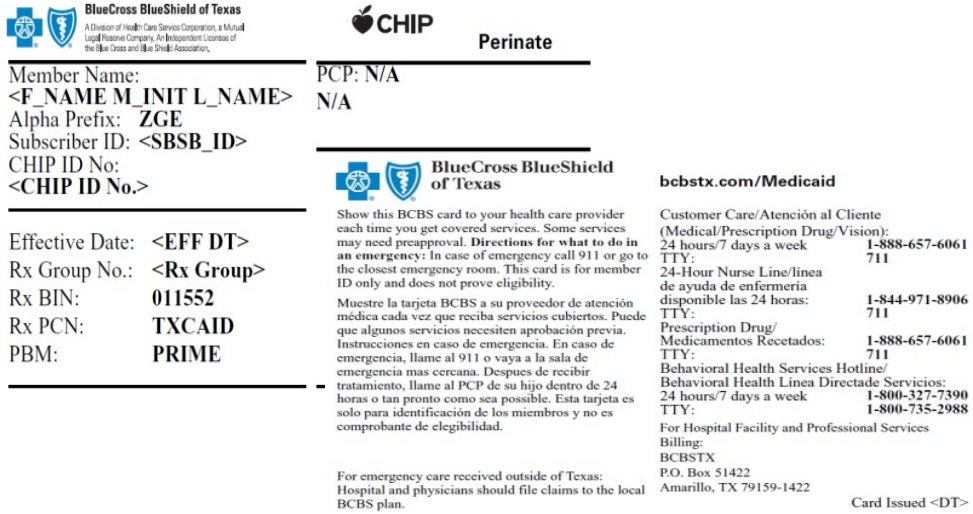
bcbstx.com/Medicaid

Customer Care/Atención al Cliente
(Medical/Prescription Drug/Vision):
24 hours/7 days a week 1-888-657-6061
TTY: 711
24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: 1-844-971-8906
TTY: 711
Prescription Drug/ Medicamentos Recetados: 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/ Behavioral Health Línea Directade Servicios:
24 hours/7 days a week 1-800-327-7390
TTY: 1-800-735-2988

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

Professional/Other Services Billing: BCBSTX, P.O. Box 51422, Amarillo, TX 79159-1422

Card Issued <DT>



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CHIP Perinate

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

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

PCP: N/A
N/A

BlueCross BlueShield of Texas

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TTY: 711
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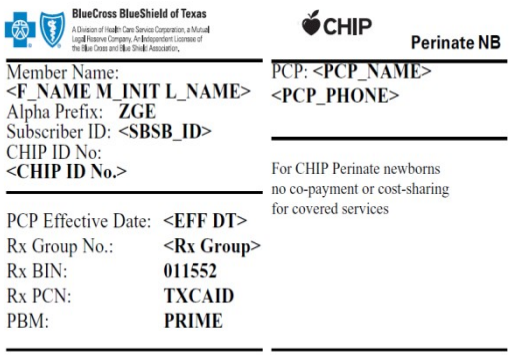
TTY: 711
Prescription Drug/ Medicamentos Recetados: 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/ Behavioral Health Línea Directade Servicios:
24 hours/7 days a week 1-800-327-7390
TTY: 1-800-735-2988

For Hospital Facility and Professional Services Billing:
BCBSTX
P.O. Box 51422
Amarillo, TX 79159-1422

Card Issued <DT>



BlueCross BlueShield of Texas
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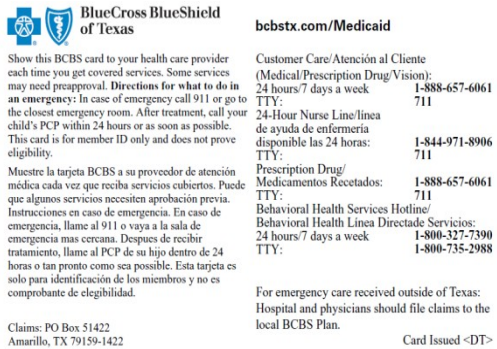
CHIP Perinate NB

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

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

PCP: <PCP_NAME>
<PCP_PHONE>

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



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Claims: PO Box 51422
Amarillo, TX 79159-1422

bcbstx.com/Medicaid

Customer Care/Atención al Cliente
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TTY: 711
24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: 1-844-971-8906
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Prescription Drug/ Medicamentos Recetados: 1-888-657-6061
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TTY: 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>

BlueCross BlueShield of Texas

Provider Onboarding/ File Maintenance

Attestation and Provider File Maintenance

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

Importance of Correct Demographic Information

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

BlueCross BlueShield of Texas

Claims Requirements

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 may be updated periodically. BCBSTX will give providers advance notice of any new edits being applied that are expected to result in material changes.
- 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 for 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 @ http://www.bcbstx.com/provider/medicaid/submitting_ndc_claims.html

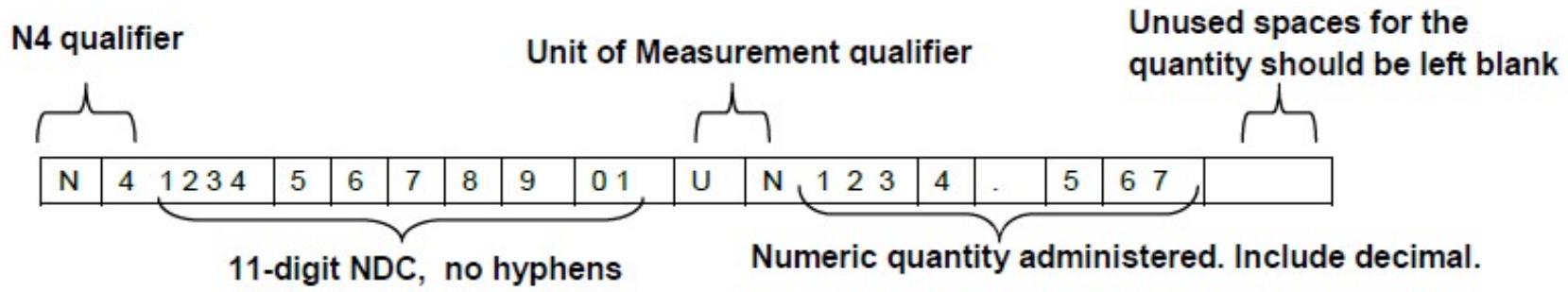
- Conversion from 10 digits to 11 digits
  - Submitting Paper Claims
  - Submitting Electronic Claims

- 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:



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

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

Claims PO Box Requirements

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

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

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

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

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

Paper Claims Submission

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

Electronic Claim Submission

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

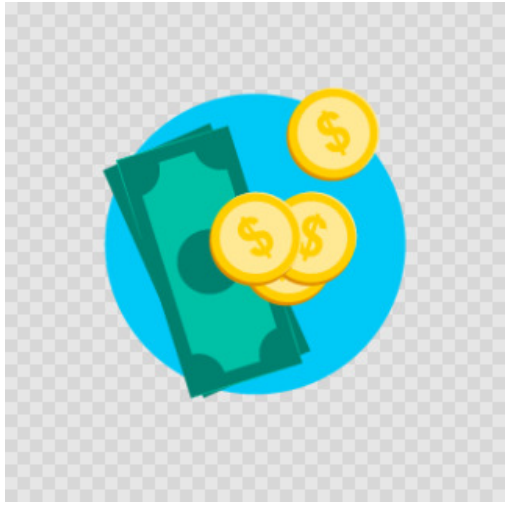
BCBSTX Alpha Prefix

- CHIP = ZGC
- STAR (Medicaid) = ZGT
- CHIP Perinate = ZGE
- STAR Kids = WZG
- Alpha + 9 digit Medicaid number (EX: ZGT123456789)

ERA/EFT

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

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



Submitting Claims

Third Party Liability (TPL) Coordination of Benefits (COB)

- If the claim has TPL or COB or requires submission to a third party before submitting to BCBSTX, the filing limit starts from the date on the notice from the third party
- BCBSTX must receive COB claims within 95 days from the date on the other carrier's RA or denial letter
- Claims should be submitted on paper with TPL or COB attached:
  - Third Party Remittance Advice (RA)
  - Third party letter explaining the denial or coverage or reimbursement

Claims Information

- Providers are prohibited from balance-billing CHIP or STAR Medicaid members for covered services
- Claim Filing With Wrong Plan – if you file with the wrong plan and can provide documentation, you have 95 days from the date of the carrier's denial letter or Remittance Advice to resubmit for adjudication
- Claim Payment – your clean claim will be adjudicated within 30 days from date of receipt. If not, interest will be paid at 1.5% per month (18% per annum)

Submitting Claims cont.

Claims Status Inquiry and Follow up

- Claim Status Inquiry:
  www.availity.com or IVR for disposition
  - **Medicaid (STAR)/ CHIP** Customer Service @ 1-877-560-8055
  - **STAR Kids** Customer Service @ 1- 877-784-6802
  - Initiate follow-up action if no response after 30 business days
  - Provide a copy of the original claim submission and all supporting documents to the claims address
- Claim Status Inquiry Payer ID HCSVC The customer service rep will perform the following:
  - Research the status of the claim
  - Advise of necessary follow-up action if any

Claims Forms On Medicaid Website

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

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

Forms Submission and Process

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

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

Submitting Appeals and Complaints

Filing an Appeal:

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

Within **30 Calendar** days of the date of the notice an action letter advising of the adverse determination.
Member or Provider may file an appeal with Provider Appeal Request Form

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

Submit Appeal by Calling:
Customer Service at 1-888-657-6061 as first option

Appeal in Writing:
Blue Cross and Blue Shield of Texas
Attention: Complaints and Appeal Department
PO Box 660717
Dallas, TX 75266-0717
Fax: 1-855-235-1055

Fair Hearings:

A member who is not satisfied with the decision made on the appeal can request a Fair Hearing.
Within **90 Days** of the notice of action a request must be submitted.
(CHIP members can request an IRO)

Request Fair Hearing in writing:
Blue Cross and Blue Shield of Texas
Attn: Complaint and Appeal Department
PO Box 660717
Dallas, TX 75266-0717
Fax: 1- 855-235-1055

BlueCross BlueShield of Texas

Physician and Mid-Level Billing

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

Submit Electronic and Paper Claims

- Texas Provider Identifier (TPI) is not required and may delay adjudication of your claim
- Must utilize your National Provider Identifier (NPI) number when billing Paper
  - 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

BlueCross BlueShield of Texas

Texas Health Steps

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

- Class action lawsuit that alleged Texas Medicaid failed to ensure children access to 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

Texas Health Steps (THSteps)

- 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 11c (Benefit Code is not required for CHIP preventive claims)
- Texas Health Steps Quick Reference Guide (www.TMHP.com)
  - Diagnosis codes: Z0000, Z0001, Z00110, Z0011, Z00121, Z00129
  - Diagnosis code: Z23 for Immunizations

Texas Health Steps (THSteps) Timely Checkups

- Newly enrolled children on STAR should be seen within 90 days of joining the plan for a timely Texas Health Steps Checkup
- Roster List of Members provided Monthly
- Existing Members birth through 35 months should receive THSteps Checkup within 60 days beyond the periodic due date based on the Member's birth date
- Existing Members age three years and older is due annually, considered timely if THSteps Checkup occurs no later than 364 calendar days after the child's birthday
- Providers should bill as an exception to periodicity
- Exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup
- Modifier 32 Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier "-32" to the basic procedure or service

Texas Health Steps (THSteps)
Mental Health Screening Procedure Code 99420

Effective January 1, 2017 Code 99420 discontinued

Replaced by two new codes

- 96160
- 96161

Required once for all clients ages 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 (THSteps) Continued

Comprehensive Care Program services include services such as:

- Medical Supplies and Durable Medical Equipment (pharmacy may provide these services)
- Therapies
- Outpatient Rehabilitation
- Private Duty Nursing
- Mental Services (provided by Magellan)

Texas Health Steps (THSteps) Benefit Code

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

Texas Health Steps (THSteps)

- Texas Vaccines for Children (TVFC)
  - Providers who administer vaccines to children 0 – 18 years of age may enroll
  - Providers who administer vaccines to children 0 – 18 years of age must be enrolled in Texas Health Steps
  - To enroll visit TMHP website: https://www.dshs.texas.gov/immunize/tvfc/default.shtm
  - BCBSTX will only reimburse the administration fee for any vaccine available through the TVFC program
  - Only time a provider is 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

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OB/GYN Billing

Billing OB/GYN Claims

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

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

Billing OB/GYN Claims
CHIP Perinate

- CHIP Perinate Mother's are entitled to a maximum of 2 postpartum visits
- 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 Maternity Claims

The following modifiers must be included for all deliveries		
U1 Medically necessary delivery prior to 39 weeks of gestation* STAR claims must include a medically necessary diagnosis from the list of approved 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.

Billing Maternity Claims (Cont'd)

- BCBSTX reimburses only one delivery or cesarean procedure per Member in a seven-month period
- Reimbursement includes multiple births
- Delivering physicians who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery
- Itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Laboratory (including pregnancy 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.

Billing OB/GYN Claims (Cont'd)

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

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

- Limited to a maximum of 21 doses per pregnancy

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

Sterilization

- Use the CMS-1500 claim form and follow appropriate coding guidelines.
- Attach a copy of the completed Sterilization Consent Form. The Sterilization consent form is available at www.tmhp.com.
- Claims will deny if the Sterilization consent form is not included with the claim

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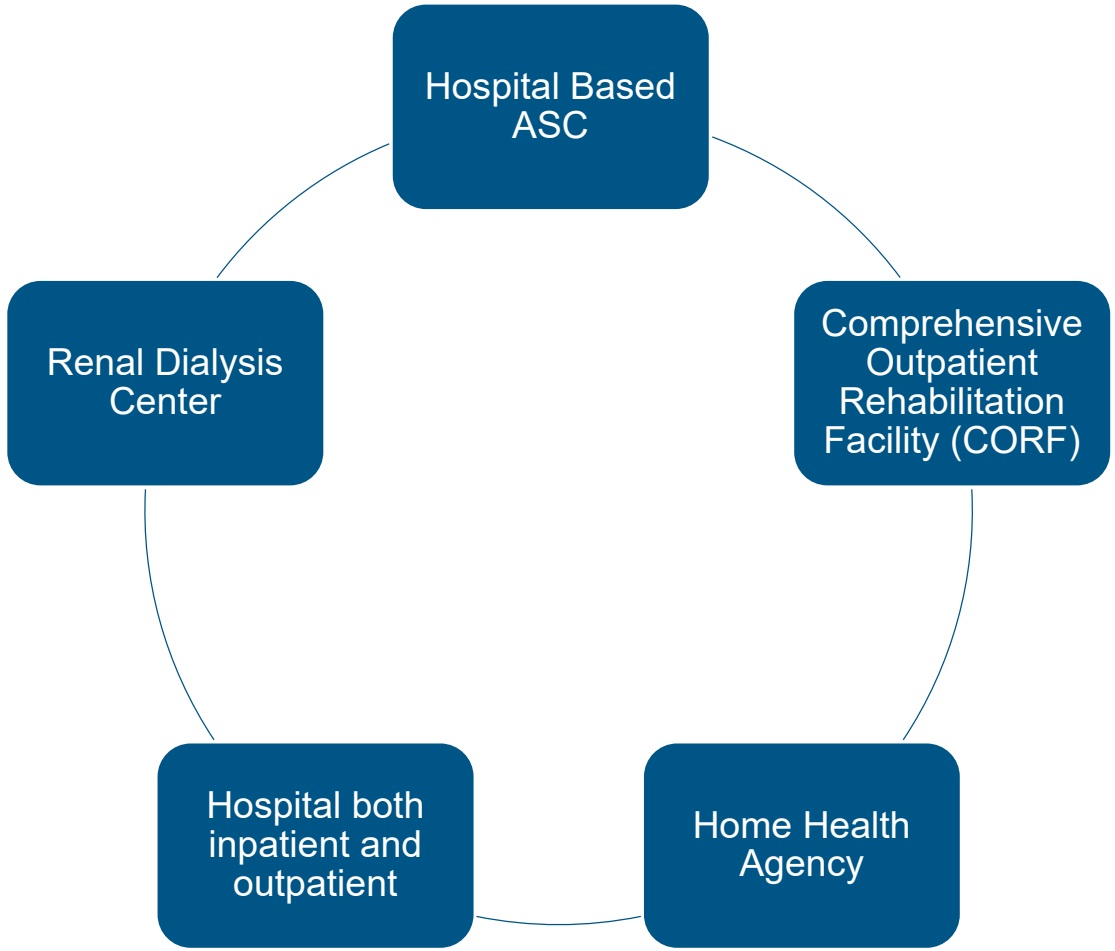
Ancillary Services

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

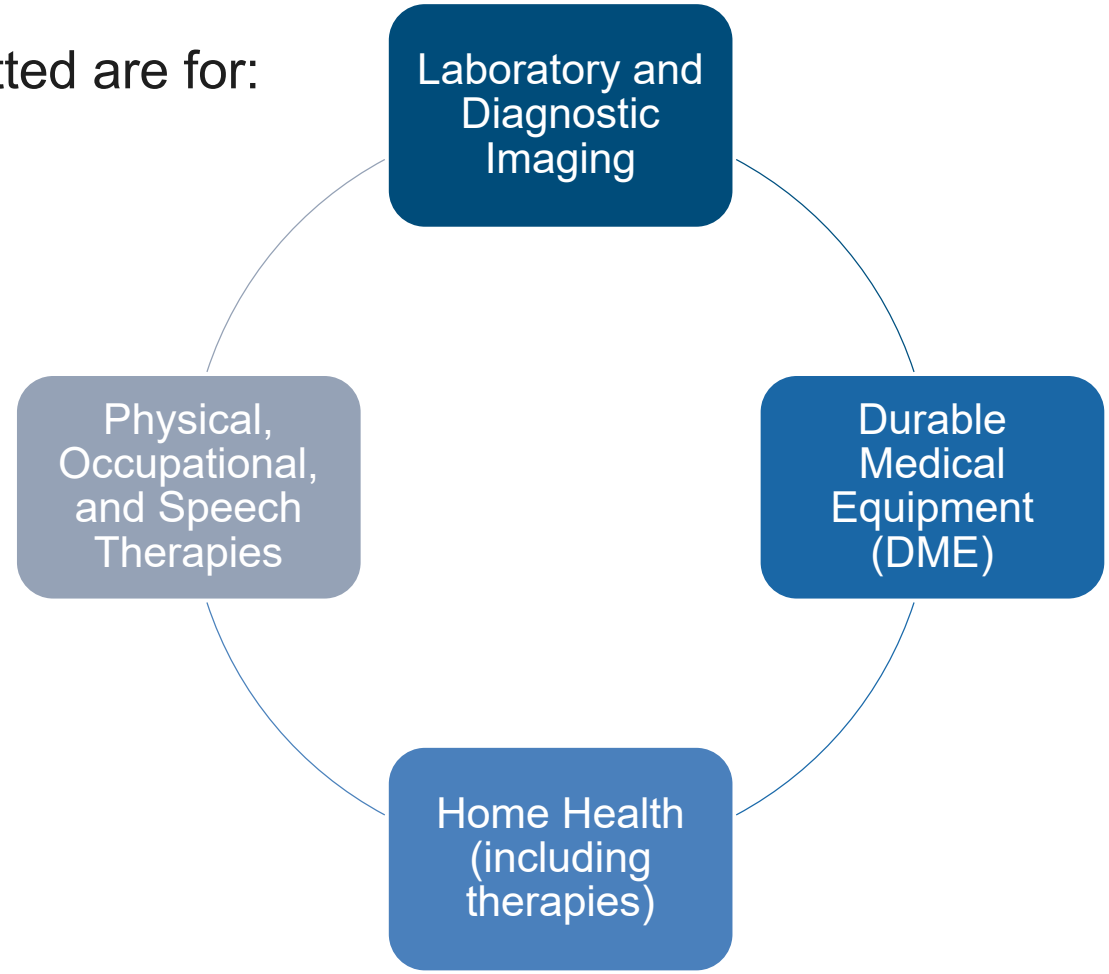
Ancillary Services Cont'd

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



Ancillary Services Cont'd

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



Ancillary Services –Lab and Radiology

- Routine Lab and X-ray do not require prior authorization
- When billing for Lab or Radiology, all required information must be included on the claim
- Superbills, or itemized statements are not accepted as claims supplements
- Attested NPI numbers for STAR 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)
- Additional modifiers should also be billed with the Therapy Codes UB/U5 to denote the provider type billing service.

Ancillary Services – PT/OT/SP Therapies

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

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Medical Management Overview

Utilization Management

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

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

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

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

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

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

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

Prior Authorizations

What Services Don't Require a Prior Authorization?

- Diagnosis and treatment of sexually transmitted diseases (out of network –OK)
- Testing for the Human Immunodeficiency Virus (HIV) (out of network – OK)
- Family Planning services to prevent or delay pregnancy (out of network – OK)
- Behavioral Health Services (in network only – Magellan Network)
- Annual Well Women exam (in-network Only)
- Prenatal services (in-network Only- Obstetric care
- Texas Health Steps (out of network- OK)
- **(*) Additional Services may apply**

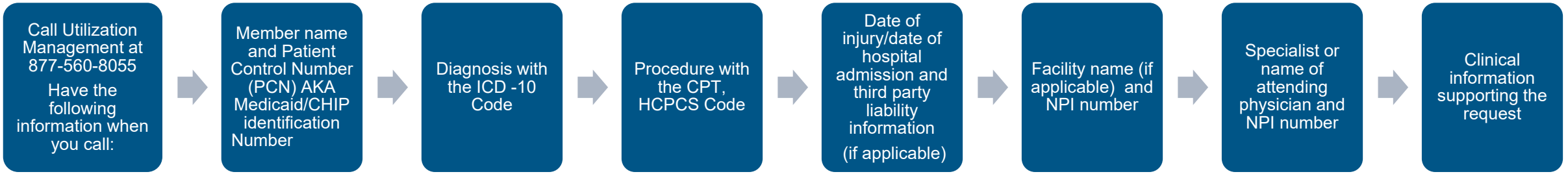
eviCore Prior Authorizations

Using eviCore

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

Note: eviCore does not process claims.

Submitting a Prior Authorization



Turn Around Times:

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

3 Business Days
Prior authorization requests (before outpatient service has been provided)

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

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

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

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Magellan Behavioral Health Overview

Magellan Care Management Center

Member and provider hotlines:

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

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

- Authorizations
- Coordination of Care
- Assistance with discharge planning
- Claims inquiries

Magellan Member and Provider Support Available

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

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

Online resources available
www.magellanprovider.com

- Includes member and provider education materials

Provider Responsibilities for Behavioral Health

Precertification is required for mental health and substance abuse services for 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

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

Provide Magellan with a thorough assessment of the member

Submitting Claims for Behavioral Health

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

When submitting claims electronically, use submitter ID #01260

Mailing Claims:

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

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Therapy Billing

Claim Form Requirements

- CMS – 1500 Claim Form:
  - Individual Therapy Providers and Non-ORF/CORF Therapy Clinics
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy

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

Therapy Policy and Billing Guidelines

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

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
- Solo providers must use rendering NPI and taxonomy in both box 24J and 33a

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

Common Denial Reasons

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

Provider Relations Representative

- Education and Training
- Assistance with problem claim resolution
- Assistance with provider attestation Issues
- Answer questions regarding program guidelines and claims filing.

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

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Thank you for attending our training.