Cook Children's Health Plan

1st Quarter 2021

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Providing CHIP and Medicaid services to Tarrant, Denton, Parker, Wise, Hood and Johnson

What's Inside

Prior Authorization Process Change for Missing Information and Incomplete Requests Webinar

Resultant from Senate Bill 1207 of the 86th Texas Legislative Regular Session, Cook Children's Health Plan is revising our process for Prior Authorization (PA) requests containing insufficient or inadequate documentation. This process will be effective April 1, 2021.

Please join our webinar on March 30, 2021 from 12:00 p.m. - 1:00 p.m. We want to ensure that all Providers are aware of this change and answer any questions. The following information will be provided during the webinar:

- Contractual reference information
- Revised letters & content information
- Timeline for submitting missing information

Prior Authorization Survey

We value your care for our Members. We want to make the process as seamless and understandable as possible. We know dealing with all Medicaid and CHIP patients and coverage can be cumbersome. Cook Children's Health Plan would like to make it less so.

Please complete this survey to help us maintain a beneficial mutual relationship with both you and your patients.

Cook Children's Health Plan Prior Authorization Survey 2021

CHIP Copayment Waiver

As a reminder, to assist families in accessing care during the COVID-19 response, HHSC will waive medical office visit copayments for all CHIP Members for services provided from March 13, 2020 through March 31, 2021.

Providers must not collect office visit copayments for CHIP Members during this time. Cook Children's Health Plan will reimburse the Provider the full rate for the service, including what would have been paid by the Member through cost-sharing.

Providers must attest that the office visit copayment was not collected and submit an attestation form and invoice detailing the claims transaction. The attestation form and invoice is located on the Provider News page of our website at cookchp.org, select the article titled CHIP Copayment Waiver Provider Notification.

Cook Children's Health Plan has thirty (30) calendar days to pay an invoice received from a Provider.

Ambulance Transportation

Cook Children's Health Plan covers emergency and medically necessary non-emergency ambulance transportation.

Emergency Ambulance Transportation

- In the event a Member's condition is life-threatening or potentially life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while in route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require Cook Children's Health Plan prior authorization
- Facility to facility transportation is considered emergent when meeting the definition found in 1 TAC §353.2. Facility to facility transport is considered emergent when the service is not eligible at the first facility.

Non-Emergency Ambulance Transportation

- Non-Emergency Ambulance Transportation is defined as ambulance transport provided for a Cook Children's Health Plan Member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the Member's home after discharge when the Member has a medical condition such that the use of ambulance is the only appropriate means of transportation
- Non-Emergency Ambulance Transportation services must be prior authorized and coordinated by Cook Children's Health Plan before an ambulance is used to transport a Member in circumstances not involving an emergency

The Provider of record, the Ambulance Provider, or those acting on their behalf may request approval for an ambulance by using the Prior Authorization Form for Health Care Services found on our website cookchp.org. Cook Children's Health Plan will provide the approval or denial for the prior authorization to the requesting provider and the ambulance provider.

The Ambulance Provider is responsible for ensuring the prior authorization was approved prior to transport as nonpayment will result without a prior authorization. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport.

Billing Tips:

- Claim form
  - CMS-1500
- Emergency transport
  - Is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes
  - The ET modifier is required for every detail on an emergency transport claim
    - The ET modifier is not required to be listed in the first position on the claim line
  - Emergency transports that use an extra attendant must bill modifier ET with the extra attendant procedure code
  - Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements
- Multiple Client Transports
  - A claim for each client must be billed with the transport procedure code and mileage procedure code with the GM modifier
- Not Medically Necessary Transports
  - Providers must use the GY modifier to submit claims for instances when the Provider is aware no medical necessity existed
    - Ambulance Providers must maintain a signed Client Acknowledgement Statement
- Emergency Transports Involving a Hospital
  - Hospital to hospital transports that meet the definition of an emergency transport do not require prior authorization
  - Providers must use modifier ET and one of the facility to facility transfer modifiers (HH, HI or IH) on each procedure code listed on the claim
- Place of Service
  - The place of service for all ambulance transports is considered the destination
- Origin and Destination Codes
  - All claims submitted must include the two-character origin and destination codes for each claim line.
  - The origin is the first character
  - The destination is the second character

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Resource: Texas Medicaid Provider Procedures Manual, Ambulance Services Handbook

Ambulatory Surgery Claim Forms

- Freestanding Ambulatory Surgery Center
  - Must be billed on the CMS 1500 form

- Ambulatory Surgery with Observation
  - Observation must be billed separately from the surgery
  - Observation must be billed on a UB-04

Texas Health Steps

To allow for continued provision of Texas Health Steps checkups during the period of social distancing due to COVID-19, HHSC allowed the remote delivery of certain components of medical checkups for children over 24 months of age (i.e. starting after the "24 month" checkup). Because some of these requirements (like immunizations and physical exams) require an in-person visit, provider must follow-up with their patients to ensure completion of any components within 6 months of the telemedicine visit.

Providers should bill using the appropriate Texas Health Steps checkup codes for the initial visit as is currently required. Providers may also bill for "add-on" codes (e.g. developmental screening, mental health screening, etc.) as they normally would. Modifier 95 must be included on the claim form to indicate remote delivery. Provider documentation should include the components that were not completed during the initial checkup using "COVID-19" as the reason for an incomplete checkup.

When the patient is brought into the office within the 6-month timeframe to complete the outstanding components of the visit, providers should bill the Texas health steps follow-up visit code (99211). Reimbursement will be identical to current rates for THSTEPS checkup codes.

Acceptable reasons for which the 6-month timeframe might not be met include, but are not limited to, the following:

- Child moves (from one service delivery area into another)
- Child switches primary care providers
- Child changes product service lines (e.g. from STAR to STAR Kids)
- Child switches MCO
- Child moves out of state
- Child dies
- Child loses eligibility
- It is still not safe in 6 months to conduct an in-person visit

Providers must document the reason the checkup was not able to be completed. Providers may also bill an acute care Evaluation and Management (E/M) code at the time of the initial telemedicine checkup or at the "6-month" follow-up visit. Modifier 25 must be submitted with the acute E/M procedure code to signify the distinct service rendered. Providers must bill the acute care visit on a separate claim without the benefit code EP.

Texas Health Steps Audit

Friendly reminder from our Compliance Department: Compliance is mandated by HHSC to audit Texas Health Steps records. Normally, these are the records that are requested from the provider:

- Developmental questionnaires
- Growth charts
- Labs
    - The labs should have results documented in the chart (or reason why it wasn't done) to get credit
- Immunization and Autism screening tools
    - Screening tools need to be scored and documented as reviewed and referrals given as necessary
- Visit notes

Federal and state mandated components must be documented in the Member's medical record for the checkup to be considered complete.

Newborn Claims Alert

Claims for newborns must be billed with the Newborn's identification number. Claims will deny if billed with the Mother's identification number. The Member information must match the eligibility file to avoid rejections and/or denials.

Newborns should receive their Member ID number within 2 weeks of birth. You can check eligibility for the newborn via the Secure Provider Portal.

Providers filing claims for services provided to newborns are still responsible for meeting timely filing deadlines. Claims must be received by Cook Children's Health Plan within 95 days of the Date of Service.

COVID-19 Toolkit

Please visit medicaid.gov and the Coronavirus Disease 2019 webpage to locate resources related to COVID-19. Under Other Resources you can locate the COVID-19 Toolkit which

provides information on the coverage and reimbursement for vaccines and vaccine administration for Medicaid and CHIP agencies.

Secure Provider Portal Reference Guide

To assist you with navigating the Secure Provider Portal please utilize the Secure Provider Portal Reference Guide. You may locate it on the Education and Training page located on our website cookchp.org.

In addition, we offer a monthly webinar on navigating the Secure Provider Portal. You can view our webinar calendar or register for a webinar by selecting the Provide Training Webinar Schedule 2021 on the Education and Training page.

Corrected Claims

Corrected claims must be received by Cook Children's Health Plan within 95 days of the date of service. They can be submitted electronically or by paper. The claim must be identified as a corrected claim.

EDI Instructions

- CMS 1500
  - In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
    - 7 = REPLACEMENT (replacement of prior claim)
    - 8 = VOID (void/cancel of prior claim)
    - In the 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected
      - You can locate the original claim number on your remittance advice
- UB04
  - The Type of Bill for UB claims are billed in loop 2300/CLM05-1
    - You will replace the third position of the TOB for 'frequency"
    - 7 = REPLACEMENT (replacement of prior claim)
    - 8 = VOID (void/cancel of prior claim)
    - In the 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected
      - This information can be found on the remittance advice

Paper Claim Instructions:

- CMS 1500
  - Replacement Claim - enter resubmission code 7 in Box 22 along with the original claim number (ICN) under Original Ref No

    - Voided claims - Enter resubmission code 8 in Box 22 along with the original claim number (ICN) under Original Ref No
- UB-04
    - Replacement Claim – in form locator 3 change the third position of your Type of Bill to a 7, in form locator 64 enter the original claim number
    - Voided claim – in form locator 4 change the third position of your Type of Bill to a 8, in form locator 64 enter the original claim number

Submitting a Secondary Claim Electronically

Payers must report paid amounts at both the claim level and service line level to ensure claim integrity. Both levels must balance. There are two different ways the claim information must balance. They are as follows:

Claim Level

- Claim Charge Amounts
    - The total charge amount reported in Loop 2300 CLM02 must balance to the sum of all service line charge amounts reported in Loop 2400 SV203
- Claim Payment Amounts
    - Balancing of claim payment information is done payer by payer. For a given payer, the sum of all line level payment amounts (Loop 2430 SVC02) less any claim level adjustment amounts (Loop 2320 CAS adjustments) must balance to the claim level payment amount (Loop 2320 AMT02)
    - Expressed as a calculation for given payer: (Loop 2320 AMT02 payer payment) = (sum of Loop 2430 SVD02 payment amounts) minus (sum of Loop 2320 CAS adjustment amounts)
    - The payer's total claim payment is reported within Loop 2320 Coordination of Benefits (COB) Payer Paid Amount AMT segment with a D qualifier in AMT01
        - The associated payer is defined within Loop 2330B child loop
- Line Level Payment Amounts
    - Line level payment information is reported in Loop 2430 SVD02
    - Line level balancing function, the receiver must know which payer the line payment belongs to
        - This is accomplished using the identifier reported in Loop 2430 SVD01
            - This identified must match the identifier of the corresponding payer identifier reported in Loop 2330B NM109

Service Line Level

- Line Adjudication Information (Loop 2430) is reported when the payer identified in Loop 2330B has adjudicated the claim and service line payments and/or adjustments have been applied

- Line Level Balancing occurs independently for each individual Line Adjudication Information Loop
- In order to balance, the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information Loop must balance to the Provider's charge for the line (Loop 2400 SV203)
  - The Line Adjudication Information Loop can repeat up to 25 times for each line item
  - The calculation for each 2430 loops is as follows: (sum of Loop 2430 CAS Service Line Adjustments) plus (Loop 2430 SVD02 Service Line Paid Amount) = (Loop 2400 SVC203 Line Item Charge Amount)

Additional Details:

- Claim Level:
  - Loop 2320 Other Subscriber Information
    - Required when the claim has been adjudicated by the payer identified in Loop 2330B
    - Required when Loop 2010AC is present
      - In this case, the claim is a post payment recovery claim submitted by a subrogated Medicaid agency
  - TR3 Example: AMT*D*411~
- Service Line Level:
  - Loop 2430 Line Adjudication Information
    - Required when the claim has been previously adjudicated by payer identified in Loop 2330B and this service line has payments and/or adjustments applied to it.
  - Loop Repeat: 15
  - TR3 Notes: To show unbundled lines
    - If, in the original claim, line 3 is unbundled into (for example) 2 additional lines, then the SVD for line 3 is used 3 times: Once for the original adjustment to line 3 and then two more times for the additional unbundled lines
  - TR3 Example: SVD*43*55*HC:84550**3~

Timely Filing

The most current filing deadline calendars are available on the TMHP website at tmhp.com.

- Filing Deadline Calendar 2020
- Filing Deadline Calendar 2021

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We strongly encourage Providers to submit their claims electronically.

- Initial claims must be received within 95 days of the date of service
- Corrected Claims must be received by Cook Children's Health Plan within 95 days of the date of service
- Secondary Claims must be received within 95 days of the date on the primary insurance explanation of payment

We strongly encourage Providers to submit Claim Reconsideration Requests and Claim Appeals via the Secure Provider Portal.

- Claim appeals must be received in writing within 120 days of the date on the explanation of payment

Provider News

Did you know we publish several Newsletters throughout the year? Visit the Provider News page located at cookchp.org and review our Behavioral Health, EVV and Quarterly Provider Newsletters.

Provider Training Webinars

We'd love to have you or a member of your team attend our provider training webinars. Visit the Education and Training page located on our website cookchp.org, to review our Provider Training Webinar Schedule and register for an upcoming webinar.

Provider Relations

How can we help you? If you need assistance or would like to know who your Provider Relations Coordinator is please email CCHPProviderRelations@cookchildrens.org.

Contact Us

If you have questions please call Provider Support Services at 888-243-3312 Monday through Friday from 8 a.m. to 5 p.m. excluding state holidays.

You may also submit a Customer Service Request via the Secure Provider Portal.

For a list of departments and contacts visit the Contact Us page located on cookchp.org.