CookChildren's Health Plan

Out of Network Provider Reference Guide

Revised: 050323

Our Promise

Knowing every child's life is sacred, we promise to improve the well-being of every child in our care and our communities.

CookChildren's Health Plan

Agenda

- Provider Support Services
- Service Delivery Area
- Benefits, Limitations, Exclusions
- Reimbursement
- Texas Medicaid
- Joining the Network
- Provider Demographic Updates
- Network Development
- Secure Provider Portal
- Other Health Insurance
- Balance Billing
- Prior Authorizations

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Agenda

- Claims
- Electronic Funds Transfer & Electronic Remittance Advice
- Provider Education
- Training Resources

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Provider Support Services

888-243-3312

A representative is available Monday – Friday, 8am-5pm, excluding state holidays.

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Service Delivery Area

Cook Children's Health Plan provides essential coverage to low-income families in our six-county service area who qualify for government-sponsored programs, including Medicaid, CHIP and STAR Kids.

The six counties our service delivery area currently covers is: Wise, Denton, Parker, Tarrant, Hood and Johnson county.

Note: In order to be listed in our Provider Directory out of area Providers must have a local or toll free number.

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Benefits, Limitations and Exclusions

Providers should verify benefits, limitations and exclusions located in the Texas Medicaid Provider Procedures Manual (TMPPM) at tmhp.com prior to rendering services. Always refer to the most recent publication.

In addition, prior to submitting services for reimbursement Providers should refer to the most recent publications of the:

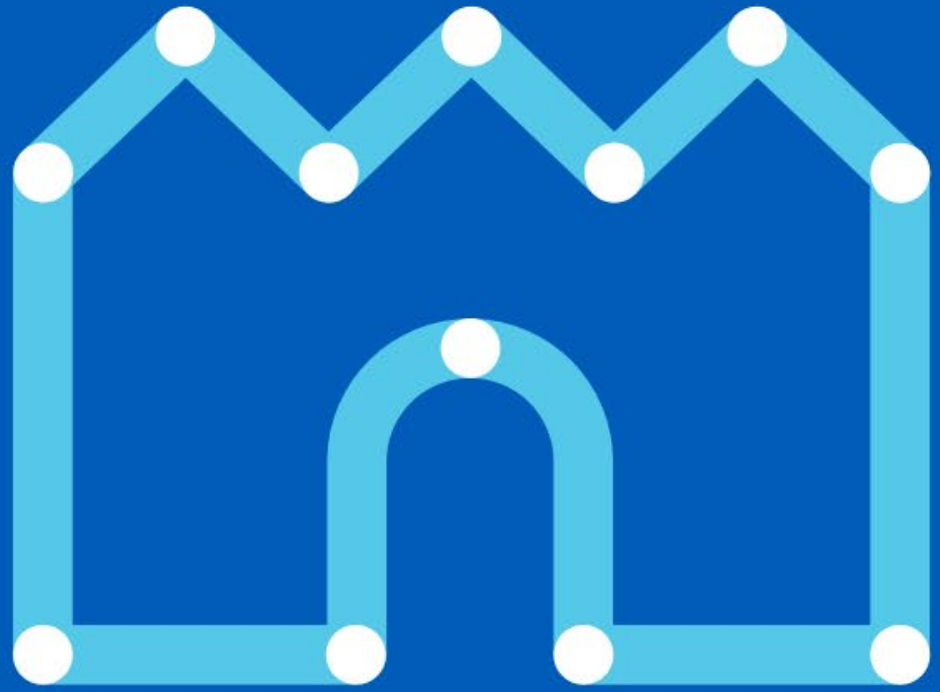
- Cook Children's Health Plan Provider Manuals located on cookchp.org
- Electronic Data Interchange Requirements located on tmhp.com and cookchp.org
- CPT, ICD-10, HCPCS coding books
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Medicaid National Correct Coding Initiative (NCCI) Edits located on CMS.gov and Medicaid.gov

Reimbursement

Non participating Providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

- Medicaid (STAR) and CHIP
  - Out of network, in area service Providers, at no less than the prevailing Medicaid fee for service rate, less five percent
  - Out of network, out of area service Providers, at no less than one hundred percent of the Medicaid fee for service rate
- STAR Kids
  - Out of network, in area service Providers, at no less than the prevailing Medicaid fee for service rate, less five percent
  - Out of network, out of area service Providers, at no less than one hundred percent of the Medicaid fee for service rate

Texas Medicaid



Texas Medicaid Provider

To be eligible for Texas Medicaid reimbursement, a Provider must be approved by the Texas Health and Human Services Commission (HHS) and enrolled with Texas Medicaid & Healthcare Partnership (TMHP).

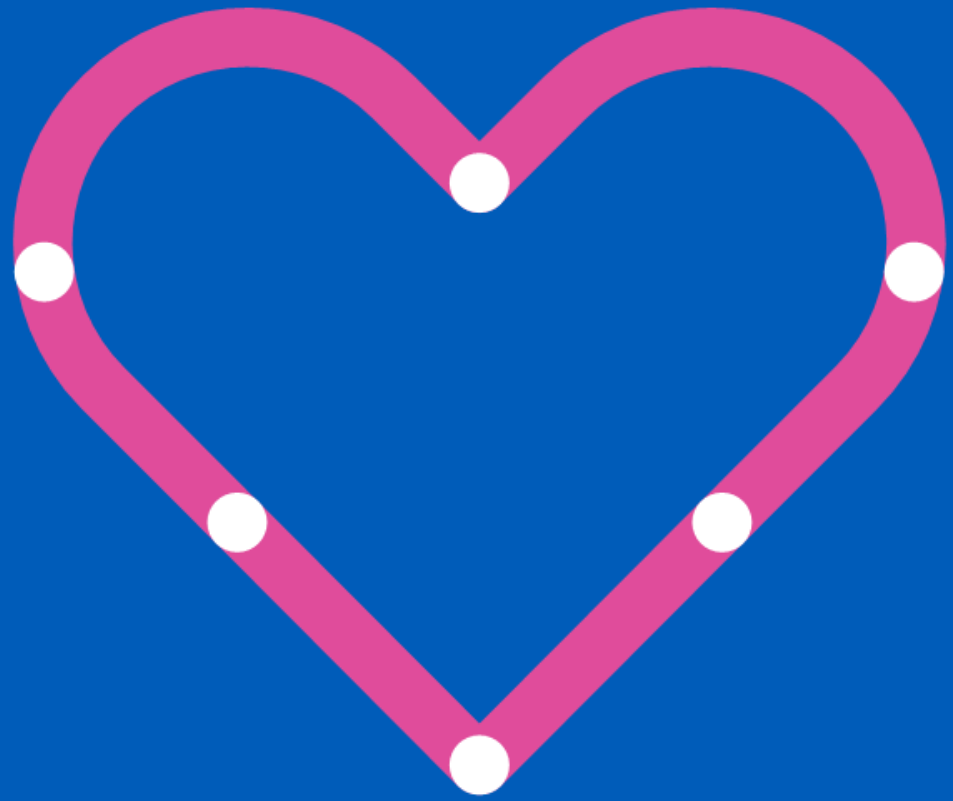
- Providers can use the online Provider Enrollment and Management System (PEMS) tool to enroll electronically through TMHP's website at tmhp.com

National Provider Identifier

Providers must ensure their National Provider Identifiers (NPI) are active and correct with the National Plan & Provider Enumeration System (NPPES) to avoid disenrollment from Texas State Medicaid.

Visit https://nppes.cms.hhs.gov to verify your NPI(s) with the NPPES registry.

Joining the Cook Children's Health Plan Network



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Joining the Network

Providers are required to credential with Cook Children's Health Plan. A Provider interested in joining our network must:

- Enroll as a Medicaid Provider via Texas Medicaid & Healthcare Partnership
  - Visit tmhp.com, select Topics, Provider Enrollment
  - TMHP Contact Center 800-925-9126, option 3
- Complete and submit the Letter of Interest Questionnaire to the health plan
  - Log in to the Secure Provider Portal
  - Select the Customer Service icon from the homepage
  - Select the Topic: Request to Join the Network

Note: Providers pending access approval to the Secure Provider Portal can submit the Letter of Interest Questionnaire form via email to cchpnetworkdevelopment@cookchildrens.org. The Letter of Interest form can be obtained from the Joining the Network page located on our website, cookchp.org.

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Credentialing

Credentialing

Cook Children's Health Plan's credentialing process is designed to meet the National Committee for Quality Assurance (NCQA) and state requirements for the evaluation of Providers who apply for participation.

Upon receipt of the LOI, Network Development will:

- Review the forms
- Submit the Provider's information to the Executive Board for approval to begin the credentialing process
- Send the Provider a Participating Provider Agreement
- Submit the Provider's information to the Credentialing Verification office, Verisys

Verisys will contact the Provider to:

- Start the credentialing process
- Accept the credentialing application
- Perform the Primary Source Verification (PSV)

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Credentialing

Providers will:

- Use Availity to complete the credentialing application
- Sign and return all contract documents including a current W9 form

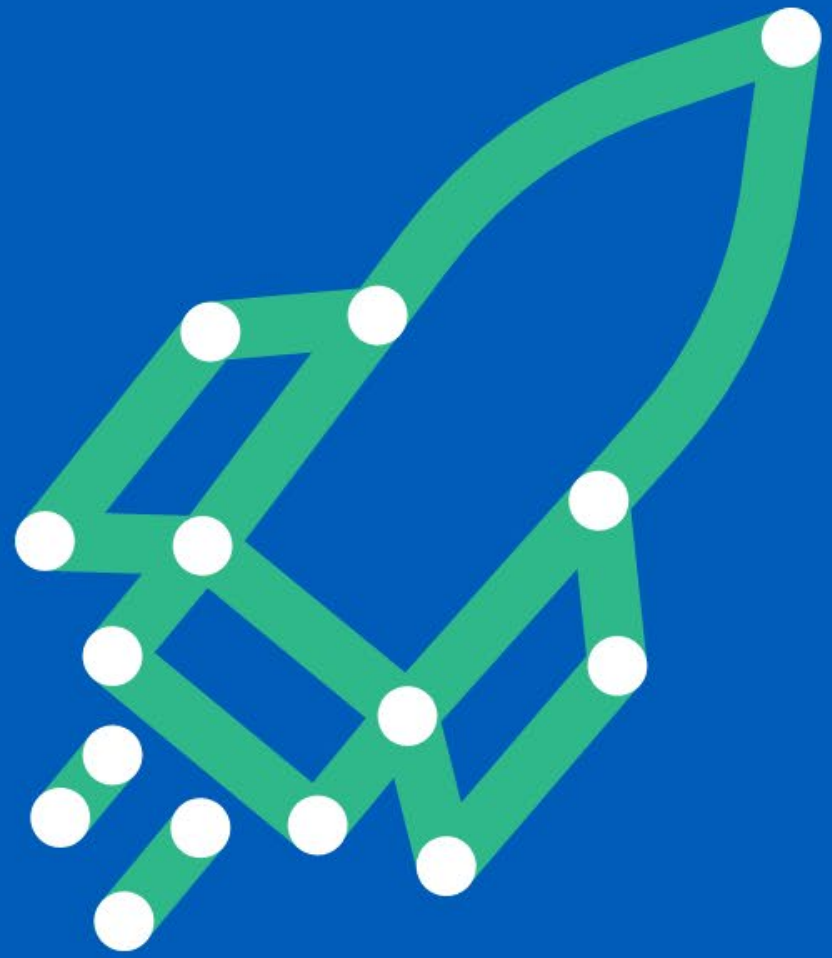
Upon receipt of a completed application and any requested documentation:

- The credentialing process will be completed within ninety days

Upon complete credentialing Network Development will:

- Send the Provider a welcome letter with the effective date of participation along with the fully executed contract

Provider Demographic Updates



Provider Demographic Information

As a Texas Medicaid Provider you are required to keep your demographic information up to date with Cook Children's Health Plan and Texas Medicaid & Healthcare Partnership (TMHP).

To update your demographic information with the health plan, submit a Customer Service Request via the Secure Provider Portal, from the homepage select the Customer Service icon, Topic: Provider Demographics Changes. Please allow ten business days to process your request.

Providers pending access approval to the Secure Provider Portal can submit the Provider Information Change Form, posted on the Manuals and Forms page located on our website, cookchp.org. Email the completed Provider Information Change Form to cchpnetworkdevelopment@cookchildrens.org.

Note: Tax ID updates cannot be processed without a properly completed current W-9 form.

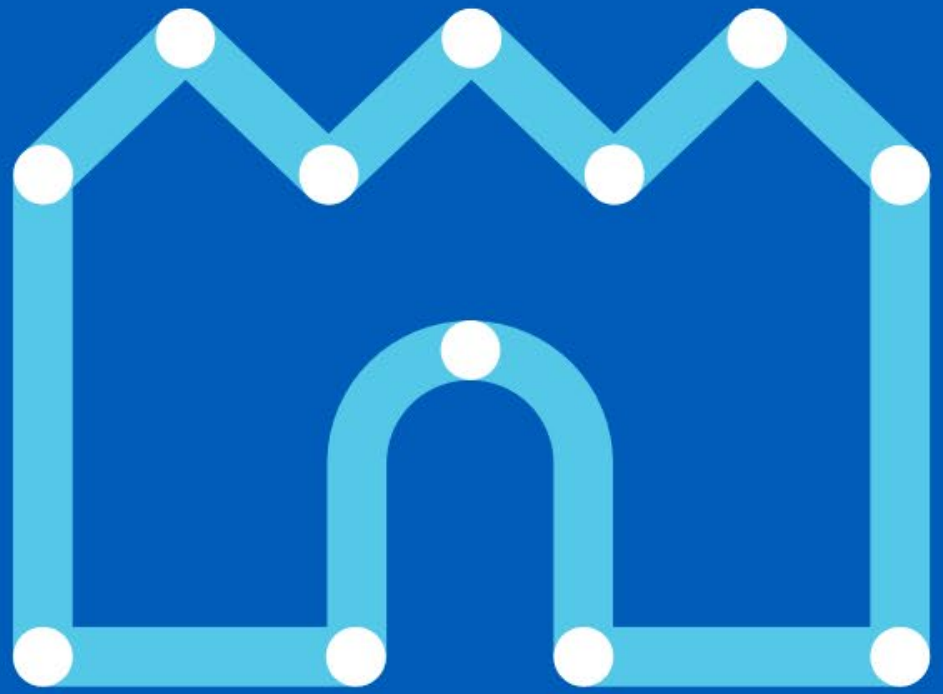
Provider Demographic Updates – TMHP

Providers can use the Texas Medicaid & Healthcare Partnership Provider Enrollment and Management System (PEMS) to update their information with TMHP.

PEMS puts everything you need in a single system for Provider enrollment, reenrollment, revalidation, change of ownership, and maintenance requests (maintaining and updating Provider enrollment record information).

PEMS is accessed through the My Account tab at tmhp.com. PEMS access is tied to the National Provider Identifier (NPI) or Atypical Provider Identifier (API) associated with the TMHP user account. Providers must ensure their NPI or API has all their current and correct information.

Network Development



Network Development

Network Development Department can assist Providers with:

- Contracting
- Credentialing
- Provider Demographic updates
- Re-credentialing

Email: cchpnetworkdevelopment@cookchildrens.org

Online: Secure Provider Portal

Phone: 888-243-3312

Fax: 682-885-8403

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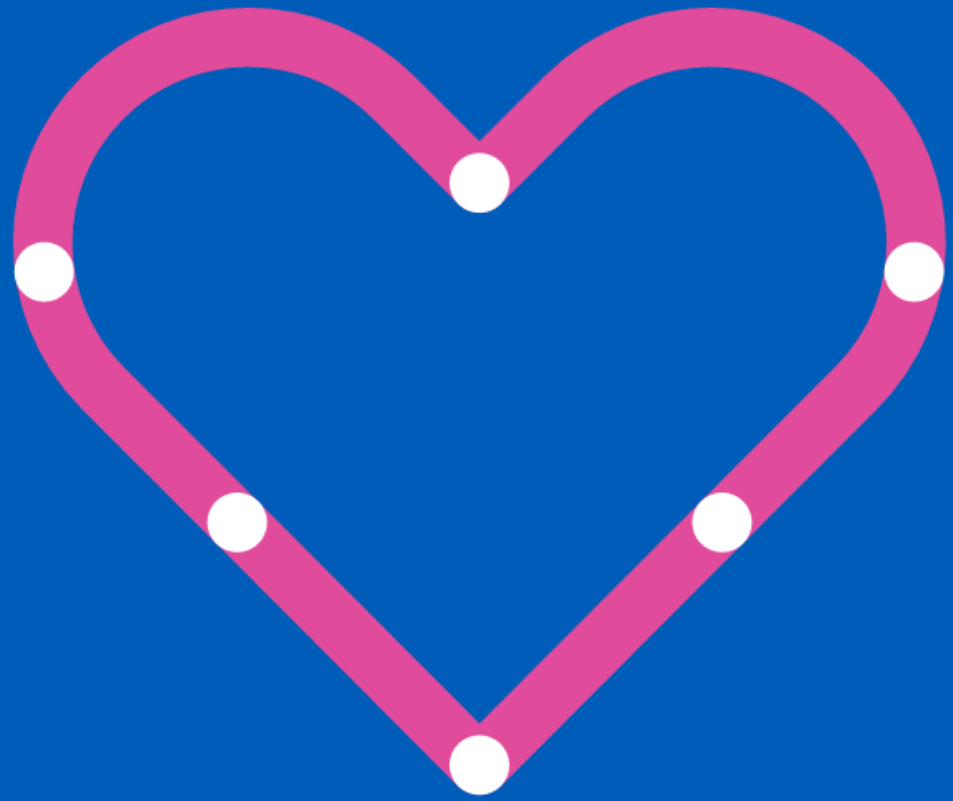
Secure Provider Portal



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Secure Provider Portal

Cook Children's Health Plan offers a secure online portal where Providers can access clinical or managed care data. By granting Providers access to EpicCare Link the amount of paper authorizations, manual claim status requests, and customer service calls are reduced.

Each Provider office, Group, or Practice must have at least one Site Administrator.

- The Site Admin will be responsible for:
  - Submitting new account requests for each staff member who requires access
  - Submitting new account requests for third parties such as Billing and Credentialing partners
  - Deactivating accounts for Users who have resigned or are terminated
  - Requesting password resets

Note: Access requests received from individuals other than the Site Administrators will be denied.

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Secure Provider Portal Access

If you do not have access to the Secure Provider Portal, review the Secure Provider Portal Training Guide on the Provider Relations page located on our website, cookchp.org, for instructions or email Provider Relations at cchpproviderrelations@cookchildrens.org for enrollment assistance.

Other Health Insurance

Coordination of Benefits

Providers must verify Member benefits prior to rendering services and must bill the Member's primary insurance carrier before submitting the claim to the health plan.

- Eligibility can be verified on the Secure Provider Portal
- Other Health Insurance will be listed under Coverages and Benefits
  - Select the Coverage Detail Report

Other Health Insurance Claims Filing

Once the primary insurance has processed the claim the Provider would submit the claim to the health plan. Claims must be received by the health plan within ninety-five days of the date of disposition listed on the primary insurance explanation of benefits.

- The other insurance information must be populated on the claim form
  - Name of the other insurance
  - Address of the other insurance
  - Policy number and group number
  - Policyholder
  - Effective date
  - Date of disposition on the other insurance explanation
  - Payment or specific denial information

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Other Insurance Claims Filing

By accepting assignment on a claim for which the Member has Medicaid coverage, Providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full.

Note: The Member cannot be held liable for any balance or copays related to Medicaid covered services as outlined in the Texas Medicaid Provider Procedures Manual, Volume 1, Section 6: Claims Filing, 6.1.4 Claims Filing Deadline and Section 8: Third Party Liability, 8.8 Other Insurance Claims Filing.

110-Day Rule

If a third party (group health plan, liability insurance, etc.) has not responded or delays payment or denial of a Provider's claim for more than one hundred ten days after the date the claim was billed, the Provider should submit the claim to the health plan for reimbursement consideration.

- The three hundred sixty-five day federal filing deadline requirement must still be met

The following information is required when submitting the claim to the health plan:

- Name and address of the Third Party
- Date the Third Party claim was billed
- Statement signed and dated by the Provider that no disposition has been received from the Third Party within one hundred ten days of the date the claim was billed

Note: For more information review the Texas Medicaid Provider Procedures Manual, Volume 1, Section 8: Third Party Liability, subsection 8.8.2.5 110-Day Rule.

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Eligibility Status

If a Member has a change in eligibility status such as new or terminated primary insurance coverage, notify the health plan via the Secure Provider Portal by submitting a Customer Service Request, select the Topic: OHI Notification.

Providers pending enrollment to the Secure Provider Portal can submit OHI information via secure email to cchpcob@cookchildrens.org.

Exhausted or Non Covered Benefit

If the services you are providing are a non covered benefit by which the primary insurance carrier or the Member has exhausted their benefits with their primary insurance carrier you should submit the denial or letter of exhausted benefits to the health plan via the Secure Provider Portal by submitting a Customer Service request, select the Topic: OHI Notification.

You will receive a Customer Relationship Management (CRM) number via the Secure Provider Portal In Basket acknowledging receipt of the request. The health plan will acknowledge receipt of the request within three business days. Providers can call Provider Support Services at 888-243-3312 for status of their request after three business days.

Once verification is complete and Providers have received notification via the Secure Provider Portal, Providers should resubmit their claims showing Cook Children's Health Plan as the primary insurance, leaving all fields related to Other Health Insurance blank.

Claim Resubmission

Once verification is complete and Providers have received notification via the Secure Provider Portal, Providers should resubmit their claims showing Cook Children's Health Plan as the primary insurance, leaving all fields related to Other Health Insurance blank.

Other Health Insurance Notice

Cook Children's Health Plan does not require EOB information from primary private insurance for the following LTSS services:

- PCS
- CFC
- DAHS
- PPECC
- MDCP Respite
- MDCP Flexible Family Support Services
- MDCP Supported Employment
- MDCP Employment Assistance
- MDCP Minor Home Modification
- MDCP Adaptive Aids

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Other Health Insurance Notice

Cook Children's Health Plan does not require EOB information from primary private insurance for the following services:

- Mental Health Rehabilitation
- Mental Health Targeted Case Management
- Case Management for Children and Pregnant Women

Other Health Insurance

Note: For more information visit the Provider Relations page located on our website, cookchp.org, and view the Other Health Insurance presentation.

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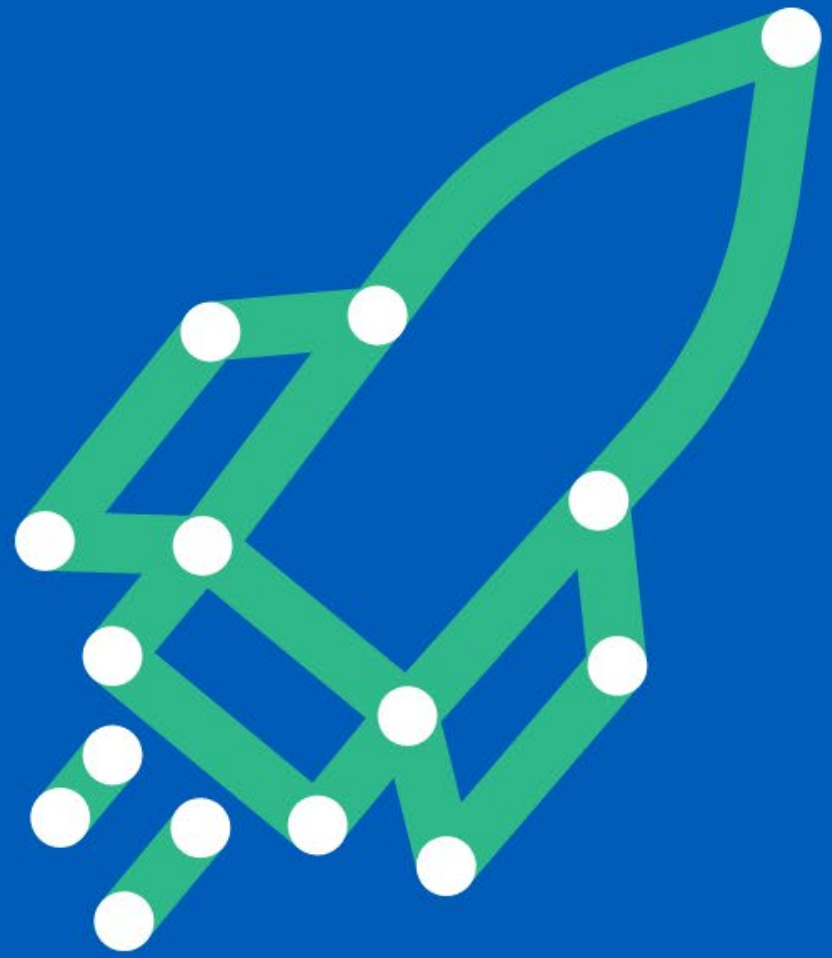
Balance Billing



Balance Billing Members

Members must not be balance billed for the amount above which is paid by the health plan for covered services.

Providers may not bill a Member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the ninety-five day filing deadline
- Failure to submit a corrected claim within the ninety-five day filing submission period
- Failure to appeal a claim within the one hundred and twenty day administrative appeal period
- Failure to appeal a utilization review determination within thirty calendar days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

Balance Billing Members

Providers may not bill a Member:

- For failing to show for an appointment
- For a third party insurance copayment

Providers may not bill for or take recourse against a Member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

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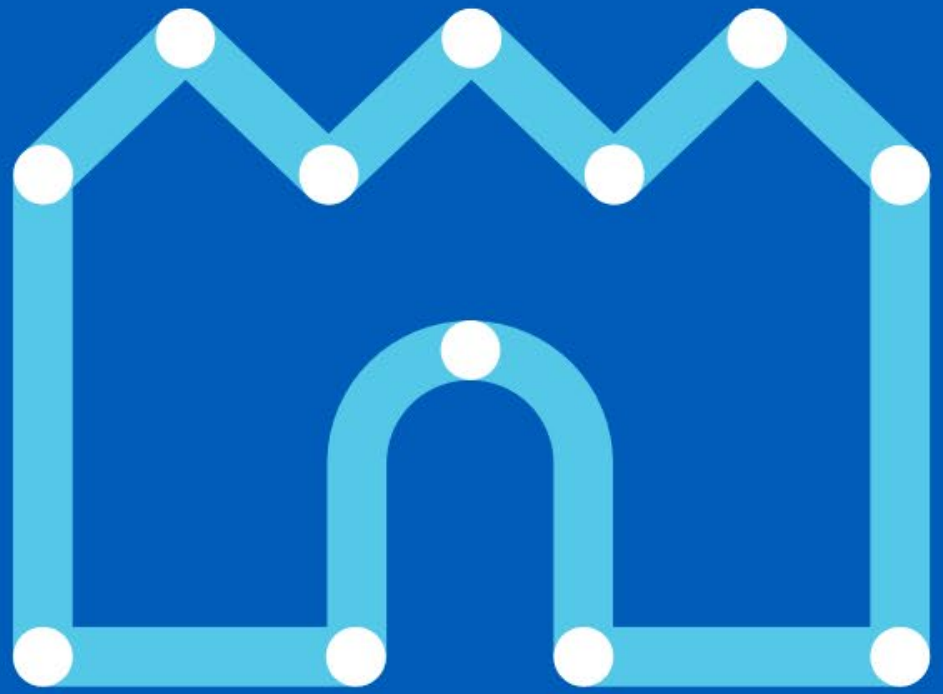
Prior Authorization



Authorization Required

Prior Authorization is always required for services rendered by an Out of Network Provider with the exception of:

- STAR and STAR Kids Family Planning
- Texas Health Steps Medical Checkups
  - Performed by those with valid Texas Health Steps Provider identifier
- Emergency care
- Physicians services
  - For uncomplicated deliveries
- Indian Health Care Provider services
  - Enrolled as a FQHC

Prior Authorization Submission

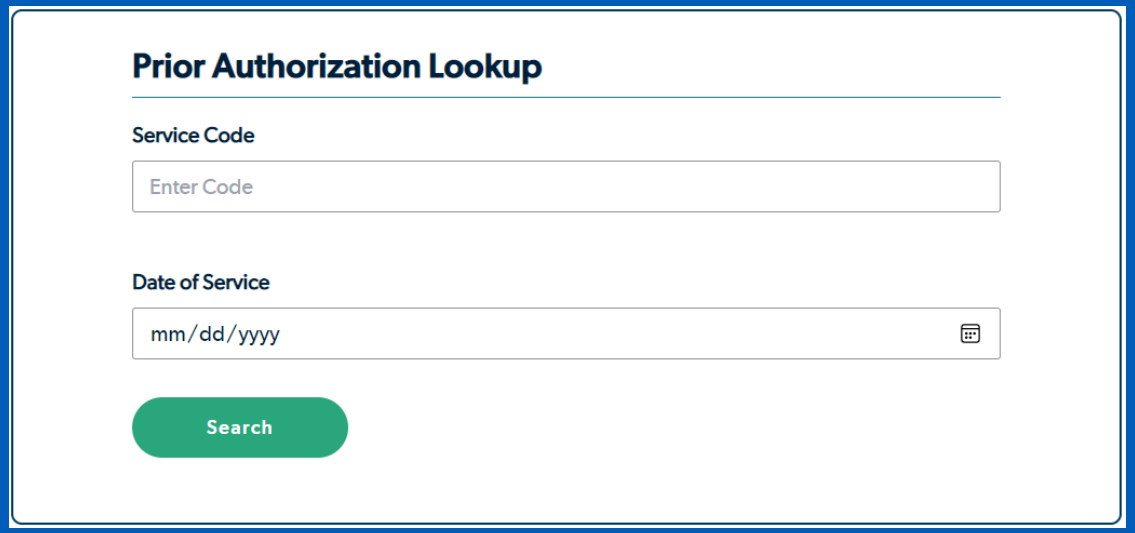
Providers must submit prior authorization requests including Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC) Services and Durable Medical Equipment (including Adaptive Aids and Home Modifications) via the Secure Provider Portal located on our website cookchp.org.

All STAR Kids LTSS Services with the exception of Private Duty Nursing (PDN) and Prescribed Pediatric Extended Care Center (PPECC) Services are authorized by the Service Coordinator. Providers should obtain the authorization from the Service Coordinator and should not submit prior authorization requests via the Secure Provider Portal.

A Title XIX form is required for Adaptive Aids and Home Modifications. Providers should submit the Title XIX form with the Durable Medical Equipment prior authorization request via the Secure Provider Portal or fax the form to 682-303-0005.

Prior Authorization Lookup Tool

To determine if a service requires prior authorization access the Prior Authorization Lookup tool on the Prior Authorization page located on our website, cookchp.org.



- Enter a valid CPT or HCPCS code in the service code field, enter the date of service and click “search”

Prior Authorization Not Required

The response Prior authorization is not required is not a guarantee of payment.

Prior authorization is not required.
To review the criteria for this service, please refer to the Texas Medicaid Provider Procedures Manual (TMPPM). You may find the most recent version at http://www.tmhp.com/resources/provider-manuals/tmppm.

Note: For services that do not require authorization, it remains the Providers responsibility to review the Texas Medicaid Provider Procedures Manual and Medicaid Fee Schedule to verify benefits, limitations and exclusions.

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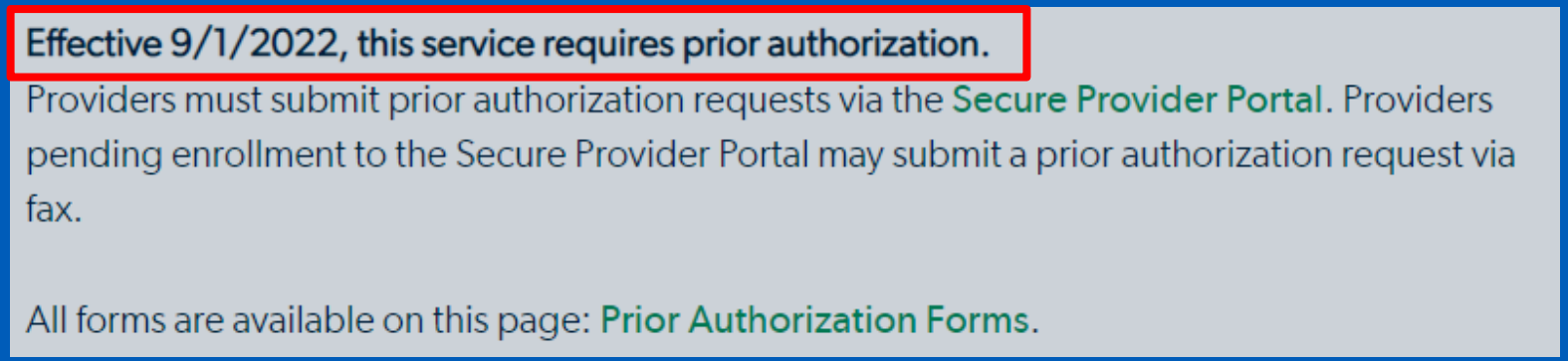
Prior Authorization Required

Prior authorization required requires Providers to submit a prior authorization request. Prior authorization is not a guarantee of payment.



Note: Prior Authorization is not a guarantee of payment.

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Authorization Number – Claim Form

If an authorization is required for the service you provided you must submit the claim form with the authorization number in the appropriate field.

Paper Claim Form:

- CMS 1500
  - Item 23
- UB-04
  - Form locator 63

Electronic Data Interchange:

- Loop 2300, Segment REF

Note: Claims submitted without the authorization number will be denied.

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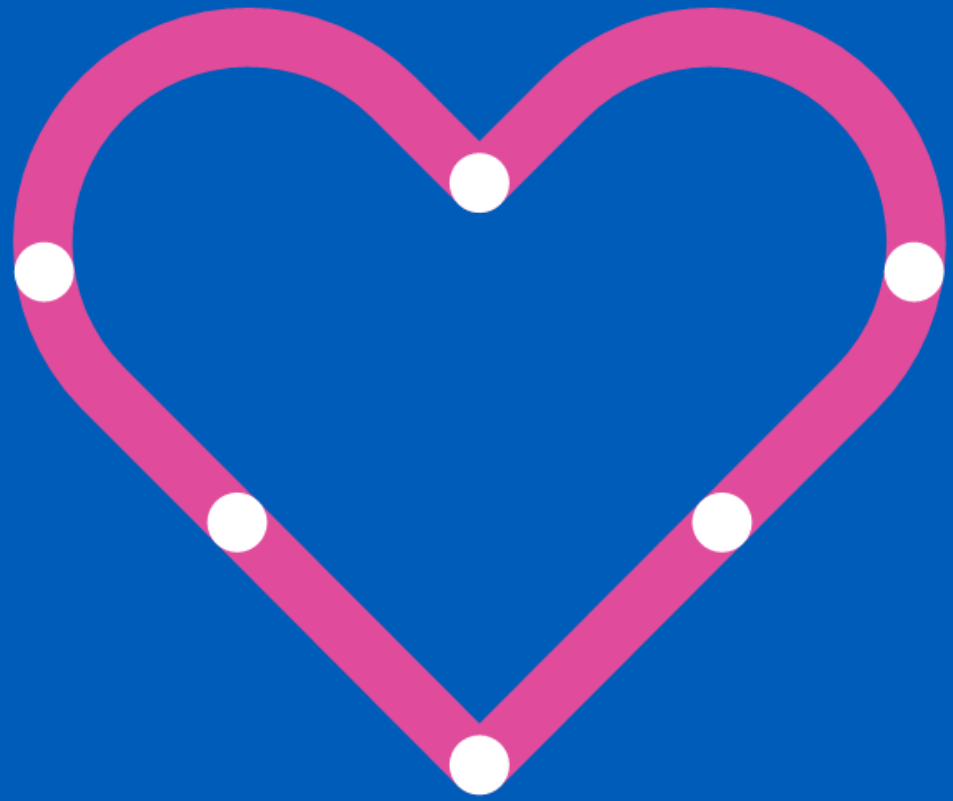
Prior Authorization Reminders

Providers must ensure that all necessary prior authorizations are obtained prior to providing services.

- Payment is subject to the Member's eligibility and benefits on the date of service
- Only one authorization number per claim
  - If the services you are billing for have more than one authorization number you will need to split the claim or the service will deny
- The requested Provider on the authorization form must match the way the Provider is credentialed and contracted with the health plan
- Authorization dates of service, procedure codes, place of service, and modifiers must match the services as billed on the claim form

Claims



W9 Required

In order for Cook Children's Health Plan to process your claim we must have a current W9.

Before submitting a claim you must:

- Complete the W9
  - Version 10-2018
    - Form W9
- Submit the W9 to Network Development
  - Email: cchpnetworkdevelopment@cookchildrens.org
  - Fax: 682-885-8403

Timely Filing Guidelines

Initial claim:

- Must be received by the health plan within ninety-five days of the date of service
  - If the claim covers multiple dates, the ninety-five day timely filing is based on the FIRST date of service on the claim form

Secondary claim:

- Must be received by the health plan within ninety-five days of the disposition date on the primary insurance Explanation of Benefits (EOB)

Corrected claims:

- Must be received by the health plan within ninety-five days of the date of service

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Timely Filing Calendar

The Filing Deadline Calendar is updated yearly and is available on tmhp.com.

- Select Resources
  - Select Quick Reference
    - Select the Filing Deadline Calendar

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Date Span Billing

Cook Children's Health Plan does not allow date span billing.

- Each date of service must have it's own claim line

Electronic Data Interchange Requirements

Primary and secondary claims can be submitted to Cook Children's Health Plan electronically. For Electronic Data Interchange (EDI) requirements visit cookchp.org and tmhp.com.

The following resources are available to assist Providers with submitting claims electronically:

- TMHP Electronic Data Interchange Companion Guides
- CCHP Electronic Data Interchange Requirements – Institutional
- CCHP Electronic Data Interchange Requirements – Professional
- 837P Acute Care Companion Guide – Professional Claim
- 837I Acute Care Companion Guide – Institutional Claim
- 837P Long Term Care Companion Guide – Professional Claim
- 837I Long Term Care Companion Guide – Institutional Claim

Note: These resources should be used in conjunction with the National Implementation Guide.

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Paper Claim Requirements

- Use an official red CMS-1500
  - Do not use copies
  - Do not use Electronic Medical Record templates
- Must submit by mail cannot submit by fax
- Do not fold claim forms
  - Use paper clips
  - Do not use staples or tape
- Print claim data within defined boxes on the claim form
- Use all capital letters
- Send Certified Mail
  - Include a letter with a list that includes the Member Name, Patient Account Number and Date of Service
  - Keep a copy of this document with your Certified Mail receipt

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Claim Adjudication

Claims are adjudicated within thirty days of the date the health plan receives the claim.

Clean Claim

A clean claim is defined as a claim containing all required information needed to process the claim. This includes but is not limited to:

- Primary Insurance EOB
- MSRP Invoice
- Procedure Codes and Modifiers

The claim form must include all the required data to adjudicate the claim. Claims are adjudicated within thirty days of the date the health plan receives the claim.

Note: A clean claim must be received by the health plan within ninety-five days of the date of service.

Rejected Claims

Rejected claims do not enter the adjudication system due to missing or incorrect information.

- Rejected claims are not considered “received”
  - They are not accepted for adjudication
  - They do not receive a claim number
- The claim is returned to the Provider along with a rejection letter
- The claim error should be fixed and the new claim submitted to the health plan

Denied Claims

Denied claims go through the adjudication process, but are denied for payment.

- The Provider must submit a written request for claim reconsideration or a claim appeal
- Claim reconsiderations and claim appeals must be received by the health plan within one hundred twenty days from the date on the health plan's Explanation of Payment

Corrected Claim Submission

A corrected claim is a correction or a change of information to a previously finalized (adjudicated) claim.

Corrected claims:

- Must be received by the health plan within ninety-five days of the date of service
- Can be submitted electronically or by paper
- Must be identified as a corrected claim
- Must reference the original claim number on the corrected claim

Note: You can locate the original claim number on your electronic remittance advice or on the remittance advice summary via the Secure Provider Portal.

Corrected Claim Instructions

CMS 1500 – Electronic:

- 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

CMS-1500 – Paper:

- Replacement claims
  - Enter resubmission code 7 in Box 22 along with the original claim number (ICN) under Original Ref No

Corrected Claim Instructions

- Voided claims
  - Enter resubmission code 8 in Box 22 along with the original claim number (ICN) under Original Ref No

UB04 – Electronic:

- 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

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Corrected Claim Instructions

UB04 – Paper:

- 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

Secondary Claim - Electronic Filing

Providers 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

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Secondary Claim – Electronic Filing

- 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 Other Payer Name, Segment NM1

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 identifier must match the identifier of the corresponding payer identifier reported in Loop 2330B NM109

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Secondary Claim – Electronic Filing

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 twenty-five 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)

Secondary Claim – Electronic Filing

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~

Secondary Claim – Electronic Filing

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) two additional lines, then the SVD for line 3 is used three 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~

Claim Number Sequence

Cook Children's Health Plan's claim number sequence includes the date the claim was received.

Here is an example of the claim number format:

- 23040100001
  - YYMMDD + five digit claim system generated ID

Note: Claims are adjudicated within thirty days of the date the health plan received the claim.

Claim Status – Phone

Providers may check claim status with a representative by calling Provider Support Services at 888-243-3312, Monday through Friday from 8am to 5pm excluding state holidays.

Claim Status – Online

Providers may check claim status online via the Secure Provider Portal.

Note: If you need assistance enrolling in or navigating the Secure Provider Portal review the Secure Provider Portal Training Guide posted on the Provider Relations page located on our website, cookchp.org.

Electronic Claim Submission Status

- Check claim status within seven days of submitting the claim electronically
  - If you are unable to locate the claim on the Secure Provider Portal within seven days of submission
    - Review the Payer Response Report provided to you by your Clearinghouse
      - This report will indicate whether the health plan accepted your claim for adjudication or rejected it due to an edit/error
    - If the claim is rejected the report will identify the rejection reason
    - Make the required corrections and submit the claim

Note: Rejected claims are not received by the health plan. You must make the needed corrections and submit the claim within the timely filing guidelines.

Paper Claim Submission Status

- Check claim status two weeks after submitting the claim to the health plan to verify the claim was received
- Providers should check claim status to ensure the claim was received by the health plan
  - It is the Providers responsibility to ensure the claim is received within the timely filing deadline
  - A rejected claim is not a received claim
- Providers can check claim status on our Secure Provider Portal
- Claims are adjudicated within thirty days from the date the health plan receives the claim
  - We recommend you check claim status via the Secure Provider Portal at a minimum every two weeks
- If the claim does not appear on the Secure Provider Portal within two weeks of mailing the claim the Provider should resubmit the claim to the health plan to ensure timely filing
  - The claim must be received by the health plan within ninety-five days of the date of service
- If a claim does not appear on an Explanation of Payment within forty-five days as a paid, denied or incomplete claim, the Provider should resubmit the claim to ensure timely filing

Claim Reconsideration

A claim reconsideration is submitted when the claim was denied because additional information is needed to adjudicate the claim. A written request for reconsideration must be received by the health plan within one hundred twenty days of the disposition date on the health plan's Explanation of Payment (EOP).

When submitting a claim reconsideration request you must provide a clear written description of what you are asking the health plan to re-review and the outcome you are expecting.

Here are example components that a Provider may send for claim reconsideration:

- Change in Member eligibility status
- Primary Insurance Explanation of Benefits
- Invoice or MSRP

Submit a Claim Reconsideration

Providers should submit claim reconsideration requests online via the Secure Provider Portal by completing a Customer Service request.

- Log in to the Secure Provider Portal
  - Select the Customer Service icon from the homepage
    - Select the Topic: Submit a Claim Reconsideration
    - Provide a written description of what you'd like the health plan to review
    - Attach supporting documentation
  - You will receive a Customer Relationship Management (CRM) number in your In Basket confirming receipt of your request
  - Allow thirty days from the date the claim reconsideration was received for processing

Claim Reconsideration Submission

Providers pending enrollment to the Secure Provider Portal, can submit claim reconsiderations by fax or mail.

Fax: 682-885-8404

Mail: Cook Children's Health Plan
Attention: Claim Reconsideration
P.O. Box 2488
Fort Worth, TX 76113-2488

Supporting Documentation

- Letter from the Provider stating why you feel the claim payment is incorrect (required)
- A copy of the original claim
- A copy of the health plan Explanation of Payment
- A copy of the primary insurance Explanation of Payment
- Prior authorization number and/or form or fax documenting the prior authorization determination
- Proof of eligibility
- If appealing a timely filing denial include:
  - Electronic acceptance reports confirming the claim was received by the health plan
  - Overnight or certified mail receipt as proof of filing received date by the health plan

Status of a Claim Reconsideration

Once a claim reconsideration determination has been made the Customer Service request will be resolved and the written decision will be provided.

- If the initial claim decision is overturned the claim will be readjudicated and a new claim number will be issued
- Intermittent status of a claim reconsideration is not available via the Secure Provider Portal
  - If it's been more than forty-five days from the date you submitted the request for claim reconsideration you may contact our Claims Department for status by calling 888-243-3312

Note: Please be prepared to provide your Customer Relationship Management (CRM) number to our Claims Department when asking for status of the claim reconsideration.

Claim Appeal

A claim appeal is defined as a written request by the Provider to further consider the original claim reimbursement decision based on the original claim information received. This means the claim was adjudicated and denied.

A written appeal must be received within one hundred twenty days of the disposition date on the health plan Explanation of Payment (EOP). When submitting a claim appeal you must provide a clear written description of what you are asking the health plan to re-review and the outcome you are expecting.

Reminders:

- Changes or errors in CPT, ICD-10 and HCPCS codes are not considered payment appeals
  - This is considered to be a corrected claim
  - Corrected claims must be received by the health plan within ninety-five days of the date of service

Submit a Claim Appeal

Providers should submit claim appeals online via the Secure Provider Portal by completing a Customer Service request.

- Log in to the Secure Provider Portal
  - Select the Customer Service icon from the homepage
    - Select the Topic: Submit a Claim Appeal
    - Provide a written description of what you'd like the health plan to review
    - Attach supporting documentation
  - You will receive a Customer Relationship Management (CRM) number in your In Basket confirming receipt of your request
  - Allow thirty days from the date the claim reconsideration was received for processing

Claim Appeal Submission

Providers pending enrollment to the Secure Provider Portal can submit claim appeals by fax or mail.

Fax: 682-885-8404

Mail: Cook Children's Health Plan
Attention: Claim Appeals
P.O. Box 2488
Fort Worth, TX 76113-2488

Supporting Documentation

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- A copy of the original claim
- A copy of the health plan Explanation of Payment
- A copy of the primary insurance Explanation of Payment
- Prior authorization number and/or form or fax documenting the prior authorization determination
- Proof of eligibility
- If appealing a timely filing denial include:
  - Electronic acceptance reports confirming the claim was received by the health plan
  - Overnight or certified mail receipt as proof of filing received date by the health plan

Status of a Claim Appeal

Once a claim appeal determination has been made the Customer Service request will be resolved and the written decision will be provided.

- If the initial claim decision is overturned the claim will be readjudicated and a new claim number will be issued
- Intermittent status of a claim appeal is not available via the Secure Provider Portal once the customer service request has been submitted
  - If it's been more than forty-five days from the date you submitted the request for claim appeal you may contact our Claims Department for status by calling 888-243-3312

Note: Please be prepared to provide your Customer Relationship Management (CRM) number to our Claims Department when asking for status of the claim appeal.

Claim Overpayments and Refunds

When an overpayment is identified by the Provider due to a billing error, the Provider should submit a corrected claim. The health plan will process the corrected claim and will recoup the overpayment.

When an overpayment is identified by the Provider due to a health plan processing error, the Provider should submit a claim appeal via the Secure Provider Portal requesting reconsideration and recoupment if appropriate.

- Log in to the Secure Provider Portal
  - Select the Customer Service icon from the homepage
    - Select the Topic: Submit a Claim Appeal

To ensure the refund request is applied correctly, Providers should include a letter of explanation or the refund request letter and the Explanation of Payment (EOP).

CookChildren's Health Plan

Claim Overpayments and Refunds

Providers can submit refund checks to:

Cook Children's Health Plan
Attention: Finance Department
PO Box 2488
Fort Worth, TX 76113-2488

Electronic Funds Transfer
&
Electronic Remittance Advice

CookChildren's Health Plan

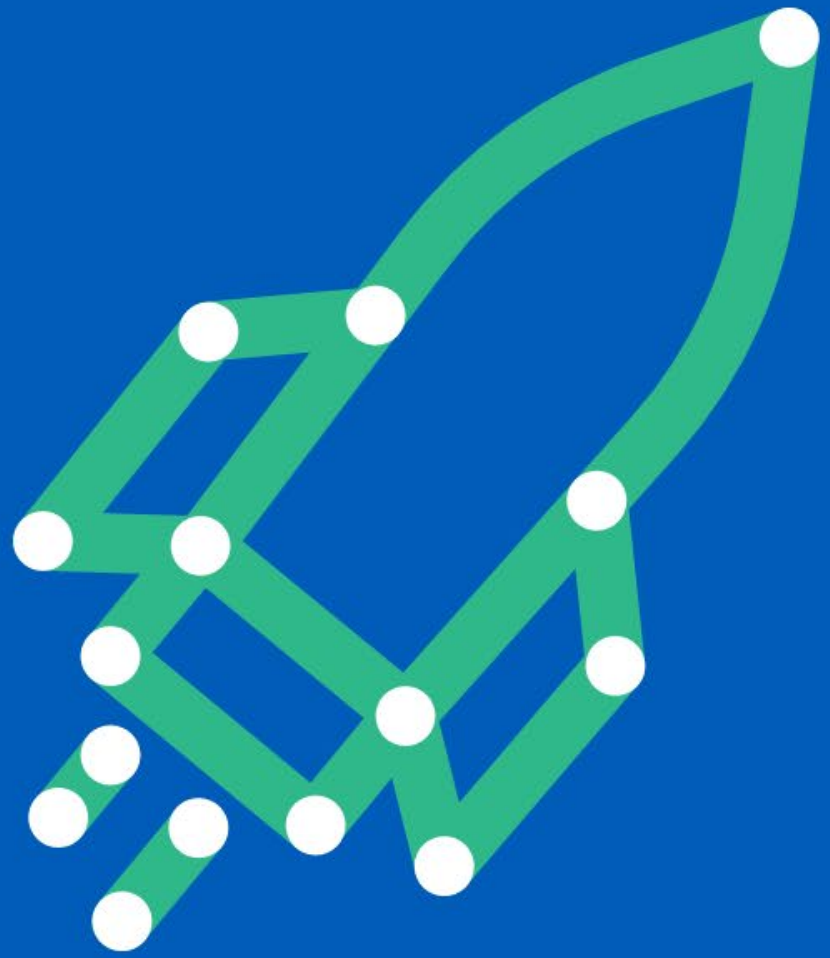
EFT & ERA

Providers must elect to receive Electronic Funds Transfer (EFT) for all Cook Children's Health Plan claim payments.

Following EFT enrollment, Providers should enroll with Availity to receive Electronic Remittance Advice (ERA).

For more information, visit the Electronic Submission Services page or the Provider Relations page located on our website, cookchp.org, and view the Electronic Funds Transfer and Electronic Remittance Advice presentation.

Provider Education



Provider Training Webinar Schedule

All Providers are welcome to attend one or more of the one hour training events hosted by our Provider Relations team.

To view the most current Provider Training Webinar Schedule or self-paced training presentations visit the Provider Relations page located on our website, cookchp.org.

- Webinars are scheduled from 12pm – 1pm CT
  - Dates and times are subject to change
- You can register for a webinar at anytime
  - You do not need to wait until the day of the event

Note: In order to register for a webinar you must have a Zoom account. You can sign up for free, zoom.us/signup.

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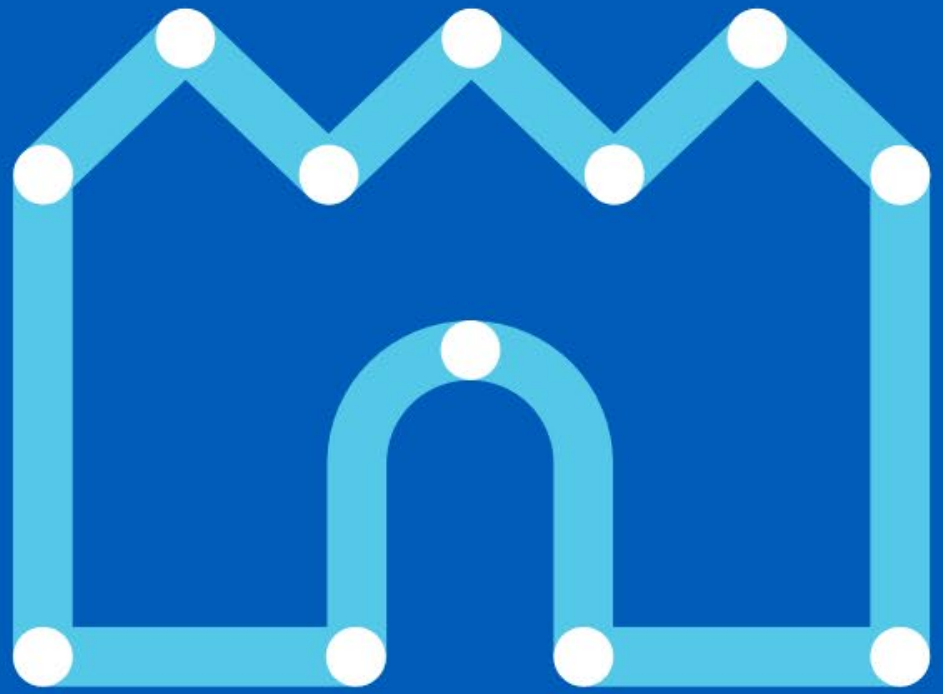
Training Resources



Training Resources

- Texas Medicaid & Healthcare Partnership Website
- Texas Medicaid & Healthcare Partnership – Medicaid Provider Enrollment
- Texas Medicaid Provider Procedures Manual
- Texas Medicaid & Healthcare Partnership - Filing Deadline Calendar
- Texas Medicaid Healthcare Partnership fee schedule
- Medicaid.gov
- Availity.com
- CMS Medicare National Correct Coding Initiative Edits
- Medicaid National Correct Coding Initiative Edits
- Provider Enrollment and Management System (PEMS)

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Training Resources

- W-9 form

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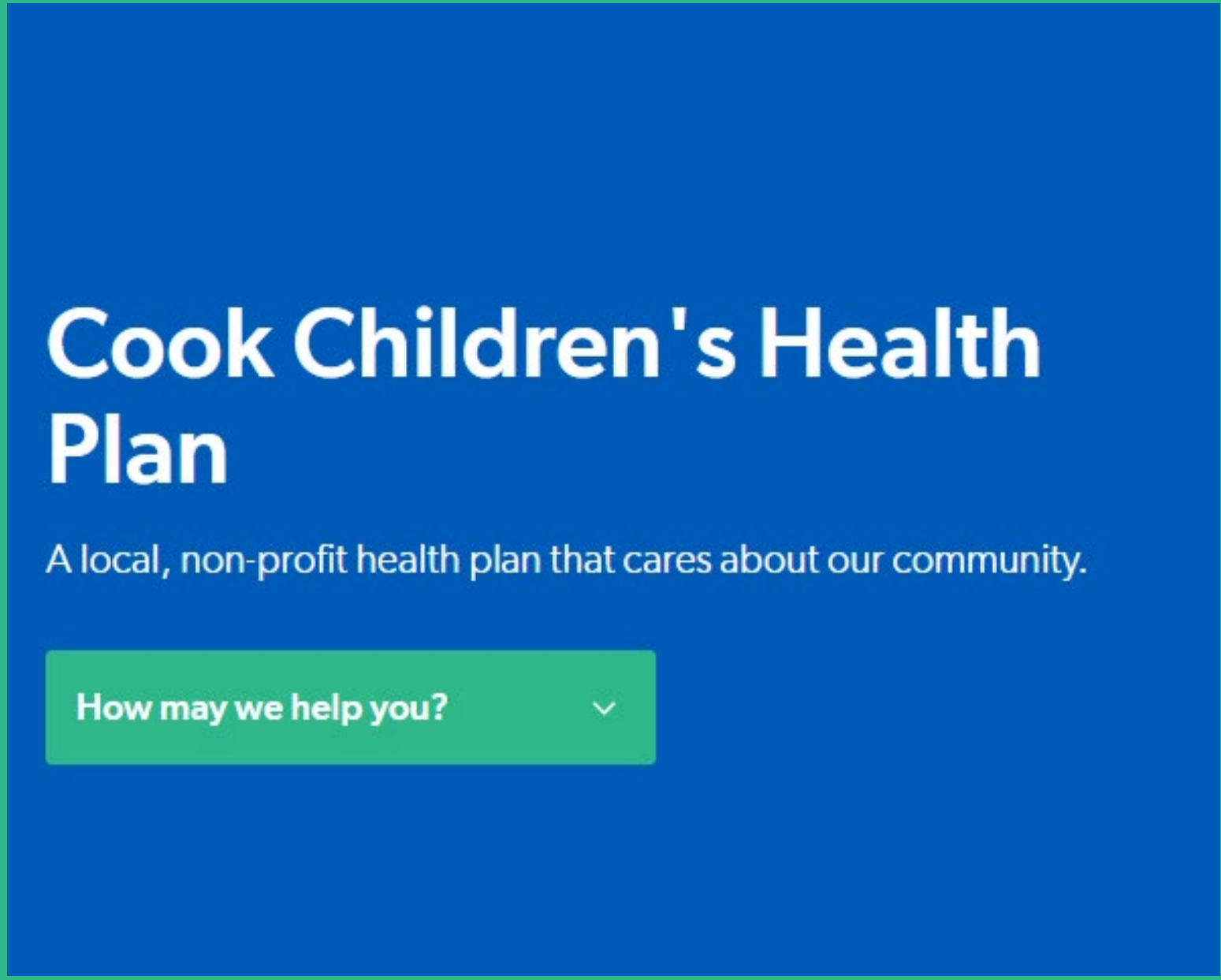
www.cookchp.org



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For Providers

- Behavioral Health Services
- Complaints and Appeals
- Electronic Submission Services
- Electronic Visit Verification
- Grand Rounds Video Library
- HHSC News
- Joining the Network
- Long Term Services and Supports
- Manuals and Forms
- Pharmacy Information
- Prior Authorization
- Private Duty Nursing
- Provider News
- Provider Relations
- Resources
- Secure Provider Portal
- Quality Improvement
- Texas Health Steps
- Therapy Information

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Thank You!