Primary Care Provider Billing Guidelines

Revised 082423

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.

Agenda

- Service Delivery Area
- Benefits, Limitations and Exclusions
- Reimbursement
- Billing and Coding Guidance
- Texas Medicaid
- Coordination of Benefits
- Other Health Insurance
- National Provider Identifier
- Taxonomy Code & Qualifier
- Coding & Billing Requirements
- Diagnosis Codes
- National Correct Coding & Medically Unlikely Edits

Agenda

- National Drug Codes
- Informational-Only Codes
- Claims
- Balance Billing
- Referrals
- Medical Checkups
- Vaccine Billing
- Sports Physicals
- Federally Qualified Health Center
- Rural Health Clinic
- Case Management for Children and Pregnant Women
- Healthy Texas Women

Agenda

- Behavioral Health Services
- Telecommunication Services
- Clinical Laboratory Improvement Amendment
- Influenza A and Influenza B
- After Hours Services
- Secure Provider Portal
- Provider Education
- Training Resources
- Cookchp.org

CookChildren's Health Plan

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.

CookChildren's
Health Plan

Benefits, Limitations and Exclusions

Providers should verify benefits, limitations and exclusions located in the Texas Medicaid Provider Procedures Manual (TMPPM) 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

Cook Children's Health Plan reimburses claims per the Texas Medicaid & Healthcare Partnership fee schedule.

- Providers should follow the benefit limitations, exclusions, and claim filing instructions within the Texas Medicaid Provider Procedures Manual
- Providers should bill their usual and customary rates
  - Do not bill less than the contracted reimbursement rate
  - If a Provider bills less than the contracted rate, the claim reimburses up to the Providers billed charge
- Claims are reimbursed based on the contracted rate schedule
  - Reimbursement will not exceed the Medicaid allowable
- Provider's agree to accept the reimbursement rate as payment in full for services rendered to Medicaid Members

Billing and Coding Guidance

Coding for healthcare services is complex and this training is not intended to provide a thorough treatment of the topic. This training includes a variety of topics based on data received from our claims and the most common billing questions received.

Providers should routinely audit their billing and coding activities to identify inconsistencies and errors and avoid improper payments. Inappropriately coded and/or billed claims can lead to audits (Fraud, Waste and Abuse) and recoupments.

Texas Medicaid

CookChildren's
Health Plan

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 the TMHP website

Coordination of Benefits

CookChildren's
Health Plan

Coordination of Benefits

Coordination of Benefits refers to the activities involved in determining Medicaid/CHIP benefits when an Member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

- Medicaid is generally the payor of last resort

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.

- If the health plan shows the Member has Other Health Insurance it will be listed under Coverage and Benefits on the Secure Provider Portal
  - Select the Coverage Detail Report

Other Health Insurance

CookChildren's Health Plan

Other Health Insurance Claims Filing

Once the primary insurance company 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

Other Health Insurance Claims Filing

Providers must report the following data when submitting the claim electronically:

- Other Subscriber Information (Loop 2320)
  - Including the Claim Filing Indicator Code
- Other Subscriber Name (Loop 2330A)
- Other Subscriber Address (Loop 2330A)
- Other Payor Name (Loop 2330B)
- Other Payor Address (Loop 2330B)
- Claim Check or Remittance Date (Loop 2330B)
- Other Payor Claim Control Number (Loop 2330B)

Note: Secondary claims submitted with missing or incorrect information will be rejected or denied. For more information review the Electronic Data Interchange Requirements on tmhp.com or cookchp.org.

Other Health 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.

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

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, 8.8.2.5 110-Day Rule.

National Provider Identifier

CookChildren's
Health Plan

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.

A National Provider Identifier (NPI) is required for all claims. Each claim must include the NPI for the:

- Billing, Attending, Rendering, Referring and Service Facility Provider (when applicable)
  - If a field on the claim form does not apply to you, leave it blank

The NPI must match the way the Provider is enrolled and attested with Texas Medicaid.

- Claims submitted with an incorrect, invalid or missing NPI will be denied

Taxonomy Code & Qualifier

CookChildren's Health Plan

Taxonomy Code

A taxonomy code is required on all claims. Each claim must include the taxonomy code for the Billing, Attending, Rendering, Referring and Service Facility Provider (when applicable).

- Billing Provider
  - If the Billing Provider Tax ID is a Social Security Number you must bill the taxonomy qualifier SY
  - If the Billing Provider Tax ID is an Employer Identification Number you must bill the taxonomy qualifier ZZ
- Service Facility
  - Only enter a Service Facility Location if the services rendered were provided in a location that is not the Provider's clinic or the Member's home
    - Such as a Hospital, Skilled Nursing Facility, etc.
- Do not partially complete a box
    - Example: If you complete item 32 you must complete 32a & 32b

CookChildren's Health Plan

Taxonomy Code

- UB-04 Claim Form
  - When submitting a UB-04 claim form, the Billing Provider taxonomy code should be in block 81
- TMHP Enrollment
  - The Provider taxonomy code and qualifier must match the way the Provider is enrolled and attested with Texas Medicaid
  - To verify your attestation with Texas Medicaid log in to your profile on tmhp.com
- Billed Services
  - The Provider taxonomy code and qualifier must match the services provided and billed
  - Claims submitted with incorrect, invalid or missing taxonomy code combination will reject or deny

Note: If a field on the claim form does not apply to you, leave it blank.

Coding & Billing Requirements

Coding & Billing Requirements

Texas Medicaid Providers must follow the coding and billing requirements of the Texas Medicaid Provider Procedures Manual (TMPPM). However, if coding and billing requirements for a particular service are not addressed in the TMPPM, and if coding and billing requirements are not otherwise specified in program policy (such as in Provider bulletins or banners), then Providers must follow the most current coding guidelines.

These include:

- Current Procedural Terminology (CPT) as set forth in the American Medical Association's most recently published "CPT books", "CPT Assistant" monthly newsletters, and other publications resulting from the collaborative efforts of American Medical Association with the medical societies
- Healthcare Common Procedure Coding System (HCPCS) as developed and maintained by the federal government

Coding & Billing Requirements

- National Correct Coding Initiative (NCCI), as set forth by the CMS and as explained in the NCCI Policy and Medicare Claims Processing Manuals
  - NCCI consists of procedure code combinations that a Provider must not bill together
  - One of the codes in the pair is considered a part of the primary procedure and not reimbursable to the same Provider on the same date of service

Note: NCCI outlines use of modifiers some of which are not currently recognized by Texas Medicaid. See the list of modifiers utilized by Texas Medicaid in subsection 6.3.5, “Modifiers” in “Section 6: Claims Filing” (Vol. 1, General Information).

Coding & Billing Requirements

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services.

Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code's description.

- Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services
- The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT
- Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim
- The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the Member

Coding & Billing Requirements

To receive reimbursement, Providers must document the following information in the Member's medical record:

- The service
- The date rendered
- Pertinent information about the Member's condition supporting the need for the service
- The care given
- Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law

CPT & HCPC Claims Auditing Guidelines

For more information view the Texas Medicaid Provider Procedures Manual, Vol 1 Claims Filing, subsection 6.4.1.2 CPT and HCPCS Claims Auditing Guidelines.

Diagnosis Code

CookChildren's
Health Plan

Diagnosis Codes

Texas Medicaid requires Providers to submit the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10 CM) diagnosis code on their claims.

- Diagnosis codes must be coded to the highest level of specificity available
  - Avoid using unspecified diagnosis codes
- All diagnosis codes submitted on a claim must be appropriate for the age of the Member as identified in ICD-10-CM
  - If a diagnosis code that is billed does not match the age of the Member on the date of service, all services associated with that diagnosis code will be denied
- Please do not bill duplicate diagnosis codes
  - A diagnosis code should only be entered once on the claim
- All diagnosis codes submitted on a claim must be appropriate for the gender of the Member as identified in ICD-10-CM

Diagnosis Codes

– If a diagnosis code that is billed does not match the gender of the Member on the date of service, all services associated with that diagnosis code will be denied

Diagnosis codes in the following categories are not valid as primary or referenced diagnosis:

- Nonspecific injury, poisoning and other consequences of external causes
- Diagnosis in the International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)
- Factors influencing health status and contact with health services, unless otherwise directed in the Texas Medicaid Provider Procedures Manual
- External causes of morbidity

Note: The only coding structure accepted by Texas Medicaid is the ICD-10-CM.

National Correct Coding & Medically Unlikely Edits

CookChildren's Health Plan

NCCI & MUE Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals.

The Centers for Medicare & Medicaid Services (CMS) NCCI and medically unlikely edits (MUE) guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS NCCI web page. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

Note: Whenever Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail. Any exceptions to NCCI code relationships are specifically noted in the policy. Providers should refer to NCCI for correct coding guidelines and specific applicable code combinations.

National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. Accurate coding and reporting of services are critical aspects of proper billing.

- Refer to the NCCI edits before unbundling services to determine if a modifier is allowed
- Using a modifier usually results in a higher payment for the Provider so make sure your chart documentation supports the codes you are billing

NCCI is comprised of two Provider-type choices of Procedure To Procedure (PTP) code pair edits:

- Practitioners
  - Physicians, Non-Physician Practitioners and Ambulatory Surgery Centers
- Hospital
  - Based on Bill Type

National Correct Coding Initiative

NCCI PTP edits prevent inappropriate payment of services that should not be reported together.

- Each edit has a Column One and Column Two HCPCS/CPT code
- If a Provider reports the two codes of an edit pair for the same Member on the same date of service, the Column One code is eligible for payment but the Column Two code is denied
- The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist
- Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination
- Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier
  - Do not append a modifier solely to bypass an edit

National Correct Coding Initiative

  - If Texas Medicaid imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicaid restrictions are fulfilled
- A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use

Modifier Indicator Table

Modifier Indicator	Definition
0 (Not Allowed)	There are no modifiers associates with NCCI that are allowed to be used with this PTP code pair, there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same Provider.
1 (Allowed)	The modifiers associated with NCCI are allowed with the PTP Code pair when appropriate.
9 (Not Allowed)	The indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

- If the modifier indicator is 0 a modifier is not allowed to be used
  - The column two code is inclusive to the column one code and cannot be unbundled
- If the modifier indicator is 1 a modifier is allowed if appropriate
  - Documentation in the medical record should support unbundling the services
- If the modifier indicator is 9 the edit has been deleted, no modifier is needed

CookChildren's Health Plan

NCCI PTP – Associated Modifiers

The following modifiers are NCCI PTP-associated modifiers and may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

- Anatomic modifiers
  - E1-E4, FA, F1-F9, TA, T1-T9, TA, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers
  - 24, 25, 57, 58, 78, 79
- Other modifiers
  - 27, 59, 91, XE, XP, XS, XU

Note: It is very important that NCCI PTP-associated modifiers only be used when appropriate. In general, these circumstances relate to separate patient encounters, separate anatomic sites, or separate specimens.

CookChildren's Health Plan

Modifier Sequencing

Coding guidelines state that modifiers should be billed in the following order:

- Pricing modifier examples
  - AA, AD, AS, KD, QK, QX, QZ, TC, 21, 22, 26, 50, 52, 53, 60, 62, 80, 82
    - If you use two pricing modifiers that include a professional or technical component (26 & TC), always use the 26 or TC first followed by the second pricing modifier
- Payment modifier examples
  - AT, GN, GO, GP, UB, U5, 24, 25, 27, 51, 57, 59, 76, 77, 78, 79, 91
    - If you have two payment modifiers, for example 51 and 59, enter 59 first and 51 second
- Location
  - Always coded last

Note: The above examples are not inclusive.

Modifier 59

Distinct procedural service: Distinct or independent from other non-Evaluation & Management (E/M) services performed on the same day.

- Is used to identify procedures/services, other than E/M codes, not normally reported together
- Should only be used if an anatomical modifier cannot clearly identify that it was separate and significant
  - If you bill left, right or bilateral modifier 59 is not appropriate
- Should be used as a last resort
- Must be supported by chart documentation
  - A different procedure or surgery
  - Different site or organ system
  - Separate incision/excision
  - Separate lesion or separate injury

CookChildren's Health Plan

Modifier 59

- Can only be appended to column two codes in the NCCI table
- Should not be
  - Appended to an E/M code
  - Appended to a non-procedural services
    - Such as HCPCS, Surgical Trays
  - Appended to the primary procedure code
  - Billed on the same claim as XE, XP, XS, XU
- Modifier 59 is the most overused modifier
- Misuse of modifier 59 opens the Provider to audits

Note: When you use modifier 59 you are requesting to unbundle services which results in additional reimbursement to the Provider.

Modifier 25

Significant, separately identifiable E/M service by the same Provider on the same day of a procedure or other service.

Modifier 25 has specific requirements:

- The E/M service must be significant
  - The problem must warrant physician work that is medically necessary
    - This can be defined as a problem that requires treatment with a prescription or a problem that would require the Member or family to return for another visit to address it
    - A minor problem or concern would not warrant the billing of an additional E/M or modifier 25
  - To determine if the E/M service is significant ask the following:
    - Is the E/M service rendered part of the standard care for the procedure
    - Did a new sign or symptom require evaluation before being treated

Modifier 25

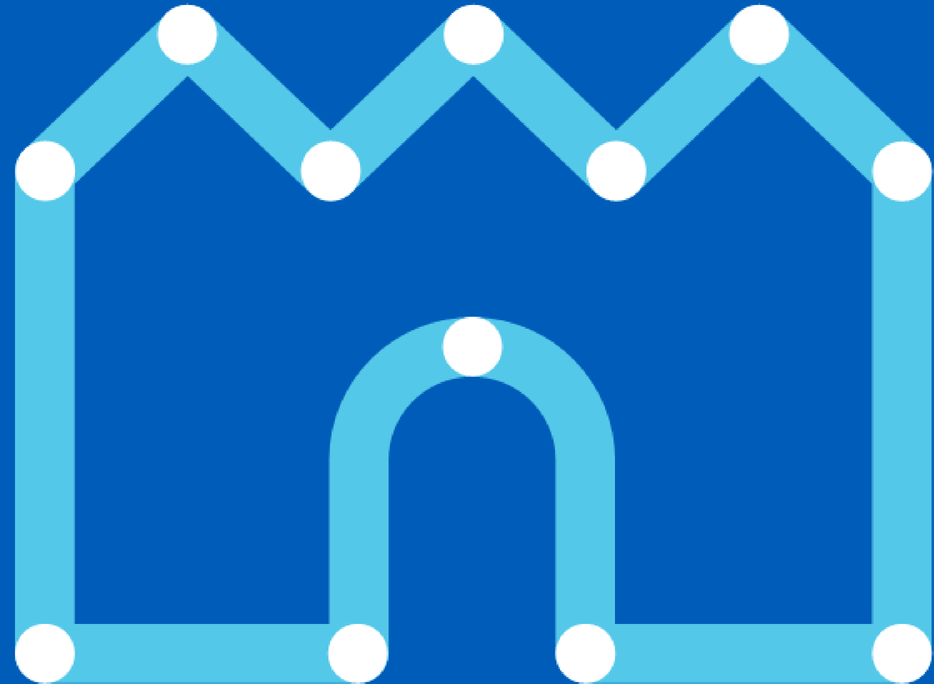
  - If you subtract the procedure from the documentation is there enough remaining in the medical records to support an E/M level
  - Does the problem or issue stand alone as a billable service
- The E/M service must be separate
  - The problem must be distinct from the other E/M service provided (example: preventive medicine) or the procedure being completed
  - Separate documentation for the E/M or modifier 25 problem must be in the medical record
- The E/M service must be provided on the same day as the other procedure or E/M service
  - This may be at the same encounter or a separate encounter on the same day
- Modifier 25 should always be appended to the E/M code
  - If provided with a preventive/medical checkup E/M (Texas Health Steps), it should be appended to the established office E/M code (99211–99215) not the preventive/medical checkup E/M

Modifier 25

- Modifier 25 should never be:
  - Appended to a vaccine code
  - Appended to the vaccine administration
  - Appended to a surgical procedure code
- Modifier 25 does not:
  - Require a separate diagnosis code

For more information view the Texas Medicaid Provider Procedures Manual, Vol 1 Claims Filing, subsection 6.4.1.1 NCCI Processing Categories.

National Drug Codes



CookChildren's
Health Plan

National Drug Code

All Texas Medicaid Providers must submit a National Drug Code (NDC) for professional or outpatient claims submitted with physician-administered prescription drug procedure.

The CMS-1500 claim (block 24A, 24D and 24G) and UB-04 claim (block 43) must include:

- NDC
  - The drug name and NDC billed must match
- Quantity
- Unit of measure
  - The unit of measure should reflect the volume measurement administered
  - Valid units of measurement codes are:
    - F2 - International unit

CookChildren's Health Plan

National Drug Code

  - GR - Gram
  - ME - Milligram
  - ML - Milliliter
  - UN - Unit
    - Unit quantities are required
- An NDC qualifier of N4 must be entered before the NDC on claims

Note: Claims submitted with missing or invalid NDC numbers will be denied.

Informational-Only Codes

CookChildren's
Health Plan

Informational-Only Procedures

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim.

- Informational-only procedure codes must be billed in the amount of at least $0.01

Claims

CookChildren's
Health Plan

Claim Filing

There are two ways to file a claim – electronically or paper. The required information is the same regardless how you choose to file the claim. Providers are encouraged to file claims electronically.

Cook Children's Health Plan uses Availity as our electronic data interchange clearinghouse for batch claim submissions. Our partnership with Availity allows Providers to submit single claim submissions at no cost via Availity.com.

Cook Children's Health Plan Payor Identification:

- CHIP Payer ID: CCHP1
- STAR/STAR Kids Payer ID: CCHP9

Providers may contact Availity Client Services at 800-282-4548 or access the Availity portal at Availity.com.

Claim Filing

While we highly encourage electronic claim submissions, should you find that you can only submit a claim on paper, please submit your claim to:

Cook Children's Health Plan
P.O. BOX 21271
Eagan, MN 55121-0271

Note: Claims submitted on paper should be sent certified mail and must include a letter that lists the Member Name, Patient Account Number and Date of Service for each claim included in the envelope.

Electronic Data Interchange Requirements

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

Paper Claim Requirements

- Use an official red CMS-1500 or UB-04
  - 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

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

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

Corrected claims:

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

For a copy of the **Filing Deadline Calendar** which is updated yearly, visit tmhp.com.

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

Corrected Claim Submissions

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 and 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 – 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"

Corrected Claim – EDI Instructions

    - 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

CookChildren's Health Plan

Corrected Claim – Paper 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
- You can locate the original claim number on your remittance advice

UB04:

- 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

Corrected Claim – Paper Instructions

- 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

CookChildren's Health Plan

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
  - 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)

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

CookChildren's Health Plan

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~

CookChildren's Health Plan

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~

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

CookChildren's Health Plan

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

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

CookChildren's Health Plan

Submit a Claim Reconsideration/Appeal

Providers should make the initial attempt to resolve claim concerns by calling Provider Support Services at 888-243-3312 and speaking to a Claim Representative. If you are unable to resolve the claim concern you should submit a claim reconsideration or appeal request 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 home page
    - Select the topic: Submit a Claim Reconsideration/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/appeal was received for processing

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

Claim Reconsideration/Appeal Submission

Providers pending enrollment to the Secure Provider Portal, can submit claim reconsiderations or appeals 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

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

Status of a Claim Reconsideration/Appeal

Once a claim reconsideration or 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 reconsideration/appeal 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 or appeal, you may contact our Claims Department for status by calling 888-243-3312

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

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

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

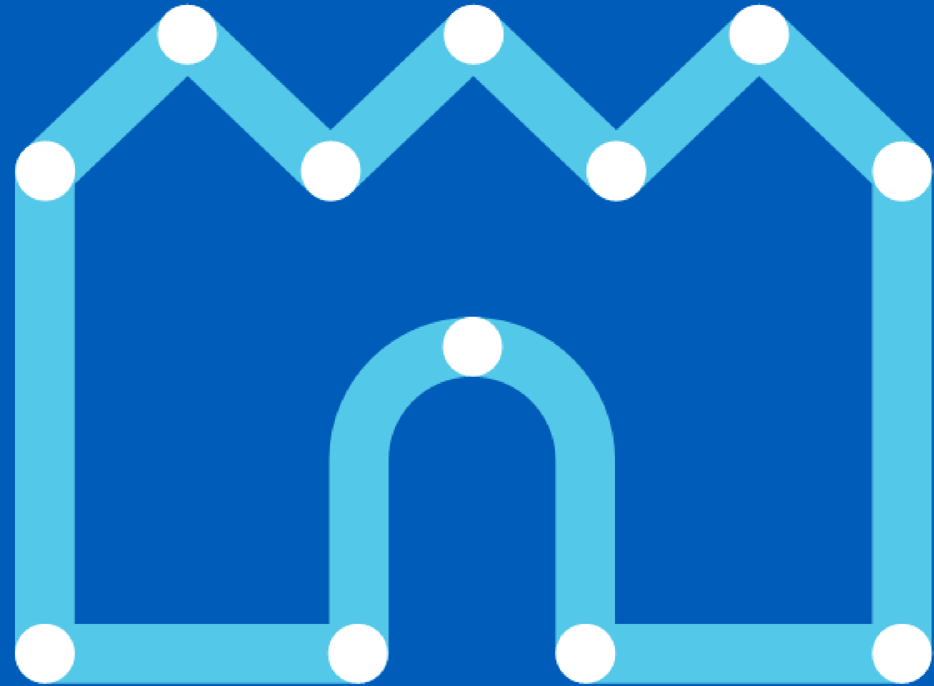
Balance Billing Members

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.

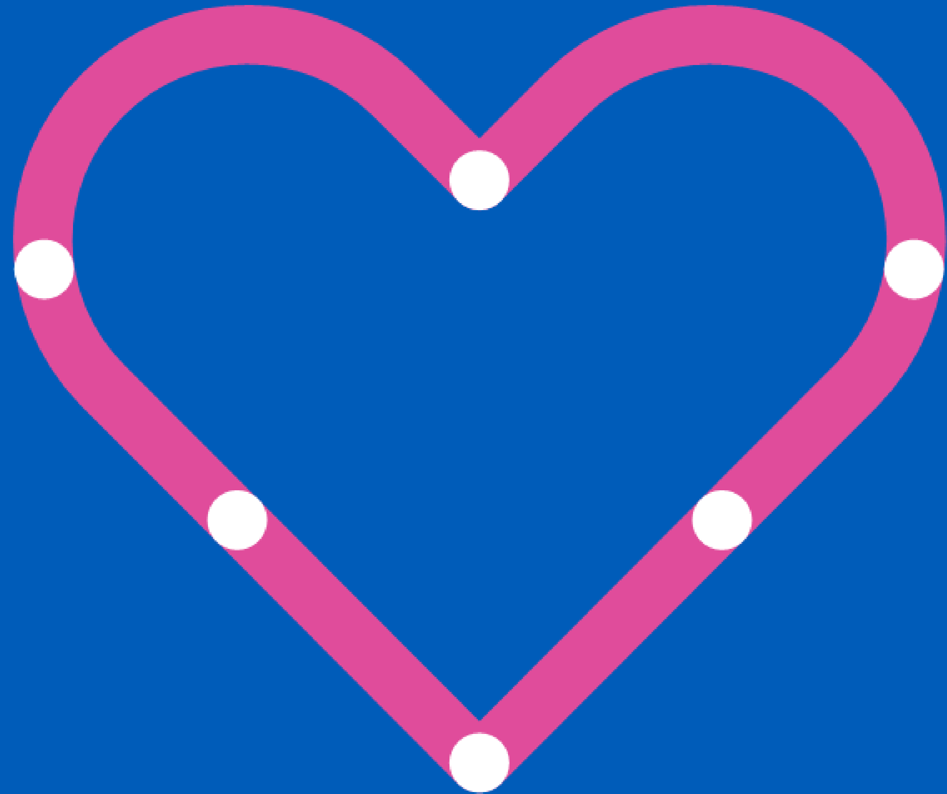
Referrals



Referrals

If a Provider identifies a health problem that is not within their scope of practice, the Provider must refer the Member to another Provider or clinic for treatment.

Medical Checkups



Medical Checkups

- Medical checkups and preventive services for CHIP Members birth through eighteen years of age
- Services are provided based on the American Academy of Pediatrics Periodicity Schedule
- AAP Periodicity Schedule lists specific medical screenings and assessments recommended at each well-child visit from infancy through adolescence
- The guidelines provide health care professionals with anticipatory guidance and the most up-to-date information on preventive screenings and services, visit-by-visit

Medical Checkup Procedure Codes

- Must bill the age appropriate preventive E/M code
- New Patient Preventive E/M
  - 99381, 99382, 99383, 99384, 99385
- Established patient preventive E/M
  - 99391, 99392, 99393, 99394, 99395
- Follow Up Visits to a THSteps
  - 99211

Reminder: Hearing and Vision Screenings performed during the medical checkup are not separately reimbursable and should not be billed on a separate claim form.

Note: A medical checkup is only complete if it includes all required components as indicated on the periodicity schedule.

Medical Checkup Modifiers

The following modifiers indicate who performed the unclothed physical exam and must be appended to the well child medical checkup preventive E/M code.

Services are provided by:

- AM – Physician, team member service
- SA – Nurse Practitioner or Clinical Nurse Specialist
- TD – Registered Nurse
- U7 – Physician Assistant

Modifier Sequencing:

- Must be listed as the primary modifier
- Modifier 25, if applicable, would be listed in the secondary modifier position

Medical Checkup Diagnosis Codes

The age appropriate diagnosis code for a preventive care medical checkup must be submitted on the claim.

- Z00.110 Newborn exam, birth to seven days
- Z00.111 Newborn exam, eight days to twenty-eight days
- Z00.129 Routine child exam, without abnormal findings, twenty-nine days through seventeen years
- Z00.121 Routine child exam, with abnormal findings, twenty-nine days through seventeen years
- Z00.00 General adult exam, without abnormal findings, eighteen through twenty years
- Z00.01 General adult exam, with abnormal findings, eighteen through twenty years

Diagnosis Code Reminder

- Bill only one age appropriate preventive diagnosis code per claim
- Must point to the age appropriate preventive diagnosis code as the primary diagnosis code for each claim line
  - This includes the preventive E/M, vaccine/toxoid, vaccine administration code, screenings, etc.
  - The Encounter for Immunization diagnosis code, Z23, may be billed as the secondary diagnosis code for the vaccine/toxoid codes(s) and vaccine administration code(s)

CookChildren's Health Plan

Immunization Diagnosis Code

If an immunization is administered as part of the preventive care medical checkup:

- Diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis

If an immunization is the only service provided during an office visit:

- Providers may submit only diagnosis code Z23 on the claim

Note: A THSteps preventive care medical checkup will not be reimbursed if the office visit is only for immunization.

Acute Care Visits - CHIP

For CHIP Members, Providers can perform a medical checkup and an acute visit on the same day and bill the services on the same claim form.

- Providers would append modifier 25 to the acute care visit E/M
- The medical records must contain documentation to support the medical necessity and the level of service of the E/M procedure code that is submitted for reimbursement

Vaccine Billing

CookChildren's Health Plan

Vaccine Billing

Cook Children's Health Plan is committed to ensuring that our staff and Providers are informed of the importance of Providers assessing the immunization status at every medical checkup to ensure all age requirements have been met.

For more information, visit the Provider Relations page located on our website, cookchp.org, and view the Vaccine Billing Guidelines presentation.

Sports Physical

CookChildren's Health Plan

Sports Physical – Value Added Service

Cook Children's Health Plan STAR, CHIP and STAR Kids Members are allowed one school/sports physical per calendar year.

- Services must be provided by a participating Provider
- Members ages three years to eighteen years are eligible
- One per calendar year
  - Defined as January 1st through December 31st of the current year
- Diagnosis code
  - Z02.5 Sports Physical
- Bill an acute E/M code
- Can be performed during medical checkup or acute visit
  - If performed in accordance with a medical checkup append modifier 25 to the above E/M

CookChildren's Health Plan

Sports Physical – Value Added Service

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are reimbursed their assigned encounter rate for general medical services.

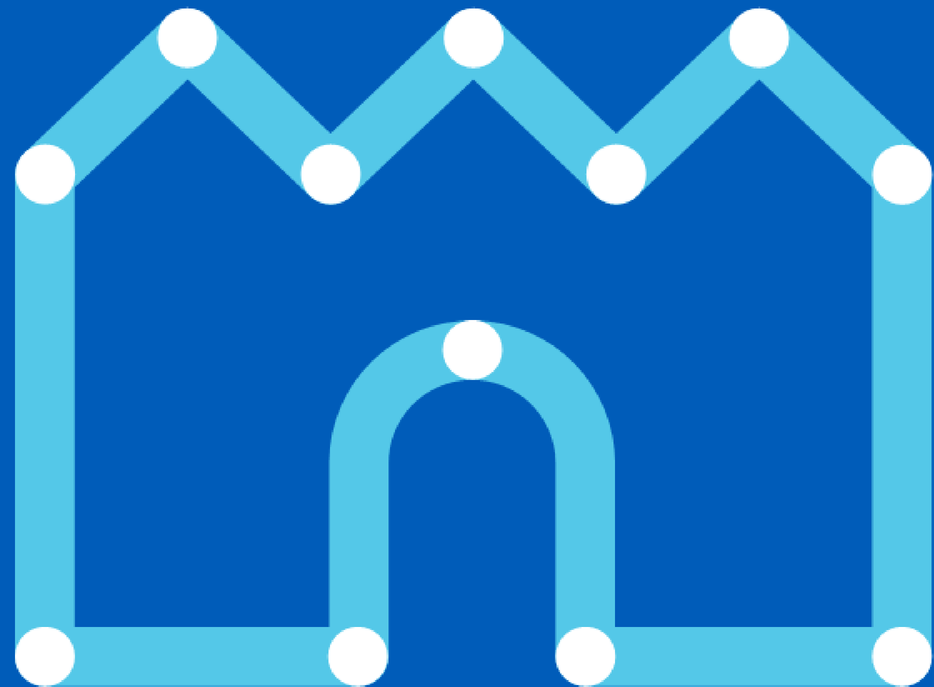
- Diagnosis code
  - Z02.5 Sports Physical
- Procedure codes
  - T1015 (must be the first listed code)
  - Bill an acute E/M code
- Modifiers
  - FQHC
    - AH, AJ, AM, SA, TD, TE, TH, U1, U2, or U7
  - RHC
    - AH, AJ, AM, SA, TD, TE, or U7

Sports Physical – Value Added Service

- Can be performed during medical checkup or acute visit
  - If performed in accordance with a medical checkup append modifier 25 to the E/M

Note: Claims for these services are billed to Cook Children's Health Plan.

Federally Qualified Health Center



CookChildren's
Health Plan

Federally Qualified Health Center

Federally Qualified Health Center's (FQHC) are reimbursed their assigned encounter rate for services. Providers must forward new encounter rate letter to cchpnetworkdevelopment@cookchildrens.org.

All services provided that are incidental to the encounter must be included in the total charge for the encounter and are not billable as a separate encounter.

Federally Qualified Health Center

The following services may be reimbursed using the FQHCs NPI:

- General Medical Services
  - Procedure code
    - T1015
  - Modifiers
    - AH, AJ, AM, SA, TD, TE, TH, U1, U2 or U7
  - Place of Service
    - 50

CookChildren's Health Plan

Federally Qualified Health Center

- THSteps Medical Services
  - Procedure code
    - 99211, 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 96160 and 96161
  - Modifier
    - AM, SA or U7
      - Must use modifier EP in addition to modifier AM, SA or U7
  - Benefit Code
    - Do not use the EP1 benefit code

Federally Qualified Health Center

- Mental Health Screening
  - Members twelve through eighteen years of age
  - Procedure Code
    - 96160 and 96161
  - One per calendar year
- Antepartum or Postpartum Care
  - Modifier
    - TH in addition to AH, AJ, AM, SA, TD, TE, TH, U1, U2 or U7
    - SA if provided by a certified nurse-midwife (CNM)

FQHC Claim Filing and Reminders

Claim Filing:

- Paper Claim Form
  - CMS-1500 form for paper claims
- Electronic Claims
  - ANSI ASC X12 837P 5010 format

Reminders:

- All E/M codes should report normal charges or the contracted rate
- Each service category (Family Planning, THSteps, Acute Care) should be billed on separate claims
  - Append modifier 25 to the T1015 and E/M code when a preventative visit and acute care visit are performed the same day

CookChildren's Health Plan

Rural Health Clinic

Rural Health Clinic

General services and copayments are billed using the Rural Health Clinic's (RHC) NPI. All other services billed using the RHC's NPI are processed as informational only.

RHCs are reimbursed their assigned encounter rate for services. Providers must forward their new encounter rate letter to:

- cchpnetworkdevelopment@cookchildrens.org

CookChildren's Health Plan

Rural Health Clinic

An encounter rate may be reimbursed to the RHC for the following services:

- General Medical Services
  - Procedure Code
    - T1015
  - Modifiers
    - Freestanding RHC
      - AJ, AM, SA, TD, TE, or U7
      - Antepartum or Postpartum use modifier TH in addition to the modifier required to designate the healthcare professional providing the service
    - Hospital-based RHC
      - AH, AJ, AM, SA, TD, TE or U7

CookChildren's Health Plan

Rural Health Clinic

- Place of Service
  - 72
- THSteps Medical Services
  - Procedure code
    - 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395
  - Modifiers
    - Freestanding RHC
      - AM, SA, or U7
    - Hospital-based RHC
      - AM, SA, or U7
  - Benefit code
    - EP1

CookChildren's Health Plan

Rural Health Clinic Claim Filing

- Paper Claim Form
  - UB-04
    - Billing Provider taxonomy code must be placed in Block 81, effective July 1, 2022
- Electronic Claims
  - ANSI ASC X12 837I 5010 format

CookChildren's Health Plan

Case Management for Children and Pregnant Women

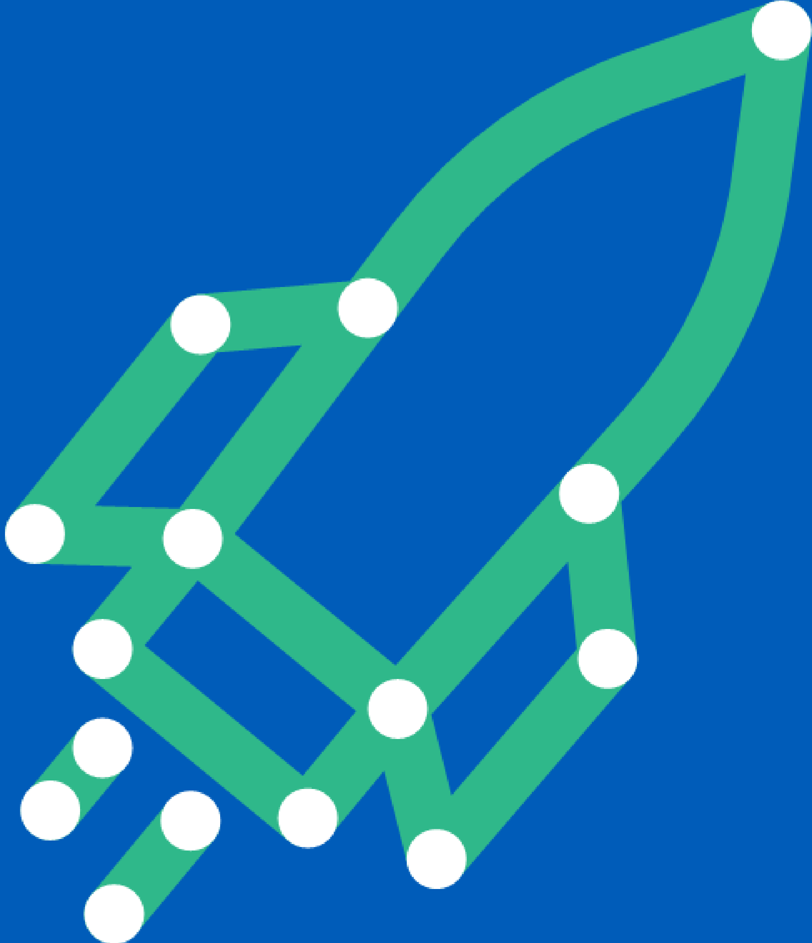
CookChildren's
Health Plan

CPW Services

Case Management services are provided to help Medicaid eligible Members gain access to necessary medical, social, educational, and other services. Case Managers assess a Member's need for these services and then develop a service plan to address those needs.

Note: For more information visit the Provider Relations page located on our website, cookchp.org and view the Case Management for Children and Pregnant Women presentation.

Healthy Texas Women

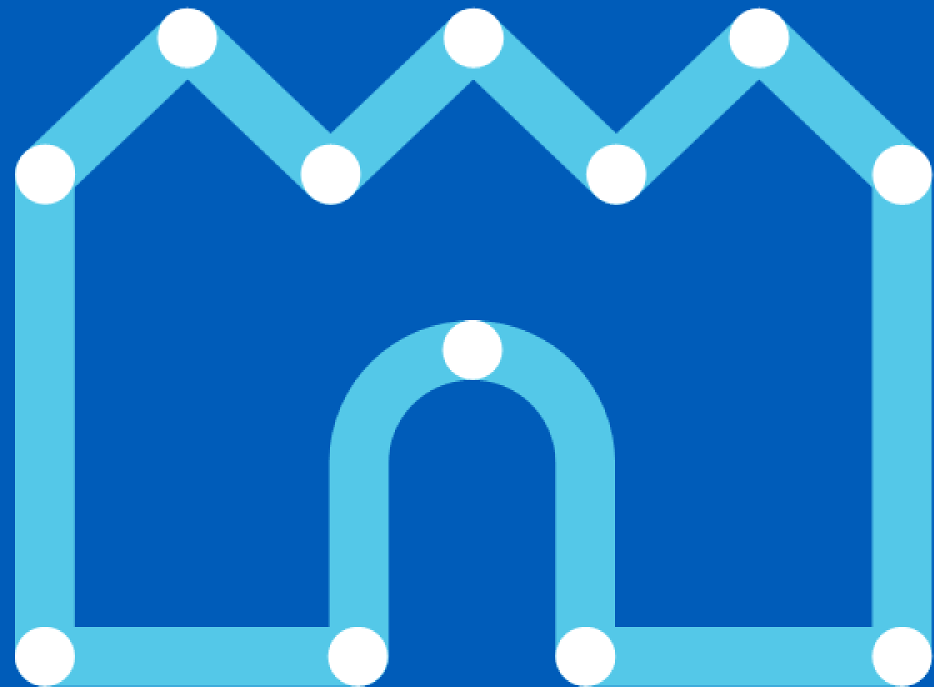


Healthy Texas Women

The goal of Healthy Texas Women is to expand access to women's health and family planning services to reduce unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and wellbeing of women and their families in the eligible population.

For more information visit the Provider Relations page located on our website, cookchp.org, and view the Healthy Texas Women presentation.

Behavioral Health Services



Outpatient Mental Health Services

Outpatient mental health services are a benefit of Texas Medicaid.

Procedure codes 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847 and 90853 are limited to specific diagnosis codes.

For more information view the guidelines outlined in the Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook, Section 4.2 Services, Benefits, Limitations.

Can be provided as telemedicine and/or telehealth if clinically appropriate.

- Audio and Video
  - Modifier 95 must be billed
- Audio-only
  - Must be billed using modifier FQ

Outpatient Mental Health Claim Filing

Diagnosis:

- Behavioral Health claims should be filed using the appropriate and current DSM diagnostic code to define the patient's condition

Behavioral health claims should be filed using the appropriate and current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic code to define the Member's condition.

Claim Form:

- Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Counselors
  - ANSI ASC X12 837P 5010 format
  - CMS-1500 paper claim form

Note: Providers should verify benefits, limitations and exclusions located in the Texas Medicaid Provider Procedures Manual at tmhp.com prior to rendering services.

Behavioral Health Testing Services

Psychological, neurobehavioral, and neuropsychological testing involves the use of formal tests and other assessment tools to measure and assess a person's emotional, and cognitive functioning in order to arrive at a diagnosis and guide treatment.

Psychological testing and neuropsychological testing services need to be billed in fifteen minute increments and are limited to eight hours per person, per calendar year are as follows:

- Procedure codes
  - 96130, 96131, 96132, 96133, 96136 and 96137
- Units
  - 30 minutes = 2 units
  - 1 hour = 4 units

Mental Health Targeted Case Management

Mental Health Targeted Case Management services are case management services provided to Members who are twenty years of age or younger with a diagnosis or diagnoses of mental illness or serious emotional disturbance (SED) and Members twenty-one years of age or older who have a serious mental illness (SMI).

Claim Form:

- ANSI ASC X12 837P 5010 format
- CMS-1500 paper claim form
- Mental health targeted case management services that are funded by a criminal justice agency (submitted with modifier HZ) are carved out and must be submitted to TMHP

Procedure code:

- T1017

Mental Health Targeted Case Management

Modifiers:

- 95 – Telemedicine/Telehealth audio and video
- FQ – Telemedicine/Telehealth audio-only
- HA – Child/Adolescent Program
- HZ – Funded by criminal justice agency
- TF – Routine Case Management
- TG – Intensive Case Management

Diagnosis codes:

- Limited to the diagnosis codes outlined in the Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook, Section 5.2.2 Mental Health Targeted Case Management

Mental Health Targeted Case Management

Can be provided as telemedicine and/or telehealth if clinically appropriate.

- Audio and Video
  - Modifier 95 must be billed
- Audio-only
  - Must be billed using modifier FQ

Mental Health Rehabilitative Services

Mental Health Rehabilitative Services are provided to Members who have a serious mental illness (SMI).

Claim Form:

- ANSI ASC X12 837P 5010 format
- CMS-1500 paper claim form
- Mental health rehabilitative services that are funded by a criminal justice agency (submitted with modifier HZ) are carved out and must be submitted to TMHP

Procedure codes:

- H2012, H0034, H2011, H2014, H2017

Mental Health Rehabilitative Services

Modifiers:

- 95 – Telemedicine/Telehealth audio and video
- ET – Emergent treatment
- FQ – Telemedicine/Telehealth audio-only
- HA – Child/Adolescent Program
- HQ – Group setting
- HZ – Funded by criminal justice agency
- TD – Services provided by an RN

Diagnosis codes:

- Reimbursement for procedure codes H0034, H2012, H2014 and H2017 are limited to the diagnosis codes outlined in the Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook, Section 5.2.3 Mental Health Rehabilitative Services

Mental Health Rehabilitative Services

Procedure codes H0034, H2014, H2017 and H2011 can be provided as telemedicine and/or telehealth if clinically appropriate.

- Audio and Video
  - Modifier 95 must be billed
- Audio-only
  - Must be billed using modifier FQ

Inpatient Psychiatric Services Claims

Claim form:

- ANSI ASC X12 837I 5010 format
- UB-04 paper claim form

Present on Admission:

- Medicaid present on admission (POA) is required

Revenue code:

- 124
  - Must be used for inpatient psychiatric services for persons birth through twenty years of age and sixty-five years of age and older in psychiatric facilities

Inpatient Psychiatric Services

Procedure codes:

- Hospital discharge
  - 99238 or 99239

Diagnosis code:

- The Member must have a psychiatric diagnosis as the principal reason for admission

SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons who are ten years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders.

Claim form:

- ANSI ASC X12 837P 5010 format
- CMS-1500 paper claim form

Procedure codes:

- H0049 - Screening resulting in a negative result and does not require a brief intervention
  - Limited to up to two screenings per rolling year

CookChildren's Health Plan

SBIRT

- 99408 or G2011 – Should be used when a brief intervention follows an SBIRT screening
  - 99408 is limited to once per day
  - 99408 and G2011 limited to four sessions per rolling year

Substance Use Disorder Services

Treatment for Substance Use Disorder (SUD) is a benefit of Texas Medicaid for persons who meet the criteria for a substance-related disorder, as outlined in the current edition of the American Psychiatric Association's Diagnostic Statistical Manual of Mental Disorders (DSM).

Claim Form:

- ANSI ASC X12 837P 5010 format
- CMS-1500 paper claim form

Outpatient Treatment Services:

- Procedure codes
  - H0004 or H0005

Substance Use Disorder Services

Opioid Treatment Providers:

- Procedure codes
  - H0001, H0004, H0005, H0020, H0033, J0570, J2315, Q9991, Q9992
  - H0001 limited to once per day, any Provider

- Diagnosis codes
  - Reimbursement for procedure codes H0004 and H0005 are limited to the diagnosis codes outlined in the Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook, Section 9.6 Outpatient Treatment Services

Substance Use Disorder Services

Procedure codes H0001, H0004, H0005 and H2011 may be provided as telemedicine and/or telehealth if clinically appropriate.

- Audio and Video
  - Modifier 95 must be billed
- Audio-only
  - Must be billed using modifier FQ

For more information, visit the Provider Relations page located on our website, cookchp.org, and view the Behavioral Health Services presentation.

Telecommunication Services

CookChildren's Health Plan

Telecommunication Services

Telemedicine, Telehealth and Telemonitoring services are a benefit of Texas Medicaid. When submitting services for reimbursement, Providers should refer to the Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook located on tmhp.com.

Providers must notify Network Development if they provide Telemedicine, Telehealth or Telemonitoring services for Provider Directory designation.

For more information, visit the Provider Relations page located on our website, cookchp.org, and view the Telecommunication Services presentation.

Clinical Laboratory Improvement Amendment

CookChildren's
Health Plan

CLIA

All Providers that bill laboratory services must have Clinical Laboratory Improvement Amendment (CLIA) certification for the procedure code being billed.

- If a Provider bills for a procedure without appropriate CLIA certification, reimbursement will be denied

Centers for Medicare & Medicaid Services (CMS) provides an updated list of waived tests to Medicare contractors on a quarterly basis.

For more information, see the Texas Medicaid Provider Procedures Manual, subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

CLIA

- Providers must have a CLIA certificate of waiver to perform waived tests
- Providers certified only to perform waived test must use modifier QW
  - CLIA Regulations
  - Texas Medicaid Provider Procedures Manual
- Fully accredited Providers such as Independent Laboratories do not require the QW modifier when billing lab procedure codes
- Only the office or lab that holds the appropriate CLIA certificate and that actually performs the laboratory test procedure may be reimbursed for the procedure
- Providers must provide the health plan with a copy of their CLIA certificate
  - Online: Secure Provider Portal
    - Customer Service Request
      - Topic: CLIA Update

CLIA

- Email: cchpnetworkdevelopment@cookchildrens.org

- CMS 1500
  - Place CLIA number in box 23
  - Electronically - ANSI 5010 - Loop 2300, segment REFO2
  - Claims will deny if the CLIA number is not populated on the claim
- UB-04
  - Place CLIA number in field 64
  - Electronically - ANSI - Loop 2300, segment REFO2
  - Claims will deny if the CLIA number is not populated on the claim

Influenza A
&
Influenza B

CookChildren's
Health Plan

Influenza A and Influenza B

- Diagnosis Code
  - Use the appropriate ICD-10 diagnosis code from the J code set for a positive flu test
- Procedure Code 87804
  - Cannot be billed with units
    - Must be billed as two lines
- Billing
  - 87804-QW
  - 87804-QW-91
  - Modifier QW indicates the procedure is a CLIA waived test
  - Modifier 91 indicates the procedure is a repeat clinical diagnostic laboratory service performed on the same day
  - Do NOT bill modifier 59

After Hours Services

CookChildren's
Health Plan

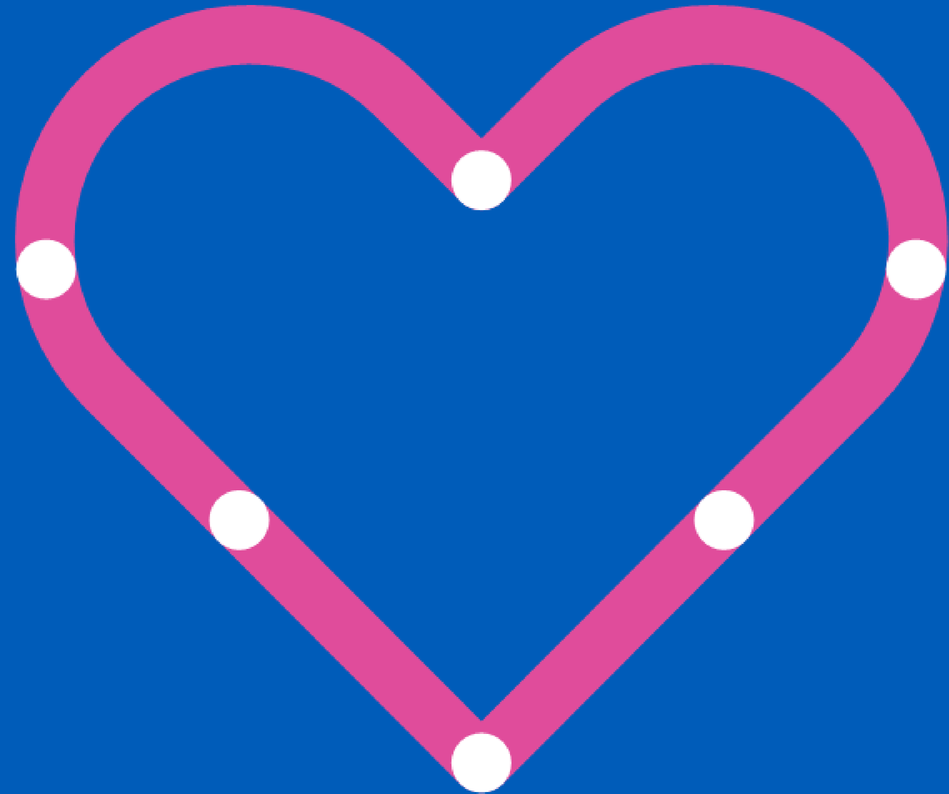
After Hours Services

- Applies to office based Providers
  - Not billable by an ER based Provider or Group
- Routine Office Hours
  - Those hours posted at the Provider's office as the usual office hours
- An after hours charge is billed when the Provider determines it medically necessary to provide after hours care for a patient with an emergent condition
  - Billed for services rendered outside of the Provider's routine office hours
    - The Physician leaves the office or home to see a Member in the emergency room
    - The Physician leaves the home and returns to the office to see a Member after the physician's routine office hours
    - The Physician is interrupted from routine office hours to attend to another Member's emergency outside of the office

After Hours Services

- Procedure codes
  - 99050, 99056, 99060
  - Limited to one per day, same Provider

Secure Provider Portal



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

Secure Provider Portal Access

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

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.

Secure Provider Portal

Need assistance in navigating the Secure Provider Portal?

- Register for a webinar by visiting the Provider Relations page located on our website, cookchp.org, select the Provider Training Webinar Schedule
  - Review the calendar and follow the instructions to register for the webinar of your choice

If you've attended our webinar and still need assistance you can access the Secure Provider Portal Training Guide located on the Provider Relations page of our website, cookchp.org, or contact the Provider Relations team at cchpproviderrelations@cookchildrens.org.

Note: Users who do not log in for ninety days will automatically be disabled due to inactivity.

Provider Education

CookChildren's
Health Plan

Provider Training

All Providers are encouraged to attend the Primary Care Provider Orientation, Texas Health Steps presentation and the Secure Provider Portal training.

The Provider Orientation includes:

- Provider Responsibilities
- Provider Resources
- Cook Children's Health Plan Products, Programs and Services

The Secure Provider Portal training includes:

- Registering for a new account
- Portal navigation
  - Member eligibility, Claim status, Claim appeals, Prior authorization, Provider reports

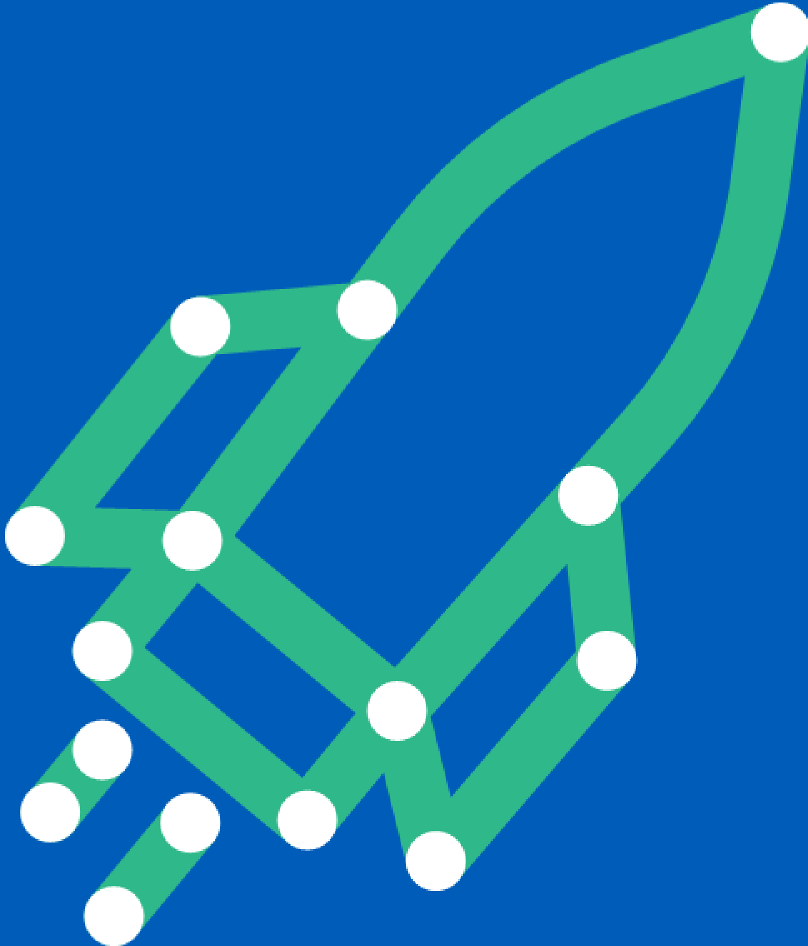
Provider Training Webinar Schedule

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.

Training Resources



CookChildren's Health Plan

Training Resources

- Texas Medicaid & Healthcare Partnership
- Texas Medicaid Provider Procedures Manual
- Texas Medicaid and CHIP Communications Resources
- Texas Medicaid & Healthcare Partnership - Filing Deadline Calendar
- CMS Medicare National Correct Coding Initiative Edits
- Medicaid National Correct Coding Initiative Edits
- American Academy of Pediatrics Periodicity Schedule
- Availity.com

www.cookchp.org

Provider Support Services

888-243-3312

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

Cook Children's Health Plan

A local, non-profit health plan that cares about our community.

How may we help you?

Cook Children's Health Plan

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

Thank You!