Specialty, Ancillary and Facility Provider Billing Guidelines

Revised: 122221

Cook Children's Health Plan

Our Promise

Knowing that every child's life is sacred, it is the promise of Cook Children's to improve the health of every child through the prevention and treatment of illness, disease and injury.

Cook Children's Health Plan

Thank You for Joining Us!

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

Always refer to the most recent publication of the Texas Medicaid Provider Procedures Manual located at tmhp.com , 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/HCPC coding guidelines and Medicaid National Correct Coding located on Medicaid.gov.

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Provider Support Services

888-243-3312

- Dedicated exclusively to Providers
- Available Monday – Friday, 8am-5pm, excluding State holidays
- Eligibility and claim status is available 24 hours a day, 7 days a week by utilizing the Interactive Voice Response (IVR) and selecting option 1

Cook Children's Health Plan

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Eligibility

Eligibility

As a contracted Provider, you are responsible for verifying Member Eligibility. It is important that you verify Member eligibility **before providing services** to ensure benefits are in place.

- Members are enrolled and dis-enrolled at the beginning of each month
- Verify Member Eligibility
  - Health Plan Identification Card
  - Secure Provider Portal
    - cookchp.org
  - Provider Support Services
    - 888-243-3312, option 1
  - TexMedConnect
    - tmhp.org

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Other Health Insurance

If the Member has Other Health Insurance (OHI) the Provider is required to file the claim with the Member's primary insurance carrier before submitting the claim to Cook Childrens Health Plan.

If the services you are providing are a non covered benefit or the Member has exhausted their benefits you can submit the denial or letter of exhausted benefits to Cook Children's 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.

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Member Dismissal

Member Dismissal

Providers may request that a Member be removed from their panel when efforts to counsel the Member have been unsuccessful regarding one of the following:

- Appointment compliance
- Cooperation with Provider treatment plan
- Inappropriate/disruptive behavior toward Provider, staff, other patients

The request to remove a Member from a Provider panel must be submitted in writing to the Member and the health plan. Notify the Member that they must select a new Provider within 30 days of the notice. The Provider must provide 30 days emergency care during the notice period.

Member Dismissal

Providers may send the notification to the health plan by mail or via the Secure Provider Portal.

Mail:
Cook Children's Health Plan
Attention: Member Services
P.O. Box 2488
Fort Worth, TX 76113

Secure Provider Portal:
Select the Topic: Request for Patient/Member Reassignment

Billing Medicaid Members

Billing Medicaid Members

Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

- Texas Medicaid Provider Procedures Manual Section 6: Claims Filing

Prior Authorization

Prior Authorization

Providers must submit all prior authorization requests via the Secure Provider Portal.

If you do not have access to the Secure Provider Portal please contact your Site Administrator to request access. If you are the Site Administrator and need to establish access for your office please utilize the Secure Provider Portal Reference guide located at cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Secure Provider Portal Reference Guide.

If you require additional assistance email Provider Relations at CCHPProviderRelations@cookchildrens.org.

Providers pending enrollment to the Secure Provider Portal may submit a prior authorization request via fax by visiting our Prior Authorization webpage located at cookchp.org.

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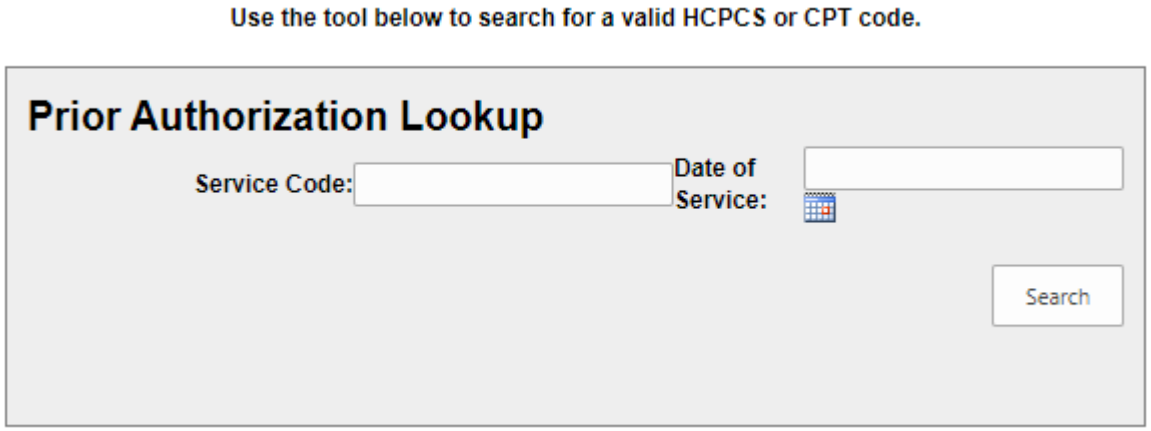
Prior Authorization Search

To access the Prior Authorization Search tool located on our website at cookchp.org, select Providers and then select Prior Authorization.



- Enter the CPT or HCPC in the service code field and select the date of service from the calendar, then click "search"

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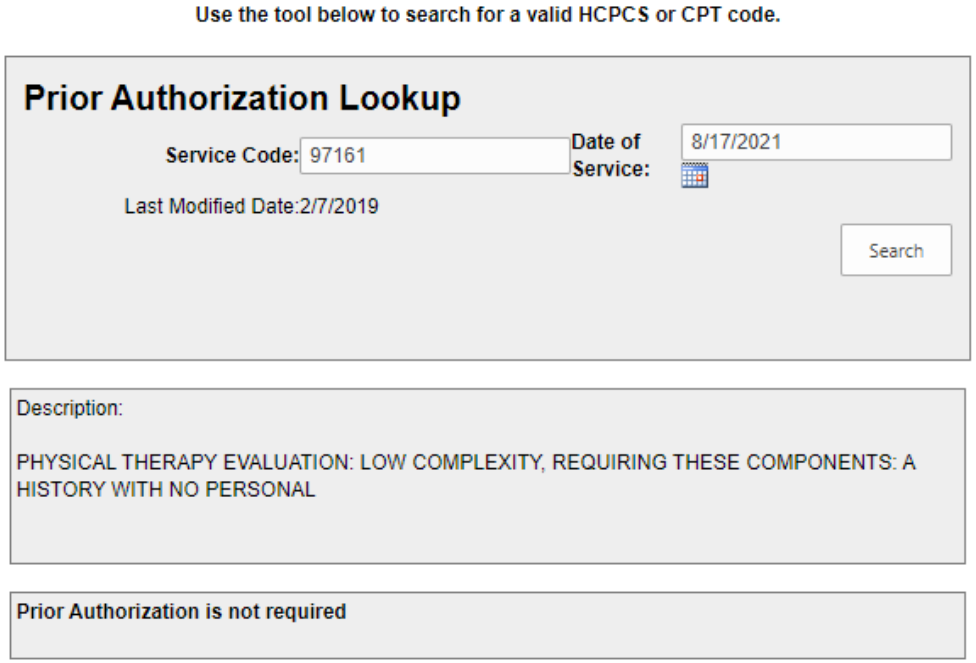
Prior Authorization Not Required

Prior authorization is not required is not a guarantee of payment. Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions.



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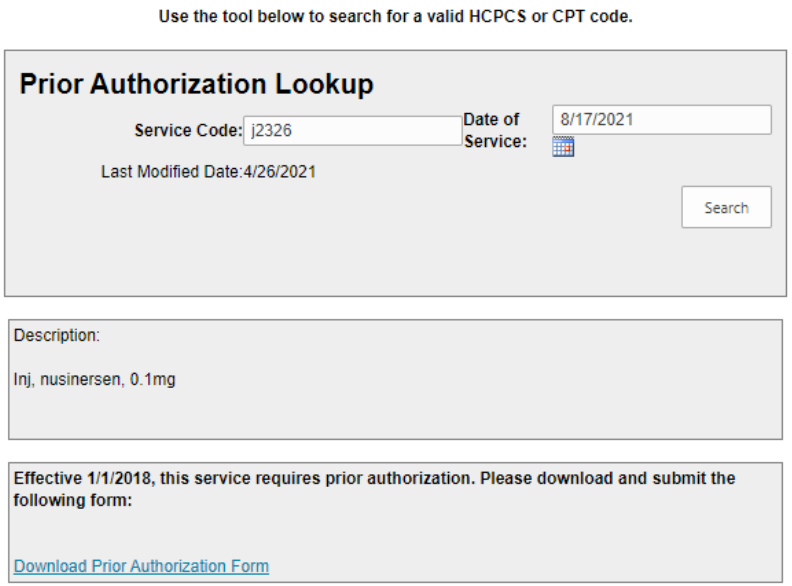
Prior Authorization Search Response

Prior Authorization required requires the Provider to submit a prior authorization request. Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions.

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.

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
- Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions
- 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 that you are 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

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Retrospective Genetic Lab Testing

- Cook Children's Health Plan follows the Texas Medicaid Provider Procedures Manual (TMPPM) regarding procedures codes 81420 and 81507
- Prior authorization requests for these procedures codes must be submitted by the ordering physician
- Requests originating from laboratories will not be processed
- Please refer to the TMPPM for full authorization criteria requirements
- Ordering Providers may submit genetic testing prior authorization request up to ten (10) days from the date the specimen is collected
- Medical necessity must be met in order for Cook Children's Health Plan to issue authorization
- Providers may contact CCHPPriorAuthorizations@cookchildrens.org for further questions specific to authorizations

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Claim Filing

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.

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

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Electronic Claim Submission

We are pleased to partner with Availity to provide a secure platform where Providers can submit single claims at no cost.

- You can register or login to Availity's portal by visiting Availity.com
  - Register
  - Login
- For questions, you can call Availity Client Services at 800-282-4548

Cook Children's Health Plan Payor Identification:

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

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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

Reminder: Your claim form must include all the required data to adjudicate your claim.

Note: A clean claim must be received by the health plan within 95 days of the date of service.

Claim Edits

An electronic claim is transmitted through a clearinghouse.

- The clearinghouse runs the claim through front-end edits
- Claims that do not pass these edits are rejected by the clearinghouse and returned to the Provider with a report indicating the claim was rejected
  - The Payer Response Report identifies the rejection reason
- Rejected claims are not received by the health plan
  - The claim will need to be corrected and submitted to the health plan
  - The health plan must receive the claim within 95 days of the date of service

A paper claim received by the health plan is scanned into a database that performs the front-end edits. If the claim does not pass the edits it is rejected and returned to the Provider with a letter explaining the reason for rejection.

Claim Edits

Front-end edits include but are not limited to:

- Eligibility
  - Is there active eligibility for the date of service billed
- Verifying Member Information matches the eligibility file
  - Name, Gender, Date of Birth, ID #
- Billing, Rendering, Referring and Servicing Facility Provider Name
  - Is the Provider's first name and last name listed on the claim
  - Does the Provider's name match Texas Medicaid enrollment
- Billing, Rendering, Referring and Servicing Facility Provider NPI
  - Is the appropriate NPI listed on the claim
  - Does the NPI match Texas Medicaid enrollment
  - If the Service Facility Location is the Provider's office or Member's home, leave this field blank

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Claim Edits

- Billing, Attending, Rendering, Referring and Servicing Facility Provider Taxonomy Code
  - Is the Provider taxonomy code listed and is a taxonomy qualifier present
  - Does the taxonomy code match Texas Medicaid enrollment
- Primary Diagnosis code
  - Is the ICD-10 valid for the date of service
  - Is it a benefit of the plan for the service provided, refer to the Texas Medicaid Provider Procedures Manual for benefits, limitations and exclusions
  - Is the ICD-10 appropriate for the Member's age, gender
- Procedure code
  - Is the CPT/HCPC code valid for the date of service
    - Is the code appropriate for the Member's age, gender

Claim Edits

Note: Claims submitted with incorrect, invalid or missing NPI and Taxonomy code combination will reject or deny. Authorization dates of service, procedure codes, place of service, and modifiers must match services on the claim.

Electronic Data Interchange

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.

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Electronic Billing Tips

- Submission of a claim to the clearinghouse does not guarantee that the claim was transmitted or received by Cook Children's Health Plan
- Providers are responsible for monitoring their error reports to ensure all transmitted claims and encounters appear on reports
- Providers should verify that their electronic claims were accepted by the health plan for payment consideration by referring to the accepted and rejected payer reports
- Some of the most common reasons for electronic professional claim rejections or denials are:
  - Member information does not match (name, date of birth, gender)
  - Billing, Rendering, Referring, Ordering Provider NPI, taxonomy code, taxonomy qualifier is blank or invalid
  - Billing, Rendering, Referring, Ordering and Attending Provider's first name is missing (you must enter the first and last name)

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Electronic Billing Tips

  - Invalid type of service or invalid type of service/procedure code combination
  - Other health insurance missing
- Post Office Box was entered instead of a valid physical, service or billing address

Paper Claim Submission

If you must submit a paper claim:

- Use an official red CMS-1500 or UB-04 claim form
  - Do not use copies
  - Do not use EMR templates
- 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

Note: Tips for submitting a paper claim can be located on our website at cookchp.org, select Providers, Electronic Submission Services and scroll down to Paper Claim Submission.

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Timely Filing Deadline

Timely filing

- Initial claim must be received by the health plan within 95 days of the date of service
  - If the claim covers multiple dates, the 95 day timely filing is based on the FIRST date of service on the claim form
- Secondary claims must be received by the health plan within 95 days from the disposition date on the primary insurance Explanation of Benefits (EOB)
- Corrected claims must be received by the health plan within 95 days of the date of service

Corrected Claim Submissions

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

- Must be received by the health plan within 95 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

Reminder: You can locate the original claim number on your remittance advice or on the Secure Provider Portal.

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Corrected Claim – EDI Instructions

CMS 1500

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - 7 = REPLACEMENT (replacement of prior claim)
  - 8 = VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected
  - You can locate the original claim number on your remittance advice

UB04

- The Type of Bill for UB claims are billed in loop 2300/CLM05-1
  - You will replace the third position of the TOB for 'frequency"
    - 7 = REPLACEMENT (replacement of prior claim)
    - 8 = VOID (void/cancel of prior claim)

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Corrected Claim – EDI Instructions

- 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

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

UB-04

- Replacement Claim
  - In form locator 3 change the third position of your Type of Bill to a 7, in form locator 64 enter the original claim number
- Voided claim
  - In form locator 4 change the third position of your Type of Bill to a 8, in form locator 64 enter the original claim number

Secondary Claim - Electronic Filing

When submitting a secondary claim to the health plan the primary payer information including the primary payment date must be submitted. In addition, Providers submitting a professional claim or a Facility submitting an outpatient facility claim 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

- The sum of all line level payment amounts (Loop 2430 SVC02) less any claim level adjustment amounts (Loop 2320 CAS adjustments) must balance to the claim level payment amount (Loop 2320 AMT02)
  - Expressed as a calculation for given payer: (Loop 2320 AMT02 payer payment) = (sum of Loop 2430 SVD02 payment amounts) minus (sum of Loop 2320 CAS adjustment amounts)
  - The payer's total claim payment is reported within Loop 2320 Coordination of Benefits (COB) Payer Paid Amount AMT segment with a D qualifier in AMT01
    - The associated payer is defined within Loop 2330B Other Payer Name, Segment NM1

Line Level Payment Amounts

- Line level payment information is reported in Loop 2430 SVD02

Secondary Claim - Electronic Filing

- 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

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)

Secondary Claim - Electronic Filing

- The Line Adjudication Information Loop can repeat up to 25 times for each line item
- The calculation for each 2430 loops is as follows: (sum of Loop 2430 CAS Service Line Adjustments) plus (Loop 2430 SVD02 Service Line Paid Amount) = (Loop 2400 SVC203 Line Item Charge Amount)

Additional Details:

- Claim Level:
  - Loop 2320 Other Subscriber Information
    - Required when the claim has been adjudicated by the payer identified in Loop 2330B
    - Required when Loop 2010AC is present
      - In this case, the claim is a post payment recovery claim submitted by a subrogated Medicaid agency
    - TR3 Example: AMT*D*411~

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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) 2 additional lines, then the SVD for line 3 is used 3 times
    - Once for the original adjustment to line 3 and then two more times for the additional unbundled lines
- TR3 Example: SVD*43*55*HC:84550**3~

Claim Status

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:

- 21040100001
  - YYMMDD + 5 digit claim system generated ID

Note: Claims are adjudicated within 30 days of the date the health plan received the claim.

Claim Status

To check claim status online you must register for access to our Secure Provider Portal.

Secure Provider Portal

- Visit cookchp.org, select Provider and then select Secure Provider Portal, login
- From the homepage:
  - Click **Select Patient**
  - Locate your patient
  - Click on the ellipses
    - Select **Claim by Member**
  - Select the appropriate **Claim #**
    - To review the details of the claim, click the **Claim #** link
  - The date range defaults to one year, but can be updated if needed

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Claim Status – Electronic Claims

- Check claim status within two weeks of submitting the claim electronically
  - If you are unable to locate the claim on the Secure Provider Portal within two weeks of submission
    - Review your 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
    - Make the required corrections and submit the claim

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

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Claim Status – Paper Claims

- Check claim status 2 weeks after submitting the claim to the health plan to verify the claim was received
- 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 95 days of the date of service

Claim Status

- Providers should check claim status within two weeks of submitting the claim to the health plan to ensure receipt
  - 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
- Claim status is also available 24 hours a day, 7 days a week by utilizing the IVR, by calling 888-243-3312 Monday-Friday from 8am to 5pm, excluding State holidays, select option 1
- Claims are adjudicated within 30 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 a claim does not appear on an Explanation of Payment within 45 days as a paid, denied or incomplete claim, the Provider should resubmit the claim to ensure timely filing

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Reimbursement

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 the 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
- Our Provider's agree to accept the reimbursement rate as payment in full for services rendered to Medicaid Members

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Claim Reconsiderations
&
Claim Appeals

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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 within 120 days of the disposition date on the health plan's Explanation of Payment (EOP).

When submitting a 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

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Submit a Claim Reconsideration

Providers should submit Claim Reconsideration requests online via our Secure Provider Portal by completing a Customer Service Request.

- Visit cookchp.org, select Providers, then select Secure Provider Portal
  - Complete a Customer Service Request
    - Select the Topic: Submit a Claim Reconsideration
  - You will receive a CRM number for tracking purposes in your In Basket
  - Status is not available on the Secure Provider Portal once it is submitted
    - If the initial claim decision is overturned the claim will be readjudicated and a new claim number will be issued
    - If the initial claim decision is upheld a letter will be mailed to the Provider
    - If it's been more than 45 days from the date you submitted the request call Claims at 888-243-3312 for status

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 120 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:

- Provider appeals must be submitted in writing
- Changes or errors in CPT codes are not considered payment appeals
  - This is considered to be a corrected claim, corrected claims must be received by the health plan within 95 days of the date of service

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Submit a Claim Appeal

Providers should submit Claim Appeals online through our Secure Provider Portal by completing a Customer Service Request.

- Visit cookchp.org, select Providers, then select Secure Provider Portal
  - Complete a Customer Service Request
    - Select the Topic: Submit a Claim Appeal
  - You will receive a CRM number for tracking purposes in your In Basket
  - Status is not available on the Secure Provider Portal once it is submitted
    - If the initial claim decision is overturned the claim will be readjudicated and a new claim number will be issued
    - If the initial claim decision is upheld a letter will be mailed to the Provider
    - If it's been more than 45 days from the date you submitted the request call Claims at 888-243-3312 for status

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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
- Explanation of Payment from another insurance company
- 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

Reconsideration & Appeal Submission

Electronically - Secure Provider Portal

- Customer Service Request
  - Topic: Submit a Claim Reconsideration
  - Topic: Submit a Claim Appeal

Fax - 682-885-8404

Email - CCHPClaimAppeals@cookchildrens.org

Mail

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

Cook Children's Health Plan

National Correct Coding Initiative

National Correct Coding Initiative

The National Correct Coding Initiative 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

National Correct Coding Initiative

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

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

National Correct Coding Initiative

- 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
  - 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 associated 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 this PTP code pair when appropriate.
9 (Not Applicable)	This 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

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NCCI Associated Modifiers

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

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

Modifier Sequencing

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

- Pricing
  - 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
  - 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
  - If 51 and 78 are the required modifiers, you would enter 78 in the first position

Modifier Sequencing

- Location
  - Always coded last

Note: The above examples are not inclusive.

Modifier 59

- Is used to identify procedures/services not normally reported together
- You are requesting to unbundle services which results in additional reimbursement to the Provider
- Should be used as a last resort
- Only use 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
- Must be supported by chart documentation

Modifier	Description
59	Distinct procedural service – distinct or independent from other non-E/M services performed on the same day.

Modifier 59

  - A different procedure or surgery
  - Different site or organ system
  - Separate incision/excision
  - Separate lesion or separate injury
- Can only be appended to column 2 codes in the NCCI table
- Should not be
  - Appended to an E/M code or non-procedural services
    - Such as HCPC, Surgical Trays
  - Appended to the primary procedure code
  - Billed on the same claim as XE, XP, XS, XU

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

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Modifier 59

- Modifier 59 is never
  - Appended to an E/M service code (example: 99213)
  - Used to indicate a non-E/M service was distinct from an E/M service provided by the same physician on the same date
  - Appended to the primary procedure code
- Modifier 59 is the most overused modifier
- Misuse of modifier 59 opens the Provider to audits

Modifier 25

The use of 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

- Modifier 25 should always be appended to the E/M code
  - If provided with a preventive/medical checkup E/M (THSteps), it should be appended to the established office E/M code (99211–99215) **not** the preventive/medical checkup E/M
- 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

Diagnosis Codes

Diagnosis Codes

Texas Medicaid requires Providers to provide International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10 CM) diagnosis codes on their claims.

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

- 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 that 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

Diagnosis Codes

- All diagnosis codes submitted on a claim must be appropriate for the gender of the Member as identified in ICD-10-CM
  - If a diagnosis code that is billed does not match the gender of the Member on that 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

National Provider Identifier and Taxonomy Codes

National Provider Identifier

Each claim must include the National Provider Identifier for the:

- Rendering Provider, Service Facility Location, Billing Provider (when applicable)
- Supervising Provider, Referring Provider and Ordering Provider (when applicable)

Reminder:

- The Provider Name & NPI must match the way the Provider is enrolled and attested with Texas Medicaid
  - Log in to your profile on tmhp.com to verify your attestation

Note: Claims submitted with incorrect, invalid or missing NPI and Taxonomy code combination will reject or deny.

Taxonomy Code & Qualifier

Each claim must include the taxonomy code for:

- Rendering, Service Facility and Billing Provider (when applicable)
  - If a field does not apply to you, leave it blank
- 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

Reminder:

- The Provider taxonomy code and qualifier must match the way the Provider is enrolled and attested with Texas Medicaid
  - Log in to your profile on tmhp.com to verify your attestation
- The Provider taxonomy code and qualifier must match the services provided/billed
  - THSteps vs Acute

Important!

- If a item does not apply, leave it blank
- Billing Provider
  - Enter the Group Name or Individual Provider First and Last Name
  - You must enter a NPI, Taxonomy code and Taxonomy qualifier
- 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

Reminder: You must enter the Provider's complete first name and last name.

Note: Claims submitted with incorrect, invalid or missing NPI and Taxonomy code combination will reject or deny.

Cook Children's Health Plan

National Drug Codes

National Drug Code

- The claim must include the NDC code, quantity and unit of measure
- An NDC qualifier of N4 must be entered before the NDC on claims

Reminder:

- Providers should refer to the current Texas Medicaid Provider Procedures Manual for additional drug code information
- The drug name and National Drug Code billed must match

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

Informational-only Codes

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.

Family Planning, Gynecology and Obstetrics

Obstetric Services

Prenatal, Delivery and Postpartum

- Itemize each service individually on one claim form and file at the time of delivery
  - The filing deadline is applied to the date of delivery
- Itemize each service individually and submit claims as the services are rendered
  - The filing deadline is applied to each individual date of service

Prenatal Only

- Estimated date of confinement (EDC) in block 24D

Laboratory & Radiology

- Must be billed separately and must be received by the health plan within 95 days of the day of service
  - This includes the pregnancy test

Obstetric Services

Delivery

- One per Member, per seven-month period

Family Planning Annual Exams

Family Planning Services

Family planning services are preventive health, medical, counseling, and educational services that assist Members in controlling their fertility and achieving optimal reproductive and general health.

Family planning services must be provided by a physician or under physician supervision.

Services include:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory services
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization

Family Planning Diagnosis Codes

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures:

Diagnosis Codes							
Z30011	Z30013	Z30014	Z30015	Z30016	Z30017	Z30018	Z3002
Z3009	Z302	Z3040	Z3041	Z3042	Z30430	Z30431	Z30432
Z30433	Z3044	Z3045	Z3046	Z3049	Z308	Z309	Z9851
Z9852							

- One of the diagnosis codes in the table above must be included in block 24E of the CMS-1500 Claim form
- The choice of diagnosis code must be based on the type of family planning service provided

CookChildren's Health Plan

Family Planning Procedure Codes

- Providers must bill the most appropriate E/M procedure code
- Annual Family Planning examination must be billed with one of the following procedure codes, modifier FP and a Family Planning diagnosis code

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

- Only the annual Family Planning Examination requires the modifier FP
  - All other Family Planning Visits do not
  - One annual exam per year
    - In addition to the annual adult well check

CookChildren's Health Plan

Family Planning Billing Criteria

- Billing requirements for the annual examination are as follows:

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code with a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with a family planning diagnosis code	As needed*
* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.	

- Annual exams billed with modifier FP will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit
- If another condition requires an E/M visit beyond the required components of the annual exam, the Provider must submit a claim for the additional visit and must append modifier 25
- Documentation to support the additional visit must be maintained in the Member's medical record

Cook Children's Health Plan

Medicaid Prenatal Care Visits

Prenatal Care Visits

Texas Medicaid reimburses prenatal care, deliveries, and postpartum care as individual procedures.

- When billing for prenatal services:
  - Providers must use the most appropriate new or established patient prenatal or postnatal visit procedure code
  - Use modifier TH with the appropriate E/M procedure code to the highest level of specificity
  - Procedure codes
    - 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

Prenatal Care Visits

- Routine pregnancies are anticipated to require around 11 visits per pregnancy
- High-risk pregnancies are anticipated to require around 20 visits per pregnancy
  - Providers can appeal with documentation supporting a complication of pregnancy
  - Documentation reflecting the need for increased visits must be maintained in the Members medical records and is subject to retrospective review

Prenatal Care Diagnosis

Diagnosis code

- Always use the most appropriate prenatal diagnosis code as the primary diagnosis and any complications as an additional diagnosis code
  - O code set for Pregnancy and Childbirth

Medicaid Deliveries

Vaginal and Cesarean Deliveries

The Procedure codes below when submitted with the appropriate modifier is a benefit for Vaginal or Cesarean deliveries.

Procedure Codes								
59409	59410	59514	59515	59612	59614	59620	59622	S8415*
* Procedure code S8415 is for home delivery supplies								

Claims will deny if submitted for a delivery prior to 39 weeks of gestation and not medically necessary, or for a delivery service with no modifier.

Modifiers	
U1	Prior to 39 Weeks and Medically Necessary
U2	39 Weeks or Later
U3	Prior to 39 Weeks and Not Medically Necessary

Cook Children's Health Plan

Vaginal and Cesarean Deliveries

Procedure code 59414 and 59525 do not require a modifier.

Procedure Codes	
59414	59525

Medicaid Postpartum Care Visits

Cook Children's Health Plan

Postpartum Care Visit

One postpartum care procedure code may be reimbursed per pregnancy.

- Procedure codes
  - Postpartum care ONLY
    - 59430
  - Or with a delivery procedure code that includes postpartum care
    - 59410, 59515, 59614, 59622

Postpartum Care Diagnosis

Diagnosis code

- Always use the most appropriate postpartum diagnosis code as the primary diagnosis and any complications as an additional diagnosis code
  - Most common diagnosis for postpartum visit is Z39.2

Wound Checks

- Wound Checks are included in the cesarean delivery
- Wound Checks should not be billed as a postpartum visit

Postpartum Encounter Claim

Providers submitting a delivery procedure code that includes postpartum care must:

- Must submit an encounter claim with procedure code 59430 with a total charge of $0.01
- Failure to submit a postpartum encounter claim when billing 59410, 59515, 59614, or 59622 may result in recoupment

HEDIS

- You should see the Member for postpartum visits between 7-84 days after delivery
  - HEDIS measures

CHIP Perinatal Care

CHIP Perinatal

CHIP Perinatal coverage provides care to unborn children of pregnant women who are not eligible for Medicaid.

- Once born the child will receive Medicaid or CHIP benefits, depending on the income
- Eligibility
  - Terms on the last day of the month immediately after delivery
- CHIP Perinatal benefits for the unborn child
  - Up to 20 prenatal visits:
    - During the first 28 weeks of pregnancy — 1 visit every 4 weeks
    - During weeks 28 to 36 — 1 visit every 2 to 3 weeks
    - 36 weeks to delivery — 1 visit per week
    - Additional prenatal visits are allowed if they are medically necessary

CHIP Perinatal

- Some laboratory testing, assessments, planning services, education and counseling
- Prescription drug coverage based on the current CHIP formulary, including prescription prenatal vitamins
- Diabetic supplies available through pharmacies with a physician prescription
- Hospital facility charges and professional services charges related to the delivery

CHIP Deliveries

Vaginal and Cesarean Deliveries

The Procedure codes below when submitted with the appropriate modifier is a benefit for Vaginal or Cesarean deliveries.

Procedure Codes								
59409	59410	59514	59515	59612	59614	59620	59622	S8415*
* Procedure code S8415 is for home delivery supplies								

Claims will deny if submitted for a delivery prior to 39 weeks of gestation and not medically necessary, or for a delivery service with no modifier.

Modifiers	
U1	Prior to 39 Weeks and Medically Necessary
U2	39 Weeks or Later
U3	Prior to 39 Weeks and Not Medically Necessary

CookChildren's℠ Health Plan

Vaginal and Cesarean Deliveries

Procedure code 59414 and 59525 do not require a modifier.

Procedure Codes	
59414	59525

CHIP Postpartum Visits/Eligibility

Cook Children's Health Plan

CHIP Postpartum Visits/ Eligibility

Postpartum visits/eligibility

- CHIP Perinatal Members are eligible for two postpartum care visits per pregnancy within 60 days
  - Eligibility terminates at the end of the month
    - Cook Children's Health Plan will reimburse the two postpartum visits even if eligibility shows termed
- Procedure codes
  - Postpartum care ONLY
    - 59430
  - Or with a delivery procedure code that includes postpartum care
    - 59410, 59515, 59614, 59622

Postpartum Encounter Claim

Providers submitting a delivery procedure code that includes postpartum care must:

- Must submit an encounter claim with procedure code 59430 with a total charge of $0.01
- Failure to submit a postpartum encounter claim when billing 59410, 59515, 59614, or 59622 may result in recoupment

Wound Checks

- Wound Checks are included in the cesarean delivery
- Wound Checks should not be billed as a postpartum visit

HEDIS

- You should see the Member for postpartum visits between 7-84 days after delivery
  - HEDIS measures

Obstetric Ultrasounds

Obstetric Ultrasound Limitations

Prior authorization is required for greater than three obstetrical ultrasounds per pregnancy. Requests for additional obstetric ultrasounds may be considered when submitted with documentation of medical necessity.

- Ultrasounds performed in the ER, Outpatient Observation or Inpatient Hospital do not count towards the three per pregnancy limit

The following procedure codes may be submitted for obstetric ultrasound services:

Procedure Codes									
76801	76802	76805	76810	76811	76812	76813	76814	76815	76816
76817									

Providers must follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the Current Procedural Terminology (CPT) manual.

CookChildren's Health Plan

Makena

Hydroxyprogesterone Caproate

Makena

- Injection administered by the Provider in the office, Patient supplied injectable
  - Provider should bill administration code 96372
  - Provider should bill the appropriate J code (J1726 or J1729) with a billed amount of $0.01
- Injection administered by Provider in the office setting, Provider supplied injectable
  - Provider should bill administration code 96372
  - Provider should bill the appropriate J code (J1726 or J1729) with their usual and customary billed amount but not less than their contracted reimbursement rate
- Documentation supporting medical necessity for the administration must be maintained in the Members medical record:

Hydroxyprogesterone Caproate

  - Treatment initiated between 16 weeks, 0 days and 20 weeks, 6 days gestation
  - Treatment continues, as medically indicated, through 36 weeks, 6 days gestation or delivery, whichever occurs first
  - Member has a singleton pregnancy
  - Member has had a prior, singleton spontaneous preterm delivery before 37 weeks gestation
- Limited to a maximum of 21 doses per pregnancy
- Diagnosis Codes
  - Procedure code J1726 and J1729 are restricted to the following payable diagnosis:
    - O09.211, O092.12, O09.213, O09.219
- Procedure code J1726 and J1729 must be submitted with an NDC
- Administered once weekly (every 7 days)

Vaccines for Pregnant Women

Vaccines for Pregnant Women

The Influenza (flu) vaccine and the Tetanus, Diphtheria, and Acellular Pertussis (Tdap) vaccine are both part of routine prenatal care and are covered benefits for pregnant Members enrolled with Cook Children's Health Plan.

Health experts recommend that women get the flu vaccine if they will be in their second or third trimester of pregnancy during the flu season.

It is important for women to get the Tdap vaccine in the third trimester of *each* pregnancy.

Vaccines for Pregnant Women

- The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code.
  - Diagnosis code Z23 should be billed as the primary diagnosis code
  - Followed by the OB/GYN diagnosis
- Bill procedure code 90715 when administering the Tdap vaccine
- Bill procedure code 90756 when administering the flu vaccine to Members who are 4 to 17 years of age
- Bill procedure code 90682 when administering the flu vaccine to Members 18 years of age and older

OB ICD-10 Guidelines

Cook Children's Health Plan

ICD-10 Guidelines

- Code from Chapter 15 of the ICD 10 are for use only on maternal records
- Codes from range O00-O9A have sequencing priority
  - Should be the primary diagnosis code
  - Additional codes can be used from other categories in conjunction with maternity codes to further specify the condition(s)
- Z33.1 Pregnancy incidental to the encounter
  - Use in place of code O00-O9A
  - Include the condition being treated
  - Document that it is not affective the pregnancy
- When delivery occurs
  - The condition that prompted the admission should be sequenced as the primary diagnosis code
  - The principal diagnosis should correspond to the main circumstance or complication of delivery

Cook Children's Health Plan

ICD-10 Guidelines

- A code for any complication of delivery should be assigned as an additional diagnosis
- If multiple conditions prompted the admission
  - The one most related to the delivery should be sequenced as the principal diagnosis
- Cesarean Delivery
  - If the patient was admitted with a condition that resulted in the performance of a cesarean procedure
    - The condition should be selected as the principal diagnosis
  - If the reason for admission was unrelated to the condition resulting in the cesarean delivery
    - The condition related to the reason for admission should be selected as the principal diagnosis

ICD-10 Guidelines

- Outcome of delivery
  - A code from category Z37 should be included on every maternal record when a delivery has occurred
  - Category Z37 is intended for use as an additional diagnosis code
  - These codes are not to be used on subsequent records or on the newborn record
- Weeks Gestation
  - A code from category Z3A should be used to indicate the weeks of gestation
  - Only include this on the maternal record
- Additional
  - Codes from category Z34 cannot be reported in conjunction with any code from Chapter 15 of the ICD-10

Long-Acting Reversible Contraception

Long-Acting Reversible Contraception

- Coverage
  - CHIP does not cover contraceptive services in accordance with state law
  - Medicaid benefit for up to two months after the pregnancy ends
- Informed Consent
  - You must ensure that patients who elect to use a LARC have given informed consent for insertion of an IUD or subdermal arm implant
  - Patients must be allowed to withdraw consent at any time
- Billing
  - Providers can only bill for product administration at the time of service
  - Please refer to Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook for the appropriate insertion and/or removal of an intrauterine contraceptive device CPT code

LARC Toolkit

The Texas Long-Acting Reversible Contraception Toolkit is a resource for Texas health care Providers.

The LARC Toolkit offers information and resources to help Providers increase LARC availability to Texas women throughout their reproductive life cycle, including prior to the first pregnancy, during the postpartum period, and whenever family planning services are received.

LARC Quick Course for Providers

Texas Health and Human Services (HHS) and Texas Health Steps offer a web-based "quick course" for Providers about LARC. This course explains why and how to integrate LARC into routine clinical practice.

Quick Course:

- LARC: What Texas Health Providers Need to know

Sterilization Consent

Sterilization Consent Form

All claims for services with an elective sterilization must have a valid Sterilization Consent Form attached

- Two forms required
  - Sterilization Consent Form
    - Federally mandated consent form
    - The consent for sterilization is valid for 180 days from the date of the Member's signature
  - Texas Medical Disclosure Panel Consent
- Individual to be sterilized must:
  - Be at least 21 years old at the time the consent is obtained
  - Be mentally competent
  - Voluntarily give his or her informed consent
  - Sign the consent form at least 30 days but not more than 180 days prior to the sterilization procedure

Cook Children's Health Plan

Sterilization Consent Form

  - May choose a witness to be present when the consent is obtained
- Consent form must be signed and dated by:
  - Individual to be sterilized
  - Physician who will perform the procedure
- Members receiving a vasectomy or tubal ligation/occlusion sterilization procedure must:
  - Be twenty-one years of age or older
  - Be mentally competent
  - Not be institutionalized in a correctional facility, mental hospital, or other rehabilitative facility
  - Not give consent in labor or childbirth
  - Not give consent if under the influence of alcohol or drugs

Sterilization

- Waiting Period
  - Services can be rendered to Members after a waiting period of 30 days
- Prior Authorization
  - Verify prior to rendering services
- Reimbursable codes
  - Male sterilization
    - 55250
  - Female sterilization
    - 58565
    - 58600
    - 58611
    - 58615

Sterilization

- 58670
- 58671

Note: Texas Medicaid does not reimburse hysterectomies performed for the sole purpose of sterilization.

Hysterectomies

Texas Medicaid reimburses hysterectomies when they are medically necessary. Providers can use the following procedure codes when submitting claims for hysterectomy procedures:

Procedure Codes									
51925	58150	58152	58180	58200	58210	58240	58260	58262	58263
58267	58270	58275	58280	58285	58290	58291	58292	58293	58294
58541	58542	58543	58544	58548	58550	58552	58553	58554	58570
58571	58572	58573	58575	59135	59525				
Providers can refer to the Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for components and fees that may be reimbursed.									

- Hysterectomy Acknowledgement Information Form
  - Attach a copy to the claim
  - Provide a copy to the patient
  - Maintain a copy in the patient medical records

Cook Children's Health Plan

Breast Pumps

Breast Pump Procedure Codes

The following breast pump procedure codes are a benefit of Texas Medicaid with the listed limitations:

Procedure Codes	Additional Information	Limitations
A4281, A4282, A4283, A4284, A4285, A4286	Breast pump parts for use with a pump that has been purchased. All parts must be submitted with modifier U8.	Each part - up to 2 times within 12 months from the breast pump date of purchase
E0602*	Purchase of a personal-use, manual breast pump	Once within 12 months from the date of birth
E0603*	Purchase of a personal-use, electric breast pump	
*Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider		

Procedure Codes	Additional Information	Limitations
E0604*	Rental of a multiple-user, hospital-grade electric breast pump	Initial 60-day rental, followed by up to three 90-day rentals within 12 months from the date of birth
*Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider		

Modifier	Description
U8	U8 denotes the replacement of a part for durable medical equipment and must be used when submitting claims for any breast pump parts

Cook Children's Health Plan

Breast Pumps

Billed using the Mother's Medicaid ID number:

- Rental or purchase of a breast pump
- Replacement
- Parts

Purchase only:

- Manual or electrical personal-use

Rental only:

- Hospital-grade

Note: Breast pumps should not be ordered or billed prior to birth of the newborn.

Breast Pump Prior Authorization

- Prior authorization is **not** required for:
  - The purchase of a manual or electric personal-use breast pump, within 12 months from the date of birth
  - Up to two each of an additional part for a purchased breast pump, within 12 months from the purchase date
  - The initial 60-day rental of a multiple-user hospital grade breast pump
- Prior authorization **is** required for:
  - The replacement of a manual or electric personal-use breast pump due to damage or loss, within 12 months from the purchase date
  - Every 90-day rental period that follows the initial 60-day rental of a multiple-user hospital grade breast pump

Therapy

Outpatient Therapy Modifiers

- One of the following modifiers is required on all outpatient therapy claims *except* ***evaluation and re-evaluation*** procedure codes
- These modifiers identify the plan of care under which the service is delivered
- One of the following modifiers must be used to indicate when services have been rendered by a licensed therapist/physician or a therapy assistant under supervision of a licensed therapist

Modifier	Description
GP	Services delivered under a outpatient physical therapy plan of care
GO	Services delivered under an outpatient occupational therapy plan of care
GN	Services delivered under an outpatient speech-language pathology plan of care

Outpatient Therapy Modifiers

- One of the following modifiers must be used to indicate when services have been rendered by a licensed therapist/physician or a therapy assistant under supervision of a licensed therapist
- These modifiers should be billed in the secondary modifier position
- These modifiers **are not required for evaluation or re-evaluation codes** because those services may not be rendered by therapy assistants

Modifier	Description
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist
U5	Services delivered by a licensed therapist or physician

Outpatient Therapy Modifiers

- Acute Therapy
  - Therapy services that will not exceed a 60 day period per request
  - After two 60 day periods, any continued therapy services must be considered chronic
- Co-Treatment
  - A Member may receive a combination of Physical Therapy, Occupational Therapy and Speech Therapy services, use modifier U3 to indicate the necessity for co-treatment
  - Modifier U3 is not used by an Early Childhood Intervention contractor for co-visits or co-treatment services
- Seating Assessments
  - The Physical Therapist completing the seating assessment must submit procedure code 97542 with modifiers GP and UC in order to bill for the seating assessment

Outpatient Therapy Modifiers

- The Occupational Therapist completing the seating assessment must submit procedure code 97542 with modifiers GO and UC in order to bill for the seating assessment

Modifier	Description
AT	Must be included on claims for acute therapy services
U3	Claims for co-treatment must be submitted with modifier U3
UC	Must be included on seating assessment claims performed by an OT or PT

Seating Assessment

Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment is required for the rental or purchase of any device meeting the definition of a wheeled mobility system.

- Seating assessments are reimbursed in 15-minute increments (units) and must be billed with the following procedure code 97542
- The Physical Therapist (PT) completing the assessment must submit procedure code 97542 with modifiers GP and UC in order to bill for the seating assessment
- The Occupational Therapist (OT) completing the assessment must submit procedure code 97542 with modifiers GO and UC in order to bill for the seating assessment

Seating Assessment

- Services for the Qualified Rehabilitation Professional (QRP) participation in the seating assessment must be submitted for reimbursement by the DME Provider billing for the wheeled mobility system using procedure code 97542 with modifier U1
- Providers must follow the authorization and documentation requirements as stated in 2.2.17.10 Seating Assessment for Manual and Power Custom Wheelchairs of the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, located in the Texas Medicaid Provider Procedures Manual on TMHP.com
- Failure to follow these guidelines will result in a rejection or denial

Fitting of Custom Wheeled Mobility

Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client.

- It may also include time spent training the client or caregiver in the use of the wheeled mobility system
- Time spent setting up the system, or travel time without the client present, is not included
- Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME Provider of the wheeled mobility system using procedure code 97542 with modifier U2

Fitting of Custom Wheeled Mobility

- Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed

Therapy Waitlist

Therapy Waitlist

HHSC Quality and Improvement Services for STAR and CHIP require all Managed Care Organizations to obtain accurate and comprehensive information regarding therapy services provided to Members.

Therapy Providers that place Members who are birth through 20 years of age on waiting lists for services, for any reason, have the option of reporting this information to Cook Children's Health Plan (CCHP) Network Development Department or Health and Human Services Commission (HHSC).

Cook Children's Health Plan

Therapy Waitlist

If a Therapy Provider is experiencing one or all of the following occurrences when treating a Cook Children's Health Plan Member it must be reported:

- Not accepting new Members
- Cannot treat the Member at the frequency assessed
- Cannot provide appropriate services for the Member needs

Maintaining a "waitlist" for evaluation of services:

- A Member placed on a waiting list should stay on the list until he or she receives the necessary therapy service

If any of these situations occur, Providers must submit notification to Cook Children's Health Plan Network Development Department or HHSC.

Cook Children's Health Plan

Therapy Waitlist

If you cannot meet the service needs of the Member(s):

- Submit a Customer Service Request via the Secure Provider Portal
  - Select the Topic: Therapy Notification – Patients on Waitlist

If you are no longer accepting new Member

- Submit a Customer Service Request via the Secure Provider Portal
  - Select the Topic: Therapy Notification – Closing Practice to New Patients

Questions? Call 888-243-3312 to speak with a Network Development representative or visit our Therapy Information page at cookchp.org.

Cook Children's Health Plan

Billing Units Based on 15 minutes

- All claims for reimbursement are based on the actual amount of billable time associated with the service
- For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded to the nearest quarter hour

Units	Number of Minutes
0 units	0 through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

Home Health Agency

Home Health Agency

Home Health Agencies providing Therapy Services

- Must bill Occupational and Physical Therapy services on a UB-04 claim form
- Speech Language provided under the CCP Program, for children 0-20 years of age, must be billed on a UB-04 claim form

Durable Medical Equipment

Durable Medical Equipment/Supplies

- Medically Necessary
- Prior Authorization Required
  - Request must reflect the number of units by which each product is measured
    - Example: 300 diapers, not 1 box
- Reimbursement
  - The Providers billed charge
  - The published fee determined by HHS
  - Manual pricing
    - When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement
    - Durable Medical Equipment (DME) and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing

Durable Medical Equipment/Supplies

- MSRP less 18%
- Provider's documented invoice cost

- Documentation of Delivery
  - Signed and dated by the Member or Caregiver
  - Delivery slip or invoice
    - Must include:
      - Member's full name and address
      - Itemized list of goods that includes the description and numerical quantities of the supplies delivered
      - The corresponding tracking number from the carrier
      - Document should include prices, shipping weights, shipping charges, etc.
  - Dated carrier tracking document

Durable Medical Equipment/Supplies

- Records
  - And claims must be retained for a minimum of 5 years from the date of service
- Refills
  - No sooner than the 28th day of the month
    - Cook Children's Health Plan has currently implemented configuration to ensure that rent to purchase items and monthly rentals are billing within the TMPPM limitations. As a result, any item that is billed on a monthly basis must have more than 28 days between each date of service that is billed
    - Services billed prior to 28 days will reject due to current Cook Children's Health Plan configuration
  - To prevent denial of claims for rendered services, please ensure that you are billing more than 28 days between each date of service

Cook Children's Health Plan

Unlisted Procedure Prior Authorization

When requesting a fee-for-service prior authorization for an unlisted procedure code, Providers must submit the following information with the prior authorization request:

- Member's diagnosis
- Medical records to support medical necessity of the requested procedure
- Clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested
- Documentation that the procedure is not investigational or experimental
- Place of service in which the procedure is to be performed
- The physician's intended fee for the procedure including the manufacturer's suggested retail price (MSRP) or other payment documentation

Unlisted Procedure - Manual Pricing

If prior authorization has been obtained for services that use manually priced procedure codes, Providers must submit the claim(s) with the MSRP that was submitted with the authorization request. The following information is also required:

- Authorization Number
- Provider Identifier
- Procedure Codes
- Dates of Service
- Types of Service
- Required Modifiers
- If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services

Unlisted Procedure Code Claim

The procedure codes and MSRP rates on the claim must match the procedure codes in the authorization letter and the MSRP rates that were submitted with the authorization request.

Note: Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

Manufacturers Suggested Retail Price

- Reimbursement
  - Lesser of the Provider's billed charges
  - Published fee determined by Texas Health and Human Services (HHS)
  - Manual Pricing
    - MSRP less 18%
    - AWP less 10.5%
    - Provider's documented invoice cost
- Billing
  - Providers should submit a paper claim when billing for a service that includes an unlisted procedure
  - Providers should submit a description of the service on the claim when billing an unlisted procedure

Manufacturers Suggested Retail Price

- Providers should submit a copy of the invoice or the MSRP for the service

Ambulance Transportation

Ambulance Transportation

Non-Emergency Ambulance Transportation:

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

Ambulance Provider

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

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

Ambulance Transportation Billing Tips

- Claim form
  - CMS-1500
- Emergency transport
  - Is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes
  - The ET modifier is required for every detail on an emergency transport claim
    - The ET modifier is not required to be listed in the first position on the claim line
  - Emergency transports that use an extra attendant must bill modifier ET with the extra attendant procedure code
  - Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements

Ambulance Transportation Billing Tips

- Multiple Client Transports
  - A claim for each client must be billed with the transport procedure code and mileage procedure code with the GM modifier
- Not Medically Necessary Transports
  - Providers must use the GY modifier to submit claims for instances when the Provider is aware no medical necessity existed
    - Ambulance Providers must maintain a signed Client Acknowledgement Statement
- Emergency Transports Involving a Hospital
  - Hospital to hospital transports that meet the definition of an emergency transport do not require prior authorization
  - Providers must use modifier ET and one of the facility to facility transfer modifiers (HH, HI or IH) on each procedure code listed on the claim

Ambulance Transportation Billing Tips

- Place of Service
  - The place of service for all ambulance transports is considered the destination
- Origin and Destination Codes
  - All claims submitted must include the two-character origin and destination codes for each claim line
  - The origin is the first character
  - The destination is the second character
- Claim for ambulance transportation
  - Exact mileage must match on the authorization and on the claim form

Telecommunication Services

Telecommunication Services

Cook Children's Health Plan follows the Texas Medicaid Provider Procedures Manual (TMPPM) related to Telecommunication Services.

- Providers may refer to the Telecommunication Services Handbook located on tmhp.com
- For exceptions due to COVID 19 please visit the Coronavirus (COVID-19) Information pages on TMHP and HHSC
- For claims that are provided via telecommunication should append modifier 95

Clinical Laboratory Improvement Amendment's

Cook Children's Health Plan

CLIA

- Providers must have a CLIA certificate of waiver to perform waived tests
- Providers must provide CCHPNetworkDevelopment@cookchildrens.org with a copy of their CLIA certificate
- For waived tests, Providers must use modifier QW as indicated on the CMS website or the 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
- 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

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CLIA

- 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

Ambulatory Surgery Center

Cook Children's Health Plan

Ambulatory Surgery

- Freestanding Ambulatory Surgery Center
  - Must be billed on the CMS 1500 form
- Ambulatory Surgery with Observation
  - Observation must be billed separately from the surgery
  - Observation must be billed on a UB-04

Influenza A
&
Influenza B

Influenza A & Influenza B

- Diagnosis Code
  - Use the appropriate ICD-10 diagnosis code from the J code set for a positive flu test
- 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 clinical laboratory improvement amendment (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

Present on Admission (POA)

Present on Admission

The Present On Admission (POA) data element on your electronic claims must contain the letters "POA"

- Followed by a single POA indicator for every diagnosis that you report
- POA indicator for the principal diagnosis should be the first indicator after "POA"
- POA for indicators for secondary diagnoses would follow
- The last POA indicator must be followed by the letter "Z" to indicate the end of the data element
- The POA on paper claims is the eighth digit of the Principal Diagnosis field (FL 67)
- The POA is the eighth digit of each of the secondary diagnosis field (FL 67 A-Q)
- Claims submitted electronically via 837, 4010 format, use segment K3 in the 2300 loop, data element K301

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Present on Admission

- Reporting Options and Definitions
  - Y - Yes (present at the time of inpatient admission)
  - N - No (not present at the time of inpatient admission)
  - U - Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
  - Y - Yes (present at the time of inpatient admission)
  - N - No (not present at the time of inpatient admission)
  - U - Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
  - W – Clinically undetermined (Provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
  - 1 – Unreported/Not used – Exempt from POA reporting (this code is the equivalent of a blank on the UB-04, but blanks are not desirable when submitting data via the 4010A1)

After Hours Services

After Hours Services

- Applies to office-based Providers
- Procedure codes
  - 99050, 99056, 99060
    - Billed for services rendered outside of the Provider's routine office hours
    - Limited to one per day, same Provider
    - 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**

After Hours Services

- Reimbursable
  - The physician leaves the office or home to see a client in the emergency
  - The physician leaves the home and returns to the office to see a client after the physician's routine office hours
  - The physician is interrupted from routine office hours to attend to another client's emergency outside of the office

Resources

Resources

Cook Children's Health Plan

- cookchp.org

Texas Medicaid Healthcare Partnership

- tmhp.com

Secure Provider Portal

- https://epiccarelink.cookchp.org/LinkHealthPlan/common/epic_login.asp

Prior Authorization Lookup

- prior Authorization Search | Cook Children's Health Plan (cookchp.org)

Availity

- http://www.availity.com/

Texas LARC Toolkit

- https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/women/texas-larc-toolkit.pdf

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Resources

LARC Quick Course for Providers

- https://www.txhealthsteps.com/static/courses/larc/sections/section-1-1.html

CMS Website – CLIA

- http://www.cms.gov/CLIA/10_Categorization_of_Tests.asp

Title XIX Hysterectomy Acknowledgement Form

- http://www.tmhp.com/Provider_Forms/Medicaid/Medicaid_Title_XIX_Ackn_Of_Hyst_Form.pdf

Sterilization Consent Form English

- http://www.tmhp.com/Provider_Forms/Medicaid/F00090_Sterilization_Consent_Form_English.pdf

Texas Medical Disclosure Panel Disclosure and Consent Forms

- https://www.dshs.texas.gov/facilities/medical-disclosure/forms.aspx?terms=Texas%20Medical%20Disclosure%20Panel%20and%20consent%20form

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Resources

NCCI Edits

- https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Service Authorization Request Form

- http://http/www.cookchp.org/SiteCollectionDocuments/2018/CCHP-ServiceAuthorizationRequestForm.pdf

Navitus

- https://pharmacies.navitus.com/

CCHP Electronic Data Interchange Requirements – Institutional

- https://cookchp.org/SiteCollectionDocuments/pdfs/provider-electronic-claims/CCHP_EDI_Filing_Requirements_Institutional_06.08.2018.pdf

CCHP Electronic Data Interchange Requirements - Professional

- https://cookchp.org/SiteCollectionDocuments/pdfs/provider-electronic-claims/CCHP_EDI_Filing_Requirements_Professional_06.08.2018.pdf

TMHP Timely Filing Calendar

- http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

Cook Children's Health Plan

Resources

Texas Medicaid Healthcare Partnership fee schedule

- https://public.tmhp.com/FeeSchedules/Default.aspx

Therapy Notification to CCHP

- https://cookchp.org/providers/Pages/therapy-information.aspx

HEDIS measures

- https://cookchp.org/SiteCollectionDocuments/pdfs/provider-relations/Providers_HEDIS.pdf

LARC: What Texas Health Providers Need to know

- https://www.txhealthsteps.com/static/courses/larc/sections/section-1-1.html

HHSC

- https://www.hhs.texas.gov/services/health/coronavirus-covid-19

CMS

- https://www.cms.gov/regulations-and-guidance/legislation/clia?redirect=/clia/10_categorization_of_tests.asp

Cook Children's Health Plan

Resources

Texas Medicaid Provider Procedures Manual

– https://www.tmhp.com/resources/provider-manuals