Texas | Medicaid • Medicare Advantage • Medicare-Medicaid Plan

Federally qualified health centers and rural health clinics orientation

Wellpoint

Coding disclaimer

- The information in this presentation does not guarantee reimbursement or payment for services.
- Coding guidance in this presentation is not intended to replace official coding guidelines or professional coding expertise.
- Wellpoint providers are expected to ensure documentation supports all codes submitted for conditions and services.
- If you have questions regarding billed claims and reimbursement, call Provider Services at **833-731-2162** or your provider relationship management representative.

Your responsibilities

Providers should review both provider and member responsibilities detailed in the provider manual found at https://provider.wellpoint.com/tx.

Health Network Management responsibilities

Provider communications/training resources

Wellpoint has curated trainings and provider communications to ensure you and and your staff are aware of updates, training, and onboarding resources that every provider– new or experienced – can use to further their education. All training resources are accessible through the Training Academy.

Visit: **https://provider.wellpoint.com/texas-provider/communications**

Marketing activities

Sanctioned marketing activities:

- Attendance at MAXIMUS-sponsored member enrollment events.
- Approved managed care organization (MCO) sponsored health fairs and community events.
- Radio, television, and print advertisements.

In Texas, the following activities are prohibited:

- Conducting direct contact marketing, except through the heath and human services commission (HHSC) sponsored enrollment events.
- Making any written or oral statement containing material that misrepresents facts or laws relating to Wellpoint or the STAR, STAR+PLUS, STAR Kids, and CHIP programs.
- Promoting one MCO over another if contracted with more than one MCO.

Provider demographic updates

Please update us immediately concerning changes in:

- Address.
- Phone.
- Fax.
- Office hours.
- Access and availability.
- Panel status.
- Tax-identification number (TIN).

Please also remember to update your demographic information with the Texas Medicaid & Healthcare Partnership (TMHP).

For additional information on how to update your demographic information, visit the State Communications and Resources page on the Wellpoint provider website at **https://provider.wellpoint.com/tx**.

Credentialing

Federally qualified health centers (FQHC) and rural health clinic (RHC) facilities must provide the following documents:

- *Letter of Intent – New Facility Form*
- Copy of *W9*

Individual practitioners must be credentialed only if performing services outside of the facility. In those cases, we would need the following:

- *Letter of Intent – New Provider Form*
- Copy of *W9*

Credentialing (cont.)

- RHCs and FQHCs are credentialed as facilities.
- The RHC and FQHC serves as the primary care provider (PCP); members choose the RHC or FQHC and not the individual provider.
- Currently, we require that the RHC and FQHC (building) have a Texas Medicaid enrollment number.
- RHCs also operating as a group and expecting fee-for-service payment must also be contracted and credentialed at the physician group level and have a Texas Medicaid enrollment number for the group.

Credentialing (cont.)

- Credentialing is for a three-year period.
- Recredentialing efforts begin six months prior to the end of the current credentialing period.
- First notice and second notice letters are faxed/mailed to providers.
- Third notice and final notice letters are mailed to providers.
- Providers who do not respond or submit a complete recredentialing packet will be decredentialed/considered out of network.
- Providers must begin the contracting and credentialing process from the beginning to rejoin the Wellpoint network.
- Notify your provider relationship management representative with changes in licensure, demographics, or participation status as soon as possible.

Medicaid enrollment

MAXIMUS — state enrollment broker:

- Provides education and enrollment services to Texans in Medicaid managed care programs, CHIP, and children's dental services.
- Conducts outreach and provides information about the Texas Health Steps program.

Enrollment:

- Enrollment kits are sent to clients by MAXIMUS following receipt of the client's eligibility from the Texas Health and Human Services Commission (HHSC).
- An MCO is automatically assigned if the enrollment process is not completed by client.

Medicaid enrollment (cont.)

- Assistance is available with the enrollment process including:
  - Personalized assistance at enrollment assistance sites and during enrollment events. Visit txmedicaidevents.com.
  - Home visits scheduled through the Enrollment Broker Helpline.
  - Submission of enrollment forms online, by mail, or fax.

Effective dates:

- Before the 15th of the month — effective the first day of following month (for example, enroll January 10 to effective February 1).
- After the 15th of the month — effective the first day of next full month (for example, enroll January 20 to effective March 1).

Plan changes:

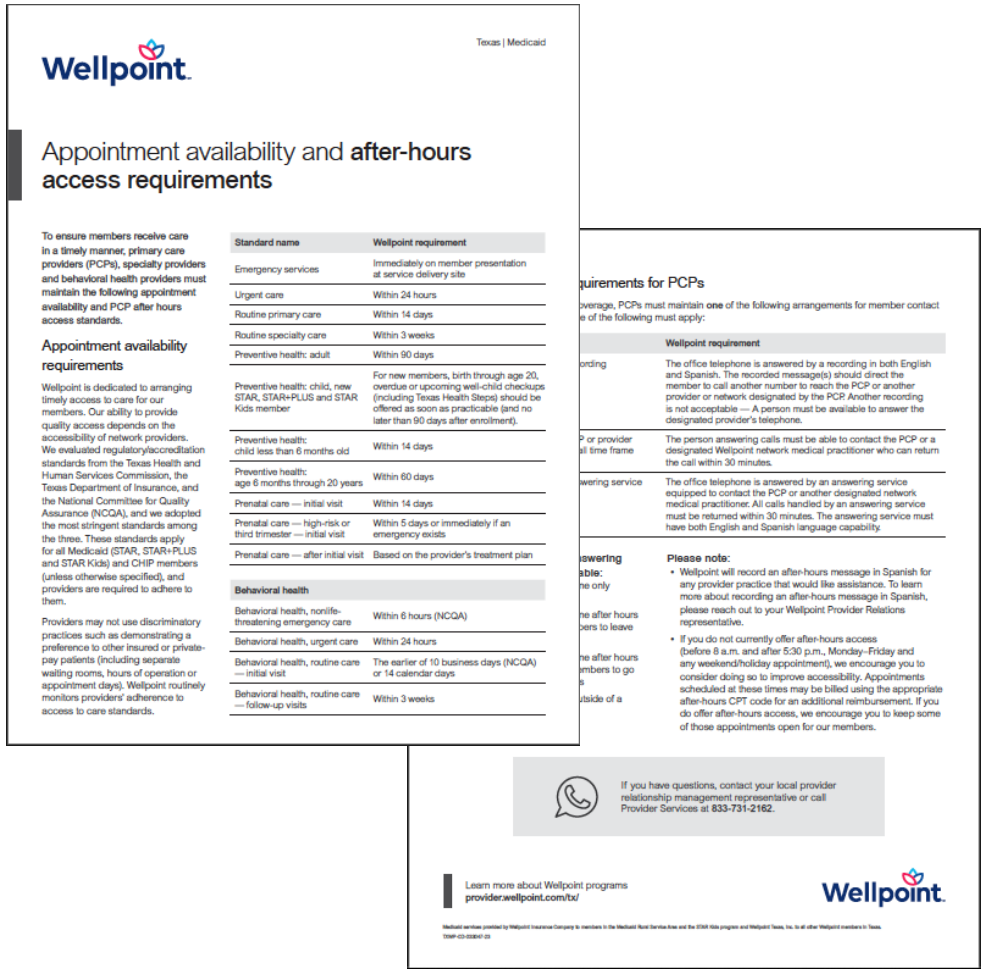
- Must contact MAXIMUS for plan changes.
- Same effective date rules apply.

Medicaid enrollment (cont.)

- Those who wish to complete the enrollment on their own may submit their applications by mail, online, or by fax. The contact information is provided below:
- Enrollment Broker Helpline: **800-964-2777**
- Special Populations Helpline: **877-782-6440**
- Mail: P.O. Box 149023
- Austin, TX 78714-9023
- Online: **https://yourtexasbenefits.com**
- Fax: **855-671-6038**

Appointment availability and after-hours standards

- We are dedicated to timely access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, Texas Department of Insurance, and National Committee for Quality Assurance (NCQA) requirements, and we follow the most stringent standards among the three sources.
- Providers are required to adhere to access standards that apply to both Medicaid and CHIP unless specified. Standards are measured from the date of presentation or request, whichever occurs first.



Wellpoint

Texas | Medicaid

Appointment availability and **after-hours access requirements**

To ensure members receive care in a timely manner, primary care providers (PCPs), specialty providers and behavioral health providers must maintain the following appointment availability and PCP after hours access standards.

Appointment availability requirements

Wellpoint is dedicated to arranging timely access to care for our members. Our ability to provide quality access depends on the accessibility of network providers. We evaluated regulatory/accreditation standards from the Texas Health and Human Services Commission, the Texas Department of Insurance, and the National Committee for Quality Assurance (NCQA), and we adopted the most stringent standards among the three. These standards apply for all Medicaid (STAR, STAR+PLUS and STAR Kids) and CHIP members (unless otherwise specified), and providers are required to adhere to them.

Providers may not use discriminatory practices such as demonstrating a preference to other insured or private-pay patients (including separate waiting rooms, hours of operation or appointment days). Wellpoint routinely monitors providers' adherence to access to care standards.

Standard name	Wellpoint requirement
Emergency services	Immediately on member presentation at service delivery site
Urgent care	Within 24 hours
Routine primary care	Within 14 days
Routine specialty care	Within 3 weeks
Preventive health: adult	Within 90 days
Preventive health: child, new STAR, STAR+PLUS and STAR Kids member	For new members, birth through age 20, overdue or upcoming well-child checkups (including Texas Health Steps) should be offered as soon as practicable (and no later than 90 days after enrollment).
Preventive health: child less than 6 months old	Within 14 days
Preventive health: age 6 months through 20 years	Within 60 days
Prenatal care — initial visit	Within 14 days
Prenatal care — high-risk or third trimester — initial visit	Within 5 days or immediately if an emergency exists
Prenatal care — after initial visit	Based on the provider's treatment plan
Behavioral health	
Behavioral health, nonlife-threatening emergency care	Within 6 hours (NCQA)
Behavioral health, urgent care	Within 24 hours
Behavioral health, routine care — initial visit	The earlier of 10 business days (NCQA) or 14 calendar days
Behavioral health, routine care — follow-up visits	Within 3 weeks

uirements for PCPs

overage, PCPs must maintain **one** of the following arrangements for member contact e of the following must apply:

	Wellpoint requirement
ording	The office telephone is answered by a recording in both English and Spanish. The recorded message(s) should direct the member to call another number to reach the PCP or another provider or network designated by the PCP. Another recording is not acceptable — A person must be available to answer the designated provider's telephone.
P or provider ll time frame	The person answering calls must be able to contact the PCP or a designated Wellpoint network medical practitioner who can return the call within 30 minutes.
wering service	The office telephone is answered by an answering service equipped to contact the PCP or another designated network medical practitioner. All calls handled by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.

swering able:
ne only
ne after hours bers to leave
ne after hours mbers to go
utside of a

Please note:

- Wellpoint will record an after-hours message in Spanish for any provider practice that would like assistance. To learn more about recording an after-hours message in Spanish, please reach out to your Wellpoint Provider Relations representative.
- If you do not currently offer after-hours access (before 8 a.m. and after 5:30 p.m., Monday–Friday and any weekend/holiday appointment), we encourage you to consider doing so to improve accessibility. Appointments scheduled at these times may be billed using the appropriate after-hours CPT code for an additional reimbursement. If you do offer after-hours access, we encourage you to keep some of those appointments open for our members.

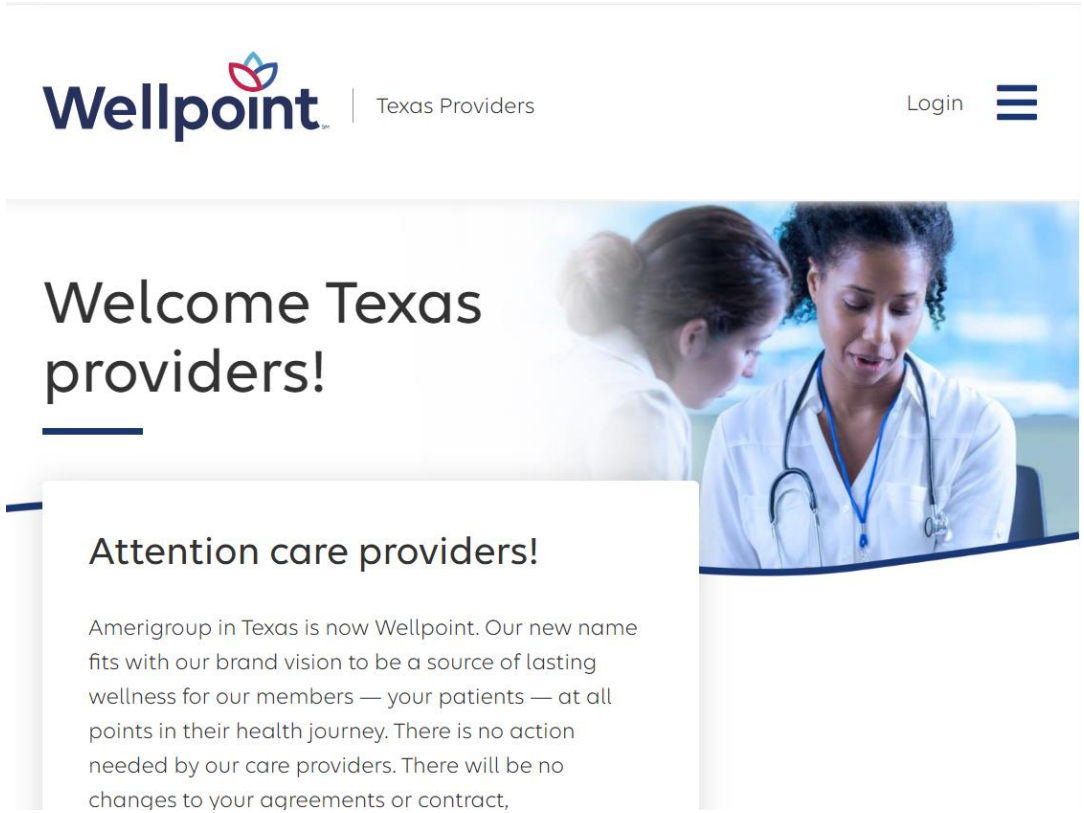
If you have questions, contact your local provider relationship management representative or call Provider Services at **833-731-2162**.

Learn more about Wellpoint programs
provider.wellpoint.com/tx/

Wellpoint

Provider website

- Available to all providers regardless of participation status.
- Multiple resources available without login.
- Accessible 24/7.
- https://provider.wellpoint.com/tx



Medicaid enrollment status

Retroenrollment:

- Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

Retrodisenrollment:

- TMHP finds that the member did not meet eligibility guidelines after application or if the member does not complete the necessary paperwork to complete the application, then the member's temporary initial enrollment can be reversed. If this occurs, the state will request funds back from the MCO who will subsequently request those funds back from the provider.

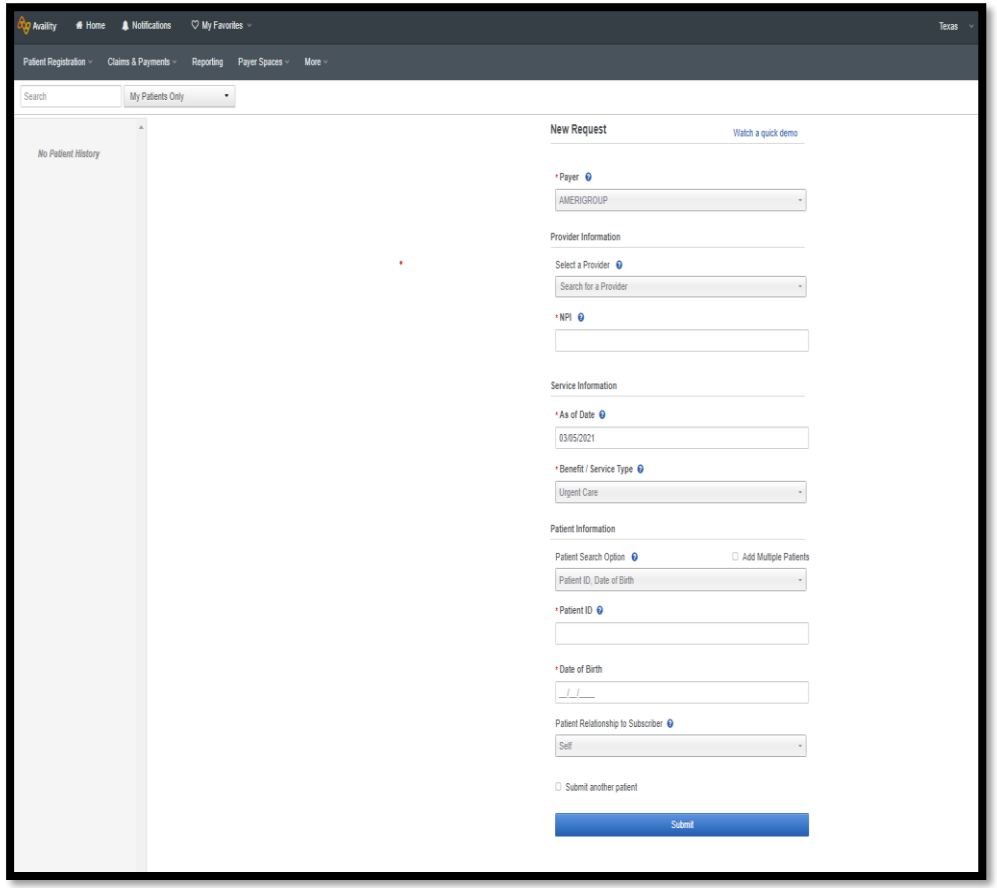
Medicare enrollment

Medicare beneficiaries can enroll in Medicare Advantage plans during certain time periods called election periods. Five important election periods are:

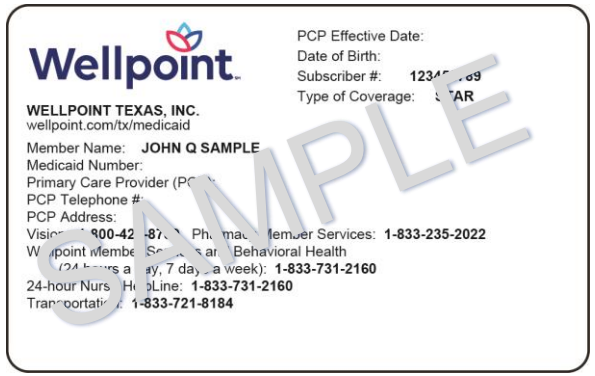
Initial coverage election period	• Occurs at an individual's 65 birthday for Medicare part A and enrolls in part B.
Annual election period (AEP)	• AEP occurs from October 15 to December 7 each year.
Medicare Advantage disenrollment period	• January 1 to February 14 each year.
Initial enrollment period for Part D	• When eligible, individual is enrolled in Part A or Part B and resides in SDA or plan.
Special election period	• Begins the month the individual becomes dually-eligible, with limitations.

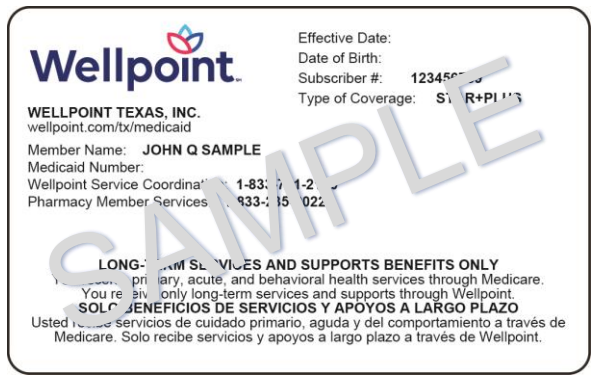
Verifying eligibility

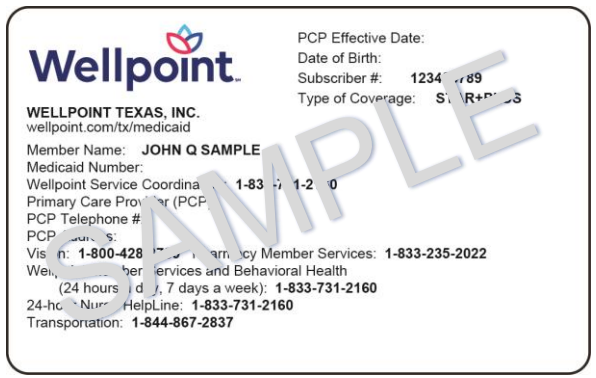
- Availity Essentials
- Check one member or use online batch management
  to check multiple
  members from multiple payers.
- Search with either Wellpoint subscriber or Medicaid/CHIP identification number.

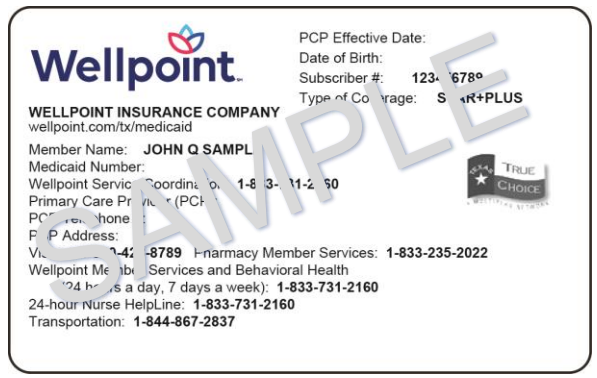


Member sample ID cards – Medicaid

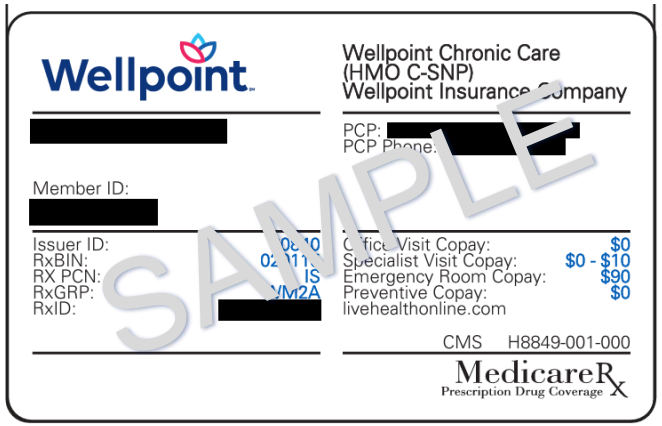


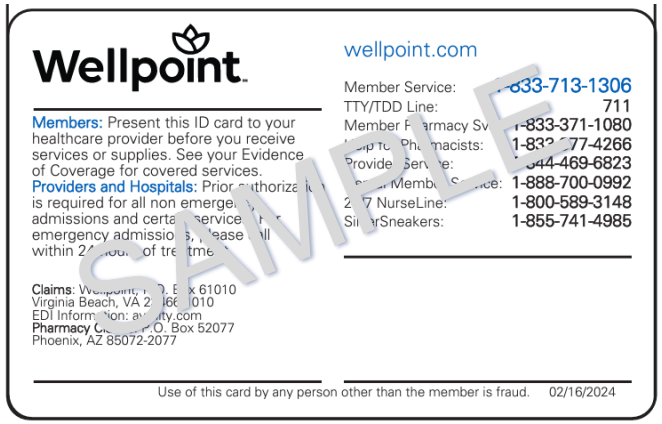




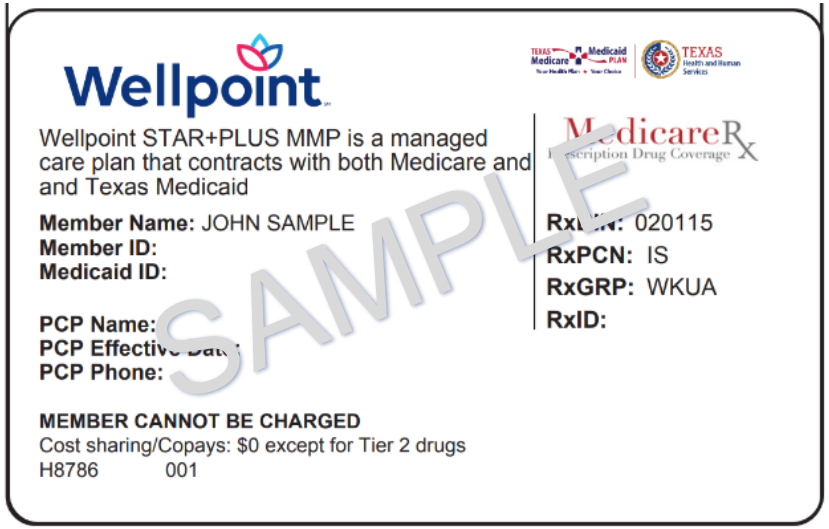


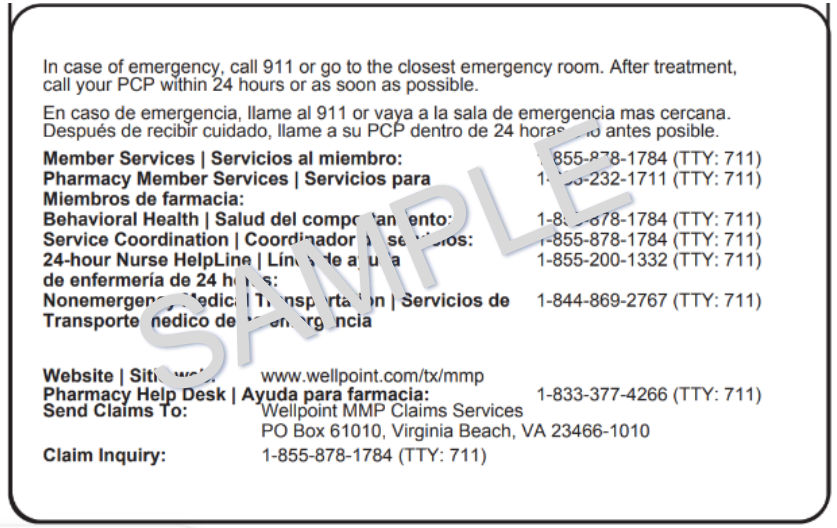
Member sample ID cards – Medicare





Member sample ID cards – MMP

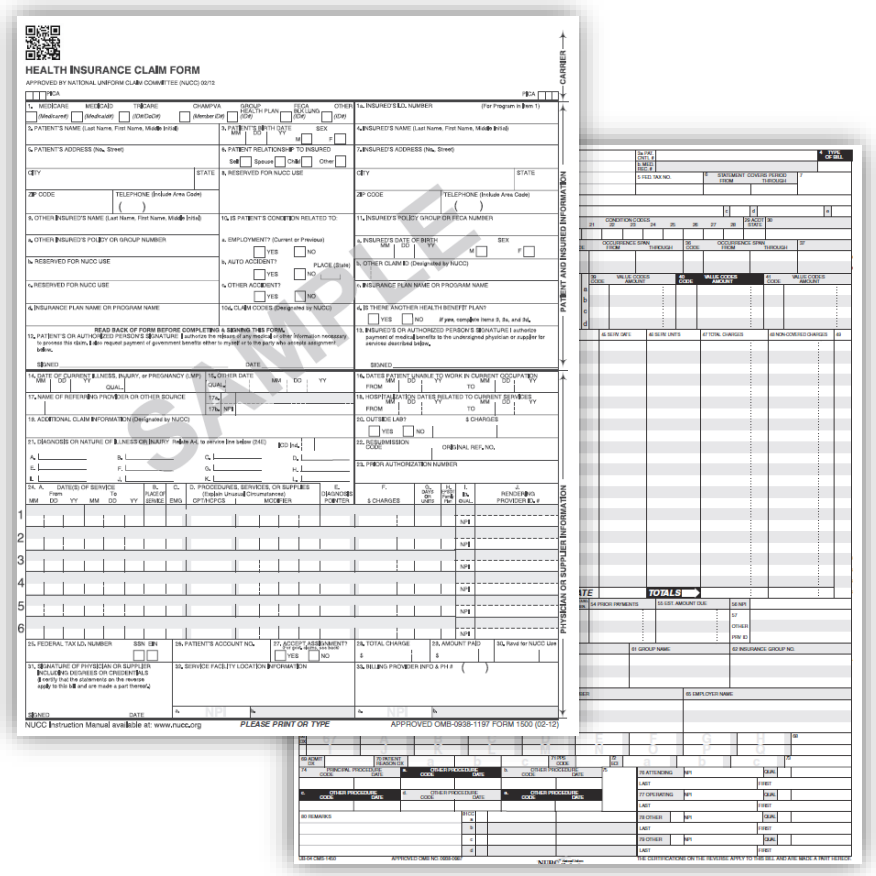




Patient 360

- Patient360 is a tool in Availity Essentials that provides an in-depth view of the treatment and care your patient is receiving. This tool allows all providers to view information regarding patient demographics, pharmacy details, authorizations on file, and claims summaries (such as what other providers the patient is seeing). Sharing relevant case information in a timely, useful, and confidential manner is a Wellpoint requirement.
- Improving provider-to-provider communication will help to eliminate barriers when coordinating member care, improve the quality of care a member receives, and improve the member's experience.
- To access Patient360, log in to **Availity.com**, select **Wellpoint** under *Payer Spaces* and Patient360 will appear under the *Applications* tab on the bottom portion of the screen.

Billing format



Paper claims should be submitted on CMS-1500, UB-04, or successor forms as applicable to the provider contract.

The taxonomy in 24J shaded should correspond with the NPI in the unshaded portion and the taxonomy in 33B should match the NPI in 33A respectively.

On the new UB-04 form, NPI should be in box 56 and taxonomy in box 57.

Claims without a verifiable ID number will be denied or rejected.

To ensure timely adjudication of a claim, please use the NPI/ taxonomy attested with TMHP.

Who can bill at an FQHC or RHC

An encounter is considered an in-person visit between a patient and a/an:

- Physician.
- Physician assistant.
- Nurse practitioner.
- Certified nurse-midwife (CNM).
- Visiting nurse.
- Other health visits (OHV) (See note below).

OHV may include a qualified clinical psychologist, clinical social worker, dentist, dental hygienist, optometrist, Texas Health Steps medical checkup, other health professionals for mental health, etc.

Who cannot be billed?

Hospital services are not considered for reimbursement to FQHC/RHC providers and cannot be billed using the facility provider number assigned to the FQHC/RHC:

- Exceptions are qualified credentialed providers performing outside of the FQHC/RHC facility. The claim would be submitted using the individual or group physician provider identifier.
- Wellpoint will reimburse the FQHC/RHC at the fee-for-service rate versus at the encounter rate.

FQHC claims submission guidelines — Medical services

All services incidental to the encounter are considered inclusive and are not reimbursed separately.

Incidental services cannot be billed as a separate encounter but are included in the total cost of the encounter.

Claims submission guidelines — Medical services

Encounters must be billed using procedure code T1015, except for:

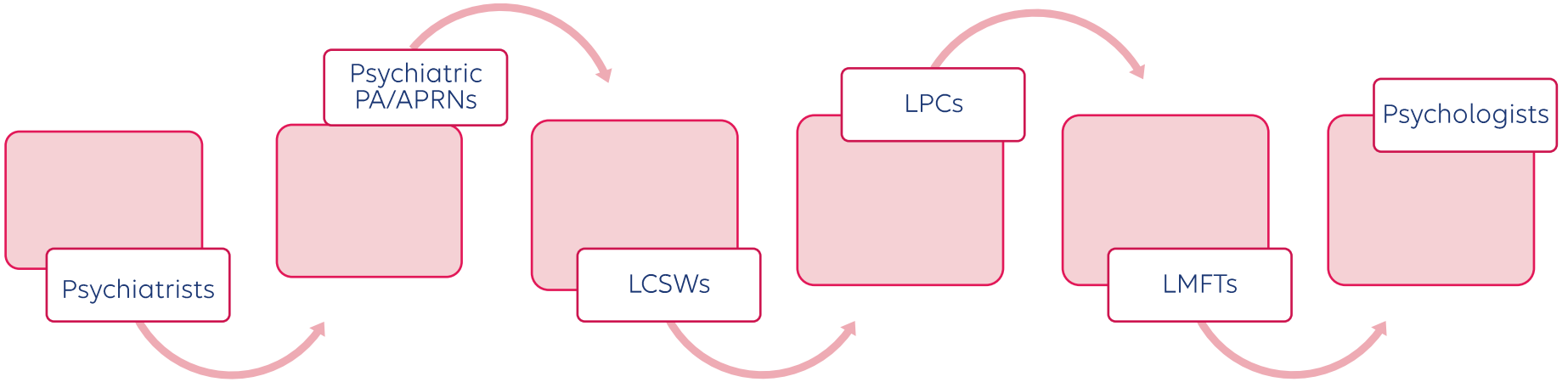
- Family planning services.
- Texas Health Steps medical and dental services.
- Immunizations.
- Vision services.
- Mental health services.
- Case management for high-risk pregnant women and infants.

- Services provided by healthcare professionals require AH, AM, SA, TD, TE, or a U7 modifier (explanation of modifiers on the following slide).
- All FQHC claims will need to be submitted with POS 50.
- All RHC claims will need to be submitted with POS 72.

General service modifiers

Modifier	Service performed
AH	AH services performed by psychologist
AJ	Services performed by social worker
AM	Services performed by physician, team member services
SA	Services performed by nurse practitioner in collaboration with physician
TD	Services performed by registered nurse
TE	Services performed by LPN or LVN
U7	Services performed by physician assistant other than assistant at surgery

Claims submission guidelines — Behavioral services



FQHC claims submission guidelines — Behavioral services

- **Mental health services codes**

Mental Health Services									
90791	90792	90832	90833*	90834	90836*	90837	90838*	90846	90847
90853	90899	96116	96130	96132	96136				
* Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2.									

- Only appropriate behavioral health services that are within the scope of the providers' practice should be rendered.

For more information regarding Mental Health Services, please visit the Texas Medicaid Provider Procedures Manual Behavioral Health and Case Management handbook:
https://www.tmhp.com/resources/provider-manuals/tmppm

Case management for children and pregnant women (CPW)

CPW covered services for FQHC providers:

CPW services include a comprehensive visit, face-to-face follow-ups, and/or telephonic follow-ups:

- These services are limited to one contact per day per person. Additional contacts on the same day will be denied.
- CPW services are not billable when a person is admitted to an inpatient hospital or other treatment facility.
- All services require documentation to support medical necessity of the service rendered. These services are subject to retrospective reviews to ensure the documentation supports the services rendered. Procedure codes and billing requirements:
  - Face-to-face or telephonic visits
  - Total of three visits
  - One comprehensive visit (face-to-face)
  - Two follow-up visits (face-to-face or telephonic)
  - T1015 is required for full encounter

Procedure code	Description	Modifiers
G9012	Comprehensive visit (in-person)	U2 and U5
G9012	Comprehensive visit (telehealth)	U2, U5, and 95
G9012	Follow-up visit (in-person)	U5 and TS
G9012	Follow-up visit (telehealth)	U5, TS, and 95
G9012	Follow-up visit (audio only)	TS and 93

For more information regarding case management for children and pregnant women:
https://provider.wellpoint.com/docs/gpp/TX_CAID_CMChildandPregWmn.pdf?v=202211171535

Claims submission guidelines — Multiple services/visits

An FQHC or RHC can bill up to five encounters in one day:

- Example of billing encounters in one day include:
  - One general medical visit.
  - Other health visit (OHV):
    - One Texas Health Steps checkup.
    - One family planning visit.
    - One mental health visit.
    - One vision care visit.

Claims submission guidelines — Exception to multiple services/visits

An exception to the encounter per day may occur when the following is presented:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and another health visit such as a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical checkup.

Claims submission guidelines — Family planning services

RHC:

- RHCs may be reimbursed for family planning services using their RHC National Provider Identifier (NPI) with the appropriate benefit code.
- Family planning services performed in the RHC setting must be billed with the appropriate modifier: AM, SA, or U7.

FQHC:

- An annual family planning examination is allowed once per state fiscal year, per patient, per provider.
- Up to three family planning encounters may be reimbursed per provider, per patient, per year.
- Only the annual family planning examination requires the FP modifier; all other family planning visits do not require the FP modifier

View the *Texas Medicaid Provider Procedures Manual* and your contract for the required family planning procedure codes and diagnosis codes.

RHC claims submission guidelines — Texas Health Steps services

- RHC facility providers may be reimbursed for Texas Health Steps medical services using their RHC NPI with the appropriate benefit code.
- View the *Texas Medicaid Provider Procedures Manual* and your contract for the required procedure codes and diagnosis codes.
- If the appropriate benefit code is not included, the service will process as informational only and will not be reimbursed.

FQHC claims submission guidelines — Texas Health Steps services

- FQHCs must enroll in the Texas Vaccines for Children Program.
- Immunizations are not considered an encounter if this is the only reason for the visit.
- EP modifier must be used for Texas Health Steps for an FQHC. In addition, the appropriate modifier must be used to identify the healthcare provider rendering the service.
- Registered nurses may not be the sole provider of a medical checkup in an FQHC

FQHC vision and dental care services

- Any services provided as emergency and therapeutic treatment are billed services to Wellpoint.
- For nontherapeutic or nonemergency services, please refer members to their dental health plan for members younger than 21, or Superior Vision of Texas (for vision services). Wellpoint waiver members should be referred to their Wellpoint Service Coordinator.
- For additional information, please view the Texas Medicaid Provider Procedures Manual at https://tmhp.com/resources/provider-manuals/tmppm.

Incidental services

- All services incidental to the encounter are considered inclusive and are not reimbursed separately.
- Freestanding RHCs: All lab services provided in the RHC's laboratory are included in the encounter. If the laboratory is a certified Medicare laboratory, is enrolled in Medicaid as an independent laboratory, and has a laboratory contract with Wellpoint, the claim should be filed under their laboratory identifier.
- Incidental services cannot be billed as a separate encounter but are included in the total cost of the encounter.

Encounter rate determination

Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC §355.8101, and those for FQHCs are calculated in accordance with 1 TAC §355.8261.

Providers are no longer required to supply a copy of encounter notice. Wellpoint will update the encounter rate based on the published date received from HHSC as applicable.

Medicare encounter rate determination/payment

- FQHCs and RHCs are reimbursed at the Medicare PPS at an all-inclusive rate.
- It is acceptable to provide more than one medically-necessary face-to-face visit with a RHC or FQHC practitioner on the same day and it is payable as one visit, except for the following circumstances:
  - The patient has an initial preventative physical examination and a separate qualified medical and/or mental health visit on the same day.
  - After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
  - The patient has both a medical visit and another health visit.
  - The patient has a diabetes self-management training or Medicaid nutrition therapy visit on the same day as an otherwise payable medical visit. Only applicable to FQHCs.

Providers are no longer required to supply a copy of encounter notice. Wellpoint will update the encounter rate based on the published date received CMS as applicable.

https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

Prior authorization requests

- Submit prior authorization (PA) requests online through **Availity**, by fax, or by calling:
  - **833-731-2162** for Medicaid
  - **855-878-1785** for MMP
  - **866-805-4589** for Medicare
  - **Availity** offers a streamlined process to request inpatient and outpatient prior authorizations.
- Obtaining a prior authorization is not a guarantee of payment.
- *Prior Authorization forms* are available at **https://provider.wellpoint.com/texas-provider/resources/forms**.

Is prior authorization required?

- Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Lookup Tool, which allows you to search by market, member's product, and CPT® code.
- All inpatient stays require prior authorization.
- All out-of-network service requests require prior authorization.
- All nonemergent ambulance transportation requires prior authorization.
- Some services/procedures have Medicaid allowable limits or age restrictions and should be verified through the *Texas Medicaid Provider Procedures Manual (TMPPM)*.
- Resources such as the Wellpoint provider website, your provider manual, Precertification Lookup Tool, and your Quick Reference Guide list services requiring prior authorization and corresponding phone and fax numbers.

Prior authorization contact information — Medicare

May be telephoned, submitted online or faxed to Wellpoint:

- Electronic submission (preferred method): **Availity**
- Telephone: **866-805-4589**
- Home health, durable medical equipment, therapies and discharge planning (fax): **888-235-8468**
- Concurrent review clinical documentation (fax): **888-700-2197**
- Behavioral health services (fax only):
  - Behavioral health (inpatient): **844-430-1702**
  - Behavioral health (outpatient): **844-430-1703**

Prior authorization contact information — MMP

- Electronic submission (preferred method): **Availity**
- Phone: **855-878-1785**
- Fax: **866-959-1537**
  - Behavioral health outpatient services: **844-430-6804**
  - Behavioral health inpatient services: **844-451-2825**
  - Concurrent review clinical documentation for inpatient: **888-700-2197**
  - Initial admission notification and all other services: **866-959-1537**
- Carelon Medical Benefits Management, Inc. via phone at **833-305-1809** or online at **carelon.com**
  - Therapy (physical, occupational, speech)
  - Spine and back management procedures
  - Radiology, cardiology
  - Oncology, radiation oncology
  - Sleep studies

Prior authorization contact information — Medicaid/CHIP

- Electronic submission (preferred method): **Availity**
- Inpatient/outpatient surgeries; other general requests:
  - Fax: **800-964-3627**
  - Phone: **833-731-2162**
- Inpatient discharge planning (fax only):
  - Physical health: **888-708-2599**
  - Behavioral health: **844-430-6805**
- Behavioral health services (fax only):
  - Behavioral health (inpatient): **844-430-6805**
  - Behavioral health (outpatient): **844-442-8010**

Prior authorization contact information — Medicaid/CHIP

- Specialized care services (fax only):
  - Back and spine procedures: **800-964-3627**
  - Durable medical equipment (DME): **866-249-1271**
  - Home health nursing (PDN, SNV, HHA): **866-249-1271**
  - Medical injectable/infusible drugs: **844-512-8995**
    - (for other services, refer to pharmacy prior authorizations document on the provider website)
  - Pain management injections and wound care: **866-249-1271**
  - Therapy (physical, occupational, and speech): **844-756-4608**

Prior authorization contact information—Medicaid/CHIP

- Carelon Medical Benefits Management via phone at **833-342-1260** or online at carelon.com:
  - Cardiology
  - Genetic testing
  - Radiology (high-tech)
  - Sleep studies
- Superior Vision (Medical/surgical): 855-313-3106 (fax); or email **ecs@superiorvision.com**.
- Nursing facility: **844-206-3445** (fax).
- Ambulance transportation:
  - Nonemergent ambulance transportation: Refer to the *Ambulance Transportation Services (Nonemergent)* section of the Medicaid/CHIP provider manual
- STAR Kids:
  - Long-term services and supports (LTSS)/ personal attendant services (PAS): **844-756-4604** (fax).

Prior authorization contact information—MMP

- LTSS/PAS for Wellpoint members requests are to be submitted by service area (fax only):
  - Austin: **877-744-2334**
  - El Paso: **888-822-5790**
  - Houston/Beaumont: **888-220-6828**
  - Lubbock: **888-822-5761**
  - San Antonio: **877-820-9014**
  - Tarrant/West RSA: **888-562-5160**
- Urgent services: **833-731-2162** (phone)

If you have questions, call Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time, excluding state-observed holidays. You may leave a confidential voicemail after-hours, and your call will be returned the next business day.

Medicaid payment methodology

- FQHCs and RHCs are paid an all-inclusive encounter rate.
- FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.
- Freestanding and hospital-based RHCs are reimbursed provider-specific per-visit rates calculated in accordance with 1 TAC §355.8101.

After-hours care rate

- As an FQHC/RHC, Wellpoint will reimburse at 100% of the Medicaid fee schedule for providing after-hours visit care services.
- After-hours visit care services are defined as care provided on weekends, holidays, or before 8 a.m. and after 5 p.m.
- After-hours procedure code is 99050.

FQHC wrap payment reminder

- All claims will need to be submitted with POS 50. Servicing and billing taxonomies must be 261QF0400X.
- We need simple billing on the first two lines of a claim that will trigger your wrap payment and flat rate payment. Every claim must have T1015 on line one with one of the applicable codes published in the TMPPM on line two.
- Wrap payments only apply to FQHCs. The process of wrapping the encounter payment does not apply to RHCs.
- You must also bill an applicable appropriate modifier in conjunction with these codes as outlined in the Texas Medicaid Providers Provider Manual. Any other code submitted (such as lab or radiology), except those designated as paid outside the encounter, will still need to be submitted.

Availity claim submission

Wellpoint has designated Availity Essentials to operate and service your electronic data interface (EDI) entry point (EDI Gateway).

Online claims submission:

- Use our free online claim submission tool at **Availity.com**:
  - You have ability to submit claims, check claims status, dispute claim payment, utilize Clear Claim Connection, and more.

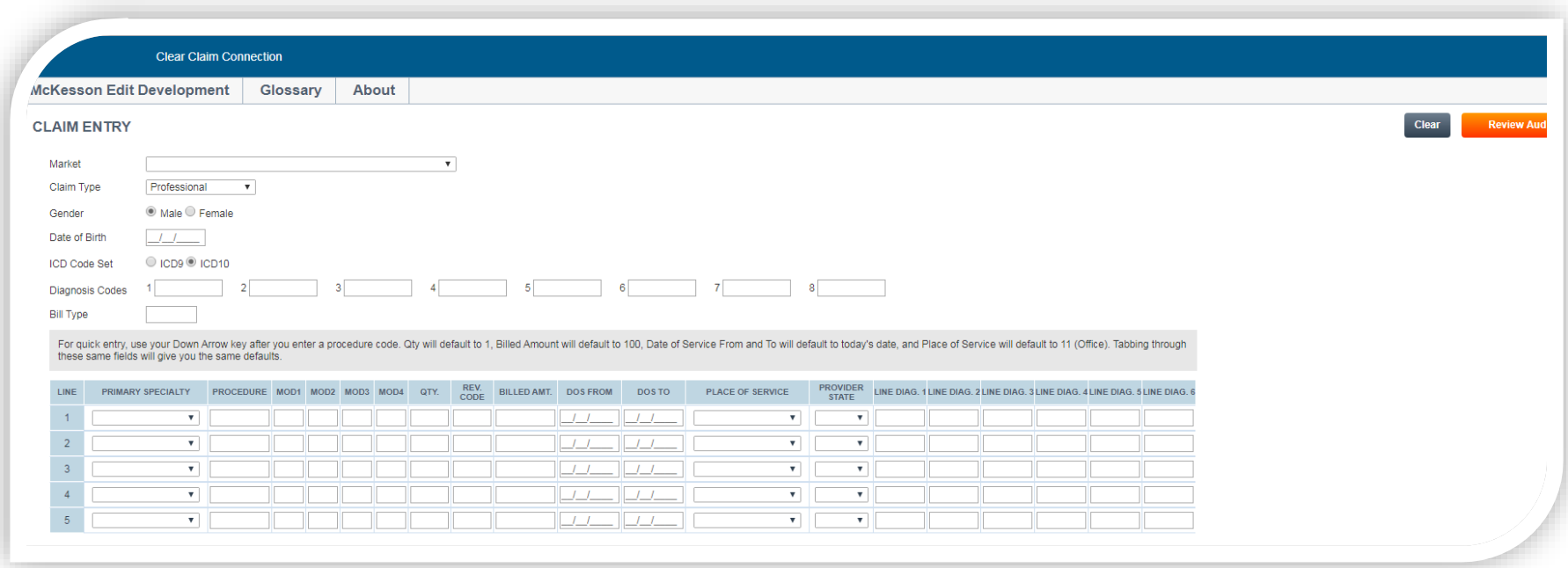
Claim submission options

- Availity Essentials
- Batch 837
- Via clearinghouse
- By mail
- Timely filing is within 95 days from the date of service.

Paper submissions	Electronic submission payer
Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010	• Availity: **800-282-4548** — 26375 • Website: Availity.com

Clear Claim Connection™

- Provides guidance for code combinations and modifiers
- Does not guarantee payment



Rejected versus denied claims

What is the difference between a rejected and a denied claim?

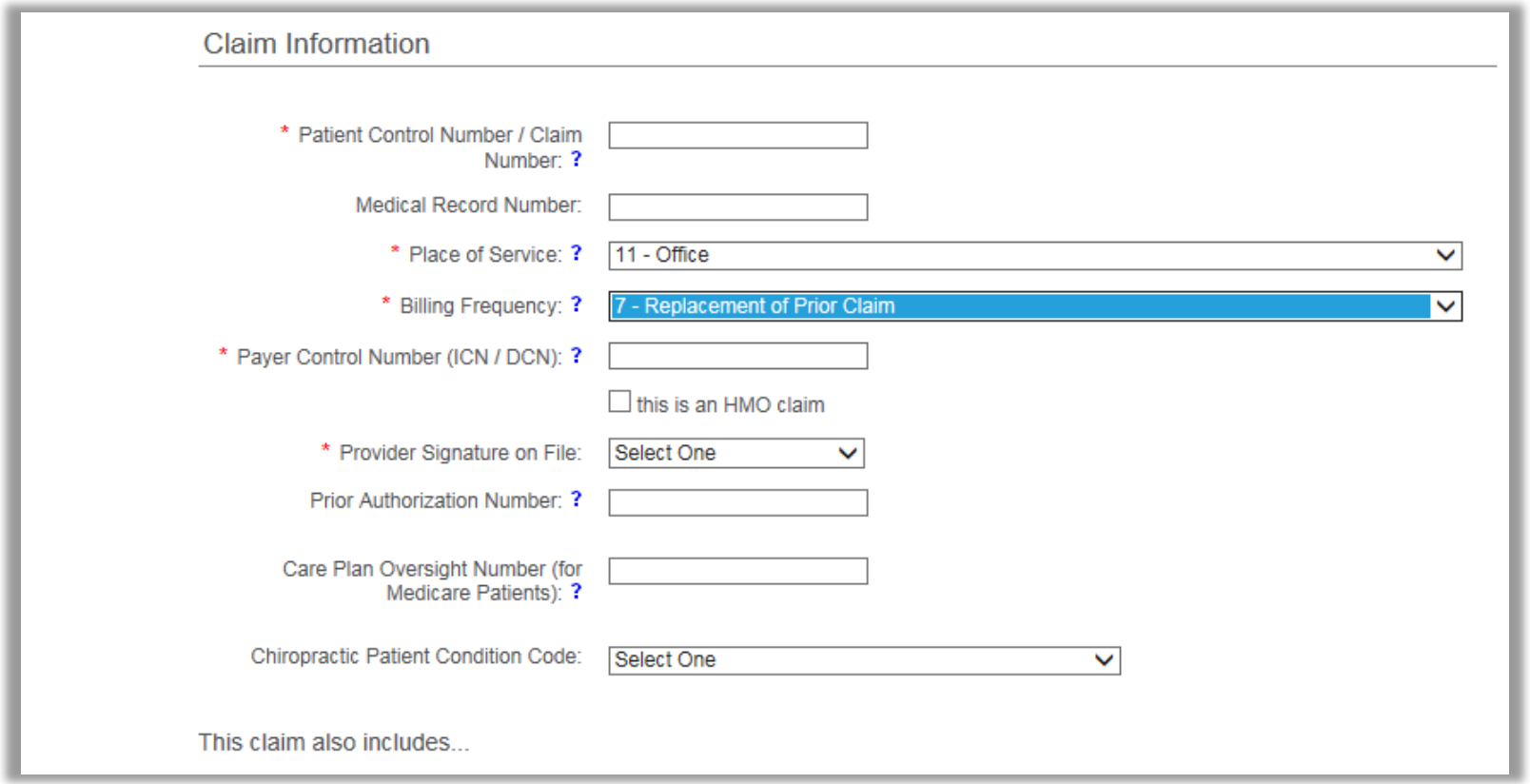
Rejected claim:

- Does not enter the adjudication system due to missing or incorrect information.
- Resubmission subject to 95-day timely filing deadline.

Denied claim:

- Does go through the adjudication process but is denied for payment.
- Appeal deadline of 120 days from the *Explanation of Payment* (*EOP*) date applies.

Submitting a corrected claim



Payment dispute process

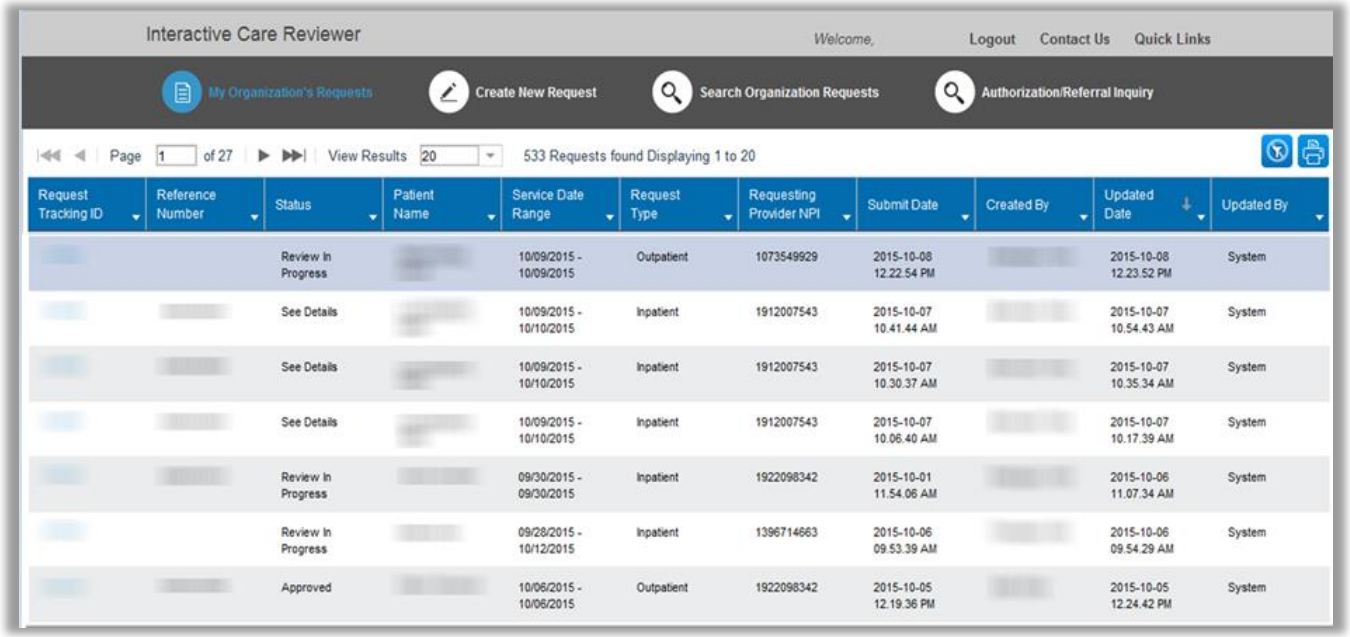
- There is a 120-day filing deadline from the date of the *EOP*.

- Providers may use the payment dispute tool at **Availity.com**. Supporting documentation can be uploaded using the attachment feature.

- Providers can submit the *Provider Payment Dispute* form and relevant supporting documentation including the original *EOP*, corrected claim, invoices, medical records, reference materials, etc.:
  - Fax: **844-756-4607**
  - Mail: Wellpoint
    Payment Dispute Unit
    P.O. Box 6159
    Virginia Beach, VA 23466-1599

Interactive care reviewer

The Interactive care reviewer (ICR) offers a streamlined process to request inpatient and outpatient prior authorization through Availity.



Healthy Rewards Program

Increase your HEDIS® quality scores while members earn rewards by ensuring your members receive health screenings, exams, and any needed tests.

Patients can inquire about the Healthy Rewards program by calling **888-990-8681** (TTY 711) or logging into their account at **wellpoint.com/tx/medicaid** to get to the Healthy Rewards site from the *Benefits* page.

Telehealth and telemedicine services

Telemedicine medical services are defined as healthcare services delivered by a physician licensed in Texas or a health professional who acts under the delegation and supervision of a health professional licensed in Texas and within the scope of the health professional's license to a patient at a different physical location using telecommunications or information technology.

Telehealth services are a benefit of Texas Medicaid. Telehealth services are defined as healthcare services, other than telemedicine medical services, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.

Telehealth and telemedicine guidelines

- Wellpoint follows the guidelines set forth by TMHP regarding telemedicine and telehealth services.
- TMHP publishes the *Texas Medicaid Provider Procedures Manual – Telecommunication Services Handbook* on their website. The handbook offers information regarding telemedicine and telehealth services, provider types, billing guidelines, procedure codes and modifiers, and documentation requirements for the services.
- The handbook can be located at: **https://tmhp.com/resources/provider-manuals/tmppm**.

Telehealth and telemedicine notifications to PCPs

- The use of telemedicine and telehealth services is intended to promote and support patient-centered medical homes and care coordination.
- As outlined in *Senate Bill 670* from the 86th Legislature, Medicaid telemedicine and telehealth providers are required to notify the Medicaid member's PCP or provider of the telemedicine or telehealth service, provided the member or their parent/legal guardian consents to the notice. This includes a summary of the telemedicine or telehealth service rendered, exam findings, a list of prescribed or administered medications, and patient instructions.

Translation services

- Translation services are available 24/7 in over 170 languages:
- Provider Services: **833-731-2162**
- Member Services: (TTY 711) **855-878-1784**
- STAR Kids Member Services:
  844-756-4600 (**TTY 711**)
- Medicare Services: **866-805-4589**
- Wellpoint Services: **855-878-1785**

Laboratory services

All clinical and anatomic laboratory services not performed in a physician's office must be sent to Clinical Pathology Laboratories, Inc., Quest Diagnostics, LabCorp, or a participating independent reference laboratory to ensure services are directed to the most appropriate setting. This Wellpoint policy does not apply to laboratory services provided by physicians in their offices, but does apply to all the following:

- Participating physicians
- Healthcare professionals
- Outpatient clinical laboratories
- Anatomic laboratory services

Quality Management

Our Quality Management team continually analyzes provider performance and member outcomes for improvement opportunities.

CAHPS

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) is an annual survey to assess consumers' experience with their health and healthcare services from a patient's perspective.

Why focus on patient experience?

- There is a strong correlation between patient experience and healthcare outcomes.
- Patients with chronic conditions demonstrate greater self-management skills and quality of life.
- Patient retention is greater when there is a high-quality relationship with the provider.
- Decreased malpractice risk.
- Efforts to improve patient experience have resulted in decreased employee turnover.

Provider Satisfaction Survey

- Wellpoint sends out a *Provider Satisfaction Survey* annually to engage our provider network to provide feedback to improve and strengthen our processes and operations.
- We use your survey responses to better understand your experiences and continue to improve our programs. You can complete the survey online by obtaining a unique password/username or you may choose to mail back your response. Please remember to complete the survey!

Questions/ comments?

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

provider.wellpoint.com/tx

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.
Medicare services provided by Wellpoint Texas, Inc. or Wellpoint Insurance Company.
Medicare-Medicaid Plan services provided by Wellpoint Texas, Inc.
TXWP-CDCRMMP-051499-24| February 2024