

Federally qualified health centers and rural health clinics orientation

Coding disclaimer

- The information in this presentation does not guarantee reimbursement, benefit coverage 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

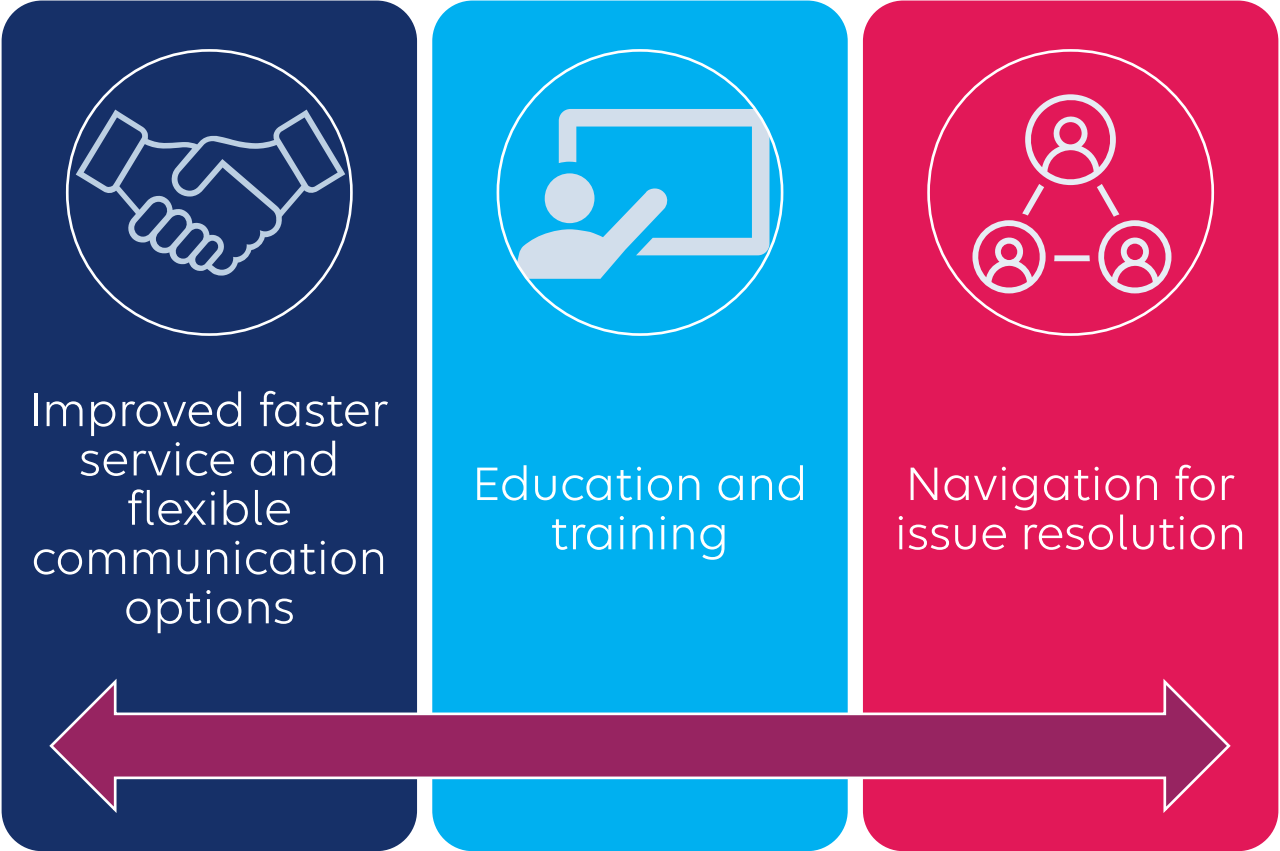
<https://provider.wellpoint.com/tx>.

Providers are also obligated to follow all applicable federal, state, and contractual obligations. You may be selected for a Wellpoint audit on these requirements. Some helpful information is located here:

- [Center for Medicare & Medicaid Services](#)
- [Texas Health and Human Services](#)
- [Texas Administrative Code](#)
- [Federal OIG Exclusions](#)
- [Texas OIG Exclusions](#)



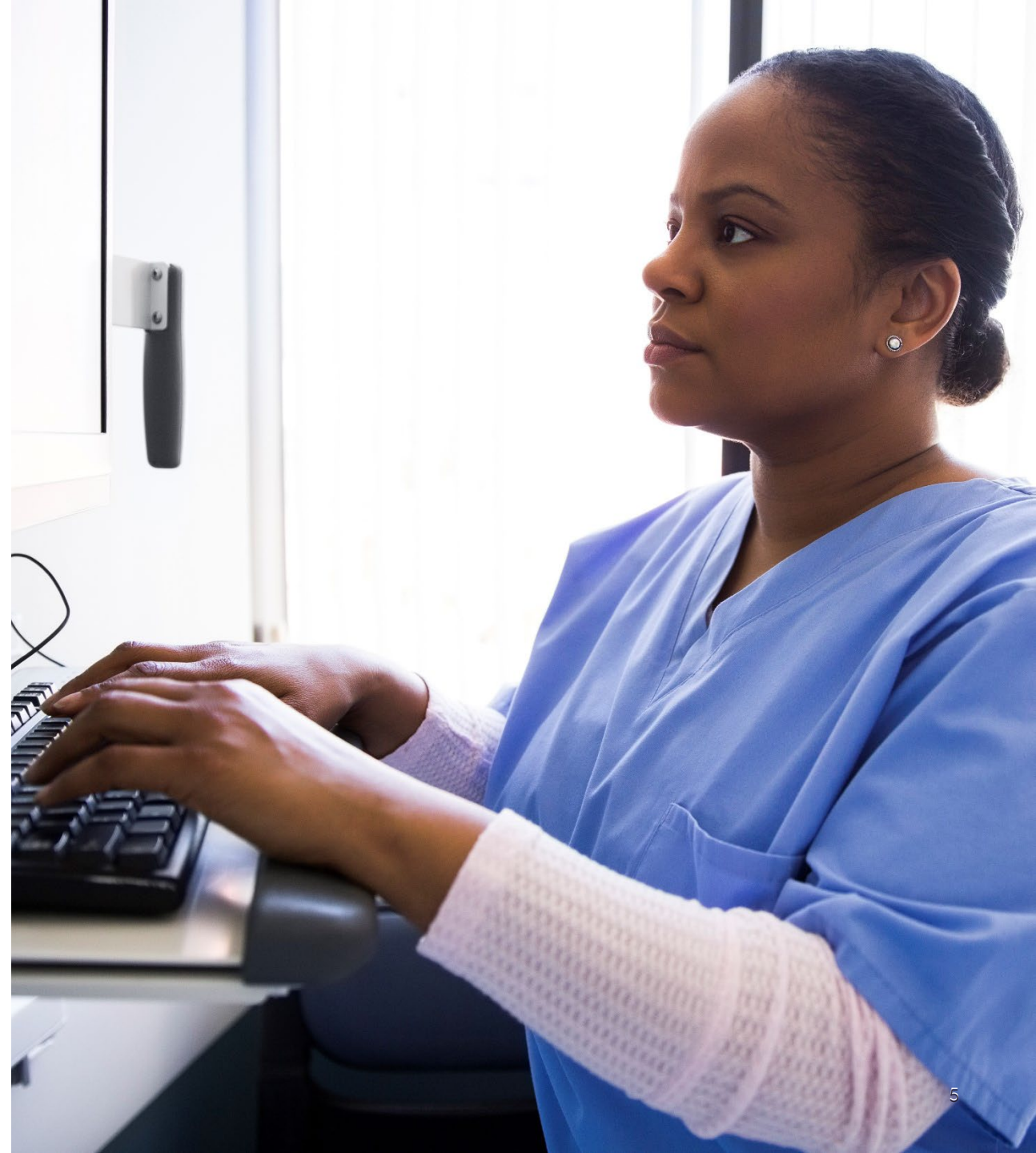
Provider relationship management representative responsibilities



Provider communications/training resources

Wellpoint has curated trainings and provider communications to ensure you 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:

- For more information, visit: <https://provider.wellpoint.com/texas-provider/resources/training-academy>.



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 Health 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.



Availity Essentials resources

Wellpoint has designated Availity Essentials to operate and service your EDI entry point (EDI Gateway) and other self-service tools. Registration for the secured content on Availity Essentials is easy.

Online claims submission

Use our free online claim submission tool at [Availity.com](https://www.availity.com). You can submit claims, check claims status, dispute claim payment, and use Clear Claim Connection, among other actions.

Eligibility verification/authorization

You can verify member eligibility and submit authorizations by simple searching with the Wellpoint subscriber or state-issued identification number. Submit prior authorization requests online through [Availity Essentials](#), by fax, or by calling Provider Services at **833-731-2162**.

Interactive Care Reviewer (ICR)

Can be accessed by any staff member at any time. ICR allows users to inquire about prior authorization requests submitted via phone, fax, ICR, or other online tools.

Digital provider enrollment: Accessible through Availity, for new enrollment of providers. A demographic change received from outside of the standard independent physician association (IPA) or physician-hospital organization (PHO) process will not be processed separately.

Demographic changes: Please submit all demographic changes through Availity Provider Data Management (PDM). Also, remember to update your demographic information with Texas Medicaid Health Partnership (TMHP). You can contact TMHP directly at **800-925-9126** for assistance.

Please visit the Availity Essentials website for additional resources. **Support:** Availity Client Services is available at **800-282-4548** (800-AVAILITY) Monday to Friday 9 a.m. to 6 p.m. CT.



Credentialing

Federally qualified health centers (FQHC) and rural health clinic (RHC) facilities must provide the following documents to be credentialed. You must supply the following documents:

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

Individual practitioners under the FQHC/RHC who are considered facility-based providers are not required to undergo credentialing. A roster is not required for FQHC/RHC facility-based providers.



Re-credentialing

- Credentialing is for a three-year period.
- Re-credentialing 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 re-credentialing packet will be de-credentialled/considered out of network.
- Providers must begin the contracting and credentialing process from the beginning to rejoin the Wellpoint network.



Things to note

- RHCs and FQHCs are credentialed as facilities and the location will be listed in the directory unless noted by the facility.
- The RHC and FQHC serve as the primary care provider (PCP); members choose the RHC or FQHC.
- We require that the RHC and FQHC (building) have an active Texas Medicaid enrollment and applicable taxonomy.



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



Medicaid enrollment status

Retro-enrollment:

- 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.

Retro-disenrollment:

- 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, which 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	<ul style="list-style-type: none">Occurs at an individual's 65th birthday for Medicare part A and enrolls in part B
Annual election period (AEP)	<ul style="list-style-type: none">Occurs from October 15 to December 7 each year
Medicare Advantage disenrollment period	<ul style="list-style-type: none">January 1 to February 14 each year
Initial enrollment period for Part D	<ul style="list-style-type: none">When eligible, individual is enrolled in Part A or Part B and resides in SDA or plan
Special election period	<ul style="list-style-type: none">Begins the month the individual becomes dually-eligible, with limitations




Member sample ID cards — Medicaid



PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR

WELLPOINT TEXAS, INC.
wellpoint.com/tx/medicaid

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-428-1789 Pharmacy Member Services: 1-833-235-2022
Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160
Transportation: 1-833-721-8184



PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT INSURANCE COMPANY
wellpoint.com/tx/medicaid


Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Wellpoint Service Coordinator: 1-833-312-1000
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-428-1789 Pharmacy Member Services: 1-833-235-2022
Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160
Transportation: 1-844-867-2837



PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR Kids

WELLPOINT INSURANCE COMPANY
wellpoint.com/tx/medicaid

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Wellpoint Service Coordinator: 1-866-964-1100
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-428-1789 Pharmacy Member Services: 1-833-370-7463
Wellpoint STAR Kids Only Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-844-756-4600
24-hour Nurse HelpLine: 1-844-756-4600
Transportation: 1-844-864-2443



PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: CHIP

WELLPOINT TEXAS, INC.
wellpoint.com/tx/medicaid

Member Name: **JOHN Q SAMPLE**
CHIP Number:
Primary Care Provider (PCP):
PCP Telephone #:
Copays: Office Visits: \$0 Emergency Room Visits: \$5
Pharmacy: \$0 for Generic / \$5 for Brand Name
Vision: 1-800-428-1789 Pharmacy Member Services: 1-833-235-2022

Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160

TDI



Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT INSURANCE COMPANY
wellpoint.com/tx/medicaid

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Wellpoint Service Coordinator: 1-833-312-1000
Pharmacy Member Services: 1-833-351-0021

LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Wellpoint.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Wellpoint.

Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160

TDI



Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: CHIP

WELLPOINT TEXAS, INC.
wellpoint.com/tx/medicaid


Member Name: **JOHN Q SAMPLE**
CHIP Perinate Number:
Pharmacy Member Services: 1-833-351-0021

Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160

TDI



Member sample ID cards — Medicare



Wellpoint Chronic Care
(HMO C-SNP)
Wellpoint Insurance Company

Member ID: [REDACTED]


PCP: [REDACTED]
PCP Phone: [REDACTED]

Issuer ID: 0810
RxBIN: 0211
RX PCN: IS
RxGRP: M2A
RxID: [REDACTED]

Office Visit Copay: \$0
Specialist Visit Copay: \$0 - \$10
Emergency Room Copay: \$90
Preventive Copay: \$0
livehealthonline.com

CMS H8849-001-000

MedicareR
Prescription Drug Coverage X



wellpoint.com

Member Service: 1-833-713-1306
TTY/TDD Line: 1-833-713-7111
Member Pharmacy Service: 1-833-371-1080
Help to Pharmacists: 1-833-777-4266
Provider Service: 1-844-469-6823
Member Service: 1-888-700-0992
24/7 NurseLine: 1-800-589-3148
Silver Sneakers: 1-855-741-4985

Members: Present this ID card to your healthcare provider before you receive services or supplies. See your Evidence of Coverage for covered services.

Providers and Hospitals: Prior authorization is required for all non-emergency admissions and certain services. For emergency admissions, please call within 24 hours of treatment.

Claims: Wellpoint, P.O. Box 61010
Virginia Beach, VA 23666-0110
EDI Information: avdity.com
Pharmacy Claims: P.O. Box 52077
Phoenix, AZ 85072-2077

Use of this card by any person other than the member is fraud. 02/16/2024



Membership assignment

Federally qualified health centers and rural health centers are designated as the primary care provider of record.



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.
- To learn more about the appointment availability and after-hours requirements visit <https://www.provider.wellpoint.com/texas-provider/resources/training-academy>




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

for PCPs

must maintain one of the following arrangements for member contact to apply:

Wellpoint requirement


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.

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.

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.


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 833-731-2182.

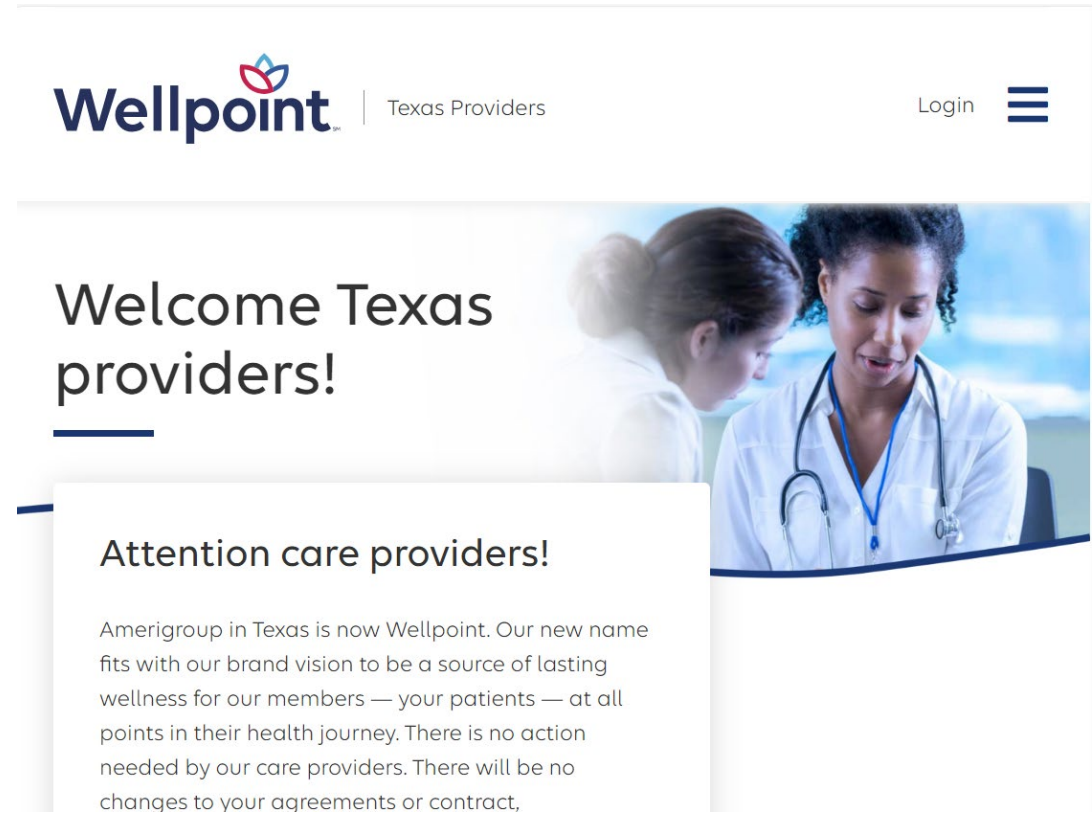
Learn more about Wellpoint programs
[provider.wellpoint.com/texas-provider/resources/training-academy](https://www.provider.wellpoint.com/texas-provider/resources/training-academy)



Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Non-Resident Fee and the CHIP Non-Resident Fee and Medicaid Texas, Inc. is an other Medicaid provider in Texas. TEXAS 03-000407-01

Provider website

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



The screenshot shows the top portion of the Wellpoint Texas Providers website. At the top left is the Wellpoint logo, followed by the text "Texas Providers". On the right side, there is a "Login" link and a hamburger menu icon. Below the header is a large banner image of two healthcare professionals in white coats. Overlaid on the bottom left of the banner is a white text box with the following content:

Welcome Texas providers!

Attention care providers!

Amerigroup in Texas is now Wellpoint. Our new name fits with our brand vision to be a source of lasting wellness for our members — your patients — at all points in their health journey. There is no action needed by our care providers. There will be no changes to your agreements or contract,



Patient360

- 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 demographic information, pharmacy details, authorizations on file, and claim 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. Using this tool will allow you to access the summary of care previously provided.
- Improving provider-to-provider communication will help eliminate barriers when coordinating member care, improve the quality of care a member receives, and improve the member experience.
- To access Patient360, log in to [Availity.com](https://www.availity.com), select **Wellpoint** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen.



Billing format

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Member Care) OTHER (Other) (For Program in Box 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 8. INSURED'S POLICY OR GROUP NUMBER

9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE

11. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized the release of any medical or other information necessary to process this claim. It also requires payment of government benefits either to employer or to beneficiary who obtains assignment of benefits.)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY CLAIM (MM DD YY) 15. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)

16. NAME OF REFERRING PROVIDER OR OTHER SOURCE (NPI) 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. OUT/OUTER LAB? 20. CHARGES

21. BRANCHED OR NATURE OF ILLNESS OR INJURY (Provide Act to service line below (244)) 22. OCCURRENCE CODE ORIGINAL REF. NO.

23. PERSON AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATED OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE (EMS CONTACTS) C. PROCEDURE, SERVICE, or SUPPLY (Include Units/Circumstances) D. CHARGES (UNIT/UNIT PRICE) E. RENDERS (NPI) F. PROVIDER ID

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ASSIGNMENT TO PHYSICIAN 28. TOTAL CHARGE 29. AMOUNT PAID 30. PAID BY NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include NPI or Credentials or Credentials ID) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PHI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Member Care) OTHER (Other) (For Program in Box 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 8. INSURED'S POLICY OR GROUP NUMBER

9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE

11. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized the release of any medical or other information necessary to process this claim. It also requires payment of government benefits either to employer or to beneficiary who obtains assignment of benefits.)

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NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

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 *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, 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).

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



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, AJ, AM, SA, TD, TE, TS, U1, U2, 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.

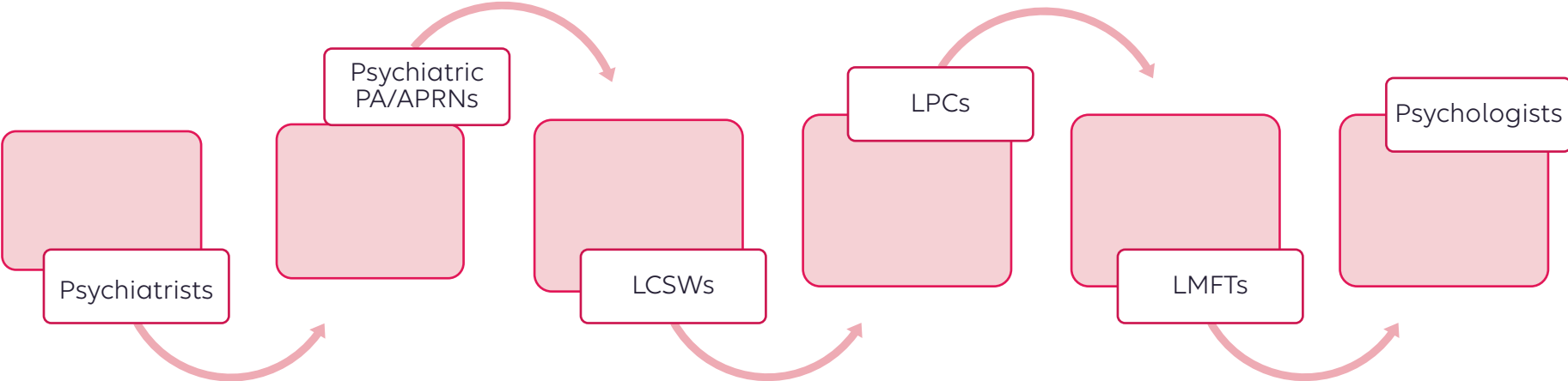


General service modifiers

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
TS	Use to indicate a case management follow-up service
U1	Services performed by a licensed professional counselor
U2	Services performed by a licensed marriage and family therapist
U7	Services performed by physician assistant other than assistant at surgery



Claims submission guidelines — behavioral services



FQHC claims submission guidelines — behavioral services

Only appropriate behavioral health services that are within the scope of the providers' practice should be rendered. For additional information on covered behavioral CPT® codes, please select the link below.

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



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 a 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



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 Texas Health Steps 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). STAR+PLUS HCBS 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>.



Home telemonitoring services updates for FQHCs and RHCs

FQHC and RHC providers performing home telemonitoring services may bill and be reimbursed for HCPCS code G0511 as an add-on procedure code, in accordance with the following requirements:

- For FQHCs, the home telemonitoring fee should not be included in any cost reporting that is used to calculate a prospective payment system (PPS) or alternative prospective payment system (APPS) per visit encounter rate.
- For RHCs, the home telemonitoring fee should not be included in any cost reporting that is used to calculate the RHC All Inclusive Rate (AIR) PPS per visit encounter rate.
- If an FQHC or RHC is eligible for the payment of both an encounter fee and a home telemonitoring fee for the same member on the same date of service, the FQHC or RHC must submit a claim for the home telemonitoring fee separately from the claim that was submitted for the encounter.



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.



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.



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. Please visit HHSC for payment posting at [Federally Qualified Health Centers | Provider Finance Department \(texas.gov\)](https://www.texas.gov/department/federally-qualified-health-centers-provider-finance) or [Rural Health Clinics | Provider Finance Department \(texas.gov\)](https://www.texas.gov/department/rural-health-clinics-provider-finance).



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 preventive 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 the encounter notice. Wellpoint will update the encounter rate based on the published date received by CMS as applicable.



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 required documentation:

- A completed prior authorization request is required to eliminate delays in processing, which includes all required essential information, documentation, current clinical information, and a signed authorization form by the requesting provider.
- **Please note:** Obtaining a prior authorization is not a guarantee of payment.



To prevent delays, Wellpoint requests the following information be included with the request to allow for timely processing:



Requesting provider's name, NPI, tax identification number, and signature



Diagnosis code, Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT)



Service request start and end date and Quantity of service units requested based on the CPT, HCPCS, or CDT requested



Member name, date of birth, and the Wellpoint subscriber and state issued identification number

Steps to process peer to peer review

Office staff may call on the requesting provider's behalf to schedule a peer review with our medical director.



Prior authorization and important contact information

If you have questions, contact 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. Please note: Submitting authorization requests digitally is the preferred method.

Inpatient/outpatient surgeries	800-964-3627 (fax), 833-731-2162 (phone)
Inpatient discharge planning (fax only):	<ul style="list-style-type: none"> Physical health: 888-708-2599 Behavioral health: 844-430-6805
Behavioral health services (digital and fax options):	<ul style="list-style-type: none"> Behavioral health (inpatient): 844-430-6805 Behavioral health (outpatient): 844-442-8010 Digital submission (preferred method) at Availity.com
Specialized care services (fax only):	<ul style="list-style-type: none"> 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 additional information, refer to pharmacy prior authorizations document on our provider website) Pain management injections and wound care: 866-249-1271 Therapy (physical, occupational, and speech): 844-756-4608
Carelon Medical Benefits Management, Inc. (formerly AIM)	833-342-1260 (phone); careloninsights.com (online): <ul style="list-style-type: none"> Cardiology Genetic testing Radiology (high-tech) Sleep studies Radiation oncology



Prior authorization and important contact information (cont.)

Superior Vision (medical/surgical)	855-313-3106 (fax); ecs@superiorvision.com (email)
Nursing facility	844-206-3445 (fax)
Ambulance Transportation (non-emergency)	Physical health (nonurgent): 866-249-1271 (fax) Behavioral health (nonurgent): 844-442-8010 (fax) Urgent: 833-731-2162 (phone)
Long-Term Services and Supports (LTSS)/ Personal Attendant Service for STAR Kids members	844-756-4604 (fax)
LTSS/PAS for STAR+PLUS members requests are to be submitted by service area (fax only):	<ul style="list-style-type: none">• Jefferson: 888-220-6828• Lubbock/West RSA: 888-822-5761• Nueces: 888-822-5790
Urgent services:	833-731-2162 (phone)
Nurse HelpLine:	833-731-2160 (TTY 711) STAR Kids: 844-756-4600



After-hours care rate

- For 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.
- The after-hours procedure code is 99050.



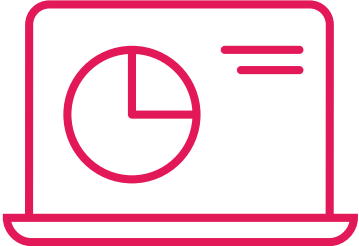
FQHC wrap payment reminder

- 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.



Claim submission options

- Electronic data interchange (EDI)
- Availity Essentials
- Paper
- Timely filing is within 95 days of the service date.



Paper submissions	Electronic submission payers	EDI hotline
Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010	<ul style="list-style-type: none">• Availity Essentials: 800-282-4548• Website: Availity.com• Payer ID: WLPNT	<ul style="list-style-type: none">• Phone: 800-590-5745



Clear Claim Connection™

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

Clear Claim Connection

McKesson Edit Development | Glossary | About

CLAIM ENTRY

Market:

Claim Type: Professional

Gender: Male Female

Date of Birth:

ICD Code Set: ICD9 ICD10

Diagnosis Codes: 1 2 3 4 5 6 7 8

Bill Type:

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PRIMARY SPECIALTY	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Clear Review Audit



Rejected versus denied claims

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

- **Rejected:**

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

- **Denied:**

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

For claims inquiries, please call Provider Services at **833-731-2162**.



Submitting a corrected claim

A corrected claim should be submitted due to errors or changes on the original submission.

We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.



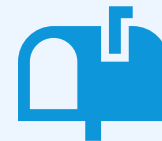
Helpful hints



A corrected claim must be received within 120 calendar days of the *Explanation of Payment (EOP)*.



The 95-day timely filing period starts with the date of the most recent OHI *Explanation of Benefits (EOB)*.



Submit a *Provider Payment Dispute and Claim Correspondence Submission Form* and your corrected claim to:
Claims Correspondence
P.O. Box 61599
Virginia Beach, VA 23466-1599

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](https://www.availity.com). Supporting documentation can be uploaded using the attachment feature.
- Providers can submit a *Provider Payment Dispute* form and relevant supporting documentation, including the original *EOP*, corrected claim, invoices, medical records, and reference materials via:
 - **Fax:** 844-756-4607
 - **Mail:** Wellpoint
Payment Dispute Unit
P.O. Box 61599
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.

Request Tracking ID	Reference Number	Status	Patient Name	Service Date Range	Request Type	Requesting Provider NPI	Submit Date	Created By	Updated Date	Updated By
		Review In Progress		10/09/2015 - 10/09/2015	Outpatient	1073549929	2015-10-08 12:22:54 PM		2015-10-08 12:23:52 PM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10:41:44 AM		2015-10-07 10:54:43 AM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10:30:37 AM		2015-10-07 10:35:34 AM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10:06:40 AM		2015-10-07 10:17:39 AM	System
		Review In Progress		09/30/2015 - 09/30/2015	Inpatient	1922098342	2015-10-01 11:54:06 AM		2015-10-06 11:07:34 AM	System
		Review In Progress		09/28/2015 - 10/12/2015	Inpatient	1396714663	2015-10-06 09:53:39 AM		2015-10-06 09:54:29 AM	System
		Approved		10/06/2015 - 10/06/2015	Outpatient	1922098342	2015-10-05 12:19:36 PM		2015-10-05 12:24:42 PM	System



Healthy Rewards program

Increase your HEDIS[®] quality scores while members earn rewards by ensuring your members receive health screenings, exams, and any needed tests. Healthy Rewards are not available for members with Medicare or CHIP Perinate.

Patients can inquire about the Healthy Rewards program by calling 833-731-2160 (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 and telehealth services are covered Medicaid benefits. The use of telemedicine and telehealth services is intended to promote and support Patient-Centered Medical Homes™ and care coordination. We encourage our network providers to offer telemedicine and telehealth capabilities to our members.
- 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.
- For additional information, please refer to your Wellpoint *Provider Manual* for Medicaid and CHIP at provider.wellpoint.com/tx and the TMHP handbook can be located at: 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.
 - Telehealth and telemedicine providers must attest that they are providing notice of all telemedicine/telehealth encounters and outcomes to the member's PCP, providing the parent/legal guardian consents.
 - To receive a copy of the attestation form, contact your representative.
 - Telemedicine and telehealth providers must keep a record of notifications to primary care physicians and providers in the member's medical records.
- Note:** ECI providers do not follow these requirements. Behavioral health providers are not required to report telemedicine or telehealth services to PCPs unless the service is provided in the school setting.



Translation services

Translation services are available 24/7 in over 170 languages:

- Provider Services: **833-731-2162**
- Member Services: **833-731-2160 (TTY 711)**
- STAR Kids Member Services: **844-756-4600 (TTY 711)**



Laboratory services

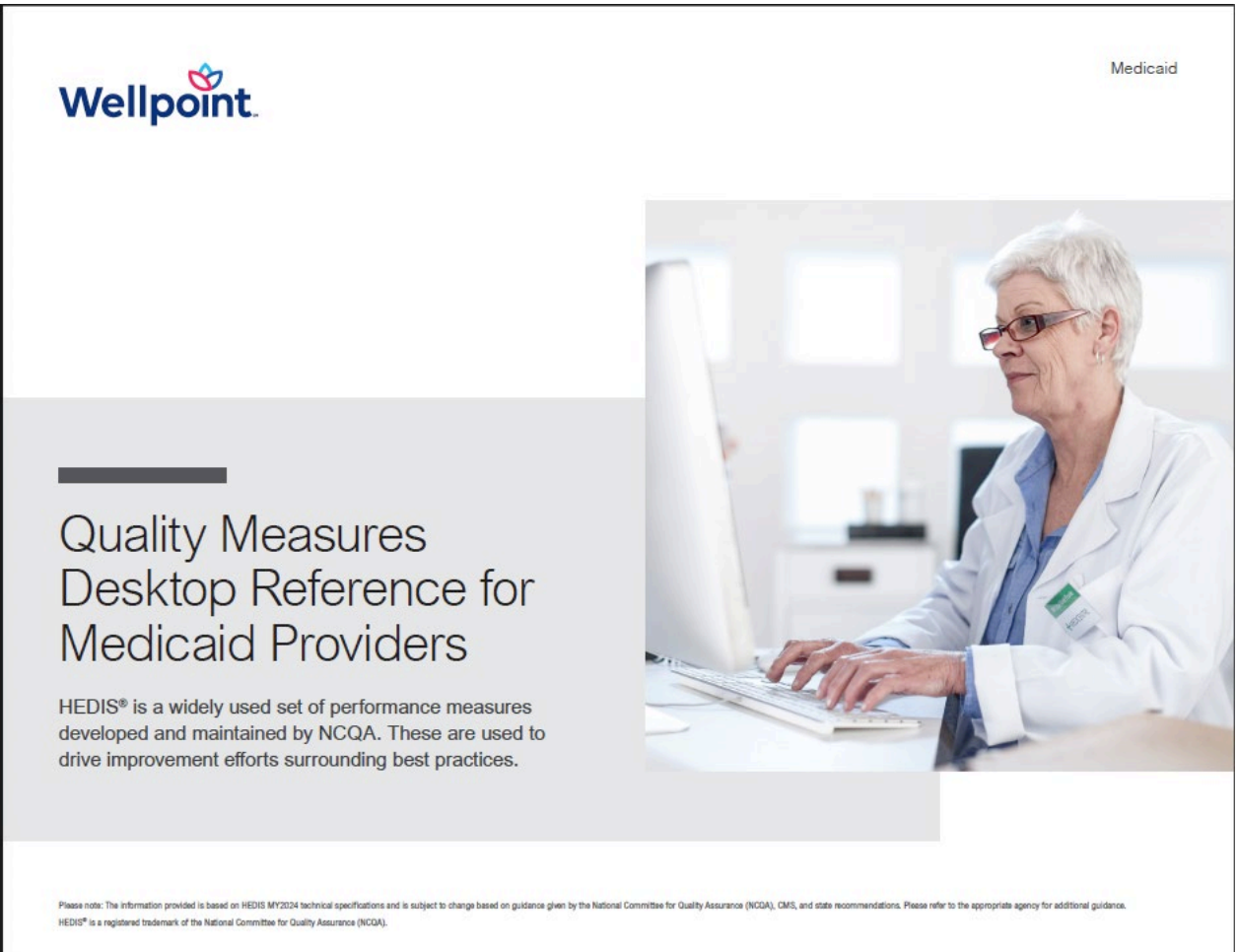
All clinical and anatomic laboratory services not performed in a physician's office must be sent to Clinical Pathology Laboratories, Inc., Quest Diagnostics, LabCorp, or a participating independent reference laboratory to ensure services are directed to the most appropriate setting. This Wellpoint policy 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.



The image shows a document cover for a 'Quality Measures Desktop Reference for Medicaid Providers'. At the top left is the Wellpoint logo, and at the top right is the word 'Medicaid'. On the right side, there is a photograph of an elderly female doctor with short white hair and glasses, wearing a white lab coat, sitting at a desk and typing on a keyboard. The main title 'Quality Measures Desktop Reference for Medicaid Providers' is centered in a large, black, sans-serif font. Below the title, a short paragraph explains that HEDIS is a widely used set of performance measures developed and maintained by NCQA, used to drive improvement efforts. At the bottom of the page, there is a small 'Please note' section with fine print regarding the information's basis on HEDIS MY2024 technical specifications and its subject to change based on guidance from the National Committee for Quality Assurance (NCQA), CMS, and state recommendations.



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.

How to improve patient experience:

- Ensure all office staff are courteous and empathetic.
- Respect cultural differences and beliefs.
- Demonstrate active listening by asking questions and making confirmatory statements.
- Spend enough time with the patient to address all their concerns.
- Provide clear explanation of treatments and procedures.
- Obtain and review records from hospitals and other providers.



Provider Satisfaction Survey

- Annually, Wellpoint sends out a *Provider Satisfaction Survey* to engage our provider network to give feedback for improving and strengthening 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!





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

provider.wellpoint.com/tx

Coverage provided by Wellpoint Insurance Company or Wellpoint Texas, Inc.