Texas | Medicaid • Medicare-Medicaid Plan

STAR+PLUS and Medicare-Medicaid Plan (MMP) overview for nursing facility providers

TXWP-CDMMP-059808-24 | June 2024

Wellpoint

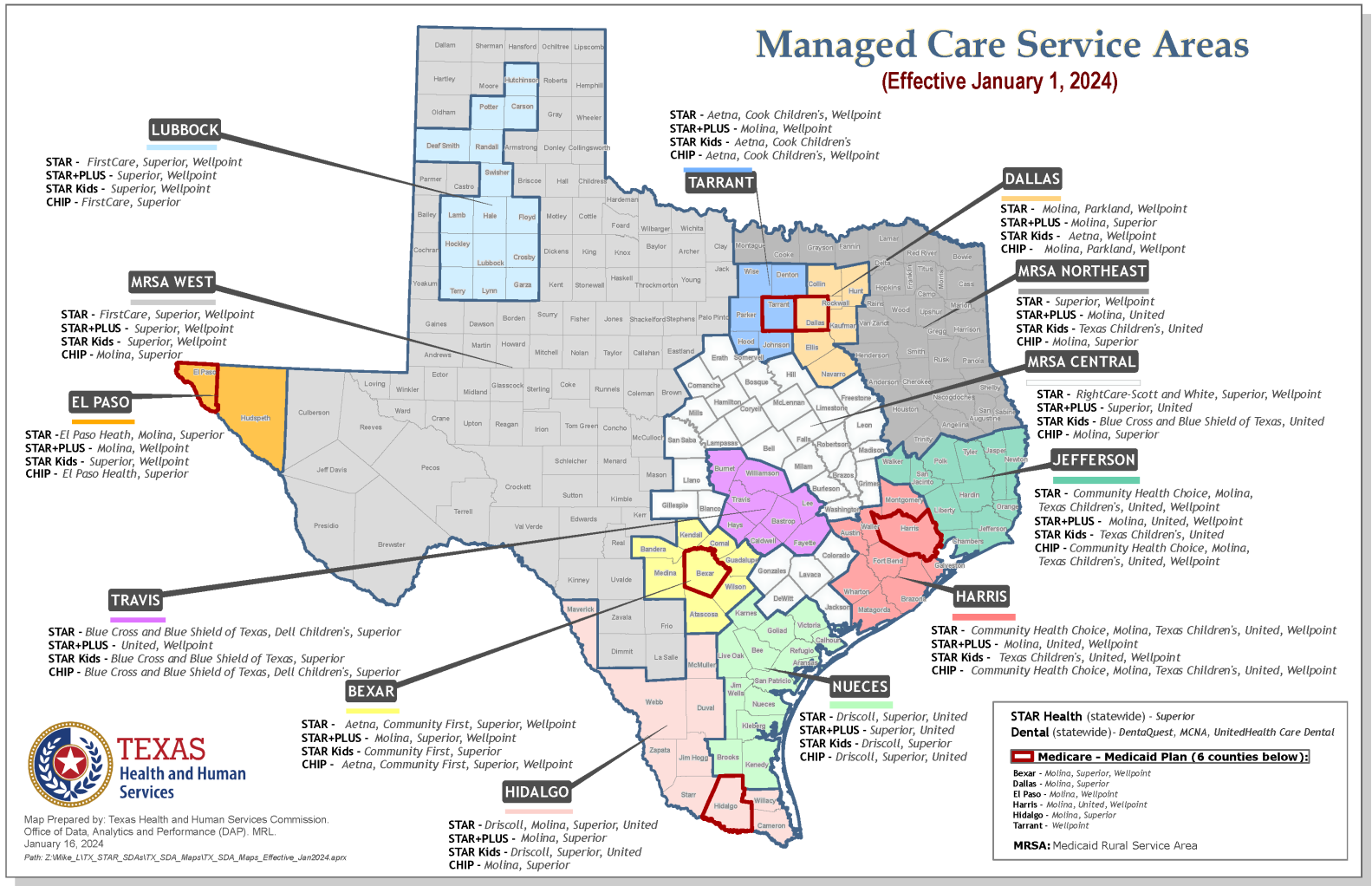
Introduction to STAR+PLUS and MMP

- The **STAR+PLUS** program is a Texas Medicaid managed care program providing integrated acute and long-term services and supports (LTSS) in a Medicaid managed care environment for elderly and disabled adults. Members are considered **nondual** if they only have the STAR+PLUS benefit.
- **Nondual** members are eligible to receive all long-term services and supports (LTSS) based on assessed need and covered value-added services. Acute care benefits are provided in conjunction with the defined benefit set for Texas Medicaid programs.
- **Dual-eligible** members are eligible to receive LTSS benefits based on assessed need and covered value-added services. Acute care benefits are provided and paid per the defined benefit set of CMS Medicare programs.

Introduction to STAR+PLUS and MMP (cont.)

- Medicare-Medicaid Plan (MMP) for Wellpoint is a Texas plan contracted with **CMS** and the **Texas Health and Human Services Commission (HHSC)**. Members on this program have both Medicare and Medicaid and are considered **dual-eligible**.
- MMP for Wellpoint integrates care and reimbursement for members who have Medicare Part A, Part B, Part D, and Medicaid benefits (dual-eligible members), and consolidates their care through one **MMP** for full access to both their Medicare and Medicaid benefits.

Wellpoint service areas for STAR+PLUS



hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/managed-care-service-areas-map.pdf

Wellpoint service areas for STAR+PLUS (cont.)

- Wellpoint is contracted by HHSC to offer STAR+PLUS in these designated service areas:
  - Bexar
  - El Paso
  - Harris
  - Jefferson
  - Lubbock
  - Tarrant
  - Travis
  - West Medicaid Rural Service Area (MRSA)

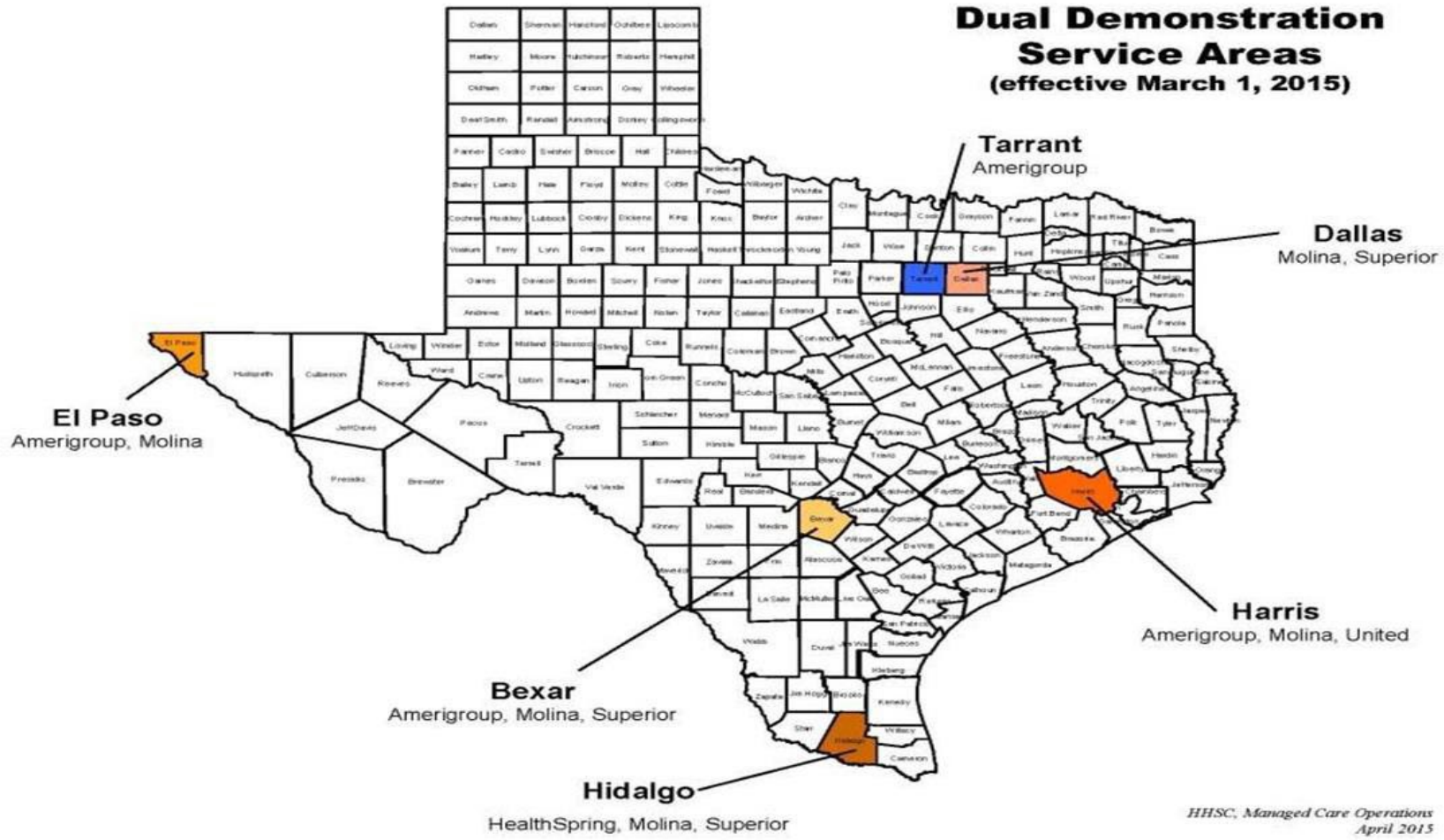
STAR+PLUS program overview

- To get services through STAR+PLUS, a member must be approved for Medicaid and be one or more of the following:
  - Age 21 or older, receiving Supplemental Security Income (SSI) benefits and able to get Medicaid due to low income
  - Not receiving SSI and able to receive STAR+PLUS Home- and Community-Based Services (HCBS)
  - Age 21 or older, receiving Medicaid through a Social Security Exclusion program, and meet program rules for income and asset levels
  - Age 21 and older residing in a nursing home and receiving Medicaid while in the nursing home
  - In the Medicaid for Breast and Cervical Cancer Program

STAR+PLUS program overview (cont.)

- If a STAR+PLUS member resides in a **nursing facility**, services covered include:
  - Daily care services, such as:
    - Room and board.
    - Medical supplies and equipment.
    - Personal needs items.
    - Social services.
    - Over-the-counter drugs.
  - Nursing facility add-on services, which include:
    - Emergency dental services.
    - Physician ordered-rehabilitative services.
    - Augmentative communication devices.
    - Customized power wheelchairs.

MMP service areas



MMP service areas (cont.)

- MMP is available through Wellpoint for dual-eligible members who reside in one of these four counties:
  - Bexar
  - El Paso
  - Harris
  - Tarrant

MMP overview

- Members can be enrolled in MMP if they:
  - Are age 21 or older.
  - Receive Medicare Part A, B, and D and are receiving full Medicaid benefits.
  - Are eligible for or enrolled in the STAR+PLUS program.

MMP overview (cont.)

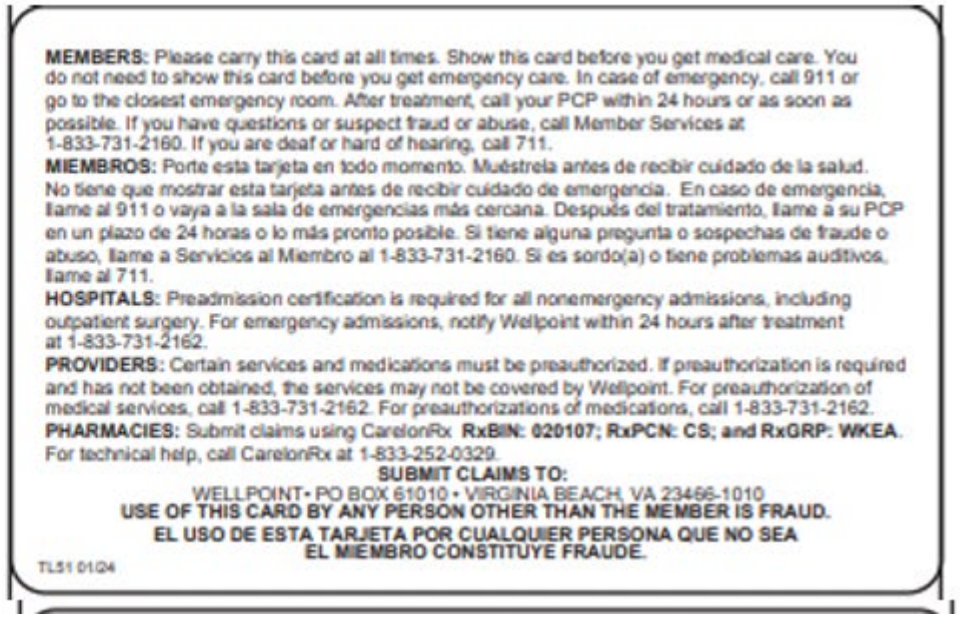
- This program integrates care and reimbursement for members who have Medicare Part A, Part B, Part D, and Medicaid benefits and consolidates their care through one MMP for full access to both their Medicare and Medicaid benefits.
- Members will have one ID card, one health plan, and one Member Services team for their MMP benefits.

MMP overview (cont.)

- Medicare is always primary for acute care benefits and pharmacy services:
  - All acute care services are covered by the member's Medicare plan (either Original Medicare or a Medicare Advantage plan).
  - Pharmacy/prescription drug services are covered by Medicare Part D.
  - Skilled nursing facility services are covered under the member's Medicare plan. Medicare SNF coinsurances are covered by the member's STAR+PLUS plan.
- Nursing facility custodial care services are covered under the member's STAR+PLUS plan.

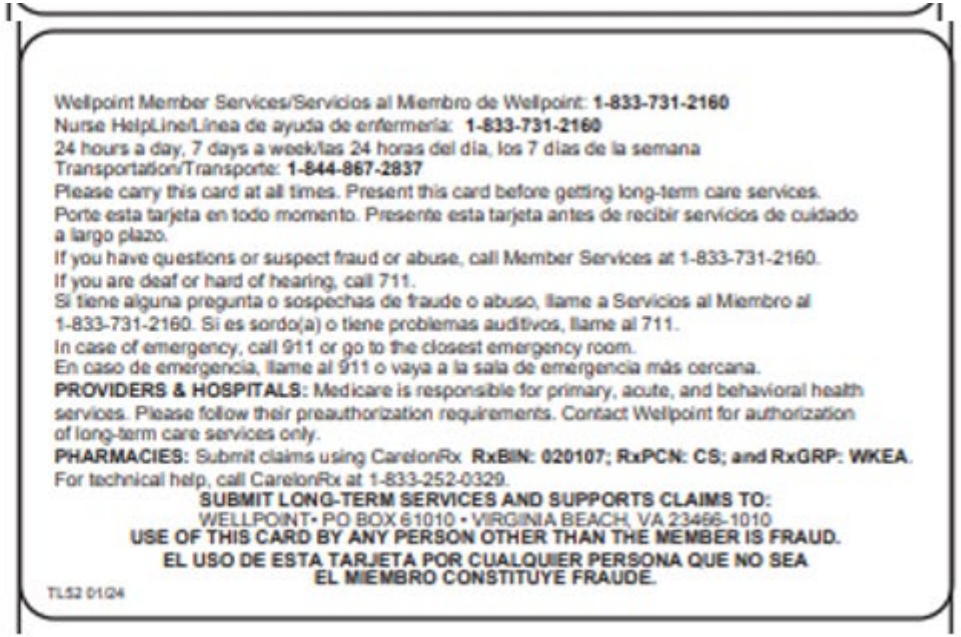
Member identification cards

Members with **STAR+PLUS only (nondual)** will have a card that looks like the example shown below.



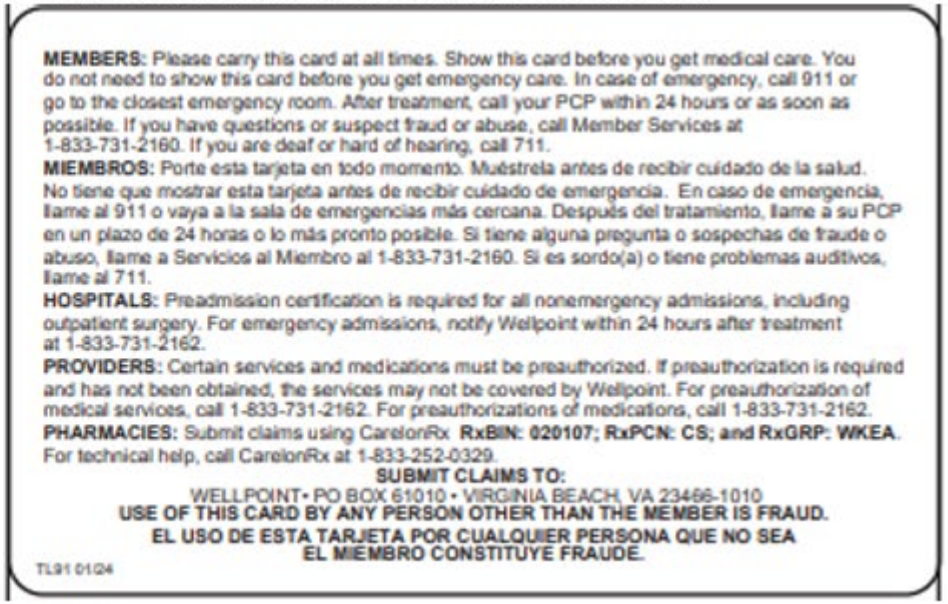
Member identification cards (cont.)

Members with **Medicare and Medicaid** who do not have MMP coverage will have a card that looks like the example shown. This card states at the bottom that the member's STAR+PLUS plan covers Long-Term Services and Supports Benefits **only** and that primary, acute, and behavioral health services are received through Medicare.



Member identification cards (cont.)

Members who reside in the **Medicaid Rural Service Area** have different ID cards for STAR+PLUS members since they are served by Wellpoint Insurance Company, whereas all other members are served by Wellpoint.

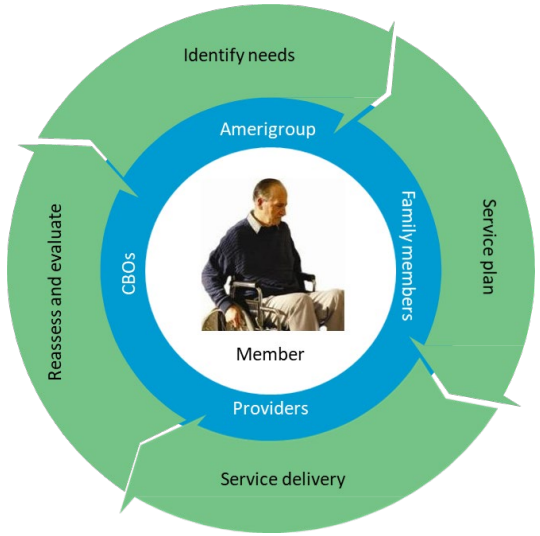


Service coordination

- A feature of the STAR+PLUS and MMP programs is **service coordination**. Service coordination means specialized care management services that are performed by a licensed, certified, and/or experienced person called a service coordinator. This includes but is not limited to the following activities:
  - Identifying a member's needs through an assessment
  - Documenting how to meet the member's needs in a care plan
  - Arranging for delivery of the needed services
  - Establishing a relationship with the member and being an advocate for the member in coordinating care
  - Helping with coordination between different types of services, including community transitions
  - Making sure the member has a primary care provider

Service coordination model

- **Reassess and evaluate:**
  - The service coordinator contacts the member and reassesses their needs and functional capabilities.
  - The service coordinator, in collaboration with the nursing facility team and the member/member's family, evaluate and revise the service plan as needed.
- **Service delivery:**
  - The member selects providers from the network.
  - The service coordinator works with the care team to authorize and deliver services as necessary.
  - The service coordinator ensures all appropriate services are authorized and delivered according to the service plan.
- **Identify needs:**
  - The member is contacted and screened for complex needs and high-risk conditions.
  - Complex and high-risk members are identified.
- **Service plan:**
  - The service coordinator makes a minimum of four quarterly visits and conducts a comprehensive assessment of all medical, behavioral, social, and long-term care needs.
  - The service coordinator works with the nursing facility team of experts to develop a service plan to meet the member's needs.
  - The service coordinator contacts the member's PCP/specialist for concurrence, if necessary.
  - The member and member's family review the service plan.



Money Follows the Person program

- **Money Follows the Person** is a program offered to STAR+PLUS and MMP members who want to leave an institutional setting and return to an independent, community-based living setting.
- Service coordinators will work with identified members, their nursing facility clinical case manager, and any key parties that the member designates to fully assess the member and their individual capability to safely reside in an independent community living setting.
- Service coordinators use the LTSS benefit of transition assistant services to facilitate the member's return to the community. This benefit:
  - Provides a one-time $2,500 benefit to purchase the necessary items or services to allow the member to exit the nursing facility.
  - Contracts with several providers who perform the coordination of this service.

Role of nursing facilities

- **Nursing facility responsibilities include but are not limited to:**
  - Verifying member eligibility.
  - Obtaining prior authorization for services prior to provision of those services.
  - Coordinating Medicaid/Medicare benefits.
  - Notifying Wellpoint of changes in members' physical condition or eligibility within one business day of identification.
  - Collaborating with the Wellpoint service coordinator in managing members' healthcare.
  - Managing continuity of care for STAR+PLUS and MMP for Wellpoint members.
  - Allowing Wellpoint service coordinators and other key personnel access to Wellpoint members in the facility and requested medical records information.

Incident reporting requirements

- Allegations of abuse, neglect, and exploitation of a member must be reported, as well as the death of a member, the involvement of law enforcement, and any environmental hazards that compromise the health and safety of a member.
- Reports made to Wellpoint or referred to Wellpoint will be investigated through our Quality Review department nursing staff.

Member informed consent

- Every provider has the responsibility to respect a member's right to informed decision making by:
  - Communicating adequate information about the member's care and/or treatment in an understandable way.
  - Respecting the member's decisions.
  - Following the member's wishes; this extends to decisions made by an authorized representative or written in an advance directive.
- Respecting a member's right to informed consent does not imply an obligation to provide care that is medically unnecessary or inappropriate.

Member informed consent (cont.)

- Every member has the right to make informed decisions regarding their healthcare and to:
  - Be informed of their health status.
  - Be involved in their care planning and treatment.
  - Request, consent, or refuse treatment.
  - Receive information in a manner that is understandable.
  - Delegate the right to make an informed decision to someone else.

Health Insurance Portability and Accountability Act

- Privacy regulations allow the transfer or sharing of member information to conduct business and make decisions about care.
- We strive to ensure both our staff and contracted providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*.
- Providers may reference the provider manual for information regarding faxing, mailing, emailing, and leaving voicemails that include member information.

Cultural competency

- Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures into a system, agency or among professionals. Cultural competency helps providers and members:
  - Acknowledge the importance of culture and language.
  - Assess cross-cultural relations.
  - Embrace cultural strengths with people and communities.
  - Expand their cultural knowledge.
  - Understand cultural and linguistic differences.

Cultural competency (cont.)

- Cultural awareness includes:
  - The ability to recognize the cultural factors (norms, values, communication patterns, and world views) that shape personal and professional behavior.
  - The ability to modify one's own behavior to respond to the needs of others while maintaining one's objectivity and identity.

Nursing facility unit rate

- The nursing facility unit rate includes the types of services included in the HHSC vendor payment rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs.
- The nursing facility unit rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing facility unit rates exclude nursing facility add-on services.

Add-on services

- The *Nursing Facility Provider Manual* has detailed information about the coverage of add-on services such as ventilator care, tracheostomy care, rehabilitative services, customized power wheelchairs, and augmentative communication devices. You can find the manual at (provider.wellpoint.com/tx > Resources > Provider Manuals and Guides > *Nursing Facility Provider Manual*.
- For nursing facility add-on therapy services, Wellpoint will accept claims received:
  - From the nursing facility on behalf of employed or contracted therapists, and;
  - Directly from contracted therapists who are contracted with the MCO. All other nursing facility add-on providers must contract directly with and directly bill the MCO.

Therapy add-on services for nursing facilities

The long-term code bill code crosswalks that include the therapy codes can be found on the HHSC website at hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/long-term-care-bill-code-crosswalks.

Services outside the nursing facility

- STAR+PLUS also covers acute care services outside of the nursing facility (billed by the provider and not by the nursing facility), including **but not limited to**:
  - Ambulance services — emergency and nonemergency transportation
  - Audiology services, including hearing aids
  - Emergency services
  - Hospital services, including inpatient and outpatient
  - Laboratory services
  - Preventive services, including an annual adult well-check
  - Radiology, imaging, and X-rays
  - Telemedicine
  - Prescription drugs, medications, and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals

Ambulance transportation services (emergent)

- Ambulance transportation service is a benefit when the member has an emergency medical condition.
- See the *Emergency Services* section of the *Nursing Facility Provider Manual* from Wellpoint for what meets the definition of an emergency medical condition.

Non-emergency ambulance transportation

- Wellpoint is responsible for authorizing non-emergency ambulance transportation for a STAR+PLUS member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation.
- A physician, nursing facility, or other healthcare provider is required to obtain authorization before an ambulance is used to transport a member in circumstances not involving an emergency.
- All requests require clinical information to support the need for the member to be transported by non-emergent ambulance transportation.

Nonemergency ambulance transportation (cont.)

- The ambulance provider may not submit an authorization request; however, they are ultimately responsible for ensuring a prior authorization has been obtained prior to transport.
- If a request for non-emergent ambulance transportation will occur after business hours, authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day.
- You can find the form at provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing facility resources > under Nursing facility forms, *Non-emergency Ambulance Prior Authorization Request Form*.

Non-emergency medical transportation

- The state's Medicaid benefit for nonemergency medical transportation (NEMT) services was carved in to managed care effective June 1, 2021. Ambulance transportation is not included.
- The Medical Transportation Program (MTP) is not going away. MTP remains for members in fee-for-service only.
- The NEMT vendor for Wellpoint is Access2Care.
- Products covered:
  - STAR, STAR Kids, STAR+PLUS, and MMP:
    - CHIP and CHIP Perinatal are excluded.

Non-emergency medical transportation (cont.)

- Medical transportation for Medicaid covered services:
  - For nursing facility members, only discharge to home and trips to/from dialysis are included. The nursing facility still provides most transportation needs.
  - If the service is not a covered Medicaid service, NEMT services cannot be used; this type of transportation would not be approved or would be considered a value-added benefit.
- Exclusions:
  - Ambulance — Emergent or nonemergent, day activity health services (DAHS), assisted living facility (ALF), nursing facility transportation except a nursing facility discharge to the member's home or if the member is receiving dialysis services, transportation without an attendant if documentation exists where the member must travel with an attendant, members 14 and younger cannot travel alone, members 15 to 17 can travel alone with written authorization from the parent, legally authorized representative (LAR) or guardian, emotional support animals that are not certified service animals cannot accompany members (may be a VAB).

Non-emergency medical transportation (cont.)

- Providers can call on a member's behalf to schedule trips. Members and providers use the same numbers to contact Access2Care based upon the member's product:
  - STAR+PLUS: **844-867-2837**
  - Medicare-Medicaid Plan (MMP) for Wellpoint: **844-869-2767**
- Members can schedule their own rides by using the Access2Care member mobile app.

Pharmacy program

- Unless otherwise covered in the nursing facility unit rate, prescriptions can be obtained from licensed prescribers within the Wellpoint network.
- Members with STAR+PLUS must adhere to the *Texas Vendor Drug Program (VDP) Formulary* and *Preferred Drug List (PDL).*
- Members with MMP continue to access pharmacy benefits through a Medicare Part D provider.
- The Medicaid formulary and drug list is available at https://txvendordrug.com/.

Pharmacy program (cont.)

- Non-formulary drugs are subject to prior authorization.
- Many over-the-counter products are covered with a written prescription (encouraged as first-line treatment).
- Unless otherwise covered in the nursing facility unit rate, prior authorization is required for:
  - Non-formulary drug requests.
  - Brand-name medications where there is a generic available.
  - High-cost injectables and specialty drugs.
  - Others as identified on the formulary.

Pharmacy program (cont.)

- Use this link to prescribe medications that require prior authorizations: https://covermymeds.com.
- Fax prior authorization forms to Wellpoint at **844-474-3341**. For MMP, fax to **844-494-8342**.
- For STAR+PLUS, call Provider Services at **833-731-2162**; for MMP, call Provider Services at **855-878-1785**.
- For medical injectables, fax **844-512-8995**. For MMP, fax **844-494-8344**.
- Prior authorization requests are processed by pharmacy technicians and pharmacists; requests that do not meet the medical necessity criteria are reviewed by the plan medical director for determination.

Credentialing

- Providers are not considered participating (in-network) until they have been credentialed with a duly executed contract with Wellpoint.
- Providers are responsible for submitting all requested information necessary to complete the credentialing or recredentialing process.
- Wellpoint adheres to NCQA standards and state requirements and follows the nursing facility credentialing standards outlined in the HHSC *Uniform Managed Care Manual*.

Credentialing (cont.)

- Wellpoint uses the Texas Association of Health Plan's (TAHP) contracted credentialing verification organization (CVO). The CVO, Verisys, is responsible for receiving completed applications, attestations, and primary source verification documents.
- Providers must be recredentialed every three years.
- If a facility moves to another location, the facility **must** be credentialed under the new address.
- More details about credentialing are available in the *Nursing Facility Provider Manual*.

Facility changes

- If your facility goes through a Change of Ownership (CHOW) or DBA name change, please be sure to reach out to your provider relationship management representative.
- When notifying your representative of the change, be sure to provide an updated *W-9* and a letter informing Wellpoint of the change. Include the effective date of the CHOW or DBA name change and provide a *Certificate of Filing or Assumed Name Certificate* for a DBA name change.
- Your representative will send you the documents required by Wellpoint to process changes in our contracting and claims system.

Quality incentive programs (QIPP/NFQIP)

- The Quality Incentive Payment Program (QIPP) through HHSC is a performance-based program that compensates providers for meeting or exceeding certain goals. For more information on this program, refer to the HHSC QIPP page at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes.
- Wellpoint has its own incentive program for STAR+PLUS and MMP providers referred to as NFQIP (Nursing Facility Quality Incentive Program). For more information on this program, reach out to your provider relationship management representative.

Authorizations for STAR+PLUS custodial care

- Nursing facilities are responsible for submitting *Form 3618* or *Form 3619,* as applicable, to the HHSC administrative services contractor, Texas Medicaid & Healthcare Partnership (TMHP).
- Once the state updates the authorization on the member's record, the state sends a *Statistical Analysis Software (SAS)* file to Wellpoint. That file is then uploaded into the Wellpoint claims processing system, which automatically generates an authorization for the facility.

Authorizations for MMP: skilled services

- Prior authorization from Wellpoint is always required for admission/readmission to a skilled nursing facility (SNF).
- Fax nursing facility requests for precertification to **844-206-3445**.
- Prior authorization forms are located at provider.wellpoint.com/tx > Resources > Forms > Prior Authorizations.
- The nursing facility should send clinical information to substantiate medical necessity and medical criteria along with a written physician order, test, treatments, prior, and current level of function, intervention performed, and results or outcomes.

Authorizations for MMP: skilled services (cont.)

- Requests are reviewed by the MMP Utilization Management team for Wellpoint within 72 hours of receipt.
- Upon approval or denial, a MMP utilization nurse will contact the facility via telephone to provide the verbal authorization or denial.
- If the authorization is medically necessary and approved, the authorization will be effective on the date of notification.
- A complete list of all covered services that require prior authorization can be found at provider.wellpoint.com/tx > Resources > Precertification Requirements.

Authorizations for MMP: Skill in Place

- Wellpoint encourages facilities to use the **Skill in Place** option for members with noncritical conditions rather than transferring to an acute care facility. Please note that members admitted to the hospital or treated in the emergency room who require skilled services upon return to the nursing facility are not opportunities for Skill in Place and are subject to medical necessity review and prior authorization.
- Skill in Place *always* requires an authorization from Wellpoint.

Authorizations for MMP: Skill in Place (cont.)

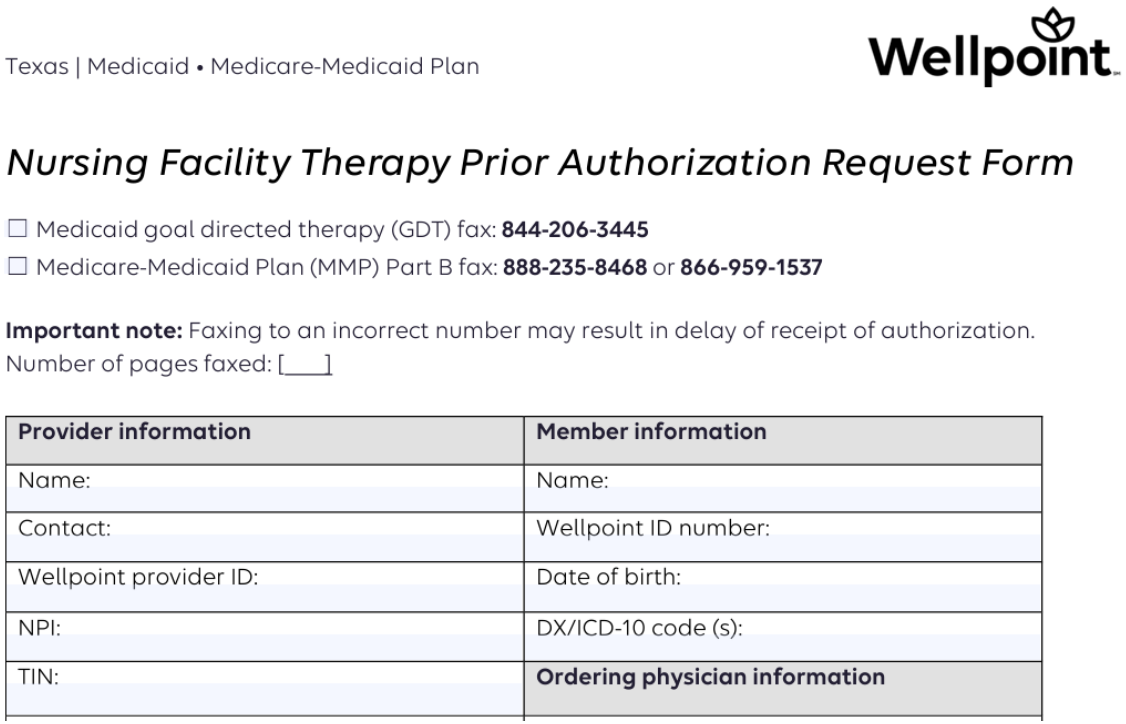
- Requests for authorization must be received within one business day of Skill in Place treatment.
- Fax authorization requests to **844-206-3445**; be sure to write *Skill in Place* on the cover sheet and include all pertinent clinical information to substantiate medical necessity.
- The skilled nursing facilities will receive an initial three-day approval for a Skill in Place request with subsequent approval based on medical necessity.
- After the initial three-day approval, the facility will be required to submit additional approval of ongoing treatment based on medical necessity.

Authorizations for goal directed therapy

- Goal directed therapy (GDT) is considered an add-on service not covered under the nursing facility unit rate for Medicaid nursing facility members who are not eligible for Medicare or other insurance.
- GDT must be provided with the expectation that the member's function will improve measurably in 30 days.
- GDT services require prior authorization.
- An evaluation should be completed prior to requesting an authorization.
- No authorization is required for the initial evaluation.
- The authorization request form is available on the Wellpoint website.

Authorizations for GDT (cont.)

The *Nursing Facility Therapy Preauthorization Request Form* is available on the Wellpoint provider website at provider.wellpoint.com/tx > Resources > Forms > Prior Authorizations.



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Wellpoint

Nursing Facility Therapy Prior Authorization Request Form

☐ Medicaid goal directed therapy (GDT) fax: **844-206-3445**
☐ Medicare-Medicaid Plan (MMP) Part B fax: **888-235-8468** or **866-959-1537**

Important note: Faxing to an incorrect number may result in delay of receipt of authorization.
Number of pages faxed: [___]

Provider information	**Member information**
Name:	Name:
Contact:	Wellpoint ID number:
Wellpoint provider ID:	Date of birth:
NPI:	DX/ICD-10 code (s):
TIN:	**Ordering physician information**

Notification requirements

- Nursing facilities are required to notify Wellpoint within one business day of:
  - New admission for an existing member.
  - Discharge of a member due to:
    - Emergency care
    - Hospitalization
    - Death
    - Extended leave from the facility
    - Significant change in condition
- The *Nursing Facility Notification Fax Form* can be found at provider.wellpoint.com/tx > Resources > Forms > Prior Authorizations.

Level of care determination appeals — TMHP

- Medicaid nursing facility residents have the right to appeal level of care determinations issued by TMHP as part of the minimum data set (MDS) medical necessity level of care determination.
- Wellpoint is not responsible for issuing MDS level of care determinations such as RUG levels of care. Appeals must be filed to TMHP.
- HCBS STAR+PLUS Waiver appeals are also to be filed to TMHP as Wellpoint is not responsible for this process.
- For additional information, refer to the TMHP website at tmhp.com or contact TMHP at **800-925-9126**.

Member complaints and appeals

- Medicaid members or their representatives may contact a member advocate or their service coordinator for assistance with writing or filing a complaint or appeal (including an expedited appeal). Complaints may be filed to dispute items such as financial liability, transportation, failure to provide services timely.
- Member complaint resolution:
  - Call Member Services toll free at **833-731-2160** (Medicaid), **855-878-1784** (MMP).
  - The Member Advocate or Member Services representative can help you or the member file a complaint with us or with the appropriate state program.
  - The complaint will be responded to within 30 days from the date we get the complaint.
  - Send written member complaints to:

Member Advocates
Wellpoint
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

Member medical appeals — STAR+PLUS

- Member medical **appeals** can be initiated by the member or the provider on behalf of the member, with the member's signed consent, and must be submitted within **60 calendar days** from the date of an adverse benefit determination.
- Member medical appeals can be submitted by:
  - Calling Member Services at **833-731-2160 (TTY 711)**; or
  - Sending a written request to —

Appeals
Wellpoint
PO Box 62429
Virginia Beach, VA 23466-2429

- For further details on the medical appeals process, refer to the *Medical Appeal Process and Procedures* section of the *Nursing Facility Provider Manual*.

Claims submission

- All nursing facility services must be billed using an electronic billing format that is 5010 level 7 edit compliant via the *HIPAA 837I* format for a *CMS-1450 Claim Form*. No paper claims will be accepted.
- Nursing facilities can bill at any frequency they wish — weekly, bi-weekly, monthly. Providers have three options for submitting claims to Wellpoint:
  - A clearinghouse or billing company that transmits to the Availity Electronic Data Interchange (EDI) Gateway
  - Availity Essentials
  - TMHP claims website
- Although providers can still bill through the TMHP claims website, it is not the preferred method for billing. Wellpoint is not responsible for any claims that do not cross over from TMHP as TMHP is not a clearinghouse. TMHP will transfer claims to Wellpoint if the claim is accepted on their end.

Timely filing limitations

- Providers must adhere to the following guidelines and time limits for claims to be considered for payment:
  - Clean claims for nursing facility unit rate or Medicare skilled nursing coinsurance claims must be submitted within 365 days from the last date of service represented on the claim.
  - All other STAR+PLUS service claims (including add-on services) must be filed within 95 days from the date of service or per the terms of the provider agreement.
  - Corrected claims must be submitted within 120 days from the date of the *Explanation of Payment (EOP).*

Corrected claims

- Providers may submit corrected claims through their EDI Vendor, if it has the capability, or through Availity Essentials.
- It is important to clearly identify that the claim is a correction to a previously submitted claim. The original claim number must be referenced on the claim. This number can be entered under the original document control number (DCN).
- Claims must be submitted with a *Type of Bill 217* to indicate a replacement/correction.

Claims adjustment

- **Clean** claims for nursing facility unit rate and Medicare coinsurance are adjudicated within 10 days from the date of submission. Wellpoint will pay providers interest on all clean claims not adjudicated within the 10-day requirement.
- **Clean** claims for nursing facility add-on services or other services negotiated into the provider's contract are adjudicated within 30 days from receipt of the claim. If not adjudicated within this 30-day requirement, these claims are also subject to interest payments.
- Claim reimbursement is based on the provider's contract. Wellpoint is responsible for paying qualified providers their liability insurance add-on and an enhanced fee to nursing facility providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment Program. The fees will be built into the provider's unit rate payment fee schedule.

Automatic claims adjustments

- Wellpoint will adjust previously adjudicated claims within 30 days from the date of receipt of an adjustment from the state using an automated process to reflect changes to things such as nursing facility daily rates, provider contracts, service authorizations, applied income, and level of service (RUG).
- Any adjustments other than the ones listed above and some denials may require a corrected claim.

Patient driven payment model (PDPM)

- The patient driven payment model (PDPM) is a new classification system within the original Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS). It has replaced the case-mix classification system, the Resource Utilization Group, version IV (RUG-IV). For dates of service October 1, 2019, and forward, CMS will no longer base SNF PPS rates on the RUG-IV classification system.
- Wellpoint has implemented the new classification for their MMP program. MMP SNF Part A claims will be processed according to the PDPM methodology.

PDPM (cont.)

- For all MMP SNF PPS claims, Wellpoint will continue to require SNFs to bill at least one revenue code 22 line with a Health Insurance Prospective Payment System (HIPPS) code. The HIPPS codes have changed to accommodate the PDPM.
- Part A SNF claims with Wellpoint are paid according to the provider's contract.*

* Please reach out to your provider relationship management representative for additional details about this program.

Respite care

- Providers must obtain authorizations for respite care directly from Wellpoint.
- Respite care claims should be submitted on a *CMS-1450* claim form in accordance with nursing facility guidelines. One unit equals one day.
- Nursing facilities will have flexibility in the Type of Bill used — 11X, 13X, or 21X.
- When submitting claims for respite care, a service code description is required next to the HCPCS code S5151. If billing for respite through Availity Essentials, you must select the check box next to the code to add.
- Reimbursement for respite care is based on the contract terms or the nursing facility daily unit rate (less the insurance add-on).

Claim coding

- The following codes should be used when billing these service types to Wellpoint:

Service type	Revenue code	Procedure code	Modifier 1	Modifier 2	Modifier 3
Daily unit rate	0100				
Ventilator – full	0230	94004	U1	UA	U7
Ventilator – partial	0230	94004	U1	UA	U8
	0230	94005	U1	UA	U8
Child trach – ages 21-22 only	0410	99199			
Respite care	0663	S5151			
Medicare co-insurance	0101				

Additional claims information

- For members with MMP, providers can bill for a skilled nursing bed and coinsurance on the same claim using a CMS-1450 format. The revenue code 0101 can be added as another line to the claim.
- The following add-on services must be billed by the provider rendering the service:
  - Emergency dental — Wellpoint uses DentaQuest (for MMP, Liberty Dental)
  - Augmentative communication devices — participating Wellpoint DME vendors
  - All other DME — participating Wellpoint DME vendors:
    - See our online Find Care tool for a list of participating vendors.

Additional claims information (cont.)

- The following nursing facility services are not the responsibility of Wellpoint and should continue to be billed by the nursing facility to TMHP for payment:
  - Services for residents under the age of 21
  - Services identified as pre-admission screening and resident review services
  - Services for hospice daily care
  - Services for daily care in a Veterans Affairs (VA) home
  - Services for hospice daily care in a VA home

Claim payment disputes — STAR+PLUS and MMP

- If you disagree with the outcome of a claim, you may utilize the Wellpoint **provider payment dispute process**.
- A provider has **120 days** from the date of an *Explanation of Payment* (*EOP*) to file a payment dispute. Providers have three options for submitting disputes:
  - Use the online payment dispute tool at Availity.com by locating your claim using the Claim Status application, if available select the Dispute button to initiate then select **Go To Request** to complete.
  - Mail dispute requests to:

    Payment Dispute Unit
    STAR+PLUS or Medicare-Medicaid Plan (MMP) for Wellpoint
    P.O. Box 61599
    Virginia Beach, VA 23466-1599

- Fax dispute requests to **844-756-4607**.

Claim payment disputes (cont.)

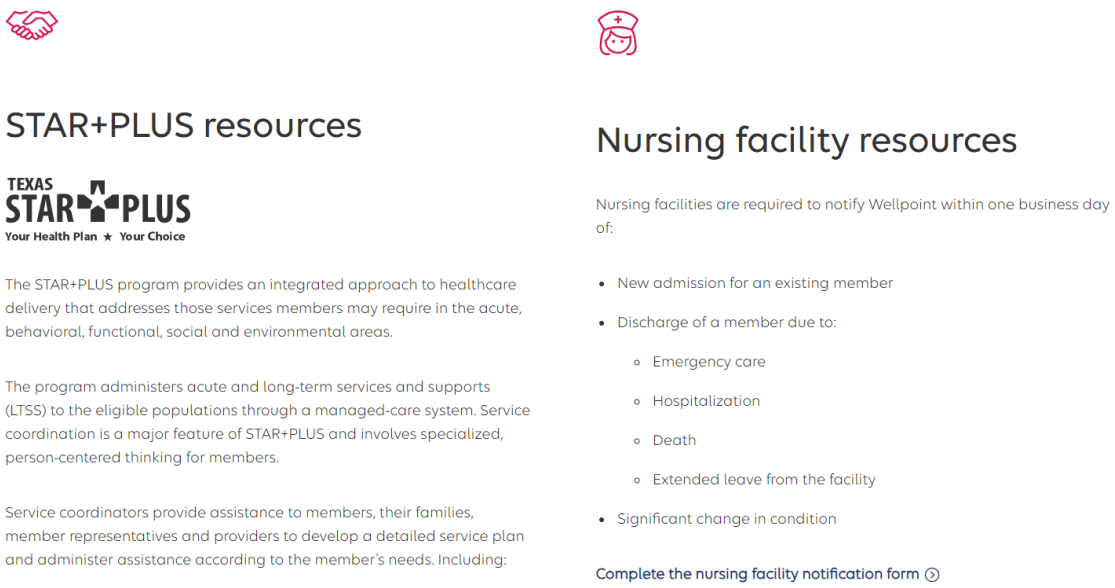
- The dispute process consists of two internal options:
  - **Claim payment reconsideration**: This is a provider's initial request to investigate the outcome of a finalized claim. Most issues are resolved with a claim payment reconsideration.
  - **Claim payment appeal**: If you disagree with the outcome of the reconsideration, you may request a claim payment appeal.
- When submitting claim payment disputes, please include as much information as you can to help the claims team understand why you think the claim was not paid as you would expect. Wellpoint will resolve the claim payment dispute within 30 calendar days of receipt.

Claim payment disputes (cont.)

- Wellpoint requires the following information when submitting a claim payment dispute by fax or mail:
  - Provider name, NPI, TIN, address, contact person name, phone number, and email
  - Member name and their Wellpoint or Medicaid ID
  - A listing of the disputed claim, which should include the Wellpoint claim number and the date(s) of service(s)
  - All supporting statements and documentation
- When submitting a payment dispute, we recommend providers retain all documentation including email correspondence and logs of telephone communication at least until the dispute is resolved.

Nursing facility resources

- There are many resources and documents available on the Wellpoint provider website at provider.wellpoint.com/tx.
- Additional nursing facility-specific information is available at provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing facility resources.



STAR+PLUS resources

TEXAS STAR+PLUS
Your Health Plan ★ Your Choice

The STAR+PLUS program provides an integrated approach to healthcare delivery that addresses those services members may require in the acute, behavioral, functional, social and environmental areas.

The program administers acute and long-term services and supports (LTSS) to the eligible populations through a managed-care system. Service coordination is a major feature of STAR+PLUS and involves specialized, person-centered thinking for members.

Service coordinators provide assistance to members, their families, member representatives and providers to develop a detailed service plan and administer assistance according to the member's needs. Including:

Nursing facility resources

Nursing facilities are required to notify Wellpoint within one business day of:

- New admission for an existing member
- Discharge of a member due to:
  - Emergency care
  - Hospitalization
  - Death
  - Extended leave from the facility
- Significant change in condition

Complete the nursing facility notification form

Interpreter services

- Another resource Wellpoint provides is interpreter services to assist providers with any communication needs they may have for our members.
- To use this resource, you can contact Provider Services:
  - Telephone services for those who are deaf or hard of hearing: **711**
  - Non-English telephone services: **833-731-2162** (language line available)
  - In-person interpretation: **833-731-2162**
  - For MMP: **855-878-1785**
- Services are available 24 hours a day, 7 days a week.
- We recommend providers call at least 24 hours prior to a member's office visit to request an interpreter.

Electronic funds transfer (EFT) registration

- To receive claims payment through EFT, providers must register through he EnrollSafe EFT Enrollment Hub at https://enrollsafe.payeehub.org.
- If the tax ID is not shared with another provider, you can enroll at the tax ID level. If you enroll a bank account for EFT at the tax ID level, all payments for that tax ID will route to that bank account. If the tax ID is shared with another provider, it is highly recommended you enroll at the NPI level.
- Contact the EnrollSafe Help Desk at **877-882-0384** or support@payeehub.org to resolve any issues.
- QIPP EFT deposits cannot be updated through EnrollSafe. Contact your provider relationship management representative for an EFT form to update these types of deposits.

Electronic remittance advice (ERA) registration

- New ERA enrollments and account changes to existing ERA enrollments are managed through Availity Essentials at Availity.com. From the main menu, select My Providers > Enrollment Center > Transaction Enrollment.
- You will receive an email notification when the ERA enrollment process is complete. From the time you are notified, allow an additional 48 hours before you start receiving ERAs.
- Once you begin receiving ERAs, you can import them into your billing system.
- If you use an EDI Vendor or Clearinghouse work with them on your registration and receipt of 835's.
- The Help & Training option in Availity Essentials provides step-by-step instructions on ERA set up. Contact Availity at **800-282-4548** to resolve any issues.

Availity Essentials

- Access Availity Essentials at Availity.com.
- If you are a new user to Availity Essentials, select the blue **Get Started** link in the top right-hand corner.
- If you are already a registered user, select the orange **Log in to Essentials** link to access the platform.
- After logging in, assistance using the Availity Essentials features can be found in the **Help & Training** section.

Provider Services team at Wellpoint

Your support system at Wellpoint includes your service coordinator, network relations consultant, and Nursing Facility Provider Services Hotline at **866-696-0710, option 6**.

Name	Title	Email	Phone number
Cheryl Green	Network Relations Consultant	cheryl.green@wellpoint.com	806-474-4157
Maribel Martinez	Network Relations Consultant	maribel.martinez@wellpoint.com	915-330-0004
Deidre Haynie	Network Relations Consultant Manager	deidre.haynie@wellpoint.com	817-861-7700
Pearl Adkison	Network Relations Consultant Manager	pearl.adkison@wellpoint.com	512-417-1592
Leslie Goffney	Network Relations Consultant	lesliem.goffney@wellpoint.com	713-414-6600
Kris Babino	Network Relations Consultant Manager	kris.babino@wellpoint.com	713-218-5151
Tim Matthews	Network Relations Consultant Manager	tim.matthews@wellpoint.com	682-265-0829

Provider Services team at Wellpoint (cont.)

- The Provider Services triage and escalation process is outlined below.
- For a listing of network relations consultants by facility, visit provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing facility resources > under Contact, *Network Relations Consultant Assignments*.

First-level contact: Nursing Facility Provider Hotline

866-696-0710, option 6

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Second-level contact: Network relations consultants

Phone numbers for each consultant are listed on the prior slide and on the Wellpoint website.

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Third-level contact: Network Relations Nursing Facility Team Lead

Tim Matthews — 682-265-0829

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Fourth-level contact: Director, Network Management

Taylor Blake — 615-519-9973

Wellpoint's Clinical Services team

- The clinical triage and escalation process is listed below.
- For a listing of service coordinators by facility, please visit our website at https://provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing facility resources > under Contact, *Wellpoint Nursing Facility Service Coordinator Assignments*.

First-level contact: Precertification Hotline

866-696-0710, option 5; Fax: 844-206-3445 (STAR+PLUS), 888-235-8468 (MMP Part B)

Second-level contact: service coordinators

866-696-0710, option 4 (Individual extensions are listed on the Wellpoint website)

Third-level contact: service coordinator managers

Manager names, emails, and phone numbers listed by service area on the Wellpoint website

Fourth-level contact: service coordinator directors

STAR+PLUS: Melanie Perez, 713-414-6617; MMP: Gloria Burton, LMSW, CCM, 832-577-8400

Nursing facility provider quick reference guide

- Available at provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing facility resources > under Documents, *Quick Reference Guide for Nursing Facility Providers*

Additional training opportunities

- Our nursing facility network relations consultant team offers monthly webinars. The webinar schedule can be found on the Wellpoint provider website at provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing facility resources > under Nursing facility training, *Nursing Facility Provider Webinar Training Schedule*.
- Additional topic-specific training is available on the Wellpoint provider website at provider.wellpoint.com/tx > Resources > STAR+PLUS.
- Providers can also reach out to their network relations consultants for additional training opportunities.
- Providers can visit the Availity Learning Hub to take course on the various Availity capabilities. Availity User ID and Password required.

Questions?

provider.wellpoint.com/tx

Medicaid coverage 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-Medicaid Plan coverage provided by Wellpoint Texas, Inc.