SCHOOL-BASED HEALTH CLAIMS AND BILLING 101

BlueCross BlueShield of New Mexico

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

MOLINA HEALTHCARE

PRESBYTERIAN

UnitedHealthcare Community Plan

CENTENNIALCARE

SCHOOL-BASED HEALTH CENTER (SBHC) MANAGED CARE ORGANIZATION (MCO) PROJECT

The collaboration between the SBHCs and the Medicaid MCOs has allowed for the development and implementation of several best practice clinical guidelines to support SBHCs in providing Early & Periodic Screening Diagnosis/Treatment Program (EPSDT) health screens; identifying and managing asthma, depression, and obesity/type-2 diabetes; communicating with primary care providers; and working with the MCOs to coordinate and manage recipient care.

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PROVIDER CREDENTIALING

What is credentialing?
The collection and verification of a providers professional qualifications.

Why is credentialing important?
Providers need to be credentialed in order to be reimbursed for the services they are providing at the SBHCs.

Services should not be rendered and/or billed until the credentialing process is complete.

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PROVIDER CREDENTIALING

Initial credentialing is processed within forty-five (45) calendar days after receipt of a ***complete*** application including *all* supporting documents:

- Complete credentialing application
- CV/Resume
- W-9
- Liability malpractice insurance face sheet

CAQH must be completed

PROVIDER CREDENTIALING

Re-credentialing is an update of the provider's original credentialing documents. This is done three years after the initial credentialing is completed for each individual provider.

Please contact your Provider Representative for questions regarding the credentialing process, help with forms, and to check credentialing status.

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SITE REVIEW

Site Reviews for Sponsoring Entity/SBHC Recertification are conducted every three years to ensure ongoing adherence to the required Human Services Department (HSD) Standards and Benchmarks set forth by the Department of Health (DOH) Office of School and Adolescent Health (OSAH).

Individual provider credentialing is not performed at the same time as the site review.

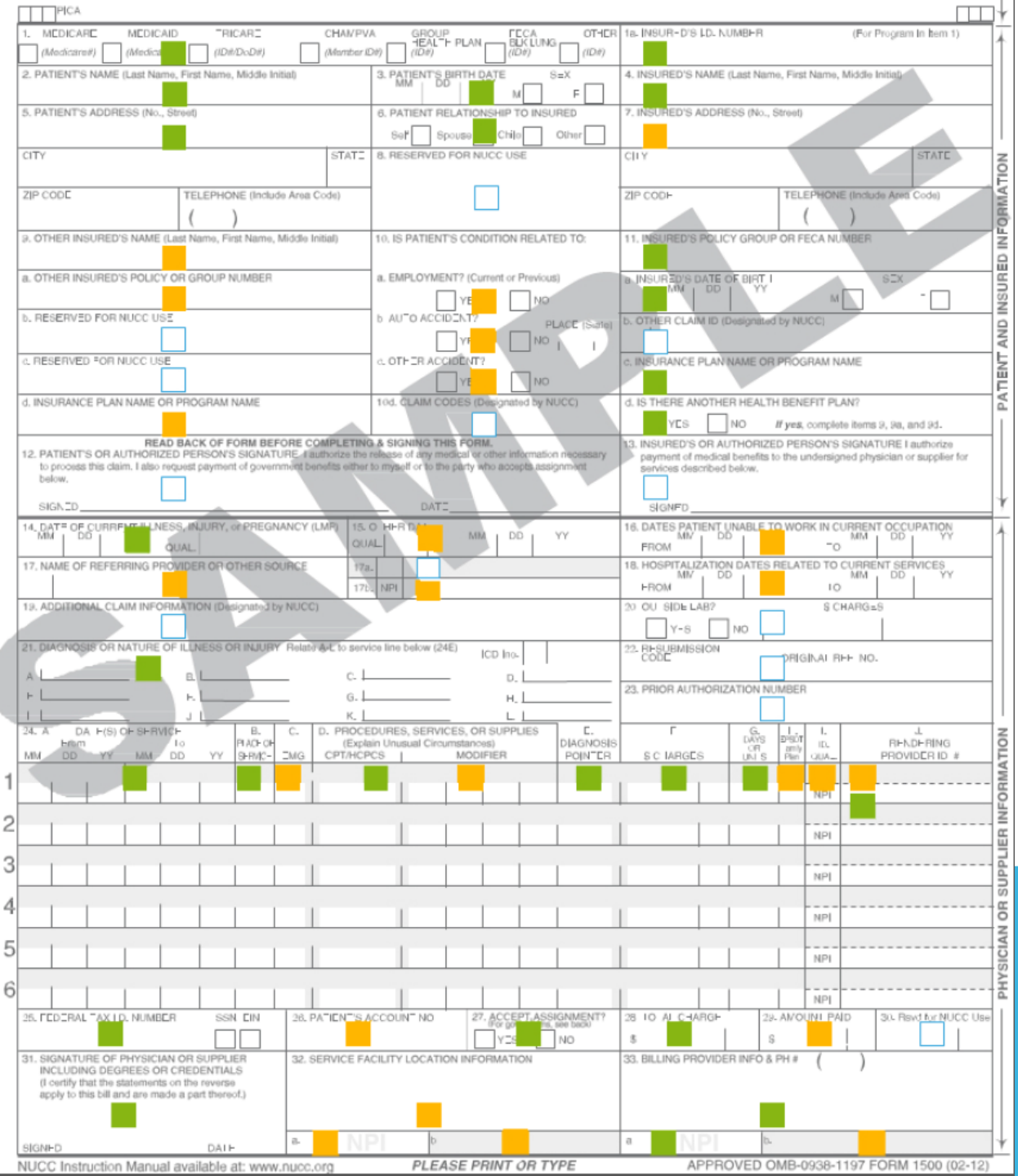
CMS-1500 (02/12) FORM AND UB-04 FORMS

All MCOs encourage SBHCs to:

- Sign up for EFT
- Bill Electronically

This will allow for faster and more efficient payment

Please contact your provider representative for questions regarding payer ID and clearing house information



KEY

- Required to file a claim
- Situational - only if appropriate to the claim
- Not required/not used

Each claim must identify:

- Patient demographics
- Insurance information
- Visit information
- SBHC location (box 32)
- Rendering provider (box 31)
- Sponsoring entity (box 33)

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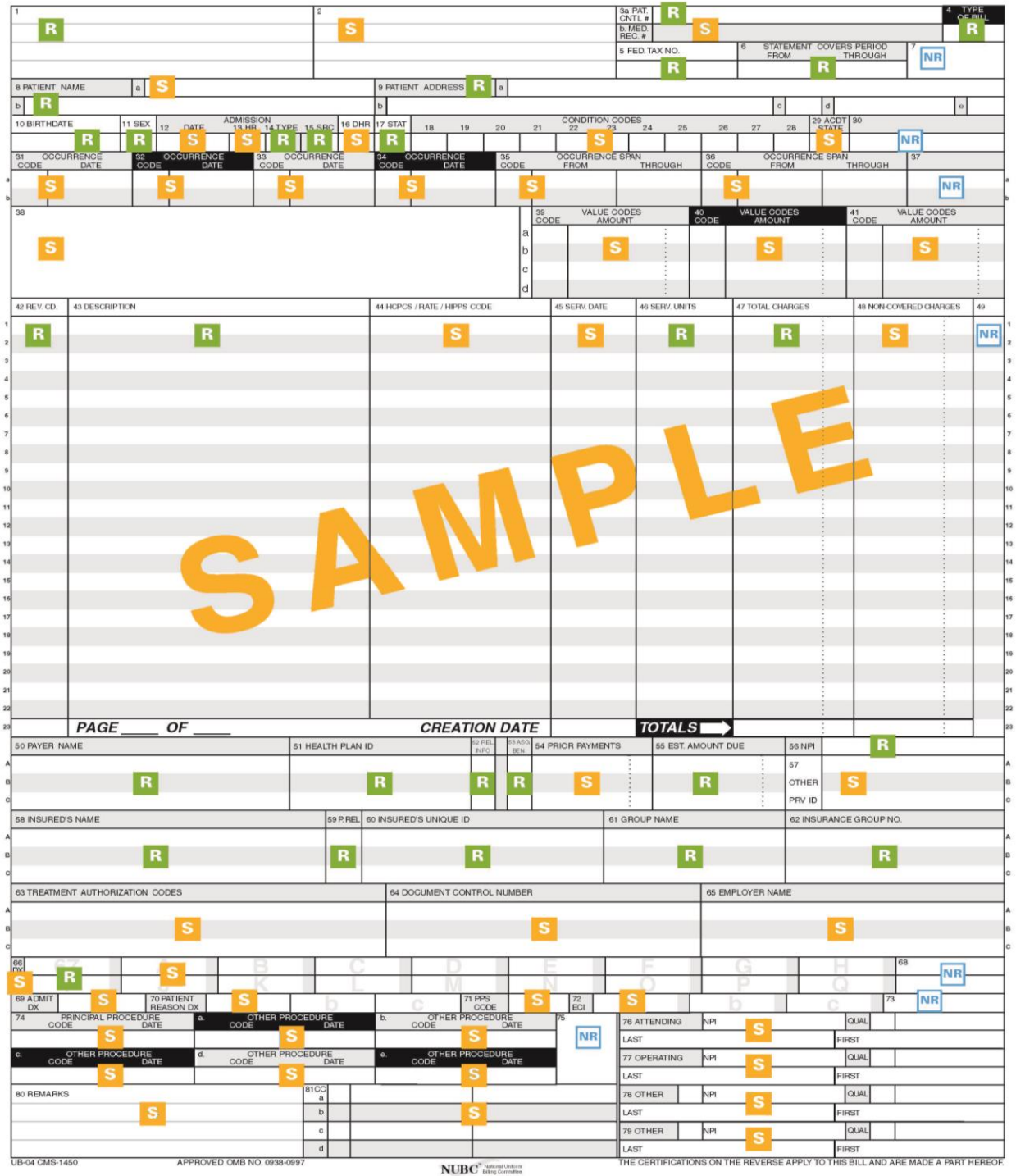

KEY

- Required to file a claim
- Situational - only if appropriate to the claim
- Not required/not used

Each claim must include:

- Patient demographics
- Insurance information
- Visit information
- Appropriate bill type (box 4)
- Tax ID number (box 5)
- Revenue code (box 42)
- Procedure Code (box 44)

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KEYS TO BILLING SBHC SERVICES

BILL USUAL AND CUSTOMARY RATES

Always bill usual and customary…not the Medicaid rate.

- Most contracts contain language that notes that they will pay ‘lesser of’ billed charges. This means if the billed charges are less than the contracted rate, the lesser amount will be paid.

- With retro rate changes, it is more difficult to adjust claims that were billed with a rate that is less than the updated rate. This may require corrected claims to be submitted.

KEYS TO BILLING SBHC SERVICES

BILL PLACE OF SERVICE (POS) 03

Always bill POS Code 03 in Box 24b on CMS 1500

- This is the appropriate code for services done in an SBHC location.
- SBHC sites that are designated as an FQHC will bill on a UB 04, which does not require this information.

KEYS TO BILLING SBHC SERVICES

BILL SBHC SERVICE ADDRESS AND NPI

Always bill the SBHC service address in Box 32 on CMS 1500 and Box 1 on UB 04.

Always bill the SBHC NPI in Box 32a. This includes those claims that are billed by the sponsoring entities.

- Each SBHC site has been given a unique NPI, which should be billed on all claims submitted for these service addresses.

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KEYS TO BILLING SBHC SERVICES

BILL TR MODIFIER FOR BH SERVICES

For SBHC, all behavioral health services should be billed with the TR modifier.

- This is how HSD identifies behavioral health services on the MCOs quarterly reports on utilization:
  - Ex 90837 TR, 90791 TR, etc.

BILLING TO SBHC INSTRUCTIONS

Advantages to billing to SBHC instructions:

- Provide accurate utilization to HSD
- Suppression of member EOBs
- Apply SBHC timely exceptions; SBHCs are allowed 120 days from the DOS to file claims
- Bypass COB requirements

T1023

T1023 with or without TR modifier –

Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter

- This service is billable and should be utilized by all SBHCs when appropriate.
- TR should be utilized when done for behavioral health services.

NATIONAL CORRECT CODING INITIATIVE (NCCI) OVERVIEW

NCCI edits identify procedure-to-procedure (PTP) codes, which are mutually exclusive as a same-day encounter.

For details on which combinations are not allowed or which modifiers are appropriate to distinguish services for certain combinations, please visit:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

TYPES OF NCCI EDITS

NCCI contains two types of edits:

1. NCCI PTP edits that define pairs of Health Care Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

    - Ex 90791 and 99214 on the same date of service

TYPES OF NCCI EDITS

2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

   - Ex 90853 billed with 2 units

NATIONAL CORRECT CODING INITIATIVE (NCCI) OVERVIEW

Most edits are a system configuration and not a manual process; please contact the MCO with questions.

- Please send documentation to support your inquiry that an edit is incorrect.

MOST COMMON DENIALS
SBHC CLAIMS

- Duplicate Claims
- Non-Credentialed or Non-Contracted Provider
- Invalid Diagnosis
- Billed Incorrectly
- Invalid Modifier

CORRECTED CLAIMS

- Each MCO has their own method for receiving corrected claims.
- All four MCOs will provide instructions on how to submit corrected claims.
- There are some differences submitting corrected claims between MCOs.

SUBMITTING A CORRECTED CLAIM

For claims billed incorrectly a corrected claim must be submitted.

Typically, a corrected claim submitted as paper should include:

- Corrected information on the claim
- Include the original claim number
- Have the term “Corrected Claim” clearly visible on the claim
- Be in the same format as originally submitted, with matching dates of service
- One claim per original claim number

Check with your MCO to determine how long you have submit claim corrections.

RESEARCHING CLAIMS

All MCOs have provider portals that providers may access to check claims status

- Providers can check if a claim has been received by the MCO, the status of the claim as well as claim details.
- Each MCO will have supporting documentation on how to appropriately check claim details and claim status.

WORKING WITH CLEARINGHOUSES

Clearinghouses facilitate the transfer of electronic transactions between payers and providers. Clearinghouses offer multi-payer solutions, batch transactions and direct data entry.

Your clearinghouse should be returning 2 levels of rejection reports to track progress of electronic claims submissions:

1. Clearinghouse level – never reach the payer but are returned to you from the clearinghouse for correction and electronic resubmission.

2. Payer level – do not enter claim processing systems for adjudication but are returned to the physician, facility or other health care professional for correction and electronic resubmission.

ENCOUNTER FORMS

SBHCs can bill for services listed on the HSD approved encounter form.

- Gray areas on the encounter form are not Centennial Care-covered services.
- All BH services should be submitted with a TR modifier.

Please contact your Provider Representative for questions regarding specific services.

DO YOU HAVE QUESTIONS?

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Such services are funded in part under contract with the State of New Mexico.

YOUR PROVIDER REPRESENTATIVES HAVE THE ANSWERS!