Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH | RIGHTCARE

Provider Overview

for Medicaid

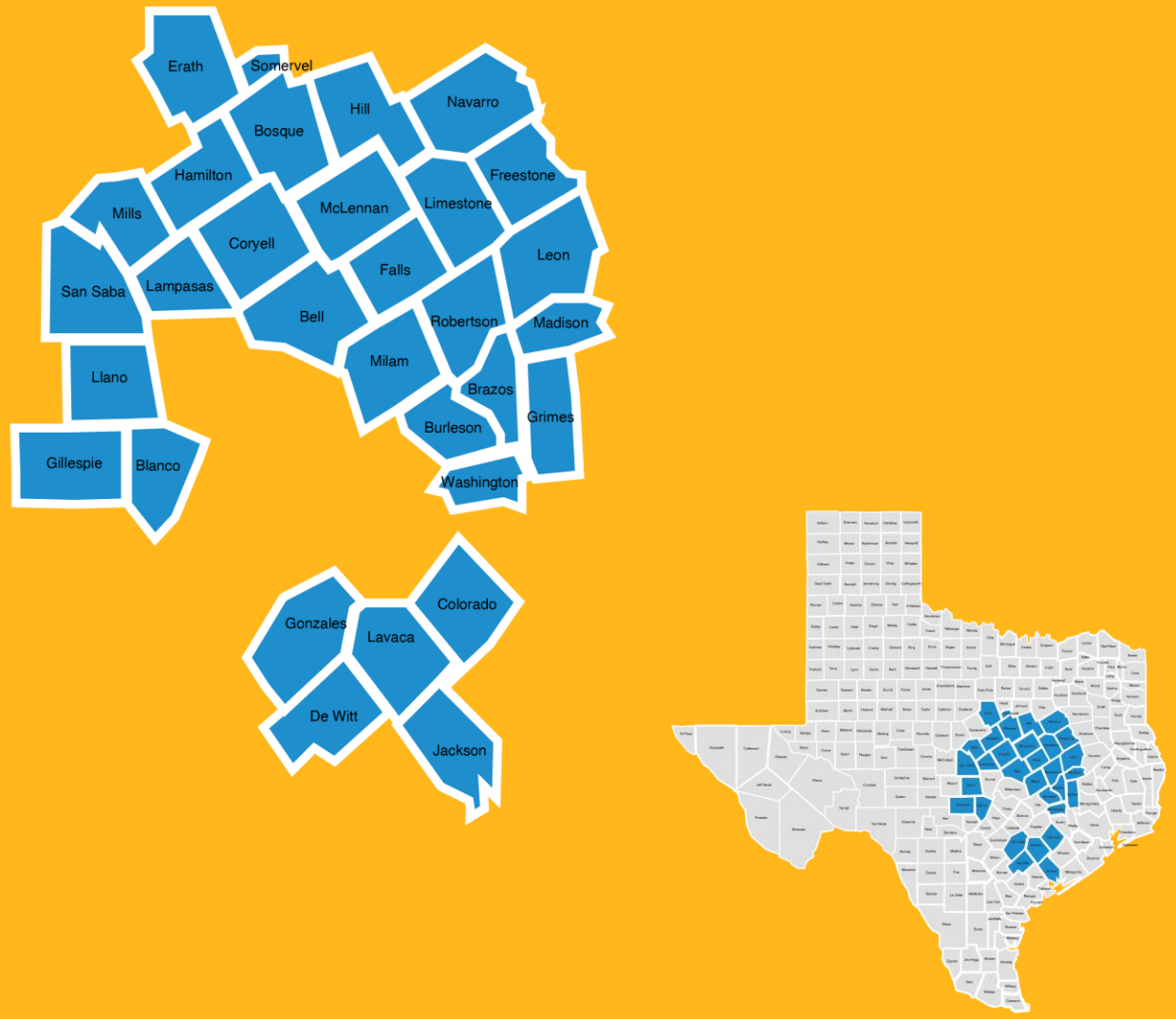
What is Medicaid?

- Medicaid is a jointly funded state and federal healthcare program, established in 1965 and currently administered by the Texas Health and Human Services Commission (HHSC).
- Medicaid pays for acute health care (physician, inpatient, outpatient, outpatient prescription pharmacy, lab, preventive care, and X-ray services).
- Medicaid also pays for long-term services and support for aged and disabled clients.
- Medicaid serves primarily low-income families, non-disabled children, related caretakers of dependent children, pregnant women, the elderly, and people with disabilities.

Central Texas MRSA

31 Counties:

Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, and Washington



Who is covered in Texas ?

Families, children, and pregnant women-based on income level, depending on age, family income and resources/assets.

Cash assistance recipients based on receipt of Temporary Assistance for Needy Families (TANF) and dependent on age.

Newborns (under 12 months) born to mothers who are Medicaid certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday.

What is managed care ?

- An important part of Medicaid is Medicaid managed care.
- Managed care refers to the body of clinical, financial, and organizational activities designed to ensure better access to health-care services, improve quality, promote more appropriate utilization of services, and contain costs.
- Originally, Texas Medicaid managed care was called the State of Texas Access Reform (STAR). STAR was established to explore different methods of building a framework of managed care around segments of Texas Medicaid.

Managed care cont'd

- Medicaid managed care utilizes health maintenance organizations (HMOs) to deliver acute care services to Medicaid Managed Care Clients. Clients who live in STAR service areas choose their HMO and a primary care provider (PCP).

- The principal objectives of Medicaid managed care are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for Medicaid clients, with a special focus on prenatal and medical checkups.

RightCare from Scott & White Health Plan

- The only Not-for-Profit health plan selected to serve the Central Texas Medicaid Rural Service Area (MRSA).
- Part of the Scott & White Health Plan (SWHP), which has been serving Central Texas since 1982.
- An affiliate of Baylor Scott & White Hospital in Temple, Texas.
- RightCare from Scott & White Health Plan covers children, pregnant women, newborns, and adults.

RightCare from Scott & White Health Plan cont'd

- Health Maintenance Organization (HMO) providing STAR services to Medicaid recipients in the Central Texas Medicaid Rural Service Area (MRSA).
- Network of significant traditional providers and facilities with a history of reliable services for the Medicaid populations.
- Open network for all members which does not limit a member's selection of an in-network PCP or a referral to an in-network specialist.

RightCare partners

- Superior Vision
  - Non-medical Vision Services
  - Benefit includes a routine eye exam and eyewear
  - Vision services that are for medical conditions of the eye require pre-authorization for referral to an Ophthalmologist
- Argus Health Systems
  - Pharmacy Services
- DentaQuest/MCNA Dental

Provider responsibilities

- Serve as a “Medical Home” (primary care provider)89
- Coordinate Patient Care
- Referrals and Authorizations
- Provide or arrange for 24-hour, 7 day a week health care coverage
- Verify Eligibility
- Update contact information including address, phone numbers, provider listing or hours of operation.
- Maintain HIPAA Compliance
- Report waste, abuse and fraud
- Report all encounter data on CMS 1500 or other appropriate documents

Provider responsibilities cont'd

- Providing, or arranging for the provision of, services to members assigned to their panel.
- Initiate Prior Authorization from RightCare referring to non-participating providers/or services requiring an authorization.
- Recognizing the role that the family members have as primary caregivers for children and other dependents and assures their participation in decision making.

Who can be a Primary Care Provider (PCP)

- Pediatrician
- Family or General Practitioner
- Internist or Geriatrician
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Obstetricians/gynecologists electing to be a PCP
- Physician Assistants (PA)
- Advance Practice Nurses (APRN)

Access to routine, urgent and emergency care

Appointment Type	Standard
New Patient	Within 14 calendar days for newborn members Within 60 calendar days for eligible members
Preventive Care	• Within 30 business days of member request • Texas Health Steps exams should be scheduled in accordance with the THSteps periodicity schedule
Routine Care	Within 5 business days of member request
Routine Specialty Care	Within 30 days of referral request
Prenatal Care	Within 14 calendar days for prenatal request, except High Risk pregnancies or members presenting for the 1st prenatal visit in the 3rd trimester must be within 5 days or as soon as possible if an emergency
Urgent Care	Within 24 hours of request
Emergency Care	Upon presentation or Same Day
After-Hours Care	Coverage available 24 hours a day/7 days a week, 365 day a year Office phone is answered after hours by an answering service advising members of options for care. After-Hours calls to be returned < 30 minutes.

Access to routine, urgent and emergency care

For Behavioral and Mental Health Care Services

Service	Standard
Routine Office Visit	10 business days
Urgent Care	24 hours
Non-life-threatening emergency care	6 hours
Life-threatening emergency care	Immediately
Telephone Access	No centralized screening or triage used

Importance of correct demographic information

- Accurate provider demographic information is necessary for accurate provider directories, online provider information, and to ensure clean claim payments.
- Providers are required to provide notice of any changes to their address, telephone number, group affiliation, and/or any other material facts, to the following entities:
  - SWHP-via the Provider Address Change Form RightCare.SWHP.org/en-us/prov/forms-tools
  - Health and Human Services Commission's administrative services contractor
  - Texas Medicaid and Healthcare Partnership (TMHP)-via the Provider Information Change Form available at TMHP.com

PCP panel of members

Open Panel

- RightCare desires all PCPs to maintain open panels and accept new members that may select the PCP for medical care. RightCare understands that there are times that a PCP's panel will become full and necessitate the PCP to close his or her panel.
- Per the contract with RightCare, a PCP may close his or her panel as long as the panel is closed to other managed care plans.

PCP panel of members cont'd

Closing a Panel

- PCPs must notify RightCare in writing of the PCP's need for the panel to be closed. The PCP's written notice should include an explanation as to why the panel needs to be closed, along with confirmation that the practice is closed to other managed care plans as well.
- PCPs should provide at least a 7-day notice of the closure of the panel.
- Once the panel is closed, RightCare will not allow the PCP to selectively accept new members unless the member or siblings of the member were existing members of the PCP.

Role of the specialty care provider

- The Specialty Care provider partners with the primary care provider to deliver specialty care to members
- A key component of the Specialist's responsibility is to maintain ongoing communication with the member's primary care provider
- Specialty providers need to be timely with their appointment scheduling
- Specialty providers are responsible to ensure necessary referrals/authorizations have been obtained prior to provision of services

Verifying eligibility

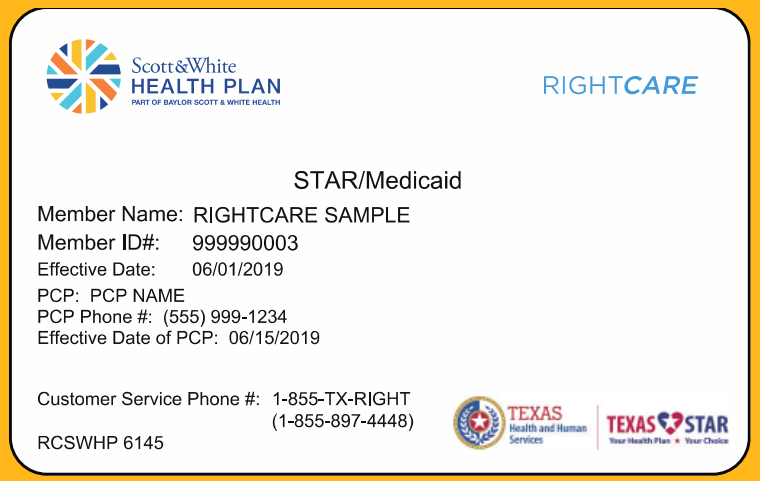
- Providers should verify Member eligibility prior to delivering service at each visit by:
- Using RightCare's electronic portal:
  - rightcare.firstcare.com
- Accessing the automated system:
  - yourtexasbenefits.com
- TexMed Connect
  - Member Identification Card
  - tmhp.com
- RightCare's Member Identification Card or Your Texas Benefit Card
  - Calling Customer Service:
  - RightCare: 1-855-TX-RIGHT (855-897-4448)
  - TMHP: 1-800-925-9126

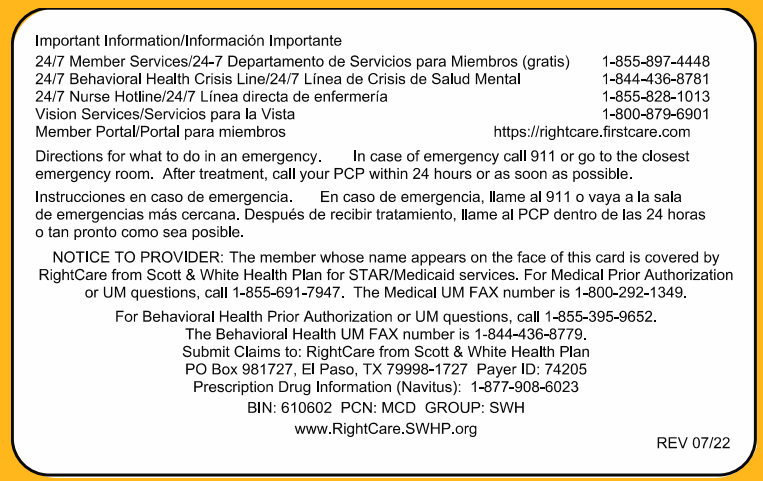
Verifying eligibility

- All ID Cards will have the following information:
  - Member name
  - Primary Care Provider
  - Prescription information
  - Program eligibility
  - Health Plan contact information

Your Texas Benefits ID card

RightCare ID card





Referrals

- The RightCare member's Primary Care Provider is responsible for and will coordinate referrals of the member to other providers, in-and-out-of-network.
- Referrals must come from the member's Primary Care Provider, as a function of the medical home.
- Specialists may not refer to other specialists.

Referrals cont'd

- Authorizations from RightCare for in-network referrals are not required for most specialty referrals.
- Exceptions include some services and specialists listed on the Prior Authorization List including, but not limited to, dermatology, plastic surgery, podiatry, and any primary care provider other than the Primary Care Provider of record (or a provider listed with RightCare as a covering provider for the Primary Care Provider).
- All out-of-network providers require an authorization.
- The in-out-of-network referral is valid for 180 days for a maximum of six visits unless otherwise authorized by the Primary Care Provider.

Specialty services available without referral

- Mental Health/Substance Abuse
- Family Planning
- OB/GYN
- THSteps
- ECI
- Non-medical Vision (Superior Vision)
- True emergency services

Cultural sensitivity

- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a Provider's relationship with patients and the health and wellness of the patients themselves.
- Texas Medicaid recipients will vary in language and culture (e.g., customs, religion, backgrounds, etc.).
- Our goal is to effectively serve members of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Marketing guidelines

- Providers must adhere to Marketing Guidelines as outlined by HHSC and referenced in their Provider Agreement.
- Providers can educate/inform patients about the Medicaid Managed Care Program in which the Provider participates.
- Providers CANNOT recommend one MCO over another MCO.
- Providers can inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate.
- Providers must distribute and/or display Health-related materials for all contracted MCOs or choose not to distribute and/or display for any contracted MCO.

Member responsibilities

- Learn and understand the rights they have under the Medicaid program.
- Abide by the health plan and Medicaid policies and procedures.
- Share information relating to their health status with their PCP.
- Learn about service and treatment options.
- Be involved in decisions relating to service and treatment options, make personal choices and take action to maintain health.

STAR/Medicaid benefits

Benefits Include, but are not limited to

- Medical and Surgical Services
- Texas Health Steps
- Transplants
- Hospital Services
- Prescriptions
- Durable Medical Equipment
- Dental and Vision Services
- Maternity Services
- Therapy-Physical, Speech, Occupational
- Mental and Behavioral Health Services

Benefits for STAR/MRSA members

- Traditional Texas Medicaid benefits plus:
  - Spell of Illness Limitation Removed
  - Clients are not limited to a 30-day spell of illness requirement
- Unlimited Prescriptions
  - Clients are not subject to a limitation on the number of prescriptions prescribed
- Adult Annual Examination
  - Clients age 21 and over are eligible for an annual physical once a year
- No Annual Inpatient Benefit Limit
  - The $200,000 annual inpatient limit is not applicable

Transportation benefits

- Transportation is available for doctor visits.
- If a STAR Medicaid member needs a ride to your office, the Medical Transportation Program (MTP) may be able to help. A member should call MTP as soon as they know their next appointment date.
- Members must call at least 48 hours before their appointment.
- Members under 18 years of age may be required to travel with an adult.
- To request services, call MTP at 1-877-MED-TRIP (1-877-633-8747).
  Hours of operation 8 AM - 5 PM.
- MTP offices also can help with money for gas for someone who drives the member to an appointment.

Value added services

- RightCare covers sports physicals as a value-added service.
- If a sports physical is requested and the child is due for a Texas Health Steps checkup, the checkup including all the required Texas Health Steps components should be completed as well.
- Providers may be reimbursed for sports physicals performed at the same time as a Texas Health Steps checkup or during a separate medical visit

Outpatient benefits

- Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders.
- Outpatient behavioral health services are limited to 30 encounters per client, per calendar year. (Additional encounters can be allowed if prior authorization is requested prior to the 25th visit).
- Includes outpatient psychiatric services, up to annual limit , ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code.

Outpatient benefits cont'd

- Medication management visits do not count against outpatient visit limit.
- Psychological and Neuropsychological testing are covered for specific diagnoses. Testing is limited to a quantity of four hours per day per client(any provider).
- Psychologicaltestingwillbelimitedtoeighthoursoftestingperclient,percalendar year (any provider).
- Covered services are a benefit for clients suffering from a mental psychoneurotic or personality disorder when provided in the office, home, SNF, outpatient hospital, nursing home or other outpatient setting.

Outpatient benefits cont'd

- Does not require a primary care provider referral.
- Neuropsychological test battery will be limited to eight hours per client, per calendar year (any provider).
- Additional benefits of preventive health care such as mental health screenings are covered under the Texas Health Steps-CCP program.
- Medicaid clients age 21 years and older may receive mental health counseling provided by a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Clinical Social Worker, and a Licensed Marriage and Family Therapist. This benefit includes 30 encounters per calendar year.

Inpatient benefits

- Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders.
- Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid program and are subject to UR requirements.
- Includes inpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities.
- Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/use are not a covered benefit for acute care hospitals without an accompanying medical condition.

Senate Bill 58 behavioral health carve in

- Mental health rehabilitative services and mental health targeted case management are available to Medicaid recipients who are assessed and determined to have:
- A severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or a other severely disabling mental disorder.
- Children and adolescents ages 3 through 17 years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance.

Behavioral health carve in cont'd

- The MCO is not responsible for providing Criminal Justice Agency funded procedure codes with modifier HZ because these services are excluded from the capitation.
- Crisis Intervention services are considered emergency behavioral health services and do not require prior authorization but providers must follow current RRUMG.
- Employment related services that provide training and supports that are not job specific and have as their focus the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to make vocational choices, attain or retain employment can be provided under Skills Training and Development. These services should not be confused with Employment Assistance or Supported Employment allowed under the HCBS STAR+PLUS Waiver.

Behavioral health carve in cont'd

- Targeted Case Management:
- Must be face to face.
- Include regular, but at least annual, monitoring of service effectiveness.
- Proactive crisis planning and management for individuals.
- Targeted case management is a Medicaid billable service provided separate from MCO service coordination.
- Mental Health Rehabilitative Services include:
- Crisis Intervention Services
- Medication Training and Support Services
- Psychosocial Rehabilitative Services
- Skills Training and Development Services
- Day Programs for Acute Needs

Adoption Assistance and Permanency Care Assistance (AAPCA)

- What is AAPCA?
- Effective September 1, 2017, AAPCA members move to managed care.
- The Adoption Assistance program provides help for certain children who are adopted from foster care.
- The Permanency Care Assistance program gives financial support to family members who provided a permanent home to children who were in foster care, but could not be reunited with their parents.
- AAPCA may provide Medicaid coverage for the child, monthly cash assistance from DFPS, and a one-time reimbursement from DFPS for some legal expenses that come with adopting or becoming the managing conservator of the child.
- Authorizations for basic care are honored for 90 days, until the authorization expires or until the health plan issues a new one.
- During the transition period, members can keep seeing current providers, even if they are out of the health plan's network.

AAPCA existing authorizations

- Authorizations for long-term care services and support are honored for six months or until a new assessment is completed.
- Approved and active prior authorizations for covered services will be forwarded to the STAR or STAR Kids health plans prior to September 1, 2017.
- Their prior authorizations are subject to the ongoing care requirements discussed before.
- Providers do not need to resubmit authorization requests to the health plans if an authorization is already in place.

AAPCA provider action

- What does this mean for you?
- Contracted providers are eligible to provide services to members who transition to RightCare.
- Current claims and authorization processes apply.
- No further action needed from contracted providers.

Notification requirements

- Required to fill out the Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form and fax it to 1.844.436.8779.
- This form is located at http://rightcare.swhp.org/en-us/prov/forms-tools
- An authorization is not warranted; however, a notification is required for new services and if the member's condition warrants a change in service.

Assessments

- Adults Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths Assessment (CANS) will be the tools used for consistency in assessment for services across the indigent and Medicaid populations.

  https://www.dshs.state.tx.us/mhsa/trr/ansa/

- Providers must have a signed user agreement with Department of State and Health Services (DSHS) to complete assessment in Clinical Management for Behavioral Health Services (CMBHS).

  https://www.dshs.state.tx.us/mhsa/trr/cans/

Members discharged from inpatient psychiatric facilities

- RightCare requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.

- Providers are asked to contact RightCare to report any missed outpatient appointment that cannot immediately be rescheduled with the member. Providers will follow-up with RightCare members and attempt to reschedule missed appointments.

Additional covered services

- Texas Medicaid Provider Procedures Manual (TMPPM) has the listings of limitations and exclusions that apply to each category of covered services.
  http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

Breast pump

- A manual or nonhospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity. The purchase of a breast pump is limited to one every three years. Providers must use procedure code E0602 or E0603 when billing for the purchase of a manual or nonhospital-grade electric breast pump. A hospital-grade breast pump (procedure code E0604) may be considered for rental, not purchase. Rental of a hospital-grade breast pump is not time-limited. If more than one type of breast pump is billed on the same day by the same provider, only one will be reimbursed.
- The following procedure codes for replacement parts are benefits of Texas Medicaid: A4281, A4282, A4283, A4284, A4285, and A4286.
- Breast pumps are to be provided for situations including the following:
- When infants are premature and unable to suck
- When infants have severe feeding problems (e.g., cleft lip and/or palate); or unable to suck;
- When mothers have difficulty establishing or maintaining an adequate milk supply due to maternal/infant illness

Breast pump cont'd

- When mothers and infants are separated (such as hospitalization or returning to work or school)
  - When mothers have temporary breastfeeding problems such as engorgement
  - When mothers have multiple births (e.g., twins, triplets, etc.)
  - Any other condition as deemed necessary by the MCO.
- What is needed?
  - Patient demographics
  - Order from doctor and insurance information (member cannot get a breast pump until after they deliver)
  - A prior authorization is not needed since the pumps are under $300.
  - Once the provider receives the prescription they will prepare the Title XIX and send it to the prescribing physician for signature.
- Locations where members can obtain breast pumps including but not limited to:
  - Mail-order, Pharmacies, Hospitals, DME providers, Local WIC offices

Migrant farm workers

- The children of migrant farm workers were identified as needing additional assistance because of unconventional living conditions, migratory work patterns, unhealthy working conditions, poverty, poor nutrition, lack of education, and illiteracy—all factors that contribute to poor health
- Providers are required to be knowledgeable about migrant farm workers and their children and the importance of services covered by Medicaid and receiving timely Texas Health Steps (THSteps) medical and dental checkups
- Flexibility in the periodicity schedule allows children to receive their THSteps medical and dental checkups before their families migrate to another area for work

Jimmo v. Sebelius settlement agreement

- On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius. The settlement involves skilled care for skilled nursing facilities (SNFs), home health (HH), inpatient rehabilitation facility (IRF), and outpatient therapy (OPT) benefits.
- The settlement agreement is intended to clarify that when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. Conversely, coverage in this context would not be available when the member's needs can be met safely and effectively through the use of non skilled personnel.

Jimmo v. Sebelius settlement agreement

- The Jimmo v. Sebelius settlement agreement does not change existing Medicare coverage requirements. It only serves to clarify that, in the context of maintenance services, coverage does not turn on the presence or absence of potential for improvement, but on the need for skilled care.
- For detailed information and frequently asked questions, please visit the Centers for Medicare & Medicaid Services (CMS) website at: https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html

Utilization Management (UM)

- InterQual criteria are used for the review of Medical Necessity as well as Provider peer-to-peer review.
- Medical Director reviews potential adverse determinations for medical necessity.
- If necessity cannot be established, denial letters will be sent to the Member and Provider that include the clinical basis for the denial and the Member appeal rights.
- Provider may also appeal on behalf of the Member, if authorized to do so.
- Obtain authorizations by contacting the Utilization Management Department.
  - Medical Utilization Management: 1-855-691-7947
  - Behavioral Health Utilization Management: 1-855-395-9652

Case Management (CM)

- RightCare Members with identified needs are assessed for Case Management enrollment.
- Members identified through various ways including, but not limited to, clinical rounds, referrals from RightCare staff, claims, hospital census, and direct from Providers or self-referral.
- CM facilitates communication between PCP, Member, managing physician and the CM team.
- Refer a Member by contacting the Case Management Department.
  - Medical Case Management: 855.691.7947
  - Behavioral Health Case Management: 855.395.9652

Disease Management (DM)

- RightCare Members with identified needs are assessed for Disease Management enrollment.
- Members with asthma, diabetes, and other complex health conditions.
- RightCare coordinates with both the Member and Providers to focus on disease specific conditions.
- Refer a Member by contacting the Disease Management Department.
  - Disease Management: 1-855-691-7947
  - Behavioral Health Disease Management: 1-855-395-9652

Prior authorization

- Participating provider submits request for services requiring prior authorization.
- Mandated list of services requiring prior authorization available at: http://rightcare.swhp.org/en-us/prov/authorizations
- PCP may request a prior authorization using the Texas Referral/Authorization Form.
- RightCare's Medical Management team receives information and reviews eligibility, benefits and medical necessity.

Prior Authorization cont'd

- Authorization are returned to requesting provider.
- Rendering provider sends findings and recommendations to PCP after the visits.
- Can be faxed in or entered on the portal.
- All out-of-network and in-patient stays require an authorization.

Services requiring prior authorization

- All other admissions, including antepartum or NICU admit require prior authorization
- Additional physical, occupational and speech therapy visits beyond the initial evaluation
- DME greater than $300 and all DME rentals, and wheeled mobility providers with Taxonomy Code 332BC200X
- All out of network physician, hospital and ancillary service requests
- Additional information available at http://rightcare.swhp.org/en-us/prov/authorizations

Services not requiring authorization

- Normal Routine Deliveries
  - 48 hours for vaginal deliveries
  - 96 hours for C-section
  - *If discharge does not take place within these timeframes, provider must notify the health plan
- Initial Therapy Request
  - Submitted using the TP-1 Form
- Continuation of Therapy
  - Submitted using the TP-2 Form if requesting services after 6 months
- DME items under $300
  - Submitted on Title XIX Form

Notification of admissions

- Hospitals must notify RightCare of all emergent admissions no later than the close of the next business day.
- All non-emergency, elective inpatient admissions require prior authorization.
- Notify RightCare regarding an urgent/emergent admission by contacting: 1.855.691.7947
- Any service/procedure that is a non covered benefit according to the Texas Medicaid Provider Procedures Manual (TMPPM) is still considered a non covered benefit according to RightCare.

Claims filing

- Professional claims are filed on CMS 1500 version 02/12.
- Facility/Hospital claims are filed on a UB-04.
- May be filed electronically through current clearinghouse or through Emdeon, RightCare's clearinghouse.
- May be filed directly through either TMHP's website or RightCare's website.

Claims filing

- Use original red forms –no copies.
- Detach claims at perforated lines before mailing.
- Do not use labels, stickers or stamps on claim form.
- Do not send duplicate copies of information.
- Do not mail claims with correspondence for other departments.
- No handwritten claims.
- Mail paper claims to:

RightCare from Scott & White Health Plan
P.O. Box 211342
Eagan, MN 55121-1342

Claim filing deadline

- Professional Claims
  - Must be received within the 95-day date of service filing deadline.
- Hospital Providers
  - Must be received within 95 days from the date of discharge.
  - Or 95 days from primary insurance EOB.

Timeliness of payment

- RightCare will pay all clean claims submitted in the acceptable format and on the appropriate claim form within thirty (30) days from the date of receipt that the claim was deemed “clean”.
- Claims that fail to be paid within this time period will be reimbursed interest on a monthly basis.

Electronic claim requirements

- Change Healthcare is Claim Clearinghouse
- RightCare Payor ID Number: 74205
- X12 837 Format accepted
- Version 5010 compliance required

Corrected Claim vs. Appeals

- Corrected claim
  - Adjustment requiring no supporting documentation from the Provider, could be prompted by the Provider or by the Plan (i.e. wrong date of birth, incorrect modifier, incorrect diagnosis code).
- Appeal
  - Request from a Provider for adjustment to a claim that requires supporting documentation from the Provider to consider the request (i.e. medical records, proof of timely filing, etc.).

Corrected Claim

- Must reference original claim # on claim form (found on EOP).
- Must be submitted within 120 days of adjudication.
- Corrected claims can be submitted electronically or by paper.
- Electronically submitted Corrected Claims was use frequency code 7
- Mail corrected claims to:
  - RightCare from Scott & White Health Plan
  - P.O. Box 211342
  - Eagan, MN 55121-1342

Appeals Process

- Submit appeal within 120 days from the date of notification or adjudication.
- Attach a copy of the appeal:
  - https://rightcare.swhp.org/en-us/prov/forms-tools
  - Include the supporting documentation.
- Use ONE appeal form and EOP for each appeal if denials are different.
- Mail appeals to:

  RightCare Scott & White Health Plan
  Medical Appeals
  MS-A4-144
  1206 West Campus Drive
  Temple, TX 76502-9915

Appeals Documentation

- Examples of supporting documentation may include but are not limited to:
  - A copy of the RightCare EOP (required).
  - The appeal form (required).
  - A copy of the claim.
  - An EOP from another insurance company.
  - Documentation of eligibility verification such as screen shot of the RightCare website, TMBC, TMHP documentation, etc.
  - EDI acceptance reports showing the claim was accepted by RightCare.
  - Prior authorization fax confirmation.
  - Certified mail receipts.

Common billing errors

- Authorization not obtained for services requiring prior authorization or claim is being billed for more units than authorized
- Provider is billing for services different than authorized and authorization not updated to correct procedures before submitting claim
- Provider didn’t request the appropriate number of units based on how claim is billed for injections
- Inappropriate modifiers or missing modifiers
- Member DOB or Name not matching ID card/Member record
- Not filed timely
- Code Combinations not appropriate for demographic or patient

Common billing errors

- Code Combinations not appropriate for demographic or patient
- No itemized bill provided when required
- Illegible paper claim
- First claim submission filed on photo-copied claim form (not the original red claim form)
- Missing NDC number

Billing the member

- A provider cannot require a down payment before providing Medicaid-allowable services to eligible members.
- A Medicaid member cannot be billed for a Medicaid covered services while eligible for Medicaid.
- It is not acceptable for the physician to charge Medicaid members, their family or the nursing facility for telephone calls, telephone consultations or to sign forms.
- Texas Medicaid members cannot be charged for failure to keep an appointment.

Billing the member cont'd

- Texas Medicaid members may not be billed for the completion of a claim form, even if it is the provider's office policy.
- Texas Medicaid members with private health insurance may not be charged a co-pay.
- RightCare members do not have co-pay.
- Medicaid payment is considered payment in full.

Medicaid third party recovery

- To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third-party insurance that the provider knows about or should know about before billing Texas Medicaid. Medicaid coverage is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been paid.
- Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third-party resources (TPR) or other insurance. A TPR is a source of payment for medical services other than Medicaid, including no-fault automobile insurance such as personal injury protection and automobile medical insurance.

Medicaid third party recovery cont'd

- Providers must make a good faith effort to determine, at the time services are delivered, or at any time thereafter, whether the services being provided to the member are a result of injuries caused by a person who is or may be liable for payment of the services.
- Providers must submit information relating to the existence or possible existence of third-party liability obtained from the member or legal representative of the member at the time a claim is submitted to the health plan for payment, or at any time thereafter, or when an informational claim is submitted under the provisions of Subchapter A, Division 1 §354.1003 of the Texas Administrative Code, relating to Time Limits for Submitted Claims.
- Scott & White Health Plan will avoid payment of trauma-related claims where third-party resources are identified prior to payment.

Refund request

Please attach the completed RightCare Refund Information Form along with a check made payable to RightCare from Scott & White Health Plan

https://rightcare.swhp.org/en-us/prov/forms-tools

Include a copy of the Explanation of Payment (EOP)

Mail to the following address:

RightCare from Scott & White Health Plan
PO Box 841476
Dallas, TX 75284-1476

Electronic funds transfer

- Benefits:
  - Easy to enroll
  - No cost to the provider
  - No lost or delayed checks
  - Less paperwork
  - EOP displays deposit amount in financial summary
  - Emailed when deposit is made

General pharmacy information

- A list of covered drugs may be accessed online at http://www.txvendordrug.com/formulary/
- A list of preferred drugs may be accessed online at http://www.txvendordrug.com/formulary/preferred-drugs.shtml
- At the current time, RightCare is only accepting electronic pharmacy benefit claims from providers.

Emergency prescription supply

- A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available.
- Applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.
- The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition.

Emergency prescription supply cont'd

- If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

Provider relations

- Responsible for Provider Orientation and Education
  - New Products, Programs, or Processes
  - Local group training sessions
- Conduct Site Surveys
  - Credentialing request
  - Complaint Resolution
- Assist with QI Initiatives
  - After Hours Compliance
  - Committee Invitations
  - Appointment Availability Compliance
- Serve as Provider Liaison, assisting Providers with any issues

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Provider services

- Assists with:
  - Claim status
  - Completion of claim forms
  - Payment questions
- Contact information:
  - 1-855-TX-RIGHT (1-855-897-4448)

Network development and contracting

- Handles all contracting for new and existing Providers to include:
  - https://swhp.org/en-us/prov/add-a-provider-form

- Amendments to existing contracts.
  - https://swhp.org/en-us/prov/modify-existing-contract

Compliance

- Fraud, Waste, and Abuse
- Individuals with knowledge about suspected Medicaid waste, abuse and fraud must report the information to the Health and Human Services Office of the Inspector General (OIG).
  - OIG Hotline at 800.436.6184
  - May also contact RightCare from Scott & White Health Plan at 888.484.6977 or (TTY) 7-1-1

http://www.hhsc.state.tx.us and select Report Waste, Abuse and Fraud link

Quality improvement

- Manages the annual HEDIS data submission process and implements interventions to improve HEDIS scores.
- Maintain compliance with quality related areas of HHSC regulations.
- Analyzes provider profiles.
- Performs medical record audits.
- Conducts provider satisfaction surveys annually.
- Review, investigates and analyzes quality of care concerns (Member Complaints).

Member affairs

- Assist Provider with non-compliant Members
- Connect Members, with socio-economic issues, to local resources (food pantry, utility bills, etc.).
- Call: 1-855-TX-RIGHT (1-855-897-4448)

Contact Numbers

Member Services (English & Spanish)*	1-855-897-4448
RightCare's Provider Relations Department*	1-855-897-4448
RightCare Health Plan TTY#	7-1-1
Behavioral Health Crisis Line24/7	1-844-436-8781
RightCare Behavioral Health CM/DM/UM	1-855-395-9652
RightCare Medical CM/DM	1-855-691-7947
RightCare Medical UM	1-855-691-7947
Block Vision-Vision Benefit Hotline*	1-800-879-6901
Member Services (English & Spanish)*	1-855-897-4448
Medicaid Managed Care Helpline	1-866-566-8989

Medicaid Managed Care TDD#	1-866-222-4306
STAR Program Helpline	1-800-335-8957
RightCare’s Eligibility Verification (IVR Line)*	1-855 897-4448
The Enrollment Broker	1-800-964-2777
WIC	1-800-942-3678
Medical Transportation Program (MTP)	1-877-633-8747
ECI Care Line	1-800-628-5115
Dental Benefit Information-DentaQuest	1-800-516-0165
Dental Benefit Information-MCNA Dental	1-800-494-6262