County Indigent Health Care Program SSI/Medicaid Reimbursement Manual

Office of Primary and Specialty Health

November 2019

TEXAS
Health and Human Services

Table of Contents

PURPOSE

- To assist counties that are not fully served by public hospitals or hospital districts in filing claims through the Texas Health and Human Services (HHSC) County Indigent Health Care Group (CIHCG) for retroactive SSI/Medicaid reimbursement for County Indigent Health Care Program (CIHCP)-eligible individuals

- To give specific instructions for processing both prescription and medical claims

- To assist counties in maximizing Medicaid reimbursements

- To clarify non-reimbursable claims

REQUIREMENTS FOR PARTICIPATION

Confidentiality Agreement

- HHSC office must have a signed Confidentiality Agreement from a participating county prior to processing that county's Medicaid reimbursement claims.

Correct Forms

- Form 112, SSI Appellant Notification
- Form 113, Appellant/Provider Assignment
- Form 114, Confidentiality Agreement
- Form UB-04 (also known as CMS-1450)
- Form CMS-1500

Texas Title XIX Medicaid-Enrolled Providers

- Reimbursement through HHSC is for health care services in which the county paid a Texas Medicaid-enrolled provider.

- To verify Active Medicaid Pharmacies please visit:
  - http://www.txvendordrug.com/providers/index.asp

GENERAL PRINCIPLES

- Regardless of Medicaid reimbursement for services, Chapter 61 determines county responsibilities for services and procedures. Medicaid reimbursement should not interfere with Chapter 61 program requirements.

- In order for HHSC to process any Medicaid reimbursable claims, the county must follow CIHCP approved payment standards.

- HHSC cannot process claims received after the 95th day from the Medicaid "Add Date"

- HHSC must enter pharmacy claims within 365 days from the date of service

- HHSC must enter non pharmacy claims within 365 days from the date of service

- Medicaid reimbursements paid to the counties may be a lesser amount than the amount counties paid to the providers. Medicaid requirements may differ from those of CIHCP.

- HHSC requires immediate notification by the county when a provider reimburses the county on a claim that the county submitted to HHSC CIHCG. Counties should consult with providers to clarify filing procedures, if applicable.

- Do not send duplicate claims to be reimbursed by HHSC or by both HHSC and the local provider. If a provider will process the claim, do not send that particular claim to HHSC. Sending such a claim to HHSC could cause overpayment.

- Adjustments may occur due to contractor overpayments, duplicate payments, or other reasons. If there is an adjustment to a previous payment, HHSC will contact the county. The county is responsible for resolving the overpayment.

- On Form 105, Monthly Financial/Activity Report, deduct the SSI/Medicaid reimbursement amounts in the month received.

- In order for HHSC to process hospital claims, **counties must show their calculations on each entry in Block 47**.

- HHSC will notify counties regarding payment.

- Form 113, Appellant/Provider Assignment, must have the correct provider's

physical address, not the Post Office box address.

MEDICAID VERIFICATION PROCESS

Counties may check Medicaid status by:

- Using the Automated Inquiry System (AIS) toll-free telephone number,
- Using the Texas Medicaid & Healthcare Partnership (TMHP) eligibility verification website,
- Reviewing the Medicaid eligibility letter from applicant/CIHCP-eligible individual; or
- Contacting the Social Security Administration office for eligibility details.
- Contacting the HHSC for eligibility details.

INSTRUCTIONS FOR CLAIMS SUBMISSION

General Requirements

- Submit **LEGIBLE** claims
  - Not cut off
  - Not faded
  - No notes obstructing required fields
- Claims must be received by HHSC within 95 days of the Medicaid Add Date **and**
  - pharmacy claims must be entered within 365 days from the date of service
  - non pharmacy claims must be entered by HHSC within 365 days from the date of service
- Only claims with dates of service within the Medicaid-eligible time period can be processed.
- One Form 112, SSI Appellant Notification, must be submitted for each provider.
- Each claim must be listed on Form 112.
- Separate the prescription drug claims from the medical claims.
- Separate claims by provider.
- Submit claims only when:
  - The corresponding Form 113 was signed by the appellant;
  - The corresponding Form 113 was signed by the provider **on or after** the date the appellant signed; and
  - The county paid the provider **on or after** the date the appellant and the provider signed the corresponding Form 113.

Requirements for Prescription Claims

- ☐ Separate claims by provider.
- ☐ List the amount paid for each prescription drug on separate lines and by date of service on the Form 112. Do not combine prescription drug payments by dates of service on the Form 112. Do not list or send more than 3 prescription drug claims per appellant per month.
- ☐ Attach copies of the prescription drug claims for each Form 112.
- ☐ Submit an appropriate Form 113 for each provider.
- Display only the Medicaid reimbursable client's name on the prescription claims.
- ☐ Ensure that each claim includes correct entries.
- ☐ Only prescription drugs listed on the Texas Vendor Drug website will be processed for payment. http://www.txvendordrug.com/dw/FormularySearch.asp
- ☐ Prescription claims must be paid according to the CIHCP approved payment formula located in the *CIHCP Handbook, Section Four, Service Delivery, Page 10*.

Requirements for Medical Claims

- ☐ Separate claims by provider.
- ☐ List the amount paid for each medical claim on separate lines and by date of service on Form 112. Do not send claims that were not paid.
- ☐ Attach copies of the claims for each Form 112.
- ☐ Submit an appropriate Form 113 for each provider.
- ☐ Ensure that each claim is on the correct form, UB-04 or CMS-1500, and that each claim includes correct entries.
- ☐ Ensure that calculations are completed on UB-04s.

SPECIFIC FORM REQUIREMENTS

Prescription Drug Claims

Ensure that the following items are on each claim:

- o Pharmacy Name and Physical Address
    - If pharmacy name and physical address are not printed on computerized printouts, the pharmacist or county must write the pharmacy name and the pharmacy's physical address on the computer printout.
- o The client's name, the prescription drug's name, the Rx number, and the eleven-digit National Dispensing Code (NDC) number for each prescription drug.
- o No more than three (3) prescription drugs per month per client.

NOTE: Supplies are not reimbursed, only prescription drugs. In addition, if there are more than three presciptions filed per month, only the three most expensive will be submitted.

CMS-1500 Claims

Ensure that the following blocks are completed.

- o Block No. **2** must have the patient name.
- o Block No. **5** must have the patient address.
- o Block No. **17** must have:
    - The ordering physician's name for laboratory services and for radiology services,
    - The referring physician/performing surgeon's name for services provided in an ambulatory surgical center (ASC) and
    - The referring physician's name for consultation services.
- o Block No. **17b** must have the National Provider Identifier for the individual in Block 17.
- o Block No. **21** must have at least one diagnosis code.
- o Block No. **24A** must have only one date per line billed. Do not accept multiple (to- from) dates on a single line detail.
- o Block No. **24A** must have the National Drug Code (NDC) qualifier of N4, followed by an 11-digit NDC number for physician-administered

prescription drug procedure codes.

- Block No. **24B** must have the correct place of service. If the patient is registered at a hospital, the place of service must indicate inpatient or outpatient status at the time of service.
- Block No. **24D** must have procedure codes. Modifiers may be necessary. Anesthesia claims require the modifiers and the number of minutes. (Minutes are usually placed in the Block No. 24 area.)
- Block No. **24E** must have the diagnosis line item reference. Enter the line item reference for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block No. 21.
- Block No. **24F** must have the charges.
- Block No. **24G** must have the number of days or units.
- Block No. **31** must have the date and an **appropriate signature**.

  - **Handwritten signature (or signature stamp) of the provider or authorized representative or**
  - **"Signature on File" statement for claims prepared by computer billing services or office-based computers.**

- Block No. **32** must be completed if the place of service in Block No. 24B is anywhere other than the home or the provider's facility.
- Block No. **33** must have the Texas Medicaid Program billing provider name, address, phone number, National Provider Identifier (NPI), and Texas Provider Identifier (TPI).

- Write the Medicaid payment rate for each CPT code listed, and write the per unit amount next to the rate, e. g., 10 units at the Medicaid payment rate of $155.50 = 15.50 per unit.

UB-04 Outpatient Hospital Claims

Ensure that the following blocks are completed.

- Block No. **1** must have the provider name, address, and phone number.
- Block No. **4** must have the three-digit Type of Bill code.
- Block No. **8b** must have the patient name.
- Block No. **9** must have the patient address.
- Block No. **12** must have the date of service.
- Block No. **13** must have the admission hour.
  - (Admission hour is the time of treatment for outpatient claims.)

- Block No. **14** must have the type of admission code
- Block No. **15** must have the source of admission code
- Block No. **17** must have the patient status code
  - Block No. **42** must have the revenue code
  - Block No. **43** must have a description of the services.
  - Block No. **43** must have N4, followed by the 11-digit NDC number for physician- administered prescription drug procedure codes.
  - Block No. **44** may need a procedure (HCPC) code if warranted by the revenue code.
  - Block No. **45** must have the dates of service.
  - Block No. **46** must have the number of units of service.
  - Block No. **47** must have the charges.

    - The charges must have the appropriate calculations completed by the county in Block 48 and divided by the number of units. (See Page 17 for detailed instructions.)

  - Block Nos. **67A through 67Q** must have at least one ICD-9-CM diagnosis code.
  - Block Nos. **76 through 79** must have the applicable physician information including national provider identifier.

  - Ensure that the Medicaid rate is written on the claim, e. g., 40%.

  - Ensure that the total amount paid is written on the claim and that the calculations for each procedure reflect this total.

Example:

Total Billed Amount
$500.00 Medicaid Rate
40%
Amount Paid $200.00

UB-04 Inpatient Hospital Claims

Ensure that the following blocks are completed.

- Block No. **1** must have the provider name, address, and phone number.
- Block No. **3b** must have the medical record number.
- Block No. **4** must have the three-digit Type of Bill code.
- Block No. **6** must have the beginning and ending date of service.
- Block No. **8b** must have the patient name.
- Block No. **9** must have the patient address.
- Block No. **12** must have the admission date.
- Block No. **13** must have the admission hour.
- Block No. **14** must have the type of admission code.
- Block No. **15** must have the source of admission code.
- Block No. **16** must have the discharge hour.
- Block No. **17** must have the patient status code.
- Block No. **42** must have the revenue codes.
- Block No. **43** must have the description of the charges.
- Block No. **46** must have the number of units of service.
- Block No. **47** must have the charges.
    - The charges must have the appropriate calculations completed by the county in Block 48 and divided by the number of units. (See Page 15 for detailed instructions.)
- Blocks **67A through 67Q** must have at least one ICD-9-CM diagnosis code.
- Block **69** must have the admitting diagnosis code.
- Blocks **72a through 72c** must have applicable present on admission indicators in the shaded areas.
- Block Nos. **74 through 74e** must have the principal and other procedure codes and dates. The provider must enter the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure code for each surgical procedure and the date each procedure was performed.
- Block Nos. **76 through 79** must have the applicable physician information including national provider identifier.

Ensure that the total amount paid is written on the claim and that the calculations for each procedure reflect this total.

REIMBURSEMENT EXCLUSIONS AND LIMITATIONS

Exclusions

Services/Procedures that cannot be processed by HHSC are:

- Mammography
- Skilled Nursing Facility services
- Hospital lab procedures
- Rural Health Care Clinics
- Dates of service within Medicaid eligibility dates

Limitations

Some limitations in processing claims for Medicaid reimbursement are:

- Lab services will be filed only for physician and independent labs.
- If anesthesia, surgery, and assistant surgery claims are submitted for the same date of service for the same client, it is possible that only one of the procedures will be reimbursed.
- Outpatient hospital claims for physical therapy/occupational therapy (PT/OT) require modifiers.
- A Federally Qualified Health Center (FQHC) is reimbursed by the CPT code rate.
- Outpatient hospital services with surgical procedures that were not an emergency are reimbursed at the ambulatory surgical center (ASC/HASC) rate.
- HHSC cannot process an anesthesia claim without an anesthesia modifier and a state defined modifier of U1 or U2.

HHSC PROCESS

After HHSC receives claims on cases, the following actions are taken:

- Verification of Medicaid eligibility dates, use of correct forms, and program requirements
- Separation of medical and prescription drug claims
- Processing of individual claims
    - **Steps for Processing Prescription Drug Claims**
        1. Verify claim requirements.
        2. Compute reimbursement amount to the county.
        3. Apply state payment procedures.
        4. Send reimbursement notification to the county.
        5. Comptroller reimburses the county.
    - **Steps for Processing Medical Claims**
        1. Verify claim requirements.
        2. Enter claim information and submit to claims contractor.
        3. Claim contractor submits to HHSC a Remittance and Status (R & S) Report, indicating payment status.
        4. Reconcile claims.
        5. Apply state payment procedures.
        6. Send reimbursement notification letter to the county. When all of the claims in the case have been reconciled, the word “Complete” will be on the letter.
        7. Comptroller reimburses the county.

TABLES

PLACE OF SERVICE CODES
(Block 24B on CMS-1500)

1-Digit Numeric Codes (for Paper Billers)	Place of Service	2-Digit Numeric Codes (for Electronic Billers)
1	Office	11, 15, 50, 60, 65, 71,72
2	Home	12
3	Hospital, Inpatient	21, 51, 52, 55, 56, 61
4	Skilled Nursing Facility (SNF) Intermediate Care Facility (ICF) Intermediate Care Facility for Mentally Retarded (ICF-MR)	31,32,54
5	Hospital, Outpatient	22, 23, 24, 62
6	Independent Lab	81
7	Birthing Center	25
8	Extended Care Facility	33
9	Other Location	03,04,05,06, 07,08,26,34,41,42, 53, 99
Indicate destination using above codes	Destination of Ambulance	Indicate destination using above codes

Type of Bill Codes

Most-Commonly Used
(Block 4 on the UB-04)

111 – Inpatient Hospital

131 – Outpatient Hospital

141 – Non-patient (laboratory or radiology charges)

731 – Federally Qualified Health Center (FQHC)

Claim Forms to Use

(Depending on Service Provided)

CMS-1500	UB-04
Advanced Practice Nurse	Ambulatory Surgical Center, Hospital-based
Ambulatory Surgical Center, Freestanding	Federally Qualified Health Center (FQHC)
Anesthetist	Hospital, Inpatient
Certified Nurse Midwife (CNM)	Hospital, Outpatient
Certified Registered Nurse Anesthetist (CRNA)	
Counseling (LCSW, LMFT, LPC, or Ph.D.)	
Durable Medical Equipment (DME)	
Federally Qualified Health Center (FQHC)	
Independent Laboratory	
Physician	

HELPFUL HINTS

Acronyms

AIS	–	Automated Inquiry System
CIHCP	–	County Indigent Health Care Program
CMS	–	Centers for Medicaid & Medicare Services (previously HCFA)
CPT	–	Current Procedural Terminology
DRG	–	Diagnosis-Related Group
EOB	–	Explanation of Benefits
HCFA	–	Health Care Financing Administration (renamed CMS July 1, 2001)
HCPCS	–	Healthcare Common Procedure Coding System
ICD-10-CM	–	International Classification of Diseases, Tenth Revision, Clinical Modification
NPI	–	National Provider Identifier
R & S	–	Remittance and Status
SSI	–	Supplemental Security Income
TMHP	–	Texas Medicaid & Healthcare Partnership
UPIN	–	Unique Physician Identification Number (for CMS) – Universal Provider Identification Number (for Texas Medicaid)

Processing Tips

- Since many of the CIHCP recipients later become Medicaid eligible, it is important that each CMS- 1500 and UB-04 submitted has the correct Medicaid codes.
  - To ensure this, ask each provider to bill the county as if the provider were billing Medicaid
  - **manually**, i. e., paper billing.
- Common reasons for non-entry of claims
  - Incomplete claim
  - Incomplete NPI. The NPI must have 10 digits. Check with the provider for their correct Medicaid billing number if you are unsure.

Calculations

Outpatient Hospital Claim

1. Multiply each entry in Block 47 by the percent rate. Write the result in Block 48.
2. Divide the amount by the number of service units. Write the result in Block 46.

Inpatient Hospital Claim Paid by Percent

1. Multiply each entry in Block 47 by the percent rate. Write the result in Block 48.
2. Divide this amount by the number of service units. Write the result in Block 46.

Inpatient Hospital Claim Paid by DRG

1. Divide the DRG amount by the total billed amount to come up with a percent.
2. Multiply each entry in Block 47 by the percent from Step 1. Write the result in Block 48.
3. Divide this amount by the number of service units. Write the result in Block 46.

INTERNAL SSI MEDICAID AUDIT

- CIHCP will be conducting random quarterly internal audits of cases submitted by counties for SSI Medicaid Reimbursement.

- All counties submitting claims for SSI/Medicaid reimbursement will be reviewed at least once per fiscal year.

- Claims will be audited for correct payment methodologies and Medicaid reimbursement procedures outlined in this manual.
- Counties are responsible for all repayments identified through the audit.

- Failure to comply with HHSC audit procedures may result in HHSC' inability to file claim reimbursement for the county.

- Counties with high percentage errors identified through the internal audit will be required to fulfill additional requirements prior to claims processing. Requirements are listed below:

    - Level 1 – The county will be required to submit payment formulas for all claims in the next three cases submitted to HHSC for reimbursement. HHSC-CIHCG will review the payment formulas for errors.

    - Level 2 – The county will be required to re-calculate all payments submitted to and paid by CIHCG for the prior two quarters and refund any overpayments to the appropriate entity.

    - Level 3 – The county will be disqualified from the SSI/Medicaid Reimbursement process for six months.

FORMS

The following forms must be used in processing claims through HHSC for SSI Medicaid reimbursement.

- Form 112, SSI Appellant Notification
- Form 113, Appellant/Provider Assignment
- Form 114, Confidentiality Agreement
- Form 115, Claim Payment Verification

The Instructions to each of the above listed forms must be followed.