CLAIMS IN-SERVICE:

Offered by Cigna Health and Life Insurance Company or its affiliates

Together, all the way.®

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H8423_MCDTX_18_71528_PR Approved

Claims Filing Support & Instructions

Today's Goals:

- Familiarize ourselves with the CMS 1500 and UB04 claim forms
- Submit corrected claims
- Submit claims appeals electronically
- Build confidence in our ability to complete the forms accurately
- Electronic Funds Transfer (EFT)
- Electronic Remittance Advice (ERA)
- Claims for Electronic Visit Verification (EVV)
- Payment Dispute Form
- Who to contact for assistance if needed

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Interacting with Cigna-HealthSpring STAR+PLUS

Claims

Claims Filing Deadline

- Cigna-HealthSpring's STAR+PLUS claim filing deadline is the same as traditional, fee-for-service Medicaid. Providers must submit claims to Cigna-HealthSpring STAR+PLUS within ninety-five (95) days from the date the covered service was rendered. If the claim is not filed with Cigna-HealthSpring STAR+PLUS within ninety-five (95) days from the date of service, the claim will be denied. The required data elements for Medicaid claims must be present for a claim to be considered a **clean claim** and can be found in the Section 8 "Managed Care" of the TMPPM.

- Cigna-HealthSpring STAR+PLUS is required to process **clean claims** within 30 days of receipt.

- **Providers should not collect payment from or bill Cigna-HealthSpring STAR+PLUS Members for any covered services. Do not balance-bill the patient.**

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Claims

Claim Filing Formats

- Cigna-HealthSpring STAR+PLUS accepts claims in both hard copy and electronic formats. Acceptable hard copy claim formats are either the CMS 1500 or UB04 claim forms.
- Electronic claims are the preferred method of submission.
- Home Health providers billing acute skilled nursing services should bill on a UB04.
- LTSS providers billing PAS, DAHS, Respite Care, Adult Foster Care, ALF, Home Delivered Meals, ERS, or Home Modifications should bill on a CMS 1500.
- Providers should refrain from submitting hand-written claims as they cannot be read by Optical Character Recognition (OCR).

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Claims

4 ways to file a claim with Cigna-HealthSpring STAR+PLUS:

1. **Electronically** – (Payer ID# 52192) – via 1 of the following 3 Cigna-HealthSpring claims clearinghouses: (1) Emdeon, (2) PayerPath, or (3) Availity.

2. **Via secure Provider Portal -** Submit CMS 1500 and UB04 as batch or individual claims. Administered by Change Healthcare for claims submissions.

3. **Via Mail** paper claims. (See next slide for address)

4. **Via the TMHP.com** provider website.

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Claims

Type of Service	Claims Address
Acute care and LTSS services (including inpatient acute care services)	Cigna-HealthSpring P.O. Box 981709 – STAR+PLUS El Paso, TX 79998-1709
Behavioral health services (including inpatient behavioral health services)	Cigna-HealthSpring P.O. Box 981709 – STAR+PLUS El Paso, TX 79998-1709
Dental services Electronic Claims: Emdeon/Availity Payer ID: CX014	DentaQuest-Claims 12121 North Corporate Parkway Mequon, WI 53092
Vision services **www.superiorvisiononline.com** 1-866-819-4298	Superior Vision 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090

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Interacting with Cigna-HealthSpring STAR+PLUS

Claims

Electronic Funds Transfer (EFT)

Cigna-HealthSpring STAR+PLUS contracts with Emdeon to deliver electronic funds transfer services. If you are an existing EFT customer with Emdeon and wish to add Cigna-HealthSpring to your service, please call 1-866-506-2830, and select Option 1 to speak with an Emdeon Enrollment Representative, mention Payer ID 52192.

- There is **no cost** for providers to enroll in EFT.
- If you would like to learn more or sign up for EFT, please visit Emdeon's ePayment Web site at www.emdeonepayment.com.

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Interacting with Cigna-HealthSpring STAR+PLUS

Claims

Electronic Remittance Advice (ERA)

Providers who are able to automatically post 835 remittance data will save posting time and eliminate keying errors by taking advantage of 835 ERA file service.

ERA Enrollment Process

- Download Emdeon Provider ERA Enrollment Form at the following location: http://www.emdeon.com/resourcepdfs/ERAPSF.pdf
- Complete and submit ERA Enrollment Form via Email or Fax to Emdeon ERA Group:
  - Email: batchenrollment@emdeon.com
  - Fax: 1-615-885-3713
- Any questions related to ERA Enrollment or the ERA process in general, please call Emdeon ePayment Solutions at 1-866-506-2830 for assistance.
- NOTE: ERA enrollment for all Cigna-HealthSpring STAR+PLUS health plans must be enrolled under Cigna-HealthSpring Payer ID “52192”.

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Electronic Visit Verification (EVV)

Claims for EVV

EVV is the electronic verification and documentation of visit data, such as the date and time the provider begins and ends the delivery of services, the attendant, the recipient, and the location of services provided
Providers that need to use EVV are:

- Personal assistance services
- Personal care services
- PAS Protective Supervision
- In-home respite services
- Community First Choice - Personal assistance services and habilitation

- EVV services are at no cost to the provider.

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Which Vendor will provide EVV services?

- DataLogic (Vesta)
- All HHSC approved EVV vendors are directly contracted with Cigna-HealthSpring (CHS) STAR+PLUS.

  - EVV vendors and CHS should be notified of any system issues that last longer than 48 hours.
  - EVV vendors and CHS should be contacted immediately (within 48 hours) of any EVV system issues that affect the ability of your attendant's or office staff to use the system as expected.

DataLogic(Vesta) Software, Inc.

Phone: 1-844-880-2400

Fax: 1-956-412-1464

www.vestaevv.com

Refer to our website for the complete EVV presentation at: https://www.cigna.com/starplus/health-care-professionals/updates-and-education/provider-education/.

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Interacting with Cigna-HealthSpring STAR+PLUS

Claims

Claim Status and Resolution of Claims Issues

Provider Services can assist providers with questions concerning eligibility, benefits, claims and claims status.

- Call Provider Services Department at **1-877-653-0331**.
- Access via the HSConnect Provider Portal under the tab Claim Search.

Interacting with Cigna-HealthSpring STAR+PLUS

Appeals & Complaints

3 ways a Provider may appeal a previously processed claim:

1. Fax the request to Cigna-HealthSpring STAR+PLUS at 1-877-809-0783.

2. Via HSConnect provider portal. *See slide 38.*

3. Mail the request to:

   Cigna-HealthSpring STAR+PLUS
   Appeals and Complaints Department
   PO Box 211088
   Bedford, TX 76095

- Requests for reconsideration must be made within 120 days from the date of remittance of the Explanation of Payment (EOP).

- Acknowledgement letter sent within 5 business days of receipt; appeal resolved within thirty (30) calendar days.

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Interacting with Cigna-HealthSpring STAR+PLUS

Appeals & Complaints

The Difference Between a Corrected Claim and an Appeal

- **Claim Appeal** – An appealed claim is a claim that has been previously adjudicated as a Clean Claim and the provider is appealing the disposition through written notification to the Managed Care Organization. e.g., discrepancy with the amount paid to a provider; a written notification appealing the disposition on a previously adjudicated clean claim is required.

- **Corrected claim** – A corrected claim is a claim that has already been adjudicated, whether paid or denied. A provider would submit a corrected claim if the original claim adjudicated needs to be changed. e.g., provider billed with an incorrect date of service/incorrect number of units
  - Corrected claims can be resubmitted via paper, by entering a “7” for the Resubmission code, and the original claim number as your Original Reference No on box 22 of the CMS 1500 form. The original claim number can be found on the original EOP.
  - Using the Cigna-HealthSpring claims portal, please see slide 33 thru 35.
  - Corrected claims are considered claims reconsiderations and are not considered claims appeals.

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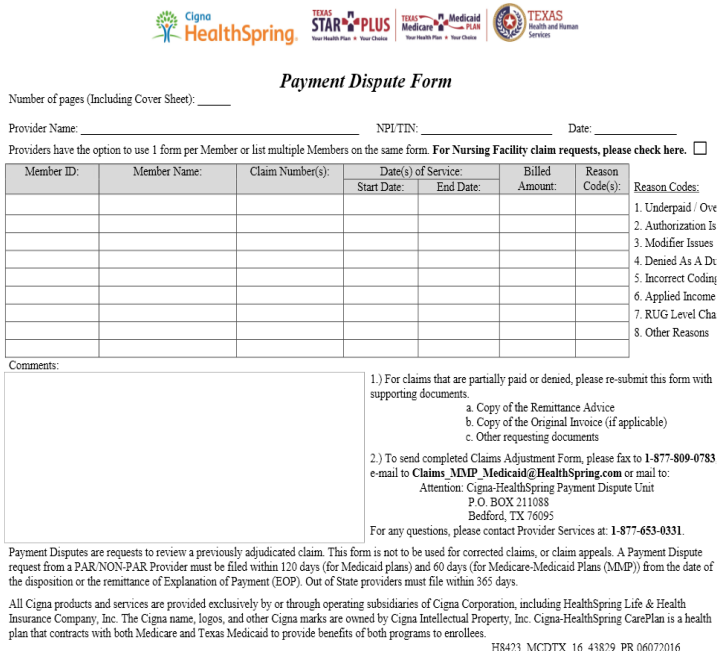
Interacting with Cigna-HealthSpring STAR+PLUS

Payment Disputes

A payment dispute is a written communication (i.e. a letter) from the Provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.

Examples of when to use the payment dispute form: (this is not a complete list)

- Denial for "timely filing", but provider has proof of timely
- Denial for "no authorization on file", but provider has authorization listed
- Denial for "benefit not covered", but per TMHP it is payable
- Denial for "no coverage", but member was active during the Date of Service (DOS)
- Provider not being paid at correct reimbursement rate, paid incorrectly
- Denial for incorrect modifier, CPT code, National Drug Code (NDC) number, NPI/TIN/TPI, Place of Service (POS), Date of Service (DOS), Type of Bill (TOB), Diagnosis (DX) code, etc. and denied incorrectly
- Denial for "no active provider contract" and provider does have an active contract listed
- Denial for insufficient units, per authorization on file there's units available, or there's no units available due to error on our end
- Denial for "bundled services", per NCCI (National Correct Coding Initiative) edits they should not be bundled
- Denial for incorrect payment



Payment Dispute Form

Number of pages (Including Cover Sheet): _____

Provider Name: _____ NPI/TIN: _____ Date: _____

Providers have the option to use 1 form per Member or list multiple Members on the same form. **For Nursing Facility claim requests, please check here.** ☐

	Member ID:	Member Name:	Claim Number(s):	Date(s) of Service: Start Date:	Date(s) of Service: End Date:	Billed Amount:	Reason Code(s):
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

Reason Codes:
1. Underpaid / Ove
2. Authorization Is
3. Modifier Issues
4. Denied As A Dc
5. Incorrect Coding
6. Applied Income
7. RUG Level Cha
8. Other Reasons

Comments:

1.) For claims that are partially paid or denied, please re-submit this form with supporting documents.
a. Copy of the Remittance Advice
b. Copy of the Original Invoice (if applicable)
c. Other requesting documents

2.) To send completed Claims Adjustment Form, please fax to **1-877-809-0783**, e-mail to **Claims_MMP_Medicaid@HealthSpring.com** or mail to:
Attention: Cigna-HealthSpring Payment Dispute Unit
P.O. BOX 211088
Bedford, TX 76095

For any questions, please contact Provider Services at: **1-877-653-0331**.

Payment Disputes are requests to review a previously adjudicated claim. This form is not to be used for corrected claims, or claim appeals. A Payment Dispute request from a PAR/NON-PAR Provider must be filed within 120 days (for Medicaid plans) and 60 days (for Medicare-Medicaid Plans (MMP)) from the date of the disposition or the remittance of Explanation of Payment (EOP). Out of State providers must file within 365 days.

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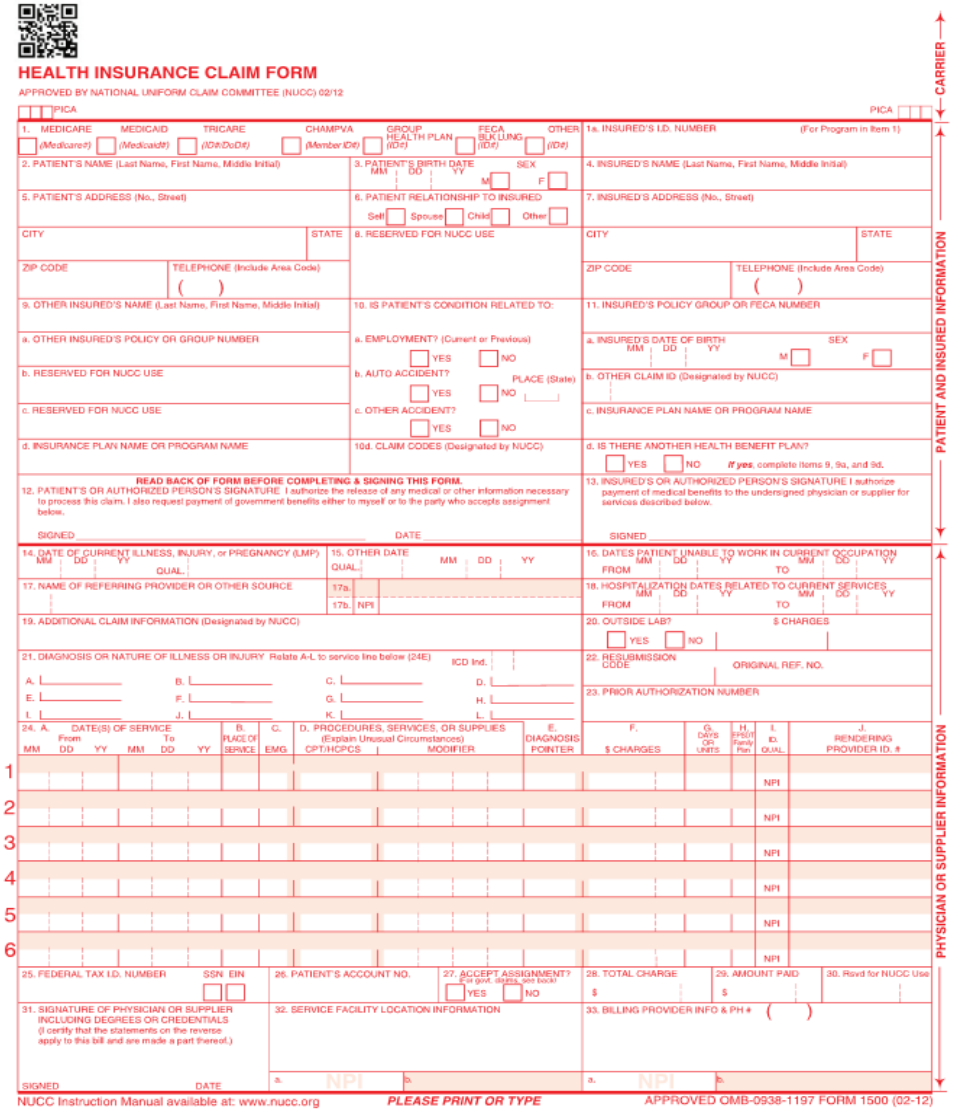
H8423_MCDTX_16_43829_PR 06072016

The Payment Dispute From can be found on our website: http://starplus.cignahealthspring.com.

CMS 1500 Overview



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

How to Complete a CMS 1500 Form

- The following slides list the minimum data required to process a claim on a CMS 1500 form.
- Providers can view a sample CMS 1500 form in the appendices of the provider manual. However, photocopies of the form should not be used to file claims with Cigna-HealthSpring STAR+PLUS.

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Patient Information

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX M F			4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Field 1 – Place a check mark or “X” in the MEDICAID Field.
Field 1a – Enter the patient's ID Number found on the patient’s Cigna-HealthSpring of Texas STAR+PLUS Identification card or the patient’s Texas Medicaid ID#.
Field 2 - Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Cigna-HealthSpring of Texas STAR+PLUS Identification Card.
Field 3 - Enter the patient's 6-digit (MM | DD | YYYY) or 8-digit (MM | DD | CCYY) and gender.
Field 4 – Leave blank.

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Patient Information (cont.)

5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)	
CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )		ZIP CODE	TELEPHONE (Include Area Code) ( )

FORMATION

Field 5 - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Field 6 – For Medicaid recipients, “Self” is always the Patient Relationship to Insured.

Field 7 – Leave blank.

Field 8- Not required. If known, please check the appropriate box to reflect the patient’s marital and work status.

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Patient Information (cont.)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFO

Field 9 – These fields are completed when the patient has other healthcare insurance, like Medicare. Otherwise, these lines can be left blank.

Field 10a through 10c - Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Any item checked "YES" indicates there may be other insurance primary to Medicaid. Identify other insurance information in item 11.

Field 11 – If another insurance resource has made payment or denied a claim, enter the name of the insurance company.

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Patient Information (cont.)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFO

Field 11a-b - The other insurance EOB or denial letter must be attached to the claim form.

Company paid $(Amount) on (Date). If the client is enrolled in Medicare, attach a copy of the MRAN to the claim form.

For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer. If another insurance resource has made payment, write (Name) Insurance Company paid $(Amount) on (Date).

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Patient Information (cont.)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 05/01/2011

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

SIGNED

Field 12 - Enter “Signature on File,” “SOF,” or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY).
NOTE: This can be "Signature on File" and/or a computer generated signature.
Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.
Field 13 - Leave blank.

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Diagnosis, Procedures & Charges

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE 7 ORIGINAL REF. NO. 12345E123456
23. PRIOR AUTHORIZATION NUMBER

Field 14, 15, 16 –Enter the first date (MM/DD/YY) of the present illness or injury. For pregnancy, enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.

Field 17 – Enter the complete name (block 17) and the NPI/API (block17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider. Enter the Texas provider identifier (TPI), which is nine digits, of the referring/ordering provider.

Field 21 - Enter the ICD-9-CM code to the highest level of specificity available, complete to five digits for each diagnosis. Enter up to four diagnoses in priority order.

Field 22 & 23 - Leave blank. Unless submitting a corrected claim, please enter 7 as the Resubmission Code, followed by the Original Claim Number in the Original Reference Number.

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Diagnosis, Procedures & Charges (cont.)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	29	11	05	01	11	12		S5125	U3	99	99	US	1	44	00	4		1D NPI	888888888 123456789
2	05	02	11	05	06	11	12		S5125	U3	99	99	US	1	220	00	20		NPI	888888888 123456789
3																			NPI	
4																			NPI	
5																			NPI	
6																			NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Field 24 - Unless otherwise specified, all required information should be entered in the unshaded portion. If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim.

Field 24a – In the **unshaded area**, enter the DOS for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given on a separate line.

Field 24a - In the **shaded area**, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231

Field 24b - Enter the appropriate place of service code(s) .

Field 24c – Enter the appropriate condition indicator for THSteps medical checkups.

Refer to: Subsection 5.3. "THSteps Medical Checkups" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks).* Block No. Description Guidelines

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Diagnosis, Procedures & Charges (cont.)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									S5125	U3	99	99	US	1				NPI	
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Field 24d - In the **unshaded** area, enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description.

Field 24d - In the **shaded** area, **NDC Optional:** In the **shaded** area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.

Field 24e - Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21 for each procedure.

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Diagnosis, Procedures & Charges (cont.)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1												44 00	4		1D NPI	888888888 123456789
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Field 24f- Enter your charge for each listed service.

Field 24g - Enter the number of days or units. If only one service is performed, the numeral 1 must be entered. If multiple identical services are performed on the same day, enter the number of units. For example, code S5125 "Attendant Care Services, 1 unit = 1 hour, would be billed as (4) units in block 24g if you provided 4 hours of services on a single day of service.

Field 24h - Leave blank.

Field 24i - Enter the ID qualifier "**1D**" in the **shaded** portion to indicate that the provider's Medicaid ID number (TPI) is being reported in the shaded portion of Field 24j or enter the qualifier "**U3**" to indicate that the provider's LTSS number is being reported in the shaded portion of Field 24j.

Field 24j - Enter the rendering provider's TPI or LTSS number in the **shaded** portion. In the lower **unshaded** portion, enter the rendering provider's NPI or API number, if available. (**Note**: FQHC/RHC provider billing for encounter services are to omit this section.)

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Provider Information

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
898989898		X	123123123	X YES NO	$ 264 00	$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED	DATE		a. NPI	b.	a. NPI	b.	

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

Field 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number [EIN] or Social Security Number [SSN]) and check the appropriate Field.

Field 26 – Optional: Enter the patient's account number assigned by the provider's of service or supplier's accounting system.

Field 27 – All providers of Texas Medicaid Program services must accept assignment to receive payment. Providers must check “yes”.

Field 28 - Enter the total charges. For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note: Indicate the page number of the attachment*** *(for example, page 2 of 3) in the top right-hand corner of the form.*

Field 29 – Enter the total amount other insurance paid on the covered services, if applicable. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.

Field 30 – Leave this box blank.

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Provider Information (cont.)

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION Texas Agency 234 1st Ave Fort Worth, TX 76101	33. BILLING PROVIDER INFO & PH # (555) 555-6666 Texas Agency 234 1st Ave Fort Worth, TX 76101			
	a. NPI b.	a. 123456789 b. 888888888			

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

Field 31 -The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to: Subsection 6.4.2.1, "Provider Signature on Claims."***

Field 32 – If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP code of the facility where the service was provided.

Field 32a - Enter NPI of the service facility location.

Field 33 - Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number.

Field 33a - Enter the NPI or API of the billing provider or group, if applicable.

Field 33b – Enter the billing provider's TPI or LTSS number.

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Place of Service Codes – (Not a Complete List)

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

POS Code	POS Name	POS Description
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (for example, medication administration).

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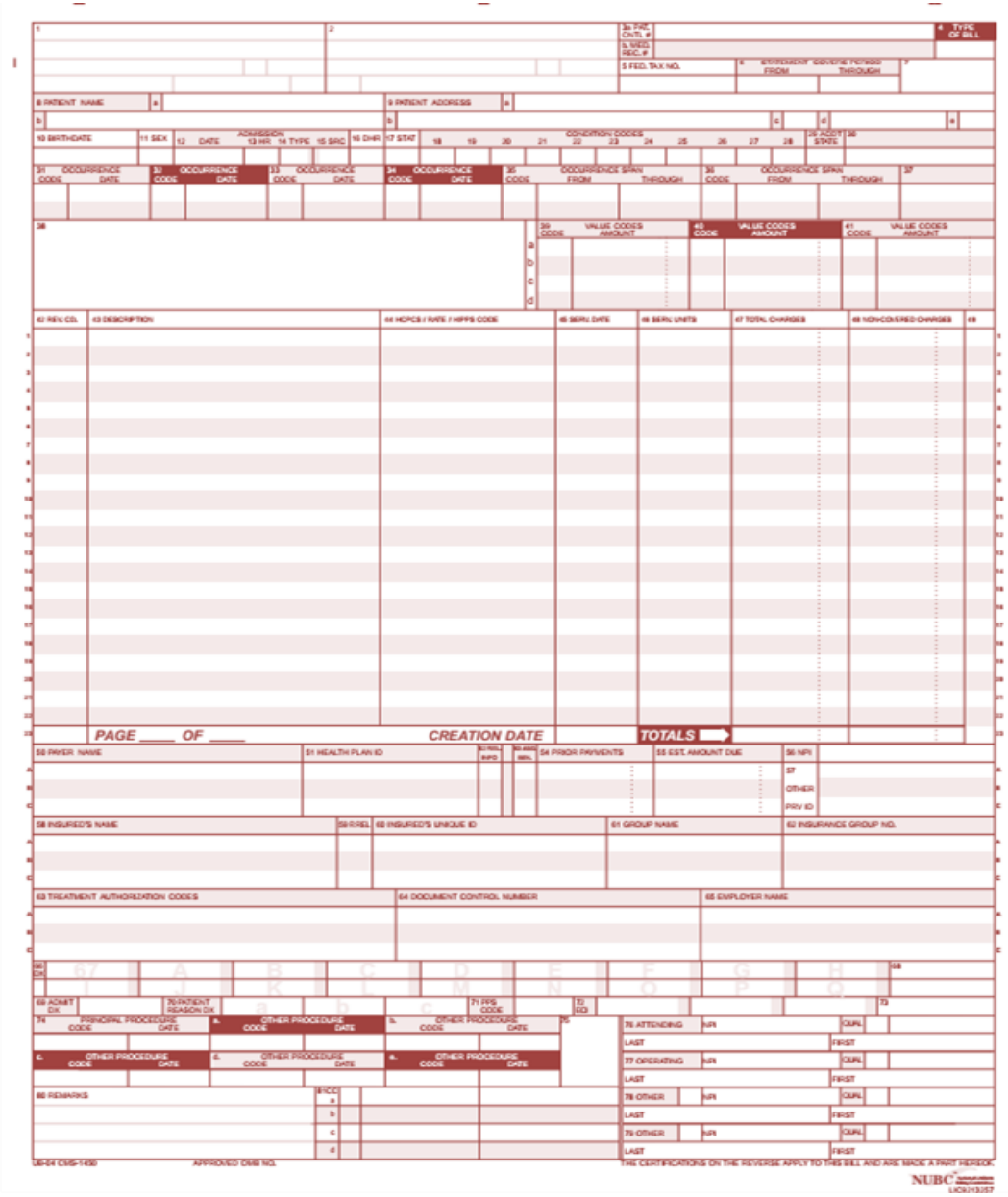
UB04 Overview



How to Complete a CMS UB04 Form

- The following slides list the minimum data required to process a claim on a CMS UB04 form.
- Providers can view a sample CMS UB04 form in the provider manual. However, photocopies of the form should not be used to file claims with Cigna-HealthSpring STAR+PLUS.

Provider Information and Patient Information

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a		9 PATIENT ADDRESS	a	
b			b		c d e

Field 1 - Enter the billing facility name, street, city, state, ZIP+4 Code, and telephone number.
Field 2 – Enter the location of the services rendered. Fill in the hospital/facility name, street, city, state, ZIP+4 Code, and telephone number.
Field 3a – Optional: Enter the patient's account number assigned by the provider's of service or supplier's accounting system.
Field 4 – Enter the Type of Bill Code.
Field 5 – Enter the Facility Tax ID.
Field 6 – Enter the beginning and ending dates of service billed.
Field 8a - Optional: Enter the patient identification number if it is different than the subscriber/insured's identification number.
Field 8b - Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification card.
Field 9a to 9b - Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).

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Diagnosis, Procedures & Charges

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

Field 10 - Enter the patient's date of birth (MM/DD/YYYY).
Field 11 - Indicate the patient's gender by entering an "M" or "F."
Field 12 - Enter the numerical date (MM/DD/YYYY) date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims.
Field 14 - Enter the appropriate type of admission code for inpatient claims.
Field 15 – Enter the appropriate source of admission code for inpatient claims.
Field 38 – Enter the Cigna-HealthSpring STAR+PLUS claims billing address.

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Diagnosis, Procedures & Charges (cont.)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	PAGE ___ OF ___	CREATION DATE		TOTALS			

Field 42 – Enter the Revenue codes. NDC Code: – Enter N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. Check the crosswalk if it applies.
Example: N400409231231GR0.025

Field 43 - Enter the Revenue Description.

Field 44 – Enter the HCPCS codes. **Home Health Services**: Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. **Outpatient**: Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.

Field 45 - Enter the Dates of Services (DOS).

Field 46 – Enter the amount of Service Units.

Field 47 – Enter the total amount of charges.

Field Page of Page - Enter the number of claims pages. Example: Page 2 of 3 (total pages).

Field Creation Date – Enter the date you created the claim.

Field Totals - Enter the total charges.

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Diagnosis, Procedures & Charges (cont.)

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
						57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

Field 50 – Enter the health plan name, Cigna-HealthSpring STAR+PLUS.
Field 51 – Enter the health plan identification number.
Field 54 – Enter the amount of prior payments made by a Third Party Resources (TPR) . Also complete Blocks 32, 61, 62, and 80 as required.
Field 56 – Enter the NPI of the billing provider.
Field 57 – Enter the TPI number (non-NPI number) of the billing provider.
Field 63 – Enter the Cigna-HealthSpring STAR+PLUS Authorization ID number.
Field 66 – Enter the primary diagnosis code as listed on the Cigna-HealthSpring STAR+PLUS Authorization.
Field 66a – 67q - Enter the secondary diagnosis code as listed on the Cigna-HealthSpring STAR+PLUS Authorization.

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Diagnosis, Procedures & Charges (cont.)

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

Field 76 – Enter the primary attending provider name and identifiers. Use the NPI number of the attending provider.

Field 77 - 79 – Enter the additional attending provider name and identifiers.

Field 80 – Enter any remarks that pertains to the claims. For example: “Signature on File”, “Corrected Claim

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Additional UB04 Billing Resources – (Not a Complete List)

http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

For additional assistance with codes and informational fields, refer to the THMP Manual.

For use with the following fields:

- Field 4 – Type of Bill
- Field 14 – Type of admission
- Field 15 – Source of admission
- Field 42-43 – Revenue codes and description
- Field 80 – Remarks

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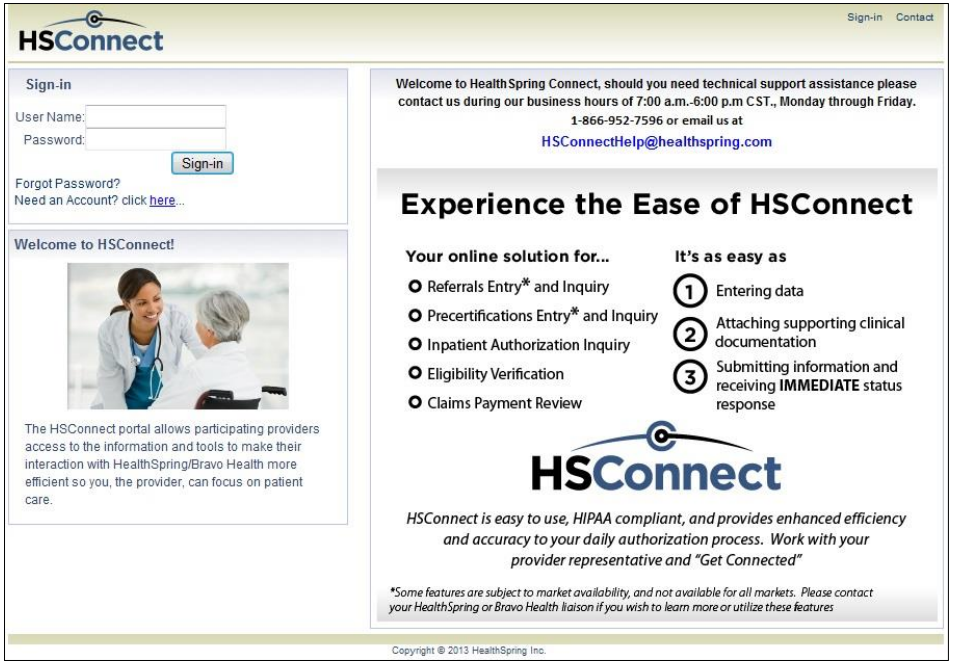
Cigna-HealthSpring CarePlan Secure Provider Portal



Providers can seek assistance with the Provider Portal by calling 1-866-952-7596.

- Cigna-HealthSpring's STAR+PLUS secure **Provider Portal** is available to participating providers only.
- Providers must have a user ID & password to access the Provider Portal. New Providers must register a User ID & Password online when accessing the Provider Portal.
- The Provider Portal allows 24-hour access and is an interactive site where participating Providers are allowed to:
  - Verify Member eligibility and PCP on file
  - Check claim status
  - Request authorizations
  - Check authorization status
  - Displays Member's Service Coordinator
  - MESAVE information for Nursing Facilities (RUG/AI)
  - MESAVE information for Member recertification date

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Cigna-HealthSpring CarePlan Secure Provider Portal

- Cigna-HealthSpring STAR+PLUS claims portal, administered by Emdeon.
- Providers must have a user ID & password to access the Claims Provider Portal
- Access the Claims portal via HSConnect by selecting the **New Claim tab**.
- Slides with portal images are for Cigna-HealthSpring STAR+PLUS provider portal only.
- Registrant must confirm their email in order to view claims under Reporting & Analytics.
- The Provider Portal allows 24-hour access and is an interactive site where participating Providers are allowed to:

  - Submit claims individually or by batch for CMS 1500 or UB04
  - Check claim status individually or by batch
  - Correct claims electronically
  - Access ERA's and electronic EOP's
  - Review Reports and Analytics
  - Submit electronic appeals

Submit Corrected Claims Electronically

Claims List - Claims List allows you to view, edit, submit and manage claims. Before using Claim List for the first time, you must have completed and saved the claim. Any claim can be edited and saved as a new claim, which helps to avoid re-keying the same information for multiple claims per patient. *Only available for CMS 1500 claims format*.

- From the *Claims tab*, select *Claims List*
- Search for your previously keyed claim in the *Search Text* field
- Once you have selected the claim that you want to correct, select *Edit*, the previously keyed claim will open and you are able to change the information within the claim template.

Note: Only available for CMS 1500 claims format.

Submit Corrected Claims Electronically (cont.)

Step 9 - Other Information

Date First Consulted

Initial Treatment Date

Date Last Seen

Assumed Care Date

Relinquished Care Date

Hospital Service Dates To

Referring Provider NPI

Referring Provider #

Referring Provider TaxID Type

-- Select --

Referring Physician Last Name

First Name

M.I.

Referring Provider State

--Select--

Referral Number

Workers Condition Code

-- Select --

Delay Reason Code

Demonstration Project Identifier

Service Authorization Exceptio

Resubmission Code

Resubmission Reference Number

Attachment Information

Remarks

CRTQ*E

Route Claim for Supplemental Data

Save | Save as New Claim

- When corrections are made, scroll to the bottom of the page, and enter the number **"7"** at the **Resubmission Code** field to indicate it's a corrected claim.
- Enter original claim number from which you are correcting at the **Resubmission Reference Number** field – the claim number must be exact.
- Do not remove existing text from the *"Remarks"* field.
- Click **Save as New Claim**.
- Your claim is now updated with your corrections.
- Return to the **Claims List** to retrieve the corrected claim from the **Claims List**
- Select the new claim from the "Claims List", click **Submit Selected**

Note: Only available for CMS 1500 claims format.

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Submit Electronic Appeal

Step 5 - Claim Line Information

* Charges	EPSDT	
000.00	--Select--	Comment...

Narrative Information

Comment(Maximum allowed characters is 281)

NAR* appealing claim for timely filing. name, ph#. ,RSN*12345E12345678

Save

Step 9 - Other Information

Date First Consulted

Hospital Service Dates To

Date Last Seen

Assumed Care Date

Relinquished Care Date

Referring Provider NPI

Referring Provider #

Referring Provider TaxID Type -- Select --

Referring Physician Last Name

First Name

M.I.

Referring Provider State --Select--

Referral Number U0012537

Workers Condition Code 1st Level appeal (request with insurance carrier)

Remarks

CRNNPI*9999999995,CRTQ*E,BLGNPI*9999999995,WCC*BGW3,RFNO*U0012537

Save | Save as New Claim | Cancel

- Retrieve the claim you want to appeal from the "Claims List"
- Once you selected the claim, choose "Edit" (the original claim will open)
- At Step 5 - select the "Comment" box, which will allow you to write the reason for appeal.
- At Step 9 - Other information → Workers Condition Code, select the option 1st Level appeal (request with insurance carrier). will appear in the drop-down box.
- The remarks will show a *BGW3 indicating it's an appealed request.
- Save claim as new and return back to the "Claims List".
- Retrieve claim and "Submit".

Note: Only available for CMS 1500 claims format.

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Claims Filing Tips

- If two identical claims are received for the same service on the same date for the same Member, one of the claims will be denied as an 'exact' duplicate; unless noted as a corrected claim (resubmission code 7 on line 22 of a 1500 form).
- If there is a break in service, do not bill for the days that you did not provide services to the patient. Enter the start date on the next line for services that resumed upon the patients return.
- If you previously filed a claim with us and were reimbursed for those services, do not file a separate claim for the entire month, which includes the same dates of service previously processed. Your claim will be denied as a duplicate.
  Example: Provider billed and was reimbursed for dates of service 10/1/16 – 10/5/16. A separate claim billed for dates of service 10/1/16 – 10/30/16.
- Providers who bill multiple units of the same procedure code should use the unit column on the CMS 1500 form. Exception those providers submitting claims using EVV will have to bill each date on a separate line, such as PAS.
- Providers billing as a group must list the:
  - Rendering provider's NPI in the unshaded portion of box 24j;
  - Rendering provider's TPI in the shaded portion of box 24j;
  - Service location address in box 32
  - Group provider's NPI in box 33a; and
  - Group's TPI in box 33b.
  - Individual providers who are part of a group should bill with their individual NPI in box 24j and the group's NPI in box 33a.

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Claims Filing Tips (cont.)

- Personal attendant services can be billed with partial or full units.
- Claims should be submitted for one Member and one provider per claim form.
- AT modifier should be billed on PT/OT/ST claims for members over age 21.
- ER/Transportation providers should use the ET modifier on their claims.
- Check NDC list and verify requirements and utilize the Nordian crosswalk link on the THMP website for valid combinations.
- Billing with a UE (used equipment) modifier for DME services will result in a claims denial.
- When using diagnosis codes, please ensure that they are valid.
- Verify that a value is entered in the units area, 24G, of the claim form.
- Claim information must match the authorization provided by Cigna-HealthSpring STAR+PLUS.
- CMS 1500 claims must be billed with a valid place of services identifier.
- Any missing or invalid data will result in a claim denial.

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Claims Filing Tips (cont.)

- Only submit claims with a single date-of-service per detail
- Only submit claims with a matching EVV transaction
- CHS will deny claims submitted using a claim line item with a span date, or a claim line item without a matching EVV transaction for the specified date of service
- CHS will conduct only prospective (pre-payment) reviews, and will no longer pay any incorrect or unmatched claims
- Insulin dependent vs. non-insulin dependent:
  - Code A4253 U9 modifier = two units
  - Code A4253 = one unit

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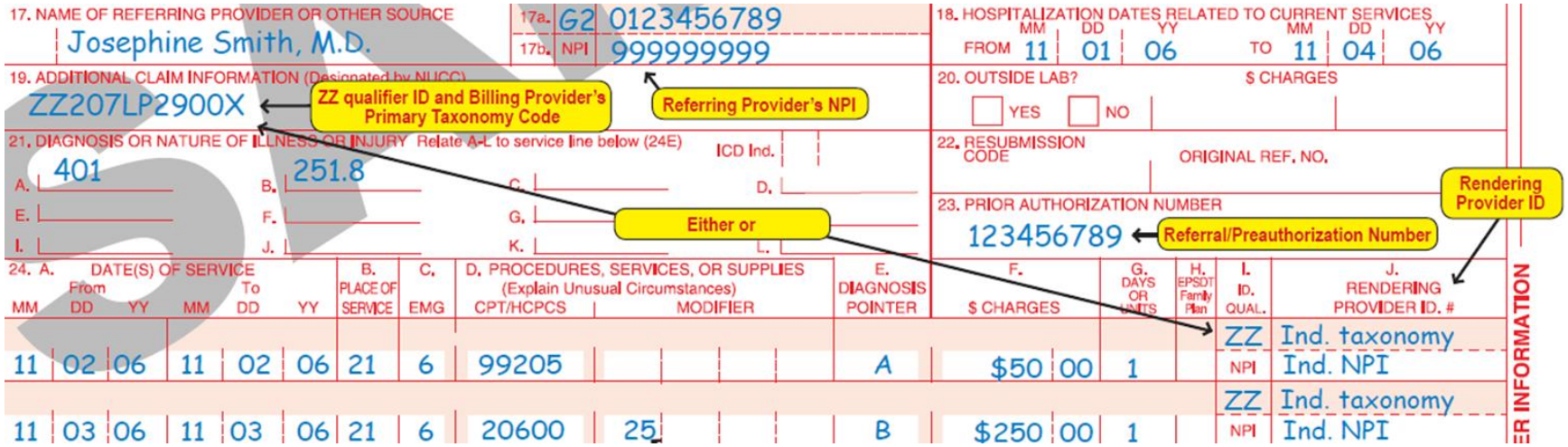
Claims Filing Tips (cont.)

Ordering, Referring, Prescribing Providers (ORP)

- Effective October 1, 2018
- NPI is required of the ordering and referring provider's submitted claims
- Claims will be denied if the NPI is missing or invalid and if the provider is not appropriately enrolled



Texas Medicaid Provider Procedures Manual
http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

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INTERACTING WITH CIGNA-HEALTHSPRING STAR+PLUS

Cigna-HealthSpring STAR+PLUS Example ID Card Below

STAR+PLUS MEDICAID ONLY 2018

Cigna HealthSpring. | TEXAS Health and Human Services | TEXAS STAR+PLUS | OPTUMRx®

Issuer/Emisor 80840
Member ID/N.º de identificación del miembro: <ID Number>
Name/Nombre: <Name>
PCP Name/Nombre del PCP: <PCP Name>
PCP Phone/Teléfono del PCP: <PCP Phone number>
PCP Effective Date/Fecha de vigencia del PCP: <Date>
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de las 24 horas o tan pronto como sea posible.

Member Services/Departamento de Servicios a los Miembros: <1-877-653-0327>
Hearing Impaired/Personas con problemas auditivos: <7-1-1>
Service Coordination/Coordinación de servicios: <1-877-725-2688>
Behavioral Health and Substance Abuse/Servicios de salud mental y abuso de sustancias: <1-877-725-2539>
Available 24 hours a day, 7 days a week
Disponible las 24 horas del día, los 7 días de la semana

For Prior Authorization/Para autorización previa: <1-877-562-4402>

Cigna-HealthSpring STAR+PLUS Claims:
<P.O. Box 981709-STAR+PLUS>
<El Paso, TX 79998-1709>

Optum Rx
RxBIN: 017010
RxPCN: CIHSCAID
RxGroup: MEDICAID

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INTERACTING WITH CIGNA-HEALTHSPRING STAR+PLUS

Cigna-HealthSpring STAR+PLUS Example ID Card Below

STAR+PLUS DUAL-ELGIBILE 2018

> Card will not have a PCP listed on the card, refer to Medicare ID card

Cigna HealthSpring. TEXAS Health and Human Services TEXAS STAR+PLUS OPTUMRx®

Issuer/Emisor 80840
Member ID/N.º de identificación del miembro: <Member ID>
Name/Nombre: <Member Name>

You receive primary, acute and behavioral health services through Medicare. You receive only long term care services through Cigna-HealthSpring. **In case of emergency, call 911** or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Usted recibe servicios de salud primarios, de cuidados agudos y del comportamiento a través de Medicare. Usted solamente recibe servicios de atención a largo plazo a través de Cigna-HealthSpring. **En caso de emergencia, llame al 911** o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de las 24 horas o tan pronto como sea posible.

Member Services/Departamento de Servicios a los Miembros: <1-877-653-0327>
Hearing Impaired/Personas con problemas auditivos: <7-1-1>
Service Coordination/Coordinación de servicios: <1-877-725-2688>
Behavioral Health and Substance Abuse/Servicios de salud mental y abuso de sustancias: <1-877-725-2539>
Available 24 hours a day, 7 days a week
Disponible las 24 horas del día, los 7 días de la semana

Long Term Care Service ONLY/Sólo servicios de atención a largo plazo

For Prior Authorization/Para autorización previa: <1-877-562-4402>

Cigna-HealthSpring STAR+PLUS Claims:
<P.O. Box 981709-STAR+PLUS>
<El Paso, TX 79998-1709>

Optum Rx
RxBIN: 017010
RxPCN: CIHSCAID
RxGroup: MEDICAID

SAMPLE

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Important Contact Information

Questions regarding claims, please contact our Provider Services Department at: 1-877-653-0331.

Questions regarding authorizations, please contact our Utilization Management Department at: 1-877-725-2688.

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Thank you for reviewing the Claims In-Service Training.

If you are ready to take the quiz and acknowledge completion click CONTINUE.

If you would like to review the training again prior to taking the quiz, then review the presentation again from the beginning slide.

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