Wellpoint

Texas | Medicaid • Medicare Advantage

Claim Solution
Resource Guide

TXWP-CDCR-059181-24

Wellpoint wants to empower all providers to be successful when filing a claim. This resource guide will provide general information to resolve most of your common billing concerns. The information in this presentation does not guarantee reimbursement or payment for services. Billing and coding guidance in this document is not intended to replace official billing or coding guidelines or professional coding expertise. Wellpoint providers are expected to ensure documentation supports all codes submitted for conditions and services. We are unable to process payments to providers for Medicaid services unless they are listed in the state master file provided by the Texas Medicaid & Healthcare Partnership (TMHP). The state master files undergo a weekly update. If you have questions regarding billed claims and reimbursement, call Provider Services at **833-731-2162**.

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What is a clean claim?

A clean claim is one submitted for medical care or healthcare services rendered to a member with the data necessary for Wellpoint, or our subcontracted claims processor, to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837 (claim type) encounter guides.

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted timely.
- Is accurate.
- Is submitted in a *HIPAA*-compliant format or using the standard claim form, including:
  - UB-04.
  - CMS-1450.
  - CMS-1500 (02-12) or successor forms.
  - The electronic equivalent of such claim form.
- Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by us.

Timely filing adherence

Providers must adhere to timely filing guidelines for Medicare and Medicaid claims:

- Submit clean claims within 95 calendar days from the date of discharge for inpatient services or within 95 calendar days from the date of service for outpatient services. For LTSS claims with a span of consecutive dates of service, the 95 calendar days begins on the first date in the span. Timely filing for STAR+PLUS nursing facility unit rate and Medicare skilled nursing coinsurance claims is 365 days from the last date of service represented on the claim.
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 95 calendar days of receiving a response from the third-party payer.
- In the case of retroactive member eligibility, submit clean claims within 95 calendar days from the date the member is added to the state's eligibility system but no later than 365 days from the date of service or the inpatient date of discharge.
- For a provider who has a new or changed enrollment in Medicaid, clean claims must be submitted within 95 days of the effective date of the Medicaid enrollment or change but no later than 365 days from the date of service.
- Nonparticipating providers located in Texas must submit clean claims to us within 95 days of service.
- Nonparticipating providers located outside of Texas must submit clean claims to us within 365 days of the date of service.
- If a provider first submits a claim to the wrong health plan within the 95-day period and produces documentation of the filing, the provider may resubmit the claim to the correct health plan within 95 calendar days of the date of the denial from the wrong health plan.
- Corrected claims must be submitted within 120 days from the date of the *Explanation of Payment (EOP)*.

Note: Claims submitted after the filing timelines outlined above will be denied.

What are acceptable billing formats?

Wellpoint accepts *CMS-1450 (UB-04)*, *CMS-1500 (02-12)*, or successor forms.

What methods can be used to submit a claim?

Paper submissions	Electronic data interchange (EDI)	Electronic submission payers
Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010 **Note:** Paper claims are not accepted when submitted by a nursing facility.	Use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)	• Availity Essentials: **800-282-4548** • Website: Availity.com • Payer ID: **WLPNT**

What is required on a claim form?

CMS-1500 (02-12) and *CMS-1450 (UB-04)* forms must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10-CM diagnosis code/revenue codes
- Date of service
- Place of service
- CPT®-4 codes/HCPCS procedure codes
- Modifiers
- Diagnosis pointers
- Itemized charges
- Days or units
- Provider's tax ID number
- Total charge
- Provider's name according to the contract
- NPI of billing provider
- Billing provider's taxonomy codes
- NPI of rendering provider
- Rendering provider taxonomy codes
- COB/other insurance information
- Authorization number or copy of authorization
- Name of referring physician
- NPI of ordering/referring/supervising provider when applicable
- Any other state-required data
- National drug codes (NDCs)
- Present-on-admission (POA) for inpatient hospital claims

When are claims adjudicated?

Clean claims are adjudicated within 30 days of receipt; 10 days for nursing facility unit rate and nursing facility Medicare coinsurance claims, 18 days for electronic pharmacy claims submission, and 21 days for nonelectronic pharmacy claims. If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

The tables on the following pages summarize the basic requirements for NPI and taxonomy code information for claim submissions to Wellpoint.

Summary NPI and taxonomy code requirements for electronic healthcare claims submissions for Wellpoint				
EDI 837P (Professional)	**EDI loop (Professional)**	**NPI**	**Taxonomy**	**Notes**
Billing/pay to hierarchical (professional)	2000A	N/A — NPI does not exist in loop/segment	Required	
Billing provider (professional)	2010AA	Required	NA — Taxonomy code does not exist in loop/segment.	
Referring provider (professional)	2010AB	Situational	NA — Taxonomy code does not exist in loop/segment.	
Rendering provider (professional)	2310A	Situational	Optional	
Purchased service provider	2310C	Situational	Situational	Required when rendering and billing are different
Service facility location	2310D	Situational	NA — Taxonomy code does not exist in loop/segment.	
Supervising provider name	2310E	Situational	NA — Taxonomy code does not exist in loop/segment.	
Rendering provider	2420A	Not required	NA — Taxonomy code does not exist in loop/segment.	
Purchased service provider	2420B	Not required	NA — Taxonomy code does not exist in loop/segment.	
Service facility location	2420C	Not required	NA — Taxonomy code does not exist in loop/segment.	
Supervising provider	2420D	Not required	NA — Taxonomy code does not exist in loop/segment.	
Ordering provider	2420E	Not required	NA — Taxonomy code does not exist in loop/segment.	
Referring provider	2420F	Not required	NA — Taxonomy code does not exist in loop/segment.	

Summary NPI and taxonomy code requirements for electronic healthcare claims submissions for Wellpoint				
Edi 837i (Institutional)	**EDI loop (Professional)**	**NPI**	**Taxonomy**	**Notes**
Billing/pay to hierarchical (institutional)	2000A	NA — Taxonomy code does not exist in loop/segment	Required	
Billing provider (institutional)	2010AA	Required	NA — Taxonomy code does not exist in loop/segment.	
Pay to provider (institutional)	2010AB	Situational	NA — Taxonomy code does not exist in loop/segment.	
Attending provider (institutional)	2310A	Situational	Optional	
Operating (institutional)	2310B	Situational	NA — Taxonomy code does not exist in loop/segment.	Require when an operating revenue/CPT code is submitted
Other provider rendering (institutional)	2310C	Situational	NA — Taxonomy code does not exist in loop/segment.	Require when an operating revenue/CPT code is submitted
Service facility name	2310D	Situational	NA — Taxonomy code does not exist in loop/segment.	
Attending physician	2310E	Situational	NA — Taxonomy code does not exist in loop/segment.	
Operating physician	2420A	Not required	NA — Taxonomy code does not exist in loop/segment.	
Other provider	2420B	Not required	NA — Taxonomy code does not exist in loop/segment.	
Supervising provider	2420C	Not required	NA — Taxonomy code does not exist in loop/segment.	
	2420D	Not required	NA — Taxonomy code does not exist in loop/segment.	

Summary NPI and taxonomy code requirements for paper healthcare claims submissions for Wellpoint				
***CMS-1500* (08-05) professional paper claim**	***CMS-1500* field location**	**NPI**	**Taxonomy**	**Notes**
Billing Provider: 33A=NPI, 33B= ZZ Qualifier + Taxonomy	33A & B	Required	Required	
Rendering Provider (*CMS-1500* (08-05)) 24I Shaded=ZZ, 24J Shaded=Taxonomy; 24J Not shaded=NPI		Situational	Situational	Required when rendering and billing are different.
Signature of Physician or Supplier	31	NA	NA	Rendering provider name should be submitted, if applicable
Service Facility Location: 32A=NPI, 32B= ZZ Qualifier + Taxonomy	32A &B	Situational	Optional	
Referring Provider 17=Referring provider name 17A= ZZ Qualifier + Taxonomy, 17B= NPI	17, 17A & B	Situational	Optional	

Summary NPI and taxonomy code requirements for paper healthcare claims submissions for Wellpoint				
Institutional *UB-04* paper claim	***UB-04* field location**	**NPI**	**Taxonomy**	**Notes**
Billing Provider 1=Provider Name 56 = NPI, 57 = ZZ Qualifier + Taxonomy	1, 56 & 57	Required	Required	
Attending Provider	76	Situational	NA — Taxonomy code cannot be entered in FL-76.	
Operating	77	Situational	NA — Taxonomy code cannot be entered in FL-76.	
Other Provider *Referring*	78 or 79	Situational	NA — Taxonomy code cannot be entered in FL-76.	Using 82 qualifier to indicate rendering

Notes:

- Situational means that the field is required only if the scenario exists on a claim.
- Any provider loop submitted on an EDI claim transmission must contain a valid NPI in order to pass compliance.
- Claim submissions for THSteps/EPSDT services must include a benefit code of EP1. The required location for a benefit code on a paper claim is the insurance plan name or program name (*CMS-1500* [08-05] FL- 11C). On an electronic submission 837P, the required location is the Subscriber Loop (Professional) 2000B Reference Identification Segment SBR03.
- Any provider field submitted on a paper claim that contains provider information must also include the NPI. If a provider field contains a name, then an NPI is expected to present on the claim. If a provider field contains an NPI, the provider name will also be expected to be on the claim.
- Any NPI/taxonomy submitted must be valid to pass compliance.

What does it mean if I don't receive an *Explanation of Payment*?

In Texas, Wellpoint distributes payment daily (except for the weekends). If your claim(s) has not been adjudicated, please check to determine if your claim was received electronically.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to the organization that submitted the claim.

What is a rejected claim?

A rejected claim does not enter the adjudication system due to missing or incorrect information. Resubmission of the claim is subject to the original timely filing deadline.

Please note that a rejected claim means that the claim is returned to the provider (either electronically for EDI claim submissions or by mail for paper claims). The claim is not recorded in Wellpoint's claim processing system and information about a rejected claim does not appear on Availity.

The most common reasons for rejection and potential solutions are listed below:

Rejection reason	Solution
Rendering NPI is present, but no taxonomy has been submitted	Resubmit claim with a valid taxonomy code. The healthcare provider taxonomy code set is an external, non-medical collection of alphanumeric codes designed to classify healthcare providers by provider type and specialty. When the rendering and billing providers are different on a claim submission, rendering NPI and taxonomy must be submitted. In the case of Medicaid claims (STAR, STAR Kids, and STAR+PLUS), the NPI/taxonomy combination must also be present on the State of Texas master provider file. Wellpoint IDs cannot be substituted for taxonomy.
Both Rendering NPI and taxonomy present but not valid against state master file	Either resubmit claim with an NPI/taxonomy combination (must be present on the State of Texas master provider file) or update your NPI/taxonomy information via the attestation process. See tmhp.com and select the NPI link across the top. Wellpoint IDs cannot be substituted for taxonomy.
No NPI submitted	Wellpoint performs the following validation on claim submissions to ensure that the NPI submitted is valid and accurate: • All NPI values submitted on a claim are verified against the National Plan and Provider Enumeration System (NPPES). • All NPI values on claims for Medicaid members (STAR, STAR Kids and STAR+PLUS) are verified against the State of Texas provider master file.

Type of issue	What do I need to do?
EDI rejected claim(s)	Contact Availity Client Services with any questions at **800-Availity (282-4548)** or email at dgrpediclaims@wellpoint.com.
Payer ID	WLPNT

What is a denied claim?

A claim that has undergone the adjudication procedure but is not approved for payment. The deadline for appeal is 120 days from the date of the *Explanation of Payment (EOP)*.

Retro Medicaid enrollment claim submission

In certain situations, your enrollment in Medicaid could potentially be effective retrospectively. TMHP could potentially provide you with a Medicaid enrollment identifier that dates back several months or even a year or more. Retro Medicaid enrollment assignments require special claim handling. Wellpoint has set up a specific process for the submission of claims related to a retroactive Medicaid enrollment identifier.

- Continue to submit your claims even though your Medicaid enrollment identifier is pending. Do not hold your claims. You will receive rejections or denials for the missing Medicaid enrollment identifier or no authorization. Retain that remittance advice or explanation of payment in your records.
- When you receive the Medicaid enrollment identifier letter, submit a copy to your provider relationship management representative within 30 days of receipt of your enrollment letter for guidance with reprocessing your claims.
- Wellpoint will review your Medicaid enrollment identifier letter and review the State Master File. Upon finding your Medicaid enrollment identifier in the State Master File, we will begin the claim reconciliation process. Wellpoint cannot pay Medicaid claims until your Medicaid enrollment identifier is published on the State Master File.
- Wellpoint will reprocess claims that are submitted prior to or within 95 days of the date of the Texas Medicaid enrollment identifier assignment notice from TMHP. If a claim is not submitted before or within the 95-day timely filing of the TMHP notice date, it will be denied.

Wellpoint will reprocess your claims subject to all Wellpoint requirements including benefits, authorizations, eligibility, and coordination of benefits.

Reminders:

- Most services for a nonparticipating provider require authorization. If you are a Wellpoint participating provider, some services still require authorization. For information about services that require authorization whether you are a participating or nonparticipating provider, visit the Wellpoint provider website at provider.wellpoint.com/texas-provider/resources/prior-authorization-requirements.
- Wellpoint cannot issue Medicaid authorizations for providers who do not have a Medicaid enrollment
- For nonparticipating providers with a retro-effective Medicaid enrollment identifier, Wellpoint will only be able to consider those claims that do not require an authorization such as emergency room visits, immunizations, Texas Health Steps checkups, and family planning services.
- If you are an out-of-state provider and do not participate with Wellpoint in Texas, you must have a Medicaid enrollment identifier from Texas to receive reimbursement.

How to submit a claim payment dispute

We have several options to file a claim payment dispute:	
Online (for reconsiderations and claim payment appeals)	Use the secure Availity Provider Payment Appeal Tool at Availity.com. Through Availity, you can upload supporting documentation and will receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity using Claim Status from the Claims & Payments menu. If available, select Dispute Claim to initiate the dispute. Go to Request to navigate directly to the initiated dispute in the appeals dashboard to add the documentation and submit.
Verbally (for reconsiderations only)	Call Provider Services at **833-731-2162**. We are encouraging the submission of payment appeals via Availity. Refer to the above Online section.
Written (for reconsiderations and claim payment appeals)	Mail all required documentation (see below for more details), including the *Provider Payment Dispute and Claim Correspondence Submission Form*, to: Wellpoint Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466-1599

Corrected claim	
Paper submission	Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as a corrected claim. Provided the claim was originally received in a timely manner, a corrected claim must be received within 120 calendar days of the *EOP.* In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Wellpoint to adjust the other health insurance (OHI) payment information, the 95-day timely filing period starts with the date of the most recent OHI *EOB*.
Availity	For corrected electronic claims, use the following frequency code: • 7 – Replacement of prior claim
EDI segments required	• Loop 2300 - CLM - Claim frequency code • Loop 2300 - REF - Original claim number

Itemized bill

An itemized bill is required under the following circumstances:

- Any claim that meets or exceeds the stop-loss provision in the provider agreement
- Any claim with charges that meet or exceed $5,000

We cannot accept itemized bills with alterations. Modified itemized bills will be returned to the servicing provider with an explanation that delineates the reason for the return.

Submit all itemized bills to:
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

Coding

Providers must use *HIPAA*-compliant codes when billing us for electronic, online, and paper claim submissions. When billing codes are updated, the provider is required to use appropriate replacement codes. We will not accept claims submitted with noncompliant codes. We edit claims using SNIP level one through six edits.

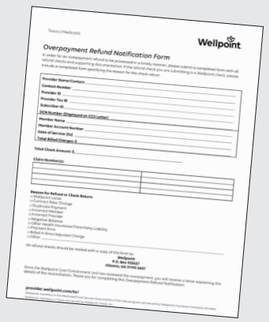
All claims submitted are processed using accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by sources that include the National Correct Coding Initiative, the uniform billing editor, CPT-4, and ICD-10-CM manuals, and successor documents. In addition, we reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. Our clinical policies and bulletins are posted on the provider website at provider.wellpoint.com/tx.

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

Type of transaction	How to enroll, update, change, or cancel	Contact to resolve issues
EFT	Use EnrollSafe (https://enrollsafe.payeehub.org) to register and manage EFT account changes.	**877-882-0384** Email: support@payeehub.org
ERA only	Register for *ERA*s at Availity.com. Use Availity to register and manage ERA account changes with these three easy steps: 1. Log in to Availity at Availity.com. 2. Select **My Providers**. 3. Select **Enrollment Center** and select **Transaction Enrollment**. Note: If you use a clearinghouse, billing service or vendor, please work with them on ERA registration.	Availity **800-282-4548**

Refund notification

It is a requirement for service providers to report any recognized overpayments and they must proceed to remit a refund to Wellpoint within a span of 60 days (about two months) from the time the overpayment was identified. The refund notification form can be found on the provider website at **provider.wellpoint.com/tx** > Resources > Forms > Claims & Billing > **Refund Notification Form (PDF)**.



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Overpayment Refund Notification Form

Billing members

Our members must not be balance billed for covered services. A member cannot be billed for failing to show for an appointment. Providers may not bill Medicaid members enrolled in Wellpoint for a third-party insurance copay. Medicaid members do not have any out-of-pocket expenses for covered services.

Private Pay Agreements

If the provider accepts the member as a private pay patient, the provider must advise members that they are accepted as private pay patients at the time the service is provided and are responsible for paying for all services received. The provider should ensure that the member signs written notification so there is no question how the member was accepted. Without written, signed documentation that the member has been properly notified of the private pay status, the provider cannot seek payment from an eligible member.

Sample Private Pay Agreement

I understand [provider's name] is accepting me as a private-pay patient for the period of _____, and I am responsible for paying for any services I receive. The provider will not file a claim to Medicaid or Wellpoint for services provided to me.

_____

Signed_____

Date_____

Client Acknowledgment Statement

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are true:

- The member requests the specific service or item.
- They were informed of the financial liability by the provider before the service.
- The provider has a written acknowledgment statement, signed by both parties, kept on record before delivering the service.

Sample Client Acknowledgment Statement Form

I understand my doctor, _____(provider name)_____ , or Wellpoint, has said the services or items I have asked for on _____(dates of service)_____ are not covered under my Wellpoint plan. Wellpoint will not pay for these services. Wellpoint has set up administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Wellpoint decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered, I understand I am liable for payment.

Member name (print)_____ Date: _____

Member signature_____

Additional resources and training

Interpreting complex claims issues on *Explanation of Payments: recoupments, negative balances, refunds, and negative balance deferred:** provider.wellpoint.com/tx > Resources > Training Academy

Reimbursement polices: provider.wellpoint.com/tx > Claims > Reimbursement Policies

Provider manual: provider.wellpoint.com/tx > Resources > Provider Manuals and Guides

Provider coding training: **Provider Coding Education (PDF)**

Training Academy: provider.wellpoint.com/tx > Resources > Training Academy

TMHP website: www.tmhp.com

CMS website: **cms.gov**

Updates to navigating paper claim forms: https://tinyurl.com/2zk8785h

Provider Enrollment and Management System (PEMS): https://tinyurl.com/mrxs9t6n

National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov

Learn more about Wellpoint programs
provider.wellpoint.com/tx

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