TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner, MPA
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Medicare/Medicare Managed Care/Railroad Collections**

Policy#: BAC 1

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to Medicare recipients. TTUHSC files electronic claims daily on behalf of individuals covered by Medicare, and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Medicare payers are billed for services where Medicare eligibility has been verified. Where eligibility cannot be verified, the patient is classified as self-pay. Medicare recipients are responsible for annual deductibles, co-payments, and/or co-insurances based on the allowable fees approved by Medicare. All patient-responsible balances bill to the patient after the claim has been adjudicated.

2) Medicare claims bill daily and electronically to Novitas Solutions, Inc. and Railroad Medicare claims bill to Palmetto GBA, both having a 365-day filing deadline. Medicare Managed Care plans, including but not limited to Aetna, Amerigroup, Care Improvement Plus, Care 1st Health Plan, Humana, Molina, United HealthCare, Wellcare and Wellmed, have filing deadlines ranging from 90 to 365 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ecttuweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIP employees work with department certified coders to

resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update insurance eligibility and re-queuing of claims.

6) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadlines range from 30 to 120 days from the denial date noted on the latest explanation of benefits.

7) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed primarily online, followed by telephone call to the payer's claims department. An online Appeal Status Tool offered by Novitas Solutions, Inc. may be accessed at https://appealsstatustool.novitas-solutions.com/webpws/ .

8) Charges determined after adjudication to be patient responsibility, which may include deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services, are billed to secondary or tertiary payers when applicable or billed to the patient. Charges that have not been assigned as patient responsibility are billed to the patient only if a completed and signed Advanced Beneficiary Notice (ABN) is on file for that specific service.

RESPONSIBILITIES

1) Medical Billing Associate (MBA) 1: Medicare and Railroad Medicare claim edits, EDI rejections, correspondence, follow-up, and appeals.

2) Senior MBA 1 and 2: Medicare Managed Care claim edits, EDI rejections, correspondence, follow-up, and appeals.

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Frank Stout
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Steven M. Wagner, MPA
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **US Marshals Service**

Policy#: BAC 2

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to US Marshals Service inmates. TTUHSC submits paper claims daily on behalf of individuals covered and under custody of US Marshals Service FSC 174, and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) US Marshals Service claims are billed for services where eligibility and custody is verified. Where eligibility and custody cannot be verified, the patient is classified as self-pay. All patient-responsible balances bill to the patient after the claim has been adjudicated. Verification by US Marshals is performed by calling or emailing: Minerva Mercado at 915-534-5013 or Minerva.Mercado@usdoj.gov, Maria Fuentes at 915-534-5010 or Maria.Fuentes@usdoj.gov or Adrian Aranda (Supervisor) at 915-534-5062 or Adrian.Aranda@usdoj.gov All emails sent outside of Texas Tech must be sent secured [SEND SECURE].

2) US Marshals Service paper claims are billed daily with the 237 form (see attached example) obtained from EMR when the inmate is seen in TTUHSC clinics; 237 forms for hospital care are obtained from Mona Pacheco at 215-546-2228 or by email at r.pacheco@epcounty.com. US Marshals Service does not have a filing deadline.

3) Designated employees review and correct all rejections found on the daily claims edit list, which is located on the Shared drive under MPIP Reference/Edit List. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 30 days. Follow-up is performed by telephone by contacting the persons mentioned in 1). Follow-up may include verification and update of insurance eligibility and re-queuing of claims.

5) MPIP designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline is one year from the denial date noted on the latest explanation of benefits.

6) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts employee of payer non-response. Status of the appeal is reviewed online, followed by telephone call to the payer's claims department.

7) Charges determined after adjudication to be patient responsibility, including patient not in custody, unable to identify arresting agency, non-covered or ineligible services, are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Medical Billing Associates (MBA)
2) Student Assistant 1: EDI rejections.

UNITED STATES MARSHALS SERVICE
DISTRICT OF El Paso TEL (915) 534-6779 FAX (915) 534-6777

PRISONER MEDICAL REQUEST (Draft for Pilot)

TO BE COMPLETED BY DETENTION FACILITY AND USMS DISTRICT OFFICE (as applicable):

- NON-EMERGENCIES: Prior to seeking outside medical attention for a prisoner, complete form and fax to USMS District Office at fax number above. USMS will notify you of approval or denial of the request.
- EMERGENCIES: *obtain treatment and notify USMS as soon as possible, and fax this form within 24 hrs.*

Prisoner name: _____ USMS No. 34382380 DOB: __-__-19__

Private Insurance: YES ☐ NO ☒ If yes, Provider Name: _____

Detention Facility: OCDF Contact Person: G Hernandez CMA

Telephone No.: 5758244884 X130 Fax No.: 5758245271

Date & Time USMS Notified of Request: 5/6/14 @ 1120

Description of Requested Services with Justification:

- Attach Medical or Dental Notes to Support Request or note below if Court-ordered.
- USMS Prisoner Health Care Standards can be found at http://www.usmarshals.gov/prisoner/standards.htm
- For medication, indicate quantity and name of drug. Generic medications should be used when available.

Pt. want to OFF site appt- follow up @ Ortho
Medical provider sent pt to ER due to
having infection (notes attached.)

Urgency of Request: Emergency ☐ Urgent (< 2 wks) ☒ Routine (2-6 wks) ☐ Standard (>6 wks) ☐

Facility/Hospital/Pharmacy providing service: MMC (915)544-1200 Appt. Date: 5/6/14 @ 1120

Health Care Provider providing service: _____ Appt. Date: _____

Estimated Cost $ _____ *NOTE: By law, USMS may only pay Medicare rates or less*

TO BE COMPLETED BY USMS DISTRICT OFFICE:

Medical Request is Approved ☐ Referred to OIMS ☐ (see OIMS section below)

District Representative Signature: _____ Date: 5-7-14

Deputies Handling Prisoner: _____ / _____

Funds obligated: $ _____ Obligation #: _____

Paid by Government Credit Card: ☐ Check: ☐ Other: ☐ (specify: _____)

TO BE COMPLETED BY USMS OFFICE OF INTERAGENCY MEDICAL SERVICES (OIMS):

OIMS REVIEW: Approved: ☐ Denied: ☐ Pending (additional information required): ☐

Comments: _____

SAMPLE

U.S. Department of Justice
United States Marshals Service

Prisoner Medical Request

INSTRUCTIONS: To be completed by detention facility and USMS district offices (as applicable).

- NON-EMERGENCIES: Prior to seeking outside medical attention for a prisoner, complete this form and fax it to the USMS district office at the fax number listed below. USMS will notify you of approval or denial of the request.
- EMERGENCIES: Obtain treatment and notify USMS by faxing this form to the number below within 24 hours.

U.S. Marshals Service Use Only:

District: Western District of Texas   Telephone: 1-915-534-6779   Fax: 1-915-534-6777

Date of Request: 3/31/2014   Time of Request: 15:00   34382380 ✓

Prisoner Name: ____ USMS Prisoner No.: ________ DOB: ________

Private Insurance? ☐ YES ☒ NO   If yes, Provider Name: ________

Detention Facility: Otero County Prison Facility (OCPF)   Contact Person: L. [illegible], MRC

Telephone: 575-434-4884 ext 132   Fax: 575-434-5571

Description of Requested Service(s) and Reason for Service(s):

- Attach medical or dental orders to support request or note below if court-ordered
- Over-the-counter (OTC) medications are covered by the per diem rate as part of inside medical care.
- OTCs should be provided by the jail without any additional cost to USMS

Pt had surgery 3/25/14 came back from UMC with orders for Ortho Consult due to (L) transverse patella fx, (L) distal radius fx [illegible]

Urgency of Request: ☐ Emergency Notification ☐ < 2 weeks ☒ 2-6 weeks ☐ > 6 weeks ☐ Hospital Admission

Facility/Hospital/Pharmacy Providing Service: Texas Tech Ortho   Appt. Date: 4/15/2014

Health Care Provider Providing Service: 4[illegible] Alberta Ave El Paso TX   Appt. Time: 7:30 a.m.

NOTE: By law, USMS may only pay Medicare rates or less.

TO BE COMPLETED BY USMS DISTRICT OFFICE:

Request is: ☑ APPROVED ☐ REFERRED TO OIMS   (USMS Districts are not allowed to deny medical requests.)

District Representative: Nunez, S.   Signature: [signature]   Date: 4/1/14

Deputies Handling Prisoner: ________ / ________

TO BE COMPLETED BY USMS OFFICE OF INTERAGENCY MEDICAL SERVICES (OIMS):

OIMS Review: ☐ APPROVED ☐ DENIED ☐ DEFERRED ☐ NOTIFIED/ACKNOWLEDGED

Comments:

OIMS Reviewer (Initials): ____ OIMS Physician (Initials): ____ Date: ____

[illegible]   Page 1 of 1   APR 1 2014   Form USM-[illegible]

SAMPLE

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Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Children's Health Insurance Plan (CHIP)/CHIP Perinate Collections**

Policy#: BAC 3

Policy: The purpose of this policy is to outline the procedure for collection of services provided to Children's Health Insurance Plan (CHIP) and CHIP Perinate recipients. TTUHSC files electronic claims daily on behalf of individuals covered by CHIP and bills patients for any outstanding co-payments, co-insurance, or non-covered services. The patient is billed for non-covered services after the claim has been processed and a waiver signed by the patient was obtained (instructions attached). Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) CHIP payers are billed for services where eligibility is verified. Where eligibility cannot be verified, the patient is classified as self-pay. CHIP recipients are responsible for co-payments; all patient-responsible balances bill to the patient after adjudication if the amount was not collected at the clinic front desk.

2) CHIP claims bill daily and electronically to El Paso First and Superior Health Plans; the filing deadline is 95 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ecttuweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIP employees will work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain outstanding for 15 days, excluding invoices for the Pediatrics department. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update of insurance eligibility and re-queuing of claims.

6) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline for CHIP claims is 120 days from the denial date noted on the latest explanation of benefits. Charges for services provided by non-covered providers or non-covered services in which there is no waiver on file are e submitted to the billing manager on an adjustment request form (Form A).

7) A minimum of 55 workfile accounts are processed on a daily basis. Status of the appeal is reviewed online within 30 days, followed by telephone call to the payer's claims department.

8) Charges determined after adjudication to be patient responsibility, including deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Senior Medical Billing Associate (MBA) 1: claim edits, EDI rejections, correspondence, follow-up, and appeals.

2) Senior Business Assistants 1: claim edits, EDI rejections, correspondence, and follow-up.

TMHP
P.O. Box 200555
Austin, Texas 78720-0555

Cost Sharing Schedule:
For CHIP Perinatal there is no cost sharing schedule that is applicable.

No Co-Payments for CHIP Perinatal members and/or CHIP Perinatal Newborn members. Co-payments do not apply to CHIP Perinatal

BILLING MEMBERS

- Co-payment
  Provider understands and agrees that Provider is responsible for collecting at the time of the service any applicable co-payments, given the limitations on those co-payments. Co-payments are the only amounts that a Provider may collect from Members.
- Non-Covered Services
  Providers must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed acknowledgement statement from the Member.
- Balance Billing
  Providers agree to accept payment made by El Paso First as payment in full. The member cannot be held liable for any balance related to covered services.

Member Acknowledgement Statement
A provider may only bill a member when the member has signed the Member Acknowledgement Statement and the following conditions are met:

- A claim is denied as not being medically necessary
- A claim is denied as part of a non-covered service,
- The service is provided at the request of the client

Example of a Member Acknowledgment Statement:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the (Program Name) as being reasonable and medically necessary for my care. I understand that El Paso First determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I

request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Private Pay Form

If the provider accepts the member as a private pay patient and informs the member at the time of service that the member will be responsible for paying for all services, the provider may bill the member. In this situation, it is recommended that the provider use a Private Pay Form. It is suggested that the provider use the Member Acknowledgement Statement provided above as the Private Pay Form. Without written, signed documentation that the member has been properly notified of their private pay status, the provider cannot ask for payment from a member. The Private Pay Form can be found as **ATTACHMENT 21(pg. 242)** of this manual.

SSI Claims

El Paso First is not responsible for processing claims for members with Supplemental Security Income (SSI).

- Prior authorization request (if necessary) for SSI clients of any age who are enrolled in El Paso First STAR Premier program must be submitted to El Paso First utilization review department prior to rendering services.
- Claims for El Paso First SSI members should be submitted directly to Texas Medicaid Health & Partnership (TMHP). If a claim for an SSI client is sent to El Paso First, the claims will be denied with the following denial reason:

D0000	**Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.**

RESOURCES FOR CLAIMS STATUS

Provider Care Unit (PCU)

The PCU department is a subsection of the claims department developed to assist providers with claims inquires. The PCU department can be reached at 915-532-3778 or 1-877-532-3778. When calling you will reach a Claims Specialist who can assist you with:

- Claim status
- Answers to claim questions
- Answers to electronic claims submission rejections or questions
- Resolving claims

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Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Commercial Insurance Collections**

Policy#: BAC 4

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to commercial insurance recipients. TTUHSC files electronic claims daily on behalf of individuals covered by commercial insurances and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Commercial payers are billed for services where eligibility has been verified. Where eligibility cannot be verified, the patient is classified as self-pay. Recipients are responsible for annual deductibles, co-payments, and/or co-insurances based on the allowable fees approved by the plan. All patient-responsible balances bill to the patient after the claim has been adjudicated.

2) Commercial claims bill daily and electronically to plans with EDI connectivity and on paper claims for plans without connectivity. The filing deadlines range from 90 to 365 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ecttuweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update insurance eligibility and re-queuing of claims.

6) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadlines range from 30 to 120 days from the denial date noted on the latest explanation of benefits.

7) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed online, followed by telephone call to the payer's claims department.

8) Charges determined after adjudication to be patient responsibility, including deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Medical Billing Associates (MBA) 1 – 3, Senior MBA 1, and Senior Business Assistants 1- 3: claim edits, EDI rejections, correspondence, follow-up, and appeals.

2) Student Assistant 1: EDI rejections.

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Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Immigration/Customs and Border Protection**

Policy#: BAC 5

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to Border Patrol Inmates. TTUHSC files paper claims daily on behalf of individuals covered and under custody of Immigration/Customs and Border Protection FSC 738 and bills patients for any outstanding non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Customs and Border Protection claims are billed for services where eligibility and custody has been verified. Where eligibility and custody cannot be verified, the patient is classified as self-pay. All patient-responsible balances bill to the patient after the claim has been adjudicated. Verification by Customs and Border Protection is performed by calling or emailing Hector Arrieta at 915-730-7231 or Hector.Arrieta@CBP.DHS.GOV. All emails sent outside of Texas Tech must be sent secured [SEND SECURE].

2) Customs and Border Protection paper claims bill daily with the MedPAR form (see attached example) obtained from Hector Arrieta when the inmate receives Emergency Room or other hospital care. MedPAR forms are obtained from Hector Arrieta at 915-730-7231 or by email at Hector.Arrieta@CBP.DHS.GOV. Customs and Border Protection has a filing deadline of one year from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed by signing on the web portal at vafscdihs@mail.va.gov or by telephone to US Department of Homeland Security. Designated

employees must sign up and create a username in order to review and obtain claim status through the web portal. Follow-up may include verification and update of insurance eligibility and re-queuing of claims.

5) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claim, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline is one year from the denial date noted on the latest explanation of benefits.

6) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed online, followed by telephone call to the payer's claims department.

7) Charges determined after adjudication to be patient responsibility, including patient not in custody, unable to ID arresting agency, or patient is ineligible, are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Medical Billing Associates (MBA)
2) Student Assistant 1: EDI rejections.

ICE Health Service Corps **Treatment, Authorization & Consultation Form**

SEND PAPER CLAIMS TO:
ICE Health Service Corps
VA Financial Services Center
PO Box 149345
Austin, TX 78714-9345

For EDI claim submission information and claim inquiries, please contact 1.800.479.0523

Claims must be submitted within one year from date of health service. Approvals are valid for 90 days from date of approval.
For proper provider claim submission information, please visit:
http://www.ice.gov/about/offices/enforcement-removal-operations/ihsc/managed-care.htm

A separate treatment authorization request will be required for services beyond and outside the scope of the original authorization. Services rendered may not be paid without an approved authorization. All payment for services is subject to detainees' eligibility and custody. Unless otherwise specified, payment for IHSC authorized health services is made in accordance with US Code Title 18, Part 3, Chapter 301, Sec. 4006. All claims are subject to retrospective review. For further information regarding IHSC, please visit our website http://www.ice.gov/about/offices/enforcement-removal-operations/ihsc/ or contact the ICE Health Services Managed Care Branch at 1.202-732-4600, M-F 0800 to 1630 EST

Please ensure all claims include the Patient Identification Information and the Authorization number

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
Name:	Alias
A#:	A#: [illegible]
Nationality: UNITED STATES	Facility: [illegible]

EXAMPLE

AUTHORIZED ACTION:
Status: Approved Auth #: 20141021444100 Authorizer: LT Precious R Arrieta
Service Type: Emergency
Referral Type: ED

To: *(Name and Phone to whom referral is being made)*

Dialogue of Request:

Approve ER visit to include Observation up to 72hrs on 12/8/2012

MedPAR is administratively approved for ER visit to include observation up to 72 hours. IAW US Border Patrol policy for access to medical care. The submitting agent attests that the alien is in custody at the time the service is provided. IHSC renders no decision as to medical necessity or appropriateness for the requested treatment, but acts as intermediary for the payment of claims IAW Title 18 USC, Part III, Chapter 301, § 4006.
Updated by LT Precious Arrieta on 23 October 2014

United States Customs and Border Protection
Office of Field Operation El Paso, TX

This Med Par request is for ED
Passport #: [illegible]
Name: [illegible]
DOB:
Nationality: United States Citizen
Referred to hospital: University Medical Center
Date of Service: 12/08/2012

Released - 12/08/2012
Diagnosis: Medical exam
Mode of Transportation: CBP GOV
- Dates of Services reviewed by MedPARs Commander Lydia Springs 10/21/2014, was advised to submit a MedPAR.

This event's case was created by MedPAR and should be verified for data correctness.

The following patient information was entered manually
Patient Alien # : OF0C0353835
Patient Border Patrol # :
Patient FIN :
Patient Last Name
Patient First Name
Patient Middle Name
Patient DOB :
Patient Sex :
Patient Nationality
Patient INS Status :
Patient MSI Number

The following provider information was entered manually
Provider ID : UMC El Paso, Texas
Provider Name : UMC Hospital
Provider Specialty Code
Provider Specialty Description :
Provider Facility Type : Hospital
Provider Type :
Provider Address 1 : 4815 Alameda
Provider Address 2 :
Provider City : El Paso
Provider State : Tx
Provider Zip : 79905
Provider Phone : (915) 544-1200

Provisional Diagnosis: V70 GENERAL MEDICAL EXAMINATION

Consultation Report:

EXAMPLE

Instructions for Usage of Treatment Authorization And Consultation Form

Referral Type Descriptions:

Consult Only - Consultative health services only that are consistent with the consultative Provider's specialty and detainee's medical condition

Emergency Room - Health services consistent with an Emergency Room setting and detainee's specified medical condition. In cases where an inpatient admission may be medically necessary following an initial Emergency Room visit, a new TAR must be submitted by the detainee's custodial facility

Medical Appointment (Not a consult) - Health services consistent with the Provider's specialty and detainee's specified medical condition.

Medical Lab/Test - Labs and/or Tests consistent with the detainee's specified medical condition

Inpatient Hospitalization - Health services consistent with an inpatient hospitalization and the detainee's specified medical condition.

Dental Services - Health services consistent with a dental Provider's specialty and detainee's specified medical condition.

Non-Formulary Medications - Any medication not included on IHSC designated formulary http://www.ice.gov/about/dfos/erfo/consistent-removal-operations.htm

EXAMPLE

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Eligibility Group Eligibility Request Definitions (GERD) Processing**

Policy#: BAC 6

Policy: The purpose of this policy is to outline the procedure for processing the results of the automatic eligibility GERD (Group Eligibility Request Definitions) reports that are processed by GE Centricity Business on a daily, weekly, and monthly basis. These GERDs send eligibility requests to participating payers through Electronic Data Interchange (EDI); the results are reviewed by designated staff and insurance information is updated in the patient services function as required.

Procedure:

1) The following GERDs are currently processed by GECB:

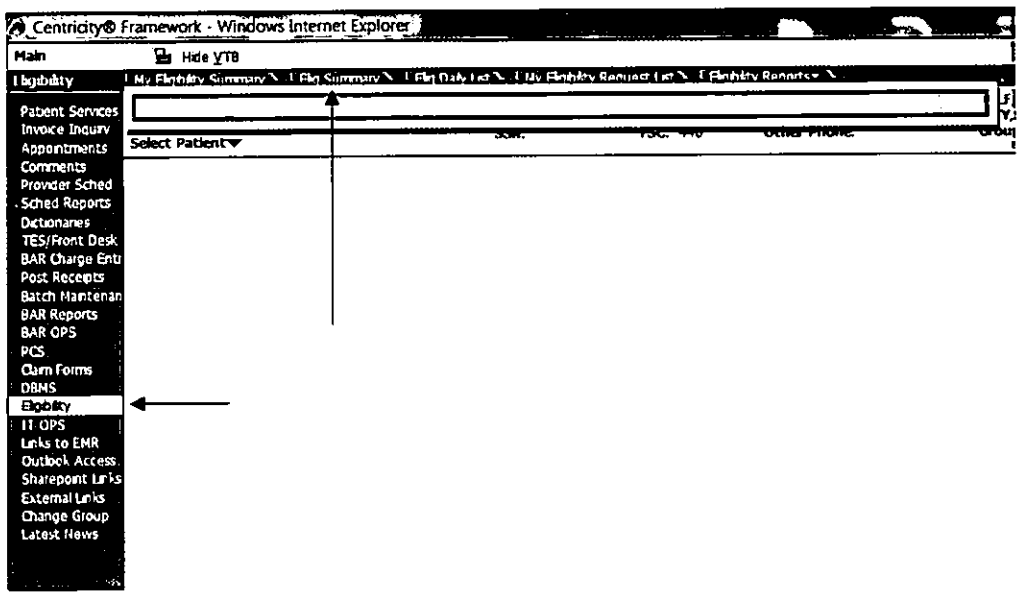
- **GRP 3 60 DAY - EL PASO** – daily request to CMS and various commercial payers is run 7 days prior to scheduled appointments for accounts containing registration FSCs corresponding to Medicare and commercial payers.
- **GRP 3 MONTHLY - EL PASO** – daily request to TMHP is run 3 days prior to scheduled appointments for accounts containing registration FSCs corresponding to Medicaid payers.
- **GRP 3_SP_INDIGENT_TX** – monthly request to TMHP on the 10th day of the month for accounts containing the Hospital District registration FSCs of 375 or 376 or other self-pay FSCs to include 1, 15, and 17 and a Texas address.
- **GRP 3_SP_INDIGENT_NM** - monthly request to New Mexico Medicaid on the 10th day of the month for accounts containing the Hospital District registration FSCs of 375 or 376 or other self-pay FSCs to include 1,15, and 17 and a New Mexico address.
- **GRP 3_MCD PENDING** – weekly request to TMHP for accounts containing pending Medicaid/SSI registration FSCs of 315 or 516 and a Texas address.
- **GRP 3_TES_MEDICAID_SELFPAY** – daily request to TMHP for invoices entered through TES containing a self-pay FSC and a Texas address.

- **GRP 3_TES_NM_MEDICAID_SELFPAY** – daily request to NM Medicaid for invoices entered through TES containing self-pay FSC and a New Mexico address.

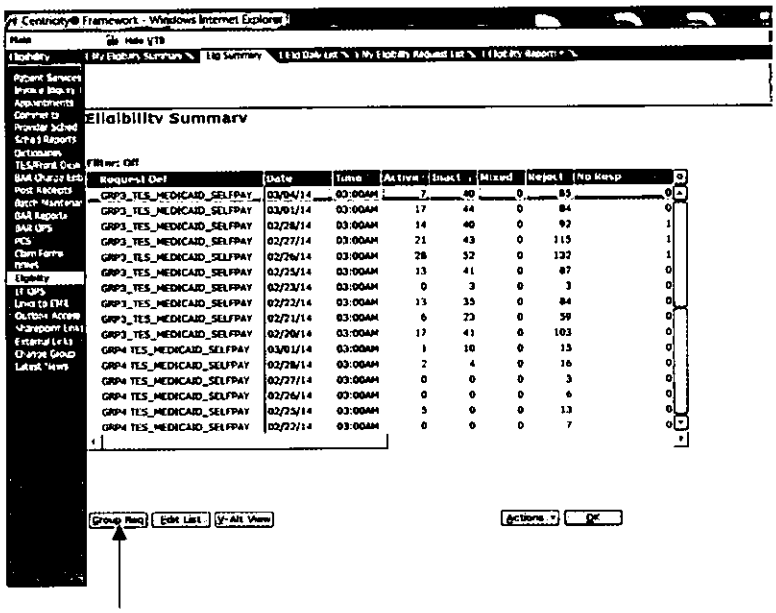
- **GRP 3_TES_MEDICARE_SELFPAY** - daily request to CMS (Centers for Medicare and Medicaid) for invoices entered through TES containing a self-pay FSC.

2) The GERD training guide is included; Reports are accessed as follows:

- Select Eligibility, then Eligibility Summary tab

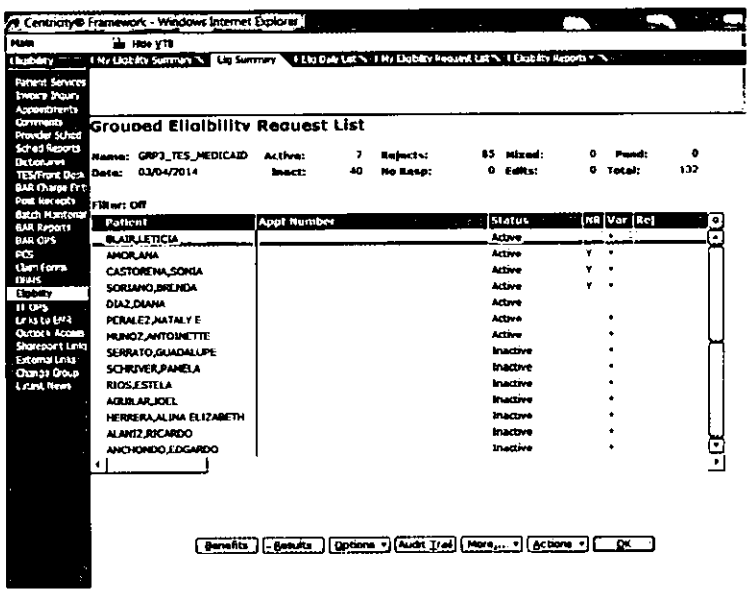


- Scroll down to desired report, for example GRP3 TES_MEDICAID_SELFPAY
- Highlight the Row and Select the 'Group Req' button at the bottom of the screen



The list of individual accounts that were processed in the GERD will appear.

- Sort by 'Status' to view all **Active, Inactive, Rejected, or Mixed** results as a group, apply filer as desired
- Review desired 'Results', update plan information in Patient Accounts, and if necessary, bill out any claims



3) Designated employees process **GRP 3 60 DAY - EL PASO** and **GRP 3 MONTHLY - EL PASO** results daily, update eligibility information as required in the patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status other than **Active** and including the status of **Active** indicating a **Needs Review (NR)** result require review.

4) Designated employees process **GRP 3_ SP_INDIGENT_TX** and **GRP 3_SP_INDIGENT_NM** results on a monthly basis, update eligibility information as required in patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status of **Active** require review.

5) Designated employees process **GRP 3_MCD PENDING** results weekly, update eligibility information as required in patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status of **Active** require review.

6) Designated employees process **GRP 3_TES_MEDICAID_SELFPAY** and **GRP 3_TES_MEDICARE_SELFPAY** daily, update eligibility information as required in patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status of **Active** require review.

RESPONSIBILITIES

1) Senior Business Assistant 1 will process **GRP 3_SP_INDIGENT_NM** monthly GERD.

2) Medical Billing Associate (MBA) 1 will process **GRP 3_ SP_INDIGENT_TX** (Letters A – L) monthly GERD.

3) Senior Business Assistant 2 will routinely process **GRP 3_ SP_INDIGENT_TX** (Letters M – Z) monthly GERD, **GRP 3_MCD PENDING, GRP 3_TES_MEDICAID_SELFPAY,** and **GRP 3_TES_MEDICARE_SELFPAY; GRP 3 60 DAY - EL PASO** Medicare plans and **GRP 3 MONTHLY - EL PASO** will be processed as time permits.

4) Senior Business Assistants 3 and 4 will process **GRP 3 60 DAY - EL PASO** for commercial plans as time permits.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Sheriff Department/Juvenile Detention Collections**

Policy#: BAC 7

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to patients who are inmates of the El Paso County Sheriff Department or the El Paso County Juvenile Probation Department. TTUHSC submits paper claims daily on behalf of individuals covered and under custody of the El Paso County Sheriff Department FSC 22 and Juvenile Probation Department FSC 327 and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) The El Paso County Sheriff Department houses adult inmates at two facilities: 601 Overland Ave., El Paso, TX, 79901 and 12501 Montana, El Paso, Texas, 79938. The Juvenile Detention department houses juvenile offenders up to 17 years of age at 6400 Delta, El Paso, Texas, 79905. Authorized services are billed as indicated below:

	Sheriff	Hospital District	Juvenile
	FSC 22/J94	FSC 376/J10	FSC 327
Non-Resident Inpatient/UMC POS 21	X		X
Non-Resident Outpatient/UMC POS 22	X		X
Non-Resident Texas Tech Clinic POS 11	X		X
Non-Resident Emergency Medicine Dept. UMC (99283, 99284, 99285) POS 23	X		X
Non-Resident Emergency Dept. all Specialties POS 23	X		
Resident Inpatient/UMC POS 21		X	X
Resident Outpatient/UMC POS 22	X		X

Resident Emergency Medicine Dept. UMC (99283, 99284, 99285) POS 23	X		X
Resident Emergency Dept. all Specialties POS 23		X	X
Jail address Inpatient/UMC POS 21	X		N/A
Jail Address Outpatient/UMC POS 22	X		N/A
Jail Address Texas Tech Clinic POS 11	X		N/A
Jail address Emergency Medicine Dept. UMC (99283, 99284, 99285) POS 23	X		N/A
Jail address Emergency Dept. all Specialties POS 23	X		N/A

2) Paper claims are billed daily; there is no filing deadline. Sheriff Department claims are mailed Certified Return Receipt to: El Paso County Sheriff's Department, 3850 Justice Dr., El Paso, Texas, 79938 or faxed to (915) 538-2246 to the attention of Theresa Elias. Juvenile Department claims and a corresponding form letter are billed by fax to (915) 849-2028 to the attention of Laura Moreno, Accounting Clerk; form letter is included.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed by contacting Theresa Elias at (915) 538-2234; follow-up for the Juvenile Probation Department is performed by contacting Laura Moreno at (915) 849-2605.

5) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with Sheriff Department of Juvenile Detention department personnel. Appeal deadlines do not apply.

6) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is completed by telephone call to the Sheriff Department or Juvenile Probation Department contacts.

7) Charges determined after adjudication to be patient responsibility, including deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Senior Business Assistants 1 and 2: claim edits, correspondence, follow-up, and appeals.

Texas Tech Physicians
of EL PASO

PO Box 9520 • El Paso, TX 79995-9520 • Phone: 915-215-4700 • Fax: 915-594-3585

Date

El Paso County Juvenile Probation Dept.
6400 Delta
El Paso, Texas 79905

Attn: Laura Moreno

Invoice#3TXXXXXXX
MRN# EXXXXXX
Juvenile Name:
Juvenile DOB:
Date of service: DD/MM/YY (CPT Code – CPT Description) $Billed Amount
DD/MM/YY (CPT Code – CPT Description) $Billed Amount
DD/MM/YY (CPT Code – CPT Description) $Billed Amount

Related Cost: $Total Amount Billed

If you have any questions please call me at 915-215-XXXX.

Sincerely,

Staff Member Name
Title

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Southwest Transplant Alliance Billing and Collections**

Policy#: BAC 8

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to patients that are eligible for organ donation. Southwest Transplant Alliance (STA) is an organization that pays all charges subsequent to the patient becoming an organ donor. This occurs once the patient has been pronounced brain dead and consent for organ donation has been obtained from the next of kin. Charges prior to this time are billed to patient's insurance or Hospital District. TTUHSC files daily electronic claims on behalf of individuals covered by STA, and bills the patient's next of kin for any outstanding balances or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Southwest Transplant Alliance (STA) is billed for services where eligibility has been verified. Where eligibility cannot be verified with STA, the patient's insurance is billed, or, if classified as self-pay, is billed to Hospital District. All patient-responsible balances are billed to the next of kin after the claim has been adjudicated.

2) Southwest Transplant Alliance claims bill daily and electronically to Southwest Transplant Alliance, 5489 Blair Road Dallas, TX 75231. The filing deadline is 365 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ecttuweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis,

provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues, and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed by contacting Karmisha Pinkard: Phone: 214-522-0255, Fax: 214-522-0430, or by email at kpinkard@organ.org. Follow-up may include verification of time and date consent was signed.

6) Denials from Southwest Transplant Alliance state 'NOT OURS', which indicates the services were performed before the consent was signed. These invoices are submitted to the patient's insurance or to Hospital District if the patient is classified as self-pay.

RESPONSIBILITIES

1) Medical Billing Associates (MBA) I: claim edits, EDI rejections, correspondence, follow-up, and appeals.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Hospital District Collections**

Policy#: BAC 9

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to uninsured patients who receive services at University Medical Center (UMC) and El Paso Children's Hospital (EPCH) that are eligible under the Hospital District MSA contract. TTUHSC files electronic claims daily on behalf of individuals eligible for coverage under the Hospital District MSA contract for uninsured individuals. A monthly claims report is issued by ESI Healthcare Business Solutions outlining claims that were accepted and paid and claims that were unaccepted and denied. Monthly reports generated by MPIP analysts identify claims that did not transmit successfully and claims that remain outstanding. The business office researches any information needed to adjudicate a claim.

Procedures:

1) ESI Healthcare Business Solutions is billed daily and electronically for services provided to uninsured patients who qualify under the Hospital District MSA program; the filing deadline is 235 days from the date of service and claims are adjudicated according to Medicare guidelines. Services performed at University Medical Center (UMC) as inpatient, outpatient, and emergency room are covered for the following departments: Internal Medicine and subspecialties, Orthopaedic Surgery, Obstetrics and Gynecology, Surgery and subspecialties, Pediatrics (Hearing and Newborn Nursery), Neurology, Family Medicine, Radiology, Anesthesiology, and Pathology. The attached Hospital District Guide outlines the specific MSA effective dates.

2) El Paso Children's Hospital (EPCH) is billed monthly for services provided to uninsured patients who qualify under the EPCH MSA program; there is no filing deadline and claims are adjudicated according to the guidelines specified in the current MSA contract. Effective February 1, 2014, services performed at EPCH as inpatient, outpatient, and emergency room are covered for the following departments: Internal Medicine and subspecialties, Orthopaedic Surgery, Obstetrics and Gynecology, Surgery and subspecialties, Pediatrics, Neurology, Family Medicine, Radiology, Anesthesiology, and Pathology. The attached Hospital District Guide outlines the specific MSA effective dates.

3) ESI provides TTUHSC with monthly reports by the 10th business day of the month, consisting of executive summary reports and an Excel spreadsheet containing accepted and unaccepted claims. Claims are processed under the Service Proxy Month method, in which services dates are held for a period of 120 days to allow for billing lag time (e.g. June 2014 Service Proxy Month represents payment for October 2014).

4) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days. All accounts are reviewed for billing of additional qualifying invoices.

5) A minimum of 55 accounts are processed on a daily basis. Designated MPIP employees review the monthly unaccepted claim report and process appeals according to the denial CAR (Claim Adjustment Reason) codes within 30 business days; see attachment for CAR Code explanations. Appeal reasons are noted on the spreadsheet and the completed spreadsheet is uploaded to the ESI FTP secure website at: https://secureftp2.esinetwork.com/Logon.aspx?ReturnUrl=/Content.aspx. Denials for coverage under another insurance plan (CAR Code 177) are researched and billed to the appropriate plan using various resources, including UMC's Invision and Net Access programs, and various other Medicare, Medicaid, and commercial insurance portals.

   UMC/EPCH Cerner: http://159.140.84.81/Prod/auth/login.aspx?CTX_FromLoggedoutPage=1

   UMC Invision:
   http://gld50gvp1.rsodm20.smsrsm.com/50GV/html/unsecured/clientPOOL50GV50GVCICSRC9H.html

   UMC NetAccess:
   http://192.168.10.16/50gv-ntap-bin/webclogn.exe/PRD?Locator=N&&&&&&&&&&&&&&

   EPCH Invision:
   http://gld50gvp1.rsodm20.smsrsm.com/40gv/html/unsecured/Client40GVCICSRC9H.html

   EPCH Net Access:
   http://192.168.10.16/50gv-ntap-bin/webclogn.exe/PRD?Locator=N&&&&&&&AUTH=el%20paso%20childrens%20hospital&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&

RESPONSIBILITIES

1) Sr. Medical Billing Associate I and Medical Billing Associate (MBA) I: claim edits, follow-up, and appeals.

HOSPITAL DISTRICT GUIDE

Hospital District (HD) Divisions
Revised 4-3-14

Department	Division / Billing Area Number	Covered Hospital	Covered Locations OPH & IPH ERH CPT Codes Not Covered: 99283 99284 99285	Service Effective - End date	Previous contract (MSA) Full 104 Write Off	NEW Service effective - End date	New contract (HD) Notes / Comment	If PT has Crime Victims
Anesthesia	1	UMC	Same	N/A	YES	11/01/2012	375 HD Pmt, Full 104 W/O** If invoice has a credit keep both HD and PT pmt, write off up to the credit amt	Bill everything to HD HD Pays 375 HD Pmt Full 104 W/O
Radiology	34	UMC	Same	N/A	NO	09/01/2012	375 HD Pmt, Balance bill the PT No 104 W/O Note: Additional 104 W/O for 19103 - Add'l 104 W/O $1,257.89 PT Bal $368.53 58340 - Add'l 104 W/O $1,291.09 PT Bal $114.02	Bill everything to HD HD Pays 375 HD Pmt Full 104 W/O
Family Medicine	3	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011	375 HD Pmt, Full 104 W/O	Bill everything to HD HD Pays 375 HD Pmt Full 104 W/O
Internal Medicine	5	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011		
Neurology	6	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011		
OB/GYN	7	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011		
Epilepsy	25	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011		
Managed Health Care ??	29	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011		
Pediatrics	11	UMC	Same	10/01/08 - 10/31/11	99460, 99462, 99464	10/01/2008	375 HD Pmt, Full 104 W/O	Bill everything to HD HD Pays 375 HD Pmt Full 104 W/O
					99238	10/01/2008	376 HD Adj, Balance bill the PT * No 104 W/O	
	11	EPCH	Same	10/01/08 - 10/31/11	Billing Area MUST be Pedi	10/01/2008	376 HD Adj, Balance bill the PT No 104 W/O	
Orthopedic Surgery & Surgery General	30066, 30067, 30068, 30069, 30070, 30071, 30072, 30073, 30075, 30078, 30102, 30103, 30104, 30105, 30106, 30107, 30108, 30111, 30112, 30113, 30115, 30153, 30154, 30160, 30167, 30196	UMC	Same	10/01/08 - 10/31/11	Yes	07/01/2011	375 HD Pmt, Full 104 W/O	Bill everything to HD HD Pays 375 HD Pmt Full 104 W/O
Orthopedic Trauma	30074, 30075, 30076, 30077, 30096, 30097, 30098, 30099, 30158, 30159	UMC	Same	10/01/08 - 10/31/11	NO	BEFORE DOS 10/1/2013	376 HD Adj, Balance Bill PT No 104 W/O	Bill Crime Victim & Keep Crime Victim Payment
Surgery Trauma	30101, 30135, 30144, 30147				YES	AFTER DOS 10/1/2013	375 HD Pmt, Full 104 W/O	Bill everything to HD, HD Pays 375 HD Pmt, Full 104 W/O

Qualifications for HD

Invoice FSC:	375, 376
Invoice balance:	> 0.00
Total Charge:	> 0.00
Locations:	1- IPH: Inpatient (POS 21) 2- OPH: Outpatient (POS 22) 23-ERH: Emergency Room-Excluding ER visit: 99283, 99284, 99285 (POS 23) HD will pay ER x-ray charges: ex. -2872178?

Notes: 375 - HD Pmt (pmt column)
376 - HD Adj (Adj column)
DOS - Date of Service
Do NOT bill HD if patient has a Commercial Ins Plan or for FSC 30 (OB Pkg)
Bill HD if patient has NO Insurance, Medicare Part A only, ER Medicaid with a second denial or Perinate, see flow chart
Filing Deadline is 235 days and 30 days to appeal
*$57.52
** No Anes Pkgs after 11-1-12. Per contract, Full W/O will take place one month after 1st invoice is sent out to PT

CAR Code	CAR Code Description	Remark Code	ESI Usage for UMC/TTech Claims
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		Claim not payable if an expected modifier was not reported.
5	The procedure code is inconsistent with the place of service.	M77	Missing valid place of service.
6	Procedure code is inconsistent with the patient's age.		Claim is not payable if the reported service code age appropriate.
7	Procedure code is inconsistent with the patient's gender.		Claim not payable if the reported service code gender appropriate.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M76	Missing/incomplete/invalid diagnosis or condition.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	M51	Claim not payable if the claim contains an invalid CPT Code or invalid for date range. Includes denial for Consult Codes not accepted by Medicare.
18	Duplicate claim/service.		Duplicate claim/service
18	Duplicate claim/service.	N233	Additional review with operative note/report
22	Claim denied as this care may be covered by another payer. Medicaid.		Medicaid pending plan through 6 months.
26	Expenses incurred prior to coverage.	N173	No Account found with matching MRN and date of service within account matching criteria.
26	Expenses incurred prior to coverage.	M127	No MRN found within patient account matching criteria.
29	The timely filing limit has expired.		Timely filing limit has expired.
31	Claim denied as patient cannot be identified as our insured. Medicare.		SSI Pending Plan up to 6 months.
38	Services not provided or authorized by designated billing providers.	N257	Claim not payable if provider id is invalid, does not have the requisite provider type (B or P), or where the claim DOS is within the effective and term dates.
38	Services not provided or authorized by designated performing providers.	N290	Claim not payable if provider id is invalid, does not have the requisite provider type (B or P), or where the claim DOS is within the effective and term dates.
45	Charges exceed our fee schedule or maximum allowable amount.		Claim paid according to the applicable payment methodology, including Midlevel Provider and Asst. or Co-Surgeons.
45	Charges exceed our fee schedule or maximum allowable amount.	M15	Payment of Bilateral/Mult Services have been bundled as they are considered components of the same procedure.
97	Global Surgery. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
177	Payment denied because the patient has not met the required eligibility requirements		Claim not payable if the Finplan of the matching registration is not a payable plan code.
B1	Non-covered Department/Visits.		Department is not included in MSA.
B14	Only one E/M visit per physician/specialty per day is covered.		

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Correspondence Processing - Payers**

Policy#: BAC 10

Policy: The purpose of this policy is to outline the procedure for processing the correspondence received by the TTUHSC El Paso MPIP office. Correspondence from payers, which is addressed to the main campus or the established MPIP PO Box, is delivered to the MPIP office by TTUHSC mail delivery staff. Examples of the correspondence received from payers include explanation of benefits for claim denials, payments, refund requests, requests for information, notification of provider enrollment, authorization notifications, prescription information, Medicare Managed Care Physical Exam and Health Maintenance Reports (HMRs), and appeal status notifications. Correspondence is sorted by the designated mail processor and distributed to the appropriate staff members for batching and processing.

Procedure:

1) Mail is delivered to the MPIP office by TTUHSC mail delivery staff; designated mail processor separates all envelopes with payments and forward them to the appropriate payment posting staff member for processing. The remaining correspondence is removed from the envelope and date stamped.

2) Mail processor sorts the correspondence by the following payer categories: Medicare and Medicaid, commercial insurance, and prescription information. Any undistinguishable mail is forwarded to a billing and collection unit supervisor or manager for review to determine appropriate action required.

3) Correspondence is forwarded to the designated billing and collection supervisor or manager for batching and distribution. The batch slip contains the distribution and due date; batches are logged into the Correspondence Log Form (see attached) and distributed to the appropriate staff members, who acknowledge receipt by initialing. Processing of correspondence is completed within 3 working days or as determined by the supervisor or manager. Upon receipt of completed batch, supervisor or manager initials the Correspondence Log Form.

Correspondence Categories:

1) Explanation of Benefits/Denials: Processor enters the denial into GE Centricity Business (GECB) using the payment posting function; invoice is researched and processed in the manner outlined

manner outlined in the denied claim policy, which may include verifying and updating the correct payer information and billing the claim, appealing the claim, or contacting the patient for additional information.

2) Refund requests: Supervisor or Manager will forward refund request to appropriate refund processing staff.

3) Requests for information: Requests for information may include medical records requests, pre-existing questionnaires, accident details, etc. Processor must determine appropriate action needed, which may require assistance from clinic personnel or information from the patient, completion of the required form, or medical record retrieval; notation of action should be entered at invoice level and/or in General Comments of GECB.

4) Provider Enrollment or other Enrollment/Credentialing Correspondence: Supervisor or Manager will scan the document and email it to the appropriate staff member in the Enrollment and Credentialing office and also forward the original via campus mail.

5) Authorization Notifications: Authorization information is entered into General Comments and the original document is forwarded to the appropriate clinical department for inclusion in the patient's Electronic Medical Record (EMR).

6) Prescription Information: Designated mail processor will forward the documentation to the clinical department of the corresponding provider.

7) Appeal Status Notifications: Medicaid appeal notifications will be noted at invoice level and the correspondence forwarded to the appropriate clinical department. All other appeal status notifications will be processed by the appropriate staff in the manner outlined in the denied claim policy.

8) Physical Exam and Health Maintenance Reports (HMRs): Medicare Managed Care physical exam forms are forwarded to Dr. Michael J. Romano, Associate Dean for Clinical Affairs, via campus mail.

9) Indistinguishable Correspondence: Supervisors will review and determine the appropriate actions required.

RESPONSIBILITIES

1) Sr. Business Assistant 1 and 2: On an alternating schedule will sort and distribute correspondence to appropriate staff for processing.

2) Senior Medical Billing Associates (MBA) 1-4, MBAs 1-6, and Sr. Business Assistants 1-4, and Student Assistants 1 and 2 will process correspondence as indicated in Correspondence Categories 1-9.

CORRESPONDENCE LOG - MONTH

Date	Due Date	Assigned To	Initials	# of Pages	Returned	Initials

BATCH CONTROL SLIP

BATCH PREPARER: INPUT OPERATOR:

Date Prepared _____ **Due Date:** _____ Date Entered _____

Employee_____ Batch # _____

Bank Deposit Date _____

Description i.e. dept/name/phone ext.)

II. CHARGES

PROCEDURE CONTROL TOTAL

(hash) _____

Total $ Charges _____

PROCEDURE CONTROL TOTAL

(hash) _____

Total $ Charges _____

PAYMENT / ADJUSTMENTS

Charge ADJ Total _____

Payment Total _____

Debit Payment Total _____

Batch Total _____

Charge ADJ Total $____

Payment Total _____

Debit Payment Total

Batch Total _____

For No Financial Change, Check One of Reasons Listed Below

|| **FSC Changes Only** [ ] DXS Only [ ] Deleted Batch
[ ] Recovery Invoices [ ] Referring Only [ ] . M (Move)

|| Comments

- ❑ *** Note: Explanation of total differences between side one and side two.
- ❑ PAST APPEAL DEADLINE Write/Offs Adjustments
- ❑ PAST FILING DEADLINE Write/Offs Adjustments
- ❑ NON-COVERED Write/Offs Adjustments
- ❑ ADJUSTMENTS REASONS BELOW: Form A
- ❑ OTHER- SEE COMMENTS BELOW:
- ❑ PAST APPEAL NEW MEXICO/PAST FILING DEADLINE NEW MEXICO INVS

Supervisor Approval: _____

Total # of sheets including Batch Slip #	**For Imaging Use Only:** numbers:	Reason for edit of page _____Double sided _____ Miscounted Total #Pages_____ Other:_____

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 4/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **University Medical Center/El Paso Children's Hospital IT Access**

Policy#: BAC 11

Policy: The purpose of this policy is to outline the procedure for obtaining access to University Medical Center and El Paso Children's Hospital medical records and practice management programs: Cerner, Net Access (Care base), Invision (OAS Gold UMC, OAS Gold El Paso Children's Hospital).

Procedures:

1) A Role Based Access Control (RBAC) request form and a Confidentiality and Security Agreement form are completed and signed for each program that the employee is requesting access. The forms are completed and given to the supervisor/manager for submission.

2) The Role Based Access Control (RBAC) request form and the Confidentiality and Security Agreement forms are emailed to Yvette Quintana-Chavez, HIPAA Compliance Officer, at Yvette.QuintanaChavez@ttuhsc.edu.

3) Upon approval by the Texas Tech Institutional HIPAA compliance officer, the forms are emailed to Sylvia Pendell, IT Office Coordinator for UMC at spendell@umcelpaso.org and processed for access.

4) Access is granted within 24 to 48 hours, after which Sylvia Pendell notifies the MPIP supervisor/manager when the passwords are ready for pick-up. Passwords are picked up by the MPIP supervisor/manager at the University Medical Center Annex building, IT Dept. Room 402.

5) Once the password is given to the employee , the supervisor/manager confirms that the employee is able to log into the programs.

6) If UMC programs are not accessed within a 6 month period, the account will be closed and the employee must submit another Role Based Access Control (RBAC) request form and the Confidentiality and Security Agreement forms again as a new process for access.

7) UMC IT is contacted for issues at 915-521-7941, option 2. Nick Torres, IT Security Representative, may be contacted via email at NTorres@umcelpaso.org for assistance.

RESPONSIBILITIES

1) Medical Billing Supervisor 1: complete registration process for MPIP billing and collection employees

Confidentiality and Security Agreement

I understand that El Paso County Hospital District (EPCHD) in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information. I also understand that EPCHD has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, EPCHD must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information")

In the course of my employment / assignment at EPCHD, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the EPCHD's Privacy and Security Policies, which are available on the EPCHD's Intranet (under Compliance & under Hospital Policies/Information Management). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

I further recognize and acknowledge that the good will of EPCHD depends, among other things, upon its keeping such services and information confidential. I recognize that the disclosure of any information by the Associate may give rise to irreparable injury to EPCHD or to the owner of such information, and that accordingly, EPCHD or the owner of such information may seek legal remedies against me which may be available.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a legitimate business need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized under State and/or Federal Regulations. I will not permit any person whatsoever to examine or make copies of any reports or other documents prepared by me or coming into my control.
3. I understand that any copies (such as printing) of Confidential Information need to be handled appropriately. I understand that leaving printed confidential material unprotected is a violation of this Agreement.
4. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
5. I will not perform any unauthorized transmissions, inquiries, modifications, or unauthorized deletions of Confidential Information.
6. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with EPCHD.
7. I will act in the best interest of the EPCHD and in accordance with its Code of Conduct at all times during my relationship with EPCHD.
8. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the EPCHD, in accordance with EPCHD's policies. **I understand that certain violations may result in reporting to proper authorities and/or legal action.**
9. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
10. I will only access software systems to review patient records when I have the patient's consent to do so or I am involved in the treatment, payment, and/or operations for that patient. By accessing a patient's record, I am affirmatively representing to EPCHD at the time of each access that I have the requisite patient consent or authority to do so, and that EPCHD may rely on that representation in granting such access to me.
11. I understand that I should have no expectation of privacy when using EPCHD information systems. EPCHD may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as logging out when away from my computer, using screen savers with activated passwords, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I understand and agree that any computer, software, and storage media provided to me by EPCHD contains proprietary and confidential information and its customers or its vendors, and that this is and remains the property of EPCHD at all times.
15. I will review and understand EPCHD's Information Management Policies.
16. I will:
    a. Use only my officially assigned User-ID and password.
    b. Use only approved licensed software.
17. If accessing the system via a Virtual Private Network (VPN), I also will:
    a. Ensure that any device I use to access EPCHD's information systems has a virus detection program installed and enabled and that the virus pattern is consistently up-to-date.
    b. Schedule periodic virus scan of local disks and memory and follow the virus remediation procedure outlined by the software vendor should the computer become infected.

c. Install and configure a host based firewall and SpyWare detection software on my computer.

d. Maintain computer safeguards and ensure that the are up-to-date by installing Microsoft Security Updates

I will never:

a. Share/disclose user-IDs, passwords.

b. Use tools or techniques to break/exploit/disable security measures

c. Connect to unauthorized networks through the systems or devices; I will use the VPN connectivity for its intended use.

d. Establish VPN connectivity with EPCHD's systems if my computer is infected until I have followed the anti-virus software vendor recommended remediation procedure and I know that my computer is free of viruses.

I understand that any software (such as VPN) provided by EPCHD is on an "AS IS" basis; without any warranties or representations expressed or implied, including but not limited to, any implied warranties of merchantability or fitness for a particular use. The entire risk as to the results and the performance of the software is assumed by me (the user), and in no event shall EPCHD be liable for any consequential, incidental or direct damages suffered in the course of installing and/or using the software

20 I will notify the EPCHD Security Administrator or appropriate Information Technology representative if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

21. I agree that my obligations under this Agreement will continue after termination and/or separation of my employment, expiration of my contract, or my relationship ceases with EPCHD.

22 Upon termination / separation, I will immediately return any documents or media containing Confidential Information to EPCHD. I'm affirmatively representing that I will destroy (appropriately dispose of) any confidential information I may have maintained that I no longer should have access to as a result of my termination.

The following statements apply to Physicians, Office Administrators and/or other Authorized representatives, who use EPCHD systems from their Practices (remote locations) and request access to the systems for their office staff):

23. I will insure that only appropriate personnel in my office will access EPCHD's software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access

24 I will accept full responsibility for the actions of my employees who may access EPCHD's software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Business Entity Name / Organization
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Department Name
Associate Id.#	Date

University Medical Center of El Paso
INFORMATION TECHNOLOGY
Role Based Access Control
Request Form

Date: ___/___/___ Add Delete Change
(Please print. All fields are required before processing request.)

Associate Name _____ Associate # _____

Department Name _____ Work/Pager No _____

Position Title _____ Position Code _____

Domain _____

Legal Title CNA COTA CRT CST DT DTR EMT GN HUC LPTA LSW LVN MD MT NA NT OT PA PT RPH RN, RRT SN

Identity Validation Information:

Last 4 digits SS# _____ DOB (MM/DD) _____

For identity verification purposes, please provide a phrase _____
(ex. Favorite color, movie, pet's name, elementary school, band.)

- I acknowledge that this User Id and Password will give me access to Protected Health Information (PHI) as well as non-patient hospital information. Disclosure of confidential information may result in my termination and/or civil/criminal penalties
- I will, under no circumstances, give my password out to any other person. If at any time I feel my password confidentiality has been compromised, I will contact the Information Technologies department immediately

User Signature _____ System Access Effective Date _____

Student/Contract/Volunteer Exp Date _____

Password requests forwarded to IT Dept by 3:00pm will be processed by the end of next business day /System Access Effective Date.

*User's work responsibilities require access to computer systems identified for this position code based on Role Based Access Control definitions. If user no longer requires system access, I understand it is my responsibility to notify IT immediately

Department Director/Manager Authorized Designee approval required for all Additions and Deletions.

Name _____ Signature _____ Date _____
(Please Print)

[illegible]

c. Install and configure a host based firewall and Spy/Ware detection software on my computer.

d. Maintain computer safeguards and ensure that the are up-to-date by installing Microsoft Security Updates

I will never:

a. Share/disclose user-IDs, passwords.

b. Use tools or techniques to break/exploit/disable security measures

c. Connect to unauthorized networks through the systems or devices; I will use the VPN connectivity for its intended use.

d. Establish VPN connectivity with EPCHD's systems if my computer is infected until I have followed the anti-virus software vendor recommended remediation procedure and I know that my computer is free of viruses.

I understand that any software (such as VPN) provided by EPCHD is on an 'AS IS' basis; without any warranties or representations expressed or implied, including but not limited to, any implied warranties of merchantability or fitness for a particular use. The entire risk as to the results and the performance of the software is assumed by me (the user), and in no event shall EPCHD be liable for any consequential, incidental or direct damages suffered in the course of installing and/or using the software

20. I will notify the EPCHD Security Administrator or appropriate Information Technology representative if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

21. I agree that my obligations under this Agreement will continue after termination and/or separation of my employment, expiration of my contract, or my relationship ceases with EPCHD

22. Upon termination / separation, I will immediately return any documents or media containing Confidential Information to EPCHD. I'm affirmatively representing that I will destroy (appropriately dispose of) any confidential information I may have maintained that I no longer should have access to as a result of my termination.

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24. I will accept full responsibility for the actions of my employees who may access EPCHD's software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Business Entity Name / Organization
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Department Name
Associate Id.#	Date

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Medical Records Requests**

Policy#: BAC 12

Policy: The purpose of this policy is to outline the procedure for obtaining and/or requesting medical records for the purpose of submitting with original claim forms when required or for appealing denied claims. Medical records are required upon original claim submission in specific cases, such as when modifiers -22, -52, -53, and -62 are appended to a CPT code on a claim, and with all Veteran's Affairs and Workers Compensation claims. Medical records are also used as supporting documentation during the claims appeal process. Sources for medical records include TTUHSC El Paso Medical Records Department, electronic medical records (EMR) for services performed at TTUHSC Clinics, University Medical Center (UMC) Medical Records Department, UMC and El Paso Children's Hospital Cerner system, and to a lesser extent, other hospitals and dialysis centers.

TTUHSC El Paso Clinics

EMR access and training has been provided to all MPIP medical billing and collection staff to facilitate the submission of medical records with original claim submissions and for claim appeals purposes. Records found in EMR are for services performed at Texas Tech clinics. Paper medical records are requested directly from the Medical Records department for dates of service before EMR was implemented. Any records not located in EMR or in the Medical Records department are requested directly from the clinical department.

Procedure for EMR:

1) Electronic Medical Records (EMR) are accessed and printed from Citrix XenApp: http://awsctx/Citrix/XenApp/auth/login.aspx

2) EMR availability by clinical department:

- Family Medicine: September 2011
- OBGYN: November 2011
- Pediatrics (Physicians East): December 2011
- Pediatrics (Alberta): July 2012
- Pediatrics (Montwood): August 2012

- Internal Medicine: May 2012
- Southwest Endocrine Consultant (SWEC): July 2012
- Orthopaedic: December 2012
- Pain Management: January 15, 2013
- Psychiatry: Feb 26, 2013
- Ophthalmology: April 02, 2013
- University Breast Care Center (UBCC)/Renamed Garbar Breast Care Center (GBCC): April 30, 2013
- Surgery: June 04, 2013
- Neurology: October 29, 2013

Procedure for Paper Charts:

1) Requests for paper medical records are emailed to any one of the following employees in the Texas Tech Medical Records department and should contain the patient's first and last name, date of birth, E number, and date of service:

   Alejandra Ruiz: alejandra.ruiz@ttuhsc.edu
   Lupe Maldonado: lupe.maldonado@ttuhsc.edu
   Rosa Cabral: rosa.cabral@ttuhsc.edu
   Lilly Savala: lily.zavala@ttuhsc.edu

2) Medical records are transferred by the Medical Records department to the following folder in the MPIP Shared Drive: **MPIP MED REC RQSTS** and are identified by the MRN number and found in the subfolder labeled for the corresponding month in which it was requested.

University Medical Center and El Paso Children's Hospital

Procedure for EMR:

1) Access and print records available in EMR using Cerner: http://159.140.84.81/Prod/auth/login.aspx

Procedure for Paper Charts (UMC):

1) Paper medical records are obtained from the UMC Medical Records department once a week or as needed by a designated trained MPIP employee. Records are transported from UMC to MPIP in a sealed portfolio.

2) A UMC Medical Records Request form (included) is completed by MPIP employees requesting records. The request form is given to the designated employee or may be faxed to the UMC Medical Records department at 915-521-7688 and addressed to the designated employee who is obtaining the records. Confirmation of fax receipt is made by calling the UMC Medical Records department at 915-521-7690.

RESPONSIBILITIES

1) Medical Billing Associate 1: retrieve records from UMC once a week.

Date requested _____

UMC Medical Record Request

Requested by _____

Charts needed to pull documentation for Texas Tech MPIP -contact Ana Deslongchamps at (915)215-4755

Invoice #	TTU-E#	UMC #	Admit/DOS	Patient Name	DOB	Physician/Notes needed

Blue= progress notes, Beige= H&P or initial hospital visit, Green=Consult notes, Beige H&P or initial hospital visit

Make sure you have the complete note, if the note references to someone else's note both notes need to be pulled. Example: agree with residents Dr OXOXOX_or if the note says: see green consult note

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/1/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout,
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Medicaid/Medicaid Managed Care Appeals Process for Clinical Departments**

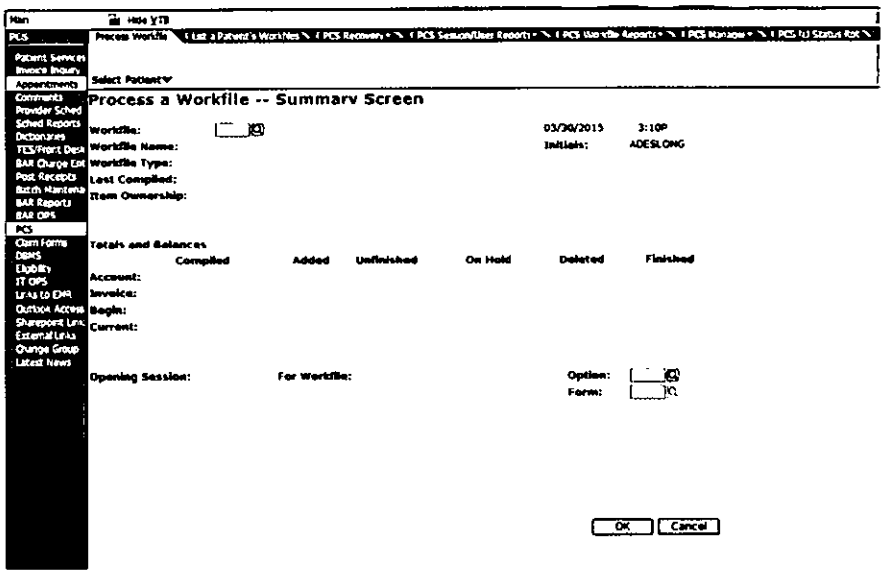
Policy#: BAC 13

Policy: The purpose of this policy is to outline the procedure for processing of appeals for Medicaid and Medicaid HMO plans. The TTUHSC business office files electronic claims daily on behalf of individuals covered by Medicaid programs, including but not limited to Medicaid Managed Care, Emergency Medicaid, Texas Women's Health Program, Children with Special Health Care Needs (CSHCN), New Mexico Medicaid, and out-of-state Medicaid plans. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal.

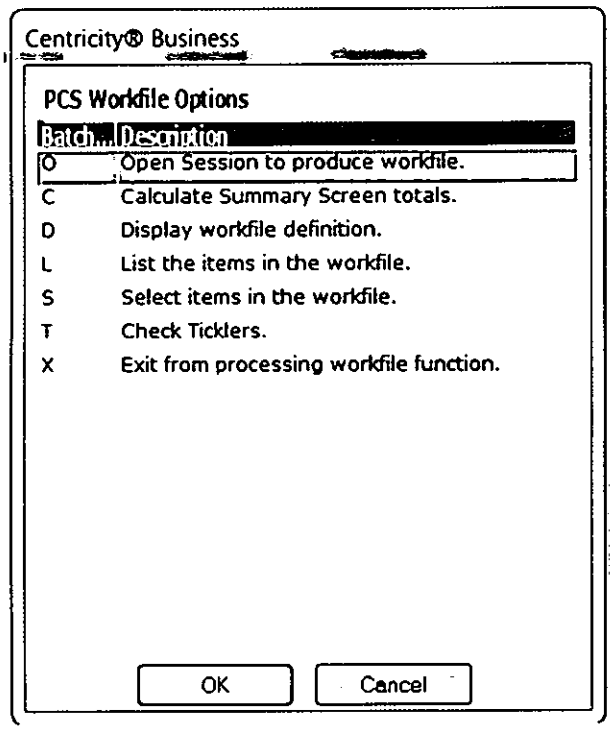
Appeals for Texas Medicaid plans are processed by clinical departments and the business office processes New Mexico Medicaid and out-of-state Medicaid denials. Texas Medicaid denied claims are placed at the Medicaid Pending Appeal FSC 335 and transfer into the departments' Paperless Collection System (PCS) workfiles for processing.

Procedures:

1) Access the assigned PCS workfile by entering the workfile number.

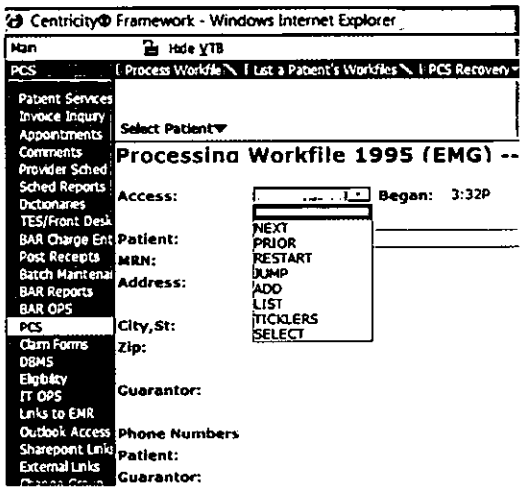


2. Under Option, select one of the following. To enter the workfile and process the invoices, select 'O'.



3. To process an invoice, select one of the following options. The most common options are:

NEXT – process the next invoice in the workfile
RESTART – use after exiting the workfile to return to the next unworked invoice
JUMP – select a specific invoice in the workfile by entering the invoice number



4. Review the invoice:

INVOICE LEVEL COMMENTS
PAYMENTS
DENIAL CODES/REASONS

- Obtain the TMHP R&S Report from the TMHP provider portal or the MPIP Repository
- Obtain Superior, El Paso First, Amerigroup, and Molina EOBs from the provider portal or the MPIP Repository

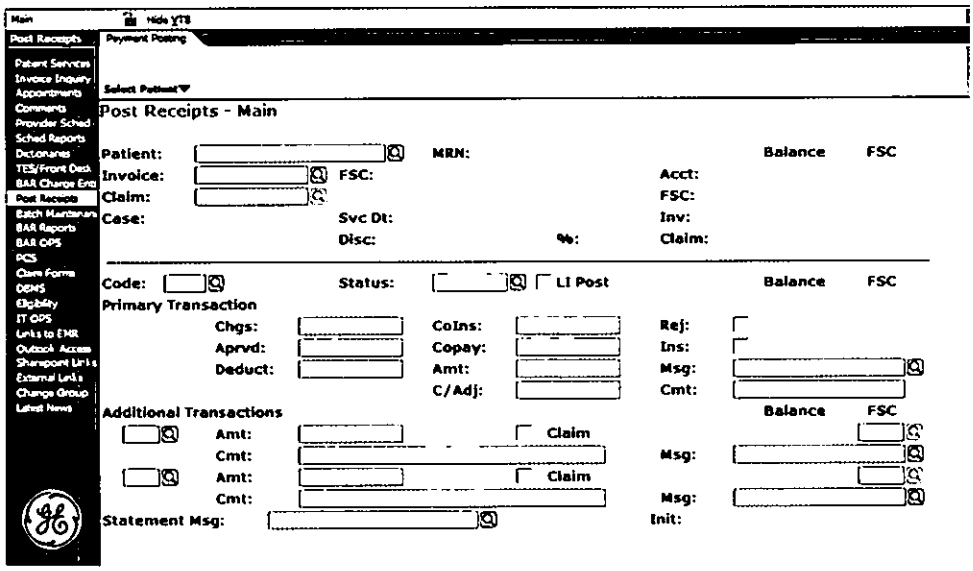
- Obtain GE Centricity EOBs for Superior, Amerigroup, El Paso First, and TMHP using the IT OPS function see attached instructions).

5. The denial information found on the R&S/EOB will determine if the invoice should be adjusted, appealed, or rebilled.

6. Review denial date on the EOB for submission within timely appeals deadline of 120 days and review the TMHP Filing Deadline Calendar for submission date deadlines. (Example included).

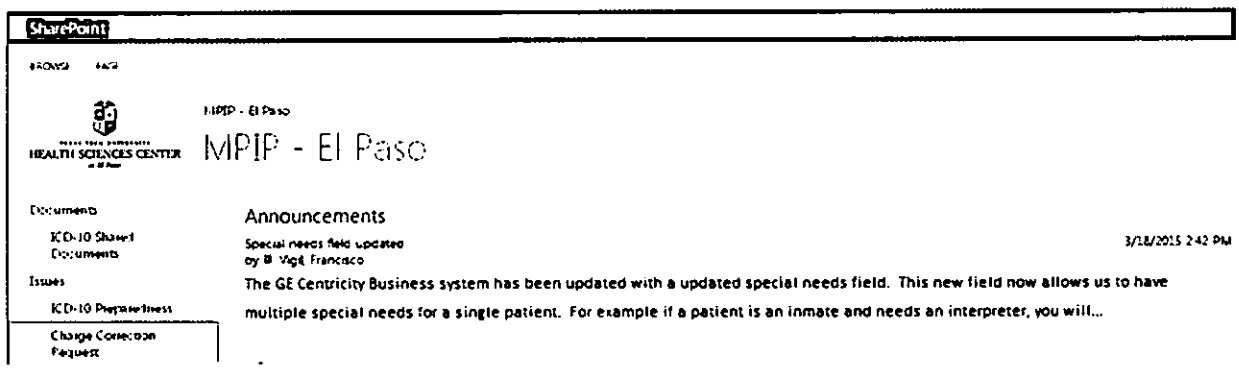
7. Adjustments

- Complete a Form A and obtain supervisor's signature
- Access the workfile and enter an invoice comment using the Post Receipts option 7 or 999 and paycode 74
- Submit Form A to MPIP office for adjustment (Sample Form A attached)



8. Paper Appeals

- If invoice requires a correction, complete a Form C using the SharePoint website: https://sharepoint.elpaso.ttuhsc.edu/support/mpip/SitePages/Home.aspx



- Specify Claim:N (selecting Claim Y will submit the claim electronically)
- Print new claim or request printed claim from MPIP
- Print the R&S/EOB

- Circle the invoice number on R&S/EOB
- Write the reason for the appeal on the bottom of the R&S
- Compile documentation in order: R&S/EOB, documentation, new claim. Pages should be numbered (1 of 3, 2 of 3, etc.)
- Make copies of all items for batching and scanning into MPIP repository
- Send by U.S. Postal Service Certified Mail
- Access the workfile and enter an invoice comment using the Post Receipts option 7 or 999 and paycode 74, record Certified Mail number

9. Rebill a Corrected Claim

- Review account to ensure no payment has been issued or received
- Claim must be within the 95-day filing deadline
- Complete a Form C using the SharePoint website
- Specify Claim: Y to submit claim electronically
- Access the workfile and enter an invoice comment using the Post Receipts option 7 or 999 and paycode 74

10. Online appeals

Online appeals are available on the provider portals for TMHP, Molina Texas, El Paso First, and Superior Health Plan.

The process is similar to the paper appeal process; however, the portal allows for uploading and submission of documentation and eliminates the need for mailing.

11. Self-Pay Charges

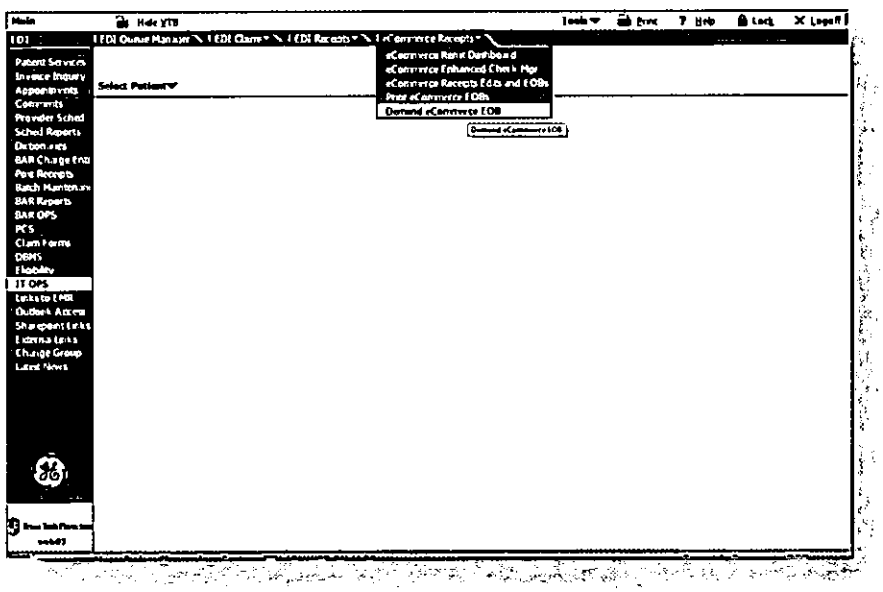
Charges determined after adjudication to be patient responsibility, including ineligibility of benefits or non-covered services, are billed to the patient. Some exceptions may apply if the services are covered under the Hospital District MSA program. Charges are billed to the patient if the patient failed to notify TTUHSC of Medicaid coverage within the filing deadline.

Printing of Explanation of Benefits through Centricity Business EDI

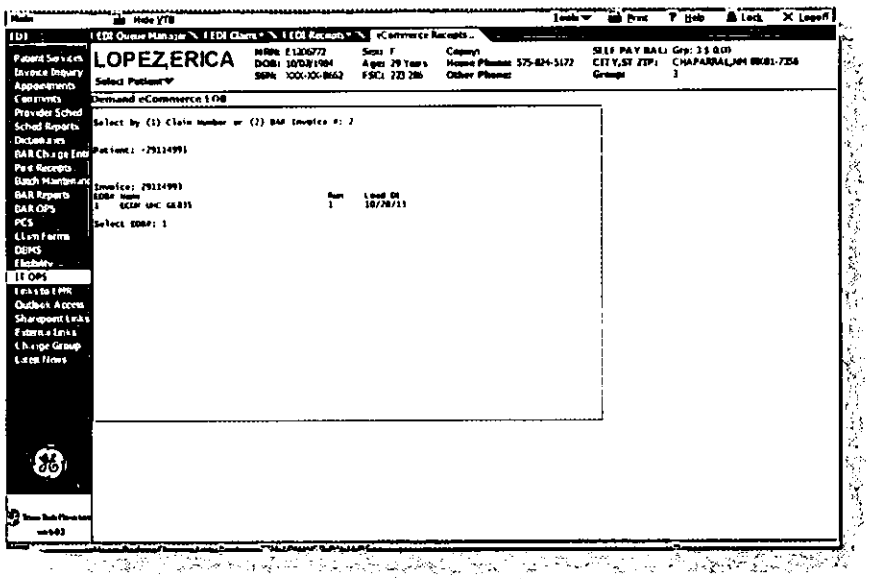
Explanation of benefits will be available for printing directly through Centricity Business EDI for plans that have transitioned to eCommerce remits. The EOBs will no longer be included in the scanned payment batches in the document repository for Blue Cross or United HealthCare. The following plans have transitioned to eCommerce remits:

- Blue Cross Blue Shield as of 11/8/13
- El Paso First as of 10/28/13
- HealthCare Options as of 10/28/13
- Preferred Administrators as of 11/4/13
- United HealthCare as of 10/28/13
- Medicare/Novitas as of 1/24/14
- Cigna as of 1/15/2015
- Humana as of 1/15/2015
- Aetna as of 1/15/2015
- Amerigroup as of 3/1/15

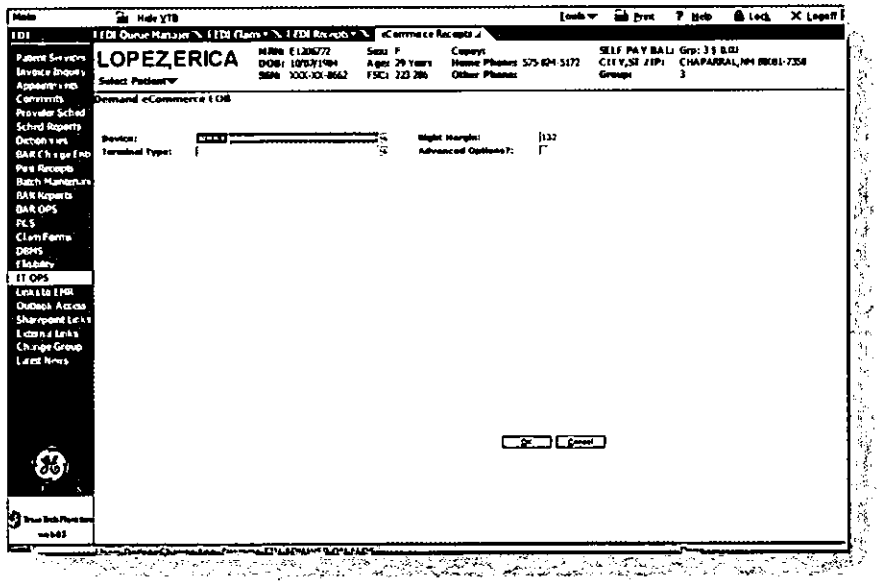
Procedure for Printing EOBs
In Centricity Business:
-Select IT OPS
-Select EDI
-eCommerce Receipts
-Demand eCommerce EOB



-Select by (2) BAR invoice number
-At Patient, enter invoice number in the following format: -12345678
-At Select EOB#, enter the number of the desired EOB (ex. 1, 2)



-Select the Device for printing



Filing Deadline Calendar for 2015

Note: If the 95th or 120th day falls on a weekend or a holiday, the filing deadline is extended to the next business day.

Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days
01/01 (001)	04/06 (096)	05/01 (121)	03/02 (061)	06/05 (156)	06/30 (181)	06/01 (121)	08/04 (216)	08/31 (243)
01/02 (002)	04/07 (097)	05/04 (124)	03/03 (062)	06/08 (159)	07/01 (182)	06/02 (122)	08/05 (217)	08/31 (243)
01/03 (003)	04/08 (098)	05/04 (124)	03/04 (063)	06/08 (159)	07/02 (183)	06/03 (123)	08/06 (218)	08/31 (243)
01/04 (004)	04/09 (099)	05/04 (124)	03/05 (064)	06/08 (159)	07/03 (184)	06/04 (124)	08/07 (219)	09/01 (244)
01/05 (005)	04/10 (100)	05/05 (125)	03/06 (065)	06/09 (160)	07/06 (187)	06/05 (125)	08/10 (222)	09/02 (245)
01/06 (006)	04/13 (103)	05/06 (126)	03/07 (066)	06/10 (161)	07/06 (187)	06/06 (126)	08/10 (222)	09/03 (246)
01/07 (007)	04/13 (103)	05/07 (127)	03/08 (067)	06/11 (162)	07/06 (187)	06/07 (127)	08/10 (222)	09/04 (247)
01/08 (008)	04/13 (103)	05/08 (128)	03/09 (068)	06/12 (163)	07/07 (188)	06/08 (128)	08/11 (223)	09/08 (251)
01/09 (009)	04/14 (104)	05/11 (131)	03/10 (069)	06/15 (166)	07/08 (189)	06/09 (129)	08/12 (224)	09/08 (251)
01/10 (010)	04/15 (105)	05/11 (131)	03/11 (070)	06/15 (166)	07/09 (190)	06/10 (130)	08/13 (225)	09/08 (251)
01/11 (011)	04/16 (106)	05/11 (131)	03/12 (071)	06/15 (166)	07/10 (191)	06/11 (131)	08/14 (226)	09/08 (251)
01/12 (012)	04/17 (107)	05/12 (132)	03/13 (072)	06/16 (167)	07/13 (194)	06/12 (132)	08/17 (229)	09/09 (252)
01/13 (013)	04/20 (110)	05/13 (133)	03/14 (073)	06/17 (168)	07/13 (194)	06/13 (133)	08/17 (229)	09/10 (253)
01/14 (014)	04/20 (110)	05/14 (134)	03/15 (074)	06/18 (169)	07/13 (194)	06/14 (134)	08/17 (229)	09/11 (254)
01/15 (015)	04/20 (110)	05/15 (135)	03/16 (075)	06/19 (170)	07/14 (195)	06/15 (135)	08/18 (230)	09/14 (257)
01/16 (016)	04/21 (111)	05/18 (138)	03/17 (076)	06/22 (173)	07/15 (196)	06/16 (136)	08/19 (231)	09/14 (257)
01/17 (017)	04/22 (112)	05/18 (138)	03/18 (077)	06/22 (173)	07/16 (197)	06/17 (137)	08/20 (232)	09/14 (257)
01/18 (018)	04/23 (113)	05/18 (138)	03/19 (078)	06/22 (173)	07/17 (198)	06/18 (138)	08/21 (233)	09/15 (258)
01/19 (019)	04/24 (114)	05/19 (139)	03/20 (079)	06/23 (174)	07/20 (201)	06/19 (139)	08/24 (236)	09/16 (259)
01/20 (020)	04/27 (117)	05/20 (140)	03/21 (080)	06/24 (175)	07/20 (201)	06/20 (140)	08/24 (236)	09/17 (260)
01/21 (021)	04/27 (117)	05/21 (141)	03/22 (081)	06/25 (176)	07/20 (201)	06/21 (141)	08/24 (236)	09/18 (261)
01/22 (022)	04/27 (117)	05/22 (142)	03/23 (082)	06/26 (177)	07/21 (202)	06/22 (142)	08/25 (237)	09/21 (264)
01/23 (023)	04/28 (118)	05/26 (146)	03/24 (083)	06/29 (180)	07/22 (203)	06/23 (143)	08/26 (238)	09/21 (264)
01/24 (024)	04/29 (119)	05/26 (146)	03/25 (084)	06/29 (180)	07/23 (204)	06/24 (144)	08/27 (239)	09/21 (264)
01/25 (025)	04/30 (120)	05/26 (146)	03/26 (085)	06/29 (180)	07/24 (205)	06/25 (145)	08/28 (240)	09/22 (265)
01/26 (026)	05/01 (121)	05/26 (146)	03/27 (086)	06/30 (181)	07/27 (208)	06/26 (146)	08/31 (243)	09/23 (266)
01/27 (027)	05/04 (124)	05/27 (147)	03/28 (087)	07/01 (182)	07/27 (208)	06/27 (147)	08/31 (243)	09/24 (267)
01/28 (028)	05/04 (124)	05/28 (148)	03/29 (088)	07/02 (183)	07/27 (208)	06/28 (148)	08/31 (243)	09/25 (268)
01/29 (029)	05/04 (124)	05/29 (149)	03/30 (089)	07/03 (184)	07/28 (209)	06/29 (149)	09/01 (244)	09/28 (271)
01/30 (030)	05/05 (125)	06/01 (152)	03/31 (090)	07/06 (187)	07/29 (210)	06/30 (150)	09/02 (245)	09/28 (271)
01/31 (031)	05/06 (126)	06/01 (152)	04/01 (091)	07/06 (187)	07/30 (211)	06/31 (151)	09/03 (246)	09/28 (271)
02/01 (032)	05/07 (127)	06/01 (152)	04/02 (092)	07/06 (187)	07/31 (212)	06/01 (152)	09/04 (247)	09/29 (272)
02/02 (033)	05/08 (128)	06/02 (153)	04/03 (093)	07/07 (188)	08/03 (215)	06/02 (153)	09/08 (251)	09/30 (273)
02/03 (034)	05/11 (131)	06/03 (154)	04/04 (094)	07/08 (189)	08/03 (215)	06/03 (154)	09/08 (251)	10/01 (274)
02/04 (035)	05/11 (131)	06/04 (155)	04/05 (095)	07/09 (190)	08/03 (215)	06/04 (155)	09/08 (251)	10/02 (275)
02/05 (036)	05/11 (131)	06/05 (156)	04/06 (096)	07/10 (191)	08/04 (216)	06/05 (156)	09/08 (251)	10/05 (278)
02/06 (037)	05/12 (132)	06/08 (159)	04/07 (097)	07/13 (194)	08/05 (217)	06/06 (157)	09/09 (252)	10/05 (278)
02/07 (038)	05/13 (133)	06/08 (159)	04/08 (098)	07/13 (194)	08/06 (218)	06/07 (158)	09/10 (253)	10/05 (278)
02/08 (039)	05/14 (134)	06/08 (159)	04/09 (099)	07/13 (194)	08/07 (219)	06/08 (159)	09/11 (254)	10/06 (279)
02/09 (040)	05/15 (135)	06/09 (160)	04/10 (100)	07/14 (195)	08/10 (222)	06/09 (160)	09/14 (257)	10/07 (280)
02/10 (041)	05/18 (138)	06/10 (161)	04/11 (101)	07/15 (196)	08/10 (222)	06/10 (161)	09/14 (257)	10/08 (281)
02/11 (042)	05/18 (138)	06/11 (162)	04/12 (102)	07/16 (197)	08/10 (222)	06/11 (162)	09/14 (257)	10/09 (282)
02/12 (043)	05/18 (138)	06/12 (163)	04/13 (103)	07/17 (198)	08/11 (223)	06/12 (163)	09/15 (258)	10/13 (286)
02/13 (044)	05/19 (139)	06/15 (166)	04/14 (104)	07/20 (201)	08/12 (224)	06/13 (164)	09/16 (259)	10/13 (286)
02/14 (045)	05/20 (140)	06/15 (166)	04/15 (105)	07/20 (201)	08/13 (225)	06/14 (165)	09/17 (260)	10/13 (286)
02/15 (046)	05/21 (141)	06/15 (166)	04/16 (106)	07/20 (201)	08/14 (226)	06/15 (166)	09/18 (261)	10/13 (286)
02/16 (047)	05/22 (142)	06/16 (167)	04/17 (107)	07/21 (202)	08/17 (229)	06/16 (167)	09/21 (264)	10/14 (287)
02/17 (048)	05/26 (146)	06/17 (168)	04/18 (108)	07/22 (203)	08/17 (229)	06/17 (168)	09/21 (264)	10/15 (288)
02/18 (049)	05/26 (146)	06/18 (169)	04/19 (109)	07/23 (204)	08/17 (229)	06/18 (169)	09/21 (264)	10/16 (289)
02/19 (050)	05/26 (146)	06/19 (170)	04/20 (110)	07/24 (205)	08/18 (230)	06/19 (170)	09/22 (265)	10/19 (292)
02/20 (051)	05/26 (146)	06/22 (173)	04/21 (111)	07/27 (208)	08/19 (231)	06/20 (171)	09/23 (266)	10/19 (292)
02/21 (052)	05/27 (147)	06/22 (173)	04/22 (112)	07/27 (208)	08/20 (232)	06/21 (172)	09/24 (267)	10/19 (292)
02/22 (053)	05/28 (148)	06/22 (173)	04/23 (113)	07/27 (208)	08/21 (233)	06/22 (173)	09/25 (268)	10/20 (293)
02/23 (054)	05/29 (149)	06/23 (174)	04/24 (114)	07/28 (209)	08/24 (236)	06/23 (174)	09/28 (271)	10/21 (294)
02/24 (055)	06/01 (152)	06/24 (175)	04/25 (115)	07/29 (210)	08/24 (236)	06/24 (175)	09/28 (271)	10/22 (295)
02/25 (056)	06/01 (152)	06/25 (176)	04/26 (116)	07/30 (211)	08/24 (236)	06/25 (176)	09/28 (271)	10/23 (296)
02/26 (057)	06/01 (152)	06/26 (177)	04/27 (117)	07/31 (212)	08/25 (237)	06/26 (177)	09/29 (272)	10/26 (299)
02/27 (058)	06/02 (153)	06/29 (180)	04/28 (118)	08/03 (215)	08/26 (238)	06/27 (178)	09/30 (273)	10/26 (299)
02/28 (059)	06/03 (154)	06/29 (180)	04/29 (119)	08/03 (215)	08/27 (239)	06/28 (179)	10/01 (274)	10/26 (299)
03/01 (060)	06/04 (155)	06/29 (180)	04/30 (120)	08/03 (215)	08/28 (240)			

Continued on page 2

Date of Service or Disposition	95 Days	120 Days
Continued from page 1		
06/29 (180)	10/02 (275)	10/27 (300)
06/30 (181)	10/05 (278)	10/28 (301)
07/01 (182)	10/05 (278)	10/29 (302)
07/02 (183)	10/05 (278)	10/30 (303)
07/03 (184)	10/06 (279)	11/02 (306)
07/04 (185)	10/07 (280)	11/02 (306)
07/05 (186)	10/08 (281)	11/02 (306)
07/06 (187)	10/09 (282)	11/03 (307)
07/07 (188)	10/13 (286)	11/04 (308)
07/08 (189)	10/13 (286)	11/05 (309)
07/09 (190)	10/13 (286)	11/06 (310)
07/10 (191)	10/13 (286)	11/09 (313)
07/11 (192)	10/14 (287)	11/09 (313)
07/12 (193)	10/15 (288)	11/09 (313)
07/13 (194)	10/16 (289)	11/10 (314)
07/14 (195)	10/19 (292)	11/12 (316)
07/15 (196)	10/19 (292)	11/12 (316)
07/16 (197)	10/19 (292)	11/13 (317)
07/17 (198)	10/20 (293)	11/16 (320)
07/18 (199)	10/21 (294)	11/16 (320)
07/19 (200)	10/22 (295)	11/16 (320)
07/20 (201)	10/23 (296)	11/17 (321)
07/21 (202)	10/26 (299)	11/18 (322)
07/22 (203)	10/26 (299)	11/19 (323)
07/23 (204)	10/26 (299)	11/20 (324)
07/24 (205)	10/27 (300)	11/23 (327)
07/25 (206)	10/28 (301)	11/23 (327)
07/26 (207)	10/29 (302)	11/23 (327)
07/27 (208)	10/30 (303)	11/24 (328)
07/28 (209)	11/02 (306)	11/25 (329)
07/29 (210)	11/02 (306)	11/30 (334)
07/30 (211)	11/02 (306)	11/30 (334)
07/31 (212)	11/03 (307)	11/30 (334)
08/01 (213)	11/04 (308)	11/30 (334)
08/02 (214)	11/05 (309)	11/30 (334)
08/03 (215)	11/06 (310)	12/01 (335)
08/04 (216)	11/09 (313)	12/02 (336)
08/05 (217)	11/09 (313)	12/03 (337)
08/06 (218)	11/09 (313)	12/04 (338)
08/07 (219)	11/10 (314)	12/07 (341)
08/08 (220)	11/12 (316)	12/07 (341)
08/09 (221)	11/12 (316)	12/07 (341)
08/10 (222)	11/13 (317)	12/08 (342)
08/11 (223)	11/16 (320)	12/09 (343)
08/12 (224)	11/16 (320)	12/10 (344)
08/13 (225)	11/16 (320)	12/11 (345)
08/14 (226)	11/17 (321)	12/14 (348)
08/15 (227)	11/18 (322)	12/14 (348)
08/16 (228)	11/19 (323)	12/14 (348)
08/17 (229)	11/20 (324)	12/15 (349)
08/18 (230)	11/23 (327)	12/16 (350)
08/19 (231)	11/23 (327)	12/17 (351)
08/20 (232)	11/23 (327)	12/18 (352)
08/21 (233)	11/24 (328)	12/21 (355)
08/22 (234)	11/25 (329)	12/21 (355)
08/23 (235)	11/30 (334)	12/21 (355)
08/24 (236)	11/30 (334)	12/22 (356)
08/25 (237)	11/30 (334)	12/23 (357)
08/26 (238)	11/30 (334)	12/28 (362)
08/27 (239)	11/30 (334)	12/28 (362)
08/28 (240)	12/01 (335)	12/28 (362)
08/29 (241)	12/02 (336)	12/28 (362)
08/30 (242)	12/03 (337)	12/28 (362)
08/31 (243)	12/04 (338)	12/29 (363)
09/01 (244)	12/07 (341)	12/30 (364)
09/02 (245)	12/07 (341)	12/31 (365)
09/03 (246)	12/07 (341)	01/04 (004)
09/04 (247)	12/08 (342)	01/04 (004)
09/05 (248)	12/09 (343)	01/04 (004)
09/06 (249)	12/10 (344)	01/04 (004)
09/07 (250)	12/11 (345)	01/05 (005)
09/08 (251)	12/14 (348)	01/06 (006)
09/09 (252)	12/14 (348)	01/07 (007)
09/10 (253)	12/14 (348)	01/08 (008)
09/11 (254)	12/15 (349)	01/11 (011)
09/12 (255)	12/16 (350)	01/11 (011)
09/13 (256)	12/17 (351)	01/11 (011)
09/14 (257)	12/18 (352)	01/12 (012)
09/15 (258)	12/21 (355)	01/13 (013)
09/16 (259)	12/21 (355)	01/14 (014)
09/17 (260)	12/21 (355)	01/15 (015)
09/18 (261)	12/22 (356)	01/19 (019)
09/19 (262)	12/23 (357)	01/19 (019)
09/20 (263)	12/28 (362)	01/19 (019)
09/21 (264)	12/28 (362)	01/19 (019)
09/22 (265)	12/28 (362)	01/20 (020)
09/23 (266)	12/28 (362)	01/21 (021)
09/24 (267)	12/28 (362)	01/22 (022)
09/25 (268)	12/29 (363)	01/25 (025)
09/26 (269)	12/30 (364)	01/25 (025)
09/27 (270)	12/31 (365)	01/25 (025)
09/28 (271)	01/04 (004)	01/26 (026)
09/29 (272)	01/04 (004)	01/27 (027)
09/30 (273)	01/04 (004)	01/28 (028)
10/01 (274)	01/04 (004)	01/29 (029)
10/02 (275)	01/05 (005)	02/01 (032)
10/03 (276)	01/06 (006)	02/01 (032)
10/04 (277)	01/07 (007)	02/01 (032)
10/05 (278)	01/08 (008)	02/02 (033)
10/06 (279)	01/11 (011)	02/03 (034)
10/07 (280)	01/11 (011)	02/04 (035)
10/08 (281)	01/11 (011)	02/05 (036)
10/09 (282)	01/12 (012)	02/08 (039)
10/10 (283)	01/13 (013)	02/08 (039)
10/11 (284)	01/14 (014)	02/08 (039)
10/12 (285)	01/15 (015)	02/09 (040)
10/13 (286)	01/19 (019)	02/10 (041)
10/14 (287)	01/19 (019)	02/11 (042)
10/15 (288)	01/19 (019)	02/12 (043)
10/16 (289)	01/19 (019)	02/16 (047)
10/17 (290)	01/20 (020)	02/16 (047)
10/18 (291)	01/21 (021)	02/16 (047)
10/19 (292)	01/22 (022)	02/16 (047)
10/20 (293)	01/25 (025)	02/17 (048)
10/21 (294)	01/25 (025)	02/18 (049)
10/22 (295)	01/25 (025)	02/19 (050)
10/23 (296)	01/26 (026)	02/22 (053)
10/24 (297)	01/27 (027)	02/22 (053)
10/25 (298)	01/28 (028)	02/22 (053)
10/26 (299)	01/29 (029)	02/23 (054)
10/27 (300)	02/01 (032)	02/24 (055)
10/28 (301)	02/01 (032)	02/25 (056)
10/29 (302)	02/01 (032)	02/26 (057)
10/30 (303)	02/02 (033)	02/29 (060)
10/31 (304)	02/03 (034)	02/29 (060)
11/01 (305)	02/04 (035)	02/29 (060)
11/02 (306)	02/05 (036)	03/01 (061)
11/03 (307)	02/08 (039)	03/02 (062)
11/04 (308)	02/08 (039)	03/03 (063)
11/06 (309)	02/08 (039)	03/04 (064)
11/06 (310)	02/09 (040)	03/07 (067)
11/07 (311)	02/10 (041)	03/07 (067)
11/08 (312)	02/11 (042)	03/07 (067)
11/09 (313)	02/12 (043)	03/08 (068)
11/10 (314)	02/16 (047)	03/09 (069)
11/11 (315)	02/16 (047)	03/10 (070)
11/12 (316)	02/16 (047)	03/11 (071)
11/13 (317)	02/16 (047)	03/14 (074)
11/14 (318)	02/17 (048)	03/14 (074)
11/15 (319)	02/18 (049)	03/14 (074)
11/16 (320)	02/19 (050)	03/15 (075)
11/17 (321)	02/22 (053)	03/16 (076)
11/18 (322)	02/22 (053)	03/17 (077)
11/19 (323)	02/22 (053)	03/18 (078)
11/20 (324)	02/23 (054)	03/21 (081)
11/21 (325)	02/24 (055)	03/21 (081)
11/22 (326)	02/25 (056)	03/21 (081)
11/23 (327)	02/26 (057)	03/22 (082)
11/24 (328)	02/29 (060)	03/23 (083)
11/25 (329)	02/29 (060)	03/24 (084)
11/26 (330)	02/29 (060)	03/25 (085)
11/27 (331)	03/01 (061)	03/28 (088)
11/28 (332)	03/02 (062)	03/28 (088)
11/29 (333)	03/03 (063)	03/28 (088)
11/30 (334)	03/04 (064)	03/29 (089)
12/01 (335)	03/07 (067)	03/30 (090)
12/02 (336)	03/07 (067)	03/31 (091)
12/03 (337)	03/07 (067)	04/01 (092)
12/04 (338)	03/08 (068)	04/04 (095)
12/06 (339)	03/09 (069)	04/04 (095)
12/06 (340)	03/10 (070)	04/04 (095)
12/07 (341)	03/11 (071)	04/05 (096)
12/08 (342)	03/14 (074)	04/06 (097)
12/09 (343)	03/14 (074)	04/07 (098)
12/10 (344)	03/14 (074)	04/08 (099)
12/11 (345)	03/15 (075)	04/11 (102)
12/12 (346)	03/16 (076)	04/11 (102)
12/13 (347)	03/17 (077)	04/11 (102)
12/14 (348)	03/18 (078)	04/12 (103)
12/15 (349)	03/21 (081)	04/13 (104)
12/16 (350)	03/21 (081)	04/14 (105)
12/17 (351)	03/21 (081)	04/15 (106)
12/18 (352)	03/22 (082)	04/18 (109)
12/19 (353)	03/23 (083)	04/18 (109)
12/20 (354)	03/24 (084)	04/18 (109)
12/21 (355)	03/25 (085)	04/19 (110)
12/22 (356)	03/28 (088)	04/20 (111)
12/23 (357)	03/28 (088)	04/21 (112)
12/24 (358)	03/28 (088)	04/22 (113)
12/25 (359)	03/29 (089)	04/25 (116)
12/26 (360)	03/30 (090)	04/25 (116)
12/27 (361)	03/31 (091)	04/25 (116)
12/28 (362)	04/01 (092)	04/26 (117)
12/29 (363)	04/04 (095)	04/27 (118)
12/30 (364)	04/04 (095)	04/28 (119)
12/31 (365)	04/04 (095)	04/29 (120)
01/01 (001)	04/05 (096)	05/02 (123)

FORM A

Prepared by: _____ Approved by: _____

Date: _____ Date: _____

Effective 7/16/14

Patient Name (last, first)	INVOICE	DOS	Adj Code	Adj Amount	FSC	Provider	Department	Comment	Eraider

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner, MD, MPA
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Medicaid/Medicaid Managed Care Collections**

Policy#: BAC 14

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to Medicaid recipients. TTUHSC files electronic claims daily on behalf of individuals covered by Medicaid programs, including but not limited to Traditional Medicaid, Medicaid Managed Care, Emergency Medicaid, Texas Women's Health Program, Children with Special Health Care Needs (CSHCN), New Mexico Medicaid, and out-of-state Medicaid plans. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify claims that were denied and require review for appeal. The business office will research any information needed to adjudicate a claim and requests assistance from departments as needed.

Procedures:

1) Medicaid claims are billed for services where eligibility has been verified. Where eligibility cannot be verified, the patient is classified as self-pay.

2) Traditional Medicaid, Emergency Medicaid, Texas Women's Health Program, and CSHCN claims bill daily and electronically to TMHP; the filing deadline is 95 days from the date of service, member certification date, or provider enrollment date.

3) Medicaid Managed Care claims bill daily and electronically to various contracted Managed Care providers, including but not limited to Amerigroup, El Paso First Health Plans, Molina, and Superior. The filing deadline is 95 days from the date of service.

4) New Mexico Medicaid and Managed Care claims bill daily and electronically to the appropriate plans, including but not limited to ACS, Molina, Presbyterian, Blue Cross Blue Shield, and Centennial plans; the filing deadline is 90 days from the date of service.

5) Out-of-state Medicaid plans bill daily and electronically or on paper within the filing deadlines specified by each plan.

6) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-

participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days

7) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ecttuweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

8) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 30 days. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update insurance eligibility and re-queuing of claims.

9) Designated employees for all New Mexico Medicaid and out-of-state plans review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline for NM Medicaid and Managed Care plans ranges from 90 to 365 days from the denial date noted on the latest explanation of benefits.

10) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed primarily online, followed by telephone call to the payer's claims department.

11) Texas Medicaid denials are appealed by the departments. Texas Medicaid denied claims are placed at the Medicaid Pending Appeal FSC 335 and transfer into the departments' Paperless Collection System (PCS) workfiles for processing. MPIP employees assist departments by providing proof of timely filing transmission reports generated from the GE eCommerce EDI claims portal or printing paper claims. MPIP designated employees process correspondence related to denials and appeals and forward to the appropriate department for review. Correspondence denials relating to eligibility and benefits are processed by MPIP employees, who update the eligibility information and bill the claim to the appropriate plan.

12) Charges determined after adjudication to be patient responsibility, including ineligibility of benefits or non-covered services, are billed to the patient. Some exceptions may apply if the services are covered under the Hospital District MSA program. Charges are billed to the patient if the patient failed to notify TTUHSC of Medicaid coverage within the filing deadline.

RESPONSIBILITIES

1) Medical Billing Associate (MBA) I, Senior MBA I, and Senior Business Assistants I and 2: Texas, New Mexico, and out-of-state/network claim edits, EDI rejections, correspondence, follow-up, and appeals.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014 Effective Date: 04/01/2015

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Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Financial Status Classification (FSC) Guide and Claim Filing Deadlines**

Policy#: BAC 15

Policy: The purpose of this policy is to outline the procedure for distributing insurance Financial Status Classification (FSC) and claim filing deadline information. Patients are assigned FSCs in GE Centricity Business that indicate insurance plan and claim filing information. Most payers have specific deadlines for initial claim and appeals submissions. A commonly used FSC Guide is distributed to the MPIP business office and departments on a yearly basis and as needed upon request.

Procedures

1) MPIP Billing and Collections managers maintain and update a listing of the most commonly used insurance FSCs and filing deadlines associated with each plan. The FSC Guide contains the following information:

   - FSC number
   - FSC mnemonic
   - Tax ID number associated with the plan
   - Description of the FSC name
   - Filing Deadline
   - Appeal Deadline

2) The FSC Guide is distributed to MPIP employees and department managers and supervisors by email on a yearly basis, most commonly at the beginning of each calendar year when most FSC changes occur. The listing is also provided as needed upon request.

RESPONSIBILITIES

1) Billing and Collections managers 1 and 2: maintain and update FSC Guide

FSC GUIDE

	FSC	Mnemonic	Tax ID	TMHP MEDICAID	Filing Deadline	Appeal Deadline	
	303	MCAID	75-2668018	Medicaid-Traditional/SSI/ER	95 days from DOS or add date	120 days from R&S Rejection	
	315	PMC	75-2668018	Medicaid Pending (Registration FSC only)	365 days from DOS	120 days from R&S Rejection	
	516	SSIP	75-2668018	Medicaid SSI Pending (Registration FSC only)	365 days from DOS	120 days from R&S Rejection	
	620	EPSDT	75-2668018	EPSDT	95 days from DOS or add date	120 days from R&S Rejection	
	318	CIDC	75-2668018	Children with Special Needs	95 days from DOS or add date	120 days from R&S Rejection	
	399	TXWH	75-2668018	TX Women's Health	95 days from DOS or add date	120 days from R&S Rejection	
	308	MAM	75-2668018	Medicaid Secondary to Traditional Medicare	95 days from Insurance EOB	120 days from R&S Rejection	
	309	MAC	75-2668018	Medicaid Secondary to Non-Contracted MAP	95 days from DOS or Insurance EOB	120 days from R&S Rejection	
	847	MAMA	75-2668018	Medicaid Secondary to Contracted MAP			
eff 2/1/13	prior to 2/1/13			SUPERIOR HEALTH PLAN MEDICAID			
640	364	ESC	75-2668018	SUPERIOR EPSDT	95 days from DOS	120 days from R&S Rejection	
440	361	SHP	75-2668018	SUPERIOR HEALTH PLAN	95 days from DOS	120 days from R&S Rejection	
386	386	IMMA	75-2668018	SUPERIOR IMH/Behavioral Health	95 days from DOS	120 days from R&S Rejection	
440	766	SHPS	75-2668018	SUPERIOR SECONDARY	95 days from Insurance EOB	120 days from R&S Rejection	
620	471	MSSE	75-2668018	SUPERIOR SSI EPSDT	95 days from DOS or add date	120 days from R&S Rejection	
303	371	MSS	75-2668018	SUPERIOR SSI MEDICAID	95 days from DOS or add date	120 days from R&S Rejection	
				MOLINA TEXAS MEDICAID			
	493	MTSM	75-2668018	Molina Texas Star Medicaid (Regular & SSI)	95 days from DOS	120 days from R&S Rejection	
	495	MTSP	75-2668018	Molina Texas Star Plus Secondary to Commercial	95 days from DOS	120 days from R&S Rejection	
	308	MAM	75-2668018	Molina Tx Star Secondary to Traditional Medicare	95 days from Insurance EOB	120 days from R&S Rejection	
	309	MAC	75-2668018	Molina Secondary to Non-Contracted MAP	95 days from Insurance EOB	120 days from R&S Rejection	
	847	MAMA	75-2668018	Molina Secondary to Contracted MAP			
				AMERIGROUP TEXAS MEDICAID			
	585	AMD	75-2668018	Amerigroup TX Medicaid (Regular & SSI)	95 days from DOS	120 days from R&S Rejection	
	588	AME	75-2668018	Amerigroup TX Medicaid (THSteps-EPSDT)	95 days from DOS	120 days from R&S Rejection	
	308	MAM	75-2668018	Amerigroup Secondary to Traditional Medicare	95 days from Insurance EOB	120 days from R&S Rejection	
	309	MAC	75-2668018	Amerigroup Secondary to Non-Contracted MAP	95 days from Insurance EOB	120 days from R&S Rejection	
	847	MAMA	75-2668018	Amerigroup Secondary to Contracted MAP			
				EL PASO FIRST MEDICAID			
	363	EPF	75-2674893	EL PASO FIRST HEALTH NETWORK	95 days from DOS	120 days from R&S Rejection	
	367	EEPF	75-2674893	EPF-EPSDT	95 days from DOS	120 days from R&S Rejection	
	373	MSEP	75-2674893	EPF-SSI	95 days from DOS or add date	120 days from R&S Rejection	
	473	EPSDT	75-2674893	EPF-SSI-EPSDT	95 days from DOS or add date	120 days from R&S Rejection	
	768	EPFS	75-2674893	EPF-SECONDARY	95 days from Insurance EOB	120 days from R&R Rejection	
				MEDICAID OUTSIDE OF EL PASO COUNTY (WITHIN TEXAS)			
	234	MON	75-2668018	OUT OF COUNTY MEDICAID	Call and verify	Call and verify	
	345	MFS	75-2668018	FIRST CARE MEDICAID HMO	Call and verify	Call and verify	
				NEW MEXICO MEDICAID			
	285	ANMS	75-2668018	AMERIGROUP NM MEDICAID PRIMARY/SECONDARY	90 days from DOS	1 year from R & S Rejection	
	287	BCBSS	75-2668018	BLUE CROSS BLUE SHIELD SALUD	6 months from DOS	90 days from R & S Rejection	
	358	CSM	75-2668018	MOLINA NM	90 days from DOS	90 days from R&S Rejection	
	301	NMMC	75-2668018	NM MEDICAID	90 days from DOS or 120 days/crt da	90 days from R & S Rejection	
	653	MPS	75-2668018	PRESBYTERIAN SALUD	90 days from DOS	1 year from DOS	
	302	OMC	75-2668018	UNITED HEALTHCARE	90 days from DOS	1 year from R & S Rejection	
				OUT OF STATE MEDICAID			
	302	OMC	75-2668018	ALL OUT OF STATE MEDICAID	Call and verify	Call and verify	
eff 2/1/13	prior to 2/1/13			CHIP PROGRAMS			
	257	CEPF	75-2674893	El Paso First	95 days from DOS	120 days from R&S	
	419	EPCP	75-2674893	EL Paso First Perinate Program	95 days from DOS	120 days from R&S	
	496	MTSC	75-2668018	Molina TX	95 days from DOS	120 days from R&S	
	459	MCHE	75-2668018	Molina TX EPSDT	95 days from DOS	120 days from R&S	
	497	MTPN	75-2668018	Molina TX Perinate	95 days From DOS	120 days from R&S	
	696	MTCE	75-2668018	Molina TX THSteps EPSDT	95 days From DOS	120 days from R&S	
639	456	CHIE	75-2668018	Superior EPSDT	95 days From DOS	120 days from R&S	
389	389	IMCH	75-2668018	Superior IMHS Behavioral Health	95 days from DOS	120 days from R&S	
443	417	CHPP	75-2668018	Superior Perinate Program	95 days from DOS	120 days from R&S	
439	256	CHIP	75-2668018	Superior-KIDS	95 days from DOS	120 days from R&S	
				MEDICARE PROGRAMS			
	214	HOS	75-2668018	HOSPICE	12 months from DOS	120 days from EOB	
	200	MED	75-2668018	MEDICARE-Traditional	12 months from DOS	120 days from EOB	
	223	MPM	75-2668018	MEDICARE PRIMARY TO MEDICAID	12 months from DOS	120 days from EOB	
	224	MEC	75-2668018	MEDICARE SECONDARY TO COMMERCIAL	12 months from DOS	120 days from EOB	
	202	RRM	75-2668018	RAILROAD MEDICARE	12 months from DOS	120 days from EOB	
	835	RRMS	75-2668018	RAILROAD MEDICARE SECONDARY	12 months from DOS	120 days from EOB	
	278	SNF	75-2668018	Skilled Nursing Facility	12 months from DOS	120 days from EOB	
				MEDICARE MANAGED CARE PLANS			
	846	AMA	75-2668018	AETNA MEDICARE ADVANTAGE	90 days from DOS	180 days from EOB	
	245	MHO	75-2668018	All Non-Contracted Medicare HMOs	Call and verify	Call and verify	
	850	AMAP	75-2668018	AMERIGROUP MEDICARE ADVANTAGE	95 days from DOS	120 days from EOB	
	862	AWMA	75-2668018	AMERIGROUP/WELLMED	90 days from DOS	60 days from EOB	Eff 7/1/14
	777	BMH	75-2668018	BIENVIVIR MEDICARE	180 days from DOS		
	872	C1MAP	75-2668018	CARE1ST HEALTH PLAN/WELLMED	90 days from DOS	60 days from EOB	Eff 1/1/14; WellMed 7/1/14
	841	HWMA	75-2668018	HEALTHSPRING/WELLMED	90 days from DOS	60 days from EOB	
	860	MAHI	75-2668018	HUMANA IPA/MCCI	95 days from DOS		Eff 7/1/13
	813	HMGC	75-2668018	HUMANA MEDICARE ADVANTAGE PLANS	365 days from DOS		
	842	HUWMA	75-2668018	HUMANA/WELLMED	90 days from DOS	60 days from EOB	
	824	LSMH	75-2668018	LIFE SYNCH MENTAL HEALTH	12 months from DOS	60 days from EOB	
	817	LMA	75-2668018	LOVELACE MEDICARE ADVANTAGE (Non-contracted	180 days from DOS	180 days from EOB	
	873	MMAD	75-2668018	MOLINA MEDICARE CLAIMS	365 days from DOS	120 days from EOB	Eff 1/1/14
	861	UHFM	75-2668018	UNITED HEALTHCARE FOCUS/WELLMED	90 days from DOS	60 days from EOB	Eff 1/1/14
	819	MCC	75-2668018	UNITED HEALTHCARE MEDICARE COMPLETE	120 days from DOS	60 days from EOB	
	840	WHMA	75-2668018	WELLCARE	180 days from DOS	90 days from EOB	
				HEALTH INSURANCE EXCHANGE (ACA/OBAMACARE) PLANS			
	465	MHIE	75-2668018	Molina Health Insurance Exchange	95 days from DOS	120 days from EOB	Eff 1/1/14
	952	BSE	75-2668018	Blue Advantage HMO	365 days from DOS	365 days from EOB	Eff 1/1/14
				HOSPITAL DISTRICT			
				Primary Stand-Alone FSC, UMC Services only - No Office Visits or Emergency Medicine covered			
	375	HDI	75-2668018	Hospital District Indigent	235 days from DOS	30 days from denial	
	376	HDS	75-2668018	Hospital District Self-Pay	235 days from DOS	30 days from denial	

FSC	Mnemonic	Tax ID	COMMERCIAL	Filing Deadline	Appeal Deadline	
700	AETTPA	752674893	Aetna	120 Days from DOS	Call and verify	
883	AUHP	752668018	Allegian Health Plans	95 days from DOS	90 days from denial	
833	CIG	752668018	Cigna/Great West	180 days from DOS	Call and verify	
717	C01	752668018	Commercial (Generic FSC, only use for non-contracted)	Call and verify	Call and verify	
700	AETTTPA	752668018	Conventry-AETNA NETWORK Mail Handlers/PCIP/GEHA Eff. 1/1/14	120 days from DOS	Call and verify	
215	FHE	752674893	First Health Network	Call and verify	Call and verify	
742	ACN	752668018	Health Scope/Advantage Care Network	Call and verify	Call and verify	
715	HPC	752674893	Health smart Preferred Care Systems	Call and verify	Call and verify	
230	IMS	752674893	Integrated Medical Systems	Call and verify	Call and verify	
413	MCRG	752674893	Medical Care Referral Group/Assured Benefits (MCRG)	Call and verify	Call and verify	
780	MULTI	752674893	Multiplan	Call and verify	Call and verify	
713	PHCS	752668018	PHCS-Private Healthcare Systems	15 months from DOS	Call and verify	
718	C02	752668018	Secondary Insurance(Generic FSC, only use for non-contracted)	Call and verify	Call and verify	
408	TTC	752674893	Texas True Choice	Call and verify	Call and verify	
717	C01	752668018	Three Rivers Provider Network	Call and verify	Call and verify	
808	UHC	752668018	United Healthcare	90 days from DOS	Call and verify	
			BLUE CROSS BLUE SHIELD OF TEXAS			
712	FBC	752668018	Federal Blue Cross Blue Shield	12 months from DOS	12 months from denial	
752	BS	752668018	TX Blue Shield	12 months from DOS	12 months from denial	
207	HMO	752674893	HMO Blue (providers added Jan 2012, Effective: 12/1/2011)	Call and verify	Call and verify	
552	OBCBS	752668018	BCBS Out of State	Call and verify	Call and verify	
			EL PASO FIRST			
255	EPFC	752674893	Health Care Options (HCO)	95 days from DOS	120 Days from Denial	
854	EPFR	752674893	Preferred Administrators (RETGH/EPCH Employees/Dependents)	12 months from DOS	120 Days from Denial	
			USA MCO			
159	USA	752674893	USA Health Network	Call and verify	Call and verify	
			TRICARE			
220	CH	752674893	Champus/Tricare West (Active duty Members and Dependents for services prior to 9/1/2011)	12 months from DOS	95 days from DOS	
520	TWR	752668018	Tricare West Region (Active Duty Members and Dependents for service dates 9/1/2011 through 3/31/2013 Deadline is 6/30/2013 to file charges prior to 4/1/2013; if you have charges after the deadline, please FSC 521 to send to address listed below.	12 months from DOS		
521	TWPUH	752668018	PGBA Tricare West Region (Partnered with United Healthcare) (Active duty Members and Dependents for service dates effective 4/1/2013)	12 months from DOS		
220	CH	752674893	Tricare for Life (P.O. Box 7890 Madison,WI 53708) Patients that have Medicare Primary and TFL Secondary			
			TRICARE (continued)			
220	CH	752674893	Champ/VA (P.O. Box 469064 Denver, Co) (Must use the Social Security ID of the patient when billing)	12 months from DOS	Call and verify	
271	TSRH	752674893	Tricare South Region/Humana	12 months from DOS	95 days from DOS	
			VETERANS ADMINISTRATION			
136	VA	752668018	Veterans Administration (P.O. Box 640290 EPT 79904)	12 months from DOS		
636	WPSVA	752668018	TriWest VAPC3 (PO Box 981646 EPT 79998-1646)	120 days from DOS		
			INMATES			
739	UBP	752668018	Immigration/Border Patrol	1 year from DOS	1 year from denial	
738	INS	752668018	Immigration/Customs & Border Protection	1 year from DOS	1 year from denial	
327	OGP	752668018	Prison Health Management/Dona Ana (Corizon)	60 days	45 days Mail to: 105 Westpark Dr. Ste 200, Brentwood TN 37027	
22	SD	75-2668018	Sheriff Department	No Deadline	No Deadline	
79	TDCJ	752668018	TX Dept Criminal Justice	No Deadline	No Deadline	
174	USM	752668018	US Marshals	No Deadline	1 year from denial	
			WORKERS COMPENSATION			
191	WC	752668018	Worker's Compensation	Majority of WC 95 days from DO	120 days from denial	
191	WC	752668018	Texas Mutual	95 Days from DOS	12 months from denial	
193	FWC	752668018	Federal Workmans Comp	12 months from DOS	12 months from denial	
			TEXAS REHAB (DARS)			
321	RE		Rehabilitation	90 Days from surgery	90 days from denial	
			CRIME VICTIMS			
334	CV	752668018	Crime Victims	No Deadline	No Deadline	
			HEALTH INSURANCE EXCHANGE (ACA/OBAMACARE) PLANS			
465	MHIE	752668018	Molina Health Insurance Exchange (eff 1/1/14)	95 days from DOS	120 days from EOB	Eff 1/1/14
952	BSE	752668018	Blue Advantage HMO (eff 1/1/14)	365 days from DOS	365 days from EOB	Eff 1/1/14
			HOSPITAL DISTRICT			
			Primary Stand-Alone FSC, UMC Services only - No Office Visits, Emergency Medicine, or Psychiatry covered			
375	HDI	75-2668018	Hospital District Indigent	235 days from DOS	30 days from denial	
376	HDS	75-2668018	Hospital District Self-Pay	235 days from DOS	30 days from denial	