Q: Can Medicaid be filed as secondary for a MAP primary through TMHP online?
A: You are not able to file Medicaid as a secondary thru TMHP the online as the MAP EOB is required. It is suggested to file the claim by paper.

Q: When I mail the paper UB-04 and the PC Print Medicare RA, the claims are returned to provider with a request for an MRAN. I think I just understood the speaker to say that I do not have to fill out the MRAN when I submit from PC Print.
A: You heard the speaker correctly. PC Print is an acceptable form

Q: How often does Medicaid pay the contracted Map plans? There is a long delay in payment of these claims for many Maps.
A: Medicaid does not reimburse for any contracted MAP. Those claims are submitted to the HMO and considered payment in full.

Q: If we are having a problem with a contracted MAP paying claims, is our only recourse HHSC?
A: Yes the only recourse is HHSC. Contact Sandra Faske
(Sandra.faske@hhsc.state.tx.us) 512-491-1876 for any Part C contracted payment or Part C contracted non payment.

Q: Okay will do ... so payments from TX Medicaid to the MAPS are not quarterly or monthly, as the contracted MAPS would have us believe?
A: Medicaid doesn't pay the MAPS; the MAPS are contracted thru HHSC.

Q: Where would I find a list of non-contracted HHSC providers?
A: There is not a separate list ... we only publish 'contracted' MAPS on the TMHP website – www.tmhp.com, then select EDI from the top blue area and then in the center section of the page go to the bottom and select HHSC Approved Medicare Advantage Plans (MAPS) contractors.

Q: You stated that as of February 1st, Audiologist did not need to have Medicare number. Does that also mean they will not need Medicaid number..
A: Audiologists will require a Medicaid number

Q: I thought they had to have a Medicare number in order to obtain a Medicaid number?
A: There are some provider types that are not required to enroll in Medicare first.
Q: We billed a claim and denied due to another physician billed surgical procedure on the same day therefore our charge was denied, ref# 726765184 I presented this question on last webinar and was not answered.
A: Please refer to the Texas Medicaid Provider Procedures Manual, Section 36, 36.4.52.8 it stated if consultations and visits are done within per and post surgery days these visit are denied.

Q: What can a provider do when a Medicaid Advantage Plan (MAP) who is contracted with HHSC does not pay to the Medicaid allowed amount and continues to assign the patient a co-insurance?
A: Contracted MAPs receive a monthly payment for each client please contact HHSC for problems related to the contracted MAP plan

Q: I have attempted to contact HHSC regarding problems with contracted MAP’s and have been told by HHSC that I must contact the MAP - is there a particular number I need to call for this issue?
A: A list of contracted MAPS are listed on TMHP.com - Select EDI in the blue field at top of the home page, then in the center section, select HHSC Approved Medicare Advantage Plan (MAP) Contractors.

Q: When Medicaid sends you faxes that they need more information on a Prior Authorization Number (PAN) how much time do you have to respond back with the information?
A: If providers have not received response within three business days that the prior authorization was requested they should call TMHP or resubmit the request.

Q: Would that be by date of service or date of filing?
A: Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) Section 6 Appeals and follow claims filing guidelines.

Q: Wellcare of Texas, a contracted MAP is not paying the Medicaid allowed, and continues to assign patient co-insurance. I have called them and they refuse to reprocess these claims correctly, who can I contact for assistance with this issue?
A: HHSC - Sandra Faske (Sandra.faske@hhsc.state.tx.us) - 512-491-1876 for any Part C contracted payment or Part C contracted non payment.

Q: What is a Julian date?
A: The Julian date is the date the claim is scanned into the system.

Q: Most of my claims are denied for PANs within 48 hours I get denial for taking more than 2 days. Why doesn’t it state that once it is faxed that we have only 48 hours to get information?
A: Your claims should not be denying “for past 24 hours, if you are following the filing deadlines in Section 5 Claims Filing of the TMPPM.

Q: If I file an adjustment request and I attach a copy of a claim along with all other required information will the request be rejected
A: No, it should not be rejected as long as all guidelines are followed.
Q: If a scheduled surgery goes observation and the itemized claim has implants (rev code 278) can the implants be bundled with the surgery code (rev code 360)?
A: Please refer to Texas Medicaid Provider Procedures Manual (TMPPM) Section 25.3.2.1 Day Surgery Guidelines as it outlines the appropriate claims filing information.

Q: Explanation of benefits (EOB) message 2008 procedure code is approved as benefit pending approval of expenditures; do we adjust that charge or wait until expenditures are approved? Will TMHP pay automatically or do we resubmit?
A: Once the codes are approved per direction from HHSC the codes will be posted on TMHP.com.

Q: When a patient is in ER, has 2 CT’S, a 450 rev code on claim & we add ES modifier, how can we be paid for both CT’S?
A: Please refer to the TMPPM, Section 12.3.5 claims Information, claims filing examples are provided in this section based training session.

Q: If a patient comes in for a scheduled surgery but ends up being admitted into observation for possible blood clot (not due to a complication) can that visit be billed as an itemized claim?
A: Please refer to TMPPM, Section; 25.3.2.1 Day surgery as it outlines the guidelines.

Q: Section 25.3.2.1 Day surgery is very vague & does not specify.
A: The guidelines state what occurs with complications after scheduled day surgery. If you require more details please reach out to your territory representative.

Q: Is there a webinar I can sign up for, for ambulance services?
A: There is a computer based training session “Ambulance Basics” located at www.tmhp.com, select from top right side link’s “I would like to register for a workshop” then on the lower far left hand side of the page select the Online Learning Center and that is where you can locate the Ambulance Basics and all of the other computer based training sessions. It will take one hour to complete the Ambulance online training.

Q: Medicaid sent me a denial of 1093 and I have appealed it several times – what is my next step?
A: Refer it to your provider Relations Representative.

Q: I have had claims where TMHP paid on the base rate or the mileage code only. I appeal the claim and they deny the claim as duplicate denial code 127. I have appealed this claim several times with all of the supporting documentation – what can I do next?
A: If you have already made contact with our Contact Center (1-800-925-9126) and there is still no resolution, reach out to your Provider Relations Representative for assistance.

Q: How do we appeal claims that are rejected for diagnosis and where do we get a list of acceptable diagnosis?
A: Provider specialty sections can identify diagnosis codes payable, however without knowing your specialty I can not give a global response.

Q: How far back can you bill? I.E. if operations started in the month of May and Medicare and Medicaid numbers were not given to us until June 7th? What happens with the claims prior to that?
A: You have 95 days from the client add date to the system but still have to have claims received by TMHP within 365 days from the date of service.
Q: In returning to provider correspondence the paper claim must have NPI and TPI numbers. Where does TPI go on the claim?
A: Box 33a is the NPI and 33b is the TPI

Q: Are CEU'S, available for this webinar?
A: No.