Q: We are a rural health clinic; would we get additional benefit if we provided fluoride varnish?
A: Rural Health clinics do not have Dentists in their clinic so, no you cannot provide this service.

Q: Please clarify: regarding the fluoride varnish, the provider is required to be a dental provider and cannot be a medical provider? Thank you
A: The provider must be a Dental provider (enrolled as a Dentist) not a Medical provider to be able to provide fluoride varnish to the client. It is a Dental procedure. This previously responded to incorrectly. Thinking were asking as an RHC

Q: We are a rural health clinic and a Texas Health steps provider. As I read the material on page 15, it states that a THStep enrolled physician can provide Fluoride varnish. I need to verify from your earlier response to me that only dentist can provide it?
A: This cannot be billed under your Rural Health provider number. If your RHC has a THSteps provider number during the check-up the Dr. can apply the fluoride treatment. Under the THSteps provider number it does include the service for Dr's to apply the fluoride varnish during the THSteps check-up. It tells you in the Texas Medicaid Provider Procedures Manual (TMPPM) how to bill for this.

Q: Family planning providers don't have to bill insurance first?
A: No, you do not have to bill other insurance first, refer to page 26 of the participants guide.

Q: We're just learning about pediatric dental services to Medicaid patients and must credential our dentists. Do you recommend attending the afternoon session to understand getting credentialed, or is that session primarily dealing with billing Issues?
A: We talk about enrollment in the afternoon session but, you can also call your representative for your area they can help

Q: Are there any measures being taken by TMHP to reduce duplicate ids? The majorities of our patients apply for HP and are required to hold billing for 3S days. We have to check their elig, before we bill. The only way to verify is to call the call center.
A: TMHP does not issue the client their client number this issued by HHSC, You can check eligibility through TMHP.com, AIS, the Automated Inquiry system or TexMedConnect

Q: What if the patient has the monthly form mailed to them at time of visit but us as the provider can not verify it online?
A: If the client cannot give you copy of the 3087, you can have them sign the acknowledgment form that they have to pay for services until they present the 3087 form to you.

Q: After we applied for CSHCN, the default TPI on our TexMedConnect is the TPI for CSHCN. Is it possible to get the default TPI changed back to our main TPI?
A: You would have to contact the EDI help desk 1-888-863-3638 to see if they can put your default back to your main TPI

Q: Are QMB pts eligible for ambulance transports to doctor’s appointments?
A: QMB’S are only for co-insurance & deductible after the claim crosses over from Medicare. You have to bill Medicare first.

Q: Medicare part A is the one that doesn’t cover doctor’s visits via ambulance. I’m new to this.
A: If Medicare Part A does not pay for this, then Medicaid would not either. QMB’S are not eligible for Medicaid services only. Only the co-insurance & deductible are payable when the Medicare claim crosses over from Medicare.

Q: Please go over the Pre Authorization process again. In a LPC office, will each session with a client have to be Pre-Authorized?
A: After the 30 encounters / visit limitation occurs, and then you have to ask for a Prior Authorization for more visits. Please reference page 30-3 in the Texas Medicaid Provider Procedures Manual (TMPPM).

Q: In regards to MR clients, does the client have to have a separate or particular axis 1 diagnosis in order to be treated by a LPC?
A: Please reference bulletin article #1 special bulletin for behavioral health providers

Q: If a STAR or HMO client is visiting a PCCM county, and needs a provider how are you paid?
A: You can call the PCP & tell them you are seeing one of their clients on an emergency visit & the PCP would be able to give you their provider number to put on your claim as the referring physician.

Q: What was the web address to send Waste and Abuse reports to?
A: www.hhsc.state.tx & select report waste, abuse and fraud.

Q: How often are the bulletins released?
A: Bulletins come out every other month

Q: Banners and Bulletins ... are these also sent by email blasts by signing up for this info to be sent to us?
A: Banners are sent on a weekly basis on the R&S reports or can be located at the THMP website library and the bulletins are mailed one copy per provider bi-monthly.

Q: Is there a way to receive these updates that are in the bulletins or banners by email blasts?
A: No not at this time

Q: How do I know who my local rep is?
A: If you go to TMHP.com, then to Providers at the top of the screen & within that screen on the far left you will see the link to find your rep. called “Regional Support”.
Q: Can you further explain how and why providers that do not accept other insurances are supposed to accept clients that have Medicaid and third party insurance?
A: If your policy in the office is that you do not accept other insurance from anyone then you do not have to accept it from Medicaid clients. But if you take OI form all other patients then you have to accept for Medicaid clients.

Q: When a change is made to our provider information, what is the time span for the changes to take effect?
A: If you have sent in a Provider Information Change (PIC) form it could take up to 14 days. If you change it through the Online Provider Lookup (OPL) tool yourself it is immediate.

Q: We have had several clients in the past that brought the temporary, hand-written form that did not show to be eligible on TexMedConnect. We were previously informed that if they did not show eligible on TexMedConnect, we did not have to accept
A: You should accept the, temporary form for eligibility. If your claim denies you can appeal the claim with a copy of that temporary form.

Q: How often should a provider submit their claims?
A: As frequently as you need.

Q: What is the time frame on receiving payment?
A: 3-4 weeks

Q: So, just to clarify, if our office does not accept Medicare from any other client, we do not have to accept Medicaid clients with Medicare, correct?
A: If you do not except Medicare from anybody even your private pay clients, then you do not have to accept it from Medicaid client has it. But, if you take Medicaid and the client has Medicare you do have to bill Medicare first.

Q: What are the eligibility dates?
A: Are you asking for the eligibility dates of a client. I am not sure what dates you are asking for?

Q: If you print out a copy of the screen from TMHP eligibility will that serve as proof of eligibility?
A: You need to use the documentation that the client has given you.

Q: If the client presents a 3087 that has an end date of example 3/31/2010 can we use that to appeal claims as proof of eligibility? Even if you print out eligibility on TMHP had it has changed.
A: If the service was given during the time of eligibility you can use the 3087 form to show they had eligibility during the time you gave the service.

Q: You mentioned that if I verify eligibility online and I keep the print out and my claim is denied as patient not eligible TMHP will not overturn the denial would the service then be the patient responsibility?
A: If the patient is not eligible during the time you gave the service, you can bill the patient. But, if they were eligible & there was other circumstances as to why your claim was denied you cannot bill the patient.

Q: I was asking how do we know what eligibility dates to include when we’re in TexMed Connect checking a client's eligibility … how do we know what date range we’re looking for? Whatever date range our services cover?
A: You can only ask for client eligibility for the dates of service you need. For instance if you ask for March eligibility, It will give you March 1st through today’s date if you are asking for it today.

Q: The client did not present a 3087 so is the one I printed from the screen good?
A: Yes, you can print it & use it to verify eligibility.

Q: What is the difference between prior authorization and pre-cert?
A: Prior authorization is for getting an authorization do the operation or service that you are asking for that patient. A Pre cert is when the hospital is asking for certification to put the patient in the hospital for the inpatient stay.

Q: Earlier you stated that we should be careful and know the difference between needing a pre-authorization and a precertification. Will this be discussed in one of the Webinars?
A: Yes, it will be discussed in Beyond the Basics.

Q: Enrolling in TMHP, does that enroll provider in all types of Medicaid plans?
A: You must enroll with TMHP enrollment first, then you must enroll with each HMO that you will be sending claims to.

Q: Will eligibility online ever be delayed where a patient may have termed and not
A: No, we update eligibility every night

Q: This is not related to the presentation, but where can I find a list of the diagnosis that are covered for certain procedures?
A: TMHP does not give a list of diagnosis for every procedure.

Q: As an LPC, if I have client who has a third party resources and Medicaid, would I have to bill the TPR before I do with Medicaid? Also, would I have to take the client even though I do not plan to work with private insurance right now?
A: If you have a patient with other insurance & Medicaid you have to bill the other insurance first & then send in the EOB from the other insurance with your claim to Medicaid. No, you cannot be selective in which clients you want to see.