ProtectTexas™
Texas Department of Health

TEXAS DEPARTMENT OF HEALTH
CENTRALIZED BILLING SYSTEM
HANDBOOK

Revised January 2004

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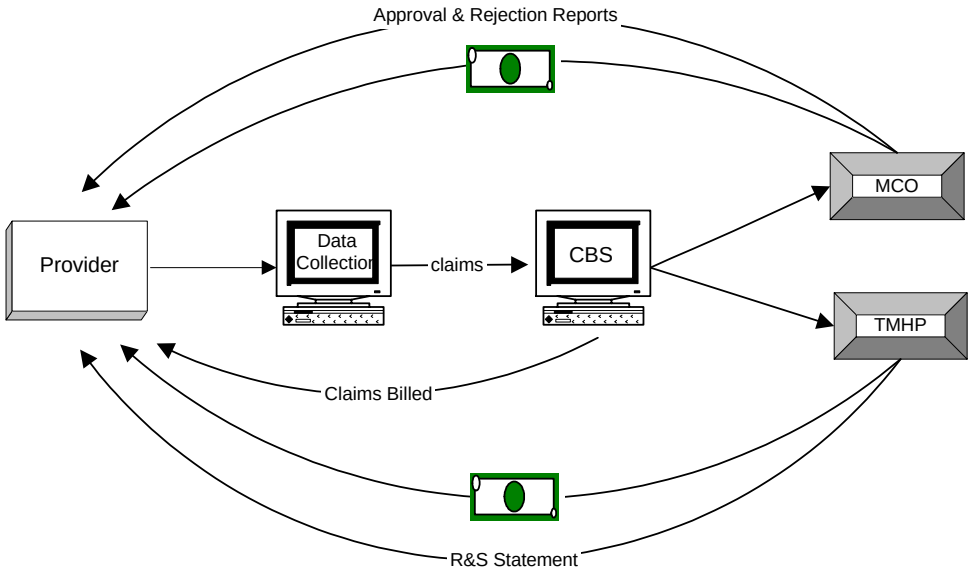
INTRODUCTION

The Centralized Billing System (CBS) is an automated system designed to submit public health claims to the Texas Medicaid claims processing contractor and the managed care insurance companies (MCO) for Medicaid Title XIX reimbursement, as well as Family Planning Titles V, X and XX. CBS is managed and maintained by the Centralized Billing Unit (CBU) with technical assistance from Information Systems (IS).

Effective January 1, 2004, the Texas Medicaid contractor changed from National Heritage Insurance Company (NHIC) to Texas Medicaid Healthcare Partnership (TMHP).

This manual has been provided to assist you with the billing of claims for Medicaid and Family Planning clients and the reimbursement and reconciliation of these claims. It is designed to explain the correct procedures that must be followed in order to ensure that the billing of eligible client services is successful. It also provides an overview of the reimbursement and reconciliation process.



ABOUT THIS MANUAL

Conventions used throughout this manual are as follows:

- "CBS" refers to the TDH Centralized Billing System.
- "CBU" refers to the Centralized Billing Unit of the Fiscal Division. Formerly Revenue and Fund Analysis (RAFA) of the Budget and Revenue Division.
- "TWICES" refers to the TDH Texas-Wide Integrated Client Encounter System.
- "IS" refers to TDH Information Systems.
- "TMHP" refers to the Texas Medicaid Healthcare Partnership.
- "R&S" refers to the Remittance and Status Report sent by TMHP.
- "95-day limit" refers to the amount of time from the date of service that Texas Medicaid will accept Medicaid claims.
- "180-day period" refers to the amount of time allowed from the R&S date to appeal claims denied by Texas Medicaid.
- "MCO" refers to a managed care insurance carrier.
- "EOB" refers to Explanation of Benefits codes. These codes explain the final disposition of an R&S transaction.
- "EOP" refers to Explanation of Pending codes. These codes explain the disposition of a claim that is pending at TMHP.
- "Rejected claim" refers to a claim that was either not accepted into the CBS system, or was not accepted into the TMHP system.
- "Denied claim" refers to a claim that was accepted into the TMHP system but denied payment.
- "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996.
- "EDI" refers to Electronic Data Interchange.

1. The CBS Billing Process

1.1 Provider Submits Claim Data

CBS accepts claim information for billing from the following claim submitters:

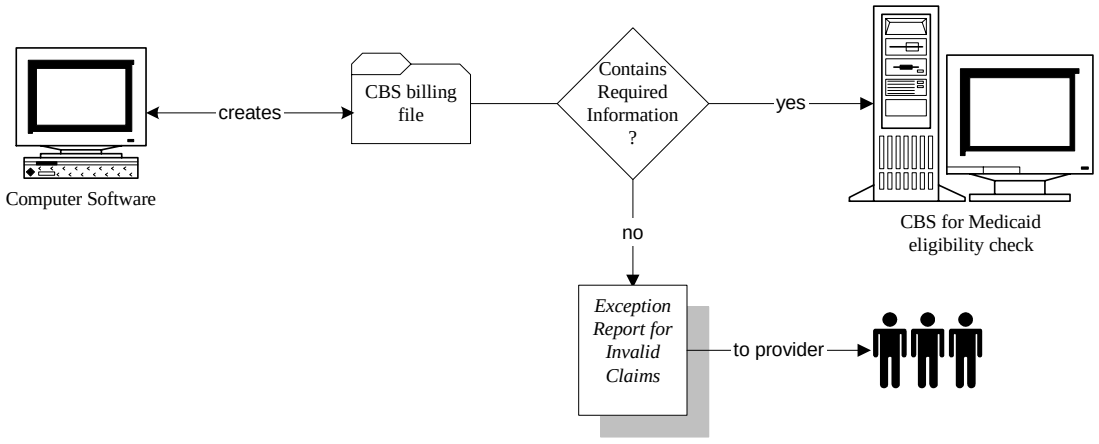
- TDH and local clinics that use TWICES. Services include Maternity, Case Management, Family Planning (Titles V, X, XIX and XX), THSteps Medical, Immunizations, and TB.
- TDH central office lab
- Women's Health Lab located at the Texas Center for Infectious Disease
- WIC Immunization clinics that use the WICWIN system

This claim information is put into a billing file that is regularly sent to CBS by the provider's data collection system. Billing files may be sent daily or on specific days of the week, depending on how the claim information is gathered. Each night CBS processes all billing files received for the day.

It is ***extremely*** important to remember that there is a 95-day filing deadline on all claims. The 95 days begins on the date of service and ends when the claim is *accepted* by TMHP or the MCO. It includes the time it takes to enter the data at the provider site and send the claim to CBS. The processing time to get the claim through CBS may take from as little as two days to as long as two weeks, or longer if there are errors on the claim.

Please note that immunization claim information that is collected through the WICWIN software is sent to the Immunization Division ImmBill system and not directly to CBS. The Immunization Division forwards the claims to CBS and this adds to the total processing time, and must still be done within the 95-day deadline.

Figure 1-2 CBS Step 1, Initial CBS Edits



1.2 Initial CBS Edits

CBS will ***not*** accept a claim if any required information is missing or incorrect. Instead, the invalid claim prints on the *Exception Report for Invalid Claims* that is returned to the provider so that the claim can be corrected. Once corrected, the provider must re-submit the claim. Remember that this process must still occur within the original 95-day limit.

The following errors will result in CBS ***not*** accepting a claim. Included with each error is the error number that appears on the *Exception Report for Invalid Claims*.

Errors on ALL Claims

1 No last name
2 Missing or invalid service date
3 Service date later than today's date
4 Claim is over 365 days old
5 Invalid birth date
6 Birth date later than today's date
7 Birth date later than service date
8 Invalid claim type
9 No claim origin
10 Billing Provider is missing
11 Billing Provider is invalid
12 Number of services is zero

Immunization Claim Errors

21 Client over 21 years old when service was given

Lab Claim Errors

16 Referring Phys last and first names are required
23 Referring Prvdr's EIN required for Cytology claims

Lab, TB, and FP Claim Errors

17 Performing Prvdr last and first names are required

THSteps Claim Errors

20 Invalid EPSDT referral.

CBS Standard Format Claims Errors (not thru ImmBill)

13 Unique service not found for service date and type
19 Invalid combination of srvc, TOS, clm type, DOS, mods
48 Modifiers must have 2 characters
61 Place of service is spaces
62 ICD-9 Diagnosis Code is spaces
63 Quantity of services is spaces or not numeric
64 Number of occurrences is spaces or not numeric
65 Service Procedure Code is not in Service Table

Family Planning Claim Errors

14 FP claim has Title Code = C, but no billable services
15 FP claim is Medicaid eligible, but no billable services
18 Service Prvdr number not in Service Prvdr table
22 Claim type should be FP for Family Planning claims
112 Family Planning claim has invalid Title Code
113 Title XX claims before 09/01/2001 cannot be billed

1.3 Checking for Medicaid Eligibility

Once a claim passes the initial CBS review for correct information outlined in section 1.2, CBS performs another check to see if the client is in the Medicaid eligibility file.

The likelihood of CBS finding the client in the Medicaid eligibility file can be improved by always including the following client information *as it appears on the Medicaid card*:

1. Both the first and last name
2. Date of birth
3. Medicaid and/or Social Security number

The CBS Medicaid eligibility check can have the following possible outcomes:

- The client is eligible for Medicaid on the date of service and the claim is billed to TMHP or a Managed Care MCO.

- The client's service date is past the last eligibility period, or the client is not found in the Medicaid eligibility file. This claim is placed **on hold** in CBS and will be checked for a match each week until the time limit has expired on the claim (95 days past service date), or the claim is billed.

- The client is not eligible for Medicaid benefits at the time of service. This claim is ***not*** accepted in CBS.

- More than one client is found containing the same information. This is called a 'multiple match' and often occurs when the client Social Security number or Medicaid number is not submitted. This claim is ***not*** accepted in CBS.

Regardless of the outcome, the claim will print on a report that is sent to the provider. Refer to section 4.1, CBS Reports.

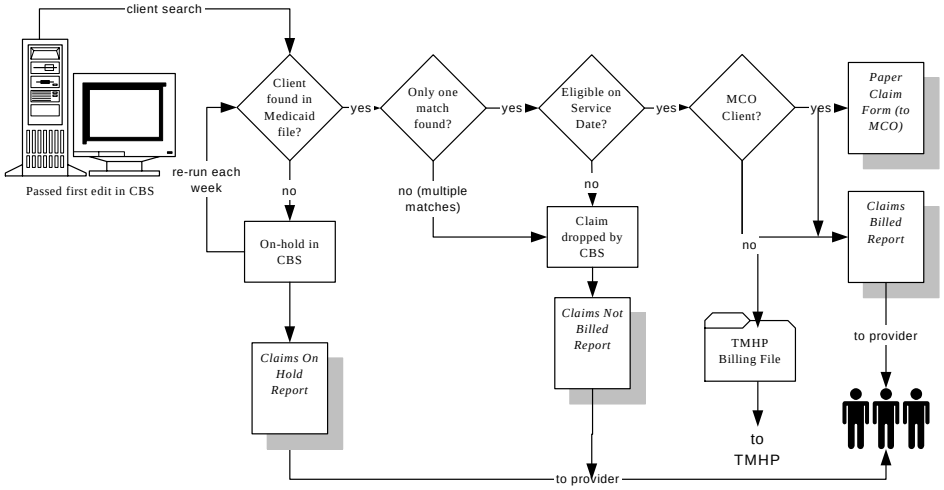
Family Planning Claims

If a Family Planning claim is sent to CBS as a Title XIX claim, the client's Medicaid eligibility is checked. If the client is eligible, the claim is billed to TMHP. If the client is not eligible, the claim is put on hold.

If a Family Planning claim is sent to CBS as a Title V or XX claim, the client's Medicaid eligibility is checked. If the client is found to be Medicaid eligible, the claim is changed to Title XIX and billed to TMHP. Family Planning claims marked as Title X are not checked for Medicaid eligibility.

All Family Planning claims, regardless of funding source, are sent to TMHP for processing in the family planning system.

Figure 1-3 CBS Step 2, Medicaid Eligibility Check



Sending Claims to TMHP

All claims that are Medicaid eligible for payment by TMHP at the time of service, as well as non-Medicaid Family Planning claims, are sent to TMHP in an electronic file that meets HIPAA EDI requirements. TMHP performs two levels of edits before accepting claims into their system.

1. The first level of edits is for HIPAA compliance. Any claim that is not compliant will be returned to CBS on a rejection report. CBS staff will make every effort to correct and resubmit these claims.

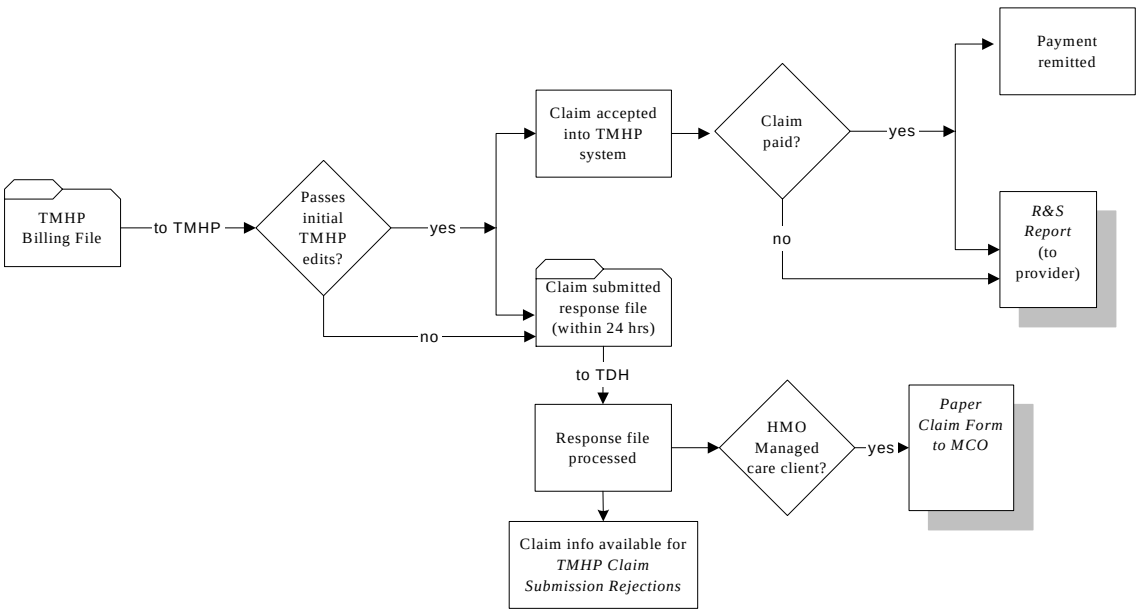
2. If the claims pass the HIPAA compliance edits, they go through an initial review before being accepted into the TMHP system. CBS receives confirmation from TMHP that the claim is accepted or rejected within a few days. Possible outcomes of TMHP's review are as follows:

    - A claim is accepted by TMHP and placed in suspense, or pending. Final disposition of the claim appears later on the R&S report.

    - A claim is ***not*** accepted by TMHP (initial rejection). Examples of an initial rejection are:
        1. The client is eligible for Medicare.
        2. The client's age is not within the age range eligible for the procedure.
        3. There are missing required data elements on the claim, such as marital status on family planning claims, or performing provider number.
        4. The client is not eligible for Medicaid on the date of service.

Any claims rejected by TMHP are printed on a *Claims Rejected by TMHP on Initial Edit* report that is generated by CBS and mailed to the provider by CBU. These claims *cannot* be appealed to TMHP. They still fall under the 95 day filing deadline, and it is the provider's responsibility to see that the claim is corrected and resubmitted to CBS. Refer to section 3.1, Correcting Claims.

Figure 1-4 Sending Claims to TMHP and Receiving Claim Submittal Response



Once a week, CBS receives an electronic file of remittance and status information on claims that have reached final disposition, either paid or denied. This data is used to update the claim data in CBS with the claim status, amount paid, and the Reason Codes. Explanation of Benefits (EOB) codes. It is the same information received by the provider on the paper R&S report (see section 4.2), except that CBS does not receive information on pending claims. Another difference is that CBS receives HIPAA-compliant Reason Codes, while the EOB codes print on the paper report. Even if a TDH provider does not submit a claim through CBS and enters it directly into TDHConnect or sends a paper claim, CBS will receive the electronic R&S information.

CBS will only receive R&S data on claims that are paid to TDH by TMHP. R&S data will not be received for any local clinic that bills through TWICES but receives their own reimbursement directly from TMHP or the MCO. CBS does *not* receive any electronic R&S data from MCO's.

2. Managed Care

Medicaid managed care is being implemented in different service areas in stages, and currently many Texas Medicaid clients live in areas of the state that are covered under managed care. If a client is enrolled in the TMHP Star Plan (PCCM model), the claim will be paid by TMHP Star. If a client is enrolled in an MCO plan, all claims for the client, with the exception of Case Management, Family Planning, and THSteps Dental, will have to be billed to the managed care insurance company (MCO) with which the client is enrolled**.**

When the client is first checked for Medicaid eligibility in CBS, it is determined if the claim should be paid by TMHP or a Managed Care MCO. If it is an MCO claim, it is flagged for managed care and run through a special CBS process. A completed *HCFA-1500* or *UB*-92 claim form is printed and a *Managed Care Claims Billed Report* is produced. The claim form is forwarded to the appropriate MCO insurance carrier, and the billed report is mailed to the provider for future reconciliation purposes.

3. Correcting or Appealing Claims

3.1 Correcting Claims

Claims that cannot be billed should be corrected before the 95-day limit passes. They are:

1. Claims that appear on the *Exception Report* and *Claims Not Billed Report* that were not accepted into CBS.

2. Claims placed on hold in CBS – these claims can be corrected to provide more information that would help find the client in the Medicaid eligibility file, such as the client's Medicaid number or social security number.

3. Claims that are accepted into CBS and billed to TMHP, but are *not* accepted (are rejected) by TMHP.

All of these claims can be corrected at the provider's data entry site and resubmitted to CBS. If you have any questions, call the CBS line at (512) 458-7549.

3.2 Appealing Denied Claims

Claims that have been accepted into the TMHP system but denied payment can be appealed if the appeal is made within 180 days of the R&S date. Refer to the Texas Medicaid Provider Procedures Manual, Section 5, for specific information on how to appeal a claim.

If a claim was denied on the R&S with $0.00 allowed and $0.00 paid, it can be corrected and resubmitted to CBS for resubmittal to TMHP.

To appeal claims denied by an MCO, the provider will need to contact the specific managed care insurance company for information.

3.3 Paper Billing of Rejected Claims to TMHP

There are situations when a claim is rejected by TMHP and cannot be billed electronically, and has to be billed on paper. An example is a claim that was billed past the 95-day deadline because of circumstances beyond the provider's control, or when TMHP shows the client as not eligible for Medicaid but the provider has documentation proving otherwise.

The provider can send these claims to TMHP on paper, but will be required to submit supporting documentation with the claim. The *Claims Rejected by TMHP on Initial Edit* report that is generated by CBS shows the run date and the TMHP batch number, and can be used as proof of when the claim was originally submitted to TMHP.

4. Reports

4.1 CBS Reports

When claims are processed in CBS, the following reports are printed and mailed to the provider by CBU:

- *Exception Report for Invalid Claims* - A list of claims that CBS rejected due to errors. See section 1.2 for the complete list of errors.
- *Claims Not Billed* - A list of clients *not* accepted into the CBS system and *not* billed. See section 1.3.
- *Claims on Hold* – A list of claims that were not found Medicaid eligible, but were placed on hold in CBS for further checking. See section 1.3.
- *Claims Billed to TMHP or HMO* - A list of claims that CBS sent to TMHP for billing, or that were identified as eligible for billing to a managed care MCO. The plan code that identifies either TMHP or the MCO is printed on the report.
- *Regular Claims Processing*, also known as the Consolidated Billing Report - This report consolidates all of the above reports into one report. Providers can request to receive the consolidated report instead of the four separate reports by contacting CBU at (512) 458-7486.

- *Claims Billed to Managed Care HMO* - A list of claims that were billed to a managed care MCO on a paper claim. These claims will have previously been identified on the *Claims Billed to TMHP or HMO* report.

- *Claims Rejected by TMHP on Initial Edit* - A list of claims that TMHP rejected from their system (see section 1.4). The TMHP batch number is included on the report if needed.

In addition to the reports mentioned above, the CBS and CBU generate a report titled *All Claims Processed by Centralized Billing System* that represents an accounting of the claims as they progress through the payment/denial/rejection process. The denials/rejections include all edits within the processing systems (CBS, TMHP, and MCO's) that might terminate the claim. This accounting mechanism allows the CBU to track the progress of claims by service, fund and entity. It also enables management to create a comparative analysis of Third Party Reimbursement utilizing the CBS, year over year.

4.2 Remittance and Status (R&S) Reports

The R&S report is generated by TMHP or the MCO and shows the status of claims that have been accepted into their systems for processing. See the *Texas Medicaid Provider Procedures Manual* for a complete explanation of this report from TMHP. For information about the R&S reports from MCO's, contact the individual MCO.

R&S reports on claims that are paid to TDH, i.e., where the provider has the TDH tax ID, are first sent to CBU and then forwarded to the provider. R&S reports for local clinics that bill thru TWICES are mailed directly to the provider.

5. TMHP Claim Number

The TMHP Claim number on the R&S is the 24-digit Internal Control Number (ICN) for a specific claim. The format for this number is PPPCCCMMMCCYYJJJBBBBBSSS, where

PPP = Program

CCC = Claim Type

MMM = Media Source (Region)

CCYY = Year in which the claim was received

JJJ = Julian date on which the claim was received

BBBBB = TMHP internal batch number

SSS = TMHP internal claims sequence within the batch

Refer to the Texas Medicaid Provider Procedures Manual for full definitions of each item.

6. Provider Responsibilities

Accurate billing of client services through CBS requires that each billing provider or clinic site:

- Complete an electronic billing agreement with TMHP, as well as provide them with a list of service providers.
- Enroll with the Texas Medicaid Program (refer to the Texas Medicaid Provider Procedures Manual, section 2).
- Comply with federal legislation.
- Meet the 95-day filing deadline and other claim submission criteria.
- Complete an agreement with CBU, as well as provide them with the Medicaid provider numbers for all billable services. Providers using TWICES can contact the TWICES Help Desk.
- If the claim payment goes to TDH, the provider must use the TDH CBU accounting address and tax ID.
- Report to CBU current information on physical address and name changes.

For more information, contact CBU at (512) 458-7486.

7. Other CBS Functions – Medicaid Eligibility Match Process

The Medicaid Eligibility Match process is used by some TDH programs/systems that do not bill through CBS, but use CBS data to determine Medicaid eligibility. CBS may perform the Match Process for these programs/systems or may provide the eligibility data for them to perform their own match.

8. TDHConnect

Providers who do not submit claims through CBS can submit claims directly to TMHP using an automated system called TDHConnect. TDH Providers may also use TDHConnect for the following:

- On-line Medicaid eligibility inquiries
- Claim status inquiries
- Appeals

TMHP will provide the TDHConnect software free of charge. For more information, contact the TMHP help desk at (888) 863-3638, or the number listed in the Texas Medicaid Provider Procedures Manual.

9. Appendix A – CBS Report Examples

Exception Report for Invalid Claims

For Claims Processed: 10/28/2003
Batch Number: 7054

Region/LHD: W005
Provider Number: 1404253-43 Claim Type: WI Name: DRISCOLL CHILDREN'S HOSPITAL -ZZ050
Facility: W005000100

Client Name Last, First MI	Submitter Client ID	Birth Date	Service Date	Claim Amount
ROSE, YELLOW	99999999098	06/23/2003	03/03/2003	$24.58
Error # 7 Birth date later than service date.		BDate=[20030623], SDate=[20030303]		
ROBINHOOD, INDIA	99999999936	04/14/2003	03/03/2003	$24.58
Error # 7 Birth date later than service date.		BDate=[20030414], SDate=[20030303]		

Total Number of Error Claims for this Provider: 2
Total Amount of Error Claims for this Provider: $49.16

0119E301.301

For Claims Processed: 12/22/2003
Batch Number: 7098

Region/LHD: 08
Provider Number: 0940918-40 Claim Type: CP Name: TCID-WHL-PATH-ZZ034
Facility:

Client Name / Proc Code	Submitter Client ID / Diag	Qty	CBS ID / Mod1	Medicaid # / Mod2	$ Amt.	Birth Date / Service Date	Date Rec'd / Elig Dates	Reason
DEBO, LATINA	WCC-03-999999				0	08/14/1974	12/22/2003	I
88141	V2509	1	26		$15.00	12/05/2003		
PRINCE, DIANNA	WCC-03-999992				0	10/16/1963	12/22/2003	I
88141	V723	1	26		$15.00	12/04/2003		
WONDER, WINTER	LBP-03-999994				0	02/12/1979	12/22/2003	M
88141	V2509	1	26		$15.00	12/12/2003		
MORNING, EARL LEI	WCC-03-299991				0	07/20/1976	12/22/2003	I
88141	6221	1	26		$15.00	12/18/2003		

Total Number of Not Billed Claims for this Provider: 4
Total Amount of Not Billed Claims for this Provider: $60.00

REASON CODES: M - Multiple matches found for this client.
I - Client ineligible for Medicaid on the service date.
D - Service date is greater than 95 days old.

1389N301.356

For Claims Processed: 10/28/2003
Region/LHD: 07 Batch Number: 7054
Provider Number: 1404253-25 Claim Type: WI Name: AUSTIN H&H S.-TRAVIS CO.HD - ZZ050
Facility: W001001200

Client Name			Submitter Client ID		CBS ID	Medicaid #		Birth Date	Date Rec'd	Reason
	Proc Code	Diag	Qty	Mod1 Mod2			$Amt.	Service Date	Elig Dates	
HAVANA, KENYA V			99112011959		1530370752	0		01/05/1990	10/28/2003	N
	90471	V069	1				$5.00	10/22/2003		
	90657	V0389	1				$0.01			

Total Number of On Hold Claims for this Provider: 1
Total Amount of On Hold Claims for this Provider: $5.01

Reason Codes: N - Client Not Found
I - Possibly Ineligible

0117H301.301

For Claims Processed: 12/25/2003
Batch Number: 7054

Region/LHD: 07
Provider Number: 1404253-25 Claim Type: WI Name: Austin H&H S.-TRAVIS CO – HD – ZZ050
Facility : W001001200

Client Name:	Submitter Client ID					CBS ID	Medicaid #	Birth Date	Cnty #		Plan Code
	Proc Code	Diag	Qty	Mod1	Mod2					$Amt	Srvc Date
CASPER, GHOST	99212010881					1130370750	99922784161	01/30/2003	453		10
	5498X	V069	1							$5.00	03/15/2003
	5716X	V069	1							$5.00	
	5723X	V069	1							$5.00	
	5730X	V069	1							$5.00	
	90657	V0389	1							$4.58	

								Claim Total:		$24.58	
MOONCHILD, SUN A	99312010847					1230370753	23509266868	05/20/1989	453		TM
	90471	V069	1							$5.00	10/22/2003
	90657	V0389	1							$0.01	

								Claim Total:		$5.01	
ROBINHOOD, CECILIA G	99412005540					1330370751	55519313947	06/24/1999	453		10
	90471	V069	1							$5.00	10/22/2003
	90707	V069	1							$0.01	
	90713	V069	1							$0.01	
	90472	V069	2							$10.00	
	90657	V0389	1							$0.01	

								Claim Total:		$15.03	

Total Amount Billed for this Provider: $44.62
Total Number of Claims for this Provider: 3

0117B301.301

HCFA-1500 Processed: 11/03/2003
Region/LHD: 11 Batch Number: 7079
Provider Number: 1352486-08 Claim Type: IM Name: IMMUNIZATION ONLY- HARLINGEN – ZZ053
Facility : R1100101

HMO: 7F - COMMUNITY HEALTH CHOICE, INC

Client Name	CBS ID#	Submitter Client ID#			Medicaid #			Birth Date	
	Procedure Code	DOS	Diagnosis	Qty		Mod1	Mod2		$Amount
MONTCHRISTI, COUNT TH	9999999539	MTEST99993M53400			999999939			02/22/2003	
	5718X	08/13/2003	V069	1					$5.00
	5725X	08/13/2003	V069	1					$5.00
	5731X	08/13/2003	V069	1					$5.00
	5747X	08/13/2003	V069	1					$5.00
								Claim Total:	$20.00

TOTAL NUMBER OF CLAIMS FOR THIS HMO: 1
TOTAL AMOUNT BILLED FOR THIS HMO: $20.00

TOTAL NUMBER OF CLAIMS FOR THIS PROVIDER: 1
TOTAL AMOUNT BILLED FOR THIS PROVIDER: $20.00

00085M31.307

Run Date: 11/03/2003 TDH- CENTRALIZED BILLING SYSTEM Page:1

Claims Rejected by TMHP on Initial Edit
*These Claims Are Not In TMHP System
Refer to Cover Sheet

Provider Number: 1363681-09 Claim Type: EP For Claims Processed: 08/02/2001
Provider Name: EPSDT – HOUSTON – ZZ035 TDH Batch Number: 5339
Facility : 0310 0100 TMHP Batch Number: C1502DUU

HMO: 7F - COMMUNITY HEALTH CHOICE, INC

Client Nam:	Submitter Client ID /Proc Code	CBS ID# /Diag	Mod1	Medicaid # Mod2	Srvc Date /Amt Billed	Rejection:
********** CLAIM ERRORS **********						
CARTMAN, ERICA RA	D145283105S636001111111	17531		5119999999	07/01/2001	CODE 00293
						CODE 00958
						CODE PR001
	90658	V0389	C7		5.00	CODE 00293
	8000Y	V2020	C7		48.19	CODE 00724
	90658	V0389	C7		5.00	CODE 00958
	90658	V0389	C7		5.00	CODE 00958
	8000Y	V2020	C7		48.19	CODE 00958
SIMPSON, LISA C	D145283105S636001111121	17532		5118888888	07/01/2001	CODE RJ001
	90658	V0389	C7		5.00	CODE 00293
	8000Y	V2020	C7		48.19	CODE 00724

********** PROVIDER FACILITY TOTALS **********

Total Number of Errors:	2
Total Number of Medicare Rejections:	0
Total Number of Managed Care Rejections:	0

********** PROVIDER FACILITY CLAIM ERROR CODES **********
The following is a description of the codes returned for this facility:
00293 THSteps medical check-ups and acute care treatment services must be billed on separate claim forms.
00724 TB skin test must be coded on the claim. Submit only 2500Y, 2503Y, and 2506Y.
00958 THIS IS NOT A VALID PROC CODE FOR THIS DATE OF SERVICE. RESUBMIT WITH A VALID PROC CODE.
PR001 Provider claims submission has been accepted for front-end processing.
RJ001 Error has been detected on claim – Please correct and resubmit.