

SCOTT & WHITE HEALTH PLAN CLAIMS DEPT
2401 South 31st Street
Temple, TX 76508

CLAIMS DEPARTMENT OVERVIEW:

A centralized department located at the main Scott & White Health Plan offices in Temple, TX performs all claims processing functions. The claims department performs functions related to claim processing, subrogation, coordination of benefits; claims adjustments, provider appeals, and customer service functions related to claims payment issues.

METHODS OF CLAIMS SUBMISSION:

Electronic Claims:

- Scott & White Health Plan encourages all providers to submit claims electronically.
- Scott & White Health Plan currently accepts electronic claims via the Availity clearinghouse.
- The Availity system is simple to use. It integrates into the software systems typically used in most physician offices and hospitals around the state.
- There is no cost to providers for submitting claims. However, medical software vendors may charge a fee for installation and maintenance of system enhancements that support claims transmissions. Contact your software vendor for more information. Fees are paid by insurance carriers to Availity to support the claim submission costs.
- Contact your office computer software company or system vendor to see if they participate or call the Availity Help line:

1- 800-282-4548

or

website: availity.com

- Providers must use their National Provider Identifier (NPI) number when submitting claims through Availity so proper provider identification can be made.
- When submitting claims, use the Scott & White Health Plan payer number – **88030**.
- Both **UB04** and **HCFA1500** claims forms are accepted electronically.
- Providers are strongly urged to work daily their accepted/rejected reports from Availity to determine what claims were not accepted by SWHP.
- Patient member identification numbers must be complete (and include the two digit suffix at the end) for a claim to be accepted electronically.

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Revised 11/03/08
Revised 6/19/09

- Only primary claims are accepted electronically. Secondary claims must be submitted via paper with the appropriate EOB from the primary payer attached so proper claim adjudication may occur.
- 95 day filing deadline.

Paper Claims:

- Paper claims are accepted on standard claim forms (UB04 and HCFA1500).
- Claim forms must be typed or computer generated to insure readability. Handwritten claim forms will be rejected and returned to the provider.
- Claim forms should be readable and cannot contain marked-through or whiteout information.
- Claim forms must contain the necessary data elements specified in the Texas Department of Insurances regulations regarding clean claim submissions.
- For routine filing, Scott & White Health Plan will not accept FAX copies of claim forms due to difficulty in reading faxed claim forms.
- Paper claim forms should be submitted to the following address:

**Scott & White Health Plan
Attn: Claims Department
2401 South 31st Street
Temple, TX 76508**

CUSTOMER SERVICE

All questions related to claims issues, including claims submissions, payments, denials, and adjustments should be directed to the Health Plan at the following number:

**1- 800-321-7947
or
254-298-3000**

Our goal is to provide you with the best customer service possible.

CLAIMS PROCESSING EDITS

The claims system processes all claims through the following edits:

- Member eligibility
- Provider eligibility
- Authorization requirements
- Member benefit levels (i.e. copay levels, etc)
- Provider pricing arrangements (contracted fee schedules, DRG rates, per diems, capitation, re-pricing, etc)
- Authorization parameters for dates, dollar limits, procedures

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- Member on review for non payment of premiums and utilization issues
- Procedure detail for valid procedures and provider level credentialing of procedures to be performed
- Edits for late submissions
- Coordination of benefits
- PCP & panel area parameters
- Claim Check Edits

Claim Check Edits:

Scott & White Heath Plan utilizes Claim Check, a code editing software program designed to insure proper coding and billing of procedure codes. Claim Check uses clinically valid edits used by CMS to edit claims. All Claim Check edits have been reviewed by the SWHP Medical Directors for appropriateness. The following Claim Check edits are currently being utilized by SWHP:

- Rebundling
- Mutually Exclusive
- Incidental
- Medical Visits
- Pre/Post Op
- Age/Sex
- Duplicate Charges
- New Visit Frequency
- Intensity of Service
- Diagnosis to Procedure

All Claim Check edits are reflected in the Explanation Code on the appropriate service line of the Explanation of Payment (EOP) issued to the provider. Providers who disagree with an edit, may request a review of the claim. A request for review along with appropriate documentation/medical records should be sent to the SWHP claims department. The Medical Directors will review the documentation for appropriateness and send back a response to the provider with the determination.

Diagnosis to Procedure Claim Check Edit

Edit will occur when the procedure billed is not related to the documented diagnosis. Example: A provider bills a diagnosis code of 424.0 (mitral valve disorder) and procedure code 43500 (gastrotomy with exploration or foreign body removal). The procedure would be identified as unexpected for that diagnosis and would deny.

DUPLICATE SUBMISSIONS

Duplicate claims submissions are discouraged. Adequate processing time should be allowed and a status check performed before another claim is submitted. Multiple duplicate submissions create processing and payment problems for both the payer and provider of service.

STATUS CHECKS & CLAIMS INQUIRIES

The online MyPlan Provider Module is a self-service option available to assist you with status checks. Calling the following number, a customer service coordinator will be happy to assist you with claim inquiries:

1-800-321-7947

or

254-298-3000

SUBROGATION AND WORKERS COMPENSATION

Subrogation refers to those instances when another person or insurance company may be responsible for payment of medical services due to an accident or injury. Scott & White Health Plan has the right to be reimbursed for expenses paid for care rendered should a third party be responsible for the injury or illness.

Scott & White Health Plan has retained the services of Ingenix to act as the Health Plan's representative regarding rights of subrogation and recovery. If your office becomes aware of a possible subrogation claim, please contact Ingenix at 1-866-680-0996. Patients wanting additional information on their subrogation claims, may also contact Ingenix at 1-866-680-0996.

Injuries on someone else's premises and motor vehicle accidents are the most common examples of incidents that will involve recovery. Scott & White Health Plan has already paid the medical expenses that Ingenix will investigate.

Workers Compensation Injuries: Any injuries related to on-the-job circumstances should be filed directly with the Workers Compensation carrier or the employer involved. Scott & White Health Plan will not pay for work-related injuries.

COORDINATION OF BENEFITS

When a Scott & White Health Plan Member is covered by more than one insurance or medical coverage plan, benefits paid by SWHP will be coordinated to avoid duplicate coverage and payment according to the member's contract with SWHP.

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Scott & White Health Plan has on file information related to a member's other insurance coverage and periodically updates that information. If you have specific Coordination of Benefits questions for a member or need clarification on how to coordinate benefits, please call the claims department for further information.

A copy of the other insurance Explanation of Benefits (EOB) must accompany any claims submitted to Scott & White Health Plan for secondary coverage determination.

COB (Coordination of Benefits) Logic

In the event that SWHP is secondary to any other coverage, including Medicare, SWHP payment will be the difference in third party allowed and third party paid less SWHP member responsibility (deductible, coinsurance), not to exceed SWHP's payment as primary (SWHP's final payment amount including member responsibility - deductible, coinsurance, copay).

Example (1)

Claim calculated with SWHP as secondary. The difference in the Third Party allowed and Third Party paid less than our payment as primary.

Procedure Code	Charge	TP Allowed	TP Paid	Member Responsibility	SWHP Pays
70450	2059.00	2059.00	2000.00	0	59.00
10140	1194.00	1194.00	1000.00	0	194.00
99283	442.00	442.00	300.00	0	142.00
Totals:	3695.00	3695.00	3300.00	0	395.00

Example (2)

Claim where difference in the Third Party allowed and Third Party paid is more than our payment as primary. In this example, the difference in the Third Party allowed and Third Party paid is \$3,645.00. SWHP's payment would be \$3,645.00, which is what we would pay as primary.

Procedure Code	Charge	TP Allowed	TP Paid	Member Responsibility	SWHP Pays
70450	2059.00	2059.00	.00	0	2059.00
10140	1194.00	1194.00	.00	0	1194.00
99283	442.00	442.00	50.00	0	392.00
Totals:	3695.00	3695.00	50.00	0	3645.00

PROVIDER CLAIMS APPEAL PROCESS

This process applies to participating providers who feel that claims for services rendered to a Scott & White Health Plan member have been paid incorrectly or denied inappropriately for whatever reason.

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- Please call the Scott & White Health Plan Claims Department (1-800-321-7947 or 254-298-3195) for clarification on the payment issues in question. Many inquiries can be handled via phone and the necessary correction can be made over the phone.
- If a participating provider believes that a claim has been denied incorrectly, an appeal may be requested using the Practitioner/Provider Appeal Request Form (under physician appeal section).
- If a participating provider determines that a claim was submitted in error or with incorrect information, resulting in a denial or an unexpected or incorrect payment, the provider will be requested to submit a new corrected claim form.
- The deadline for filing a claims appeal request is up to 45 days from the date of the claim denial.

SENIORCARE CLAIMS

Senior Care is an enhancement program to Medicare Coverage. Scott & White Health Plan has a contractual arrangement with CMS to administer this program. Scott & White Health Plan acts as the Medicare Intermediary for Part B services for Senior Care members only.

Part A Services – All claims billed on a UB04 for Part A services should be filed with Medicare Part A and filed secondary with Scott & White Health Plan for possible secondary coverage.

Part B Services – Check your provider contract for specifics on Part B billing.

(Exception: CPT codes 90801 – 90899 for psychiatric services and 90918 – 90999 for dialysis services should be filed directly with Medicare.)

PROVIDER REIMBURSEMENT

The Provider Reimbursement section will help clarify SWHP reimbursement methodologies and practices. The Modifier Payment Policy and Bilateral and Multiple Surgical Procedures Professional Payment Policy specifies how to bill claims with modifiers so that they are processed correctly, as well as provide information on the standard payment adjustments associated with the modifiers allowed by SWHP.

It is important for providers and their staff to review these policies to clarify the information needed in the billing process and understand how services are reimbursed. The Modifier Payment Policy for example requires providers to bill modifiers in accordance with the SWHP Modifier Priority Table to avoid denial.

- [Modifier Payment Policy](#)
- [Modifier Priority Table](#)

- [Bilateral and Multiple Surgical Procedures Professional Payment Policy](#)

LOCUM TENENS BILLING

Network physicians may on occasion utilize a locum tenens physician to provide services in their office while they are temporarily out for a period of time.

It is the responsibility of the network physician to provide oversight of the locum tenens physician in relation to services that can be performed and authorization/pre-certification requirements for SWHP members and billing.

Services performed by the locum tenens physician should be billed to the SWHP/ICSW under the provider name and number of the network physician who is providing oversight. It is the responsibility of the network physician to provide reimbursement to the locum tenens physician.

Please contact the Provider Relations Department to advise of the name of the locum tenens physician and length of time that services will be provided.

STATUTORY VERIFICATION / DECLINATION

Definitions:

Statutory Verification: A verification that is requested pursuant to Senate Bill 418 under the Texas Insurance Code. A Statutory Verification serves as a guarantee of payment if granted. Declination of Statutory Verification does not mean that a claim for the services for which Statutory Verification is being sought will be denied, it simply means that we are unable to guarantee payment based upon the information we have at the time of the Declination.

Declination: Refusal to give a Statutory Verification. This does not equate with claim denial or adverse determination. The reason for issuing a Declination must be given in the Declination.

To request a statutory verification, contact the Scott & White Health Plan Customer Service Center at 800-321-7947 (toll free) or 254-298-3000 (locally) and provide the state mandated required elements.

Required elements: The elements required from a provider before the Statutory Verification rules apply are as follows:

Required elements: The elements required from a provider before the Statutory Verification rules apply are as follows:

1. Name of Provider

2. Provider's federal tax ID number
3. Patient Name
4. Patient SWHP ID number
5. Patient date of birth
6. Patient Relationship with Enrollee
7. Presumptive diagnosis, if known, otherwise presenting symptoms
8. Description of proposed procedure or procedure codes
9. Place of service code where services will be provided, and if other than provider's office, name of hospital or facility where proposed service will be provided
10. Proposed date of service
11. Group number
12. Name and contact of any other carrier, if known to provider

For a routine care statutory verification, Scott & White Health Plan will respond within five (5) days.