

**SCOTT & WHITE HEALTH PLAN CLAIMS DEPT**  
**2401 South 31<sup>st</sup> 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 Texas Health Information Network (THIN) clearinghouse.
- The THIN 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 THIN to support the claim submission costs.
- Contact your office computer software company or system vendor to see if they participate or call the Texas Health Information Network Help line:

**972-766-5480**

- Providers must use their SWHP assigned provider number when submitting claims through THIN so proper provider identification can be made. For questions regarding your SWHP assigned provider number call our Health Plan offices at 254-298-3000 or 1-800-321-7947 and ask for the claims department.
- When submitting claims, use the Scott & White Health Plan payer number – **88030**.
- Both **UB92** and **HCFA1500** claims forms are accepted electronically.
- Providers are strongly urged to work daily their accepted/rejected reports from THIN 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.
- 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 (UB92 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 31<sup>st</sup> 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
- 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

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.

### **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**

Calling the following number, a financial member relations coordinator will be happy to assist you in performing status checks and 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.

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.

### **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.

- 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, send a copy of the Explanation of Payment (EOP) with a note of explanation clearly identifying the reason for the appeal and any supporting documentation to Scott & White Health Plan. Please address the envelope Attention: Claims Appeals
- 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 UB92 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 – For contracted physicians within the Scott & White Health Plan network, Scott & White Health Plan acts as the intermediary for Part B services. File these services with SWHP on a HCFA1500 (or electronically) as the primary carrier. If you are a contracted provider, DO NOT file with Medicare for Senior Care members for Part B services. Scott & White Health Plan will make reimbursement according to your contractual arrangement with SWHP.

All claims for Part B professional services for SWHP Senior Care members should be filed directly with SWHP, not Medicare. (Exception: CPT codes 90801 – 90899 for psychiatric services and 90918 – 90999 for dialysis services should be filed directly with Medicare.)

For more information on how to file Senior Care claims please contact the Scott & White Health Plan claims department.

### **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.

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Claim #

MEDICAL AUTHORIZATION

PATIENT'S NAME:

DATE OF BIRTH:

I AUTHORIZE:

TO RELEASE COPIES OF MY MEDICAL RECORDS COVERING THE PERIOD

FROM: THRU:

TO: SCOTT AND WHITE HEALTH PLAN  
2401 SOUTH 31ST  
TEMPLE TX 76508-3000  
ATTN: CLAIMS PROCESSING DEPT.

THE COPIES ARE FOR THE PURPOSE OF CLAIMS PROCESSING.

THE SPECIFIC RECORDS TO BE RELEASED ARE:

\_\_\_\_\_ EMERGENCY ROOM REPORT

\_\_\_\_\_ DAILY PROGRESS NOTES

\_\_\_\_\_ ADMIT SUMMARY

\_\_\_\_\_ DISCHARGED SUMMARY

OTHER  
\_\_\_\_\_

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR A PERIOD OF THREE (3) MONTHS UNLESS REVOKED BY ME IN WRITING.

\_\_\_\_\_  
Signature of Patient or  
Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness