TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014  Effective Date: 04/01/2015

Ana Deslongchamps,  Frank Stout
Unit Associate Director  Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,  
MPIP Managing Director

Department: BAC-Billing and Collections

TITLE: Medicare/Medicare Managed Care/Railroad Collections

Policy#: BAC 1

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to Medicare recipients. TTUHSC files electronic claims daily on behalf of individuals covered by Medicare, and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Medicare payers are billed for services where Medicare eligibility has been verified. Where eligibility cannot be verified, the patient is classified as self-pay. Medicare recipients are responsible for annual deductibles, co-payments, and/or co-insurances based on the allowable fees approved by Medicare. All patient-responsible balances bill to the patient after the claim has been adjudicated.

2) Medicare claims bill daily and electronically to Novitas Solutions, Inc. and Railroad Medicare claims bill to Palmetto GBA, both having a 365-day filing deadline. Medicare Managed Care plans, including but not limited to Aetna, Amerigroup, Care Improvement Plus, Care 1st Health Plan, Humana, Molina, United HealthCare, Wellcare and Wellmed, have filing deadlines ranging from 90 to 365 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ectuweb1/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIP employees work with department certified coders to
resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update insurance eligibility and re-queuing of claims.

6) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadlines range from 30 to 120 days from the denial date noted on the latest explanation of benefits.

7) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed primarily online, followed by telephone call to the payer’s claims department. An online Appeal Status Tool offered by Novitas Solutions, Inc. may be accessed at https://appealstatustool novitas-solutions.com/webpws/.

8) Charges determined after adjudication to be patient responsibility, which may include deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services, are billed to secondary or tertiary payers when applicable or billed to the patient. Charges that have not been assigned as patient responsibility are billed to the patient only if a completed and signed Advanced Beneficiary Notice (ABN) is on file for that specific service.

RESPONSIBILITIES

1) Medical Billing Associate (MBA) 1: Medicare and Railroad Medicare claim edits, EDI rejections, correspondence, follow-up, and appeals.

2) Senior MBA 1 and 2: Medicare Managed Care claim edits, EDI rejections, correspondence, follow-up, and appeals.
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Ana Deslongchamps
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner
MPIP Managing Director

Department: BAC-Billing and Collections

TITLE: US Marshals Service

Policy#: BAC 2

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to US Marshals Service inmates. TTUHSC submits paper claims daily on behalf of individuals covered and under custody of US Marshals Service FSC 174, and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) US Marshals Service claims are billed for services where eligibility and custody is verified. Where eligibility and custody cannot be verified, the patient is classified as self-pay. All patient-responsible balances bill to the patient after the claim has been adjudicated. Verification by US Marshals is performed by calling or emailing: Minerva Mercado at 915-534-5013 or Minerva.Mercado@usdoj.gov, Maria Fuentes at 915-534-5010 or Maria.Fuentes@usdoj.gov or Adrian Aranda (Supervisor) at 915-534-5062 or Adrian.Aranda@usdoj.gov. All emails sent outside of Texas Tech must be sent secured [SEND SECURE].

2) US Marshals Service paper claims are billed daily with the 237 form (see attached example) obtained from EMR when the inmate is seen in TTUHSC clinics; 237 forms for hospital care are obtained from Mona Pacheco at 215-546-2228 or by email at r.pacheco@epcounty.com. US Marshals Service does not have a filing deadline.

3) Designated employees review and correct all rejections found on the daily claims edit list, which is located on the Shared drive under MPIP Reference/Edit List. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.
4) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 30 days. Follow-up is performed by telephone by contacting the persons mentioned in 1). Follow-up may include verification and update of insurance eligibility and re-queuing of claims.

5) MPIP designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline is one year from the denial date noted on the latest explanation of benefits.

6) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts employee of payer non-response. Status of the appeal is reviewed online, followed by telephone call to the payer’s claims department.

7) Charges determined after adjudication to be patient responsibility, including patient not in custody, unable to identify arresting agency, non-covered or ineligible services, are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Medical Billing Associates (MBA)
2) Student Assistant I: EDI rejections.
**PRISONER MEDICAL REQUEST (Draft for Pilot)**

TO BE COMPLETED BY DETENTION FACILITY AND USMS DISTRICT OFFICE (as applicable):

- Non-URGENT/DEADLINE: Prior to seeking outside medical attention for a prisoner, complete this form and fax to USMS District Office as its number above. USMS will notify you of approval or denial of the request.
- EMERGENCIES: If a life-threatening or necessary, and fill this form within 24 hrs.

<table>
<thead>
<tr>
<th>Prisoner name:</th>
<th>USMS No.</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance: YES □ NO □</td>
<td>34382390</td>
<td></td>
</tr>
<tr>
<td>Detention Facility:</td>
<td>OCEP</td>
<td>Contact Person: A. Hernandez</td>
</tr>
<tr>
<td>Telephone No.:</td>
<td>5758244884 x130</td>
<td>Fax No.: 5758245271</td>
</tr>
<tr>
<td>Date &amp; Time USMS Notified of Request:</td>
<td>5/11/14 @ 120</td>
<td></td>
</tr>
</tbody>
</table>

**Description of Requested Services with Justification:**

- Attach Medical or Dental Notes to support request or note below if Court-ordered.
- USMS Prisoner Health Care Standards can be found at [http://www.usmarshals.gov/services/standards.htm](http://www.usmarshals.gov/services/standards.htm)
- For medication, indicate quantity and name of drug. Generic medications should be used when available.

**Medical Provider Sent to ER due to Having Infection (notes attached)**

**Urgency of Request:** Emergency □ Urgent (2 weeks) □ Routine (2-6 weeks) □ Standard (>6 weeks) □

**Facility/Hospital/Pharmacy providing service:** LMC 01551240 □ App't Date: 5/14/14 □

**Healthcare Provider providing service:**

**Estimated Cost $**

**NOTE:** By law, USMS may only pay Medicare rates or less

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**TO BE COMPLETED BY USMS DISTRICT OFFICE:**

- Media Review: Approved □ Denied □ Pending (additional information required) □
- District Representative Signature: [Signature]
- Date: [Date]
- Deputy Handling Prisoner: [Signature]
- Funds obligated: $ □ Obligation: □
- Paid by Government Credit Card: □ Check: □ Other: □ (specify): □

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**TO BE COMPLETED BY USMS OFFICE OF INTERAGENCY MEDICAL SERVICES (OIMS):**

- OIMS Review: Approved □ Denied □ Pending (additional information required) □
- Comments: □

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Sample
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Ana Deslongchamps,
Unit Associate Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: BAC-Billing and Collections

TITLE: Children’s Health Insurance Plan (CHIP)/CHIP Perinate Collections

Policy#: BAC 3

Policy: The purpose of this policy is to outline the procedure for collection of services provided to
Children’s Health Insurance Plan (CHIP) and CHIP Perinate recipients. TTUHSC files electronic claims
daily on behalf of individuals covered by CHIP and bills patients for any outstanding co-payments, co-
insurance, or non-covered services. The patient is billed for non-covered services after the claim has been
processed and a waiver signed by the patient was obtained (instructions attached). Paperless Collection
System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to
identify denied claims requiring review for appeal. The business office researches any information to
adjudicate claims and requests assistance from departments as needed.

Procedures:

1) CHIP payers are billed for services where eligibility is verified. Where eligibility cannot be
verified, the patient is classified as self-pay. CHIP recipients are responsible for co-payments; all
patient-responsible balances bill to the patient after adjudication if the amount was not collected
at the clinic front desk.

2) CHIP claims bill daily and electronically to El Paso First and Superior Health Plans; the filing
deadline is 95 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located
on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing
insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-
participation, etc. MPIP employees work with department certified coders to resolve coding
issues and report excessive and/or unusual rejection issues to the billing and collections
supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI
claims portal, which may be accessed at https://edi_idxasp.com/ectuweb/Login.action.
Rejections are caused by missing or invalid insurance information, place of service, diagnosis,
provider non-participation, etc. MPIP employees will work with department certified coders to
resolve any coding issues and report any excessive and/or unusual rejection issues to the billing
and collections supervisor or manager. Claim edits are resolved within 3 business days.
5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain outstanding for 15 days, excluding invoices for the Pediatrics department. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update of insurance eligibility and re-queueing of claims.

6) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline for CHIP claims is 120 days from the denial date noted on the latest explanation of benefits. Charges for services provided by non-covered providers or non-covered services in which there is no waiver on file are submitted to the billing manager on an adjustment request form (Form A).

7) A minimum of 55 workfile accounts are processed on a daily basis. Status of the appeal is reviewed online within 30 days, followed by telephone call to the payer's claims department.

8) Charges determined after adjudication to be patient responsibility, including deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Senior Medical Billing Associate (MBA) 1: claim edits, EDI rejections, correspondence, follow-up, and appeals.

2) Senior Business Assistants 1: claim edits, EDI rejections, correspondence, and follow-up.
TMHP
P.O. Box 200555
Austin, Texas 78720-0555

Cost Sharing Schedule:
For CHIP Perinatal there is no cost sharing schedule that is applicable.

No Co-Payments for CHIP Perinatal members and/or CHIP Perinatal Newborn members. Co-payments do not apply to CHIP Perinatal

BILLING MEMBERS

- Co-payment
  Provider understands and agrees that Provider is responsible for collecting at the time of the service any applicable co-payments, given the limitations on those co-payments. Co-payments are the only amounts that a Provider may collect from Members.

- Non-Covered Services
  Providers must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed acknowledgement statement from the Member.

- Balance Billing
  Providers agree to accept payment made by El Paso First as payment in full. The member cannot be held liable for any balance related to covered services.

Member Acknowledgement Statement
A provider may only bill a member when the member has signed the Member Acknowledgement Statement and the following conditions are met:

- A claim is denied as not being medically necessary
- A claim is denied as part of a non-covered service,
- The service is provided at the request of the client

Example of a Member Acknowledgement Statement:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the (Program Name) as being reasonable and medically necessary for my care. I understand that El Paso First determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I
request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Private Pay Form

If the provider accepts the member as a private pay patient and informs the member at the time of service that the member will be responsible for paying for all services, the provider may bill the member. In this situation, it is recommended that the provider use a Private Pay Form. It is suggested that the provider use the Member Acknowledgement Statement provided above as the Private Pay Form. Without written, signed documentation that the member has been properly notified of their private pay status, the provider cannot ask for payment from a member. The Private Pay Form can be found as ATTACHMENT 21(pg. 242) of this manual.

SSI Claims

El Paso First is not responsible for processing claims for members with Supplemental Security Income (SSI).

- Prior authorization request (if necessary) for SSI clients of any age who are enrolled in El Paso First STAR Premier program must be submitted to El Paso First utilization review department prior to rendering services.
- Claims for El Paso First SSI members should be submitted directly to Texas Medicaid Health & Partnership (TMHP). If a claim for an SSI client is sent to El Paso First, the claims will be denied with the following denial reason:

<table>
<thead>
<tr>
<th>D0000</th>
<th>Claim not covered by this payer/contractor.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You must send the claim to the correct payer/contractor.</td>
</tr>
</tbody>
</table>

RESOURCES FOR CLAIMS STATUS

Provider Care Unit (PCU)

The PCU department is a subsection of the claims department developed to assist providers with claims inquiries. The PCU department can be reached at 915-532-3778 or 1-877-532-3778. When calling you will reach a Claims Specialist who can assist you with:

- Claim status
- Answers to claim questions
- Answers to electronic claims submission rejections or questions
- Resolving claims

Last Revision: 01-13-12

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Ana Deslongchamps,  Frank Stout
Unit Associate Director  Assoc Dean/Asst VP, Finance and Administration
Steven M. Wagner  MPIN Managing Director

Department: BAC-Billing and Collections

TITLE: Commercial Insurance Collections

Policy#: BAC 4

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to commercial insurance recipients. TTUHSC files electronic claims daily on behalf of individuals covered by commercial insurances and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Commercial payers are billed for services where eligibility has been verified. Where eligibility cannot be verified, the patient is classified as self-pay. Recipients are responsible for annual deductibles, co-payments, and/or co-insurances based on the allowable fees approved by the plan. All patient-responsible balances bill to the patient after the claim has been adjudicated.

2) Commercial claims bill daily and electronically to plans with EDI connectivity and on paper claims for plans without connectivity. The filing deadlines range from 90 to 365 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIN Shared Drive under MPIN Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIN employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ectuwweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIN employees work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.
5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update insurance eligibility and re-queuing of claims.

6) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadlines range from 30 to 120 days from the denial date noted on the latest explanation of benefits.

7) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed online, followed by telephone call to the payer’s claims department.

8) Charges determined after adjudication to be patient responsibility, including deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Medical Billing Associates (MBA) 1 – 3, Senior MBA 1, and Senior Business Assistants 1- 3: claim edits, EDI rejections, correspondence, follow-up, and appeals.

2) Student Assistant 1: EDI rejections.
Department: BAC-Billing and Collections

TITLE: Immigration/Customs and Border Protection

Policy#: BAC 5

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to Border Patrol inmates. TTUHSC files paper claims daily on behalf of individuals covered and under custody of Immigration/Customs and Border Protection FSC 738 and bills patients for any outstanding non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Customs and Border Protection claims are billed for services where eligibility and custody has been verified. Where eligibility and custody cannot be verified, the patient is classified as self-pay. All patient-responsible balances bill to the patient after the claim has been adjudicated. Verification by Customs and Border Protection is performed by calling or emailing Hector Arrieta at 915-730-7231 or Hector.Arrieta@CBP.DHS.GOV. All emails sent outside of Texas Tech must be sent secured [SEND SECURE].

2) Customs and Border Protection paper claims bill daily with the MedPAR form (see attached example) obtained from Hector Arrieta when the inmate receives Emergency Room or other hospital care. MedPAR forms are obtained from Hector Arrieta at 915-730-7231 or by email at Hector.Arrieta@CBP.DHS.GOV. Customs and Border Protection has a filing deadline of one year from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed by signing on the web portal at va.fscdihss@mail.va.gov or by telephone to US Department of Homeland Security. Designated
employees must sign up and create a username in order to review and obtain claim status through the web portal. Follow-up may include verification and update of insurance eligibility and re-queuing of claims.

5) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claim, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline is one year from the denial date noted on the latest explanation of benefits.

6) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed online, followed by telephone call to the payer’s claims department.

7) Charges determined after adjudication to be patient responsibility, including patient not in custody, unable to ID arresting agency, or patient is ineligible, are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Medical Billing Associates (MBA)
2) Student Assistant I: EDI rejections.
ICE Health Service Corps

Treatment, Authorizations & Consents Form

SEND PAYROLL CLAIM TO:
ICE Health Service Corps
14945
Au (4) 77134-5345
Auction, TX 77134-5345

For ICE claim submission information and claim resource, please contact: 1-800-479-0123

Claims must be submitted within one year from date of health services. Approvals are valid for 90 days from date of approval.

For proper provider claim submission information, please visit:

A separate treatment authorization request will be required for services rendered outside the scope of the original authorization. Services rendered may not be paid without an approved authorization. All payment for services is subject to retention until eligibility and payment is confirmed. Unless otherwise specified, payment for ICE authorized health services is made in accordance with US Code Title 18, Part III, Chapter 301, Sec. 4006. All claims are subject to retrospective review. For further information regarding ICE, please visit our website: http://www.ice.gov/about-us/offices/enforcement/immigration-and-criminal-operations

Please ensure that claims include the Patient Identification Information and the Authorization number.

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:

<table>
<thead>
<tr>
<th>Number</th>
<th>ID Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A123456789</td>
<td>USA</td>
</tr>
</tbody>
</table>

AUTHORIZED ACTION:

Medical Approval: 20140121-1413 00

Authorizer: LT Prichard, B. Malott

Referral Fate: 73

Date (Month and Year to which referral is being made)

Date of Request:

Approve 12/31/2013 to include Observation up to 72hrs on 12/31/2013

MedPAR is administratively approved for 12/31/2013 to include observation up to 72 hours. Law US Border Patrol duty for access to medical care. The submitting agent attests that the alien is in custody at the time the service is provided. ICE renders no decision on medical necessity of appropriateness for the requested treatment, but acts as intermediary for the payment of claims. 2014 Title 18 USC, Part III, Chapter 301, § 4006.

Updated by LT Prichard Antonio on 23 October 2014

United States Customs and Border Protection
Office of Field Operations O Paso, TX

This Med Par request is for:

Name: 

DOB: 

Nationality: United States Citizen

Date of Service: 12/06/2013

MedPAR Authorization Form

Release Date: 12/08/2012
Diagnosis: Medical exam
Mode of Transportation: CAB CAB
- Dates of Services reviewed by MedPAR Coordinator: 01/31/2012
This event's care was reviewed by MedPAR and should be verified for data completeness.

The following patient information was entered manually:
- Patient Allen #: O3CC35331585
- Patient ID: 35331585
- Patient Last Name
- Patient Middle Name
- Patient Given Name
- Patient DOB
- Patient Sex
- Patient Nationality
- Patient INS Status
- Patient HHS Number

The following provider information was entered manually:
- Provider ID: LMC 133200, Texas
- Provider Name: LMC Hospital
- Provider Specialty Code
- Provider Specialty Description
- Provider Entity Type: Hospital
- Provider Type:
- Provider Address 1: 4315 Alonnesa
- Provider Address 2:
- Provider City: El Paso
- Provider State: TX
- Provider Zip: 79905
- Provider Phone: (915) 344-1200

- Provisional Diagnosis: V70 GENERAL MEDICAL EXAMINATION

Consultation Report:

Instructions for Usage of Treatment Authorization And Consultation Form

Reimbursement Types Descriptions:

Consult Only - Consultative health services only that are consistent with the consultant provider's specialty and the patient's medical condition.

Emergency Room - Health services consistent with an Emergency Room setting and the patient's specified medical condition. In cases where an inpatient admission may be medically necessary following an initial Emergency Room visit, a new TAR must be submitted by the patient's primary facility.

Medical Appointment (not a consult) - Health services consistent with the provider's specialty and the patient's specified medical condition.

Medical Lab/Test - Lab and/or test consistent with the patient's specified medical condition.

Inpatient Hospitalization - Health services consistent with an inpatient hospitalization and the patient's specified medical condition.

Dental Services - Health services consistent with a dental provider's specialty and the patient's specified medical condition.

Non-Formulary Medications - Any medication not included on InSC designated formulary.

http://www.ihc.gov/about/ceo/forproviders/services/medforms/medforms.html
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Ana Deslongchamps,  Frank Stout
Unit Associate Director  Assoc Dean/Asst VP, Finance and Administration
Steven M. Wagner,  
MPIP Managing Director

Department: BAC-Billing and Collections

TITLE:  Eligibility Group Eligibility Request Definitions (GERD) Processing

Policy#: BAC 6

Policy: The purpose of this policy is to outline the procedure for processing the results of the automatic eligibility GERD (Group Eligibility Request Definitions) reports that are processed by GE Centricity Business on a daily, weekly, and monthly basis. These GERDs send eligibility requests to participating payers through Electronic Data Interchange (EDI); the results are reviewed by designated staff and insurance information is updated in the patient services function as required.

Procedure:

1) The following GERDs are currently processed by GECB:

   • GRP 3 60 DAY - EL PASO – daily request to CMS and various commercial payers is run 7 days prior to scheduled appointments for accounts containing registration FSCs corresponding to Medicare and commercial payers.

   • GRP 3 MONTHLY - EL PASO – daily request to TMHP is run 3 days prior to scheduled appointments for accounts containing registration FSCs corresponding to Medicaid payers.

   • GRP 3_SP_INDIGENT_TX – monthly request to TMHP on the 10th day of the month for accounts containing the Hospital District registration FSCs of 375 or 376 or other self-pay FSCs to include 1, 15, and 17 and a Texas address.

   • GRP 3_SP_INDIGENT_NM - monthly request to New Mexico Medicaid on the 10th day of the month for accounts containing the Hospital District registration FSCs of 375 or 376 or other self-pay FSCs to include 1,15, and 17 and a New Mexico address.

   • GRP 3_MCD PENDING – weekly request to TMHP for accounts containing pending Medicaid/SSI registration FSCs of 315 or 516 and a Texas address.

   • GRP 3_TES_MEDICAID_SELFPAY – daily request to TMHP for invoices entered through TES containing a self-pay FSC and a Texas address.
- **GRP 3_TES_NM_MEDICAID_SELFPAY** – daily request to NM Medicaid for invoices entered through TES containing self-pay FSC and a New Mexico address.

- **GRP 3_TES_MEDICARE_SELFPAY** – daily request to CMS (Centers for Medicare and Medicaid) for invoices entered through TES containing a self-pay FSC.

2) The GERD training guide is included; Reports are accessed as follows:

- Select Eligibility, then Eligibility Summary tab

![Eligibility Summary Screenshot](image)

- Scroll down to desired report, for example **GRP3_TES_MEDICAID_SELFPAY**
- Highlight the Row and Select the ‘Group Req’ button at the bottom of the screen
The list of individual accounts that were processed in the GERD will appear.

- Sort by 'Status' to view all Active, Inactive, Rejected, or Mixed results as a group, apply filter as desired
- Review desired 'Results', update plan information in Patient Accounts, and if necessary, bill out any claims

3) Designated employees process GRP 3 60 DAY - EL PASO and GRP 3 MONTHLY - EL PASO results daily, update eligibility information as required in the patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status other than Active and including the status of Active indicating a Needs Review (NR) result require review.
4) Designated employees process GRP 3_SP_INDIGENT_TX and GRP 3_SP_INDIGENT_NM results on a monthly basis, update eligibility information as required in patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status of Active require review.

5) Designated employees process GRP 3_MCD PENDING results weekly, update eligibility information as required in patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status of Active require review.

6) Designated employees process GRP 3_TES_MEDICAID_SELFPAY and GRP 3_TES_MEDICARE_SELFPAY daily, update eligibility information as required in patient services insurance fields, note appropriate eligibility information in General Comments, and bill out any outstanding or improperly billed invoices. All accounts with a status of Active require review.

RESPONSIBILITIES

1) Senior Business Assistant 1 will process GRP 3_SP_INDIGENT_NM monthly GERD.

2) Medical Billing Associate (MBA) 1 will process GRP 3_SP_INDIGENT_TX (Letters A – L) monthly GERD.

3) Senior Business Assistant 2 will routinely process GRP 3_SP_INDIGENT_TX (Letters M – Z) monthly GERD, GRP 3_MCD PENDING, GRP 3_TES_MEDICAID_SELFPAY, and GRP 3_TES_MEDICARE_SELFPAY; GRP 3 60 DAY - EL PASO Medicare plans and GRP 3 MONTHLY - EL PASO will be processed as time permits.

4) Senior Business Assistants 3 and 4 will process GRP 3 60 DAY - EL PASO for commercial plans as time permits.
Texas Tech University Health Sciences Center El Paso Medical Practice Income Plan Policy and Procedure

Revised Date: 10/01/2014  Effective Date: 04/01/2015

Ana Deslongchamps,  Frank Stout
Unit Associate Director  Assoc Dean/Asst VP, Finance and Administration
Steven M. Wagner,  
MPIP Managing Director

Department: BAC-Billing and Collections

TITLE: Sheriff Department/Juvenile Detention Collections

Policy#: BAC 7

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to patients who are inmates of the El Paso County Sheriff Department or the El Paso County Juvenile Probation Department. TTUHSC submits paper claims daily on behalf of individuals covered and under custody of the El Paso County Sheriff Department FSC 22 and Juvenile Probation Department FSC 327 and bills patients for any outstanding co-payments, co-insurance, or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) The El Paso County Sheriff Department houses adult inmates at two facilities: 601 Overland Ave., El Paso, TX, 79901 and 12501 Montana, El Paso, Texas, 79938. The Juvenile Detention department houses juvenile offenders up to 17 years of age at 6400 Delta, El Paso, Texas, 79905. Authorized services are billed as indicated below:

<table>
<thead>
<tr>
<th></th>
<th>Sheriff FSC 22/194</th>
<th>Hospital District FSC 376/110</th>
<th>Juvenile FSC 327</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Resident Inpatient/UMC POS 21</td>
<td>X</td>
<td></td>
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<tr>
<td>Non-Resident Outpatient/UMC POS 22</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>Non-Resident Texas Tech Clinic POS 11</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Resident Emergency Medicine Dept. UMC (99283, 99284, 99285) POS 23</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Non-Resident Emergency Dept. all Specialties POS 23</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Inpatient/UMC POS 21</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Resident Outpatient/UMC POS 22</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2) Paper claims are billed daily; there is no filing deadline. Sheriff Department claims are mailed Certified Return Receipt to: El Paso County Sheriff’s Department, 3850 Justice Dr., El Paso, Texas, 79938 or faxed to (915) 538-2246 to the attention of Theresa Elias. Juvenile Department claims and a corresponding form letter are billed by fax to (915) 849-2028 to the attention of Laura Moreno, Accounting Clerk; form letter is included.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed by contacting Theresa Elias at (915) 538-2234; follow-up for the Juvenile Probation Department is performed by contacting Laura Moreno at (915) 849-2605.

5) Designated employees review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with Sheriff Department of Juvenile Detention department personnel. Appeal deadlines do not apply.

6) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is completed by telephone call to the Sheriff Department or Juvenile Probation Department contacts.

7) Charges determined after adjudication to be patient responsibility, including deductibles, co-insurance, co-payments, benefit maximums, or non-covered or ineligible services are billed to secondary or tertiary payers when applicable or billed to the patient.

RESPONSIBILITIES

1) Senior Business Assistants 1 and 2: claim edits, correspondence, follow-up, and appeals.
El Paso County Juvenile Probation Dept.
6400 Delta
El Paso, Texas  79905

Attn: Laura Moreno

Invoice# JXxxxxxxxx
MRN# Exxxxxxxx
Juvenile Name:
Juvenile DOB:
Date of service: DD/MM/YY (CPT Code – CPT Description) SBilled Amount

Related Cost: $Total Amount Billed

If you have any questions please call me at 915-215-XXXX.

Sincerely,

Staff Member Name
Title
Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to patients that are eligible for organ donation. Southwest Transplant Alliance (STA) is an organization that pays all charges subsequent to the patient becoming an organ donor. This occurs once the patient has been pronounced brain dead and consent for organ donation has been obtained from the next of kin. Charges prior to this time are billed to patient's insurance or Hospital District. TTUHSC files daily electronic claims on behalf of individuals covered by STA, and bills the patient's next of kin for any outstanding balances or non-covered services. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify claims requiring review for appeal. The business office researches any information to adjudicate claims and requests assistance from departments as needed.

Procedures:

1) Southwest Transplant Alliance (STA) is billed for services where eligibility has been verified. Where eligibility cannot be verified with STA, the patient's insurance is billed, or, if classified as self-pay, is billed to Hospital District. All patient-responsible balances are billed to the next of kin after the claim has been adjudicated.

2) Southwest Transplant Alliance claims bill daily and electronically to Southwest Transplant Alliance, 5489 Blair Road Dallas, TX 75231. The filing deadline is 365 days from the date of service.

3) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

4) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxsasp.com/ecttwweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis,
provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues, and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

5) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 15 days. Follow-up is performed by contacting Karmisha Pinkard: Phone: 214-522-0255, Fax: 214-522-0430, or by email at kpinkard@organ.org. Follow-up may include verification of time and date consent was signed.

6) Denials from Southwest Transplant Alliance state 'NOT Ours', which indicates the services were performed before the consent was signed. These invoices are submitted to the patient's insurance or to Hospital District if the patient is classified as self-pay.

RESPONSIBILITIES

1) Medical Billing Associates (MBA) 1: claim edits, EDI rejections, correspondence, follow-up, and appeals.
Texas Tech University Health Sciences Center El Paso
Medical Practice Income Plan Policy and Procedure

Revised Date: 10/01/2014  Effective Date: 04/01/2015

Ana Deslongchamps,  
Unit Associate Director

Frank Stout  
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,  
MPIP Managing Director

Department: BAC-Billing and Collections

Title: Hospital District Collections

Policy#: BAC 9

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to uninsured patients who receive services at University Medical Center (UMC) and El Paso Children's Hospital (EPCH) that are eligible under the Hospital District MSA contract. TTUHSC files electronic claims daily on behalf of individuals eligible for coverage under the Hospital District MSA contract for uninsured individuals. A monthly claims report is issued by ESI Healthcare Business Solutions outlining claims that were accepted and paid and claims that were unaccepted and denied. Monthly reports generated by MPIP analysis identify claims that did not transmit successfully and claims that remain outstanding. The business office researches any information needed to adjudicate a claim.

Procedures:

1) ESI Healthcare Business Solutions is billed daily and electronically for services provided to uninsured patients who qualify under the Hospital District MSA program; the filing deadline is 235 days from the date of service and claims are adjudicated according to Medicare guidelines. Services performed at University Medical Center (UMC) as inpatient, outpatient, and emergency room are covered for the following departments: Internal Medicine and subspecialties, Orthopaedic Surgery, Obstetrics and Gynecology, Surgery and subspecialties, Pediatrics (Hearing and Newborn Nursery), Neurology, Family Medicine, Radiology, Anesthesiology, and Pathology. The attached Hospital District Guide outlines the specific MSA effective dates.

2) El Paso Children's Hospital (EPCH) is billed monthly for services provided to uninsured patients who qualify under the EPCH MSA program; there is no filing deadline and claims are adjudicated according to the guidelines specified in the current MSA contract. Effective February 1, 2014, services performed at EPCH as inpatient, outpatient, and emergency room are covered for the following departments: Internal Medicine and subspecialties, Orthopaedic Surgery, Obstetrics and Gynecology, Surgery and subspecialties, Pediatrics, Neurology, Family Medicine, Radiology, Anesthesiology, and Pathology. The attached Hospital District Guide outlines the specific MSA effective dates.
3) ESI provides TTUHSC with monthly reports by the 10th business day of the month, consisting of executive summary reports and an Excel spreadsheet containing accepted and unaccepted claims. Claims are processed under the Service Proxy Month method, in which services dates are held for a period of 120 days to allow for billing lag time (e.g., June 2014 Service Proxy Month represents payment for October 2014).

4) Designated employees review and correct all rejections found on the daily claims edit list located on the MIPIP Shared Drive under MIPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-participation, etc. MIPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days. All accounts are reviewed for billing of additional qualifying invoices.

5) A minimum of 55 accounts are processed on a daily basis. Designated MIPIP employees review the monthly unaccepted claim report and process appeals according to the denial CAR (Claim Adjustment Reason) codes within 30 business days; see attachment for CAR Code explanations. Appeal reasons are noted on the spreadsheet and the completed spreadsheet is uploaded to the ESI FTP secure website at: https://secureftp2.esinetwork.com/Logon.aspx?ReturnUrl=/Content.aspx. Denials for coverage under another insurance plan (CAR Code 177) are researched and billed to the appropriate plan using various resources, including UMC’s Invision and Net Access programs, and various other Medicare, Medicaid, and commercial insurance portals.

UMC/EPCH Cerner: http://159.140.84.81/Prod/auth/login.aspx?CTX_FromLoggedoutPage=1

UMC Invision:

UMC NetAccess:

EPCH Invision:

EPCH Net Access:
## Hospital District Guide

<table>
<thead>
<tr>
<th>Department</th>
<th>Billing Code</th>
<th>Service Effective</th>
<th>Full Line Items</th>
<th>HMO Service Effective</th>
<th>End Date</th>
<th>MB everything</th>
<th>HO Payment</th>
<th>MB everything</th>
<th>HO Payment</th>
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<td>Isthmus</td>
<td>1</td>
<td>Same</td>
<td>N/A</td>
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<td>375 MB Post, Full Line HO**</td>
<td>375 MB Post, Full Line HO**</td>
<td>MB everything</td>
<td>HO Payment</td>
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<td>MB</td>
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<td>MB everything</td>
<td>HO Payment</td>
<td>MB everything</td>
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<td>HO Payment</td>
<td>MB everything</td>
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<td>Waterbury</td>
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<td>MB everything</td>
<td>HO Payment</td>
<td>MB everything</td>
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<td>CAR Code</td>
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<td>Remark Code</td>
<td>ESI Usage for UM/GT Tech Claims</td>
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<tr>
<td>4</td>
<td>The procedure code is inconsistent with the modifier used or a required modifier is missing.</td>
<td>M77</td>
<td>Claim not payable if an expected modifier was not reported.</td>
<td></td>
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<tr>
<td>5</td>
<td>The procedure code is inconsistent with the place of service.</td>
<td></td>
<td>Missing valid place of service.</td>
<td></td>
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<tr>
<td>6</td>
<td>Procedure code is inconsistent with the patient's age.</td>
<td></td>
<td>Claim is not payable if the reported service code age appropriate.</td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Procedure code is inconsistent with the patient's gender.</td>
<td></td>
<td>Claim not payable if the reported service code gender appropriate.</td>
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</tr>
<tr>
<td>16</td>
<td>Claim/Service lacks information which is needed for adjudication.</td>
<td>M76</td>
<td>Missing/incomplete/invalid diagnosis or condition.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Additional information is supplied using remittance advice remarks codes whenever appropriate.</td>
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<tr>
<td>16</td>
<td>Claim/Service lacks information which is needed for adjudication.</td>
<td>M51</td>
<td>Claim not payable if the claim contains an invalid CPT Code or invalid for date range. Includes denial for Consult Codes not accepted by Medicare.</td>
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<td></td>
<td>Additional information is supplied using remittance advice remarks codes whenever appropriate.</td>
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<td>18</td>
<td>Duplicate claim/service.</td>
<td>H233</td>
<td>Duplicate claim/service.</td>
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<tr>
<td>18</td>
<td>Duplicate claim/service.</td>
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<td>Additional review with operative note/report.</td>
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<td>22</td>
<td>Claim denied as this care may be covered by another payer, Medicaid.</td>
<td>H173</td>
<td>Medicaid pending plan through 6 months.</td>
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<td>26</td>
<td>Expenses incurred prior to coverage.</td>
<td>M127</td>
<td>No Account found with matching MNH and date of service within account matching criteria.</td>
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<td></td>
<td>Expenses incurred prior to coverage.</td>
<td></td>
<td>No MNH found within patient account matching criteria.</td>
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<td>29</td>
<td>The timely filing limit has expired.</td>
<td></td>
<td>Timely filing limit has expired.</td>
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<tr>
<td>31</td>
<td>Claim denied as patient cannot be identified as our insured, Medicare.</td>
<td>N257</td>
<td>Claim not payable if provider Id is invalid, does not have the requisite provider type (B or P), or where the claim DOS is within the effective and term dates.</td>
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<tr>
<td></td>
<td>Services not provided or authorized by designated billing providers.</td>
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<tr>
<td>38</td>
<td>Services not provided or authorized by designated billing providers.</td>
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<tr>
<td>38</td>
<td>Services not provided or authorized by designated performing providers.</td>
<td>N290</td>
<td>Claim not payable if provider Id is invalid, does not have the requisite provider type (B or P), or where the claim DOS is within the effective and term dates.</td>
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</tr>
<tr>
<td>45</td>
<td>Charges exceed our fee schedule or maximum allowable amount.</td>
<td>M15</td>
<td>Payment of Bilateral/Mult Services have been bundled as they are considered components of the same procedure.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>97</td>
<td>Global Surgery. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
<td></td>
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<tr>
<td>177</td>
<td>Payment denied because the patient has not met the required eligibility requirements</td>
<td></td>
<td>Claim not payable if the Fispal of the matching registration is not a payable plan code.</td>
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<td></td>
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<tr>
<td>81</td>
<td>Non-covered Department/Visits</td>
<td></td>
<td>Department is not included in MSA.</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>814</td>
<td>Only one E/M visit per physician/specialty per day is covered.</td>
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</tr>
</tbody>
</table>
Texas Tech University Health Sciences Center El Paso
Medical Practice Income Plan Policy and Procedure

Revised Date: 10/01/2014

Effective Date: 04/01/2015

Ana Deslongchamps,
Unit Associate Director

Frank Stolfi
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: BAC-Billing and Collections

Title: Correspondence Processing - Payers

Policy#: BAC 10

Policy: The purpose of this policy is to outline the procedure for processing the correspondence received by the TTUHSC El Paso MPIP office. Correspondence from payers, which is addressed to the main campus or the established MPIP PO Box, is delivered to the MPIP office by TTUHSC mail delivery staff. Examples of the correspondence received from payers include explanation of benefits, payments, refund requests, requests for information, notification of provider enrollment, authorization notifications, prescription information, Medicare Managed Care Physical Exam and Health Maintenance Reports (HMRs), and appeal status notifications. Correspondence is sorted by the designated mail processor and distributed to the appropriate staff members for batching and processing.

Procedure:

1) Mail is delivered to the MPIP office by TTUHSC mail delivery staff; designated mail processor separates all envelopes with payments and forward them to the appropriate payment posting staff member for processing. The remaining correspondence is removed from the envelope and date stamped.

2) Mail processor sorts the correspondence by the following payer categories: Medicare and Medicaid, commercial insurance, and prescription information. Any undistinguishable mail is forwarded to a billing and collection unit supervisor or manager for review to determine appropriate action required.

3) Correspondence is forwarded to the designated billing and collection supervisor or manager for batching and distribution. The batch slip contains the distribution and due date; batches are logged into the Correspondence Log Form (see attached) and distributed to the appropriate staff members, who acknowledge receipt by initialing. Processing of correspondence is completed within 3 working days or as determined by the supervisor or manager. Upon receipt of completed batch, supervisor or manager initials the Correspondence Log Form.

Correspondence Categories:

1) Explanation of Benefits/Denials: Processor enters the denial into GE Centricity Business (GECB) using the payment posting function; invoice is researched and processed in the manner outlined
manner outlined in the denied claim policy, which may include verifying and updating the correct payer information and billing the claim, appealing the claim, or contacting the patient for additional information.

2) **Refund requests:** Supervisor or Manager will forward refund request to appropriate refund processing staff.

3) **Requests for information:** Requests for information may include medical records requests, pre-existing questionnaires, accident details, etc. Processor must determine appropriate action needed, which may require assistance from clinic personnel or information from the patient, completion of the required form, or medical record retrieval; notation of action should be entered at invoice level and/or in General Comments of GECB.

4) **Provider Enrollment or other Enrollment/Credentialing Correspondence:** Supervisor or Manager will scan the document and email it to the appropriate staff member in the Enrollment and Credentialing office and also forward the original via campus mail.

5) **Authorization Notifications:** Authorization information is entered into General Comments and the original document is forwarded to the appropriate clinical department for inclusion in the patient's Electronic Medical Record (EMR).

6) **Prescription Information:** Designated mail processor will forward the documentation to the clinical department of the corresponding provider.

7) **Appeal Status Notifications:** Medicaid appeal notifications will be noted at invoice level and the correspondence forwarded to the appropriate clinical department. All other appeal status notifications will be processed by the appropriate staff in the manner outlined in the denied claim policy.

8) **Physical Exam and Health Maintenance Reports (HMRs):** Medicare Managed Care physical exam forms are forwarded to Dr. Michael J. Romano, Associate Dean for Clinical Affairs, via campus mail.

9) **Indistinguishable Correspondence:** Supervisors will review and determine the appropriate actions required.

**RESPONSIBILITIES**

1) **Sr. Business Assistant 1 and 2:** On an alternating schedule will sort and distribute correspondence to appropriate staff for processing.

2) **Senior Medical Billing Associates (MBA) 1-4, MBAs 1-6, and Sr. Business Assistants 1-4, and Student Assistants 1 and 2** will process correspondence as indicated in Correspondence Categories 1-9.
# CORRESPONDENCE LOG - MONTH

<table>
<thead>
<tr>
<th>Date</th>
<th>Due Date</th>
<th>Assigned To</th>
<th>Initials</th>
<th># of Pages</th>
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</table>
BATCH CONTROL SLIP

BATCH PREPARER: 

INPUT OPERATOR: 

Date Prepared 

Due Date: 

Date Entered 

Employee 

Batch # 

Bank Deposit Date 

Description i.e. dept/name/phone ext.) 

II. CHARGES

PROCEDURE CONTROL TOTAL 

(hash) 

Total $ Charges 

Total $ Charges 

PAYMENT / ADJUSTMENTS 

Charge ADJ Total 

Payment Total 

Debit Payment Total 

Batch Total 

For No Financial Change, Check One of Reasons Listed Below 

[ ] FSC Changes Only 

[ ] DXS Only 

[ ] Recovery Invoices 

[ ] Referring Only 

[ ] Deleted Batch 

[ ] M (Move) 

[ ] Comments 

☐ *** Note: Explanation of total differences between side one and side two. 

☐ PAST APPEAL DEADLINE Write/Offs Adjustments 

☐ PAST FILING DEADLINE Write/Offs Adjustments 

☐ NON-COVERED Write/Offs Adjustments 

☐ ADJUSTMENTS REASONS BELOW: Form A 

☐ OTHER-SEE COMMENTS BELOW: 

☐ PAST APPEAL NEW MEXICO/PAST FILING DEADLINE NEW MEXICO INVS 

Supervisor Approval: 

Total # of sheets including Batch Slip # 

For Imaging Use Only: numbers: 

Reason for edit of page 

Double sided 

Total # of Pages 

Miscounted 

Other: 

4
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

Revised Date: 10/01/2014  Effective Date: 4/01/2015

Ana DeTroy
Unit Assistant Director

Frank Stout
Assoc Dean/Asst VP, Finance and Administration

Steven M. Wagner,
MPIP Managing Director

Department: BAC-Billing and Collections

TITLE: University Medical Center/El Paso Children’s Hospital IT Access

Policy#: BAC 11

Policy: The purpose of this policy is to outline the procedure for obtaining access to University Medical Center and El Paso Children’s Hospital medical records and practice management programs: Corner, Net Access (Care base), Invision (OAS Gold UMC, OAS Gold El Paso Children’s Hospital).

Procedures:

1) A Role Based Access Control (RBAC) request form and a Confidentiality and Security Agreement form are completed and signed for each program that the employee is requesting access. The forms are completed and given to the supervisor/manager for submission.

2) The Role Based Access Control (RBAC) request form and the Confidentiality and Security Agreement forms are emailed to Yvette Quintana-Chavez, HIPAA Compliance Officer, at Yvette.QuintanaChavez@ttuhsc.edu.

3) Upon approval by the Texas Tech Institutional HIPAA compliance officer, the forms are emailed to Sylvia Pendell, IT Office Coordinator for UMC at spendell@umcelpaso.org and processed for access.

4) Access is granted within 24 to 48 hours, after which Sylvia Pendell notifies the MPIP supervisor/manager when the passwords are ready for pick-up. Passwords are picked up by the MPIP supervisor/manager at the University Medical Center Annex building, IT Dept. Room 402.

5) Once the password is given to the employee, the supervisor/manager confirms that the employee is able to log into the programs.

6) If UMC programs are not accessed within a 6 month period, the account will be closed and the employee must submit another Role Based Access Control (RBAC) request form and the Confidentiality and Security Agreement forms again as a new process for access.

7) UMC IT is contacted for issues at 915-521-7941, option 2. Nick Torres, IT Security Representative, may be contacted via email at NTorres@umcelpaso.org for assistance.
RESPONSIBILITIES

1) Medical Billing Supervisor 1: complete registration process for MPIP billing and collection employees
Confidentiality and Security Agreement

I understand that El Paso County Hospital District (EPCHD) in which or for whom I work, volunteer, or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information. I also understand that EPCHD has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, EPCHD must ensure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my employment, assignment at EPCHD, I understand that I may come into possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job-related duties in accordance with the EPCHD’s Privacy and Security Policies, which are available on the EPCHD’s Intranet (under Compliance & Under Hospital Policies/Information Management). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

I further recognize and acknowledge that the good will of EPCHD depends, among other things, upon the keeping such services and information confidential. I recognize that the disclosure of any information by the Associate may give rise to irreparable injury to EPCHD or to the owner of such information, and that accordingly, EPCHD or the owner of such information may seek legal remedies against me which may be available.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a legitimate business need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized under State and/or Federal Regulations. I will not permit any person whatsoever to examine or make copies of any reports or other documents prepared by me or coming into my control.
3. I understand that any copies (such as printing) of Confidential Information need to be handled appropriately. I understand that leaving printed confidential material unprotected is a violation of this Agreement.
4. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient’s name is not used.
5. I will not perform any unauthorized transmissions, queries, modifications, or unauthorized deletions of Confidential Information.
6. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with EPCHD.
7. I will act in the best interest of the EPCHD and in accordance with its Code of Conduct at all times during my relationship with EPCHD.
8. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the EPCHD, in accordance with EPCHD’s policies. I understand that certain violations may result in reporting to proper authorities and/or legal action.
9. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
10. I will only access software systems to review patient records when I have the patient’s consent to do so, or I am involved in the treatment, payment, and/or operations for that patient. When accessing a patient’s record, I am affirmatively representing to EPCHD that at the time of each access that I have the requisite patient consent or authority to do so, and that EPCHD may rely on that representation in granting such access to me.
11. I understand that I should have no expectation of privacy when using EPCHD information systems. EPCHD may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as logging out when away from my computer, using screen savers with activated passwords, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with accepted security standards.
14. I understand and agree that any computer, software, and storage media provided to me by EPCHD remains property of EPCHD and Confidential Information is the customer’s or its vendor’s, and that this is and remains the property of EPCHD at all times.
15. I will review and understand EPCHD’s Information Management Policies.
16. I will:
   a. Use only my officially assigned User-ID and password.
   b. Use only approved licensed software.
17. If accessing the system via a Virtual Private Network (VPN), I also will:
   a. Ensure that any device I use to access EPCHD’s information systems has a virus detection program installed and enabled and that the virus program is consistently up-to-date.
   b. Schedule periodic virus scan of local disks and memory and follow the virus remediation procedure outlined by the software vendor should the computer become infected.
e. Install and configure a host-based firewall and SpyWare detection software on my computer.

d. Maintain computer safeguards and ensure that they are up-to-date by installing Microsoft Security Updates.

I will never

a. Share/delude user IDs, passwords

b. Use tools or techniques to break/execute/disable security measures

c. Connect to unauthorized networks through the systems or devices, I will use the VPN connectivity for its intended use.

d. Establish VPN connectivity with EPCHD’s systems if my computer is infected until I have followed the anti-virus software vendor recommended remediation procedure and I know that my computer is free of viruses.

I understand that any software (such as VPN) provided by EPCHD is on an “AS IS” basis; without any warranties or representations expressed or implied, including but not limited to, any implied warranties of merchantability or fitness for a particular use. The entire risk as to the results and the performance of the software is assumed by me (the user), and in no event shall EPCHD be liable for any consequential, incidental or direct damages suffered in the course of installing and/or using the software.

I agree that the EPCHD Security Administrator or appropriate Information Technology representative if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

21. I agree that my obligations under this Agreement will continue after termination and/or separation of my employment, expiration of my contract, or my relationship exists with EPCHD.

22. Upon termination of separation, I will immediately return any documents or media containing Confidential information to EPCHD. I’m affirmatively representing that I will destroy (appropriately dispose of) any confidential information I may have maintained that I no longer should have access to as a result of my termination.

The following statements apply to Physicians, Office Administrators and/or other Authorized representatives, who use EPCHD systems from their Office (remote locations) and request access to the medical records of their office staff:

23. I will ensure that only appropriate personnel in my office will access EPCHD’s software systems and Confidential information and I will annually train such personnel on issues related to patient confidentiality and access.

24. I will accept full responsibility for the actions of my employees who may access EPCHD’s software systems and Confidential Information.

I, ___________________________ (Employee/Vendor/Office Staff/Physician), hereby agree to abide by the terms and conditions set forth in this agreement and I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Table:

<table>
<thead>
<tr>
<th>Employee/Office Staff/Physician Signature</th>
<th>Business Entity Name/Organization</th>
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<tr>
<th>Employee/Office Staff/Physician Printed Name</th>
<th>Department Name</th>
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</table>

Date: ___________________________
University Medical Center of El Paso
INFORMATION TECHNOLOGY
Role Based Access Control
Request Form

Date _______ _______ Add Delete Change
(Please print. All fields are required before processing request.)

Associate Name __________________________
Department Name _________________________
Position Title ____________________________
Username ________________________________

Legal Title CNA COTA CRT CST DT DTR RN RNH LPN LSN LVN MD MT NA NT OT PA PT RPH RN,
RM SN

Identity Validation Information:
Last 4 digits SS# __________ DOB (MM/DD) ____________

For identity verification purposes, please provide: please
(ex. Favorite color, movie, pet’s name, elementary school, band...)

- I acknowledge that this User Id and Password will give me access to Protected Health Information (PHI) as well as non-
patient hospital information. Disclosure of confidential information may result in my termination and/or civil/penal
pursuits.
- I will, under no circumstances, give my password to any other person. If at any time I feel my password confidentiality
has been compromised, I will contact the Information Technologies department immediately.

User Signature __________ System Access Effective Date ________
Student/Contract/Volunteer Exp Date ________

Password requests forwarded to IT Dept by 3:00pm will be processed by the end of next business day (System
Access Effective Date).

*User’s work responsibilities require access to computer systems identified for this position code based on Role Based Access Control
definitions. If user no longer requires system access, I understand it is my responsibility to notify IT immediately.

Department Director/Manager Authorized: (signature) approval required for all Additions and Deletions.

Name ____________________________ Signature __________________________
(Please Print) Date ________

El Paso, TX 79903 11/02
c. Install and configure a host-based firewall and SpyWare detection software on my computer.

d. Maintain computer safeguards and ensure that the are up-to-date by installing Microsoft Security Updates.

I will never:

a. Share/disclose user IDs, passwords.

b. Use tools or techniques to break/exploit/disable security measures.

c. Connect to unauthorized networks through the systems or devices, I will use the VPN connectivity for its intended use.

d. Establish VPN connectivity with EPCHD's systems if my computer is infected until I have followed the anti-virus software vendor recommended remediation procedure and I know that my computer is free of viruses.

I understand that any software (such as VPN) provided by EPCHD is on an "AS IS" basis, without any warranties or representations expressed or implied, including but not limited to, any implied warranties of merchantability or fitness for a particular use. The entire risk as to the results and the performance of the software is assumed by me (the user), and in no event shall EPCHD be liable for any consequential, incidental or direct damages suffered as a course of installing and/or using the software.

20. I will notify the EPCHD Security Administrator or appropriate Information Technology representative if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

21. I agree that my obligations under this Agreement will continue after termination and/or separation of my employment, expiration of my contract, or my relationship ceases with EPCHD.

22. Upon termination or separation, I will immediately return any documents or media containing Confidential Information to EPCHD. I'm affirmatively representing that I will destroy (appropriately dispose of) any confidential information I may have maintained that I no longer should have access to as a result of my termination.

The following statements apply to Physicians, Office Administrators and/or other Authorized representatives, who use EPCHD systems from their Practices (remote locations) and request access to the systems for their office staff:

23. I will ensure that only appropriate personnel in my office will access EPCHD's software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.

24. I will accept full responsibility for the actions of my employees who may access EPCHD's software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff, Physician Signature

Business Entity Name / Organization

Employee/Consultant/Vendor/Office Staff, Physician Printed Name

Department Name

District/Office

Date
TITLE: Medical Records Requests

Policy#: BAC 12

Policy: The purpose of this policy is to outline the procedure for obtaining and/or requesting medical records for the purpose of submitting with original claim forms when required or for appealing denied claims. Medical records are required upon original claim submission in specific cases, such as when modifiers -22, -52, -53, and -62 are appended to a CPT code on a claim, and with all Veteran’s Affairs and Workers Compensation claims. Medical records are also used as supporting documentation during the claims appeal process. Sources for medical records include TTUHSC El Paso Medical Records Department, electronic medical records (EMR) for services performed at TTUHSC Clinics, University Medical Center (UMC) Medical Records Department, UMC and El Paso Children’s Hospital Cerner system, and to a lesser extent, other hospitals and dialysis centers.

TTUHSC El Paso Clinics

EMR access and training has been provided to all MPIP medical billing and collection staff to facilitate the submission of medical records with original claim submissions and for claim appeals purposes. Records found in EMR are for services performed at Texas Tech clinics. Paper medical records are requested directly from the Medical Records department for dates of service before EMR was implemented. Any records not located in EMR or in the Medical Records department are requested directly from the clinical department.

Procedure for EMR:

1) Electronic Medical Records (EMR) are accessed and printed from Citrix XenApp:

2) EMR availability by clinical department:
   - Family Medicine: September 2011
   - OB/GYN: November 2011
   - Pediatrics (Physicians East): December 2011
   - Pediatrics (Alberta): July 2012
   - Pediatrics (Montwood): August 2012
• Internal Medicine: May 2012
• Southwest Endocrine Consultant (SWEC): July 2012
• Orthopaedic: December 2012
• Pain Management: January 15, 2013
• Psychiatry: Feb 26, 2013
• Ophthalmology: April 02, 2013
• University Breast Care Center (UBCC)/Renamed Garbar Breast Care Center (GBCC): April 30, 2013
• Surgery: June 04, 2013
• Neurology: October 29, 2013

Procedure for Paper Charts:

1) Requests for paper medical records are emailed to any one of the following employees in the Texas Tech Medical Records department and should contain the patient’s first and last name, date of birth, E number, and date of service:
   - Alejandra Ruiz: alejanra.ruiz@ttuhsc.edu
   - Lupe Maldonado: lupe.maldonado@ttuhsc.edu
   - Rosa Cabrall: rosa.cabrall@ttuhsc.edu
   - Lilly Savala: lily.savala@ttuhsc.edu

2) Medical records are transferred by the Medical Records department to the following folder in the MPIP Shared Drive: MPIP MED REC RQSTS and are identified by the MRN number and found in the subfolder labeled for the corresponding month in which it was requested.

University Medical Center and El Paso Children’s Hospital

Procedure for EMR:

1) Access and print records available in EMR using Cerner: http://159.140.84.81/Prod/auth/login.aspx

Procedure for Paper Charts (UMC):

1) Paper medical records are obtained from the UMC Medical Records department once a week or as needed by a designated trained MPIP employee. Records are transported from UMC to MPIP in a sealed portfolio.

2) A UMC Medical Records Request form (included) is completed by MPIP employees requesting records. The request form is given to the designated employee or may be faxed to the UMC Medical Records department at 915-521-7688 and addressed to the designated employee who is obtaining the records. Confirmation of fax receipt is made by calling the UMC Medical Records department at 915-521-7690.

RESPONSIBILITIES

1) Medical Billing Associate 1: retrieve records from UMC once a week.
Date requested __________________
Requested by ____________________
Charts needed to pull documentation for Texas Tech MPP: contact Ana Desilongmamps at (915) 215-4755

<table>
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<tr>
<th>Invoice #</th>
<th>TTU-#</th>
<th>UMC #</th>
<th>Admit/DOS</th>
<th>Patient Name</th>
<th>DOB</th>
<th>Physician/Notes needed</th>
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Blue: progress notes, Burg: h&p or initial hospital visit, Green: consult notes, Burg: h&p or initial hospital visit
Make sure you have the complete note, if the note references another doctor’s note both notes need to be pulled. Example: agree with resident Dr. OXO; if the note says: see green consult note
TITLE: Medicaid/Medicaid Managed Care Appeals Process for Clinical Departments

Policy#: BAC 13

Policy: The purpose of this policy is to outline the procedure for processing of appeals for Medicaid and Medicaid HMO plans. The TTUHSC business office files electronic claims daily on behalf of individuals covered by Medicaid programs, including but not limited to Medicaid Managed Care, Emergency Medicaid, Texas Women's Health Program, Children with Special Health Care Needs (CSHCN), New Mexico Medicaid, and out-of-state Medicaid plans. Paperless Collection System (PCS) workfiles are utilized to identify invoices remaining for 30 days requiring follow-up and to identify denied claims requiring review for appeal.

Appeals for Texas Medicaid plans are processed by clinical departments and the business office processes New Mexico Medicaid and out-of-state Medicaid denials. Texas Medicaid denied claims are placed at the Medicaid Pending Appeal FSC 335 and transfer into the departments' Paperless Collection System (PCS) workfiles for processing.

Procedures:

1) Access the assigned PCS workfile by entering the workfile number.

<table>
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<td>Workfile Number:</td>
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<td>Workfile Status:</td>
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<tr>
<td>Workfile Narrative:</td>
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<td>Workfile Ownership:</td>
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<td>Total and Remaining</td>
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<td>Option:</td>
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<td>Form:</td>
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</table>

1|Page
2. Under Option, select one of the following. To enter the workfile and process the invoices, select ‘O’.

3. To process an invoice, select one of the following options. The most common options are:

   NEXT – process the next invoice in the workfile
   RESTART – use after exiting the workfile to return to the next unworked invoice
   JUMP – select a specific invoice in the workfile by entering the invoice number

4. Review the invoice:

   INVOICE LEVEL COMMENTS
   PAYMENTS
   DENIAL CODES/REASONS
   • Obtain the TMHP R&S Report from the TMHP provider portal or the MPIP Repository
   • Obtain Superior, El Paso First, Amerigroup, and Molina EOBs from the provider portal or the MPIP Repository
• Obtain GE Centricity EOBs for Superior, Amerigroup, El Paso First, and TMHP using the IT OPS function see attached instructions.

5. The denial information found on the R&S/EOB will determine if the invoice should be adjusted, appealed, or re-billed.

6. Review denial date on the EOB for submission within timely appeals deadline of 120 days and review the TMHP Filing Deadline Calendar for submission date deadlines. (Example included).

7. Adjustments

• Complete a Form A and obtain supervisor’s signature
• Access the workfile and enter an invoice comment using the Post Receipts option 7 or 999 and paycode 74
• Submit Form A to MIP office for adjustment (Sample Form A attached)

8. Paper Appeals

• If invoice requires a correction, complete a Form C using the SharePoint website:
  https://sharepoint.elpaso.tuhsc.edu/support/mipip/SitePages/Home.aspx

- Specify Claim:N (selecting Claim Y will submit the claim electronically)
- Print new claim or request printed claim from MIP
- Print the R&S/EOB
9. Rebill a Corrected Claim

- Review account to ensure no payment has been issued or received
- Claim must be within the 95-day filing deadline
- Complete a Form C using the SharePoint website
- Specify Claim: Y to submit claim electronically
- Access the workfile and enter an invoice comment using the Post Receipts option 7 or 999 and paycode 74

10. Online appeals

Online appeals are available on the provider portals for TMHP, Molina Texas, El Paso First, and Superior Health Plan.

The process is similar to the paper appeal process; however, the portal allows for uploading and submission of documentation and eliminates the need for mailing.

11. Self-Pay Charges

Charges determined after adjudication to be patient responsibility, including ineligibility of benefits or non-covered services, are billed to the patient. Some exceptions may apply if the services are covered under the Hospital District MSA program. Charges are billed to the patient if the patient failed to notify TTUHSC of Medicaid coverage within the filing deadline.
Printing of Explanation of Benefits through Centricity Business EDI

Explanation of benefits will be available for printing directly through Centricity Business EDI for plans that have transitioned to eCommerce remits. The EOBs will no longer be included in the scanned payment batches in the document repository for Blue Cross or United HealthCare. The following plans have transitioned to eCommerce remits:

- Blue Cross Blue Shield as of 11/8/13
- El Paso First as of 10/28/13
- HealthCare Options as of 10/28/13
- Preferred Administrators as of 11/4/13
- United HealthCare as of 10/28/13
- Medicare/Novitas as of 1/24/14
- Cigna as of 1/15/2015
- Humana as of 1/15/2015
- Aetna as of 1/15/2015
- Amerigroup as of 3/1/15

Procedure for Printing EOBs

In Centricity Business:
- Select IT OPS
- Select EDI
- eCommerce Receipts
- Demand eCommerce EOB
- Select by (2) BAR invoice number
- At Patient, enter invoice number in the following format: -12345678
- At Select EOB#, enter the number of the desired EOB (ex. 1, 2)

- Select the Device for printing
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<th>120 Days</th>
<th>Date of Service or Disposition 95 Days</th>
<th>120 Days</th>
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Continued on page 2
Department: BAC-Billing and Collections

TITLE: Medicaid/Medicaid Managed Care Collections

Policy#: BAC 14

Policy: The purpose of this policy is to outline the procedure for billing and collection of services provided to Medicaid recipients. TTUHSC files electronic claims daily on behalf of individuals covered by Medicaid programs, including but not limited to Traditional Medicaid, Medicaid Managed Care, Emergency Medicaid, Texas Women's Health Program, Children with Special Health Care Needs (CSHCN), New Mexico Medicaid, and out-of-state Medicaid plans. Paperless Collection System (PCS) work files are utilized to identify invoices remaining for 30 days requiring follow-up and to identify claims that were denied and require review for appeal. The business office will research any information needed to adjudicate a claim and requests assistance from departments as needed.

Procedures:

1) Medicaid claims are billed for services where eligibility has been verified. Where eligibility cannot be verified, the patient is classified as self-pay.

2) Traditional Medicaid, Emergency Medicaid, Texas Women's Health Program, and CSHCN claims bill daily and electronically to TMHP; the filing deadline is 95 days from the date of service, member certification date, or provider enrollment date.

3) Medicaid Managed Care claims bill daily and electronically to various contracted Managed Care providers, including but not limited to Amerigroup, El Paso First Health Plans, Molina, and Superior. The filing deadline is 95 days from the date of service.

4) New Mexico Medicaid and Managed Care claims bill daily and electronically to the appropriate plans, including but not limited to ACS, Molina, Presbyterian, Blue Cross Blue Shield, and Centennial plans; the filing deadline is 90 days from the date of service.

5) Out-of-state Medicaid plans bill daily and electronically or on paper within the filing deadlines specified by each plan.

6) Designated employees review and correct all rejections found on the daily claims edit list located on the MPIP Shared Drive under MPIP Reference/Edit List. Rejections are caused by missing insurance information, invalid place of service, missing diagnosis, FSC mismatch, provider non-
participation, etc. MPIP employees work with department certified coders to resolve coding issues and report excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

7) Designated employees review and correct all rejections found on the daily GE eCommerce EDI claims portal, which may be accessed at https://edi.idxasp.com/ectuweb/Login.action. Rejections are caused by missing or invalid insurance information, place of service, diagnosis, provider non-participation, etc. MPIP employees work with department certified coders to resolve any coding issues and report any excessive and/or unusual rejection issues to the billing and collections supervisor or manager. Claim edits are resolved within 3 business days.

8) Designated employees review the assigned PCS daily workfiles and follow-up invoices that remain for 30 days. Follow-up is performed using provider portals when available and by telephone. Follow-up may include verification and update insurance eligibility and re-queuing of claims.

9) Designated employees for all New Mexico Medicaid and out-of-state plans review assigned PCS daily workfiles and research denied claims requiring appeal. The employee determines reasons for the denial and performs necessary actions to correct or appeal the claims, including corresponding with MPIP or department certified coders for review of proper coding and/or billing guidelines, obtaining medical records, and communicating with claim department personnel. Claims are appealed online when possible, followed by telephone and written appeals. The appeal deadline for NM Medicaid and Managed Care plans ranges from 90 to 365 days from the denial date noted on the latest explanation of benefits.

10) A minimum of 55 workfile accounts are processed on a daily basis. After claims have been appealed, a 30-day tickler placed on the invoice alerts the designated employee of payer non-response. Status of the appeal is reviewed primarily online, followed by telephone call to the payer’s claims department.

11) Texas Medicaid denials are appealed by the departments. Texas Medicaid denied claims are placed at the Medicaid Pending Appeal FSC 335 and transfer into the departments’ Paperless Collection System (PCS) workfiles for processing. MPIP employees assist departments by providing proof of timely filing transmission reports generated from the GE eCommerce EDI claims portal or printing paper claims. MPIP designated employees process correspondence related to denials and appeals and forward to the appropriate department for review. Correspondence denials relating to eligibility and benefits are processed by MPIP employees, who update the eligibility information and bill the claim to the appropriate plan.

12) Charges determined after adjudication to be patient responsibility, including ineligibility of benefits or non-covered services, are billed to the patient. Some exceptions may apply if the services are covered under the Hospital District MSA program. Charges are billed to the patient if the patient failed to notify TTUHSC of Medicaid coverage within the filing deadline.

RESPONSIBILITIES

1) Medical Billing Associate (MBA) 1, Senior MBA 1, and Senior Business Assistants 1 and 2: Texas, New Mexico, and out-of-state/network claim edits, EDI rejections, correspondence, follow-up, and appeals.
TITLE: Financial Status Classification (FSC) Guide and Claim Filing Deadlines

Policy#: BAC 15

Policy: The purpose of this policy is to outline the procedure for distributing insurance Financial Status Classification (FSC) and claim filing deadline information. Patients are assigned FSCs in GE Centricity Business that indicate insurance plan and claim filing information. Most payers have specific deadlines for initial claim and appeals submissions. A commonly used FSC Guide is distributed to the MPIP business office and departments on a yearly basis and as needed upon request.

Procedures

1) MPIP Billing and Collections managers maintain and update a listing of the most commonly used insurance FSCs and filing deadlines associated with each plan. The FSC Guide contains the following information:
   - FSC number
   - FSC mnemonic
   - Tax ID number associated with the plan
   - Description of the FSC name
   - Filing Deadline
   - Appeal Deadline

2) The FSC Guide is distributed to MPIP employees and department managers and supervisors by email on a yearly basis, most commonly at the beginning of each calendar year when most FSC changes occur. The listing is also provided as needed upon request.

RESPONSIBILITIES

1) Billing and Collections managers 1 and 2: maintain and update FSC Guide
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**AMERICAN TEXAS MEDICARE**

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**MEDICARE PROGRAMS**

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**HOSPITAL DISTRICT**

*Primary Stand-Alone FSC, LACE Services Only, No Office Visitors or Emergency Medicine Covered*

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<td>Texas Blue Cross</td>
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</tr>
<tr>
<td>717</td>
<td>CIGNA</td>
<td>7565276018</td>
<td>Three Rivers Provider Network</td>
<td>Call and verify</td>
</tr>
<tr>
<td>802</td>
<td>UHC</td>
<td>7565276018</td>
<td>United Healthcare</td>
<td>90 Days from DSB</td>
</tr>
<tr>
<td>711</td>
<td>FSC</td>
<td>7565276018</td>
<td>Blue Cross/Blue Shield of Texas</td>
<td>12 months from DSB</td>
</tr>
<tr>
<td>752</td>
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<td>Texas Blue Shield</td>
<td>12 months from DSB</td>
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<td>717</td>
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<td>HMO (provider added Jan 2012, Effective 12/1/2011)</td>
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<td>132</td>
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<td>BCBS Out of State</td>
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<td>255</td>
<td>EFFC</td>
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<td>HealthCare Options (HCO)</td>
<td>95 Days from DSB</td>
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<td>854</td>
<td>EFPR</td>
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<td>Preferred Administrators (PPO) (Employees/Dependents)</td>
<td>12 months from DSB</td>
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<td>159</td>
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<td>USA Health Network</td>
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<tr>
<td>220</td>
<td>OD</td>
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<td>Tricare</td>
<td>95 Days from DSB</td>
</tr>
<tr>
<td>530</td>
<td>TMID</td>
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<td>Tricare West Region (Active Duty Members and Dependents for Services Prior to 8/1/2011)</td>
<td>12 months from DSB</td>
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<tr>
<td>531</td>
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<td>Tricare West Region (Active Duty Members and Dependents for Services Prior to 8/1/2011)</td>
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<tr>
<td>521</td>
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<td>(Active Duty Members and Dependents for Services Effective 8/1/2011)</td>
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<td>220</td>
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<td>7565276018</td>
<td>Tricare for Life (P.O. Box 7890 Madison, WI 53708)</td>
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<tr>
<td>220</td>
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<td>(Patients that have Medicare Primary and Tricare Secondary)</td>
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<td>220</td>
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<td>Tricare (P.O. Box 480054 Denver, CO)</td>
<td>95 Days from DSB</td>
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<tr>
<td>271</td>
<td>TURN</td>
<td>7565276018</td>
<td>Tricare South Region/Honors</td>
<td>95 Days from DSB</td>
</tr>
<tr>
<td>271</td>
<td>TURN</td>
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<td>Tricare South Region/Honors</td>
<td>95 Days from DSB</td>
</tr>
<tr>
<td>136</td>
<td>VA</td>
<td>7565276018</td>
<td>Veterans Administration (P.O. Box 600580 Denver, CO 80206-5800)</td>
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<td>632</td>
<td>VRPA</td>
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<td>Veterans Reserve (P.O. Box 100010 Denver, CO 80280-0010)</td>
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<td>739</td>
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<tr>
<td>758</td>
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<td>Immigration/Border Patrol</td>
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<td>527</td>
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<td>Prison Health Management/Divine Ana (Corrections)</td>
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<td>TX Department of Criminal Justice</td>
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<td>174</td>
<td>USAH</td>
<td>7565276018</td>
<td>US Marshals</td>
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<td>ES Benefits</td>
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<td>191</td>
<td>WC</td>
<td>7565276018</td>
<td>Workers' Compensation</td>
<td>120 Days from DSB</td>
</tr>
<tr>
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<td>WC</td>
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<td>Workers' Compensation</td>
<td>120 Days from DSB</td>
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<tr>
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<td>WC</td>
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<td>Workers' Compensation</td>
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<tr>
<td>321</td>
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<td>Realization</td>
<td>90 Days from Surgery</td>
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<tr>
<td>334</td>
<td>CV</td>
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<td>Crimes Victims</td>
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<td>416</td>
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<td>Health Insurance Exchange (HIX/AHEADS)</td>
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<td>Blue Advantage HMO (9/8/2014)</td>
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<td>Hospital District Indigent</td>
<td>90 Days from DSB</td>
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