Long-term services and supports

TXWP-CDMMP-060022-24 | June 2024

Wellpoint℠

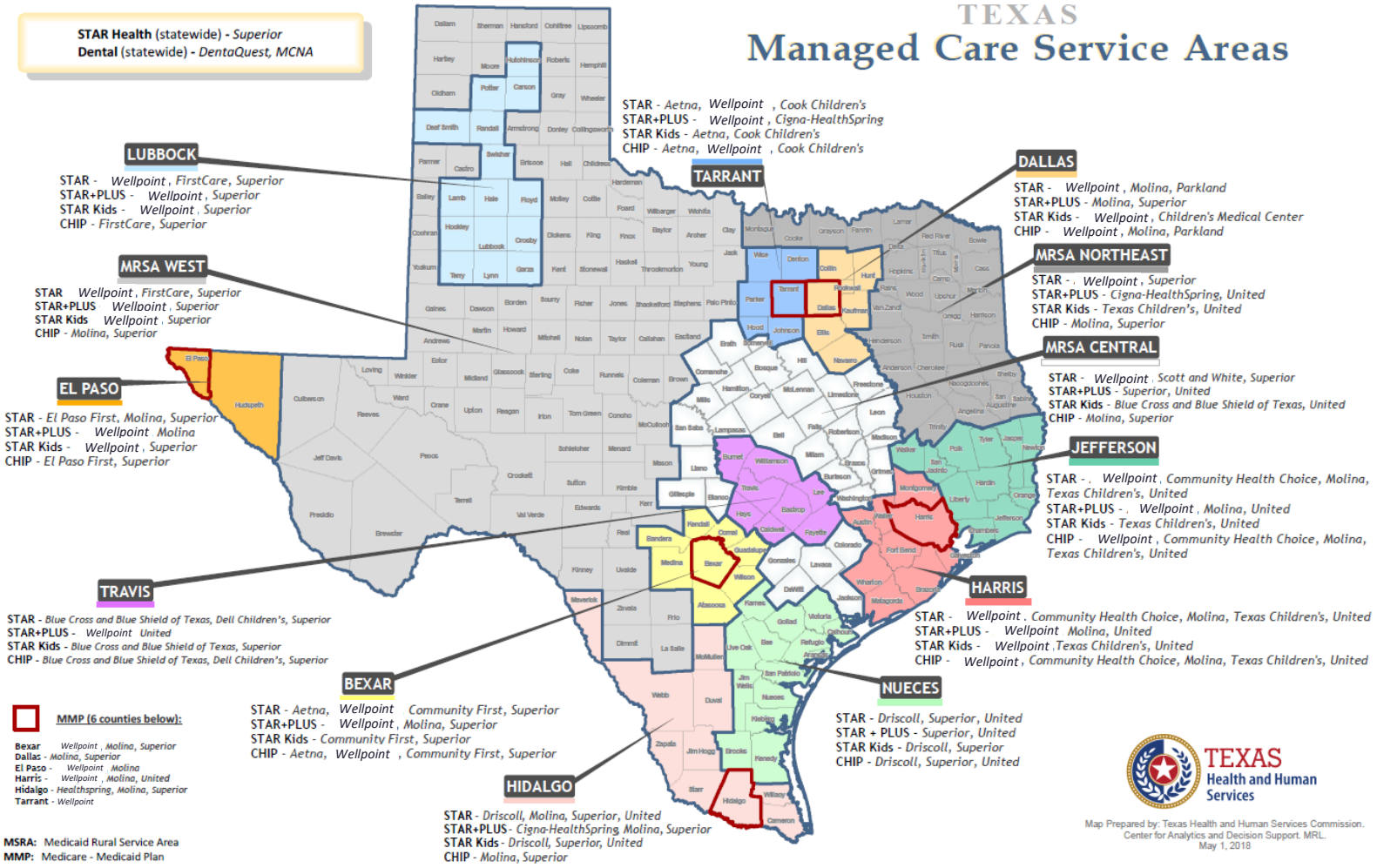
Long-term services and supports design

- Managed care is designed to integrate acute, behavioral, social, environmental, and long-term services and supports (LTSS).
- Managed care is the preferred delivery system model designed around preventive care, person-centered planning, and stable community living for all members.
- Service coordination is the cornerstone to the program. Local, dedicated service coordination teams help members and providers navigate healthcare delivery systems and interface with Wellpoint.

Long-term services and supports design (cont.)

- Service coordinators act as the member's advocate. They will assess for need, develop a care plan, and arrange for the delivery of the needed services.
- Multidirectional communication means members and providers can talk with the Service Coordination team to help manage the member's needs.

Managed care service areas map



Why Wellpoint?

Wellpoint offers experience with:

- Managing Medicaid programs for more than 20 years, facilitating the integration of physical, behavioral, and long-term healthcare services while emphasizing community-based care.
- Dedicated service coordination through person-centered service and care planning.
- Completing comprehensive health assessments of members to develop detailed service plans.
- Providing comprehensive disease management programs.

Why Wellpoint? (cont.)

Wellpoint offers experience with:

- Encouraging collaborative and stable relationships between providers and members.
- Working with community-based organizations, resources, and outreach services.
- Providing a full continuum of resources to promote continuity of care.

Service coordination

- Service coordination provides the member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the member's well-being, independence, integration in the community, and potential for productivity.

Service coordination (cont.)

- Specialized care management service that is performed by a licensed individual called a service coordinator and includes the following:
  - Providing a holistic evaluation of the member's individual dynamics, needs, and preferences
  - Educating and helping provide health-related information to the member, the member's legally authorized representative (LAR), and others in the member's support network
  - Helping to identify the member's physical, behavioral, functional, and psychosocial needs
  - Engaging the member, the member's LAR and other caregivers in the design of the member's individual service plan

Service coordination (cont.)

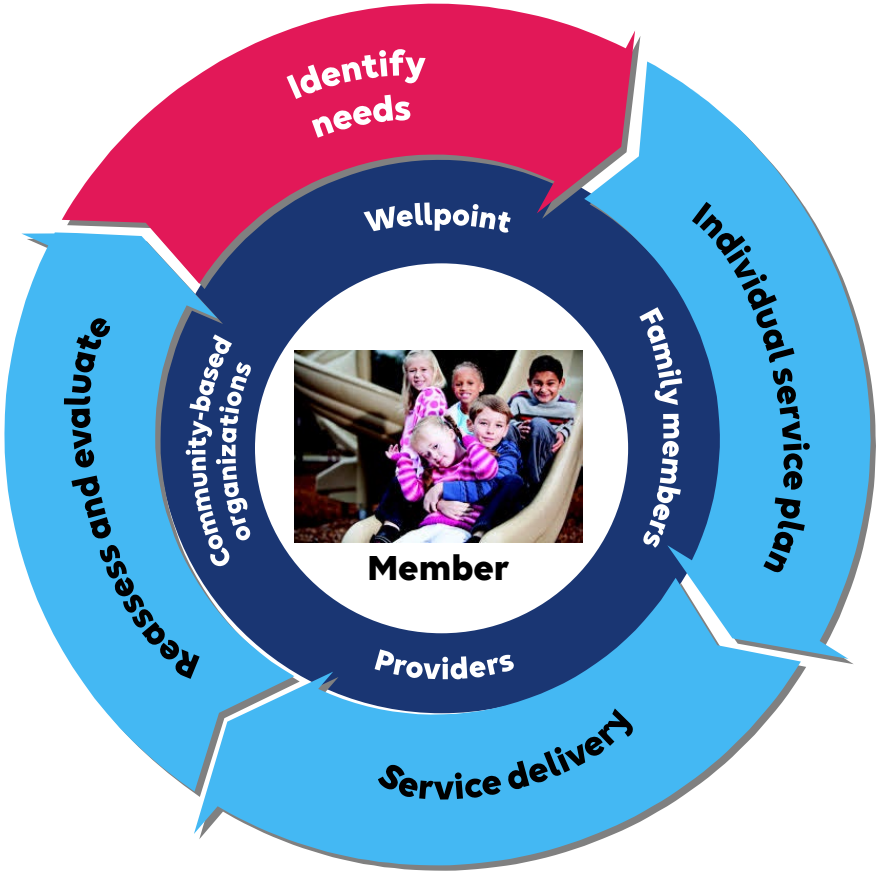
- Connecting the member to covered and noncovered services necessary to meet the member's identified needs
- Monitoring to ensure the member's access to covered services is timely and appropriate

Service coordination model

Identify needs:

- Members are contacted and screened for complex needs and high-risk conditions.
- The service coordinator identifies complex and high-risk members for a home visit in the next two weeks.*

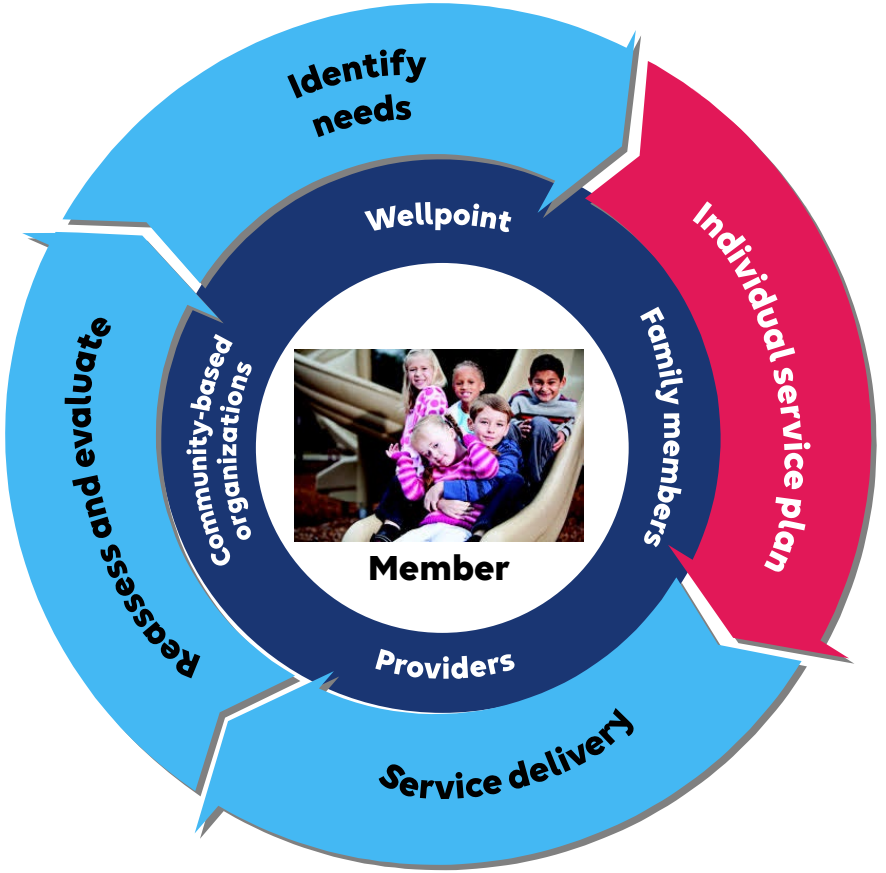
* Wellpoint contacts all members within 90 days of eligibility.



Service coordination model (cont.)

Individual Service Plan:

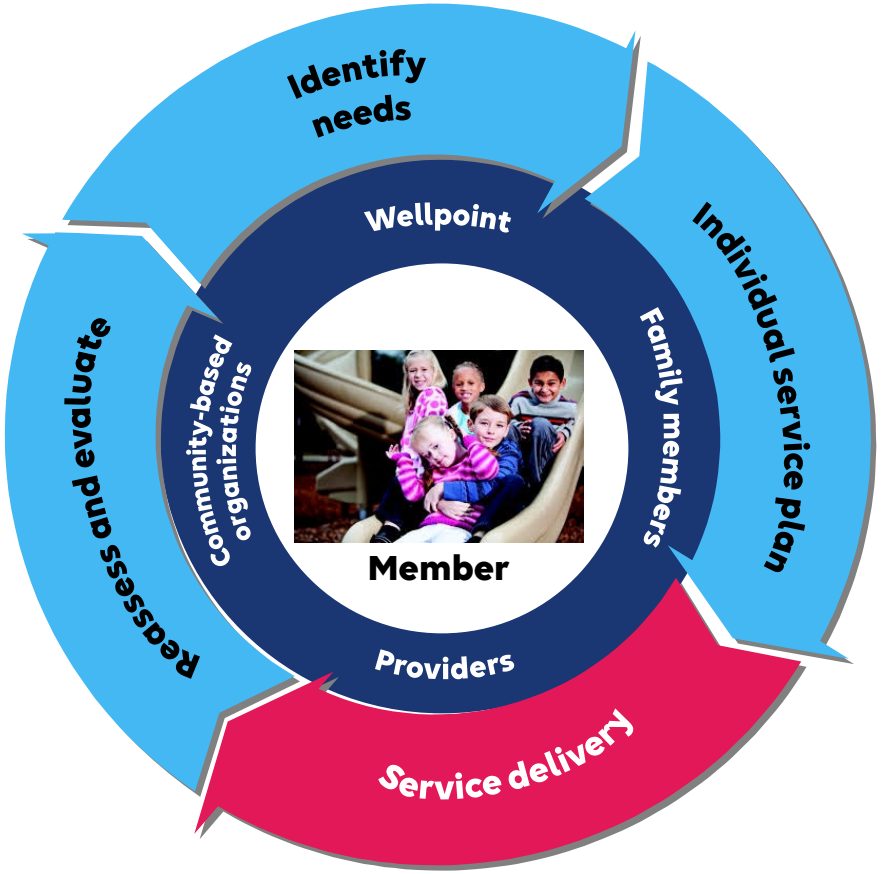
- The service coordinator makes a home visit and conducts a comprehensive assessment of all medical, behavioral, social, and long-term care needs.
- The service coordinator works with a team of experts to develop a service plan to meet the member's needs.
- The service coordinator contacts the member's PCP for concurrence.
- The member and member's family review and sign the service plan.



Service coordination model (cont.)

Service delivery:

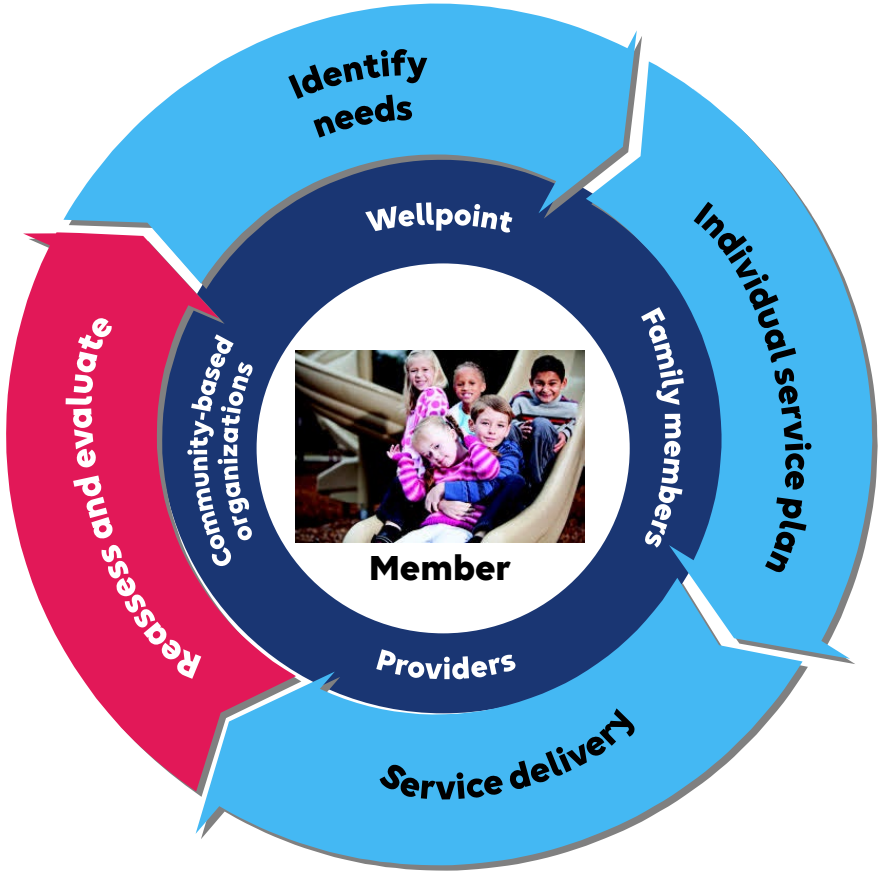
- The member selects providers from the network.
- The service coordinator works with the care team to authorize and deliver services.
- The service coordinator ensures all appropriate services are authorized and delivered according to the service plan.



Service coordination model (cont.)

Reassess and evaluate:

- The service coordinator contacts member and reassesses the member's needs and functional capabilities.
- The service coordinator and member evaluate and revise the service plan as needed.



LTSS prior authorization

- All LTSS require an authorization for services to be rendered to a member.
- To request an authorization, complete a *Prior Authorization Request Form* and fax the request to the appropriate number per product.
- https://provider.wellpoint.com/tx > Resources > Forms
- The approval or denial of a PA request will be faxed back to the provider.

STAR+PLUS MMP (Medicare-Medicaid Plan) service area fax numbers:

- Austin: **877-744-2334**
- El Paso: **888-822-5790**
- Houston/Beaumont: **888-220-6828**
- Lubbock: **888-822-5761**
- San Antonio: **877-820-9014**
- Tarrant/West RSA: **888-562-5160**

STAR Kids fax number: **844-756-4604**
MMP fax number: **844-206-3450**

Referrals

- **LTSS referrals:** A provider can make a referral directly to Wellpoint if a member requires specific LTSS services. Depending on the type of service, the member's service coordinator will complete an assessment with them in order to authorize and coordinate the care for the service.
- **In-network referrals:** A provider can make a referral directly to another provider or specialist physician that is in-network with Wellpoint to provide and administer the service that is being referred. Certain services may require an authorization.

Role of LTSS providers

- LTSS provider responsibilities include:
  - Contacting Wellpoint (or using Availity) to verify member eligibility.
  - Coordinating Medicaid and Medicare benefits.
  - Obtaining authorizations for services prior to provision of those services.
  - Notifying us immediately if unable to render authorized services to the full extent authorized.
  - Notifying Wellpoint of changes in a member's physical condition or eligibility.
  - Partnering with our service coordinator in managing a member's healthcare.

Role of LTSS providers (cont.)

- LTSS provider responsibilities include:
  - Managing continuity of care.
  - Developing and updating quarterly plans for delivering employment assistance services (employment assistance providers).
  - Developing and updating quarterly plans for delivering supported employment services (supported-employment providers).

Role of LTSS providers (cont.)

- All home- and community-based support services agency providers must notify Wellpoint if a member experiences any of the following:
  - A significant change in physical or mental condition or environment
  - Hospitalization
  - An emergency department visit
  - Two or more missed appointments

HCBS settings: heightened scrutiny update September 2021

Overview

As part of the federal home- and community-based services (HCBS) settings regulations, CMS requires states to submit settings for heightened scrutiny (HS) review. Texas Health and Human Services Commission (HHSC) has identified STAR+PLUS assisted living facilities (ALFs) as settings that need to undergo heightened scrutiny.

https://www.hhs.texas.gov/sites/default/files/documents/heightened-scrutiny-faq.pdf

https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/hcbs/hcbs-settings-heightened-scrutiny-update.pdf

Providers should contact the service coordinator for copies of Member Individual Service Plans.

Your responsibilities

- Providers should review both member and provider responsibilities, which are detailed in the provider manuals.
- The Medicaid provider manuals can be accessed by visiting https://provider.wellpoint.com/tx > Resources > Provider Manuals and Guides
- The MMP provider manual can be accessed by visiting: https://provider.wellpoint.com/tx > Resources > Provider Manuals and Guides

Ongoing credentialing

- Recredentialing occurs every three years or sooner if required by state law.
- Please notify the Texas Medicaid & Healthcare Partnership (TMHP) and Wellpoint if you have any changes in licensure, demographics or participation status.

Check status on eligibility, authorizations, and claims

- Wellpoint offers both online and telephonic options for checking the status of eligibility, authorizations, PA, and claims:
  - **Online:** Visit Availity for registration, member eligibility, precertification and benefits information, claims submission, claims status inquiry, and payment disputes.
  - **Telephonic:** Access is available by calling Medicaid Provider Services at **833-731-2162** Monday through Friday, 8 a.m. to 5 p.m. CT. For MMP Provider Services, please call **855-878-1785**.

Continuity of care

90 -day continuity of care:

- Wellpoint ensures members receiving services through a PA or where an authorization was not previously required, or who are transitioning from another managed care organization (MCO) or from Medicaid fee-for-service, receive continued authorization of those services for the same amount, duration, and scope.
- For both STAR+PLUS and STAR Kids members, continuity of care does not exempt providers from following billing guidelines, such as correct coding and timely filing. Claims can be denied for these errors.

Continuity of care (cont.)

90-day continuity of care for acute care services:

- Members will receive continued authorization of those services for the same amount, duration and scope for the shortest period of the following:
  - Ninety calendar days after the transition to a new MCO
  - The time it takes for us to evaluate and assess the member and issue or deny a new authorization
  - Until the end of the current authorization period

Continuity of care (cont.)

90-day continuity of care for LTSS:

- For members enrolling in an existing program and service area, we will honor existing LTSS authorizations for up to 90 calendar days or until we have evaluated and assessed the member and issued new authorizations.

Medical transportation services

- The state's Medicaid non-emergency medical transportation (NEMT) services benefit was carved in to managed care effective June 1, 2021.
- *Non-medical transportation service* is a new benefit and means: curb-to-curb transportation to or from a medically necessary nonemergency covered healthcare service in a standard passenger vehicle that is scheduled not more than 48 hours before the transportation occurs including transportation related to:
  - Discharge of a recipient from a healthcare facility.
  - Receipt of urgent care.
  - Obtaining pharmacy services and prescription drugs.

Medical transportation services (cont.)

  - Any other transportation to or from a medically necessary, nonemergency covered healthcare service the commission considers appropriate to be provided by a transportation vendor, as determined by commission rule or policy.
- Medical Transportation Program (MTP) is not going away. MTP remains for members in fee-for service only.
- The NEMT vendor for Wellpoint is Access2Care.
- Products covered:
  - STAR, STAR Kids, STAR+PLUS, and STAR+PLUS MMP
  - CHIP and CHIP Perinatal are ***excluded***.

Medical transportation services (cont.)

- Medical transportation for Medicaid covered services such as:
  - Doctor's office, dental visit-may be coordinated with DMO, dialysis center, pharmacy, hospital discharge, travel outside service delivery area (long distance travel) behavioral health, nursing facility (NF): discharge to home or trips to/from dialysis only
- If the service is not a covered Medicaid service, NEMT services cannot be used. This type of transportation would not be approved or may be considered a value-added benefit.

Medical transportation services (cont.)

- Exclusions:
  - Ambulance-emergent or non-emergent, day activity health services (DAHS), assisted living facility (ALF), NF transportation except a NF discharge to the member's home or if the member is receiving dialysis services, transportation without an attendant if documentation exists where the member must travel with an attendant, members 14 years and younger cannot travel alone, members 15-17 can travel alone with written authorization from the parent, legally authorized representative (LAR) or guardian, emotional animals that are not certified animals cannot accompany members (may be a VAB)

Medical transportation services (cont.)

- Providers are able to call on a member's behalf to schedule trips. Members and providers use the same numbers to contact Access2Care based upon the member's product:
  - **833-721-8184** STAR
  - **844-867-2837** STAR+PLUS
  - **844-864-2443** STAR Kids
  - **844-869-2767** STAR+PLUS MMP
  - **855-823-8587** TTY 711
- Members have the ability to schedule their own rides by using the Access2Care Member Mobile APP.

Cultural competency

We expect our providers and their staff to continually increase knowledge, skill, attitudes, and sensitivities to diverse cultures.

The result is effective care and services for all people by taking into account each person's conditions, values, and linguistic needs.

Critical events

Providers are obligated to identify and report to the state a critical event or incident such as abuse, neglect, or exploitation related to LTSS delivered in the STAR+PLUS and STAR Kids programs.

In the Medicaid/CHIP, STAR+PLUS Nursing Facility, and MMP provider manuals, see section *Reporting Abuse, Neglect, or Exploitation (ANE)* for further information.

Member complaints and appeals

- Medicaid members or their representatives may contact a member advocate or their service coordinator for assistance with writing or filing a complaint or appeal (including an expedited appeal). Complaints may be filed to dispute financial liability, transportation, failure to provide services timely, etc.
- Member complaint resolution:
  - Call us toll free at **833-731-2160 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m. CT.
  - STAR Kids: **844-756-4600**
  - MMP: **855-878-1784**
  - The member advocate or Member Services representative can help you or the member file a complaint with us or the appropriate state program.

Member complaints and appeals (cont.)

- Complaint will be responded to within 30 days from the date we get the complaint
- Send member complaints to:

  Member Advocates

  Wellpoint

  2505 N. Highway 360 Suite 300

  Grand Prairie, TX 75050

Fraud, waste, and abuse

- Wellpoint follows and meets all requirements set by Texas HHSC Office of Inspector General, Texas Government (Code *531.113* and *533.012*, and *1 TAC 353.501-353.505*).
- In order to ensure compliance with requirements, Wellpoint will complete the following:
  - **Utilization management reviews**: This review process makes sure the service that is requested for the member is medically needed and that the member meets certain medically necessary criteria to be approved for the service that is requested.
  - **Fraud, waste, and abuse training**: Training is provided to all employees and subcontractors with Wellpoint. Information about fraud, waste, and abuse is also on our website for both members and providers.

Fraud, waste, and abuse (cont.)

- **Audits**: The audit process allows for Wellpoint to monitor services and ensure services are being rendered and authorized correctly. Depending on the type of audit, these will be completed at various times. Audits are performed on claims, authorizations, and LTSS provider agencies. Internal audits are performed on service coordinator's assessments.

Electronic payment services

If you sign up for electronic remittance advice (ERA) or electronic funds transfer (EFT), you can:

- Start receiving ERAs and import the information directly into your patient management or patient accounting system.
- Route EFTs to the bank account of your choice.
- Create your own custom reports within your office.
- Access reports 24/7.

Electronic payment services (cont.)

- EnrollSafe is safe, secure, and available 24 hours a day:
  - You can log onto the EnrollSafe enrollment hub at https://enrollsafe.payeehub.org to enroll in EFT. You'll be directed through the EnrollSafe secure portal to the enrollment page, where you'll provide the required information to receive direct payment deposits.

Electronic payment services (cont.)

- Electronic remittance advice (ERA) makes reconciling your EFT payment easy and paper-free.
- Now that you are enrolled in EFT, using the digital ERA is the very best way to reconcile your deposit. You'll be issued a trace number with your EFT deposit that matches up with your ERA on Availity. To access the ERA, log onto Availity.com and use the Claims and Payments tab. Select Send and Receive EDI Files, then select *Received Files* Folder. When using a **clearinghouse** or **billing service**, they will supply the 835 ERA for you. You also have the option to view or download a copy of the **Remittance Advice** through the Remittance Inquiry app.

LTSS billing grid

- Both the state's STAR+PLUS and STAR Kids LTSS billing matrix can be found on the HHSC website:
  - For STAR+PLUS: See Appendix XVI, Long Term Service and Supports Codes and Modifiers: https://www.hhs.texas.gov/handbooks/starplus-handbook/appendix-xvi-long-term-services-supports-codes-modifiers
  - For STAR Kids: See Appendix III, LTSS Billing Matrix and Crosswalk: https://www.hhs.texas.gov/handbooks/star-kids-handbook/appendix-iii-ltss-billing-matrix-crosswalk
- LTSS billing information, including Wellpoint fee schedules, are on Availity.

LTSS billing grid (cont.)

- HHSC has updated the LTSS billing matrix for both the STAR+PLUS and STAR Kids programs. The updates reflect new codes, changes to the units of service, revised procedure codes, modifiers, and compliance to the National Correct Coding Initiative in Medicaid (NCCI) standards and follow the requirements for the billing structure outlined in the *Texas Medicaid Provider Procedures Manual*.
- The LTSS billing matrix was **effective December 1, 2022**.

For more information regarding LTSS billing matrix changes to STAR+PLUS and STAR Kids effective December 1, 2022, please refer to the HHSC website links below:

- LTSS Billing matrix for STAR+PLUS: https://www.hhs.texas.gov/handbooks/starplushandbook/appendix-xvi-long-term-services-supports-codes-modifiers
- LTSS billing matrix for STAR Kids : https://www.hhs.texas.gov/handbooks/star-kidshandbook/appendix-iii-ltss-billing-matrix-crosswalk

Attendant compensation enhancement payment

- Participation requires a contract or contract amendment with Wellpoint, and participation in the HHSC program for attendant compensation enhancement.
- Participation is not guaranteed. Participation in the HHSC program does not constitute automatic enrollment into the Wellpoint program. Amendments are prospective only.
- Wellpoint will make an exception for:
  - Providers who only have an HHSC community-based alternatives (CBA) contract, as CBA contracts are no longer awarded in STAR+PLUS and STAR Kids areas.
  - Cases where HHSC will not offer participation due to funding restrictions.

Attendant care enhancement payment

- Wellpoint uses the state's rate enhancement structure, which has 35 levels.
- Providers must include the enhancement amount in their billed charge. Attendant enhancement payment is made at the time of claim payment.
- Participation with Wellpoint must be renewed every year with submission of forms within the timeframe given. Forms received after the due date will not be accepted.

Attendant care enhancement payment (cont.)

- The program requires providers to submit an annual report of how they allocated the additional compensation funds paid through this program per qualified methods, as described in *1 TAC § 355.103(b)(2)(A-B)* and *355.105(b)(2)(B)(xi):*
  - Reporting periods are based on the state's fiscal year of September 1 through August 31.
  - Reports to Wellpoint are due each January 30 following the close of the state's fiscal year.

Electronic visit verification (EVV)

- EVV is a computer-based system that electronically verifies that service visits occur, including documentation of the date and time that service delivery begins and ends.
- EVV replaces paper timesheets for EVV required services.
- EVV visit transactions are required for EVV claim payment and must fully match the claim.
- Before serving a Wellpoint member, all providers must be fully onboarded and using an HHSC-approved EVV system. Please refer to the *HHSC EVV Policy Handbook, section 4000 EVV System and Setup, and section 4100 EVV System Selection* for more information at https://www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook.
- For questions regarding EVV please contact Wellpoint EVV email box at: TXEVVSupport@wellpoint.com.

EVV (cont.)

- Visit maintenance must be completed within 95 days from date of service.
- Wellpoint offers EVV policy training for program providers and FMSAs once a month covering:
  - EVV policies.
  - EVV program provider, FMSA, and CDS employer requirements.
  - EVV claims.
  - EVV claims matching process and much more.
- To meet the EVV training policy requirements, providers are encouraged to register and attend one of the monthly Wellpoint EVV provider training sessions.
- Providers are encouraged to frequently check the Wellpoint EVV provider website at https://provider.wellpoint.com/tx/ > resources > electronic visit verification for updates, changes and alerts on:
  - The EVV provider training schedule, found under the *EVV Training Schedule and Materials* section.
  - All EVV policies and procedures, posted under the *EVV Policies & Procedures* section. Please read all *EVV Policies & Procedures*.

EVV (cont.)

Personal care services (PCS)

The *EVV PCS Service Bill Codes Table* provides current billing codes and details for EVV relevant services. Program providers must use the appropriate HCPCS and modifier combinations to prevent EVV visit transaction rejections and EVV claim match denials. The information can be viewed in Excel or PDF.

On the Excel version, the tab titled *MCO EVV Services* shows all the procedure codes and services required to use EVV under Wellpoint.

EVV PCS Service Bill Codes Table – Version 12.0 (Excel)

On the PDF version, when the **payer** is listed as MCO, these are the procedure codes and services required to use EVV under Wellpoint.

EVV PCS Service Bill Codes Table – Version 12.0 (PDF)

EVV (cont.)

Home health care services (HHCS)

The *EVV HHCS Service Bill Codes Table* provides current billing codes and details for EVV relevant services. Program providers must use the appropriate HCPCS and modifier combinations to prevent EVV visit transaction rejections and EVV claim match denials. The information can be viewed in Excel or PDF.

On the Excel version, the tab titled *MCO EVV Services* shows all the procedure codes and services required to use EVV under Wellpoint.

EVV HHCS Service Bill Codes Table — Version 2 (Excel)

On the PDF version, when the **payer** is listed as MCO, these are the procedure codes and services required to use EVV under Wellpoint.

EVV HHCS Service Bill Codes Table — Version 2 (PDF)

EVV (cont.)

- Effective since January 1, 2024, Wellpoint and HHSC implements EVV for Medicaid home healthcare service.
- Starting with dates of service on and after December 1, 2023, all claims submitted for EVV home healthcare services must be submitted to TMHP. The claim will be rejected by Wellpoint if the claim is submitted directly to Wellpoint. The provider will be informed to submit the claim to TMHP.
- Wellpoint and HHSC refer to EVV home healthcare services as *Cures Act Home Health Care Services* or *Cures Act HHCS*.
- For Wellpoint, the *Cures Act HHCS* impacts the following programs: STAR, STAR+PLUS, STAR+PLUS MMP, and STAR Kids.
- HHSC will continue analyzing the impacted services and may update the EVV HHCS required services accordingly.

Billing and reimbursement

Billing requirements:

- Check eligibility, at a minimum, the first of every month.
- Be sure you have an authorization to provide for the service for which you are billing.
- Bill within 95 days of the date of service.
- LTSS are billed on a *CMS-1500* or as otherwise noted in the provider's contract using the coding defined per the uniform billing code set.
- Use a valid ICD-10-CM diagnosis code.

Billing and reimbursement (cont.)

- Include your NPI and taxonomy code or your assigned application programming interface in the correct box or field location.
- Bill via paper, electronic clearinghouse, or Availity.
- Reimbursement is based on the terms of your contract with Wellpoint.
- Claim disputes may be filed within 120 days from the date of an *Explanation of Payment*.
- Wellpoint offers claim support via a dedicated claim unit and through our local Provider Relations representatives.

Claims

- Claims must be received within 95 calendar days from the date of service or discharge.
- For paper claims, send to:
  Wellpoint
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

Claims can be submitted electronically or by paper, via:

- Availity.
- Batch 837.
- Clearinghouse.
- U.S. mail.

Claims (cont.)

Electronic data interchange (EDI) submission:

- Use the Availity EDI Gateway at https://apps.availity.com/web/welcome/#/edi to begin the process.
- The Payer ID list can be found on the Availity website at https://apps.availity.com/public/apps/payer-list/#/basic .
- Providers who wish to use a clearinghouse or billing company should work with that organization to ensure connectivity to the Availity EDI Gateway.
- Availity Client Services can be contacted for assistance at **800-AVAILITY (800-282-4548)** Monday through Friday from 7 a.m. to 6:30 p.m. , Central time.

Claims (cont.)

Rejected claims:

- Claims that have been rejected either by mail or EDI must be resubmitted correctly within the 95 -day filing limit.
- Once successfully accepted, the claim will be adjudicated for benefits payable.

Claims (cont.)

Accepted claims:

- These are claims that have been accepted into the claim payment platform, have adjudicated, and have produced a paid or denied response.
- Providers can file a corrected claim for accepted claims within 120 days of processing found on the *Explanation of Payment* and label as the run date.
- Providers must correct necessary items via Availity by locating the original claim, correcting it, and resubmitting it in a corrected claim format or via paper submission.

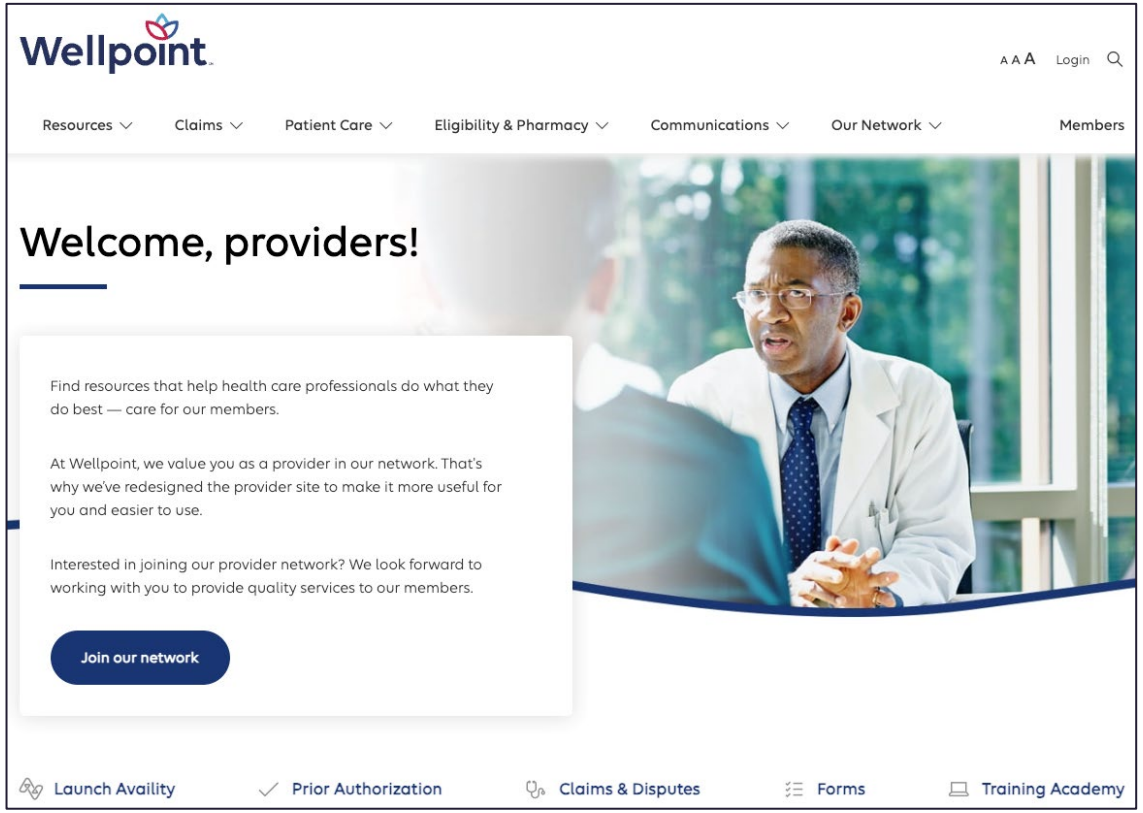
Claims (cont.)

Accepted claims:

- Claims for additional units must reflect the original claim's billed units plus the added units. The provider's billed charge should include the billed amount for original units plus the billed amount for added units to equal the full billed charge.

The provider website and Availity

- The provider website is available to all providers, regardless of participation status.
- The website provides valuable information including provider manuals and important announcements.



provider.wellpoint.com/tx

The provider website and Availity (cont.)

- Wellpoint collaborates with Availity, a multi-payer portal, for providers to conduct transactions and exchange information with many payers in one online location.
- With a single sign-on, providers can move between the resources and tools of both the Wellpoint and Availity sites.
- Providers use Availity for registration, member eligibility, PA, and benefits information, as well as claims submission, status inquiry, and payment disputes.
- Providers use the Wellpoint provider site for information, tools, and resources.

Availity

Key features of Availity:

- **Multiple payers:** Multiple payers can be accessed with a single sign-on.
- **No charge:** Wellpoint transactions are available at no charge to providers.
- **Accessible:** Availity functions are available 24/7 from any computer with internet access.
- **User-friendly:** It's easy to find the necessary information needed within Availity's standard screen format, increasing staff productivity.
- **Compliant:** Availity is compliant with the *HIPAA* regulations.

Availity (cont.)

Key features of Availity:

- **Training:** No-cost, live, web-based, and prerecorded training webinars are available to users; FAQ and comprehensive help topics are available online as well.
- **Support:** Availity Client Services is available at **800-AVAILITY (800-282-4548)**, Monday through Friday from 7 a.m. to 6:30 p.m. Central time.
- **Reporting:** Reporting by user allows the primary access administrator to track associates' work.

Availity (cont.)

- Providers now have the ability to submit claim payment disputes through Availity with more functionality, including:
  - Immediate acknowledgement at the time of submission.
  - Notification when a dispute has been finalized.
  - A worklist of open submissions to check the status of a dispute submitted through Availity.
- This means an enhanced experience when:
  - Filing a claim payment dispute.
  - Checking the status of your claim payment dispute.
  - Viewing your claim payment dispute history.
  - Sending supporting documentation.

Availity (cont.)

- With electronic functionality, when a claim payment dispute is submitted through Availity, Wellpoint will:
  - Investigate the request.
  - Communicate an outcome through Availity.
  - Notify the Availity user who submitted the claim payment dispute that an outcome has been determined and the review has been completed.
  - Include any next steps available in case you are not satisfied with the outcome of the decision.

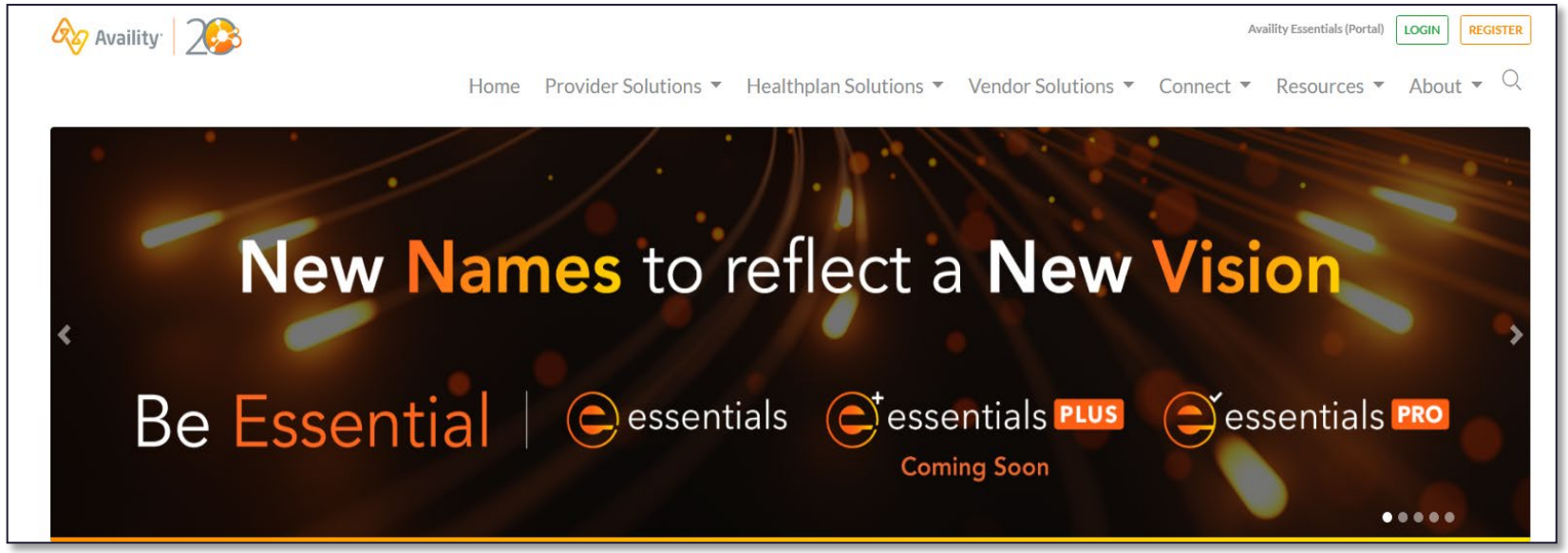
Availity (cont.)

Registering for a scheduled Availity webinar or listening to a recording:

- Log in to Availity > Help & Training > Get Trained.
- From the Availity Learning Center, enroll in a training using one of the following methods: Select the Help and Training dropdown > Get Training > Sessions > select the date of the webinar > Appeal webinar > Enroll.
- For instructions on how to submit an appeal, Select Help and Training dropdown > Get Training > Select Courses > enter Appeal. There is an Availity Training Demo step by step on how to submit an Appeal.

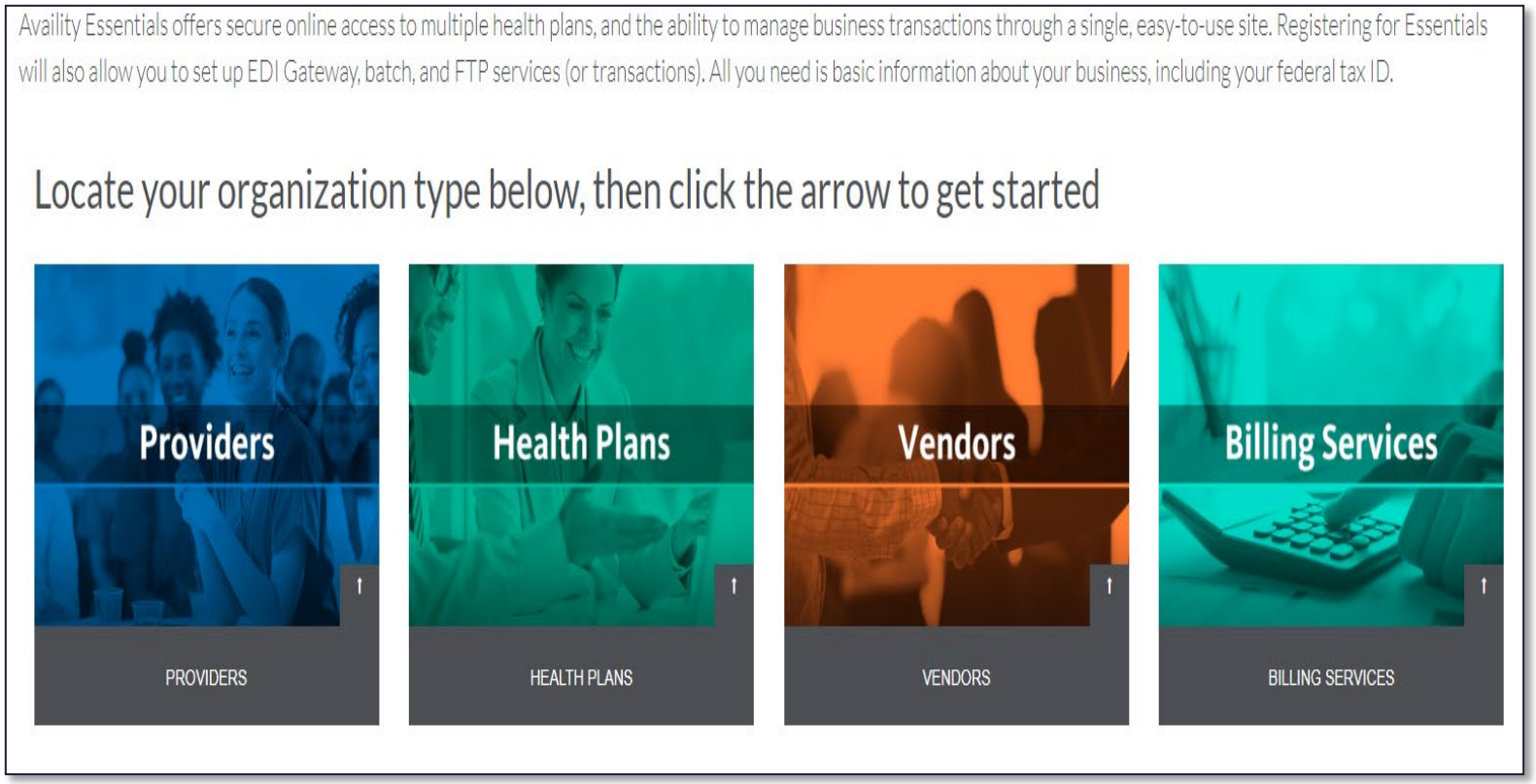
Availity (cont.)

- We encourage providers to register so they can use the secured content on the website.
- Select **Register** to begin the registration process on the Availity site.



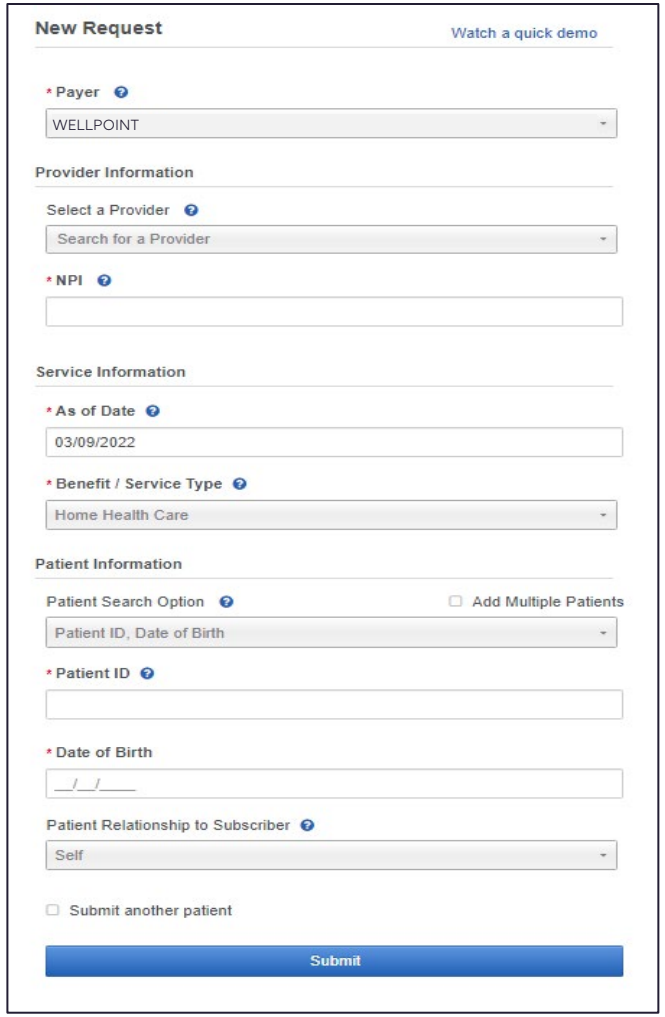
Website registration (cont.)

- The registration process is easy.
- There are multiple resources and trainings available to support Availity and our provider site navigation.



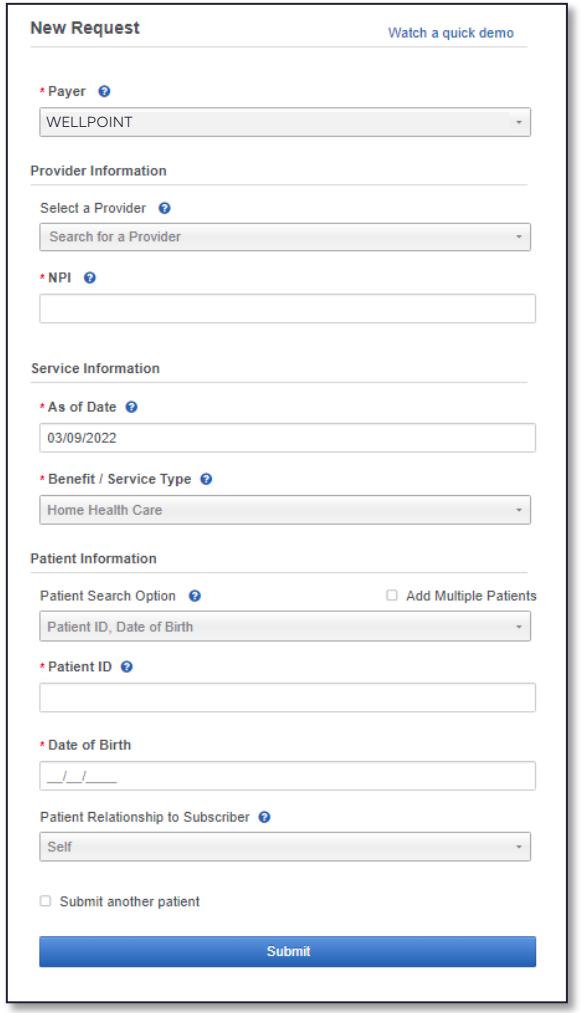
Verifying eligibility

- Availity allows providers to easily check eligibility and benefits.



Verifying eligibility (cont.)

- Check one member or use online batch management to check multiple members from multiple payers.

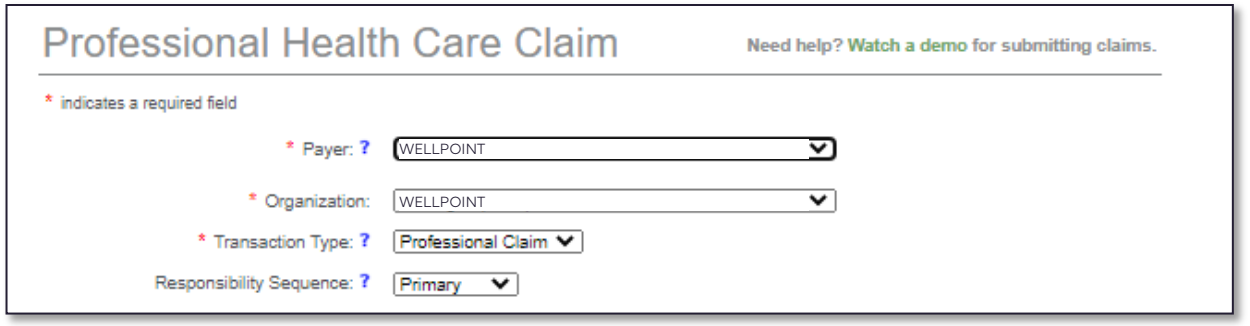


Submitting claims

- Submitting claims through Availity is easy. Simply enter the required information and select **Submit**, and your claim is on its way to Wellpoint. Claims are usually entered into our system in as quickly as 24 to 48 hours.

Submitting claims (cont.)

- Assistance is at your fingertips:
  - Select the blue question mark for additional information about a field.
  - Select **Learn More** for help topics related to the page you are on at the time.



Provider Services

Contact your Provider Services representative with any questions you may have:

- Medicaid: **833-731-2162**
- MMP: **855-878-1785**

Network Relations consultants

Deidre Haynie
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682-321-8207

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Kristal Babino
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984-867-1469

Cheryl Green
cheryl.green@wellpoint.com
806-474-4157

Need help?

Medicaid Provider Services: 833-731-2162

MMP Provider Services: 855-878-1785

Provider website
provider.wellpoint.com/tx

EVV support
txevvsupport@wellpoint.com

provider.wellpoint.com/tx

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.
Medicare-Medicaid Plan services provided by Wellpoint Texas, Inc.