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About CapStar

CapStar is the participating network for Caprock Health Plans. Caprock provides turnkey Health Plan administration Services to businesses, schools, and governmental entities electing to self-insure their employee-sponsored health benefit plan. They key to our success is the ability to provide superior service in a fully automated yet “high touch” environment where every provider is treated with honor and respect.

Philosophy of CapStar

CapStar was birthed with a vision to serve and improve the quality of life for our customers, employees, and families that utilize our network. We provide an expansive, quality network for those employers who encompass 100 counties with the west Texas region, where customer service is more than a trite slogan.
Network Participation Guidelines

Contact Information

Capstar Health Network
4401 82nd Street, Suite 1200
Lubbock, Texas 79424

Remit Address:
P.O. Box 54192
Lubbock, Texas 79453

Main Number: 806-783-9995
Fax Number: 806-783-9991
Toll Free: 800-747-9446

www.capstarhealth.com
Send provider updates to: providerupdates@capstarhealth.com

Provider Relations: 806-783-9995 Ext. 222
Customer Service: 806-783-9995
Credentialing

We are dedicated to providing our Customers with access to effective health care and we review the credentials of participating physicians and other health care professionals in order to maintain and improve the quality of care and services delivered to our Customers.

All Providers are required to complete a Provider application. All requested information must be presented with a provider application in order to process the information. If you are *CAQH certified we will not need the paperwork associated with the application, just your CapStar provider application and your number associated with CAQH. The CAQH process is available to physicians and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online. Please see the information below on how to access CAQH through their website.

If you are not CAQH certified, we need the Capstar provider application as well as the Texas Standardized Credentialing application returned to Provider Relations with the appropriate documents.

The following information must be current:

- State License
- DEA
- Controlled Substance Abuse
- Malpractice Insurance Certificate

*CAQH—Council for affordable Quality Healthcare

Providing information for credentialing and other business applications doesn't have to be time-consuming and inefficient. CAQH’s Universal Provider Data source is an established, free service to physicians and other healthcare providers that simplifies and improves the data collection process. With UPD, you enter information online, one time, to satisfy application requirements, such as those for credentialing, of participating health plans, hospitals, and other managed care organizations. Updates and re-attests can be made instantly. Only you control and authorize access to your information. Encryption technology keeps your data safe. Please contact www.caqh.org.
Delegated Credentialing

CapStar does offer delegated credentialing for groups that meet NCQA guidelines or URAQ standards for all new Provider groups or re-credentialing of groups. The Provider groups credentialing policies and procedures are reviewed for compliance with our credentialing entity. A delegated credentialing agreement must be signed for group to be granted delegated status. Provider must agree to an annual audit visit.

**Roster:** Provider must send an initial Provider roster following up with monthly updates for providers with changes in name, address, phone number, fax number, specialty and additions and terminations.

**Audit:** An integral part of the quality process is a structured review of the practitioner’s office site. A site review will be conducted as part of the initial credentialing process. The site review must be conducted and placed in the practitioner file prior to the credentialing decision.

For a copy of what our on-site evaluation and audit form please contact Provider Relations.

**Physician Status:** Delegated group will notify CapStar within 10 days if a hospital revokes or suspends the clinical privileges of a physician except in the case of non-compliance with medical record requirements.

**Data Submission:** All updates including adds, terms or changes need to be received in writing via email, fax, or by mail. If submitting electronically please include the following information:

- Name
- TIN—Tax Identification Number
- NPI—National Provider Identification
- Licensure—current, active and in good standing
- Federal DEA certificate and State Controlled Substance Registration
- Board certification current and in good standing (if applicable) Specialty
- Current and adequate malpractice coverage
- New Information to add or change
- Old information if being replaced
- Effective date of change
Dispute Resolution

The dispute resolution and appeal resolution mechanism is available to any participating Cap-Star provider that wishes to initiate the process. If you have a concern or a complaint about your relationship with CapStar, send us a letter containing the details to the address listed in your agreement with us. One of our representatives will look into your complaint and try and resolve it through an informal discussion. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described in your agreement.

If your concern or complaint relates to a matter involving CapStar administrative issues, such as credentialing, or claim appeal processes, we will follow the dispute procedures in those departments to resolve the concern or complaint. If, after following those procedures, one of the parties remains dissatisfied, an arbitration proceeding may be filed according to the dispute resolution section in our Agreement.
**Utilization Management**

**Overview:**

CapStar is committed to effectively managing health care utilization while maintaining quality of care and service. This will ensure that members receive quality medical services based on medical necessity.

**Goals:**

- Effectively utilize available health care benefit resources.
- Ensure and provide for medical appropriateness of care.
- Assist in monitoring the quality of medical services provided by and /or accessed through the CapStar network.

**Objectives:**

- Correctly interpret written benefit information to ensure accurate and efficient administration of health care programs for our employer groups.
- Ensure that patients receive medically necessary treatment at the most appropriate level of care.
- Through education, facilitate communication and develop partnerships among members, providers, and the organization in an effort to enhance cooperation and appropriate utilization of health care services.
- Provide access to appropriate, cost-efficient health care services.
- Identify members who may incur extensive health care expenses or require ongoing medical care for chronic or catastrophic illnesses for the purpose of providing comprehensive case management and coordination of care.
- Collect and analyze utilization data to favorable impact provider practice patterns in all settings.
- Communicate effectively with our Customers.
In-Network Specialists

Members may self-refer to in-network specialists. Prior authorization must be obtained for services requested for non-contracted providers.

OB/GYN Services

Female members can self-refer to in-network providers for routine OB/GYN services.

Prior Authorization

Unless otherwise prohibited by law, prior authorizations are necessary for certain services before they are actually rendered. Authorizations are based on benefits as well as medical necessity, which are supported through clinical information supplied by requesting providers. Prior authorizations can be obtained by calling the number on the back of the members identification card.

Emergency Services

Emergency Services, are health care procedures, treatments, or services delivered to a member after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in: (i) jeopardy to the person’s health; (ii) serious impairment of bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) disfigurement to the person.

- Members, or their providers, need to notify CapStar within 24-hours following an emergency admission.
- All follow-up or continuing care must be arranged by an in-network provider.
Claims Submission

Please refer to your patients health plan identification card for important information regarding filing claims with CapStar. As a provider with CapStar, you agree to submit clean claims, in a timely manner, for services to Covered Individuals. The acceptable claim forms are listed below:

- CMS-1500 or successor form
- UB-04 or successor form

To receive proper payment and application of deductibles and coinsurance, it is important that you accurately code all diagnoses and services (according to national coding guidelines). The importance of coding accurately can affect a Customer’s level of coverage under his or her benefit plan, and may vary for different services. A claim must be submitted for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the Customer at the time of service.

Please allow enough time for your claims to process before sending a second submission. You can check your status of your claim online at my.caprockhp.com.

Time Limits for filing claims

All claims must be submitted by provider within 90 days from the date of service.
Complete Claims Requirements:

- Customer’s name
- Customer’s address
- Customer’s gender
- Customer’s date of birth (dd/mm/yyyy)
- Customer’s relationship to subscriber
- Subscriber’s name (enter exactly as it appears on the Customer’s Health ID card)
- Subscriber’s ID number
- Subscriber’s employer group name
- Subscriber’s employer group number
- Rendering Physician, Health Care Professional, or Facility name
- Rendering Physician, Health Care Professional, or Facility Representative’s Signature
- Address where service was rendered
- Physician, Health Care Professional, or Facility “remit to” address
- Phone number of Physician, Health Care Professional, or Facility performing the service
- Physician’s, Health Care Professional’s, or Facility’s NPI and federal TIN
- Date of service(s)
- Place of service(s)
- Number of services (day/units) rendered
- Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate
- Current ICD-9-CM (or its successor) diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item
- Charges per service and total charges
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if applicable
• Retail purchase cost or a cumulative retail rental cost for DME greater than $1,000

• Current NDC (National Drug Cod) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPPS 837 Professional

• Method of Administration (Self or Assisted) for Hemophilia Claims—the method of administration must be noted and submitted with the claim form with applicable J-CODES and hemophilia factor, in order ensure accurate reimbursement. Method of administration is either noted as self or assisted.

**Information need to complete UB-04 Form:**

• Date and hour of admission

• Discharge date and hour of discharge

• Customer status-at-discharge code

• Type of bill code (3 digits)

• Type of admission (e.g. emergency, urgent, elective, newborn)

• Current four-digit revenue code(s)

• Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines

• Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines

• Current ICD-9-CM (or its successor) procedure codes for inpatient procedures

• Attending physician ID

• Bill all outpatient procedures with the appropriate revenue and CPT or HCPCS codes

• Provide specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic) for outpatient services

• Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449) submitted on a UB-04

• Submit claims according to any special billing instructions that may be indicated in your agreement with us

• On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the Customer was admitted to inpatient status

If you have any questions about submitting claims to us, please contact Customer Service at the phone number listed on the Customer’s health care ID card.
Claims sent by mail:

Please submit claim to the address as identified on the Customer’s health ID card.

Caprock Health Plans

P.O. Box 21548

Eagan, MN 55121

Electronic submission of claims:

CapStar does accept electronic claims submission. Claims may be submitted electronically through our clearinghouse in a process know as Electronic Date Interchange (EDI). SDS ( ) is the clearinghouse we use, and the routing number is CAPHP. We recommend this method as it is faster and more accurate.

EDI Number: CAPHP

Claim Reimbursement:

Providers need to bill for services for a Covered Individual at the normal retail rate. The Payor will reimburse the provider once your benefits are applied. An EOB (explanation of benefits) will be sent to you detailing the payment. The provider is not allowed to charge a Covered Individual for services beyond copayments, coinsurance or deductibles as outlined in their benefit plan.

Any non-covered services under the applicable benefit plan may be charged to the Covered Individual provided you first obtain the customer’s written consent. Please keep a copy of the consent in the Customer’s medical record.

Because the payors vary, please verify a covered Individual’s benefits by calling the number on the back of the Customer’s health ID card.

Eligibility:

Please verify the eligibility of all CapStar Customer’s by calling the number on the back of the Covered Individual’s health ID card. Verification of eligibility is not a guarantee of payment.
Precertification Guidelines:

Recommended Targeted Outpatient Procedure

Nasal surgeries
Blepharoplasty
Ventral hernia repair
Varicose vein surgery
Sclerotherapy
Panniculectomy
Breast Reduction
UP3/UPPP - uvulopalatopharyngoplasty
Excess skin removal arms and chest and legs
Maxillo-facial surgery- *unless orthognathic surgery is excluded by plan language
Shock wave lithotripsy for plantar fasciitis
Hysterectomies
Tonsillectomies/Adenoidectomies in adults
Biopsies (while these are for practical purposes always certified we use the information to find cancer cases early)
AICD and Biventricular device insertions
Bariatric (weight loss) Surgery
Following back or neck procedures: IDET (intradiscal Electrothermal Annuloplasty), Percutaneous Radiofrequency Neurotomy, Artificial Intervertebral Disk Implantation, Automated Percutaneous Lumbar Diskectomy (APLD)
AV Fistula or graft access for dialysis

Diagnostic testing:

PET scans
CT angiogram
CT Calcium screening/screening CT of the heart
MRI of the heart

Other:

Chemotherapy/radiation oncology
DME over $2000
Infusions/high cost injectables
Home Care
Dialysis
Sample ID Cards

Medical ID Card

Member Social xxx-xx-xxxx

PPO Physician Office: $XX Copay per office visit
PPO Other: 80% After $XXX plan year deductible
Non-PPO: 60% After $XXXX Plan year deductible

Pre-Certification is required:
Please call xxx-xx-xxxx prior to any Hospital admission or Surgery (within 48 hours of an emergency admission). Failure to pre-certify will result in a reduction of Benefits.

To locate an in-network provider, PPO Provider call:
(800) 747-9446

SUBMIT CLAIMS TO:
EDI#: CAPHP
CAPROCK HEALTHPLANS
PO BOX 21548
EAGAN MN 55121

Direct questions regarding eligibility, benefits or claim status, to:
CAPROCK HEALTHPLANS:
PO BOX 54139
LUBBOCK TX 79453-4139
(806) 783-9995

All verifications are subject to plan provisions, limitations & eligibility at time of service.

Possession of this card does not guarantee eligibility. Willful misuse of this card to obtain benefits is considered fraud.
Complaints and Appeals

Any complaints and appeals may be filed by contacting our Customer Services department

At the following number:

Main Number: 1-806-783-9995—CapStar Health Network

Toll Free Number: 800-747-9446—CapStar Health Network

Fax Number: 806-783-9991—CapStar Health Network

Complaints may also be filed by mail and sent to the following address:

CapStar Health Network
4401 82nd Street, Suite 1200
Attention: Provider Relations
Lubbock, TX 79424

How to Contact us

Provider Relations:

Toll Free Number: 1-800-747-9446

Main Number: 806-783-9995

- Information regarding contract terms, reimbursement, & effective dates
- Payor information
- Escalated issue resolution
- Information about network participation or how to add a new provider
Provider Application

Please click below to download our Provider or Hospital Application. If you are not CAQH certified, please click on the link below for the Texas Standardized application.

Please complete the applications and forward to CapStar with the appropriate paperwork necessary to complete your participation through the CapStar Network.

Provider Updates

Please forward all updates to the following email box:

providerupdates@capstarhealth.com

Updates can include:

- Demographic changes
- Tax Identification changes
- Termination notification