Providing CHIP and Medicaid services to Tarrant, Denton, Parker, Wise, Hood and Johnson counties.

Summer

Cook Children's Health Plan

Provider Newsletter

August 2018

What's inside

- Provider Training Webinars
- Deactivating Secure Provider Portal Users
- Secondary claim edits and Important Billing information
- Other Health Insurance/Coordination of Benefits Information
- Long Term Services and Supports Billing
- Filing a Complaint with Cook Children's Health Plan
- Filing an Appeal with Cook Children's Health Plan
- Selecting the Most Appropriate Diagnosis Codes
- Prior Authorization for Laboratory Codes
- Prior Authorization Lookup
- THSteps Prior Authorization Requirements for Dental Anesthesia
- Physical, Occupational, and Speech Therapy Benefit Changes Effective September 1, 2017
- Texas Health Steps Medical Record Documentation

What's New?

Provider Training Webinars!

We are excited about this new interactive opportunity to connect with our partner providers! Are you are a newly contracted provider? Existing provider who has new staff? Would your office like to learn more about Texas Health Steps, educational resources and health plan updates?

If so, plan to attend a Provider Training Webinar. All contracted providers are welcome to attend one or more of the 1 hour training events hosted by our Provider Relations team. Many of our training events are communicated by email. If your email address has changed, please be sure to notify us to ensure email delivery. Send notification of email changes to CCHPNetworkDev@cookchildrens.org

Visit our Education & Training page for a current training schedule at www.cookchp.org.

Deactivating Secure Provider Portal User ID's

It is important to deactivate the Secure Provider Portal access of any user who is no longer a part of your staff. Please notify us if you have departing staff with access to protected information on the portal. Include the following with your request: employee name, email address, last day of employment, user name if available, and the provider's Tax ID number. Send the change request by email to our Network Development team at CCHPNetworkdev@cookchildrens.org or call 682-885-2247.

Secondary Claim Edits and Important Billing Information Effective September 1, 2018

Cook Children's Health Plan greatly appreciates you and your staff serving our Members' healthcare needs. We recognize that timely, accurate claim payment is a vital part of your business.

As previously communicated in June 2018, the Claim File Indicator and Coordination of Benefits (COB) claim edits will become effective for claims filed September 1, 2018 and ongoing. Claims that do not pass these edits will be rejected and returned to the provider for correction and resubmission.

Please take the time to review these edits to determine how they will impact your claims effective September 1, 2018. Should you have any questions, or if you are unsure about how these edits have affected your claims please feel free to contact your Provider Relations team at (800) 964-2247. To view the Notification click here

REMINDERS

Other Health Insurance/Coordination of Benefits Information

We have updated our Other Health Insurance (OHI) process to include a new fax number and a new email address. Notification of a change to OHI such as, termination of primary insurance, can be submitted electronically through our Secure Provider Portal, or on paper by email or fax.

To view the Other Health Insurance document click here

Long Term Services and Supports Billing

Providers submitting claims for Long Term Services and Supports (LTSS) must bill in compliance with the LTSS Billing Matrix. To view the LTSS Billing Matrix and Crosswalk on the HHS website click here

LTSS billing tips:

- Always check Member eligibility prior to providing services
- Claims must be completed in accordance with TMHP billing guidelines
- Use appropriate modifiers and procedure codes from LTSS Billing Matrix
- Use a valid ICD-10 diagnosis code
- Be sure you have an authorization to provide for the service for which you are billing
- Always use the service codes and modifiers listed on the approved authorization received from CCHP
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact our Care Management team
- Claims must be received within 95 days from the date of service
- Claims that have been rejected either by mail or electronic data interchange must be resubmitted correctly and received within the 95 day filing limit
- Claim appeals must be received within 120 days from the date of the Explanation of Payment

Filing a Complaint with Cook Children's Health Plan

Providers that wish to file a complaint about Cook Children's Health Plan or one of our Members can do so by submitting their complaint in writing. Providers may submit a written complaint as follows:

- Faxing a written complaint to: 682-885-2148
- Submitting a written complaint by email to: CCHPCompliance@cookchildrens.org
- Mailing a written complaint to:
  Cook Children's Health Plan
  Attn: Compliance
  P.O. Box 2488
  Fort Worth, TX 76113-2488
  Contact Number: 682-885-2866

If the Provider is not happy with the resolution of the complaint, they have the right to file a complaint with the Health and Human Services Commission (HHSC). When filing a complaint with Health and Human Services Commission, providers must submit a letter to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

Providers may also submit a written complaint by email to: HPM_Complaints@hhsc.state.tx.us

Filing an Appeal with Cook Children's Health Plan

Provider appeals must be submitted in writing and received by the health plan within one hundred twenty (120) calendar days of the printed disposition date on the Explanation of Payment. Providers may submit appeals online through our Provider Secure Portal at cookchp.org by selecting Claims Appeal. Supporting documentation can be uploaded using the attachment feature. Supporting documentation may include but is not limited to:

- Letter from the provider stating why they feel the claim payment is incorrect (required)
- Copy of the original claim
- Copy of the health plan explanation of payment
- Explanation of payment from another insurance company
- Prior authorization number and/or form or fax documenting the prior authorization determination
- Eligibility verification documentation
- Electronic acceptance reports confirming the claim was received by the health plan
- Overnight or certified mail receipt as proof of filing received date by the health plan

Written appeals should be mailed, faxed, or emailed to:

Cook Children's Health Plan
Attention: Appeals
P.O. Box 2488
Fort Worth, TX 76113-2488
Fax: 682-885-8404
CCHPClaimAppeals@cookchildrens.org

Note: Changes or errors in CPT codes are not considered payment appeals. Corrected claims should be resubmitted to the health plan with a notation of corrected claim.

Selecting the Most Appropriate Diagnosis Codes

Providers must remember that all diagnosis codes submitted on a claim must be appropriate for the patient's age, gender, and medical conditions as identified in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Select the code that represents your patient's condition (laterality, anatomical location, trimester, type of diabetes, established complications and comorbidities, severity, acuity, etc) in the most detailed way possible.

To avoid fraudulent billing, providers must submit the ICD codes that are most appropriate for the services provided. Recording inaccurate diagnoses for patients may compromise their quality of treatment and the historical accuracy of their medical records.

Prior Authorization for Laboratory Codes

CCHP requires prior authorization on some laboratory codes. The prior authorization request must be completed, signed and dated by the provider rendering direct care to the Member. Prior authorization requests from laboratory providers will not be processed. The requesting provider must share the authorization number with the laboratory provider submitting the claim. The requesting provider must confirm that the laboratory provider is in network with CCHP.

To facilitate a determination of medical necessity and avoid unnecessary denials, the requesting physician must provide correct and complete information, including accurate medical necessity of the services. Medical documentation that is submitted by the physician must verify the Member's diagnosis and/or family history. Requisition forms from the laboratory are not sufficient for the establishment of a Member's personal or family history.

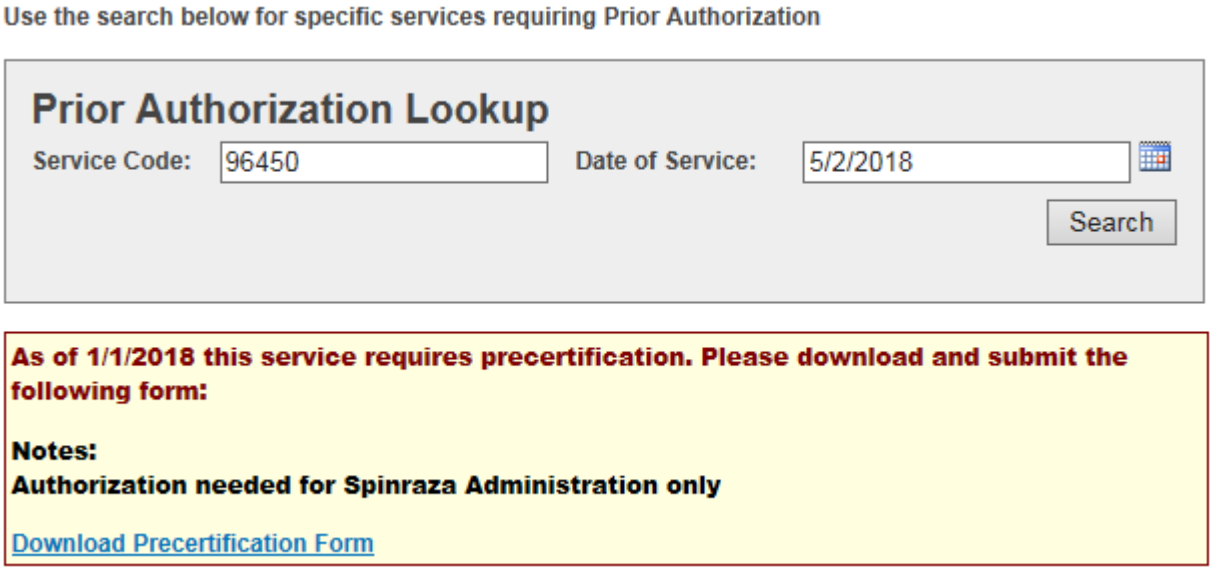
Visit our website cookchp.org and use our Prior Authorization Lookup tool to confirm if a service code requires prior authorization. Remember that prior authorization is not a guarantee of payment. Payment is subject to the Member's eligibility and benefits on the date of service.

PRIOR Authorization Lookup

Effective immediately, CCHP will no longer provide a printable version of codes that require prior authorization. Please use the Prior Authorization Lookup function located on our website under the Provider tab to confirm if a procedure code requires prior authorization. This online tool reduces the risk of outdated information being used as a resource when submitting prior authorization request.

To access the Prior Authorization Lookup tool on our website click here

In addition, if a service code has special indications, it will be detailed in Notes (see example below):



THSteps Prior Authorization Requirements for Dental Anesthesia

As a reminder, effective for dates of service on or after July 1, 2017, prior authorization is required for Level 4 deep sedation and general anesthesia provided in conjunction with therapeutic dental treatment for CCHP dental clients from ages 0 through six years.

The dentist performing the therapeutic dental service is responsible for submitting proper documentation to obtain prior authorization for both the dental therapeutic and anesthesia services. When the prior authorization is approved, the treating dentist must provide the anesthesia prior authorization information and number to the appropriate anesthesiology provider. Failure to obtain prior authorization may result in a denial of reimbursement for both services.

Anesthesia services provided by a dentist should use procedure code D9223. Any anesthesia services provided by an anesthesiologist (MD/DO) or certified nurse anesthetist (CRNA), should use procedure code 00170, with an EP modifier.

Approval of prior authorization and payment of claims for all Level 4 sedation in clients who are six years of age and younger is not granted solely based on the Criteria for Dental Therapy Under General Anesthesia Form (22 point form).

Prior authorization is required for clients who are 7 through 20 years of age and are in need of general anesthesia, but do not meet the Criteria for Dental Therapy Under General Anesthesia 22 point threshold. The dentist providing therapeutic dental services under general anesthesia is responsible for obtaining prior authorization for both services as described above.

A link to the *THSteps PA Requirements for Dental Anesthesia* in its entirety can be found at www.cookchp.org / Providers / Provider News / THSteps PA Requirements for Dental Anesthesia or by clicking here.

CookChildren's Health Plan

Physical, Occupational, and Speech Therapy Benefit Changes
Effective September 1, 2017

Effective September 1, 2017, the billing structure for Physical Therapy (PT) and Occupational Therapy (OT) individual treatment procedure codes changed for Home Health Agencies from per visit to time-based increments of 15-minute units. Time-based treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour. PT and OT time-based treatment codes are payable as 15-minute units for all provider types.

The billing structure for individual Speech Therapy (ST) treatment changed for CORF/ORF and independent therapists from timed and payable in units to payable per encounter and limited to once a day for all providers. ST individual treatment is defined per encounter for all provider types.

PT, OT and ST group treatment is payable as an untimed procedure code for all providers for PT, OT and ST. The billing structure for PT and OT group treatment changed for outpatient rehabilitation facility (ORF) and independent therapists from timed and payable in units to payable per encounter and reimbursed once per day for all providers. The billing structure for ST group treatment changed for CORF/ORF and independent therapists from timed and payable in units to payable per encounter and reimbursed once per day for all providers.

Licensed therapists and physicians must use a modifier to designate whether a treatment was delivered to the client by a licensed therapy assistant. Modifiers are required on all claims for PT. OT and ST treatment procedure codes.

For dates of service beginning September 1, 2017, providers should submit claims for services provided in appropriate amounts or units or daily encounters authorized according to the new billing structure. Benefit language in the Texas Medicaid Provider Procedures Manual (TMPPM) has been updated to clarify the changes. To view the TMPPM click here

Texas Health Steps Medical Record Documentation

This is a reminder to Texas Health Steps providers of the importance of documenting the complete Texas Health Steps checkup. Each of the six checkup components and their individual elements must be completed at the time of the checkup and documented in the medical record. The medical record must contain documentation of any screening tools used during the Texas Health Steps checkup.

For providers to be reimbursed, each of the following six checkup components and their individual elements must be completed and clearly documented in the medical record:

1. Comprehensive health and developmental history
2. Comprehensive unclothed physical examination
3. Appropriate immunizations
4. Appropriate laboratory/screening tests
5. Health education
6. Oral health referral

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. THSteps checkups are subject to retrospective review and possible recoupment if the medical record does not include all required documentation.

The Texas Health Steps checkup components are outlined in the Texas Health Steps Medical Checkups Periodicity Schedule found on the THSteps website at www.dshs.texas.gov/thsteps/providers.shtm. Details on each component are listed in the current Texas Medicaid Provider Procedures Manual, Children's Services Handbook, Section 5.3.11, Mandated Components.

Online education on checkup documentation is available within THSteps Online Provider Education modules. These modules are free and offer continuing education for healthcare professionals. Visit the Online Provider Education website at: http://www.txhealthsteps.com/

COOK CHILDREN'S HEALTH PLAN

682-885-2247 OR 800-964-2247 TOLL FREE

Hours of Operation: Monday – Friday 8 – 5

Visit our website at cookchp.org

Distribution Group	Type of Issue/Request	Email Address/Faxes
Coordination Of Benefits/Other Health Insurance	Other Health Insurance research request, notifications and Third Party Resources/Cost Avoidance Verification Reports	CCHPCOB@cookchildrens.org
Interpreter/Translations	Linguistic Services, Interpreter Requests, ISP translation Requests, Interpreter complaints	CCHPInterpreterRequest@cookchildrens.org
Customer Service	Any member demographic updates, PCP changes, ID Card requests, Value Added Services forms, legal documentation	682-885-8401, Star Kids 844-843-0004 CCHPCustomerSvc@cookchildrens.org
Member Advocates	Access to Care requests from HHSC and Maximus, complaints/appeals assistance for Members, request for member call backs from a Member Advocate	CCHPMemberAdvocate@cookchildrens.org
Claims Department	Claim Status, Payments, Appeals or Questions	CCHPClaims@cookchildrens.org CCHPClaimAppeals@cookchildrens.org
Care Management	Prior-Authorizations, Case Management, Referrals, Disease Management, Member Education Requests	682-885-8402 844-346-8402 Toll Free Fax CCHPStarKidsCoordination@cookchildrens.org 682-303-0005 STAR Kids LTSS 844-843-0005 Toll Free Fax
Compliance	Member & Provider Complaints, Fraud, Waste, and Abuse	682-303-0276 CCHPcompliance@cookchildrens.org
Network Development	Credentialing, Contracting, Demographic Changes, NPI/TPI updates, Billing Updates	682-885-8403 CCHPNetworkDev@cookchildrens.org
Finance	Electronic Fun Transfer, Electronic Remittance Advice	CCHPFinance@cookchildrens.org
Quality	Quality of Care Concerns, HEDIS, Access and Availability	CCHPQualityImprovement@cookchildrens.org
Provider Relations	Provider Education and Training	682-885-8436 CCHPProviderRelations@cookchildrens.org

Department	Phone Number	Fax Number	Services Provided
National Vision Administrators (NVA)	888-830-5630 providers@e-nva.com	888-830-5560	Vision Services
Beacon Health Services	855-481-7045 Provider.Relations@beaconhs.com	855-371-9227	Mental Health Services
Navitus Pharmacy	866-333-2757 providerrelations@navitus.com 877-908-6023 (toll Free)	866-808-4649	Provider Relations/Contracts Texas Provider Hotline

Availity 800-282-4548

CHIP Payor ID
CCHP1

STAR/STAR Kids Payor ID
CCHP9

Paper Claims Address:
Cook Children's Health Plan
P. O. Box 961295
Fort Worth, TX 76161-1295

Appeals, COB and General Mailing Address:
Cook Children's Health Plan
P. O. Box 2488
Fort Worth, TX 76113-2488