Winter

Cook Children's Health Plan

Provider Newsletter

January 2018

What's inside

Long Acting Reversible Contraception

Long Acting Reversible Contraception

Background

On October 13, 2015, HHSC issued operational guidance to Medicaid managed care organizations (MCOs) to implement changes in order to reimburse hospitals and federally qualified health centers (FQHCs) appropriately for providing Medicaid covered long acting reversible contraception (LARC) devices in the same amount, duration, and scope as the Medicaid benefit requires, including, adopting claim processing procedures to implement add -on FQHC reimbursement for LARC devices and hospital reimbursement for immediate postpartum LARC devices.

Operational Guidance

Effective January 1, 2016, Texas Medicaid benefit changes related to LARC were applied to support the 2016 annual Healthcare Common Procedure Coding System (HCPCS) updates effective for dates of service on or after January 1, 2016. The added 2016 HCPCS procedure codes, J7297 and J7298, may be billed beginning January 1, 2016.

Procedure code J7302 was discontinued on December 31, 2015 and will no longer be reimbursed.

Procedure codes J7297 and J7298 will not require a rate hearing for pricing. Proposed reimbursement rate changes for LARC devices were presented at a public rate hearing on November 12, 2015 for procedure codes J7302 and J7302 with modifier U1. Procedure codes J7297 and J7298 will replace procedure codes J7302 and J7302 with modifier U1. The new rates will be effective for dates of services on or after January 1, 2016.

Medicaid MCOs must update claim processing procedures to include these procedure code changes.

TMHP Bulletins related to LARC

TMHP has posted the following provider notifications related to changes to LARC reimbursement:

- Reimbursement Methodology to Change for Long- Acting Reversible Contraception (LARC) Devices Effective January 1, 2016
- Reimbursement Rate Changes for Some Procedure Codes to Be Effective November 1, 2015 and January 1, 2016 for Texas Medicaid.

The Texas LARC Toolkit

PROVIDER CLAIM APPEAL REMINDER

Providers may submit appeals online through our Provider Secure Portal at www.cookchp.org and by selecting provider appeal. Supporting documentation can be uploaded using the attachment feature. Provider may also submit appeals in writing and must be received by the health plan within one hundred twenty (120) calendar days of the printed disposition date on the Explanation of Payment with all supporting documentation. Written appeals should be mailed or faxed to:

Cook Children's Health Plan
Attention: Appeals
PO Box 2488
Fort Worth, TX 76113-2488
CCHPClaimAppeals@cookchildrens.org

Fax: 682-885-8401
Phone: 682-885-2247 or Toll Free: 800-964-2247

Important Reminder
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.

BILLING AND RENDERING PROVIDER REQUIREMENTS

Cook Children's Health Plan is taking steps to improve the speed and accuracy in processing paper claims. We highly encourage *electronic claim submissions.* If you find that you can only submit a claim on paper, please follow these tips:

- Print claim data within defined boxes on the claim form
- Handwritten claim forms cannot be accepted and will be returned
- Use all capital letters
- Print using 10-pitch Pica type (12-point) Courier font. Do not use fonts smaller or larger than 12 points. Do not use proportional fonts, such as Arial or Times Roman
- Do not use dashes or slashes in date fields
- Use paper clips on claims or appeals if they include attachments. Do not use glue, tape, or staples
- Place the claim form on top when sending new claims followed by any medical records or other attachments
- Number the pages when sending attachments or multiple claims for the same Member (e.g., 1 of 2, 2 of 2)
- Do not total the billed amount on each claim form when submitting multi-page claims for the same Member
- Do not fold claim forms

Completion of the CMS 1500 also requires the following provider information:

- ZZ ID Qualifier (24I shaded)
- Rendering Provider NPI (24J unshaded)
- Rendering Provider Taxonomy Code (24J shaded)
- Billing Provider NPI (33a unshaded)
- ZZ ID Qualifier and Billing Provider Taxonomy Code (33b shaded)
- If applicable, Referring, Ordering or Supervising Provider Name and NPI (17a & 17b)
    - If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19
    - The following qualifiers must be used:
        - DN = Referring Provider
        - DK = Ordering Provider
        - DQ = Supervising Provider
- If you do not have an NPI, place your Atypical Provider ID (API)/LTSS# in Box 33b

Helpful sites NUCC Uniform Claim Committee TMPPM 6.5.4CMS-1500 Instruction Table Submission of Clean Claims

PN-2-2017

TELEMEDICINE AND TELEHEALTH SERVICES

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL
TELECOMMUNICATION SERVICES HANDBOOK
TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2 DECEMBER 2017

Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:

- Client assessment by a health professional
- Diagnosis, consultation, or treatment by a physician
- Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health-care services or medical specialty expertise

Telehealth is defined as health services other than telemedicine that:

- Are delivered by licensed or certified health professionals who are acting within the scope of their license or certification.
- Require the use of advanced telecommunications technology other than telephone or facsimile technology including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health care services or medical specialty expertise.

Before receiving a telehealth service, the client must receive an initial evaluation for the same diagnosis or condition by a physician or other qualified health-care professional licensed in Texas. A required initial evaluation must be performed in-person or as a telemedicine visit that conforms to Title 22 Texas Administrative Code (TAC) 174 (relating to Telemedicine). If the client is receiving the telehealth services to treat a mental health diagnosis or condition, the client is not required to receive an initial evaluation by a physician or other qualified health-care professional licensed in Texas.

A client receiving telehealth services must be evaluated at least annually by a physician or other healthcare professional that is licensed in Texas and qualified to determine if the client has a continued need for services. The evaluation must be performed in person or as a telemedicine visit that conforms to 22 TAC 174. This evaluation requirement does not apply to a patient receiving telehealth services for the treatment of a mental health diagnosis or condition from a qualified behavioral health provider licensed in Texas.

Telehealth services are reimbursed in accordance with 1 TAC Chapter 355.
Written policies and procedures must be maintained and evaluated at least annually by both the distant site provider and the patient-site presenter and must address all of the following:

- Client privacy to assure confidentiality and integrity of client telehealth services
- Archival and retrieval of client service records
- Quality oversight mechanisms

Access and Availability

Uniform Managed Care Terms & Conditions

CCHP is committed to making sure our Members are able to get the care they need (access) within reasonable timeframes (availability) see 8.1.3.1 of the Uniform Managed Care Contract. HHSC requires network providers to offer our Members access to covered services 24 hours a day, 7 days a week. In order to ensure our Primary Care Providers and Specialty Care Providers are meeting these standards, the Quality Department calls all of our network providers on an annual basis during and after regular business hours. PCP surveys will be fielded in September, October and November. If issues are identified providers will be mailed a letter via certified mail with a list of deficiencies.

- The MCO (CCHP) must provide coverage for Emergency Services to Members 24 hours a day and seven (7) days a week without regard to prior authorization or the Emergency Service provider's contractual relationship with the MCO.
- The MCO (CCHP) must require, and make best efforts to ensure, that PCPs are accessible to STAR, STAR Kids, CHIP, and CHIP Perinate Newborn Members 24 hours a day, seven (7) days a week and that Network Primary Care Providers (PCPs) have after-hours telephone availability consistent with Section 8.1.4.
- The MCO (CCHP) must ensure that Network Providers offer office hours to Members that are at least equal to those offered to the MCO's commercial lines of business or Medicaid fee-for-service participants if the provider accepts only Medicaid patients.

For more information on Access and Availability please click Here.

HEDIS

What is HEDIS?

Healthcare Effectiveness Data and Information Set (HEDIS) is a performance measurement tool that is coordinated and administered by the NCQA (National Committee for Quality Assurance). It is used by more than 90% of America's Health Plans. NCQA has a set deadline of May 9th for health plans to gather HEDIS data. HEDIS data is always collected for activities performed during the previous calendar year. For example, HEDIS 2018 covers care provided during calendar year 2017. Results are used to measure performance, identify quality initiatives, and provide educational programs for providers and members. HEDIS measure requirements and calendar due dates can change on an annual basis.

How is HEDIS data used?

- HEDIS data is used to measure the Quality of care received by health plan members
- HEDIS consists of 81 measures across 5 domains of care
- Some measures are considered "accreditation" measures and a plan seeking NCQA accreditation is scored on their performance for those measures
- HHSC uses some of the HEDIS measures to evaluate each health plan's performance against a set of '*At Risk Performance Measures and Quality Challenge Measures'.* Health plans may be subject to performance based penalties or incentives each year.
    - HHSC contracts with an external quality review organization (EQRO) to develop Quality of Care Reports that benchmark the performance for each health plan in Texas.
- Some health plans may collect their own HEDIS data (medical records) for NCQA Accreditation or for a more comprehensive annual assessment of their plan results to submit to the EQRO organization.

HEDIS CONTINUED

Your role in HEDIS

As a Provider, you play a central role in promoting the health of our members. You and your office staff can help facilitate the HEDIS process by:

1. Providing the appropriate care within the designated timeframes
2. Accurately documenting all care in the patient's medical record
3. Accurately coding all claims and submitting them in a timely manner
4. And lastly, by responding to our requests for medical records within 14 business days

HEDIS is reported collectively for each plan; not by provider or member. **Your cooperation and timeliness in providing the requested medical record information is greatly appreciated!**

Cook Children's will be collecting medical records for the following HEDIS measures this year:

HEDIS Measure	Description	Key Information Needed
Well-Child Visits in the First 15 Months of Life (W15)	This measure is looking for at least 6 visits with a PCP between 0 and 15 months of age. Records needed from birth to 12/31/2017.	• A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance • Growth charts • Include all visits (sick and well-child) that occurred during the year.
Childhood Immunization Status (CIS)	This measure is looking for all immunizations to be completed by 2 years of age. Records needed include calendar year 2016 and 2017.	• A note indicating the specific antigen name and the immunization date. • If vaccine is not given, document history of specific disease, anaphylactic reaction or contraindication for specific vaccine. • A note saying "Immunizations are up to date" does not count.
Controlling High Blood Pressure (CBP) (ages 18 to 65)	This measure is looking for adequate Blood Pressure control	• Blood pressure control, BP less than 140 systolic and less than 90 diastolic. • Documented diagnosis of hypertension.
Comprehensive Diabetes Care (CDC) (ages 18-to 75)	This measure focuses on the type of clinical care provided to diabetic members between the ages of 18-75.	• Hemoglobin A1c testing and control • Blood pressure control, a BP less than 140 systolic and less than 90 diastolic. • Medical attention for nephropathy. • Retinal eye exam.
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	This measure is looking for a visit to a PCP between 1/1/2017 and 12/31/2017.	• A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance • Growth charts • Include all visits (sick and well-child) that occurred during the year.
Adolescent Well-Care Visits (AWC) (ages 12 to 21)	This measure is looking for a visit to a PCP or OB/GYN between 1/1/2017 and 12/31/2017	• A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory (includes tobacco use, drugs& alcohol use, sexual activity, guidance)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	This measure is inclusive to patients 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year	• Height, Weight and BMI percentile • Discussion on diet and nutrition • Discussion on current physical activities.
Prenatal and Postpartum Care (PPC)	Female members who delivered a live birth between November 6, 2016 and November 5, 2017.	Documentation must include: • Prenatal care visit within the first trimester or within 42 days of enrollment. • Post-partum care visit within 21 to 56 days after delivery.

COOK CHILDREN'S HEALTH PLAN MAIN NUMBER:

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

Hours of Operation: Monday – Friday 8:00am – 5:00pm
Visit our website at www.cookchp.org

Department	Fax Number	Service Provided
Member Services	682-885-8401 STAR Kids 844-843-0004 cchpmemberservices@cookchildrens.org	Eligibility, Benefits, or General Inquiries
Claims Department	682-885-8404 CCHPClaimAppeals@cookchildrens.org CCHPClaims@cookchildrens.org	Claims Status, Payments, Appeals or Questions
Care Management	682-885-8402 844-346-8402 Toll Free Fax CCHPStarKidsServiceCoordination@cookchildrens.org 682-303-0005 STAR Kids LTSS 844-843-0005 Toll Free Fax	Prior-Authorizations, Case Management, Referrals, Disease Management, Member Education Requests
Compliance	682-303-0276 CCHPCompliance@cookchildrens.org	Member & Provider Complaints, Fraud, Waste, and Abuse
Network Development	682-885-8403 CCHPNetworkDev@cookchildrens.org	Credentialing, Contracting, Demographic Changes, NPI/TPI update, Billing Updates
Finance	CCHPFinance@cookchildrens.org	Electronic Fund Transfer, Electronic Remittance Advice
Quality	CCHPQualityImprovement@cookchildrens.org	Quality of care concerns, HEDIS, Access and Availability
Provider Relations	682-885-8436 CCHPProviderRelations@cookchildrens.org	Provider Education & Training

Department	Phone Number	Fax Number	Service Provided
National Vision Administrators (NVA)	888-830-5630 providers@e-nva.com	888-830-5560	Vision Services
Beacon Health Services	855-481-7045 ProviderRelations@beaconhs.com	855-371-9227	Mental Health Services

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

CHIP Payor ID
CCHP1

STAR/STAR Kids Payor ID
CCHP9

AVAILITY 1-800 282-4548