Cook Children's Health Plan

Comments or suggestions may be emailed to:
Network Development
CCHPNetworkDev@cookchildrens.org
or call 682-885-2247

February 2013

PROVIDER NEWSLETTER

COOK CHILDREN'S HEALTH PLAN MEMBERSHIP:

Cook Children's Health Plan membership as of January 1, 2013 is **108,619**. We now cover **72,762** Medicaid STAR members and **35,857** CHIP members. We appreciate your continued support.

THSTEPS TRAINING

As part of CCHP's effort to keep you and your members informed on the importance of Texas Health Steps, CCHP wanted to remind you of the on-line courses provided by the Department of State Health Services (DSHS). The training consists of a number of self-paced, web-based modules on a variety of important topics. Continuing Education (CE) credit can be awarded to eligible participants after the successful completion of each module. Courses are designed to enhance your ability to provide preventive health and other services to Medicaid-eligible children and youth. The Web site address is: www.txhealthsteps.com

FRAUD, WASTE & ABUSE PROGRAM

Cook Children's Health Plan (CCHP) is required by the Texas HHSC Office of Inspector General to implement a Fraud, Waste and Abuse Program. This program analyzes provider billings and payments to ensure compliance with the State Medicaid policy. CCHP has partnered with Health Management Solutions (HMS) to oversee the claims data review. HMS randomly selects claims by specific provider type and compares utilization of services and billing patterns, billing errors, adjudication errors, benefit coverage, NCCI edit reviews and potential waste, abuse or fraudulent behavior.

When a provider's claims data is randomly audited, HMS will send CCHP a claims analysis for the past three years of a provider's claims history. CCHP will review the analysis and may send the provider a letter educating them on the areas that have been identified by HMS. If CCHP identifies claim overpayments during the claims analysis, CCHP is required to recoup the identified overpayments. The education letter sent to the provider will include the overpayment amount, if applicable, and request recoupment. Providers are given 45 days to respond to the request for recoupment. If no response is received, the overpayments will be automatically recouped from future claims.

Dental Surgery

We have recently received an increasing number of claims from Anesthesiologist who are billing for a history and physical examination prior to providing anesthesia for the surgery. Although it is appropriate for an Anesthesiologists to perform and bill for an E/M history and physical code prior to the provision of anesthesia services for the dental procedure, our claims' system, as with most payers is set up to automatically deny claims for an E&M service on the same date of service as an anesthesia procedure claim. For continuity of care purposes, and in support of the Medical Home, the history and physical should be performed by the member's primary care physician (PCP) prior to being referred for dental surgery as the provider most knowledgeable with the patient's past medical and medication history.

IMMUNIZATION-RELATED REQUIREMENTS REGARDING VACCINE BENEFIT & CLAIMS FILING PROCEDURES

Per 8.1.24 of the Uniform Managed Care Contract related to immunizations

- Providers are expected to follow the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac), to include parental consent on the Vaccine Information Statement.

- Providers are expected to follow the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule.
    - CHIP providers need to follow the AAP Periodicity Schedule for CHIP Members

- If enrolled as a Texas Vaccines for Children (TVFC) provider, a CHIP provider serving CHIP-enrolled patients age 18 and under can order and utilize TVFC immunization doses at no charge to the provider. The vaccine supply is provided by the Department of State Health Services, and the administration of the vaccine should be billed to the MCO.

  Please note: Providers need to indicate the vaccine administration AND the vaccine itself on the claim form. Providers should understand that they will not be reimbursed for the vaccine, but it must appear on the claim. MCO's should also urge the importance of entering the immunization into ImmTrac.

For information on TVHC enrollment and ordering supplies go to: https://www/dshs.state.tx.us/immunization/toolkit/kit1.shtm, or call the Immunization Branch at (512) 776-3711; TVFC Provider Enrollment Fax: (512) 776-7743

In addition, HHSC has received the following questions regarding vaccines for the CHIP perinatal clients (Mother/Perinate). HHSC wants to make sure that all CHIP Perinate Plans are aware of the benefit and that their providers are following the appropriate protocol for administration of the vaccine and for reimbursement.

1. Are vaccines for the mother/Perinate (such as TDAP and flu) a covered benefit under CHIP Perinatal?

   Yes, vaccines (such as TDAP and flu) are covered benefits of CHIP Perinatal

2. Are vaccine costs built into the CHIP Perinatal premium?

   Yes, costs for the vaccine serum and injection procedure are built into the CHIP Perinatal premium. CHIP Perinate providers should file a claim with the client's CHIP Perinatal health plan in order to receive reimbursement for the vaccine and injection

3. Are CHIP Perinatal members prohibited from receiving vaccines from Adult Safety Net (ASN) or Texas Vaccine for Children (TVFC) because they should be receiving vaccines through their CHIP Perinatal Plan?

   CHIP Perinatal members (above age 18) are prohibited from receiving vaccines from ASN and TVFC. CHIP Perinatal clients are considered to have health insurance coverage, and therefore are not eligible for the ASN. Likewise, CHIP Perinatal clients over age 18 do not meet the age requirements for TVFC.

PCP RATE INCREASE

Primary Care Provider Rate Increase Delayed

Texas will be increasing Medicaid primary care rates, including those for certain physical visits and vaccine administration, as quickly as possible. However, the State did not receive final federal regulations on the rate increase until November 1, 2012. This was too late to allow the state to meet the January 1, 2013 implementation date authorized in the Affordable Care Act. Once the State increases primary care rates, we will make retroactive payments for the increase for providers and services that qualify under the federal regulations. The State is working with the U.S. Centers for Medicare and Medicaid Services to obtain federal approval for the State's plan to increase primary care rates. We will continue to keep providers informed of the process and timeline.

General Overview:

Pursuant to Section 1202 of the Affordable Care Act (ACA), states must reimburse specific procedure codes and providers at the Medicare reimbursement rate in calendar years 2013 and 2014 for services provided in Medicaid Fee-For-Service and Managed Care. The purpose of this letter is to inform you on some of the requirements and information we currently are aware of.

Requirements:

- The Primary Care Provider (PCP) Rate Increase is effective for claims submitted to the Managed Care Organizations (MCO's) with a date of services beginning on January 1, 2013, and ending on December 31, 2014

- HHSC will publish a fee schedule for the Medicaid rate increase annually. This fee schedule is an exception fee schedule for Qualified services and will apply to those Primary Care Physicians identified to receive the increased rate. This schedule is not considered to be the current Medicaid fee schedule and **does not apply to the CHIP Program**

- Non-physician practitioners rendering services under the direct supervision of a provider who is eligible for the rate increase will be eligible for the increased reimbursement for the designated services

- HHSC will provide the MCO's a listing of providers who are eligible for the increased reimbursement. The provider must be on this listing in order to be eligible for the increased reimbursement

- Please be aware, final rates for the increase may not be available on January 1, 2013. There is no need for them to take any action regarding these payment corrections; they will be processed automatically as we receive the data.

The following procedure codes are subject to the rate increase:

Evaluation and Management	99201 - 99499
Vaccine Administration Codes	90460, 90461, 90471, 90472, 90473, and 90474
Non Medicare covered services included in the rate increase	
Initial Preventive Services	99381 - 99387
Established Preventive Services	99391 - 99397
Risk Factor and BH Counseling	99401 – 99404; 99404, 99408, 99411, 99412, 99420 and 99429
Non face-to-face services	99441 - 99444

ED Utilization Reduction Process Improvement Program

The state of Texas Health and Human Services commission requires each Medicaid Managed Care Health Plan to participate in the Process Improvement Program (PIP). The PIP's should be concentrated around specific areas to improve outcomes and improve the health of the plan's members. One of the PIP's Cook Children's Health Plan (CCHP) will be involved with for calendar year 2013 is to reduce the utilization of the Emergency Department (ED) for Potentially Preventable Visit (PPV), which would typically be handled by the Primary Care Physician's (PCP) office. We will be reviewing 56 different PPV diagnoses.

As part of this year's PIP process, we have partnered with Cook Children's Medical Center Emergency Department (CCMC). CCMC will provide us with a listing of CCHP members who visited the ED for ACSC's the prior day. Our Care Management department will review the listing and contact members to evaluate their needs and assist with care coordination. This follow up may include encouraging or assisting members with scheduling a PCP appointment. Members who have established a medical home with their PCP usually seek care for routine needs through their PCP instead of the ED. We will keep your office informed of special situations as we become aware of them.

In addition, CCHP will be running a listing each month of the claims paid for the prior month and a rolling 12 months ED visits. We will provide you with a summary of your members who visited CCMC's ED for your information. We will note those members which may have multiple visits during a specific month and over the past 12 months. We understand not all ED visits are avoidable, but there are situations where the services could have been provided by the PCP. The intent of the information is to serve you with a possible opportunity to establishing a relationship with this member.

If you have any questions or concerns with this information please feel free to contact us.

The Texas Health Steps Program (THSteps)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service (medical, dental, and case management) for children from birth through 20 years of age. In Texas, EPSDT is known as the Texas Health Steps (THSteps) Program. Below are some important reminders for providers and resources that may be helpful for your patients:

- Ensure all age appropriate STAR members receive their THSteps check-ups (well child exam) within 90 days of enrollment
- Identify children of Migrant Farm Workers and assist in getting them accelerated services
- The Medical Transportation Program (MTP) provides transportation to appointments for covered medical and dental services. MTP can reimburse gas money if the client has an automobile but no funds for gas. Call MTP toll free at 1-877-MEDTRIP (1-877-633-8747) 8-5, Monday through Friday for further assistance.
- Pharmacies may provide a 72-hour emergency supply of medication when a prescription is denied because lack of prior authorization and the prescriber cannot be reached.
- Case Management for Children and Pregnant Women is for those who have health problems, or are at high risk to have health problems, meet eligibility requirements, have an unmet need, and want case management services. This is a State service that provides:
    - ✓ Access to medical or dental services
    - ✓ Access to medical supplies or equipment
    - ✓ Work on school or education issues
    - ✓ Access to other services

Referrals can be made through 877-THSteps (877-847-8377) or for a list of providers go to:
http://www.dshs.state.tx.us/caseman

WHAT IS HEDIS?

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that members have the information they need to reliably compare the performance of healthcare plans. The performance measures in HEDIS are related to many significant public health issues such as asthma and diabetes. HEDIS also includes a standardized survey of members' experiences that evaluates plan performance in areas such as customer services, access to care and claims processing. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA).

Annually, Managed Care Organizations (MCO's)/Health Plans (HP's) collect and report on select measures to demonstrate their individual plan's performance to the State of Texas. Historically, these select measures monitored the internal HP functions.

For 2013, the At-Risk Premium Program has undergone significant changes by the State which include:

- Premium "at-risk" increased from 1% to 5% at stake
- HP performance is now evaluated by its performance on select HEDIS measures
- Beginning in 2013, the Quality Challenge Program will distribute a portion of the recouped 5% dollars to the HPs performing highest on a predetermined set of HEDIS and AHRQ measures, which differ from those in the At-Risk Premium Program

Listed below are the items that will be measured for 5% At-Risk and Quality Challenge:

5% At-Risk

1. Childhood Immunization Status
2. Well Child Visits in the third, fourth, fifth and sixth years of life
3. Adolescent Well-Care Visits
4. Prenatal and Postpartum Care
5. Use of Appropriate Medications for People with Asthma

Quality Challenge

1. Appropriate testing for children with Pharyngitis
2. Weight assessment and counseling for nutrition and physical activity for children/adolescents
3. Follow-up care for children prescribed ADHD medication

The Quality Improvement Department and Provider Relations will work with your offices to help you better understand how these measures affect you.

IMPORTANT PHONE NUMBERS:

Cook Children's Health Plan	8 a.m. – 5 p.m., Monday – Friday
Member services	800-964-2247 or 682-885-2247 www.cookchp.org 682-885-2148 fax
Care management	800-862-2247 or 682-885-2247 www.cookchp.org 682-885-8402 fax
Mental Health Services -LifeSynch	866-331-1577
Vision Services – OptiCare	800-465-6853
Network Development/Provider Relations	682-885-2247 or CCHPNetworkDev@cookchildrens.org