Volume I, 2015

Cook Children's Health Plan

COOK CHILDREN'S HEALTH PLAN MEMBERSHIP:
JANUARY 2015
CHIP: 20,240 STAR: 97,836

What's inside

REMINDER: PROVIDERS MUST ADHERE TO NCCI GUIDELINES WHEN SUBMITTING CLAIMS

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted on or after October 1, 2010, must be filed in accordance with the National Correct Coding Initiative (NCCI) guidelines.

NCCI was developed by the Centers for Medicare & Medicaid Services (CMS) to promote the correct coding of health care services by providers, and it consists of pairs of procedure codes that should not be reported together. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.

The guidelines can be found in the NCCI Policy and Medicare Claims Processing Manuals, which are available on the CMS website at: www.cms.hhs.gov/NationalCorrectCodinitEd.

For more information, call the TMHP Contact Center at (800) 925-9126 or the TMHP-SCHCN Services Program Contact Center at (800) 568-2413.

MEDICAL RECORD REQUEST

Cook Children's Health Plan "CCHP" is a Medicaid and CHIP managed care organization that contracts with the Texas Health and Human Services Commission "THHSC" to provide services to beneficiaries of these programs. The contract requires CCHP to monitor service patterns for providers and beneficiaries using nationally recognized guidelines and standards for like providers. CCHP contracts with a third party vendor to analyze CCHP's claims data and to compare it to providers in like specialties. This analysis allows CCHP to determine areas where additional education or assistance may be needed.

Per Chapter 1.4.10 of the Texas Medicaid Provider Procedures Manual, General Medical Record Documentation Requirements, recoupment of overpayments when the medical record documentation does not support the level of service billed is permitted. This chapter also states that retrospective reviews of medical records can be performed on all providers and any mandatory requirement not present in the medical record subjects the associated services to recoupment.

UPDATE TO TEXAS SUPPLEMENTAL NDC FILE

Note: This article applies to claims submitted to TMHP for processing.

The Texas Supplemental National Drug Code (NDC) file has been updated with the procedure code/NDC pairs in the table below. Claims submitted with these procedure code/NDC pairs and dates of service on or after the indicated dates may have been denied in error by Texas Medicaid. Affected claims will be reprocessed and providers may receive additional payment, which will be reflected on Remittance and Status (R&S) Reports.

The procedure codes/NDC pairs in the following table were added to the Texas Supplemental NDC file on October 30, 2014:

Procedure Code	NDCs	Effective Date
J9045	63323-0172-05	May 9, 2006
J2405	00143-9890-01	December 28, 2006
J2405	00781-3010-95	December 4, 2008
J2405	76045-0103-20	August 27, 2013
J3490	00781-3003-95	October 3, 2005
J7307	00052-4330-01	April 8, 2014

For more information, call the TMHP Contact Center at 1-800-925-9126.

FOLLOW-UP TO 'GYNECOLOGICAL AND REPRODUCTIVE HEALTH BENEFITS TO CHANGE FOR TEXAS MEDICAID'

Note: This article applies to claims submitted to TMHP for processing.

This is a follow-up to an article titled "Gynecological and Reproductive Health Benefits to Change for Texas Medicaid," which was posted on the TMHP website on November 14, 2014. Additional information is available about the new Texas Medicaid – Title XIX Acknowledgment of Hysterectomy Information form.

There will be a grace period for the new Texas Medicaid – Title XIX Acknowledgment of Hysterectomy Information form that becomes effective on January 1, 2015. During the grace period, acknowledgments that are signed by the client before April 1, 2015, using the older version of the form, will be accepted.

Acknowledgments that are signed by the client on or after April 1, 2015, must be on the new Texas Medicaid – Title XIX Acknowledgment of Hysterectomy Information form.

For more information, call the TMHP Contact Center at 1-800-925-9126.

PRIOR AUTHORIZATION REQUIREMENTS CHANGING 04/01/2015

CCHP is updating the prior authorization list to reflect changes in CPT and HCPCS codes. A copy of the new prior authorization code and requirements listing will be sent to providers no later than 03/01/2015. The PA list can also be found on the CCHP website at www.cookchp.com.

Please note one change - CCHP will require authorization for all therapy provided as outpatient or in the home – for evaluations and therapy services (physical, occupational and speech.)

Authorization requirements do NOT apply to Early Childhood Intervention (ECI) services appropriately billed by ECI providers. For members receiving ECI services we request that, when possible, a copy of the Individual Family Service Plan is faxed to Care Management.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS) MEASURES

Quality improvement, performance assessment, and transparency in reporting have become key expectations for all participants involved in the health care continuum. Health plans, physicians, hospitals, and other health facilities are all linked by activities designed not only to measure, but to improve, health outcomes and to facilitate more informed patient/consumer decisions.

Health plans are evaluated on many metrics, but the most widely utilized measurement criteria is that developed by the National Committee for Quality Assurance (NCQA). This specialized measurement system is known as the Healthcare Effectiveness Data and Information Set (HEDIS), which includes measures of clinical quality quantified using both data from claims and medical record reviews.

Texas Health and Human Services Commission (HHSC) has requested that we collect medical records for the following HEDIS measures:

- Adolescent Well Care Visits
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Prenatal and Postpartum Care

In the coming weeks and months, you may receive a request from us for medical records validating services that occurred in calendar year 2014. We may also request medical records for prenatal or postpartum visits that occurred in calendar year 2013. We appreciate your assistance in providing timely access to the medical information as requested and are willing to support you in delivering the medical records in whatever way necessary (e.g. scheduling a time for us to retrieve your records in person).

The Cook Children's Health Plan staff members conducting the medical record requests and reviews are licensed clinicians and are familiar with clinical practices and have received specialized training in maintaining protected health information. All of our data transmission sources, barring postal mail, are HIPAA-compliant.

Your prompt response will ensure that we accurately represent the high quality of care that you provide to our Members. We greatly appreciate your cooperation and facilitation of this important initiative. If you have questions or concerns, please contact Crystal O'Reilly, Director of Quality Improvement, at Crystal.OReilly@cookchildrens.org or 682-885-1410.

CLEAN CLAIM REQUIREMENTS

A "clean" claim is one that contains all necessary information to adjudicate the claim and does not require any external development or research prior to payment. Clean claims must be filed during the appropriate filing period. Claims must be received by CCHP within 95 days from each service date.

CCHP requires claims submitted to meet the criteria of a clean claim, with all elements included in the submission. Any claim not containing the required elements may be returned without consideration.

Example: If the age and gender submitted on the claim does not match the information in our system, the claim will be denied.

If you would like to know more information on the elements of a clean claim please visit our website at www.cookchp.com, click on the Providers tab in the gold bar and select Manuals. You will have the option to view the Cook Children's Provider Manuals for Chip and Star.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
BALANCE BILLING

Balance billing is the practice of charging managed care plan members for costs of covered services that are in excess of authorized cost-sharing and program reimbursement rates. The existing HHSC rule prohibits providers from balance billing CHIP members

In August 2013, the federal Centers for Medicare and Medicaid Services (CMS) clarified that the practice of balance billing CHIP members by out-of-network providers is impermissible under federal law. The rule amendments clarify current policy by aligning the rules with current federal law. HHSC amends the balance billing rules to clarify that balance billing is prohibited by any network or non-network provider who provides covered medical or dental services to a CHIP member.

The amendments are intended to prevent the unauthorized billing of CHIP members and their families for covered services. As a result, the amendment will help ensure that CHIP remains affordable for families

Please Note: Cook Children's Health Plan will adhere to HHSC's directive.

For additional information, please reference Chapter 370 of the State Children's Health Insurance Program.

MEDICAID PROVIDER NOTIFICATION:
STATEWIDE IMPLEMENTATION OF
ELECTRONIC VISIT VERIFICATION (EVV) INITIATIVE

All agencies providing services subject to EVV that have not selected an EVV vendor by close of business on February 10, 2015 will be assigned to one of the four HHSC approved EVV vendors for the provision of EVV services. This assignment will be by default.

Provider agencies assigned an EVV vendor by HHSC by default will receive notification from HHSC prior to the March 1, 2015 implementation date. The notification will include contact information for the EVV vendor to which the provider agency has been assigned. HHSC also will notify each of the four EVV vendors. This notification will include a list of provider agency assignments.

COVERED SERVICES

The following services are subject to EVV requirements for attendant services beginning March 1, 2015 and for private duty nursing (PDN) services beginning June 1, 2015:

Services	Description
Managed Care	Personal assistance services (PAS), personal care services (PCS) and private duty nursing (PDN) services provided in the home and in the community in the managed care STAR+PLUS and STAR health programs

TRAINING INFORMATION

HHSC, in coordination with Medicaid MCOs, THMHP, EVV vendors, and DADS, will be conducting provider education and training on the operational requirements and the use of EVV. Provider agencies should monitor MCO, TMHP, HHSC and DADS websites for additional information regarding EVV implementation.

Provider agencies are encouraged to sign-up for email updates at:
https://public.govdeliver.com/accounts/TXHHSC/subscriber/new

Questions about EVV implementation or the Medicaid Electronic Visit Verification Provider System Selection Form may be sent to: Managed_Care_Initiatives@hhsc.state.tx.us

MODIFIER 59

The CPT Manual defines modifier 59 as follows:

"Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedure/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Effective January 1, 2015 Modifiers XE, XS, XP and XU were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

XE – "Separate encounter, a service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service.
XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"
XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"
XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

FLU PREVENTION INFORMATION

The 2013/2014 Flu season is upon us, and Cook Children's Health Plan would like to thank you for taking care of our members.

Vaccines that are available through Texas Vaccines for Children (TVFC) will not be reimbursed by Texas Medicaid for clients who are 18 years or age and younger. Provider may bill the vaccine for $.01 so that the claim can be processed but may not otherwise charge Medicaid for the vaccine obtained from TVFC.

The administration fee may be reimbursed through Texas Medicaid if the claim includes the appropriate vaccine procedure code and the specific diagnosis code of the condition necessitating the vaccine. Diagnosis code V202 may be used unless there is a more specific diagnosis code.

A provider will be paid for use of private stock when TVFC posts a message on its website that no stock is currently available. In that case, the Medicaid claim should include modifier U1, which indicates private stock.

Texas Health Steps (THSteps) providers are encouraged to provide influenza vaccinations to clients during their periodic THSteps medical checkups, or anytime during flu season. Although THSteps providers may not bill for vaccine administration procedure codes (90465, 90466, 90471, or 90472) using the THSteps provider number, they may file claims for vaccine administration using their Acute Medicaid provider identifiers.

Providers must not charge Medicaid clients for any out-of-pocket costs, including administration or vaccine fees

BEACON HEALTH SERVICES

Cook Children's Health Plan (CCHP) transitioned to Beacon Health Services as our behavioral health care network provider as of October 1, 2013. CCHP members will have received new identification cards listing Beacon Health Services as their behavioral health care network provider, including the direct number they can call for services.

Beacon Health Services will utilize one number for both the CHIP and STAR program. The number is:

CHIP Beacon phone number: (855) 481-7045
STAR Beacon phone number: (855) 481-7045

Providers may contact Beacon directly at (855) 481-7045 for further information.

NATIONAL VISION ADMINISTRATORS (NVA)

Cook Children's Health Plan (CCHP) transitioned from OptiCare to National Vision Administrators (NVA) as our vision network provider effective December 1, 2013.

If you have any specific questions, please feel free to contact CCHP or NVA at the following numbers:

CCHP: (800) 964-2247 or (682) 885-2247
NVA - Provider Relations: (888) 682-2020 or providers@e-nva.com

QUICK NOTES AND UPDATES

- The only claim form that is being accepted is the CMS-1500 Claim Form Version 02/12. CCHP continues to receive the old CMS-1500 version 08/05 paper claim form, please discard the old paper claim form to avoid having your claims returned to your office.

- Claims and encounters must be filed no later than ninety-five (95) calendar days following the date of service using a standard CMS-1500 form or a UB-04 form. Claim appeals and corrective adjustments must be submitted within 120 days of the disposition date on the EOB where the denial appears. All appeals must be in writing.

NEW CARE MANAGEMENT 800 FAX LINE:

The Care Management Department has added a toll free fax number. This is another option in addition to our local fax number when sending authorization requests or referrals for care coordination/case management:

- Local Fax Number – 682-885-8402
- Toll Free Fax Number – 1-844-643-8402
- Local Phone Number – 682-885-2247
- Toll Free Phone Number –1- 800-862-2247

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; 682-885-2148 fax - www.cookchp.org
Care Management 800-862-2247 or 682-885-2247; 682-885-8402 fax - www.cookchp.org
Network Development 682-885-2247 or CCHPNetworkDev@cookchildrens.org
Mental Health Services - Beacon Health Services CHIP-866-331-1577; STAR-855-481-7045
Vision Services – CCHP: (800) 964-2247 or (682) 885-2247
NVA - Provider Relations: (888) 682-2020 or providers@e-nva.com