Cook Children's Health Plan

4th Quarter Newsletter

888-243-3312
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Providing CHIP and Medicaid services to Tarrant, Denton, Parker, Wise, Hood and Johnson

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Online Education Classes for Members

Cook Children's Health Plan and Tarrant County Public Health are teaming up to help Members learn more about health topics.

Courses are available online in English and Spanish at no cost to the Member.

Encourage Members to sign up for courses today! To register for a course Members should visit cookchp.org, select Members, Resources, and Events and Classes.

Aunt Bertha, now known as Findhelp

Aunt Bertha's name has changed to Findhelp. Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help. Want to know more about this program, please visit their website at findhelp.org.

Provider Advisory Group

Providers are welcome to participate in Cook Children's Health Plan Provider Advisory Group. The Provider Advisory Group meets quarterly and gives Providers an opportunity to share feedback and suggestions with the health plan.

If you are interested in joining the Advisory Group, contact your Provider Relations Representative at:

- 888-243-3312
- CCHPProviderRelations@cookchildrens.org

You may also register on our Provider Relations page, selecting schedule, and select the registration link for the upcoming Advisory webinar you chose to attend.

Neonatal Level of Care Designation for Hospital Providers Rendering Neonatal Inpatient Services

The hospital address submitted to Department of State Health Services on the neonatal level of care designation application must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on the file. Providers can refer to your DSHS approval letter for the correct address.

Click here for more information.

2021 Annual Provider Prior Authorization Survey Results

Cook Children's Health Plan conducted its 2nd Annual Provider Prior Authorization Survey from March 1st through March 31st, 2021. We reviewed the feedback from our Providers and reached out individually to address any issues and/or concerns.

In an effort to improve the efficiency and quality of the prior authorization process, we would like to share improvements as a result of the survey.

2021 Annual Provider Prior Authorization Survey Results

Medicaid and CHIP COVID-19 Flexibilities

Providers can obtain the most current COVID-19 flexibility updates by visiting:

- HHSC Coronavirus Provider Information
- Texas Medicaid & Healthcare Partnership

Recent flexibility updates include:

- CHIP Copayment Waiver to end January 31, 2022
- Changes related to Appeals and Fair Hearings that are valid through November 30, 2021
- THSteps Medical Checkups via Remote Delivery During Implementing COVID-19 restrictions
- Updated COVID-19 Guidance for MCOs regarding Durable Medical Equipment

Secure Provider Portal

We encourage all Providers to request access and utilize the Secure Provider Portal. Providers can verify eligibility, check claim status, submit claim appeals/reconsiderations, and request prior authorizations.

If you do not have access to the Secure Provider Portal please refer to the Secure Provider Portal Reference Guide to request account access.

For assistance in navigating the Secure Provider Portal, plan on attending our monthly webinar by visiting the Provider Relations page located on cookchp.org, view our Provider training webinar schedule to register for the date of your choice.

National Correct Coding Initiative (NCCI)

The National Correct Coding Initiative was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

- NCCI edits are updated quarterly
- Providers should refer to the Centers for Medicare & Medicaid Services (CMS) website for the updated Medicaid NCCI rules, relationships, and general information
- NCCI updates can also be accessed under Rate and Code Updates located on tmhp.com

Accurate coding and reporting of services are critical aspects of proper billing.

- Refer to the NCCI edits before unbundling services to determine if a modifier is allowed
- Using a modifier usually results in a higher payment for the Provider so make sure your chart documentation supports the codes you are billing

NCCI edits prevent inappropriate payment of services that should not be reported together.

- Each edit has a column one and column two HCPCS/CPT code
- If a Provider reports the two codes of an edit pair for the same Member on the same date of service:
    - The column one code is eligible for payment
    - The column two code is denied
- The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist
- Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination
- Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier
    - Do not append a modifier solely to bypass an edit
    - If Texas Medicaid imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicaid restrictions are fulfilled
- A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

- Anatomic Modifiers
    - E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers
    - 24, 25, 57, 58, 78, 79
- Other Modifiers
    - 27, 59, 91, XE, XS, XP, XU

Provider Enrollment and Management System (PEMS) Schedule

Texas Medicaid & Healthcare Partnership (TMHP) is in the process of rolling out the Provider Enrollment and Management System (PEMS). Providers must use this new system to enroll.

This new system will be the single tool for enrollment, reenrollment, revalidation, and maintenance request.

- Beginning September 1, 2021: Some Children with Special Health Care Needs-Family Support Services (CSHCN-FSS), Kidney Health Care (KHC) program, and long-term services and supports (LTSS) Providers will participate in a soft launch of PEMS. Soft launch participation will be based on interest
- From September to November 2021: TMHP will begin testing PEMS functionality for acute care and long-term care Providers. Participating Providers will use a test environment to practice enrollment and record management tasks
- December 13, 2021: All Providers will use PEMS

TMHP will post more information about the upcoming changes, including Provider Training and resources prior to implementation. For more information, call the TMHP Contact Center at 800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 800-568-2413.

Therapy Services Provided by a Home Health Agency

Skilled Nursing, Home Health Aide, Occupational Therapy and Physical Therapy Services provided by a Medicaid enrolled Home Health Agency must be billed on a UB-04.

Providers must only use type of bill 321 in form locator 4 of the UB-04. Other type of bills are invalid and will result in a claim denial.

When completing a claim form, all required information must be included on the claim.

- Prior authorization numbers must be indicated on the claim form in block 63 of the UB-04
- Point of Origin for Admission of Visit must be indicated on the claim form in block 15
    - Providers can refer to the National Uniform Billing Code website for the current list of Point of Origin for Admission or Visit codes

Resource: Texas Medicaid Provider Procedures Manual, Vol 1 Claims Filing and Vol 1 Texas Medicaid Fee for Service Reimbursement.

Enrollment or Changes in Electronic Fund Transfer

Providers can enroll in Electronic Funds Transfer (EFT) or make a change to their current EFT by submitting a Customer Service Request via the Secure Provider Portal. Select the topic: Electronic Funds Transfer New Request or Electronic Funds Transfer Change Request, complete the form, attach a voided check or letter from the bank and submit the request. A tracking number will be provided. Please allow 4 weeks for validation and implementation.

Texas Health Steps (THSteps)

Medical Checkup Preventive Diagnosis Code

Providers must bill the age appropriate preventive diagnosis code for the Texas Health Steps (THSteps) visit.

- Bill only one age appropriate preventive diagnosis code per claim
  - Z00.110, Z00.111, Z00.129, Z00.121, Z00.00, Z00.01
- Each claim line must point to the age appropriate preventive diagnosis code as the primary diagnosis code
  - This includes the preventive E/M, vaccine/toxoid, vaccine administration code, screenings, etc.
  - The Encounter for Immunization diagnosis code, Z23, may be billed as the secondary diagnosis code for the vaccine/toxoid code(s) and vaccine administration code(s)

Quick Reference Guide

Providers can utilize the Texas Health Steps Quick Reference Guide when performing THSteps medical checkups.

Postpartum Depression Screening

Postpartum depression screening procedure codes G8431 and G8510 may be reimbursed when billing for postpartum depression screening in the office.

THSteps Providers may receive separate reimbursement for postpartum depression screening, in addition to the infant's THSteps medical checkup or follow-up visit.

Postpartum depression screening must be submitted under the infant's Medicaid ID number and will be restricted to Members who are 12 months of age or younger.

- Only one procedure code may be reimbursed per Provider in the 12 months following the infant's birth
  - Code G8431 or G8510

Postpartum Depression Screening Guidelines

- Providers are required to screen using a validated tool
  - Edinburgh Postnatal Depression Scale
  - Postpartum Depression Screening Scale
  - Patient Health Questionnaire 9
- Screening should occur at least once during the postpartum period
- A positive screening requires the THSteps Provider to develop a referral plan with the Mother

Ambulance Transportation

Cook Children's Health Plan covers emergency and medically necessary non-emergency ambulance transportation.

Emergency Ambulance Transportation

- In the event a Member's condition is life-threatening or potentially life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while in route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require Cook Children's Health Plan prior authorization
- Facility to facility transportation is considered emergent when meeting the definition found in 1 TAC §353.2
- Facility to facility transport is considered emergent when the service is not eligible at the first facility

Non-Emergency Ambulance Transportation

- Non-Emergency Ambulance Transportation is defined as ambulance transport provided for a Cook Children's Health Plan Member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the Member's home after discharge when the Member has a medical condition such that the use of ambulance is the only appropriate means of transportation
- Non-Emergency Ambulance Transportation services must be prior authorized and coordinated by Cook Children's Health Plan before an ambulance is used to transport a Member in circumstances not involving an emergency

Prior Authorization

The Provider of record, the Ambulance Provider, or those acting on their behalf may request approval for an ambulance by using the Prior Authorization Form for Health Care Services found on our website cookchp.org. Cook Children's Health Plan will provide the approval or denial for the prior authorization to the requesting Provider and the ambulance Provider.

The Ambulance Provider is responsible for ensuring the prior authorization was approved prior to transport as nonpayment will result without a prior authorization. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport.

Billing Tips

- Claim Form
  - CMS-1500
- Emergency Transport
  - Is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes
  - The ET modifier is required for every detail on an emergency transport claim
    - The ET modifier is not required to be listed in the first position on the claim line
    - Emergency transports that use an extra attendant must bill modifier ET with the extra attendant procedure code

        - Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements
- Multiple Client Transports
    - A claim for each client must be billed with the transport procedure code and mileage procedure code with the GM modifier
- Not Medically Necessary Transports
    - Providers must use the GY modifier to submit claims for instances when the Provider is aware no medical necessity existed
        - Ambulance Providers must maintain a signed Client Acknowledgement Statement
- Emergency Transports Involving a Hospital
    - Hospital to hospital transports that meet the definition of an emergency transport do not require prior authorization
    - Providers must use modifier ET and one of the facility to facility transfer modifiers (HH, HI or IH) on each procedure code listed on the claim
- Place of Service
    - The place of service for all ambulance transports is considered the destination
- Origin and Destination Codes
    - All claims submitted must include the two-character origin and destination codes for each claim line
    - The origin is the first character
    - The destination is the second character

Resource: Texas Medicaid Provider Procedures Manual, Ambulance Services Handbook

Autism Services Effective February 1, 2022

Effective for dates of service on or after February 1, 2022, Autism Services, to include Applied Behavior Analysis (ABA) evaluation and treatment, will be a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Texas Medicaid recipients who are 20 years of age and younger and who meet the criteria outlined in the Autism Services benefit description. Texas Health and Human Services Commission (HHSC) is releasing a draft of the Medicaid Autism Services benefit to providers.

The new Medicaid Autism Services benefit includes coverage of medically necessary ABA services for individuals with Autism Spectrum Disorder (ASD) and provides for coordination of the service array in interdisciplinary team meetings.

The outline of the Medicaid Autism Services Policy can be found at this link.

Benefits, Limitations and Exclusions

Provider should refer to the most recent publication of the Texas Medicaid Provider Procedures Manual, Cook Children's Health Plan Provider Manuals, Electronic Data Interchange Requirements, CPT/ICD-10/HCPC coding guidelines and Medicaid National Correct Coding.

Provider Training Webinars

We would love to have you or a member of your team attend our Provider training webinars. Visit the Provider Relations page located on our website cookchp.org, to review our provider training webinar schedule and register for an upcoming webinar.

Provider Relations

How can we help you? If you need assistance or would like to know who your Provider Relations Coordinator is please email CCHPProviderRelations@cookchildrens.org.