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

Summer 2019

Cook Children's Health Plan
888-243-3312
CCHPProviderRelations@cookchildrens.org

What's inside

Provider Services Support
888-243-3312

Make sure to use the dedicated Provider Services Support telephone number 888-243-3312. Our dedicated staff is here to help you Monday – Friday, 8am to 5pm!

Provider Training Webinar Schedule

We'd love to have you or a member of your team attend one or more of our Provider training webinars. The most up to date schedule can always be found under Education & Training on our website. Visit the link and register for a webinar at any time. Please make sure that we have your correct email address so that you can receive invitations and other important information from the Health Plan.

Provider Updates

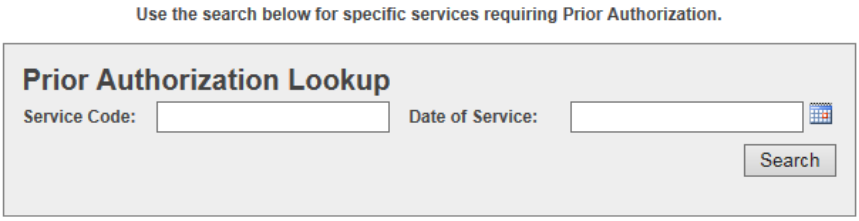
Do we have the most up to date contact information for your practice? The Provider Relations Team utilizes email to send out Training invites, Newsletters and Notifications. Network Providers must inform both Cook Children's Health Plan and the Health and Human Services administrative services contractor of any changes to the Provider's contact information including address, telephone and fax number, office contact name and email address, group affiliation, tax identification numbers, etc. Providers may update their information by completing the Provider Demographic Information Change Request Form. You may also call 888-243-3312 and ask for Network Development.

Zika Virus Testing Limitation Update

Effective for dates of service on or after July 1, 2019, the limitation for Zika virus testing procedure code 87662 will change and may be reimbursed up to two times on the same day by the same Provider. It will no longer be limited to one per day. The Medicaid Provider notification can be found at Updated Limitation for Zika Virus Testing

Prior Authorization Lookup

Some services require prior authorization from Cook Children's Health Plan (CCHP) in order for reimbursement to be issued to the Provider. Use our Prior Authorization Lookup tool to see if a prior authorization is needed. It's quick and easy. If an authorization is needed, you can access the Secure Provider Portal to submit it online. Visit cookchp.org, select Providers from the menu and click on Prior Authorization Lookup.



Interpreter Services

CCHP will provide face-to-face interpreter services or phone interpretation services for most of the commonly spoken languages around the world. Contact Provider Support Services at 888-243-3312 or CCHPInterpreterRequest@cookchildrens.org in order to request interpreter services. A 2-day advance notice is required. Providers must notify the Health Plan as soon as possible in the event of a cancellation.

Services for the Hearing Impaired

CCHP has a service agreement with Texas Interpreting Services (TIS). TIS employs staff Members who are proficient in sign language communications for hearing impaired individuals. If a Provider is in need of a sign language interpreter, a 2-day advance notice is required. They can contact CCHP at 888-243-3312 and the Health Plan will coordinate services with TIS. Providers must notify CCHP as soon as possible in the event of a cancellation.

Influenza (flu) and Tetanus, Diphtheria, and Acellular Pertussis (Tdap) for Pregnant Women

The Influenza (flu) vaccine and Tetanus, Diphtheria, and Acellular Pertussis (Tdap) vaccine are both part of routine prenatal care and are covered benefits for pregnant Members enrolled with CCHP.

Health experts recommend that women get the flu vaccine if they will be in their second or third trimester of pregnancy during the flu season. It is important for women to get the Tdap vaccine in the third trimester of *each* pregnancy.

Billing Tips

- The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code.
    - Diagnosis code Z23 may also be included
- Bill procedure code 90715 when administering the Tdap vaccine
- Bill procedure code 90756 when administering the flu vaccine to Members who are 4 to 17 years of age
- Bill procedure code 90682 when administering the flu vaccine to Members 18 years of age and older

Flu Prevention and Testing

The flu season in the United States begins in October and continues through the end of May. Flu vaccines are a covered benefit for all Members enrolled with CCHP. The optimal time to receive flu vaccine is as early in the season as it is available. However, Members should continue to receive the flu vaccine through March. The vaccine may be administered one time per flu season.

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

The administration fee may be reimbursed through CCHP if the claim includes the appropriate vaccine procedure code and the specific diagnosis code of the condition necessitating the vaccine.

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 claim should include modifier U1, which indicates private stock.

Providers are encouraged to provide flu vaccinations to Members during their periodic medical checkups, or anytime during flu season.

<u>Billing Tips</u>
Diagnosis Code

- The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code
    - Diagnosis code Z23 may also be included

Procedure Code

- Bill procedure codes 90655, 90657, 90685, and 90687 are limited to Members who are 6 through 35 months of age
- Bill procedure codes 90686 and 90688 are limited to Members who are 6 months of age and older
- Bill procedure codes 90656 and 90658 are limited to Members who are 3 years of age and older

- Bill procedure code 90756 is limited to Members who are 4 years of age and older
- Bill procedure code 90682 is limited to Members who are 18 years of age and older

Administration Code

- Bill procedure code 90460 when administrating the vaccine with counseling
- Bill one of the following procedure codes when billing the vaccine without counseling
  - Procedure code 90471
  - Procedure code 90472
  - Procedure code 90473
  - Procedure code 90474

Flu Testing Influenza A & Influenza B

Providers may diagnose Members with the flu based on symptoms and clinical judgement or they may choose to use a flu diagnostic test. When testing for Influenza A and/or Influenza B utilize the following:

- Diagnosis Code
  - Use the appropriate ICD-10 diagnosis code from the J code set for a positive flu test
- Procedure Code 87804
  - Cannot be billed with units
  - If testing for strains A and B, the procedure code must be billed as two lines
- Billing
  - Use procedure code 87804-QW when billing for the first strain
    - Modifier QW – a clinical laboratory improvement amendment (CLIA) waived test
  - Use procedure code 87804-91 when billing for the second strain
    - Modifier 91 – repeat clinical diagnostic laboratory services on the same day
  - Do NOT bill modifier 59

Adolescent Mental Health Screenings

THSteps will allow Members 12 through 18 years of age to receive a mental health screening (procedure codes 96160 or 96161) using one or more of the validated, standardized mental health screening tools recognized by THSteps, once per calendar year during a THSteps checkup.

- Code 90610 is billed when the screening tool was completed by the adolescent
- Code 96161 is billed when the screening tool is completed by the parent or caregiver on behalf of the adolescent

THSteps recommends all Members who are 12 through 18 years of age receive a mental health screening using one of the THSteps recognized mental health screening tools.

The following validated, standardized mental health screening tools will be added:

- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance abuse])

Providers may refer to the current **Texas Medicaid Provider Procedures Manual, Children's Services Handbook** for additional Texas Health Steps Mental Health screening information.

Critical Congenital Heart Disease (CCHD) Screening

Critical Congenital Heart Disease (CCHD) represents a group of heart defects that cause serious, life-threatening symptoms and requires intervention within the first days or first year of life. CCHD is one of the leading causes of death in infants less than one year old. The CDC reports that 7,200 infants are born with this condition each year in the United States.

State law requires all newborns to receive CCHD screening prior to discharge from a hospital, birthing facility or birthing center. CCHD screening is included on the Texas Health Steps Medical Checkup Periodicity Schedule.

Newborns not screened prior to discharge should be screened as soon as possible, preferably at the first checkup within a few days of birth.

- Screening for CCHD is not required when the parent declines the screening

Physicians can use the CCHD Toolkit to assist with implementing CCHD screening. It provides educational and technical information on screening for CCHD.

Required Reporting
Newborn screening for CCHD requires that confirmed cases be reported to DSHS. Use the CCHD Reporting Form to document confirmed cases. Completed forms can be faxed or mailed as follows:

FAX to:
Fax Number: (512) 776-7593
Attention: CCHD Program

MAIL to:
Attention: CCHD Program
Texas Department of State Health Services
Newborn Screening Genetics Branch
P.O. Box 149347, MC 1918
Austin, Texas 78714-9347

The THSteps online program provides a module on CCHD. Healthcare Providers learn about performing state-mandated newborn screening for CCHD, evaluating results, and providing appropriate follow-up. Free continuing education credit is provided after module and test completion.

Early Childhood Intervention (ECI)

For Members birth to 36 months of age with a developmental delay or disability, Early Childhood Intervention (ECI) services may be able to help. Services can be provided in the home and other places your child goes regularly, for example, a childcare center, park, library or other community setting.

ECI services feature:

- Individualized planning process
- Family-centered services
- Case Management
- Familiar settings
- Professional Providers
- Plans for continuing services

The following services are provided at no cost to the family regardless of income:

- Evaluation/assessment
- Development of the Individual Family Service Plan (IFSP)
- Case Management
- Translation and Interpreter Services

A referral to ECI happens when a parent or someone else, such as a child's doctor contacts ECI to recommend that a child have an evaluation. The evaluation determines if a child is eligible for ECI services.

Within a few days of receiving a referral, someone from the local ECI program nearest your home will contact the Member to set up the first visit. The visit must occur within 45 days of the time ECI received the referral. This is a time for ECI to learn about the Member and family, as well as to give you information about ECI.

ECI is here to help and can become an important resource for all families. For more information about ECI, call the Department of Assistive and Rehabilitative Services (DARS) inquiries line at 800-628-5115 or you can also go to their website.

CCHP Durable Medical Equipment/Supplies (DME) Prior Authorization Request Form

Effective September 1, 2019, CCHP will not require a Title XIX to be submitted with Prior Authorization requests. All Providers requesting Prior Authorization for Durable Medical Equipment (DME) and Medical Supply should use the CCHP Durable Medical Equipment/Supplies (DME) Prior Authorization Request Form. Click here for the

form. Providers may also use the current Texas Standard Prior Authorization Request Form located on tmhp.com.

Durable Medical Equipment (DME) Refill Guidelines and MSRP

CCHP has currently implemented configuration to ensure that rent to purchase items and monthly rentals are billed within the Texas Medicaid Provider Procedures Manual (TMPPM) limitations. As a result, any item that is billed on a monthly basis must have more than 28 days between each date of service that is billed.

- Services billed prior to 28 days will reject due to current CCHP configuration
- To prevent denial of claims for rendered services, please ensure that you are billing more than 28 days between each date of service

Reimbursement
Providers may be reimbursed for DME either by the lesser of the Provider's billed charges or the published fee determined by Texas Health and Human Services (HHS) or through manual pricing. If manual pricing is used, the Provider must request prior authorization and submit documentation of either of the following:

- The Manufacturer Suggested Retail Price (MSRP) or Average Wholesale Price (AWP), whichever is applicable
- The Provider's documented invoice cost

Manually priced items are reimbursed as follows as is appropriate:
- MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable
- The Provider's documented invoice cost

(TMPPM 2.4.2)

Authorization
Prior authorization is required
Only mark prior authorizations URGENT if they are truly an urgent request

Documentation of Delivery
Must include:
- Delivery slip or invoice signed and dated by Member or caregiver
- Dated carrier tracking document that includes the shipping date and delivery date must be printed from the carriers website as confirmation
    - The carrier tracking document must be attached to the delivery slip or corresponding invoice

Billing Tips
- Providers should submit a paper claim when billing for a service that includes an unlisted procedure
- Providers should submit a description of the service on the claim when billing an unlisted procedure

- Providers should submit a copy of the invoice or the MSRP for the service

Records
All DME claims/records must be retained for a minimum of 5 years from the date of service.

Electronic Visit Verification Changes (EVV)

New Provider Data Validation Process – Improves Quality

The Texas Health and Human Services Commission (HHSC) is implementing an Electronic Visit Verification (EVV) Provider data validation process for all contracted Providers required to use EVV. This will improve data quality by standardizing EVV data within the Vesta EVV system, which will help reduce data element errors on visits. For more information on how this change affects you please visit HHSC's Electronic Visit Verification page.

Billing Policy Changes for Providers required to use EVV

Effective September 1, 2019, all EVV relevant claims must be submitted to TMHP. Providers who submit their claims to their Managed Care Organization (MCO) for dates of service on or after September 1, 2019 will have their claim(s) denied or rejected for resubmission to TMHP. Once the matching process has been performed by TMHP, all claims will be forwarded to the appropriate payer for final adjudication and processing.

Once a claim with EVV relevant services has been received at TMHP it will be matched against the EVV visits data sent to TMHP by Vesta. If the following data elements do not match, the claim will deny:

- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Date of Service
- Medicaid Identifier of the Individual
- Service Identifier as Healthcare Common Procedure Coding System and any associated Modifier(s)
- Units of Service delivered

For more information regarding this change please visit CCHP's Electronic Visit Verification page.

EVV Service Bill Codes Table

Detailed bill code information for Electronic Visit Verification (EVV) services is now available in the EVV Service Bill Codes table on the HHSC EVV website.

The EVV Service Bill Codes table identifies the EVV program and service bill codes required for EVV-relevant services that are currently in use and those with changes effective September 1, 2019.

Program Providers must use the correct Healthcare Common Procedure Coding System (HCPCS) code/modifier combinations listed in the EVV Service Bill Codes table for all claims. Use of the correct codes will help prevent EVV visit transaction rejections and EVV claim match denials. For more information, contact HHSC EVV Operations at electronic_visit_verification@hhscstate.tx.us.

EVV Computer-Based Training Courses

Electronic Visit Verification (EVV)-related computer-based training (CBT) modules will become available on the TMHP Learning Management System (LMS).

Providers can access the TMHP LMS through the TMHP website on the TMHP Education webpage, or directly at learn.tmhp.com.

For more information about the LMS, program Providers can refer to the *Learning Management System (LMS) Job Aid for Providers* . For CBT log-in or access issues, email TMHP LMS support at TMHPTrainingSupport@tmhp.com.

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

Date Span Billing

CCHP does not allow date span billing. Billing for each date of service must be on a separate line item.

Therapy Modifiers

Always refer to your National Correct Coding Initiative (NCCI) edits and the TMPPM to determine if a modifier is allowed.

- NCCI Edits
- Texas Medicaid Provider Procedures Manual

Modifier AT

The AT modifier must be included on claims for acute therapy services.

- Most adult therapy claims are considered acute
- For acute therapy services, prior authorization requests may not exceed a 60 day period per each request. After two 60 day authorized periods, any continued requests for therapy services must be considered under the chronic sections of the TMPPM.

Consider using one of the following modifiers instead of modifier 59; chart documentation must support the use of an X modifier.

Modifier XE

Separate Encounter

- Use to describe separate encounters on the same date of service
- Should not be appended to the primary procedure

Modifier XP

Separate Practitioner

- Use to describe a service that is distinct because it was performed by a different practitioner
- Should not be appended to the primary procedure

Modifier XS

Separate Structure

- Use to describe a separate organ or structure
- Should not be appended to the primary procedure

Modifier 59

Distinct procedural service – distinct or independent from other non-E/M services performed on the same day.

- Most used modifier
- Most abused modifier
- **Should be used as a last resort**

It is inappropriate to use modifier 59 and XE, XP or XS on the same claim.

Beacon Health Options

CCHP has partnered with Beacon Health Options (Beacon) to manage the delivery of mental health and substance use disorder services for all our Members. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all CCHP Members receive timely access to clinically appropriate behavioral health care services, CCHP and Beacon believe that quality clinical services can achieve improved outcomes for our Members. Information is available through Beacon on behavioral health benefits and services such as:

- Locating Behavioral Health Providers
- Making an urgent appointment
- Arranging an appointment in a timely manner
- Checking Member benefits and eligibility

In addition, Beacon has a PCP Toolkit that may assist you with identification of behavioral health conditions, as well as next steps in treatment of behavioral health conditions.

Contents include:

- Overview of each behavioral health condition
- Diagnostic references
- Prescribing references
- Member resources
- Screening tools

Contact Beacon:

- Phone: 855-481-7045
- Fax: 855-371-9227
- Provider Relations: 781-496-4769
- Provider Maintenance: 866-612-7795
- Credentialing Applications: 866-612-7790
- Recredentialing Applications: 866-612-7792
- Email: Providerrelations@beaconhs.com
- Website: https://www.beaconhealthoptions.com/providers/dashboard/

Anxiety and Depression Performance Improvement Project

CCHP and Beacon Health Options are committed to reducing potentially preventable emergency department visits and inpatient stays among Members with complex needs and anxiety and/or depression.

The target population would include:

- All Members who have a diagnosis of anxiety or depression identified by the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Warehouse (CCW) algorithms
- Complex Needs = 3 or more Emergency Department (ED) visits AND 2 or more Inpatient stays
- Physicians should use screening tools (i.e., PHQ-2 & 9, GAD-7) in Beacon's Texas Primary Care Toolkit at each appointment with a Member to determine if they screen positive for anxiety and/or depression
- Should a Member have a positive outcome, they can be directed to contact Beacon at 855-481-7045 to be connected with a Behavioral Health professional
- You can also start the process on a Members behalf by filling out the PCP Behavioral Health Recommendation Form
- If a Member is in crisis and appears to be an imminent threat to themselves or someone else, *Beacon recommends that your crisis call protocols be observed and 911 be called immediately*
- Beacon has licensed Behavioral Health clinicians available 24-7 by phone to assist in assessing and triaging Members

Outcome Measures:

- Reduce high utilization among Members who have anxiety or depression
- Reduce potential preventable Emergency Room visits among Members
- Reduce potential preventable admissions among Members

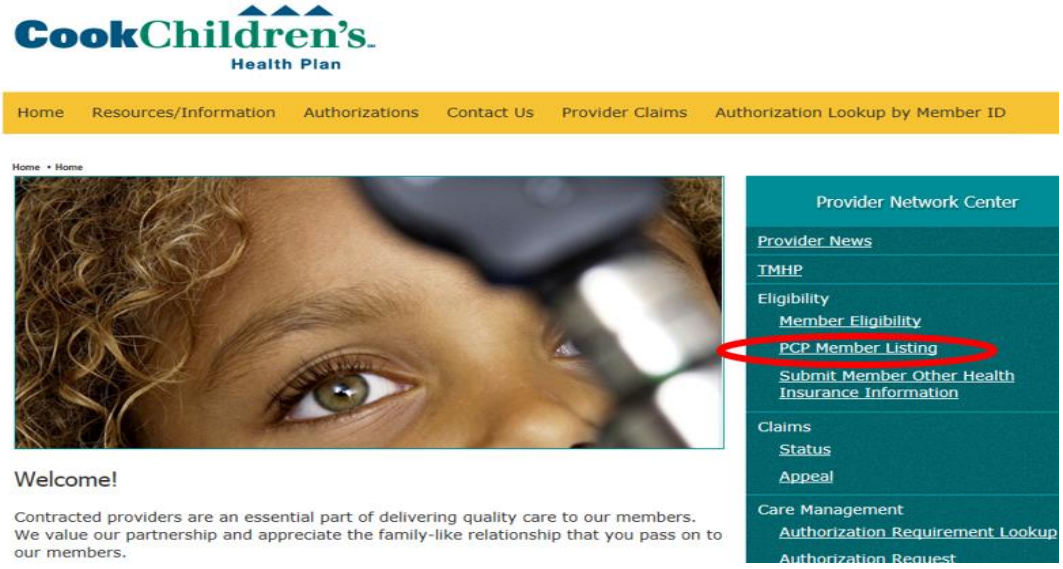
PCP Membership Listing

Providers may look up their Membership listing by following these easy steps:

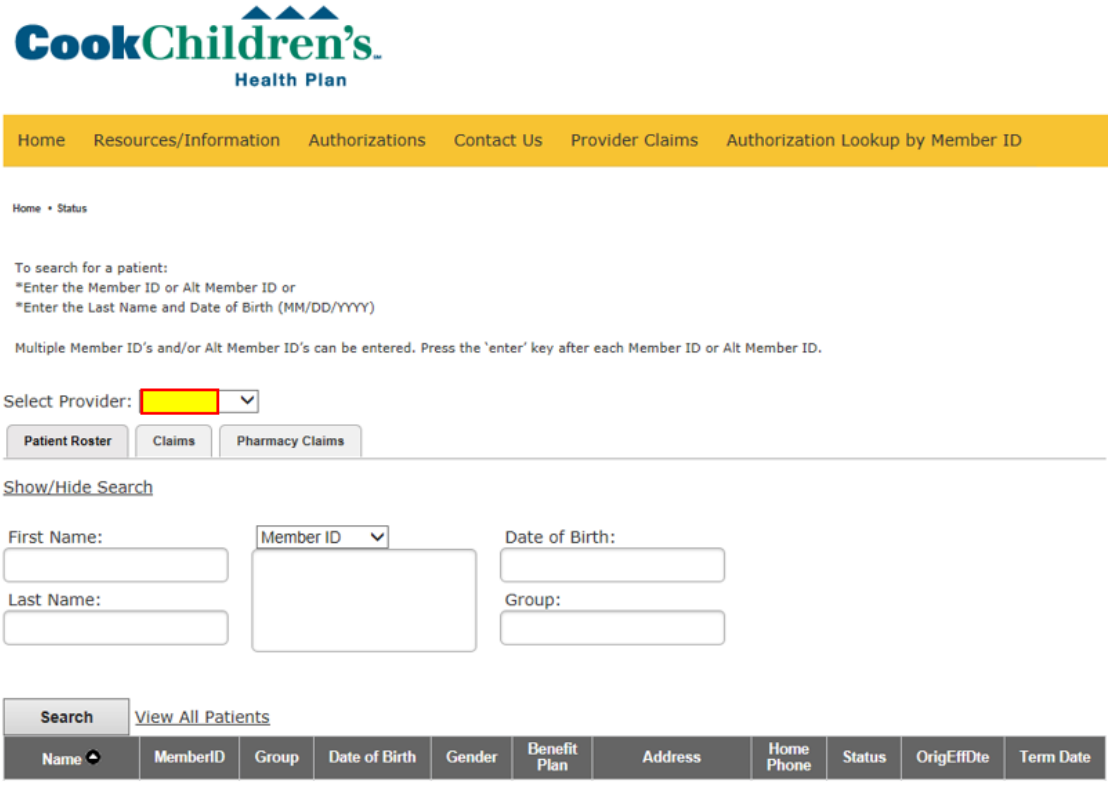
- Please visit cookchp.org
- Click the Providers Tab in the Top Banner
- Click Secure Provider Portal

- Log In

Once you are logged in click on PCP Member Listing on the Right Banner Menu.

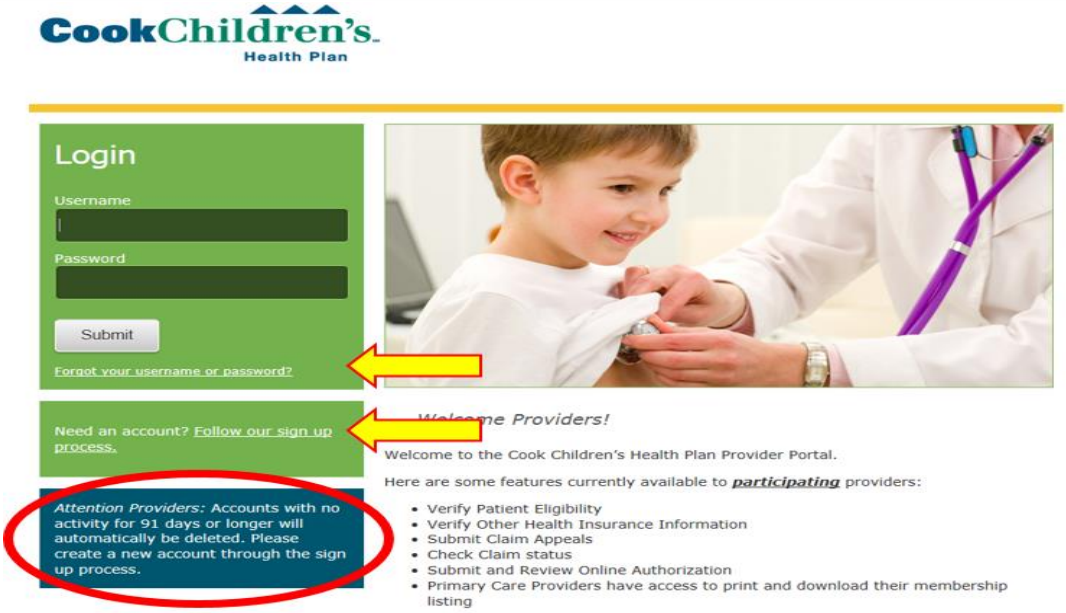


Select the Provider and click Patient Roster. You will see a current Member listing for the selected Provider.



For Secure Provider Portal issues:

- If you forget your username or password, select the link and follow the process
- Email CCHPNetworkdev@cookchildrens.org or call 888-243-3312 ask for Network Development Department if you need further assistance



If an employee is terminated or resigns, please notify CCHPNetworkdev@cookchildrens.org or call 888-243-3312 immediately with the following information:

- Employee Name
- Email address
- Last day of employment
- User name if known

Terminated employees will continue to have access to the Secure Provider Portal until you have contacted us with the information above.

Claim Follow-up

CCHP provides an effective mechanism for researching the status of a claim. Providers can log into our Secure Provider Portal and select Provider claims on the Top Banner to get status. We recommend you frequently check claim status to ensure your claim was received by CCHP.

If within 30 days the claim does not appear on the Secure Provider Portal as a received or processed claim, the Provider should resubmit the claim to CCHP within 95 days of the date of service. Providers are expected to check their clearinghouse report and resolve any transmission failures, file rejection, rejected claims before rebilling claims or calling the claims department. Providers should retain all claim and file transmission records as they may be needed as proof of timely filing.

National Drug Code

Effective 9/1/2019 Claims submitted with missing or invalid NDC numbers will be rejected.

Billing Tips

- The claim must include the NDC code, quantity and unit of measure
- An NDC qualifier of "N4" must be entered before the NDC on claims

Providers may refer to the current **Texas Medicaid Provider Procedures Manual, Children's Services Handbook** for additional Drug Code Information.

Inpatient Claims – Present on Admission (POA)

To group diagnoses into the proper Diagnostic Related Grouping (DRG), Medicaid present on admission (POA) reporting is required for all inpatient hospital claims. All hospital Providers are required to submit a POA value for each diagnosis on the claim form. No hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are consider POA.

The *Deficit Reduction Act of 2005* requires a quality adjustment in diagnosis related group (DRG) payments for certain hospital-acquired conditions. Texas Medicaid has adopted rules that cover reimbursement denials and reductions for preventable, adverse events that occur in a hospital setting.

The rules impose the same reimbursement denials and reductions for preventable adverse events that the Medicare program imposes for the same types of health-care-associated adverse conditions.

The following table shows the POA values:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission	Payment will be made by Medicare when a hospital-acquired condition (HAC) is present
N	Diagnosis was not present at the time of admission	No payment will be made by Medicare when an HAC is present
U	Documentation was insufficient	No payment will be made by Medicaid when an HAC is present
W	Clinically undetermined	Payment will be made by Medicaid when an HAC is present:
(blank)	Exempt from POA reporting	Exempt from POA reporting
Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table.		

Note: If a diagnosis code is exempt from POA reporting, Providers should leave the POA indicator field blank on the claim.

A complete list of POA exempt diagnosis codes can be found on the CMS website.

Contact Us

CookChildren's Health Plan

888-243-3312
Monday – Friday 8am to 5pm
cookchp.org

Department	Type of Issue or Request	Email Address	Fax Number
Care Management	Prior-Authorizations, Case Management, Referrals, Disease Management, Member Education	CCHPPriorauthorizations@cookchildrens.org CCHPDenialandAppeal@cookchildrens.org	682-885-8402 844-346-8402 682-303-0005 STAR Kids LTSS 844-843-0005
Claims Department	Claim Status, Payments, Appeals or Questions	CCHPClaims@cookchildrens.org CCHPClaimAppeals@cookchildrens.org	682-885-2148 682-888-8404
Compliance	Member and Provider Complaints, Fraud, Waste and Abuse	CCHPCompliance@cookchildrens.org	682-303-0276
Coordination of Benefits	Other Health Insurance, Third Party Resources, Cost Avoidance Verification Reports	CCHPCOB@cookchildrens.org	682-885-8401
Customer Service	Member Demographic Updates, PCP Changes, ID Card Requests, Value Added Services, Legal Documentation	CCHPCustomerSVC@cookchildrens.org	682-885-8401 STAR Kids 844-843-0004
Electronic Visit Verification	Open Visit Maintenance Unlock Requests, EVV Questions	CCHPEVV@cookchildrens.org	
Finance	Electronic Funds Transfer, Electronic Remittance Advice	CCHPFinance@cookchildrens.org	682-885-8482
Interpreter Services	Interpreter Requests, Translation Requests, Interpreter Complaints	CCHPInterpreterRequest@cookchildrens.org	682-885-8401

Department	Type of Issue or Request	Email Address	Fax Number
Member Advocates	STAR Kids Member Assistance for Access to Care, Complaints and Appeals	CCHPMemberAdvocate@cookchildrens.org	682-885-8401
Network Development	Credentialing, Contracting, Demographic Changes (TPI, NPI, Billing Updates)	CCHPNetworkDev@cookchildrens.org	682-885-8403
Provider Relations	Provider Education and Training	CCHPProviderRelations@cookchildrens.org	682-885-8436
Quality	Quality of Care Concerns, HEDIS, Access and Availability	CCHPQualityImprovement@cookchildrens.org	682-885-8494

Vendor	Service	Email Address Website	Number
Availity	Claims Clearinghouse CHIP Payor ID: CCHP1 STAR/STAR Kids Payor ID: CCHP9	Website: www.availity.com	Ph.: 800-282-4548
Beacon Health Services	Mental Health Services	Email: TexasProviderRelations@beaconhealthoptions.com Website: www.beaconhealthoptions.com/providers/login/	Ph.: 855-481-7045 Fax: 855-371-9227
National Vision Administrators	Vision Services	Email: Providers@e-nva.com	Ph.: 888-830-5630 Fax: 888-830-5560
Navitus Pharmacy	Prescription Services	Email: Providerrelations@navitus.com Website: www.navitus.com	Ph.: 866-333-2757 Hotline: 877-908-6023 Fax: 866-808-4649

Paper Claims Mailing 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