



Texas Children's
Health Plan
A Subsidiary of Texas Children's Hospital

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Provider NEWS

April 2002

Verifying Health Plan member eligibility prior to treating is provider's responsibility

Providers are responsible for verifying Texas Children's Health Plan-member eligibility prior to providing care. Tools that can help include member-identification cards and telephone verification.

Member identification cards

Both commercial- and Medicaid-HMO members should present an identification card at the time of service. Commercial HMO members who have not yet received an identification card may present an enrollment form as proof of eligibility.

Medicaid-HMO members also may present Form 3087 or Form 1027 from the Texas Department of Human Services as proof of eligibility. Form 3087 is the monthly Medical Care Identification form TDH mails to all

Medicaid-eligible members. Form 1027 is the initial Medicaid-verification letter TDH provides. The form or letter will indicate the month of eligibility and whether the member is a STAR-Medicaid or traditional-Medicaid member.

Telephone verification

HMO identification cards identify members; they do not confirm eligibility. Member eligibility can change on a monthly basis without notice. Providers should call the customer-service unit of the member's primary HMO to verify eligibility after reviewing a member's identification card. If TCHP is the primary HMO provider, offices can use the Fax Recall or eSTEPP systems.

TCHP recommends providers verify eligibility through all available means prior to providing care to members.

Quality improvement ongoing at Health Plan

One way the Texas Children's Health Plan achieves its goal of high-quality healthcare and service to its members is through its Quality Improvement Program.

This program provides the foundation for continuous monitoring, evaluation and improvement of member care and services.

The program outlines TCHP's quality improvement goals and objectives and the committees (composed of key leaders and physicians) responsible for facilitating and overseeing various program activities.

In addition, it explains how TCHP monitors and evaluates different aspects of care and nonclinical service.

Each year TCHP evaluates its Quality Improvement Program to identify improve-

ment successes, areas of strength and opportunities for improvement.

The program is revised as necessary to continue providing high-quality care and service.

For instance, one of the program's many objectives is to improve utilization of preventive-healthcare services. TCHP routinely assesses the rate at which members obtain immunizations and well-child checkups.

Assessment results are shared with the program's committees, which evaluate for improvement. Depending upon the findings, the committees may or may not recommend changes.

Providing high-quality healthcare and service is a complex task and the Quality Improvement Program helps Texas Children's Health Plan achieve its goal.



Providers asked to rate Health Plan

Each March, Texas Children's Health Plan mails "Provider Satisfaction Surveys" to all network primary care providers and specialists.

Providers have the opportunity to assess TCHP's performance in each area of the organization, including claims operations, medical management, member services and network development.

Please take a moment to complete the survey. Providers' candid answers will help TCHP to improve its service to customers.

Use Fax Recall for information after hours

Texas Children's Health Plan's automated Fax Recall system allows TCHP providers to check eligibility, benefits and claims status after hours. The service is available 24 hours a day, Monday through Saturday.

Providers may call (832) 825-7921 and enter the member's identification number and the provider's fax number. The requested information will be faxed to the provider's office within three minutes.

For additional information about Fax Recall, please contact a TCHP provider services representative at (832) 824-2695.

Providers should consult product lists before making a referral

Because contractual relationships may vary from one Texas Children's Health Plan provider group to the next, providers must know exactly which products are included in their TCHP contract.

Texas Children's Health Plan offers three HMO products. These are HMO Blue STAR, the Children's Health Insurance Program, and Texas Children's Individual Medical Coverage.

When referring a member to a specialist or another physician for services, it is important to know if the physician to whom the member is being referred participates in the same products as the referring physician.

This information can be found in the "Directory of Participating Primary Care Physicians" and the

"Directory of Participating Specialist Physicians". TCHP prints and mails the lists to all participating providers quarterly.

Physician names are listed along the left margin of the report, while product names are listed across the top of the report.

Physicians who participate in the HMO Blue STAR program, Children's Health Insurance Program, or Texas Children's Individual Medical coverage have an effective date in the cell labeled with that product. A blank cell indicates the physician is not participating in a product and referrals for that product should be directed to another physician.

To ask additional questions about referrals, please contact a TCHP provider services representative at (832) 824-2695.

Claims management made easier with convenient Web-based system

Texas Children's Health Plan's new Web-based system, eSTEPP, formerly known as MD Portal, allows providers to view claims status, verify member eligibility and access referrals in real time.

eSTEPP lets providers view the same information as TCHP computer systems. By logging onto the Internet and eSTEPP, provider offices can access information without speaking to a Member Services representative.

Provider computers must have Explorer 5.0 or higher, with 128-bit encryption installed on a Windows-based computer system. Providers interested in obtaining an application to install eSTEPP should contact their Texas Children's Health Plan provider relations' representative.



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Health Plan providers should expect survey phone calls

Texas Children's Health Plan providers will receive a phone call from Provider Relations this month. The biannual phone survey is part of an effort to ensure TCHP members are able to schedule appointments in a timely manner.

The brief survey measures each office's ability to comply with established appointment-accessibility standards.

See the chart on this page for the standards reviewed in the survey.

Provider Relations also will call primary care providers after normal business hours to ensure access to medical care is available 24 hours a day, seven days a week.

Texas Children's Health Plan guidelines require PCPs to have an answering service that is able to reach the physician, an answering machine

indicating how to reach the physician or another provider accepting calls. Providers should return pages or messages within 30 minutes.

Appointment type	Accessibility standard
Emergency care	Immediate appointment or emergency room referral
Urgent complaint	Appointment within 24 hours
Routine sick care (non-urgent)	Appointment with primary care provider within 3 days; Appointment with specialist within 14 days
Well-care visits <6 mos	Within 30 days
Well-care visits >6 mos	Within 14 days
Prenatal visit	Within 14 days
Average office wait time	No more than 30 minutes

The newest additions



Please welcome the following physicians to Texas Children's Health Plan's network of providers:

PCP

- Mark Kreit, MD
- Linda Neely, MD
- Khozema Palanpurwala, MD
- Lillie Slaughter, MD
- Dominique Isenhower, MD
- Thanh Slavek, DO
- Baltimore Williams, MD

Specialty

- Family practice
- Pediatrics
- Pediatrics
- Family practice
- Pediatrics
- Family practice
- Family practice

- Michael Kaldis, MD
- Kaare Kolstad, Jr., MD
- John Laurent, MD
- Gary Lepow, DPM
- Alison Lin, MD
- David Linter, MD
- Walter Lowe, MD
- George Mallory, Jr., MD
- Mark Maffet, MD
- Gynette Master, MD
- Gregory McIntosh, DO
- Hatem Megahed, MD
- J. Bruce Moseley, MD
- Barry Nelms, MD
- Kathleen Neville, MD
- Ronald Newman, MD
- Christie Obukofe, MD
- Shea Palamountain, MD
- Brian Parsley, MD
- Marianka Pille, MD
- Josef Prchal, MD
- Elie Saber, MD
- Jack Su, MD
- Cyril Tawa, MD
- Kevin Varner, MD

- Orthopedic surgery
- Orthopedic surgery
- Neurosurgery
- Podiatry
- Ophthalmology
- Orthopedic surgery
- Orthopedic surgery
- Pulmonary medicine
- Orthopedic surgery
- Ophthalmology
- Urology
- Neurosurgery
- Orthopedic surgery
- Orthopedic surgery
- Hematology
- Ear, nose and throat
- OB/GYN
- General pediatric medicine
- Orthopedic surgery
- General pediatric medicine
- Hematology
- Nephrology
- Hematology
- Cardiology
- Orthopedic surgery

Specialist

- Nidal Abdel-Rahman, MD
- Joseph Allen, MD
- Samuel Attia, MD
- Dennis Bier, MD
- Michael Braun, MD
- William Bryan, MD
- Plinio Caldera, MD
- Richard Chudacoff, MD
- Benjamin Eidem, MD
- Laura Erdman, MD
- Stephen Esses, MD
- Gerard Gabel, MD
- Stephen Gottschalk, MD
- Thomas Hallisey, DC
- David Hildreth, MD
- Eldon Hopkins, MD

Specialty

- Pain management
- General pediatric medicine
- Urology
- Endocrinology
- Nephrology
- Orthopedic surgery
- Orthopedic surgery
- OB/GYN
- Cardiology
- OB/GYN
- Orthopedic surgery
- Orthopedic surgery
- Hematology
- Chiropractic
- Hand surgery
- Orthopedic surgery



Health Plan offers tips on writing Vendor Drug Program prescriptions

For physicians who have not used the Vendor Drug Program, the following explains how to write prescriptions for the VDP. The only difference between a VDP prescription and a normal prescription is that an extra step is needed when prescribing a brand-name drug when a generic is available.

In addition to signing the “no substitution” line, the physician also must write “medically necessary” on the prescription in his or her own handwriting.

Procedure for obtaining prior authorizations not always clear

Providers often find it difficult to remember whether the primary care provider or the specialist should initiate a prior authorization for services.

Listed below are two scenarios designed to help alleviate the confusion.

Scenario 1:

A PCP refers a Texas Children's Health Plan member to an in-network specialist. The specialist determines hospitalization is needed. Who is responsible for obtaining the authorization?

Answer:

The Health Plan provider with the most current medical information about the member should initiate the prior-authorization request. In this case, the in-network specialist should initiate the request.

Services requiring prior authorization must be phoned in to (832) 824-7648, or faxed to (832) 825-2499. The prior-authorization request should be used.

Scenario 2:

A PCP refers a Texas Children's Health Plan member to a specialist. The specialist evaluates the patient and determines the patient needs emergency surgery.

The available surgeon is not in the TCHP network. Who is responsible for getting the authorization?

Answer:

If the treating physician is an out-of-network provider, then the PCP is responsible for obtaining the authorization.

In this instance, the PCP should initiate the prior authorization. The surgeon is not in the Texas Children's Health Plan network and would not have access to TCHP's medical management policies and procedures.

Providers who have questions about authorizations should call the Health Plan's Medical Management Department at (832) 824-2600.

Helpful hints:

- Allow three-to-five business days for processing a prior-authorization request. Call (832) 824-7635 with prior authorization requests for medically urgent services.
- The TCHP provider with the most current medical information about the member should initiate the Prior Authorization request. If the treating physician is an out of network provider, then the primary care physician will be responsible for obtaining the authorization.
- TCHP providers can initiate a Prior Authorization request by faxing the Prior Authorization form to TCHP at 832-825-2499.
- When submitting a prior authorization request, supply all information pertaining to a patient's care.

Refer to the “Prior Authorizations” section of the Texas Children's Health Plan Provider Manual for a detailed list of information to be included on the request.

- The Medical Management Department will review all requests for services. Requests failing to meet clinical criteria will be referred to the Health Plan Medical Director for review.
- When submitting claims, the authorization number should be indicated clearly on the claim form.

Committee issues new guidelines

Texas Children's Medical Advisory Committee recently reviewed and approved a practice guideline dealing with prenatal care and issued new Prenatal Care Guideline Recommendations. This guideline focuses on one of the State's priority areas of concern, prenatal care.

The Minimum Standards of Care for Children with Type 1 Diabetes practice guideline was again reviewed and approved by TCHP's Medical Advisory Committee.

These two practice guidelines are enclosed in this newsletter. Please place them in your TCHP Provider Handbook for reference.