the checkup

by Texas Children's Health Plan Medical Directors

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Grand Rounds CME Series – Provided by Texas Children's Hospital and presented by Texas Children's Health Plan

Save the Date!

Application of Brief Behavioral Intervention: Evidence-based Therapy for Behavior Difficulties

Saturday, November 18, 2017
8:30 a.m. Registration & breakfast
9 a.m. – 12 p.m. Workshop
Location: UT Health Cooley Center
7440 Cambridge St, Houston, TX 77030
Register online now at TexasChildrensHealthPlan.org/CME
Free registration for Texas Children's Health Plan Contracted Providers.

In this ISSUE

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Specialists

Provider Alert

Changes to **physical, occupational and speech therapy benefits** for all ages

Effective for dates of service on or after September 1, 2017, physical therapy (PT), occupational therapy (OT) and speech therapy (ST) benefits for all ages will change for Texas Medicaid.

Please visit http://tinyurl.com/ybp3s5pe to review for changes to this medical benefit policy that applies to the following:

- Billing structure changes for PT, OT and ST services
- Procedure codes end-dating August 31, 2017
- Required modifiers
- Claims filing changes
- Clarification to benefit

Providers may refer to the current Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy and Speech Therapy Services Handbook (TMPPM), section 7.2.1 "Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units," for additional information on how to calculate billing 15-minute units.

Providers must list all relevant procedure codes on the Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form when requesting prior authorization for therapy services.

Prior Authorization changes
Changes to TCHP Prior Authorizations for PT, OT and ST services:

- For therapy authorizations with approved dates of service spanning the September 1, 2017 transition date, Texas Children's Health Plan has created a revised authorization in our system that reflects the new billing structure using the same authorization number.
- For all therapy requests that were submitted prior to September 1, 2017, the revised authorization will start on September 1 and cover through the end of the authorized period. Providers will not need to change their authorization reference number for claims submission.
- Dates of service prior to September 1, 2017 will be authorized using the current billing structure.
- All requests for therapy authorizations for dates of service on or after September 1, 2017 should be submitted according to the new billing structure.
- Texas Children's Health Plan will continue to prefer the Texas Standard Prior Authorization form available on our website for therapy requests. This form can be found at http://tinyurl.com/mh9vk7l

LARC

Improve maternal health outcomes through immediate postpartum LARC insertion

Immediate postpartum Long Acting Reversible Contraception (LARC) insertion refers to the insertion of an intrauterine device (IUD) in the delivery room immediately after delivery of the placenta, or insertion of an IUD or subdermal contraceptive implant prior to hospital discharge. LARCs are beneficial to subsequent maternal health outcomes as they enhance family planning and safer birth spacing.

The postpartum period is a convenient opportunity to initiate LARCs, especially given the engagement of women with health care services during this time. In addition, it is a time to optimize reimbursement as the women retain their Medicaid coverage at delivery. In January 2016, Texas Medicaid revised its reimbursement policies to enable hospitals and providers to receive full reimbursement (outside the global fee for delivery) for the LARC device and the provider insertion procedure fee when women receive a LARC postpartum, prior to being discharged from the hospital.

LARC devices are a benefit when administered in a hospital setting in addition to the diagnosis related group payment when a LARC device is inserted immediately postpartum. When a LARC device is inserted immediately postpartum, facilities will be paid an outlier payment for the following codes: J7300, J7301, J7307. Hospitals who obtain the LARC device via the 340B drug program will need to use the U8 modifier on the claim line.

For more information on immediate postpartum LARC insertion, please refer to the HHSC LARC Toolkit. It can be found at **http://tinyurl.com/yb8fqobx.**

If you have any questions or need additional information about LARC billing, please contact **Provider Relations** by calling **832-828-1008** or toll-free **1-800-731-8527.**

Prior Authorization of Texas Health Steps (THSteps) **dental therapy** under **general anesthesia** for members who are **six years of age or younger**

Effective July 1, 2017, Texas Children's Health Plan will be required to implement prior authorization for Level 4 deep sedation and general anesthesia provided in conjunction with therapeutic dental treatment for Medicaid dental clients from ages 0 through six years. All Level 4 services must be authorized prior to rendering services. Anesthesia services provided by a dentist should use procedure code D9223. Any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA), should use procedure code 00170, with an EP modifier. Texas Children's Health Plan will also require prior authorization for facility fees associated with dental therapy under general anesthesia billed with code 41899.

Requests for prior authorization for anesthesiologist/CRNA and facility charges must include:

- Location where the procedure will be performed.
- Narrative detailing the reason for the proposed level of anesthesia.
- Proof of authorization for the dental services from the dental maintenance organization (DMO).

The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Emergency Treatment
In cases of an emergency medical condition, accident or trauma, prior authorization is not necessary. A narrative and appropriate pre- and post-treatment radiographs/photographs must be submitted with the claim. These will be reviewed by the MCO for appropriateness prior to payment.

HEDIS Spotlight: Antidepressant medication management

HEDIS stands for **Healthcare Effectiveness Data and Information Set.** It is a widely used set of performance measures utilized by the nation's health plans and an essential tool to ensure our members are getting the best healthcare possible. It is extremely important that our providers understand the HEDIS® specifications and guidelines. In this section of *The Checkup*, we will highlight different HEDIS metrics. We will provide a description of the measures, the correct billing codes to support services rendered, and tips to direct you to available resources and tools.

Visit TheCheckup.org for complete article.

MEASURE

Antidepressant Medication Management

MEASURE DESCRIPTION:
The percentage of members 18 years of age and older who were treated with antidepressant medication had a diagnosis of major depression and remained on an antidepressant medication treatment. This measure is strictly related to medication compliance.
Two rates are reported:

- Effective Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days or 12 weeks.
- Effective Continuation Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 180 days or six months. The clock starts at the earliest prescription dispensing date for an antidepressant medication during the intake period.

CODING

ICD-10 CM codes for major depression: F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

For your information...

Visit TheCheckup.org for more articles like these.

For provider manuals, pharmacy directories, and other resources, visit **www.TexasChildrensHealthPlan.org/for-providers/provider-resources**

Appointment availability standards

- What are appointment availability standards?
- How do you as a provider with Texas Children's Health Plan play a role?

In 2015 Senate Bill 760 passed, requiring Texas Health and Human Services Commission (HHSC) to monitor the provider networks of managed care organizations. Texas Children's Health Plan would like to ensure members are able to schedule appointments with providers in accordance with the HHSC's appointment accessibility guidelines.

Provider Type	Level/Type of Care	Appointment Accessibility Standards
OB/GYN	• Emergency services	Immediately
	• Urgent condition	Within 24 hours
	• Prenatal care for initial appointments	14 days
	• Prenatal care for initial appointments for high-risk pregnancies or new members in third trimester	Initial appointment must be offered within 5 days, or immediately, if emergency exists
	• Appointments for ongoing OB care must be available in accordance to treatment plan as developed by the provider	Must be available in accordance to the treatment plan as developed by the provider
Primary Care Physicians	• Emergency services	Immediately
	• Urgent condition	Must be provided within 24 hours
	• Primary routine care	Within 14 days
	• Preventive health services for adult members	Within 90 calendar days
	• Preventive health services for members less than 6 months of age	Offered as soon as possible but no later than 14 days of enrollment for newborns
	• Preventive health services for members 6 months through age 20	Must be provided within 60 days
	• New members 20 years of age or younger to receive a Texas Health Steps checkup	Within 90 days of enrollment`
Specialty Care	• Emergency services	Immediately
	• Urgent condition	Must be provided within 24 hours
	• Specialty routine care	Must be provided within 21 days
Behavioral Health	• Emergency services	Immediately
	• Urgent condition	Within 24 hours
	• Care for non-life threatening emergency - Behavioral Health*	Within 6 hours
	• Initial visit for routine care - Behavioral Health*	10 days
	• Follow-up routine care - Behavioral Health*	90 days
	• Initial outpatient behavioral health visit (This does not apply to CHIP Perinate members)	14 days

*National Committee for Quality Assurance (NCQA) Guidlines

Primary Care Physicians AFTER HOURS: Accessible 24 hours a day, seven days a week, must return call within 30 mins.

Acceptable: Telephone is answered after-hours by answering service and meets the language requirement of the major population groups which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the Designated Provider's telephone. Any other recording is not acceptable.

The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.