2018

the RightCare update

an annual publication for participating providers for RightCare

Scott&White HEALTH PLAN PART OF BAYLOR SCOTT & WHITE HEALTH | RightCare

TEXAS Health and Human Services | TEXAS STAR Your Health Plan ★ Your Choice

Included in this issue:

RCSWHP 9181

SWHP is BUZZING with changes as they welcome a new Credentialing Verification Organization

Introducing Aperture and Availity

The Uniform Managed Care Contract (UMCC) now requires all Medicaid health plans to utilize the Texas Association of Health Plans-contracted Credentialing Verification Organization (CVO), Aperture Credentialing, LLC. Scott and White Health Plan/RightCare has decided to use this CVO for all lines of business.

Contracted RightCare/SWHP provider group; adding a provider to your contract:

- Go to swhp.org and choose the Provider tab. Scroll down to "Provider Resources" and click on "Manage Provider Account." Choose "Add Provider to Existing Contract" to complete and submit the Add a Provider form.
- A RightCare/SWHP representative will contact you via email to request that you fill out and return a Provider Information Form (PIF). The information listed on the PIF is entered into our database, which generates a file that is sent to Aperture Credentialing, LLC.
- Aperture Credentialing, LLC will contact you via mail with instructions on how to fill out a credentialing application through the Availity online portal or submit a paper application via email or fax. RightCare/SWHP does not currently utilize CAQH. If you are currently utilizing CAQH for your application information, you can download your application from the CAQH website. Along with your application, a current copy of your license, malpractice insurance, DEA, CLIA and Radiation certificate, (if applicable) is needed. Please ensure that your attestation pages are signed and currently dated. This application can be faxed or mailed to Aperture.
  - o Fax: 866-293-0421.
  - o Mail: Aperture Credentialing
    P.O. Box 221049
    Louisville, KY 40252-1049

  Please include the request letter from Aperture with your submission, as it includes bar code identification to aid in processing time.
- Once a full application is received by Aperture and your license has been verified, RightCare/SWHP will add you to the network as an "Expedited Provider." While practicing as an Expedited Provider, you will not be listed as a Primary Care Provider (PCP) or be included in the provider directory. You will be listed after you have successfully completed the full verification process.

BUZZING continued

- Aperture will return fully verified information to RightCare/SWHP and your file will go to the RightCare/SWHP Credentialing Committee for final approval.

Aperture Questions? Customer Service for Providers: 855.743.6161, option # 3.
Availity Questions? 1.800.Availity (1.800.282.4548)

Non-contracted groups that want to be contracted with SWHP/RightCare:

- Go to swhp.org, choose the Provider tab and click the "Join our Network" button.
- You'll find some helpful links to information about joining the RightCare/SWHP network and the credentialing processes.
- Select "Join Now" to complete the New Provider Contract Request form, attach files (if needed), and select "SUBMIT." You will then be contacted by a RightCare/SWHP representative for the next part of the contracting process.

Board Certification Requirement:

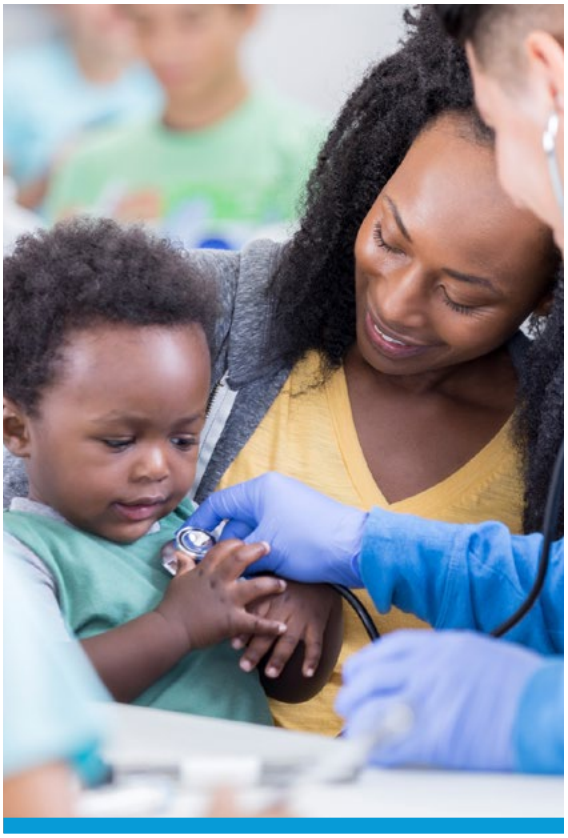
For non-boarded physicians (not applicable for board-eligible physicians):

RightCare by Scott and White Health Plan (SWHP) requires physicians to have current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certification (or be in the active process of obtaining such) in their practicing specialty.

If a provider is NOT board certified, or let the certification lapse, RightCare/SWHP requires the provider to annually obtain at least 50 AMA Physician Recognition Award (PRA) or equivalent CME credits, of which 25 must be Category I. Twenty-five of those 50 credits (Category I, II, or a combination of both) must be in the field in which the provider practices medicine. Failure to complete the required 50 CME credits per year will result in the removal of the provider as an eligible practitioner within RightCare/SWHP's network.

Hospital Privilege Requirement:

Providers are required to admit RightCare/SWHP members who require hospitalization to an SWHP-contracted facility, unless it is an emergency. A list of RightCare/SWHP facilities can be found at swhp.org. Click on "Find a Provider" in the menu; in the "select a plan" box choose "RightCare STAR Medicaid Network" from the dropdown list. Then choose "hospital" as the specialty and click the "search" box.



Specialists must have hospital privileges at a RightCare/SWHP-contracted facility. If the provider is a non-admitting specialty, such as a primary care physician, and does not have privileges, the provider is required to sign a "Hospital/Facility Privilege Form."

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHARLES SMITH
EXECUTIVE COMMISSIONER

Dear Texas Health Steps Provider:

As a Texas Health Steps (THSteps) provider, you affect the lives of many young Texans, and the Health and Human Services Commission (HHSC) understands documenting the THSteps components of the checkup can be challenging.

One federal and two state contracted reviews of medical records have shown that missing documentation is the **largest factor** and the **primary cause** of records being reviewed and money being recouped. HHSC would like to assist you in documenting all of the required components and elements of the THSteps checkups in order to reflect the work you perform to complete each checkup.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements, and each are outlined in the *Texas Health Steps Medical Checkup Periodicity Schedule* found on the THSteps internet Provider Information page. For providers to be reimbursed, each of the following six checkup components and their individual elements must be completed and clearly documented in the medical record:

1.	**Comprehensive health and developmental history** - This includes nutrition screening, developmental and mental health screening and TB screening. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record.
2.	**Comprehensive unclothed physical examination** - This includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening.
3.	**Appropriate immunizations** - This is established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
4.	**Appropriate laboratory/screening tests** - This includes newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.
5.	**Health education** (including anticipatory guidance)
6.	**Oral health referral** - This establishes a main dentist beginning at 6 months, then every 6 months until the parent or caregiver reports a dental home is established.

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Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. THSteps checkups are subject to retrospective review and possible recoupment if the medical record does not include all required documentation.

Information on checkup documentation is available within THSteps Online Provider Education modules. These modules are free and offer continuing education for healthcare professionals. You can link to the Online Provider Education website at: http://www.txhealthsteps.com/

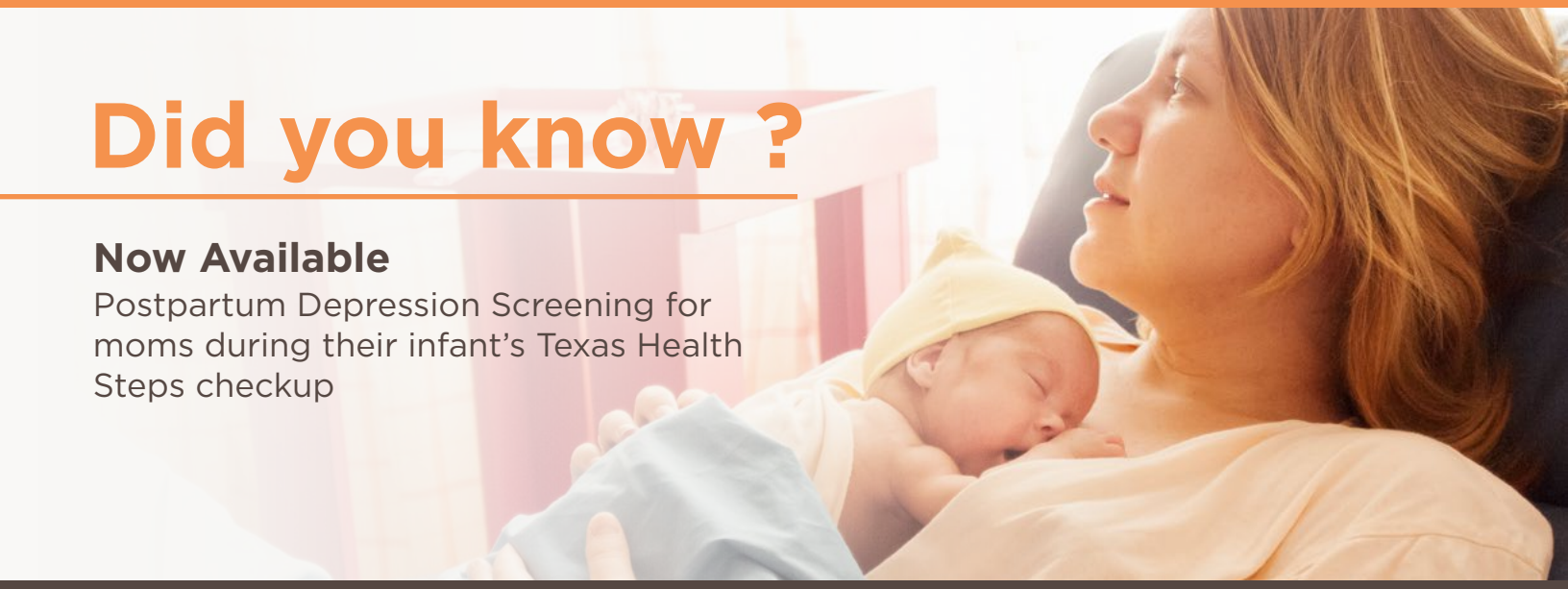
The following attached documents can be used as resources to assist you in completing THSteps checkup documentation.

1. **Texas Health Steps Clinical Record Review Tool with Instructions (Excel)** – This clinical record review tool is available to assist you in self-audits in preparation for health plans quality reviews. This electronic format will self populate totals with numerical values.
2. **Texas Health Steps Clinical Record Review Tool (PDF) –** This PDF is the clinical record review tool to use as a paper copy. See instructions for paper copy use on Excel workbook.
3. **THSteps Regional Provider Relations Representatives Contact List** – THSteps Provider Relations regional staff are available to share with you and your staff process efficiencies implemented by providers and their expertise on checkup documentation requirements.

The care you provide to children can be complicated and difficult. It is important in all aspects of the process to acknowledge your work through adequate and complete documentation.

Thank you for all you do for the health and well-being of children and adolescents across Texas.

Did you know ?



Now Available

Postpartum Depression Screening for moms during their infant's Texas Health Steps checkup

Effective for dates of service on or after July 1, 2018, postpartum depression screening will be a benefit of Texas Medicaid.

Postpartum Depression **Screening Benefits**

Federally qualified health centers and Texas Health Steps medical providers (in the office setting) may receive separate reimbursement for a mother's postpartum depression screening at the infant's Texas Health Steps medical checkup or follow-up visit. Applicable procedure codes are G8431 and G8510.

Note: Screening the mother for postpartum depression during the infant's Texas Health Steps medical checkup is recommended, not required.

Screening Guidelines

Validated tools must be used and may include the following:

Edinburgh Postnatal Depression Scale
Postpartum Depression Screening Scale
Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the Texas Health Steps provider to develop a referral plan with the mother.

Source: https://hhs.texas.gov/about-hhs/communications-events/news/2018/05/texas-health-steps-postpartum-depression-screening-benefit

SWADMIN_238_2018

Documentation Requirements

Documentation in the infant's medical record must include the name of the screening tool used and the date screening was completed. If the mother screens positive for depression, at a minimum, the provider must note that a referral plan was discussed with the mother and a referral to an appropriate provider was made. Documentation should also include any health education or anticipated guidance provided, along with the time period recommended for the infant's next appointment.

Submitting Claims for Postpartum Depression Screening

Postpartum depressing screening must be submitted under the infant's Medicaid client number and will be restricted to clients who are 12 months of age and younger. Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service and provider, as one of the following Texas Health Steps medical checkup or follow-up visit procedure codes:

99211	99382	99392
99381	99391	

Only one procedure code, either G8431 or G8510, may be reimbursed per provider, in the 12 months following the infant's birth.

Appointment Availability and After-Hour Access Requirements

To ensure members receive care in a timely manner, Primary Care Providers (PCPs), specialty providers , and behavioral health providers must maintain the following appointment availability and after-hour access standards.

Appointment and Access Standards

Standard name	Scott & White Health Plan requirement
Urgent Care	Within 24 hours
Routine Care	Commercial:21 calendar days Medicaid:14 calendar days Medicare:30 calendar days
Prenatal Care—initial visit	Within 14 days
High risk & New member 3rd Trimester	Within 5 days or immediately if emergency exists
Preventative Care Adult (21 and Over)	Commercial and Medicaid: 90 days Medicare: 30 days
Preventative Health Care (6 months—20 years)	Within 60 days
Newborn	Within 14 days
Behavioral Health	
Behavioral health, nonlife-threatening emergency care	Within 6 hours
Urgent Care	Within 24 hours
Initial Outpatient Behavioral Health Care (prescriber/non-prescriber)	10 business days, Medicaid: 14 days
Routine Behavioral Health (prescriber/non-prescriber)	14 days
Specialty Care	
Urgent Care	24 Hours
Routine Care	Commercial and Medicaid: 21 calendar days, Medicare: 30 calendar days

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Scott & White Health Plan is dedicated to arranging timely access to care for our members.

After-hour access requirements for PCPs

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for member contact after normal business hours.

One of the following must apply:

- **Have the office telephone answered by an answering service that can contact the PCP.** All calls answered by an answering service must be returned within 30 minutes.
- **Have the office telephone answered after normal business hours by a recording.** The recorded message should direct the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the call at the second number.
- **Have the office telephone transferred after hours to another location** where someone will answer the telephone. The person answering the calls must be able to contact the PCP to return the call within 30 minutes.

The following are not acceptable:

- **Answering the office telephone only during office hours**
- **Answering the office telephone after hours with a recording telling members to leave a message.**
- **Answering the office telephone after hours with a recording directing members to go to the ER for needed services.**
- **Returning after-hours calls outside of a 30-minute time frame.**

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If you have questions, contact your Provider Relations representative.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention. SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers. Clients may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the client to treatment if the screening results reveal severe risk of alcohol or substance abuse.

SBIRT Training

Providers that perform SBIRT must be trained in the correct practice of this method and will be required to complete at least four hours of training. Proof of completion of SBIRT training must be maintained in an accessible manner at the provider's place of service. Information regarding available trainings and standardized screening tools can be found through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Screening

Screening clients for problems related to alcohol or substance use identifies the individual's level of risk and determines the appropriate level of intervention indicated for the individual. Providers must explain the screening results to the client, and if the results are positive, be prepared to subsequently deliver, or delegate to another provider, brief intervention services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance abuse risk.

Brief Intervention

Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance abuse. During the session, brief intervention involves motivational interviewing techniques (such as the Brief Negotiated Interview) that is focused on raising the client's awareness of his or her alcohol or substance use and its consequences. The session is also focused on motivating the client toward behavioral change. Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a client's readiness to make behavioral changes related to their alcohol or substance use.

Note: Providers may choose to schedule multiple screening and brief intervention sessions in a rolling year in order to provide ongoing support to a client at risk for substance abuse who is receptive to behavior change.

Referral to Treatment

If the provider determines that the client is in need of more extensive treatment or has a severe risk for alcohol or substance abuse, the client must be referred to an appropriate substance use treatment provider. Referral to more extensive treatment is a proactive process that facilitates access to care for clients who require a more extensive level of service than SBIRT provides. Referral is an essential component of the SBIRT intervention because it ensures that all clients who are screened have access to the appropriate level of care. SAMHSA Treatment Locator: https://findtreatment.samhsa.gov/

Note: If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

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RIGHT*CARE*

MEMBER UPDATE

CHANGES TO RIGHTCARE'S EXTRA BENEFITS**
Starting September 1, 2017, Right*Care* has new and updated benefits for Members.

NEW PROGRAMS:

- Pregnant moms can now get up to $120 in gift cards for getting care while pregnant and after delivery:
  - $50 for completing a prenatal visit in the first trimester or within 42 days of enrollment;
  - $20 for getting a flu shot while pregnant; and
  - $50 for getting a postpartum visit between 21 and 56 days after delivery
- $50 for taking newborns to all 6 Texas Health Step visits
- Back to School Healthy Gift Pack (August each year) which includes:
  - Insulated lunch bag;
  - Healthy snacks; and
  - Facts on being healthy.
- Love to be Active Gift Pack (January each year) which includes:
  - Sports items
  - Active games; and
  - Facts on being healthy.
- Health Sleep Kit for members in Level 2 or 3 Asthma Case Management which includes:
  - Pillow protector
  - Mattress cover
  - And info on taking care of asthma at home

UPDATES:

- Short-term Phone Help now offers gift cards to pregnant members who have a pre-paid cell phone.
- Antipsychotic medication adherence gift card program
- $50 towards newborn car seat is now just the 4-month Texas Health Step visit to qualify.

REMOVED:

- Weight Management Pedometer
- Healthy Outcomes
- Gift cards for immunizations
- Step up Scale Down Weight loss program

Restrictions and limitations may apply.

Right*Care* is here to help. For more information on the changes visit our website at www.rightcare.swhp.org or call us at 1-855-TX-RIGHT (1-855-897-4448).

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-897-4448 (TTY: 7-1-1). Scott & White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-897-4448 (TTY: 7-1-1). Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-897-4448 (TTY: 7-1-1). Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Taxonomy

Professional Claims Submitted to MCOs Must IncludeRendering Provider Taxonomy Code, Effective September 1, 2018

Effective September 1, 2018, the rendering provider taxonomy code must be included on professional claims submitted to Managed Care Organizations (MCOs).

Currently, the National Provider Identifier (NPI) of the rendering provider actually providing the service to the client is required on professional claims billed to MCOs.

The Federally Mandated Provider Enrollment for Federally Qualified Health Centers (FQHC) Webinar Frequently Asked Questions (FAQ) document provides additional information about the rendering provider taxonomy code requirement. The FAQ document can be located in the Helpful Links section of the Provider Enrollment – Texas Medicaid – New Providers page.

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

Medical Policy Coverage Updates

The Peer to Peer Opportunity policy has been added to the Medical Coverage Policies and is available to RightCare providers.

RightCare will afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician prior to the issuance of an adverse determination consistent with Texas Administrative Code and Texas Insurance Code regarding adverse determinations.

Please visit the Provider Home Page on **rightcare.swhp.org** to view the medical policy in its entirety.

If you have any questions regarding SWHP's Medical Coverage Policies, please do not hesitate to contact the SWHP Customer Advocacy Department at 1-800-321-7947 or 254-298-3000, or email the SWHP Medical Directors at **SWHPMedicalDirectors@BSWHealth.org**.

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RIGHTCARE

Obstetric Benefit

RightCare would like to make you aware of a notice posted on the TMHP website.

Effective December 1, 2017, benefits for obstetric procedure codes 59812, 59820, and 59821 will change for Texas Medicaid. Claims submitted for the surgical treatment of an early intrauterine failed pregnancy must include one of the following diagnosis codes as the referenced or primary diagnosis: O021; O0339; O034; O071; O0730; O0739.

Providers must conduct a comprehensive medical history and examination to make a definitive diagnosis of early intrauterine failed pregnancy. The diagnosing of the client may also require the following procedures, which may be separately reimbursed:

- Serum human chorionic gonadotropin (hCG) testing
- Other lab tests
- Ultrasound examination

Documentation of the client's early intrauterine failed pregnancy and the surgical treatment must be maintained by the performing provider in the client's medical record. Procedure codes 59812, 59820, and 59821 will no longer require the following:

- Modifier G7
- Physician certification statement

Note: Providers may refer to the current Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook, subsection 4.1.7, "Obstetric Ultrasound," for additional information on limitations for obstetric ultrasounds.

For any questions or concerns, please contact RightCare Customer Service at 1-855-TX-RIGHT (1-855-897-4448) from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday (except on state-approved holidays).

Therapy Policy

RightCare would like to know if any of the following occur when scheduling and/or treating RightCare members for any therapy services:

- your office cannot treat a patient at the frequency commensurate with that member's assessed needs;
- your office creates a waiting list for Medicaid beneficiaries; or
- your office can no longer accept new patients.

If any of the above is the case with your office, please contact RightCare Customer Service by sending an email to **SWHPProviderRepresentatives@BSWHealth.org** immediately to assist in eliminating any access to care barriers for our members.

For any questions or concerns, please contact RightCare Customer Service at 1-855-TX-RIGHT (1-855-897-4448) from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday (except on state-approved holidays).

Neonatal Designations

A new rule for neonatal levels of care designation was adopted on June 9, 2016, as part of House Bill 15. More information on this rule can be found in the Texas Administrative Code, Title 25, Part 1, Chapter 133, Subchapter J.

By September 1, 2018, hospitals will need to have a neonatal level of care designation. By September 1, 2020, hospitals will need to have a maternal level of care designation. A hospital that has not received a neonatal level of care designation or a maternal level of care designation by the above dates will not be eligible to receive reimbursement through the Medicaid program for neonatal and maternal services, with the exception of emergency services as required to be provided or reimbursed under state or federal law.

The Department of State Health Services (DSHS) is currently accepting applications for neonatal level of care designation. Applications must be received by the DSHS before July 1, 2018, to be approved for designation by the Executive Commissioner before September 1, 2018. Applications and additional resource documents can be found at the following website: **https://www.dshs.texas.gov/emstraumasystems/neonatal.aspx**.

RightCare is committed to keeping you informed. Please contact RightCare Customer Service at 1-855-TX-RIGHT (1-855-897-4448) if you have any questions regarding this notification.

Updated PA

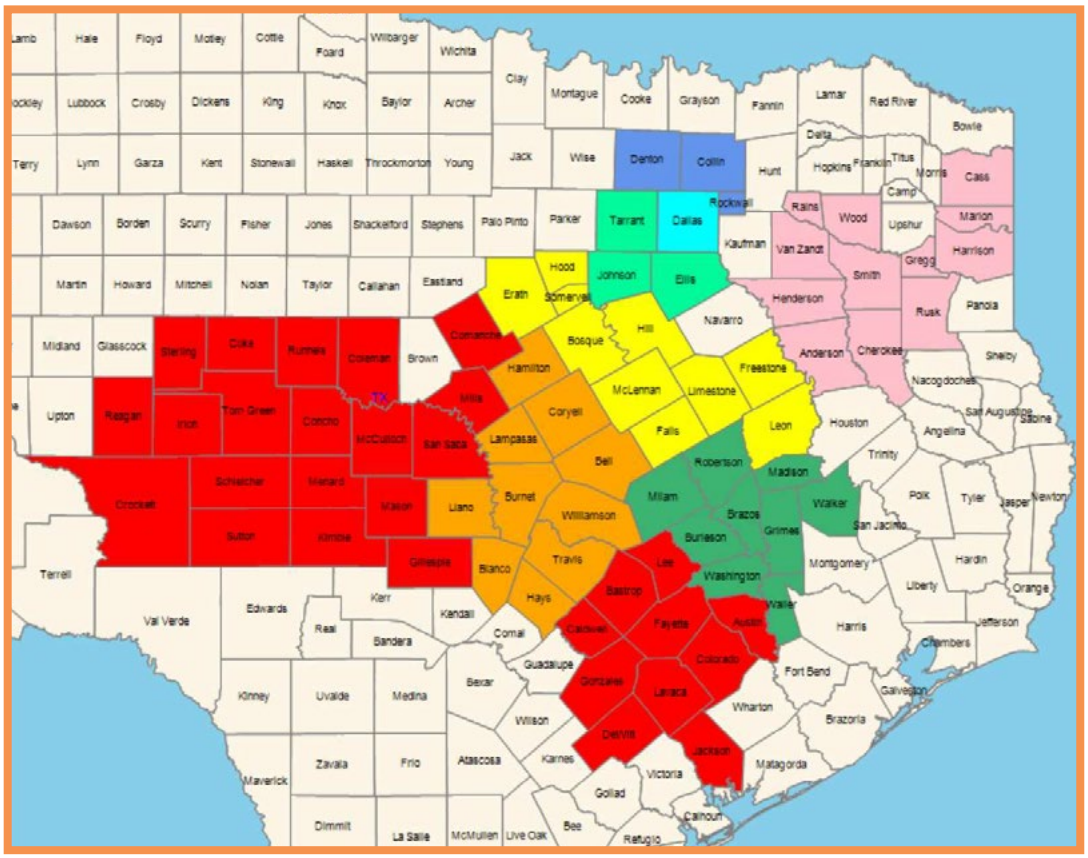
The current RightCare Prior Authorization Lists are located on the Authorizations page at rightcare.swhp.org.

Please note that if a service or procedure is not on any of the Prior Authorization Lists, then it does not require prior authorization. Please also note that all services or procedures performed by non-participating providers do require prior authorization. Please review the Prior Authorization Lists before submitting your requests.

For any questions or concerns, please contact RightCare Medical Management at 1-855-691-7947 from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday (except on state-approved holidays).

RightCare Provider Relations
Representative Territory Map

Who is your RightCare Provider Relations Representative ("PR Rep")? To identify who your PR Rep is, please use the following map, which lists the name and cell phone number of each PR Rep, along with a color-coded legend that shows the counties that each PR Rep covers. The PR Reps serve as your liaison with RightCare. They are available to assist you with information regarding policies, procedures, questions, and issues or concerns.



	Bobbie Weakly	254-780-7834		Matthew Munoz	254-374-0900
	Claudia Santillan	214-814-1392		Neha Patel	214-617-8992
	Crystal Cochran	254-654-4142		Bobbie Weakly	254-780-7834
	Liz Mullenax	254-541-8057		Bobbie Weakly (Statewide)	254-780-7834
	Louis Limas	817-221-0682			