

the RightCare update

a quarterly publication for participating providers for RightCare



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ACA Re-enrollment for Medicaid Providers

As a requirement of the Patient Protection and Affordable Care Act (PPACA), state Medicaid agencies must revalidate the enrollment of all providers in state Medicaid programs. The original re-validation deadline was March 24, 2016, and was extended by the Centers for Medicare and Medicaid Services (CMS) to allow states additional time to process provider applications. For Texas Medicaid, this means all providers, including ordering and referring providers, who have not met all PPACA revalidation requirements must do so through re-enrollment by Sept. 24, 2016.

To avoid disenrollment on Sept. 25, 2016, and possible disruption in claims payment, providers should submit a re-enrollment application to the state or TMHP immediately.

APPLICATIONS RECEIVED ON OR BEFORE JUNE 17, 2016

To avoid potential disruption in payment, a complete re-enrollment application must be received

on or before June 17, 2016 in order to be re-validated by Sept. 24, 2016. For Texas Medicaid, this means all providers, including ordering and referring providers, who have not met all PPACA re-validation requirements must do so through re-enrollment by Sept. 24, 2016. Complete applications that are received on or before June 17, 2016, will most likely complete the re-enrollment process by Sept. 24, 2016. In the event that the re-enrollment process is not completed by Sept. 24, 2016, and the provider is still working toward addressing identified deficiencies at that time, the provider will continue to remain enrolled in Texas Medicaid as long as the provider continues to respond to deficiency notifications within the defined time frame for response. Continued enrollment is contingent upon continuing to meet deficiency correction timelines and receiving final application approval. Providers should submit a re-enrollment application to the state or TMHP today.

APPLICATIONS RECEIVED AFTER JUNE 17, 2016

Texas Medicaid will normally process complete applications received after June 17, 2016; however, Texas Medicaid cannot guarantee that those applications will be completely processed by the Sept. 24, 2016 deadline. If final approval on an application received after June 17, 2016 is not completed by Sept. 24, 2016, the provider will be dis-enrolled from Texas Medicaid. Providers including, but not limited to, ordering and referring providers, will be dis-enrolled from Texas Medicaid with an effective date of Sept. 25, 2016 if the application is received after June 17, 2016, and a final determination on the application is pending. Though these applications will continue to be processed, a gap in enrollment will exist between Sept. 25, 2016,

and the date the application is approved. Providers whose applications are denied will remain dis-enrolled with an effective date of Sept. 25, 2016. Providers with a gap in Medicaid enrollment will not be eligible to receive reimbursement for claims with dates of service during the time the provider is not enrolled in Texas Medicaid. If the re-enrollment application is approved at a later date, the re-enrollment date will be the date the application was approved. The effective date will not be retroactive to the date the provider was dis-enrolled. Additionally, dis-enrolled providers will not be eligible to participate in Medicaid managed care organizations (MCOs) or dental maintenance organizations (DMOs) during the dis-enrolled period.

Medicaid Third-Party Recovery

Reminder Regarding Provider Requirements

To the extent allowed by federal law, a healthcare service provider must seek reimbursement from available third-party insurance that the provider knows about or should know about before billing Texas Medicaid. Medicaid coverage is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been paid.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third-party resources (TPR) or other insurance. A TPR is a source of payment for medical services other than Medicaid, including no-fault automobile insurance such as personal injury protection and automobile medical insurance.

Providers must make a good faith effort to determine, at the time services are delivered, or at any time thereafter, whether the services being provided to the member are a result of injuries caused by a person who is or may be liable for payment of the services.

Providers must submit information relating to the existence or possible existence of third-party liability obtained from the member or legal representative of the member at the time a claim is submitted to the health plan for payment, or at any time thereafter, or when an informational claim is submitted under the provisions of Subchapter A, Division 1 §354.1003 of the Texas Administrative Code, relating to Time Limits for Submitted Claims. Scott & White Health Plan will avoid payment of trauma-related claims where third-party resources are identified prior to payment.

HHSC Uniform Managed Care Contract, 8.2.8 Third Party Liability and Recovery and Coordination of Benefits Texas Medicaid Provider Procedures Manual, Section 4.12 Third Party Liability (TPL) Title 1, Part 15, § 354.2322, Texas Administrative Code



Texas physicians can now e-prescribe **controlled substances (EPCS)**

Electronic prescriptions for controlled substances are now allowed in Texas. In 2013, the Texas Department of Public Safety adopted Drug Enforcement Administration issued rules that allow for the electronic prescribing of schedule II controlled substances.

More than 80 percent of pharmacies in Texas accept electronic prescriptions for controlled substances (EPCS), and it is believed to be a simple, more secure form of prescription delivery. EPCS allows for increased prescription accuracy, resulting in improved patient safety.

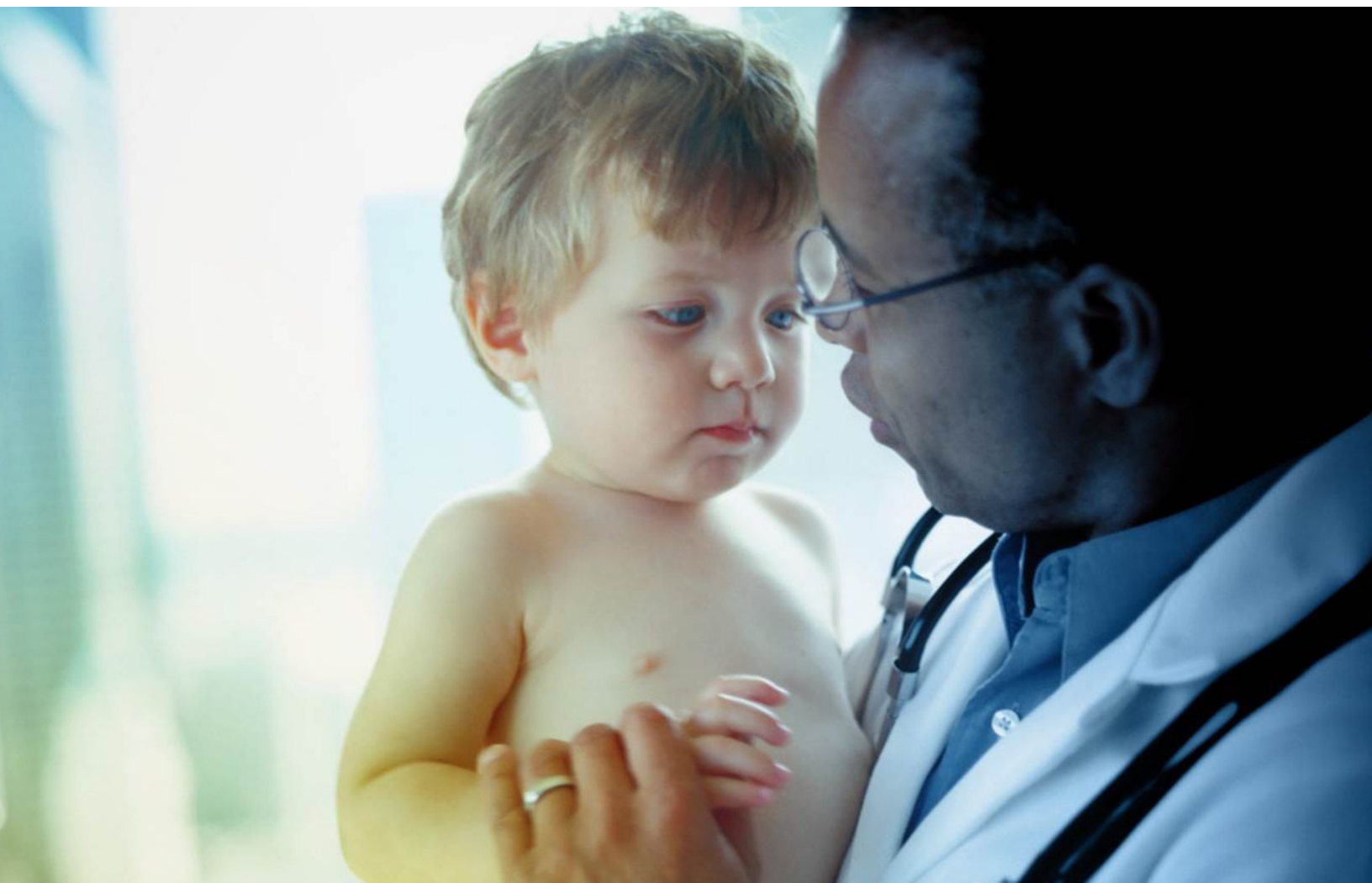
To learn more about EPCS visit:

<http://getepcs.com>

Questions can be emailed to

Medicaid_HIT@hhsc.state.tx.us

with EPCS as the subject.



Appointment **Wait Times**

Health and Human Services Commission (HHSC) directs that all contracted RightCare providers from Scott & White Health Plan be in compliance with the Uniform Managed Care Contract rule 8.1.3.1 Waiting Times for Appointments. The chart below details the rule.

LEVEL/TYPE OF CARE	TIME TO TREATMENT (CALENDAR DAYS)
Treatment for an Urgent Condition, including urgent specialty care	Provided within twenty-four (24) hours
Routine primary care (child and adult)	Provided within fourteen (14) days
Preventive health services for newborn members	Offered within fourteen (14) days of enrollment
Preventive health services for new child member	Offered within ninety (90) days of enrollment
Initial outpatient behavioral health visits (child and adult)	Provided within fourteen (14) days
Preventive health services for adults	Offered within ninety (90) days of enrollment
Prenatal care (not high-risk)	Provided within fourteen (14) days of request
High-risk pregnancies or new members in the third trimester	Offered within five (5) days of request

Six components required for completion of Texas Health Steps medical checkups

Texas Health Steps (THSteps) provides medical checkups and preventive services for Medicaid client's birth through 20 years of age based on the Texas Health Steps Periodicity Schedule. The Periodicity Schedule lists specific medical screening components for infants and children and the various ages when screenings are required. All components must be completed and documented appropriately during each checkup for the checkup to be considered complete.

Texas Health and Human Services Commission (HHSC) procured the services of Altarum Institute to complete a study of THSteps medical checkup completeness. The study was conducted via chart review and was completed in March 2015. The results of the study were recently released to each managed care organization. Below are the average medical checkup completion rates for RightCare providers for each of the six required elements:

Health History	Physical Exam	Immunizations	Lab Tests	Health Education	Dental Referral	Overall Average	N
69.2%	92.9%	57.3%	55.5%	82.6%	26.1%	64.3%	321

RightCare encourages all THSteps providers to monitor individual practices to ensure THSteps medical checkup completeness in each of the six areas. A THSteps orientation will be placed on the RightCare website in the near future.

Additional resources:

Texas Health Steps Provider Forms web page (on the DSHS website)

- 1-877-THSTEPS (DSHS): 1-877-847-8377
- TMHP General Inquiry: 1-800-925-9126
- Texas Health Steps Dental (TMHP Contact Center): 1-800-568-2460

Pediatric Asthma **Management**

Asthma affects more than 5 million children in the United States. Each year, asthma accounts for more than 3 million physician visits, 570,000 emergency department visits, 164,000 hospital stays, 8.7 million prescriptions and 10 million missed school days (NIH, 2007). The National Asthma Education and Prevention Program provide guidelines for improving asthma care. By adhering to these guidelines, physicians can prescribe an asthma management plan to relieve symptoms, control disease and allow normal activity in children. Before the age of 5, 80 percent of children with asthma will develop symptoms. These symptoms include coughing, wheezing, shortness of breath, rapid breathing and chest tightness (Wright, 2004). These symptoms are usually worse during evening or early morning hours. There are certain triggers such as exercise, cold weather or allergens that can precipitate symptom onset. In children, clinical assessment is the primary diagnostic tool. However, pulmonary function tests should be

done to confirm the diagnosis of asthma. An asthma management plan should include education, trigger avoidance, and medication. The primary goal of the management plan is to enable children to function without limitations from asthma (Chipps, 2011). Education for patients and their caregivers must focus on the avoidance of triggers, the importance of compliance, the use of prescribed medication, and proper training on the use of inhalation devices.

Chipps B, Zeiger RS, Murphy K, et al. Longitudinal validation of the test for Respiratory and Asthma Control in Kids in pediatric practices. *Pediatrics* 2011; 127:e737. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051) Wright RJ, Mitchell H, Visness CM, et al. Community violence and asthma morbidity: the Inner-City Asthma Study. *American Journal of Public Health* 2004; 94:625

Diabetes Prevention **Starts During Pregnancy**

Diabetes rates have quadrupled since 1980 with the vast majority of new cases being type 2 diabetes mellitus. In addition to the 9.3 percent of the American population with diabetes, the CDC also published that 1 in 3 American adults has pre-diabetes (CDC, 2016). The good news is that the American Diabetic Association (ADA), the CDC, and the National Institutes of Health (NIH) all agree: Type 2 diabetes is a metabolic disease that can be prevented, or its onset prolonged, through lifestyle modification, diet control, and overweight/obesity control.

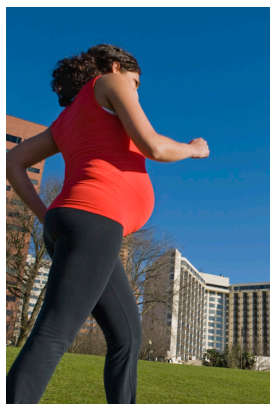
It has long been known that gestational weight gain has significant short- and long-term implications for both the mother and child. Some of the risks for excessive gestational weight gain include: macrosomia, postpartum weight retention, maternal obesity, and an

increased risk of child obesity. In a recent study regarding gestational weight gain, 47 percent of American pregnant women gained more than the recommended weight (Deputy, Sharma, & Kim, 2015). Increased weight gain, especially early in pregnancy, represents statistically significant, and yet modifiable, risk for gestational diabetes. It is also well-documented that nearly half of women with a history of gestational diabetes will develop type 2 diabetes over the course of the next 10 years. According to studies done at Yale University School of Medicine, children who are born to mothers with gestational diabetes are six times more likely to have diabetes (Rivas, 2014). And women who developed gestational diabetes during a previous pregnancy have a 60 percent chance of developing it again.

For years, researchers evaluated the effects of both genetics and lifestyle modifications on the incidence of diabetes. At first, it was proposed that type 1 diabetes was genetic while type 2 was the result of lifestyle choices. At the turn of the century, research looked into the effects of pediatric onset of diabetes in teens. Was the removal of physical education to blame? Fox News Health recently reported a 3-year-old Texan diagnosed with type 2 diabetes (Fox News, 2015). Looking into the root cause, researchers found that type 2 diabetes travels down the family tree at rates well above that of type 1.

Risk of developing type 2 diabetes when another family member has type 1 diabetes (Schneider, 2014)

Father	15-33%
Sibling	33%
Mother	40%



Based on this new understanding of type 2 diabetes, the CDC has recommend a few simple steps that can be taken to cut these risks in half:

- Screen women at risk for Gestational Diabetes during first prenatal visit.
- Monitor gestational weight gain.
 - Consider a referral to dietician/nutritionist - for the whole family.
 - Encourage weight loss - for the whole family.
- Encourage breastfeeding until the age of 9 months.
- Screen both the mother and child for diabetes at regular intervals post-delivery.

CDC. (2015, December 1). CDC - Number of Persons - Diagnosed Diabetes - Data & Trends - Diabetes DDT. Retrieved from <http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm> CDC. (2016, January 14). National Diabetes Prevention Program | Diabetes | CDC. Retrieved February 1, 2016, from <http://www.cdc.gov/diabetes/prevention/index.html> Deputy, N. P., Sharma, A. J., & Kim, S. Y. (2015). Gestational Weight Gain - United States, 2012 and 2013. Morbidity and Mortality Weekly Report (MMWR), 64(43), 1215-1220. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6443a3.htm?s_cid=mm6443a3_e Fox News Health. (2015, September 17). 3-year-old with Type 2 diabetes youngest diagnosed in world. Children's Health. Rivas, A. (2014, August 25). Exposure to Gestational Diabetes Makes Kids 6 Times More Likely to Have Diabetes. Medical Daily. Retrieved from <http://www.medicaldaily.com/exposure-gestational-diabetes-makes-kids-6-times-more-likely-have-diabetes-299724> Schneider, C. (2014, September 8) Diabetes and the Risk to Your Family Tree. DiabetesCare.Net Retrieved from: <http://www.diabetescare.net/authors/clara-schneider/diabetes-and-the-risk-to-your-family-tree>

An Easy Way to Capture the Quality of Prenatal & Postpartum Care

There are hundreds of Current Procedural Terminology (CPT) codes that are used for reimbursement purposes, which may not always represent the quality of care a patient receives. However, there are some prenatal and postpartum category II codes that can be used for performance measurement. The use of 0500F, 0502F, 0503F patient management codes is an easy way to capture professional level performance for specific clinical purposes, such as prenatal and postpartum care. The use of category II codes will decrease the need for record abstraction and chart reviews, and thereby minimize administrative burden on physicians and other health care professionals, hospitals, and entities seeking to measure the quality of patient care.

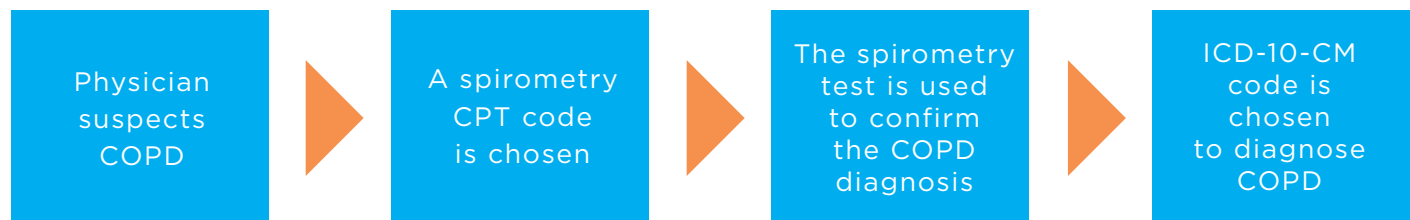
The code requirements are:

- 0500F** Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care; report the date of visit and the date of the last menstrual period)
- 0501F** Subsequent prenatal care visit (excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care, such as an upper respiratory infection)
- 0503F** Used for a postpartum care visit

Spirometry Testing for Chronic Obstructive Pulmonary Disease (COPD)

On October 1, 2015, the new American Academy of Professional Coders (AAPC) implemented the new ICD-10-CM codes to replace the previously used ICD-9-CM codes. The implementation of the new ICD-10-CM codes increased the total number of codes for each individual disease or diagnoses from the old ICD-9-CM codes. Like most of the other diseases, COPD saw an increase in the number of codes used to identify the diagnosis. The use of and the proper coding for spirometry testing is important based on the recommendation from National Committee for Quality Assurance (NCQA). NCQA measures the use of spirometry testing for patients 40 years of age or older with a new diagnosis of COPD or newly active COPD. This is a measurement every accreditation-seeking health plan must comply with, including Scott & White Health Plan.

Now that we know spirometry testing is important to NCQA, let's bring coding for spirometry testing and COPD together. NCQA recommends that patients receive appropriate spirometry testing to confirm the diagnosis of COPD in two years prior to the diagnosis or within six months of the diagnosis. In the past (ICD-9-CM), there was only one code for the diagnosis of COPD: 496. With ICD-10-CM, a physician can choose one of several codes to diagnose COPD: J44.0, J44.1, J44.9. Not only is there an increase in the number of codes that can be used, but there are additional codes to identify specific circumstances as they relate to COPD, such as exposure to environmental tobacco smoke, history of tobacco use, or tobacco dependence. To ensure correct and timely processing of claims, the appropriate COPD code should be selected with a spirometry CPT code to identify that a spirometry test was used to confirm the diagnosis of COPD: 94010, 94014-94016, 94060, 94070, 94375, 94620.



While learning the new ICD-10-CM codes, physicians can utilize the Epic 3M Encoder to help identify the proper code needed for any disease.

National Committee for Quality Assurance. (2015). HEDIS 2016 Technical Specifications for Health Plans (Vol. 2). Washington, DC: National Committee for Quality Assurance.

