RightCare
SCOTT&WHITE HEALTH PLAN
Now part of Baylor Scott & White Health

# The RightCare Update

WINTER 2015 A QUARTERLY PUBLICATION FOR PARTICIPATING PROVIDERS FOR RIGHTCARE

# Medicaid Providers Must Re-Enroll in Texas Medicaid by March 2016

Federal Medicaid Regulations mandate that all providers must re-enroll in Texas Medicaid by March 2016.

Texas Medicaid must comply with federal regulations, which require all providers to revalidate their enrollment information every three to five years. In accordance with this mandate, the Centers for Medicare & Medicaid Services (CMS) require that states complete the initial re-enrollment of all providers by March 24, 2016. For Texas Medicaid, any provider enrolled before January 1, 2013, must re-enroll by March 24, 2016. Providers can begin this process immediately.

Federal regulations at 42 CFR 455.410 and 455.450 require that all participating providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment.

CMS has defined three levels of risk (limited, moderate and high) and assigned provider types to each category based on assessment of risk of fraud, waste, and abuse. For Medicaid provider types not recognized under Medicare, HHSC has assessed the risk using similar criteria to those used by CMS.

Another requirement from the regulation requires that, beginning on or after March 25, 2011, States must collect the applicable application fee for any newly enrolling or reenrolling institutional provider. This requirement does not apply to individual physicians or non-physician practitioners, or providers that are enrolled in Medicare or another State's Medicaid program or CHIP or to those that have already paid the fee to Medicare or another State Medicaid program or CHIP. As of calendar year 2015, the application fee is $553.

Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions (FAQ) can be found on the Texas Medicaid Healthcare Partnership (TMHP) website http://www.tmhp.com/TMHP_File_Library/ACA/Affordable%20Care%20Act%20FAQs.pdf)

The purpose of this FAQ is to answer the questions that Texas Medicaid providers might have about changes to Texas Medicaid enrollment. The FAQ also outlines in detail the risk categories and level of screening associate with each and also speaks to the application fee exceptions. Subjects covered in the FQA include

- Risk Categories
- Provider Screening
- Application Fee
- Re-enrollment
- Surety Bonds
- Enrollment of Ordering and Referring-Only Providers
- Compliance Program
- PCP Rate Increase
- For Assistance Completing the Application or Other ACA Questions
- Additional ACA Resources and Education

TMHP will hold workshops in various locations around the state, so that providers will have the opportunity to receive personalized help with the re-enrollment process. Providers will be informed of the locations of the workshops, along with specific dates and times, in upcoming TMHP articles (http://www.tmhp.com/Pages/Topics/ACA.aspx). Please contact a TMHP provider enrollment representative for guidance on the re-enrollment process at 1-800-925-9126, option 2.

# Balance Billing the Patient

Scott & White Health Plan does not allow you to balance bill patients for covered services.

Balance billing is the practice of billing the patient for the difference between what Scott & White Health Plan pays for covered services and the "retail" price you charge uninsured patients for those services.

**Review your contract for details**

In your contract with us, it states that you shall not look to Scott & White Health Plan members for payment for covered services, except to the extent that the applicable Plan specifies a copayment, coinsurance or deductible, or the service is not a covered benefit.

**Balance billing rules under Medicare**

The Medicare Managed Care Manual, Chapter 4, Section 170, states in part: "Medicare Advantage members are responsible for paying only the plan-allowed cost-sharing (copayments or coinsurance) for covered services."

If a member inadvertently pays a bill, which is Scott & White Health Plan's responsibility, you must refund the amount to the enrollee.

**Balance billing rules under Medicaid**

While providers and facilities may choose whether to participate in the Medicaid program, those who do must comply with all applicable guidelines, including balance billing. It's also important for providers to understand that Medicaid is considered to be the payer of last resource, meaning that if the patient has other coverages, they should be billed prior to billing Medicaid.

It goes against the Medicaid guidelines to balance bill a Medicaid patient, their family or their power of attorney for any unpaid balance once Medicaid has paid what they allow under the Medicaid fee schedule. This simply means that the provider must adjust off the leftover balance once any applicable charges for a copayment, deductible or coinsurance is met.

NOTE: A balance does not constitute, "coinsurance" due.

42 C.F.R. § 447.15 Acceptance of State payment as payment in full

A state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.

Basically, this means that a provider is not to bill the difference between the amount paid by the state Medicaid plan and the provider's customary charge to the patient, the patient's family or a power of attorney for the patient.

Billing and coding personnel should be familiar with their state guidelines pertaining to the proper procedures and requirements for billing Medicaid.

For further questions and information, please contact Provider Relations at 1-800-321-7947, ext. 203064.

# Texas Health Steps Policy Change

**Texas Health Steps Policy Change effective November 1, 2015** - Benefit criteria for Texas Health Steps medical checkups will change for dates of service on or after November 1, 2015.

**Diagnosis Codes** – Diagnosis codes Z0000 and Z0001 will be added as payable diagnosis codes for procedure codes 99385 and 99395.

**Laboratory Screening** - Age-appropriate and risk-based laboratory testing as noted on the periodicity schedule is considered part of the medical checkup.

- Anemia screening- removal of the mandatory screenings at ages 18 months and females at 12 years of age, leaving the mandatory screening at 12 months of age only.
- Human Immunodeficiency Virus (HIV) screening- to add to the current risk based screening for ages 11 through 20 years, the mandatory requirement to screen once between the ages of 16 to 18 years of age, regardless of risk.
- Dyslipidemia Screening (previously hyperlipidemia screening)-to add to the current risk based screening for clients 24 months to 20 years of age, mandatory screening requirements once for all clients between the ages of 9-11 years of age and again for all clients between the ages of 18-20 years of age, regardless of risk.

**Autism Screening** - The Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT R/F) may also be used to complete the required autism screening at 18 and 24 months of age.

**Mental Health Screening** – Mental health screening is a required component at each checkup birth through 20 years of age. Mental health screening using one of the following validated, standardized mental health screening tools recognized by THSteps is required once for all clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)

Procedure code 99420 must be submitted for mental health screenings when one of the validated, standardized mental health screening tools recognized by THSteps is used. Procedure code 99420 must be submitted on the same date of service by the same provider as procedure code 99384, 99385, 99394, or 99395, and will be limited to once per lifetime. Providers may be separately reimbursed when screening is completed using one of the required tools. The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals that are made. Mental health screening at other checkups does not require the use of a validated, standardized mental health screening tool.

**Newborn Screening** - State-mandated newborn screening for critical congenital heart disease (CCHD) is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 33, §§ 33.011, and the Texas Administrative Code (TAC), Title 25, Part 1, Chapter 37, Subchapter E, §§ 37.75 - 37.79.

**Telemedicine/Telehealth Services** - THSteps preventive care medical checkups are not a benefit as a telemedicine or telehealth service.

# Prenatal and Postpartum Care

RightCare from Scott & White Health Plan (RightCare) focuses on improving maternal well-being and birth outcomes of our members. In an effort to ensure expected mothers are seen within 42 days of RightCare enrollment and postpartum mothers are seen between 21 and 56 days after delivery, a multidisciplinary team of nurses, social workers and outreach staff offers assistance to schedule prenatal and postpartum care (PPC) visits in a timely manner.

To increase the quality of PPC, the National Committee for Quality Assurance (NCQA) recommends that proper obstetric (OB) coding, documentation and procedures are followed.

For prenatal and postpartum coding, the NCQA approved International Statistical Classification of Diseases (ICD-10) and Current Procedural Terminology (CPT) value sets for OB services. In 2016, Scott & White Health Plan (SWHP) will disseminate coding resources that will assist providers to easily access prenatal and postpartum coding information.

The national standard for prenatal documentation requires an OB/GYN or other prenatal care practitioners (i.e., CNM, NP practicing OB care) to record the date when the prenatal care visit occurred and evidence of one of the following:

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).

- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or
  - TORCH antibody panel alone, or
  - A rubella antibody test/titer with an Rh incompatibility blood typing, or o Echography of a pregnant uterus.

- Documentation of LMP or EDD in conjunction with either of the following:
  - Prenatal risk assessment and counseling/ education.
  - Complete OB history

For postpartum care, NCQA requires an OB/GYN or other prenatal care practitioners (i.e., CNM, NP practicing OB care) to record the date when the postpartum care visit occurred and evidence of one of the following:

- Pelvic exam

- Evaluation of weight, BP, breast and abdomen.
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.

- Notation of postpartum care, including but not limited to:
  - Notation of postpartum care, "PP care," "PP check," "6-week check."
  - A pre-printed "Postpartum Care" form in which information was documented during the visit.

If you are an OB/GYN provider and would like more information regarding the quality of prenatal or postpartum care, or are interested in participating in PPC initiatives, contact the SWHP Quality Improvement Department at 254-298-3397.

## Upper Respiratory Tract Infection (URTI): No Reason to Visit the ED

Would you encourage your patients to go to the Emergency Department (ED) when they have the following symptoms:

- Sniffles
- Cough
- Congestion
- Sore Throat
- Ear Infections
- Green or Yellow Mucus

None of the symptoms listed above are solely a sign of a bacterial infection; therefore, an ED visit is not needed. When patients have these symptoms, it is important to encourage them to avoid the ED and come in for a routine office visits or after-hours office visit.

The National Committee for Quality Assurance (NCQA) recommends that medical professionals encourage over-the-counter remedies. Studies show cough suppressants, plenty of fluids, and plenty of rest are the best ways to treat a viral respiratory infection. It is important to remind patients that antibiotics will not treat a viral respiratory infection. A viral respiratory infection needs time to run its course, which can take as long as two weeks (Cleveland Clinic, 2007).

According to the New England Healthcare Institute (2010), unnecessary use of the ED can result in higher costs for member and the healthcare system, while putting additional strain on healthcare resources. Remember, the symptoms listed above are normal for a viral respiratory infection. Encourage members during routine care visits to consult their primary care physician if the symptoms listed above continue.

**References:**

Cleveland Clinic. (2007). The common cold & viral upper respiratory illness (Viral URI). Retrieved from https://my.clevelandclinic.org/ccf/media/files/Head Neck/Viral URI patient info 2007 trifold.pdf

New England Healthcare Institute. (2010). A matter of urgency: Reducing emergency department overuse. Retrieved from http://www.nehi.net/writable/publication files/file/nehi ed overuse issue brief 032610finaledits.pdf

# Urgent Care and After-Hour Clinics

Approximately 85% of patients who go to an ER do not have a true medical emergency. According to the Division of Health Care Statistics, U.S. Department of Health and Human Services, only 15 % of patients seen at hospital emergency rooms were truly emergency cases. Studies have shown that urgent care facilities provide the same level of care as the ER and the cost is 700% more in the ER!

Urgent Care and After-Hour Clinics provides the following benefits.

- Reduces strain on the overloaded ER system
- Reduces patients costs of care
- Shortens time patients spend in the clinic
- Provides superb medical treatment in comfortable surroundings

Please visit the RightCare from Scott & White Health Plan (RightCare) website to find the nearest Urgent Care and After-Hour Clinics near you, and share this information with your RightCare members (http://rightcare.prismisp.com/?ReviseSearch=true).

# Authorization Requests Through Clear Coverage

Scott & White Health Plan is excited to announce the upcoming implementation of Clear Coverage in the first quarter of 2016. Clear Coverage is a web-based system that provides an automated method for providers and health plans to manage authorizations for outpatient and inpatient services, at the point of decision. Clear Coverage enables automated authorization, notification, eligibility and direction of members to in-network service providers. Clear Coverage provides the following benefits:

- Providers have immediate access to coverage, medical appropriateness and network rules, driving the consistent application of evidence based medicine.
- Providers have transparency into the evidence based medical necessity.
- Allows for Health Plans to do exception based UM and only touch those requests that do not meet medical necessity.
- Secured PHI transmission
  - Scanning and attaching only required elements from the medical record, reducing the need to print and fax.
- Faster turnaround around times
  - Due to an instant decision based on medical necessity, when applicable
  - Eliminates need for numerous call backs when clinical is attached to the request.

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# RightCare from Scott & White Health Plan Quick Reference Card

**1-855-TX-RIGHT (1-855-897-4448)**

TEXAS STAR
Your Health Plan ★ Your Choice

## As CLAIMS

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| **Paper Submission (Claims & Corrected Claims)** | Filling deadline is 95 days from the date of service.<br>**Professional services (CPT) must be submitted on a CMS 1500 claim form.**<br>**Inpatient services must be billed on a UB-04 claim form.**<br>No handwritten claims.<br>Do not use labels, stickers, or stamps on the claim form.<br>Corrected claims should be marked corrected and must reference the original claim number to be considered. | Mail paper claims and corrected claims to:<br>**RightCare from Scott & White Health Plan**<br>**P.O. Box 3757**<br>**Corpus Christi, Texas 78463-3757** |
| **Electronic Submission (Claims & Corrected Claims)** | RightCare provides EMDEON as a clearinghouse free of charge through registration on our website.<br>**RightCare Payor ID: 74205**<br>**EMDEON Customer Service: 1-877-667-1512**<br>Corrected claims must use a resubmission code of 7 and reference the original claim number to be considered. | Providers can submit electronic claims to TMHP through **TexMedConnect** for services to Medicaid clients whose benefits are administered by a Medicaid Managed Care Organization (MCO).<br>https://secure.tmhp.com/TexMedConnect |
| **Claims Status** | RightCare's Above Health Portal: https://rightcare.abovehealth.com<br>**Claims Customer Service: 1-855-TX-RIGHT (1-855-897-4448)** | |
| **Appeals** | If a provider determines a claim needs to be appealed, the claim must be sent to the following address. Claims appeals information can be found in the Provider Manual or by visiting our website at www.rightcare.swhp.org. | **RightCare from Scott & White Health Plan**<br>**MS-A4-144, Medicaid Appeals**<br>**1206 West Campus Drive**<br>**Temple, Texas 76502-9915** |

## CHECK/VERIFY MEMBER ELIGIBILITY

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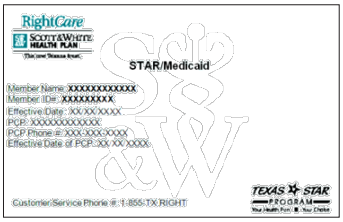
| **Ways to Verify Member Eligibility** | ❖ RightCare's Above Health Portal: https://rightcare.abovehealth.com<br>❖ Eligibility Verification Line (IVR Line): 1-800-925-9126<br>❖ Internet via TexMedConnect (registration required), see www.tmhp.com<br>❖ **Calling customer service: 1-855-TX-RIGHT (1-855-897-4448)**<br>❖ Accessing the IVR System<br>❖ Form H1027-A- Medicaid Eligibility Verification (Temporary Medicaid Card)<br>❖ RightCare Member's Medicaid ID Card<br>❖ Your Texas Benefits Medicaid ID Card |  |
| **Prior Authorizations (PA)** | While RightCare requires in-network primary care providers to refer members for specialty care, most referrals to in-network specialists do not require prior authorization.<br>The prior authorization request form and additional information may be found in your provider manual or online at www.rightcare.swhp.org. | **Medical Management**<br>**Telephone:1-855-691-7947**<br>**Facsimile: 1-512-383-8703**<br><br>**Behavioral Health Management**<br>**Telephone: 1-855-395-9652**<br>**Facsimile: 1-844-436-8779** |
| **Provider Assistance** | RightCare has Provider Relations Representatives available in your area for additional assistance and program education. Provider resources and handouts are available online at www.rightcare.swhp.org or by calling **1-855-TX-RIGHT (1-855-897-4448)**. | |

## ADDITIONAL SERVICES

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| **Value-Added Services** | ❖ Car Seats after Prenatal & THSteps Visits<br>❖ Step Up Scale Down (Weight Loss Program)<br>❖ Health-related cellular telephone services<br>❖ Dental for Pregnant Women<br>❖ Gifts for Asthmatics, Diabetics, & Weight Management<br>❖ Smoking Cessation Program & Products<br>❖ Annual Sports Physicals<br>❖ Annual Vision Exam for Adults<br>❖ Pharmacy Discount<br>❖ Additional Transportation Assistance<br>❖ Gift Card Programs<br>❖ Online Life Style Management Programs<br>❖ Diaper Program | **Pharmacy Services** | Navitus Health Solutions<br>Members: 1-855-TX-RIGHT (1-855-897-4448)<br>Providers: 1-877-908-6023<br>Pharmacy Providers: 1-877-908-6023 |
| **Medicaid Transportation Program (MTP)** | MTP: 1-877-633-8747<br>STAR Members need to call 48 business hours in advance of needing service. | **Dental Services** | DentaQuest: 1-800-516-0165<br>MCNA Dental: 1-800-494-6262<br>Liberty Dental: 1-877-550-4374 (Pregnant Women) |
| **24 Hour Crisis Hotline** | 1-844-436-8781 | **Vision Services** | Block Vision: 1-800-879-6901 |