Objectives

As a result of this training session, you will be able to:

- Understand Parkland Community Health Plan (PCHP) and its products
- Describe features and benefits of Parkland HEALTHfirst, Parkland KIDSfirst, Parkland CHIP Perinate & Parkland CHIP Perinate Newborn
- Identify Parkland HEALTHfirst and Parkland KIDSfirst members
- Describe the prior authorization, eligibility and claims submission processes
- List the behavioral health, ob/gyn, vision and Texas Health Steps services
- Locate the list of benefits on the Parkland HEALTHfirst and Parkland KIDSfirst website
- Locate additional resources about Medicaid and CHIP
- Recognize the differences between Medicaid managed care and traditional Medicaid
Overview

- PCHP contracts with the Texas Health and Human Services Commission (HHSC) to provide Medicaid Managed Care and CHIP in the Dallas service area.
- Medicaid Managed Care includes member assignment to an in-network PCP to establish a medical home. The PCP coordinates the member’s medical care, and the health plan works with the PCP, specialists, etc. to ensure appropriate care.
- HHSC determines and provides member eligibility for the Medicaid Program and CHIP to PCHP.
- PCHP does not sell or market this program directly.
- All enrollment and disenrollment is handled through HHSC’s CHIP and Medicaid enrollment broker (Maximus).
Service Areas

- Collin
- Dallas
- Ellis
- Hunt
- Kaufman
- Navarro
- Rockwall
PCHP Programs

- Parkland HEALTHfirst
- Parkland KIDSfirst
- Parkland CHIP Perinate
- Parkland CHIP Perinate Newborn
General Program Overview

- PCP selection is required or member is “defaulted” to a PCP upon enrollment into a plan
- Most specialty care is coordinated through PCP. Please note that members do not need a referral from PCPs to get behavioral health care services.
- Members access PCHP in-network Medicaid & CHIP providers
- Members may see any Texas Health Steps provider for Texas Health Steps covered services
- Copayments
  - Medicaid – copayments do not apply
  - CHIP – copayments apply based on the federal poverty level (FPL)
  - CHIP Perinate – copayments do not apply
  - CHIP Perinate Newborn – copayments do not apply
Lab services
- LabCorp

Use of contracted radiology facilities

Prior authorization required for all inpatient hospitalizations and selected outpatient services

Prescription drugs

Direct access (self-referral)
- Ob/Gyn
- Vision services – coordinated through Superior Vision
- Therapeutic optometry – in-network providers only; excludes surgery
- Behavioral health – coordinated through Beacon (Medicaid) and Beacon Health Strategies (CHIP)
- Texas Health Steps exams (Medicaid benefit only)
- Family planning (Medicaid benefit only)
General Program Overview (continued)

Additional Medicaid Programs and Covered Services

- The Early Childhood Intervention Program offers services in the home or in the community for children, birth to three years old who are developmentally delayed. Some of the services for children include: screenings, physical, occupational, speech and language therapy, and activities to help children with barriers to effective learning.

- Medicaid members are eligible to obtain DME/Medical Supplies when ordered by a network provider.
  - For equipment/supplies costing < $1000 the provider must complete the appropriate Home Health DME/Medical Supplies Physician Order Form.
  - Prior authorization is required where the cost of the medical equipment and/or supplies is over $1000.
General Program Overview (continued)

Additional Medicaid Programs and Covered Services

- LogistiCare provides transportation services to Medicaid eligible clients that have no transportation by the most cost-effective means.

  - LogistiCare provides a variety of transportation services for demonstrated medical necessity including via bus, taxi, van service, or airplane.

  - LogistiCare may pay for an attendant with a documented request demonstrating medical need, for a minor, or to accommodate a language barrier.

  - LogistiCare will reimburse gas costs if the member has an automobile but no fuel funds.

  - To arrange for transportation services, please contact LogistiCare at 1-877-633-8747.
Some Medicaid Benefits have cost or service limits. Some of these benefits include:

- Home Health, DME and Medical Supplies including, but not limited to, Diabetic Supplies, Glucose Strips, etc.
- Therapies including Occupational, Speech and Physical Therapy.
- Psychological and Neuropsychological testing.
- Outpatient mental and behavioral health services including group and individual therapy sessions.

For a full listing of Medicaid benefit limitations, please refer to the current Texas Medicaid Provider Procedures Manual, found at www.tmhp.com.
Texas Agency Administered Programs and Case Management Services (additional resources)

- Texas Department of Family and Protective Services (TDFPS) – Medicaid only
- Essential Public Health Services
- School Health and Related Services (SHARS) – Medicaid only
- Early Childhood Intervention (ECI) Case Management/Service Coordination
- Department of State Health Services (DSHS) Targeted Case Management
- DSHS Mental Health Rehabilitation (Behavioral Health)
- DSHS Case Management for Children and Pregnant Women
- THSteps Medical Case Management – Medicaid only
- THSteps Dental including Orthodontia – Medicaid Only
- THSteps Environmental Lead Investigation (ELI) – Medicaid Only
- Women, Infants, and Children (WIC) Program
- Department of Assistive and Rehabilitative Services (DARS) Case Management for the Visually Impaired
- Tuberculosis Services Provided by DSHS-Approved Providers
- Medical Transportation – Medicaid only (Transportation Services)
- Department of Aging and Disability (DADS) Hospice Services
Texas Provider Marketing Guidelines

- Purpose

  The purpose of the Texas Provider Marketing Guidelines is to provide guidance to the State of Texas Medicaid fee-for-service, Medicaid Managed Care, Children’s Health Insurance Program (CHIP), Children’s Medicaid Dental, and CHIP Dental Providers, referral to as Medicaid, on permissible and prohibited provider marketing.

  The information provided is not intended to be comprehensive, or to identify all applicable state and federal laws and regulations. Providers remain responsible for and must comply with all applicable requirements of state and federal laws and regulations.
# Texas Provider Marketing Guidelines

## Examples of Permissible and Prohibited Marketing Activities

<table>
<thead>
<tr>
<th>Permissible</th>
<th>Prohibited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sending Marketing Materials to every person within a specific zip code, without specifically targeting Medicaid clients.</td>
<td>Unsolicited personal contact such as direct mail, telephone, and door-to-door solicitation.</td>
</tr>
<tr>
<td>Sending an appointment reminder to a Medicaid client.</td>
<td>Offering gifts or other inducements designed to influence a client's choice of Provider.</td>
</tr>
<tr>
<td>Participation at a health awareness education event And making available branded giveaways valued of No more than 10 dollars, individually.</td>
<td>Providing giveaways or incentives Valued at over 10 dollars, individually, or passing out materials.</td>
</tr>
<tr>
<td>General dissemination of Marketing Materials via television, radio, newspaper, Internet, or billboard advertisement.</td>
<td>Dissemination of material or any other attempts to communicate intended to influence the Client's choice of Provider.</td>
</tr>
<tr>
<td>Provider marketing conducted at: • Community—sponsored educational event • Health fair • Outreach activity or • Other similar community or nonprofit event And which does not involve unsolicited personal contact or promotion of the provider's practice that is not intended as health education.</td>
<td>Sending Marketing Materials to a client to offer inducements or incentives.</td>
</tr>
<tr>
<td>Provider marketing for the purpose of: • Providing appointment reminder • Distributing promotional health materials • Providing information about the types of services offered by the provider • Coordination of care</td>
<td>Unsolicited personal contact at a child care facility or any other type of facility; or targeting clients solely because the client receives Medicaid/CHIP benefits.</td>
</tr>
</tbody>
</table>
Value-Added Services

- Free 24-hour nurse line
- Sports/school physicals (Medicaid and CHIP age 19 and under)
  - Available only at the Parkland COPC clinics
- Free membership to Boys & Girls Clubs of America
- Free prenatal classes and infant car seats (HEALTHfirst, KIDSfirst and CHIP Perinate)
- Free Health Education Classes
- Newsletters
Member Eligibility Verification

- Use the Parkland Community Health Plan website at: https://www.parklandhmo.com/

- Parkland HEALTHfirst
  - 1-888-672-2277 (option 3)

- Parkland KIDSfirst, Parkland CHIP Perinate, Parkland CHIP Perinate Newborn
  - 1-888-814-2352
Your Texas Benefits Medicaid Card

The Texas Health and Human Services Commission now uses digital technology to streamline verifying eligibility and accessing a member’s Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card, which replaces the Medicaid ID letter (Form 3087) clients have been getting in the mail every month.
- An online website where Medicaid providers can get up-to-date information on a patient’s eligibility and history of services and treatments paid by Medicaid.
Your Texas Benefits Medicaid Card (continued)

This is where your name appears.

This is your Medicaid ID number.

This is HHSC’s agency ID number. Doctors and other providers need this number.

If you have a health plan, its name and phone number will be listed here. Call this number if you have questions about your doctor or services.

Drug stores use these numbers.

This is the date your card was sent to you.
Parkland HEALTHfirst ID Card

Parkland HEALTHfirst members should present:

- Your Texas Benefit Card* AND
- Parkland HEALTHfirst ID Card

* A member may have a temporary Medicaid identification form (Form 1027-A), which will include the plan indicator
Parkland CHIP Perinate Newborn Member ID Card

Provider Orientation

Member Name: [NAME]
MEMBER ID: [ID]
DOB: [DATE]
EFFECTIVE:

Co-payments apply for the CHIP Perinate Newborns.

In case of an emergency, please call 911.

Indicaciones en caso de emergencia.

En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al proveedor principal (FPD) de su hijo dentro de 24 horas o tan pronto como sea posible.

Para más información sobre servicios de emergencia, favor de referirse al Manual para Miembros.

Co-payos no se aplican para el CHIP Perinate Newborns.

Co-payos no se aplican para el CHIP Perinate Newborns.

Pharmacy Coverage:
- Rx (Rx)
- PDP (PDP)
- Medicare (MED)
- Prime (PRM)

Pharmacy ID:
[PHARMACY ID]

For claims, mail to:
Claims Processing Center
P.O. Box 61000
Phoenix, AZ 85062
Phone: 888-778-7099

For general inquiries, call:
1-800-355-2582

Member Services:
1-800-355-2582

Office Hours:
Mon-Fri 8am-5pm MST

For a list of participating providers, visit:
[website link]

En caso de emergencia, favor de llamar al 911.
# Parkland CHIP Perinate Member ID Card
(<185% FPL)

## Provider Orientation

<table>
<thead>
<tr>
<th>Parkland CHIP Perinate</th>
<th>Attention Provider: You Must Call 1-855-314-2139 For Pre-certification or Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name:</strong></td>
<td><strong>Member ID:</strong></td>
</tr>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Address:</strong></td>
</tr>
</tbody>
</table>

### Health Care Services
- **Limited to the care of the unborn child.**

### Co-pagos no se aplica.
- Los servicios de la asistencia médica son limitados al cuidado del niño no nacido.

### Instructions in Case of Emergency
- **In case of an emergency, please call 911**
- **Pharmacy Coverage**
  - RX: 610006
  - RX: 610007
  - RX: 610008
  - RX: 610009
  - RX: 610010

### Hospital Facility Billing
- THI-JHU: Claim Administrator
- 123456, Suite Trace Plaza
- Austin, TX 78721

### Other Services Billing
- THI-JHU: Claim Administrator
- 123456, Suite Trace Plaza
- Austin, TX 78721

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For more information about emergency services, please refer to the manual for members.
Parkland CHIP Perinate Member ID Card (+186% FPL)

Health Care Services are limited to the care of the unborn child.

In case of an emergency, please call 911

Provider Orientation
PCHP Claims Submission for Medical

- Electronic submission

- PCHP accepts electronic filing through Change HealthCare, and accepts CMS 1500 and UB-04 formats

- Claims must be filed within 95 days from the date of service

- Payer ID# 66917
PCHP Claims Submission for Medical

- Paper claims
  
  Parkland Community Health Plan
  Attention: Claims Department
  P.O. Box 61088
  Phoenix, AZ 85082

- Claims appeals
  - Any correspondence or mail sent to PCHP regarding a true claims appeal should be specified: “Medicaid Appeals Department”
  - If the envelope does not indicate appeal, the claim will be processed as a re-submission NOT an appeal
PCHP Claims Submission for Medical

- Providers may not bill or require payment from Members for Medicaid covered services.

Providers may not bill, or take recourse against Members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to the current Texas Medicaid Provider Procedure’s Manual found on the TMHP website at www.tmhp.com
Electronic Remittance Advice and Electronic Funds Transfer Enrollment

- Forms for requesting an Electronic Funds Transfer and/or an Electronic Remittance Advice can be found on the Parkland Community Health Plan website at: https://www.parklandhmo.com/.

- When filling out these forms please:
  - Submit one enrollment form per Tax ID
  - Include your NPI #
  - Attach a voided check or bank letter
  - Obtain signatures by two authorized individuals
    - A healthcare professional – MD, CFO, CEO, etc
    - A supervisor-level authorized office or billing manager
  - Complete all sections marked with an asterisk and Fax the form to 1-855-596-8401.

- Please allow 10-15 business days for processing.
Referral Process for Medicaid and CHIP

Prior authorization for in-network referrals are not required for most specialties. Exceptions are dermatology, and any PCP other than PCP of record (or designated covering provider).

**PCP** sends Texas Standard Prior Authorization form to specialist with all pertinent information, including test results, etc., if available. *Refer to the Prior Authorization list for exceptions for specific specialty care requirements.*

**Specialist** provides follow-up information to PCP post-visit. *Refer to Prior Authorization list for procedures that require prior authorization.*
Prior Authorization Process

**Participating provider** submits TX Universal Authorization Form or other appropriate form to request services on Prior Auth list

**PCHP Patient Management** receives information and reviews eligibility, benefits and medical necessity and returns authorization to requesting provider

**PCP** may request a Prior Authorization via:
- Fax (referral form)

**Rendering provider** sends information to PCP post-visit
Behavioral Health Services

- Parkland HEALTHfirst
  - Coordinated through Beacon Health Strategies
  - 1-800-945-4644

- Parkland KIDSfirst
  - Coordinated through Beacon Health Strategies
  - 1-800-945-4644
Behavioral Health Services

- **Direct Access**
  - Members may access BH benefits, without a referral from their PCP.
  - Member Services available 24/7

- **PCP involvement**
  - Provide screening, evaluation, treatment and/or referrals (as medically appropriate) for any behavioral health problem/disorder
  - Treat for mental health and/or substance abuse disorders with their scope of practice
  - Inform members how and where to obtain behavioral health services
Behavioral Health Services

- Members have direct access to behavioral health providers.
- Beacon Health Strategies providers must send initial and quarterly (or more frequently if clinically indicated) summary reports to the PCP, with the member or member’s legal guardian’s consent.
- Beacon Health Strategies providers must refer members with known or suspected and untreated physical health problems to their PCP for examination and treatment.
- Beacon Health Strategies providers must be licensed to provide physical health care services.
- Clinical decision making is based on LOCUS, CALOCUS and TCADA standards
- Routine care must be offered within 14 days of request, urgent care within 24 hours and emergency situations must be responded to immediately
- Following an inpatient stay, members should be offered an outpatient follow up appointment within 7 days of discharge
- Screening, brief intervention, and referral to treatment (SBIRT) for substance use related issues is a benefit of Texas Medicaid. See Provider Handbook for further detail.
Behavioral Health Services

- Prior authorization is not required for routine outpatient therapy.
- Prior authorization is required for these services.
  - Inpatient admissions
  - Residential admission
  - Partial hospitalization admissions
  - Psychological and neurological testing
  - Outpatient ECT
  - Biofeedback
  - Outpatient detoxification
  - Psychiatric home care services
  - Amytal interviews
  - Applied Behavioral Analysis (ABA)

Note: Prior authorization requests for behavioral health may be phoned or faxed to PCHP
Vision Services

Vision Services coordinated through Superior Vision 1-800-879-6901

- **Direct access**
  - Members may access routine vision services, without a referral from their PCP, provided they are coordinated through Superior Vision

- **Non-routine vision services**
  - PCP can refer directly to a participating ophthalmologist for non-routine vision services
  - In-network ophthalmologists and optometrists may perform non-surgical services within the scope of their licenses without a referral from the member’s PCP or an authorization from PCHP
Pharmacy Coverage

- PCHP covers prescription medications as of March 1, 2012.
- PCHP Pharmacy plan is administered by Navitus
- Our members can get their prescriptions at no cost (Medicaid) or at low co-pays (CHIP) when:
  - They get their prescriptions filled at a network pharmacy
  - Their prescriptions are on the preferred drug list (PDL) or formulary.
- It is important that you as the provider know about other prescriptions your patient is already taking. Also, ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.
- Members should contact our Member Services for Pharmacy questions
  - Parkland HEALTHfirst 1-888-672-2277
  - Parkland KIDSfirst, Parkland CHIP Perinate, Parkland CHIP Perinate Newborn 1-888-814-2352
Pharmacy Coverage

- Navitus Texas Provider Hotline (Pharmacy) 1-877-908-6023
  - We strive to resolve each call correctly, completely, and professionally the first time. Our relentless pursuit of superior customer service is what sets us apart.
  - **Our Customer Care Commitment to our Network Pharmacies:**
    - We will be **responsive** to our customer’s needs.
    - We will be **respectful** of our customers at all times.
    - We will be **realistic** about what we can or cannot do.
    - We will **resolve** our customer’s issues in a timely fashion.
    - We will take personal **responsibility** for our customer relationships.
Pharmacy Coverage

- **Preferred drug list**
  - You can find out if a medication is on the preferred drug list. Many preferred drugs are available without prior authorization (PA). Check the list of covered drugs on our website.
  - The Texas Medicaid preferred drug list is now available on the [Epocrates drug information system](https://online.epocrates.com/home) at https://online.epocrates.com/home.
  - The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm, Pocket PC handheld device or smart phone.
Pharmacy Coverage

- **Formulary drug list**
  - The Texas Drug Code Formulary (http://www.txvendordrug.com/formulary/formulary-information.shtml) covers more than 32,000 line items of drugs including single source and multi source (generic) products. You can check to see if a medication is on the state’s formulary list. Remember before prescribing these medications to your patient that it may require prior authorization.
  
  - If you want to request a drug to be added to the formulary, please contact PCHP. We will then forward the information to the Formulary department of the Vendor Drug Program.
Pharmacy Coverage

- **Over the counter drugs**
  - PCHP also covers certain over-the-counter drugs if they are on the list. Some of these may have rules about whether they will be covered. If the rules for that drug are met, PCHP will cover the drug. Check the list of covered drugs at [www.txvendordrug.com/pdl/](http://www.txvendordrug.com/pdl/)
  - All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

- **Mail order form for your members**
  - You can assist your member in completing the MOD form (on [www.parklandhmo.org](http://www.parklandhmo.org)) if you are prescribing a maintenance medication.
  - Mail order is optional
Pharmacy Coverage

Generics

- Generic bioequivalent medications represent a considerable cost savings to health care. Those products available generically will be covered with the generic equivalent only (if the generic equivalent is on the preferred drug list), unless the brand has been specifically authorized or as otherwise noted. Generic forms of medications will be substituted as they become available unless otherwise designated. Parkland Community Health Plan may grant an exception to the generic substitution.

Obtaining Pharmacy Prior Authorization

- Navitus receives and processes pharmacy prior authorizations for our contracted Texas Managed Medicaid MCO members.
- The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC.
- Information regarding the formulary and the specific prior authorization criteria can be found at the Vendor Drug Website, Epocrates, and SureScripts certified vendors for e-Prescribing.
Pharmacy Coverage

- Prescribers can access prior authorization forms online via www.navitus.com under the “Providers” section or have them faxed by Customer Care to the prescribers office.
- Prescribers will need their NPI and State to access the portal.
- Completed forms can be faxed 24/7 to Navitus at 920-735-5312. Prescribers can also call Navitus Customer Care at 877-908-6023 > prescriber option and speak with the Prior Authorization department between 8a-5p M-F Central Time to submit a PA request over the phone.
- Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request.
- The provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.
Pharmacy Coverage

- Medications that require prior authorization will be undergo an automated review to determine if the criteria are met.
- If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization.
- When a Prior Authorization is required and the provider is not available to submit the PA request, pharmacies are to dispense a 72 hour supply subject to pharmacist professional judgment.
- The following message will be returned to pharmacies on all electronically submitted claims that rejects because the prior authorization criteria have not been met:

  “Prescriber should call our Member Services or pharmacist should submit 72 hour Emergency Rx if prescriber not available.”
Pharmacy Coverage

- **Obtaining a 72 Hour Emergency Fill**
  - Federal and Texas law require pharmacies to dispense a 72-hour emergency supply of a prescribed drug when the medication is needed without delay and the prescriber is not available to complete the prior authorization.
  - Applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical PA needing prescriber’s prior approval.
  - The pharmacy will submit an emergency 72-hour prescription when warranted; this procedure will not be used for routine and continuous overrides.
  - For further details on the 72 hour emergency supply requests, please use this link to the State VDP website: [http://www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf](http://www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf)
Pharmacy Coverage

- For a 72-hr emergency prescription, pharmacies should submit the following information:
  - “8” in “Prior Authorization Type Code” (Field 461-EU).
  - “8Ø1” in “Prior Authorization Number Submitted” (Field 462-EV).
  - “3” in “Days Supply” (Field 4Ø5-D5, in the Claim segment of the billing transaction).
  - The quantity submitted in “Quantity Dispensed” (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.
Pharmacy Coverage & DME

- Certain Disposable Medical Supplies (DMS) will be payable under the pharmacy benefit
- Some examples include Compression Stockings, Ketostix, Aerochambers, Peak Flow Meters and Diabetes Testing Supplies.
- Navitus will respond with a paid claim response if the DMS product is covered
- Submit claims for DMS in same manner as a traditional pharmaceutical drug claim
- Many Durable Medical Equipment (DME) are covered under the medical benefit
- Pharmacies are encouraged to enter into a contract directly with MCO plans for DME covered benefits
- Pharmacies may be required to be accredited for DME services to participate
Pharmacy Coverage

NAVITUS SUPPORTS E-PRESCRIBING FOR MEDICAID

- Navitus provides point of care information available through Surescripts
  - Eligibility confirmation
  - Daily updates to eligibility facilitator
- Medication history
- Formulary and PDL benefit confirmation
- Formulary “alternative” drug list
- Formulary lists will be updated no less frequently than weekly
- Navitus expects pharmacies to have ability to accept e-prescriptions and facilitate refills with prescribers
Ob/Gyn Services

- Female patients have direct access to in-network Ob/Gyn specialists
- If an Ob/Gyn needs to refer for out-of-network specialty care for related services, the physician must initiate the referral through PCHP patient management unit
- PCHP allows Pregnant Members past the 24th week of pregnancy to remain under the care of their current Ob/Gyn through the Member’s postpartum checkup, even if the provider is Out-of-Network. She may select an Ob/Gyn within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.
To obtain a list of participating dental providers, members may contact:
- Texas Health Steps at 1-877-THSTEPS (1-877-847-8377)
- PCHP Member Services
  • 1-888-672-2277

Beginning March 1, 2012, there will be 3 state-wide dental health organizations for Medicaid and CHIP

<table>
<thead>
<tr>
<th>Medicaid STAR</th>
<th>CHIP</th>
</tr>
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<tbody>
<tr>
<td>• DentaQuest: 1-800-516-0165 1-800-508-6775</td>
<td></td>
</tr>
<tr>
<td>• MCNA Dental: 1-800-494-6262 1-800-494-6262</td>
<td></td>
</tr>
</tbody>
</table>
Preventive Health Care

- Medicaid members
  - Texas Health Steps – use periodicity schedule in provider manual for members ages 0 – 21
  - Medicaid members age 21 and older – use the U.S. Preventive Services Task Force, American Cancer Society and the Centers for Disease Control and Prevention (CDC) recommendations published in the provider manual

- CHIP members
  - Well-child visits - use the American Academy of Pediatrics preventive health guidelines
The Texas Vaccines for Children Program (TVFC)

Texas leads the nation in the number of uninsured and underinsured children. The TVFC program helps to ensure that our children receive the complete series of immunizations required to protect them from vaccine-preventable diseases.

- **Benefits of Participation**
  - The TVFC program allows at-risk children to more easily access immunizations
  - The program eliminates the financial barriers to full immunization
  - Children receive vaccines from their PCP and other “medical home” providers

- **Enrollment and participation is easy**
  - More program information and an enrollment application can be found at: [http://www.dshs.state.tx.us/immunize/tvfc/default.shtm](http://www.dshs.state.tx.us/immunize/tvfc/default.shtm)
ImmTrac – the Texas Vaccine Registry

- *ImmTrac* is an important component of Texas’ strategy to improve vaccine coverage rates.
- The *ImmTrac* Registry serves to consolidate immunization records from multiple sources into a single registry.
- Texas law states that health care providers must report to *ImmTrac* all vaccines administered to a child under 18 years of age within 30 days of administration.
- *ImmTrac* allows providers Internet access to immunization histories on and also supports reminder and recall capability.
- *ImmTrac* is available free of charge to authorized health care providers.

More information about the Texas Immunization Registry is available at [http://www.dshs.state.tx.us/immunize/providers.shtm](http://www.dshs.state.tx.us/immunize/providers.shtm).
Texas Health Steps

- Also known as the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program
- Eligibility includes Medicaid recipients from birth to age 21
- Members may see any Texas Health Steps provider (self-referral)
- Covered services
  - Periodic comprehensive physical examinations
  - Periodic dental checkups
  - Hearing and vision screening
  - Immunizations and lab work
  - Case management
Texas Health Steps – Complete Checkup

- Document all components of the checkup that were performed during the visit. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for a list of the necessary elements that make up a complete check-up. The TMPPM can be found on the TMHP website at www.tmhp.com.
  - Patients’ medical records need to support diagnosis and procedures billed
  - Charts are subject to review for claims and quality of care

- Billing for Texas Health Steps checkup
  - Only complete medical checkups will be considered for reimbursement under the Medicaid managed care program
  - All components of the checkup are included in the reimbursement code for the comprehensive medical exam (Refer to the Texas Medicaid Provider Procedures Manual for the correct billing codes)
  - A provider must bill for Texas Health Steps services in accordance with state standards
Texas Health Steps Immunizations

- Immunizations and medical checkups should be administered according to the periodicity schedule
- Vaccines are supplied free of charge to Texas Health Steps providers for Medicaid clients
  - Call 1-800 SHOTS 4 U (1-800-746-8748)
  - [www.immunizetexas.org](http://www.immunizetexas.org)
- Report immunization data to
  - [www.ImmTrac.com](http://www.ImmTrac.com) or call 1-800-348-9158
Oral Evaluation and Fluoride Varnish

New benefit for Medicaid program

- Texas Health Steps providers can become certified by the Department of State Health Services to provide oral evaluation fluoride varnish
- For certification requirements, please access www.dshs.state.tx.us/thsteps
- Texas Health Steps providers can bill for oral evaluation fluoride varnish when performed on the same day as the Texas Health Steps medical check-up
As a Texas Health Steps (THSteps) provider you affect the lives of many young Texans. The care you provide helps prevent serious or chronic health-care problems and often helps young patients begin to develop positive lifelong health-care habits. Being a THSteps provider can be very rewarding. It can also be very challenging, especially when it comes to medical checkup documentation. Independent studies of Texas Health Steps medical checkups indicate that records were most commonly missing documentation of appropriate laboratory tests and immunizations.
THSteps checkups are made up of six primary components, many including individual components. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. Comprehensive health and developmental history which includes nutrition screening, developmental and mental health screening and TB screening;
2. Comprehensive unclothed physical examination which includes measurements; height or length, weight, fron-to-occipital circumference, BMI, blood pressure, and vision and hearing screening;
3. Appropriate immunizations, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV;
4. Appropriate laboratory tests which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia;
5. Health education (including anticipatory guidance); and
6. Dental referral every 6 months until the parent or caregiver reports a dental home is established.
For you to be reimbursed for THSteps checkups, each of the six components and their individual elements must be completed and documented in the medical record. 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. 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. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

In support of successful checkup documentation and to assist in documenting each of the components and elements of the checkups, the THSteps program recommends use of the THSteps Child Health Record Forms, which are available for download on the THSteps provider information webpage. Each checkup form is age-specific and can assist you with documenting all required checkup components and elements, including developmental and mental health screenings, laboratory screenings, immunizations, and the dental referral as required until the caregiver reports a dental home is established. The components and elements outlined in the forms can be integrated into electronic health records.
THSteps Checkup Documentation -- Essential to Medical Records, cont...

- To stay current on THSteps policy and available resources, visit the frequently updated THSteps website for information and policy updates. Information on checkup documentation is also available within THSteps Online Provider Education modules. These modules are free and offer continuing education for healthcare professionals. They are available at www.txhealthsteps.com.

- Qualified and caring THSteps providers are vital to keeping young Texans healthy. The preventive health care you provide to young Texans is valued. It is important to reflect this care in the completeness of your medical documentation.
Texas Health Steps and the Frew Settlement

- Frew vs. Smith 1993 -- a lawsuit filed against the state on behalf of children in the Texas Medicaid program, alleging these clients were unable to access appropriate health care services

- Results of settlement
  - Enhanced rates for pediatricians and subspecialists, such as neurologists
  - Investments that will enhance medical care for children in rural and inner urban areas
  - Improved state call centers to help Medicaid patients better understand treatment options

- For more information, please refer to https://www.parklandhmo.com/
Texas Health Steps and the Frew Settlement (continued)

What does the Frew settlement agreement mean for providers?

- Increased fees for the provision of services
- Provide a complete checkup within 90 days of patient’s enrollment in a Medicaid HMO and educate patient’s parent or guardian regarding the benefits of preventive healthcare
- Ensure provision of medical and dental checkups according to periodicity schedule
- Document complete checkups or patient refusal of services
- Provide accelerated services to children of migrant farm workers who may be out of area when services are due
- Cooperate with compliance monitoring of medical records documentation
- PCHP will inform pharmacists about THSteps and coverage of items in pharmacies
Texas Health Steps and the Frew Settlement (continued)

Your responsibility as the child’s provider:

- Educate the child’s parent or guardian regarding the health benefits of preventive care
- Schedule complete checkups in a timely manner according to the periodicity schedule
- Perform complete exam and document all components of Texas Health Steps exam within 90 days of member enrollment
- Perform timely, complete exam and document all components of Texas Health Steps exam (within 60 days of birthday) according to periodicity schedule
- Cooperate with compliance monitoring of medical records documentation
Texas Health Steps and Children of Migrant Farm Workers

- Children of a migrant farm worker (MFW) who are due for Texas Health Steps medical checkup, may receive their checkup, on an accelerated basis, before leaving the area.

- Please allow these MFW children to obtain Texas Health Steps services expeditiously.

- Performing a make-up exam for a late Texas Health Steps medical checkup is not considered an accelerated service; it is considered a “late checkup”.

- You will be provided notice when one of your patients is MFW. Be aware that the patient is at higher risk of exposure to pesticides and job-related injuries and be prepared to address those risks.

- If, during the course of your examination, you identify a patient who may be MFW, please notify our Migrant Hotline at 1-800-327-0016.
Access and Availability Requirements

- All Participating Providers must make Covered Services available and accessible to Covered Persons during normal business hours. All Participating Providers must provide telephone access to Covered Persons 24 hours a day, 7 days per week, regarding urgent or Emergency Care questions, and must meet the following standards:

<table>
<thead>
<tr>
<th>Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>Routine Specialist care referrals must be provided within 30 calendar days of the referral</td>
</tr>
<tr>
<td>After-hours</td>
<td>Coverage must be available after normal posted business hours 7 days a week, 365 days a year</td>
</tr>
<tr>
<td>After-hours calls returned</td>
<td>≤ 30 minutes</td>
</tr>
<tr>
<td>In-office wait time</td>
<td>≤ 30 minutes</td>
</tr>
</tbody>
</table>
Access and Availability Requirements

- Each PCP shall provide covered services at their offices during normal business hours, and be accessible to Covered Persons 24 hours per day, 7 days per week. The PCP shall arrange for appropriate coverage with other Participating Providers if he/she is unavailable due to vacation, illness, or leave of absence. PCP’s must be accessible to Covered Persons 24 hours a day, 7 days a week, via one of the following methods: (1) office phone answered by answering service, with calls returned by PCP within 30 minutes; (2) office phone answered by recording in each language of the major population groups served by the PCP, with a recording giving the PCP’s or another Participating Provider’s direct number, which must be answered (referring the Covered Person to another recording is not acceptable); (3) office phone transferred to another location that answers and contacts the PCP or another designated Participating Provider, with the call to be returned within 30 minutes. PCP’s may not have a phone message that directs the Covered Person to simply leave a message or to go to the emergency room for any service needed, although direction to go to the emergency room for Emergency Care is appropriate.
Access and Availability Requirements

The following are the established PCHP access standards for PCP’s

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Covered Person</td>
<td>New Covered Persons should be offered appointments as soon as possible after enrollment but in no case later than within:</td>
</tr>
<tr>
<td>• Newborn</td>
<td>• 14 calendar days of enrollment for newborns</td>
</tr>
<tr>
<td>• Children</td>
<td>• 60 calendar days of enrollment for all other Covered Persons</td>
</tr>
<tr>
<td>• Adult</td>
<td></td>
</tr>
<tr>
<td>Preventative Care</td>
<td>For CHIP - Physicals/Well-child checkups for:</td>
</tr>
<tr>
<td>Newborns</td>
<td>As soon as possible for Covered Persons who are due or overdue for services in accordance the AAP guidelines</td>
</tr>
<tr>
<td>Children &lt; 21</td>
<td>For Medicaid – Covered Persons under the age of 21, per THSteps Periodicity Schedule, but in no case later than 60 days from date of request.</td>
</tr>
<tr>
<td>Adult &gt; 21</td>
<td>For all newly enrolled Covered Persons (Medicaid and CHIP), appointments must be offered within 14 days of enrollment for newborns; 60 days for all others.</td>
</tr>
</tbody>
</table>
## Access and Availability Requirements

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Primary Care</td>
<td>Within 14 calendar days of request.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Upon presentation</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 14 calendar days of request, except for high risk pregnancies or new Covered Persons in the third trimester for whom an appointment must be offered within 5 calendar days, or immediately, if an emergency exists</td>
</tr>
<tr>
<td>Initial Behavioral Health Care</td>
<td>Within 14 calendar days of request</td>
</tr>
</tbody>
</table>
Access and Availability Requirements

- Specialty Care Providers Access and Availability Requirements

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Medical Care</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Urgent Medical Care</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Upon presentation</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 14 calendar days of request, except for high risk pregnancies or Covered Persons in the third trimester for whom an appointment must be offered within 5 calendar days, or immediately, if an emergency exists</td>
</tr>
<tr>
<td>Initial Behavioral Health Care</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Routine Behavioral Health Care</td>
<td>Within 14 calendar days of request</td>
</tr>
</tbody>
</table>

Specialists shall arrange for appropriate coverage by a participating provider when unavailable due to vacation, illness or leave of absence. As a participating PCHP physician, you must be accessible to Covered Persons 24 hours a day, 7 days a week. The following are acceptable and unacceptable phone arrangements for contacting physicians after normal business hours.
Access and Availability Requirements

- CHIP Perinatal Provider Access and Availability Requirements.

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Routine Care</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>High risk pregnancy or new Covered Person visits</td>
<td>Within 5 days</td>
</tr>
</tbody>
</table>
PCHP has an ongoing Quality Assessment and Performance Improvement (QAPI) Program that is comprehensive in scope, including both the quality of clinical care and service for all aspects of our health care delivery system. The PCHP QAPI program is:

- Tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status.

- Compliant with all State and federal requirements for Quality Improvement (QI).

- Directed by a multidisciplinary committee whose members bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program.
Cultural Competency

- Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. The PCHP Cultural competency program is geared toward:
  
  - Improving health care access and utilization
  - Enhancing the quality of services within culturally diverse and underserved communities
  - Promoting cultural and linguistic competence as essential approaches in the elimination of health disparities.

- Additional provider-focused Cultural Competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at: http://www.hrsa.gov/culturalcompetence/index.html
Fraud and Abuse Policy

- Parkland Community Health Plan recognizes that its responsibility and commitment to detecting, preventing, investigating and reporting of waste, abuse, and fraud for all services pertaining to the Medicaid and CHIP programs, including services provided by subcontractors (behavioral health and vision services).

- Parkland Community Health Plan also recognizes that it is responsible for investigating and reporting waste, abuse or fraud related to the filing of false claims against the United States Government or failure of an MCO to provide services required under contract with the state of Texas, enrollment/marketing violations and wrongful denial of claims.

- Parkland Community Health Plan employees must adhere to the Corporate Code of Conduct to ensure ethical behavior and actions of all employees, and participate in annual training regarding corporate policies and procedures.
## Fraud vs. Abuse

<table>
<thead>
<tr>
<th>Fraud</th>
<th>Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>The intent to abuse the system.</td>
<td>The misuse of the Medicaid/CHIP program without the intent to commit fraud.</td>
</tr>
<tr>
<td>The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an authorized benefit.</td>
<td>Business, medical or recipient practices that result in unnecessary reimbursement/cost to the program.</td>
</tr>
</tbody>
</table>
What is waste?

- Less than fraud and less than abuse
- Involves practices that are not cost efficient such as ordering medical services or supplies beyond a patient’s needs.
Reporting Waste, Abuse and Fraud by a Provider or Client

Please contact the following:

Parkland Community Health Plan
Attention: SIU Coordinator
P.O. Box 569005
Dallas TX 75356-9441
1-888-672-2277

To report providers:
Office of Inspector General
Medicaid Provider Integrity/Mail Code 1361
PO Box 85200
Austin, TX 78708-5200

To report clients:
Office of Inspector General
General Investigations/Mail Code 1362
PO Box 85200
Austin, TX 78708-5200

 сможет ли в этом случае поехать на полицию и вы хотите поговорить с человеком, звоните в HHSC Office of Inspector General Fraud Hotline at 1-800-436-6184.
Maintaining Contact Information

- Network providers must inform PCHP and HHSC’s administrative services contractor of any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:
  - The production of an accurate provider directory
  - The support of an accurate online provider lookup function
  - The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member’s PCP
  - The guarantee of accurate claim payment delivery information
Log in to https://www.parklandhmo.com/ to access:

- Provider manual
- Provider directory/provider search
- Provider newsletters
- Member handbook
- Links to subcontractors
- Complaints and appeals process
- Link to secure web portal
Web Portal Online Tools

- Log in to https://www.parklandhmo.com/ and access our secure web portal.

- Once registered, you can:
  - Verify member eligibility
  - Identify a member’s PCP
  - Download and print up-to-date rosters
  - Receive preventive health and wellness reminders
  - Request prior authorization
  - Check the status of a prior authorization request
  - Verify claims status
  - View and print remittance advice
  - Verify issued checks
Federally Mandated Provider Re-Enrollment Process

- Texas Medicaid must comply with federal regulations that require all providers to resubmit 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.
- Texas Medicaid providers that enrolled before January 1, 2013, must be fully re-enrolled by March 24, 2016. This requirement applies to those providing services through Medicaid managed care organizations or through traditional fee-for-service Medicaid.
- For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.
Questions?