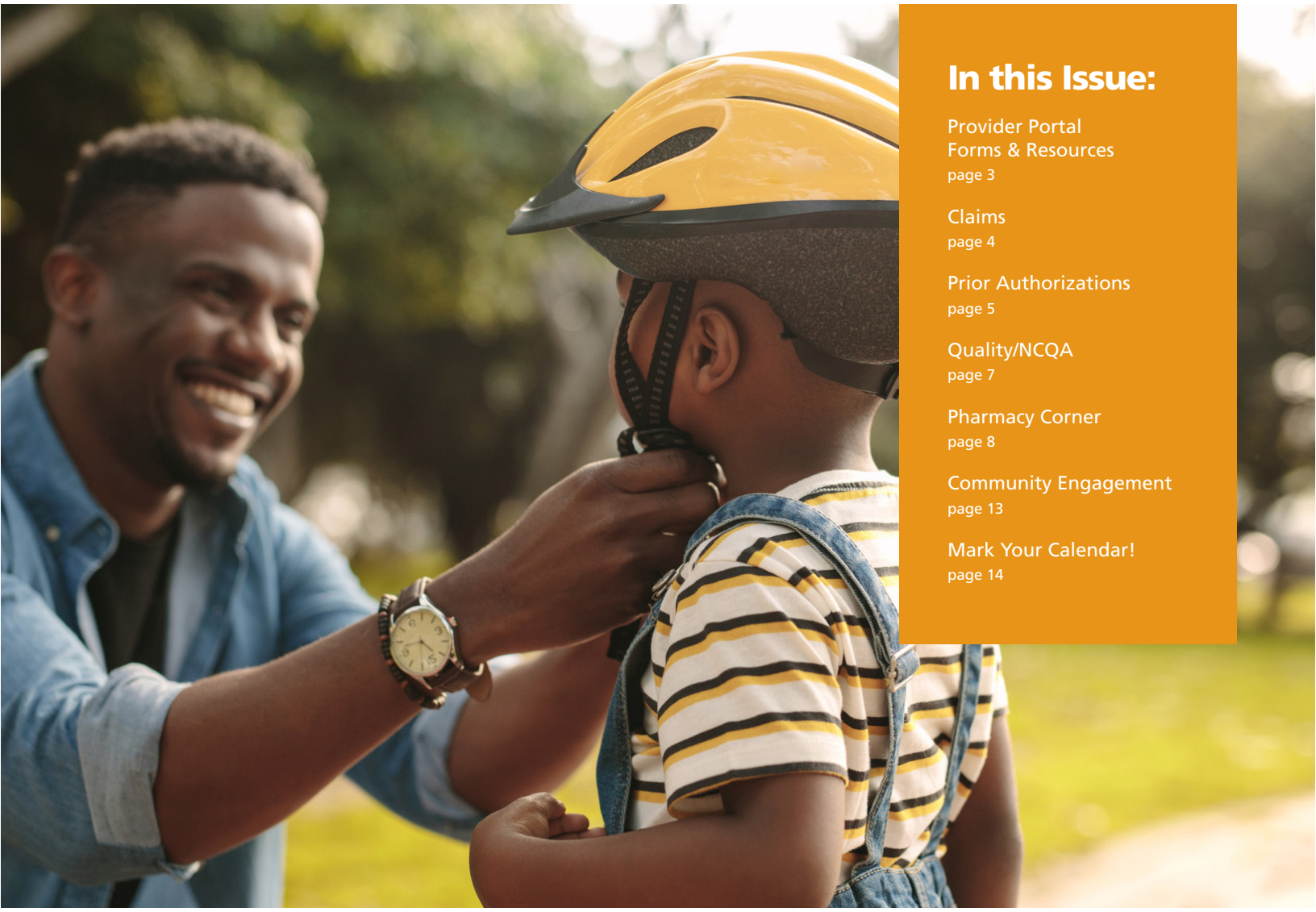
Parkland Community Health Plan

# Provider Newsletter

Changing the way communities think about healthcare by connecting people to meaningful health and wellness experiences.



## In this Issue:



## A Note from the CEO

As we move into the second half of 2021, I'd like to take a moment to thank you for being part of Parkland Community Health Plan's provider network. Record numbers of people have signed up for Medicaid and CHIP coverage during the COVID-19 pandemic, so the service you provide to members is more important than ever.

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# A Note from the CEO

**CONTINUED**

You may recall that in April 2020, the Texas Health & Human Services Commission (HHSC) began automatically extending Medicaid and CHIP coverage in response to COVID-19. HHSC recently announced that it would end this extension for CHIP and CHIP Perinate members and that those members would receive renewal packets in the mail starting in April 2021. Please encourage your patients to look for their renewal packets in the mail; they can also visit YourTexasBenefits.com to see if it's time for them to renew.

For more information, click here.

As you know, PCHP transitioned from third-party administration of our services on April 1. While many aspects of that transition have gone smoothly, others continue to be fine-tuned. As many of you are aware, the Provider Portal experience has not been as seamless and user-friendly as we would like. We hear and value your feedback on the portal and we are actively working to address the issues that have surfaced and make the necessary updates as soon as possible.

> I've been encouraged by the high level of participation in our recent Provider Town Hall meetings – hearing from you in forums like the town halls enables us to identify issues as they arise and make improvements more quickly.

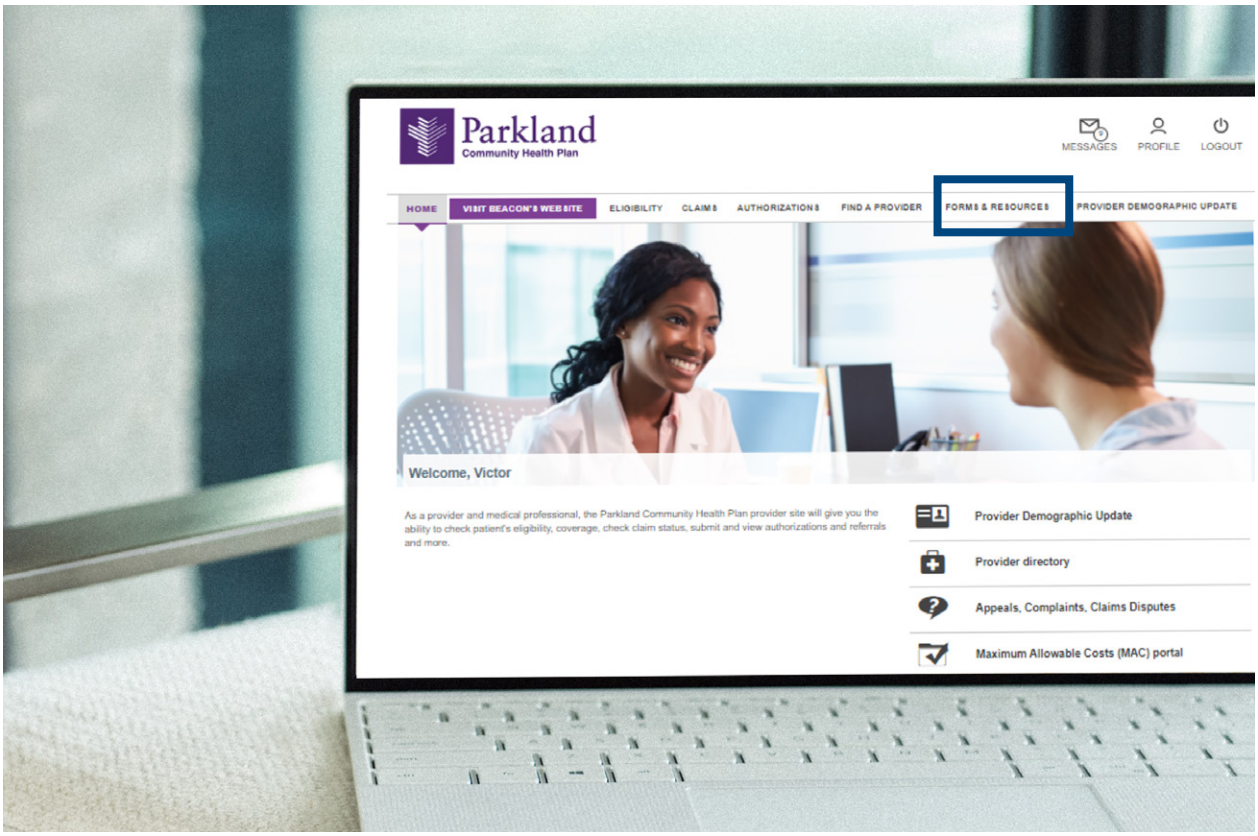
I encourage you to save the dates for our next Provider Quality Forum on August 13 and our next Provider Town Hall is on September 15.

**JOHN W. WENDLING**
CEO
Parkland Community Health Plan

## View the Q1 and Q2 Provider Town Halls

| | | |
|---|---|---|
| 2nd Quarter Provider Town Hall | 6/16/2021 | https://youtu.be/FEE2g4l34XY |
| 1st Quarter Provider Town Hall | 3/17/2021 | https://youtu.be/cW3C3A6GXL4 |

# Provider Portal Forms & Resources




The Forms & Resources section of Parkland Community Health Plan's Provider Portal offers providers quick access to information including:

- Network Directory
- Provider Manual
- Forms
- Resources
- PAC Meeting Calendar
- Town Hall Calendar
- Resource Document Process Flow
- PCHP Operational Process Flow

For additional help or training on using the PCHP Provider Portal, click here.

# Claims

Parkland Community Health Plan has completed a thorough investigation of all denials for missing the "EP1" indicator on the 837. It has been determined that the claims denied correctly.

If a Provider bills a claim that is identified as THSteps-related, based on the "Texas state manual" and did not bill the Benefit code "EP1," as indicated in the Texas manual, then claims would deny as billed incorrectly, with the specific reason that the claim should be billed with the appropriate code for these services.

For more information, please refer to the following resources:

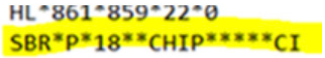
- THSteps Billing Requirements
- Texas Medicaid Provider Procedures Manual (TMPPM), Section 6: Claims Filing

Please be sure to submit correct claims.

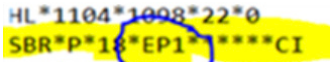
- Claims will be denied correctly if the EP1 was not billed.
- Per the TMPPM (Texas Medicaid Provider Procedures Manual), Section 6: Claims Filing:
  - Paper Claims: Providers should use field 11c for the Benefit code.
  - Electronic Claims: This field is translated to loop 2000B, segment SBR03, for sending the Benefit code.

Below are examples which provide the EDI information that the claims were not billed with the EP1 indicator.

**Incorrect**




**Correct**




**Per Texas Medicaid Provider Procedures Manual — June 2021**

Section 6.3.6 Benefit Code

A Benefit code is an additional data element used to identify state programs.

Providers that participate in the following programs must use the associated Benefit code when submitting claims and authorizations:

| Program | Benefit Code |
|---|---|
| Comprehensive Care Program (CCP) | CCP |
| THSteps Medical | EP1 |
| THSteps Dental | DE1 |
| Family Planning Agencies | FP3 |
| Hearing Aid Dispensers | HA1 |
| Maternity | MA1 |
| County Indigent Health Care Program | CA1 |
| Early Childhood Intervention (ECI) Providers | EC1 |
| Tuberculosis (TB) Clinics | TB1 |
| IDD Case Management Providers | MH2 |

# Prior Authorizations

Prior Authorizations (PA) can be submitted through our new Provider Portal or by faxing them to 1-844-303-1382.


All information listed below is **required** to initiate the PA review process. If PCHP receives an incomplete PA request, PCHP will be unable to process and will notify the requesting provider and member no later than three (3) business days after the prior authorization receive date.

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)
- Rendering provider's name
- Rendering provider's National Provider Identifier (NPI)
- Rendering provider's Tax Identification Number
- Service requested – Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT)
- Service requested start and end date(s)
- Quantity of service units requested based on the CPT, HCPCS, or CDT requested

# Prior Authorizations

**CONTINUED**

Tips for Requesting Authorizations:

- Always verify member eligibility prior to providing services.
- Complete the entire form and attach supporting documentation prior to submitting.
- A prior authorization is not required for a maternity inpatient stay for normal spontaneous vaginal deliveries (SVD) up to three days and C-Section deliveries up to five days. If the member has complications that will exceed this timeframe, please send a notification with clinical updates for the extended stay.
- A prior authorization is not required for observation for participating or in-network providers.
- For outpatient services, prior authorization should be obtained as soon as possible prior to a scheduled service, but within no less than three business days of the date of service and before the services are rendered. The provider must notify PCHP of an inpatient admission request within one business day.
- No prior authorization is required for office visits for participating or in-network providers.
- Initial and subsequent clinical for all inpatient stays should be faxed to Concurrent Review at 214-266-2084.
- A prior authorization is not needed when an Ultrasound is performed in emergent or urgent situations. CHIP Perinate members can receive one Ultrasound without an authorization.
- Serial Ultrasounds can be authorized for the duration of the pregnancy if the member has a diagnosis that warrants them.

You can find more information about Prior Authorizations on the PCHP website or in the PCHP Provider Manual.

To request an authorization, find out which services require authorization, or check on the status of an authorization, visit our secure Provider Portal. Need help with authorizations and more? Please call our Provider Customer Service line at 1-888-672-2277 (HEALTH*first)* or 1-888-814-2352 (KIDS*first*).

# Quality/NCQA

Please join us for the next PCHP Provider Quality Quarterly Forum on Friday, August 13, from 8–9 a.m. We will be addressing subjects such as HEDIS performance and best practices, Quality of Care complaints, and Quality efforts.

**WebEx information:**
PHHS.WebEx.com
Meeting number (access code): 120 972 4563
Meeting password: BCjpgYTJ426

**NCQA Accreditation**
PCHP is proud to announce that we are pursuing accreditation from the National Committee for Quality Assurance. We expect to achieve this goal by the second quarter of 2022. Questions or comments? Please contact Jeniffer Gonzalez at Jeniffer.Gonzalez@phhs.org.

# Pharmacy Corner

**COVID-19 Vaccine Submission**

As part of Operation Warp Speed, the federal government is committed to ensuring that all Americans have access to a COVID-19 vaccine. Effective December 17, 2020, Navitus will cover up to two vaccine doses with the same NDC for multiple-dose products, every 12 months. Only those pharmacies that have entered into the CDC COVID-19 Vaccination Program Provider Agreement for Pharmacies and Retail-Based Clinics with the U.S. government will be in the NaviCare COVID-19 Vaccine Network. Such pharmacies must follow the NCPDP guidelines for billing claims appropriately.

### Single-Dose Vaccine

| | |
|---|---|
| NDC (407-D7) | Appropriate NDC |
| Quantity Dispensed (442-E7) | mLs per vaccine |
| Incentive Amount Submitted (438-E3) | $40.00 |
| Professional Service Code (440-E5) | MA (Medication Administered) |
| Day Supply (405-D5) | 1 |
| Ingredient Cost Submitted (409-D9) | $0.00 or $0.01 |
| Gross Amount Due (430-DU) | Equals Incentive Amount Submitted |
| Basis of Cost Determination (423-DN) | 15 |

### Multi-Dose Vaccine – 1st Dose

| | |
|---|---|
| NDC | Appropriate NDC |
| Quantity Dispensed (442-E7) | mLs per vaccine |
| Incentive Amount Submitted (438-E3) | $40.00 |
| Submission Clarification Code (420-DK) | 2 (other override) |
| Professional Service Code (440-E5) | MA (Medication Administered) |
| Day Supply (405-D5) | 1 |
| Ingredient Cost Submitted (409-D9) | $0.00 or $0.01 |
| Gross Amount Due (430-DU) | Equals Incentive Amount Submitted |
| Basis of Cost Determination (423-DN) | 15 |

### Multi-Dose Vaccine – 2nd Dose

| | |
|---|---|
| NDC | Appropriate NDC |
| Quantity Dispensed (442-E7) | mLs per vaccine |
| Incentive Amount Submitted (438-E3) | $40.00 |
| Submission Clarification Code (420-DK) | 6 (starter dose) |
| Professional Service Code (440-E5) | MA (Medication Administered) |
| Day Supply (405-D5) | 1 |
| Ingredient Cost Submitted (409-D9) | $0.00 or $0.01 |
| Gross Amount Due (430-DU) | Equals Incentive Amount Submitted |
| Basis of Cost Determination (423-DN) | 15 |

# Pharmacy Corner

**CONTINUED**

Pharmacies are responsible for ensuring the patient receives the correct NDC and dose at time of service.

Per NCPDP guidance, "In order to clearly identify whether the claim is for an initial dose or final dose of the vaccine series, a Submission Clarification Code value should be submitted on all claims for two-dose vaccines."

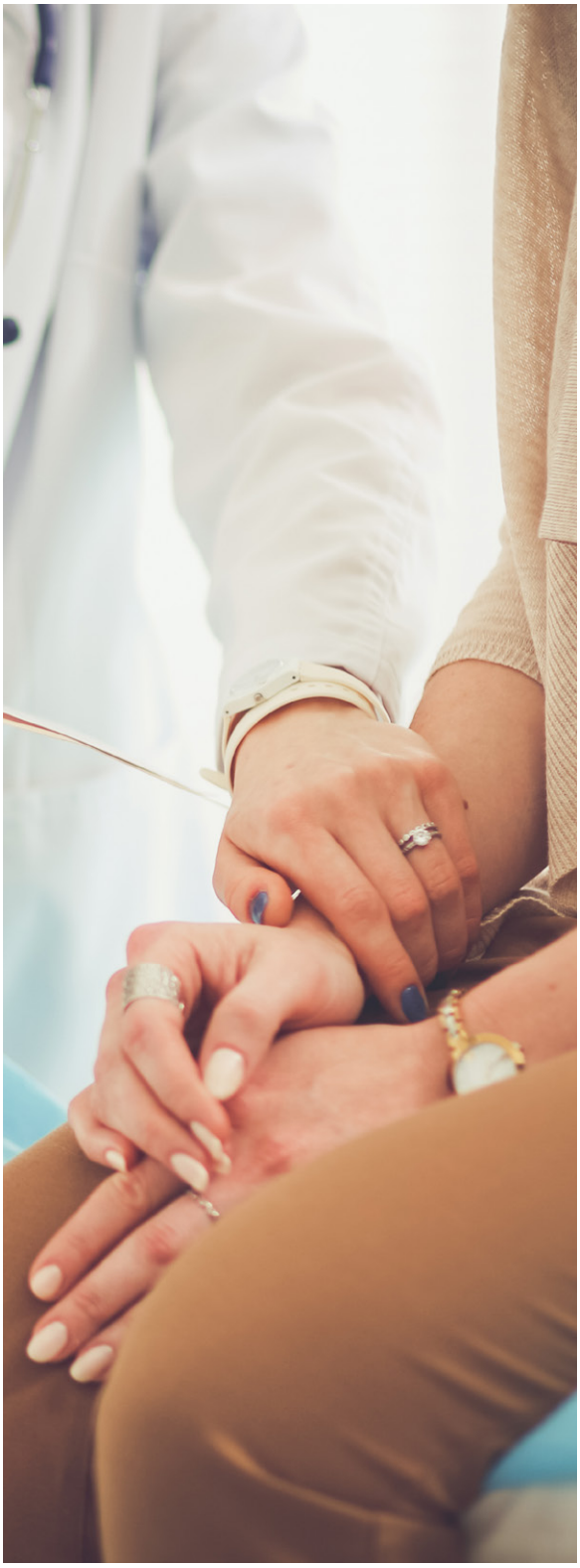
Initial Dose(s):

- Submission Clarification Code of 2 "Other Override" – defined as "used when authorized by the payer in business cases not currently addressed by other SCC values" to indicate the first dose of a two-dose vaccine is being administered. This is not required for a single-dose vaccine.

Final Dose:

- Submission Clarification Code of 6 "Starter Dose" – defined as "the pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment" to indicate the final dose of a two-dose vaccine is being administered. This is not required for a single-dose vaccine.

To ensure seamless claims processing, make sure your pharmacy's National Provider Identifier (NPI) is registered with NCPDP. Navitus requires that claims submitted at the point of service utilize the NCPDP D.0 telecommunications format.



# Pharmacy Corner

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**Are You Culturally Competent?**

Cultural and linguistic competency is the ability to provide respectful and responsive care to members with diverse values, beliefs, and behaviors, including tailoring healthcare delivery to meet members' social, cultural, and linguistic needs. The National Culturally and Linguistically Appropriate Services (CLAS) Standards, developed by the Health and Human Services Office of Minority Health, aim to improve healthcare quality and advance health equity by establishing a collective set of mandates and guidelines that inform, guide, and facilitate culturally and linguistically appropriate services.

**Communicating Across Cultures**

Clear communication is the foundation of culturally and linguistically competent care.

Guiding the Conversation

- Initial greetings can set the tone for an interaction. If the patient's preference is not clear, ask how they would like to be addressed (e.g., Mr. Jones, Michael, Ms. Gonzalez).
- Some individuals can tell you more about themselves through storytelling than by answering direct questions. Ask open-ended questions whenever possible.
- Inquire about preferred language and preferred method of communication (i.e., written, spoken, graphics, sign language, assistive listening devices, etc.).
- Consider treatment plans with respect to the patient's culture-based beliefs about health.
- Ask about any complementary or alternative medicine possibly used by the patient.

Assisting Patients Whose First Language Is Not English

- Speak slowly and try not to raise your voice.
- Use simple words and avoid jargon.
- Do not use acronyms or idioms, and avoid technical language if possible (e.g., shot vs. injection).
- Please articulate words.
- Give information in small chunks and short sentences.
- Repeat important information and have the patient repeat information back to you.
- Inform the interpreter of any specific patient needs.
- Hold a brief introductory discussion.
- Reassure the patient about confidentiality.
- Allow enough time for the interpreted sessions.
- Avoid interrupting during interpretation.
- Speak in the first person.
- Talk to the patient directly, rather than addressing the interpreter.

Please remember that it is never permissible to ask a minor, family member, or friend to interpret.

# Pharmacy Corner

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**PCHP's Language Access Services**

PCHP strives to ensure good communication with members by providing language access services. Providing language access services is a legal requirement for healthcare systems that are recipients of federal funds; a member cannot be refused services due to language barriers. Language access services ensure mutual understanding of illness and treatment, increase patient satisfaction, and improve the quality of healthcare for Limited English Proficiency (LEP) patients.

PCHP provides the following services to members at no cost, when needed:

- Written material in other formats (i.e., large print, audio, accessible electronic formats, Braille)
- Written material translated into languages other than English
- Relay Service (711)
- 24-Hour Nurse Advice Line
- Bilingual/Bicultural Staff

**Oral and Sign Language Interpretation and Translation Services:**

PCHP can help providers arrange interpretation and translation services, but pursuant to Title VI of the Civil Rights Act of 1964, services provided for members with LEP, Limited Reading Proficiency (LRP), or limited hearing or sight are the financial responsibility of the provider. Under no circumstances are members responsible for the cost of these services.

Sources:

*U.S. Department of Health & Human Services: Office of Minority Health. Health Research & Educational Trust, 2013.*

*Industry Collaboration Effort, Better Communication, Better Care: Provider Tools to Care for Diverse Populations.*

*Industry Collaboration Effort, Cultural and Linguistic Services, 2017.*

# Pharmacy Corner

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**Texas Medicaid Pharmacy Prior Authorization (PA) Process and Dispensing 72-Hour Emergency Fills**

Navitus processes all Texas Medicaid pharmacy prior authorizations (PAs) for PCHP. Medications that require PA will undergo an automated review to determine if the PA criteria are met.

PCHP provides the following services to members at no cost, when needed:

- If all criteria are met, the claim will be approved and paid, and the pharmacy will continue with the dispensing process.
- If the automated review determines that not all criteria are met, the claim will reject, and the pharmacy will receive a message indicating that the drug requires prior authorization. The pharmacy should then contact the prescriber to initiate the PA process. HHSC requires that a 72-hour emergency supply of a prescribed drug be provided only in cases where the following criteria are all met:
  - PA is required
  - The provider is not available to submit the PA request
  - The medication is needed immediately

This requirement applies to non-preferred drugs on the Preferred Drug List (PDL) and/or any drugs subject to a clinical PA. This procedure should not be used for routine and continuous overrides, to circumvent step therapy requirements, or for nonemergency medications. This override can be used more than once only if the provider remains unavailable to submit the PA request and reasonably good-faith efforts have been made to contact the prescribing provider. Pharmacists should assist their patients by notifying and following up with the prescriber for such PA requests.

Pharmacists should use their clinical discretion in determining when an emergency supply should be dispensed prior to the PA request. A 72-hour emergency supply is warranted when a medication is needed immediately, without delay (e.g., antibiotics, asthma). Medications that do not meet the 72-hour emergency supply may include those that do not have an immediate impact (e.g., acne, hepatitis C, and cholesterol treatments). Pharmacies may download 72-hour emergency override instructions from the "download" page at www.txvendordrug.com/resources/downloads.

# Community Engagement

PCHP's Community Outreach team is committed to providing health service education and resources that help us retain and expand our member base. The main goal for Community Outreach is to provide PCHP members with health education as needed, as well as education about our health plan's benefits. Our Community Outreach specialists are certified Community Health Workers (CHWs) who serve as liaisons between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Community Outreach specialists are assigned to the seven counties in PCHP's service area: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

If providers have PCHP members who need further assistance with education, resources, or benefits, they can contact the Community Outreach team at PCHP_CommunityOutreach@phhs.org.

# Mark Your Calendar!

Don't miss our upcoming provider meetings! Contact your PCHP Provider Business Consultant (PBC) for more information. PBCs serve as the primary liaison between PCHP and our provider network. If you don't know who your PBC is, please email us at PCHP.ProviderRelations@phhs.org.

| Quarterly Meetings | Date |
|---|---|
| Provider Quality Forum | Friday, Aug. 13 |
| Provider Quality Forum | Nov. (TBD) |
| Provider Town Hall | Wednesday, Sept. 15 |
| Provider Town Hall | Wednesday, Dec. 15 |
| Provider Advisory Committee | Wednesday, Sept. 29 |
| Provider Advisory Committee | Wednesday, Dec. 22 |

# Need Help?

Need help with questions, claims, payments, authorizations, or more? Please call our Provider Customer Service line at 1-888-672-2277 (HEALTH*first*) or 1-888-814-2352 (KIDS*first*).