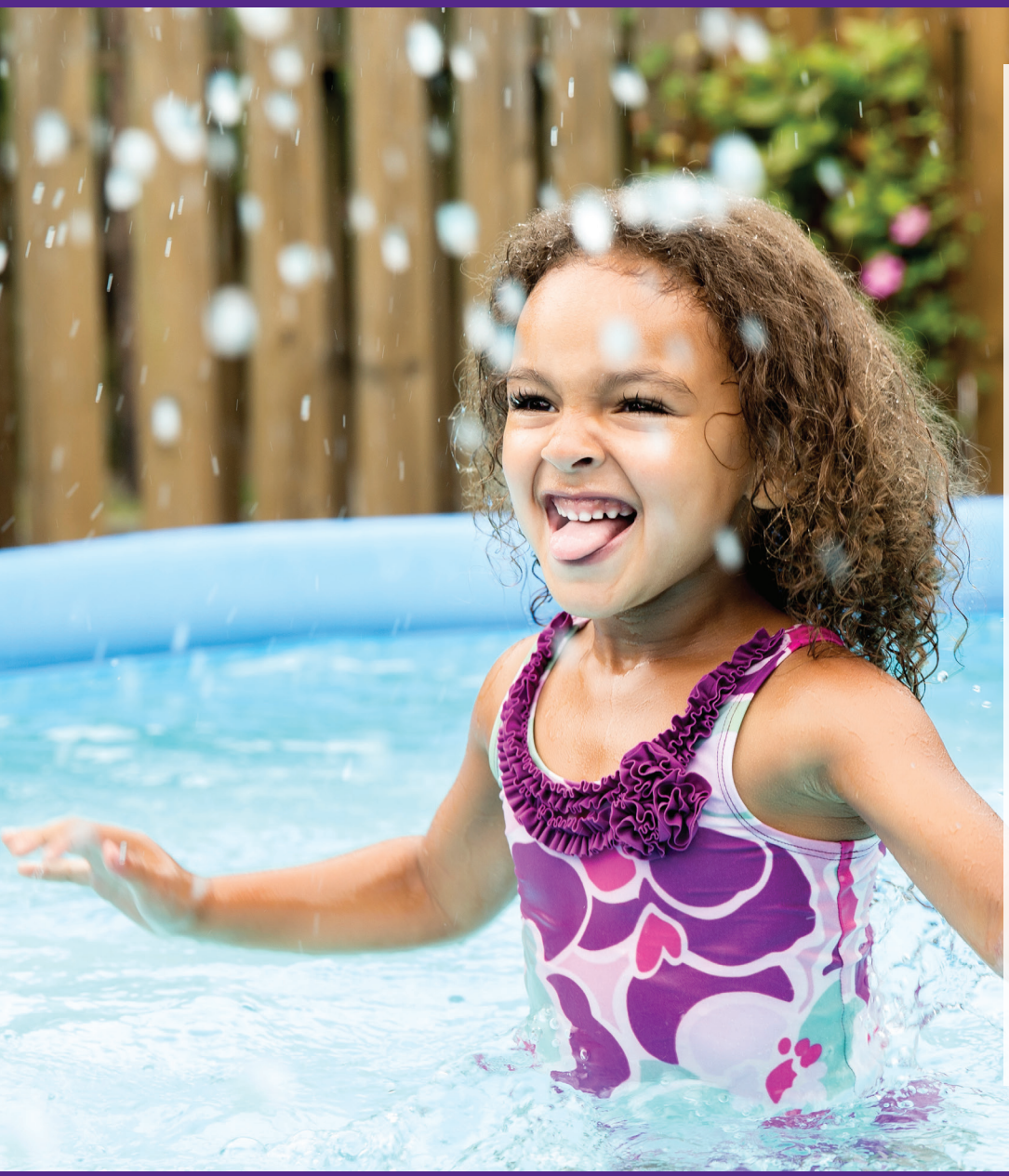
Parkland
Community Health Plan, Inc.

The Pulse

Summer 2019



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Provider Newsletter

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A Message from John W. Wendling

Parkland Community Health Plan (PCHP) is going on two decades of serving North Texas. We have incorporated the vision of the Texas Department of Health & Human Services Commission (HHSC) and the Texas Department of Insurance (TDI), in partnership with providers and other stakeholders, to ensure access to necessary healthcare services and supports for eligible children and adults.

PCHP and the State of Texas have worked hand-in-hand to review program metrics, make improvements and explore new initiatives to improve the member experience and assure responsible stewardship of public funds.

In today's dynamic healthcare environment, we know the best outcomes are achieved when members are engaged, families and other caregivers are involved in their care, and provider incentives are aligned with member treatment goals.

At PCHP, we are committed to providing integrated solutions that promote the delivery of care in a way that addresses the needs of the **whole** person.

We strive to ensure an innovative, interconnected collaboration of members, providers, advocates and others in the community, so members can achieve long-term wellness through fiscally sound practices.

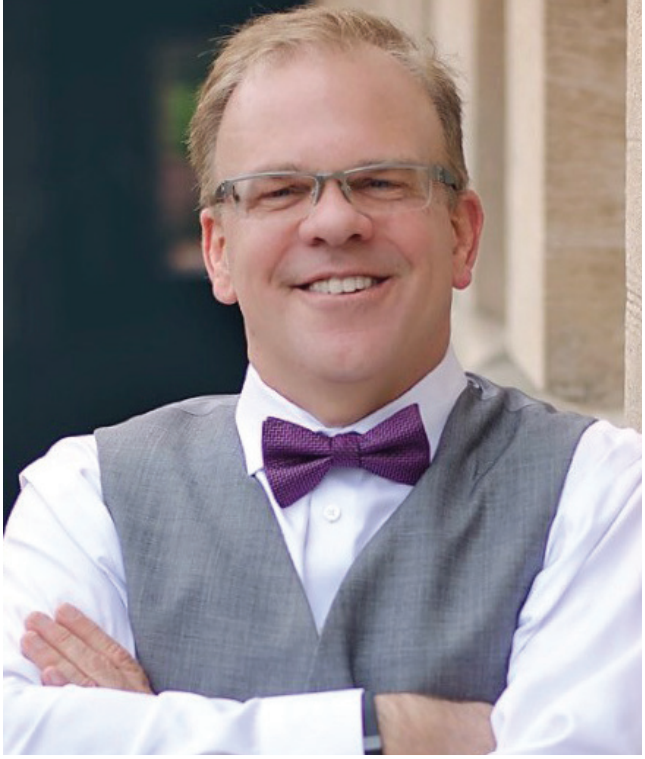
At Parkland Community Health plan, our Mission is to:

- Provide access to high-quality healthcare services, **ensuring our members** receive patient-centered care.
- To maximize our experience, knowledge and relationships as a Texas-based, provider-owned organization that **incentivizes providers for quality care delivery.**
- PCHP achieves this by **acting first and always** with respect, integrity and excellence in our actions and operations.

Serving Texas is a privilege that we take seriously. It is our honor to partner with our community.

John

John W. Wendling
Executive Director
Parkland Community Health Plan



Provider Relations… News You Can Use

Please share this information with your staff in an effort to ensure your claims are handled correctly.

The following scenarios impact claim payment delays and/or denials:

- Offices submit claims/bills with different NPI/TPI numbers vs. what is listed on the state's Master file causing claim denials.
- Attestation is not updated or completed (please contact TMHP if you receive any correspondence and remember to act immediately).
- Diagnosis/procedure codes do not support modifiers billed – see your manual for additional guidance.
- Provider's address is listed incorrectly in our system resulting in payments being distributed to the incorrect address. Please send any address changes or demographic changes to: TXProviderEnrollment@aetna.com.

Remember, we are here to help, so please stay connected with your Provider Relations Representative as we focus on improving our communication, education and outreach. Thanks for all you do and we are so glad you are a part of our Network.

Access to Care Guidelines

OBGYN/Prenatal Care – STAR Program Thresholds

Level/Type of Care	Time to Treatment (Calendar Days)	Threshold
Low-Risk Pregnancies	Within 14 calendar days	85%
High-Risk Pregnancies	Within 5 calendar days	51%
New Members in the Third Trimester	Within 5 calendar days	51%

Vision Care Threshold

Level/Type of Care	Standard	Threshold
Specialist Physician Access: Ophthalmology, Therapeutic Optometry	Members must be allowed to have access without a PCP referral to eye Health Care Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.	99.0%

Primary Care Provider Thresholds

Standard	STAR Child	STAR Adult	CHIP	STAR+PLUS
Preventive health services - within ninety (90) calendar days	99.0%	99.0%	99.0%	99.0%
Routine primary care - within fourteen (14) calendar days	99.0%	95.8%	90.7%	87.2%
Urgent care - within twenty-four (24) hours	99.0%	99.0%	99.0%	99.0%

Behavioral Health Thresholds

Standard	STAR Child	STAR Adult	CHIP	STAR+PLUS
Initial outpatient behavioral health visit (child and adult within fourteen (14) calendar days	75%	79%	83%	89%

Providers and Members May Request Behavioral Health Case Management

Provider Referral

Complete and submit the "Behavioral Health Case Management Referral Form" and return via email to Beacontexas.icm@beaconhealthoptions.com. Or Fax to **1-855-371-9227.**

Self-Referral

The member can call and request Intensive Case Management Services through Beacon Member Services: **1-800-945-4644**.

Help Us Stop Fraud and Abuse

Provider Referral

Please remember that it is your responsibility as a Medicaid program provider to report any suspected fraud and abuse. To report fraud or abuse, call the Parkland Community Health Plan compliance hotline at **1-800-436-6184**. We prefer, but do not require, that you provide enough information to help us investigate, including:

- Name of the Parkland Community Health Plan member or provider you suspect of fraud
- Member's Parkland Community Health Plan card number
- Name of doctor, hospital or other health care provider
- Date of service
- Amount of money that Parkland Community Health Plan paid for service, if applicable
- Description of the acts you suspect involve fraud or abuse

You can also visit the Parkland Community Health Plan website at **www.parklandhmo.com/** and you can email us suspected fraud information. Thank you for your continued support.

Pharmacy Lock-In

Dr. Nneka Cos-Okpalla, PharmD, MBA

Pharmacy Corner

Members may be "locked-in" or assigned to a single pharmacy/provider for a number of reasons. It is important for pharmacies to understand why a lock-in may be in place and how to communicate with members. If your pharmacy is not part of the member's lock-in, you will receive a reject message indicating that your pharmacy cannot fill for that member. If your pharmacy is part of the member lock-in, you will not receive a rejection; the claim will submit correctly.

Members often are locked-in for the following reasons:

- Case/Utilization Management – Members with complex therapies and multiple medications who need support to ensure the medications are well managed by the pharmacy, unsafe therapy is prevented, and appropriate therapeutic choices are made between the prescriber and pharmacist. This usually is initiated and authorized by the health plan.
- Improper Use/Shopping Patterns – Members using multiple pharmacies to obtain medications that may be misused or abused. This usually is initiated and authorized by the health plan.
- Identity Theft – Members who have experienced identity theft and want to ensure their pharmacy benefits are not used improperly. Members usually choose their preferred and familiar pharmacies because of an established relationship. This may be requested by the member or health plan.

When a lock-in is established for case management or improper use, member complaints should be directed to the health plan. There may be other factors outside the pharmacy realm that have influenced the decision and are beyond the pharmacy's knowledge. For members choosing a lock-in because of identity theft, we encourage the pharmacy to note the member's pharmacy account in the event the member could be at risk for other identity misuse, such as financial or credit card activity.

Swimmer's Ear – Drying it Up!

Fun at the pools, swimming lessons, water parks, etc. signals summer and time to discuss Swimmer's Ear or Acute Otitis Externa (AOE). Each year, more than 6 million cases of AOE will cause painful infections in the ear canal of children and teenagers, interrupting many vacations and days of summer fun. Caused primarily by a bacterial infection, the two most common pathogens causing AOE are Pseudomonas aeruginosa and Staphylococcus aureus with symptoms including rapid onset of ear canal inflammation resulting in pain, itching, ear canal swelling and redness, and possible decreased hearing. There may be purulent discharge. Swimmer's ear should be suspected if the patient has been swimming recently, especially in fresh water, or if there is a history of minor trauma to the ear canal, such as the use of cotton swabs or other objects (such as bobby pins) to remove ear wax. Patients will complain of tenderness and pain when the earlobe is gently manipulated.

Recommendations for Practice: Prevention:

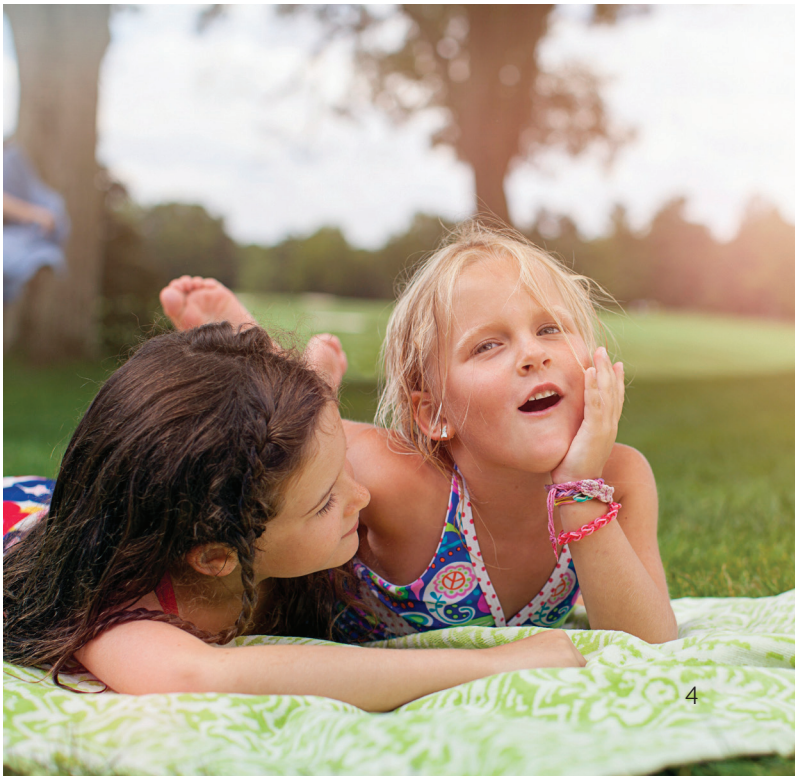
- Advise against ear cleaning with cotton swabs or other objects (such as bobby pins) that may cause trauma to the ear canal. Ear plugs are controversial due to the potential for trauma to the ear canal.
- Gently dry the ear with a blow dryer on the low setting after swimming or bathing.
- Prophylactic ear drops, such as a 1:1 solution of isopropyl alcohol and white vinegar (acetic acid) can be used or a commercial preparation designed to prevent swimmer's ear [covered on TX Vendor Drug Program (VDP) Preferred Drug List (PDL)] can be considered.

Treating AOE:

- Topical antibiotic OTIC preparations should be considered first line treatment. OTIC antibiotic and steroid combinations have been shown to be highly successful, with cure rates of 87-97%.
- A prescription for neomycin/polymixin B/hydrocortisone ($) OTIC suspension, which is available on the TX VDP PDL, is a good choice, written as 3-4 drops in the affected ear 3-4 times daily. Neomycin can cause sensitivity reactions and may not be appropriate if tympanic erforation is suspected.
- If tympanic perforation is suspected, Ciprodex ($$$) OTIC suspension (Ciprofloxacin/dexamethasone), 3-4 drops in affected ear twice daily for 7 to 10 days, is a good choice and is also available on the TX Medicaid VDP PDL. Ciprofloxacin drops are not ototoxic and are safe to use when a tympanostomy tube or other tympanic membrane opening is present.
- Oral antibiotics should ONLY be considered if the infections has spread beyond the ear canal or other risk factors are present
- During treatment, the ear canal should be kept dry, and patients should be counseled not to swim for 7 to 10 days. Usual duration of treatment is a week, but can be extended to two.
- Patients who have not responded to treatment in 48 to 72 hours should be reassessed.
- Swimmer's ear can be painful, and an analgesic such as acetaminophen or an NSAID such as ibuprofen can be prescribed. Be sure to specify a weight-based dose for each of these medications.

References

Clinical Practice Guideline: Acute Otitis Externa. Rosenfeld RM, Schwartz SR, Cannon CR, Roland PS, Simon GR, Kumar KA, Hunag WW, Haskell HW, Robertson PJ. Otolaryngol Head Neck Surg. 2014 Feb; Vol. 150(1S) S1–S24. doi: 10.1177/0194599813517083A.



Claim Filing Instructions Change Notice – Provider Taxonomy

Effective 7/1/2019, Parkland Community Health Plan will require rendering and billing taxonomies on the claims submitted electronically or via paper.

Required Data Element	Paper CMS 1500	Electronic – CMS 1500
Billing Provider Taxonomy	Box 33b with qualifier ZZ	Loop ID – 2000A Segment – PRV03
Rendering Provider Taxonomy	Box 24j – shaded area with qualifier ZZ in 24i	Loop ID – 2310B Segment – PRV03 Loop ID – 2420A Segment – PRV03

Required Data Element	CMS 1450 (UB-04)	Electronic – CMS 1450 (UB-04)
Billing Provider Taxonomy	Box 81CC with qualifier B3	Loop ID – 2000A Segment – PRV03
Rendering Provider Taxonomy	Not Applicable (n/a)	Not Applicable (n/a)

If these data elements are missing or invalid, claim will be rejected with a remit message of:

N255 – if billing taxonomy is invalid or missing

N288 – if rendering taxonomy is invalid or missing

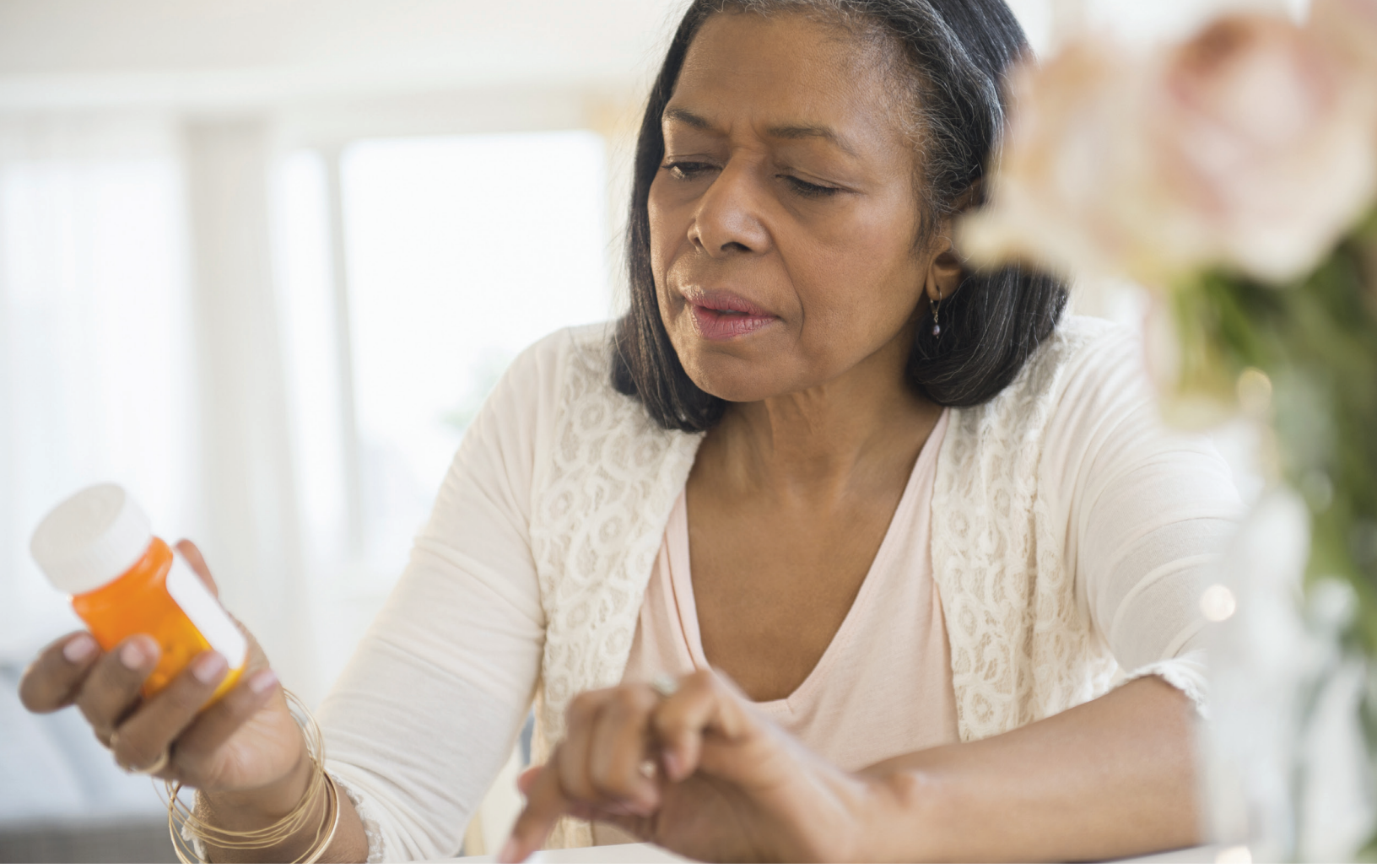
Provider taxonomy (rendering and billing) will be considered invalid if the submitted taxonomy is not one of the taxonomies with which the provider record is enrolled with Texas Medicaid & Healthcare partnership (TMHP). It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment with TMHP is included on all electronic and paper transactions. Note that rejected claims do not count as clean claims; please ensure that claim is submitted within 95 days from the date of service.

Per the HHSC contract requirements, a clean claim must have all the necessary data for the claim processor to adjudicate and accurately report the claim. Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate claim type encounter guides.

For any questions please reach out to Provider Relations at:

HEALTH*first*
1-888-672-2277

KIDS*first*
1-888-814-2352



Prior Authorization (PA) Process and Dispensing 72-Hour Emergency Fill

Navitus processes Texas Medicaid pharmacy prior authorizations (PAs) for Parkland Community Health Plan.

Medications that require PA for these groups will undergo an automated review to determine if the PA criteria are met. 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 notify the prescriber.

HHSC requires a 72-hour emergency supply of a prescribed drug be provided only in cases where (1) a PA is required, (2) the provider is not available to submit the PA request, and (3) the medication is needed immediately. This requirement applies to non-preferred drugs on the Preferred Drug List (PDL) and any drug affected by a clinical or therapeutic PA edit that necessitates prescriber approval prior to dispensing.

This procedure should not be used for routine and continuous overrides, but can be used more than once only if the provider remains unavailable to submit the PA request. Pharmacists should assist their patients by notifying and following up with the prescriber for such PA requests. Pharmacists should use 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, etc.). 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, cholesterol treatments).

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Prior Authorization (PA) Process and Dispensing 72-Hour Emergency Fill

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Prior authorization requires a practitioner to receive pre-approval for select drugs on a payer's formulary. When a pharmacy receives a reject message indicating a prior authorization (PA) is required, the pharmacy can initiate the PA process by contacting Navitus' Customer Care. Customer Care will send the appropriate form directly to the practitioner's office. The PA process requires a practitioner's signature and direct authorization on the PA form. The pharmacy cannot write a prescription or complete a PA form on the practitioner's behalf and is not authorized to sign or submit the PA form to Navitus. Practitioner authorizations or proxy agreements with the pharmacy are not an acceptable way for pharmacies to write prescriptions or complete PA forms in place of a practitioner. They must be written, reviewed and authorized directly by the practitioner.

Audit Corner

Billing for Unbreakable Packages - An unbreakable package, also referred to as a unit-of-use package, is prescription medication that contains a quantity designed and intended to be dispensed directly to a patient for a specific use without modification, except for the addition of a prescription label by a dispensing pharmacist. Examples of unbreakable packages include eye and eardrops, inhalers, insulin vials, and test strips. Pharmacies should bill for multiples of whole packages with the true days' supply and allow the claim to reject before reducing the day supply and/or quantity. If the order is written for a quantity that calculates as a days' supply greater than the plan will allow, the quantity must be reduced to meet the plan limits. Navitus will allow the pharmacy to round down to the max day supply when 50% or greater of the final unbreakable package is needed to reach the max day supply.

- **Drops example** – Order is written for 10ml. One 5ml bottle of eye drops is a 20-day supply and the max days' supply for the plan is 30. Navitus will allow two 5ml bottles to be billed as a 30-day supply because 50% of the second bottle will be used to reach 30 days. The pharmacy should refill, if allowed, based on the true days' supply of 40.

- **Test Strip example** – Three 50-count boxes of test strips is a 37.5-day supply. The pharmacy should reduce the quantity to two 50-count boxes as a 25-day supply, because only 20 strips from the third 50-count box (40%) will be used by the maximum 30-day supply allowed.

- **Insulin Pens example** – One box of insulin pens is a 40-day supply. Most pharmacies do not open boxes of pens; however, doing so is preferred for member adherence. We do not require the pharmacy to open insulin pen boxes unless its corporate policy requires the pharmacy to do so. Pharmacies should calculate and bill the true days' supply and may reduce the days' supply to 30 only if a 7X-Day Supply Exceeds plan limitation rejection is received.

It is important to note in all situations when the pharmacy is not able to bill the true days' supply, the pharmacy must refill according to that true days' supply and not the billed days' supply. It is also recommended not to utilize auto-refill programs for these claims as they can result in overfilling and recoveries due to refill too soon.

Formulary Changes

Texas Medicaid and Chip Patients: Please utilize the formulary and PDL on the VDP website for Texas Medicaid. For CHIP patients, please utilize the formulary on the VDP website, **www.txvendordrug.com/**.

Legislative Update

With just over a week left in the 2019 Texas Legislature, a variety of pharmacy priority bills are still making their way through the legislature.

May 15, 2019 – Texas Senate unanimously passed two pharmacy bills increasing patients' access to care.

- **HB 3441** – ensures pharmacists are paid for services that are within a pharmacist's scope of practice and that other providers are paid for providing (payment parity).
- **HB 1757** – adds pharmacists to the list of practitioners in the Insurance Code.

SB 1235 – Provider Enrollment Bill: Streamlines provider enrollment and credentialing. TAHP supports. Voted favorably from House Human Services.

TPA and other pharmacy organizations are working hard to advance the following:

- **SB 1056** - (collaborative practice) by Sen. Judith Zaffirini, which has already passed the Senate, was passed out of the House Public Health Committee last week and awaits the Calendars Committee and consideration on the House floor.
- **SB 420** - which would remove the requirement for pharmacists to check the Prescription Monitoring Program (PMP) for refill prescriptions, was voted out of the House Public Health Committee this week; it now awaits the Calendars Committee and consideration on the House floor.
- **HB 1455** - regarding wholesale audits, passed the House and was reported favorably from the Senate Business and Commerce Committee this week; it has been recommen ded for the Senate local/uncontested calendar.
- **HB 1905** - regarding due process protection before termination from a health plan, was amended onto **HB 1914** - on the House floor last week. HB 1914 passed the House and has been received in the Senate
- **HB 2174** - mandating electronic prescribing of controlled substances, passed the House and is expected to be reported favorably from the Senate Health and Human Services Committee.
- **HB 3388** - was voted favorably from the Senate Health and Human Services Committee Wednesday evening, May 15. It is on Senate Intent Calendar. The bill, which easily passed the House on May 3, requires PBMs in Medicaid managed care to establish a reimbursement floor for pharmacies, which guarantees pharmacies will be paid the Medicaid fee-for-service rate of the National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee.

April 2019 Drug Utilization Review Board Meeting Summary

The Texas Drug Utilization Review (DUR) Board meets quarterly in Austin to make recommendations about outpatient prescription drugs in the Medicaid program.

Key Details

A summary of the April 26 DUR board meeting is now available from the Vendor Drug Program website. This includes:

- A recording of this meeting's webcast
- Approved minutes from the Jan. 25, 2019 meeting
- A summary of clinical prior authorization and preferred drug list recommendations
- The preferred drug list class review schedule for the next meeting

The next board meeting is scheduled for July 26. Meeting dates and instructions for submitting written materials to the board and publicly testifying before the board are available on the Texas Vendor Drug Program website.

Resources

www.txvendordrug.com/about/news/2019/05/april-2019-drug-utilization-review-board-meeting-summary

Contact

vdp-formulary@hhsc.state.tx.us

Smoking and Tobacco Use Cessation Counseling Benefits to Change for Texas Medicaid on May 1, 2019

Effective for dates of service on or after May 1, 2019, smoking and tobacco use cessation counseling benefits will change for Texas Medicaid.

Overview of Benefit Changes

Changes to this benefit include the following:

- Expansion to include additional clients
- Additional payable diagnosis codes

Smoking and tobacco use cessation counseling benefits will no longer be restricted to women with a diagnosis of pregnancy related complications due to tobacco use.

Effective for dates of service on or after May 1, 2019, procedure codes 99406 and 99407 will become benefits for male and female clients ages 10 and older

Additional Diagnosis Restrictions

In addition to the currently payable diagnosis codes for pregnancy complications, procedure codes 99406 and 99407 will be updated to include the following payable diagnosis codes:

New Payable Diagnosis Codes						
F17200	F17201	F17203	F17208	F17209	F17210	F17211
F17213	F17218	F17219	F17220	F17221	F17223	F17228
F17229	F17290	F17291	F17293	F17298	F17299	
New Payable Diagnosis Codes						
O99330	O99331	O99332	O99333	O99334	O99335	

Existing Limitations

Procedure codes 99406 and 99407 may be billed in any combination by the same or different provider and are limited to eight services per rolling year. Additional services require documentation of medical necessity to exceed the established limit.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Texas Medicaid Standing Order for Mosquito Repellent

HHSC covers mosquito repellents for the prevention of the Zika virus for people enrolled in Medicaid and CHIP.

Key Details

The Texas Medicaid Standing Order for Mosquito Repellent is revised and available for use with the mosquito repellent benefit for people enrolled in Medicaid and CHIP. The current standing order signed by Dr. Lisa Glenn was valid through April 30, 2019. The revised standing order signed by Dr. Ryan Van Ramshorst is effective May 1, 2019 and valid for one year.

Guidance

Pharmacy Benefit Manager (PBM) staff must update pharmacy claim systems to ensure proper processing. MCOs should ensure pharmacy staff are informed about and have access to the revised standing order. For more information contact VDP-Formulary@hhsc.state.tx.us.

I, the undersigned Physician,

1. represent that I:

a. am licensed to prescribe drugs in the State of Texas;

b. practice medicine in the State of Texas; and

c. am in good standing with the Texas Medical Board;

2. in compliance with Federal and State of Texas statutes and regulations, including the rules and regulations of the Texas Medical Board, Texas State Board of Pharmacy, including Texas statutes governing the practice of pharmacy and any rules and regulations promulgated under Texas law regulating the practice of pharmacy;

3. in association with pharmacists licensed in the State of Texas;

4. for the purpose obtaining Federal Financial Participation from the Centers for Medicaid and Medicare Services; and

5. for the purpose of preventing disease transmission by mosquitos,

issue this Standing Order, authorizing pharmacists to dispense mosquito repellent.

Terms

The mosquito repellent may be dispensed using this Standing Order only under the following terms:

1. The mosquito repellent is dispensed by a Pharmacist licensed by and in good standing with the Texas State Board of Pharmacy.
2. The Pharmacist operating under this Standing Order has reviewed and understands all Terms in this Standing Order.
3. The mosquito repellent may be dispensed only for patients in the following programs:

a. Texas Medicaid

b. Children's Health Insurance Program (CHIP)

c. CHIP Perinate

4. The dispensed mosquito repellent is intended for the prevention of disease transmission by mosquitos.
5. The dispensed mosquito repellent must be a mosquito repellent listed on the Texas Medicaid/CHIP formulary.
6. A mosquito repellent dispensed to a child may contain no more than 30 percent N, N-Diethyl-meta-toluamide (DEET), 20 percent picaridin, 30 percent oil of lemon eucalyptus, or 20 percent IR3535.
7. The mosquito repellent may only be dispensed for females ages 10 to 45, or pregnant females of any age.
8. The pharmacist must note on the prescription label for the patient to "Use topically, as directed".
9. The prescription record for the dispensed mosquito repellent will be stored in the pharmacy dispensing system.
10. A copy of this Standing Order shall be maintained at the pharmacy during the term of the Standing Order.
11. This Standing Order may be terminated by the Physician at any time upon delivery of written notice to the pharmacy. This Standing Order shall remain in full effect for one year from the date signed, unless terminated by the Physician in writing, prior to one year from the signed date.
12. Any party that uses any of the physician's information below for any purpose other than for the dispensing of mosquito repellent under this Standing Order, shall be referred to the Inspector General for fraud.

This Standing Order is issued in my official capacity as the Medical Director for the Texas Health and Human Services system. In my judgment, and on the recommendation of the Commissioner of the Texas Department of State Health Services, it is necessary and appropriate to make the above listed mosquito repellents as easily and widely available as possible to the populations for which they are indicated. Given the federal requirement that this Medicaid pharmacy benefit may only be accessed when prescribed by a health professional, this Standing Order will remove an administrative barrier to the access of this necessary product.

Parkland Community Health Plan, Inc.
P.O. Box 569005
Dallas, TX 75356-9005

Important Phone Numbers

Provider Relations and Member Services
HEALTH*first* – **1-888-672-2277**
KIDS*first* – **1-888-814-2352**

Extension Numbers
Member Service – 5428
Member Service (Spanish) – 5432
Pre-Certification – 4021
Provider Relations – 5430
Claims – 5191
Nurse – 4120

Superior Vision
1-800-879-6901

LogistiCare-Medical Transportation
(For Medicaid members only)
1-877-633-8747 (24/7)
1-855-687-3255 (M-F 8-5)

Nurse Line
1-888-667-7890 (HEALTH*first*)
1-800-357-6162 (KIDS*first*)

Report Fraud, Waste or Abuse
1-800-436-6184

Behavioral Health Benefits
1-888-800-6799

Prior Authorization Fax#
1-866-835-9589

Dental
MCNA Dental
1-855-691-6262

DentaQuest
1-800-516-0165 (Medicaid)
1-800-508-6775 (CHIP)

Navitus (Pharmacy)
1-877-908-6023

BIN# 610591
PCN: ADV
GROUP# RX8801
Prior Auth fax – **920-735-5312**