Parkland
Community Health Plan, Inc.

The Pulse

Spring 2019

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Pharmacy Corner

Dr. Nneka Cos-Okpalla, PharmD, MBA

Identifying and treating Seasonal Affective Disorder

Season Affective Disorder (SAD) is a type of depression that appears related to seasonal changes. This recurrent depression may happen every year and occurs most commonly in the fall and winter when the daylight hours shorten, but it may also occur in the spring and summer.

SAD may affect up to 5 percent of the population and seems to be more common in Northern climates and in individuals with a personal history of depression and those with a close relative who has depression. Symptoms include feelings of depression, hopelessness, or worthlessness, as well as sleep and appetite disturbances, low energy, and suicidal ideas or thoughts of death.

Theories about etiology include consideration of the effect of fewer daylight hours, which may lead to a disruption of circadian rhythms and changes in serotonin and melatonin levels. Like other types of Major Depressive Disorder, SAD can contribute to poor functioning at work or school and in social situations. Substance use may increase in individuals with SAD. Individuals with SAD are also at risk for suicide. It is important to treat SAD when symptoms are causing functional impairment, include suicidal thoughts, or are associated with risky substance use patterns.

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Identifying and treating Seasonal Affective Disorder *Continued from page 1*

Assessment should include review of a physical examination and indicated laboratory evaluations. DSM-5 criteria are used to make the definitive diagnosis. In addition to antidepressant medication and psychotherapy, there is a body of evidence showing the efficacy of phototherapy or light therapy, which may be *first* line of defense for some patients with fall/winter SAD. Phototherapy involves exposure to a light box that emits light similar to natural outdoor light. This appears to cause an alteration in the neurotransmitters that are impacted by reduced exposure to sunlight. Light therapy has few side effects and may bring improvement in a few days, but can take a few weeks to take effect.

References:

- **www.nimh.nih.gov/health/topics/seasonal-affective-disorder/index.shtml**
- **www.mayoclinic.org/diseases-conditions/seasonal-affective-disorder**

HHSC Clinical Edit Proposals

OLUMIANT is an oral prescription medicine used to treat adults with moderately to severely active rheumatoid arthritis (RA) who have not responded well enough to or could not tolerate at least one medicine called a tumor necrosis factor (TNF) antagonist.

Criteria Summary

- Age >18
- Trial of TNF in 180 days
- Duplicate Therapy with JAK inhibitor, DMARD, or immunosuppressant
- Contraindication with strong OAT3 inhibitor (e.g. Probenecid)
- No GI, hepatic, or renal issues
- No TB or Hepatitis
- QL 1/DAY

EPIDIOLEX is a cannabidiol oral solution (100 mg/mL for oral administration) that is indicated for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS) or Dravet syndrome (DS) in patients 2 years of age and older.

Criteria Summary

- Age ≥2
- Diagnosis
- If previous history of drug, approval should be granted

ORILISSA is a gonadotropin-releasing hormone (GnRH) receptor antagonist indicated for the management of moderate to severe pain associated with endometriosis.

Criteria Summary

- Age ≥18
- Diagnosis
- History of NSAID and oral contraceptive in last 180 days
- Contraindicated with OATP-1B1 inhibitor (e.g. cyclosporine and gemfibrozil)
- No Osteoporosis, no Child Pugh C
- Child Pugh B check for length of history and dosing of Orilissa
- QL 1/DAY

Texas Standard PA Request Form compliance grace period has ended

Starting January 1, 2019, the 90-day grace period for compliance with the exclusive use of the Texas Standard Prior Authorization Request Form has ended. From this date forward, providers must use the Texas Standard Prior Authorization Request Form, which can be found at **www.texaschildrenshealthplan.org/for-providers**. Click on Downloadable Forms on the left-hand side, and then click Standard Prior Authorization Form or Behavioral Health Authorization Form to download. As a reminder, the following essential information is required to start the authorization process:

- Member Name, Member Date of Birth, and Member Medicaid/CHIP ID
- Requesting Provider's Name and Requesting Provider's NPI Number
- Rendering Provider's Name and Rendering Provider's NPI Number
- Service Requested CPT code, Number of Units Requested, and Dates of Service requested

Parkland Community Health Plan may return an incomplete prior authorization request when the form does not contain all of the essential information listed above and request that the provider resubmit the request with all of the appropriate information included. Processing of the authorization will not begin until all essential information is received.

Pharmacy Reimbursable Services

Beginning September 1, 2019, Rider 23 will allow pharmacists to bill for the drug & administration of:

Long-acting antipsychotic injectable and Vivitrol
- Goal: increase access to these products
- Both Long-acting antipsychotic injectables and Vivitrol require pharmacists to be trained in order to begin administering them
- The vendor drug program (VDP) will reimburse pharmacies the same rate as medical providers, unless changed by legislature (no target date for communication)

Flu vaccine
- Fee for Service (FFS) currently does not allow through pharmacy benefit. VDP will discuss with CMS the age requirements for pharmacy administration
- Flu vaccine will be added to formulary

Comments/Questions:
- How do we ensure the administration code is not billed twice? FFS currently has a process in place to monitor this. The Managed Care Organizations (MCOs) that use Pharmacy Benefit Managers (PBMs) need to ensure coordination with medical claims.
- VDP was asked to provide a list of pharmacies able to administer long-acting antipsychotic injectables and Vivitrol.

Patients's Advance Directives

A patient's Advance Directive must be honored to the fullest extent permitted under law. Providers should discuss Advance Directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to a patient directive prior to service whenever possible. In no event may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. Patients have the right to file a complaint if they are dissatisfied with the handling of an Advance Directive and/or if there is a failure to comply with Advance Directive instructions.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in a prominent section of the medical record. The medical record should also document if a patient chooses not to execute an Advance Directive. Let your patients know that advance care planning is a part of good health care.

Reporting Waste, Abuse and Fraud by a Provider or Covered Person

If you suspect a covered person or provider has committed waste, abuse, or fraud, you must report it to one of the following:
- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us/** and pick " I WANT TO: Report Waste, Abuse, and Fraud" to complete the online form; or
- Via Written Notice to PCHP at:
  Parkland Community Health Plan
  Attention: Fraud and Abuse Reports
  PO Box 569005
  Dallas, TX 75356-9005

Contact PCHP toll free numbers in the "Important Contact Information" section of your Provider Manual.

Reporting Abuse, Neglect or Exploitation of Covered Persons

Provider is required to report abuse, neglect or exploitation of Covered Persons to PCHP, regardless of the source of allegation.

Means for Compliance
State Program Requirements: As part of the agreement to participate in the State Programs, the Participating Provider agrees to provide the State Agencies, their related entities, enforcement arms and agents:
- All information required under the PCHP provider agreement, including but not limited to the reporting requirements and other information related to the Participating Provider's performance of its obligations under the contract.
- Any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC. The Participating Provider shall not transfer an identifiable Covered Person record, including a patient record, to another entity or person without written consent from the Covered Person or someone authorized to act or his or her behalf; however, the Provider understands and agrees that HHSC may ask to transfer a Covered Person's record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Covered Person.

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Reporting Abuse, Neglect or Exploitation of Covered Persons *Continued from page 3*

Cooperation with Texas Department of Family and Protective Services (TDFPS): For children under Texas Department of Family and Protective Services care, Participating Providers will:

- Provide medical records to TDFPS.
- Schedule medical and behavioral health appointments as requested by TDFPS.
- Provide periodic written updates on treatment status of Covered Persons, as required by TDFPS.

Required Child Abuse Reporting: Upon recognition of abuse and neglect, Preferred Providers must contact TDFPS by calling toll-free at **1-800-252-5400** or by using the TDFPS secure website at **www.txabusehotline.org**.

Do your patients need Integrated Care Management Services?

The Integrated Care Management (ICM) Program is a collaborative process of bio-psychosocial assessment, planning, facilitation, care coordination, evaluation, and advocacy for service and support options to meet a member's needs.

If you have patients that need integrated care management or if you have any questions about these services, call Member Services department toll-free at:

- **1-888-672-2277** HEALTH*first*
- **1-888-814-2352** KIDS*first*

Just ask to speak to a case manager or you can email a referral directly to the Care Management department at MBUTXCMReferral@aetna.com.Involvement in the ICM program is voluntary. Members have the right to opt out of the ICM program at any time.

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%

Primary Care Provider Threshold

Standard	STAR Child	STAR Adult	CHIP	STAR+PLUS
Preventive health services - within ninety (90) calendar days	99.00%	99.00%	99.00%	99.00%
Routine primary care - within fourteen (14) calendar days	99.00%	95.80%	90.70%	87.20%
Urgent care - within twenty-four (24) hours	99.00%	99.00%	99.00%	99.00%

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%

Provider Relations...News You Can Use

As we shared last year, each quarter our Provider Relations department will focus on identifying top trends that we would like our provider community to be aware of in an effort to promote provider satisfaction and minimize pain points. 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.

Important Message - Updating Provider Information

It is important for Parkland Community Health Plan (PCHP) to keep our provider network information current. Up-to-date provider information allows PCHP to accurately generate provider directories, process claims and communicate with our network of providers. Providers must notify PCHP of changes in writing at least 30 days in advance when possible, such as:

- Change in practice ownership or Federal Tax ID number
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- **Primary Care Providers Only:** If your practice is open or closed to new patients
- When a provider joins or leaves the practice

Changes should be submitted on the Provider Information Update Form located on the PCHPs website at www.parklandhmo.org under the Provider Forms section.

Send changes via email to: **PCHP.CREDENTIALING@phhs.org**

Contact your Provider Services Representative at **1-888-672-2277** if you have questions.

Utilization Management

The UM department adheres to the below timelines for making coverage determinations.

- Within 3 business days after receipt of the request for routine authorization of services
- Within 1 business day after receipt of the request for urgent authorization of services
- Within 1 business day for concurrent hospitalization decisions

Requests for urgent care services that do not qualify as urgent will be handled within the routine authorization of services timeline. Routine care or elective surgeries are examples of care that typically would not qualify as urgent. To avoid rescheduling of appointments, please keep in mind the timelines above for making coverage determination prior to the appointment being made.

The following are the fax numbers to submit your requests. Please submit the Texas Standard Prior Authorization of Services form and include all pertinent information, ICD 10 code(s), dates of service and signature.

- Prior Authorization Fax: **1-800-240-0410**
- Concurrent Review: **1-866-720-8936**

Parkland Community Health Plan, Inc.
P.O. Box 569005
Dallas, TX 7536-9005

Important Phone Numbers

Provider Relation and Member Services Lines:
HEALTH*first*..... **1-888-672-2277**
KIDS*first*..... **1-888-814-2352**

Extensions 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#
1-800-240-0410

Dental
MCNA Dental
1-855-691-6262

Denta Quest
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: 1-920-735-5312