V1-2019

Provider Newsletter

Karen Hill, M.D.
Senior Vice President, Medical Affairs
Community Health Choice

CommunityHealthChoice.org

713.295.2295 | 1.888.760.2600

COMMUNITY HEALTH CHOICE

In this issue

Working Life Forward

A new look for Community

As you can see, we have refreshed our Community Health Choice brand! We have very intentionally honored our legacy by keeping the colors and our name the same. What's different is our bold new message and the graphic appearance of our logo and communications.

This new look is our way of showing you, our Members, and the world how committed we are as a nonprofit health insurance company to do more than is expected to keep the wheels of progress and healthy living moving forward for all of us.

We do it by working to address the issues that concern you and our Members most. Working to connect them with you—to forge long-term relationships of value and trust. Working to offer special benefits and programs they need, not just to get the care they need when they are sick, but to keep them strong, healthy, and happy well into the future. Working to present innovations that make high-quality health care easier to access in their communities. And to keep everyone moving in the same positive direction.

CLIA Requirement

Community will deny claims for CLIA-waived lab services if Provider does not have a valid CLIA certification on file. If you have submitted your CLIA and have claims that have been denied for this reason, please follow our standard claims-appeal process. Please be sure that all appeals follow timely filing guidelines.

Rendering Provider Requirement

Community requires Providers to bill using a Rendering Provider NPI for all claims submitted.

New Electronic Payment Method

In June 2019, Community will partner with Change Healthcare and ECHO Health, Inc. to provide these new electronic methods. Many of our Providers already work with Change Healthcare today.

Below we have outlined the payment options and any action items needed by your office.

1 **Virtual Card Services** Going forward, if we don't have a documented choice of payment for you, the default method of payment will now be virtual card rather than a paper check. Virtual cards allow your office to process our payments as credit card transactions. Virtual card payments are generally received 7-10 days earlier than paper checks since there are no print and mail delays. Your office will receive fax notifications, each containing a virtual card with a number unique to that payment transaction. Once the number is received, you simply enter the code into your office's credit card terminal to process payment as a regular card transaction. If the card is not processed within 30 days, the virtual transaction will be voided and a paper check will automatically be sent to your office. To avoid delay please process the card or notify us of your preference from the other options below. Normal transaction fees apply based on your merchant acquirer relationship.

2 **EFT/ACH** You can enroll for EFT/ACH by providing your banking account information, and once your enrollment is verified begin receiving payment via electronic funds transfer (EFT). Setting up EFT is a fast and reliable method to receive payment. If you wish, each time a payment is made to you, you can elect to receive an email notification. You will need to provide a Change Healthcare payment draft number and payment amount as part of the enrollment authentication.

3 **Paper Check** If there are concerns with electronic payments, you must elect to opt out of Virtual Card Services or remove your EFT enrollment to receive paper checks and paper explanation of payments.

Sports Physicals

A sport physical is a value-added service for Community Members since it is not a covered benefit for Medicaid. Community will pay for sport physicals for Medicaid Members ages 4 to 19 (limited to one per calendar year). Providers must use the relevant codes based on the athletic training evaluations requiring these components:

- History and physical activity profile with number of comorbidities that affect physical activity.
- Examination of affected body area and other symptomatic or related systems addressing any of the following elements: body structures, physical activity, and/or participation deficiencies.
- Clinical decision-making of level of complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.
- Time duration spent face-to-face with the patient and/or family.

If a Community Member requests a sports physical, it may be a good idea to confirm they are up to date with their THSteps exam as well. If not, the checkup including all the required THSteps components should be completed as well.

Code	Level of Complexity	Number of Comorbidities	Number of Elements Addressed	Time Duration
97169	Low	0	1-2	15 minutes
97170	Moderate	1-2	3 or more	30 minutes
97171	Moderate	3 or more	4 or more	45 minutes
97172	Re-evaluation of athletic training established plan of care requiring these components: • assessment of patient's current functional status when there is a documented change • revised plan of care using a standardized patient assessment instrument and/or measureable assessment of functional outcome with an update in management options, goals, and interventions			20 minutes

Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook Updated

Information posted December 14, 2018

Note: Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

This is an update to the current Texas Medicaid Provider Procedures Manual, Volume 2, Gynocological, Obstetrics, and Family Planning Title XIX Services Handbook, subsection 4.1.2, "Vaginal and Cesarean Deliveries." The lanuage regarding the use of modifiers for the processing of delivery claims was revised and will be updated with the January 2019 release.

The following statements will be updated in the handbook section state above:

- The following procedure codes when submitted with the appropriate modifier may be a benefit for vaginal or cesarean deliveries:

Procedure Codes								
59409	59410	59514	59515	59612	59614	59620	59622	S8415*
* Procedure code S8415 is for home delivery supplies								

- The following modifiers must be billed with the procedure codes indicated above for vaginal and cesarean deliveries:

Modifiers	
U1	Prior to 39 weeks and medically necessary
U2	39 weeks or later
U3	Prior to 39 weeks and not medically necessary

For more information, call the TMHP contact center at 1-800-925-9126.

Texas Health Steps Postpartum Depression Screening Benefit

Effective for dates of service on or after July 1, 2018, postpartum depression screening will be a benefit of Texas Medicaid.

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder, and postpartum psychosis.

Postpartum psychosis is a more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

Immediate or emergent medical attention may also be necessary when the risk of imminent harm or danger is present.

Postpartum Depression Screening Benefits

Procedure codes G8431 and G8510 will be a benefit when services are provided by federally qualified health centers and Texas Health Steps medical Providers in the office setting.

The American Academy of Pediatrics recommends the infant's Provider screen mothers for postpartum depression, which is the most common form of postpartum mood disturbance.

Screening mothers for postpartum depression is appropriate for the general postpartum population, and is recommended within the first few months following birth up to the infant's first birthday.

Note: Screening for postpartum depression during the infant's Texas Health Steps medical checkup is recommended, not required.

Texas Health Steps medical Providers may receive separate reimbursement for postpartum depression screening, in addition to the infant's Texas Health Steps medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the infant's medical checkups or follow-up visits.

Note: New benefits that are adopted by Texas Medicaid must complete the rate-hearing process to receive public comment on proposed Texas Medicaid reimbursement rates. After the rate hearing, expenditures must be approved before the rates are adopted by Texas Medicaid.

Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the Texas Health Steps Provider to develop a referral plan with the mother.

Positive Screenings

Texas Health Steps Providers must discuss the screening results with the mother, discuss the possibility of depression, and discuss the impact depression may have on the mother, family, and health of the infant.

The Texas Health Steps Provider and mother should discuss her options so the Provider can refer her to an appropriate Provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

Texas Health Steps Providers should refer the mother to a Provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate Providers include, but are not limited to, the following:

- Mental health clinicians
- The mother's primary care Provider
- Obstetricians and gynecologists
- Family physicians
- Community resources such as local mental health authorities

Note: Referral to an emergency center may be necessary when the risk for imminent harm or danger is present, such as mothers who report suicidal thoughts or thoughts of harming herself or the baby.

Resources for support in the interim should be provided until the mother is able to access care.

Scheduling a return visit for the infant, sooner than the next scheduled visit, may be appropriate in some cases.

Documentation Requirements

Documentation in the infant's medical record must include the name of the screening tool used and the date screening was completed.

If the mother screens positive for depression, at a minimum, the Provider must note that a referral plan was discussed with the mother and a referral to an appropriate Provider was made.

Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

Submitting Claims for Postpartum Depression Screening

Postpartum depressing screening must be submitted under the infant's Medicaid client number, and will be restricted to clients who are 12 months of age and younger.

Screening and referral is not contingent upon the mother's Medicaid eligibility.

Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service and Provider, as one of the following Texas Health Steps medical checkup or follow-up visit procedure codes: **99211, 99381, 99382, 99391, 99392**

Only one procedure code, either G8431 or G8510, may be reimbursed per Provider, in the 12 months following the infant's birth.

For more information, call the TMHP Contact Center at 1.800.925.9126.

Community Health Choice Prior Authorization Guide Changes Effective January 1, 2019

Based on utilization trends in 2018, we have made a few changes to our prior authorization list, making it easier for Members to obtain certain services. The list of services requiring prior authorization can be found on the Community Health Choice Provider Portal under the path defined by Provider Tools > Authorizations/Notifications > Authorization.

The Community Health Choice Prior Authorization Guide applies to all Community Health Choice products. We ask that requests for prior authorization be submitted on Community's Preferred Prior Authorization Form, which can be found under Provider Tools > Authorizations/ Notifications > Notifications. For the most recent version of our Prior Authorization Guide, be sure to look on our Provider Portal.

Community's Preferred Prior Authorization Form

Community Health Choice now has a preferred prior authorization form that can be found on our Provider Portal under the following path: Provider Tools > Authorizations/Notifications > Notifications. Please note, we still accept the Texas Standard Prior Authorization Form.

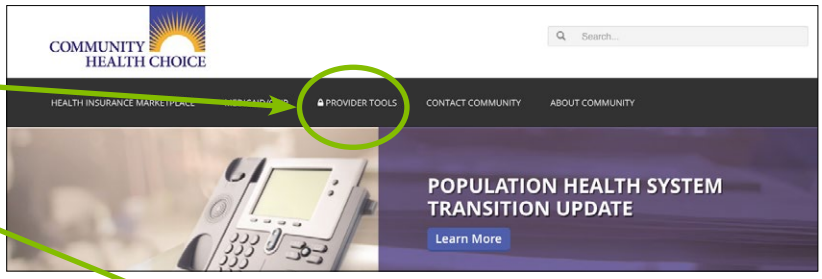
Therapy Wait List

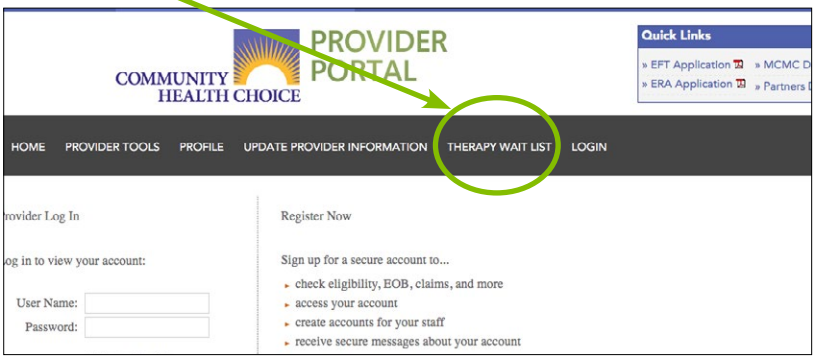
If a Therapy Provider cannot treat a patient at the frequency commensurate with that person's assessed needs, and if they create a waiting list for the Medicaid beneficiaries, and if a therapy Provider can no longer accept new patients, the Provider needs to notify Community. We are encouraging our Providers to inform us via our Provider Portal.

The tool posted on our Provider Portal is only applicable to STAR Providers at this time and is specific to Physical Therapy, Speech Therapy, and Occupational Therapy only.

To access Community's Therapy Wait List Form:

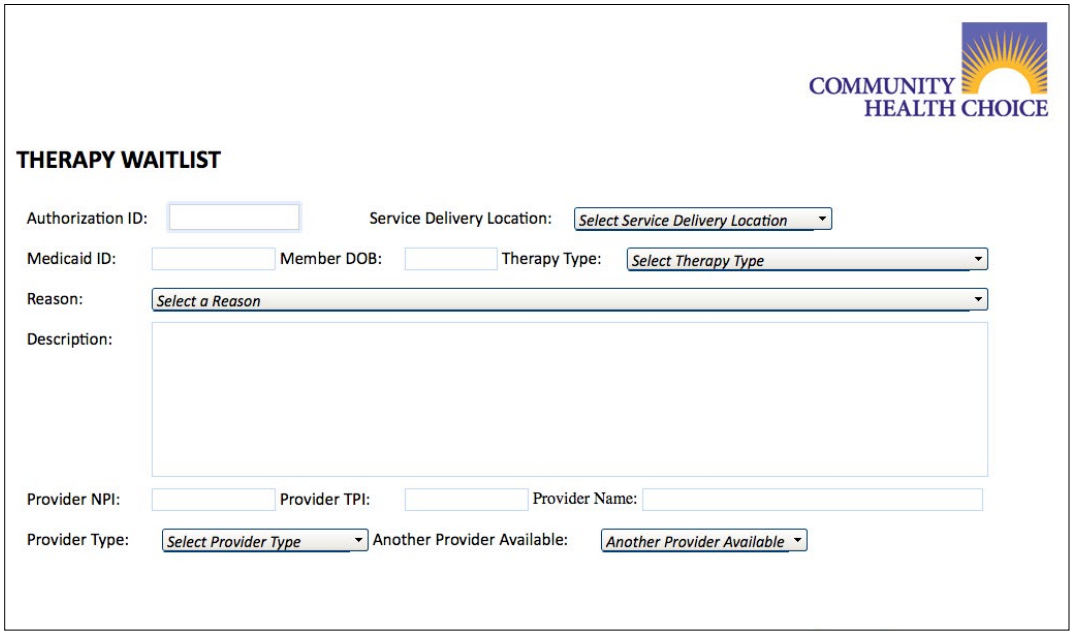
1. Go to our Provider Portal and click on **Provider Tools**.
2. Under Provider Tools you will see a banner of options. **Therapy Wait List** is the fifth option.
3. When you click on the Therapy Wait List option, you will be forwarded to the **Therapy Wait List Form** to complete. All fields must be completed in order to submit.





Once you submit this form to Community Health Choice, it will be routed to an internal team that will work directly with the ordering Provider, the Member, and the New Therapy Provider to ensure the Community Member receives the therapy necessary.

If you have any questions, please contact your local Provider Engagement Representative.



Welcome to Pharmacy Corner! We continue to see some challenges in the prior-authorization arena and want to address common questions we continue to receive.

Q: How do I know where to submit a prior authorization for an injectable drug?

A: It can often be confusing whether to avail of an injectable drug as a medical benefit or a pharmacy benefit. We want to make sure the pathway is clear so that you are not being bounced around among different departments. If the medication will be administered in your office or by a clinician, submit those requests to the medical benefit department. If the medication will be self-administered by your patient, submit those requests to the pharmacy benefit (Navitus). If submitting a request to Navitus, please specify on the prior-authorization form that the Member will be self-administering the requested drug.

We also recognize that not every office follows a buy-and-bill process. The same rules previously mentioned still apply. All medications that will be clinician-administered should still go to the medical benefit side to be reviewed for medical necessity. If your office does not buy and bill, please make sure to include in your request what pharmacy your patient will be getting the medication from (under the Service Provider/Facility section).

Clinician-injected:
Medical (Medicaid): 713.295.2294 (Phone), 713.295.7019 (Fax)
Medical (Commercial): 713.295.6704 (Phone), 713.295.7019 (Fax)

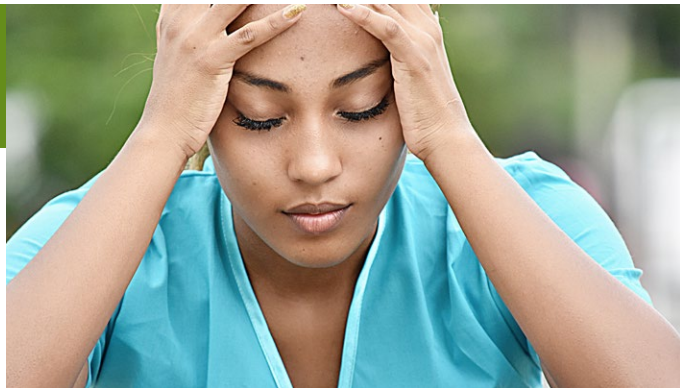
Self-injected:
Pharmacy (Medicaid): 877.908.6023 (Phone), 855.668.8553 (Fax)
Pharmacy (Commercial): 866.333.2757 (Phone), 855.668.8551 (Fax)

Q: My office does not buy and bill injectable drugs. What pharmacies are in Community Health Choice's network?

A: Clinician-administered drugs are reviewed under the medical benefit (Utilization Management) for medical necessity. If your office does not buy and bill, please make sure to include in your request what pharmacy your patient will be getting the medication from. If choosing not to buy and bill, it is the responsibility of the Provider to find a pharmacy to dispense the requested medication. Some pharmacies in our network include but are not limited to:

Soleo Health: 832.981.1000
Deliver It Pharmacy: 281.277.1071
Southside Pharmacy: 713.660.8890 or 713.660.8888

Managing Your Stress



Your body and mind are designed to recover and recharge after periods of stress, but this cannot happen if stress persists. That is why finding healthy ways to manage stress is vital.

Here are some ideas to help you take control of your stress:

Find the cause of your stress and make a change.

Set limits and be ready to say "no" without guilt or excuses. If you have job stress, ask your boss to set clear priorities. Be willing to work out conflicts and misunderstandings with the people in your life. Built-up anger or resentment is a stressor you don't need.

Reframe your stress.

Try to take an objective look at the stressors in your life. Are they really so bad? Are you seeking perfection where perfection isn't needed? Can you view a stressful challenge as an opportunity rather than a burden? How would you advise a friend in your situation?

Get enough sleep.

This may seem impossible, especially if your stress keeps you awake at night. Your sleep troubles may stem in part from poor bedtime habits. Try these tips to improve sleep quality:

- Go to bed and wake up at the same time each day.
- Avoid late-night snacking, alcohol or rousing activities.
- Don't read, work or watch TV in bed.
- Make your bedroom cool, dark, and comfortable.

Take time to relax.

Find a few minutes each day to let off steam and wind down. Relaxation techniques like deep breathing have been proven to induce your body's relaxation response. This is how your body naturally recovers from stress and restores normal body function. Prayer and meditation are other ways to return to a calm state and shore up the inner strength to manage stressful moments.

Eat right and exercise.

Make small changes to improve your lifestyle. Avoid emotional eating, which is eating too much or eating unhealthy foods to deal with stress. Find a physical outlet, such as brisk walking. Exercise is also a physical way to release stress and improve sleep.

Lean on friends and family.

People feel stressed when they don't have the resources to cope with the demands they face. Ask people who love and care about you for help during stressful times. This could mean taking your kids so that you can have a few moments to yourself, helping with household chores or listening to your cares and concerns.

Get ready to manage your stress.

Make a plan to deal with your stress. Take on one change at a time. Otherwise, making too many changes at once could become a source of stress. Don't expect all your stress to go away, but do expect to feel less stress and more control.

When stress won't go away.

Some people feel trapped by stressful relationships or situations. If stress continues to be a problem for you even after making changes, get help. Talk to your doctor or a mental health Provider. Your doctor may suggest medicine to help with stress and worry. Therapy can help you recognize and change behaviors and situations that contribute to the stress you are feeling.

Impacted Serum with Instrumentation Proper Documentation

Cerumen (ear wax) can build up in the ear canal, which may lead to symptoms of discomfort, dizziness, and impaired hearing for which patients seek medical care. Coding for cerumen removal depends on two factors: whether the cerumen is impacted, and if the cerumen is impacted, the method used to remove it. If earwax is impacted, it may be removed by one of two general methods: lavage (irrigation) or instrumentation. For removal by lavage, the correct code is 69209 (removal impacted cerumen using irrigation/lavage, unilateral). For removal using instrumentation (e.g., forceps, curette, etc.), turn instead to 69210 (removal impacted cerumen requiring instrumentation, unilateral). Medical records documentation must support the technique used to remove the impacted cerumen.

Sharing Medical Records

Title XIX of the Social Security Act, sections 1902 and 1903, mandates utilization control of all Texas Medicaid services under regulations found at Title 42 CFR, Part 456. Utilization review activities required by Texas Medicaid are completed through a series of monitoring systems developed to ensure the quality of services provided, and that all services are both medically necessary and billed appropriately. Once a Provider receives the request for medical records, the Provider must submit the information electronically or by hard copy within 60 calendar days. It is important that Providers cooperate by submitting all requested documentation in a timely manner because no response or insufficient documentation will result in recoupment of funds.

How to Appropriately Use Modifier 25

Modifier 25 is used to facilitate billing of E/M services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable E/M service by the same physician on the day of a procedure. Modifier 25 indicates the patient's condition required a significant, separately identifiable E/M service beyond the usual care associated with the procedure or service.

Title XIX Form Required Signature Not Stamp

The completed Title XIX Form must be maintained by the dispensing Provider and the prescribing physician in the client's medical record. The physician must maintain the original signed and dated copy of the Title XIX Form. The completed Title XIX Form is valid for a period up to six months from the physician's signature date.

Special Investigations Unit

Our Special Investigations Unit (SIU) team is responsible for minimizing Community's risk to healthcare fraud. The SIU team partners with Community's Customer Service Claim Centers and others to help identify suspicious claims, stop payments to fraudulent providers, and report wrongdoers to the appropriate entity, including but not limited to the Office of Inspector General.

The SIU team also works with state and federal law enforcement and regulatory agencies to detect, prevent, and prosecute healthcare fraud. The SIU team includes trained professionals with expertise in investigations, audits, health care, nursing, and accounting.

How to Report Healthcare Fraud

- Call the Compliance hotline at 1.877.888.0002
- Email us: SIU@CommunityHealthChoice.org
- Write to us:

Community Health Choice
c/o Special Investigations Unit
2636 S Loop West, Suite 125
Houston, TX 77054

HEDIS Criteria

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Which Members are included in the measure? How is a Member considered compliant?

Members between 3 and 17 years of age as of December 31 of the measurement year are included in the measure. These Members must receive an outpatient visit with a primary care Provider or OBGYN with the following during the measurement year:

- BMI percentile
- Counseling for nutrition
- Counseling for physical activity

What documentation is needed in the medical record?

BMI

- Evidence of height, weight, and BMI percentile (percentile or percentile plotted on age-growth chart)
  - Absolute BMI value will not be accepted
  - BMI percentile should be expressed as a percentage
  - Ranges and threshold do not meet the criteria.
  - Documentation cannot include <1% or >99% (either 0% or 100%).

Counseling for Nutrition

- Evidence of at least ONE of the following (with the date discussed included):
  - Discussion of current nutrition behaviors
  - Checklist indicating nutrition was discussed
  - Counseling or referral for nutrition education
  - Patient received educational materials on nutrition during face-to-face visit
  - Anticipatory guidance for nutrition
  - Weight or obesity counseling

Counseling for Physical Activity

- Evidence of at least ONE of the following (with the date discussed):
  - Discussion of current physical activity behaviors
  - Checklist indicating physical activity was discussed
  - Counseling or referral for physical activity
  - Member received educational materials on physical activity during a face-to-face visit
  - Anticipatory guidance specific to the child's physical activity
  - Weight or obesity counseling

What codes are used for billing?

The following codes are used to identify BMI percentile, counseling for nutrition, and physical activity:

Description	CPT	ICD-10	HCPCS
BMI less than 5th percentile for age		ICD-10: Z68.51	
BMI at 5th to <85th percentile for age		ICD-10: Z68.52	
BMI at 85th to <95th percentile for age		ICD-10: Z68.53	
BMI at ≥95th percentile for age		ICD-10: Z68.54	
Counseling for Nutrition	97802-97804	Z71.3	G0270, G0271, G0447, S9449, S9452 & S9470
Counseling for Physical Activity		Z02.5 & Z71.82	G0447 & S9451

*HCPCS – Healthcare Common Procedure Coding System
**Use ICD-10 diagnosis code with either CPT or HCPCS code depending on the service rendered.

HCPCS code **G0447** can be used for both Nutrition and Physical Activity.

- For Counseling for Nutrition, you can bill HCPCS code G0447 with ICD-10 code Z71.3.
- For Counseling for Physical Activity, you can bill HCPCS code G0447 with ICD-10 code Z02.5 or Z71.82.

What is the code description?

Counseling for Nutrition

Code System	Code	Description
ICD-10	Z71.3	Dietary counseling and surveillance
HCPCS	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes.
HCPCS	G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes.
HCPCS	G0447	Face to face behavioral counseling for obesity, 15 minutes
HCPCS	S9449	Weight management classes, non-physician provider, per session
HCPCS	S9452	Nutrition classes, non-physician Provider, per session
HCPCS	S9470	Nutritional counseling, dietitian visit

Counseling for Physical Activity

Code System	Code	Description
ICD-10	Z02.5	Encounter for examination for participation in sport
ICD-10	Z71.82	Exercise counseling
HCPCS	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
HCPCS	S9451	Exercise classes, non-physician Provider, per session

How to improve the WCC measure?

- Discuss and document nutrition and physical activity during at least one office visit annually.
- Document height, weight, and BMI percentile
- Document all services and procedures performed on the medical record
- Utilize billing codes as outlined in this presentation to ensure you receive credit for WCC, which may also decrease the number of chart reviews required during HEDIS season
- If you have patients who are challenged to schedule an annual well-child visit, use sick visits or sports physicals as an opportunity to perform WCC services.
  - To fulfill criteria, these counseling sessions cannot be geared toward the presenting problem for which the visit was intended, and must occur each measurement year.

Antibiotic Use

Antibiotic resistance is a rapidly growing problem. The HEDIS measure *Appropriate Treatment for Children with Upper Respiratory Infection (URI)* is designed around one aspect of this issue.

The inclusion population for this measure is Members age 3 months to 18 years who have an outpatient or emergency department visit, during which the only diagnosis was for an upper respiratory infection of unspecified origin. The relevant ICD-10 diagnosis codes include:

Code	Definition
J00	Acute nasopharyngitix (common cold)
J06.0	Acute laryngopharyngitis
J06.9	Acute upper respiratory infection, unspecified

Members who are considered to have received appropriate treatment are those who did not fill an antibiotic prescription within three days of the diagnosis.

We know you have patients and parents asking about antibiotics, especially during flu season. So how can you address their concerns, while providing appropriate treatment and fighting antibiotic resistance?

- Spend a couple of minutes on education with the patient
  - Be clear when illness is due to virus
  - Handouts and other tangibles can serve as a guide for patients, even if it's a written prescription for more fluids or other supportive care advice. The Centers for Disease Control and Prevention (CDC) has terrific ready-to-use materials and references!
  - Give an expectation for duration of symptoms and when to come back if not improving
- Here are a few things to remind your patients about:
  - Antibiotics fight bacteria. They will not help if your infection is not caused by bacteria
  - Antibiotics can be harmful when taken unnecessarily
  - If you take antibiotics when you don't need them, they may not work when you do need them

Focus on Moms and Babies - A Provider Tag-Team Approach

Providers, please help us encourage our Members to go to their prenatal and postpartum appointments! Stress to them that these appointments are extremely necessary and beneficial to both them and their newborn child. Try the tag-team approach explained below.

Primary Care Providers (PCPs)

Pregnant Members under 21 still need comprehensive care visits in addition to prenatal visits. Refer Members to an OB/GYN if they have not yet chosen one. During their newborn's four-week checkup, stress the importance of scheduling a postpartum appointment.

OB/GYNs

As a part of birth preparation, educate Members about choosing a PCP for their newborn and scheduling well-child checkups. Since the first checkup occurs 24 to 48 hours after birth at the hospital, and another checkup within five days after leaving the hospital, providing information early can help Members know what to expect before and after their baby leaves the hospital.

In addition, when you see our Members in the hospital room and during their first office visit after delivery, please stress the importance of a postpartum appointment for four to six weeks after delivery. Ask your front-office staff to offer to schedule one of these appointments when they check in or out.

Stress to our Members the importance of routine newborn checkups toward the end of their pregnancy and again during their postpartum visits. Assist our Members by referring them to a pediatrician if they have not chosen one yet.

PCPs and OB/GYNs

If you need help locating a PCP and/or OB/GYN in our network, you can contact Member Services directly at 1.888.760.2600 or ask Members to contact us.

Community's Mom & Baby Efforts

Community reaches out in many ways to our Moms and Babies to help them get the care they need. Here are some of the highlights:

Conception to Early Childhood

- We make live calls to new pregnant Members to help them find OB/GYNs and to encourage early prenatal care. We also make pre-delivery calls in the third trimester to make sure that Members are ready for their delivery. During the pre-delivery calls, we prime the Members for timely postpartum care, as well as newborn preventive care.
- For newborns, we also make a live welcome call to make sure that the Member has a PCP and is on track for preventive care. On the same call, we talk to the mom about her own postpartum care.
- We help STAR Members get rewarded for timely prenatal, postpartum, and newborn checkups through the Mom & Baby Community Rewards program (see page 19).
- Members who sign up for the Mom & Baby Community Rewards program get automated reminders about their prenatal, postpartum, and well-child checkups.
- When we speak with Members, we educate them about helpful resources such as WIC, smoking cessation, and Text4Baby.

FOCUS ON MOMS AND BABIES

INTRODUCING MOM & BABY COMMUNITY REWARDS FOR STAR MEMBERS

Community has launched a new Community Rewards program for Mom & Baby! This program encourages timely prenatal and postpartum care, as well as timely newborn checkups. It is designed to link maternal and child health, from conception to early childhood. You can mention the rewards program to help encourage appointment compliance. Thank you for providing quality care for our Members!

MOMS RECEIVE:

- A $25 gift card for early prenatal visit (within 42 days of enrollment effective date)
- A $25 gift card for timely postpartum visit (21 to 56 days after delivery)

BABIES RECEIVE:

- Up to $60 for timely well-child checkups (a $10 gift card for each of 6 checkups completed before 15 months of age)
- A $25 bonus gift card after all 6 checkups are completed

WHO CAN PARTICIPATE?

This program is for Moms and Babies in our STAR program. Moms with pregnancy Medicaid and newborn STAR babies are eligible.

HOW DO MEMBERS GET THE GIFT CARDS?

Eligible Members automatically receive phone calls to tell them about the rewards program and to remind them about checkups. Members can activate the program and report checkups during these calls, or they can do so online through their My Member Account.

After reporting their activities, they can select an instant electronic gift card or have the gift card mailed to them.

For more information on this program, please contact our Member Services Department at 1.888.760.2600.

CommunityHealthChoice.org

fl_mombaby_provider_0119

COMMUNITY HEALTH CHOICE
COMMUNITY CARES.

Allergy Blood Testing

CPT **86001, 86003** and **86005** are benefits of Texas Medicaid. Please review Section 9.2.4.2 of the TMHP manual for additional information regarding these codes.

Procedure code **86001** is limited to **20 allergens per rolling year**, any Provider.

Procedure code **86003** is limited to **30 allergens per rolling year**, any Provider.

Procedure code **86005** is limited to **4 multi-allergen tests per rolling year**, same Provider.

Corrected Claims

- For **CMS 1500** claims, use **resubmission code 7** in **Box 22** for corrected claim along with the **original claim** (note: not to be used if original claim was rejected).
- For **UB 04** claims, submit with the appropriate **resubmission code 7** in the third digit of the bill type (**117–Inpatient claim or 137 Outpatient claim**), the original claim number in Box 64, and a copy of the original EOP.

Provider filing guidelines for Medicaid

95 days for in-state Providers

365 days for out-of-state Providers

120 days from the original EOP (explanation of payment) for claims payment reconsideration

Prenatal Appointment Availability Requirements

Per the UMCC, Section 8.1.3.1, prenatal care must be provided within 14 days of the initial appointment except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance with the treatment plan as developed by the Provider.

Level/Type of Care	Time to Treatment (Calendar Days)
Low-Risk Pregnancies	14 Days
High-Risk Pregnancies	5 Days
New Member in the Third Trimester	5 Days

Provider Directory Accuracy

Ensure your office is properly listed in the Provider Directory and that your claims payments are sent to the correct address by providing timely advance notification of demographic changes, including:

- addition or termination of any healthcare professional from your practice;
- any change in address(es) or contact information where you render covered services, including the addition or closure of an address;
- any change in billing information, including but not limited to a change in your legal structure, payment-remit address, or change in Tax Identification Number; or
- any change in other demographic or other information that may be required for Community to meet state, federal, and health plan obligations.

Additionally, Community requests that all Providers report plans for retirement and out-of-service area moves at least 90 days prior to the effective date of change. This will help ensure continuous access to care for Members throughout the termination period.

Written request for updates can be emailed to ProviderRelationsInquiries@CommunityHealthChoice.org or faxed to 713.295.7039.

Provider Access and After-Hours Availability

As a reminder, Community conducts annual surveys to ensure that participating Providers are compliant with all-access availability and after-hours access standards. Additionally, HHSC and/or its contractor perform random telephonic surveys to Providers without notice to ensure that new and existing Members have access to care.

The Appointment Availability and Accessibility Standards are as follows:

Service	Appointment Availability
Emergent	Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities
Urgent	Must be provided within 24 hours, including urgent specialty care and behavioral health services
Primary Routine Care	Must be provided within 14 days, including behavioral health
Specialty Routine Care	Must be provided within 21 days
Routine Care Dental	Within eight weeks for dental
Initial Outpatient Behavioral Health Visit	Must be provided within 14 days (this requirement does not apply to CHIP Perinatal)
Prenatal Care	Initial appointment must be provided within 14 days for non-high-risk pregnancies. For high-risk pregnancies or new Members in the third trimester, initial appointment must be provided within five days or immediately. Appointments for ongoing care must be available in accordance with the treatment plan as developed by the Provider.
Preventive Care Physical/ Wellness Exams	Newborns (less than 6 months of age): within 14 days; Children (6 months to 20 years): within two months; Adults (21 years and older): within 90 days; New Members: within 90 days of enrollment *Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. *CHIP Members should receive preventive care in accordance with AAP guidelines

Emergent/Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could result in one or all of the following:

- Health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) is in serious jeopardy
- Serious impairments to bodily functions
- Serious dysfunction of any bodily organ or part
- Inadequate time to safely transfer a Member who is pregnant and having contractions to another hospital before delivery, or if a hospital transfer might pose a threat to the health or safety of the woman or the unborn child
- Member is a threat to themselves or others; exhibits acute onset of psychosis or severe thought

Urgent Condition: A health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe that his or her condition requires medical treatment or evaluation or treatment within 24 hours by the Member's Primary Care Provider or designee to prevent serious deterioration of the Member's condition or health.

Routine or Preventive (Non-Emergent): Postponement of treatment will not endanger life, limb, or mental faculties of patient, i.e., patient's condition permits adequate time to schedule necessary history and physical, laboratory, radiology, or other diagnostic studies on an outpatient basis.

Additionally, it is required that PCPs are accessible to Members 24 hours a day, 7 days a week. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage

1. The office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable; and
3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical provider who can return the call within 30 minutes.

Unacceptable after-hours coverage

1. The office telephone is only answered during office hours;
2. The office telephone is answered after-hours by a recording that tells Members to leave a message;
3. The office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed; and
4. Returning after-hours calls outside of 30 minutes.

Community Announcement

Community now requires all contracted THSteps Providers to take an Annual Texas Health Steps Provider Training.

Log in to your Provider portal at https://provider.communityhealthchoice.org to complete this Annual Mandatory Training by Dec 31 of each calendar year.

If you have any questions, please call/contact your Provider Engagement Representative.

Early Childhood Intervention (ECI)

Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services Commission for families with children from birth to age 3 with developmental delays, disabilities or certain medical diagnoses that may impact development. ECI services support families as they learn how to help their children grow and learn.

Providers are required to refer children to the ECI program as soon as possible, but no longer than seven days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals. To refer families for services, Providers should use the recently updated ECI referral form available on the Texas Health and Human Services website at https://hhs.texas.gov/services/disability/early-childhood-intervention-services/how-make-a-referral-eci.

For additional ECI information, Providers can visit the HHS ECI website at

https://hhs.texas.gov/services/disability/early-childhood-intervention-services.

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women is a Medicaid benefit that provides health-related case management services to children from birth through 20 years of age with a health condition and to high-risk pregnant women of any age. Case managers help clients gain access to needed medical, social, educational, and other services. Provider can make a referral to Case Management by calling 1.877.847.8377.

Integrating Postpartum Depression Screening into Routine Infant Medical Checkups

Texas Health Steps Providers can now receive separate reimbursement for conducting maternal postpartum depression screening once per Provider, in the 12 months following the infant's birth during a Texas Health Steps checkup when the screening is completed using a validated screening tool.

Validated screening tools include the following:

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PPDS)
- Patient Health Questionnaire (PHQ-9)

The Medicaid Provider notification regarding this benefit can be found at TMPH's website.

New free tutorial on Postpartum Depression Screening is also available at https://www.txhealthsteps.com/static/courses/ppd/sections/intro.html?utm_source=courseannouncement&utm_medium=email&utm_campaign=ppd

THSteps Checkup Timeliness

New Community Members must complete a checkup within 90 days of enrollment with Community. Members participating in the Head Start program should receive their checkup within 45 days of enrollment with Community or enrollment with the Head Start program. This is a Head Start requirement.

Existing Community Members must complete a checkup in accordance with the THSteps Medical Checkup Periodicity Schedule. Follow the schedule below:

The Membership Panel is available on our online Provider Portal titled "Panel Report (Medicaid/CHIP)" at https://providerportal.communitycares.com/Providers/Secure/Panel_Report.aspx

Complete before the next checkup age		
Newborn	3-5 days	2 weeks
2 months	4 months	
Complete within 60 days of these checkup ages		
6 months	9 months	12 months
15 months	18 months	24 months
	30 months	
Complete on or after the birthday but before the next birthday		
Members ages 3 through 20 need a checkup once a year		

THSTEPS CHECKUP DOCUMENTATION – ESSENTIAL TO MEDICAL RECORDS

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** that includes nutrition screening, developmental and mental health screening, and TB screening;
2. **Comprehensive unclothed physical examination** that includes measurements; height or length, weight, fronto-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** that 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 six 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.

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.

THSTEPS MEDICAL CHECKUP PERIODICITY SCHEDULE

The THSteps Medical Checkup Periodicity Schedule for Members ages 0-20.

The periodicity schedule can be downloaded via http://www.dshs.texas.gov/thsteps/providers.shtm

Exception-to-Periodicity Checkups

Exception-to-Periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances, and might cause the total number of checkups to exceed the number allowed for the Member's age range if the Member was to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

- Medically necessary. For example:
  - Member with developmental delay, suspected abuse or other medical concerns, or
  - Member in a high-risk environment, such as living with a sibling with elevated blood lead level of 5 mcg/dL or greater
- Required to meet state or federal checkup requirements for Head Start, day care, foster care or preadoption
- Provide an accelerated checkup to the Member's birthday. For example, a four-year checkup could be performed prior to the member's fourth birthday if the Member is a member of a migrant family that is leaving the area. Use modifier 32 when billing for this type of checkup.
- When needed before a dental procedure requiring general anesthesia

When billing for an exception-to-periodicity checkup, Provider must include:

- Age-appropriate procedure codes
- Diagnosis codes
- Provider type modifiers
- Condition indicators as a medical checkup (NU, ST, S2)
- Appropriate exception-to-periodicity modifiers listed in the table below

Modifiers indicate the reason for the exception-to-periodicity Checkup:

Modifier	Description
SC	Medically necessary (developmental delay or suspected abuse) Environmental high-risk (sibling of child is elevated blood level)
23	Dental services provided under general anesthesia
32	To meet state or federal requirements for Head Start, daycare, foster care or pre-adoption Accelerated services for children of traveling farmworkers

Claims for exception-to-periodicity checkups that do not include one of the exception-to-periodicity modifiers will be denied as exceeding periodicity.

CHILDREN OF TRAVELING FARMWORKERS

A traveling farmworker's principal employment is agricultural on a seasonal basis. They move from place to place and live away from home for more than a few days at a time to work on a farm or in fields. These jobs include preparing crops, growing vegetables and fruits, planting trees, raising or caring for livestock or poultry or preparing dairy products.

A traveling farmworker is someone who:

- has been employed in this capacity within the last 24 months
- established a temporary abode for the purposes of such employment

Their children, from **birth through age 17**, are considered children of traveling farmworkers. Children of traveling farmworkers due for a THSteps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but it should be billed as a checkup. For example, a 4-year-old checkup may be performed prior to the child's fourth birthday if the child is a member of a traveling family that is leaving the area. Providers must use the CPT modifier "32" when providing accelerated services outside of the periodicity schedule.

Performing a make-up exam for a late THSteps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

If you have any patients from Community who meet this criterion, please refer them to Wellness Services at 713.295.6789. Our goal is to arrange for all healthcare services they may need before they leave for the new job.

HEAD START PROGRAM

Program Description

Head Start programs promote school readiness of children ages 0-5 years of age from low-income families by supporting their development in a comprehensive way. The Early Head Start program serves pregnant women, infants, and toddlers, and the Head Start program serves children ages 3 to 5 years.

How You as a Provider Can Help

Within 45 days of enrollment, Head Start may require new enrollees to complete a THSteps/Well-Child Checkup as part of the enrollment requirements. After the initial Checkup, all Head Start students are required to complete their THSteps/Well-Child Checkups according to the periodicity schedule.

As a healthcare Provider, you can help by making sure the children receive their initial checkup within 45 days of enrollment.

For more information on Head Start programs, please visit: https://www.acf.hhs.gov/ohs

THSTEPS MEDICAL CHECKUP BILLING PROCEDURE CODES

http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf

Texas Health Steps Quick Reference Guide

Remember: Use Provider Identifier • Use Benefit Code EP1

Texas Health Steps Medical Checkup Billing Procedure Codes

Texas Health Steps Medical Checkups

99381	99382	99383	99384	99385*
99391	99392	99393	99394	99395*

* For c ents who are 18 through 20 years of age, use d agnos s code Z0000 or Z0001

Texas Health Steps Follow up Visit

Use procedure code 99211 for a Texas Health Steps follow-up visit.

ICD 10 Diagnosis Codes

Z00110	Routine newborn exam, birth through 7 days
Z00111	Routine newborn exam, 8 through 28 days
Z00129	Routine child exam
Z00121	Routine child exam, abnormal
Z0000	General adult exam
Z0001	General adult exam, abnormal

Point-of Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

Procedure Codes	Vaccine
90632 or 90633† with (90460/90461 or 90471/90472)	Hep A
90620† or 90621† with (90460/90461 or 90471/90472)	MenB
90636 with (90460/90461 or 90471/90472)	Hep A/Hep B
90644	Hib-MenCY
90647† or 90648† with (90460/90461 or 90471/90472)	Hib
90649†, 90650†, or 90651† with (90460/90461 or 90471/90472)	HPV
90630, 90654, 90655†, 90656†, 90657†, 90658†, 90685†, 90686†, 90687† or 90688† with (90460/90461 or 90471/90472); 90660† or 90672† with (90460/90461 or 90473/90474); 90661, 90673, 90674, 90682 or 90756† with (90471/90472)	Influenza
90670† with (90460/90461 or 90471/90472)	PCV13
90680† or 90681† with (90460/90461 or 90473/90474)	Rotavirus
90696† with (90460/90461 or 90471/90472)	DTaP-IPV
90698† with (90460/90461 or 90471/90472)	DTap-IPV-Hib
90700† with (90460/90461 or 90471/90472)	DTaP
90702† with (90460/90461 or 90471/90472)	DT
90707† with (90460/90461 or 90471/90472)	MMR
90710† with (90460/90461 or 90471/90472)	MMRV
90713† with (90460/90461 or 90471/90472)	IPV
90714† with (90460/90461 or 90471/90472)	Td
90715† with (90460/90461 or 90471/90472)	Tdap
90716† with (90460/90461 or 90471/90472)	Varicella
90723† with (90460/90461 or 90471/90472)	DTap-Hep B-IPV
90732† with (90460/90461 or 90471/90472)	PPSV23
90733 or 90734† with (90460/90461 or 90471/90472)	MPSV4
90743, 90744†, or 90746 with (90460/90461 or 90471/90472)	Hep B
90748† with (90460/90461 or 90471/90472)	Hib-Hep B

† Indicates a vaccine distributed by TVFC

Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

Oral Evaluation and Fluoride Varnish

Use procedure code 99429 with U5 modifier.

Developmental and Autism Screening

Developmental screening with use of the ASQ, ASQ:SE or PEDS is reported using procedure code 96110.

Autism screening with use of the M-CHAT or M-CHAT R/F is reported using procedure code 96110 with U6 modifier.

Mental Health Screening

Mental Health Screening in adolescents with the use of the PSC 17, PSC-35, Y-PSC, PHQ-9, PHQ-A (depression screen), CRAFFT, and PHQ-A (Anxiety, mood, substance use) is reported using procedure code 96160 or 96161. Only one procedure code (96160 or 96161) may be reimbursed per client per calendar year.

Postpartum depression screening with the use of a validated screening tool including the Edinburgh Postnatal Depression Scale, PHQ-9 or Postpartum Depression Screening Scale is reported using procedure code G8431 or G8510. Only one procedure code (G8431 or G8510) may be reimbursed per client.

Modifiers

Performing Provider

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

AM (Physician)	SA (Nurse Practitioner)	TD (Nurse)	U7 (Physician Assistant)

Exception to Periodicity

Use with Texas Health Steps medical checkups procedure codes to indicate the reason for an exception to periodicity.

23 (Unusual Anesthesia)	32 (Mandated Services)	SC (Medically Necessary)

FQHC and RHC

Federally qualified health center (FQHC) providers must use modifier EP for Texas Health Steps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for Texas Health Steps medical checkups.

Vaccine/Toxoids

Use to indicate a vaccine/toxoid *not available* through TVFC and the number of state defined components administered per vaccine.

U1	Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available

Vaccine Administration and Preventive E/M Visits

Use with Texas Health Steps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.

25	Significant, separately identifiable evaluation

Condition Indicator Codes

One of the Condition Indicators below is required whether a referral was made or not.

Referral Status	Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

Texas Health Steps Quick Reference Guide - revised 03/01/2019 1

THSteps Mental Health Screening Change For 12 to 18 Year Olds

THSteps allows Members 12 through 18 years of age to receive a mental health screening (procedure codes 96160 or 96161) using one or more of the validated, standardized mental health screening tools recognized by THSteps once per calendar year during a THSteps checkup. For more information on this benefit change, please visit TMHP's website.

HHSC'S MEDICAL TRANSPORTATION PROGRAM FOR MEDICAID MEMBERS

Medicaid provides transportation at no cost for THSteps patients and most others who use Medicaid medical and dental services.

What kind of ride is offered?

- Bus or a ride-sharing service
- Mileage reimbursement if the Member has a car or knows someone who can drive them to the appointment
- For trips that require overnight stay, MTP might pay for lodging and meals

How you can help

- Tell Medicaid patients about free ride service when you schedule appointments.
- Remind patients about Medicaid free rides if they miss an appointment.
- Provide the Medicaid free ride phone number: 1.855.687.4786 Monday to Friday, 8:00 a.m. to 5:00 p.m. Patients should call at least two workdays before the appointment (the sooner, the better).
- Please note: children younger than age 14 must be accompanied by the parent, guardian or other authorized adult at the medical or dental Checkup.
- Call 1.888.513.0706 if the ride does not show up.

Learn more: http://www.txhealthsteps.com/cms/?q=node/88http://www.txhealthsteps.com/cms/?q=node/88#clients-1

COMMUNITY'S TRANSPORTATION SERVICES FOR CHIP MEMBERS

We offer free transportation for CHIP Members to doctors' appointments when no other transportation is available with prior approval by our case manager.

The Member or guardian must call Community Member Services at 1.888.760.2600 for approval at least three business days before the appointment. This value-added service is only available to CHIP Members where transportation services are available.

THE TRUTH ABOUT PROPOSED PUBLIC RULE CHANGES

Here's what your Members need to know now.

Immigration is a hot topic these days, with plenty of misinformation floating around. As a result, many immigrants, including our Members and those who should apply for benefits, are living in unnecessary fear of being deported for applying for or using health care and other public assistance benefits.

Community wants to reassure our Members that they may continue receiving health care without fear.

The vast majority of our Members are required to have a green card, so they are not impacted by any proposed changes. They will not be targeted for deportation for applying for or using their benefits. Victims of violence and human trafficking, abused children, refugees, and asylees are also protected.

It's a complicated issue, to be sure. But it's important for our Members to remember that any proposed changes to the law are just that—proposed. Nothing is going into effect yet.

Who should be concerned?

Individuals who do not have immigration status and plan to apply for a green card in the next couple of years should speak to an immigration attorney if they're worried about being on benefits, as accepting benefits could impact their eligibility for a green card if the rule change goes into effect in the future.

Free, qualified legal help is available.

BakerRipley is a Houston-area nonprofit that offers a multitude of services and provides immigrants with advice and services ranging from consultation and legal representation to citizenship classes and tax preparation services.

Jill Campbell, an immigration attorney at BakerRipley, reassures clients with the facts. "There are many categories of immigrants who are not, under any circumstances, going to have a public-charge evaluation when they're applying for their green cards, including refugees, asylees, and immigrants who obtained their green card under VAWA," she said. Current green card holders should not be unnecessarily concerned. But there are some steps that they should take:

Simple recommendations:

Green card holders and their children have permanent lawful status in the U.S. and should not be afraid to apply for and use the benefits they qualify for as long as they:

- Are truthful on all benefits applications
- Do not leave the country for six months or more in one trip, as this may lead to a public charge evaluation upon their return to the United States

Advise your patients to call 713.273.3707 for additional information regarding the BakerRipley Immigration and Citizenship Program.

Integrating Postpartum Depression Screening into Routine Infant Medical Checkups

Maternal and child health are intricately linked, and both can be affected by postpartum depression. Texas Health Steps Providers can now receive separate reimbursement for conducting maternal postpartum depression screening during an infant's preventive medical checkup. Read on to learn about the policy and gain access to resources to help you implement it in your practice.

Take the course by visiting the link below-

https://www.txhealthsteps.com/static/courses/ppd/sections/intro.html?utm_source=courseannouncement&utm_medium=email&utm_campaign=ppd

The following continuing education is only available to THSteps Providers:

Online Provider Education – Free Continuing Education (CE) Hours

Texas Health Steps' online program offers more than 60 CE-accredited courses that cover a broad array of health topics. These topics range from wellness and prevention essentials, like breastfeeding and immunization, to specialized courses about treating children with asthma, diabetes, high blood pressure, and many other chronic health conditions.

First-time users will need to register. The courses are available at: http://www.txhealthsteps.com/cms/

TMHP Online Provider Education

TMHP offers a variety of training for Providers online using computer-based training (CBT) modules on the TMHP Learning Management System (LMS). Medicaid Providers can access this training from any location with Internet access, anytime, at their convenience. TMHP CBT modules offer flexible training experience by allowing Providers to play, pause, rewind, and even search for specific words or phrases within a CBT module. **First-time users will need to register.**

CBT Topics include:

- Children with Special Health Needs Service Program Basics
- Claim Forms
- Claims Appeals
- Client Eligibility
- Crossover Claims
- Family Planning
- Texas Health Steps – Medical Services
- Provider Enrollment on the Portal
- And much more

To access the training, please visit: http://learn.tmhp.com/

Vendor Drug Program Continuing Education for Prescribing Providers

As a Medicaid-prescribing Provider, you can help Medicaid clients get their medications quickly and conveniently with a few simple steps. By prescribing a preferred product or obtaining a prior authorization before the client leaves the office, the prescription can be filled without delay. This eliminates the need for the pharmacy to contact the prescribing Provider's office for a therapeutic substitution, as well as the need to initiate the prior authorization process.

For a list of Medicaid Drug Formulary and free continuing education credits, please visit:

https://www.txvendordrug.com/providers/prescriber-education

Feedback

What do you think about our Provider Newsletter? Do you have any feedback you would like to share with us? We are always working to make the content and format **easy to understand, helpful** to you and your staff, and **applicable** to your day-to-day work.

If you have any comments, suggestions, or ideas for future articles you would like to see, please email us at CommunityProviderNewsletter@CommunityHealthChoice.org

CONTACT INFORMATION

MEDICAL AFFAIRS

Peer-to-Peer Discussions
713.295.2319

Senior Vice President, Medical Affairs
Karen Hill, M.D.

Associate Medical Directors
Valerie Bahar, M.D.
Lisa Fuller, M.D.
Karen Gray, M.D.

Utilization Management
Phone: 713.295.2221
Fax: 713.295.2283 or 84

Care Management: Asthma, Congestive Heart Failure, Diabetes, High-Risk Pregnancy
713.295.2303

Diabetic Supplies/Outpatient Perinatal
Fax: 713.295.7028
Toll-free fax: 1.844.247.4300

CLAIMS

- Inquiries
- Adjudication

CommunityHealthChoice.org or 713.295.2295

Community will accommodate three claims per call.

REFUND LOCKBOX

Community Health Choice
P.O. Box 4818
Houston, TX 77210-4818

ELECTRONIC CLAIMS *(CHIP & STAR)*

Submit directly through Community's online claims portal:
CommunityHealthChoice.org > Provider Tools > Claims Center
Payer ID: 48145

Change HealthCare (Formerly Emdeon)	1.800.735.8254
Availity	1.800.282.4548
RelayHealth	1.563.585.4411
Gateway EDI	1.800.969.3666
TMHP (STAR only)	www.tmhp.com

ELECTRONIC CLAIMS-UB, CMS-1500 *(MARKETPLACE)*

Submit directly through Community's Online Claims Portal:
CommunityHealthChoice.org > For Providers > Provider Tools > Claims Center

Change HealthCare: 1.800.735.8254
Payer ID: 60495

PHARMACY

Navitus Health Solutions
1.877.908.6023
www.navitus.com

BEHAVIORAL HEALTH

Beacon Health Options
1.877.343.3108
www.beaconhealthoptions.com

ADVERSE DETERMINATIONS & MEDICAL NECESSITY APPEALS

Community Health Choice
Attn: Medical Necessity Appeals
Fax: 713.295.7033

All appeals must be in writing and accompanied by medical records.

MEMBER SERVICES & SPECIALIST SCHEDULING

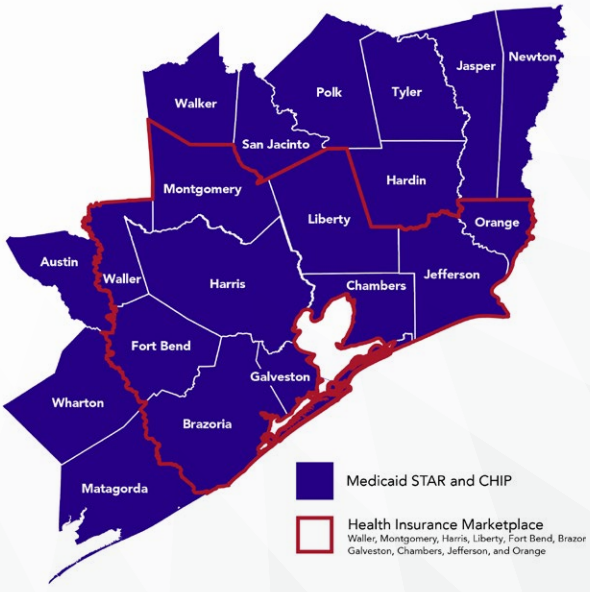
713.295.2294 or 1.888.760.2600

PROVIDER RELATIONS

For general questions or to submit your updates:

- 713.295.2295
- ProviderRelationsInquiries@CommunityHealthChoice.org
- Contact your Provider Engagement Representative.

SERVICE AREA MAP



CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services