

V2-2019

Provider Newsletter

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Behavioral Health Transitions to Community!

Community Health Choice (Community) has made the decision to terminate our contract with Beacon Health Strategies, our behavioral health services Provider, for our CHIP/STAR and Marketplace Membership.

Effective **September 1, 2019**, Community Health Choice will begin to coordinate behavioral health services directly for our CHIP/STAR and Marketplace Membership.

Community Health Choice is excited about this opportunity to insource behavioral health services for our CHIP/STAR and Marketplace Members and provide a truly integrated delivery model to these populations. The integrated model will also provide a strong clinical and operational foundation for future DSNP and STAR+PLUS programs that we anticipate implementing in January and June 2020, respectively.

Frequently Asked Questions

How does this affect CHIP/STAR and Marketplace Members who are currently receiving behavioral health services?

- Member benefits will not be affected. Beacon will continue coordinating behavioral health services until

the end of their contract, which is midnight on August 31, 2019. The phone number to call for behavioral health benefits will not change.

- Our plan is to add all current Beacon Providers to our network. If a Provider does not join our network by July 15, 2019, we will notify affected Members and assist them in choosing another Provider.

What Members will receive notification and when?

Community Health Choice will only notify Members who are actively receiving services from a Provider who will not participate in our network by July 15, 2019, which is more than 30 days before the transition date.

Community Health Choice will also notify Members who are no longer actively receiving services from a Provider who will not participate in our network by July 15, 2019, but did receive a service from that Provider in the past 12 months.

Should you have any questions, please contact Provider Services at 713.295.2295 or email at ProviderWebInquiries@CommunityHealthChoice.org.

Transition to Interqual Criteria

After careful evaluation, Community Health Choice (Community) has decided to transition to InterQual Criteria for evidence-based clinical guidelines, effective **September 1, 2019**, for medical and behavioral health services.

InterQual is a nationally recognized utilization management (UM) tool that will provide us with reliable, evidence-based clinical decision support. InterQual is trusted by more than 4,600 hospitals and facilities and more than 280 managed-care organizations. InterQual criteria is also continuously updated with the most recent evidence and clinical standards, using a wide variety of medical specialists to manage and validate their medical criteria sets.

InterQual is known for its clinical integrity, innovative technology, and service excellence. We are confident it will help us continue to meet the following objectives:

- Assure optimal and consistent utilization management decision-making
- Support the appropriateness of care
- Manage medical costs
- Foster appropriate utilization of resources

Frequently Asked Questions

Where can Providers or Members access the criteria?

The InterQual Criteria is not available directly to Providers from Community. InterQual is a proprietary product that Community Health Choice is not able to legally share. Provider organizations may purchase access to Provider criteria directly from Change Healthcare. In alignment with federal and state requirements and InterQual's guidelines, Members have the right to request from Community Health Choice a copy of criteria used in the event of a denied request for service.

How does this impact Member benefits?

This change does not impact Member benefits.

Will there be any changes to the pre-authorization, prior approval or the precertification list process for Providers?

No, the change to InterQual clinical decision support criteria does not change those processes.

Where can Providers or Members find more information about this change?

Members are encouraged to call the phone number located on the back of their ID card. Providers are encouraged to call Provider Services at 713.295.2295 or email Provider Services at ProviderWebInquiries@CommunityHealthChoice.org.

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

We have made a few changes to our prior authorization list to include behavioral health 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 programs.

We ask that requests for prior authorization be submitted on Community Health Choice 's Preferred Prior Authorization Form, which can be found under Provider Tools > Authorizations/Notifications > Notifications.

Please note that we still accept the Texas Standard Prior Authorization Form.

You will find the most recent version of our Prior Authorization Guide on our Provider Portal. Call our Provider Services line at 713.295.2295 if you have any questions.

Automated Prior Authorization Process

TriZetto® Touchless Authorization Processing™ (TTAP) is a cloud-based healthcare IT solution for payers and Providers. TTAP automates prior authorization and referral requests using a 278/275-based authorization engine.

Effective **October 1, 2019**, Community Health Choice (Community) would like to make TTAP available as a solution that streamlines and automates the prior authorization process for Providers in our networks. You will be able to enter an authorization request, answer a few questions, and receive an authorization for a Covered Service automatically, saving time and creating efficiency for your staff. Additionally, it will allow Community Health Choice to maintain both business and clinical rules while significantly decreasing the prior authorization review cycle.

In submitting prior authorizations to this automated, real-time solution, you will realize multiple benefits immediately, including:

- Almost immediate, fully automated authorization responses
- Simplified and expedited authorization transactions
- Automated determination of authorization requirements

There is no additional cost to you for using this solution.

Your Provider Engagement Representative will contact you to schedule training for your practice.

You may also visit our Provider Portal at <https://Provider.CommunityHealthChoice.org/> to access the TTAP Training Guide or contact Provider Services at 713.295.2295 should you have any questions.



Breast Pumps

Benefit Not Allowed in Prenatal Period

Breast pumps are subject to medical necessity requirements. Medical necessity cannot be established in the prenatal period, thus breast pumps are not a benefit in the prenatal period.

Deactivated NCCI MUE Limitations for Substance Use Disorder Treatment and Breast Pump Replacement Parts

Texas Medicaid has received approval from the Centers for Medicare and Medicaid Services (CMS) to deactivate the National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) limitation currently in place for the following substance use disorder treatment and breast pump replacement parts procedure codes for dates of service **on or after January 1, 2019**:

Procedure Codes	Descriptions
A4281, A4282, A4284, A4286	Breast pump replacement parts
H0005	Group therapy for substance use disorder treatment

Effective **June 1, 2019**, there will no longer be a MUE limiting H0005 to one (1) per date of service.

Effective **June 1, 2019**, breast pump replacement part procedure codes A4281, A4282, A4284, and A4286 may be reimbursed up to a maximum of two (2) of each breast pump replacement parts when billed on the same date of service, as appropriate for the typically bilateral nature of the benefit.

Please note that there were no updates to the Texas Medicaid Provider Procedures Manual (TMPPM) associated with these changes, as the purpose of the NCCI MUE deactivations was to align reimbursement with current policy language.

New Process for Therapy Waitlist for Physical, Occupational, and Speech Therapy

PT, OT, and ST Providers will now have the option to report waiting list data directly to HHSC in addition to continuing to report it to Community. If the data is reported to HHSC, then HHSC will share it with Community Health Choice for us to respond to Members who are submitted on waiting list reports.

Effective June 3, 2019, therapy Providers that have placed children on waiting lists for services for any reason have the option to report this information directly to HHSC. Alternatively, Providers may also continue sending waiting lists directly to Community. Waiting list information sent to HHSC must be reported on the HHSC "Therapy Waitlist Provider Reporting Template."

You will find the HHSC template in our Provider Portal under the path defined by Provider Tools > Therapy Waitlist Provider Reporting Template.



Therapy Provider Name:			NPI:			Waitlist Data as of Date:			
Provider Street:									
City, Zip:						Note: * indicates that each cell in the respective column has a drop-down menu			
Patient First Name	Patient last name	Date of Birth	Patient Medicaid ID	Therapy Type Needed*	Date Patient First Requested Therapy Service	Date Patient Added to Waitlist	MCO Name*	Service Delivery Area*	MCO Program*

- If the waiting list has been updated, send it either to Community Health Choice or to HHSC via the HHSC dedicated email: TX_HHS_THERAPY_MONITORING@hhsc.state.tx.us
- A patient placed on the waiting list should stay on the list until she or he receives the necessary therapy service.
- HHSC staff will monitor the dedicated email box every Monday and Wednesday. Frequency of reporting will be monitored and the schedule will be adjusted if necessary.
- HHSC will send waiting list information reported by therapy Providers to Community Health Choice.



Updated Limitation for Zika Virus Testing Effective July 1, 2019

Effective for dates of service **on or after July 1, 2019**, the limitation for Zika virus testing (procedure code 87662) will change.

Effective for dates of service **on or after July 1, 2019**, Texas Medicaid may reimburse viral DNA-based Zika testing (procedure code 87662) up to two times on the same date of service by the same Provider.

The update aligns Zika virus testing reimbursement policy with updated Texas Department of State Health Services and U.S. Centers for Disease Control and Prevention testing guidelines for asymptomatic pregnant women with increased or ongoing risk for exposure to the Zika virus.

This change allows for concurrent testing of blood and urine samples as recommended in the updated clinical practice guidelines.

Tobacco Use Cessation Services Provided in a Group Setting

Effective for dates of service **on or after July 1, 2019**, tobacco use cessation services may be provided in a group setting for Medicaid-eligible clients.

Tobacco use cessation services delivered in a group setting will be limited to a maximum of eight participants per group.

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

Claims for tobacco use cessation services delivered in a group setting must be submitted with modifier HQ.

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.*

Providers will be notified in a future banner message or notification if a proposed reimbursement rate will change or if a procedure code will not be reimbursed because the expenditures are not approved.

Providers may also refer to the following website for details related to rate hearings: www.hhs.texas.gov/about-hhs/communications-events/meetings-events.

Recertification Requirements for Members

HHSC requires that all STAR and CHIP Members recertify. STAR Members are required to recertify annually. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions.

The family needs to:

- Review the information on the renewal application.
- Correct any information.
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, staff checks to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program (Medicaid or CHIP), HHSC sends the family a letter informing them about the referral and then looks to see if the child can obtain benefits in the other program. If the child qualifies, the coverage in the new program (Medicaid or CHIP) begins the month following the last month of the other program's coverage.

Some of the benefits that Community Health Choice Members can enjoy include the following:

- Memberships to Neighborhood Centers, Inc. (NCI) and Boys and Girls Club,
- Youth Sports League allowance up to \$40,
- No cost, fun Member events such as Rockets and Astros games, and The Children's Museum
- And much more!

Community Health Choice contacts Members when their recertification date is coming up to ensure there is no interruption to their healthcare benefits.

Please be sure to remind your Community Health Choice Members to recertify annually.

Community Health Choice's Application Sites

Did you know that Community Health Choice has over 20 established sites throughout the Harris service area to assist Community Health Choice Members with recertification and potential Members with application assistance?

For more information regarding the specific locations, please contact our Provider Services Department at 713.295.2295. Members can also contact Member Services at 713.295.2294.



CareerReady

Community Health Choice is leading the way in Houston with a job training and education pilot program called CareerReady. CareerReady connects Community Health Choice Members who are high school seniors and pregnant women with the resources they need to pursue an education that will enable them to be hired for a job that offers a livable wage. This program furthers Community Health Choice's purpose to fulfill the mission of Medicaid – offering a ladder out of poverty and up the economic ladder.

In 2018, Community Health Choice accepted 32 Scholars as their first cohort into CareerReady. As a part of CareerReady, Scholars are awarded a scholarship to attend Houston Community Health Choice College with the goal of completing a job certification program. The first cohort enrolled in programs such as certified nurse's aide, EKG technician, phlebotomy, paralegal, plumbing and human resources. Along with the scholarship, each Scholar is assigned a Life Coach to help them navigate the process of applying for school, enrolling in classes, connecting them to community resources, and building up the Scholar's soft skills. The Life Coach also helps the Scholars with preparing for employment and applying for jobs.

This year, CareerReady established partnerships with Legacy Community Health Choice Health, Harris Health, and El Centro de Corazon to provide them with an applicant pool of newly trained CareerReady Scholars eligible for open positions at their organizations. Community Health Choice also personally invested in the career development of the Scholars by providing two paid supplemental employment opportunities. This provided eligible Scholars valuable work experience in a learning environment related to their fields of study.

The 2019 CareerReady application cycle opened in the spring. Members are eligible to apply for CareerReady if they delivered a baby in the calendar year or if they are a 2019 graduating high school senior from the Association of the Advancement of Mexican Americans (AAMA) Sanchez Charter School. So far, 21 Scholars have been accepted as a part of the 2019 cohort.

To learn more about CareerReady and how you can help support this program, contact the Life Services Team at LifeServices@CommunityHealthChoice.org.

Balance Billing

Members enrolled in STAR and CHIP have certain rights and protections against balance billing.

Members are not responsible for any covered services. Medicaid reimbursement is considered as payment in full for those services covered under Texas Medicaid (TMHP Manual 1.6.9).

Balance billing is illegal under both state and federal law (Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997). Please refer to the Texas Administrative Code Chapter 354 Rule §354.1005 and §354.1131.

CHIP Members are responsible for their copayments, as applicable, to their Federal Poverty Level (FPL).

Reminder: New Electronic Payment Method

In Volume 1 of the Provider Newsletter, we communicated that Community Health Choice partnered with Change Healthcare and ECHO Health, Inc. to provide new electronic payment methods. Many of our Providers already work with Change Healthcare today.

As a reminder, below are 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.

4 Online: You can now log into www.providerpayments.com to gain online access to detailed explanation of payment for all ECHO transactions. If you wish, you can elect to receive an email notification each time Community makes a payment to you.

We appreciate your support as we implement these new payment options and we look forward to continuing to work with you to deliver a positive experience for our Members - your patients. If you have additional questions regarding your payment options, please contact ECHO Health toll-free at 1.833.629.9725.

Long Acting Reversible Contraception (LARC)

Hospitals

Procedure codes for LARCs may be reimbursed in addition to the hospital diagnosis related group (DRG) payment when insertion is performed immediately postpartum.

Procedure Codes

J7297, J7298, J7300, J7301, J7307

“Immediately postpartum” refers to insertion within 10 to 15 minutes of placental delivery, after vaginal or cesarean delivery, for intrauterine devices (IUDs) or insertion prior to discharge for implantable contraceptive capsules.

When seeking reimbursement for an IUD or implantable contraceptive capsule inserted immediately postpartum, hospital/facility Providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.

FQHCs

FQHCs may receive reimbursement for the following procedure codes in addition to the FQHC encounter payment:

Procedure Codes

J7297, J7298, J7300, J7301, J7307

When seeking reimbursement for an IUD or implantable contraceptive capsule, Providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations.

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.

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





Complaints and Appeals

At Community, we strive to provide the best possible service to both our Members and Providers. To help expedite resolution to appeals, complaints, and payment appeals, it is important that you and your staff have the appropriate information.

“Appeal” means the formal process by which a Member, or a Member’s representative, requests a review of a Community Health Choice Action.

“Action” is: 1) the denial or limited authorization of a requested Medicaid service, including type or level of service; 2) the reduction, suspension or termination of a previously authorized service; 3) the denial, in whole or in part, of payment for a service; 4) the failure to provide a service in a timely manner; 5) the failure of Community Health Choice to act within the timeframes of its contract with HHSC. An adverse determination is one type of Action.

“Adverse Determination” is a decision by Community Health Choice that a service furnished to a Member, or proposed to be furnished to a Member, is not medically necessary or appropriate.

A Provider may request an appeal of an adverse determination within 60 calendar days of the date of Community Health Choice 's written notification of an adverse determination. Please send supporting documentation along with a copy of the original request for covered services to:

Community Health Choice
Attn: Medical Appeals
2636 South Loop West, Ste. 125
Fax: 713.295.7033

Appeals may also be submitted online at the Community Health Choice website with supporting documentation at <https://www.CommunityHealthChoice.org>.

“Complaint” refers to an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. Complaint has the same meaning as grievance, as provided by 42 C.F.R. §438.400(b). Possible subjects for Complaints include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Member’s rights regardless of whether remedial action is requested. Complaint includes the Member’s right regardless of whether remedial action is requested. Complaint includes the Member’s right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

A Provider may file a complaint at any time with Community Health Choice. Send Complaints to:

Community Health Choice
Attn: Service Improvement
2636 South Loop West, Ste. 125
Houston, TX 77054
Fax: 713.295.7036

Email: ServiceImprovement@CommunityHealthChoice.org

Complaints may also be submitted online at the Community Health Choice website <https://www.CommunityHealthChoice.org>.

“Payment Appeal” or **“Request for Claim Reconsideration”** is any claim payment disagreement between the health care Provider and Community Health Choice for reason(s) including, but not limited to:

- Denials for timely filing
- The failure of Community Health Choice to pay timely
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a Provider
- Inappropriate or unapproved referrals initiated by Providers (i.e., a Provider payment appeal may arise if a Provider was required to get authorization for a service, did not request the authorization, provided the service, and then submitted the claim)
- Provider medical appeals without the Member’s consent.
- Retrospective review after a claim denial or partial payment.
- Request for supporting documentation.

Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 713.295.2295.

To submit a payment appeal in writing, please send it to:

Community Health Choice
Attn: Claims-Provider Payment Reconsideration
2636 South Loop West, Ste. 125
Houston, TX 77054

Email: ProviderWebInquiries@CommunityHealthChoice.org

A network or non-network Provider should file a payment reconsideration request within 120 calendar days of the date of the Explanation of Payment (EOP), or for retroactive medical necessity reviews, as of the date of the denial letter. The appeal should include an explanation of what is being appealed and why. Supporting documentation must be attached to the request. Examples of appropriate supporting documentation include the following:

- Letter stating the reason(s) why the Provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Community Health Choice EOP
- EOP or Explanation of Benefits (EOB) from another carrier
- Evidence of eligibility verification (e.g., a copy of ID card, panel report, the TMHP/TexMedNet documentation, call log record with the date and name of the Community Health Choice person the Provider's staff spoke with when verifying eligibility)
- Medical records
- Approved authorization form from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified or overnight mail receipt with the claim or appeal log, if more than one claim or appeal was submitted
- EDI claim transmission reports indicating that the claim was accepted by Community Health Choice; rejection reports are not accepted as proof of timely filing

Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

Community Health Choice requires that Providers report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131 - 97.134 using the required forms and procedures for reporting STDs.

Providers must coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia, and HIV receive risk reduction and partner elicitation/notification counseling.

Providers must have procedures in place to protect the confidentiality of Members provided STD/HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared.

Providers who provide STD/HIV services must comply with all state laws relating to communicable disease reporting requirements.

Visit the CDC website at <https://www.cdc.gov/std/treatment/default.htm> for information related to treatment and screening of STDs and <https://www.cdc.gov/std/hiv/default.htm> for HIV/AIDS.

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 in 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.

Title XIX Form Required Signature – Not Stamp

The dispensing Provider and the prescribing physician must maintain the completed Title XIX Form 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 of up to six months from the physician's signature date.

Special Investigations Unit

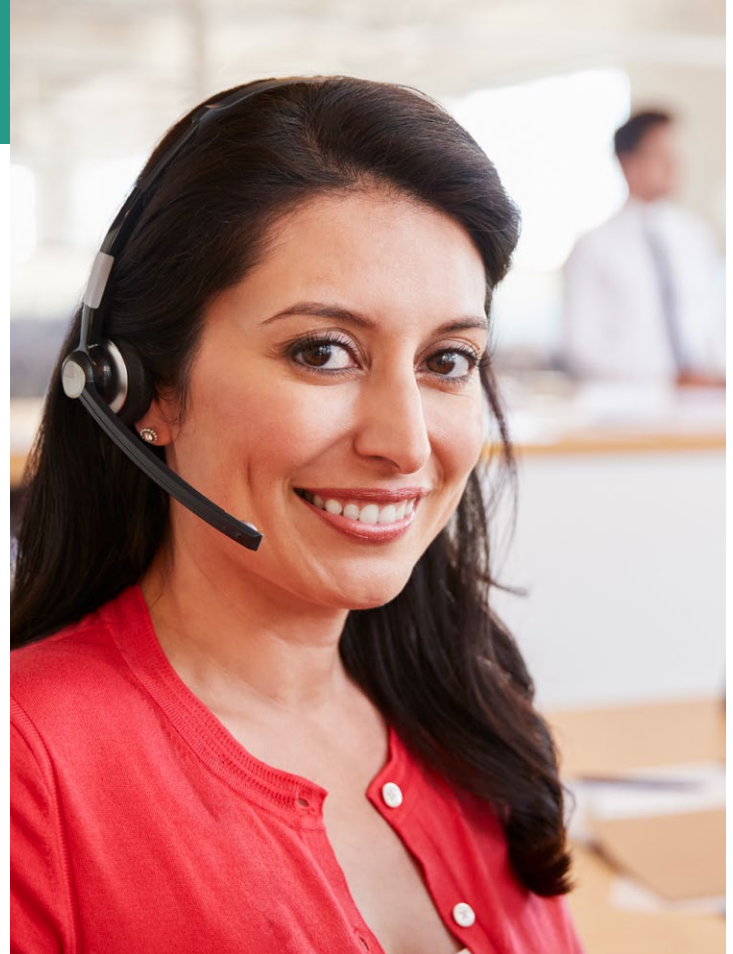
Our Special Investigations Unit (SIU) team is responsible for minimizing Community Health Choice 's risk to healthcare fraud. The SIU team partners with Community Health Choice 's Customer Service Claim Centers and others to help identify suspicious claims, stop payments to fraudulent Providers, and 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 at:

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



Help us Keep Adolescents Healthy with Timely Immunizations!

By the time they turn 13 years old, adolescents should receive at least one dose of quadrivalent meningococcal conjugate vaccine (MenACWY), tetanus, diphtheria, and acellular pertussis, absorbed vaccine (Tdap) and two doses of human papillomavirus vaccine (HPV).

However, in 2017, the rate of adolescents receiving all three vaccinations by age 13 was only 27.69% among Medicaid Members in the state of Texas.¹

Figure 1 illustrates a relatively low immunization rate for HPV compared to both meningococcal vaccine and Tdap individually, as well as a low immunization rate for timely administration of all three recommended vaccines for adolescents overall among Medicaid Members in Texas.

Vaccine	Age-Appropriate Vaccination Rate
HPV	30.11%
Meningococcal	79.63%
Tdap	81.99%
All three	27.69%

Summer is the perfect time for students to catch up on their immunizations as they prepare to return to school, where they are at increased risk of contracting communicable diseases. Please educate Members on the importance of including vaccination in their preventive care visits:

- Meningococcal vaccine prevents meningococcal meningitis and severe complications of the disease like neurologic sequelae, limb amputation, and death
- Tdap prevents diphtheria, tetanus, pertussis which protects them and the young infants and older adults they come in contact with against complications including severe pneumonia and death
- HPV vaccine prevents cancers due to HPV in both males and females.²

Encourage adolescents to receive at least one dose of all three immunizations (and two doses of HPV vaccine) prior to turning 13 years old. Additionally, giving meningococcal, Tdap and HPV vaccine together increases vaccine rates for all three immunizations and provides a good immune response.³

Finally, here are a few tips to keep adolescents healthy with timely immunizations:³

- Meningococcal conjugate (MenACWY): 1 dose at 11-12 years of age, with a booster dose at 16 years of age; (and consideration for serogroup B meningococcal vaccines (MenB): 16-18 years of age).
- Tdap: 1 dose at 11-12 years of age; pregnant adolescents should receive 1 dose during each pregnancy at 27-36 weeks of gestation.
- HPV vaccine for males and females: 2 doses at 9-14 years of age for persons at 0 and 6-12 months; 3 doses for persons 15-26 years of age and 9-26 years of age for immunocompromised at 0, 1-2, and 6 months.
- Review vaccination records at every visit and catch up to the recommended schedule if behind.
- Record the vaccinations in ImmTrac for easy documentation, especially for students.

References:

1. Texas Healthcare Learning Collaborative: <https://thlcportal.com/home>
2. National Cancer Institute: <https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-vaccine-fact-sheet>
3. Bernstein, Henry and Joseph A Bocchini Jr, Committee on Infectious Diseases, The Need to Optimize Adolescent Immunization, Pediatrics, <https://pediatrics.aappublications.org/content/139/3/e20164186>

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

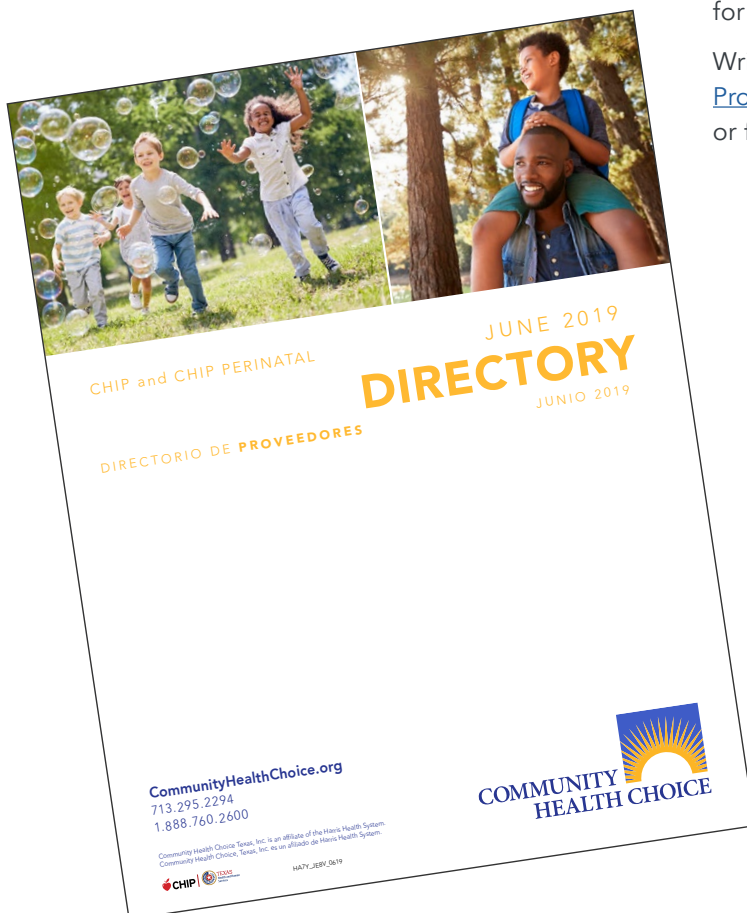
Provider Directory Accuracy

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 Health Choice to meet state, federal, and health plan obligations.

Additionally, Community Health Choice 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 Health Choice 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.

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 nasopharyngitis (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.



Welcome to the pharmacy corner!
For this edition, we wanted to highlight a hot topic that has been in the news quite frequently as of late – **the opioid crisis.**

What is the impact?

Drug overdose deaths continue to increase in the United States. Did you know that on average, 130 Americans die every day from an opioid overdose?¹ What is of greater concern is that this includes misuse of and addiction to prescription pain relievers! It is estimated that the total “economic burden” of prescription opioid misuse alone in the United States is \$78.5 billion a year.²

What can we do about it?

The Texas Prescription Monitoring Program (PMP) collects and monitors prescription data for all Schedule II, III, IV, and V Controlled Substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. Prescribers have always been encouraged to check the PMP to help eliminate duplicate and over-prescribing of controlled substances, as well as obtain critical controlled substance history information. **Beginning September 1, 2019**, prescribers (other than a veterinarian) will be required to check the patient’s PMP history before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.

How do I access the Texas Prescription Monitoring Program?

You can sign up to register by going to this website: <https://texas.pmpaware.net/login>. Additional information is available on the Texas State Board of Pharmacy website: <https://www.pharmacy.texas.gov/PMP/>

References:

1. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at <http://wonder.cdc.gov>.
2. Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Med Care*. 2016;54(10):901-906. doi:10.1097/MLR.0000000000000625.

In Other News

We wanted to remind prescribers of how to access the Community Health Choice formulary. You can access the formulary through the Community Health Choice website (<https://www.CommunityHealthChoice.org>).

- Medicaid: For Providers > Provider Tools > Pharmacy Formulary (Medicaid/CHIP)
- Marketplace: For Providers > Provider Tools > Pharmacy Formulary (Marketplace)

Please submit clinical records with prior authorization requests. Clinical records help give us a clear picture of the Member’s history and the progression of his or her condition. We often find that the original determination could have been different, if we had received the Member’s clinical records initially.

We thank you for everything you do for our Members. We look forward to continuing to partner with you. We hope you and your office staff are having a wonderful summer!

Annual Provider Training

Community Health Choice 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 December 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>.



THSteps Medical Checkup Billing Procedure Codes

The Texas Health Steps Quick Reference Guide has been updated. The Condition Indicator Codes table now states that a condition indicator is required whether a referral is made or not. In addition, the title of the Indicator column has changed to Referral Status.

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

Providers can access the updated Texas Health Steps Quick Reference Guide located on the Texas Medicaid & Healthcare Partnership (TMHP) website at http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_ORG.pdf.

Community Health Choice encourages Providers to regularly visit the Texas Health Steps website for updates and other valuable information on Texas Health Steps medical checkups at <https://www.dshs.texas.gov/thsteps/Providers.shtm>.



Back-to-School Checkups

Summer is here, which means now is the time that school-aged Members visit their doctor’s office for back-to-school checkups. Community Health Choice recommends its network Providers to include some other important components into one single checkup. This makes it a “one-stop” visit for the Member and the Provider’s office.

1. THSteps/Well-Child Checkup

This checkup tracks healthy growth and identify Member’s health problems early. This also allows the Provider to assess and answer any questions/concerns related to the Member’s health, which might interfere with his/her school.

2. Sports and Physical Exams

Members who participate in sports will need their annual sports and physical checkup. A sports and school physical checkup is a value-added service for Community Health Choice Members since it is not a covered benefit for Medicaid. Community Health Choice will pay sports and school physicals for Medicaid Members ages 4 to 19 once per rolling year. Providers must use 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

	Level of Complexity	No. of Comorbidities	No. 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: <ul style="list-style-type: none"> • 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 measurable assessment of functional outcome with an update in management options, goals, and interventions 			20 minutes

3. Flu, Vaccine, and other Immunizations

- Seasonal flu activity can begin as early as October and continue to occur as late as May.
- Getting young children vaccinated can help protect them from flu since young children are more vulnerable to serious flu complications.
- This is also a great time to administer any immunizations that the Member might need prior to attending their school.

Remember, Community Health Choice allows you to bill all of the above checkups on the same day. Please read “Billing THSteps Medical Checkup and Other Services on the Same Day” section of this newsletter for billing tips.

Below is the chart that summarizes the 2019 - 2020 Immunization requirements for the schools in the state of Texas.

2019 - 2020 Texas Minimum State Vaccine Requirements for Students Grades K - 12

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This document is not intended as a substitute for the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements by the Texas Education Code, Chapter 38.

IMMUNIZATION REQUIREMENTS

A student shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a public or private elementary or secondary school in Texas.

Vaccine Required (Attention to notes and footnotes)	Minimum Number of Doses Required by Grade Level												Notes		
	Grades K - 6th						Grade 7th	Grades 8th - 12th							
	K	1	2	3	4	5	6	7	8	9	10	11		12	
Diphtheria/Tetanus/Pertussis ¹ (DTaP/DTP/DT/Td/Tdap)							5 doses or 4 doses	3 dose primary series and 1 booster dose of Tdap / Td <i>within the last 5 years</i>	3 dose primary series and 1 booster dose of Tdap / Td <i>within the last 10 years</i>						<p>For K – 6th grade: 5 doses of diphtheria-tetanus-pertussis vaccine; 1 dose must have been received on or after the 4th birthday. However, 4 doses meet the requirement if the 4th dose was received on or after the 4th birthday. For students aged 7 years and older, 3 doses meet the requirement if 1 dose was received on or after the 4th birthday.</p> <p>For 7th grade: 1 dose of Tdap is required if at least 5 years have passed since the last dose of tetanus-containing vaccine.*</p> <p>For 8th – 12th grade: 1 dose of Tdap is required when 10 years have passed since the last dose of tetanus-containing vaccine.*</p> <p>*Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.</p>
Polio ¹							4 doses or 3 doses								<p>For K – 12th grade: 4 doses of polio; 1 dose must be received on or after the 4th birthday. However, 3 doses meet the requirement if the 3rd dose was received on or after the 4th birthday.</p>
Measles, Mumps, and Rubella ^{1,2} (MMR)							2 doses								<p>For K – 12th grade: 2 doses are required, with the 1st dose received on or after the 1st birthday. Students vaccinated prior to 2009 with 2 doses of measles and one dose each of rubella and mumps satisfy this requirement.</p>
Hepatitis B ²							3 doses								<p>For students aged 11 – 15 years, 2 doses meet the requirement if adult hepatitis B vaccine (Recombivax[®]) was received. Dosage (10 mcg /1.0 mL) and type of vaccine (Recombivax[®]) must be clearly documented. If Recombivax[®] was not the vaccine received, a 3-dose series is required.</p>
Varicella ^{1,2,3}							2 doses								<p>For K – 12th grade: 2 doses are required with the 1st dose of received on or after the 1st birthday.</p>
Meningococcal ¹ (MCV4)								1 dose							<p>For 7th – 12th grade, 1 dose of quadrivalent meningococcal conjugate vaccine is required on or after the student's 11th birthday. Note: If a student received the vaccine at 10 years of age, this will satisfy the requirement.</p>
Hepatitis A ^{1,2}							2 doses								<p>For K – 10th grade: 2 doses are required, with the 1st dose received on or after the 1st birthday.</p>

NOTE: Shaded area indicates that the vaccine is not required for the respective grade.

↓ Notes on the back page, please turn over.↓

Rev. 03/2019

Billing THSteps Medical Checkup and Other Services on the Same Day

A. THSteps Medical Checkup and Immunization Administration on the Same Day

The age-appropriate diagnosis code for preventive care medical checkups must be submitted on the claim. If an immunization is administered as part of a preventive care medical checkup, diagnosis code Z23 may also be included on the claim. In addition to the age-appropriate diagnosis, for claims that are submitted with an immunization administration procedure code and a preventive evaluation and management (E/M) visit, Providers may append modifier 25 to the preventive E/M visit procedure code to identify a significant, separately identifiable E/M service that was rendered by the same Provider on the same day as the immunization administration.

Providers may only choose to submit diagnosis code Z23 on the claim if an administration is the only service provided during an office visit.

B. THSteps Medical Checkup and Acute Care Visit on the Same Day

Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a Checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provide for different diagnoses. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit.

C. THSteps Medical Checkup and Sports and School Physical on the Same Day

A sports and school physical is a value-added service for Community Health Choice Members since it is not a covered benefit for Medicaid. Community Health Choice will pay sports and school physicals for Medicaid Members ages 4 to 19 (limited one per year). Provider must use procedure code 97169, 97170, 97171, or 97172 depending on the level of complexity when billing for sports physicals.

For more information regarding the sports and physical codes, see the New Sports and School Physical Procedure Codes article.



THSteps Checkup Timeliness

New Community Health Choice 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 Health Choice or enrollment with the Head Start program. This is a Head Start requirement.

Existing Community Health Choice 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.CommunityHealthChoice.org/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

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

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);
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>


Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

		COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE																																																								
		DEVELOPMENTAL SURVEILLANCE				MENTAL HEALTH		MEASUREMENTS										VISION		HEARING		LABORATORY TESTS				Health Education/Anticipatory Guidance																																
		Nutritional Screening		Review of Milestones		ASQ, ASQ:SE, or PEDS		M-CHAT or M-CHAT-R/F™		Mental Health: Psychosocial/Behavioral Health Screening		Postpartum Depression Screening		TP Questionnaire with Skin Test if Risk Identified		Unoldthead Physical Examination		Critical Congenital Heart Defect Screening		Length		Height		Weight		BMI		Fronto-Occipital Circumference		Blood Pressure		Visual Acuity		Subjective Vision		Newborn Hearing Test (OAE or ABR)		Audiometric Screening		Subjective Hearing		Dental Referral		Screen/Administer Immunizations According to AQP Guidelines		Newborn Screening Panel		Blood Lead Screening		Anemia		Dyslipidemia		Type 2 Diabetes				
AGE		History		Nutritional Screening		Review of Milestones		ASQ, ASQ:SE, or PEDS		M-CHAT or M-CHAT-R/F™		Mental Health: Psychosocial/Behavioral Health Screening		Postpartum Depression Screening		TP Questionnaire with Skin Test if Risk Identified		Unoldthead Physical Examination		Critical Congenital Heart Defect Screening		Length		Height		Weight		BMI		Fronto-Occipital Circumference		Blood Pressure		Visual Acuity		Subjective Vision		Newborn Hearing Test (OAE or ABR)		Audiometric Screening		Subjective Hearing		Dental Referral		Screen/Administer Immunizations According to AQP Guidelines		Newborn Screening Panel		Blood Lead Screening		Anemia		Dyslipidemia		Type 2 Diabetes		Health Education/Anticipatory Guidance
Newborn	D/C to 5 days	Mandatory																																																								
	2 weeks	Mandatory																																																								
Months	2	Mandatory																																																								
	4	Mandatory																																																								
	6	Mandatory																																																								
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LEGEND

- Mandatory
- If not completed at the required age, must be completed at the first opportunity if age appropriate.
- For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- Recommended
- Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: <http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/>. For free online provider education: txhealthsteps.com.



TEXAS Health and Human Services
Texas Health Steps

E03-13634 July 1, 2018

THSteps Medical Checkup Periodicity Schedule

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

		COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE																							
		* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhpb.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx . Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm .																							
Years	AGE	History	Nutritional Screening	MENTAL HEALTH		TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS				VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS				Health Education/Anticipatory Guidance			
				Mental Health: Psychosocial/ Behavioral Health Screening	PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, QRAFT, or Patient Health Questionnaire for Adolescents			Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	Audiometric Screening	Subjective Hearing			Dyslipidemia	Type 2 Diabetes	STD/STI Screening	HIV Test				
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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 Health Choice 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>.



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/88><http://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 legal guardian must call Community Health Choice 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.

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
- Client Eligibility
- Family Planning
- Texas Health Steps – Medical Services
- Provider Enrollment on the Portal
- And much more
- Claims Appeals
- Crossover Claims

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.

Vice President, Medical Affairs
Lisa Fuller, M.D.

Associate Medical Directors
Valerie Bahar, 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 Health Choice 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 Health Choice 's online claims portal:
CommunityHealthChoice.org >
Provider Tools > Claims Center
Payer ID: 48145

Change HealthCare 1.800.735.8254

Availity 1.800.282.4548

Gateway EDI 1.800.969.3666

TMHP (STAR only) www.tmhp.com

ELECTRONIC CLAIMS-UB, CMS-1500 (MARKETPLACE)

Submit directly through Community Health Choice '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 (until 8/31/19)
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 SERVICES

For general questions or to submit your updates:

- 713.295.2295
- Provider Portal
- Contact your Provider Engagement Representative.

SERVICE AREA MAP

