V3-2019

Provider Newsletter

Dr. Felecia Garner
Beheavioral Health Medical Director

CommunityHealthChoice.org

713.295.2295 | 1.888.760.2600 (Medicaid/CHIP)
713.295.6704 (Marketplace)

COMMUNITY HEALTH CHOICE

In this issue

3 COMMUNITY NEWS

Marketplace Open Enrollment

Behavioral Health Transitioned to Community!

Dr. Felecia Garner, Behavioral Health Medical Director

American Citizenship

Statewide Performance Improvement Project to Address Reduction of Beneficiaries With Complex Needs

Prior Authorization Guide

Non-Invasive Prenatal Testing (Cell-Free Fetal DNA) - Aneuploidy Testing

Automated Prior Authorization Process

13 HHSC NOTIFICATIONS

Severe Lung Disease and Vaping Health Alert

14 BUSINESS DEVELOPMENT/ COMMUNITY AFFAIRS

Recertification Requirements for Members

15 CLAIMS

Balance Billing

Top Billing Errors

Electronic Payment Methods

19 COMPLIANCE

Special Investigations Unit

20 MEDICAL AFFAIRS

Winter is Coming!

Potential Health Screenings and Annual Wellness Visit Information

Medical Review Guideline

24 NETWORK MANAGEMENT/ PROVIDER OPERATIONS

Provider Directory Accuracy

Provider Access and After-Hours Availability

Prenatal Appointment Availability Requirements

28 PERFORMANCE EXCELLENCE

HEDIS Season Is Almost Here

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

Immunizations for Adolescents (IMA)

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

34 PHARMACY CORNER

35 TEXAS HEALTH STEPS

Community Announcement

Early Childhood Intervention (ECI)

THSteps Medical Checkup Billing Procedure Codes

Sports and Physical Exams

Billing THSteps Medical Checkup and Other Services on the Same Day

THSteps Checkup Timeliness

THSteps Checkup Documentation *Essential to Medical Records*

THSteps Medical Checkup Periodicity Schedule

THSteps Medical Checkup Periodicity Schedule

Children of Traveling Farmworkers

HHSC's Medical Transportation Program for Medicaid Members

Community's Transportation Service for CHIP Members

46 PROVIDER CONTINUING EDUCATION

Online Provider Education – Free Continuing Education (CE) Hours

TMHP Online Provider Education

Vendor Drug Program Continuing Education for Prescribing Providers

Marketplace Open Enrollment

Open enrollment for Health Insurance Marketplace is **November 1 through December 15, 2019**. Here is a quick overview of what Members can look forward to with Community in 2020.

Community Updates

- Service Area Expansion – Community has expanded our Marketplace service area to include the following counties: Walker, San Jacinto, Polk, Tyler, Jasper, Newton, Hardin, Austin, Wharton, and Matagorda. This means we will now offer CHIP, STAR, and Marketplace in the same 20-county service area.
- Great Plans; Easy Selection – Most of our 2020 plans cost the same or less than last year.

Benefit Highlights

- 24/7/365 Telehealth –Talk with a doctor using your phone, computer or mobile app. Most of our plans offer this convenient care.
- 24/7/365 Nurse Line – Get health education or help determining where to go for care.
- Strong Network – We have one of the largest doctor and hospital networks in Southeast Texas.
- Preventive Care – Take advantage of services that can address potential health issues before they become serious: immunizations, well-woman visits, certain cancer screenings, alcohol and tobacco screenings and counseling, and more. These services do not have a copay if you go to an in-network provider.
- Covered Services before Deductible – Get care like primary care doctor visits, urgent care, and generic prescription drugs at a copay amount before you reach your deductible. Most of our plans offer this.
- Community Rewards – Members can participate in the 2020 Wellness and Engagement Program.
    - Complete a 10-question health questionnaire to save 10% on monthly premiums.
    - Earn $25 gift cards (up to $150) for completing health related activities. Start earning gift cards on day one: January 1, 2020. They will need to create or log in to your My Member Account to enroll.

Plan Selection Help

We can help your patients choose the best plan for their needs.

- New to Community: We can take them through their options to make sure they get all the coverage they need at a price that fits their budget.
- Re-enrolling with Community: We can review their benefits with them to make sure they don't pay for more coverage than they need. They can also log in to their My Member Account to chat, email or text with our Member Services team.

Questions?

Please contact our Provider Services line at 713.295.6704 or your Provider Engagement Representative.

Behavioral Health Transitioned to Community!

As previously communicated, Community Health Choice (Community) made the decision to terminate the contract with Beacon Health Strategies (Beacon), our behavioral health services provider, for our CHIP, STAR, and Marketplace membership. Community began coordinating behavioral health services directly for our Members as of **September 1, 2019**.

Frequently Asked Questions

What happens if I have a Member who is currently receiving behavioral health services?

To allow for appropriate continuity of care and avoid any disruption in care, Community will honor authorizations previously in place with Beacon until December 31, 2019.

For new authorizations, please submit requests to Community and include supporting documentation.

What is the basis that Community utilizes to determine medical or behavioral necessity?

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

Community transitioned to InterQual Criteria for evidence-based clinical guidelines effective September 1, **2019**, for medical and behavioral health services.

Where can Providers or Members access InterQual criteria?

The InterQual Criteria is not available directly to Providers from Community. InterQual is a proprietary product that Community 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 a copy of criteria used in the event of a denied request for service.

What Behavioral Health Services require prior authorization?

The list of services are subject to change and will be updated as required. Please visit the Provider Portal at https://provider.CommunityHealthChoice.org/ for the most recent prior authorization guide.

- Applied Behavior Analysis (ABA) Therapy
- Electroconvulsive Therapy (ECT)
- Facility to Facility Transfers
- Inpatient services
- Intensive Outpatient Program (IOP)
- Intensive Outpatient Treatment (except when provided in a SUDs facility)
- Neuropsychological testing

- Out-of-network services
- Outpatient Psychotherapy Visits that exceed 30 visits in a calendar year by any Provider in any setting
- Partial Hospitalization Program (PHP)
- Psychiatric Day Treatment (may not be a covered benefit on all products)
- Psychological testing
- Residential Treatment Facility
- Substance Use Disorder (SUD) Treatment in an Inpatient Setting

How do I know if I am in Community's CHIP, STAR, and/or Marketplace programs?

Please visit our website and access the Online Provider Directory here. If you are not in the Online Directory, please contact Provider Services at 1.877.343.3108 (Medicaid/CHIP) or 1.855.539.5881 (Marketplace) for assistance. You may also email us at ProviderWebInquiries@CommunityHealthChoice.org.

I am a Behavioral Health Provider; whom do I contact at Community?

	MEDICAID/CHIP	MARKETPLACE
HOURS OF OPERATION	Monday - Friday, 8:00 a.m. – 5:00 p.m. (Medicaid) Monday - Friday, 6:00 a.m. – 6:00 p.m. (CHIP) Saturday/Sunday/Holidays, 9:00 a.m. – 12:00 p.m.	Monday - Friday, 6:00 a.m. – 6:00 p.m. Saturday/Sunday/Holidays, 9:00 a.m. – 12:00 p.m.
MEMBER SERVICES	• Toll-free: 1.877.343.3108 • Fax: 713.295.2293 • MemberServices@CommunityHealthChoice.org	• Toll-free: 1.855.539.5881 • Fax: 713.295.2293 • MemberServices@CommunityHealthChoice.org
PROVIDER SERVICES	• Claims Inquiries • Status of authorization requests • EFT/ERA Request • Provider Education In-Services • Provider Updates (Address/Phone/Tax ID)	
	• 713.295.2295 • Fax: 713.295.7039 • ProviderWebInquiries@CommunityHealthChoice.org	• 713.295.6704 • Fax: 713.295.7039 • ProviderWebInquiries@CommunityHealthChoice.org
PROVIDER PORTAL	https://Provider.CommunityHealthChoice.org/	
AUTHORIZATIONS & NOTIFICATIONS	• Toll-free: 1.877.343.3108 • Fax inpatient PA forms to: 713.576.0932 • Fax outpatient PA forms to: 713.576.0931	• Toll-free: 1.855.539.5881 • Fax inpatient PA forms to: 713.576.0932 • Fax outpatient PA forms to: 713.576.0930
PHARMACY SERVICES (OUTPATIENT)	• Prior authorization request forms • Drug formulary search • Prior authorization clinical criteria • List of medications with quantity limits • Network pharmacy directory/search • Over-the-counter (OTC) catalog	
	Navitus Health Solutions • Toll-free: 1.877.908.6023 • Web site: www.navitus.com	Navitus Health Solutions • Toll-free: 1.866.333.2757 • Web site: www.navitus.com
CASE MANAGEMENT	• Assists patients with accessing behavioral health services • Coordinates and tracks 7/30 day post-hospital appointments • Assists with safe discharge plans • Works with community support services to coordinate care BHCaseManagementReferrals@CommunityHealthChoice.org	
BEHAVIORAL HEALTH CRISIS LINE FOR MEMBERS	**PROVIDED BY THE HARRIS CENTER:** • Counseling via telephone for crisis situations • Referrals for mental health treatment	
	1.877.343.3108 Option 1	1.855.539.5881 Option 1

	MEDICAID/CHIP	MARKETPLACE
	• Claims filing deadline is 95 days from date of service. • Member ID cards will reflect correct information for claims submissions. • Call Member Services to verify eligibility.	
CLAIMS	**Electronic submission:** Payer ID 48145 **Paper Claims:** Community Health Choice P.O. Box 301404 Houston, TX 77230 **Refund Lockbox:** Community Health Choice P.O. Box 4818 Houston, TX 77210-4818	**Electronic submission:** Payer ID 60495 **Paper Claims:** Community Health Choice P.O. Box 301424 Houston, TX 77230 **Refund Lockbox:** Community Health Choice P.O. Box 4626 Houston, TX 77210-4626
EFT/ERA	**Payment methods:** Virtual Card, EFT/ACH or Paper Check • Enroll to receive EFT through Settlement Advocate for Community only: https://view.echohealthinc.com/EFTERADirect/CommunityHealthChoice/index.html. • Enroll to receive EFT from all payers processing payments on the Settlement Advocate platform: https://view.echohealthinc.com/EFTERA/efterainvitation.aspx. A fee for this service may apply. • Contact ECHO Health toll-free at 1.833.629.9725 for questions regarding payment options. **ERA (835):** • Log into www.providerpayments.com to gain online access to detailed EOPs for all ECHO transactions.	
CLAIMS PAYMENT RECONSIDERATION	Requests for reconsideration must be made within **120** days from the date of the Explanation of Payment (EOP). Please include the reason for your request in your documentation, e.g., billing issues such as incorrect modifiers, diagnostic codes, overpayments, and underpayments. Community Health Choice Attn: Claims Payment Reconsideration 2636 S. Loop West, Suite 125 Houston, TX 77054	Requests for reconsideration must be made within **180** days from the date of the Explanation of Payment (EOP). Please include the reason for your request in your documentation, e.g., billing issues such as incorrect modifiers, diagnostic codes, overpayments, and underpayments. Community Health Choice Attn: Claims Payment Reconsideration 2636 S. Loop West, Suite 125 Houston, TX 77054
APPEALS	Appeals deadline is 30 days from the date of last disposition of the authorization. Please include the reason for your appeal in your documentation, e.g., medical issue, adverse determination, authorization appeals. Community Health Choice Attn: Behavioral Health Appeals P.O. Box 1411 Houston, TX 77230 Fax: 713.576.0934 (Standard Requests) Fax: 713.576.0935 (Expedited Requests)	

Dr. Felecia Garner, Behavioral Health Medical Director

We welcome Dr. Felecia Garner to the Community family!

Dr. Garner holds board certifications from the American Board of Psychiatry and Neurology in General Psychiatry and Child and Adolescent Psychiatry and comes to Community with a wealth of clinical and managed care experience. She is a graduate of Xavier University of Louisiana in New Orleans and University of Texas Houston Health Science Center, where she received her Doctorate of Medicine and completed general residency training in Psychiatry and then fellowship training in Child and Adolescent Psychiatry.

After completing training, Dr. Garner provided direct patient care through University of Texas Health Science Center at Houston and The Harris Center for Mental Health and IDD, where she also served as medical director for the Early Onset Adolescent Psychosis Program and later, the IDD Division, with extensive responsibilities including providing leadership, direction and supervision to psychiatrists, nurses, and other unit clinical staff in the IDD Division.

As recently as 2018, Dr. Garner served on the faculty of University of Texas Houston Health Science Center and Baylor College of Medicine as clinical assistant professor in the Department of Psychiatry and Behavioral Sciences, where she provided direct supervision of Child and Adolescent Psychiatry Fellows undergoing specialty training.

Dr. Garner is also active in multiple professional societies, including the American Academy of Child and Adolescent Psychiatrists, Texas Society of Child and Adolescent Psychiatry, and Mary Susan Moore Society, to name a few. Her deep roots in the Houston community are evidenced by her involvement in multiple community organizations committed to service by her tenure on the Axis Point Community Outreach Program Advisory Board, the Board of Directors for the John P. McGovern Museum of Health and Medical Science, her leadership and service to The Links Incorporated, and her dedication to the Women's Empowerment Ministry of HOPE Church of Pearland.

We are excited and fortunate to have Dr. Garner join us. Her knowledge, experience, and leadership will help support the needs of our Members with behavioral health conditions in their journey toward wellness, as well as the goals of Community's integration of Behavioral Health and Physical Health to provide holistic and comprehensive services to our Members – your patients.

Providers, tear out and use this resource as you treat patients who may be impacted.

Business Development/Community Affairs

AMERICAN CITIZENSHIP

To be an American citizen means becoming part of one of the most culturally diverse and most exciting countries in the world, a place where you have endless opportunities and the freedom to create a better life for you and your family.

DO NOT WAIT TO START LIVING THE AMERICAN DREAM AS A U.S. CITIZEN!

To determine if you are eligible to apply for naturalization and get assistance with the process:

Find a Local, Accredited Organization on The United States Department of Justice Website.	**OR**	**Hire a Private Attorney**

If you are eligible, you can complete the form N-400 Application for naturalization online or ask a legal expert to assist you with this process.

Benefits of Becoming A U.S. Citizen

1. Petition for family members
2. Travel with a U.S. Passport
3. Vote
4. Become eligible for federal jobs
5. Become an elected official
6. Obtain citizenship for children born abroad

Statewide Performance Improvement Project to Address Reduction of Beneficiaries With Complex Needs

Community implemented the Performance Improvement Project in January 2019 titled "Reducing Beneficiaries with Complex Needs." The project was identified by Texas Health and Human Services (HHS) as a priority area for the state, and will run from 1/1/2019 to 12/31/2020. HHSC defines Beneficiaries with Complex Needs as Members with a diagnosis of anxiety and/or depression who had 3 or more emergency department (ED) visits and 2 or more inpatient stays in the measurement year.

The goal of this project is to reduce potentially preventable emergency department visits and inpatient stays among STAR and CHIP Members with anxiety and/or depression through improved medication management among primary care providers (PCPs) and improved treatment for behavioral health conditions.

Primary Care Provider Toolkit

Community developed a comprehensive PCP Toolkit for PCPs to assist with identifying and treating behavioral health issues, including anxiety and depression. It includes information on the most common behavioral health issues, including guidelines for diagnosis and treatment, fact sheets for Members, and assessment tools. You may access the PCP Toolkit via our online Provider Portal. Conditions included in the toolkit:

- Anxiety
- Depression

For additional information, visit the SAMHSA website to obtain a copy of: "Core Competencies for Integrated Behavioral Health and Primary Care" at www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf.

Anxiety Disorders

Overview

Anxiety disorders are the most common mental health concern in the U.S. An estimated 40 million adults in the U.S. (18%) have an anxiety disorder. Meanwhile, approximately 8% of children and teenagers experience an anxiety disorder. Most people develop symptoms before age 21. More information can be found in our PCP Toolkit.

Symptoms

People typically experience one or more of the following symptoms:

Emotional symptoms:

- Feelings of apprehension or dread
- Feeling tense or jumpy
- Restlessness or irritability
- Anticipating the worst and being watchful for signs of danger

Physical symptoms:

- Pounding or racing heart and shortness of breath
- Sweating, tremors, and twitches
- Headaches, fatigue, and insomnia
- Upset stomach, frequent urination or diarrhea

Screening Tool

Community recommends the use of the GAD-7 (Generalized Anxiety Disorder), a 7-question screening tool that identifies whether a complete assessment for anxiety is indicated. The GAD-7 screening tool can be found on the Anxiety and Depression Association of America (ADAA) website at https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf.

Major Depressive Disorder

Overview

An estimated 16 million Americans (or 7%) had at least one major depressive episode in the past year. People of all ages and all racial, ethnic, and socioeconomic backgrounds experience depression, but it does affect some groups more than others. Women are twice as likely to experience depression. Major Depressive Disorder, referred to colloquially as depression, is not equivalent to feeling down, sorrowful or to the experience of legitimate grief. Depression is not a disorder of will power nor is it an indicator of low self-efficacy or laziness. Depression is a serious, biologically mediated, genetically heritable illness, that can result in significant deleterious effects if not addressed. More information can be found in our PCP Toolkit.

Symptoms

A change in an individual's level of function as indicated by:

- Changes in sleep
- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest or pleasure in activities
- Hopelessness or guilty thoughts
- Changes in movement (less activity or agitation)
- Physical aches and pains
- Suicidal thoughts

Screening Tools

The most common tests utilized include:

- The Beck Depression Inventory (BDI)
- BDI Interactive Tool
- The Hamilton Depression Scale (HAM-D)
- Patient Health Questionnaire-9 (PHQ-9)

Community's Behavioral Health Case Management Program

Connecting Members to Community's Case Management Program

- Members may self-refer to any in-network behavioral health Provider.
- Members can also call Community Health Choice regarding how and where to obtain behavioral health services. No prior approval from the PCP is required.
- Providers may refer Members suspected of having a developmental delay or a developmental disability, seriously emotionally disturbed (SED), mental illness or chemical dependency by:
  - Calling Provider Services or
  - Faxing referral information to our dedicated behavioral health fax line

Case Management (Behavioral Health)

Phone: 713.295.2295
Fax: 713.576.0933

E-mail: BHCasemanagementreferrals@CommunityHealthChoice.org

Prior Authorization Guide

Log on to your Provider Portal to see the full guide. The following are changes to the Prior Authorization Guide, effective January 1, 2020.

Behavioral Health Services

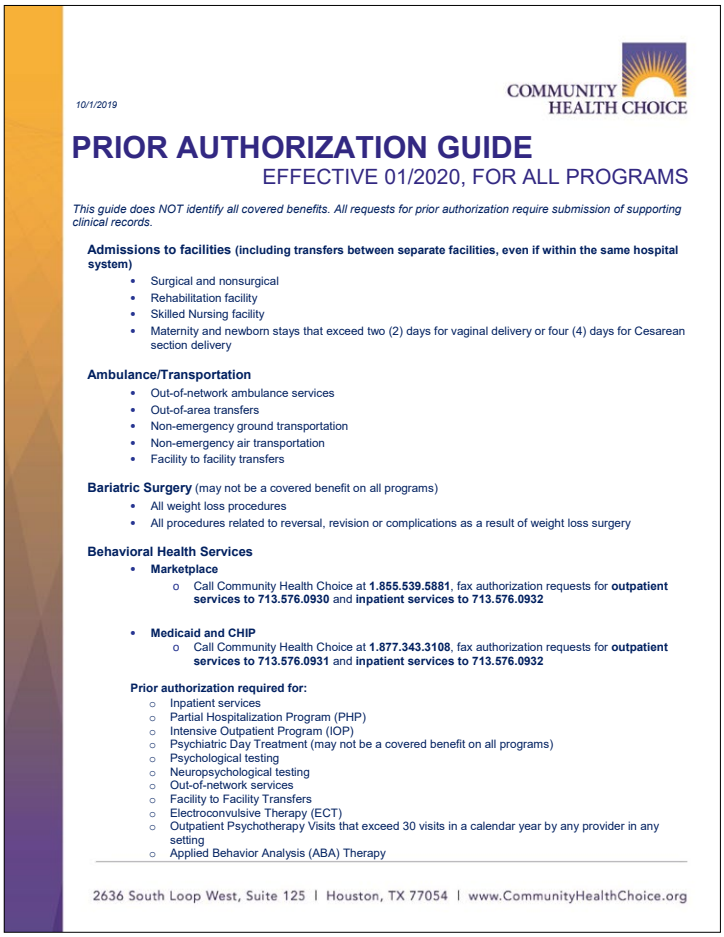
The addition of two (2) behavioral health services:

- Transcranial Magnetic Stimulation
- Wilderness Programs

Injectable Drugs

The addition of a long-acting injectable that is excluded from prior authorization requirement

- Aristada Initio (currently with a miscellaneous J code of J3490)



10/1/2019

COMMUNITY HEALTH CHOICE

PRIOR AUTHORIZATION GUIDE

EFFECTIVE 01/2020, FOR ALL PROGRAMS

This guide does NOT identify all covered benefits. All requests for prior authorization require submission of supporting clinical records.

Admissions to facilities (including transfers between separate facilities, even if within the same hospital system)

- Surgical and nonsurgical
- Rehabilitation facility
- Skilled Nursing facility
- Maternity and newborn stays that exceed two (2) days for vaginal delivery or four (4) days for Cesarean section delivery

Ambulance/Transportation

- Out-of-network ambulance services
- Out-of-area transfers
- Non-emergency ground transportation
- Non-emergency air transportation
- Facility to facility transfers

Bariatric Surgery (may not be a covered benefit on all programs)

- All weight loss procedures
- All procedures related to reversal, revision or complications as a result of weight loss surgery

Behavioral Health Services

- **Marketplace**
  - Call Community Health Choice at **1.855.539.5881**, fax authorization requests for **outpatient services to 713.576.0930** and **inpatient services to 713.576.0932**
- **Medicaid and CHIP**
  - Call Community Health Choice at **1.877.343.3108**, fax authorization requests for **outpatient services to 713.576.0931** and **inpatient services to 713.576.0932**

Prior authorization required for:

- Inpatient services
- Partial Hospitalization Program (PHP)
- Intensive Outpatient Program (IOP)
- Psychiatric Day Treatment (may not be a covered benefit on all programs)
- Psychological testing
- Neuropsychological testing
- Out-of-network services
- Facility to Facility Transfers
- Electroconvulsive Therapy (ECT)
- Outpatient Psychotherapy Visits that exceed 30 visits in a calendar year by any provider in any setting
- Applied Behavior Analysis (ABA) Therapy

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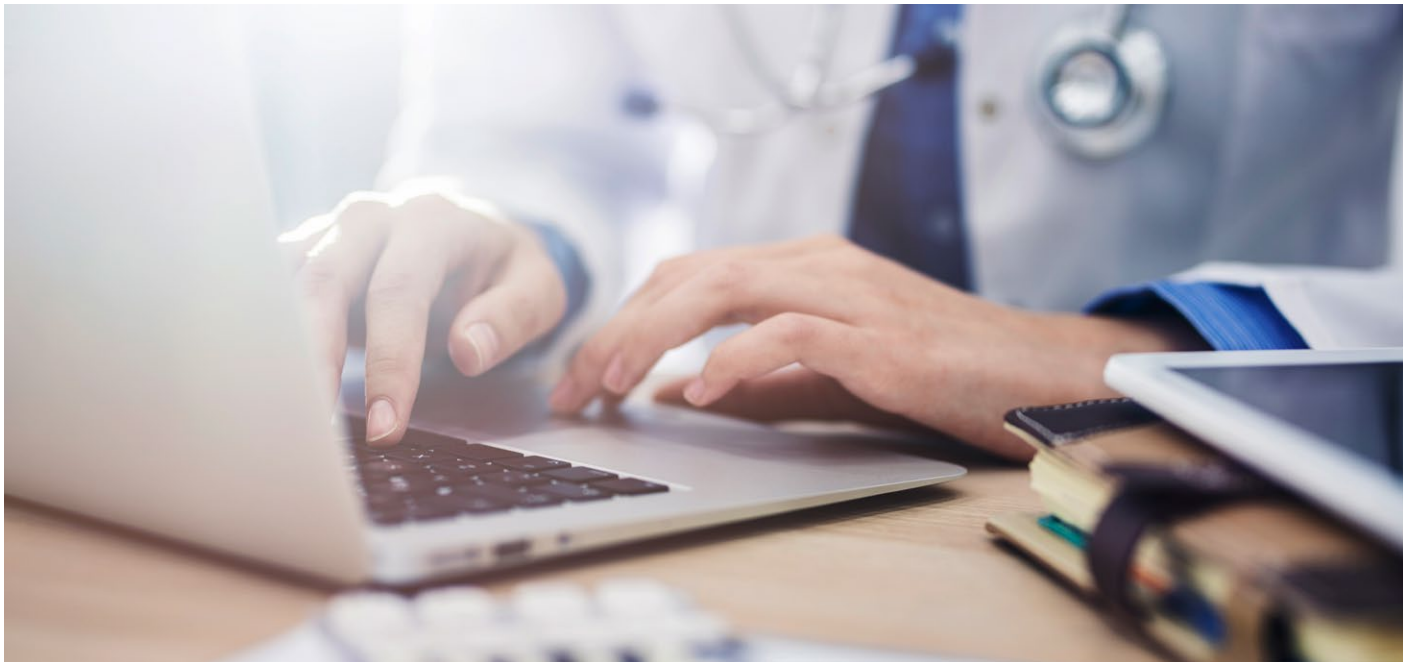
Non-Invasive Prenatal Testing (Cell-Free Fetal DNA) - Aneuploidy Testing

Community requires prior authorization requests from OB/GYN providers, MFMs, family practice physicians who are practicing obstetrics, and laboratories according to physician orders for Non-Invasive Prenatal Testing (Cell-Free Fetal DNA) - Aneuploidy Testing. Non-Invasive Prenatal Testing (Cell-Free Fetal DNA) - Aneuploidy Testing is done in the prenatal period to screen for chromosomal abnormalities in Members at risk.



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 **January 6, 2020**, Community would like to make TTAP available to you 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 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.

The Provider Portal at https://provider.CommunityHealthChoice.org/ will soon include access to the TTAP Training. Your Provider Engagement Representative may also contact you to schedule training for your practice.

Severe Lung Disease and Vaping Health Alert

The Texas Department of State Health Services (DSHS) is making new recommendations due to an increase in lung disease reportedly linked to vaping. Several states, including Texas, have reported cases of pulmonary disease in patients who use vaping products. Reported cases involve both nicotine and tetrahydrocannabinol (THC) products.

Providers should be aware of these symptoms:

- Cough
- Shortness of breath
- Fatigue
- Nausea
- Vomiting
- Diarrhea

Providers should inquire if the symptoms have become more severe over time since the onset.

DSHS recommends that healthcare providers:

- Ask patients presenting with respiratory symptoms about vaping history. If possible, inquire about the types of products used and methods of use.
- If vaping fluid commonly used by the patient is available, ask that it be set aside (not used) in case it is needed for testing.
- Be aware that some suspect cases have required high-level intensive care and respiratory support.

Any suspected cases should be reported to the Texas Department of State Health Services.

Community emphasizes that screening and basic information about tobacco cessation is an expected part of any routine office visit.

HHSC reminds providers of these additional support services available as health plan benefits:

Tobacco Cessation Benefits in Medicaid

- Medicaid provides tobacco cessation counseling (procedure code 99406 & 99407) in individual and group settings to Members 10 years and older with a diagnosis of nicotine dependence.
- Adolescents with a nicotine dependency diagnosis related to aerosolized nicotine delivered by vape device are eligible for tobacco cessation counseling.
- The Medicaid formulary includes select medications and nicotine replacement products to support tobacco cessation.

Contact your health plan about additional supports that may be offered as a value-added service.

Tobacco Cessation Benefits in CHIP

A health plan-approved tobacco cessation program covers up to a $100 limit per 12-month coverage period. Tobacco cessation program services are for a 12-month coverage period. The health plan may require prior authorization and use of a formulary.

CHIP Perinatal Program:

- Tobacco cessation programs are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

The CHIP formulary includes select medications to support tobacco cessation.

Quick Links:

DSHS–E–Cigarettes

American Pediatric Association–E–Cigarettes

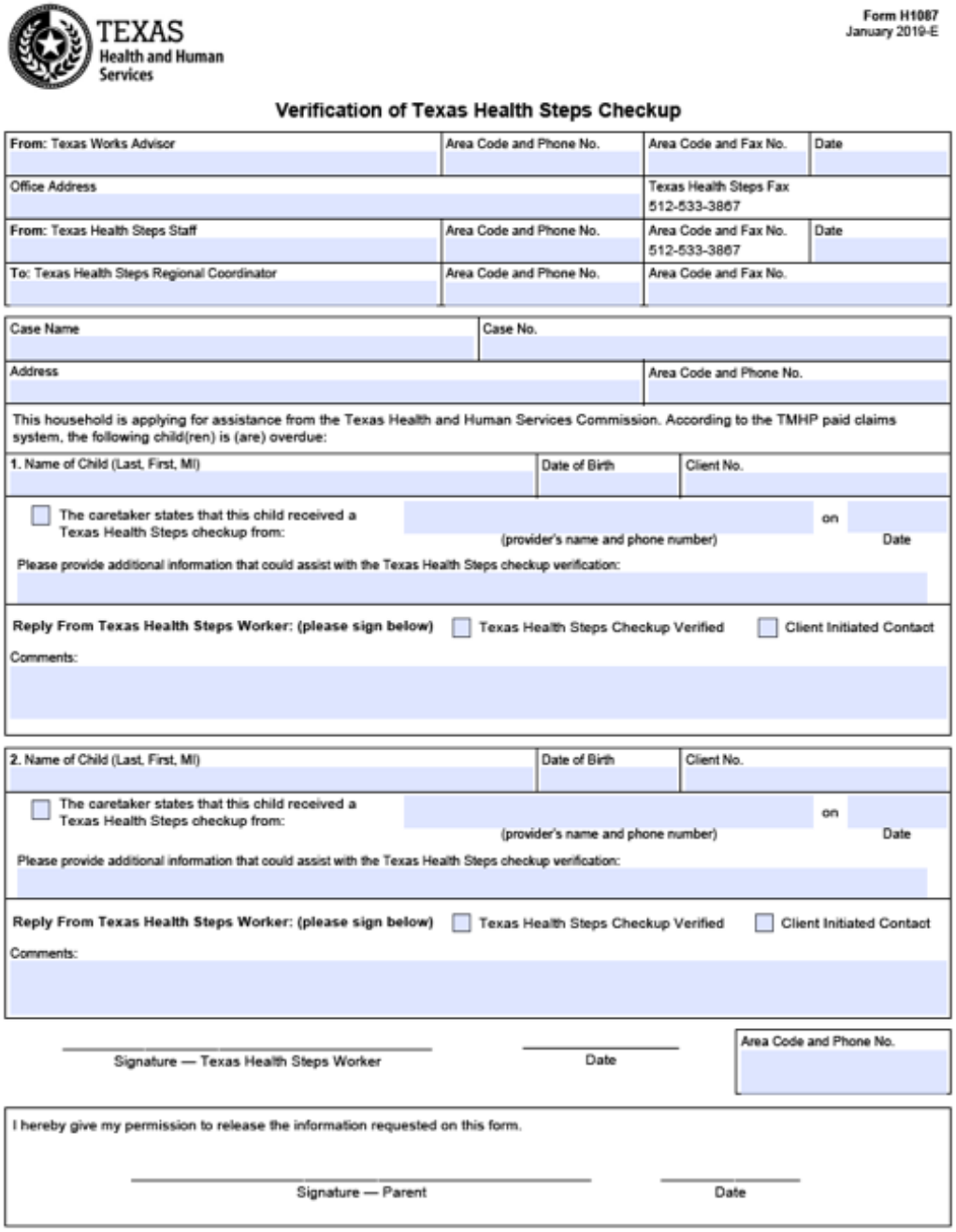
American Medical Association–Recommendations for the public

THSteps–Screening and counseling for adolescents

Recertification Requirements for Members

In addition to annual recertification for STAR and CHIP, Members are sometimes required to self-declare their THSteps exam. There are instances where proof of completion is required and after-visit summaries are not accepted. HHSC requires that Form H1087 (Verification of Texas Health Steps Checkup) be completed.

If a Member contacts your office regarding this requirement, please assist them in providing the necessary information so as not to cause any interruption in their coverage. Form H1087 can be found here: https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1087-verification-texas-health-steps-checkup.



TEXAS
Health and Human Services

Form H1087
January 2019-E

Verification of Texas Health Steps Checkup

From: Texas Works Advisor	Area Code and Phone No.	Area Code and Fax No.	Date
Office Address		Texas Health Steps Fax 512-533-3867	
From: Texas Health Steps Staff	Area Code and Phone No.	Area Code and Fax No. 512-533-3867	Date
To: Texas Health Steps Regional Coordinator	Area Code and Phone No.	Area Code and Fax No.	

Case Name	Case No.
Address	Area Code and Phone No.

This household is applying for assistance from the Texas Health and Human Services Commission. According to the TMHP paid claims system, the following child(ren) is (are) overdue:

1. Name of Child (Last, First, MI)	Date of Birth	Client No.

☐ The caretaker states that this child received a Texas Health Steps checkup from: _____ (provider's name and phone number) on _____ Date

Please provide additional information that could assist with the Texas Health Steps checkup verification:

Reply From Texas Health Steps Worker: (please sign below) ☐ Texas Health Steps Checkup Verified ☐ Client Initiated Contact

Comments:

2. Name of Child (Last, First, MI)	Date of Birth	Client No.

☐ The caretaker states that this child received a Texas Health Steps checkup from: _____ (provider's name and phone number) on _____ Date

Please provide additional information that could assist with the Texas Health Steps checkup verification:

Reply From Texas Health Steps Worker: (please sign below) ☐ Texas Health Steps Checkup Verified ☐ Client Initiated Contact

Comments:

_____ Signature — Texas Health Steps Worker

_____ Date

Area Code and Phone No.

I hereby give my permission to release the information requested on this form.

_____ Signature — Parent

_____ Date

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).

Top Billing Errors

Community aims to adjudicate Clean Claims timely and accurately. The following are top reasons that cause denials or delays in payment.

Who	What	Causes of denials or delays	Do
All Providers	**Frequency Code 7:** Indicates the new claim is a replacement or corrected claim – the information present on this bill represents a complete replacement of the previously issued bill	• Resubmitting the same claim multiple times • Submitting corrected claims changing the Member • Submitting corrected claims changing the Provider • Submitting corrected claims changing the Date of Service	Allow 30 days between submissions
	Modifier 25	• Using a 25 modifier when billing for services performed during a postoperative period if related to the previous surgery • Adding modifier 25 if there is only an E/M service performed during the office visit (no procedure done). • Using a modifier 25 on any E/M on the day a "Major" (90 day global) procedure is being performed • Adding modifier 25 to an E/M service when a minimal procedure is performed on the same day	Use a 25 modifier when billing for services performed during a postoperative period if related to the previous surgery
ECI Providers	IFSP forms	Submitting IFSP forms to Community	Not submit IFSP forms to Community
FQHCs	Incorrect Place of Service (POS)	Submitting claims with POS 11	Bill with POS 50
	T1015	Not reporting the correct FQHC PPS rate	Include FQHC's PPS rate
	2nd and subsequent lines of each claim	Not including all services delivered during patient visit at normal charges	Include **ALL** services delivered during patient visit at normal charges

Electronic Payment Methods

In Volumes 1 and 2 of the Provider Newsletter, we communicated that Community partnered with Change Healthcare and ECHO Health, Inc. to provide new electronic payment methods.

Frequently Asked Questions

What are the payment methods available through ECHO?

a) **Virtual Card (vCard)** – Virtual Visa debit transaction

b) **EFT/ACH** – Automatic deposits direct to your bank account

c) **Paper Checks by mail**

How do I register on the ECHO portal?

To register go to www.ProviderPayments.com. You will need to provide your tax identification number along with an ECHO draft number and amount number from a payment issued by ECHO.

Virtual Card

What is required to accept Virtual Card (vCard)?

QuicRemit allows for Virtual Visa Card debit transaction as one payment method. You must have a credit card terminal in your office to use this payment method.

Please help me understand how I receive notification of Virtual Card (vCard) Payment.

Your office will receive fax or mail notifications, each containing a virtual credit card with a number unique to that payment transaction. Once the number is received, you enter the code into your office's credit card terminal to process payment as a regular card transaction.

Can my Virtual Card (vCard) Payment be emailed?

The first attempt to receive a Virtual Card is by fax; if unsuccessful then by mail. At this time, Virtual Cards cannot be emailed for security purposes.

What are the advantages of Virtual Card (vCard)?

As part of this process, an improved EOP will be introduced that combines payment information, instructions, and remittance data in a single document. Detailed explanations for each [Payer Name] payment you receive will be available for review online at www.providerpayments.com. Virtual Card payments are not subject to printing and mailing delays commonly associated with paper checks.

What will happen if I don't process my Virtual Card within 60 days?

If the Virtual Visa is not processed within 60 days, the transaction will be voided, and a new payment will be issued to your office in another payment method.

What else should I know about Virtual Card (vCard)?

Normal credit card transaction fees apply. Payments are received 3-7 days earlier than paper checks sent by US Postal Service.

How do I opt out of the Virtual Card?

To opt out of the Virtual card you can contact ECHO directly at 888.834.3511.

Can I opt into the Virtual Card option?

The Virtual Card is an opt-out only option. The option to opt in is not available.

Will there be any disruption to payment?

There will be no disruption to payment.

Electronic Payment Methods

Electronic Funds Transfer (EFT)

Is EFT/ACH available?

Yes, electronic deposits to your bank accounts are available. Transaction fees by your bank may apply.

How do I sign up for EFT?

You may sign up for EFT payments by accessing this website: https://view.echohealthinc.com/EFTERADirect/CommunityHealthChoice/index.html.

How do I check the status of my EFT enrollment?

To check the status of an EFT enrollment Providers can contact ECHO at 888.834.3511.

How do I contact ECHO if I am having technical support issues?

For assistance with any technical support issues Providers can contact ECHO at 888.834.3511.

What will my bank statement reflect once the EFT transaction is processed?

The payment will appear on your bank statement from Huntington National Bank and ECHO as "HNB – ECHO".

Is there a user guide available?

To access the Provider Payments Portal Quick Reference Guide, go to www.ProviderPayments.com and log in with your account information. The User Guide can be accessed by clicking the Help button on the portal.

Electronic Remittance Advice – ERA (also known as an 835 file)

How do Providers enroll to receive 835 files from their desired clearinghouse for ECHO payments?

- ECHO can supply the hard copy ANSI 835 Enrollment Form.
- The Provider may access https://view.echohealthinc.com/EFTERA/efterainvitation.aspx and select the option to enroll in an ERA only.

Do I have to enroll for a specific Payer ID to receive my 835s from the Change Healthcare clearinghouse?

If you are enrolled to receive your 835s from the Change Healthcare clearinghouse (CHC), you will be required to also enroll at CHC for ECHO's payer ID 58379. Please refer to Change Healthcare's on-line payer list for the most current instructions.

Is a single enrollment for all payors available or do I have to enroll for each payor separately?

Single and multiple payor enrollments are available. If a single enrollment is preferred, use the ANSI 835 Enrollment Form. If multiple payor enrollments are desired, this is completed automatically using the online ERA enrollment. A fee may apply.

Are there fees associated with the ERA enrollment?

Fees are not applied to an ERA-only enrollments.

Who do I contact if I have not received my 835 files?

- You may send an e-mail to EDI@echohealthinc.com or
- Contact Customer Service at 888.834.3511, Monday to Friday, between the hours of 8 am to 6 pm, EST.

What is the standard naming convention for the 835 files?

- If the provider is receiving payments from ECHO directly, the file naming convention is "ANSI835_ProviderTIN_UniqueIdentifier"

How soon after I enroll will I receive my 835 files?

You will receive your 835 with next issued payment.

What is an Electronic Remittance Advice (ERA)?

An ERA is an electronic file that contains claim payment and remittance information. It is often referred to by its HIPAA transaction number, 835.

Electronic Payment Methods

What are the advantages of receiving ERAs?

In conjunction with practice management software package that can handle an ERA (also known as an 835 file), it is possible to reduce manual posting of claim payments and reconciling patient accounts, thereby saving your practice time and money.

Do I need a special computer software to use ERAs?

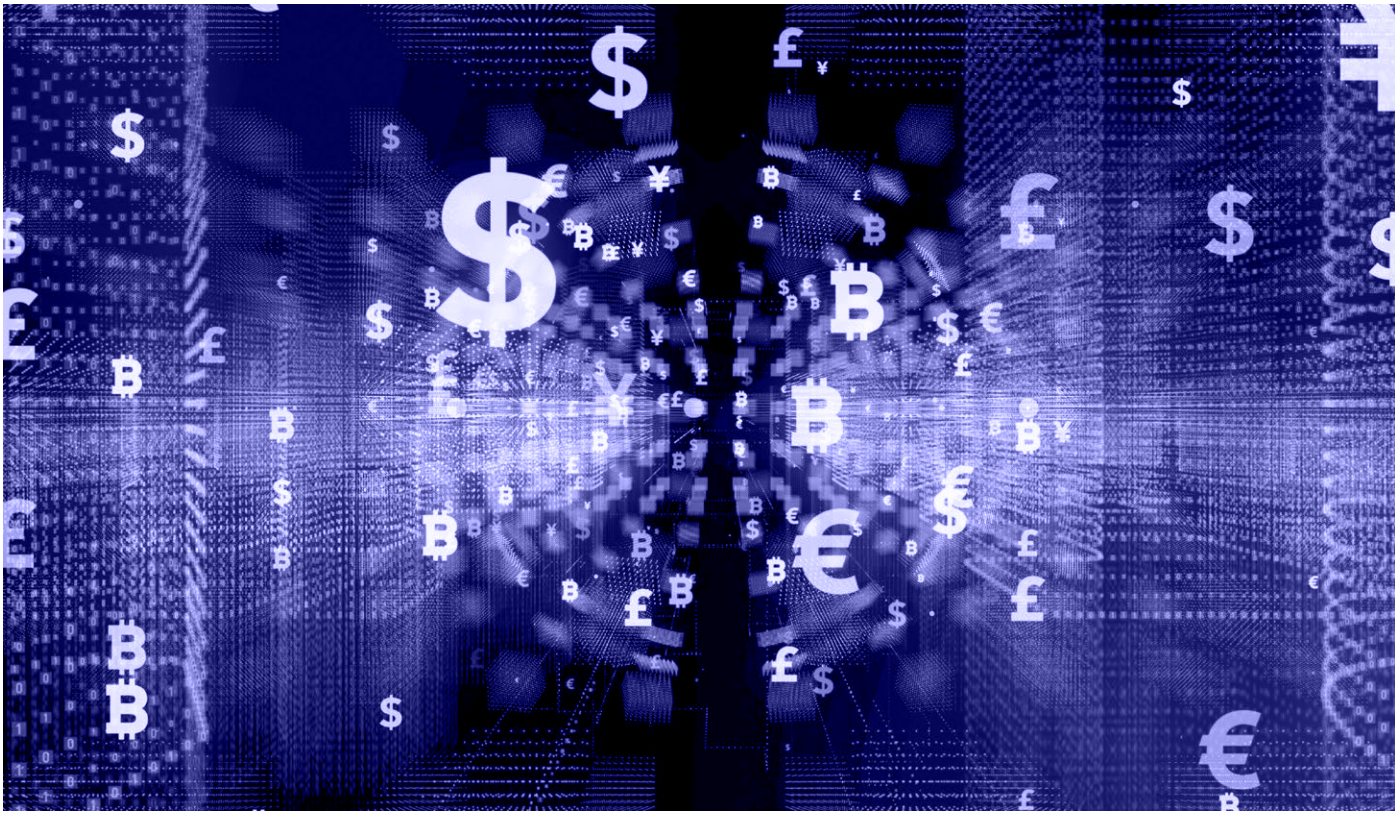
To use ERAs, you will either need practice management software that can import an ASC X12 Health Care Claim Payment/Advice (835) transaction, version 5010A1; or you will need to contract with a clearinghouse that can translate this format to one that your practice management system can import.

Why doesn't the information on my ERA match my paper remittance advice?

Paper remittance advices are a proprietary product of the payer, so they can utilize a custom design and proprietary code sets. However, ERAs are regulated by HIPAA and must use mandated data elements and code sets such as claims status codes and adjustment reason codes. These codes are not the same as the payers internally developed codes available on paper remittances advices. Consequently, the wording for these codes may not match, but they will still convey the same general meaning.

Are pended claims included in ERAs?

No. ERAs only include final status paid or denied claims.



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 Health Care 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

Winter is Coming!

Flu season is right around the corner, and this is an important time to work on two of our quality measures:

- Appropriate Treatment for Children with Upper Respiratory Infections
- Potentially Preventable ED Visits

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 ageds 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

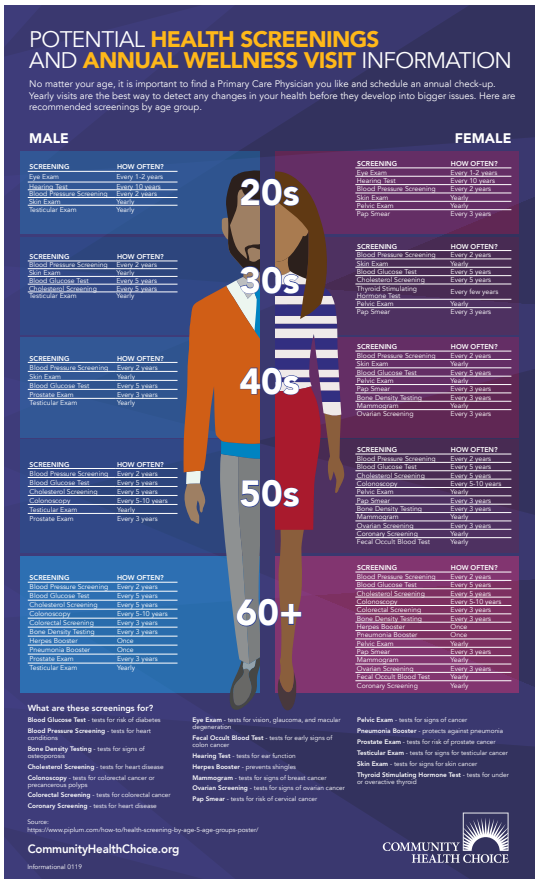
*Note: For this measure, the HEDIS 2019 technical specifications will continue to be used in 2020 by both HHSC and by Community.

Potentially Preventable ED Visits (PPVs)

During cold and flu season, PPV rates tend to be high. In addition to the high-quality care you are already providing, here are some proactive steps you can take to reduce PPVs among your patients:

- Help Community spread the word about its Nurse Advice Line, which is available 24 hours a day 7 days a week. By calling the Nurse Advice Line, Members can receive advice on the appropriate care setting. The phone number is 1.888.332.2730, and it is printed on the Member ID card. Community will also be communicating this service to Members, and your help matters.
- Make sure that patients understand your office's after-hours resources, including your answering service. Let them know how long they can expect to wait for a callback.
- Explain your office's process for sick visits. Let patients know whether you offer walk-ins or only scheduled appointments. Emphasize your availability for sick care.

With the cold weather coming, patient requests for antibiotics and ED visits will be on the rise. Community is here to support you in your efforts to help our Members get the right care at the right place!



Potential Health Screenings and Annual Wellness Visit Information

Community encourages all Members to establish a medical home and select a PCP. Receiving primary medical care and preventive health services are important steps that Members can take to manage their health.

Community developed the following infographic. It is available is both English and Spanish. The intent is to help communicate the importance of yearly visits to help detect any changes in health before they develop into bigger issues. Please contact your Provider Engagement Representative if you would like copies of this infographic for your exam room(s).

Medical Review Guideline

NON-INVASIVE PRENATAL TESTING (CELL-FREE DNA) – ANEUPLOIDY TESTING

EFFECTIVE DATE: January 1, 2020

Purpose: The purpose of this guideline is to provide criteria used by Utilization Management to review requests for non-invasive prenatal testing. The goal of Community Health Choice (Community) in adopting these guidelines is not to disrupt the physician-patient relationship, nor to diminish physician autonomy. Instead, it is to promote patient safety and improve clinical outcomes through the adherence of evidence-based practices.

This guideline does not address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline (Guideline). If there is a discrepancy between this Guideline and a Member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Target Audience: This guideline is intended for providers in the following specialties: Family Medicine, Laboratories, Obstetrics/Gynecology, and Maternal-Fetal Medicine.

Background

Aneuploidy is defined as having one or more extra or missing chromosomes, leading to an unbalanced chromosome number in a cell.

The incidence of fetal aneuploidy increases as a woman ages but can affect any woman regardless of age and is not related to race or ethnicity. Other factors do however increase the risk of fetal aneuploidy including a history of a prior pregnancy with fetal aneuploidy or the presence of fetal anomalies.

The most common aneuploidies not related to sex chromosome disorders are the autosomal trisomies with Down syndrome (trisomy 21) being the most common.

The most common sex chromosome aneuploidy is Klinefelter syndrome (47, XXY). The only viable monosomy is Turner syndrome (45, X).

This test screens for trisomy 21, trisomy 18, and trisomy 13, and the sex chromosomes aneuploidies.

Understanding Cell-Free Dna

Circulating cell-free DNA (which are short fragments of DNA–cfDNA) in the maternal circulation come from both the mother and the fetal-placenta unit. Maternal hematopoietic cells are the source of most of the maternal cfDNA, but the primary source of the fetal cfDNA is the apoptosis of the placental cell.

cfDNA screening currently gives information about the three most common aneuploidies and about fetal sex chromosomes but does not typically provide information about other aneuploidies.

cfDNA testing is the most sensitive screening option for these aneuploidies: trisomy 21, trisomy 18, and trisomy 13

cfDNA testing can be performed as early as 10 weeks to term.

Because of limited evidence regarding its efficacy, cell-free DNA testing is not recommended for aneuploidy screening in women with multiple gestations (since data regarding the risk of aneuploidy are more limited in multiple gestations compared with singleton pregnancies). No method of aneuploidy screening is as accurate in twin gestations as it is in in singleton pregnancies.

cfDNA testing is also known as non-invasive prenatal testing (NIPT)

Criteria For NIPT Testing: CPT 81420, 81507

Screening for fetal aneuploidy, and ALL of the following are documented:

- **Pregnancy at increased risk for aneuploidy, as indicated by 1 or more of the following:**
  - Maternal age of 35 years or older at time of delivery
  - Conventional screening test is abnormal (e.g. first trimester screen, sequential screen, integrated screen, or quad screen)
  - Fetal ultrasound (ie, fetal nuchal translucency, hypoplastic nasal bone) indicates increased risk of aneuploidy
  - Parental balanced translocation (Robertsonian) with increased risk of trisomy 21 or 13
  - Prior pregnancy with trisomy 21, 18, or 13
- **Single-gestation pregnancy**—the use of NIPT for screening twin pregnancies is not yet endorsed by ACOG, ACMG, or other professional societies.
- **Genetic counseling needs to accompany this testing**. This can be provided by the obstetrician, genetic counselor, nurse specialist in genetics, maternal-fetal medicine (MFM) specialist, or other medical provider with expertise in genetic counseling who is not affiliated with the genetic laboratory. For the OB/MFM, documentation of genetic counseling would be expected in the office notes therefore the lab requisition order is usually sufficient to support this requirement has been satisfied.
- **Noninvasive prenatal screening using cell free DNA of maternal plasma for fetal sex chromosome aneuploidies (CPT 81479, 81599) is considered investigational**.
- **Noninvasive prenatal screening using cell-free DNA of maternal plasma for microdeletions (CPT 81422) is considered investigational.**

References

1. UptoDate: Prenatal screening for common aneuploidies using cell-free DNA. Last updated; June 24, 2019-Aug 2019
2. ACOG: Practice Bulletin: Screening for Fetal Aneuploidy-Number 163, May 2016 Reaffirmed 2018

Provider Directory Accuracy

The Centers for Medicare & Medicaid Services (CMS) require the maintenance of accurate data in Provider directories. Up-to-date Provider information allows Community to:

- Accurately generate Provider directories
- Process claims
- Communicate with our network of Providers
- Help patients locate your practice information

Providers must notify Community in writing at least 30 days in advance (when possible) of changes, such as:

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

Next steps

- Update your profile in Council for Affordable Quality Healthcare, Inc. (CAQH) at https://proview.caqh.org/.
- You can provide a written request for updates to ProviderRelationsInquiries@CommunityHealthChoice.org or via fax 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.

Prenatal Appointment Availability Requirements

Per the UMCC, Section 8.1.3.1, Prenatal care must be provided within 14 days for initial appointment except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within 5 days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to 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

HEDIS Season Is Almost Here

Review Measures and What is Requested

Community collects data for the Healthcare Effectiveness Data and Information Set (HEDIS®) on an annual basis from Providers. Each year, Community sends initial medical record requests to Providers' offices in early to mid-February requesting relevant clinical information. The request includes a list of patients and a detailed description of the needed clinical information from each patient's medical record. The list may include one or multiple providers in a practice. The Members identified on each list are randomly chosen and each patient on the list is associated with claims that have been submitted by your practice. If the information is incorrect, please contact us thorough our dedicated email at HEDIS@CommunityHealthChoice.org.

Community performs medical record reviews for specific HEDIS® performance measures as required by the National Committee for Quality Assurance (NCQA). Prior to submitting requests to providers, Community compiles medical and pharmacy claims data for the identified Members. When Community can identify a claim that meets the NCQA requirement for the measures and Members then medical record review is not required.

However, claims data is limited and often does not include specific values or results for tests and screenings performed as required by NCQA. Pharmacy data can be limited because it only captures Members who have a Community pharmacy benefit. Therefore, requests for medical record documentation from patient records supplement what we already have captured in claims. Documentation requests may vary based upon the specific measure and criteria specified by NCQA and the claims and pharmacy data we already have for a particular patient.

Community keeps all personal health information (PHI) confidential and only shares to the extent permitted by federal and state law. Only whether the presence or absence of a particular procedure is documented is under review. These activities are considered healthcare operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, and patient authorization is not required.

Providers who participate in the Community network must provide the requested medical record information to comply with state and federal regulatory and accreditation requirements. We do not generally reimburse for medical record copies required for HEDIS® medical record collection. For additional information on reimbursement, please see your Participation Agreement or contact your Network Management representative.

Who Will Request Medical Records

Due to the volume of records we need to collect to comply with regulatory requirements, Community partners with health information organizations to help coordinate collection. As a result, we have contracted with KDJ Consultants to perform HEDIS® medical record collection and data abstraction on our behalf. They will request copies of chart components be sent by mail or fax for offsite review. If you would prefer for them to complete the medical record review in your practice location, we can work with you to make those arrangements.

We thank you in advance for your prompt attention and assistance during this process.

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.

Immunizations for Adolescents (IMA)

Immunizations for Adolescents (IMA) is a new HEDIS measure that Community will begin tracking in 2020.

The denominator for this measure includes Members who turn 13 years old in the measurement year (January 1, 2020 – December 31, 2020). Members must be continuously enrolled in the 12 months prior to their 13th birthday, with one allowable gap of up to 45 days.

Members are considered compliant if they receive all 3 of the following age-appropriate vaccines:

- One dose of Meningococcal serogroups A,W,C,Y vaccine on or between the Member's 11th and 13th birthday, AND
- One dose of Tdap (tetanus, diphtheria toxoids and acellular pertussis) vaccines on or between the Member's 10th and 13th birthday, AND
- All appropriate HPV (human papillomavirus) vaccine doses on or between the Member's 9th and 13th birthday:
  - Two doses with dates of service at least 146 days apart, OR
  - Three doses with 3 different dates of services.

Focus on HPV

Currently, the biggest challenge in this measure is the HPV vaccine, as detailed in Figure 1:

Figure 1: Age-Appropriate Vaccination Rates among Medicaid Enrollees in Texas, 2017 [1]

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

HPV vaccination is a challenge due to both multiple dosing and parental hesitancy. To improve your HPV rates, here are some helpful tips to keep in mind:

- Group HPV, meningococcal, and Tdap vaccinations to be administered on the same day. Schedule subsequent HPV dose(s) before patient leaves.

- Be an advocate for the HPV vaccination, and take the time to talk to hesitant parents. Focus the conversation on cancer prevention. [2]
- When initially communicating with parents, presume they are ready to vaccinate their children. Indicate that HPV vaccination is part of the routine immunization schedule, alongside meningococcal and Tdap. [3]
- When announcing which vaccines the patient is due for, place the HPV vaccine in the middle of the list. Example: "Johnny is due for his meningococcal, HPV, and Tdap vaccines today."
- Well-child checkups are optimal for administering age-appropriate vaccines, but utilize every visit as an opportunity to catch patients up on immunizations.
- Keep up with patient's immunization records by using the Texas Immunization Registry (ImmTrac) and encourage your colleagues to do so as well.

For more information on how to improve HPV vaccination rates, including resources for patients and office posters, go to www.cdc.gov/hpv/hcp/index.html.

Rerences:

1 Texas Healthcare Learning Collaborative: https://thlcportal.com/home

2 Gilkey, M. (2016). Provider communication and HPV vaccination: The impact of recommendation quality. Vaccine, 34(9), 1187-1192. doi: 10.1016/j.vaccine.2016.01.023

3 Opel, D. (2015). The Influence of Provider Communication Behaviors on Parental Vaccine Acceptance and Visit Experience. American Journal of Public Health, 105(10).

4 NCQA. (2019). HEDIS® 2020: Technical Specifications for Health Plans (Volume 2).

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.

Is the flu vaccine already available?

YES! Flu vaccines are available at retail pharmacies who offer this service to Members with a $0 copay. For Texas Medicaid, the state has expanded the benefit for this season and allows coverage of the flu vaccine for people age seven and older in a pharmacy setting. For Marketplace, please be reminded that CVS is not an in-network pharmacy.

What about RSV season?

The 2019-2020 respiratory syncytial virus (RSV) season begins October 1. This season's prior authorization criteria are the same used for last year's season, based on the American Academy of Pediatrics guidance. We have two preferred pharmacies:

Lumicera Specialty Pharmacy	**Avella Specialty Pharmacy**
Phone: 1.855.847.3554	Phone: 1.877.470.7608
Fax: 1.855.847.3588	Fax: 1.877.480.1746

In other news, we wanted to remind prescribers to 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.

Other pieces of information that can be helpful for review include the following:

- New start or continuation of care (and how long Member has been on medication)
- Member diagnosis
- Past alternatives tried including drug name and strength, trial dates, and outcome (i.e. ineffective, partial response, adverse event such as rash or hives)

We often find that the original determination could have been different if we had received the Member's clinical records initially.

Finally, long-acting behavioral injectable medications such as Invega Sustenna and Abilify Maintena do not require a prior authorization for Marketplace Members. This went into effect January 1, 2019. These medications are available under both the medical and pharmacy benefit. Our goal is to ensure Members have timely access to these essential medications.

Thank you for everything you do for our Members! We look forward to continuing to collaborate with you. We hope you and your office staff had a wonderful summer!

Community Announcement

Community 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 31st 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_QRG.pdf.

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

Sports and Physical Exams

Members who participate in sports will need their annual sports and physical checkup. A sports and school physical is a value-added service for Community Members since it is not a covered benefit for Medicaid. Community will pay sports and school physicals for Medicaid Members ages 4 to 19 (limited to one 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: • 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

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 *within the last 5 years*	3 dose primary series and 1 booster dose of Tdap / Td *within the last 10 years*					**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. **For 7th grade:** 1 dose of Tdap is required if at least 5 years have passed since the last dose of tetanus-containing vaccine.* **For 8th – 12th grade:** 1 dose of Tdap is required when 10 years have passed since the last dose of tetanus-containing vaccine.* *Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.
Polio[1]	4 doses or 3 doses													**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.
Measles, Mumps, and Rubella[1, 2] (MMR)	2 doses													**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.
Hepatitis B[2]	3 doses													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.
Varicella[1, 2, 3]	2 doses													**For K – 12th grade:** 2 doses are required with the 1st dose of received on or after the 1st birthday.
Meningococcal[1] (MCV4)								1 dose						**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.
Hepatitis A[1, 2]	2 doses													**For K – 10th grade:** 2 doses are required, with the 1st dose received on or after the 1st birthday.

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

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.

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.

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

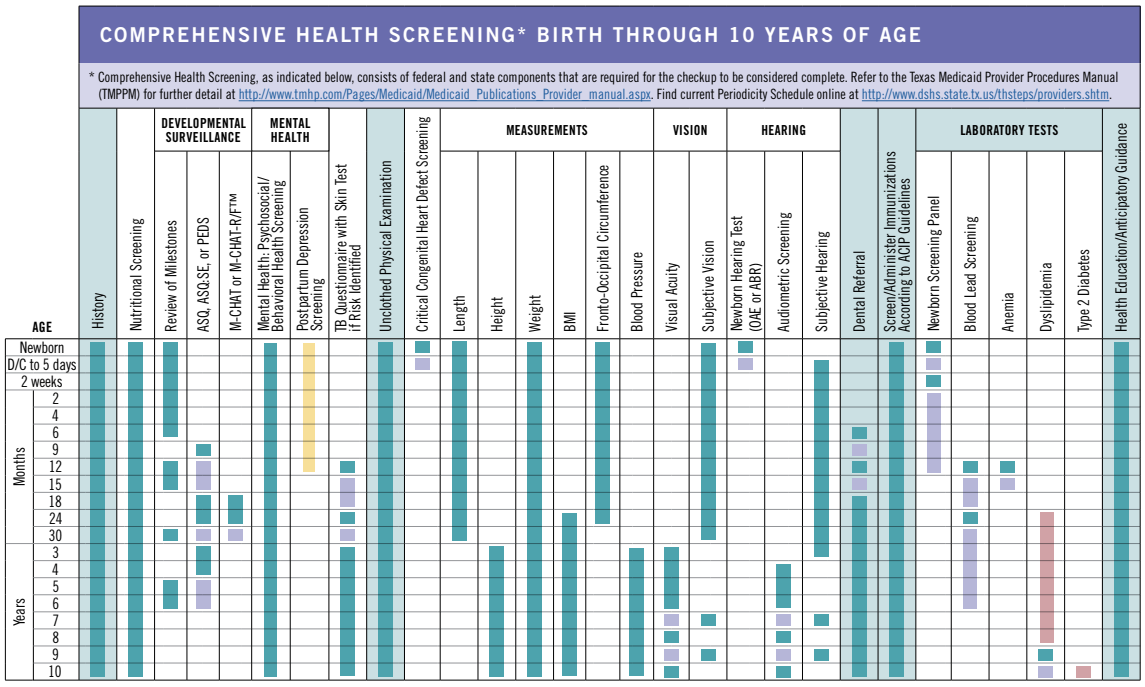
The THSteps Medical Checkup Periodicity Schedule for Members ages 0-20.

The periodicity schedule can be downloaded via 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

* 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.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.



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.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.

AGE	History	Nutritional Screening	MENTAL HEALTH: Mental Health: Psychosocial/ Behavioral Health Screening	MENTAL HEALTH: PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, CRAFFT, or Patient Health Questionnaire for Adolescents	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS: Height	MEASUREMENTS: Weight	MEASUREMENTS: BMI	MEASUREMENTS: Blood Pressure	VISION: Visual Acuity	VISION: Subjective Vision	HEARING: Audiometric Screening	HEARING: Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS: Dyslipidemia	LABORATORY TESTS: Type 2 Diabetes	LABORATORY TESTS: STD/STI Screening	LABORATORY TESTS: HIV Test	Health Education/Anticipatory Guidance
Years 11	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
12	■	■	■	▒	■	■	■	■	■	■	■		■		■	■	■	■	■	■	■
13	■	■	■	▒	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■
14	■	■	■	▒	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
15	■	■	■	▒	■	■	■	■	■	■	■		■		■	■	■	■	■	■	■
16	■	■	■	▒	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
17	■	■	■	▒	■	■	■	■	■	■	■		■		■	■	■	■	■	■	■
18	■	■	■	▒	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
19	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
20	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

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.

E03-13634 July 1, 2018

TEXAS Health and Human Services
Texas Health Steps

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.

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

Community's Transportation Service 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 (3) 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: 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:

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.
Felecia Garner, M.D.
Karen Gray, M.D.

PHYSICAL HEALTH

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

BEHAVIORAL HEALTH

1.877.343.3108 (Medicaid/CHIP)
1.855.539.5881 (Marketplace)
Fax: 713.576.0930 (Marketplace Outpatient)
Fax: 713.576.0931 (Medicaid Outpatient)
Fax: 713.576.0932 (Inpatient)
Fax: 713.576.0933 (Case Management)
Fax: 713.576.0934 (Appeals - Standard)
Fax: 713.576.0935 (Appeals - Expedited)

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

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

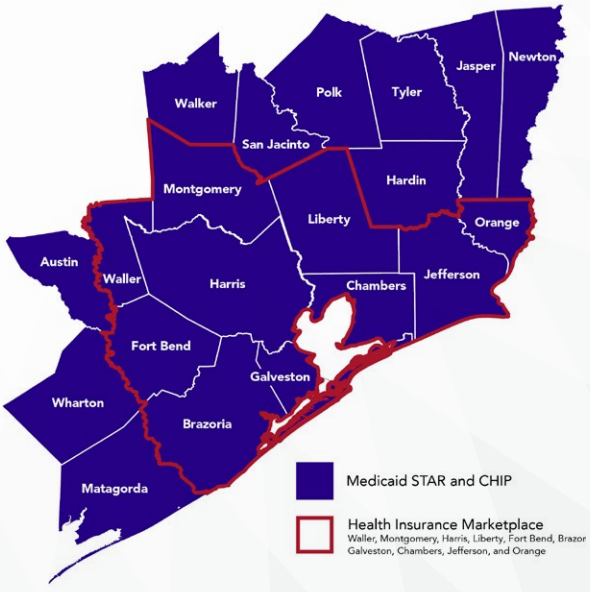
713.295.2294 or 1.888.760.2600

PROVIDER SERVICES

For general questions or to submit your updates:

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

SERVICE AREA MAP



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

Health Insurance Marketplace