

V4-2019

Provider Newsletter

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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 share with your Provider Engagement Representative or email us at ProviderRelationsInquiries@CommunityHealthChoice.org.

Community Earns 5-Star Rating



Health and Human Services has posted its [Managed Care Report Cards for 2019](#). Results are a combination of Member satisfaction feedback and medical bills submitted for CHIP and Medicaid.

Ratings are based on a scale of one to five stars. Overall ratings describe the health plan as a whole compared to other health plans around the state.

Thank YOU for helping make these scores possible!

Harris Service Area STAR Medicaid Ratings

- ★ ★ ★ ★ ★ Overall Health Plan Quality
- ★ ★ ★ ★ ★ Parents give high ratings to their child's personal doctor
- ★ ★ ★ ★ ★ Staying healthy: Babies get regular checkups
- ★ ★ ★ ★ ★ Common Chronic Conditions: Children get medicine for asthma

Jefferson Service Area STAR Medicaid Ratings

- ★ ★ ★ ★ ★ Overall Health Plan Quality – Highest Performance
- ★ ★ ★ ★ ★ Common Chronic Conditions
- ★ ★ ★ ★ ★ Children get medicine for asthma
- ★ ★ ★ ★ ★ Children see the doctor for ADHD



October 2019 Fourth Quarter NCCI Updates for Texas Medicaid

(Posted September 25, 2019)

Effective **October 1, 2019**, the fourth quarter 2019 National Correct Coding Initiative (NCCI) updates will be implemented for claims processed by TMHP for Texas Medicaid.

Providers can refer to the [Centers for Medicare & Medicaid Services \(CMS\)](#) website for updated Medicaid NCCI rules, relationships, and general information. A link to the CMS Medicaid NCCI website is also available on the [Code Updates – NCCI Compliance](#) web page on the TMHP website.

Providers are encouraged to monitor the CMS website regularly for updates to Medicaid NCCI rules and guidelines.

Reminder: New Version of the Sterilization Consent Form

(Posted October 17, 2019)

This is a reminder that beginning **October 24, 2019**, Providers must use only the new version of the Sterilization Consent Form that was revised on November 9, 2018, with an effective date of April 26, 2019. All previous versions of the form will receive a final denial.

Providers can refer to the article titled "[Clarification and Update to Changes to the Sterilization Consent Form, Instructions, and Denial Letter Effective April 26, 2019](#)," for information about changes to the form.

For more information, call the TMHP Contact Center at 1.800.925.9126 (select Option 2 and then Option 3).

You can access the Sterilization Consent Forms (English and Spanish) via our Provider Portal at: <https://Provider.communityhealthchoice.org/>Provider Tools>Authorization/Notifications>.

Update Regarding Attending Provider NPI Requirements for Outpatient Claim Submissions

(Posted October 18, 2019)

Beginning **November 1, 2019**, TMHP will update the Texas Medicaid Provider Procedures Manual, Claims Filing Handbook, to add language regarding Attending Provider National Provider Identifier (NPI) requirements. In addition, TMHP will update block 76 of the UB-04 CMS-1450 instruction table to require attending Provider information for outpatient claims.

The following language will be added:

The attending Provider is the individual who would normally be expected to certify and re-certify the medical necessity of the number of services rendered or who has primary responsibility for the patient's medical care and treatment.

Note: Outpatient claim Providers may be instructed to submit the ordering Provider name and NPI number in the attending Provider field.

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

2020 Healthcare Common Procedure Coding System Annual Update Coming January 2020

(Posted November 15, 2019)

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

Effective **January 1, 2020**, for dates of service on or after January 1, 2020, TMHP will apply the 2020 Healthcare Common Procedure Coding System (HCPCS) additions, changes, and deletions.

Deleted procedure codes will no longer be benefits of Texas Medicaid or the Children with Special Health Care Needs (CSHCN) Services Program.

The information will be available on the TMHP website on January 1, 2020. For more information, call the TMHP Contact Center at 1.800.925.9126 or the TMHP-CSHCN Services Program Contact Center at 1.800.568.2413.

Reminder: Medicaid Providers Must Ensure all Client Medical Record Entries are Legible, Dated, and Signed

(Posted December 05, 2019)

Reminder: All client medical record entries must be legible to individuals other than the author, dated (month, day, and year), and signed by the performing Provider.

Medicaid Providers are required to comply with this medical record documentation requirement. Failure to comply with this requirement subjects the associated services to recoupment.

Providers can refer to the *Texas Medicaid Provider Procedures Manual, Vol.1*, General Information, Provider Enrollment and Responsibilities, section 1.6.11, “General Medical Record Documentation Requirements,” for more information.

For more information, call the TMHP Contact Center at 1.800.926.9126.



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 by 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>



Correct Coding Initiative

(Previously posted on the Provider Portal in August 2019)

Accurate coding and reporting of services on medical claims submitted to Community Health Choice (Community) is critical in assuring proper payment to Providers. As of October 1, 2019, all of Community's lines of business upgraded their code-auditing system from HMS® to ClaimsXten™, Change Healthcare's next-generation solution for ensuring proper coding on health insurance claims.

The upgrade to ClaimsXten allows Community to better validate claims-coding accuracy and more closely align claims adjudication with medical policies, benefit plans, and the Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI). The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported and to prevent improper payments when services are reported with incorrect units of service.

For Providers, implementation of the ClaimsXten software means that correct coding on claims submitted to Community will be more important than ever. Providers will see new edits on their remittance notices when claims are not coded in accordance with current coding practices.

What Is ClaimsXten?

ClaimsXten is robust code-auditing software designed to ensure health insurance claims are coded properly. The software relies on clinically supported rules and logic influenced by national medical societies, current coding practices, and the NCCI.

ClaimsXten contains rules, each of which consists of the logic necessary to execute a specific payment policy or guideline. Each rule has an associated set of clinical data that, when applied, results in an edit. The edit is a recommendation to deny, review, modify or allow a specific claim line.

ClaimsXten simplifies payment rules and analyzes claims in the context of claims history. It offers enhanced analysis of coding for issues such as deleted CPT codes, unbundled services, appropriateness of procedures for age and gender, invalid modifiers, medically unlikely number of units for the same date of service, and investigational procedures.

Providers will see benefits of the ClaimsXten upgrade that include:

- Improved adjudication accuracy and consistency

- Streamlined claims adjudication
- Fewer manual reviews
- Enhanced payment transparency
- Reduced appeals
- Clinically supported rules and logic

What is NCCI?

The ClaimsXten auditing logic will better align Community's claims adjudication with CMS' National Correct Coding Initiative.

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding and incorrect payments for medical services. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice. According to the NCCI Policy Manual, NCCI includes three types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code Edits.

1. **NCCI PTP edits** prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a Provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment, but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.
2. **Medically Unlikely Edits (MUEs)** prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same Provider for the same beneficiary on the same date of service.
3. **Add-on code edits** consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if, and only if, one of its primary codes is also eligible for payment.

For more information regarding this change, please contact your local Provider Engagement Representative or call Provider Services at 713.295.2295 for Medicaid/STAR or 713.295.6704 for Marketplace.

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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

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).



Scholar
Medical Business Office Professional

CareerReady – Community’s Investment into the Career Paths of our Membership

Over the years, Community has provided monetary support to community-based organizations to fund programs that focus on alleviating the social determinants negatively affecting our underserved communities. In 2015,

Community decided to be strategic with this financial support and invest in programs that address the social determinants outside of health.

With the implementation of our new social determinants of health programs, Community is addressing two social determinants outside of health: economic stability and education. Within these determinants, Community is looking to improve the opportunities for our Members to have better employment, opportunities, higher income to support their families, high-quality early childhood education, and vocational training opportunities. To lead these programs, Community’s Leadership created the Life Services Team to focus on addressing the social determinants of our Members.

Community piloted their Life Services Program called CareerReady in 2018. CareerReady targets high school seniors and pregnant women on our Medicaid and CHIP Health Plans. The ultimate goal of the CareerReady Program is to have accepted Members earn a continuing education certification, gain employment where they can apply their certification, and achieve economic stability to get themselves and their family Members off public assistance.

Each Member accepted into CareerReady is called a CareerReady Scholar and is connected to a Life Coach. The Life Coach serves as a guide to help Scholars on their career training journey. In 2018, we accepted 32 Scholars into CareerReady and thus far in 2019, we have accepted 20 Scholars. Currently, we are in the process of interviewing to fill 10 more spots in our CareerReady scholarship program for 2019.

The Life Coach and Scholar meet regularly to map out short and long-term goals, identify realistic academic and career pathways, enroll in classes, search for job opportunities and prepare for employment. Unfortunately, the majority of our Scholars do not have work experience in their industry of study. As a result, their resumes do not match job postings and as a job candidate, they lack soft-skills that match the industry in which they are hoping to pursue a career. Since 2018, the Life Services Team has been identifying the barriers for employment and in response, implemented different ways of addressing these issues in the past year.

Once the Scholar is near the completion of their certificate program, the Life Coach will refer them to the Employer Partner Specialist. The Employer Partner Specialist will meet with the Scholar to assess their soft skills and interview skills, and guide them to employment opportunities.

Throughout the year, the Employer Partner Specialist works on forming partnerships with different employers across the city that have job openings in our graduating Scholars’ fields of study. These partnerships are formed in the hope that these organizations will invest in our Scholars and provide them with a learning and employment opportunity so they may eventually fill an employment gap an employer might be facing.

Our current Employer Partners are Harris Health System, Legacy Community Health, and El Centro de Corazon. We are soon to graduate Scholars in Patient Care Tech, EKG, Certified Nurse Aide, Payroll Specialist, Child Development Associate, Electrician, and Pharmacy Technician. We are looking to add more employers to our Employer Partner Database who are willing to interview our Scholars for job openings at their organization. Building a partnership will allow us to make a lasting impact for our Scholars.

If you are interested in learning more about our CareerReady Scholars, contact the Life Services Manager at Jenny.Mathai@CommunityHealthChoice.org.

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 South Loop West, Suite 125
Houston, TX 77054



Reporting Provider or Recipient Waste, Abuse or Fraud

Let us know if you think a doctor, dentist or pharmacist at a drug store, other healthcare Providers or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law.

For example, tell us if you think someone is:

- Getting paid for services that were not given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid or CHIP ID
- Using someone else's Medicaid or CHIP ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184;
- Visit <https://oig.hhsc.state.tx.us/>. Under the box labeled "I want to" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to Community at:

Community Health Choice
Chief Compliance Officer
2636 South Loop West, Suite 125
Houston, TX 77054
1.877.888.0002

Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings.

1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include:
 - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - assessment, clinical impression or diagnosis;
 - plan for care; and
 - date and legible identity of the patient and the author.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses along with allowed conditions should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT, Level II, and Level III HCPCS and ICD codes reported on claim forms submitted to Community must be supported by the documentation in the medical record.



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.

Soon, Community will make available TTAP 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.

POTENTIAL HEALTH SCREENINGS AND ANNUAL WELLNESS VISIT INFORMATION

No matter your age, it is important to find a Primary Care Physician you like and schedule an annual check-up. Yearly visits are the best way to detect any changes in your health before they develop into bigger issues. Here are recommended screenings by age group.


MALE		FEMALE	
SCREENING	HOW OFTEN	SCREENING	HOW OFTEN
20s			
Eye Exam	Every 1-2 years	Eye Exam	Every 1-2 years
Blood Pressure Screening	Every 2 years	Blood Pressure Screening	Every 2 years
Cholesterol Screening	Every 4-6 years	Cholesterol Screening	Every 4-6 years
Diabetes Screening	Every 3 years	Diabetes Screening	Every 3 years
Tuberculin Exam	Yearly	Tuberculin Exam	Yearly
30s			
Blood Pressure Screening	Every 2 years	Blood Pressure Screening	Every 2 years
Cholesterol Screening	Every 4-6 years	Cholesterol Screening	Every 4-6 years
Diabetes Screening	Every 3 years	Diabetes Screening	Every 3 years
Tuberculin Exam	Yearly	Tuberculin Exam	Yearly
40s			
Blood Pressure Screening	Every 2 years	Blood Pressure Screening	Every 2 years
Cholesterol Screening	Every 4-6 years	Cholesterol Screening	Every 4-6 years
Diabetes Screening	Every 3 years	Diabetes Screening	Every 3 years
Tuberculin Exam	Yearly	Tuberculin Exam	Yearly
50s			
Blood Pressure Screening	Every 2 years	Blood Pressure Screening	Every 2 years
Cholesterol Screening	Every 4-6 years	Cholesterol Screening	Every 4-6 years
Diabetes Screening	Every 3 years	Diabetes Screening	Every 3 years
Tuberculin Exam	Yearly	Tuberculin Exam	Yearly
60+			
Blood Pressure Screening	Every 2 years	Blood Pressure Screening	Every 2 years
Cholesterol Screening	Every 4-6 years	Cholesterol Screening	Every 4-6 years
Diabetes Screening	Every 3 years	Diabetes Screening	Every 3 years
Tuberculin Exam	Yearly	Tuberculin Exam	Yearly

What are these screenings for?

- Blood Glucose Test** - tests for risk of diabetes
- Blood Pressure Screening** - tests for heart disease
- Bone Density Testing** - tests for signs of osteoporosis
- Cholesterol Screening** - tests for heart disease
- Colorectal Screening** - tests for colorectal cancer or precancerous polyps
- Coronary Artery Calcium (CAC) Screening** - tests for heart disease
- Eye Exam** - tests for vision, glaucoma, and macular degeneration
- Fecal Occult Blood Test** - tests for early signs of colon cancer
- Hearing Test** - tests for ear function
- Herpes Blood Test** - tests for signs of genital herpes
- Mammogram** - tests for signs of breast cancer
- Ovarian Screening** - tests for signs of ovarian cancer
- Pap Smear** - tests for risk of cervical cancer
- Pneumonia Screening** - tests for signs of cancer
- Prostate Exam** - tests for signs of prostate cancer
- Prostate Specific Antigen (PSA) Test** - tests for signs of prostate cancer
- Tuberculin Exam** - tests for signs of tuberculosis
- Skin Exam** - tests for signs of skin cancer
- Thyroid Stimulating Hormone (TSH) Test** - tests for under or overactive thyroid

Source: <https://www.papum.com/how-to/health-screening-by-age-5-age-groups-prostate/>

CommunityHealthChoice.org
Informational 0119



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 in 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).



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.

Postpartum Care

In order to optimize the health of our Texas Medicaid Members, Community follows the guidance of the American College of Obstetrics and Gynecology's (ACOG) recommendation that postpartum care should be an ongoing process with services and support that are tailored to each woman's individual needs (woman-centered).

1. If an acute postpartum issue/problem arises during the first 3 weeks (21 days) postpartum, a CPT evaluation and management code (99212-99215) should be used with follow-up ongoing care as needed. Visits for suture, staple removal or other routine wound care during the post-operative period following a Cesarean section or repair of lacerations are not considered problem or postpartum visits, and thus are not eligible for payment as separate visits.
2. The comprehensive postpartum visit should be performed after 4 weeks but no later than 12 weeks, provided the Member still has coverage on Medicaid and should be billed using 59430.

Reference: ACOG Committee Opinion #736 May 2018, [Optimizing Postpartum Care](#)



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.



Performance Improvement Project to Improve 7-Day and 30-Day Follow-up Visits After Hospitalization for Mental Illness (HEDIS FUH)

Community will implement the Performance Improvement Project beginning January 2020 titled **“Improving 7-Day and 30-Day Follow-up Visits After Hospitalization for Mental Illness.”** The project is identified by the Texas Health and Human Services (HHS) as one of the priority areas for the State, and it will run from January 1, 2020 to December 31, 2021..

The goal of this project is to improve follow-up visits within 7 days and 30 days after discharge among STAR and CHIP Members ages 6 years and older who were hospitalized for mental illness. It has been broadly recognized that follow-up care by trained mental health clinicians helps improve patient health outcomes and prevent readmissions. Recommended post-discharge treatment includes a visit with a mental health Provider within 30 days of discharge. Ideally, patients should see a mental health Provider within 7 days after discharge.

Measure Description

According to The National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), the measure assesses Members ages 6 years and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the following:

- The percentage of Members who received follow-up within 7 days after discharge
- The percentage of Member who received follow-up within 30 days after discharge

Help Us

- Provide Member reminder calls within 24 hours to confirm appointments
- Reach out within 24 hours if the Member does not keep scheduled appointment and to schedule another appointment
- Work with the Member to develop the treatment plan and evaluate their medication along with the side effects
- Schedule the next follow-up appointment before the Member leaves the office
- Share community resources for additional support, as well as offer the 24/7 toll-free urgent support if the Member is experiencing thoughts of harming themselves or others

MEMBER SAFETY PLAN
Please complete and share it with your therapist or a mental health professional.

Step 1: What are some of the warning signs or triggers I may experience that let me know a crisis is developing? (thoughts, images, mood, situation, behavior)

- _____
- _____
- _____

Step 2: What are some healthy activities I can do to take my mind off my problems?

- _____
- _____
- _____

Step 3: What settings provide me a distraction? (place of worship, park, gym)

- _____
- _____
- _____

Step 4: What family or friends can I ask for help?

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: What things in my life are worth living for?

- _____
- _____
- _____

Step 6: What professionals or agencies can I contact in a crisis?

1. Clinician Name _____ Phone _____
2. Clinician Name _____ Phone _____
3. Community Health Choice Behavioral Health Crisis Hotline: STAR/CHIP/DSNP – 1.877.343.3108

Step 7: Safety (When to go to the ER):

- _____
- _____

bh_safetyplan_1219

COMMUNITY HEALTH CHOICE

Primary Care Provider Toolkit

Community has developed a comprehensive PCP Toolkit for PCPs to assist in identifying and treating behavioral health issues. It includes information on the most common behavioral health issues, including guidelines for diagnosis and treatment, fact sheets for Members, and assessment tools. Conditions included in the toolkit:

- ADHD in Children and Adults
- Alcohol and Substance Abuse/Addiction
- Anxiety
- Autism
- Bipolar Disorder
- Eating Disorders
- Major Depression
- Opiates
- PTSD
- Schizophrenia



Access the PCP Toolkit online at www.CommunityHealthChoice.org.

Community's Behavioral Health Case Management

Connecting Members to Community's Case Management Program

- Members may self-refer to any in-network behavioral health Provider.
- Members may 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 at 713.576.0933, or
 - Faxing referral information to our dedicated behavioral health fax line at 713.576.0933.

Annual Texas Health Steps Provider Training

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 31** of each calendar year.

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

Flu Season

Community encourages you to educate Members on flu prevention and the importance of getting the annual flu vaccination, which is a covered benefit. Providers are encouraged to administer the flu vaccine during a THSteps medical checkup visit. When billing the THSteps visit, Providers need to include:

- Age-appropriate diagnosis code for preventive care medical checkups on the claim
- Diagnosis code Z23 for immunization administration
- Modifier 25 to identify a significant, separately identifiable evaluation and management service

Providers who are only administering the flu vaccine during an office visit can only submit diagnosis code Z23 on the claim.

Texas Vaccines for Children (TVFC) program covers flu vaccines for Providers currently enrolled in the program. To learn more about how to enroll in the TVFC program, please visit <https://www.dshs.texas.gov/immunize/tvfc/info-for-Providers.aspx>.

Health Education

Health Education, including anticipatory guidance, is one of the six primary federally mandated component of each Texas Health Steps (THSteps) medical checkup. This component includes age-appropriate counseling and health education, which assist the patient and their parent/guardian in understanding the expected growth and development. The counseling and health education topics should be individualized and prioritized according to questions and concerns the patient and their parent/guardian may have as well as findings obtained during the completion of the health history and physical exam.

As a THSteps Provider, you can help families to adopt healthy ways of living during your individual interaction with patients and help them to develop positive lifelong health-care habits, using the following anticipatory guidance elements:

- Family Well-Being
- Development and Behavior
- Nutrition Counseling
- Routine Care
- Safety

For information on individual age-specific anticipatory guidance, please visit <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/Provider-portal/health-services-Providers/thsteps/thsteps-anticipatory-guidance.pdf>.

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 <u>before</u> the next checkup age		
Newborn	3-5 days	2 weeks
2 months	4 months	
Complete <u>within 60 days</u> of these checkup ages		
6 months	9 months	12 months
15 months	18 months	24 months
	30 months	
Complete <u>on or after</u> 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 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

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



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 serve Community Health Choice Members 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 Management for Medicaid Members

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

Rides 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, MTM might pay for lodging and meals

Help Us

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



Community's Transportation Service for CHIP Members

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

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

Online Provider Education – Free Continuing Education (CE) Hours

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

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

Below are a couple of courses that you may find useful:

- **XALD: Newborn Screening, Treatment, and Referral**

The goal of this tutorial is to equip birth facilities, Texas Health Steps Providers, and other health professionals to screen newborns for X-linked adrenoleukodystrophy (XALD), communicate out-of-range screening results, and provide appropriate referrals and care coordination.

https://www.txhealthsteps.com/455-xald-newborn-screening-treatment-and-referral?utm_source=courseannouncement&utm_medium=email&utm_campaign=XALD_TB

- **Guidelines for Tuberculosis Screening, Testing, and Treatment**

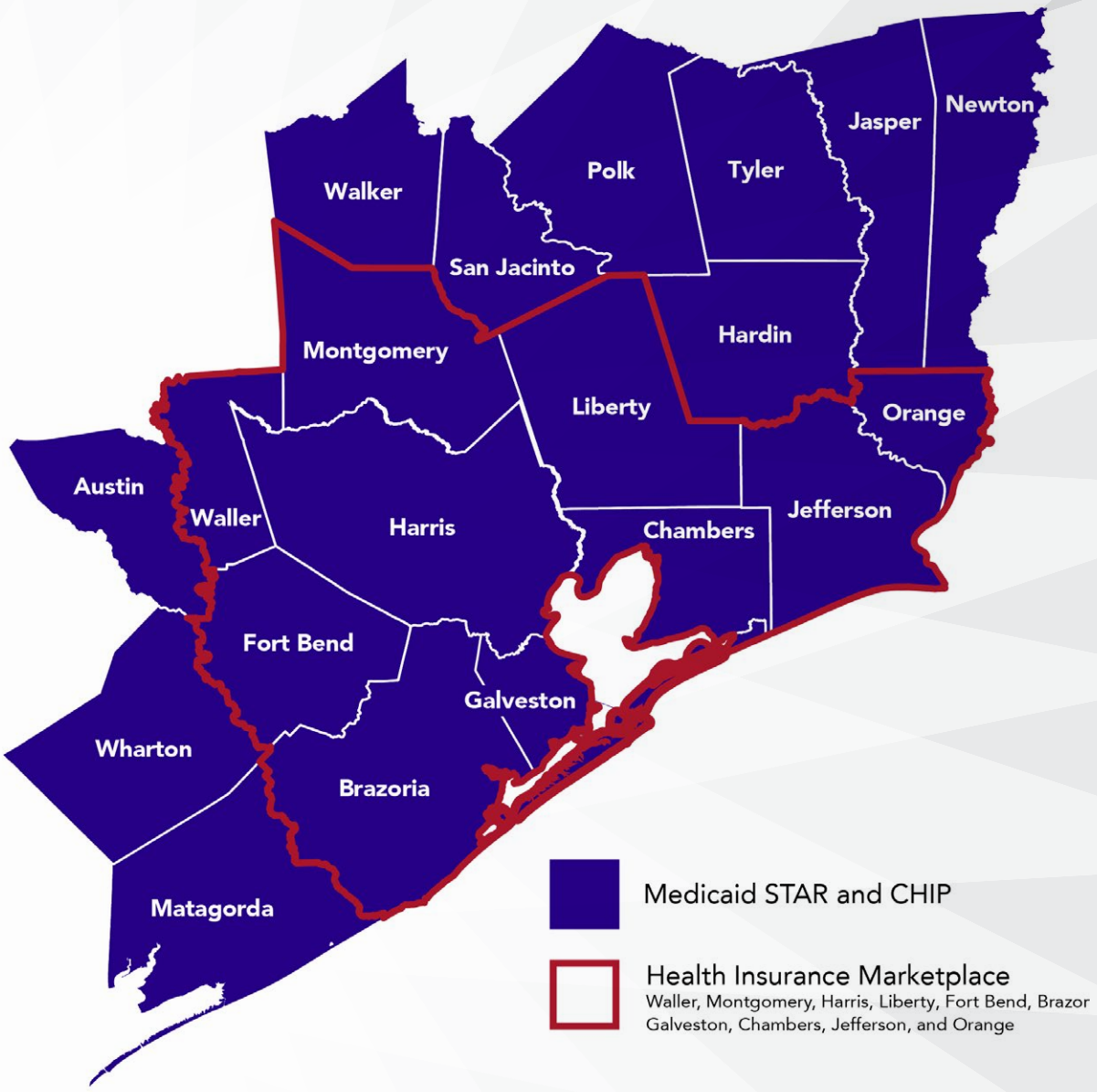
The goal of this tutorial is to equip Texas Health Steps Providers and others to employ best practices for tuberculosis (TB) screening, testing, and treatment in children and adolescents. https://www.txhealthsteps.com/460-guidelines-tuberculosis-screening-testing-and-treatment?utm_source=courseannouncement&utm_medium=email&utm_campaign=XALD_TB

Vendor Drug Program Continuing Education (CE) 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 CE credits, please visit www.txvendordrug.com/Providers/prescriber-education.

SERVICE AREA MAP



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 our 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.

