V1-2020

Provider Newsletter

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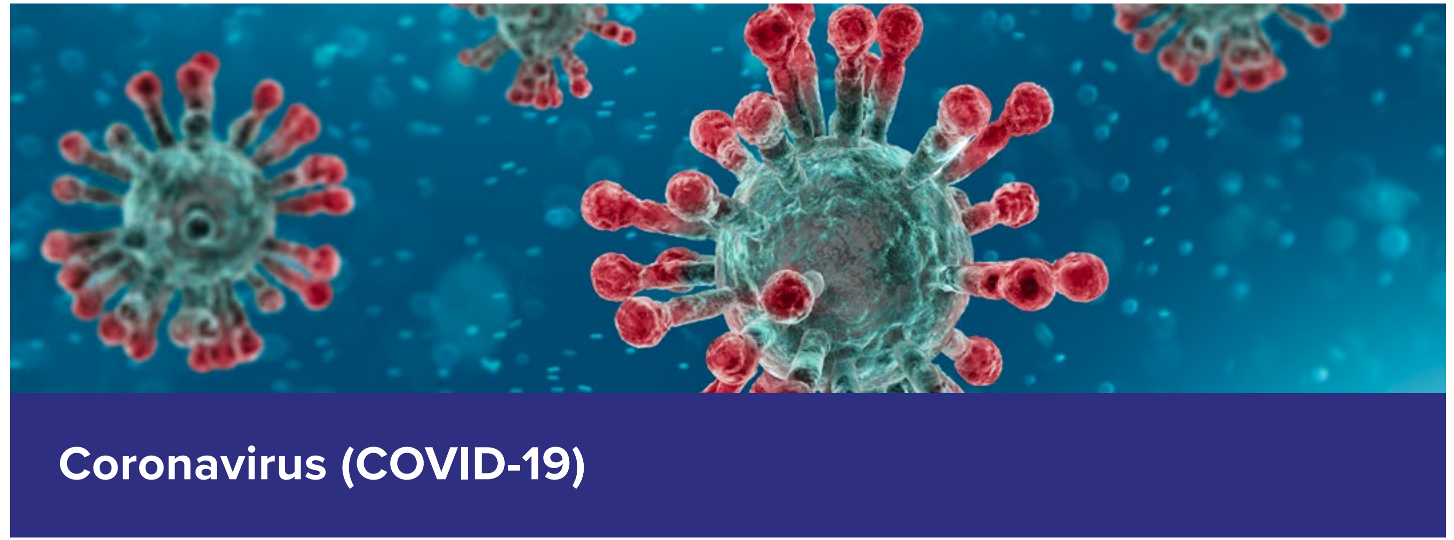
Feedback

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.



Coronavirus (COVID-19)

Community Health Choice is monitoring the coronavirus disease (COVID-19) and the most updated information from the Centers for Disease Control and Prevention (CDC), Texas Department of State Health Services, and the Harris County Public Health Department. We have implemented the following actions to support the timely evaluation, testing, and treatment for COVID-19 related illnesses:

1) Waive prior authorizations for diagnostic tests and covered services that are medically necessary and consistent with CDC guidance.
2) Cover, with no cost share to Member, medically necessary diagnostic tests that are consistent with CDC guidance.
3) Waive early medication refill limits on prescription maintenance medications.
4) Encourage use of telemedicine services and ensure Members are aware of telemedicine benefits, as well as the availability of Community's Nurse Advice Line.
5) Waive copay and Member cost-share for telemedicine services of any modality for any reason for 90 days, including:
   a) Marketplace and DSNP Members: Continue zero cost telemedicine services;
   b) Marketplace, DSNP, and CHIP Members: Waive Member copay/cost-share for telemedicine services provided by network providers;
   c) STAR Members – Access to and coverage of telemedicine services provided by network providers.

Visit these websites for more information

- CDC Provider Page
- Center for Clinical Standards and Quality/Quality, Safety and Oversight Group
- Claims for Telephone (Audio Only) Behavioral Health Services
- Claims for Telephone (Audio Only) Medical
- COVID-19 Coding Guidance
- CMS Partner Toolkit
- DSHS COVID-19 Specimen Collection and Submission Instructions
- DSHS Novel Coronavirus Testing Algorithm
- Harris County Public Health COVID-19 Provider Page
- HHS COVID-19 Provider page
- Telemedicine/Telehealth: Therapies
- Texas Department of State Health Services (DSHS) Criteria to Guide Testing of PUIs for COVID-19
- Texas DSHS Provider Page
- THSteps Medical and Dental Check-ups during COVID-19
- Waiver of CHIP copayments

Visit our website for more information at https://provider.communityhealthchoice.org/coronavirus/. We will update this page as more information is made available.

To read what Community is sharing with Members about COVID-19, please click here.

Waiver of CHIP Copayments

To assist families in accessing care during the COVID-19 response, HHSC is waiving office visit copayments for all CHIP Members for services provided from **March 13, 2020, through April 30, 2020**.

Providers must not collect office visit copayments for CHIP Members during this time. Community Health Choice will reimburse the Provider the full rate for the service, including what would have been paid by the Member through cost-sharing.

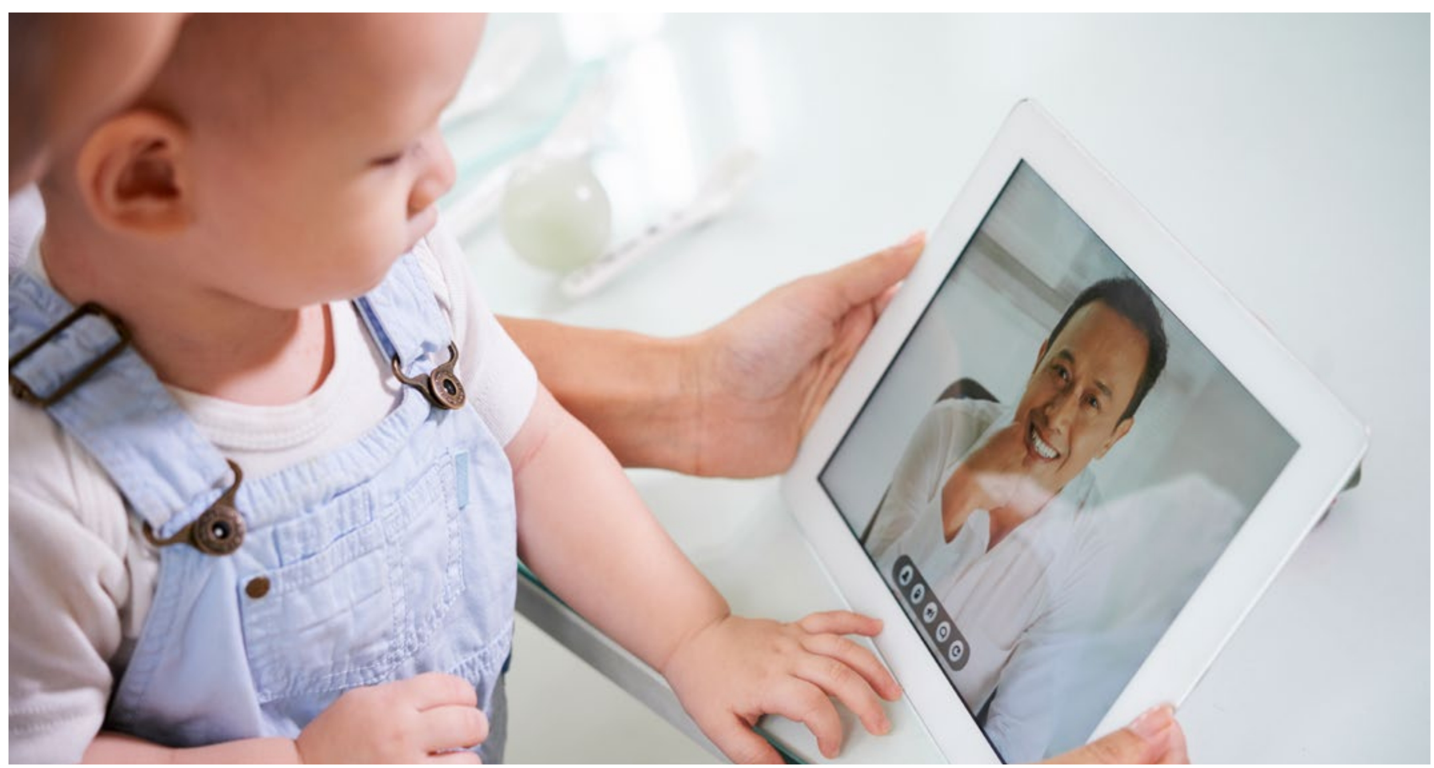
Providers must attest that the office visit copayment was not collected by using the attestation form on page 5 and submit an invoice to Community Health Choice.

Community Health Choice will have 30 calendar days to pay an invoice received from a Provider. If Community Health Choice has already reimbursed a Provider for waived CHIP office visit copayments without using the attestation form, Community Health Choice will document the amount paid and the process used to confirm that a copayment was not collected by the Provider.

CHIP Copayments for Teleservices

On March 9, 2020, HHSC clarified that CHIP copayments are not required for covered services delivered via telemedicine or telehealth to CHIP Members. HHSC encourages the use of teleservices in lieu of in-person office visits, as appropriate.

Should you have any questions, please contact our Provider Services line at 713-295-2295 or your Provider Engagement Representative.



COVID-19: WAIVER OF CHIP PAYMENTS

PROVIDER ATTESTATION FORM

Date: ______________________________

I, ____, certify that the attached invoiced amounts represent office visit copays that my practice did **not** collect for dates of service on **March 13, 2020, through April 30, 2020**, for CHIP Members in accordance with direction from Texas Health and Human Services.

The above and the attached are true and correct to the best of my knowledge and belief. I know that I may be subject to penalties if I provide false or untrue information. All original documents will be retained and preserved as required by law, and such documents will be submitted, or access to such documents permitted, as required by HHSC or any agency of the state or federal government or their representative(s).

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Print Provider Name Provider NPI

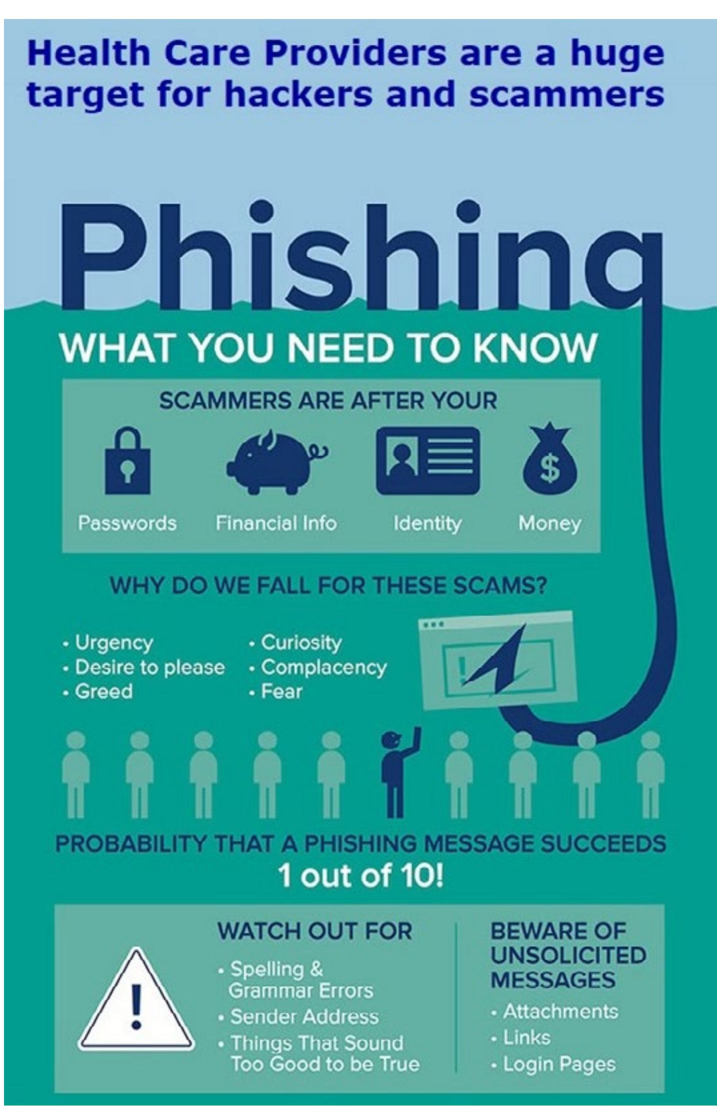
Submit Attestation Form and Invoice via mail, email or fax to:
Community Health Choice
Attn: **Provider Relations**
2636 S Loop West, Suite 125
Houston, TX 77054
ProviderRelationsInquiries@communityhealthchoice.org
Fax: 713-295-7039

Be Aware of Phishing!

The World Health Organization (WHO) has issued an alert about ongoing coronavirus-themed phishing attacks that impersonate the WHO and try to steal confidential information and deliver malware. The worldwide spread of the new coronavirus is being used by bad guys to scare people into clicking on links, opening malicious attachments or giving out confidential information. Be careful with anything related to the coronavirus, i.e., e-mails, attachments, any social media, texts on your phone...anything! Look out for topics like:

- Check updated coronavirus map in your city
- Coronavirus Infection warning from local school district
- CDC or World Health Organization emails or social media coronavirus messaging
- Keeping your children safe from coronavirus
- Phone call to raise funds for "victims"

There will be a number of scams related to this, so please remember to **Think Before You Click!**



Taxonomy Codes Required as of May 1, 2020

Taxonomy codes are administrative codes set for identifying the Provider type and area of specialization for healthcare Providers. Each taxonomy code is a unique 10 character alphanumeric code that enables Providers to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual Provider and organizational Provider level. These codes are self-reported, both by registering with the National Plan and Provider Enumeration System (NPPES) and by electronic and paper claims submission.

Taxonomy Codes registered with NPPES at the time of NPI application are reflected on the confirmation notice document received from NPPES with the Provider's assigned NPI number. Current taxonomy codes registered, including any subsequent changes, may be obtained on an inquiry basis by visiting the NPI Registry website at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

A Provider can have more than one taxonomy code. It is critical to register all applicable taxonomy codes with NPPES and to use the correct taxonomy code to represent the specific specialty when filing claims. This will assist in more accurate and timely processing of claims.

Effective **May 1, 2020**, Community will require that claims for all Members include the correct taxonomy codes. This includes Medicaid, CHIP/CHIP Perinate, Marketplace, and Medicare lines of business.

- Claims submitted without the correct taxonomy codes and NPI numbers will be denied.
- The taxonomy code and NPI number for both the rendering and the billing Provider must match the appropriate combination.
- The rendering Provider is the person providing the care. For institutional claims, this includes the attending physician.
- The billing Provider is the practice submitting the bill. When the billing Provider identifier is a group practice, the claim must include the performing Provider identifier for the physician who performed the service.
- Group billing Providers are not required to submit the taxonomy code on electronic claims – but they can include the taxonomy code to assist with the NPI crosswalk for claims processing.

<table>
<tr><th>Taxonomy Type</th><th>Paper Claim Box</th><th>837P Loop (CMS1500) Professional</th><th>837I Loop (UB04) Institutional</th><th>EDI Segment (all three segments are to be used for each loop a taxonomy will be provided)</th><th>PRV Codes</th></tr>
<tr><td>Billing Provider</td><td>CMS 1500
Box: 33B

UB04
Box: 81</td><td>2000A – Billing Provider Specialty Information</td><td>2000A – Billing Provider Specialty Information</td><td rowspan="3">PRV01 Provider Code (Input one of the two-letter codes listed to the right)

PRV02 Reference Identification Qualifier (Input the PRV02 code listed to the right)

PRV03 Provider Taxonomy Code (Input the provider's taxonomy number here.)

Example:
PRV*BI*PXC*207N00000X~</td><td rowspan="3">PRV01 Codes:
• AT = Attending Provider
• BI = Billing Provider
• PE = Performing (Rendering) Provider

PRV02 Code:
• PXC = Health Care Provider Taxonomy Code

PRV03 Code:
• Taxonomy Number</td></tr>
<tr><td>Rendering Provider</td><td>CMS 1500
Box: 24J</td><td>2310B – Rendering Specialty Information</td><td></td></tr>
<tr><td>Attending Provider</td><td></td><td></td><td>2310A – Attending Provider Specialty Information</td></tr>
</table>

FQHC & RHC – Billing Requirement

Effective **June 1, 2020**, Community will only accept claims from FQHCs and RHCs according to the Medicare Claims Processing Manual, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers. This will apply to all claims for Members in the **Marketplace** and **Medicare (including HMO D-SNP)** Programs.

- Electronic format: ASC X12 837 institutional claim transaction
- Paper format: Form CMS-1450 (UB04), Type of Bill 77X

Revenue Codes

- 0519: Supplemental payment for visit by Medicare Advantage patient
- 0521: Clinic visit by the patient to the FQHC
- 0522: Home visit by the FQHC practitioner
- 0524: Visit by FQHC practitioner to skilled nursing facility patient (SNF) in a covered Part A stay
- 0525: Visit by FQHC practitioner to SNF patient not in a covered Part A stay, or other residential facility
- 0527: Home visit by Visiting Nurse Service when in a home health shortage area
- 0528: Visit by FQHC practitioner to other non-FQHC site (e.g., scene of accident)
- 0900: Behavioral Health Treatment Services

HCPCS Codes

FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes. RHCs are only required to report the appropriate revenue code for medical and mental health services.

- G0466: FQHC Visit, New Patient
- G0467: FQHC Visit, Established Patient
- G0468: FQHC Visit, Initial Preventative Physical Exam or Wellness Visit
- G0469: FQHC Mental Health Visit, New Patient
- G0470: FQHC Mental Health Visit, Established Patient
- G0511: FQHC Chronic Care Management / General Behavioral Health Integration
- G0512: FQHC Psychiatric Collaborative Care Model Services

Each G Code on a claim must be accompanied by a qualifying visit code. The full list of qualifying codes is available in the CMS website.

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

Resources:

FQHC PPS Website

G-Codes and Qualifying Codes

FQHC Center Page

Community Leaders Earn Invitations to ACAP Leadership Academy

Dr. Felecia Garner, behavioral health medical director, and Derek Wilson, director of analytics, were recently selected to attend the 2020-2021 Association for Community Affiliated Plans (ACAP) Leadership Academy. ACAP is a national trade association that represents not-for-profit safety-net health plans.

The one-year Academy program gives plan leaders a unique networking opportunity through a series of in-person and virtual meetings as they learn and share important information about Medicaid-managed care issues.

Dr. Garner and Mr. Wilson attended the kickoff meeting in Washington, D.C., on February 10, where they met safety-net plan leaders from around the nation and learned about the history of Medicaid-managed care, along with the program's current challenges and opportunities.

The kickoff coincided with ACAP's fly-in meeting and Capitol Hill visits with members of Congress about safety-net health plans like ours and the importance of Medicaid, CHIP, Medicare, and Marketplace programs to the Members we serve. They met with representatives from the offices of senators Ted Cruz and John Cornyn and representatives Sylvia Garcia, Randy Weber, Brian Babin, Kevin Brady, and Pete Olson on topics including behavioral and mental health, the need to focus on whole person care by integrating behavioral and physical health care, opioid use disorders, rural health, Medicaid pharmacy costs, and the proposed Medicaid Fiscal Accountability Regulation—a bill that may limit states' federal Medicaid funding.

Telehealth Services Becomes a Benefit for Early Childhood Intervention Providers

Effective March 1, 2020

(Information posted January 6, 2020)

Effective for dates of service on or after **March 1, 2020**, telehealth services delivered remotely to children who are eligible for the Early Childhood Intervention (ECI) Program and Medicaid will become a benefit for ECI providers. Telehealth services may be reimbursed to ECI providers for services rendered in the office, home, and other location settings.

Reimbursement

The following procedure codes can be billed for services rendered as telehealth services through the ECI program:

Procedure Codes					
92507	92508	92521	92522	92523	92524
92526	92610	97110	97112	97150	97165
97166	97167	97168	97530	97535	S9152
T1027					

Procedure Codes Billed With Modifiers

The procedure codes in the table below should be billed with the following modifiers:

- Modifier **GO** for Occupational Therapy Services (OT)
- Modifier **GN** for Speech Therapy Services (ST)
- Modifier **AT** for acute OT or ST services

Procedure code **T1027** should be billed with the **U1** modifier.

Procedure Codes					
92507	92508	92521	92522	92523	92524
92526	92610	97112	97150	97165	97166
97167	97168	97530	97530	S9152	

Documentation

ECI providers are not required to provide the patient's primary care physician with a treatment summary.

For more information, call the TMHP Contact Center at 800-925-9126.

Data Quality Issues Experienced by MCOs via Texas Immunization Registry

Managed care organizations (MCOs) like Community utilize a data exchange format known as Immunization History Query (IHQ) files to request immunization data on Members from the Texas Immunization Registry to meet reporting needs for HHSC, the National Committee for Quality Assurance or internal stakeholders.

The IHQ files are submitted in a batch submission about once per month. The registry processes the IHQ files to query and identify if the Member is a registry client. In return, the registry provides Community an Immunization History Response (IHR) file that contains the vaccination records of the Members who are registry clients.

If healthcare Providers address the following issues, the overall data quality of patient and immunization data is expected to increase, as well as the patient participation in the registry, which will allow healthcare Providers to provide better and more reliable care.

1. Outdated Form of Data Exchange

IHQs are an outdated format to exchange data that impacts the MCOs and the registry.

Impacts to MCOs:

- Don't receive data back in a timely fashion
  - IHQ files often take 2-4 weeks to process
- Data returned on Members may contain data gaps
  - Due to the outdated format of requesting data, the IHR files are returned with a vaccine code set (CPT) that may result in gaps of missing data
  - The registry utilizes a vaccine code set (CVX) for recording its immunization data, and not every CVX code is mapped to a designated CPT code
  - This results in vaccination histories containing no vaccine code
- Data cannot be corrected to fill in the gaps
  - The vaccinations histories that contain no vaccine code cannot be corrected, as the CPT mapping to the CVX codes are set by the CDC

Impacts to Registry:

- Texas Department of State Health Services (DSHS) servers cannot handle the volume submitted by MCOs
  - IHQ files are submitted in large quantities by MCOs which causes strain on the systems and impacts other data exchange submissions
- Long processing times
  - Due to the large number of IHQ files and their sizes, the system get bogged down for long periods of time which slows down the overall file processing

2. Gaps in Data

MCOs often ask why the vaccination information for their Members is incomplete or does not contain data. Below is a summary of factors that account for those issues:

- The registry is opt-in, requiring individuals to sign an official DSHS consent form to have their information stored in the registry (i.e. not all MCO Members are registry clients)
- The registry contains only immunization data reported to it (i.e. not all healthcare Providers report to the registry)
- Data quality issues prevent the immunization data from being imported to the registry (i.e. patient and vaccination information errors or Provider location information errors)

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

After Hours

- **CPT Coding Description of 99050**

  Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturdays or Sundays), in addition to basic service.

  (Code 99050 is intended to describe circumstances under which patient-requested care is outside of the usual time frame of the routine scheduling. An example of when this code might be used is when an office has regularly posted office hours of Monday-Friday from 8:30 a.m. to 5 p.m., and a patient is seen by the physician at 7 p.m. or during the weekend outside of the usual time. The physician would report the appropriate Evaluation and Management Service (E/M), and any other therapeutic (eg, wound repair), and/or diagnostic (eg, X-ray) service(s) provided, in addition to code 99050, to indicate that the service was requested and performed outside of the posted office hours.)

- **Medicare** does not reimburse for Miscellaneous Services "after hours" codes 99050-99053. It is bundled into the payment for Evaluation & Management codes.

- **Industry standard:**

  CPT code 99050 is eligible for separate reimbursement, in addition to the basic covered service, if the basic service provided meets all of the criteria described below:

  ✓ It is reported with an office setting place of service;

  ✓ It is rendered at a time other than the practice's regularly scheduled and/or posted office hours; and

  ✓ The basic service time is based on arrival time, not actual time services commence.

REMINDER: Correct Coding Initiative

As previously communicated in Volumes 3 and 4 of the Provider Newsletter, all of Community's lines of business upgraded their code-auditing system from HMS® to ClaimsXtenTM, Change Healthcare's next-generation solution for ensuring proper coding on health insurance claims effective October 1, 2019.

Accurate coding and reporting of services on medical claims submitted to Community is critical in assuring proper payment to Providers. 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	• 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

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).

Census 2020

The 2020 Census count starts on April 1, 2020. Community understands the importance of making sure the count is accurate. In the 2010 Census, the most undercounted population was children 0 – 5 years old—a large segment of our CHIP/Medicaid membership. Therefore, Community will launch a messaging campaign, to educate and promote completion.

Please partner with us in stressing the importance of completing the census to your patients. Fliers are available for distribution. Please contact your Provider engagement representative if you would like to have these in your office.

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.

Special Investigations Unit

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

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

How to Report Healthcare Fraud

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

Behavioral Health

The Importance of the 7-Day and 30-Day Follow-Up Visits

Community is committed to providing our Members with the support they need after a behavioral health admission. When successfully managed, this transition can help you monitor your patients, monitor medication compliance, and ensure they are safe. However, we need your help!

Providers must ensure that our Members have scheduled a follow-up appointment within seven days of discharge from an inpatient behavioral health admission. These do not include visits on the date of discharge. Patients should also have a follow-up visit with a mental health practitioner within 30 days of discharge.

Our behavioral health team contacts Members by mailing a Welcome Home Packet to all of our Members who have been admitted to an inpatient psychiatric hospital. The Welcome Home Packet consists of the following:

- **Welcome Home Letter** welcoming the Member home after their inpatient admission. This letter provides support, as well as education about the services we offer at Community and other links to resources available through the Community website. It also encourages them to attend their aftercare appointments and call us if they encounter any.
- **Member Safety Plan** can be completed by the Member and reviewed with the Provider. It outlines any triggers that may lead to another hospitalization, helps identify supports prior to a crisis episode, and helps them to recall calming and grounding places and activities, as well as steps they can take to identify and seek help when needed.
- **BH Services Postcar**d lists groups and Local Mental Health Authorities (LMHAs) in the area, as well as information about transportation services and other resources.

We will also follow up with a phone call to every Member to ensure they have an appointment at the time of discharge.

We understand that critical window to receive care is within the first seven days of discharge, and that to have a follow up appointment within 30 days of that discharge by a licensed behavioral health professional can be challenging. Early follow-up and care coordination can reduce incidents of readmission.

Mental Health and Wellbeing Services

NATIONAL ALLIANCE ON MENTAL ILLNESS 713.970.4419 www.nami.org	500+ local groups for support and education Monday-Friday 10 a.m. to 6 p.m.
ALCOHOLICS ANONYMOUS 24/7 Helpline: 713.686.6300 www.aa.org	Regular group meetings open to anyone for help with a drinking problem
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD 24-hour Crisis Line: 713.970.7000 Choose option 1 www.theharriscenter.org	Provides behavioral health and intellectual and developmental disability (IDD) services while also providing assessment and outpatient behavioral health services for the mentally ill in 36 different sites across Harris County
SPINDLETOP CENTER 1.409.839.1000 www.spindletopcenter.org	Outpatient, psychiatric, and community support services in the Beaumont area for mental health issues of all kinds
TEXANA CENTER 281.239.1300 www.texanacenter.com	Behavioral health services in Austin, Colorado, Fort Bend, Matagorda, Waller, and Wharton counties Walk-in crisis help 8 a.m. to 4 p.m.
GULF COAST CENTER 1.409.763.2373 www.gulfcoastcenter.org	Services, programs, and employment assistance for intellectual and developmental disabilities, mental illness, HIV or substance abuse in Galveston and Brazoria counties
TRI-COUNTY BEHAVIORAL HEALTHCARE 1.936.538.1102 www.tricountyservices.org	Serving Liberty, Walker, and Montgomery counties with a comprehensive range of board-certified psychiatrists and mental health professionals
BURKE CENTER 1.936.634.5010 www.myburke.org	Mental health and intellectual and developmental disability services in 12 East Texas counties

Go to their websites for more information.

Call for transportation services to behavioral health appointments.
STAR Members: 1.855.687.4786
CHIP Members: 713.295.2294

For more behavioral health services or information, please call us toll-free at 1.877.343.3108.

bh_services_1219

TEXAS Health and Human Services | CHIP | TEXAS STAR | URAC ACCREDITED HEALTH PLAN | COMMUNITY HEALTH CHOICE

Behavioral Health

Anxiety and Depression: What You Can Do!

Delivering behavioral health services in a primary care setting can help reduce stigma with mental health diagnosis. The primary care setting is also becoming the first line of identification for behavioral health issues and the PCP, the center of care for behavioral and physical health disorders.

Community developed a comprehensive PCP Toolkit for primary care Providers to assist in identifying behavioral health conditions through well-known screening tools, Condition specific fact sheets, as well as other patient centered information.

The Toolkit includes condition-specific information about depression and anxiety as outlined below :

- Anxiety (Generalized Anxiety Disorder 7-item Scale)
- Depression (PCP Depression Assessment, PHQ-9 Questions)
- Adolescent Depression (Adolescent PHQ-9)
- Postpartum Depression (Edinburgh Postnatal Depression Scale)
- Eating Disorders (SCOFF Questions)
- OCD (OCD Screening Test, OCD Screening Tool)

We welcome our Providers to access the PCP Toolkit online at http://www.communityhealthchoice.org. For referrals to our telephonic case management program, please contact our Provider call center.

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 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 713.295.2295 for Medicaid/STAR; 713.295.6704 for Marketplace; or 713.295.5007 for HMO D-SNP.
    - Faxing referral information to our dedicated behavioral health fax line at 713.576.0933.

Physical Health

Genetic Testing

Community is committed to working with you to support improved health outcomes, positive care experiences, and affordability of healthcare services for our Members. By working together, we can provide access to medically necessary genetic and molecular lab testing that can support medical decision-making and essential therapeutic interventions.

Please be aware that all genetic and molecular lab testing requires prior authorization with the exception of the following:

- Karyotype/chromosomes and/or FISH when ordered by a Maternal Fetal Medicine specialist
- Cystic Fibrosis screening (not full sequencing)

Ordering care Provider should complete and submit prior authorization requests for ALL genetic and molecular lab testing requiring authorization. This will avoid any potential delays in care and claims payment for both your practice and laboratories.

To process authorization requests efficiently and in a timely manner, please submit requests to Community via the Provider Portal. Alternatively, requests can be sent via fax at 713-295-2283 (STAR/CHIP) or 713-295-7019 (Marketplace). Include supporting documentation, clinical notes, etc., to avoid any delays.

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 three 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 four 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

Authorizations: Reminders

Provider requesting to update an authorization prior to the submission of a claim

Information needed:

1. Confirm Member name and Member ID
2. Confirm requesting and treating Provider/facility information and contact information
3. Approved authorization/episode that needs to be updated
4. Code(s)/services to be updated on the authorization, including start and end date
5. Number of services (units/visits) to be added to the existing approved authorization

Provider requesting to add services that have already been performed to an already approved authorization on file and have not filed on a claim yet

- Request a new authorization for the additional services as a retrospective review request for the additional services to Appeals/Retro team prior to billing the claim.
- Fax completed TSPA request form to 713-295-7033.

Provider requesting to extend a previously approved authorization.

- The request to extend the authorization should be submitted one week prior to the current authorization expiring.
- If the services have been rendered, they will need to submit a retrospective request.
- If the services have not been rendered, it will be a new request to submit to the prior authorization team.
- If the authorization has already expired and the services have been rendered, submit a request for a retrospective authorization.

The Medical Affairs appeals team processes claim appeals for contracted Providers for claims that have been denied for the following reasons:

1. Prior authorization required
2. Service not a benefit
3. Benefit exceeds services authorized (reviewed for medical necessity)
4. Benefit exceeds plan services (reviewed for medical necessity)
5. Not covered by benefit (reviewed for medical necessity)

Always include supporting documentation and clinical notes to support your request for authorization to avoid delays or denial of service.

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.

HEDIS™ Quick Reference Guide

Community strives to provide quality health care to our Members as measured through HEDIS™ quality metrics. We created a HEDIS™ Quick Reference Guide to help you increase your practice's HEDIS™ rates. You may access the Quick Reference Guide via the Provider Portal at https://provider.communityhealthchoice.org/ >Provider Tools>Forms and Reference Guides.

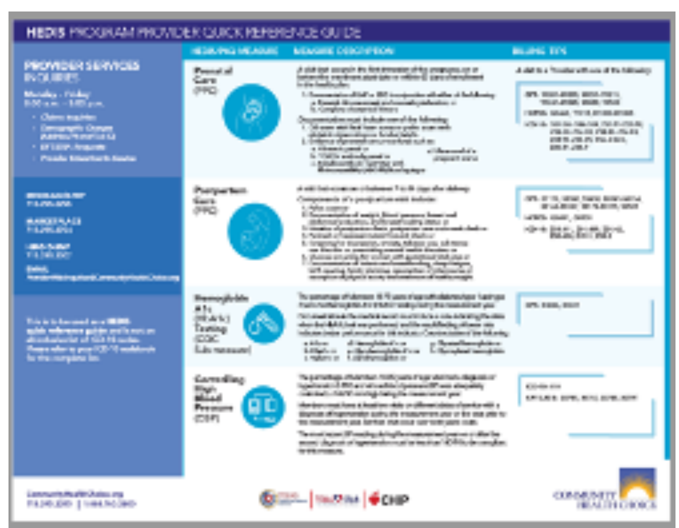
Please always follow state and/or CMS billing guidance and ensure the HEDIS™ codes are covered prior to submission.

How Can You Improve your HEDIS™ Scores?

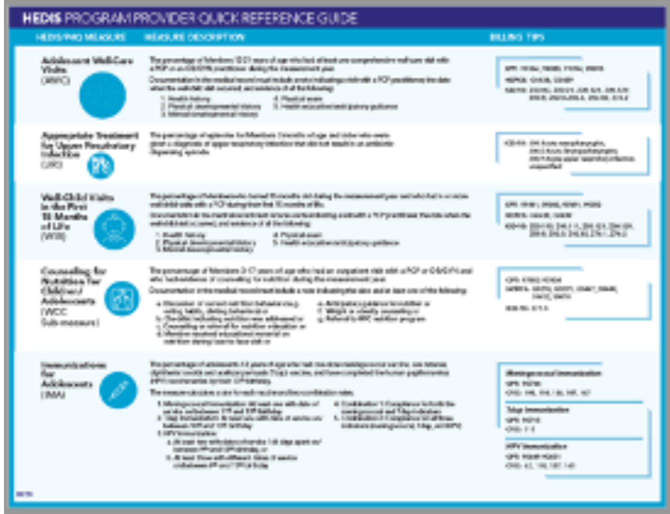
- Submit a claim for each and every service rendered
- Make sure chart documentation reflects all services billed
- Bill for all delivered services
- Ensure that all claims are submitted in an accurate and timely manner
- Consider including CPT II codes to provide additional details and reduce medical record requests

Suggestions to Increase Member Adherence:

- Send postcard and/or text reminders to Members to reinforce the importance of annual well visits.
- Schedule follow-up appointments with patients before they leave the office.
- Consider creating a Member registry identifying Members prescribed high risk medications to monitor compliance. (ex ADHD, psychotropics)
- Evaluate current processes related to outside referrals for lab and specialty appointments to ensure referrals are completed and results received and documented.



HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE



HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE

Early Childhood Intervention (ECI)

Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services for families with children birth up to age three, with developmental delays, disabilities or certain medical diagnosis 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 a delay is suspected in the child's development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals. To refer families for services, providers should use the recently updated ECI referral form available on the Texas Health and Human Services website at https://hhs.texas.gov/services/disability/early-childhood-intervention-services/how-make-a-referral-eci.

For additional ECI information, providers can visit the HHS ECI website at:
https://hhs.texas.gov/services/disability/early-childhood-intervention-services

Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW) is a state Medicaid benefit that provides health-related case management services to children birth through 20 years of age with a health condition and to high-risk pregnant women of any age. Case managers help clients gain access to needed medical, social, educational, and other services. This program is separate from services offered by Community.

Provider can make a Referral to Case Management by calling 1-877-847-8377.

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.

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:

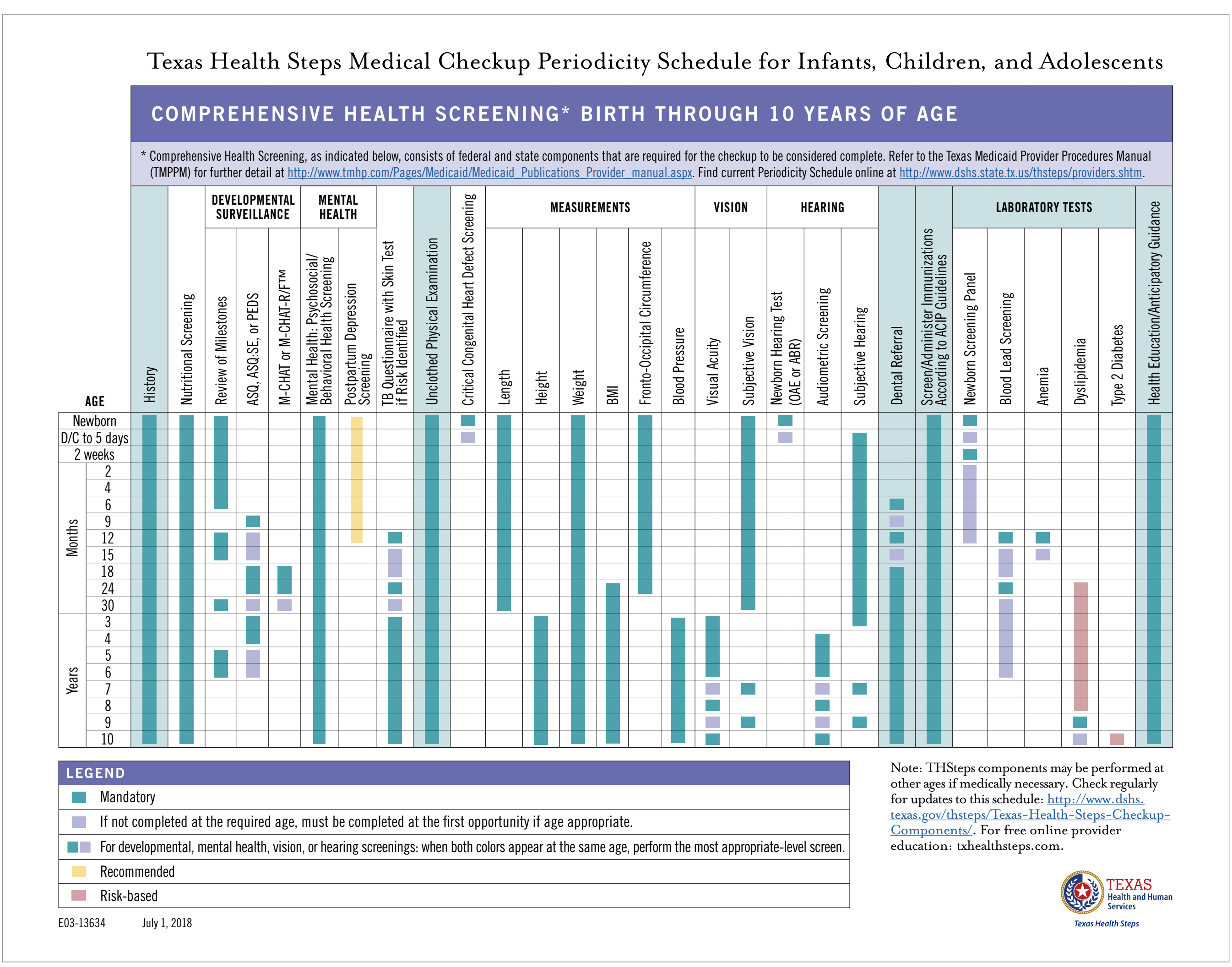
The Membership Panel is available on our online Provider Portal titled "Panel Report (Medicaid/CHIP)" at https://Providerportal.CommunityHealthChoice.org/Providers/Secure/Panel_Report.aspx.

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 Medical Checkup Periodicity Schedule

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



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.

(M = Mandatory; C = If not completed at the required age, must be completed at the first opportunity if age appropriate; R = Recommended; RB = Risk-based)

AGE	History	Nutritional Screening	Developmental Surveillance: Review of Milestones	Developmental Surveillance: ASQ, ASQ:SE, or PEDS	Developmental Surveillance: M-CHAT or M-CHAT-R/F™	Mental Health: Mental Health: Psychosocial/ Behavioral Health Screening	Mental Health: Postpartum Depression Screening	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	Critical Congenital Heart Defect Screening	Measurements: Length	Measurements: Height	Measurements: Weight	Measurements: BMI	Measurements: Fronto-Occipital Circumference	Measurements: Blood Pressure	Vision: Visual Acuity	Vision: Subjective Vision	Hearing: Newborn Hearing Test (OAE or ABR)	Hearing: Audiometric Screening	Hearing: Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	Laboratory Tests: Newborn Screening Panel	Laboratory Tests: Blood Lead Screening	Laboratory Tests: Anemia	Laboratory Tests: Dyslipidemia	Laboratory Tests: Type 2 Diabetes	Health Education/Anticipatory Guidance
Newborn	M	M	M			M	R		M	M	M		M		M			M	M				M	M					M
D/C to 5 days	M	M	M			M	R		M	C	M		M		M			M	C		M		M	C					M
2 weeks	M	M	M			M	R		M		M		M		M			M			M		M	M					M
Months 2	M	M	M			M	R		M		M		M		M			M			M		M	C					M
4	M	M	M			M	R		M		M		M		M			M			M		M	C					M
6	M	M	M			M	R		M		M		M		M			M			M	M	M	C					M
9	M	M		M		M	R		M		M		M		M			M			M	C	M	C					M
12	M	M	M	C		M	R	M	M		M		M		M			M			M	M	M	C	M	M			M
15	M	M	M	C		M		C	M		M		M		M			M			M	C	M		C	C			M
18	M	M		M	M	M		C	M		M		M		M			M			M	M	M		C				M
24	M	M		M	M	M		M	M		M		M	M	M			M			M	M	M		M		RB		M
30	M	M	M	C	C	M		C	M		M		M	M				M			M	M	M		C		RB		M
Years 3	M	M		M		M		M	M			M	M	M		M	M				M	M	M		C		RB		M
4	M	M		M		M		M	M			M	M	M		M	M			M		M	M		C		RB		M
5	M	M	M	C		M		M	M			M	M	M		M	M			M		M	M		C		RB		M
6	M	M	M	C		M		M	M			M	M	M		M	M			M		M	M		C		RB		M
7	M	M				M		M	M			M	M	M		M	C	M		C	M	M	M				RB		M
8	M	M				M		M	M			M	M	M		M	M			M		M	M				RB		M
9	M	M				M		M	M			M	M	M		M	C	M		C	M	M	M				M		M
10	M	M				M		M	M			M	M	M		M	M			M		M	M				C	RB	M

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

E03-13634 July 1, 2018

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

The periodicity schedule can be downloaded via https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers

Billing THSteps Medical Checkup and Other Services on the Same Day

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

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

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

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

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

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

A sports and school physical is a value-added service for Community 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 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 New Sports and School Physical Procedure Codes article.

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.

Exception-to-Periodicity Checkups

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

- Medically necessary. For example:
  - Member with developmental delay, suspected abuse or other medical concerns or
  - Member in a high-risk environment, such as living with a sibling with elevated blood lead level of 5 mcg/dL or greater
- Required to meet state or federal checkup requirements for Head Start, day care, foster care or pre-adoption
- Provide an accelerated checkup to the Member's birthday. For example, a 4-year checkup could be performed prior to the Member's 4th birthday if the Member is a member of a migrant family that is leaving the area. Use modifier 32 when billing for this type of checkup.
- When needed before a dental procedure requiring general anesthesia

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

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

Modifiers indicate the reason for the exception to periodicity checkup:

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

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

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

Medical Transportation Program (MTP) for Medicaid

Health and Human Services offers non-emergency transportation at no cost for THSteps patients and most others who are eligible for Medicaid medical and dental services.

What Kind of Rides Are 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

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).
- 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 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.

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 Dec 31st of each calendar year. If you have any questions, please contact your Provider Engagement Representative.

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/.

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

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

Medicare
Fax: 713.295.7059 (Prior Authorizations)
Fax: 713.295.2284 (Notification of Admissions)
Fax: 713.295.7030 (Clinical Submission)
Fax: 713.295.7030 (Complex Care & Discharge Planning)

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)

Medicare
Fax: 713.576.0932 (Inpatient Prior Authorizations)
Fax: 713.576.0930 (Outpatient Prior Authorizations)

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 | 1.866.333.2757 (Medicare)
www.navitus.com

VISION SERVICES

Medicare
Evolve Vision
Toll-free: 1.800.531.2818 | www.visionbenefits.envolvehealth.com

Dental Services

Medicare
FCL Dental
Toll-free Member Services: 1.866.844.4251
Toll-free Provider Services: 1.877.493.6282
www.fcldental.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.

Medicare
Phone: 713.295.5007 or toll-free 1.833.276.8306
https://provider.communityhealthchoice.org/medicare
ProviderWebInquiries@CommunityHealthChoice.org