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Provider Newsletter

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CommunityHealthChoice.org

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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.

Welcome, Lisa Wright

Community Health Choice (Community) is excited to announce the appointment of Lisa Wright as our next President and Chief Executive Officer. Ms. Wright's tenure began on May 5, 2020, and she acknowledges the extreme circumstances under which she joins Community. She comes to Community from WellCare as North Region President, Medicare, for seven states where she directed and led the execution of business strategies and operational plans. Prior to WellCare, Ms. Wright held several positions at United Healthcare, most recently leading the Dual Special Needs Plan (DSNP), Medicare-Medicaid Plan (MMP), and Nursing Facilities (NF) lines of business in Texas. Before working at United Healthcare, Ms. Wright worked for Anthem Blue Cross Blue Shield in the Medicaid division. She holds a Bachelor of Arts in Communications from the University of Kentucky and a Masters of Business Administration from the University of Maryland, University College.

> "It is a privilege to join an organization, especially during these unprecedented times when each of us are maneuvering and balancing this new normal that now defines us." – Lisa Wright

Both Ms. Wright and Community's Board of Directors acknowledge and thank Catherine Mitchell for the incredible job she did as both interim CEO and COO during this last year.

> "I want to thank Catherine Mitchell for her enormous contribution as interim president," says Ms. Wright. "She has led Community through an extremely difficult period, and I would like to personally express my sincere appreciation and gratitude for all she achieved for both the organization and this team."

Coronavirus (COVID-19)

Community continues to monitor 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.

In addition to the information included in this edition of the Provider Newsletter, please visit our website, where you will find a page dedicated to COVID-19 with the most current information, updates, and resources: https://Provider.communityhealthchoice.org/coronavirus/.

Be Aware of Smishing!

Please be aware of a new Coronavirus cyber scam via text messages!

Smishing is a new coronavirus scam related to contact tracing. Contact tracing is an important piece in the fight against coronavirus. Contact tracing is when public health officials call people who have tested positive for coronavirus and find out where they have been, so they can warn others who may have been in the same area. These health officials may first send a text letting you know to expect a call.

According to the Federal Trade Commission (FTC), however, while public health officials may send a text message prior to a phone call, they will never include a link.

Do not click any links in a contact tracing text message!

The malicious links immediately download malware onto your device or take you to a phishing website asking for personal data or a password. The image to the right from the FTC illustrates a malicious text.

Additionally, if you get a call from a contact tracer, they will never ask you for money or your Social Security number, bank account information or credit card number.

Other ways to protect yourself:

- Implement two-factor authentication on all your accounts (especially email and banking accounts)
- Enable auto updates on critical software like operating systems
- Backup your data regularly

Prior Authorization Automated Solution

During the fourth quarter of 2020, Community will make available 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.

Once available, you can visit our Provider Portal at https://provider.communityhealthchoice.org/ to access the Authorization Request Training Guide.

If you have any questions, please contact your Provider Engagement Representative or contact Provider Services at 713.295.2295 (Medicaid/CHIP), 713.295.6704 (Marketplace) or 713.295.5007 (Medicare) should you have any questions.

Recertification Extensions for STAR and CHIP Members

Due to COVID-19, Medicaid (STAR) and CHIP coverage has been extended until further notice.

For STAR recertification periods ending in:

- March, April, May, June, July, and August 2020, coverage has been extended until further notice.

For CHIP certification periods ending in:

- April 2020, coverage has been extended until July 2020
- May 2020, coverage has been extended until August 2020

HHSC will reach out directly to Members informing them of recertification requirements as needed. No action is necessary from the Member or the Provider as the benefits will be automatically extended for the majority of our Members. Benefits are automatically extended for a majority of Members.

Note: There are still cases where Members have termed, so it is important to verify eligibility prior to rendering services.

Urgent Care

In an effort to better serve our Members, we identified several Members that accessed emergency room services for potentially preventable ED visits and provided a personalized list of participating urgent care facilities within a 10-minute drive from their home. We also continue to communicate with PCPs on the use of our PCP Tool Kit for behavioral health conditions that may be treated in the PCP care setting.

We hope to accomplish the following with these campaigns:

- Educate Members on the appropriate care setting based on their condition
- Provide local urgent care facilities within the Member's community
- Promote our 24-hour Nurse Help Line at 1.888.332.273
- Identify community-based initiatives to collaborate with our urgent care facilities
- Educate our Providers on the use of our PCP Tool Kit

To access the most current urgent care facilities or PCP Tool Kit, please visit our website at www.communityhealthchoice.org or contact your Provider Engagement Representative.

Maternity Services: Claim Requirement Effective August 1, 2020

Numerous nationally recognized metrics exist for measuring the quality of obstetrical services, i.e., 1) timeliness of prenatal care, 2) preterm birth rates, 3) primary C-section rates, and 4) postpartum care. In most cases, it is relatively easy to measure physician performance for each of these metrics – with the exception of the metric related to postpartum visits.

While the Texas Medicaid Provider Procedures Manual (TMPPM) and existing Community Health Choice (Community) Provider agreements allow physicians to bill for the delivery and postpartum visit using a single CPT code (59410, 59515, 59614, or 59622), this practice restricts Community's ability to determine an actual postpartum visit.

Additionally, when more than one Provider is involved in the care of a Member, Community may receive a claim for the single CPT code indicating delivery and postpartum care from one Provider and a separate claim for postpartum visit(s) from a different Provider for the same Member, complicating claims payment.

Effective August 1, 2020, Community will not accept the following billing codes for maternity services: 59410, 59515, 59614, and 59622. Providers must bill with the appropriate prenatal, delivery, and postpartum visit codes for our STAR, CHIP, and CHIP Perinatal Members.

For additional information specific to CPT codes and billing for maternity services, please review the TMPPM.

REMINDER: CHIP PERINATAL

CHIP Perinatal (CHIP P) covers prenatal care, labor with delivery, and two postpartum visits within 60 days after delivery or end of pregnancy. Because a mother's CHIP P enrollment ends at the end of the month in which the pregnancy ended, she may still receive those covered postpartum visits after her enrollment period ends. For example, if a CHIP P-enrolled mother delivered her baby on February 15, her enrollment ends on February 28. However, she may receive covered postpartum visits until April 15.

Should you have additional questions, please contact your Provider Engagement Representative or call the Provider Services line at 713.295.2295.

Don’t Let This Happen to You: Top Billing Errors

To ensure that we adjudicate claims correctly and accurately, please avoid these common billing errors. These are the top reasons that cause denials or delays in payment.

Who	What	Causes of denials or delays	Do
All Providers	Rendering Provider	• Claim does not include rendering Provider’s NPI • Billing NPI is not the Group NPI • Provider is not enrolled with the Medicaid program	Include the rendering Provider’s NPI.
	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 • 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	Add modifier 25 to an E/M service when level of service can be supported as significant, separately identifiable. All procedures have “inherent” E/M service included.
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
Therapy Providers	Modifiers	• Submitting claims without the proper modifier or no modifier at all. • Modifiers GP, GO, and GN are required on all claims except when billing evaluation and re-evaluation procedure codes. • The AT modifier must be included on claims for acute therapy services.	Include the appropriate modifier.

Balance Billing

STAR and CHIP

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).

Marketplace

Marketplace Members are responsible for out-of-pocket expense or cost-sharing amounts, such as copayments, coinsurance or deductibles for Covered in the Services identified Member's Benefit Plan/Program. Reimbursement is considered as payment in full for those services and balance billing is prohibited.

Medicare D-SNP

Medicare D-SNP Members are responsible for out-of-pocket expense or cost-sharing amounts, such as copayments, coinsurance or deductibles for Covered in the Services identified Member's Benefit Plan/Program. Reimbursement is considered as payment in full for those services, and balance billing is prohibited.

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 published in the 2019 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 the 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.

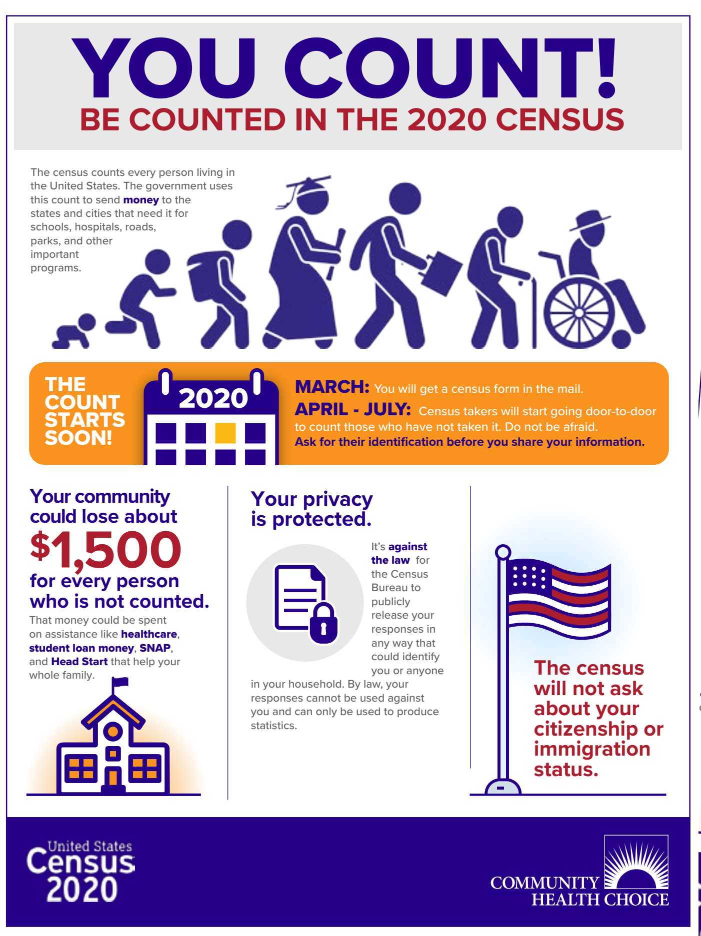
1. **NCCI PTP edits** prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a Provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for 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.

Census 2020

The 2020 Census count started 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.



Special Investigations Unit

The Special Investigations Unit (SIU) department at Community welcomes our new director, Andrea Lopez! Andrea recently joined Community from another MCO, where she was the director of SIU and managed a team of 70 associates.

SIU is designed to detect, prevent, and correct potential fraud, waste or abuse to safeguard against improper payments. Audits are routinely conducted via medical record review for appropriate coding and documentation of services billed to ensure claim payments to Providers are accurate.

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, Ste. 125
  Houston, TX 77054
  1.877.888.0002

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
  Special Investigations Unit
  2636 S Loop West, Ste. 125
  Houston, TX 77054

Don’t Let This Happen to You: Medical Record Documentation Errors

Community routinely conducts audits and reviews via medical records for appropriate coding and documentation of services billed to ensure claim payments to Providers are accurate. To avoid issues including but not limited to requests for refunds from Community or regulatory agencies, please follow the principles of documentation listed below which are applicable to all types of medical and surgical services in all settings:

- The medical record must be complete and legible.
- 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.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses along with allowed conditions should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- 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.

Behavioral Health

Managing Mental Health During COVID-19

During a crisis such as the COVID-19 pandemic, it is common for everyone to experience increased levels of distress and anxiety, particularly as a result of social isolation. Physicians and other frontline healthcare professionals are particularly vulnerable to negative mental health effects as they strive to balance the duty of caring for patients with concerns about their own well-being and that of their family and friends. *Please note that this information is not intended and should not be construed to be legal, financial, medical or consulting advice. Physicians and other qualified healthcare Providers should exercise their professional judgement in connection with the provision of services and should seek legal advice regarding any legal questions.*

Take Care of Yourself

- Feel free to feel your feelings – You and your colleagues are likely to feel immense pressure given the potential surge in care demands and risks of infection and equipment shortages, among other stressors. Experiencing stress and the feelings associated with it are by no means a sign of weakness or a reflection on your ability to do your job.[1]
- Intentionally employ coping strategies – Put into practice strategies that have worked for you in the past during times of stress. These can include getting enough rest and finding respite time during work or between shifts, eating meals (ideally, healthy food, on a schedule), engaging in physical activity, and staying in contact (with appropriate social distancing) with family and friends.[2]
- Perform regular check-ins with yourself – Monitor yourself for symptoms of depression/stress disorder such as prolonged sadness, difficulty sleeping, intrusive memories and/or feelings of hopelessness. Talk to a trusted colleague or supervisor. Be open to seeking professional help if symptoms persist or worsen over time.[3]
- Take breaks from the news and social media – Make a regular habit of stepping away from your computer and smart phone from time to time. When returning online, focus on information from reputable sources, not just sources in your social media feed.[4] You don't have to take in everything produced by a 24/7 news cycle.
- Be fortified by remembering the importance and meaning of your work – Remind yourself that despite the current challenges and frustrations, yours is a noble calling – taking care of those in need in a time of great uncertainty. Make sure to take time to recognize the efforts and sacrifices made by your colleagues.[5]

Take care of your staff

- Adjust staffing procedures and schedules (where possible) – When able and within applicable legal limits, rotate workers from higher-stress to lower-stress functions. Partner inexperienced workers with more experienced colleagues who can provide support, monitor stress, and reinforce safety practices. Implement flexible schedules for workers who are directly impacted or have a family member impacted by the outbreak.[6]
- Offer access to psychosocial support – Provide staff responding to the outbreak with access to sources of psychosocial support, making this as much of a priority as ensuring their physical safety.[7]
- Monitor and review staff member well-being – Regularly and supportively monitor wellbeing and psychosocial status of staff to identify risks and emerging issues and adaptively respond to their needs.[8]
- Create an environment of open communication – Encourage staff to speak openly about their concerns. Provide brief, regular forums to update staff on the status of the practice and how management is addressing challenges. Provide mechanisms for staff to express their concerns, ask questions, and encourage peer-support amongst colleagues.[9] For individual concerns related to one's mental health and well-being, encourage communication with trusted colleagues in addition to accessing your employee assistance program.

Behavioral Health

Take care of your patients

- Establish a system to identify and provide care for mental health conditions – Ideally, every healthcare practice already has or can put in place a system (along with at least one staff member trained) to identify and provide care for patients with common and severe mental health conditions during this time.[10] This is particularly important since the stigma associated with mental health may cause patients to be reluctant in seeking support for both COVID-19 and any mental health condition(s).[11] Also, previously stable individuals may become less stable. Employ telemedicine to deliver care where possible, particularly given the recent relaxation of requirements by CMS and SAMHSA, among others.[12] Reach out to your state medical association/society for more detailed information and resources on licensure, coverage, and payment policies.
- Facilitate additional training for frontline staff – As time and resources permit, frontline workers should have training on basic psychosocial care principles and psychological first aid. Online training may be used if it is not possible to train staff in person due to remote or distributed work, limited time and/or concern about the risk of infection.[13]
- Verify referral pathways – Confirm the status of established referral pathways for patients with mental health conditions and that all staff responding to the outbreak are aware of and use such system(s) if/when needed.[14] If no such pathways exist, reach out to local organizations such as state departments of health and medical societies for guidance and recommendations for resources.
- Provide clear understandable communication to patients – Use “plain English” in messages with patients, particularly those with intellectual, cognitive, and psychosocial disabilities and employ approaches to communication that do not rely solely on written information where possible.[15]
- Incorporate guidance about stress into general care practices – Emotional distress and anxiety are common during pandemics such as the COVID-19 outbreak. It is important to help patients acknowledge that stress exists and help normalize it. Basic strategies can be used to teach them how to recognize signs of distress (such as worry, fear, insomnia, etc.) and when discussing ways to reduce them (e.g., healthy diet, exercise, talking to loved ones, meditation, etc.).[16] Additional forms of treatment, such as cognitive behavioral therapy, can also be effective.[17]

Resources

[1, 2, 15] World Health Organization; Center for the Study of Traumatic Stress

[3, 4, 5, 16] Center for the Study of Traumatic Stress

[6] World Health Organization

[7, 8, 9, 10, 13, 14] Inter-Agency Standing Committee Reference Group for Mental Health and Psychological Support in Emergency Settings

[11] World Health Organization

[12] Centers for Medicare & Medicaid Services; Substance Abuse and Mental Health Services Administration

[17] American Psychological Association

Reporting Child Abuse and/or Neglect and Required Documented Provider Training Protocols

Due to the current events surrounding the COVID-19 pandemic, there has been a decrease of reporting child abuse. Child abuse advocates fear that children are not attending daycare or schools lack professionals to monitor and report child abuse cases. In March 2020, there were 4% less child abuse reports compared to 2019. According to the American Psychological Association (APA), many families are financially strained, and their childcare support system may not be available, contributing to increased stress and abuse risk factors. There are also less caseworkers conducting home visits at this time. The Centers of Disease Control (CDC) reports 1 in 7 children have experienced child abuse and/or neglect in the past year, and in 2018, 1,770 children died of abuse and neglect. In 2011, Child Protective Services (CPS) reported 65,948 cases of abuse in Texas that include physical, sexual, emotional, trafficking, and neglect.

It is imperative that Providers continue to remain diligent to monitor and report child abuse and suspected child abuse as required by law. If the child is in imminent danger, call 9-1-1 to report immediately the abuse and be sure also to file a report with Texas Department of Family and Protective Services (DFPS) at 1.800.252.5400 24 hours a day. If you suspect a child is being abused, by law, the report must be completed within 48 hours by contacting DFPS. Be sure to document your call ID number to ensure you have a record of reported suspected abuse. Failure to report suspected child abuse or neglect is a misdemeanor punishable by imprisonment of 180 days and/or a fine of up to $2,000 [Texas Family Code Section 261.101 (a)]. Also, if a child under 14 is diagnosed with a sexually transmitted infection (STI) or found to be pregnant, the Provider is required to report as child abuse.

Documented Provider training is also mandated for all Medicaid Providers and must be included in office policies and procedures for all new and current staff members. The training must also outline who and when to report abuse or suspected child abuse. DFPS also provides an online training resource on their website. As a reminder, be sure to include the required elements in the training module, which is located on the checklist for HHSC reporting that is included below. Providers may also complete a THSteps visit outside the periodicity schedule when child abuse is suspected and must include modifier SC on the claim.

If you are aware of someone who needs mental health services or COVID-19 mental health resources, you may call our Behavioral Health Crisis Line provided by the Harris Center at 1.877.343.3108, 24 hours a day, 7 days a week or the HHS COVID-19 Mental Health Support Line at 1.833.986.1919, respectively.

References:

- https://www2.texasattorneygeneral.gov/files/vs/suspectchildabuse.pdf
- https://americanspcc.org/child-abuse-statistics/
- https://www.houstonchronicle.com/news/houston-texas/houston/article/Child-abuse-reports-down-in-Texas-since-COVID-19-15241353.php
- http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2020/Jun_2020%20TMPPM.pdf (1.7 Provider Responsibilities)
- https://www.apa.org/topics/covid-19/domestic-violence-child-abuse
- https://www.dfps.state.tx.us/Training/Reporting/recognizing.asp
- https://statutes.capitol.texas.gov/Docs/FA/htm/FA.261.htm
- https://Provider.communityhealthchoice.org/medicaidchip/resources/forms-and-reference-guides/
- https://www.dshs.state.tx.us/coronavirus/mental-health.aspx
- https://hhs.texas.gov/sites/default/files/documents/services/mental-health-substance-use/covid-19-mental-health-support-line.pdf

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 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 the 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

Organization	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

Anxiety and Depression: What You Can Do!

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

Community has developed a comprehensive PCP Toolkit for primary care Providers to assist in identifying behavioral health conditions through well-known screening tools and 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:
    - o Calling Provider Services at 713.295.2295 for Medicaid/STAR; 713.295.6704 for Marketplace; or 713.295.5007 for HMO D-SNP.
    - o Faxing referral information to our dedicated behavioral health fax line at 713.576.0933.

Physical Health

Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with CO

The Centers for Disease Control and Prevention (CDC) issued a Health Advisory on May 14, 2020, informing healthcare Providers of a Multisystem Inflammatory Syndrome in Children (MIS-C) associated with COVID-19 infection. The Health Advisory and additional information provided by the CDC provide a case definition for this syndrome and a recommendation for healthcare Providers to report patients meeting the case definition to local, state, and territorial health departments to enhance knowledge of risk factors, pathogenesis, clinical course, and treatment of this syndrome.

Case Definition for Multisystem Inflammatory Syndrome in Children (MIS-C):

- An individual aged <21 years presenting with fever, laboratory evidence of inflammation, and evidence of clinically severe illness requiring hospitalization, with multisystem (>2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological); AND
- No alternative plausible diagnoses; AND
- Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology or antigen test; or COVID-19 exposure within the 4 weeks prior to the onset of symptoms

Additional information is available on the Health Advisory and the CDC pages, as well as the CDC's 24-hour Emergency Operations Center:

- https://emergency.cdc.gov/han/2020/han00432.asp
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html#anchor_1589580133375
- CDC's 24-hour Emergency Operations Center at 1.770.488.7100.
- After-hour phone numbers for health departments are available at the Council of State and Territorial Epidemiologists website at https://resources.cste.org/epiafterhours.

Wellness Services During COVID-19

The American Academy of Pediatrics (AAP) issued a statement on the importance of prioritization of well care services, including childhood Immunizations, and provided guidance on telehealth for pediatric well care. Recommendations include:

- Prioritize well child visits
- Provide care that is consistent with Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents (4th Edition), and Bright Futures/AAP Recommendations for Preventive Pediatric Health Care
- In-person visits for newborn to 24 months are strongly suggested
- Telemedicine services for pediatric patients over 24 months and then complete missed elements (comprehensive physical exam, laboratory testing, immunizations, etc.) when an in-person visit is possible

Visit the following websites for additional information and resources:

- AAP Guidance on Providing Pediatric Well-Care During COVID-19
- AAP Pediatric Practice Management Tips During the COVID-19 Pandemic
- CDC Information for Pediatric Healthcare Providers

Resources for Neonatal Abstinence Syndrome Awareness

June is Neonatal Abstinence Syndrome (NAS) Awareness Month in Texas. In recognition of NAS Awareness Month, HHSC hosted several NAS-related events on Zoom featuring CE credit. If you were unable to make it on the date and time, NAS recorded the presentations for later viewing.

- NAS Symposium website: https://wp.uthscsa.edu/nas-symposium/
- Where to register for and access each course: https://ce.uthscsa.edu/browse/nursing

Telemedicine in Chronic Disease Management

Chronic disease management continues to be a major concern for healthcare Providers and their patients. A chronic disease is one that lasts three months or longer, such as cancer, type 2 diabetes, and chronic heart disease. Telemedicine, including what is known as remote patient monitoring, can reduce the cost of chronic disease management. Doctors and specialists can use live video and audio, mobile devices, and other smart digital tools to manage a patient's condition from a distance, reducing the need for in-person consultations.

Telemedicine can help with increasing access to specialized care, monitoring patient lifestyle changes, triaging new symptoms in real-time, and reducing hospital readmissions.

- **Increase Access to Specialized Care**

  With around 57 million Americans living in a rural area, many patients across the country lack access to care facilities. They may have to drive long distances to see their primary care Provider or a specialist, which tend to be in short supply in rural areas. Patients with a chronic condition tend to have more trouble traveling long distances to see a care Provider. They may suffer from a lack of mobility or have trouble sitting still for long periods of time. Patients with chronic diseases also tend to rely on specialized care when treating their symptoms, which can be hard to find in certain parts of the country, making it that much harder for them to see their care Provider on a regular basis.

  Telemedicine allows patients to communicate with care Providers, including specialists, from the comfort of their own home. This increases the patient's access to specialized care, while reducing the cost of care by lowering or even eliminating travel expenses. Some patients will see their condition get worse if they fail to see their care Provider on a regular basis, but telemedicine can make it easier for patients to get the care they need.

- **Monitor Patient Lifestyle Changes**

  In addition to medication and other forms of treatment, patients living with chronic conditions may have to change their lifestyle if they want their condition to improve. This may include changes in diet, quitting smoking, and getting more exercise. When left to their own devices, however, some patients may have trouble following through on these kinds of treatment regimens, which means their condition will only worsen.

  Care Providers who can remotely monitor a patient's condition will know whether the patient is following the treatment guidelines. Doctors can use mobile devices and live video and audio to quickly remind patients to take their medication, eat healthy or find ways to stay active, improving the patient's chances of recovery.

- **Triage New Symptoms in Real Time**

  Patients with chronic diseases may see a new symptom pop up from time to time. This may be a minor concern, a sign their condition is deteriorating or the start of a new chronic condition. Some patients may decline to consult with their care Provider about this new symptom until their health takes a turn for the worse, especially if they have to travel long distances for an in-person consultation.

  Telemedicine can help patients quickly consult with their care Provider about the new symptom as it appears in real time. The doctor will then either recommend a change in treatment or urge them to visit a local emergency room if the condition is serious. This ensures the patient will receive the care they need on a timely basis as opposed to ignoring the symptom all together.

- **Reduce Hospital Readmissions**

  Patients with chronic diseases account for 81% of all hospital admissions, which tend to be one of the most expensive aspects of care. Doctors and specialists who can remotely monitor a patient's condition can help the patient manage their treatment regime, reducing their chances of being readmitted to the hospital. This reduces the cost of care for both patients and care Providers. Doctors can use telemedicine to make sure patients are keeping up with certain lifestyle changes, answer questions about medication, and triage new symptoms quickly to reduce hospital readmission rates.

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.

Postpartum Care

In order to optimize the health of our 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 is 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

Don't Let This Happen to You: Denials or Processing Delays of Authorization Requests

It is important that Providers submit all necessary information to avoid authorization denials or processing delays. Here are a few reminders to help avoid issues.

1. **Provider requesting to update an authorization prior to initiating services**
    - If a discrepancy is noted on the approval form, call the Provider Hotline to have the authorization updated with the correct information. Please be prepared to discuss the nature of the discrepancy and what needs to be corrected.
2. **Provider requesting to add services that have already been performed to an already approved authorization on file**
    - Request for additional services should always be authorized prior to rendering services.
    - If an unforeseen and/or urgent need require additional services to be rendered without an authorization, fax completed TSPA form to 713.295.7033. The form should indicate the unforeseen and/or urgent reason as to why an authorization was not obtained prior to performing services. Submission of a request to have services added to an authorization does not guarantee they will be added to an already approved authorization.
    - Failure to obtain prior authorization may impact claims payment.
3. **Provider requesting to extend a previously approved authorization**
    - Outpatient requests: The request to extend the authorization should be submitted one week prior to the current authorization expiring with justification as to why the authorization timeframe needs to be extended. A request to extend a previously approved authorization, does not constitute medical necessity or guarantee an authorization will be extended.
    - Inpatient concurrent requests: The request for additional days should be requested with supporting clinical information prior to member's discharge from a facility.
    - If the services have been rendered, a claim will need to be submitted for payment of services rendered
    - If the authorization has already expired and the services have been rendered, a claim will need to be submitted for payment of services rendered
4. **Provider requesting authorization for genetic testing**
    - Prior authorization must be obtained by the Ordering or Referring Provider before Rendering Provider performs initial lab services.
    - Ordering or Referring Provider should submit the TSPA form for prior authorization of requested laboratory services with sufficient clinical information to support the request for a medical necessity authorization. To ensure proper processing of the authorization, the TSPA form should be submitted prior to or the same day the lab services are being initiated. If the request is approved, the approval notification will be sent to the Ordering/Referring and the Rendering Provider.
    - Ordering Provider and Rendering Providers should coordinate to ensure the prior authorization has been obtained prior to rendering any laboratory services as well as the submission of claim for services.
    - Ordering Provider should **not** refer Member or send lab specimen to contracted/non-contracted independent laboratory (Rendering or Servicing Provider) without prior authorization from Community.
    - If services have been rendered by the independent laboratory without a prior authorization, then a claim will need to be submitted for payment for laboratory services.
    - Failure to obtain prior authorization may impact claims payment.

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

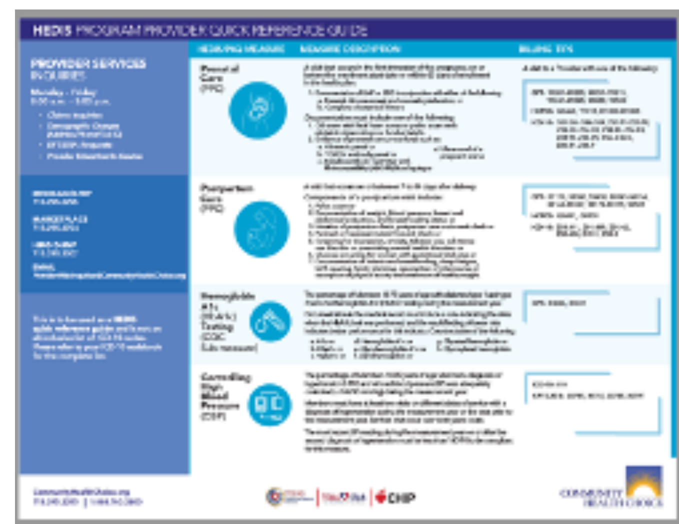
Next steps

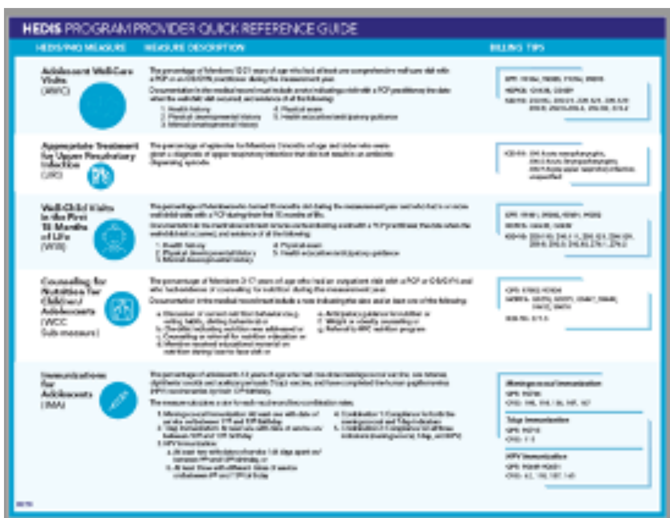
- Update your profile in Council for Affordable Quality Healthcare, Inc. (CAQH) at https://proview.caqh.org/.
- You can provide a written request for updates to ProviderRelationsInquiries@CommunityHealthChoice.org or via fax to 713.295.7039.

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.


HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE


HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE

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.

REMINDER: THSteps Medical Checkups via Remote Delivery during Implementation of COVID-19 Restrictions

To allow for continued provision of THSteps checkups during the period of social distancing due to COVID-19, HHSC is allowing remote delivery of certain components of medical checkups for children over 24 months of age (i.e. starting after the "24-month" checkup).

Since some of these requirements (like immunizations and physical exams) require an in-person visit, Providers must follow-up with their patients to ensure completion of any components within six months of the telemedicine visit.

When the patient is brought into the office within the six-month time frame to complete the outstanding components of the visit, Providers should bill the THSteps follow-up visit code (99211). Reimbursement will be identical to current rates for THSteps checkup codes. Providers must document the reason the checkup was not able to be completed. Acceptable reasons for which the six-month time frame might not be met include, but are not limited to, the following:

- Child moves (from one service delivery area into another)
- Child switches primary care Providers
- Child changes product service lines (e.g. from STAR to STAR Kids)
- Child switches MCOs
- Child moves out of state
- Child dies
- Child loses eligibility
- It is still not safe in six months to conduct an in-person visit

Providers may also bill an acute care E/M code at the time of the initial telemedicine checkup or at the "six-month" follow-up visit. Modifier 25 must be submitted with the acute care E/M procedure code to signify the distinct service rendered. Providers must bill the acute care visit on a separate claim without benefit code EP1.

This guidance applies to both new and established patients and is applicable for Members in both managed care and fee-for-service Medicaid.

Telemedicine or telephone-only delivery of THSteps checkups for children birth through 24 months of age (i.e. from the first newborn checkup through the "24 month" checkup) is not permitted.

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 3, with developmental delays, disabilities or certain medical diagnoses that may impact development. ECI services support families as they learn how to help their children grow and learn.

Providers are required to refer children to the ECI program as soon as 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:

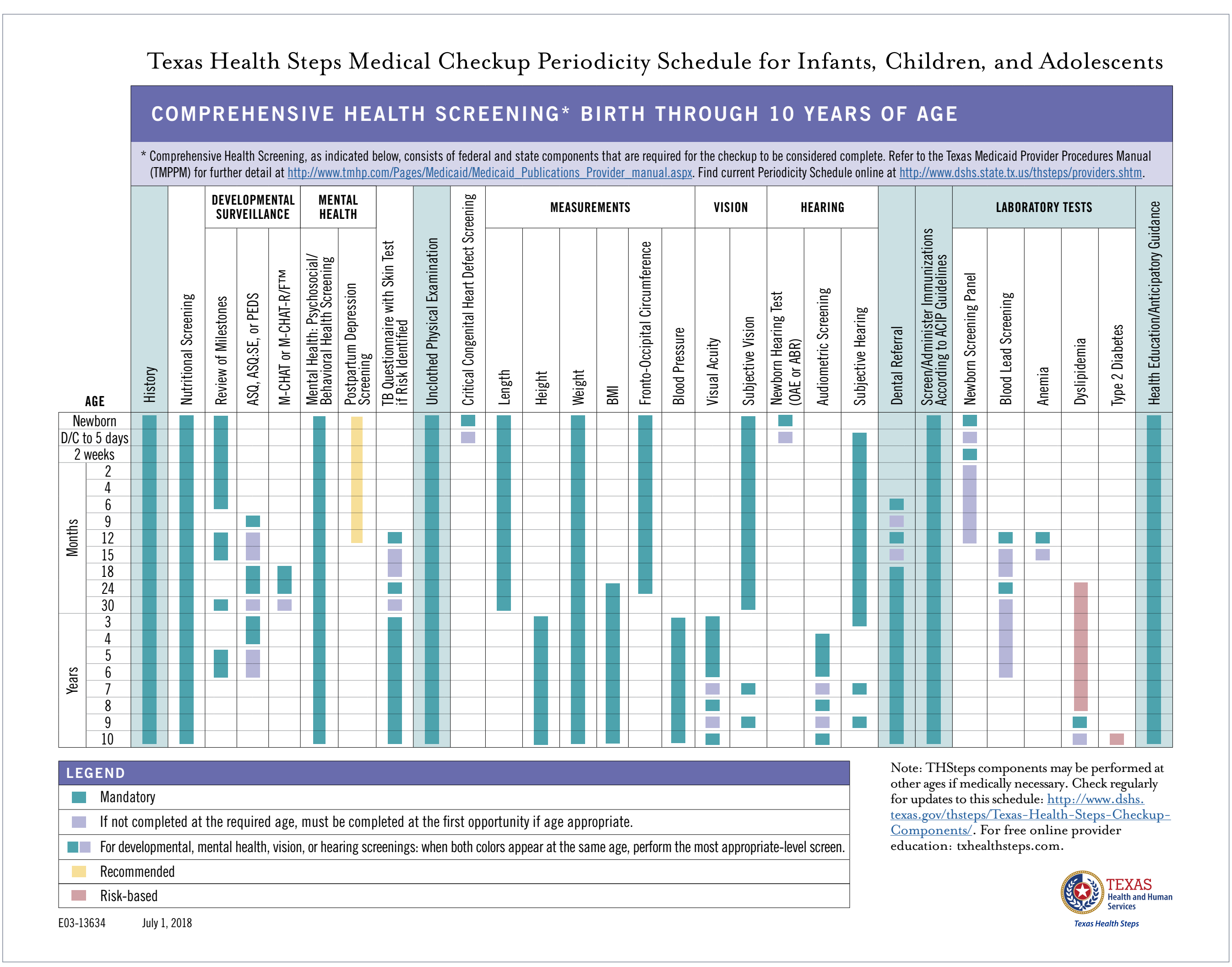
The Membership Panel is available on our online Provider Portal titled "Panel Report (Medicaid/CHIP)" at https://Providerportal.CommunityHealthChoice.org/Providers/Secure/Panel_Report.aspx.

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.

Column headings: History; Nutritional Screening; DEVELOPMENTAL SURVEILLANCE: Review of Milestones, ASQ, ASQ:SE, or PEDS, M-CHAT or M-CHAT-R/F™; MENTAL HEALTH: Mental Health: Psychosocial/Behavioral Health Screening, Postpartum Depression Screening; TB Questionnaire with Skin Test if Risk Identified; Unclothed Physical Examination; Critical Congenital Heart Defect Screening; MEASUREMENTS: Length, Height, Weight, BMI, Fronto-Occipital Circumference, Blood Pressure; VISION: Visual Acuity, Subjective Vision; HEARING: Newborn Hearing Test (OAE or ABR), Audiometric Screening, Subjective Hearing; Dental Referral; Screen/Administer Immunizations According to ACIP Guidelines; LABORATORY TESTS: Newborn Screening Panel, Blood Lead Screening, Anemia, Dyslipidemia, Type 2 Diabetes; Health Education/Anticipatory Guidance

AGE: Newborn; D/C to 5 days; 2 weeks; Months: 2, 4, 6, 9, 12, 15, 18, 24, 30; Years: 3, 4, 5, 6, 7, 8, 9, 10

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.

To the right is the chart that summarizes the 2020-2021 Immunization requirements for the schools in the state of Texas.

2020 - 2021 Texas Minimum State Vaccine Requirements for Students Grades K - 12

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

IMMUNIZATION REQUIREMENTS

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

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

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

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

Rev. 01/2020

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 the 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 following table

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 the 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 December 31 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
Envolve 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