COMMUNITY HEALTH CHOICE

PROVIDER NEWSLETTER

V1-2018

IN THIS ISSUE

CommunityHealthChoice.org
713.295.2295 | 1.888.760.2600

COMMUNITY HEALTH CHOICE
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ORDERING, REFERRING, AND PRESCRIBING PROVIDERS UPDATE

Effective January 15, 2018, TMHP and the Vendor Drug Program require all Providers who order, refer, and prescribe for traditional FFS Medicaid, Children with Special Healthcare Needs Services Program, or Healthy Texas Women Members to be in enrolled in the Texas Medicaid program. While HHSC has allowed a three-month grace period from Jan. 15 to April 16, 2018, for Providers to complete their enrollment process, it is critical that this be done as soon as possible.

You can read more about these requirements by visiting the link below.
http://www.tmhp.com/TMHP_File_Library/FAQ/ORP_Providers_FAQs.pdf

NEW VISION VENDOR

Effective April 1, 2018, Community will transition from Superior Vision of Texas, our current vision services vendor, to Envolve Vision of Texas. Envolve will provide routine and value-added services to all STAR, CHIP, and Marketplace Members under age 19.

Envolve Vision
Toll free: 800.334.3937
https://visionbenefits.envolvehealth.com

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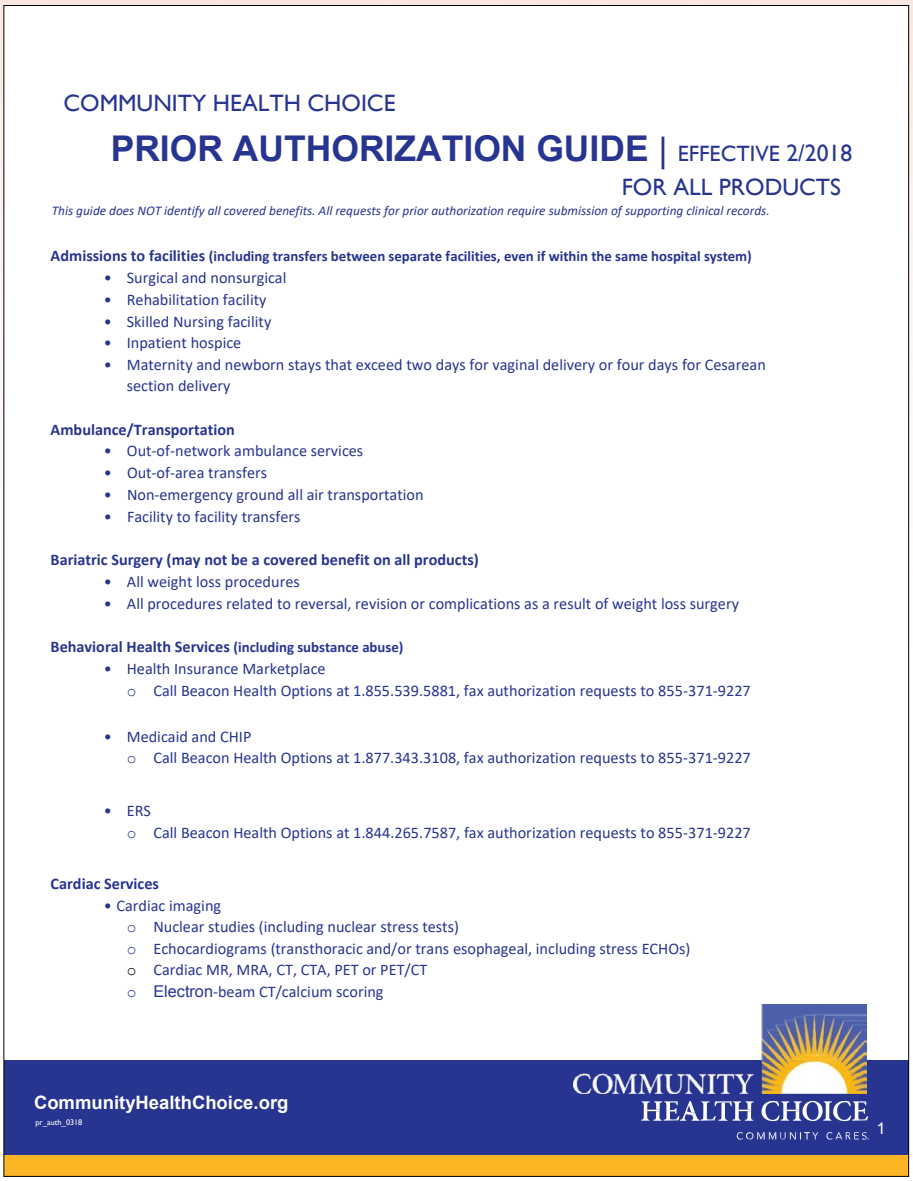
PRIOR AUTHORIZATION GUIDE

Effective February 1, 2018 Community posted changes to the Prior Authorization Guide on the Provider Portal for review. Please review the posted 2018 Prior Authorization Guide for a full listing of all services that require prior authorization. Some changes were made to the prior authorization guide. In summary the changes are:

- Removal of prior authorization requirement for breast tomosynthesis/3D mammography
- Removal of prior authorization requirement for routine stress testing under Cardiac Services
- Addition of prior authorization requirement for hearing aids and amplifiers under Durable Medical Equipment and Prostheses
- Chemotherapy agents and biological/immunotherapy medications still require prior authorization but have been categorized under a newly labeled category, Injectable Drugs
- Addition of prior authorization requirement for tonsillectomy and adenoidectomy; and for colonoscopy if under 50 years or less than 5 years since prior colonoscopy under Outpatient Procedures/ Surgeries

Please review the posted 2018 Prior Authorization Guide for a full listing of all services that require prior authorization.



COMMUNITY HEALTH CHOICE

PRIOR AUTHORIZATION GUIDE | EFFECTIVE 2/2018
FOR ALL PRODUCTS

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

Admissions to facilities (including transfers between separate facilities, even if within the same hospital system)
- Surgical and nonsurgical
- Rehabilitation facility
- Skilled Nursing facility
- Inpatient hospice
- Maternity and newborn stays that exceed two days for vaginal delivery or four days for Cesarean section delivery

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

Bariatric Surgery (may not be a covered benefit on all products)
- All weight loss procedures
- All procedures related to reversal, revision or complications as a result of weight loss surgery

Behavioral Health Services (including substance abuse)
- Health Insurance Marketplace
  - Call Beacon Health Options at 1.855.539.5881, fax authorization requests to 855-371-9227
- Medicaid and CHIP
  - Call Beacon Health Options at 1.877.343.3108, fax authorization requests to 855-371-9227
- ERS
  - Call Beacon Health Options at 1.844.265.7587, fax authorization requests to 855-371-9227

Cardiac Services
- Cardiac imaging
  - Nuclear studies (including nuclear stress tests)
  - Echocardiograms (transthoracic and/or trans esophageal, including stress ECHOs)
  - Cardiac MR, MRA, CT, CTA, PET or PET/CT
  - Electron-beam CT/calcium scoring

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PRIOR AUTHORIZATION REQUIRED FOR GENETIC AND MOLECULAR LAB TESTING

ALL genetic and molecular lab testing requires prior authorization with the following two exceptions:

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

To help expedite requests for authorizations efficiently and in a timely manner, please submit requests via the Provider Portal. Alternatively, requests may be sent via fax to 713.295.2283 or 1.844.899.2495. Please include supporting documentation, clinical notes, etc., to avoid any delays. Please do not submit requests for authorization of any service via regular mail.

MEMBERS WITH SPECIAL HEALTHCARE NEEDS

Members with chronic physical, developmental, behavioral, or emotional conditions are identified as Members with Special Healthcare Needs (MSHCN). Members designated with complex health needs can speak with our team about integrated care and treatment service management. Members have direct access to a Community Care Management team for assistance with care coordination. Contact the Care Management Department at 832.242.2273 or toll-free at 1.844.297.4450 from 8:00 a.m. to 5:00 p.m. for further assistance.

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PHARMACY PRIOR AUTHORIZATIONS

We at Community recognize that the prior authorization process can be challenging, especially as your patients change insurance plans or transition care from one Provider to another. We wanted to address a few common questions we often receive to bring more clarity to this arena.

Q: I get denial letters from a company called Navitus. Who are they?

A: Navitus is Community's benefit manager that manages the formulary and handles the initial receipt of pharmacy prior authorization requests.

Q: How do I know what medications are covered?

A: You might notice that when you look for the pharmacy formulary through the Community Health Choice website, it will route you to the Navitus website. This is because Navitus manages the formulary referenced above. The quickest way to get to the formulary is through the Navitus website (www.navitus.com).

- Medicaid: Prescribers > Texas Medicaid STAR/CHIP > Formulary
- Marketplace: Prescribers > Go to Prescriber Log in (NPI required) > Formulary > Select a Navitus Client (Community Health Choice) > Complete Exchange Formulary

You can also find all of the criteria requirements for specific medications on the same website where you can access the pharmacy formulary.

Q: My patient meets all the criteria listed on the denial letter. Why did my prior authorization request get denied?

A: Many times we find that prior authorization requests are missing information. Please be sure to answer all applicable questions on the prior authorization forms and sign the bottom of the request. Upon initial submission, we advise that you submit the Member's clinical records along with the prior authorization form. When Members change plans, doctors, etc., information can be lost in the changing of hands. Clinical records help give us an idea of the patient's course history and the progression of their disease state. We recognize that sometimes you may not know the plan's criteria for a specific medication. Specific criteria can be found where the pharmacy formulary is accessed as addressed above. If you receive a denial letter and your Member in fact meets the criteria listed, you are always eligible for a reconsideration request. These requests are submitted to Navitus. In these instances, be sure to note at the top of the prior authorization form that you are requesting a "reconsideration request." We know time and access to care is valuable for all our Members, and we want to make sure you know that option is available to you.

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PHARMACY PRIOR AUTHORIZATIONS (CONTINUED)

Q: How do I know where to submit a prior authorization for an injectable drug?

A: It can often be confusing whether to classify an injectable drug as a medical benefit or a pharmacy benefit. We want to make sure the pathway is clear so that you are not being directed to multiple departments. If the medication will be administered in your office or by a clinician, submit those requests to the medical benefit department. If the medication will be self-administered by your patient, submit those requests to the pharmacy benefit (Navitus). If submitting a request to Navitus, please specify on the prior authorization form that the Member will be self-administering the requested drug. We also recognize that not every office follows a buy-and-bill process. The same rules previously mentioned still apply. All medications that will be clinician-administered should still go to the medical benefit side to be reviewed for medical necessity. If your office does not buy and bill, please be sure to include in your request from which pharmacy your patient will be getting the medication from.

Clinician-injected:

- Medical (Medicaid): 713.295.2294 (phone), 713.295.7019 (fax)
- Medical (Marketplace): 713.295.6704 (phone), 713.295.7019 (fax)

Self-injected:

- Pharmacy (Medicaid): 877.908.6023 (phone), 855.668.8553 (fax)
- Pharmacy (Marketplace): 866.333.2757 (phone), 855.668.8551 (fax)

Q: My office does not buy and bill injectable drugs. What pharmacies are in the Community Health Choice network?

A: There are two pharmacies that Community utilizes for offices that do not buy and bill – Soleo Health and Deliver It Pharmacy.

- Soleo Health: 832.981.1000
- Deliver It Pharmacy: 281.277.1071

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HEALTH CARE TREATMENTS FOR HEROIN AND OPIOID MISUSE

Treatment for opioid misuse looks the same in most movies and shows. First, people who misuse opioids suddenly stop using them (some call this "going cold turkey"). Then they go through a long, hard withdrawal and get violently ill. Then they go to an inpatient rehabilitation center for counseling, which teaches them how to live without opioids. In the movies, all it takes to stop using opioids is willpower.

Real life is not like the movies. It takes much more than willpower to stop using opioids.

Opioid misuse causes long-term or permanent changes in the brain. It is a long-term, or chronic, condition. Treatment should include different types of care over a long period of time. It should help people learn to manage their opioid misuse.

It is not enough to treat opioid misuse as a short-term condition. People who get long-term care are less likely to start misusing opioids again. That is important because 2.5 million people misuse opioids in the U.S. More than 33,000 people died from opioid overdoses in 2015 alone.

Long-term care can include Medication-Assisted Treatment (MAT). Examples of MAT are methadone or buprenorphine with naloxone. When someone is on MAT, they are not using one drug instead of another. When someone is on MAT, they are not "still using;" they are in recovery. MAT is an evidenced-based best practice that can be a life-saving treatment option.

Healthcare treatments

There are different types of treatment for opioid misuse, and they can be very expensive. People looking for treatment should contact their healthcare Providers. They should ask what types of treatment are covered by their insurance. The goal is to get the most effective care, and the most effective care varies from person to person. Experts say the best treatment plans:

- Are centered on that specific person
- Use methods that limit the person the least
- Use methods that work best for that person

Settings

There are two main settings for opioid misuse treatments:

- **Inpatient withdrawal management**—stay at a hospital or rehabilitation center for care
- **Outpatient withdrawal management**—stay at home and go to a doctor, hospital, or rehabilitation center for care

Inpatient withdrawal management settings offer safe 24-hour-a day care. Programs are highly structured, and clients receive medical care and counseling. Not everyone needs inpatient or residential treatment.

Types of inpatient settings include:

- Inpatient withdrawal management
  - *This used to be called "inpatient detox"*
  - *This level of care helps people stop misusing substances*
  - *MAT may be started while an inpatient*
  - *Aims to help people get ready for outpatient treatment*
- Short-term residential programs:

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HEALTH CARE TREATMENTS FOR HEROIN AND OPIOID MISUSE (CONTINUED)

  - *Used at the beginning of treatment*
  - *Helps people through withdrawal management*
  - *Begin counseling*
  - *Get people ready for outpatient treatment*
- Recovery housing:
  - *Supervised group living*
  - *Safe place to live after inpatient/residential treatment*
  - *Often teach life skills like using transportation and finding work*
  - *Aims to ease people back into the community*

Outpatient settings include many types of treatment. They often focus on behavioral treatments for opioid misuse, which include:

- Psychotherapy
- Family therapy
- Cognitive-Behavioral therapy (CBT)
- Mindfulness-Based Stress Reduction (MBSR)

The outpatient setting is where ongoing MAT occurs. While MAT may be started during inpatient withdrawal management, it continues in the outpatient setting. Some people do not need inpatient treatment and may start MAT in the outpatient setting.

Settings include:

- Hospitals
- Treatment centers
- Doctors' and therapist' offices

Successful outpatient treatment includes medical treatment. Medication-Assisted Treatment (MAT) combines behavioral therapy and medicine.

Medication-Assisted Treatment (MAT)

MAT helps people more than medicine or behavioral therapy alone. Some people do not understand using medicine for opioid misuse. They think it trades one bad habit for another. This is not true. People who misuse opioids have strong cravings. Some medicines can help reduce those cravings.

MAT helps people use opioids less and leads to fewer deaths from overdose. It leads to fewer illegal acts and shared diseases. MAT helps people be more social and stay in treatment longer. MAT is helpful for pregnant women, as it leads to fewer babies born dependent on opioids. It also shortens mothers' hospital stays.

Doctors use several medicines to treat opioid misuse, including:

- Methadone (Methadose®, and Dolophine®)
- Buprenorphine (Butrans®, Subutex®, Belbuca®, Probuphine®)
- Naltrexone (Vivitrol®, Revia®, Depade®)
- Naloxone (Narcan®)

Methadone has been around for a long time. It can make withdrawal easier by stopping or reducing symptoms and cravings, and it is safe to take with opioids. Doctors decide how much people should take each day. Some people take pills at home, while others take liquid doses or wafers at a doctor's office or clinic. People must be careful with methadone, as it builds up in the body. People could get sick or overdose if they take too much. People should tell their doctors if they take other medicines. They should avoid alcohol and other opioids.

Buprenorphine is a very weak type of opioid and lasts a long time. This reduces people's cravings. People take it

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HEALTH CARE TREATMENTS FOR HEROIN AND OPIOID MISUSE (CONTINUED)

every day as a film, tablet, or skin patch. Doctors mostly use buprenorphine with other medicines.

The U.S. Food and Drug Administration just approved a new type of buprenorphine. Doctors put a Probuphine® implant under the clients' skin. The implant lets out a small amount of buprenorphine for six months. Doctors only give it to people who have been stable on buprenorphine. They hope Probuphine® will help people stick to their treatment plans.

Naltrexone blocks the effects of opioids. People take naltrexone as a pill or long-lasting injection. Long-lasting injections are more effective for opioid misuse.

Naloxone is used for opioid emergencies. It blocks opioid receptors to reverse opioid overdoses. Emergency professionals carry naloxone. It comes as a shot that can go under the skin or into a muscle or vein. It also comes as a nasal spray. Clients or their families may be able to get naloxone so they have it at home and are prepared in case of an opioid overdose emergency.

Looking ahead

Researchers are looking for new ways to treat opioid misuse. Experts are testing the following treatments to see if they work and are safe. They include:

- Naltrexone implant
- Vaccine to keep opioids away from the brain
- Transcranial Direct Current Stimulation (TDCS)

Resources

Narconon
www.narconon.org
1.800.775.8750

National Institute on Drug Abuse
www.drugabuse.gov
1.301.443.1124

Substance Abuse and Mental Health Services Administration
www.samhsa.gov
1.877.726.4727

By Beth Landau

https://www.achievesolutions.net/achievesolutions/en/beacon/

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FALSE CLAIMS ACT AND PROMPT REPORTING OF OVERPAYMENT/ERRORS

Section 6402(a) of the Patient Protection and Affordable Care Act (ACA) established new section 1128J of the Social Security Act, which requires Providers and suppliers who submit claims to Medicare and Medicaid to report and return identified overpayments within 60 days or face potential liability under the federal False Claims Act (FCA). In section 8.1.4.8.4, the UMCC makes it mandatory for MCOs such as Community to require that its Providers submit overpayments within 60 days from identification. Please contact your Provider Engagement Representative or send an email to SIU@Communityhealthchoice.org if you have any questions about processing an identified overpayment by Community.

HIPAA

Covered entities and business associate workforce members must be aware of their responsibilities when given access to information systems that create, receive, transmit, or maintain electronic Protected Health Information (ePHI). Such access is a privilege and should only be used for legitimate job-related activity. Have you recently checked to see who has access to your patients' records?

Please contact your Provider Engagement Representative or send an email to DSPC@Communityhealthchoice.org if you have any questions regarding ensuring the privacy or security of Community Members data.

REPORTING ISSUES TO COMPLIANCE

If you are aware of an incident or have reason to suspect unethical behavior or other wrong doing that would be in violation of Community's policies, procedures, and Code of Conduct, please report the issue to Compliance by calling our hotline at 1.877.888.0002. You may also report issues online at https://www.reportlineweb.com/chc. Remember, you and your office are a critical partner of our Compliance program at Community. If you suspect something, tell us.

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HEDIS SEASON IS UPON US!

As you know, Community Health Choice is required to collect medical records for Health Effectiveness Data and Information Set (HEDIS) reporting. We would like to thank our Providers in advance for their cooperation and assistance with this effort. This is an annual requirement of the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the State of Texas Department of State Health Services (DSHS).

Frequently Asked Questions

When is the collection period?

The medical record collection period has begun and will run through May 4, 2018.

How will the request be sent?

You will be contacted by CIOX Health, our record retrieval vendor, by fax, email, or phone. If you have questions, please contact your Provider Engagement Representative.

What will be requested?

The medical records for specifically identified Members.

How do I respond to the request?

CIOX Health will work closely with you on the most efficient method for submitting medical records.

Am I required to respond?

This is a required quality improvement activity within the contract with Community Health Choice.

What should the record include?

- Member name (on each page)
- Member date of birth
- Member Health Plan ID
- Date of service
- Provider signature with credentials
- Diagnostic information and notes

We know that time with your patients—our Members—is valuable. We ask that you respond to the medical records request within 5-7 days. Our vendor CIOX Health can arrange an on-site record retrieval, if necessary.

Thank you for your continued partnership to provide quality care to the residents of Southeast Texas.

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RISK ADJUSTMENT UPDATE

For Providers who also participate in Marketplace, we would like to personally thank many of you who helped Community successfully retrieve medical records as required for the Risk Adjustment Data Validation (RADV) audit prescribed by CMS. We had a tremendous response rate, which helps to ensure an accurate plan-level risk score.

This year Community will be developing coding and documentation resources that will further improve the Risk Adjustment program, and RADV will once again kick off in late summer of 2018.

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (HEDIS WCC)

Texas Health and Human Services (HHS) has identified Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (HEDIS WCC) to be an at-risk measure. Community Health Choice and Molina Healthcare are collaborating to work with Providers to help increase the rate for eligible Members for this measure.

The measure identifies Members between the ages of 3 and 17 years old who received an outpatient visit with a primary care Provider or OB/GYN and should show evidence of the following:

1. BMI Percentile Documentation
2. Counseling for Nutrition
3. Counseling for Physical Activity

While BMI percentile documentation is not currently an at-risk measure with HHS, we encourage our Providers to document Members' BMI percentile in their medical record.

Sub-Measure	Required Elements	Medical Record
1. BMI Percentile Documentation	BMI Percentile	• BMI percentile must be documented as a value (e.g. 85th percentile) or plotted on an age-growth chart • Ranges and threshold do not meet the criteria • Documentation cannot include <1% or >99% (either 0% or 100%)
	Weight & Height	Date and value
2. Counseling for Nutrition	Documentation of counseling for nutrition or referral for nutrition education	• Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors) • Checklist indicating nutrition was addressed • Counseling or referral for nutrition education • Member received educational materials on nutrition materials during a face-to-face visit • Anticipatory guidance for nutrition • Weight or obesity counseling
3. Counseling for Physical Activity	Documentation of counseling for physical activity or referral for physical activity	• Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation) • Checklist indicating physical activity was addressed • Counseling or referral for physical activity • Member received educational materials on physical activity during a face-to-face visit • Anticipatory guidance specific to the child's physical activity • Weight or obesity counseling

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BILLING TIPS FOR HEDIS WCC

Description	Codes
BMI at <5th percentile for age	**ICD-10:** Z68.51
BMI at 5th percentile to <85th percentile for age	**ICD-10:** Z68.52
BMI at 85th percentile to <95th percentile for age	**ICD-10:** Z68.53
BMI at ≥95th percentile for age	**ICD-10:** Z68.54
Counseling for Nutrition	**CPT:** 97802-97804 **ICD-10:** Z71.3 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470
Counseling for Physical Activity	**ICD-10:** Z02.5, Z71.82 **HCPCS:** G0447, S9451

MODIFIER QW REQUIRED

Effective Jan. 1, 2018, for dates of service on or after July 1, 2016, the following procedure codes will require modifier QW:

- 80305
- 87633

Claims submitted with Modifier QW with dates of service on or after July 1, 2016, through Jan. 1, 2018, that may have been incorrectly denied will be reprocessed. Providers may receive additional payment, which will be reflected on future Remittance & Status reports. Reminder: Providers must have the required Clinical Laboratory Improvement Amendment certification on file with TMHP, and they must use the QW modifier when it is required, per the Centers for Medicare & Medicaid Services. Claims will be denied if the QW modifier is not present on applicable CLIA-waived tests.

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PROVIDER PORTAL

Community's online Provider Portal offers secure 24 hours a day, 7 days a week access to online tools and services.

Providers can view Member eligibility and benefits, claim status, and the status of pre-authorization. Additionally, the Provider Portal includes:

- Provider news
- Quick links to resources/documents
- Provider Manual and Quick Reference guides
- Credentialing information
- Commonly requested forms
- Policies and guidelines
- Eligibility and benefits status
- Remittance updates
- Referrals

Accessing our Provider Portal

1. Go to www.CommunityHealthChoice.org
2. Click on "For Providers" on the top left side.
3. Click on "Provider Login" and enter your user ID and password.
4. Click "Login."

If you do not have an account, and you are currently contracted with Community:

1. Click "Register Today."
2. Fill out the entire form to apply for a new account. Incomplete forms will cause delays.

If you have questions or issues during the registration process, please contact Provider Communications:

HHSC: 713.295.2295 or toll-free at 1.888.760.2600
Marketplace: 855.315.5386

CREDENTIALING REMINDER

Credentialing is required for all physicians and Providers prior to seeing Community's Members, including advanced practice nurses and physician assistants as defined in 28 TAC 11.1902.

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PROVIDER DIRECTORY ACCURACY

Ensure your office is properly listed in the Provider Directory and that your claims payments are sent to the correct address by providing timely advance notification of demographic changes, including:

- addition or termination of any healthcare professional from your practice;
- any change in address(es) or contact information where you render covered services, including the addition or closure of an address;
- any change in billing information, including but not limited to a change in your legal structure, payment-remit address, or change in Tax Identification Number; or
- any change in other demographic or other information that may be required for Community to meet state, federal, and health plan obligations.

Additionally, Community requests that all Providers report plans for retirement and out-of-service area moves at least 90 days prior to the effective date of change. This will help ensure continuous access to care for Members throughout the termination period.

Written request for updates can be emailed to ProviderRelationsInquiries@CommunityHealthChoice.org or faxed to 713.295.7039.

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PROVIDER ACCESS AND AFTER-HOURS AVAILABILITY

As a reminder, Community conducts annual surveys to ensure that participating Providers are compliant with all access availability and after-hours access standards. Additionally, HHSC and/or its contractor perform random telephonic surveys to Providers without notice to ensure that new and existing Members have access to care.

The Appointment Availability and Accessibility Standards are as follows:

Service	Appointment Availability
Emergent	Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities
Urgent	Must be provided within 24 hours, including urgent specialty care and behavioral health services
Primary Routine Care	Must be provided within 14 days, including behavioral health
Specialty Routine Care	Must be provided within 21 days
Routine Care Dental	Within eight weeks for dental
Initial Outpatient Behavioral Health Visit	Must be provided within 14 days (this requirement does not apply to CHIP Perinatal)
Prenatal Care	Initial appointment must be provided within 14 days for non-high-risk pregnancies. For high-risk pregnancies or new Members in the third trimester, initial appointment must be provided within five days or immediately. Appointments for ongoing care must be available in accordance with the treatment plan as developed by the Provider.
Preventive Care Physical/Wellness Exams	Newborns (less than 6 months of age): within 14 days; Children (6 months to 20 years): within two months; Adults (21 years and older): within 90 days; New Members: within 90 days of enrollment *Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. *CHIP Members should receive preventive care in accordance with AAP guidelines

Emergent/Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could result in one or all of the following:

- Health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) is in serious jeopardy
- Serious impairments to bodily functions
- Serious dysfunction of any bodily organ or part
- Inadequate time to safely transfer a Member who is pregnant and having contractions to another hospital before delivery, or if a hospital transfer might pose a threat to the health or safety of the woman or the unborn child
- Member is a threat to themselves or others; exhibits acute onset of psychosis or severe thought

Urgent Condition: A health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe that his or her condition requires medical treatment or evaluation or treatment within 24 hours by the Member's Primary Care Provider or designee to prevent serious deterioration of the Member's condition or health.

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PROVIDER ACCESS AND AFTER-HOURS AVAILABILITY (CONTINUED)

Routine or Preventive (Non-Emergent): Postponement of treatment will not endanger life, limb, or mental faculties of patient, i.e., patient's condition permits adequate time to schedule necessary history and physical, laboratory, radiology, or other diagnostic studies on an outpatient basis.

Additionally, it is required that PCPs are accessible to Members 24 hours a day, 7 days a week. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. the office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. the office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
3. the office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. the office telephone is only answered during office hours;
2. the office telephone is answered after-hours by a recording that tells Members to leave a message;
3. the office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed; and
4. returning after-hours calls outside of 30 minutes.

HOW TO SUBMIT/REPORT OVERPAYMENTS TO COMMUNITY

Last quarter, we published the following article. Please make note of the corrected addresses where refunds along with Community's Overpayment Form should be mailed.

In order for Community Health Choice to process an overpayment refund in a timely manner, please submit a completed form with all refund checks and supporting documentation.

If the refund check you are submitting is a Community Health Choice check, please include a completed form specifying the reason for the check return.

The following information is also required:

- Provider Name/Contact
- Contact Phone Number
- Provider Tax ID
- Member Name
- Member ID Number
- Date of Service
- Total Billed Charges
- Claim Numbers
- Reason for Refund or Check Return

Once Community Health Choice has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation.

All refunds/checks, along with Community's Overpayment Form, should be mailed to:

Medicaid, CHIP, and CHIP Perinate
Community Health Choice
Attn: Claims
P.O. Box 4605
Houston, TX 77210-4626

Marketplace
Community Health Choice
Attn: Claims
P.O. Box 4626
Houston, TX 77210-4626

Our refund form can be found on our Provider Portal.

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THSTEPS CHECKUP TIMELINESS

New Community Members must have a THSteps/Well-child checkup **within 90 days** of enrollment, except for Head Start students, who must be within 45 days of enrollment.

Existing Community Members

- Ages 0-30 months:
  - *Due before the next checkup: newborn, 3-5 days, 2 weeks, 2 months, 4 months, and 6 months*
  - *Due within 60 days of the periodicity date: 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months.*
- Ages 3-20 years:
  - *Once a year, on or after the birthday but before the next birthday. Community recommends a checkup to be completed as soon as possible after the member's birthday every year.*

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

HEAD START PROGRAM

Program Description

Head Start programs promote school readiness of children 0-5 years of age from low-income families by supporting their development in a comprehensive way. The Early Head Start program serves pregnant women, infants, and toddlers, and the Head Start program serves children ages 3 to 5 years.

How You as a Provider Can Help

Within 45 days of enrollment, Head Start may require new enrollees to complete a THSteps/Well-Child Checkup as part of the enrollment requirements. After the initial Checkup, all Head Start students are required to complete their THSteps/Well-Child Checkups according to the periodicity schedule. As a healthcare Provider, you can help by making sure the children receive their initial checkup within 45 days of enrollment. For more information on Head Start programs, please visit: https://www.acf.hhs.gov/ohs.

Health Education

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

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

- Family
- Development and behavior
- Nutrition
- Routine Care
- Safety

For information on individual age-specific anticipatory guidance, please visit http://www.dshs.texas.gov/thsteps/Anticipatory-Guidance.shtm

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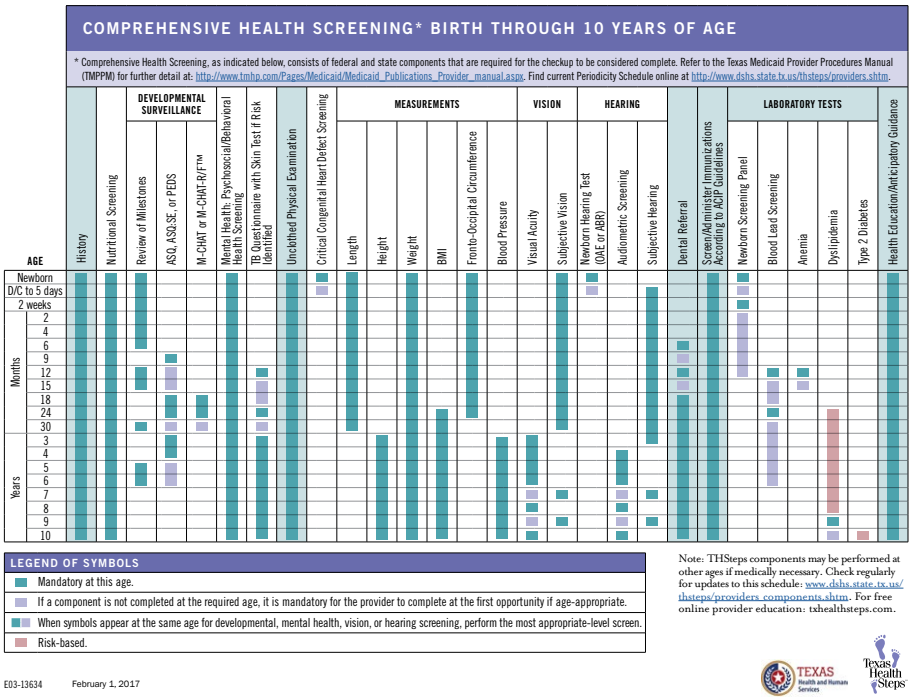
THSTEPS MEDICAL CHECKUP PERIODICITY SCHEDULE

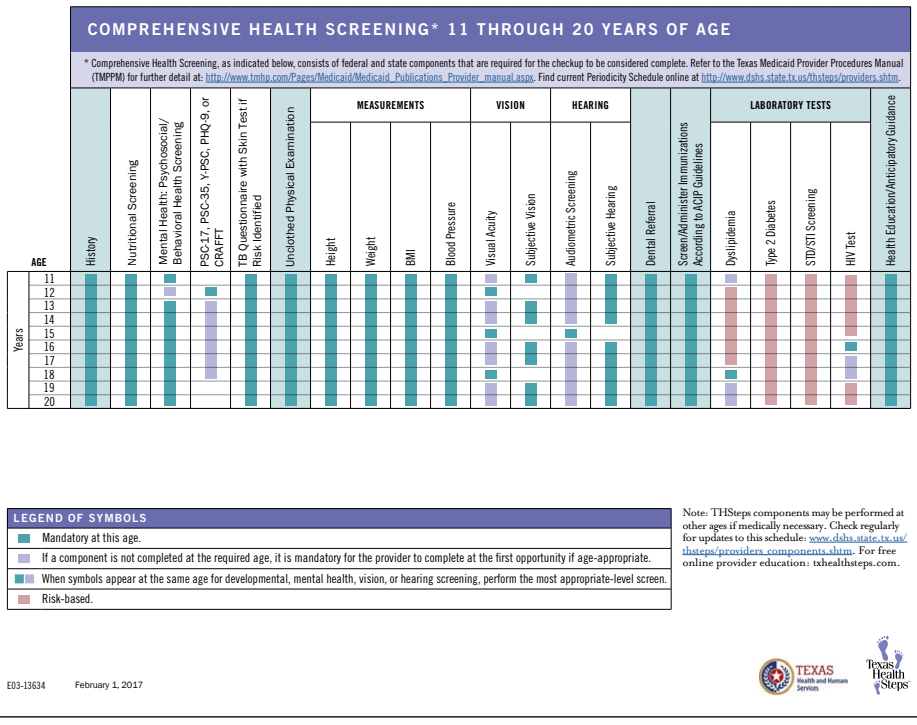
The THSteps Medical Checkup Periodicity Schedule for Members ages 0-20.

The periodicity schedule can be downloaded via http://www.dshs.texas.gov/thsteps/providers.shtm.

THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents



THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents



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THSTEPS CHECKUP DOCUMENTATION – ESSENTIAL TO MEDICAL RECORDS

THSteps checkups are made up of six primary components, many of which include individual components. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history,** which includes nutrition screening, developmental and mental health screening, and TB screening
2. **Comprehensive unclothed physical examination**, which 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,** which include newborn screening of 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.

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THSTEPS MEDICAL CHECKUP BILLING PROCEDURE CODES

Effective February 1, 2018, TMHP has updated the Texas Health Steps Quick Reference Guide. To download a copy, please visit http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf

Exception-to-Periodicity Checkups

Exception-to-Periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances that 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*
  - *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
- Needed to provide an accelerated checkup to the Member's birthday. For example, a 4-year-old checkup could be performed prior to the Member's fourth 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) Environmental high-risk (sibling of child has elevated blood level)
23	Dental services provided under general anesthesia
32	To meet state or 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.

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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 to one per year). Provider must use procedure code 97169, 97170, 97171, or 97172, depending on the level of complexity when billing for sports physicals. For more information regarding the sports and physical codes, see the "New Sports and School Physical Procedure Codes" article in Volume 2, 2017.

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HHSC'S MEDICAL TRANSPORTATION PROGRAM FOR MEDICAID MEMBERS

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

What kind of rides are offered?

- Bus or ride-sharing service
- Mileage reimbursement if the member has a car or knows someone who can drive them to the appointment
- For trips that require overnight stay, MTP might pay for lodging and meals

How you can help

- Tell Medicaid patients about free ride service when you schedule appointments.
- Remind patients about Medicaid free rides if they miss an appointment.
- Provide the Medicaid free-ride phone number: **1.855.687.4786** Monday to Friday, 8:00 a.m. to 5:00 p.m. Patients should call at least two workdays before the appointment (the sooner, the better).
- Please note: children younger than age 14 must be accompanied by the parent, guardian, or other authorized adult at the medical or dental Checkup.
- Call **1.888.513.0706** if the ride does not show up.

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

COMMUNITY'S TRANSPORTATION SERVICE FOR CHIP MEMBERS

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

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

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CHILDREN OF TRAVELING FARMWORKERS

A traveling farmworker's principal employment is agricultural on a seasonal basis. They move from place to place and live away from home for more than a few days at a time to work on a farm or in fields. These jobs include preparing crops, growing vegetables and fruits, planting trees, raising or caring for livestock or poultry, or preparing dairy products.

A traveling farmworker is someone who:

- has been employed in this capacity within the last 24 months
- established a temporary abode for the purposes of such employment

Their children **ages birth up to the day of their 18th birthday** 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 **CPT modifier 32** when providing accelerated services outside of the periodicity schedule.

Performing a make-up exam for a late THSteps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

If you have any patients from Community who meet this criteria, 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.

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ONLINE PROVIDER EDUCATION – FREE CONTINUING MEDICAL EDUCATION (CME) HOURS

Texas Health Steps' online program offers more than 60 CME-accredited courses that cover a broad array of health topics. These topics range from wellness and prevention essentials such as breastfeeding and immunization to specialized courses about treating children with asthma, diabetes, high blood pressure, and many other chronic-health conditions. **First-time users will need to register.**
The courses are available at: http://www.txhealthsteps.com/cms/

TMHP ONLINE PROVIDER EDUCATION

TMHP offers a variety of training for Providers online using computer-based training (CBT) modules on the TMHP Learning Management System (LMS). Medicaid providers can access this training anytime from any location with internet access. TMHP CBT modules offer flexible training experience by allowing providers to play, pause, rewind, and even search for specific words or phrases within a CBT module. **First-time users will need to register.**

CBT topics include the following and much more:

- Children with Special Health Needs Service Program Basics
- Claim Forms
- Claims Appeals
- Client Eligibility
- Crossover Claims
- Family Planning
- Texas Health Steps – Medical Services
- Provider Enrollment on the Portal

To access training, please visit: http://learn.tmhp.com/.

VENDOR DRUG PROGRAM CONTINUING EDUCATION FOR PRESCRIBING PROVIDERS

As a Medicaid-prescribing Provider, you can help Medicaid clients get their medications quickly and conveniently with a few simple steps. By prescribing a preferred product or obtaining a prior authorization before the client leaves the office, the prescription can be filled without delay. This eliminates the need for the pharmacy to contact the prescribing Provider's office for a therapeutic substitution, as well as the need to initiate the prior-authorization process.

For a list of Medicaid Drug Formulary and free continuing-education credits, please visit https://www.txvendordrug.com/providers/pharmacy-education.

FEEDBACK

What do you think of our Provider Newsletter? Do you have any feedback you would like to share with us? We are always working to make the content and format **easy to understand**, **helpful** to you and your staff, and **applicable** to your day-to-day work.

If you have any comments, suggestions, or ideas for future articles you would like to see, please email us at CommunityProviderNewsletter@CommunityHealthChoice.org.

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CONTACT INFORMATION

MEDICAL AFFAIRS

Peer-to-Peer Discussions
713.295.2319

Senior Vice President, Medical Affairs
Karen Hill, M.D.

Senior Vice President, Clinical Policy and Partnerships
Fred Buckwold, M.D.

Associate Medical Directors
Valerie Bahar, M.D.
Lisa Fuller, M.D.

Utilization Management
Phone: 713.295.2221
Fax: 713.295.2283 or 84

Care Management: Asthma, Congestive Heart Failure, Diabetes, High-Risk Pregnancy
713.295.2303

Diabetic Supplies/Outpatient Perinatal
Fax: 713.295.7028
Toll-free fax: 1.844.247.4300

CLAIMS

- Inquiries
- Adjudication

CommunityHealthChoice.org or
713.295.2295

Community will accommodate three claims per call.

REFUND LOCKBOX

Amegy Bank
P.O. Box 4605
Houston, TX 77210-4605

ELECTRONIC CLAIMS *(CHIP & STAR)*

Submit directly through Community's online claims portal:
CommunityHealthChoice.org >
Provider Tools > Claims Center
Payer ID: 48145

Change HealthCare (Formerly Emdeon)	1.800.735.8254
Availity	1.800.282.4548
RelayHealth	1.563.585.4411
Gateway EDI	1.800.969.3666
TMHP (STAR only)	www.tmhp.com

ELECTRONIC CLAIMS-UB, CMS-1500 (HIM)

Submit directly through Community's Online Claims Portal:
CommunityHealthChoice.org > For Providers > Provider Tools > Claims Center

Change HealthCare: 1.800.735.8254
Payer ID: 60495

PHARMACY

Navitus Health Solutions
1.877.908.6023
www.navitus.com

BEHAVIORAL HEALTH

Beacon Health Options
1.877.343.3108
www.beaconhealthoptions.com

ADVERSE DETERMINATIONS & APPEALS

Community Health Choice, Inc.
Attn: Appeals
Fax: 713.295.7033

All appeals must be in writing and accompanied by medical records.

MEMBER SERVICES & SPECIALIST SCHEDULING

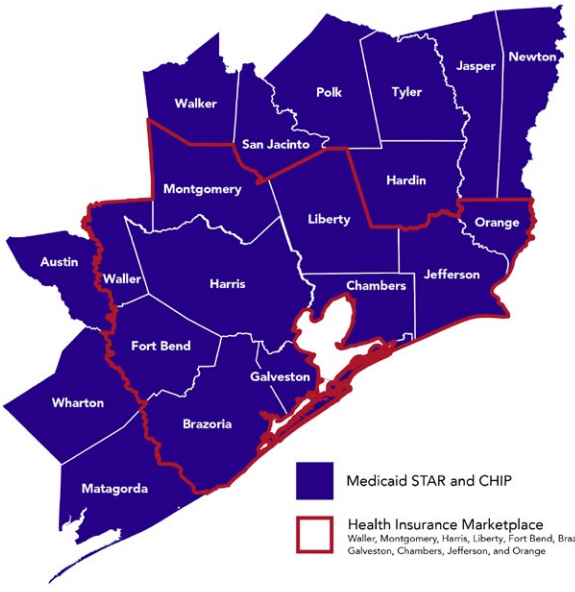
713.295.2294 or 1.888.760.2600

PROVIDER RELATIONS

For general questions or to submit your updates:

- CommunityHealthChoice.org
- ProviderRelationsInquiries@CommunityHealthChoice.org
- Contact your Provider Relations Representative.

SERVICE AREA MAP



TEXAS STAR
Your Health Plan ★ Your Choice

CHIP We've got your kids covered.

TEXAS Health and Human Services