COMMUNITY HEALTH CHOICE

PROVIDER NEWSLETTER

V2-2018

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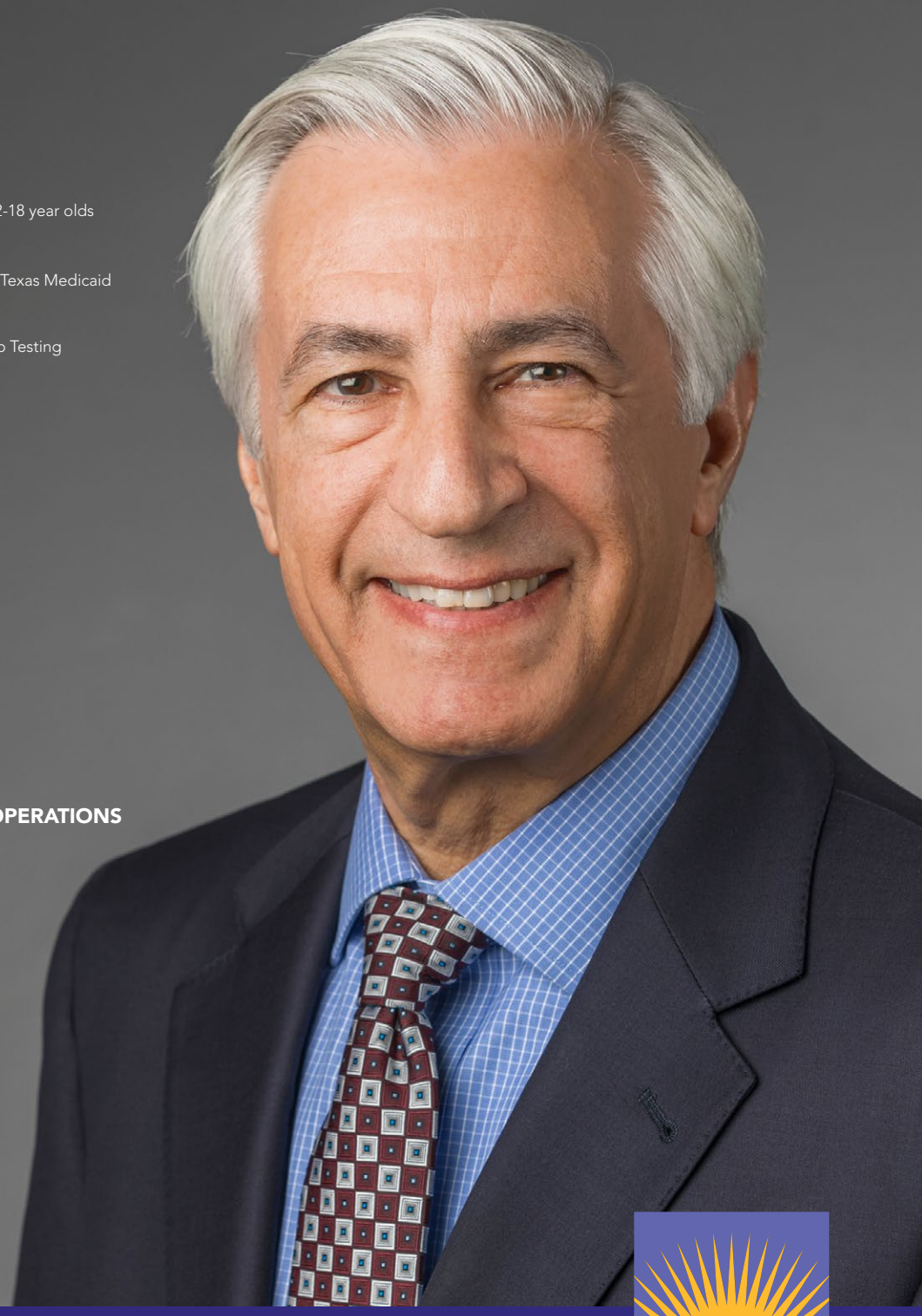

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BEST WISHES DR. BUCKWOLD

Dr. Fred Buckwold, Community's Senior Vice President for Clinical Policy and Partnerships, is retiring effective July 31, 2018. Dr. Buckwold served as the Chief Medical Officer (CMO) for Community from 2010 through 2017. Prior to joining Community, Dr. Buckwold had a private practice in Internal Medicine and Infectious Diseases, and then served in various medical management positions with Cigna, Evercare and UniCare prior to joining Community. He has worked closely with Dr. Karen Hill, Community's Senior Vice President of Medical Affairs, for the past year to ensure a smooth transition as she assumed the CMO role.

Under Dr. Buckwold's leadership, the Medical Affairs staff tripled in size along with Community's growth in membership and programs. He hired several key clinical leaders, including current Medical Directors Valarie Bahar and Lisa Fuller, as well as department managers in Utilization Management and Care Management. Without his help, our Medical Affairs department would not have been able to support the bigger better Community that we are today. He has been a wonderfully collaborative leader with our entire Community team, as well as with you, our Provider partners.

We will miss Dr. Buckwold's leadership but appreciate his desire to travel more and spend time with his grandson and the rest of his family. Please join us in wishing Dr. Buckwold the best in retirement.

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TEXAS HEALTH STEPS POSTPARTUM DEPRESSION SCREENING

Effective for dates of service on or after July 1, 2018, postpartum depression screening will be a benefit of Texas Medicaid.

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder and postpartum psychosis.

Postpartum psychosis is a more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

Immediate or emergent medical attention may also be necessary when the risk of imminent harm or danger is present.

Postpartum Depression Screening Benefits

Procedure codes G8431 and G8510 will be a benefit when services are provided by federally qualified health centers and Texas Health Steps medical providers in the office setting.

The American Academy of Pediatrics recommends the infant's provider screen mothers for postpartum depression, which is the most common form of postpartum mood disturbance.

Screening mothers for postpartum depression is appropriate for the general postpartum population, and is recommended within the first few months following birth, up to the infant's first birthday.

Note: Screening for postpartum depression during the infant's Texas Health Steps medical checkup is recommended, not required.

Texas Health Steps medical providers may receive separate reimbursement for postpartum depression screening, in addition to the infant's Texas Health Steps medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the infant's medical checkups or follow-up visits.

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

Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the Texas Health Steps provider to develop a referral plan with the mother.

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TEXAS HEALTH STEPS POSTPARTUM DEPRESSION SCREENING (CONTINUED)

Positive Screenings

Texas Health Steps Providers must discuss the screening results with the mother, discuss the possibility of depression, and the impact depression may have on the mother, family and health of the infant.

The Texas Health Steps Provider and mother should discuss her options so the Provider can refer her to an appropriate Provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

Texas Health Steps Providers should refer the mother to a Provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate Providers include, but are not limited to, the following:

- Mental health clinicians
- Obstetricians and gynecologists
- Community resources such as local mental health authorities
- The mother's primary care provider
- Family physicians

Note: Referral to an emergency center may be necessary when the risk for imminent harm or danger is present, such as mothers who report suicidal thoughts or thoughts of harming herself or the baby.

Resources for support in the interim should be provided until the mother is able to access care. Scheduling a return visit for the infant, sooner than the next scheduled visit, may be appropriate in some cases.

Documentation Requirements

Documentation in the infant's medical record must include the name of the screening tool used and the date screening was completed.

If the mother screens positive for depression, at a minimum, the Provider must note that a referral plan was discussed with the mother and a referral to an appropriate Provider was made.

Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

Submitting Claims for Postpartum Depression Screening

Postpartum depressing screening must be submitted under the infant's Medicaid client number, and will be restricted to clients who are 12 months of age and younger.

Screening and referral is not contingent upon the mother's Medicaid eligibility.

Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service and provider, as one of the following Texas Health Steps medical checkup or follow-up visit procedure codes:

Procedure Codes

99211	99381	99382	99391	99392

Only one procedure code, either G8431 or G8510, may be reimbursed per provider, in the 12 months following the infant's birth.

For more information, call the TMHP Contact Center at 1-800-925-9126.

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TEXAS HEALTH STEPS MENTAL HEALTH SCREENING CHANGE FOR 12-18 YEAR OLDS

Effective for dates of service on or after July 1, 2018, mental health screening benefits will change for Texas Health Steps.

Overview of Benefit Changes

Mental health screening for behavioral, social and emotional development is required at each Texas Health Steps checkup birth through age 20.

Major changes to this medical benefit policy include the following:

- Changes to limitation for mental health screening for clients 12 through 18 years of age
- Update to mental health screening tools recognized by Texas Health Steps

Limitation Change for Mental Health Screening

Effective July 1, 2018, Texas Health Steps will allow clients 12 through 18 years of age to receive a mental health screening (procedure codes 96160 or 96161) using one or more of the validated, standardized mental health screening tools recognized by Texas Health Steps, once per calendar year during a Texas Health Steps checkup.

Texas Health Steps recommends all clients who are 12 through 18 years of age receive a mental health screening using one of the Texas Health Steps recognized mental health screening tools

Update to Mental Health Screening Tools Recognized by Texas Health Steps

The following validated, standardized mental health screening tools will be added:

- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance abuse])

Providers may refer to the current Texas Medicaid Provider Procedures Manual, Children's Services Handbook, subsection 5.3.11.1.3 "Mental Health Screening," for additional Texas Health Steps Mental Health Screening information.

For more information, call the TMHP Contact Center at 1-800-925-9126

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HOSPITAL PROVIDERS BILLING NEONATAL CLAIMS MUST SUBMIT APPLICATION FOR NEONATAL LEVEL OF DESIGNATION BEFORE JULY 1, 2018

Hospital providers rendering neonatal services should submit their neonatal designation applications to the Texas Department of State Health Services as soon as possible. Completed applications must be submitted before July 1, 2018. If an application is received after July 1, it will not be considered as submitted in time for approval by the executive commissioner before the August 31 deadline.

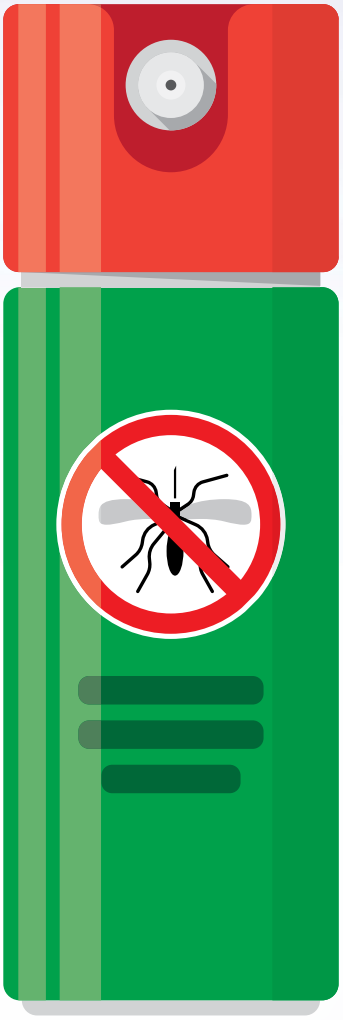
There is no grace period for Medicaid reimbursement payments if a facility is not designated.

Each hospital provider location will be considered separately for designation. The state office will determine the designation level for each location based on, but not limited to, the location's resources and level of care capabilities.

Providers with questions or needing further assistance with the designation process can refer to the Neonatal Program website: http://www.dshs.texas.gov/emstraumasystems/neonatal.aspx.

Providers can refer to the article published on this website on March 22 titled: "Hospital Providers Billing Neonatal Claims Must Submit Application for Neonatal Level of Designation before July 1, 2018."

MOSQUITO REPELLENT BENEFIT



Mosquito repellent for the prevention of Zika virus became a continuous, year-round benefit for Texas Medicaid and CHIP on February 12, 2018.

Please remind your patients to take advantage of this benefit to reduce the spread of Zika and other mosquito-borne illnesses. In June, Harris County Health and Human Services announced that mosquito samples in three Harris county locations (77026, 77338, and 77087) and two Montgomery County locations tested positive for the West Nile virus.

Quick overview:

- Covered programs - Medicaid, CHIP, and CHIP-Perinatal.
- Eligible Members:
  - *pregnant women of any age;*
  - *females, ages 10 through 55; and*
  - *males, age 14 and older*
- The pharmacy benefit for approved mosquito repellents is limited to one can/bottle per prescription fill, with up to two fills allowable per calendar month.
- A prescription is required for claim approval of mosquito repellent when the standing order is not used by a pharmacy.

Read the full notice at www.CommunityHealthChoice.org. Log into your account and go to Medicaid/CHIP > Provider Tools > Zika Mosquito Repellent Benefit Notices or at https://www.txvendordrug.com/sites/txvendordrug/files/docs/formulary/mosquito-repellent-notice-prescriber-en.pdf.

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UPDATED ZIKA TESTING GUIDELINES

The Texas Department of State Health Services (DSHS) has updated its statewide testing guidance for asymptomatic pregnant women based on local and national trends and increasing scientific knowledge of the disease and the limitations of available tests. These changes are explained below. Testing guidance for symptomatic individuals has not changed.

Zika Testing in High-Risk Areas:

- New: Test asymptomatic pregnant women with ongoing risk of possible Zika virus exposure OR residing in Cameron, Hidalgo, Kinney, Maverick, Starr, Val Verde, Webb, Willacy, and Zapata counties three times during pregnancy using PCR only.
- Previously, the recommendation was to test asymptomatic pregnant women in Cameron, Hidalgo, Kinney, Maverick, Starr, Val Verde, Webb, Willacy, and Zapata counties with both PCR and IgM.

Updated Statewide Testing Guidelines:

- New: Test asymptomatic pregnant women with recent possible exposure to Zika virus but no ongoing exposure (i.e., travelers): test as soon as possible up to 12 weeks after exposure using PCR only.
- Previous guidance recommended both PCR and IgM testing.

** Ideally, testing should occur at the first prenatal visit and each subsequent trimester. Repeated PCR testing is not recommended after an initial positive PCR test result during pregnancy.*

DSHS continues to recommend that healthcare providers consult with their local health department or DSHS Regional Office to facilitate appropriate test selection and submission of specimens. Preconception counseling should be provided to patients contemplating having a baby. The current comprehensive guidance on Zika testing can be found at http://texaszika.org/healthcareprof.htm.

Additional Precautions

DSHS recommends that all Texans continue to take precautions to avoid mosquito bites while traveling to areas where Zika is circulating. This is particularly important for women who are or may become pregnant and their sexual partners.

For More Information

Texas-specific information and links to CDC resources: TexasZika.org.

ANESTHESIA REIMBURSEMENT BENEFIT LANGUAGE CLARIFIED FOR TEXAS MEDICAID

Effective for dates of service on or after May 1, 2018, anesthesia reimbursement benefit language has been clarified for Texas Medicaid.

Anesthesia Reimbursement Benefit Language Clarifications

The following has been clarified in the Anesthesia Reimbursement benefit policy:

- An anesthesia practitioner is defined as an anesthesiologist who performs the anesthesia service alone or medically directs a certified registered nurse anesthetist (CRNA), anesthesiologist assistants (AA) or other qualified professional.
- When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA or qualified professional, the QY and U1 modifier combination must be billed together when the CRNA, AA or qualified professional is part of a clinic or group.
- Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist and is directed by the physician.
- Epidural and subarachnoid infusion (not including labor and delivery)
    - *Epidural and subarachnoid infusion for pain management is payable for acute, chronic and postoperative pain management.*
    - *Procedure code 01996 is payable to CRNAs and physicians and is limited to once per day and will be denied when billed on the same day as a surgical/anesthesia procedure.*
    - *Procedure code 01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30 day limitation.*

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PRIOR AUTHORIZATION GUIDE

Please log into your account and review the posted 2018 Prior Authorization Guide for all produces that require prior authorization. Go to Medicaid/CHIP > Provider Tools > Authorization / Notifications.

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 following 2 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 can be sent via fax at 713.295.2283 or 1.844.899.2495. Include supporting documentation, clinical notes, etc., to avoid any delays.

Please do not submit requests for authorization of any service via regular mail.

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PHARMACY PRIOR AUTHORIZATIONS

Thank you for taking the time to read our newsletter! This is the second issue for the pharmacy corner and we are excited to share more tidbits with you. We at Community Health Choice recognize that the prior authorization process can be a challenging one, especially as your patients change insurance plans or transition care from one provider to another. We wanted to continue to address common questions we often receive to bring more clarity into this arena.

Q: How do I know if the drug I am asking for has specific criteria requirements?

A: Community Health Choice works with a pharmacy benefit manager called Navitus. Navitus manages the Community Health Choice formulary in addition to prior authorization criteria. By accessing the formulary, you can determine if a requested medication has specific criteria requirements. You can access the formulary through the Community Health Choice website, but the most direct 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
- ERS: Prescribers > Go to Prescriber Log in (NPI required) > Formulary > Select a Navitus Client (Community Health Choice) > Complete Formulary

Upon opening the formulary, search for the drug that you are trying to request. If the medication has the legend of "PA" next to it, then that drug has drug-specific criteria.

Q: How do I see the drug specific criteria in advance?

A: As alluded to in the previous question, you would need to go to the Navitus website to access drug specific criteria (www.navitus.com)

- Medicaid: Prescribers > Texas Medicaid STAR / CHIP > Prior Authorization Forms
- Marketplace & ERS: Prescribers > Go to Prescriber Log in (NPI required) > Prior Authorization > Select a Navitus Client (Community Health Choice) > Search for the Drug Name in the search field

The drug specific criteria are listed on the fax form, often in check mark form so that it is clear to see if the member meets the criteria.

Q: What kind of information do you expect us to submit with the prior authorization request?

A: Many times we find that there is missing information with the prior authorization requests that are submitted. Often this is due to the wrong prior authorization form being utilized to submit the request. Please reference the previous questions to ensure that you are using the most up to date and applicable form for your prior authorization requests.

Please make sure to answer all applicable questions on the prior authorization forms and sign the bottom of the request. We advise that upon initial submission 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.

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

- Is this a new start for the Member or a continuation of care? If a continuation of care, how long as the Member been on the medication?
- What is the Member's diagnosis?
- Has the Member tried other alternatives previously? If so, what did the Member try, when did the Member try them, and what was the outcome (i.e. rash, hives, nausea)?

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MYTHS AND FACTS ABOUT SUICIDE

Psychiatrist Gabriela Cora, M.D., is sorry so many people are afraid to talk about suicide. When she talks to teenagers at suicide-prevention programs, she asks if they would help a person sitting next to them who was choking. They all said yes. And what about someone who might be having a heart attack? Again, they wouldn't hesitate to help.

"It's important to dispel the myths associated with suicide," said Dr. Cora. "One is that [the risk of dying by] suicide is somehow different from choking or a heart attack or walking under a dangerous wire, but it is not." The consequences of all three are the same. So, when someone needs help to stay alive, you give that help or find someone who can.

Here are a few myths and facts about suicide and attempted suicide:

Myth 1: Most people who talk about completing suicide won't do it. They really want someone to stop them.

Fact: Almost all people who take their own life talk or write about it first. It is important to take such talk seriously. Yes, they want attention, but it is in the form of help. Help them get it.

Myth 2: It is dangerous to even mention the word suicide around someone who has attempted it. It might stir up bad memories.

Fact: No, you won't stir up a person's desire to kill themself by talking about it. In fact, you may even start a good conversation that will help your relationship. Talk is good. You might even learn something about your friend that will help you understand them better.

Myth 3: Only young people kill themselves.

Fact: Young people, ages 15-24, are at high risk. But the risk for elderly people is even higher. One reason is the medication many people over age 65 take for various health conditions that come with aging. Some prescription and over-the-counter drugs cause symptoms of depression, which can start a person thinking about suicide. Depression is not a natural part of aging. It is diagnosable and treatable at any age. There is no reason for anyone to live with untreated depression.

Myth 4: Once people decide to kill themselves, there is nothing anyone can do to stop them.

Fact: Most people who attempt to take their own life do not want to die; they just want to get rid of their emotional pain. Author Sue Blauner attempted suicide three times before she decided she really wanted to live. Learning how to live took time.

"When I was struggling, sometimes if I could talk to someone, it helped," said Blauner. "When I thought about suicide, it wasn't because I wanted to be dead; I just wanted to get rid of the pain."

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MYTHS AND FACTS ABOUT SUICIDE (CONTINUED)

Myth 5: People die by suicide to hurt those around them.

Fact: While it is true that the after effects of a death by suicide in a family or workplace can be long-lasting and horrific, people complete suicide because they are depressed; because they make an impulsive decision while under the influence of drugs or alcohol; or because they are overwhelmed by anger, fear or hopelessness.

Blauner says the suicidal person is so wrapped up in his misery that he or she does not realize they are affecting other people.

Many times, a chemical imbalance causes depression. This problem is easily treated. When a person talks about suicide, they are putting out a signal of an underlying emotional health problem that is as clear as a cough or fever signaling a respiratory infection. If you hear someone express a desire to die by suicide, you should always take that talk seriously.

Myth 6: Most people never even think of suicide.

Fact: Every person alive faces ups and downs, successes, and tragedies. That's how life works. When bad things happen, it's not unusual for someone to think about death, but very few consider it as a good option. If we have strong support systems, we can usually find ways out of our misery. People who complete suicide are in so much pain, they have lost hope their pain will ever go away. And most believe no one will help them.

What are the major risk factors?

- Depression and/or substance use
- History of attempted suicide
- Family history of substance use or mental health problems
- Family history of suicide
- Domestic violence
- Firearms in the home
- Incarceration
- Exposure to suicidal behavior of others
- Lack of social support

Substance use raises the risk of suicide in several ways. First of all, alcohol is a depressant, as are many drugs people use to get high. Substance use can push a person into poor mental health by letting them slip into depression slowly. They may feel good while high but crash after the drug wears off. Second, because they use drugs or drink, they may lose the support of those they need and love. Without the support of a family or friends, they may not be able to find their way through depression to get the help they need. Third, mind-altering substances lower a person's inhibitions while they increase impulsiveness. They may do something under the influence that they would never do while sober.

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MYTHS AND FACTS ABOUT SUICIDE (CONTINUED)

What other major risk factors are there for attempted suicide?

- Being male or elderly put you at highest risk
- Recent divorce or loss of family member
- Physical or sexual abuse

What are the numbers?

- Suicide is the 10th leading cause of death in the U.S.
- About 44,000 people die by suicide every year.
- Every year in the U.S., there are substantially more suicide attempts than actual completed suicides.
- Substance use may be involved in at least half of all suicides and suicide attempts. Forty percent of deaths by suicide are among men who are depressed or have an alcohol problem and are over the age of 45.
- The risk of death by suicide is highest during the first year after an attempt.

When we understand the facts of suicide, we are better able to prevent it.

If you or your loved one are in a crisis and need help immediately, call 1-800-273-TALK (8255) or 1-800-SUICIDE (784-2433) any time, any day. Or go to www.suicide.org. These 24-hour suicide prevention lifelines are free services available to anyone. All calls are confidential.

By Paula Hartman Cohen

https://www.achievesolutions.net/achievesolutions/en/Topic.do?centerId=590&topicId=533

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HEALTH CARE FRAUD

Health care fraud can affect everyone - including you. Certainly, only a small percentage of health care providers and consumers deliberately engage in health care fraud. However, even a small amount of health care fraud can raise the cost of health care benefits for everyone. How you can help avoid and prevent health care fraud?

What is health care fraud?

Health care fraud is a crime. It is committed when a dishonest provider or consumer intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits payable.

The following are some examples of provider health care fraud:

- billing for services not actually performed;
- falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary;
- misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery;
- upcoding – billing for a more costly service than the one actually performed;
- unbundling – billing each stage of a procedure as if it were a separate procedure;
- accepting kickbacks for patient referrals;
- waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan;
- billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract.

Some examples of consumer health care fraud are:

- filing claims for services or medications not received;
- forging or altering bills or receipts;
- using someone else's coverage or insurance card.

Community is working to minimize health care fraud

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

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

How to Report Health Care Fraud

- Call the Compliance hotline at 1.877.888.0002
- Email us: SIU@communityhealthchoice.org
- Write to us:
  Community Health Choice
  c/o Special Investigations Unit
  2636 S Loop West, Suite 125
  Houston, TX 77054

THE HEDIS 2018 SEASON HAS ENDED

Thank you to all of our Providers who participated in submitting records to CIOX and Community. We value your partnership with us. The information we gain from collected records allows us to improve care and service for our Members-your patients.

For continued success, please keep up the following good work by:

1. Ensuring Provider signatures and credentials are on your records
2. Ensuring Member name is included on every page
3. Documenting the comprehensive health and developmental history, including physical and mental health development
4. Documenting the health education including anticipatory guidance
5. Documenting BMI including percentile

We look forward to partnering with you again in HEDIS 2019!

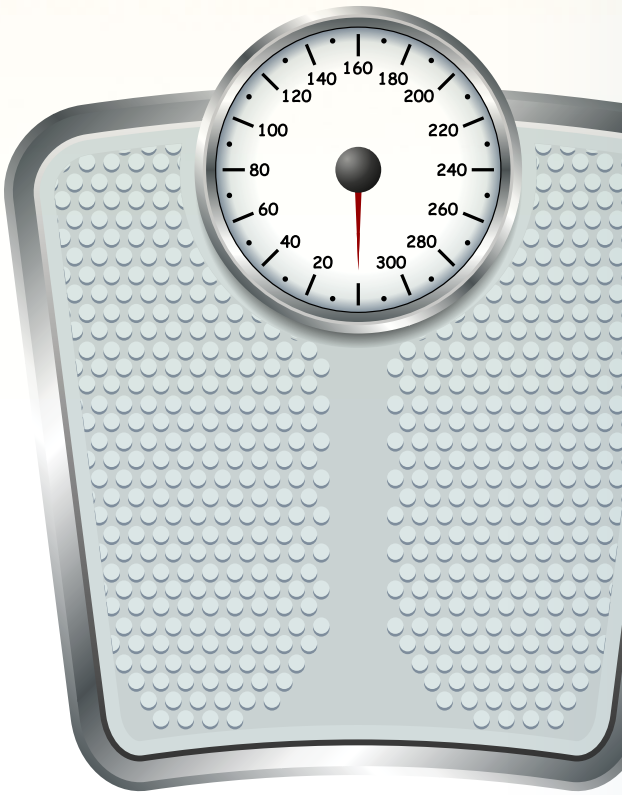
HEDIS CRITERIA

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN AND ADOLESCENTS

Which Members are included in the measure? How is a Member considered compliant?

Members between ages 3-17 years old as of December 31st of the measurement year. These Members must receive an outpatient visit with a primary care provider or OBGYN with the following during the measurement year:

- BMI percentile
- Counseling for nutrition
- Counseling for physical activity



What documentation needed in the medical record?

BMI

- Evidence of height, weight, and BMI percentile (percentile or percentile plotted on age-growth chart)
  - *Absolute BMI value will not be accepted*
  - *BMI percentile should be expressed as a percentage*
  - *Ranges and threshold do not meet the criteria.*
  - *Documentation cannot include <1% or >99% (either 0% or 100%).*

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HEDIS CRITERIA (CONTINUED)

Counseling for Nutrition

- Evidence of at least ONE of the following with date discussed:
  - *Discussion of current nutrition behaviors*
  - *Checklist indicating nutrition was discussed*
  - *Counseling or referral for nutrition education*
  - *Patient received educational materials on nutrition during face-to-face visit*
  - *Anticipatory guidance for nutrition*
  - *Weight or obesity counseling*

Counseling for Physical Activity

- Evidence of at least ONE of the following with date discussed:
  - *Discussion of current physical activity behaviors*
  - *Checklist indicating physical activity was discussed*
  - *Counseling or referral for physical activity*
  - *Member received educational materials on physical activity during a face-to-face visit*
  - *Anticipatory guidance specific to the child's physical activity*
  - *Weight or obesity counseling*

What codes are used for billing?

The following codes are used to identify BMI percentile, counseling for nutrition and physical activity:

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

HEDIS CRITERIA (CONTINUED)

What is the Code Description?

Counseling for Nutrition

Code System	Code	Description
ICD-10	Z71.3	Dietary counseling and surveillance
HCPCS	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
HCPCS	G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
HCPCS	G0447	Face to face behavioral counseling for obesity, 15 minutes
HCPCS	S9449	Weight management classes, non-physician provider, per session
HCPCS	S9452	Nutrition classes, non-physician provider, per session
HCPCS	S9470	Nutritional counseling, dietitian visit

Counseling for Physical Activity

Code System	Code	Description
ICD-10	Z02.5	Encounter for examination for participation in sport
ICD-10	Z71.82	Exercise counseling
HCPCS	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
HCPCS	S9451	Exercise classes, non-physician provider, per session

How to Improve WCC Measure

- Discuss and document nutrition and physical activity during at least one office visit annually.
- Document height, weight and BMI percentile.
- Document all services and procedures performed on the medical record
- Utilize billing codes as outlined in this presentation to ensure you receive credit for WCC, as well as may also decrease the number of chart reviews required during HEDIS season
- If you have patients who are challenged to schedule an annual well-child visit, use sick visits or sports physicals as an opportunity to perform WCC services.
    - *To fulfill criteria, these counseling sessions cannot be geared toward the presenting problem for which the visit was intended, and must occur each measurement year.*

A TAG-TEAM APPROACH TO PRENATAL/ POSTPARTUM VISITS FOR MOM AND WELL-BABY CHECKUPS

Please help us encourage our Members to go to their prenatal and postpartum appointments! Stress to them that these appointments are extremely necessary and beneficial to both them and their newborn child. Try the tag-team approach explained below.

Primary Care Providers (PCPs):

Pregnant Members under 21 still need comprehensive care visits in addition to prenatal visits. Refer Members to an OB/GYN if they have not yet chosen one. During their newborn's four-week checkup, stress the importance of scheduling a postpartum appointment.

OB/GYNs:

Provide prenatal education about choosing their newborn a PCP and scheduling checkups as a significant part of birth preparation. Since the first two checkups are within 24 to 48 hours after birth while at the hospital and again within five days after leaving the hospital, providing information early can help expectant Members know what to expect before and after their baby leaves the hospital.

In addition, please stress the importance of a postpartum appointment for four to six weeks after delivery when you see our Members in the hospital room and during their first office visit after delivery. Ask your front-office staff to offer to schedule one of these appointments when they check in or out.

Stress to our Members the importance of routine newborn checkups toward the end of their pregnancy and again during their postpartum visits. Assist our Member by referring them to a pediatrician if they have not chosen one yet.

If you need help locating a PCP and/ or OB/GYN in our network, you can contact Member Services directly at 1.888.760.2600 or ask Members to contact us.

RISK ADJUSTMENT SEASON IS UPON US!

As you know, for Providers who also participate in Marketplace, Community Health Choice is required to collect medical records for the Risk Adjustment Data Validation (RADV) audit prescribed by the Centers for Medicare & Medicaid Services (CMS). RADV is the process of verifying that diagnosis codes submitted for payment are supported by medical record documentation. We would like to thank our Providers in advance for their cooperation and assistance with this annual CMS requirement.

Frequently Asked Questions

When is the collection period?

The medical record collection period began May, 2018 and will run through December 7, 2018.

How will the request be sent?

Community Health Choice may contact you by mail, fax and/or phone. If you have questions, please contact your Provider Engagement Representative or email us at RiskAdjustment@CommunityCares.com.

What will be requested?

Community Health Choice will request medical records for specifically identified Members for services provided in 2017.

How do I respond to the request?

Please respond to the request by submitting the requested medical record via mail or fax, in paper or electronic form. We ask that you respond to the medical records request within 5-7 days.

Am I required to respond?

This is a required quality improvement activity within your 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
- Legible Provider signature with credentials
- Progress notes and diagnostic information

Thank you for your continued partnership to provide quality care to our Members – your patients.

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ORDERING, REFERRING, AND PRESCRIBING PROVIDERS

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.

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 ADDRESS FOR HHSC REFUNDS BEING SENT TO COMMUNITY

Effective July 1, 2018, please note the new lockbox address for Medicaid, CHIP, and CHIP Perinate Refunds:

Community Health Choice
PO Box 4818
Houston, TX 77210-4818

NPI AND TAXONOMY CODE REMINDER

To be eligible for Texas Medicaid reimbursement, a Provider must obtain a National Provider Identifier (NPI) for the National Plan and Provider Enumeration System (NPPESS).

Additionally, during the enrollment process, Providers must select a primary and, if applicable, secondary taxonomy code associated with their Provider type. Providers will be supplied a list of taxonomy codes to choose from that correspond to the services rendered by the type of provider they wish to enroll as. Providers must verify the taxonomy code associated with their provider type and specialty before beginning the online attestation process.

CLAIM SUBMISSION REMINDER

At Community, our goal is to process all claims at initial submission. Before we can process a claim, it must be a "clean" or complete claim submission, which includes the following information:

- Correct Member Information (Name, Member ID, Date of Birth, etc.)
- Date(s) of Service
- Provider Name and required information
- Group Name and required information (if applicable)
- Rendering Provider information (if applicable)
- Billed amount
- Standard Current Procedural Terminology (CPT®) code sets and modifiers
- Standard Health Care Procedure Coding System (HCPCS) code sets and modifiers
- Standard Diagnostic Related Groupings (DRG) or Revenue codes (facility)
- Standard International Classification of Diseases (ICD-10) codes, tenth revision
- Accurate entries for all the fields of information contained in the UB04 or CMS-1500 forms

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PROVIDER PARTICIPATION CRITERIA

Since 2015, Community has maintained Provider Participation Criteria for Physicians and Ancillary Providers. The following Participation Criteria applies to all Physicians and Ancillary Providers, subject to exception based on Community's sole discretion (e.g., unique geographic or demographic circumstances or specific Member access and availability needs).

Physicians

Criteria Type	Criteria	STAR	CHIP	Health Insurance Marketplace	Existing Provider	New Provider	Additional Notes
Regulatory	Participation in THSteps	Yes	N/A	N/A	Yes	Yes	Applies to PCP Providers only
	Participation in Wellness	N/A	Yes	Yes	Yes	Yes	Applies to PCP Providers only
	Attested NPI Number	Yes	Yes	N/A	Yes	Yes	
	Medicare Number (preferred)	Yes	Yes	Yes	Yes	Yes	Does not apply to pediatric or OB/GYN Providers
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	Yes	Yes	
	Not currently on Govt. Exclusion List	Yes	Yes	Yes	Yes	Yes	
Administrative	Internet Access - Office/Patient Care Setting	Yes	Yes	Yes	Yes	Yes	
	Facsimile	Yes	Yes	Yes	Yes	Yes	
	Hospital Privileges at Participating Hospital or Surgery Center	Yes	Yes	Yes	Yes	Yes	Or advanced approval of acceptable coverage (e.g., hospitalist or designation)
	Submission of authorization requests via Provider Portal	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Yes	Yes	Through existing clearinghouse partnerships
	EDI - Electronic Funds Transfer	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Remittance Advice	Yes	Yes	Yes	Yes	Yes	
	Adherence to HIPAA Standard Transactions	Yes	Yes	Yes	Yes	Yes	
	Participation in CAQH program	Yes	Yes	Yes	Yes	Yes	
Quality	Mandatory Signature on Community's Commitment to Quality	Yes	Yes	Yes	Yes	Yes	Applies to PCPs and OB/GYNs only
Not required, Inquiry Only							
Administrative	Electronic Medical Record (EMR)	Yes	Yes	Yes	Yes	Yes	
Quality	Patient Satisfaction Measurement Tool	Yes	Yes	Yes	Yes	Yes	

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PROVIDER PARTICIPATION CRITERIA (CONTINUED)

Ancillary/Facility Providers

Criteria Type	Criteria	STAR	CHIP/ CHIP P	Health Insurance Marketplace	Existing Provider	New Provider	Additional Notes
Administrative	Valid Texas Medicaid Number	Yes	Yes	No	Yes	Yes	
	Valid Medicare Number	Yes	No	Yes	Yes	Yes	
	At least one line dedicated for facsimile	Yes	Yes	Yes	Yes	Yes	
	Submission of authorization requests via Provider Portal	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Yes	Yes	Through existing clearinghouse partnerships
	EDI - Electronic Remittance Advice	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Funds Transfer	Yes	Yes	Yes	Yes	Yes	
Regulatory	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	Yes	Yes	

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PROVIDER PARTICIPATION CRITERIA (CONTINUED)

As we continue efforts to assess and support the quality and administrative efficiency of our Participating Providers, the following Provider Participation Criteria applies to all Urgent Care Providers.

Urgent Care

Criteria Type	Criteria	STAR	CHIP	Health Insurance Marketplace	Existing Provider	New Provider	Additional Notes
Administrative	Has valid Texas Medicaid Number	Yes	Yes	N/A	Yes	Yes	Applies to PCP Providers only
	Has valid Medicare Number	Yes	Yes	Yes	Yes	Yes	Applies to PCP Providers only
	Internet Access - Office/Patient Care Setting	Yes	Yes	Yes	Yes	Yes	
	Facsimile	Yes	Yes	Yes	Yes	Yes	Does not apply to pediatric or OB/GYN Providers
	Electronic Medical Records	Yes	Yes	Yes	Yes	Yes	
	Electronic submission of prescriptions (e-Prescribe)						
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Funds Transfer	Yes	Yes	Yes	Yes	Yes	
	EDI - Electronic Remittance Advice	Yes	Yes	Yes	Yes	Yes	
	Visit summary to PCP within 24 hrs or the next business day	Yes	Yes	Yes	Yes	Yes	
	Adherence to HIPAA Standard Transactions	Yes	Yes	Yes	Yes	Yes	
Quality	Onsite services (i.e., lab, x-ray, etc)	Yes	Yes	Yes	Yes	Yes	
Not required, Inquiry Only							
Administrative	Accreditation - Urgent Care Association of America (UCAOA)	Yes	Yes	Yes	Yes	Yes	
	Certification - Certified Urgent Care (CUC) Program	Yes	Yes	Yes	Yes	Yes	
	Electronic Medical Records	Yes	Yes	Yes	Yes	Yes	
	Electronic submission of prescriptions (e-Prescribe)	Yes	Yes	Yes	Yes	Yes	
Quality	Patient Satisfaction Measurement Tool	Yes	Yes	Yes	Yes	Yes	

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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.

CREDENTIALING REMINDER

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

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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.

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BACK-TO-SCHOOL CHECKUPS

Summer is here, which means now is the time that the school-aged Members visit their doctor's office for back-to-school checkups. Community recommends its network Providers to include some other important components into one single checkup. This makes it a "one-stop" visit for the Member and the Provider's office.

1. THSteps/Well-Child Checkup

This checkup tracks healthy growth and identify Member's health problems early. This also allows the Provider to assess and answer any questions/concerns related to the Member's health, which might interfere with his/her school.

2. Sports and Physical Exams

Members, who participate in sports, will need their annual sports and physical checkup. A sports and school physical is a value-added service for Community Members since it is not a covered benefit for Medicaid. Community will pay sports and school physicals for Medicaid Members ages 4 to 19 (limited one per calendar year). Providers must use relevant codes based on the athletic training evaluations, requiring these components:

- History and physical activity profile with number of comorbidities that affect physical activity
- Examination of affected body area and other symptomatic or related systems addressing any of the following elements: body structures, physical activity, and/or participation deficiencies
- Clinical decision making of level of complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome
- Time duration spent face-to-face with the patient and/or family

Code	Level of Complexity	No. of Comorbidities	No. of Elements Addressed	Time Duration
97169	Low	0	1 – 2	15 minutes
97170	Moderate	1 – 2	3 or more	30 minutes
97171	Moderate	3 or more	4 or more	45 minutes
97172	Re-evaluation of athletic training established plan of care requiring these components: • assessment of patient's current functional status when there is a documented change • revised plan of care using a standardized patient assessment instrument and/or measureable assessment of functional outcome with an update in management options, goals, and interventions			20 minutes

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BACK-TO-SCHOOL CHECKUPS (CONTINUED)

3. Flu, vaccine, and other immunizations

- Seasonal flu activity can begin as early as October and continue to occur as late as May. Setting young children get vaccinated help protect them from flu since young children are more vulnerable to serious flu complications.
- This is also a great time to administer any immunizations that the Member might need prior to attending their school.

Remember, Community allows you to bill all of the above checkups on the same day. Please read "Billing THSteps Medical Checkup and Other Services on the Same Day" section of this newsletter for billing tips.

Below is the chart that summarizes the 2018 Immunization requirements for the schools in the state of Texas.

2018 - 2019 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 child-care facility or public or private elementary or secondary school in Texas.

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

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

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UPDATES ON MEDICAID BENEFITS EFFECTIVE JULY 1, 2018

THSteps Postpartum Depression Screening Benefit

Postpartum depression screening during an infant's Texas Health Steps (THSteps) checkup will become a benefit of Texas Medicaid. Texas Health and Human Services (HHS) will update the Texas Medicaid Provider Procedure Manual (TMPPM) to incorporate this new benefit.

The Medicaid provider notification regarding these changes can be found at TMPH's website.

THSteps Mental Health Screening Change For 12 To 18 Year Olds

THSteps will allow Members 12 through 18 years of age to receive a mental health screening (procedure codes 96160 or 96161) using one or more of the validated, standardized mental health screening tools recognized by THSteps, once per calendar year during a THSteps checkup. For more information on this benefit change, please visit TMHP's website.

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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 have a checkup 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 be completed as soon as possible after the Member's birthday.*

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, ages 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 health care 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

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THSTEPS MEDICAL CHECKUP PERIODICITY SCHEDULE

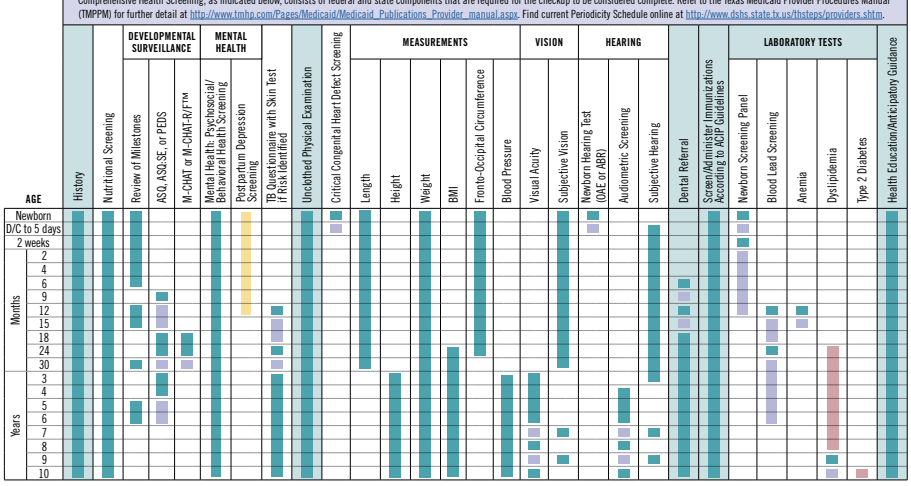
The THSteps Medical Checkup Periodicity Schedule for Members ages 0-20.

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

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.



LEGEND

- Mandatory
- If not completed at the required age, must be completed at the first opportunity if age appropriate.
- For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- Recommended
- Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/. For free online provider education: txhealthsteps.com.

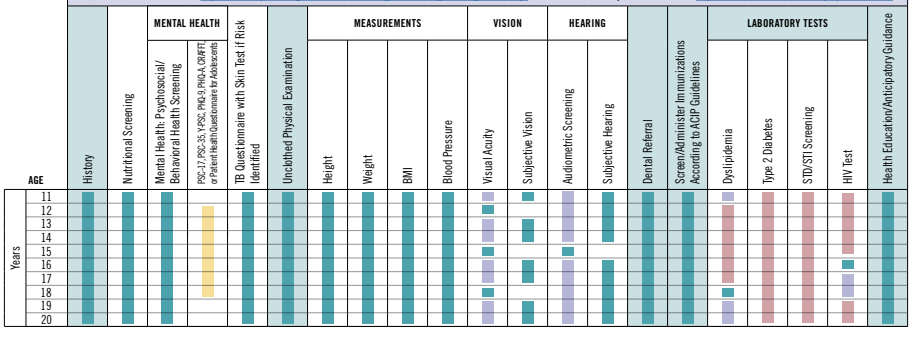
TEXAS Health and Human Services
Texas Health Steps

E03-13634 July 1, 2018

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.



LEGEND

- Mandatory
- If not completed at the required age, must be completed at the first opportunity if age appropriate.
- For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- Recommended
- Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/. For free online provider education: txhealthsteps.com.

TEXAS Health and Human Services
Texas Health Steps

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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** 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 blood lead level assessment appropriate for age and risk factors, and anemia;
5. **Health education** (including anticipatory guidance); and
6. **Dental referral** every 6 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 July 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

Texas Health Steps Quick Reference Guide

Remember: Use Provider Identifier • Use Benefit Code EP1

THSteps Medical Checkup Billing Procedure Codes

THSteps Medical Checkups

99381	99382	99383	99384	99385*
99391	99392	99393	99394	99395*

* For clients who are 18 through 20 years of age, use diagnosis code Z0000 or Z0001.

THSteps Follow-up Visit

Use procedure code 99211 for a THSteps follow-up visit.

ICD 10 Diagnosis Codes

Z00110	Routine newborn exam, birth through 7 days
Z00111	Routine newborn exam, 8 through 28 days
Z00129	Routine child exam
Z00121	Routine child exam, abnormal
Z0000	General adult exam
Z0001	General adult exam, abnormal

Point-of Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

Procedure Codes	Vaccine
90632 or 90633† with (90460/90461 or 90471/90472)	Hep A
90620† or 90621† with (90460/90461 or 90471/90472)	MenB
90636 with (90460/90461 or 90471/90472)	Hep A/Hep B
90644	Hib-MenCY
90647† or 90648† with (90460/90461 or 90471/90472)	Hib
90649†, 90650†, or 90651† with (90460/90461 or 90471/90472)	HPV
90630, 90654, 90655†, 90656†, 90657†, 90658†, 90685†, 90686†, 90687† or 90688† with (90460/90461 or 90471/90472); 90660† or 90672† with (90460/90461 or 90473/90474); 90661, 90673, 90674, 90682 or 90756† with (90471/90472)	Influenza
90670† with (90460/90461 or 90471/90472)	PCV13
90680† or 90681† with (90460/90461 or 90473/90474)	Rotavirus
90696† with (90460/90461 or 90471/90472)	DTaP-IPV
90698† with (90460/90461 or 90471/90472)	DTap-IPV-Hib
90700† with (90460/90461 or 90471/90472)	DTaP
90702† with (90460/90461 or 90471/90472)	DT
90707† with (90460/90461 or 90471/90472)	MMR
90710† with (90460/90461 or 90471/90472)	MMRV
90713† with (90460/90461 or 90471/90472)	IPV
90714† with (90460/90461 or 90471/90472)	Td
90715† with (90460/90461 or 90471/90472)	Tdap
90716† with (90460/90461 or 90471/90472)	Varicella
90723† with (90460/90461 or 90471/90472)	DTap-Hep B-IPV
90732† with (90460/90461 or 90471/90472)	PPSV23
90733 or 90734† with (90460/90461 or 90471/90472)	MPSV4
90743, 90744†, or 90746 with (90460/90461 or 90471/90472)	Hep B
90748† with (90460/90461 or 90471/90472)	Hib-Hep B

† Indicates a vaccine distributed by TVFC

Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

Oral Evaluation and Fluoride Varnish

Use procedure code 99429 with U5 modifier.

Developmental and Autism Screening

Developmental screening with use of the ASQ, ASQ:SE or PEDS is reported using procedure code 96110.

Autism screening with use of the M-CHAT or M-CHAT R/F is reported using procedure code 96110 with U6 modifier.

Mental Health Screening

Mental Health Screening in adolescents with the use of the PSC 17, PSC-35, Y-PSC, PHQ-9, PHQ-A (depression screen), CRAFFT, and PHQ-A (Anxiety, mood, substance use) is reported using procedure code 96160 or 96161. Only one procedure code (96160 or 96161) may be reimbursed per client per calendar year.

Postpartum depression screening with the use of a validated screening tool including the Edinburgh Postnatal Depression Scale, PHQ-9 or Postpartum Depression Screening Scale is reported using procedure code G8431 or G8510. Only one procedure code (G8431 or G8510) may be reimbursed per client.

Modifiers

Performing Provider

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

AM (Physician)	SA (Nurse Practitioner)	TD (Nurse)	U7 (Physician Assistant)

Exception to Periodicity

Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

23 (Unusual Anesthesia)	32 (Mandated Services)	SC (Medically Necessary)

FQHC and RHC

Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for THSteps medical checkups.

Vaccine/Toxoids

Use to indicate a vaccine/toxoid *not available* through TVFC and the number of state defined components administered per vaccine.

U1	Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available

Vaccine Administration and Preventive E/M Visits

Use with THSteps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.

25	Significant, separately identifiable evaluation

Condition Indicator Codes

Use one of the Condition Indicators below if a referral was made.

Indicator	Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

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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 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.

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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 the 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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CONTACTING YOUR PROVIDER REPRESENTATIVE

Community is dedicated to precise communication with you. Your first and quickest resource is our Provider Portal for Eligibility and Claim Inquiries. Please contact your Provider Representative if you would like training and/or information on how to sign into our portal. If you need to speak with a representative, we have some requirements before we answer your questions and concerns.

- Our first request will always be for your Tax ID. Please have this ready along with a couple additional identifiers such as NPI and address.
- If the call is regarding a specific Member, please provide the Member ID number, date of birth, name and address.
- Questions concerning authorizations or appeals should include the Authorization ID Number.
- If you have called previously, providing us with the Call Tracking Number will ensure we can quickly open the item for which you need additional information.

We value you as our partners in the community. If you have feedback to ensure positive experiences on your phone call with Community, please let us know.

REACH OUT AND READ PROGRAM IN PROVIDER OFFICES

Reach Out and Read "gives young children a foundation for success by incorporating books into pediatric care and encouraging families to read aloud together."

In keeping with our KinderReady Social Determinants of health mission to create pathways for underserved residents of Southeast Texas to access high-quality, affordable preschool programs and promote strong parent engagement to support kindergarten readiness and future academic success, Community Health Choice collaborated with the UT Physicians – Rosenberg Clinic to launch its program.

Every child from ages 6 months to 5 years receives a book as part of a well-child exam. Books are available in English and Spanish.

"Children get so excited, sometimes with a squeal of delight," said **Sevahn A. Carril, M.D.**, pediatrician at UT Physicians – Rosenberg. "It is one of my favorite parts of their checkup. I love walking in with a brand new book and watching how thrilled they are with it. The hope is that because of the books, parents may read with them every night."

Visit **Reach Out and Read Texas** for more information on starting your own program.

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LEAD EXPOSURE SCREENING AND TREATMENT

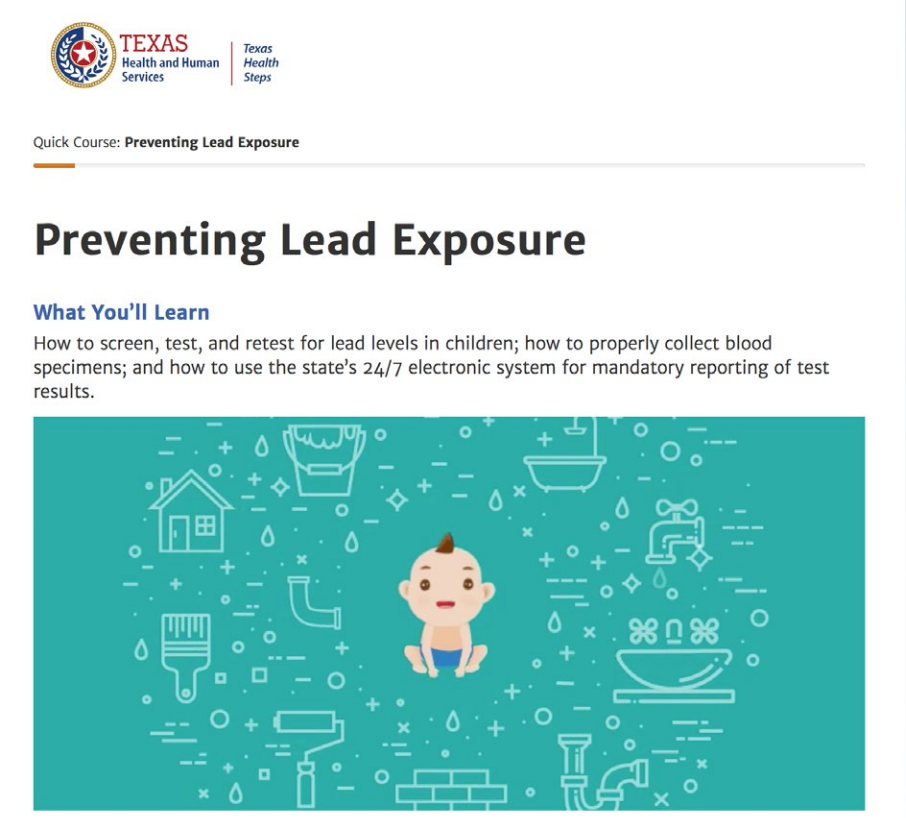
Did you know that Medicaid covers lead screening, follow-up testing, and environmental lead investigations?

Texas law (Tex. Health & Safety Code Chapter 88 and 25 Tex. Admin. Code Chapter 37, Subchapter Q) requires that all blood lead test results for children 14 years and younger be reported to the state's 24/7 electronic system.

This short course covers what providers need to know to screen, test, and retest children; properly collect blood specimens; use the mandatory reporting system; and protect Texas children from being exposed to lead in the first place.

Take the course by visiting the link below –

http://www.txhealthsteps.com/static/courses/preventing-lead-exposure/lead-qc-1.html



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

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

The courses are available at: http://www.txhealthsteps.com/cms/

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TMHP ONLINE PROVIDER EDUCATION

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

First-time users will need to register.

CBT topics include 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/prescriber-education

FEEDBACK

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

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

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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

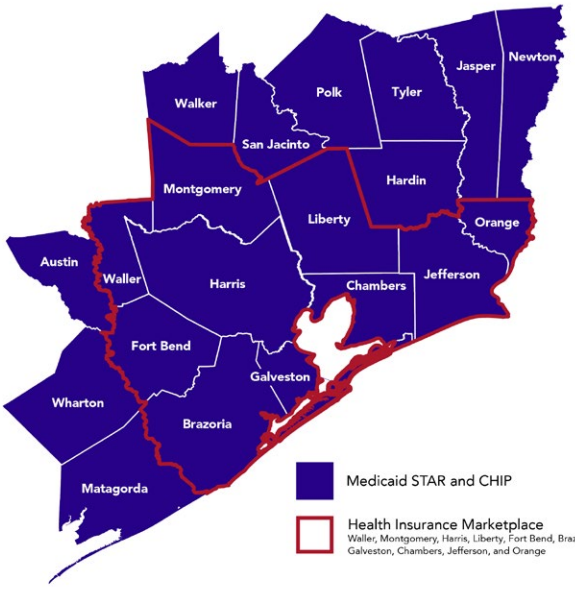
713.295.2294 or 1.888.760.2600

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
Heal h and Human
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