COMMUNITY HEALTH CHOICE

PROVIDER NEWSLETTER

V3-2018

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CommunityHealthChoice.org
713.295.2295 | 1.888.760.2600

COMMUNITY HEALTH CHOICE
COMMUNITY CARES.

CLIA REQUIREMENT

Beginning January 1, 2019, Community will deny claims for CLIA-waived lab services if Provider does not have a valid CLIA certification.

RENDERING PROVIDER REQUIREMENT

Effective January 1, 2019, Community will require all Professional and Institutional claims for all STAR, CHIP, CHIP-P and Marketplace to include the Rendering Provider NPI for all claims submitted. Community will deny claims if the Rendering Provider NPI is not present on the claim.

PREVENTIVE VISITS

The CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA). This means that the CPT code set must be used for all financial and administrative health care transactions sent electronically.

Community requires practitioners to use CPT codes when submitting claims for services provided to members. If there is no CPT code that identifies the services performed, a Provider may report those services with a HCPCS code, if available. Otherwise, the appropriate CPT "unlisted" code may be submitted with a complete description of services provided.

The general components of a preventive medicine visit (CPT codes 99381-99397) include:

- a comprehensive history and examination,
- anticipatory guidance/risk factor reduction interventions/counseling,
- ordering of appropriate immunizations or laboratory/diagnostic procedures, and
- management of insignificant problems.

Always match preventive medicine codes with an appropriate diagnosis. Remember: The ICD-10 diagnosis code always should identify correctly the chief reason for the visit. A preventive medicine service is not a problem-oriented visit, so do not code it as one. Instead, use an ICD-10-CM code to support the services provided.

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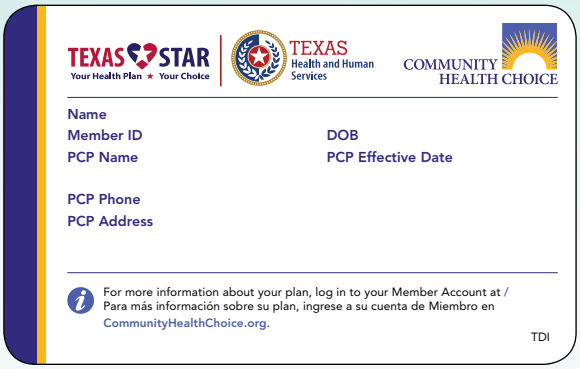
A NEW LOOK FOR A NEW YEAR!

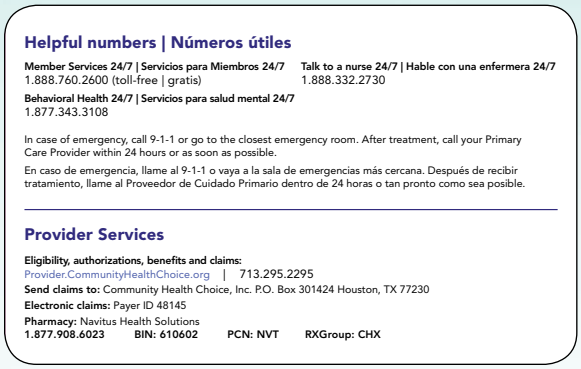
Community is pleased to introduce our newly redesigned Member identification cards effective January 1, 2019. CHIP Perinate Member IDs will also be redesigned in the near future. We are excited to launch new Member identification cards that are easier to read for both Providers and Members. The new cards feature the following key components:

- Provider's name, phone number and address so Members can quickly contact your practice
- Link for Members to navigate their personalized Community account
- Instant Access for pharmacy and behavioral healthcare needs

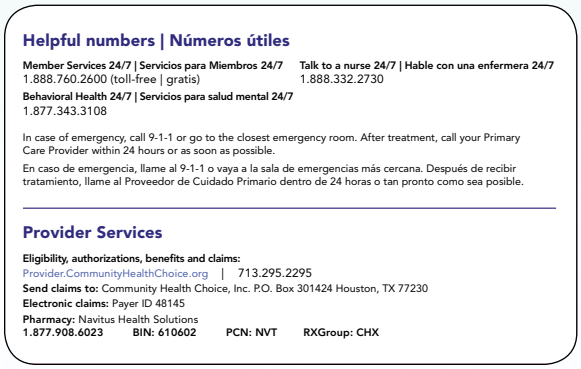
Please feel free to contact your Provider Engagement Representative if you have additional questions and concerns regarding our new look.

Redesigned STAR Member ID





Redesigned CHIP Member ID



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NEONATAL LEVEL OF CARE DESIGNATION REQUIRED FOR HOSPITAL PROVIDERS RENDERING NEONATAL INPATIENT SERVICES

Effective for dates of admission on or after September 1, 2018, hospitals enrolled in Texas Medicaid may be reimbursed for inpatient neonatal services only if the hospitals have received a neonatal level of care designation from the Department of State Health Services in accordance with 25 Texas Administrative Code §§133.181 -133.190.

The neonatal level of care designation applies for Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

Hospitals That Do Not Meet Minimum Requirements for Neonatal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for neonatal services will not be reimbursed for inpatient neonatal services rendered to Texas Medicaid and CSHCN Services Program clients. Hospitals without a neonatal level of care designation may be reimbursed for emergency services provided or reimbursed under state or federal law to stabilize an infant prior to transport to a facility capable of providing the appropriate level of care.

Claims for inpatient neonatal services submitted by hospitals that do not have a neonatal level of care designation on file will be denied. Providers can appeal the claim with documentation of the emergency services required.

If neonatal inpatient services are rendered by a facility that has applied for (but not yet received) a neonatal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge). The facility is also responsible for keeping their claim appeals active while awaiting neonatal level of care designations in order to adhere to the 120-day claim appeal deadline.

Requirements to obtain a neonatal level-of-care designation only apply to facilities located in Texas. Those entities physically located outside of Texas but enrolled in Texas Medicaid (i.e. out-of-state or border state facilities) are exempt from requiring a neonatal level of care designation for inpatient services rendered to neonatal clients.

Note: When submitting paper claims for inpatient neonatal services rendered at a facility with an address that is different from the provider's physical address, providers must enter the address of the facility where services were rendered in the remarks field.

Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a neonatal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a neonatal level of care designation.

Important: The hospital address submitted to DSHS on the neonatal level of care designation application must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on file. For example, numbers must be spelled out as words or left numeric on the claim to match the address submitted to DSHS on neonatal level of care designation application, "street" or "avenue" must either be spelled out or abbreviated, etc.

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NEONATAL LEVEL OF CARE DESIGNATION (CONTINUED)

Address on Neonatal Designation Application	Correct	Incorrect (Claim May Be Denied)
12345 First Street	12345 First Street	12345 1st Street
6 Maine Street	6 Main Street	Six Maine St.

Providers can refer to the DSHS approval letter for the correct address.

Change of Address for a Neonatal Designation

Neonatal designated address that require updates/corrections must be updated through DSHS not TMHP. Refer to www.dshs.texas.gov/emstraumasystems/formsresources.shtm#neonatal to complete the Neonatal Facility Designation application.

Transfers

When Texas Medicaid or CSHCN Services Program clients are neonates on the date of admission and are subsequently transferred to another facility, neonatal level of care designation requirements will apply to all facilities involved in that client's continuous inpatient stay.

TPI Change Due to Split or Merge

Hospitals with a Texas Provider Identifier (TPI) change that is due to a split or merge will be responsible for notifying DSHS. Also, hospitals must notify DSHS of any maintenance required on their neonatal level of care designation address due to an address change.

Crossover Claims for Dual-eligible Clients

Neonatal level of care designation requirements will also apply for inpatient crossover claims.

Resources

Other Health and Human Services Commission (HHSC) websites/resources:

- HHSC announcement: Maternal and Neonatal Levels of Care Change In Effective Dates
- HHSC website: Neonatal Level of Care Designation
- HHSC webinars: Neonatal Care Designation

Neonatal Level of Care Designation Reminder

Reminder: Hospitals must apply for a neonatal level of care designation for each physical location. Information about applying for the designation can be found at www.dshs.texas.gov/emstraumasystems/formsresources.shtm.

DSHS will assign one of four neonatal level of care designations to each hospital location based on the services and care provided at each hospital location.

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

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TELEMEDICINE AND TELEHEALTH SERVICES BENEFIT POLICY LANGUAGE UPDATED

Effective for dates of service on or after October 1, 2018, telemedicine and telehealth benefit policy language will be updated for Texas Medicaid. The policy updates are a component of the Health and Human Services Commission (HHSC) implementation of Senate Bill (S.B.) 1107 (85th Legislature, 2017). As additional S.B. 1107 implementation activities continue, HHSC authorizes providers to render telemedicine and telehealth services in accordance with the policy updates effective October 1, 2018.

For more information visit the link below-

http://www.tmhp.com/News_Items/2018/08-Aug/8-17-18%20Telemedicine%20and%20Telehealth%20Services%20Benefit%20Policy%20Language%20Updated,%20Effective%20October%201,%202018.pdf

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TEXAS HEALTH STEPS POSTPARTUM DEPRESSION SCREENING BENEFIT

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 center 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.

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TEXAS HEALTH STEPS POSTPARTUM DEPRESSION SCREENING BENEFIT (CONTINUED)

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.

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

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.

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TEXAS HEALTH STEPS POSTPARTUM DEPRESSION SCREENING BENEFIT (CONTINUED)

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 Code				
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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PRIOR AUTHORIZATION

Effective January 1, 2019 the following updates will be made to Community's Authorization Guide.

Please be sure to log into the Provider Portal to review these updates once they become effective.

Cardiac Services:

Prior authorization requirement **lifted** for Cardiologists.

For providers who are not Cardiologists, prior authorization requirement remains for:

- 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*

Durable Medical Equipment (DME) and Prostheses:

Prior authorization requirement **lifted** for Cochlear implants, hearing aids and amplifiers

- Providers need to be aware that there are claims limitations in place for all of these items that will prevent payment beyond the limits.

Prior authorization requirement **lifted** for diabetic supplies or other supplies exceeding the amount needed for 30 days or as specified in the product benefit

- Providers need to be aware that there are claims limitations in place for all of these items that will prevent payment beyond the limits.

Prior authorization requirement was **added** for DME rental exceeding 3 months, regardless of the purchase price

Prior authorization requirement remains for DME items with a purchase price exceeding $500 regardless of purchase or rental

Hospice

Prior authorization requirement **lifted** for inpatient and home based hospice care

Injectable Drugs:

Prior authorization criteria for injectable drugs **changed to >$500 billed charges** given in a provider's office, clinic setting, infusion suite or home unless self- administered (formerly PA required for injectables >$500 AWP)

Prior authorization requirement lifted for the following injectable drugs:

- Haldol (Haloperidol Decanoate) – **J1631**
- Prolixin (Fluphenazine Decanoate) – **J2680**
- Risperdal Consta (Risperidone) – **J2794**
- Zyprexa Relprevv (Olanzapine Extended Release Injectable Suspension) – **J2358**
- Invega Sustenna (Paliperidone Palmitate) – **J2426**
- Invega Trinza (Paliperidone) - **J2426**
- Abilify Maintena (Aripiprazole) – **J0401**
- Aristada (Aripiprazole Lauroxil) – **J1942**

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PRIOR AUTHORIZATION (CONTINUED)

Outpatient Procedures/Surgeries:

Prior authorization requirement **lifted** for colonoscopy (if under 50 years of age or <5 years since last colonoscopy)

Radiology/Imaging Services:

Prior authorization requirement **lifted** for the following radiology/imaging services for pediatric members under 21 years (when done in any place of service except inpatient, emergency room, or observation bed status):

- CT Scans, including CT angiography and electron-beam CT scanning (coronary artery imaging)
- MRA
- MRI
- PET Scan
- Nuclear stress test, SPECT Scans
- Stress echocardiography

THERAPY WAIT LIST

If a Therapy Provider cannot treat a patient at the frequency commensurate with that persons assessed needs, and if they create a waiting list for the Medicaid beneficiaries, and if a therapy provider can no longer accept new patients, the provider needs to notify Community. We are encouraging our Providers to inform us via our Provider Portal.

To notify us if a Therapy Provider has a wait-list, visit https://providerportal.communityhealthchoice.org/therapywaitlist and complete the wait-list form.

MEDICAL NECESSITY APPEALS

Appeals deadline is 30 days from the date of last disposition of the authorization. Please include the reason for your appeal in your documentation, e.g., medical issue, adverse determination, authorization appeals.

Mail to: Community Health Choice
Attn: Medical Necessity Appeals
2636 S Loop West, Suite 125
Houston, TX 77054
Web site: CommunityHealthChoice.org
Fax: 713.295.7033

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WELCOME TO THE PHARMACY CORNER!

We continue to see some challenges in the prior authorization arena and want to address some common questions we continue to receive.

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

A: Often times we receive prior authorization requests with no clinical records. Please submit clinical records with the request. Clinical records help give us a clear clinical picture of the member's course history and the progression of his/her condition. Other pieces of information that can be helpful for review include the following:

- New start or continuation of care (and how long member has been on medication)
- Member diagnosis
- Past alternatives tried including drug name and strength, trial dates, and outcome (i.e. ineffective, partial response, adverse event such as rash or hives)

Q: When I submit a request to Navitus for pharmacy prior authorization requests, I get a letter entitled Prior Authorization Notice and Peer to Peer Offering. Is this a Denial?

A: When Navitus initially receives a request, they will send a letter entitled "Prior Authorization Notice and Peer to Peer Offering". This letter is not an adverse determination. This letter is intended to give you information regarding what criteria requirements have not been met. It also is meant to inform you of information that may be missing with the request. Navitus' numbers are provided in this letter if there are additional records or information you would like to submit for clinical review.

Q: What is the difference between a reconsideration request versus an appeal?

A: A reconsideration request is submission of new information that was not submitted with the original request. These requests are submitted to Navitus. In these cases, make sure to notate on the request that you are asking for a "reconsideration request".

An appeal is a provider and member right to request for a medication that does not meet the clinical edit criteria and/or is being used for off-label use. These requests are submitted to Community Health Choice's Appeal Department.

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

A: Clinician-administered drugs are reviewed under the medical benefit (Utilization Management) for medical necessity. If your office does not buy and bill, please make sure to include in your request what pharmacy your patient will be getting the medication from. If choosing not to buy and bill, it is the responsibility of the provider to find a pharmacy to dispense the requested medication. Some pharmacies in our network include, but are not limited to:

Soleo Health: 832 981 1000
Deliver It Pharmacy: 281 277 1071
Southside Pharmacy: 713 660 8890 or 713 660 8888

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ADHD: WHAT IS IT?

ADHD stands for attention-deficit/hyperactivity disorder. It is one of the most common disorders among school-age kids. ADHD can also continue into adulthood. People with ADHD have trouble paying attention and staying focused. Many of them are also hyperactive and compulsive. Boys are three to four times more likely to have ADHD than girls.

ADHD vs. ADD

Sometimes ADHD is referred to simply as ADD, or attention deficit disorder. This is especially true when there is an absence of hyperactivity. Although people often mean the same thing by both, ADHD is the clinically correct term. Within ADHD, there are three subtypes.

Types of ADHD

Predominantly hyperactive-impulsive: This is the most disruptive type. A person with this type will be more hyper than inattentive. This often causes problems in the classroom. It is more common among boys. Symptoms include:

- Trouble sitting still
- Constant talking
- Interrupting
- Impatience

Predominantly inattentive: This is sometimes called ADD. There may or may not be hyperactivity involved. If there is, it is less prevalent. This type is not as easy to notice. More girls tend to have this type. Symptoms include:

- Short attention span
- Easily bored and distracted
- Trouble learning new things
- Trouble finishing tasks

Combined type: This is the most common type among children. It is a mix of hyperactive-impulsive and inattentive symptoms.

Causes of ADHD

ADHD used to be blamed on poor parenting. This is no longer believed to be the case. It is now thought to be caused by a group of factors. Genes may play a major role. Other possible factors include smoking and alcohol use during pregnancy. Brain injuries and exposure to lead may also increase the risk of developing ADHD. Sugars, food coloring and other additives have also been blamed, but more research is needed.

Diagnosing ADHD

Most children act hyper, impulsive and distracted at certain times. A child with ADHD will behave this way more often and to a greater degree. It is important that the child's doctor rule out other possible causes first. Some conditions that may mimic ADHD-like symptoms include:

- Hearing problems
- Vision problems
- Learning problems
- Middle ear infections
- Seizures

Sometimes the child may simply be reacting to a stressful event or situation. To be diagnosed with ADHD, the child must display symptoms for at least 6 months. These symptoms should also be more severe than those of other children the child's age.

ADHD is not as easy to detect in adults. The symptoms are the same as in children, but tend to be less obvious. An adult with ADHD will have had symptoms as a child, though they were undetected.

Diagnosis, whether for children or adults, should always be done by a licensed health professional.

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ADHD: WHAT IS IT? (CONTINUED)

Co-existing disorders

Certain disorders tend to co-exist with ADHD. Among these are:

- Oppositional defiant disorder (ODD)
- Conduct disorder
- Bipolar disorder
- Learning disorders
- Depression and anxiety
- Tourette's syndrome

Treatment of ADHD

There is no cure for ADHD, but symptoms can be effectively controlled. Treatment consists of medication and therapy. Pills known as stimulants are typically used. Despite their name, stimulants have a way of calming down kids with ADHD. There are many different brands of stimulants, such as Adderall®, Dexedrine® and Ritalin®. Each may produce different results and side effects, depending on the child. Parents and doctors should work closely together to decide which drug and dose works best.

Therapy teaches children with ADHD how to adjust their behavior during difficult situations. Guidance is given in practical areas such as organizing and completing chores and homework. Social skills are taught to help these children interact better with their peers. Parents and teachers can also learn how best to encourage proper behavior in the child.

Resource

National Institute of Mental Health
www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml

By Kevin Rizzo
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https://www.achievesolutions.net/achievesolutions/en/beacon

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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

HEALTH
CARE
FRAUD

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NEW QUICK REFERENCE GUIDES ARE HERE!

ONE FOR HEDIS AND ONE FOR CLINICAL DOCUMENTATION

HEDIS 2019 will be here before you know it. Be sure to document medical records and bill claims accurately. Submitting the correct ICD10-CM, CPT and HCPCS codes decreases the need for requesting medical records during the upcoming HEDIS season.

One of the measures that we have been paying special attention to is the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC). The HCPCS codes will be used as informational only when billed on the same day as the THStesp/Well Checkup. The HCPCS codes will not pay. Including the HCPCS codes on the claim will let Community know that the counseling was provided. The codes below are codes that can be billed on the claim by the member's PCP. The guide includes other codes that can be billed by non-physician providers. To complete the picture for counseling, include the appropriate BMI Percentile diagnosis code on the claim.

	CPT- ICD10- HCPS	Code	Description
Nutritional Counseling	CPT	97802	Medical nutrition therapy; initial assessment and intervention, individual face-to-face with the patient, each 15 minutes
	CPT	97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
	CPT	97804	Group (2 or more individual(s)), each 30 minutes
	HCPCS	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis - individual
	HCPCS	G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis - group
	HCPCS	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
	ICD-10	Z71.3	Dietary counseling and surveillance
Physical Activity Counseling	HCPCS	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
	ICD-10	Z02.5	Encounter for examination for participation in sport
	ICD-10	Z71.82	Exercise Counseling
BMI Percentile	ICD-10	Z68.51	Body Mass Index pediatric, less than 5th percentile for age
	ICD-10	Z68.52	Body Mass Index pediatric, 5th percentile to less than 85th percentile for age
	ICD-10	Z68.53	Body Mass Index pediatric, 85th percentile to less than 95th percentile for age
	ICD-10	Z68.54	Body Mass Index pediatric, greater than or equal to 95th percentile for age

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NEW QUICK REFERENCE GUIDES ARE HERE! (CONTINUED)

HEDIS Quick Reference Guide

HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE

PROVIDER RELATIONS INQUIRIES

Monday - Friday,
8:00 a.m. - 5:00 p.m.

- *Claims Inquiries*
- *Provider Changes* (Address/Phone/Tax ID)
- *EFT/ERA Request*
- *Provider Education In-Service*

LOCAL 713.295.2295
TOLL FREE 1.888.760.2600
EMAIL *ProviderRelations@CommunityHealthChoice.org*
WELLNESS LINE 713.295.6789
WEB SITE *CommunityHealthChoice.org*

This is to be used as a **HEDIS quick reference guide** and is not an all-inclusive list of ICD-10 codes. Please refer to your ICD-10 codebook for the complete list.

HEDIS/P4Q MEASURE	MEASURE DESCRIPTION	BILLING TIPS
Prenatal Care (PPC)	A visit that occurs in the first trimester of the pregnancy or within 42 days of enrollment in the health plan. ***Components of a prenatal visit include:*** 1. Documentation of LMP or EDD in conjunction with either of the following: a. Prenatal risk assessment and counseling/education; or b. Complete obstetrical history ***Documentation must include one of the following:*** 1. OB exam with fetal heart tone or pelvic exam with obstetrics observations or fundus height. 2. Evidence of prenatal care procedures: a. Obstetric panel b. TORCH antibody panel c. Rubella antibody/titer with Rh-incompatibility (ABO/Rh blood typing) d. Ultrasound (echocardiography) of pregnant uterus	A visit to a Provider with one of the following: **CPT:** 99201-99205, 99211-99215, 99241-99245, 99500, G0463, H1000-H1005 **ICD-10:** O09.00 – O9A.519, Z03.71 – Z03.79, Z33.1 – Z33.2, Z34.00 – Z34.03, Z34.80 – Z34.83, Z34.90 – Z34.93, Z36
Postpartum Visit (PPC)	A visit that occurs on or between 21–56 days after delivery ***Components of a postpartum visit include:*** 1. Pelvic exam; or 2. Documentation of weight, blood pressure, breast and abdominal evaluation, breast feeding status; or 3. Notation of Postpartum check, postpartum care or 6-week check.	**CPT:** 59430 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430 Z39.1, Z39.2
Potentially Preventable Emergency Department Visits (PPV)	Emergency department visits for conditions that could otherwise be treated by a care provider in a non-emergency setting	***Examples include:*** Upper respiratory tract infections; Otitis Media; Non-bacterial gastroenteritis; Nausea and vomiting; Fever Cellulitis and other bacterial skin infections; Abdominal pain; Urinary tract infections; Constipation; Headaches other than migraines; Contusions
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	The percentage of children 3 months – 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription during the measurement year.	**ICD-10:** J00 Acute nasopharyngitis J06.0 Acute laryngopharyngitis J06.9 Acute upper respiratory infections, unspecified
Well-Child Visit in the First 15 Months of Life (W15)	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life. Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following: 1. Health History 2. Physical development history 3. Mental developmental history 4. Physical exam 5. Health education/anticipatory guidance	**CPT:** 99381, 99382, 99391, 99392 **HCPCS:** G0438, G0439 **ICD-10:** Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.0, Z02.82, Z02.89, Z02.9

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HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE

HEDIS/P4Q MEASURE	MEASURE DESCRIPTION	BILLING TIPS
Adolescent Well-Care Visit Age 12–21 years (AWC)	One THSteps/ Comprehensive Well–Child visit with a PCP/OB/GYN during the measurement year. Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following: 1. Health History 2. Physical development history 3. Mental developmental history 4. Physical exam 5. Health education/anticipatory guidance	**CPT:** 99384, 99385, 99394, 99395 **HCPCS:** G0438, G0439 **ICD-10:** Z00.00, Z00.01, Z00.8, Z02.0-Z02.6 Z02.82, Z02.89, Z02.9
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Member ages 3-17 during the measurement year Need documentation of counseling for nutrition and physical activity.	***Nutrition Counseling*** **CPT:** 97802-97804 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470 **ICD-10:** Z71.3 ***Physical Activity Counseling*** **HCPCS:** G0447, S9451 **ICD-10:** Z02.5, Z71.82

Weight Assessment and Counseling for Nutrition and Physical Activity (Children/Adolescents) Age 3-17 years (WCC)

One visit with PCP or OB/GYN and who had all of the following completed in the same visit:

1. BMI percentile documented (based on the CDC's BMI-for-age growth charts NOT absolute BMI value)
2. Counseling for nutrition
3. Counseling for physical activity

Physical Activity Counseling Examples:

- Discussion of current physical activity behaviors (e.g. exercise routine, participation in sport activities, exam for sport activities)
- Checklist indicting physical activity was addressed
- Counseling or referral for physical activity education
- Member received educational material on physical activity during face-to-face visit
- Anticipatory guidance for physical activity
- Weight or Obesity counseling

Nutritional Counseling Examples:

- Discussion of current nutrition behaviors (e.g. eating habits, dieting behaviors) Checklist indicting nutrition was addressed
- Counseling or referral for nutrition education
- Member received educational material on nutrition during face-to-face visit
- Anticipatory guidance for nutrition
- Weight or Obesity counseling

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NEW QUICK REFERENCE GUIDES ARE HERE! (CONTINUED)

TOP 10 SUGGESTIONS FOR CLEAR AND DETAILED DOCUMENTATION

CLINICAL DOCUMENTATION, CODING AND REPORTING

Through a variety of annual audits, the Centers for Medicare & Medicaid (CMS) validates that diagnoses submitted to health insurance plans match all clinical documentation. This is especially true for Medicaid and the Health Insurance Marketplace (HIM). For Medicaid, this involves the annual HEDIS* review. For HIM, this review is called Risk Adjustment Data Validation. In both audits, the diagnosis codes related to a claim are validated through medical records to confirm the patient's health status and/or completed services. Successful audits for health insurance plans ensure that plans pay claims accurately, manage costs and realize as much efficiency, as possible. So, if documentation matches the claim, the plan can avoid unnecessary payments back to CMS and other governing bodies.

TOP 10 SUGGESTIONS FOR CLEAR DETAILED DOCUMENTATION

Missing diagnoses and wrong diagnoses can and will affect each patient's medical record accuracy. Clear and detailed documentation can improve the accuracy of the coding. Here are the top 10 recommendations to help combat these discrepancies.

1 HISTORY VS. CHRONIC

Know when to document "history of" vs. "chronic."

- Past conditions that are not active and not being addressed should be documented as "history of." Use a follow-up code to explain a visit addressing a past condition, such as a yearly follow up for cancer in remission.
- If the long- standing condition continues to be monitored, evaluated, addressed or treated, document as a chronic condition.

2 EXCLUDES 1 RULE

Ensure the **EXCLUDES 1 RULE** does not apply to any of the documented diagnoses.

For example, J03- Acute Tonsillitis may not be coded with J02- Acute Sore Throat.

3 M.E.A.T.

Document how each chronic condition is being:

- Monitored
- Evaluated
- Addressed
- Treated

Condition must be treated on an ongoing basis to be reported.

4 ASSESSMENT & PLAN

And for all diagnoses…if you are documenting that the condition is currently being monitored, evaluated, addressed or treated, the diagnosis should be listed in the Assessment & Plan and coded as such.

5 ACTIVE STATUS CONDITIONS

Active status conditions should be reported at every encounter. Examples are missing limbs, colostomies and/or transplants.

6 CHRONIC VS. ACUTE

If a chronic diagnosis can be misconstrued as acute, be sure to document as chronic such as *chronic hepatitis.*

7 HIGHEST *(But Accurate)* SPECIFICITY

State conditions to the greatest specificity but only to the specificity that is supported in the documentation.

- Is it major depressive, disorder, single episode, severe without psychotic features? Or
- Actually, major depressive disorder, recurrent, mild?

The first is the highest specificity, but the second might be more accurate.

8 CONFLICTING DIAGNOSES

Is it Type 2 diabetes mellitus without complications, or

Is it Type 2 diabetes mellitus with diabetic polyneuropathy?

Document the appropriate diagnosis, consistently.

9 DIABETES

Speaking of diabetes…document any relationships that cause diabetes. Coders shouldn't assume. If the diabetes is caused by long-term steroid use, spell it out.

10 VALID RECORDS MUST HAVE:

- Electronic signature, or
- A legible written signature
- The Provider's credentials, and
- The date of the encounter and signature

Don't forget, missing or inaccurate diagnoses can impact claims, payments and audits. Clear and detailed records prevent these errors.

HEDIS – Health Effectiveness Data Information Set
If there is ever a question about how best to code a medical record for a Community Health Choice Member, please do not hesitate to contact us at RiskAdjustment@CommunityCares.com. We are also available for training coders, billers and providers.

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HEDIS_top10cdi_0818

To get a copy of either or both of the reference guides, or if you have any questions, please contact your Provider Engagement Representative. Or email us at ProviderRelationsInquiries@CommunityHealthChoice.org.

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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%).*

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*

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HEDIS CRITERIA (CONTINUED)

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

*HCPCS – Healthcare Common Procedure Coding System
**Use ICD-10 diagnosis code with either CPT or HCPCS code depends on the service rendered.

HCPCS code G0447 can be used for both Nutrition and Physical Activity.

- For Counseling for Nutrition, you can bill HCPCS code G0447 with ICD-10 code Z71.3.
- For Counseling for Physical Activity, you can bill HCPCS code G0447 with ICD-10 code Z02.5 or Z71.82.

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

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HEDIS CRITERIA (CONTINUED)

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.*

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FOCUS ON MOMS AND BABIES

A PROVIDER TAG-TEAM APPROACH

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

Primary Care Providers (PCPs):

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

OB/GYNs:

As a part of birth preparation, educate members about choosing a PCP for their newborn and scheduling well-child checkups. Since the first checkup occurs 24 to 48 hours at the hospital, and another checkup within five days after leaving the hospital, providing information early can help members know what to expect before and after their baby leaves the hospital.

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

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

PCPs and OB/GYNs:

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

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FOCUS ON MOMS AND BABIES

INTRODUCING MOM & BABY COMMUNITY REWARDS FOR STAR MEMBERS

Community has launched a new Community Rewards program for Mom & Baby! This program encourages timely prenatal and postpartum care, as well as timely newborn checkups. It is designed to link maternal and child health, from conception to early childhood.

Moms receive:

- A $25 gift card for early prenatal visit (within 42 days of enrollment effective date)
- A $25 gift card for timely postpartum visit (21 to 56 days after delivery)

Babies receive:

- Up to $60 for timely well-child checkups (a $10 gift card for each of 6 checkups completed before 15 months of age)
- A $25 bonus gift card after all 6 checkups are completed

Who can participate?

This program is for Moms and Babies in our STAR program. Moms with pregnancy Medicaid and newborn STAR babies are eligible.

How do members get the gift cards?

Eligible members automatically receive phone calls to tell them about the rewards program and to remind them about checkups. Members can activate in the program and report checkups during these calls, or they can do so online through their My Member Account.

After reporting their activities, they can select an instant electronic gift card or have the gift card mailed to them.

For more information on this program, please contact our Member Services department at [phone number].

COMMUNITY'S MOM & BABY EFFORTS

Community reaches out in many ways to our Moms & Babies to help them get the care they need. Here are some of the highlights:

Conception to Early Childhood

- We make live calls to new pregnant members to help them find OB/GYNs and to encourage early prenatal care. We also make pre-delivery calls in the third trimester to make sure that members are ready for their delivery. During the pre-delivery calls, we prime the members for timely postpartum care as well as newborn preventive care.
- For newborns, we also make a live welcome call to make sure that the member has a PCP and is on track for preventive care. On the same call, we talk to the mom about her own postpartum care.
- We help STAR members get rewarded for timely prenatal, postpartum, and newborn checkups through the Mom & Baby Community Rewards program (see page X).
- Members who sign up for the Mom & Baby Community Rewards program get automated reminders about their prenatal, postpartum, and well-child checkups.
- When we speak with members, we educate them about helpful resources such as WIC, smoking cessation, and Text4Baby.

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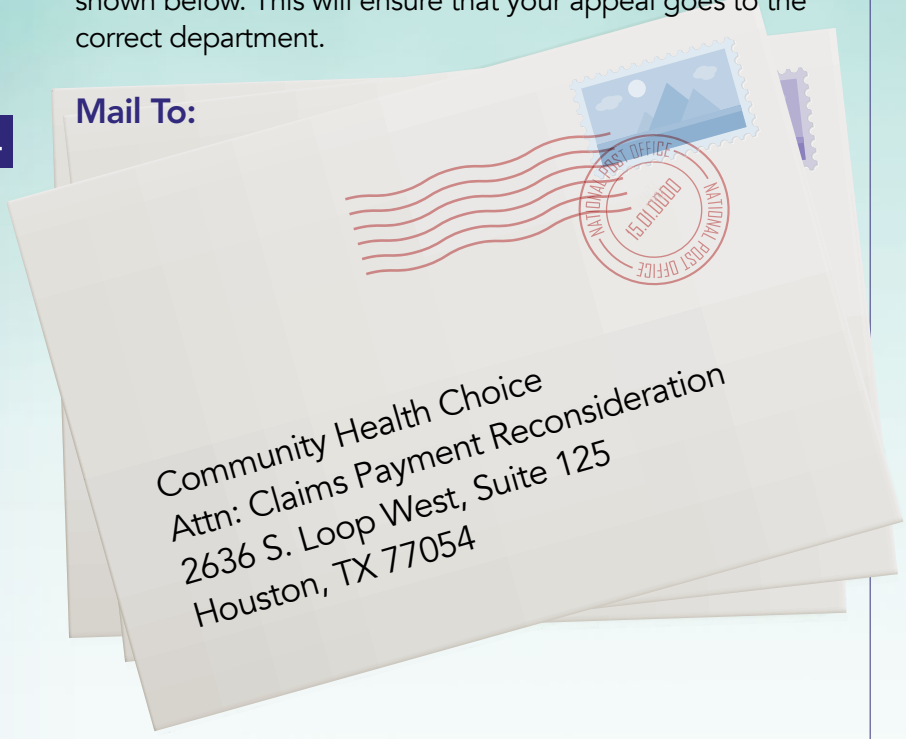
CLAIMS PAYMENT RECONSIDERATIONS

When submitting a claims payment reconsideration, always be sure to specify the type of appeal you are submitting, as shown below. This will ensure that your appeal goes to the correct department.



NEW ADDRESS FOR MEDICAID REFUNDS BEING SENT TO COMMUNITY

Effective July 1, 2018-Please note the new lockbox address for Medicaid Refunds:

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

WEB INQUIRIES

Did you know that you are able to create a web inquiry through our Provider Portal if you have questions regarding a claim? If there are more multiple claims in question, you can list the additional claims in the Memo of the web inquiry.

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.

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

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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.

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COMMUNITY ANNOUNCEMENT FOR THSTEPS PROVIDERS

Community now requires all contracted THSteps providers to take an Annual Texas Health Steps Provider Training.

Log in to your provider portal at https://provider.communityhealthchoice.org to complete this Annual Mandatory Training by Dec 31st of each calendar year.

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

THSTEPS CHECKUP TIMELINESS

New Community members must complete a checkup within 90 days of enrollment with Community. Members participating in the Head Start program should receive their checkup within 45 days of enrollment with Community or enrollment with the Head Start program. This is a Head Start requirement.

Existing Community members must complete a checkup in accordance with the THSteps Medical Checkup Periodicity Schedule. Follow this schedule:

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

Complete before the next checkup age	
Newborn	2 months
3-5 days	4 months
2 weeks	
Complete within 60 days of these checkup ages	
6 months	18 months
9 months	24 months
12 months	30 months
15 months	
Complete on or after the birthday but before the next birthday	
Members ages 3 through 20 need a checkup once a year	

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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 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

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, and might cause the total number of checkups to exceed the number allowed for the member's age range if the member was to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

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

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

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

Modifiers indicate the reason for the exception to periodicity Checkup:

Modifier	Description
SC	Medically necessary (developmental delay or suspected abuse) Environmental high-risk (sibling of child is 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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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 4th birthday, if the child is a member of a traveling family that is leaving the area. Providers must use the CPT modifier "32" when providing accelerated services outside of the periodicity schedule.

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

If you have any patients from Community that 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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THSTEPS PROVIDER OUTREACH REFERRAL SERVICE AND HOW IT WORKS

The Texas Health Steps Provider Outreach Referral Service (MAXIMUS) is utilized by any Texas Health Steps providers who request outreach and follow-up for a Texas Health Steps patient who needs assistance:

- Scheduling a follow-up appointment
- Rescheduling a missed appointment
- Scheduling transportation to an appointment
- With other outreach services

This outreach service is administered by the Texas Health Steps program and provides necessary outreach and follow-up with Texas Health Steps patients.

- Contacting a patient to schedule a follow-up appointment.
- Contacting a patient to reschedule a missed appointment.
- Contacting a patient to assist with scheduling transportation to the appointment.
- Contacting a patient for other patient-related outreach services.

Link to download the instructions and the THSteps Provider Outreach Referral Form: http://www.dshs.state.tx.us/thsteps/POR.shtm

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 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.

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

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 is offered?

- Bus or a ride sharing service
- Mileage reimbursement if the member has a car or knows someone who can drive them to the appointment
- For trips that require overnight stay, 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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ONLINE PROVIDER EDUCATION - FREE CONTINUING EDUCATION (CE) 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/

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:

- 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
- And much more

To access the 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

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INTEGRATING POSTPARTUM DEPRESSION SCREENING INTO ROUTINE INFANT MEDICAL CHECKUPS

Maternal and child health are intricately linked, and both can be affected by postpartum depression. Texas Health Steps providers can now receive separate reimbursement for conducting maternal postpartum depression screening during an infant's preventive medical checkup. Read on to learn about the policy and gain access to resources to help you implement it in your practice.

Take the course by visiting the link below-

https://www.txhealthsteps.com/static/courses/ppd/sections/intro.html?utm_source=courseannouncement&utm_medium=email&utm_campaign=ppd

DIABETES SCREENING, DIAGNOSIS, AND MANAGEMENT

The incidence of diabetes is on the rise among young people. Primary care providers who gain a solid understanding of diabetes can help children and their families adhere to treatment plans and reduce the negative effects of the disease. This module provides important information about risk-based screening and practical guidance for developing and maintaining effective treatment plans.

Enroll in the course by visiting the link below-

https://www.txhealthsteps.com/378-diabetes-screening-diagnosis-and-management?utm_source=courseannouncement&utm_medium=email&utm_campaign=diabetes

HPV VACCINATION IN TEXAS: WHAT PEDIATRICIANS SHOULD KNOW

Take a few minutes to learn about current research related to HPV vaccination and get practical guidance about how to promote routine vaccination in your practice.

Take the course by visiting the link below-

https://www.txhealthsteps.com/static/courses/hpv-vaccination-in-texas/?utm_source=course-announcement&utm_medium=email&utm_campaign=hpvpod-2018

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CONCUSSION: DIAGNOSIS, TREATMENT AND PREVENTION

Keep up with the latest protocols for diagnosing and treating sports-related concussion. This module provides step-by-step guidelines for on-field and off-field assessment, follow-up testing, and resuming school and activity for children and youth. You'll also learn useful conversation tips and risk-reduction strategies to share with patients and families.

Enroll in the course by visiting the link below-

https://www.txhealthsteps.com/388-concussion-diagnosis-treatment-and-prevention?utm_source=courseannouncement&utm_medium=email&utm_campaign=mh-head

ADOLESCENT SUBSTANCE USE

Experimentation is a natural and healthy part of adolescence, but experimenting with alcohol and other substances can have serious, long-term consequences. This module provides guidelines for integrating substance use screening and intervention into routine practice and preventing, treating, and managing substance use disorders in primary care.

Enroll in the course by visiting the link below-

https://www.txhealthsteps.com/392-adolescent-substance-use?utm_source=courseannouncement&utm_medium=email&utm_campaign=ASU-IYV

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.

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

Community Health Choice
P.O. Box 4818
Houston, TX 77210-4818

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 & MEDICAL NECESSITY APPEALS

Community Health Choice
Attn: Medical Necessity Appeals
Fax: 713.295.7033

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

MEMBER SERVICES & SPECIALIST SCHEDULING

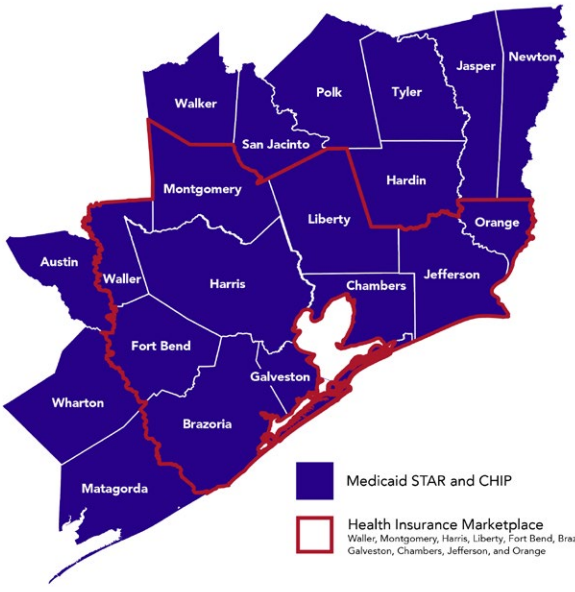
713.295.2294 or 1.888.760.2600

PROVIDER RELATIONS

For general questions or to submit your updates:

- 713.295.2295
- 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