V4-2018

Provider Newsletter

CommunityHealthChoice.org

713.295.2295 | 1.888.760.2600

COMMUNITY HEALTH CHOICE

In this issue

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

Beginning February 1, 2019 Community will require Providers to bill using a Rendering Provider NPI for all claims submitted.

Enhanced Claims Requirements for CHIP Perinate Claims

Obstetric Delivery Enhanced Claim Requirements for CHIP Perinate Program Claims:

CHIP Perinate mothers are entitled to a maximum of 2 postpartum visits. CHIP Perinate mothers' eligibility ends at the end of the month the baby was born.

If a Provider calls to check benefits after the month of the baby's birth, they will be advised the CHIP Perinate mother is not eligible.

CHIP Perinate mothers may receive their postpartum visits after their eligibility ends (at the end of the month of the baby's birth).

Effective January 1, 2019, in order to be reimbursed for the postpartum visits, Providers must bill using the CPT delivery codes that include postpartum care. See below for a list of codes.

The reimbursement amount for the procedure codes below includes both postpartum care visits. If the Provider bills any other code and the date of service is after the CHIP Perinate mother's eligibility has ended, the Provider will not receive payment for the postpartum care.

If the claim was submitted with the incorrect code, Providers may re-submit the original delivery claim with the correct code within the 120-day appeal deadline.

Acceptable Bundled Codes

Procedure Code	Code Description
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59515	C-Section delivery only; including postpartum care
59614	Vaginal delivery only, after previous Cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery; including postpartum care

Additional Claims Information

- Claims billed with the delivery codes 59409, 59514, 59612, and 59620 will be denied.
- Corrected claims can be submitted within 120 days from the Explanation of Payment (EOP) date for payment with the bundled procedures.
- Global delivery codes (CPT Codes 59400, 59510, 59610, 59618) will continue to not be reimbursable.
- Applicable modifier (U1, U2, U3) is required.

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

New Electronic Payment Method

In early 2019, Community will partner with Change Healthcare and ECHO Health, Inc. to provide these new electronic methods. Many of our Providers already work with Change Healthcare today.

Below we have outlined the payment options and any action items needed by your office.

1 **Virtual Card Services** Going forward, if we don't have a documented choice of payment for you, the default method of payment will now be virtual card rather than a paper check. Virtual cards allow your office to process our payments as credit card transactions. Virtual card payments are generally received 7-10 days earlier than paper checks since there are no print and mail delays. Your office will receive fax notifications, each containing a virtual card with a number unique to that payment transaction. Once the number is received, you simply enter the code into your office's credit card terminal to process payment as a regular card transaction. If the card is not processed within 30 days, the virtual transaction will be voided and a paper check will automatically be sent to your office. To avoid delay please process the card or notify us of your preference from the other options below. Normal transaction fees apply based on your merchant acquirer relationship.

2 **EFT/ACH** You can enroll for EFT/ACH by providing your banking account information, and once your enrollment is verified begin receiving payment via electronic funds transfer (EFT). Setting up EFT is a fast and reliable method to receive payment. If you wish, each time a payment is made to you, you can elect to receive an email notification. You will need to provide a Change Healthcare payment draft number and payment amount as part of the enrollment authentication.

3 **Paper Check** If there are concerns with electronic payments, you must elect to opt out of Virtual Card Services or remove your EFT enrollment to receive paper checks and paper explanation of payments.

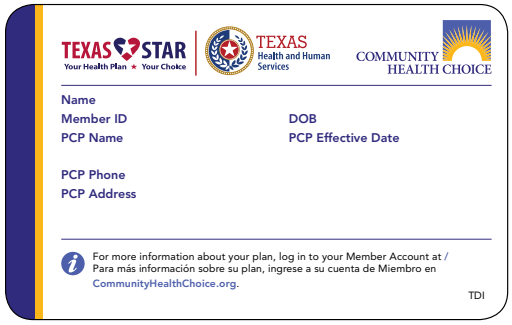
A New Look for a New Year!

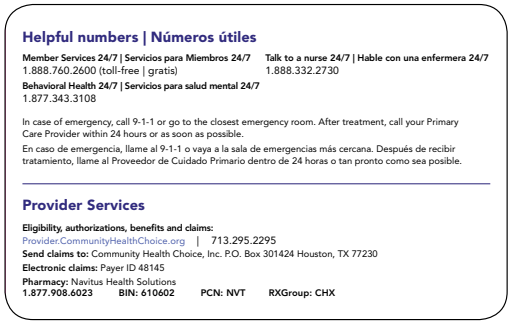
Community is pleased to introduce our newly redesigned Member identification cards effective January 1, 2019. We are excited to launch new Member identification cards that are easier to read for both Providers and Members. The new cards feature the following key components:

- 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

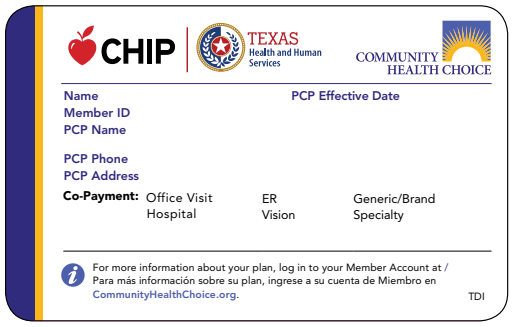
Please feel free to contact your Provider Engagement Representative if you have additional questions and concerns regarding our new look.

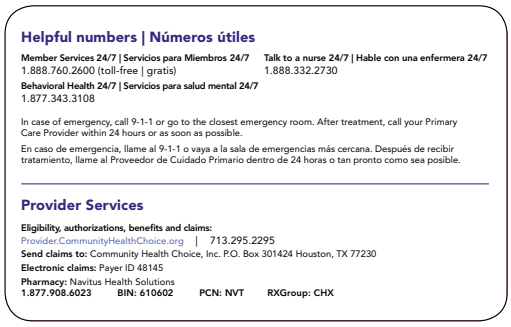
Redesigned STAR Member ID

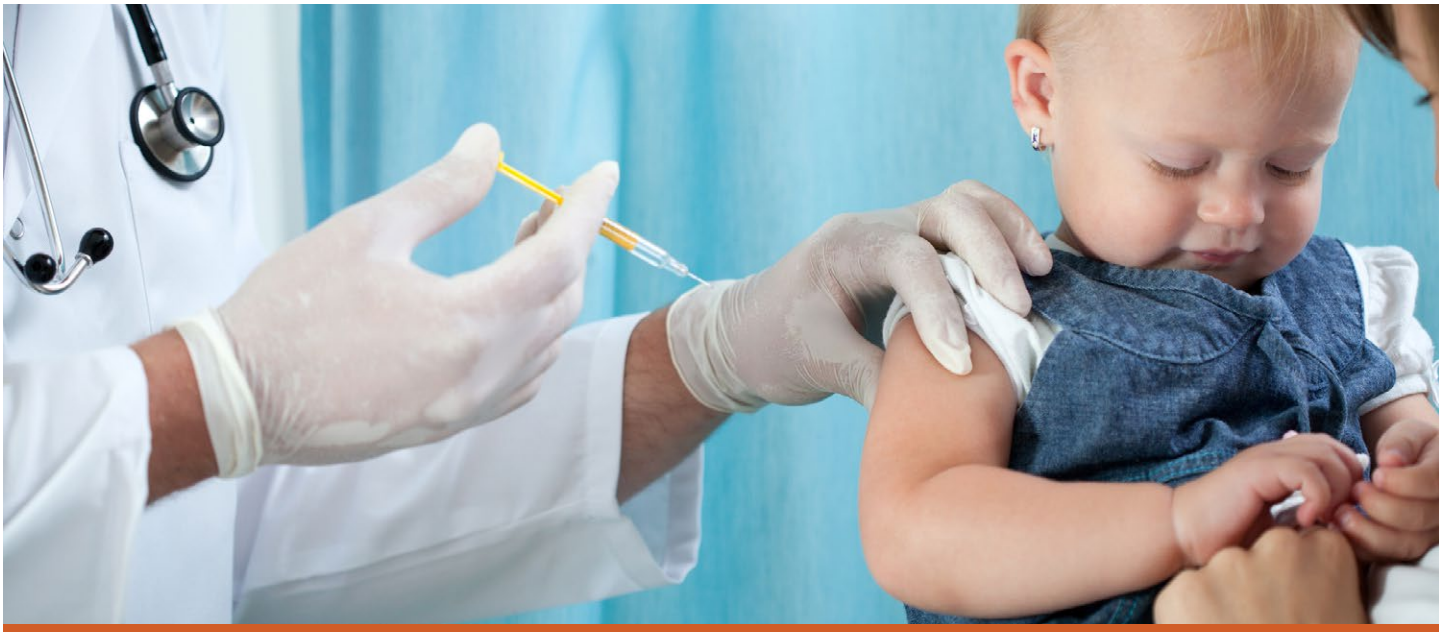




Redesigned CHIP Member ID







Reminder: Vaccine Coverage for CHIP Perinatal Members

In 2017, a notice was shared regarding coverage of vaccines for CHIP Perinatal (CHIP-P) Members. This notice serves as a reminder regarding which vaccines are covered for CHIP-P Members.

Key Details:

The Tetanus, Diphtheria, and Acellular Pertussis (Tdap) vaccine is part of routine prenatal care and is a covered benefit in CHIP-P.

This vaccine is recommended by the Centers for Disease Control and Prevention (CDC), American Academy of Pediatrics (AAP), and American College of Obstetricians and Gynecologists (ACOG) as part of routine prenatal care:

- CDC: https://www.cdc.gov/pertussis/pregnant/mom/get-vaccinated.html
- AAP: https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Updates-TDAP-Recommendations.aspx
- ACOG: https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Update-on-Immunization-and-Pregnancy-Tetanus-Diphtheria-and-Pertussis-Vaccination

Guidance:

CHIP MCOs must ensure their Member services staff and Providers are aware this is a covered benefit and that claims are being appropriately reimbursed for this service.

Resources:

Original Notice: https://hhs.texas.gov/about-hhs/communications-events/news/2017/12/reminder-chip-p-coverage-tdap-vaccine

Health Alert from DSHS: Infant Botulism and History of Honey Pacifiers

November 16, 2018

BACKGROUND: Honey can contain spores of Clostridium botulinum, an organism that produces a potent neurotoxin known to cause severe illness in infants. Infant botulism occurs when C. botulinum spores in food, dust, or other materials are inhaled or ingested and germinate in the gut of infants who have not yet developed mature intestinal flora. For this reason, parents are advised not to feed honey (raw or otherwise) to children younger than 12 months old.

Infant botulism: Symptoms of botulism in infants under 12 months of age typically start with constipation and may include poor feeding and/or weak sucking, weakness, drooping eyelids, loss of head control and difficulty breathing. Severity can range from mild illness with gradual onset to paralysis, respiratory failure, and death. Prompt recognition of a suspect case, administration of antitoxin, and initiation of supportive care can halt progression of the disease.

The Texas Department of State Health Services will coordinate confirmatory testing at the DSHS laboratory. To obtain the antitoxin (Baby BIG) for treatment, physicians can contact the DSHS Emerging and Acute Infectious Disease Branch or the California Infant Botulism Treatment and Prevention Program.

Recent trends: Cases are rare; between 2013 and 2017, Texas has averaged 7 to 8 cases of infant botulism annually. However, since August, four patients have been treated for infant botulism and have a history of using a honey pacifier purchased in Mexico.

Investigators noted that these honey pacifiers and other food-containing pacifiers are available for sale at retailers as well as online, and that parents may not be aware of their potential danger.

Recommendations: Infants (children less than 12 months of age) should not be given honey, or pacifiers containing honey or other food products, because of the risk of contracting infant botulism. Consumption of honey is widely recognized as a risk factor for infant botulism by healthcare and public health professionals.

Infant botulism is a serious illness that requires urgent medical attention. All suspect cases should be immediately reported to public health officials.

For more information, contact DSHS at 512.776.7676.

Standing Order Update for Medicaid Mosquito Repellent

An update to the 2018-19 Texas Medicaid Standing Order for Mosquito Repellent is now available for use with the Texas Medicaid mosquito repellent benefit. The benefit is for people enrolled in Medicaid (both traditional and managed care) and CHIP.

The revised standing order is signed by Dr. Lisa Glenn. The document is effective Nov. 1 and is valid for one year from the date it was signed. The previous standing order signed by Dr. Rajendra Parikh is valid through Oct. 31. Pharmacies may directly obtain a copy of the renewed standing order upon request by emailing VDP_Formulary@hhsc.state.tx.us.

Refer to the Mosquito Repellent Benefit for Pharmacies (PDF) for more information:

- A prescription from a valid healthcare Provider is required for any pharmacy/ pharmacist not operating under a standing order, for the dispensing of mosquito repellent to people enrolled in Medicaid or CHIP
- People enrolled in the Healthy Texas Women program do not require a prescription
- People enrolled in the CSHCN program require a prescription for mosquito repellent from a healthcare Provider.

Fetal Testing Procedure Codes 59020 and 59025 Updated Effective January 1, 2019

Information posted November 16, 2018

Note: Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

Effective for dates of service on or after January 1, 2019, the interpretation and technical components of fetal testing procedure codes 59020 and 59025 will become benefits of Texas Medicaid for female clients who are 10 through 55 years old.

Procedure codes 59020 and 59025 will be updated to include the following:

Procedure Code	Component	Place of Service	Payable Provider Types
59020*	Interpretation	Office, inpatient hospital, outpatient hospital	Nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA), physician, and certified nurse midwife (CNM) Providers
	Technical	Inpatient hospital, outpatient hospital	NP, CNS, PA, physician, CNM Providers
59025	Total**	Inpatient hospital, outpatient hospital	NP, CNS, PA, physician, CNM Providers
	Interpretation, technical	Office, inpatient hospital, outpatient hospital	NP, CNS, PA, physician, CNM Providers

* The total component of procedure code 59020 will remain a benefit in the inpatient and outpatient hospital settings. **The total component of procedure code 59025 will also remain a benefit in the office setting.

The total and technical components of procedure codes 59020 and 59025 will be denied when submitted for the same date of service as an ambulatory surgical center claim for the same procedure code.

The total component of procedure codes 59020 and 59025 will be denied when submitted for the same date of service, by the same Provider, as delivery procedure code 59410, 59515, 59614, or 59622.

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.

For more information, call the TMHP Contact Center at 1.800.925.9126.

Procedure Code T4528 with Modifier U1 No Longer a Benefit January 1, 2019

Information posted November 16, 2018

Note: Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

Effective for dates of service on or after January 1, 2019, procedure code T4528 with modifier U1 will no longer be a benefit of Texas Medicaid or the Children with Special Health Care Needs (CSHCN) Services Program.

Procedure code T4528 without modifier U1 will remain a benefit of Texas Medicaid and the CSHCN Services Program. Providers may refer to the current Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, subsection 2.2.14.2, "Diapers, Briefs, Pull-ons, and Liners" for benefit information about procedure code T4528.

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.

Shingles Vaccine Procedure Code 90750 to Become a Benefit of Texas Medicaid January 1, 2019

Information posted November 16, 2018

Note: Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

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.

For more information, call the TMHP Contact Center at 1.800.925.9126.

Effective for dates of service on or after January 1, 2019, shingles vaccine procedure code 90750 will become a benefit for clients who are 50 years of age and older as follows:

Place of Service	When Services are Provided by
Office	Nurse practitioner, clinical nurse specialist, physician assistant, physician, pharmacy, pharmacist, and certified nurse midwife Providers
Home	Nurse practitioner, clinical nurse specialist, physician assistant, physician, and federally qualified health center Providers
Outpatient hospital	Hospital Providers
Other location	Nurse practitioner, clinical nurse specialist, physician assistant, and physician Providers

Substance Use Disorder Benefits to Change for Texas Medicaid January 1, 2019

Information posted November 16, 2018

Substance Use Disorder Benefits to Change for Texas Medicaid January 1, 2019

Information posted November 16, 2018

Note: Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

Effective for dates of service on or after January 1, 2019, substance use disorder (SUD) benefits will change for Texas Medicaid.

Overview of Benefit Changes

Major changes to this medical benefit policy include the following:

- Updated benefit language
- Prior authorization changes
- Procedure code updates
- Diagnosis code updates

Updated Benefit Language

SUDs are chronic, relapsing medical illnesses that require an array of best practice medical and psychosocial interventions of sufficient intensity and duration to achieve and maintain remission and support progress toward recovery. SUD may include problematic use of alcohol, prescription drugs, illegal drugs (e.g., cannabis, opioids, stimulants, inhalants, hallucinogens, "club" drugs, other synthetic euphoriants), and other substances that may be identified in the future.

Treatment for SUD is a benefit of Texas Medicaid for individuals who meet the criteria for a substance-related disorder, as outlined in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat an individual's problematic use of alcohol or other drugs, including prescription medication.

SUD services may include the following:

- Withdrawal management services
- Individual and group SUD counseling in an outpatient setting
- Residential treatment services
- Medication assisted treatment
- Evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions

Level of care (e.g., outpatient, residential, inpatient hospital) and specific services provided must adhere to current evidence-based industry standards and guidelines for SUD treatment, such as those outlined in the current edition of the American Society of Addiction Medicine's Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions, as well as the licensure requirements outlined in Texas Administrative Code (TAC) Title 25 Chapter 448 pertaining to Standards of Care.

SUD treatment services (outpatient or residential) may only be delivered in a licensed chemical dependency treatment facility (CDTF). Medication assisted treatment (MAT) may also be delivered by appropriately trained physicians, nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) in the office setting.

SUD withdrawal management in an inpatient hospital setting may be provided for individuals who meet hospital level of care requirements as a result of the severity of their withdrawal syndrome and/or the severity of their co-occurring conditions. These services may be reimbursed as general hospital inpatient services.

The treatment setting and the intensity or level of services will vary depending on the severity of the individual's SUD and what is clinically appropriate. The intensity or level of services refers to the number of hours of services per week, as well as the types of services the individual receives.

Upon admission into a treatment setting, a face-to-face multi-dimensional assessment must be conducted by a qualified credentialed counselor (QCC) or intern as defined in DSHS TAC §448.101 to determine a course of treatment that is medically necessary and clinically appropriate. The assessment must be signed off by a QCC.

Evaluation, Treatment, or Referral for Co-Occurring Conditions

CDTFs shall facilitate access to physical health, mental health, and ancillary services if those services are not available through the program and are necessary to meet treatment goals or individual needs.

Individuals in residential CDTFs commonly require medications unrelated to their SUD treatment for which costs are not covered in the reimbursement for SUD or MAT services. These medications, if included in the Medicaid formulary, may be obtained and reimbursed through the individual's Medicaid pharmacy benefit.

Individuals in residential CDTFs also commonly require other services that are benefits of Texas Medicaid, but not included in the CDTF rate. Claims for these services can be submitted by the appropriate Providers.

CDTFs should screen each individual for risk for contracting tuberculosis, Hepatitis B and C, HIV antibody, and sexually transmitted infections, and if appropriate, provide access to testing and follow up. Testing may be performed on site and billed by the ordering Provider if appropriate testing facilities are available that are compliant with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Withdrawal Management Services

Withdrawal management, formerly known as detoxification, is the medical and behavioral treatment of individuals experiencing or potentially experiencing withdrawal symptoms as a result of ceasing or reducing substance use.

Withdrawal management involving opioids, alcohol, sedatives, hypnotics, or anxiolytics will vary depending on the severity of the withdrawal symptoms experienced but will typically involve medications to treat symptoms in addition to supportive care, observation, and monitoring. Withdrawal management involving stimulants, inhalants, and cannabis typically involves supportive care, observation and monitoring, and medications to treat withdrawal symptoms as required.

Withdrawal management may be performed in an outpatient setting for individuals experiencing mild to moderate withdrawal symptoms that can be successfully, as well as safely, managed outside of a residential setting or an inpatient hospital. Withdrawal management in a residential setting may be required for individuals whose multidimensional assessment indicates one or more of the following circumstances that would make outpatient withdrawal management unsafe and/or unsuccessful:

- A level of severity of withdrawal, medical, and/or mental health complication
- Sufficient challenges with readiness to change, ability to stop using, and/or social support

Withdrawal management in an inpatient hospital setting may be required for individuals whose severity of medical withdrawal (e.g., impending delirium tremens, severe withdrawal seizures), comorbid medical conditions (e.g., severe liver impairment, acute pneumonia, endocarditis, dementia), and/or comorbid psychiatric conditions (e.g., severe suicidality, acute and unstable psychosis or mania) requires a hospital level of care.

Individual and Group SUD Counseling in an Outpatient Setting

Counseling for substance use disorders is designed to assist individuals in developing a better understanding of their SUD, help to establish treatment goals and plans for achieving those goals, and provide interventions to assist individuals in accordance with the plan. The overall intent of the service is to assist individuals in understanding their SUD and developing the skills and supports needed to address their SUD over time. Counseling may be done individually or in a group setting with multiple members. Group counseling sessions are limited to a total of 16 individuals per session.

Outpatient counseling services are appropriate for the following:

- Individuals with less severe disorders
- Individuals who are in the early stages of change
- As a step down from more intensive services
- Individuals who are stable but for whom ongoing monitoring is appropriate

Note: For individuals unable or unwilling to access SUD treatment services at a CDTF, psychotherapy delivered by a licensed practitioner of the healing arts (LPHA) may be an alternative treatment option to address an individual's SUD.

Outpatient services may be appropriate at the start of treatment, throughout treatment, or after an episode of residential or inpatient treatment, depending on individual acuity, severity, comorbidity, needs, or preferences. Outpatient services can address active symptoms as well as provide ongoing treatment for individuals in partial or full remission who need continuing help to maintain progress. Abstinence should not necessarily be a requirement for participation in outpatient services.

Residential Treatment Services

Residential treatment programs provide a structured therapeutic environment where individuals reside with staff support and deliver comprehensive substance use disorder treatment with attention to co-occurring conditions as appropriate. The frequency and duration of services should be based on meeting the individual's needs and achieving the individual's treatment goals.

Residential services are appropriate for individuals who require a structured therapeutic environment to stabilize SUD and develop coping and recovery skills. Residential treatment programs may specialize in the unique needs of a specific population such as adolescents or pregnant or parenting women with children.

Episodes of residential treatment may be required for individuals with more severe SUD, more significant medical or psychiatric comorbidities, more significant challenges with sustaining motivation or maintaining control in an outpatient setting, and/or a living environment that jeopardizes their current ability to be successful in outpatient treatment.

Residential SUD treatment services may only be provided by a licensed CDTF.

Medication Assisted Treatment

MAT is the use of FDA-approved medications in combination with psychosocial treatment to treat substance use disorders, particularly alcohol and opioid use disorders.

MAT is a recognized best practice for alcohol use disorder (AUD) and opioid use disorder (OUD). All individuals with AUD and OUD should be educated about the availability of MAT and the evidence supporting MAT and have the opportunity to receive MAT regardless of where they are receiving SUD services. This could be accomplished on site or through a written agreement with a collaborating opioid treatment program (OTP) or office-based opioid treatment (OBOT) program.

Initiation or induction of MAT can appropriately occur in lieu of withdrawal management for opioid use disorders, may begin early in withdrawal management for either AUD or OUD, and can be initiated as appropriate at any point in time during the course of treatment. Duration of MAT is determined on an individual basis, depending on the individual's unique needs and treatment goals.

Determination of which MAT medication to use is also an individualized treatment decision based on Provider assessment and the individual's needs and treatment goals. Providers are encouraged to offer as many treatment options as possible (within the parameters of their licensing and scope of practice) to maximize the individual's choice and access to care.

MAT may be utilized as appropriate, as part of the service array delivered by outpatient Providers or residential treatment services programs at CDTFs.

Opioid treatment programs (also referred to as narcotic treatment programs) are the only settings permitted by law to provide methadone for OUD and must comply with additional federal and state requirements, rules on licensure, and scope of practice, including physician delegation, supervision, and prescriptive authority. Opioid treatment programs can also provide or administer other forms of MAT.

CDTFs, physicians, NPs, and PAs may prescribe and provide for the administration of long acting injectable naltrexone (Vivitrol) to treat cravings associated with either opioid use disorder or alcohol use disorder.

Physicians, NPs, and PAs who have received a federal waiver to dispense buprenorphine may choose to incorporate this form of MAT into their medical practice while also providing or referring for other types of treatment services (also referred to as OBOT).

Certain MAT medications to treat alcohol and opioid use disorders (such as buprenorphine, disulfiram, acamprosate, and naltrexone), are available as a pharmacy benefit and may be prescribed to individuals by their physician or other qualified healthcare professional. Providers may refer to the Vendor Drug Program Formulary for additional information on covered medications.

Prescribing of certain MAT medications may be done via telemedicine presuming all other applicable state and federal laws are followed.

A prescription for an opioid antagonist (e.g., naloxone) should be given to all individuals receiving treatment for opioid use disorder, and instruction should be provided on how to administer if needed.

Claims for urinalysis drug screens ordered by a physician, NP, or CNS to monitor compliance with MAT may be submitted by the individually enrolled physician or other qualified healthcare professional.

The following MAT procedure codes may be separately reimbursed from withdrawal management and treatment services in the outpatient or residential setting: Procedure Codes H0020, H2010, J0570, J2315, Q9991, Q9992.

Exclusions

SUD treatment services for tobacco use disorder as the primary diagnosis are not a covered benefit, although a comprehensive SUD treatment approach should address tobacco use if reducing or eliminating this substance is part of the individual's treatment goal.

With the exception of prescribing MAT medications via telemedicine, SUD treatment services may not be delivered via telemedicine or telehealth.

Prior Authorization Changes

All prior authorization requests must be completed and signed by a Qualified Credentialed Counselor (QCC).

Prior authorization requests for outpatient treatment services beyond the annual limitation of 135 units of group services and 26 hours of individual services per calendar year will no longer be limited to individuals who are 20 years of age and younger. Requests may be submitted for individuals of any age.

Prior authorization may be considered for individuals enrolled in a Medicaid MCO when admitted to SUD services, and whose eligibility changes to fee-for-service during treatment. Requests must be submitted within three business days after the date that fee-for-service eligibility started.

Revised Forms

Beginning January 1, 2019, the following revised prior authorization forms are to be used when submitting prior authorization requests:

- Outpatient Withdrawal Management Authorization Request Form
- Outpatient Substance Use Disorder Counseling Extension Request Form
- Residential Withdrawal Management Authorization Request Form
- Residential Substance Use Disorder Treatment Request Form (Revised August 31, 2018)

The following forms will no longer be accepted after January 31, 2019:

- Ambulatory (Outpatient) Detoxification Authorization Request Form
- Ambulatory (Outpatient) Substance Use Disorder Counseling Extension Request Form
- Residential Detoxification Authorization Request Form
- Residential Substance Use Disorder Treatment Request Form (Revised February 1, 2016)

If the discontinued forms are submitted on or after February 1, 2019, TMHP will return the form to the Provider with a request that the revised form be submitted with all required documentation.

Providers may refer to the article titled, "Revised Prior Authorization Forms for Substance Use Disorder Services to be Effective January 1, 2019," which was published on this website November 16, 2018, for additional information about the revised forms.

Procedure Code Updates

Modifiers HF and HG will no longer be required to identify the SUD services performed.

The following Providers will be added as payable for procedure codes H2010 and J2315:

Procedure Code	Place of Service	Provider Type
H2010	Office setting	NP, CNS, PA providers
J2315	Outpatient setting	CDTF

Diagnosis Codes

The following diagnosis codes will be added as payable for procedure codes H0004 and H0005: Diagnosis Codes

F10121	F1014	F10150	F10151	F10180	F10181	F10182	F10221	F10231	F1024
F10250	F10251	F1026	F1027	F10280	F10282	F10921	F1094	F10950	F10951
F1096	F1097	F10980	F10981	F10982	F11121	F11122	F11129	F1114	F11150
F11151	F11221	F1123	F1124	F11250	F11251	F1190	F11921	F1193	F1194
F11950	F11951	F12121	F12150	F12151	F12221	F12250	F12251	F1290	F12921
F12950	F12951	F1310	F13121	F1314	F13150	F13151	F1319	F13221	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F1326	F1327	F1329	F1390
F13921	F13930	F13931	F13932	F13939	F1394	F13950	F13951	F1396	F1397
F14121	F1414	F14150	F14151	F14221	F1423	F1424	F14250	F14251	F1490
F14921	F1494	F14950	F14951	F15121	F1514	F15150	F15151	F15221	F1523
F1524	F15250	F15251	F1590	F15921	F1593	F1594	F15950	F15951	F16121
F1614	F16150	F16151	F1621	F16221	F1624	F16250	F16251	F1690	F16921
F1694	F16950	F16951	F18121	F1814	F18150	F18151	F1817	F18221	F1824
F18250	F18251	F1827	F1890	F18921	F1894	F18950	F18951	F1897	F19121
F1914	F19150	F19151	F1916	F1917	F19221	F19230	F19231	F19232	F19239
F1924	F19250	F19251	F1926	F1927	F1990	F19921	F19930	F19931	F19932
F19939	F1994	F19950	F19951	F1996	F1997				

The following diagnosis codes will no longer be payable for procedure codes H0004 and H0005: Diagnosis Codes

F17208	F17209	F17218	F17219	F17228	F17229	F17298	F17299

For more information, call the TMHP Contact Center at 1.800.925.9126.

Correction to 'Update to "Proposed Reimbursement Rates Changes and Updates for Texas Medicaid to Be Effective March 1, 2017 and April 1, 2017"'

Information posted November 21, 2018

This is a correction to an article titled 'Update to "Proposed Reimbursement Rates Changes and Updates for Texas Medicaid to Be Effective March 1, 2017 and April 1, 2017,"' which was published on this website March 21, 2017.

In the original article, the table for non-clinical services listed incorrect Relative Value Units (RVU) for some procedure codes.

The table below lists the correct RVUs:

Non-Clinical Laboratory Services								
TOS*	Procedure Code	Age Range	Non-Facility (N)/ Facility (F)	Medicaid RVU** Effective 4/1/2017	Medicaid Conversion Factor Effective 4/1/2017	Medicaid Fee Effective 4/1/2017	Percent Reduction	Adjusted Medicaid Fee Effective 4/1/2017
5	88358	0-20	N/F	2.53	$28.0672	$71.01	0%	$71.01
5	88358	21-999	N/F	2.53	$26.7305	$67.63	0%	$67.63
5	88360	0-20	N/F	3.96	$28.0672	$111.15	0%	$111.15
5	88360	21-999	N/F	3.96	$26.7305	$105.85	0%	$105.85
5	88365	0-20	N/F	5.01	$28.0672	$140.62	0%	$140.62
5	88365	21-999	N/F	5.01	$26.7305	$133.92	0%	$133.92
*Type of Service (TOS): 5 = Laboratory Services **Relative Value Unit (RVU)								

Affected claims with dates of service beginning April 1, 2017 through November 8, 2018, will be reprocessed. No action on the part of the Provider is required. Providers may receive additional payment, which will be reflected on future Remittance and Status Reports.

Update to Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

Information posted November 21, 2018

Note: Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

On November 1, 2018, TMHP updated the Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook, Section 8.1, "Enrollment" (for nurse practitioners and clinical nurse specialists), and Section 10.1, "Enrollment" (for physician assistants [PAs]).

The update states that advanced practice registered nurses (APRNs) and PAs may be included as primary care Providers in the Provider network for Medicaid and the Children's Health Insurance Program (CHIP) (both fee-for-service and managed care), regardless of whether the physician supervising the APRN is enrolled in Medicaid or in the Provider network.

For more information, call the TMHP Contact Center at 1.800.925.9126.

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.

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.

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: **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.

Community Health Choice Prior Authorization Guide Changes Effective January 1, 2019

Based on utilization trends in 2018, we have made a few changes to our prior authorization list, making it easier for Members to obtain certain services. The list of services requiring prior authorization can be found on the Community Health Choice Provider Portal under the path defined by *Provider Tools > Authorizations/Notifications > Authorization*.

The Community Health Choice Prior Authorization Guide applies to all CHC products. We ask that requests for prior authorization be submitted on Community's Preferred Prior Authorization Form, which can be found under Provider Tools > Authorizations/Notifications > Notifications.

As always, all requests require submission of a prior authorization form and supporting clinical records. However, on January 1, 2019, the following changes will be effective to the *Community Health Choice Prior Authorization Guide*:

Cardiac Services:

Prior authorization is no longer required for cardiac services ordered by participating cardiologists.

For all other Providers, the prior authorization requirement remains for:

- 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 is no longer required for:

- Cochlear implants, hearing aids and amplifiers. *Please note these items remain subject to plan specific benefit limits.*
- Diabetic supplies or other supplies exceeding the amount needed for 30 days. *Please note these items remain subject to plan specific benefit limits.*

Prior authorization is now required for DME rental exceeding 3 months (regardless of the purchase price) in addition to all DME items with a purchase price exceeding $500 regardless of purchase or rental.

Hospice

Prior authorization is no longer required for inpatient and home based hospice care.

Injectable Drugs:

Prior authorization remains a requirement for injectable drugs given in a Provider's office, clinic setting, infusion suite or home unless self-administered, but the threshold has been changed to >$500 billed charges.

Prior authorization is no longer required 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

Outpatient Procedures/Surgeries:

Prior authorization is no longer required for colonoscopy.

Radiology/Imaging Services:

Prior authorization is no longer required for the following radiology/imaging services for pediatric Members under 21 years:

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

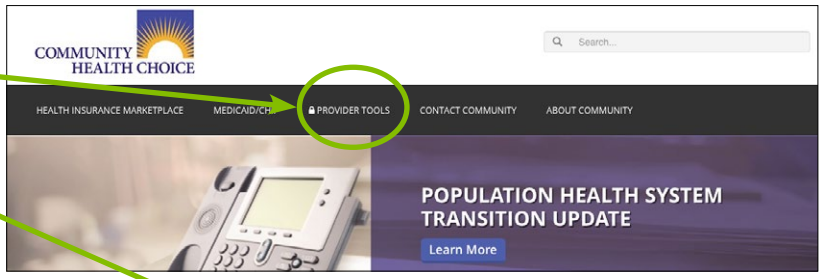
Therapy Wait List

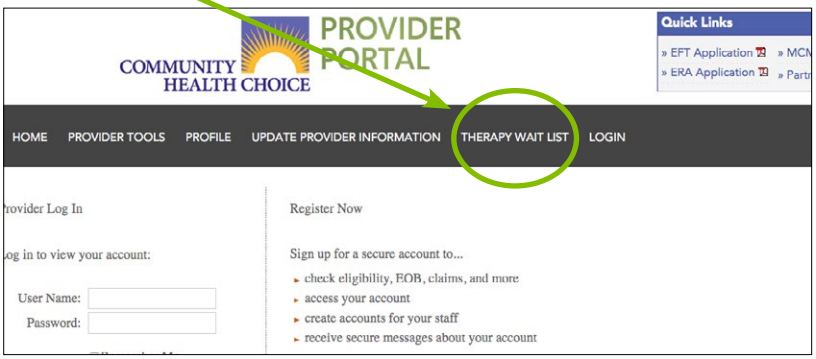
If a Therapy Provider cannot treat a patient at the frequency commensurate with that person's assessed needs, and if they create a waiting list for the Medicaid beneficiaries, and if a therapy Provider can no longer accept new patients, the Provider needs to notify Community. We are encouraging our Providers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

The tool posted on our Provider Portal is only applicable to STAR Providers at this time and is specific to Physical Therapy, Speech Therapy and Occupational Therapy only.

To access Community's Therapy Wait List Form:

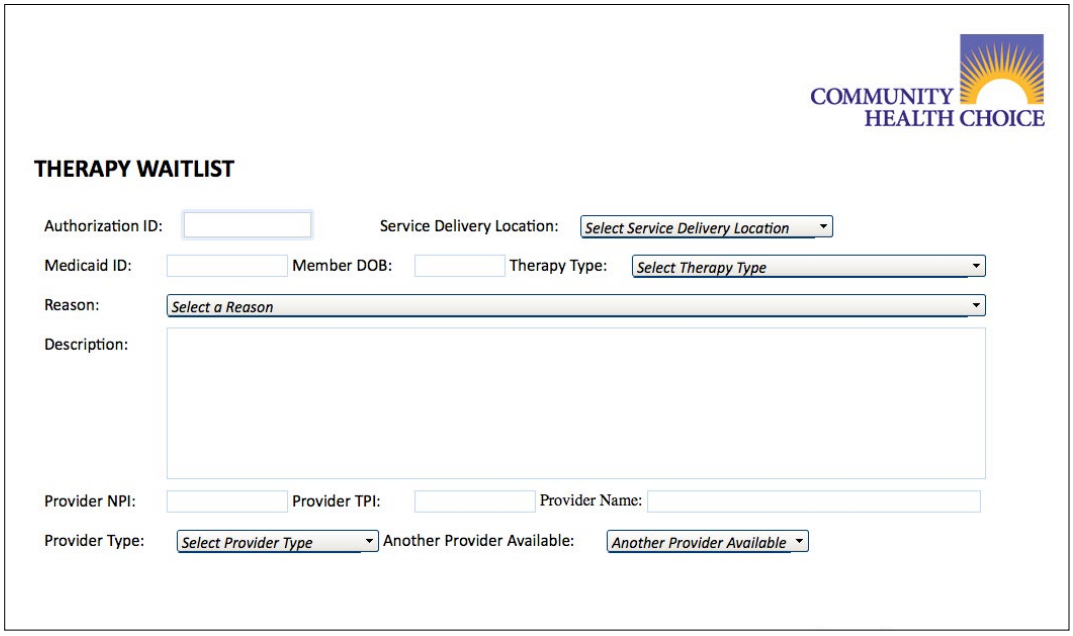
1. Go to our Provider Portal and click on **Provider Tools**.
2. Under Provider Tools you will see a banner of options. **Therapy Wait List** is the fifth option.
3. When you click on the Therapy Wait List option, you will be forwarded to the **Therapy Wait List Form** to complete. All fields must be completed in order to submit.





Once you submit this form to Community Health Choice, it will be routed to an internal team that will work directly with the ordering Provider, the Member and the New Therapy Provider to ensure the Community Member receives the therapy necessary.

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



Welcome to pharmacy corner! In this edition, we would like to share some news for the new year and talk about a few important pharmacy-related topics.

What's New for 2019?

Starting January 1, 2019, a majority of long-acting behavioral injectable medications will no longer require a prior authorization. These include Haldol, Prolixin, Risperdal Consta, Zyprexa Relprevv, Invega Sustenna, Invega Trinza, Abilify Maintena, and Aristada. These medications will be available under both the medical and pharmacy benefit. The reason for this change is to proactively remove barriers to care between our Members and these essential drugs.

Pharmacy Prior Authorization Fax Forms

Often we notice that the prior authorization forms being utilized are our general prior authorization forms, which result in us not obtaining all the necessary information to complete the request. Many drugs on the formulary have drug specific fax forms, which gives you information in advance of what requirements we have and allows you to easily see if the Member meets criteria. To access the drug specific criteria go to www.navitus.com

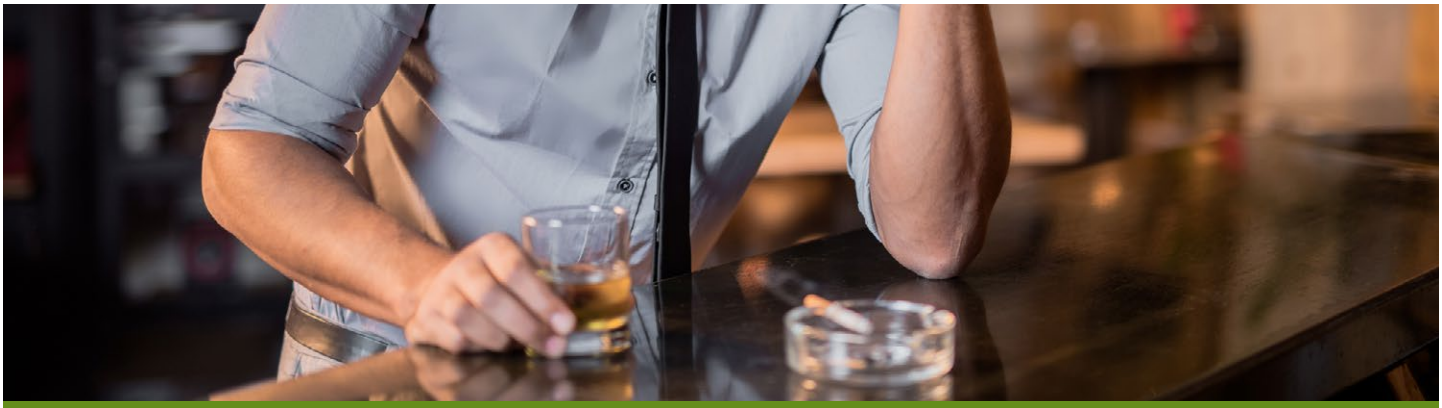
- Medicaid: Prescribers > Texas Medicaid STAR / CHIP > Prior Authorization Forms
- Marketplace & ERS: Prescribers > Go to Prescriber Log in (NPI required) > Prior Authorization > Select a Navitus Client (Community Health Choice) > Search for the drug name in the search field

Drug Samples

We understand that sometimes samples a way to offer our Members medications they might not otherwise be able to afford. However, we know that this supply can often be unreliable or inconsistent. Please note that we do not authorize non-formulary medications simply because a Member has been established on samples. The Member will still be subject to the prior authorization criteria that we have in place.

Provision of samples often cut out the pharmacy and pharmacist. By doing this, we believe there could be a risk to our Members because important safety checks are removed from the process. Pharmacists often are able to check allergies and contraindications with other conditions and medications and can have access to pieces of information the Member may not divulge during his/her office visits. Pharmacists can also help improve medication adherence and evaluate factors that may affect a Member's ability to take a medication (i.e. diet, lifestyle, etc.) through the relationship they build with our Members.

We thank you for everything you do for our Members. We look forward to continuing to partner with you. We wish you and your office staff a happy new year!



Smoking and Mental Health

Many people who have mental health problems smoke regularly. A large study in the United States found that people with mental illness are about twice as likely to smoke as other people. The study also found that people with mental illness consume less than half of all the cigarettes smoked in the United States.

Despite high smoking rates, studies show that people with mental illness can, and want to, quit smoking. In fact, quit rates for people who smoke and have mental illness are nearly as high as for other people. But people with mental illness face barriers to quitting that can keep them from trying in the first place.

This article will talk about:

- Factors that may find the link between smoking and mental illness
- What keeps those who smoke and have mental illness from quitting
- Quitting methods that can help people with mental illness

beacon health options

Why do people with mental illness smoke more?

Many theories try to explain such high smoking rates, including:

- **Genetics.** Some people inherit genes that increase their chance of smoking and mental illness. Certain gene variations that play a role in both mental and drug overuse problems also appear to play a role in smoking behavior.
- **Brain chemicals.** Nicotine affects the action of certain brain chemicals involved in mental illness and alcohol and drug problems. Dopamine is one type of brain chemical that is affected by nicotine. It is involved in the brain's reward and pleasure system.
- **Self-medication.** Some people with mental illness smoke to lessen symptoms. A person may light up to cope with depression or anxiety. People with schizophrenia may light up to help memory and attention.

Smoking may be a risk factor for mental illness

Research suggests that smoking raises your chance of mental illness. For instance, people who smoke are more likely than those who don't or used to smoke to have a first-time panic attack. Nearly all people who smoke and have schizophrenia regularly smoked before developing the disease. Young people who smoke have a higher future chance of depression and anxiety.

Why is quitting difficult for people who smoke and have mental illness?

People who smoke and have mental illness want to quit, and they can. But they may need more intensive treatment than those without it. Many believe that people who smoke and have mental illness can't quit. Because of this stigma, doctors might not ask people with mental illness about their tobacco use or quitting. Many people also believe that quitting would threaten mental health recovery by taking away a coping method and worsening symptoms. This is why smoking is tolerated in some drug and alcohol treatment programs. But studies do not support this, and it is not allowed in most inpatient programs.

What methods can help people who smoke and have mental illness quit for good?

Methods proven to help most people who smoke quit can most often help people with mental illness as well. Experts have found that people who smoke and have mental illness benefit the most from quit-smoking programs that:

- **Are intensive**. This means they offer four or more one-on-one office visits, each of which last at least 10 minutes.
- **Deliver quit-smoking interventions through many types of care Providers**. Successful programs also blend quit-smoking treatment with medical and mental health care.
- **Support the use of drugs to take care of withdrawal symptoms and cravings**. People with mental illness seem to have more withdrawal symptoms when quitting than other people. Some people might benefit from long-term use of quitting medicines.
- **Give useful counseling such as cognitive-behavioral therapy (CBT), as well as social support**. CBT focuses on identifying and changing harmful patterns of thinking, behavior, and feeling. Individual or group therapy, or a mixture of both, can work. Groups of eight to 10 people that meet once a week for seven to 10 weeks have the most successful quit rates. With the developing popularity and acceptance of the phone as a key social-networking tool, phone counseling support is also on the rise.
- **Check depressive or other mental health symptoms and medication side effects** while quitting.

With individualized treatment and support that fits the person, more people with mental illness can quit smoking for good.

Resources

www.smokefree.gov

Guide to Quitting Smoking. American Cancer Society, 2014. Available at: http://www.cancer.org/Healthy/StayAwayfromTobacco/GuidetoQuittingSmoking/index

CHOICES (Consumers Helping Others Improve Their Condition by Ending Smoking)
www.njchoices.org

National Mental Health Consumers' Self-help Clearinghouse
www.mhselfhelp.org

By Christine P. Martin

https://www.achievesolutions.net/achievesolutions/en/Content.do?contentId=395

Access to Medical Records

Contracts with Community Health Choice include provisions for the Provider to provide access to medical records that support claim payments for local, state or regulatory purposes. Failure to provide access to medical records upon request may be subjected to recoupment of claims paid.

Further, medical records and claims must support the level of care given to our Members and paid by Community. For education or concerns, please reach out to your local Provider Engagement Representative or call the Provider Services line at 713.295.2295, and they will be happy to assist.

Medical Supplies Physician Order Form for Health Services (Title XIX)

Durable Medical Equipment and Medical Supplies Physician Order form for Home Health Services (Title XIX) must contain the physician's signature on the form. Use of signature stamps and date stamps for the physician's attestation are not acceptable and may result in recoupment of claims.

Special Investigations Unit

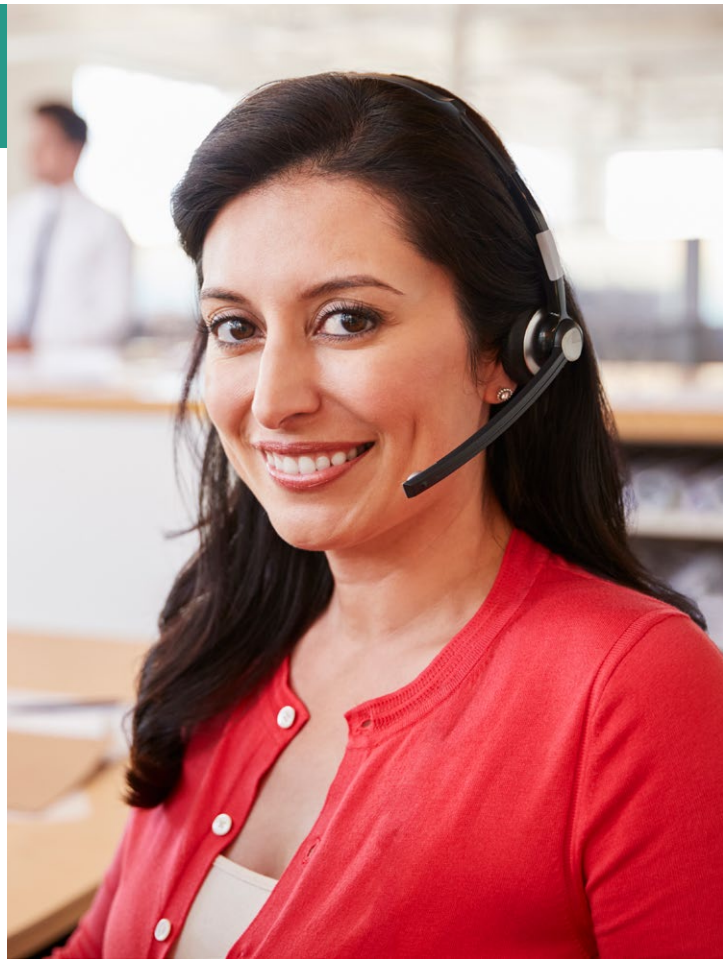
Our Special Investigations Unit (SIU) team is responsible for minimizing Community's risk to healthcare fraud. The SIU team partners with Community's Customer Service Claim Centers and others to help identify suspicious claims, stop payments to fraudulent providers, and report wrongdoers to the appropriate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

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

How to Report Healthcare Fraud

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

Community Health Choice
c/o Special Investigations Unit
2636 S Loop West, Suite 125
Houston, TX 77054



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 3 and 17 years of age as of December 31 of the measurement year are included in the measure. 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 is 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 the date discussed included):
  - 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 the 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

*HCPCS – Healthcare Common Procedure Coding System
**Use ICD-10 diagnosis code with either CPT or HCPCS code depending 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 Pprovider, 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 the 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, which 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.

Antibiotic Use

Antibiotic resistance is a rapidly growing problem. The HEDIS measure *Appropriate Treatment for Children with Upper Respiratory Infection (URI)* is designed around one aspect of this issue.

The inclusion population for this measure is Members age 3 months to 18 years who have an outpatient or emergency department visit, during which the only diagnosis was for an upper respiratory infection of unspecified origin. The relevant ICD-10 diagnosis codes include:

Code	Definition
J00	Acute nasopharyngitix (common cold)
J06.0	Acute laryngopharyngitis
J06.9	Acute upper respiratory infection, unspecified

Members who are considered to have received appropriate treatment are those who did not fill an antibiotic prescription within three days of the diagnosis.

We know you have patients and parents asking about antibiotics, especially during flu season. So how can you address their concerns, while providing appropriate treatment and fighting antibiotic resistance?

- Spend a couple of minutes on education with the patient
  - Be clear when illness is due to virus
  - Handouts and other tangibles can serve as a guide for patients, even if it's a written prescription for more fluids or other supportive care advice. The Centers for Disease Control and Prevention (CDC) has terrific ready-to-use materials and references!
  - Give an expectation for duration of symptoms and when to come back if not improving
- Here are a few things to remind your patients about:
  - Antibiotics fight bacteria. They will not help if your infection is not caused by bacteria
  - Antibiotics can be harmful when taken unnecessarily
  - If you take antibiotics when you don't need them, they may not work when you do need them

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.

Community's Mom & Baby Efforts

Community reaches out in many ways to our Moms and 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 31).
- 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.

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. You can mention the rewards program to help encourage appointment compliance. Thank you for providing quality care for our Members!

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 1.888.760.2600.

CommunityHealthChoice.org

fl_mombaby_provider_0119

COMMUNITY HEALTH CHOICE
COMMUNITY CARES.

National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service and Family Planning Providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure.

N4 must be entered before the NDC on claims.

National Drug Unit of Measure: The submitted unit of measure should reflect the volume measurement administered. Refer to the NDC Package Measure column on the Texas NDC-to-HCPCS Crosswalk.

The valid units of measurement codes are:

- F2—International unit
- GR—Gram
- ME—Milligram
- ML—Milliliter
- UN—Unit

Note: Unit quantities are required

Paper Claim Submissions

Block No.	Description	Guidelines
UB-04 CMS 1450		
43	Revenue codes and description	This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR). • The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025). **Example:** N400409231231GR0.025
UB-04 CMS 1450		
24A	Dates of service	In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). **Example:** N400409231231
24D	Procedures, services, or supplies	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.

Block No.	Description	Guidelines
2017 Claim Form		
32A	Dates of service	In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). **Example:** N400409231231
32D	Procedures, services, or supplies Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Modifier	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
32F	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME.

National Drug Unit

Claims will be edited for the value submitted in the NDC quantity field. In order to convert the HCPCS units submitted into the NDC quantity; use the Texas NDC-to-HCPCS Crosswalk to review the "HCPCS Description" and the "NDC Label" description to identify the quantity.

The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes and National Drug Codes (NDC). The Texas file is published at least quarterly. The Texas NDC-to-HCPCS Crosswalk can be found at www.txvendordrug.com/formulary/clinician-administered-drugs.shtml. Clinician-administered drugs that do not have an appropriate NDC to HCPCS combination for the procedure code that is submitted are not payable.

Claim Refund/ Recoupment Requests

Please be aware that a recoupment is not performed at the time a refund is requested via letter from Community Health Choice. We allow Providers 60 days to send a response if they do not agree with the request. If you determine that the request for a refund is incorrect or payment has already been refunded, please attach supporting documentation to the refund request letter and forward to the physical address on the refund letter. If no correspondence is received from the Provider, we will recoup the funds from new day claims 60 days from the date of the notification letter.

Claims address:
Community Health Choice, Inc.
Attn: Claims Department
PO Box 301424
Houston, Texas 77230-1424

FQHC reminder

To qualify as an FQHC visit, and receive the FQHC encounter rate, the encounter must include a valid "Qualifying Visit."

Sterilization consent forms.

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form. Please ensure all fields are completed when submitting.

Note: The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.

Refer to the TMHP website at www.tmhp.com for:

- Sterilization Consent Form (English)
- Sterilization Consent Form (Spanish)
- Sterilization Consent Form Instructions

Securing Your Web Portal Access

We are all accountable for protecting Member and Provider information. In an effort to increase further security compliance, please take a moment to create individual user accounts for each of your staff Members. It is never recommended for everyone to use the same credentials due to employee turnover and security.

If you have questions, please contact your local Provider Engagement Representative.

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.

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.

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.

Community Announcement

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 31 of each calendar year.

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

Integrating Postpartum Depression Screening into Routine Infant Medical Checkups

Texas Health Steps Providers can now receive separate reimbursement for conducting maternal postpartum depression screening once per Provider, in the 12 months following the infant's birth during a Texas Health Steps checkup when the screening is completed using a validated screening tool.

Validated screening tools include the following:

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PPDS)
- Patient Health Questionnaire (PHQ-9)

The Medicaid Provider notification regarding this benefit can be found at TMPH's website.

New Free Tutorial on Postpartum Depression Screening is also available at https://www.txhealthsteps.com/static/courses/ppd/sections/intro.html?utm_source=courseannouncement&utm_medium=email&utm_campaign=ppd

THSteps Mental Health Screening Change For 12 to 18 Year Olds

THSteps allows 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.

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 the schedule below:

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

THSTEPS CHECKUP DOCUMENTATION – ESSENTIAL TO MEDICAL RECORDS

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

1. **Comprehensive health and developmental history** that includes nutrition screening, developmental and mental health screening and TB screening;
2. **Comprehensive unclothed physical examination** that includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening;
3. **Appropriate immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV;
4. **Appropriate laboratory tests** that include newborn screening blood lead level assessment appropriate for age and risk factors, and anemia;
5. **Health education** (including anticipatory guidance); and
6. **Dental referral** every six months until the parent or caregiver reports a dental home is established.

For you to be reimbursed for THSteps checkups, each of the six components and their individual elements must be completed and documented in the medical record. Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element.

To stay current on THSteps policy and available resources, visit the frequently updated THSteps website for information and policy updates. Information on checkup documentation is also available within THSteps Online Provider Education modules. These modules are free and offer continuing education for healthcare professionals. They are available at www.txhealthsteps.com.

Qualified and caring THSteps Providers are vital to keeping young Texans healthy. The preventive health care you provide to young Texans is valued. It is important to reflect this care in the completeness of your medical documentation.

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 four-year checkup could be performed prior to the member's fourth birthday if the Member is a Member of a migrant family that is leaving the area. Use modifier 32 when billing for this type of checkup.
- When needed before a dental procedure requiring general anesthesia

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

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

Modifiers indicate the reason for the exception to periodicity Checkup:

Modifier	Description
SC	Medically necessary (developmental delay or suspected abuse) Environmental high-risk (sibling of child 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.

CHILDREN OF TRAVELING FARMWORKERS

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

A traveling farmworker is someone who:

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

Their children **ages birth up to the day of their 18th birthday** are considered children of traveling farmworkers. Children of traveling farmworkers due for a THSteps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but it should be billed as a checkup. For example, a 4-year-old checkup may be performed prior to the child's fourth birthday, if the child is a member of a traveling family that is leaving the area. Providers must use 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.

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 healthcare Provider, you can help by making sure the children receive their initial checkup within 45 days of enrollment.

For more information on Head Start programs, please visit: https://www.acf.hhs.gov/ohs

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

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

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.

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 ride 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 SERVICES 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.

In 2017, Community established a new Life Services team within the Community Affairs Department to create initiatives surrounding social determinants of health.

The team identified three priority initiatives that focus on social factors greatly influencing its Membership: early childhood development, job training, and education.

They laid the foundation for the career program by creating a scholarship program that covers all tuition, books, and supplies for eligible Members to attend Houston Community College with the goal of completing a job certification program, such as a certified nurse assistant, medical scribe, or occupational therapy assistant. The objective of this program, CareerReady, is to help Members achieve economic independence through furthering their education and career trajectory.

CareerReady's mission is to open opportunities for educational advancement for certain Community Members, including high school seniors and pregnant women between the ages of 18 and 30. Community hopes to help these participants succeed through addressing the social needs that may influence employment and academic performance.

CareerReady participants are assigned a life coach who helps Members by:

- Providing assistance to overcome any hurdles faced while applying for college;
- Making connections to community resources to address social needs such as food, clothing, housing, and transportation;
- Building program participants' soft skills including conducting mock interviews and resume editing;
- Assisting with the employment search; and
- Providing participants support during their enrollment in school and their first years of employment.

In its pilot year, Community partnered with the Association of the Advancement of Mexican Americans (AAMA) Sanchez Charter School, a local charter school. Community worked with high school counselors and career advisors to recruit students eligible for the scholarship. To engage pregnant women for CareerReady, Community promoted the scholarship opportunity via email, postal mail, and social media to eligible Members. During the pilot year, Community officially accepted 35 people: 12 high school seniors and 23 pregnant women; 32 Members remain in the program at the time of this report.

For the coming year, funding to accept 20 additional CareerReady scholars has been provided by Community using its surplus dollars.

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

The following continuing education is only available to THSteps Providers:

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

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

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 *(MARKETPLACE)*

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

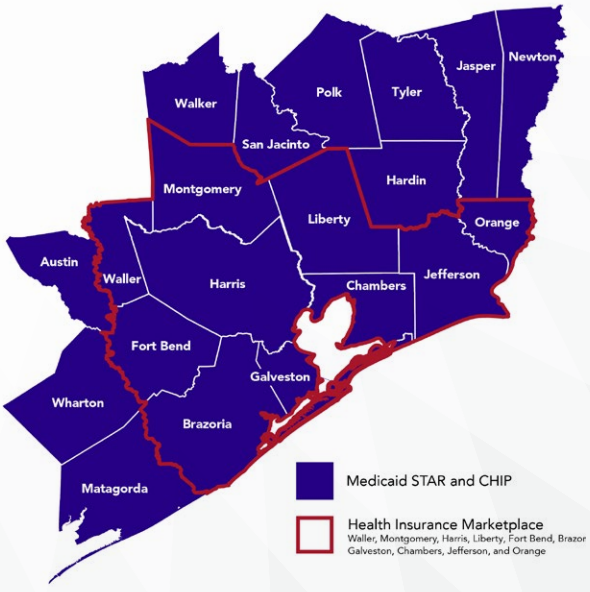
713.295.2294 or 1.888.760.2600

PROVIDER RELATIONS

For general questions or to submit your updates:

- 713.295.2295
- ProviderRelationsInquiries@CommunityHealthChoice.org
- Contact your Provider Engagement Representative.

SERVICE AREA MAP



CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services