

V3-2020

# Provider Newsletter

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Chief Medical Officer



**CommunityHealthChoice.org**

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# Feedback

What do you think about our Provider Newsletter? Do you have any feedback you would like to share with us? We are always working to make the content and format **easy to understand**, **helpful** to you and your staff, and **applicable** to your day-to-day work. If you have any comments, suggestions or ideas for future articles you would like to see, please share with your Provider Engagement Representative or email us at [ProviderRelationsInquiries@CommunityHealthChoice.org](mailto:ProviderRelationsInquiries@CommunityHealthChoice.org).

## Welcome, Dr. Porter-Sales

### Dr. Vernicka Porter-Sales recently joined Community Health Choice (Community) as Chief Medical Officer.

Dr. Porter-Sales has spent most of her career serving the vulnerable Members of society. She was born and raised in Houston and is overjoyed about this opportunity to serve the very community that supported her. She earned her bachelor's degree from Tuskegee University and completed her doctorate from Philadelphia College of Osteopathic Medicine. She subsequently completed her pediatric internship and residency training at Children's Hospital of New Jersey at Newark Beth Israel and UMDNJ-Cooper Hospital in Camden, N.J., respectively.

After three years in group practice, six years in private practice, serving as pediatric section chair for two hospitals, and medical correspondent for a local news station in Beaumont, Texas, she embarked on a career in healthcare administration, initially taking a role with Accretive Health. Shortly thereafter, she joined UnitedHealthcare as medical director on the national Medicaid team covering several states. During that time, she rose to lead her Utilization Management (UM) teams covering the Texas and Ohio health plans. In collaboration with the local health plan and colleagues, she was able to realize \$2 million in savings on therapy utilization in her first year covering the Texas Membership. She was then selected to lead the rollout of Texas Star Kids products in the UHC Community Plan of Texas, which focused on medically fragile children. In addition, she led case management, disease management, and interdisciplinary rounds, as well, quality initiatives for the LTSS, CHIP, and TANF populations whose Membership was over 300,000. Dr. Porter-Sales successively moved on to a senior medical director role with the UHC Employee & Individual commercial division overseeing large group accounts spanning the U.S. while leading a team of 16 medical professionals.

Her most recent position was with Aetna/CVS Health as a regional medical director again serving several Medicaid states. In conjunction with her extensive career path, she remains passionate about promoting equality in all aspects of the healthcare delivery system.

Dr. Porter-Sales is a longtime Member of The Links, Inc., Jack and Jill of America, Alpha Kappa Alpha Sorority, and American Academy of Pediatrics.

## Our New Website is Up and Running For You

We are excited to announce the launch of our new website. We built the site from the ground up with a special focus on meeting your needs, and it's all based on generous feedback we received from Providers like you.

We think you will like what you see. The site is designed to help everyone find whatever they need quickly and easily, thanks to smarter navigation, better organization, and a new search tool. And of course, the site works seamlessly across any device.

**A new Provider portal is coming your way soon, but for now, we invite you to explore our new site at [CommunityHealthChoice.org](https://CommunityHealthChoice.org). Thanks for helping us build it.**





## Coronavirus (COVID-19)

Community continues to monitor the coronavirus disease (COVID-19) and the most updated information from the Centers for Disease Control and Prevention (CDC), Texas Department of State Health Services, and Harris County Public Health Department.

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

## Hurricanes Laura and Delta Information for Medicaid Providers

Texas providers rendering services to evacuees from Louisiana due to Hurricanes Laura and Delta may complete the Hurricane Emergency Expedited Application with Louisiana Medicaid to receive reimbursement for services rendered to Louisiana Medicaid clients for the fee-for-service program.

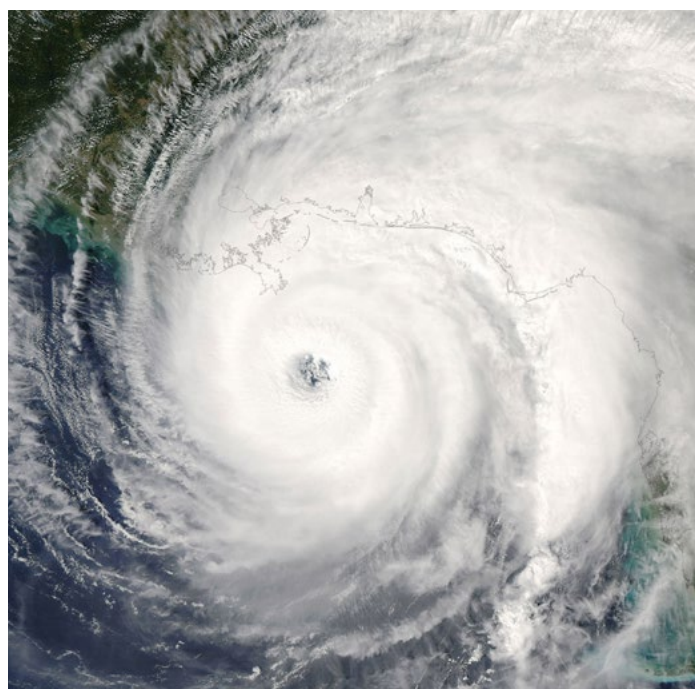
If providing care to a Louisiana managed care enrollee, providers will need to contact the clients' managed care organization (MCO) in order to be reimbursed for services provided. Refer to the [Healthy Louisiana Hurricane Laura Provider Assistance Frequently Asked Questions \(FAQ\)](#) document for MCO credentialing contact information.

### Louisiana Medicaid Resources

- [Louisiana Medicaid Provider Enrollment](#)
- [Louisiana Medicaid Provider & Plan Resources](#) (Managed Care Information)
- [Louisiana Department of Health Informational Bulletin 20-17 Revised October 8, 2020: Hurricanes Delta and Laura Provider Assistance FAQs](#)

Article published in the TMHP site: <http://www.tmhp.com/news/2020-10-09-hurricanes-delta-and-laura-information-medicaid-providers>.

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



## Community's Service Lines

As a local, non-profit, Managed Care Organization (MCO), Community's mission is to improve the health and well-being of underserved Texans by opening doors to healthcare and health-related social services.

In addition to STAR, CHIP, CHIP Perinate, and Health Insurance Marketplace, we are pleased to offer Community Health Choice (HMO D-SNP) - a Medicare Advantage Dual Special Needs plan for people with both Medicare and Medicaid. This new plan combines all the benefits of Original Medicare (Parts A and B) with prescription drug coverage (Part D).

HMO D-SNP Members have access to comprehensive medical care, including services such as hospital care, surgery, X-rays, physical/speech/occupational therapies, prescription drugs, emergency services, durable medical equipment, transplants, routine health checkups, and preventive screenings. HMO D-SNP Members also receive extra benefits such as:

- Routine dental services
- Vision benefits, including an allowance for eyewear
- Routine hearing services, including a hearing aid allowance
- Help coordinating benefits
- 24-hour Nurse Help Line
- Transportation assistance

### Medicare Advantage Enrollment Periods

Annual Election Period (AEP)	During AEP, beneficiaries can...	
<b>October 15–December 7</b> (Changes will take effect on January 1.)	<ul style="list-style-type: none"> <li>• Change from Original Medicare to a Medicare Advantage Plan.</li> <li>• Change from a Medicare Advantage Plan back to Original Medicare.</li> <li>• Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.</li> <li>• Switch from a Medicare Advantage Plan that does not offer drug coverage to a Medicare Advantage Plan that offers drug coverage.</li> <li>• Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that does not offer drug coverage.</li> <li>• Join a Medicare Prescription Drug Plan.</li> <li>• Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan.</li> <li>• Drop Medicare prescription drug coverage completely.</li> </ul>	
Medicare Open Enrollment Period (MA OEP)	During OEP, beneficiaries can...	During OEP, beneficiaries cannot...
<b>January 1–March 31</b> (Only one change can be made during this period. Changes will take effect the first of the month after the plan received the request.)	<ul style="list-style-type: none"> <li>• If in a Medicare Advantage Plan (with or without drug coverage), switch to another Medicare Advantage Plan (with or without drug coverage).</li> <li>• Disenroll from the Medicare Advantage Plan and return to Original Medicare. If choosing to do so, can join a Medicare Prescription Drug Plan.</li> <li>• If enrolled in a Medicare Advantage Plan during the Initial Enrollment Period, change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months of Medicare eligibility.</li> </ul>	<ul style="list-style-type: none"> <li>• Switch from Original Medicare to a Medicare Advantage Plan.</li> <li>• Join a Medicare Prescription Drug Plan if on Original Medicare.</li> <li>• Switch from one Medicare Prescription Drug Plan to another if on Original Medicare.</li> </ul>

## Special Election Periods (SEP)

- Beneficiaries can make changes to their Medicare health and Medicare prescription drug coverage when certain events happen in their life, i.e., move or lose other insurance coverage.
- These opportunities to make changes are called Special Enrollment Periods (SEPs) and are in addition to the regular enrollment periods that happen each year.
- Rules about when beneficiaries can make changes and the type of changes they can make are different for each SEP.

## Health Insurance Marketplace, STAR, CHIP, CHIP Perinate

Below is additional information to remember about Health Insurance Marketplace, STAR, CHIP and CHIP Perinate:

Product	Enrollment Period	Description and Benefits
Health Insurance Marketplace	November 1–December 15 (Open Enrollment Period)	Affordable options for individuals and families <ul style="list-style-type: none"> <li>• A wide range of deductibles and copay plans</li> <li>• One of the largest doctor networks in Southeast Texas</li> <li>• Easy plan selection and enrollment through <a href="http://healthcare.gov">healthcare.gov</a></li> </ul>
Texas STAR Medicaid	All year	For Very Low-Income Children and Pregnant Women <ul style="list-style-type: none"> <li>• No Cost to residents who cannot afford health Insurance</li> <li>• Coverage for children through the first month of their 21st birthday.</li> <li>• Pregnant women must be at or below 185% of the Federal Poverty Level and recertify each year.</li> </ul>
Texas CHIP and CHIP Perinatal	All year	Low copays (\$50 or less) for most doctor visits and \$16 prescription drugs <ul style="list-style-type: none"> <li>• Coverage for children under the age of 19</li> <li>• Coordinated prenatal and medically necessary specialty care for pregnant women</li> <li>• Based on income, coverage is:</li> <li>• 12 straight months of CHIP Perinatal benefits split between the mother's prenatal care and the baby's birth OR Full Medicaid benefits for the baby at birth</li> <li>• Family income must be between 100% and 200% of the Federal Poverty level</li> </ul>

To learn more, please contact Provider Services at 713.295.2295 for Medicaid/STAR, 713.295.6704 for Marketplace or 713.295.5007 for HMO D-SNP.

## Recertification for STAR and CHIP Members

The Public Health Emergency declaration is set to end on November 30, 2020. Members who are due for recertification are receiving communication from HHSC to send documentation to the state to recertify their benefits. Please encourage your patients to send the documentation to the state to avoid a lapse in coverage.

STAR and CHIP Members will remain covered as long as there is a public health emergency declaration, but once the declaration is lifted, Members will have 30 days to get their information submitted to the state or risk losing coverage.

Community is also reaching out to Members who are due for recertification to remind them of the importance of completing the necessary documentation requested by HHSC. We are also able to assist Members virtually, over the phone or in some limited cases, face-to-face at application assistance/recertification sites in the community.



## Newborn Coverage and Claim Submission

Providers rendering services to newborns should be aware of the following:

- Newborn ID cards should not be required to render service for newborns.
- Newborns will be enrolled to their eligible mothers who are enrolled with Community for at least 90 days following the date of birth.
- Community will accept Provider claims for newborn services based on mother's name or Medicaid ID number.
- Mothers are encouraged to notify the local authority of the birth of their newborn child so an ID number can be rendered.





## Lack of Transportation Causing Missed Appointments?

In some situations, Members without transportation access may wait for a medical emergency just to be able to see a doctor. Missed appointments also mean that they cannot address their questions and concerns, or update physicians on changes in their health history or life circumstances.

Contact Community's Member Services at 713.295.2294 if you have a STAR or CHIP Member who needs help with transportation to and from appointments.



## Healthy Texas Women

The Healthy Texas Women Program provides family planning exams, related health screenings, and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185% of the federal poverty level). An application must be submitted for services through this program.

To learn more about services available through the Healthy Texas Women Program, write, call or visit the program's website:

Healthy Texas Women Program  
P.O. Box 149021  
Austin, TX 78714-9021  
Phone: 1.800.335.8957

Website: <https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women>

Fax: (toll-free) 1.866.993.9971

## Urgent Care

In a continuing effort to better serve our Members, Members who access emergency room services for potentially preventable ED visits receive a personalized list of participating urgent care facilities within a 10-minute drive from the Member's home. We also continue to communicate with PCPs on use of our PCP Tool Kit for behavioral health conditions that may be treated in the PCP care setting.

We hope to accomplish the following with these campaigns:

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

To access the most current urgent care facilities or PCP Tool Kit, please visit our website at [www.communityhealthchoice.org](http://www.communityhealthchoice.org) or contact your Provider Engagement Representative.

## Welcome, Gwendolyn Dalcour

Gwendolyn Dalcour joined the Community team as the new director of claims. Gwen's most recent experience is with Kelsey-Seybold as the director of Managed Care Services with overview of claims, configuration, and Utilization Management (UM) responsibilities. Prior to that, Gwen was the associate vice-president over Medicare/Medicaid (MMP) claims and configuration at Virginia Premier Health Plan.

Gwen is a divisional leader with more than 20 years of progressive leadership experience within Claims Operations, including Medicare, Commercial, Special Needs Plans, and MMP health plans. Gwen believes in practicing a collaborative leadership style with an integrated approach to process improvement initiatives with emphasis on both staffing and operational successes. She promotes transparency and has a successful track record of leading and developing high performing teams while establishing meaningful partnerships with organizational leaders.

## AMA COVID-19 New Code Updates

The American Medical Association (AMA) announced an update to Current Procedural Terminology (CPT®) that includes two new COVID-19 codes, effective September 8, 2020.

Code	Long Description	Short Description
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative.20	SARS-COV-2 ANTB QUANTITATIVE
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease.	ADDL SUPL MATRL&STAF TM PHE

## CMS Suspended Codes and Deleted Edits Reinstated by CMS

CMS updated the Practitioner and Outpatient NCCI Quarterly PTP files for Q4 2020.

In response to COVID-19 Public Health Emergency (PHE), the codes CMS had previously identified as "temporarily suspended" effective December 31, 2020, are reinstated effective October 1, 2020.

The code pairs include the services such as those listed below:

- Emergency department visits, levels 1-5
- Domiciliary, rest home, or custodial care services, new and established patients, all levels
- Home visits, new and established patient, all levels
- Care planning for patients with cognitive impairment
- Psychological and neuropsychological testing
- Therapy services, physical and occupational therapy, all levels
- Other services such as venipuncture, burn treatments, stereotactic radiation treatment management, injections of diagnostic/therapeutic substances lumbar or sacral

The links to the CMS MUE and PTP quarterly changes are:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE>

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits>

The link to the National Medicaid CCI and MUE changes are:

[https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version\\_Update\\_Changes](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes)



## Ambulatory and Long-Term Electroencephalogram Benefits Changing for Texas Medicaid on October 1, 2020

Ambulatory and long-term electroencephalogram (EEG) monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG. Established Medicaid coverage for ambulatory EEG is limited to three units (each unit 24 hours) for each physician for the same client per six months when medically necessary.

Effective for dates of service on or after October 1, 2020, ambulatory and long-term EEG benefits will change for Texas Medicaid. The time increment for each unit will no longer be 24 hours.

Time increments for each unit of the following procedure codes are defined in their respective descriptions.

Procedure Codes						
95705*	95706	95707	95708	95709	95710	95711
95712	95713	95714	95715	95716	95717	95718
95719	95720	95721	95722	95723	95724	95725
95726						

\*Procedure code 95700 (setup, patient education, and takedown) will be limited to three units per six months for each physician for the same client, in addition to the 3 units allowed for the procedure codes listed in the table above.

## ClaimsXten: Update Effective January 1, 2021

Accurate coding and reporting of services on medical claims submitted to Community Health Choice (Community) is critical in assuring proper payment to Providers. Community utilizes Change Healthcare's code-auditing system, ClaimsXten™ that allows Community to better validate claims-coding accuracy and more closely align claims adjudication with medical policies, benefit plans, and the Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI).

Effective **January 1, 2021**, Community will implement the following ClaimsXten rules when processing claims.

Rule	Description
Global Component	Identifies claim lines with procedure codes, which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule also detects when duplicate submissions occurred for the total global procedure or its components across different Providers.
Obstetrics Package Rule	This rule audits potential overpayments for obstetric care. It will evaluate claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery, and postpartum services, i.e. 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.
Inpatient Consultations	Identifies claim lines containing inpatient consultations that should have been billed at the appropriate level of subsequent hospital care. This rule is appropriate for professional claims only.
Outpatient Consultations	Identifies claim lines containing office or other outpatient consultations that should have been billed at the appropriate level of office visit, established patient or subsequent hospital care.
PCP Consultations	Identifies claim lines containing consultation codes that are billed by a Member's primary care physician (PCP).
Ambulance Bundled Services	This rule recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same Provider, and on Same Claim Only.
Medicaid NCCI DME	Identifies claims containing code pairs found to be unbundled in accordance to the CMS NCCI for Durable Medical equipment (DME) claims.
Therapy Services Professional	Audits claims to determine if an evaluative or re-evaluative therapy procedure code(s) has been submitted with appropriate therapy modifier and meets functional reporting requirements, as well as appropriate times a given untimed evaluative or re-evaluative therapy procedure should be reported on a particular date of service.
Revenue Procedure Validation-Facility	Identifies claim lines containing observation revenue codes and determines if the revenue code was submitted with procedure codes that are not HCPCS observation care services.
Revenue Codes that Require HCPCS Code	CMS Outpatient Prospective Payment System (OPPS) Integrated Outpatient Code Editor (I/OCE) requires certain revenue codes to be reported with a Healthcare Common Procedure Coding System (HCPCS) code. Revenue codes are summary billing codes required on the UB-04 claim form to represent the type of service provided and where it was performed.
Therapy Services Facility	Audits claims to determine, if an evaluative or re-evaluative therapy procedure code(s) has been submitted with an appropriate therapy modifier as well as Revenue code, meets functional reporting requirements as well as appropriate times a given untimed evaluative or re-evaluative therapy procedure should be reported on a particular date of service.

### Resources:

National Correct Coding Initiative Edits <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index>

NCCI PTP edits <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits>

Medically Unlikely Edits (MUEs) <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE>

Add-on code edits <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits>

For more information regarding this change, please contact your local Provider Engagement Representative or call Provider Services at 713.295.2295 for Medicaid/STAR, 713.295.6704 for Marketplace or 713.295.5007 for HMO D-SNP.

## Long-Acting Reversible Contraception (LARC)

### Hospitals

Procedure codes for LARCs may be reimbursed in addition to the hospital diagnosis related group (DRG) payment when insertion is performed immediately postpartum.

Procedure Codes				
J7297	J7298	J7300	J7301	J7307

“Immediately postpartum” refers to insertion within 10 to 15 minutes of placental delivery, after vaginal or cesarean delivery, for intrauterine devices (IUDs) or insertion prior to discharge for implantable contraceptive capsules.

When seeking reimbursement for an IUD or implantable contraceptive capsule inserted immediately postpartum, hospital/facility Providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.

### FQHCs

FQHCs may receive reimbursement for the following procedure codes in addition to the FQHC encounter payment:

Procedure Codes				
J7297	J7298	J7300	J7301	J7307

When seeking reimbursement for an IUD or implantable contraceptive capsule, Providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations.



## Don't Let This Happen to You: Top Billing Errors

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

Who	What	Causes of denials or delays	Do
All Providers	Rendering Provider	<ul style="list-style-type: none"> <li>Claim does not include rendering Provider's NPI</li> <li>Billing NPI is not the Group NPI</li> <li>Provider is not enrolled with the Medicaid program</li> </ul>	Include the rendering Provider's NPI.
	<b>Frequency Code 7:</b> Indicates the new claim is a replacement or corrected claim – the information present on this bill represents a complete replacement of the previously issued bill	<ul style="list-style-type: none"> <li>Resubmitting the same claim multiple times</li> <li>Submitting corrected claims changing the Member</li> <li>Submitting corrected claims changing the Provider</li> <li>Submitting corrected claims changing the Date of Service</li> </ul>	Allow 30 days between submissions
	Modifier 25	<ul style="list-style-type: none"> <li>Using a 25 modifier when billing for services performed during a postoperative period if related to the previous surgery</li> <li>Using a modifier 25 on any E/M on the day a "Major" (90 day global) procedure is being performed</li> <li>Adding modifier 25 to an E/M service when a minimal procedure is performed on the same day</li> </ul>	Add modifier 25 to an E/M service when level of service can be supported as significant, separately identifiable. All procedures have "inherent" E/M service included.
ECI Providers	IFSP forms	Submitting IFSP forms to Community	Not submit IFSP forms to Community
FQHCs	Incorrect Place of Service (POS)	Submitting claims with POS 11	Bill with POS 50
	T1015	Not reporting the correct FQHC PPS rate	Include FQHC's PPS rate
	2nd and subsequent lines of each claim	Not including all services delivered during patient visit at normal charges	Include <b>ALL</b> services delivered during patient visit at normal charges
Therapy Providers	Modifiers	<ul style="list-style-type: none"> <li>Submitting claims without the proper modifier or no modifier at all.</li> <li>Modifiers GP, GO, and GN are required on all claims except when billing evaluation and re-evaluation procedure codes.</li> <li>The AT modifier must be included on claims for acute therapy services.</li> </ul>	Include the appropriate modifier.

## Balance Billing

### STAR and CHIP

Members enrolled in STAR and CHIP have certain rights and protections against balance billing. Members are not responsible for any Covered Services. Medicaid reimbursement is considered as payment in full for those services covered under Texas Medicaid (TMHP Manual 1.6.9).

Balance billing is illegal under both state and federal law (Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997). Please refer to the Texas Administrative Code Chapter 354 Rule §354.1005 and §354.1131.

CHIP Members are responsible for their copayments, as applicable, to their Federal Poverty Level (FPL).

### Marketplace

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

### Medicare

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

## After Hours

- **CPT Coding Description of 99050**

Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.

*(Code 99050 is intended to describe circumstances under which patient-requested care is outside of the usual time frame of the routine scheduling. An example of when this code might be used is when an office has regularly posted office hours of Monday-Friday from 8:30 AM to 5 PM, and a patient is seen by the physician at 7 PM or during the weekend outside of the usual time. The physician would report the appropriate Evaluation and Management Service (E/M) and any other therapeutic (e.g., wound repair) and/or diagnostic e.g., X-ray service(s) provided, in addition to code 99050, to indicate that the service was requested and performed outside of the posted office hours.)*

- **Medicare** does not reimburse for Miscellaneous Services “after hours” codes 99050-99053. It is bundled into the payment for Evaluation & Management codes.

- **Industry standard:**

CPT code 99050 is eligible for separate reimbursement, in addition to the basic covered service, if the basic service provided meets all of the criteria described below:

- ✓ It is reported with an office setting place of service;
- ✓ It is rendered at a time other than the practice's regularly scheduled and/or posted office hours; and
- ✓ The basic service time is based on arrival time, not actual time services commence.

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

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

- The medical record must be complete and legible.
- The documentation of each patient encounter must include:
  - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
  - assessment, clinical impression, or diagnosis;
  - plan for care; and
  - date and legible identity of the patient and the author.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses along with allowed conditions should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The CPT, Level II, and Level III HCPCS and ICD codes reported on claim forms submitted to Community must be supported by the documentation in the medical record.





## Reporting Provider or Recipient Waste, Abuse or Fraud

Let us know if you think a doctor, dentist or pharmacist at a drug store, other healthcare Providers or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law.

### For example, tell us if you think someone is:

- Getting paid for services that were not given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid or CHIP ID
- Using someone else's Medicaid or CHIP ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

### To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184;
- Visit <https://oig.hhsc.state.tx.us/>. Under the box labeled "I want to," click "Report Waste, Abuse and Fraud" to complete the online form; or

- You can report directly to Community at:

Community Health Choice  
 Chief Compliance Officer  
 2636 S. Loop West, Ste. 125  
 Houston, TX 77054  
 1.877.888.0002

### How to Report Healthcare Fraud

- Call the Compliance hotline at 1.877.888.0002
- Email us: [SIU@CommunityHealthChoice.org](mailto:SIU@CommunityHealthChoice.org)
- Write to us at:

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

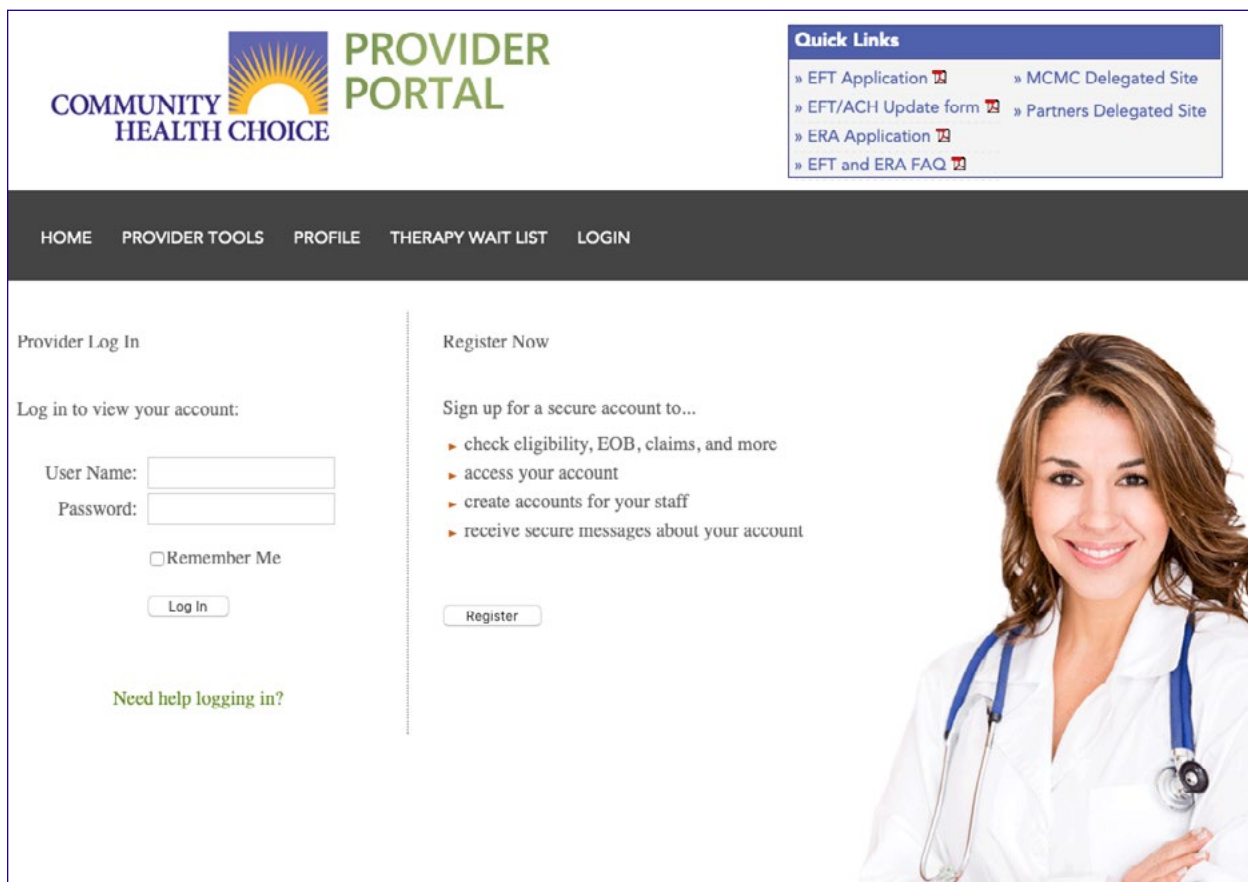
## Automated Prior Authorization Process

Earlier this summer, we communicated that Community Health Choice (Community) would provide an automated prior authorization solution for Providers in our networks, including a means for fully automated authorization responses. While the complete functionality of the tool is unavailable at this time, Community strives to provide excellent service to our entire network and will continue to work toward improving your experience with us.

You will soon receive additional information about a solution in our Provider Portal with benefits including:

- Easy submission of prior authorization requests,
- Access to an online catalogue of procedures that require Prior Authorization, and
- Visibility of authorization status.

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



The screenshot displays the Community Health Choice Provider Portal. At the top left is the logo with a sun icon and the text "COMMUNITY HEALTH CHOICE". To its right, "PROVIDER PORTAL" is written in green. A "Quick Links" box on the top right contains links for EFT Application, EFT/ACH Update form, ERA Application, EFT and ERA FAQ, MCMC Delegated Site, and Partners Delegated Site. A dark navigation bar below the header includes links for HOME, PROVIDER TOOLS, PROFILE, THERAPY WAIT LIST, and LOGIN. The main content area is split: the left side features a "Provider Log In" section with fields for User Name and Password, a "Remember Me" checkbox, a "Log In" button, and a "Need help logging in?" link. The right side has a "Register Now" section with a sign-up prompt and a list of benefits: checking eligibility/EOB/claims, accessing the account, creating accounts for staff, and receiving secure messages. A "Register" button is at the bottom of this section. On the far right is a large image of a smiling female doctor in a white coat with a stethoscope.



## Prior Authorization Guide Effective January 1, 2021

Providers will find the Prior Authorization Guide effective January 1, 2021, for all programs in the Provider Portal at <https://Providerportal.communityhealthchoice.org> in the Authorization Guides section.

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

### Medical/Acute Services

<b>Marketplace</b>	Phone: 713.295.6704 Notification of Admission: 713.295.2284 (fax) Prior Authorization services: 713.295.5019 (fax)
<b>Medicaid/CHIP</b>	Phone: 713.295.2295 Notification of Admission: 713.295.2284 (fax) Clinical Submission: 713.295.7030 (fax) Prior Authorization services: 713.295.2283 (fax)
<b>HMO D-SNP</b>	Phone: 713.295.5007 Notification of Admission: 713.295.2284 (fax) Clinical Submission: 713.295.7030 (fax) Prior Authorization services: 713.295.7059 (fax)

### Admissions to Facilities

(including transfers between separate facilities, even if within the same hospital system)

- Surgical and nonsurgical
- Rehabilitation facility
- Skilled nursing facility
- Maternity and newborn stays that exceed two (2) days for vaginal delivery or four (4) days for Cesarean section delivery

### Ambulance/Transportation

- Non-emergency ground transportation
- All air transportation

### Bariatric Surgery

(may not be a covered benefit on all programs)

- All weight loss procedures
- All procedures related to reversal, revision or complications as a result of weight loss surgery

### Cardiac Services

For Providers who are **not** cardiologists, prior authorization is required for:

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

### Dental Procedures

(may not be a covered benefit on all programs)

- Facility, anesthesia, and related medical services for dental care
- Orthognathic and other oral surgery procedures

### Durable Medical Equipment (DME) and Prostheses

- CPAP machines, purchased or rented
- Canned nutritionals
- Cranial molding helmets/bands
- Custom wheelchairs
- Limb prostheses
- Scooters
- DME with purchase price exceeding \$500
- DME rental exceeding three (3) months

### Genetic/Molecular Testing, except:

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

### Home Health Care including, but not limited to:

- All nursing services
- Home infusion therapy
- Rehabilitative/habilitative services

## Prior Authorization Guide Effective January 1, 2021 (continued)

### Hyperbaric Therapy

### Investigational/Experimental Protocols

### Injectable Drugs

- Injectable drugs >\$500 billed charges given in a Provider's office, clinic setting, infusion suite or home unless self-administered with the following exceptions:
- Injectable drugs that do not require prior authorization:
  - 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
  - Aristada Initio – J1943
- Please check the formulary under the pharmacy benefit for prior authorization of self-administered drugs.

### Laboratory Testing

- Out-of-network laboratory services
- Genetic testing
- Tumor marker testing

### Out-of-Area Services (except emergencies)

### Out-of-Network Services (except emergencies)

### Outpatient Procedures/Surgeries

- Balloon sinuplasty
- Biofeedback (all)
- Cardiac devices including implantable defibrillators, defibrillator vests, cardiac resynchronization therapy, and ventricular assist devices
- Circumcision if over one (1) year of age
- GI tract imaging by capsule endoscopy

- Osteochondral allograft or autologous chondrocyte implantation
- Spinal procedures including artificial intervertebral disc replacement, spinal fusion, and vertebroplasty/kyphoplasty
- Temporomandibular joint (TMJ) surgery
- Umbilical hernia surgery if under five (5) years of age
- Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures, or other surgeries for obstructive sleep apnea
- Varicose vein procedures

### Pain Management Procedures including but not limited to:

- External or implanted infusion pumps or stimulator devices
- Epidural steroid injections

### Pregnancy Services

- Terminations/Abortions
- For OBs who are not MFM specialists, authorization required for:
  - Use of 17-P
  - More than two (2) NSTs or BPPs (with or without NST)
  - More than two (2) ultrasounds (except nuchal translucency, CPT 76813)

### Proton Beam Radiation Therapy

Radiology/Imaging Services (when done in any place of service except inpatient, emergency room, or observation bed status) require prior authorization for Members 21 years and over including:

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

## Prior Authorization Guide Effective January 1, 2021 (continued)

### Reconstructive/Plastic Surgery/ Possible Cosmetic Procedures

- Such as abdominoplasty, blepharoplasty, breast procedures, craniofacial surgery, liposuction, otoplasty, rhinoplasty, septoplasty, etc.

### Rehabilitative/Habilitative Services

- All Speech Therapy services, except initial evaluations and reevaluations
- Physical and Occupational Therapy services, except initial evaluation and re-evaluations
- ABA Therapy (see Behavioral Health Services for additional information)

### Transplantation

- All transplant services, including transplant evaluation
- All organ and tissue transplants

### Wound Care Services

- Wound vacuum devices
- Specialized wound dressings

### Behavioral Health Services

<b>Marketplace</b>	Phone 1.855.539.5881 Prior authorization services: Outpatient services 713.576.0930 (fax) Inpatient services 713.576.0932 (fax)
<b>Medicaid/ CHIP</b>	Phone 1.877.343.3108 Prior authorization services: Outpatient services 713.576.0931 (fax) Inpatient services 713.576.0932 (fax)
<b>HMO D-SNP</b>	Phone 1.877.343.3108 Outpatient services: 713.576.0939 (fax) Inpatient services 713.576.0932 (fax)

- Inpatient services
- Partial Hospitalization Program (PHP)
- Intensive Outpatient Program (IOP)
- Psychiatric Day Treatment (may not be a covered benefit on all programs)
- Psychological testing
- Neuropsychological testing
- Out-of-network services
- Facility to Facility Transfers
- Electroconvulsive Therapy (ECT)
- Outpatient Psychotherapy Visits that exceed 30 visits in a calendar year by any Provider in any setting
- Applied Behavior Analysis (ABA) Therapy
- Transcranial Magnetic Stimulation (TMS)
- Substance Use Disorder Treatment in an Inpatient Setting
- Residential Treatment Facility
- Wilderness Programs

## Behavioral Health

### During Stress of Pandemic, Know Suicide's Warning Signs

Financial struggles, social isolation and anxiety are triggering feelings of hopelessness and helplessness during the COVID-19 pandemic, so it's important to know the warning signs when someone is contemplating suicide, an expert says.

A U.S. Centers for Disease Control and Prevention report released earlier this year showed a 25% rise in U.S. suicide rates over the past two decades, and suicide was already among the leading causes of death in the United States before the pandemic.



"It is extremely important for people to be aware of warning signs that indicate a friend or loved one may be at risk for suicide," said Nadine Chang, a clinical psychologist at Gracie Square Hospital in New York City.

"The key to suicide prevention is early identification of these warning signs. In the current environment, it is more important than ever that we check on loved ones. The clues are sometimes subtle, but being aware of warning signs can mean the difference between life and death," she said in a hospital news release.

Suicide warning signs include: changes in behavior; depression; lack of motivation; extreme reactions to challenges; making arrangements such as giving away possessions, getting financial affairs in order, writing a will; talking about suicide, and hoarding medications.

"Take these signs seriously," Chang said. "If you notice someone is in trouble, reach out and establish a connection. In cases of imminent danger, don't be afraid to call 9-1-1.

"Despite increases in research and funding for suicide prevention, we are still seeing suicide rates climb. Today people are experiencing job loss, financial stress, natural disasters and illness, any one of which can lead to feelings of hopelessness and helplessness, the two strongest correlates for suicide," Chang added.

If you're having thoughts of suicide, call 911 or go to the nearest emergency room. Other resources available 24/7 include The National Suicide Prevention Lifeline at 1.800.273.8255.

#### More information

The U.S. National Institute of Mental Health has more on suicide prevention at <https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>.

Source: <https://www.doctorslounge.com/index.php/news/hd/98404>

## The Importance of the 7-Day and 30-Day Follow-Up Visits

Community is committed to providing our Members with the support they need after a behavioral health admission. When successfully managed, this transition can help you monitor your patients, monitor medication compliance, and ensure they are safe. However, we need your help!

Providers must ensure that our Members have scheduled a follow-up appointment within seven days of discharge from an inpatient behavioral health admission. These do not include visits on the date of discharge. Patients should also have a follow-up visit with a mental health practitioner within 30 days of discharge.

Our behavioral health team contacts Members by mailing a Welcome Home Packet to all Members who have been admitted to an inpatient psychiatric hospital. The Welcome Home Packet consists of the following:

- **Welcome Home Letter** welcoming the Member home after their inpatient admission. This letter provides support, as well as education about the services we offer at Community and other links to resources available through the Community website. It also encourages them to attend their aftercare appointments and call us if they encounter any problems.
- **Member Safety Plan** can be completed by the Member and reviewed with the Provider. It outlines any triggers that may lead to another hospitalization, helps identify supports prior to a crisis episode, and helps them to recall calming and grounding places and activities, as well as steps they can take to identify and seek help when needed.
- **BH Services Postcard** lists groups and Local Mental Health Authorities (LMHAs) in the area, as well as information about transportation services and other resources.

We will also follow up with a phone call to every Member to ensure they have an appointment at the time of discharge.

We understand that the critical window to receive care is within the first seven days of discharge, and that to have a follow-up appointment within 30 days of that discharge by a licensed behavioral health professional can be challenging. Early follow-up and care coordination can reduce incidents of readmission.

### Mental Health and Wellbeing Services

**NATIONAL ALLIANCE ON  
MENTAL ILLNESS**  
713.970.4419  
[www.nami.org](http://www.nami.org)

500+ local groups for support and education  
Monday-Friday 10 a.m. to 6 p.m.

**ALCOHOLICS ANONYMOUS**  
24/7 Helpline: 713.686.6300  
[www.aa.org](http://www.aa.org)

Regular group meetings open to anyone for help with a drinking problem

**THE HARRIS CENTER FOR  
MENTAL HEALTH AND IDD**  
24-hour Crisis Line:  
713.970.7000  
Choose option 1  
[www.theharriscenter.org](http://www.theharriscenter.org)

Provides behavioral health and intellectual and developmental disability (IDD) services while also providing assessment and outpatient behavioral health services for the mentally ill in 36 different sites across Harris County

**SPINDLETOP CENTER**  
1.409.839.1000  
[www.spindletopcenter.org](http://www.spindletopcenter.org)

Outpatient, psychiatric, and community support services in the Beaumont area for mental health issues of all kinds

**TEXANA CENTER**  
281.239.1300  
[www.texanacenter.com](http://www.texanacenter.com)

Behavioral health services in Austin, Colorado, Fort Bend, Matagorda, Waller, and Wharton counties  
Walk-in crisis help 8 a.m. to 4 p.m.

**GULF COAST CENTER**  
1.409.763.2373  
[www.gulfcoastcenter.org](http://www.gulfcoastcenter.org)

Services, programs, and employment assistance for intellectual and developmental disabilities, mental illness, HIV or substance abuse in Galveston and Brazoria counties

**TRI-COUNTY BEHAVIORAL  
HEALTHCARE**  
1.936.538.1102  
[www.tricountybehavioral.org](http://www.tricountybehavioral.org)

Serving Liberty, Walker, and Montgomery counties with a comprehensive range of board-certified psychiatrists and mental health professionals

**BURKE CENTER**  
1.936.634.5010  
[www.myburke.org](http://www.myburke.org)

Mental health and intellectual and developmental disability services in 12 East Texas counties

Go to their websites for more information.

Call for transportation services to behavioral health appointments.

STAR Members: 1.855.687.4786

CHIP Members: 713.295.2294

For more behavioral health services or information, please call us toll-free at 1.877.343.3108.

bh\_services\_1219





## Anxiety and Depression: What You Can Do

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

Community has developed a comprehensive PCP Toolkit for primary care Providers to assist in identifying behavioral health conditions through well-known screening tools and condition-specific fact sheets, as well as other patient-centered information.

The Toolkit includes condition-specific information about depression and anxiety as outlined below:

- Anxiety (Generalized Anxiety Disorder 7-item Scale)
- Depression (PCP Depression Assessment, PHQ-9 Questions)
- Adolescent Depression (Adolescent PHQ-9)
- Postpartum Depression (Edinburgh Postnatal Depression Scale)
- Eating Disorders (SCOFF Questions)
- OCD (OCD Screening Test, OCD Screening Tool)

We welcome our Providers to access the PCP Toolkit online at <http://www.communityhealthchoice.org>. For referrals to our telephonic case management program, please contact our Provider call center.



### Community's Behavioral Health Case Management Program

#### Connecting Members to Community's Case Management Program

- Members may self-refer to any in-network behavioral health Provider.
- Members can also call Community regarding how and where to obtain behavioral health services. No prior approval from the PCP is required.
- Providers may refer Members suspected of having a developmental delay or a developmental disability, seriously emotionally disturbed (SED), mental illness or chemical dependency by:
  - o Calling Provider Services at 713.295.2295 for Medicaid/STAR; 713.295.6704 for Marketplace; or 713.295.5007 for HMO D-SNP.
  - o Faxing referral information to our dedicated behavioral health fax line at 713.576.0933.

## Physical Health

### Administering Flu Vaccines During the COVID-19 Pandemic

CDC has released [Interim Guidance for Immunization Services During the COVID-19 Pandemic](#). This guidance is intended to help immunization Providers in a variety of clinical and alternative settings with the safe administration of vaccines during the COVID-19 pandemic. This guidance will be continually reassessed and updated based on the evolving epidemiology of COVID-19 in the United States. Healthcare Providers who give vaccines should also consult guidance from state, local, tribal, and territorial health officials.

For the complete interim guidance for [immunization services during the COVID-19 pandemic](#).

### Wellness Services During COVID-19

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

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

Visit the following websites for additional information and resources:

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



In May, HHSC provided guidelines for Providers in relation to remote delivery of certain components of medical checkups for children over 24 months of age during the COVID-19 response. HHSC has published a frequently asked questions (FAQs) document regarding this guidance, which is available at this link <https://hhs.texas.gov/sites/default/files/documents/services/health/coronavirus-covid-19/thsteps-telemedicine-guidance-Providers.pdf>.

## Office Strategies for Improving Immunization Rates

The following information is from the American Academy of Pediatrics [website](#) that may help your practice and the well-being of your patients.

**Standing Orders** – Standing orders for immunizations include office policies, procedures, and orders to provide recommended immunizations to patients. For example, a standing order might be in place to instruct healthcare personnel (as allowed by the state) to give a specific vaccine to all patients for whom the vaccine is recommended based on the harmonized immunization schedule. Standing orders should include procedures for vaccinating eligible patients and contraindications. [Access sample standing orders for vaccines](#).<sup>1</sup> Also consider making a change in your office with these practice-change tools:

- [Sample Standing Orders Project Charter](#)
- [Sample Standing Orders Plan-Do-Study-Act \(PDSA\) Cycle 1](#)
- [Sample Standing Orders PDSA Cycle 2](#)

<sup>1</sup>The Community Guide. Community Preventive Services Task Force (<https://www.thecommunityguide.org/sites/default/files/assets/Vaccination-Standing-Orders.pdf>).

**Provider Prompts** – Provider prompts usually consist of electronic prompts in Electronic Health Records (EHRs) or notes/flags in paper charts. Most EHR Provider prompts are automatic pop-up alerts that notify the viewer that the patient is due/overdue for an immunization. Other EHR Provider prompts may show up as a "to-do" task, even if the patient is not scheduled that day for an appointment. Many EHRs have Provider prompts pre-installed that can be customized in the office. Notes/flags in paper charts must be added manually, after review of the chart for due vaccines.

**Hold Family-Friendly Office Hours** – Holding vaccination clinics with special hours (evenings and/or Saturdays) at your practice allows for more opportunities for busy families to access vaccination services. This has been proven to work especially well for the influenza vaccine.

**Assign an Immunization Champion for Your Practice** – An immunization champion can serve as a steward and advocate of immunizations in your practice. This role can be filled by any clinical staff. Being the immunization champion should be written into that job description and that staff should have time devoted to perform those tasks. Offices should cross-train staff and appoint a different person to

fill-in and complete these duties in case the immunization champion is unavailable. It is also suggested that if the immunization champion is not a physician, a physician should provide oversight to the immunization champion. An immunization champion would be responsible for the following:

- Unloading, stocking, and monitoring vaccines
- Vaccine ordering
- Managing vaccine inventory
- Implementing office-wide strategies to increase vaccination coverage

**Provide a Strong Recommendation** – Studies have shown that parents trust their pediatrician's guidance.<sup>2</sup> Be sure to give a strong recommendation for all vaccines on the current immunization schedule. It is important to state that you recommend all vaccines on the schedule and not merely mention that they are available. For example, some Providers may shy away from discussing the HPV vaccine. It is especially important to strongly recommend the HPV vaccine, as parents often have more questions about it.

If you do not already, consider these tools to help you make a strong recommendation for vaccines in your practice:

- [Sample Vaccine Recommendations Project Charter](#)
- [Sample Vaccine Recommendations PDSA Cycle 1](#)
- [Sample Vaccine Recommendations PDSA Cycle 2](#)

<sup>2</sup>Freed GL, Clark SJ, Butchart AT, Singer DC, and Davis MM. Sources and Perceived Credibility of Vaccine-Safety Information for Parents. 2011. Pediatrics, 127, 1, Supplement 107-112.

**Provider Feedback** – Providers change their behavior (e.g., clinical practices) based on feedback that they are different from those of their peers. Consider running an immunization rate report through your EHR or perform a chart audit to determine the percentage of your patients who are up-to-date on immunizations. Benchmark this data against yourself annually. You can also benchmark this data against the national and state (or city) data from the National Immunization Survey.

**Educate Patients and Their Parents** – Educate parents and patients about each recommended vaccine and the disease it prevents. Let parents know that vaccines are safe and effective, and that not vaccinating could put their children at risk for very serious diseases. Take every opportunity

## Office Strategies for Improving Immunization Rates (continued)

to educate parents and patients. Let them know at each visit what vaccines they can expect at their next health supervision appointment and provide handouts on these vaccines and diseases. This allows parents time to consider their questions, find answers, and discuss their most serious concerns with their pediatrician.

### Resources:

- [AAP Risk Communication Videos](#)
- [AAP Communication with Families Web page](#)
- [CDC Provider Resources for Immunization Conversations with Parents](#)

**Include All Recommended Vaccinations at Every Visit** – It is important to vaccinate whenever possible, because you don't know when a patient will be back in your office. Use sick-child and chronic care visits as a time to immunize. Be

sure to check what vaccinations, if any, are due every time a patient is in the office. Always screen for contraindications. Most vaccines can be given even if the child has a mild illness.<sup>3</sup>

<sup>3</sup> CDC. Chart of Contraindications and Precautions to Commonly Used Vaccines. 2011. Accessed on April 12, 2013 at: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications-vacc.htm>.

**Hold Team Huddles** – Many practices have implemented daily clinical team meetings or "huddles" to improve the flow and quality of care they deliver. These meetings can focus on pre-visit planning, strategizing treatment plans for patients with special or complex needs, and addressing daily workflow and communication issues.<sup>4</sup> Incorporating immunization planning into these meetings can increase immunization rates.

<sup>4</sup> Rodriguez HP1, Meredith LS, Hamilton AB, Yano EM, Rubenstein LV. "Huddle up!: The adoption and use of structured team communication for VA medical home implementation." *Health Care Manage Rev.* 2014 Jul 15





## Genetic Testing

Community is committed to working with you to support improved health outcomes, positive care experiences, and affordability of healthcare services for our Members. By working together, we can provide access to medically necessary genetic and molecular lab testing that can support medical decision-making and essential therapeutic interventions.

Please be aware that all genetic and molecular lab testing requires prior authorization with the exception of the following:

- Karyotype/chromosomes and/or FISH when ordered by a maternal fetal medicine specialist
- Cystic Fibrosis screening (not full sequencing)

Ordering-care Provider should complete and submit prior authorization requests for ALL genetic and molecular lab testing requiring authorization. This will avoid any potential delays in care and claims payment for both your practice and laboratories.

To process authorization requests efficiently and in a timely manner, please submit requests to Community via the Provider Portal. Alternatively, requests can be sent via fax at 713.295.2283 (STAR/CHIP) or 713.295.7019 (Marketplace). Include supporting documentation, clinical notes, etc., to avoid any delays.

## Postpartum Care

In order to optimize the health of our Medicaid Members, Community follows the guidance of the American College of Obstetrics and Gynecology's (ACOG) recommendation that postpartum care should be an ongoing process with services and support tailored to each woman's individual needs (woman-centered).

1. If an acute postpartum issue/problem arises during the first 3 weeks (21 days) postpartum, a CPT evaluation and management code (99212-99215) should be used with follow-up ongoing care as needed. Visits for suture, staple removal or other routine wound care during the post-operative period following a Cesarean section or repair of lacerations are not considered problem or postpartum visits, and thus are not eligible for payment as separate visits.
2. The comprehensive postpartum visit should be performed after 4 weeks, but no later than 12 weeks provided the Member still has coverage on Medicaid and should be billed using 59430.

Reference: ACOG Committee Opinion #736 May 2018, [Optimizing Postpartum Care](#)





## Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

Community requires that Providers report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131 - 97.134 using the required forms and procedures for reporting STDs.

Providers must coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia, and HIV receive risk reduction and partner elicitation/notification counseling.

Providers must have procedures in place to protect the confidentiality of Members who are provided STD/HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared.

Providers who provide STD/HIV services must comply with all state laws relating to communicable disease reporting requirements.

Visit the CDC website at <https://www.cdc.gov/std/treatment/default.htm> for information related to treatment and screening of STDs and <https://www.cdc.gov/std/hiv/default.htm> for HIV/AIDS.

## 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.

Prenatal Appointment Availability Requirements

Per the UMCC, Section 8.1.3.1, prenatal care must be provided within 14 days for initial appointment except for high-risk pregnancies or new Members in the third trimester for whom an initial appointment must be offered within 5 days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the Provider.

Level/Type of Care	Time to Treatment (Calendar Days)
Low-Risk Pregnancies	14 Days
High-Risk Pregnancies	5 Days
New Member in the Third Trimester	5 Days

## Provider Directory Accuracy

The Centers for Medicare & Medicaid Services (CMS) require the maintenance of accurate data in Provider directories.

Up-to-date Provider information allows Community to:

- Accurately generate Provider directories
- Process claims
- Communicate with our network of Providers
- Help patients locate your practice information

Providers must notify Community in writing at least 30 days in advance (when possible) of changes, such as:

- Change in practice ownership or federal tax ID number
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- Primary Care Providers only: If your practice is open or closed to new patients
- When a Provider joins or leaves the practice

## Next steps

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



CHIP and CHIP PERINATAL 2020

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**COMMUNITY HEALTH CHOICE** 

## Is the Flu Vaccine Already Available?

**YES! Flu vaccines are available at retail pharmacies who offer this service to Members with a \$0 copay.**

For Texas Medicaid, the state has expanded the benefit for this season and allows coverage of the flu vaccine for people age 7 and older in a pharmacy setting. For Marketplace, please be reminded that CVS is not an in-network pharmacy.

## Flu and COVID-19

Influenza (flu) and COVID-19 are both contagious respiratory illnesses, but they are caused by different viruses. COVID-19 is caused by infection with a new coronavirus (called SARS-CoV-2) and flu is caused by infection with influenza viruses. Because some of the symptoms of flu and COVID-19 are similar, it may be hard to tell the difference between them based on symptoms alone, and testing may be needed to help confirm a diagnosis. Flu and COVID-19 share many characteristics, but there are some key differences between the two.

While more is learned every day, there is still a lot that is unknown about COVID-19 and the virus that causes it. This table compares COVID-19 and flu, given the best available information to date.

Flu Symptoms	COVID-19 Symptoms
<p>Influenza (flu) can cause mild to severe illness, and at times can lead to death. Flu is different from a cold. Flu usually comes on suddenly. People who have flu often feel some or all of these symptoms:</p> <ul style="list-style-type: none"> <li>• Fever* or feeling feverish/chills</li> <li>• Cough</li> <li>• Sore throat</li> <li>• Runny or stuffy nose</li> <li>• Muscle or body aches</li> <li>• Headaches</li> <li>• Fatigue (tiredness)</li> <li>• Some people may have vomiting and diarrhea, though this is more common in children than adults.</li> </ul> <p>*It is important to note that not everyone with flu will have a fever.</p>	<p>People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:</p> <ul style="list-style-type: none"> <li>• Fever or chills</li> <li>• Cough</li> <li>• Sore throat</li> <li>• Congestion or runny nose</li> <li>• Muscle or body aches</li> <li>• Headache</li> <li>• Fatigue</li> <li>• Shortness of breath or difficulty breathing</li> <li>• New loss of taste or smell</li> <li>• Nausea or vomiting</li> <li>• Diarrhea</li> </ul> <p>This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.</p>

To learn more about COVID-19, visit <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

To learn more about flu, visit <https://www.cdc.gov/flu/index.htm>.

Resources:

- CDC's Frequently Asked Flu Questions: 2020-2021 Season: <https://www.cdc.gov/flu/season/faq-flu-season-2020-2021.htm>
- Flu vs COVID-19: <https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm>



## STAR/CHIP: Synagis Update

**Respiratory Syncytial Virus (RSV) causes mild symptoms in most people but can also cause severe illnesses such as pneumonia or bronchiolitis in some infants and children. Palivizumab (Synagis) is available for the prevention of RSV infection in infants and children who are at high-risk for severe illnesses from RSV. Patients should receive one dose per month, up to five doses.**

Access to Synagis is available on the Texas Medicaid formulary year-round as long as the patient meets the criteria for approval.

The start of RSV season varies based on a patient's county of residence. A county table and local RSV season dates are available on the Navitus website at <https://www.navitus.com/texas-medicaid-star-chip/synagis.aspx> or on the Texas Vendor Drug Program website at [www.TxVendorDrug.com/formulary/prior-authorization/synagis](http://www.TxVendorDrug.com/formulary/prior-authorization/synagis).

For the 2020-2021 RSV Season, the Synagis eligibility criteria continue to be based on the 2014 American Academy of Pediatrics (AAP) Guidelines for RSV prophylaxis. Criteria follow HHSC's Synagis clinical edit document.

- Prescriber must submit BOTH the Texas Standard Prior Authorization form AND the Synagis Prior Authorization Request form to one of the preferred pharmacies. Pharmacy will then forward to Navitus for review.
- Pharmacy will receive the initial prior authorization (PA) approval for the first dose. The approval will be accompanied by a Synagis Renewal Prior Authorization Request form.
- Prior to the next and any subsequent doses, the pharmacy must submit the completed Synagis Renewal Prior Authorization Request form and receive approval.
- Once the renewal PA is received, Navitus will process and either approve or deny the Synagis Renewal PA based on the information received.

Example of what pharmacies will receive:

- Approval is limited to ONE monthly dose at a time per Texas Vendor Drug Program (VDP) rules.
- Navitus will not approve all doses for the RSV season with the initial PA request.
- Pharmacies must submit a Synagis Renewal Prior Authorization Request with each dose with documentation of the following:
  - Has client been hospitalized for Respiratory Syncytial Virus (RSV) infection during this RSV season?  
Yes = DENY; No = next question
  - Has the previously dispensed dose(s) been administered to client?  
Yes = next question; No = DENY
  - Please document all previous doses and dates of administration for the current RSV season.
    - Table with 6 rows and these columns
      - DOSE # 1-5
      - DATE OF ADMINISTRATION
      - DOSE (mg)
  - Patient's current weight in kilograms (kg) and the date the weight was measured must be on the request form. Failure to provide current weight will result in denial of request

The preferred pharmacies for Synagis are:

- Lumicera – 1.855.847.3554; Fax 1.855.847.3558
- Walmart Specialty Pharmacy – 1.877.453.4566; Fax 1.866.537.0877

Resources:

- Navitus-Synagis: <https://txstarchip.navitus.com/pages/synagis.aspx>
- Synagis Prior Authorization Request Form: [https://txstarchip.navitus.com/pdf-documents/pa-forms/synagis-2019-2020\\_tx-mcaid\\_092419-\(2\).aspx](https://txstarchip.navitus.com/pdf-documents/pa-forms/synagis-2019-2020_tx-mcaid_092419-(2).aspx)

## HEDIS Measures: Major Changes to Well-Child Visit Measures

Some HEDIS measures were revised for this upcoming season. One of the bigger changes to the new HEDIS measures is regarding well-child visits. The Well-Child Visits in the First 15 Months of Life (W15) measure was revised to Well-Child Visits in the First 30 Months of Life (W30). Also, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) measures have been combined into Child and Adolescent Well-Care Visits (WCV).

Two important factors related to these measures also should be noted:

- First, hybrid data collection has been discontinued. Validation will only be based on claim information.
- Second is very good news: Telehealth visits will now be allowed toward compliance.

While this means health plans will not be reaching out for medical records for these two measures any longer, it becomes even more crucial that the billing contains the essential elements of the measure requirements for compliance. If the Member was seen for one of these well-care visits, please insure that at least one of the required codes is provided.

### Billing Guidelines for Measure Validation

CPT: 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461

HCPCS: G0438, G0439, S0302

ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

### Breakdown of W30 and WCV

#### Well-Child Visits in the First 30 Months of Life (W30)

This measure is looking at two different rates. First, the percentage of Members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. Second, the percentage of Members who turned 30 months old during the measurement year and who had two or more well-child visits with a PCP during ages 15 months to 30 months.

#### Child and Adolescent Well-Care Visits (WCV)

This measure is looking at the percentage of Members who are between the ages of 3 and 21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

# HEDIS Quick Reference Guide

Community strives to provide quality health care to our Members as measured through HEDIS quality metrics. We created a HEDIS Quick Reference Guide to help you increase your practice's HEDIS rates. You may access the Quick Reference Guide via the Provider Portal at <https://Provider.communityhealthchoice.org/> >Provider Tools>Forms and Reference Guides.

Please always follow state and/or CMS billing guidance and ensure the HEDIS codes are covered prior to submission.

## How Can You Improve Your HEDIS Scores?

- Submit a claim for each and every service rendered
- Make sure chart documentation reflects all services billed
- Bill for all delivered services
- Ensure that all claims are submitted in an accurate and timely manner
- Consider including CPT II codes to provide additional details and reduce medical record requests

## Suggestions to Increase Member Adherence:

- Send postcard and/or text reminders to Members to reinforce the importance of annual well visits.
- Schedule follow-up appointments with patients before they leave the office.
- Consider creating a Member registry identifying Members prescribed high-risk medications to monitor compliance. (ex ADHD, psychotropics)
- Evaluate current processes related to outside referrals for lab and specialty appointments to ensure referrals are completed and results received and documented.

HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE		
PROVIDER SERVICES INCLUDES	MEASURE DESCRIPTION	BILLING TIPS
<b>Annual Well Visit (AWV)</b> Monthly - Primary 15-30 min - 100% rate • Chronic conditions • Comprehensive history • Address psychosocial • All HEDIS measures • Provide research-based	<b>Annual Well Visit (AWV)</b> A well visit is a comprehensive physical exam or comprehensive health assessment that includes: 1. Comprehensive history 2. Comprehensive physical exam 3. Comprehensive psychosocial assessment 4. Comprehensive health assessment 5. Comprehensive health assessment 6. Comprehensive health assessment 7. Comprehensive health assessment 8. Comprehensive health assessment 9. Comprehensive health assessment 10. Comprehensive health assessment	<b>BILLING TIPS</b> A well visit is a comprehensive physical exam or comprehensive health assessment that includes: • CPT 99201-99203 • CPT 99211-99213 • CPT 99214-99215 • CPT 99216-99217 • CPT 99218-99219 • CPT 99220-99221 • CPT 99222-99223 • CPT 99224-99225 • CPT 99226-99227 • CPT 99228-99229 • CPT 99230-99231 • CPT 99232-99233 • CPT 99234-99235 • CPT 99236-99237 • CPT 99238-99239 • CPT 99240-99241 • CPT 99242-99243 • CPT 99244-99245 • CPT 99246-99247 • CPT 99248-99249 • CPT 99250-99251 • CPT 99252-99253 • CPT 99254-99255 • CPT 99256-99257 • CPT 99258-99259 • CPT 99260-99261 • CPT 99262-99263 • CPT 99264-99265 • CPT 99266-99267 • CPT 99268-99269 • CPT 99270-99271 • CPT 99272-99273 • CPT 99274-99275 • CPT 99276-99277 • CPT 99278-99279 • CPT 99280-99281 • CPT 99282-99283 • CPT 99284-99285 • CPT 99286-99287 • CPT 99288-99289 • CPT 99290-99291 • CPT 99292-99293 • CPT 99294-99295 • CPT 99296-99297 • CPT 99298-99299 • CPT 99300-99301 • CPT 99302-99303 • CPT 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00184-00185 • CPT 00186-00187 • CPT 00188-00189 • CPT 00190-00191 • CPT 00192-00193 • CPT 00194-00195 • CPT 00196-00197 • CPT 00198-00199 • CPT 00200-00201 • CPT 00202-00203 • CPT 00204-00205 • CPT 00206-00207 • CPT 00208-00209 • CPT 00210-00211 • CPT 00212-00213 • CPT 00214-00215 • CPT 00216-00217 • CPT 00218-00219 • CPT 00220-00221 • CPT 00222-00223 • CPT 00224-00225 • CPT 00226-00227 • CPT 00228-00229 • CPT 00230-00231 • CPT 00232-00233 • CPT 00234-00235 • CPT 00236-00237 • CPT 00238-00239 • CPT 00240-00241 • CPT 00242-00243 • CPT 00244-00245 • CPT 00246-00247 • CPT 00248-00249 • CPT 00250-00251 • CPT 00252-00253 • CPT 00254-00255 • CPT 00256-00257 • CPT 00258-00259 • CPT 00260-00261 • CPT 00262-00263 • CPT 00264-00265 • CPT 00266-00267 • CPT 00268-00269 • CPT 00270-00271 • CPT 00272-00273 • CPT 00274-00275 • CPT 00276-00277 • CPT 00278-00279 • CPT 00280-00281 • CPT 00282-00283 • CPT 00284-00285 • CPT 00286-00287 • CPT 00288-00289 • CPT 00290-00291 • CPT 00292-00293 • CPT 00294-00295 • CPT 00296-00297 • CPT 00298-00299 • CPT 00300-00301 • CPT 00302-00303 • CPT 00304-00305 • CPT 00306-00307 • CPT 00308-00309 • CPT 00310-00311 • CPT 00312-00313 • CPT 00314-00315 • CPT 00316-00317 • CPT 00318-00319 • CPT 00320-00321 • CPT 00322-00323 • CPT 00324-00325 • CPT 00326-00327 • CPT 00328-00329 • CPT 00330-00331 • CPT 00332-00333 • CPT 00334-00335 • CPT 00336-00337 • CPT 00338-00339 • CPT 00340-00341 • CPT 00342-00343 • CPT 00344-00345 • CPT 00346-00347 • CPT 00348-00349 • CPT 00350-00351 • CPT 00352-00353 • CPT 00354-00355 • CPT 00356-00357 • CPT 00358-00359 • CPT 00360-00361 • CPT 00362-00363 • CPT 00364-00365 • CPT 00366-00367 • CPT 00368-00369 • CPT 00370-00371 • CPT 00372-00373 • CPT 00374-00375 • CPT 00376-00377 • CPT 00378-00379 • CPT 00380-00381 • CPT 00382-00383 • CPT 00384-00385 • CPT 00386-00387 • CPT 00388-00389 • CPT 00390-00391 • CPT 00392-00393 • CPT 00394-00395 • CPT 00396-00397 • CPT 00398-00399 • CPT 00400-00401 • CPT 00402-00403 

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

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

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

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

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

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

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

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



## EPSDT and Requests for Extended Ophthalmoscopy

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), known as Texas Health Steps (THSteps) in Texas, refers to the Medicaid's program obligation to provide a comprehensive array of prevention, diagnostic, and treatment services for infants, children and adolescents in the program. EPSDT is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

THSteps-Comprehensive Care Program (CCP) is an expansion of the EPSDT service as mandated by the Omnibus Budget Reconciliation Act of 1989, which requires states to provide all medically necessary treatment for correction of physical or mental health conditions to THSteps-eligible clients (birth through 20 years of age) when federal financial participation (FFP) is available. THSteps and THSteps-CCP do not apply to CHIP.

Exceptions include: experimental or investigational treatment, services or items not generally accepted as effective and/or not within the normal course and duration of treatment, and services for the caregiver or Provider convenience.

Please see below for THSteps CCP coverage of ophthalmoscopy.

### Extended Ophthalmoscopy

According to the American Academy of Pediatrics 2018 guidance [Screening Examination of Premature Infants for Retinopathy of Prematurity](#), infants born premature or with low birth weight are at risk for developing retinopathy of prematurity (ROP). Because of the usually predictable and sequential nature of ROP progression and the proven benefits of timely treatment in reducing the risk of vision loss, efficacious care now requires that infants who are at risk receive carefully timed retinal examinations to identify treatment-requiring ROP in time for that treatment to be effective.

Texas Medicaid Vision Services policy currently limits coverage of ophthalmoscopy (procedure codes 92201 and 92202) to two services per year. With evidence of medical necessity, additional screening examinations of premature infants for retinopathy of prematurity must be considered through THSteps-CCP.

#### Resources:

For more information on THSteps-CCP please see [TMPPM Children's Services Handbook, Section 2, "Medicaid Children's Services Comprehensive Care Program \(CCP\)"](#)





## Early Childhood Intervention (ECI)

Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services for families with children birth up to age 3, with developmental delays, disabilities or certain [medical diagnoses](#) that may impact development. ECI services support families as they learn how to help their children grow and learn.

Providers are required to refer children to the ECI program as soon as a delay is suspected in the child's development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals. To refer families for services, Providers should use the recently updated ECI referral form available on the Texas Health and Human Services website at <https://hhs.texas.gov/services/disability/early-childhood-intervention-services/how-make-a-referral-eci>.

For additional ECI information, Providers can visit the HHS ECI website at: <https://hhs.texas.gov/services/disability/early-childhood-intervention-services>

## Sports and Physical Exams

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 rolling year). Providers must use relevant codes based on the athletic training evaluations, requiring these components:

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

Billing Code	Level of Complexity	No. of Comorbidities	No. of Elements Addressed	Time Duration
97169	Low	0	1 – 2	15 minutes
97170	Moderate	1 – 2	3 or more	30 minutes
97171	Moderate	3 or more	4 or more	45 minutes
97172	Re-evaluation of athletic training established plan of care requiring these components: <ul style="list-style-type: none"> <li>• assessment of patient's current functional status when there is a documented change</li> <li>• revised plan of care using a standardized patient assessment instrument and/or measureable assessment of functional outcome with an update in management options, goals, and interventions</li> </ul>			20 minutes

# THSteps Checkup Timeliness

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

**Existing Community Health Choice Members** must complete a checkup in accordance with the THSteps Medical Checkup Periodicity Schedule. Follow the schedule below:

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



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

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

## THSteps Medical Checkup Periodicity Schedule

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

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents																												
COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE																												
* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at <a href="http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx">http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx</a> . Find current Periodicity Schedule online at <a href="http://www.dshs.state.tx.us/thsteps/providers.shtm">http://www.dshs.state.tx.us/thsteps/providers.shtm</a> .																												
AGE	History	Nutritional Screening	DEVELOPMENTAL SURVEILLANCE			MENTAL HEALTH	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	Critical Congenital Heart Defect Screening	MEASUREMENTS					VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS					Health Education/Anticipatory Guidance		
			Review of Milestones	ASQ, ASQ:SE, or PEDS	M-CHAT or M-CHAT-R/F™					Mental Health, Psychosocial/Behavioral Health Screening	Postpartum Depression Screening	Length	Height	Weight	BMI	Fronto-Occipital Circumference	Blood Pressure	Visual Acuity			Subjective Vision	Newborn Hearing Test (OAE or ABR)	Audiometric Screening	Subjective Hearing	Newborn Screening Panel		Blood Lead Screening	Anemia
Newborn																												
D/C to 5 days																												
2 weeks																												
2																												
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10																												

LEGEND

Mandatory

If not completed at the required age, must be completed at the first opportunity if age appropriate.

For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.

Recommended

Risk-based

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

TEXAS

Health and Human Services

Texas Health Steps

### LEGEND

<span style="background-color: #00728f; color: white; padding: 2px;">Mandatory</span>
<span style="background-color: #d9d9d9; color: #00728f; padding: 2px;">If not completed at the required age, must be completed at the first opportunity if age appropriate.</span>
<span style="background-color: #00728f; color: white; padding: 2px;">For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.</span>
<span style="background-color: #ffcc00; color: #00728f; padding: 2px;">Recommended</span>
<span style="background-color: #ff9999; color: #00728f; padding: 2px;">Risk-based</span>

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



E03-13634

July 1, 2018

The periodicity schedule can be downloaded via <https://hhs.texas.gov/doing-business-hhs/Provider-portals/health-services-Providers/texas-health-steps/medical-Providers>.

## THSteps Medical Checkup Billing Procedure Codes

Effective **June 10, 2020**, TMHP 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](http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf).

## Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW) is a state Medicaid benefit that provides health-related case management services to children birth through 20 years of age with a health condition and to high-risk pregnant women of any age. Case managers help clients gain access to needed medical, social, educational, and other services. This program is separate from services offered by Community.

Provider can make a referral to Case Management by calling 1.877.847.8377.



## Children of Traveling Farmworkers

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

A traveling farmworker is someone who:

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

Their children, from **birth through age 17**, are considered children of traveling farmworkers. Children of traveling farmworkers due for a THSteps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this

circumstance is an accelerated service, but it should be billed as a checkup. For example, a 4-year-old checkup may be performed prior to the child's fourth birthday if the child is a Member of a traveling family that is leaving the area. Providers must use the CPT modifier "32" when providing accelerated services outside of the periodicity schedule.

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

If you serve Community Health Choice Members who meet this criterion, please refer them to Wellness Services at 713.295.6789. Our goal is to arrange for all healthcare services they may need before they leave for the new job.





## THSteps Checkup Documentation

### *Essential to Medical Records*

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

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

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

To stay current on the THSteps policy and available resources, visit the frequently updated THSteps website for information and policy updates. Information on checkup documentation is also available within THSteps Online Provider Education modules. These modules are free and



offer continuing education for healthcare professionals. They are available at [www.txhealthsteps.com](http://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.



## Head Start Program

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>

## Annual Texas Health Steps Provider Training

Community requires all contracted THSteps Providers to take an Annual Texas Health Steps Provider Training. Log in to your Provider portal at <https://Provider.communityhealthchoice.org> to complete this annual mandatory training by December 31 of each calendar year. If you have any questions, please contact your Provider Engagement Representative.

## Online Provider Education – Free Continuing Education (CE) Hours

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

**First-time users will need to register.** The courses are available at <http://www.txhealthsteps.com/cms/>.

## 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 (CE) for Prescribing Providers

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

**For a list of Medicaid Drug Formulary and free CE credits, please visit** [www.txvendordrug.com/Providers/prescriber-education](http://www.txvendordrug.com/Providers/prescriber-education).

## SERVICE AREA MAP





## MEDICAL AFFAIRS

**Peer-to-Peer Discussions:** 713.295.2319

**Chief Medical Officer:** Vernicka Porter-Sales, M.D.

### Associate Medical Directors

Valerie Bahar, M.D.

Felecia Garner, M.D.

Karen Gray, M.D.

## PHYSICAL HEALTH

### Utilization Management

Phone: 713.295.2221 | Fax: 713.295.2283 or 84

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

713.295.2303

### Diabetic Supplies/Outpatient Perinatal

Fax: 713.295.7028 | Toll-free fax: 1.844.247.4300

### Medicare

Fax: 713.295.7059 (Prior Authorizations)

Fax: 713.295.2284 (Notification of Admissions)

Fax: 713.295.7030 (Clinical Submission)

Fax: 713.295.7030 (Complex Care & Discharge Planning)

## BEHAVIORAL HEALTH

1.877.343.3108 (Medicaid/CHIP)

1.855.539.5881 (Marketplace)

Fax: 713.576.0930 (Marketplace Outpatient)

Fax: 713.576.0931 (Medicaid Outpatient)

Fax: 713.576.0932 (Inpatient)

Fax: 713.576.0933 (Case Management)

Fax: 713.576.0934 (Appeals - Standard)

Fax: 713.576.0935 (Appeals - Expedited)

### Medicare

Fax: 713.576.0932 (Inpatient Prior Authorizations)

Fax: 713.576.0930 (Outpatient Prior Authorizations)

## CLAIMS

• Inquiries • Adjudication

CommunityHealthChoice.org or 713.295.2295

Community Health Choice will accommodate three claims per call.

## REFUND LOCKBOX

Community Health Choice

P.O. Box 4818

Houston, TX 77210-4818

## ELECTRONIC CLAIMS

**(Medicaid/CHIP & HMO D-SNP)**

Submit directly through our online claims portal:

CommunityHealthChoice.org > Provider Tools > Claims Center

Payer ID: 48145

Change HealthCare: 1.800.735.8254

Availability: 1.800.282.4548

Gateway EDI: 1.800.969.3666

TMHP (Medicaid only): www.tmhp.com

## ELECTRONIC CLAIMS-UB, CMS-1500 (MARKETPLACE)

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

Change Healthcare: 1.800.735.8254

Payer ID: 60495

## PHARMACY

### Navitus Health Solutions

1.877.908.6023 | 1.866.333.2757 (Medicare)

www.navitus.com

## VISION SERVICES

Envolve Vision

Toll-free: 1.800.531.2818 | www.visionbenefits.envolvehealth.com

## Dental Services

FCL Dental

Toll-free Member Services: 1.866.844.4251

Toll-free Provider Services: 1.877.493.6282

www.fcl dental.com

## ADVERSE DETERMINATIONS & MEDICAL NECESSITY APPEALS

### Community Health Choice

Attn: Medical Necessity Appeals

Fax: 713.295.7033

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

## Member SERVICES & SPECIALIST SCHEDULING

713.295.2294 or 1.888.760.2600

## Provider SERVICES

### For general questions or to submit your updates:

- Provider Portal
- Contact your Provider Engagement Representative.
- ProviderWebInquiries@CommunityHealthChoice.org

### Medicaid/CHIP

713.295.2295

### Marketplace

713.295.6704

### Medicare

713.295.5007 or toll-free 1.833.276.8306

https://Provider.communityhealthchoice.org/medicare