V4-2020

Provider
Newsletter

CommunityHealthChoice.org

713.295.2295 | 1.888.760.2600 (Medicaid/CHIP)
713.295.6704 (Marketplace)
713.295.5007 (HMO D-SNP)

COMMUNITY HEALTH CHOICE

In this issue

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.

A Year to Remember

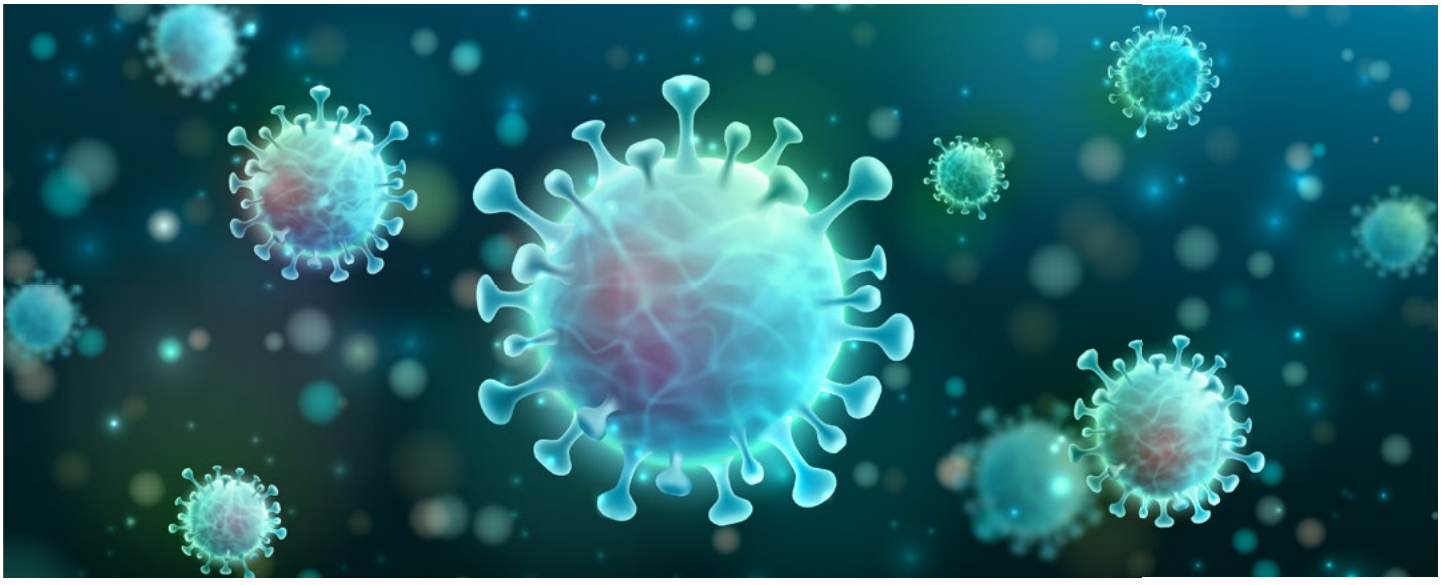
A whole lot happened this year – whether locally, state or nationwide; economically, politically, environmentally; or socially. As 2020 comes to a close, all of us at Community Heath Choice THANK YOU for your relentless work in caring for all of your patients and our Members throughout the year.

We wish you, your staff, and family health and well-being in the New Year.

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 the 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/.



Helping Members and Their Families Find Work Through a New Partnership with WorkTexas

Community is leading the way with a job training and education program called CareerReady. CareerReady connects high school seniors and pregnant women who are Community Medicaid members with the resources they need to pursue an education that will enable them to be hired for a job that offers a livable wage. Through a scholarship, Community will cover tuition and supplies for a job certification at Houston Community College or San Jacinto College. Students who meet the eligibility requirements for the CareerReady program will be matched with a Life Coach who will support the student in completing their certification program and reaching their career goals.

For more information on the CareerReady program, please visit https://www.communityhealthchoice.org/life-services/careerready-scholarship-for-high-school-seniors/.

Email:
LifeServices@CommuniyHealthChoice.org
Phone: 281.384.0551

Community is partnering with WorkTexas at Gallery Furniture to address the social needs of the greater Houston area and to reach more Community Members through CareerReady. WorkTexas offers job certification programs in carpentry, welding, electrical, automotive, child development, and more.

The goal of WorkTexas is to provide students with education and job training to help them get a job and make a livable wage. WorkTexas offers hands-on training with potential employers. Students can learn a skill and graduate within six months. WorkTexas is available to anyone. Priority admission into WorkTexas programs is given to Community Members. Joining WorkTexas is no cost for Community Members, their parents or partners. Each Community Member is assigned a Life Coach through Community's CareerReady program to support their success during the process of finishing their job training and finding a job.

For more information on Work Texas, please visit https://worktxads.force.com/portal/s/.

You can sign up through the link above or in person at:

Gallery Furniture
6006 North Fwy., Houston, TX 77076
Monday – Friday: 9:00 a.m. – 5:00 p.m.

Recertification for STAR and CHIP Members

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 or contact your Provider Engagement Representative.

REMINDER: 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™ which 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).

As indicated in the previous volume of the newsletter, Community will implement the following ClaimsXten rules when processing claims effective January 1, 2021.

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 with 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 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.

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.

Don’t Let This Happen to You: Top Billing Errors

Community aims to adjudicate Clean Claims timely and accurately. The following are top reasons that cause denials or delays in payment.

Who	What	Causes of denials or delays	Do
All Providers	Rendering Provider	• Claim does not include rendering Provider’s NPI • Billing NPI is not the Group NPI • Provider is not enrolled with the Medicaid program	Include the rendering Provider’s NPI.
	Frequency Code 7: 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	• Resubmitting the same claim multiple times • Submitting corrected claims changing the Member • Submitting corrected claims changing the Provider • Submitting corrected claims changing the Date of Service	Allow 30 days between submissions
	Modifier 25	• Using a 25 modifier when billing for services performed during a postoperative period if related to the previous surgery • Using a modifier 25 on any E/M on the day a “Major” (90 day global) procedure is being performed • Adding modifier 25 to an E/M service when a minimal procedure is performed on the same day	• 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.
	Unlisted Procedures	• A more appropriate procedure or service code is available • No supporting documentation • Appropriate modifier missing for unlisted DME, orthotics and prosthetics	• Include the most current and appropriate procedure or service code available. • Include supporting documentation when unlisted procedure or service code is inevitable. • Include appropriate modifier.
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 **ALL** services delivered during patient visit at normal charges
Therapy Providers	Modifiers	• Submitting claims without the proper modifier or no modifier at all. • Modifiers GP, GO, and GN are required on all claims except when billing evaluation and re-evaluation procedure codes. • The AT modifier must be included on claims for acute therapy services.	Include the appropriate modifier.

Community routinely reviews its internal processes to ensure that Provider claims adjudicate according to any NCCI edits, regulatory requirements and/or industry standards.

Provider Type	Program	Description	Reminders
Institutional	• Medicaid • CHIP • Marketplace • HMO D-SNP	*72-Hour Rule* All diagnostic or outpatient services rendered during the DRG payment window (the day of and three calendar days prior to the inpatient admission) should be bundled with the inpatient services.	Community will adjudicate claims according to the 72-hour rule. In the event Community adjudicates the claim for outpatient services in error, Community will initiate the recoupment process accordingly; including when the outpatient claim has already been paid.
Professional	• Medicaid • CHIP • Marketplace • HMO D-SNP	*Modifier 50 (Bilateral Procedures)* Procedures performed on both sides (right and left) on the same day/session.	Community will apply appropriate reductions and adjudicate claims accordingly.
Professional	• Medicaid • CHIP • Marketplace • HMO D-SNP	*Modifier 51 (Multiple Procedures)* If multiple procedures are performed on a patient the same day/session, the second and any subsequent procedures are subject to reduced reimbursement.	Community will adjudicate claims accordingly. Appropriate discounts will apply even if the Provider fails to bill with modifier 51.
Professional	• Medicaid • CHIP • Marketplace • HMO D-SNP	*Modifier 62 (Co-Surgeon Services)* Co-Surgeon involved in the care of a patient at surgery. Each Co-Surgeon should submit the same CPT Code with modifier 62.	Community will adjudicate claims accordingly. Co-surgeon claim with missing modifier 62 will be paid in full on initial claim received.
Professional	• Marketplace • HMO D-SNP	*Status Code Indicator B (Bundled codes)* Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).	Community will adjudicate claims accordingly.
Professional	• Marketplace • HMO D-SNP	*Status Code Indicator P* Bundled/Excluded codes for which there are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision.	Community will adjudicate claims accordingly.

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 in the Services identified Member's Benefit Plan/Program. Reimbursement is considered as payment in full for those services and balance billing is prohibited.

Medicare

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

Prevent Problems – Self Audit

Medical professionals have specific responsibilities when they accept reimbursement from a government program. They "have a duty to ensure that the claims submitted to federal healthcare programs are true and accurate,"[1] and that their medical record documentation supports and justifies billed services. Medical professionals' documentation is open to scrutiny by many, including employers, federal and state reviewers, and auditors.[2,3] They can protect themselves and their practices by implementing an internal self-auditing strategy.

There are five basic self-audit rules medical professionals can use to get started:

1. Develop and implement a solid medical record documentation policy if there is not one in place. If there is one in place, make sure the policy covers meeting federal and state Medicaid regulations. The policy should address what actually happens in everyday practice.
2. Develop or use one of the available standard medical audit tools. The tool should cover the documentation policy criteria and coding standards as part of the review.
3. Choose a staff member who understands documentation and coding principles to select a random sample of records for a specific time period. Decide how many records should be reviewed and then pull every "nth" chart for that time period.
4. Resist being the one to choose and audit your own charts. Most professionals can read their own writing and understand the meaning of records they wrote even if the documentation is not in the record. Removing bias is important. For best results, make the audit as realistic as possible.
5. Use the self-audit results for improving practice compliance. There is no real value in conducting a self-audit unless discovered issues are resolved. Review and analyze the audit findings. Identify the common documentation, coding, and billing problems, and solve the problems found. Then educate staff members and hold them accountable for making changes. After implementing any corrective action, audit the process again to ensure improved compliance and successful implementation.

Electronic health records (EHRs) require similar methods, but the unique nature of an EHR requires extra precautions.

1. Make sure auto-fill and keyword features are turned off. Watch for "cloned" notes—notes that appear identical for different visits; these may not reflect the uniqueness of the encounter or the patient's description of their chief complaint.
2. Make sure all notes have a date and time stamp, even when updating patient history and life events. Separate notes entered at different times by paragraph returns or other clear punctuation or spacing.
3. Make sure any edits to the patient's record are also initialed or identified with the person making the edit.

Reference

Excerpt from: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-medicalprof-factsheet.pdf

1 U.S. Department of Health and Human Services. Office of Inspector General. (2000, October 5). Notices. OIG Compliance Program for Individual and Small Group Physician Practices. 65 Fed. Reg. 59434 and 59435. Retrieved October 13, 2015, from https://oig.hhs.gov/authorities/docs/physician.pdf

2 Social Security Act §1902(a)(30)(A). Retrieved October 13, 2015, from https://www.ssa.gov/OP_Home/ssact/ title19/1902.htm

3 Post-Payment Review Process, 42 C.F.R. § 456.23. Retrieved October 13, 2015, from http://www.ecfr.gov/cgibin/text-idx?SID=c288145a7b1d00cb5b0c6e5afa5ec51d&mc=true&node=se42.4.456_123&rgn=div8

Reporting Provider or Recipient Fraud, Waste or Abuse

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 fraud, waste or abuse, 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 Fraud, Waste or Abuse" 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
- Write to us at:

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

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.

Prior Authorization Guide Effective January 1, 2021

You can find the Prior Authorization Guide for all programs in the Provider Portal at https://providerportal.communityhealthchoice.org in the Authorization Guides section.

Retrospective Review

Community may perform a Retrospective Review for services or supplies for which an authorization has not previously been sought and a claim has not been submitted. This review will only be performed upon receipt of clinical information by Community from the rendering Provider. If the request for authorization is received without the supporting clinical records, Community will notify the Provider that the records must be received in order to perform the Retrospective Review.

Community will not issue a retrospective authorization without documentation explaining why the request was not requested prior to rendering the service.

Community will issue a determination within 30 calendar days of the receipt of a request for a utilization management determination. The 30-day period for Retrospective Review may be extended once by Community for a period not to exceed 15 days if Community:

1. determines that an extension is necessary due to matters beyond Community's control; and
2. notifies the Provider of record and the Member before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which Community expects to make a determination.

If the extension is required because of a failure of the Provider of record or the Member to submit information necessary to reach a determination on the request, the notice of extension will:

1. specifically describe the required information necessary to complete the request; and
2. give the Provider of record and the Member 45 days from the date of receipt of the notice of extension to provide the specified information.

If the period for making the determination is extended because of the failure of the Provider of record or the Member to submit the information necessary to make the determination, the period for making the determination is calculated from the date on which Community sends the notification of the extension to the Provider of record or the Member until the earlier of:

1. the date on which the Provider of record responds to the request for additional information; or
2. the date by which the specified information was to have been submitted.

Once Community receives the medical records, the documents are reviewed for medical necessity. Community bases the review determinations solely on the medical information available to the attending Provider or ordering Provider at the time the medical care was provided. The process for Retrospective Review of medical necessity and appropriateness will are under the direction of Community's Medical Director.

If a claim is submitted prior to Community's receipt of a request for authorization or the request is administratively denied for lack of information, a retrospective authorization review will not be conducted. Community will follow claims processing rules.

Reminders

Inpatient Requests:

- For inpatient admissions occurring over a weekend or holiday, Providers should notify Community within one business day (Monday-Friday, not including weekends or weekdays that fall on a federal holiday) of the inpatient admission.
    - If timely notification is not received and the Member is still inpatient, a Retrospective Review will be conducted from the time notification is received. The days prior to notification will be administratively denied for lack of notification. The days after the notification is received at Community will be reviewed retrospectively for a medical necessity determination.

- If Member is admitted and discharged from inpatient facility without notification and/or request for authorization, Community will allow three (3) business days from the date of discharge for the Provider to submit request for a retrospective authorization review. Requests received after the allowed three business days from date of discharge will be administratively denied for lack of notification.

Outpatient Requests:

- Outpatient requests that require prior authorization for non-emergent medical services should be submitted prior to the Provider rendering services.
  - If the Provider requests authorization for already initiated and ongoing services and pre-authorization was required, the days prior to the notification will be administratively denied for lack of notification. The days after notification is received will be reviewed based on the Retrospective Review process.
  - If the Provider requests authorization after services are rendered/completed and pre-authorization was required, the request will be administratively denied for lack of notification.
  - If the Provider requests for an existing authorization to be changed for any reason (i.e. adding CPT/HCPS codes, changing of dates of service) the ordering Provider will have to submit a request to terminate the approved authorization. After the termination is received, a new request with the updated information for services can be initiated. If necessary, a current physician order may be required.
  - For outpatient service requests based on a Member being discharged from an inpatient facility, Community will allow the Provider three business days from date of discharge to request a retrospective authorization review. Provider must submit clinical information with the hospital physician orders for medical necessity review. Example: Member discharged on Friday evening, home health services provided on Saturday; the Provider has until Wednesday to request a Retrospective Review. If the request is submitted after the three business days, the request will be administratively denied for lack of notification.

Other extenuating circumstances:

- Inability to know certain situations – i.e. eligibility verification issues, Member was unconscious at presentation; additional medical services required while performing a procedure.
- Requests under these circumstances will be reviewed retrospectively for medical necessity authorization. The request for Retrospective Review for other extenuating circumstances must be submitted within 30 days of the Provider rendering the service. If not submitted within thirty (30 days), requests received after the allowed 30 days from date of will be administratively denied for lack of notification.

Discharge Planning

We want to provide timely and appropriate discharge planning services for a seamless transition from a hospital, skilled nursing or rehabilitation facility to the Member's home setting. Discharge planning may include but is not limited to the following:

- Home Health Services
  - Skilled Nurse Visits
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
- Outpatient Services
  - Physical Therapy, Occupational Therapy, Speech Therapy
- Durable Medical Equipment (including supplies)
- Any other urgent discharge needs for the member's transition back into the home setting

Please be sure to submit prior authorization requests to Community at least **24 to 48 hours prior to discharge from a hospital, skilled nursing or rehabilitation facility**.

If a Member is discharged during non-business hours and/or weekend, Providers should submit discharge planning requests the following business day. If necessary, all discharge authorizations will be reviewed for evaluation and initial treatment.

For a continuation of treatment and services after discharge authorization, new physician orders from Member's PCP or specialist will be required. These requests must be submitted to the Prior Authorization fax number based on the Member's benefit program (STAR, CHIP, Marketplace or HMO D-SNP).

Remember:

- Complete the Texas Standard Prior Authorization request form. Please consider using Community's Preferred Prior Authorization form instead.
- Attach discharge order from the hospital (signed script, discharge paperwork, electronic or verbal order, and Title 19). Include ICD-10 code(s), CPT, and/or HCPCS code(s) with frequency, duration, and amount of visits or visits being requested.
- For members transitioning from an Acute hospital to **LTAC or SNF**:
  - Fax request (PA form and transfer orders with clinical information) to: 713-295-2284
- For members transitioning from an Acute hospital, LTAC or SNF to **Home** (place of residence):
  - Fax request (PA form and discharge orders with clinical information to: 713-848-6940
- Fax Behavioral Health authorization requests to: 713-576-0932

All discharge planning authorization requests will follow established processes and procedures related to eligibility, benefits, medical necessity, and other regulatory requirements.

Behavioral Health

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**	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**	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**	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**	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**	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**	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.tricountyservices.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**	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

Behavioral Health

PCP Toolkit

Community developed a comprehensive PCP Toolkit for primary care Providers to assist in identifying behavioral health conditions through well-known screening tools, condition-specific fact sheets, and other patient centered information. Delivering behavioral health services in a primary care setting can help reduce stigma with mental health diagnosis. The primary care setting is also becoming the first line of identification for behavioral health issues and the PCP the center of care for behavioral and physical health disorders.

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)

You can 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:
  - Calling Provider Services at 713.295.2295 for Medicaid/STAR; 713.295.6704 for Marketplace; or 713.295.5007 for HMO D-SNP.
  - Faxing referral information to our dedicated behavioral health fax line at 713.576.0933.

Physical Health

Genetic and Molecular Lab Testing

Community is committed to working with Providers 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 and
- Cystic Fibrosis screening (not full sequencing).

Members are often referred to or have their specimen sent to laboratories for genetic and molecular testing without an authorization. While these laboratories may be in Community's network, these services require prior authorization from Community.

Ordering care Providers must 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 the lab.

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.

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.

Click on this link for 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 THSteps / 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 (FAQ) 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.

Fetal Middle Cerebral Artery Doppler (CPT Code 76821)

The use of this testing is for assessment of fetal anemia and its sequelae. It is to be performed only by maternal fetal medicine specialists (MFMs) with prior authorization. It is usually used in any condition that will result in fetal anemia:

- Alloimmunization of pregnancy
- Twin to twin transfusion (TTTS)
- Twin anemia polycythemia sequence (TAPS)
- Non-immune hydrops fetalis

Fetal Umbilical Artery Doppler Velocimetry (CPT Code 76820)

Umbilical artery doppler velocimetry is used in surveillance of fetal well-being usually in conjunction with other fetal surveillance methods such as biophysical profiles (BPPs), non-stress tests (NSTs) or both. This assessment has been shown to reduce perinatal mortality and morbidity in high-risk obstetric pregnancies. It is most useful in pregnancies complicated by intrauterine growth restriction (IUGR), twin (multifetal) pregnancies (especially in the setting of discordant twin growth and twin-twin transfusion), and/or hypertensive diseases. Umbilical artery Doppler velocimetry has not been shown to be predictive of outcomes in fetuses without growth restriction.

According to Community's internal policy, this is a covered benefit when Maternal Fetal Medicine (MFM) specialists or radiologist with specialty training in fetal imaging perform this procedure. Participating (i.e. in network) MFMs do not require prior authorization for fetal umbilical artery doppler velocimetry. Community requires prior authorization for all other Providers.

Vascular Study (Uterine Artery) CPT Code 93976

Community requires prior authorization for an arterial inflow and venous outflow of abdominal, pelvic, scrotal contents, and/or retroperitoneal organs; limited study (CPT code 93976). This assessment's clinical utility (specifically of the uterine artery) is currently limited to the first trimester only, when treatment can be instituted to decrease the risk of adverse outcomes. However, at present, the evidence does not support use of this study in any particular group of patients.

Maternal Fetal Medicine (MFM) specialists or radiologists perform this procedure. ALL requests require prior authorization whether or not the physician is in network with Community Health Choice.

Provider Demographic Information and Directory Accuracy

The Centers for Medicare & Medicaid Services (CMS) require 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

What can you do to help?

- Ensure your information in the NPPES is accurate (NPI number, taxonomy, etc.). Please visit the NPPES webpage for more information at https://nppes.cms.hhs.gov/#/.
- Update demographic information in the TMHP Provider Information Management System (PIMS). Please visit the TMHP Medicaid Providers homepage. For more information on using the PIMS, please reference the TMHP PIMS User Guide (PDF).
- Update your profile in Council for Affordable Quality Healthcare, Inc. (CAQH) at https://proview.caqh.org/
- 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

You can provide written request for updates to ProviderRelationsInquiries@CommunityHealthChoice.org or via fax to (713) 295-7039.

Member Access to Care

Appointment 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

Flu and COVID-19

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.

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 much 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
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: • Fever* or feeling feverish/chills • Cough • Sore throat • Runny or stuffy nose • Muscle or body aches • Headaches • Fatigue (tiredness) • Some people may have vomiting and diarrhea, though this is more common in children than adults. *It is important to note that not everyone with flu will have a fever.	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: • Fever or chills • Cough • Sore throat • Congestion or runny nose • Muscle or body aches • Headache • Fatigue • Shortness of breath or difficulty breathing • New loss of taste or smell • Nausea or vomiting • Diarrhea This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

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

HEDIS Season is Almost Here

Review Measures and What is Requested

Community collects data for the Healthcare Effectiveness Data and Information Set (HEDIS®) on an annual basis from Providers. Each year, Community sends initial medical record requests to Providers' offices in early to mid-February requesting relevant clinical information. The request includes a list of patients and a detailed description of the needed clinical information from each patient's medical record. The list may include one or multiple Providers in a practice. The Members identified on each list are randomly chosen and each patient on the list is associated with claims that have been submitted by your practice. If the information on the medical request is incorrect, please contact us thorough our dedicated email at QualityValidation@CommunityHealthChoice.org.

The medical record review is for specific HEDIS® performance measures as required by the National Committee for Quality Assurance (NCQA). Prior to submitting requests to Providers, Community compiles medical and pharmacy claims data for the identified Members. When Community can identify a claim that meets the NCQA requirement for the measures and Members, then medical record review is not required. However, claims data is limited and often does not include specific values or results for tests and screenings performed as required by NCQA. Pharmacy data can be limited because it only captures Members who have a Community pharmacy benefit. Therefore, requests for medical record documentation from patient records supplement what we already have captured in claims. Documentation requests may vary based upon the specific HEDIS measures and criteria specified by NCQA and the claims and pharmacy data we already have for a particular patient.

Community keeps all personal health information (PHI) confidential and only shares to the extent permitted by federal and state law. Only whether the presence or absence of a particular procedure is documented is under review. These activities are considered healthcare operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, and patient authorization is not required. Providers who participate in the Community network must provide the requested medical record information to comply with state and federal regulatory and accreditation requirements. We do not generally reimburse for medical record copies required for HEDIS® medical record collection. For additional information on reimbursement, please see your Participation Agreement or contact your Network Management representative.

Who Will Request Medical Records

Due to the volume of records we need to collect to comply with regulatory requirements, Community partners with health information organizations to help coordinate collection. As a result, we have contracted with KDJ Consultants to perform HEDIS® medical record collection and data abstraction on our behalf.

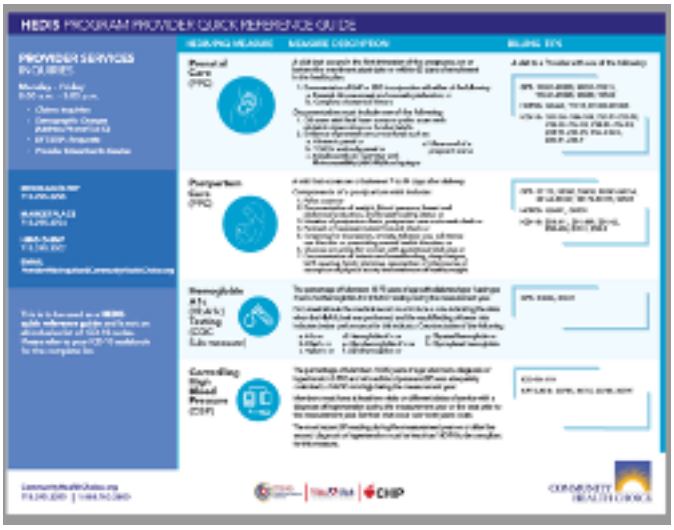
KDJ Consultants will request copies of chart components to be sent by mail or fax for offsite review. KDJ Consultants also have the capability to set up EMR access to review medical records remotely. If you would like to set up EMR access, please contact QualityValidation@CommunityHealthChoice.org so procedural details can be worked out.

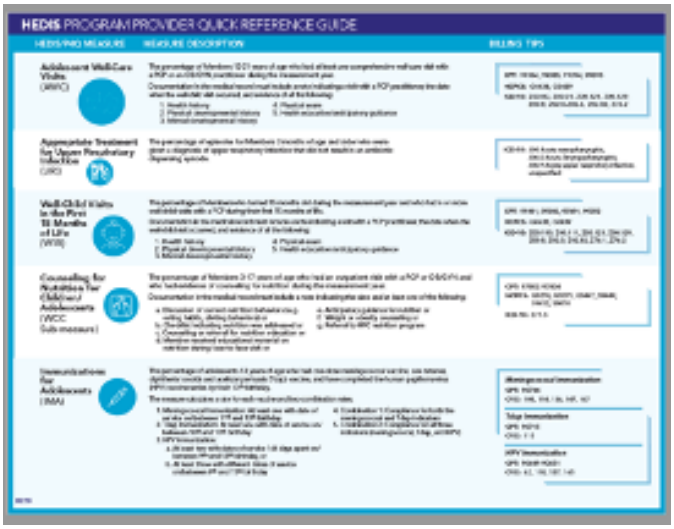
We appreciate your help and prompt attention during this medical record collection process.

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.

Newborn Screening in Texas

An important component of a THSteps medical checkup is the newborn screening test, which is performed on each newborn delivered in Texas. Every baby born gets two newborn screening blood tests that check for a number of genetic and heritable disorders. Finding and treating these disorders early can prevent serious complications such as growth and developmental delays, deafness, blindness, intellectual disabilities, seizures, and sudden or early death. Each newborn screen is indicated on the THSteps Periodicity Schedule.

A current list of screened disorders is available at www.dshs.texas.gov/newborn/screened_disorders.shtm.

Additional information about newborn screening is available on the Newborn Screening Program website at www.dshs.texas.gov/newborn/default.shtm.

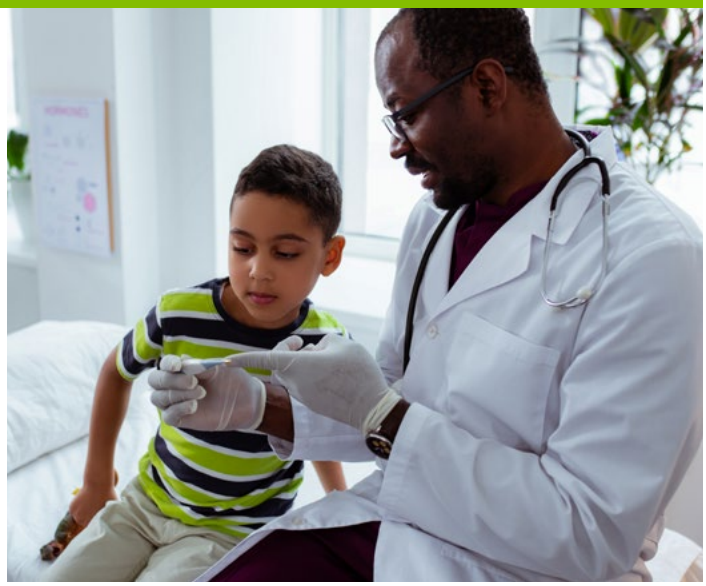
Community encourages THSteps providers to take training on Newborn Screening provided by the HHSC and DSHS at https://www.txhealthsteps.com/437-newborn-screening

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.



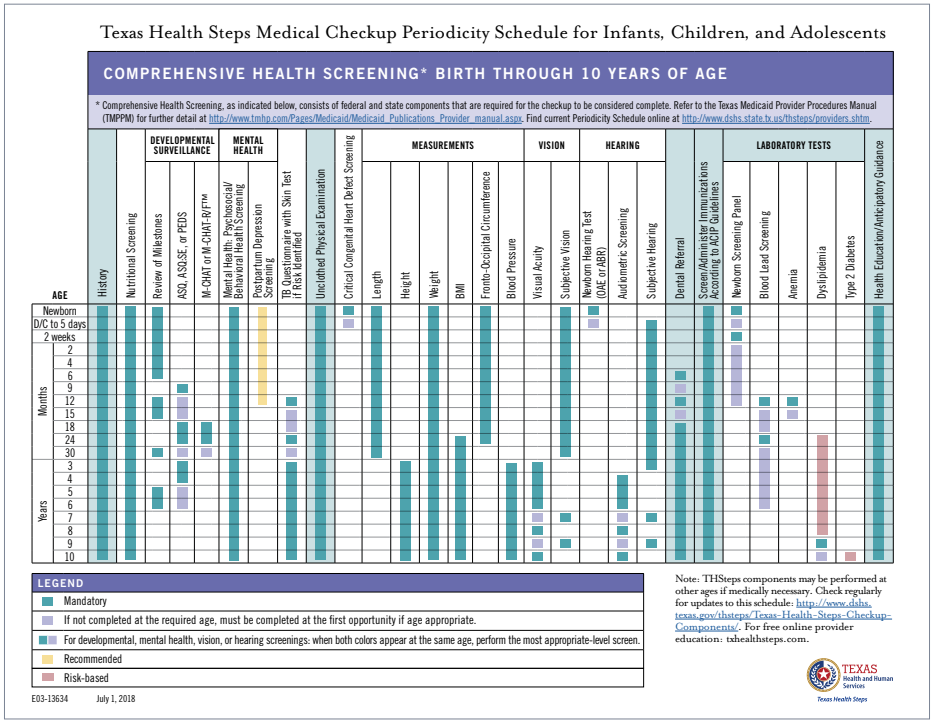
Complete before the next checkup age		
Newborn	3-5 days	2 weeks
2 months	4 months	
Complete within 60 days of these checkup ages		
6 months	9 months	12 months
15 months	18 months	24 months
	30 months	
Complete on or after the birthday but before the next birthday		
Members ages 3 through 20 need a checkup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

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.

THSteps Medical Checkup Periodicity Schedule

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

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



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

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

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

AGE	History	Nutritional Screening	DEVELOPMENTAL SURVEILLANCE: Review of Milestones	DEVELOPMENTAL SURVEILLANCE: ASQ, ASQ-SE, or PEDS	DEVELOPMENTAL SURVEILLANCE: M-CHAT or M-CHAT-R/F™	MENTAL HEALTH: Mental Health: Psychosocial/ Behavioral Health Screening	MENTAL HEALTH: Postpartum Depression Screening	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	Critical Congenital Heart Defect Screening	MEASUREMENTS: Length	MEASUREMENTS: Height	MEASUREMENTS: Weight	MEASUREMENTS: BMI	MEASUREMENTS: Fronto-Occipital Circumference	MEASUREMENTS: Blood Pressure	VISION: Visual Acuity	VISION: Subjective Vision	HEARING: Newborn Hearing Test (OAE or ABR)	HEARING: Audiometric Screening	HEARING: Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS: Newborn Screening Panel	LABORATORY TESTS: Blood Lead Screening	LABORATORY TESTS: Anemia	LABORATORY TESTS: Dyslipidemia	LABORATORY TESTS: Type 2 Diabetes	Health Education/Anticipatory Guidance
Newborn	■	■							■	■	■		■		■			■	■					■					■
D/C to 5 days	■	■							■	■	■		■		■			■	■					■					■
2 weeks	■	■	■			■	■		■	■	■		■		■			■	■					■					■
Months 2	■	■	■			■	■		■	■	■		■		■			■	■					■					■
Months 4	■	■	■			■	■		■	■	■		■		■			■	■					■					■
Months 6	■	■	■			■	■		■	■	■		■		■			■	■					■					■
Months 9	■	■	■	■		■	■		■	■	■		■		■			■	■					■					■
Months 12	■	■	■	■		■	■	■	■	■	■		■		■			■	■					■		■	■		■
Months 15	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Months 18	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Months 24	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Months 30	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 3	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 4	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 5	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 6	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 7	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 8	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 9	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■
Years 10	■	■	■	■	■	■	■	■	■	■	■		■		■			■	■					■		■	■		■

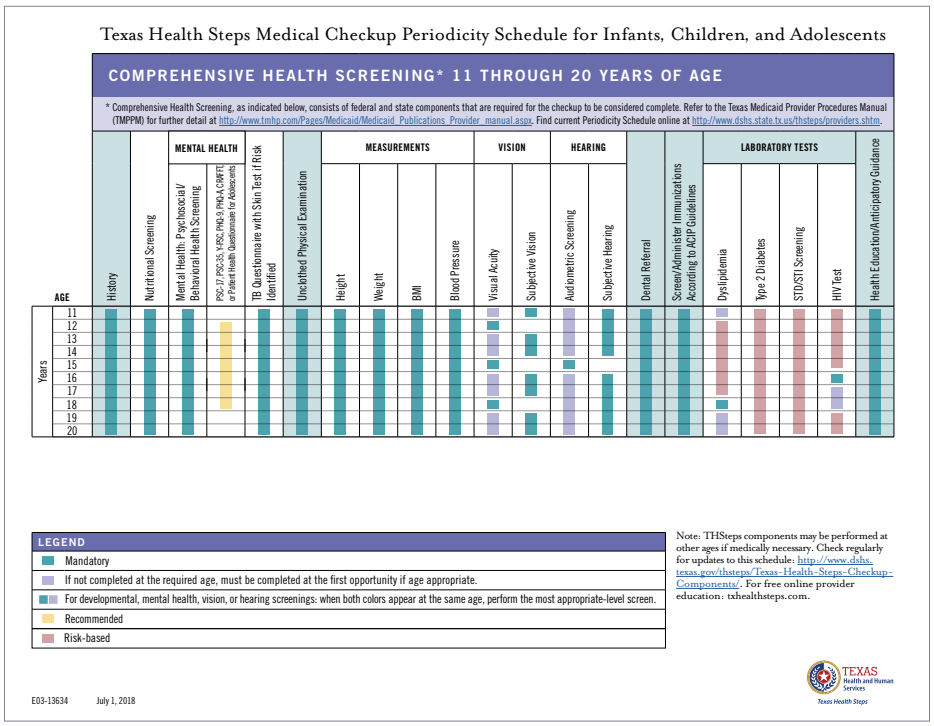
LEGEND

- 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.

TEXAS Health and Human Services
Texas Health Steps

E03-13634 July 1, 2018



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

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

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

AGE	History	Nutritional Screening	MENTAL HEALTH: Mental Health: Psychosocial/ Behavioral Health Screening	MENTAL HEALTH: PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, CRAFFT, or Patient Health Questionnaire for Adolescents	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS: Height	MEASUREMENTS: Weight	MEASUREMENTS: BMI	MEASUREMENTS: Blood Pressure	VISION: Visual Acuity	VISION: Subjective Vision	HEARING: Audiometric Screening	HEARING: Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS: Dyslipidemia	LABORATORY TESTS: Type 2 Diabetes	LABORATORY TESTS: STD/STI Screening	LABORATORY TESTS: HIV Test	Health Education/Anticipatory Guidance
Years 11	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 12	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 13	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 14	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 15	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 16	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 17	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 18	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 19	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 20	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

LEGEND

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

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

TEXAS Health and Human Services
Texas Health Steps

E03-13634 July 1, 2018

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.

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

THSteps Medical Checkup Billing Procedure Codes

Effective June 10, 2020, TMHP has updated the Texas Health Steps Quick Reference Guide. To download a copy, please visit http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf.

- **THSteps Medical Checkup and Immunization Administration on the Same Day**

  The age-appropriate diagnosis code for preventive care medical Checkups must be submitted on the claim. If an immunization is administered as part of a preventive care medical Checkup, diagnosis code Z23 may also be included on the claim. In addition to the age-appropriate diagnosis, for claims that are submitted with an immunization administration procedure code and a preventive evaluation and management (E/M) visit, Providers may append modifier 25 to the preventive E/M visit procedure code to identify a significant, separately identifiable E/M service that was rendered by the same Provider on the same day as the immunization administration.

  Providers may only choose to submit diagnosis code Z23 on the claim if an administration is the only service provided during an office visit.

- **THSteps Medical Checkup and Acute Care Visit on the Same Day**

  Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a Checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provide for different diagnoses. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit.

- **THSteps Medical Checkup and Sports and School Physical on the Same Day**

  A sports and school physical is a value-added service for Community members since it is not a covered benefit for Medicaid. Community will pay sports and school physicals for Medicaid Members ages 4 to 19 (limited to one per calendar year). Provider must use procedure code 97169, 97170, 97171 or 97172, depending on the level of complexity when billing for sports physicals.

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

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.

Medical Transportation Program (MTP) for Medicaid

Health and Human Services offers non-emergency transportation at no cost for THSteps patients and most others who are eligible for Medicaid medical and dental services.

What Kind of Rides Are Offered?

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

How You Can Help

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

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

Community's Transportation Service for CHIP Members

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

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

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.

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
Availity: 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.fcldental.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