Provider
Newsletter

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.

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.

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/.
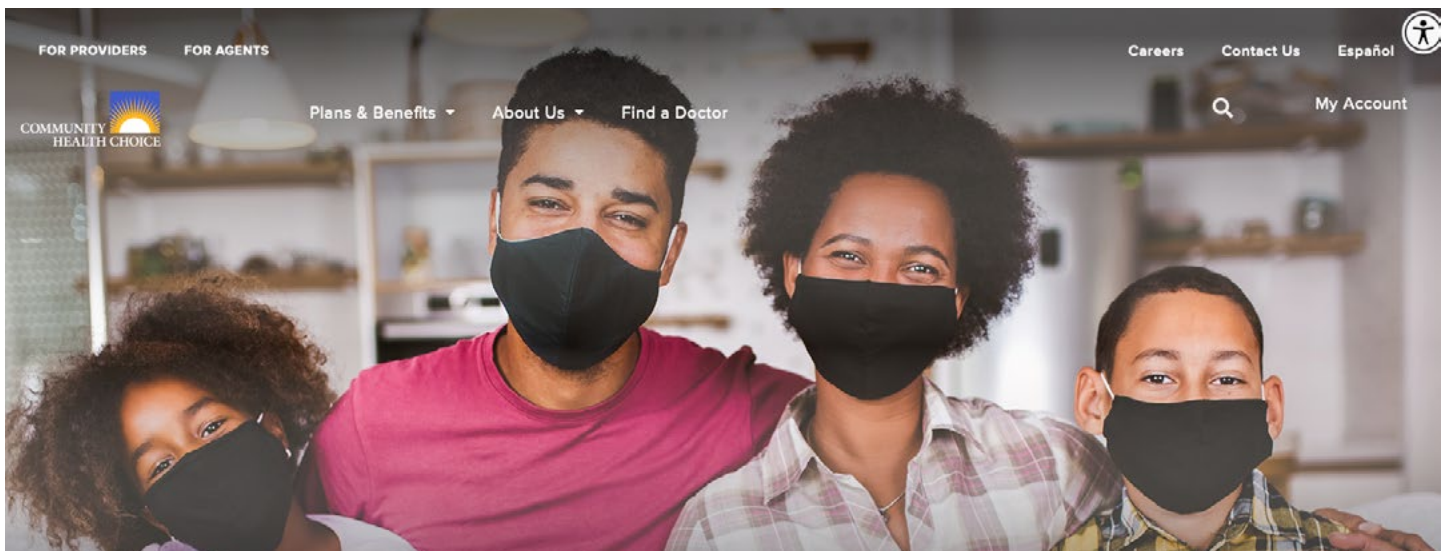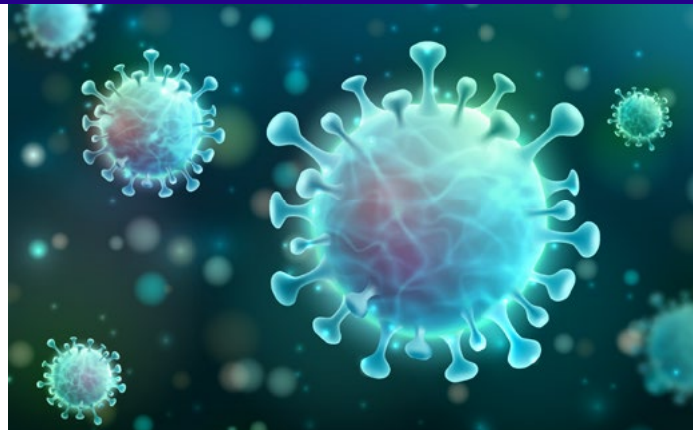
Special Enrollment Period (February 15 - August 15, 2021)

If you have patients who need health coverage, they have a second chance to enroll in one of Community's Health Insurance Marketplace plans!

In response to the COVID-19 Public Health Emergency, the Centers for Medicare & Medicaid Services (CMS) announced a Special Enrollment Period (SEP) for the Health Insurance Marketplace. This SEP is open to all Marketplace-eligible individuals and families who are submitting new applications or updating existing applications.

For more information, please contact Provider Services at 713.295.6707 or visit our website.

- Benefit Plan information: https://www.communityhealthchoice.org/health-insurance-marketplace/shop-our-2021-plans/
- Special Enrollment Period: https://www.communityhealthchoice.org/health-insurance-marketplace/special-enrollment-period/

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

Guidance on Asthma Education Coverage in Medicaid and CHIP

Asthma education in the home setting

- Certified respiratory care practitioners who are physician providers, home health agencies or respiratory therapists may provide asthma education in the home setting.
  - The respiratory care practitioner must be certified by the National Asthma Educator Certification Board (NAECB) as a certified asthma educator.
- For a client age 0-20 with a chronic underlying respiratory illness or a newly diagnosed long-term respiratory condition that is currently resulting in a suboptimal respiratory status, procedure codes S9441 or 98960 are payable for services rendered in the patient's home with the following limitations:
  - S9441 and 98960 are payable for ages 0-20 only.
  - S9441 and 98960 are each limited to once per day, by any Provider, and twice per lifetime.
  - S9441 and 98960 will not be reimbursed in any combination if submitted on the same date of service by any Provider.
- Please refer to TMPPM Certified Respiratory Care Practitioner (CRCP) Services Handbook.

Group clinical visit for asthma

- Physicians or other qualified healthcare professionals including Advanced Practice Nurses (NP, CNS) or Physician Assistants (PAs), as well as Registered Nurses in both the office and outpatient hospital setting may provide Group Clinical Visits for clinical services and educational counseling to a group of clients with asthma.
- Procedure code 99078 (educational services provided in group clinical setting visits by physician or other qualified health care professional) is payable for all ages covered for Texas Medicaid.
- Group visits must be at least one hour and no longer than 2 hours with a minimum of 2 clients and maximum of 20 clients.
- Group visits for conditions of asthma are limited to a maximum of four per year for any provider.
- Group visits are only for established patients and must include CDC-approved Asthma Education and Prevention Programs. Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with the following diagnoses codes:

  - J440, J441, J449, J4520, J4521, J4522, J4530, J4531, J4532, J4540, J4541, J4542, J4550, J4551, J4552, J45901, J45902, J45909, J45990, J45991, J45998
- Please refer to TMPPM Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook, Chapter 9.2.56.2 Group Clinical Visits and Chapter 9.2.56.3 Group Clinical Visits for Asthma.

Asthma education via telemedicine or telehealth

- Medicaid MCOs are prohibited by law from denying reimbursement for an otherwise medically necessary Medicaid-covered benefit solely because the service was delivered remotely.
- Remote group clinical visits for asthma education may be billed using **99078** with modifier **95**.
- Individual asthma education may be billed using **S9441** or **98960** with modifier **95**.

CHIP Coverage

- Asthma education is covered by CHIP under Physician/Physician Extender Professional Services.
- CHIP coverage includes remote delivery as telehealth or telemedicine services.

Additional Information:

S9441: Asthma education, non-physician provider, per session.

98960: Education and training for patient self-management by a qualified, non-physician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes.

99078: Educational services provided in group clinical setting visits by physician or other qualified healthcare professional.

Resources:
TMPPM
Texas Healthcare Learning Collaborative Portal
DSHS Asthma Program
DSHS Resource: Emergency Department Visit Rates for Asthma, Child Asthma, and Adult Asthma by Demographics, Public Health Region, County, and Total Charges by Primary Payer, Texas 2018 (see attachment)

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	Taxonomy	• The taxonomy code and NPI number for both the rendering and the billing Provider are not present on the claim	Include the taxonomy code and NPI number for both the rendering and the billing Provider appropriately.
	Services/Billing Codes in Participating Agreement	• Authorization request includes services or billing codes NOT included in the Participating Agreement. • Billing codes not included in the Participating Agreement. • Billing codes not accepted or payable with Medicaid (i.e., G0410)	Request authorization and bill for the services and/or billing codes as specified in Participating Agreement with Community.
	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. • Include original claim number in box 64 of UB04 or box 22 of the CMS1500 form.
	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 and 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.

Provider Type	Program	Description	Reminders
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
PT/ST/OT 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.

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

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

Both the recent winter storm Uri and past Hurricane Harvey showed the major need Houston-area residents have for plumbers, electricians, and construction workers. Community has scholarships available for our Members to start their careers in these fields and others through a program called CareerReady.

CareerReady connects high school seniors and pregnant women that 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 the scholarship, Community will cover tuition and supplies for a job certification at Houston Community College or San Jacinto College. Every Member in CareerReady will be matched with a Life Coach who will support them in applying for school, completing their certification program, and reaching their career goals.

To make CareerReady available for parents and family members of Community Members, Community is collaborating with WorkTexas at Gallery Furniture. WorkTexas offers job certification programs in carpentry, welding, electrical, automotive, child development, and more. Similar to CareerReady, 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 and their families. Joining WorkTexas is no cost for Community Members, their parents or partners. As a bonus, each Community Member is assigned a Life Coach through Community's CareerReady program to support their success through the process of finishing their job training and finding a job.

For more information on the CareerReady program and WorkTexas, please visit:

https://www.communityhealthchoice.org/life-services/

Email:
LifeServices@CommuniyHealthChoice.org
Phone: 281.384.0551

Sign up for WorkTexas 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.

Are you ready to start your career?

Community Health Choice is partnering with WorkTexas at Gallery Furniture!

Learn a skill. Graduate in the next 6 months!
- Auto Technician
- Child Development Associate
- Electrical
- Horticulture (garden cultivation and management)
- Carpentry/Construction
- Welding

After training, students will have the chance to interview with potential employers.

This Community Health Choice opportunity is free for...
- Community Members
- Family of Community Members who are on Medicaid or CHIP

Space is limited for the next semester.
SIGN UP TODAY!

Priority admission for Community Members and family.

In person at
Gallery Furniture North Freeway
6006 North Fwy.
Houston, TX 77076
Monday - Friday:
9:00 a.m. - 5:00 p.m.

Online at
https://www.galleryfurniture.com/
work-texas-trade-school.html

Each student will be assigned a Life Coach through Community's CareerReady program to support their success through the process.

Not ready to start now? WorkTexas is also accepting applications for future classes. Ask them how you can hold a spot.

Questions? Visit https://www.communityhealthchoice.org/life-services/.

The Social Needs of Our Members and ICD-10 Z-Codes Through a New Partnership With WorkTexas

Community values the great care and attentiveness you provide for our Members, your patients. To help track and address the social needs of our Members, we ask you to include Social Determinants of Health (SDoH) ICD-10 Z codes on the claims you submit to Community. SDoH are the conditions in the places where people live, learn, work and, play that affect a wide range of health and quality of life risks and outcomes. They include:

- Access to healthcare, insurance coverage, and healthy foods
- Education and health literacy
- Employment
- Living situations and environments
- Social support networks

As a health plan, why does Community care?

The SDoH of every patient who comes into your office can affect their overall health and response to care provided. Medicaid enrollees are particularly likely to struggle with basic needs like housing, transportation, and food. With your help, we can help remove the barriers and improve the health and overall quality of life for the Members we serve. With the ICD-10 Z-Code data, Community will better understand the unique needs of Community Members. Community will use this information to better serve our

Members and create programs to address their social needs. In addition, Community will use this information to advocate at the state and federal level for social programs to address these needs.

How can you help address the social need?

Community has a new partnership with Aunt Bertha, a network that connects people seeking help to verified social care providers. This service is available to you as a Provider of Community for free.

You can connect to the Aunt Bertha network through the website specifically created for Community Members: https://community.auntbertha.com/

You can also access Community's Aunt Bertha page through the Provider website under Tools and Resources. The Aunt Bertha website lists local organizations that address social needs by zip code. Using Aunt Bertha is as easy as 1, 2, 3. Once you identify the social need of your patient, the only thing you need is the zip code in which the patient lives. Type that zip code into Community's Aunt Bertha page and a list of resources will come up. Click on the social need column to narrow it down by social need. Finally, share the list of resources with your patient.

List of common ICD-10 Z-Codes

Please use the following list of ICD-10 codes to include in the appropriate claims you submit. These codes do not address all social needs that influence health and wellness. However, these codes will help us better understand and address some of the SDoH of your patients.

Abuse (history of)
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.811 psychological abuse in childhood
Z62.812 neglect in childhood
Z62.819 unspecified abuse in childhood

Education
Z55.0 Illiteracy and low-level literacy
Z55.1 Schooling unavailable and unattainable
Z55.2 Failed school examinations
Z55.3 Underachievement in school
Z55.4 Educational maladjustment and discord with teachers and classmates
Z55.8 Other problems related to education and literacy
Z55.9 Problems related to education and literacy, unspecified

Family/Primary Support Group Issues (Relationship)
Z63.31 Absence of family member due to military deployment
Z63.32 Other absence of family member
Z63.4 Disappearance and death of family member
Z63.5 Disruption of family by separation and divorce
Z63.71 Stress on family due to return of family member from military deployment
Z63.79 Other stressful life events affecting family and household
Z63.0 Problems in relationship with spouse or partner
Z63.6 Dependent relative needing care at home
Z63.8 Other specified problems related to primary support group
Z63.9 Problem related to primary support group, unspecified

Economic Difficulties
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
Z59.0 Homelessness
Z59.1 Inadequate housing
Z59.9 Problems related to housing and economic circumstance, unspecified

Environmentally
Z77.011 Contact with and (suspected) exposure to lead
Z77.1 Contact with and (suspected) exposure to environmental pollution and hazards in the physical environment
Z59.3 Problems related to living in residential institution
Z59.4 Lack of adequate food and safe drinking water.
Z57.2 Occupational exposure to dust
Z57.31 Occupational exposure to environmental tobacco smoke
Z57.39 Occupational exposure to other air contaminants
Z57.4 Occupational exposure to toxic agents in agriculture
Z57.5 Occupational exposure to toxic agents in other industries
Z57.8 Occupational exposure to other risk factors
Z57.9 Occupational exposure to unspecified risk factor

Nutrition and Food Insecurity
Z59.4 Lack of adequate food
Z71.3 Dietary counseling and surveillance
Z59.4 Lack of adequate food and safe drinking water
Z62.819 Unspecified abuse in childhood

COMMUNITY AFFAIRS

Parent/Sibling-Child Issues

Z62.0 Inadequate parental supervision and control

Z62.1 Parental overprotection

Z62.3 Hostility towards and scapegoating of child

Z62.6 Inappropriate (excessive) parental pressure

Z62.820 Parent-biological child conflict

Z62.821 Parent-adopted child conflict

Z62.822 Parent-foster child conflict

Z62.890 Parent-child estrangement NEC

Z62.891 Sibling rivalry

Sleep Issues

Z72.820 Sleep deprivation

Z72.821 Inadequate sleep hygiene

Stress (Not listed elsewhere)

Z73.3 Stress, not elsewhere classified

Substance Use

Z63.72 Alcoholism and drug addiction in family

Z71.41 Alcohol abuse counseling and surveillance of alcoholic

Z71.42 Counseling for family member of alcoholic

Z71.51 Drug abuse counseling and surveillance of drug abuser

Z71.52 Counseling for family member of drug abuser

Employment

Z56.0 Unemployment, unspecified

Z56.1 Change of job

Z56.2 Threat of job loss

Z56.4 Discord with boss and workmates

Z56.5 Uncongenial work environment

Z56.6 Other physical and mental strain related to work

Z56.89 Other problems related to employment

Z56.9 Unspecified problems related to employment

Psychosocial Issues

Z64.0 Problems related to unwanted pregnancy

Z64.4 Discord with counselors

Z65.1 Imprisonment and other incarceration

Z65.2 Problems related to release from prison

Z65.3 Problems related to other legal circumstances

Z65.4 Victim of crime and terrorism

Z65.5 Exposure to disaster, war, and other hostilities

Z65.8 Other specified problems related to psychosocial circumstances

Z65.9 Problem related to unspecified psychosocial circumstances

Social Issues

Z60.0 Problems of adjustment to life-cycle transitions

Z60.4 Social isolation, exclusion, and rejection

Z60.3 Acculturation difficulty

Z60.5 Target of (perceived) adverse discrimination and persecution

Z60.8 Other problems related to social environment

Z60.9 Problem related to social environment, unspecified

Transportation difficulty

Z91.89 Other specified risk factors, not elsewhere classified

Upbringing Issues

Z62.21 Child in welfare custody

Z62.22 Institutional upbringing

Z62.29 Other upbringing away from parents

Z62.898 Other specified problems related to upbringing

Z62.9 Problem related to upbringing, unspecified

Provider Self Audit

Community relies upon the healthcare industry to assist in the identification and resolution of matters that adversely affect the Medicaid, Marketplace, and Medicare Advantage Programs, and believes that a cooperative effort in this area will serve our common interest of protecting the financial integrity of these programs and ensuring proper payments to providers.

Community believes the use of self-audits assists Providers in preventing the submission of erroneous claims or engaging in unlawful conduct involving healthcare programs. Community's self-audit protocol is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, potentially violate state administrative law, regulation or policy governing the Medicaid, Marketplace, and Medicare Advantage programs, or matters exclusively involving overpayments or errors that do not suggest violations of law.

To assist Providers with self-audits, Community has developed a self-audit process which includes an introductory letter, spreadsheet of claims the Provider is expected to self-audit, and instruction for completing and returning the results of the self-audit.

Self-Audit Process

1. Community's Special Investigation Unit (SIU) will supply the Provider a list of all claims subject to the self-audit.
2. The Provider will review their medical record documentation.
3. Upon review of medical record documentation, the Provider will determine if:
   a. Documentation supports the service billed
   b. Documentation identified that a more appropriate code should have been billed
   c. Documentation or lack of documentation determined the service(s) should not have been billed
4. The Provider will indicate their findings on the spreadsheet of claims provided.
5. The Provider is required to return the completed spreadsheet and signed attestation form to Community's SIU by the due date populated on their request letter:

Via U.S. Mail:
Community Health Choice
ATTN: SIU
2636 South Loop West, Suite 125
Houston, TX 77054

Via Secure Email: SIU@communityhealthchoice.org

SIU Contact Information

For any questions, concerns or extensions the Provider may have, they can reach out to Community's SIU via email. If the Provider prefers a phone call, they may indicate in their email their call-back information and SIU will return the call as soon as possible.

Reporting Provider or Recipient Fraud, Waste or Abuse

Let us know if you think a doctor, dentist, pharmacist, other healthcare Provider or Member receiving 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 <u>must</u> be complete and legible.
- The documentation of each patient encounter <u>must</u> 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 <u>must</u> be supported by the documentation in the medical record.

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 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 except for those services that fall under the Start of Care guidelines. The days after notification is received will be reviewed based on
  - 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

Perinatal Transmission of HIV

The Perinatal HIV hotline for immediate advice on HIV management in pregnant women and their infants, including referral to:

Perinatal HIV Hotline
https://nccc.ucsf.edu
1.888.448.8765
24 hours, seven days a week

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
- 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.

Texas Vaccines for Children (TVFC) Program

The Texas Vaccines for Children Program (TVFC) makes vaccines available to eligible children of Texas. These vaccines are available at no cost to Providers in order to immunize eligible children (birth - 18 years of age). These vaccines are supplied to doctors, local health departments, and Department of State Health Services Sub-offices to be administered to eligible children.

Community will require Providers to participate in the VFC program for both STAR and CHIP members based on the documentation provided below.

The Texas Medicaid Provider Procedures Manual (TMPPM), Section 5 THSteps Medical includes the following (https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2021-03-TMPPM.pdf):

5.1.3 Texas Vaccines for Children (TVFC) Program

The TVFC program provides vaccines at no cost to the provider. The vaccines are recommended according to the Recommended Childhood and Adolescent Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. THSteps Providers are strongly encouraged to enroll in TVFC at DSHS and must do so in order to obtain free vaccines for clients who are birth through 18 years of age. Local and public health departments that are not otherwise enrolled as a provider that is authorized to receive reimbursement for vaccine administration fees should enroll as a Comprehensive Care Program (CCP) provider. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $14.85, is considered for reimbursement. When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use an ACIP-recommended product that is not distributed through TVFC, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Chapter 4: Billing and Administration from the TVFC and ASN Provider Manual

(https://www.dshs.texas.gov/immunize/docs/11-13602.pdf). "Sites are required to enroll in the TVFC Program to obtain vaccines at no cost to vaccinate TVFC-eligible children, including Medicaid and CHIP children."

If you are not enrolled in TVFC, please consider enrolling. The process is simple:

1. Verify that you meet the provider eligibility requirements.
2. Complete the Vaccine Education Online web-based training course and submit the certificate of completion.
3. Complete Module 10 (Vaccine Storage and Handling) and Module 16 (Vaccines for Children) of the CDC You Call The Shots Training, and submit certificates of completion.
4. Complete and submit the Provider Agreement Form.
5. Agree to screen for patient eligibility and maintain screening records.
6. Agree to maintain vaccine safety and inventory.

Please contact the nearest Health Services Regional Office or a TVFC Consultant.

Email: TVFCEnrollment@dshs.state.tx.us
Toll-Free: 800.252.9152
Phone: 512.458.7284
Member Panel Reports

Member Panel Reports

If you are a primary care physician (PCP), we urge you to review your panel report regularly. You can access a list of Members assigned to your panel via our Provider Portal. You may also request a copy from your Provider Engagement Representative.

Review the reports to identify new patients and call them to schedule a new patient visit or to schedule established patients that may be in need of wellness visits or vaccinations.

In the event a Community Member sees you and is not on your panel, you may complete the "Member Request to Change Primary Care Provider" form while the Member is in your office and submit it to Community. Community will review and make the PCP change accordingly.

You will find the "Member Request to Change Primary Care Provider" form at: https://provider.communityhealthchoice.org/wp-content/uploads/sites/2/2020/12/Member-Request-to-Change-Primary-Care-Provider.pdf

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 number
    - 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.

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

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 with 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

Spotlight on Quality Measures

HEDIS MEASURE DESCRIPTION and BILLING CODES

Well Child Visits in the First 15 Months (W30)

Children who turned 15 months old during the measurement year: six or more well-child visits.
- CPT: 99381, 99382, 99391, 99392
- HCPCS: G0438, G0439, S0302
- ICD-10: Z00.110, Z00.111, Z00.121, Z00.129, Z76.1, Z76.2, Z00.2

Well Child Visits for Age 15 Months - 30 Months (W30)

Children who turned 30 months old during the measurement year: two or more well-child visits.
- CPT: 99382, 99392
- HCPCS: G0438, G0439, S0302
- ICD-10: Z00.121, Z00.129, Z00.2, Z76.2

Immunizations for Adolescents – Combination 2 (IMA)

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
- Meningococcal-CPT: 90734; CVX: 108, 114, 136, 147, 167
- Tdap-CPT: 90715; CVX: 115
- HPV-CPT: 90649, 90650, 90651; CVX: 62, 118, 137, 165

Child Immunization Status – Combination 10 (CIS)

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
- Dtap-CPT: 90698, 90700, 90723; CVX: 20, 50, 106, 107, 110, 120
- IPV-CPT: 90698, 90713, 90723; CVX: 10, 89, 110, 120
- MMR-CPT: 90707, 90710; CVX: 03, 94
- VZV-CPT: 90710, 90716; CVX: 21, 94
- HiB-CPT: 90644, 90647, 90648, 90698, 90748; CVX: 17, 46-51, 120, 148
- HepB-CPT: 90723, 90740, 90744, 90747, 90748; CVX: 08, 44, 45, 51, 110
- PCV-CPT: 90670; HCPCS: G0009; CVX: 133, 152
- HepA-CPT: 90633; CVX: 31, 83, 85
- RV-CPT: 90681, 90680; CVX: 119, 116, 122
- Flu-CPT: 90655, 90657, 90661, 90673, 90685-90689; HCPCS: G0008; CVX: 88, 140, 141, 150, 153, 155, 158, 161

HEDIS MEASURE DESCRIPTION and BILLING CODES

Weight Assessment and Counseling for Nutrition Children/Adolescents (WCC-Nutrition)

Of Members 3–17 years of age who had an outpatient visit with a PCP, the percentage who had evidence of counseling for nutrition during the measurement year. Documentation must include a note indicating the date and at least one of the following:

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

- CPT: 97802-97804
- HCPCS: G0270, G0271, G0447, S9449, S9452, S9470
- ICD-10: Z71.3

Asthma Medication Ratio (AMR)

The percentage of Members 5–21 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Medications include: Dyphylline-guaifenesin, Omalizumab, Dupilumab, Benralizumab, Mepolizumab, Reslizumab, Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Formoterol-mometasone, Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone, Montelukast, Zafirlukast, Zileuton, Theophylline, Albuterol, Levalbuterol.

- ICD-10: J45.21, J45.22, J45.30-J45.32, J45.40- J45.42, J45.50-J45.52, J45.901-J45.902, J45.909, J45.991, J45.998

Appropriate Treatment for Upper Respiratory Infection (URI)

The percentage of episodes for Members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that The did not result in an antibiotic dispensing event.

- ICD-10: J00, J06.0, J06.9

HEDIS MEASURE DESCRIPTION and BILLING CODES

Prenatal Care (PPC)

The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following.

1. Documentation indicating the woman is pregnant or references to the pregnancy; for example:
    - ✓ Documentation in a standardized prenatal flow sheet or
    - ✓ Documentation of LMP, EDD or gestational age or
    - ✓ A positive pregnancy test result or
    - ✓ Documentation of gravidity and parity or
    - ✓ Documentation of complete obstetrical history or
    - ✓ Documentation of prenatal risk assessment and counseling/education.

2. A basic physical obstetrical examination that includes auscultation for fetal heart tone or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal flow sheet may be used).

3. Evidence that a prenatal care procedure was performed, such as:
    - ✓ Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) or
    - ✓ TORCH antibody panel alone or
    - ✓ A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing or
    - ✓ Ultrasound of a pregnant uterus
    - CPT: 99201-99205, 99211-99215, 99241-99245, 99483, 99500
    - HCPCS: G0463, T1015, H1000-H1005
    - ICD-10: Z32.01, O09.00-O9A.519, Z03.71-Z03.79, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, Z36-Z36.5, Z36.81-Z36.9

Postpartum Care (PPC)

The percentage of deliveries that had one postpartum visit on or between 7 and 84 days after delivery while enrolled with Community. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.

1. Pelvic exam

2. Evaluation of weight, BP, breasts, and abdomen.
    - ✓ Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component

3. Notation of postpartum care, including but not limited to:
    - ✓ Notation of "postpartum care," "PP care," "PP check," "6-week check."
    - ✓ A preprinted "Postpartum Care" form in which information was documented during the visit

4. Perineal or cesarean incision/wound check

5. Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.

6. Glucose screening for women with gestational diabetes

7. Documentation of any of the following topics:
    - ✓ Infant care or breastfeeding
    - ✓ Resumption of intercourse, birth spacing or family planning
    - ✓ Sleep/fatigue
    - ✓ Resumption of physical activity
    - ✓ Attainment of healthy weight
    - CPT: 57170, 58300, 59430, 99501, 88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175
    - HCPCS: G0123, G0124, G0141, G0143-G0145, G0147-G0148, P3000-P3001, Q0091, G0101
    - ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

HEDIS MEASURE DESCRIPTION and BILLING CODES

Prenatal Depression Screening (PND)

The percentage of deliveries in which Members were screened for clinical depression during pregnancy using a standardized instrument.

- HCPCS: G8431, G8510

Postpartum Depression Screening (PDS)

The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.

- HCPCS: G8431, G8510

You may access the Quick Reference Guide via the Provider Portal at https://provider.communityhealthchoice.org/ > Resources > Forms and Reference Guides.

Please always follow state and/or CMS billing guidance and ensure the HEDI codes are covered prior to submission of a claim.

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.

Wellness Services During COVID-19

The American Academy of Pediatrics (AAP) previously 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

THSteps Checkup Timeliness

New Community Health Choice Members <u>must</u> 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 <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.

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.

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.

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

E03-13634   July 1, 2018

TEXAS Health and Human Services — Texas Health Steps

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.

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.

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

E03-13634   July 1, 2018

TEXAS Health and Human Services — Texas Health Steps

Exception to Periodicity Checkups

Exception-to-Periodicity checkups are complete medical checkups completed outside the time frames listed in the THSteps Periodicity Schedule due to extenuating circumstances, and might cause the total number of checkups to exceed the number allowed for the Member's age range if the Member was to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

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

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

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

Modifiers indicate the reason for the exception to periodicity checkup:

Modifier	Description
SC	• Medically necessary (developmental delay or suspected abuse) • Environmental high-risk (sibling of child has elevated blood level)
23	• Dental services provided under general anesthesia
32	• To meet state or federal requirements for Head Start, daycare, foster care or pre-adoption • Accelerated services for children of traveling farmworkers

Claims for exception-to-periodicity checkups that do not include one of the exception-to-periodicity modifiers will be denied as exceeding periodicity.

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

- **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.

To download a copy, please visit
http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf.

Early Childhood Intervention (ECI)

Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services for families with children from 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.

Effective June 1, 2021, Access2Care will be our transportation provider for Medicaid Members.

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.
Rachael Roberts, 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)

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

CommunityHealthChoice.org