V4-2021

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.

House Bill 3459: Prior Authorization Transparency "Gold Carding"

Community Health Choice (Community) would like to communicate information regarding House Bill (HB) 3459.

What is HB 3459?

- House Bill 3459 prohibits a Health Maintenance Organization (HMO) that uses Prior Authorizations from requiring a Provider to obtain a Prior Authorization for a service if the Plan approved or would have approved 90% of the Prior Authorization requests submitted by that Provider within the most recent six-month evaluation period.

What program does this impact?

- This only applies to Health Insurance Marketplace.

How will this work for Providers?

- Community will "Gold Card" all Providers who have a 90% approval rating on their prior authorization requests for the previous six months
  - Gold Card entails not having to request prior authorizations for treatment.
  - Gold Card lasts at least six months after which we may review for renewal.
- The look-back period for Gold Card will begin on Jan. 1, 2022, through June 30, 2022.
- After June 30, 2022, Community will conduct analysis and notify Providers of their Gold Card status.
- Gold Card status will commence on Oct. 1, 2022.

*Please note this is subject to change as we await additional information from the Texas Department of Insurance and HB 3459 continues to evolve.

Non-Emergency Medical Transportation for STAR Members

Non-emergency Medical Transportation (NEMT) Services provides transportation to non-emergency healthcare appointments for STAR Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and any other places they receive Medicaid services. These trips do NOT include ambulance trips.

As of **June 1, 2021**, Community Health Choice (Community) began providing transportation services for STAR Members and will use **Access2Care** to provide NEMT Services.

- **Access2Care** is available 365 days a year, 7 days a week, 24 hours a day.
- Members can call **Access2Care** toll-free at **1.844.572.8194** at least 48 hours before the scheduled appointment. They may be able to get a ride sooner for an urgent care appointment.
- Members can also schedule transportation through the **Access2Care** (A2C) Member app which they can download from their app store.
- Providers can also arrange transportation for Members by calling **Access2Care** at **1.844.572.8194** or schedule online by visiting the Community Provider Portal for the link to **Access2Care's** reservation system.

What services are part of Access2Care's Services?

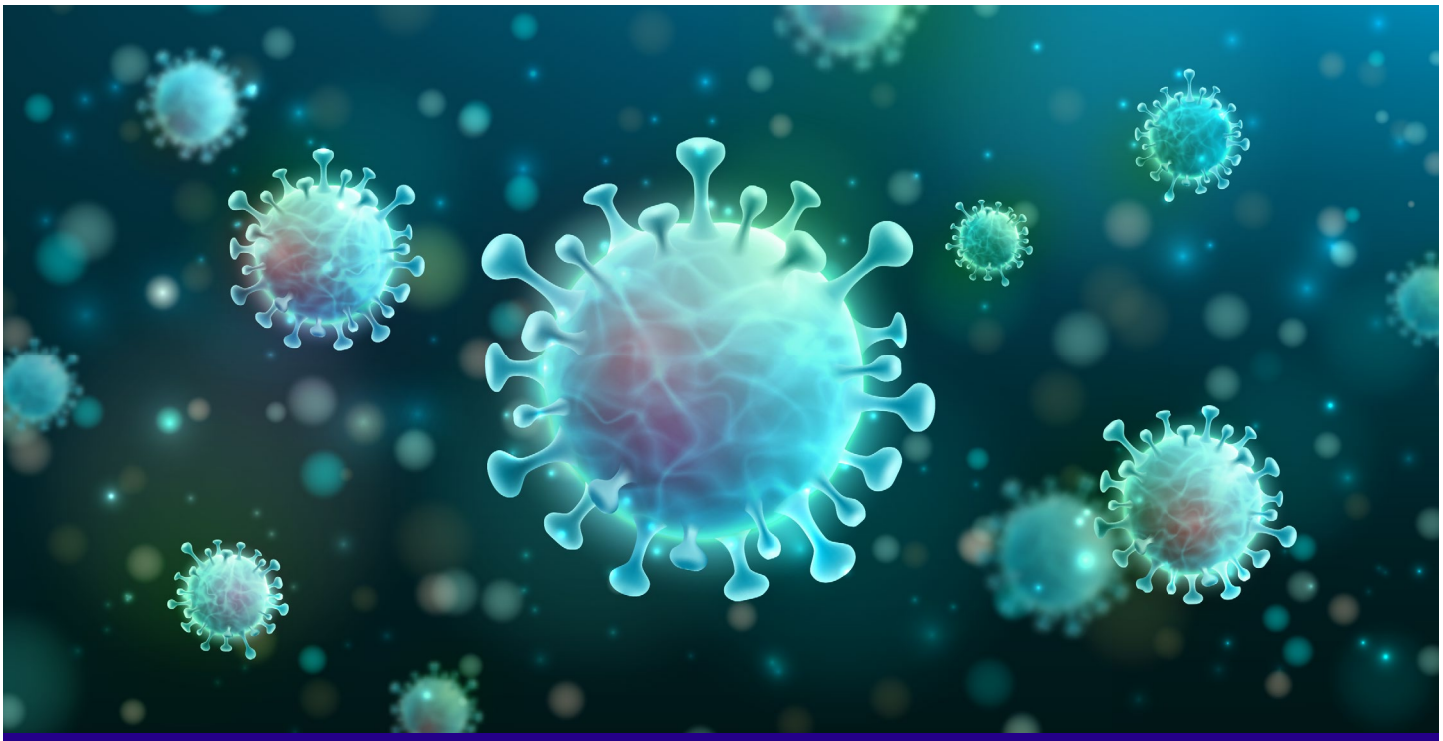
- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus
- Commercial airline transportation services
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service; the ITP can be the Member, a responsible party, a family member, a friend or a neighbor. Pre-approval is required to be an ITP.
- If a Member is 20 years old or younger, he/she may be able to receive the cost of meals associated with a long-distance trip to obtain healthcare services. The daily rate for meals is $25 per day for the Member and $25 per day for an approved attendant.
- If a Member is 20 years old or younger, Member may be able to receive the cost of lodging associated with a long-distance trip to obtain healthcare services. Lodging services are limited to the overnight stay and do not include any amenities used during their stay such as phone calls, room service or laundry service.
- If a Member is 20 years old or younger, he/she may be able to receive funds in advance of a trip to cover authorized Access2Care services.
- If a Member needs an attendant to travel to their appointment with him/her, Access2Care will cover the transportation costs of the attendant.
- Children 14 years old and younger must be accompanied by a parent, guardian or other authorized adult.
- Children 15-17 years old must be accompanied by a parent, guardian or other authorized adult or have consent from a parent, guardian or other authorized adult on file to travel alone. Parental consent is not required if the healthcare service is confidential in nature.

Forms for the Provider to Complete

There may be times when **Access2Care** will require additional documentation from the Member's Provider or parent/guardian. The *Travel Assessment Form* will be available to Providers from the Community site. Providers will complete the form to address the following about the Member:

- Health plan information
- Level of disability
- Recommended transportation
- Attendant necessity for the trip
- Provider's information

If you have questions about NEMT services or if Members, your patients, need this service, please contact us at 713.295.2295.



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/.

Marketplace Open Enrollment

Marketplace Open Enrollment is Nov. 1, 2021–Jan. 15, 2022.

The Open Enrollment Period for the Health Insurance Marketplace ends Jan.15, 2022. During open enrollment, anyone who is eligible can sign up for healthcare coverage that will start Jan. 1, 2022, if they enrolled by Dec. 15, 2021. For people who enroll Dec. 16, 2021, to Jan. 15, 2022, their coverage starts Feb. 1, 2022.

Information needed for a Marketplace Application

Members will need the following documents and information to complete a Marketplace application and select a healthcare plan:

- Names and social security numbers for everyone in their tax household applying for health insurance. A tax household includes anyone Members claim on their tax return.
- Earned income information: recent pay stubs for everyone who is working or self-employment records (Schedule C from the previous year's tax return).
- Unearned income information–unemployment payments, pension, retirement, real estate income, social security (RSDI or SSI) income or capital gains.

The next step is to go to Community's Marketplace enrollment options page, complete an application, and select their 2022 healthcare coverage. Members can review our 2022 plans here.

Medicare Open Enrollment

Medicare is for senior citizens (65+) and people with disabilities who are receiving social security. Medicare has an Annual Election Period (AEP).

Each year, however, there is also a Medicare Advantage Open Enrollment Period from January 1 – March 31. During this time, Members who are enrolled in a Medicare Advantage Plan (Medicare Part C) and want to change health plans may do one of the following:

- Switch to a different Medicare Advantage Plan
- Go back to Original Medicare and, if needed, also join a Medicare Prescription Drug Plan

When Members switch Medicare Advantage Plans or go back to Original Medicare with or without a Medicare drug plan, their new coverage will start the first day of the month after their new plan gets their request for coverage.

Community Health Choice offers a Medicare Advantage Dual Special Needs Plan (D-SNP) that provides all of the coverage provided by both Original Medicare and Medicaid plus extra benefits like dental, vision, hearing, transportation, and more. Members can call 1.833.276.8306 (TTY users should call 711) to learn more.

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

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	Electronic Claim Submission	• Billed with the incorrect payer number and member number	Bill with the appropriate payer number and member number
	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 in 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, 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
	Rendering NPI	Including a rendering NPI may hold up claim payment or deny claim payment.	Not include rendering NPI since it is not required
	Billed Group vs Rendering Provider	Submitting claims with Rendering Provider	Bill with Group vs Rendering Provider
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
	Second 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.
Skilled Nursing Facility	Revenue Codes	Not billing with appropriate codes	Bill appropriate (subacute) level of care revenue codes

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

Medicare D-SNP

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

Billing for Immunization Administration with Counseling Documentation Guidelines

Report codes 90460 and 90461 only when the physician or qualified healthcare professional provides face-to-face counseling of the patient/family during the administration of a vaccine. Counseling is a discussion with a patient and/or family concerning one or more of the following but is not limited to:

- Obtaining information on potential contraindications to receiving a particular vaccine(s)
- Reviewing/discussing the relevant CDC Vaccine Information Statement(s) (VIS)
- Reviewing/discussing risks and benefits of specific vaccine(s).

For more details on the definition of "Counseling," please refer to the evaluation and management (E/M) service guidelines in your current CPT codebook.

Helping Our Members Find a Job and Start Their Careers

Community Health Choice (Community) has scholarships available for our Members to start their careers through a program called CareerReady. CareerReady connects 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. Initially, CareerReady was only available to Medicaid Members who were high school seniors or pregnant. NOW, CareerReady is available for Marketplace Members between the ages of 18 to 30 years, too! 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.

In addition, to make CareerReady available for parents and family Members of Community Health Choice (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 at 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.

To apply for CareerReady, please visit:

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

Email: LifeServices@CommuniyHealthChoice.org

Phone: 281.384.0551

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

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

The Social Needs of Our Members and ICD-10 Z-Codes

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 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 free as a Provider of Community.

You can connect to the **Aunt Bertha** network through a website created specifically 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 needs of your patient, the only thing you need is the zip code of where 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 Ppsychological 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

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 on 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 that includes an introductory letter, spreadsheet of claims the Provider is expected to self-audit, and instructions for completing and returning the results of the self-audit.

Self-Audit Process

1. Community's Special Investigation Unit (SIU) will supply the Provider with 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 to:

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, please 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.

Special Services Education

Community Health Choice (Community) SIU is responsible for the identification and investigation of potential waste, fraud and abuse, and to ensure the fair and correct payment of claims submitted to Community. Community encourages Providers to implement necessary policies, processes, and procedures to ensure compliance with federal and state laws, regulations, and policies relating to the Medicaid, Marketplace, and Medicare Advantage Programs. The following information is aimed to serve as helpful recommendations in regard to special services.

For example:

CPT Code 99000 handling and/or conveyance of specimen for transfer from the office to laboratory.

CPT Code 99001 handling and/or conveyance of specimen for transfer from the patient to laboratory.

Documentation for Provider's requests:

These codes may be used to reflect the work involved in the preparation of a specimen prior to sending it to the laboratory. This work may include centrifuging a specimen, separating serum, labeling tubes, packing the specimens for transport, filling out lab forms, and supplying necessary insurance information and other documentation. Medical record documentation should clearly reflect the work provided to support the special services billed.

For additional guidance on documentation of services, see the references below but do not limit yourself to only these references:

https://www.cms.gov

TMHP.com

Special Investigations Unit

Email: SIU@CommunityHealthChoice.Org

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 fraud, waste or abuse, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184;
- Visit https://oig.hhsc.texas.gov/report-fraud-waste-or-abuse. Click on the box labeled "IG's Fraud Reporting Form" to complete the online form; or
- You can report directly to Community at:

  Community Health Choice
  Chief Compliance Officer
  2636 South Loop West, Suite 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, Suite 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
  - 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 Reminders

Providers should submit prior authorization requests:

1. At least 5 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility or hospice facility
2. At least 30 days prior to the initial evaluation for organ transplant services
3. Within 24 hours of any inpatient admission, including emergent inpatient admissions
4. At least 5 days prior to the scheduled start of home health services, except those enrollees needing home health services after hospital discharge

Prior Authorization Catalog

Community has released the Prior Authorization Catalog for 2022. This list contains prior authorization requirements for participating care Providers. Please visit our website at https://provider.communityhealthchoice.org/resources/prior-authorization-information/ for additional information.

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 the 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 a 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 service 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 are 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 ensure 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 # 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 number 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.

Anxiety & Depression Screening

Patients may not know they are anxious or depressed when they come into a Primary Care Physician's office. Often times, they will come in for physical symptoms that may be caused by anxiety and depression. Some of these symptoms may be weight gain/loss, back pain, sleeping issues, lack of energy, and headaches. With the change in lifestyle caused by the Covid-19 Pandemic, rates of depression in adults have continued to increase.

According to the Centers for Disease Control and Prevention, adults with symptoms of anxiety or depressive disorder increased from 36.4% to 41.5% from August 2020 to February 2021 (CDC, 2021). Despite the prevalence of depression among adults, depression goes undiagnosed in primary care settings about half the time (American Psychiatric Association, 2021).

What can we do to improve?

- Utilize Community's PCP Toolkit for guidelines and screening tools for anxiety and depression.
- Ask patients specific questions about their mental health.
- Provide accessible learning materials about anxiety and depression disorders to patients.
- Bridge the gap between primary care and specialty care depending on patient needs.
- Screen Members for depression and/or anxiety at their annual physicals.

Primary Care Physician Coordination

- Must screen, evaluate, refer and/or treat any behavioral health problems and disorders, including anxiety and depression.
- May provide behavioral health services within the scope of their practice.
- Must maintain patient confidentiality of behavioral health information.

Screening Tools

Anxiety

- GAD-7 (Generalized Anxiety Disorder)

Depression

- The Beck Depression Inventory (BDI)
- BDI interactive Tool
- The Hamilton Depression Scale (HAM-D)
- Patient Health Questionnaire-9 (PHQ-9)

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, as well as 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.

Helpful Tips: 7 and 30 Day Follow Up Visits After Hospitalization for Mental Illness

Mental illnesses are extremely prevalent with about one in four adults in the U.S. suffering from a mental illness in a given year, and one in two developing at least one mental illness at some point in their life. Because of this, there are over 2,000,000 hospitalizations each year for mental illness problems in the U.S.

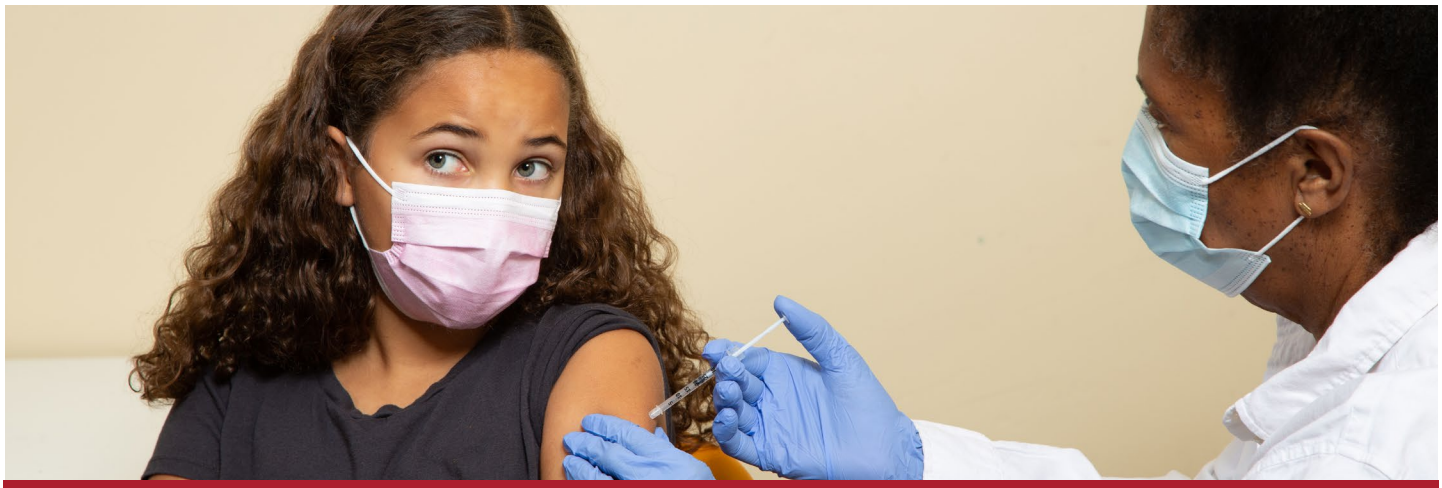
When our Members are hospitalized, we must ensure they have a 7 day and 30-day post-hospitalization visit. Patients hospitalized for mental health issues are especially vulnerable post-discharge. A follow-up visit at these critical points is necessary to ensure their health and well-being.

Recommendations prior to discharge

1. Identify and remove barriers that prevent our Members from coming to follow-up appointments.
2. Consider case management to help with our Members' needs.
3. Remind Members of the importance of follow-up visits.
4. Ensure Members have adequate access to prescribed medications.
5. Send discharge paperwork to the appropriate outpatient mental health provider within 24 hours.
6. Coordinate care between behavioral health and primary care physicians.
7. Reach out to Members who cancel appointments to reschedule as soon as possible.

Community's Behavioral Health 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.



Human Papillomavirus (HPV) Vaccination

The vaccine for HPV can prevent infection from some types of HPV. Many public health efforts target widespread vaccination for HPV, as it can cause cervical, vaginal, vulvar, penile, and anal cancers. The vaccination prevents infections that cause over 90% of these cancers (CDC, 2020).

According to the Centers for Disease Control and Prevention, 80% of people will be infected with HPV in their lifetime. HPV vaccination is cancer prevention. It can prevent up to 32,000 cases of cancer caused by HPV infections.

Vaccination Recommendations

Start talking early	On Time	Late	Late
Ages 9-10	Ages 11-12	Ages 13-14	Ages 15-26
2 doses	2 doses	2 doses	3 doses

Talking to Parents: Common Concerns

- It is important to stress to parents that this is a cancer prevention vaccine. Vaccination **prior to sexual contact** is the best way to ensure the HPV vaccine is effective.
- Data shows HPV vaccination at a young age **does not affect age of initiating sexual activity**
- HPV can infect both men and women. These infections commonly cause tongue and tonsil cancer in men, which is why vaccinations are important for both **boys and girls**.
- Try to recommend the HPV vaccine to parents on the same day and in the same way as other vaccinations.
- The HPV vaccine is long lasting and **does not wear off**.
- **There is no evidence showing that HPV vaccination affects fertility:** Not getting the vaccine leaves individuals susceptible to HPV cancer and pre-cancers that can affect fertility.

The HPV vaccine has undergone 12 years of monitoring so far and has been proved to be safe and effective. More than 270 million doses have been distributed worldwide. The most common side effects are:

- Pain, redness or swelling in the arm where the shot was given
- Dizziness or fainting (this can occur after any vaccine, and is more common among adolescents)
- Nausea
- Headache

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
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.

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) requires 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.

Appointment and After-Hours Availability

As a reminder, HHSC and/or its contractor perform random telephonic surveys to Providers without notice to ensure that new and existing Members have access to care. Community also conducts annual surveys to ensure that participating Providers are compliant with all access availability and after-hours access standards.

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.
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

HEDIS Season is Upon Us!

As you know, Community Health Choice is required to collect medical records for Health Effectiveness Data and Information Set (HEDIS) reporting. We would like to thank our Providers in advance for their cooperation and assistance with this effort. This is an annual requirement of the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the State of Texas HHSC.

Frequently Asked Questions:

1) When is the collection period?

The medical record collection period has begun and will run through May 4, 2018. How will the request be sent? You will be contacted by CIOX Health, our record retrieval vendor, by fax, email or phone. If you have questions, please contact your Provider Engagement Representative.

2) What will be requested?

The medical records for specifically identified Members.

3) Am I required to respond?

This is a required quality improvement activity in the contract with Community Health Choice.

4) What should the record include?

- Member name (on each page)
- Member date of birth
- Member health plan ID
- Date of service
- Provider signature with credentials
- Diagnostic information and note

5) Who will request medical records?

Community partners 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.

We know that time with your patients—our Members—is valuable. We ask that you respond to the medical records request within 5-7 days.

Thank you for your continued partnership to provide quality care to the residents of Southeast Texas.

Risk Adjustment Update

For Providers who have participated in Community's Marketplace, we would like to personally thank those of you who helped Community successfully retrieve medical records as required for the Risk Adjustment Data Validation (RADV) audit prescribed by CMS. We had a tremendous response rate, which helps to ensure an accurate plan-level risk score. RADV will once again kick off in late summer of 2022.

Currently, Community has partnered with ChartFast to work on the Marketplace suspecting project, so if you receive a request from them, please provide the requested patient information.

Thank you again for your participation!

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.

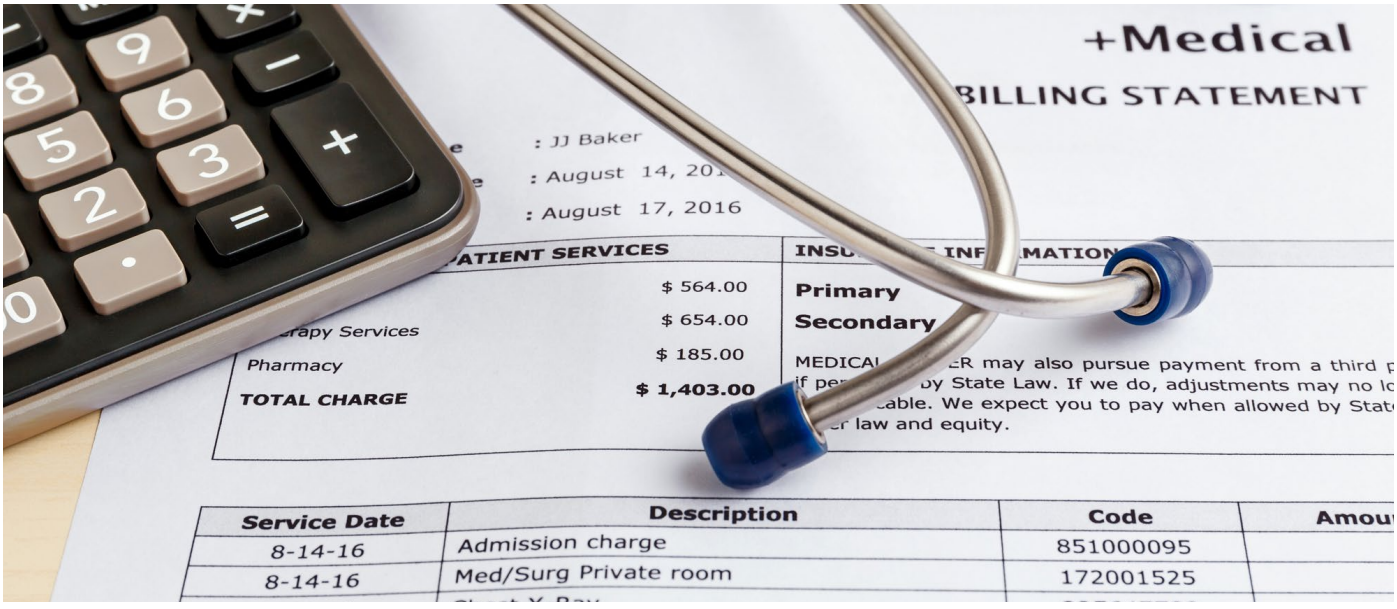
Medications include: Dyphylline-guaifenesin, Omalizumab, Dupilumab, Benralizumab, Mepolizumab, Reslizumab, Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Formoterol-mometasone, Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone, Montelukast, Zafirlukast,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

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.

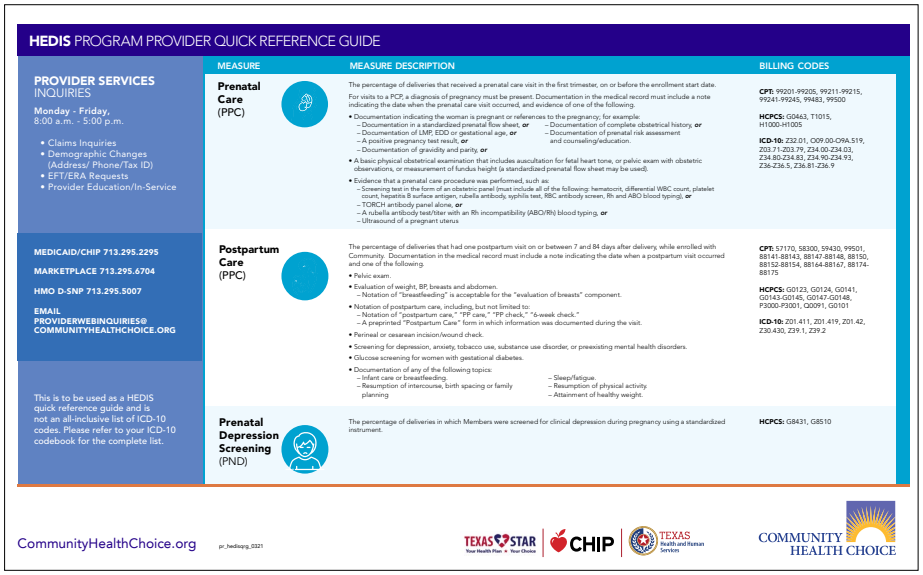
Please always follow state and/or CMS billing guidance and ensure the HEDI codes are covered prior to submission of a claim.

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.



HEDIS PROGRAM PROVIDER QUICK REFERENCE GUIDE

PROVIDER SERVICES INQUIRIES

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

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

MEDICAID/CHIP 713.295.2295

MARKETPLACE 713.295.6704

HMO D-SNP 713.295.5007

EMAIL PROVIDERWEBINQUIRIES@COMMUNITYHEALTHCHOICE.ORG

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

MEASURE	MEASURE DESCRIPTION	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. • 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. • 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). • 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. • Pelvic exam. • Evaluation of weight, BP, breasts and abdomen. – Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component. • 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. • Perineal or cesarean incision/wound check. • Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders. • Glucose screening for women with gestational diabetes. • 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
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

CommunityHealthChoice.org pr_hedisqrg_0321

TEXAS STAR Your Health Plan • Your Choice | CHIP | TEXAS Health and Human Services | COMMUNITY HEALTH CHOICE

Sports and Physical Exams

A sports and school physical is a value-added service for Community Members since it is not a covered benefit for Medicaid. Community will pay sports and school physicals for Medicaid Members ages 4 to 19 (limited one per **rolling** year). Providers must use relevant codes based on the athletic training evaluations, requiring these components:

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

Code	Level of Complexity	No. of Comorbidities	No. of Elements Addressed	Time Duration
97169	Low	0	1 – 2	15 minutes
97170	Moderate	1 – 2	3 or more	30 minutes
97171	Moderate	3 or more	4 or more	45 minutes
97172	Re-evaluation of athletic training established plan of care requiring these components: • assessment of patient's current functional status when there is a documented change • revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions			20 minutes

Health Education

Health Education, including anticipatory guidance, is one of the six primary federally mandated component of each Texas Health Steps (THSteps) medical checkup. This component includes age-appropriate counseling and health education, which assist the patient and their parent/guardian to understand the expected growth and development. The counseling and health education topics should be individualized and prioritized according to questions and concerns the patient and their parent/guardian may have as well as findings obtained during the completion of the health history and physical exam.

As a THSteps Provider, you can facilitate families to adopt healthy ways of living during your individual interaction with patients and help them to develop positive lifelong health-care habits, using the following anticipatory guidance elements:

- Family Well-Being
- Development and Behavior
- Nutrition counseling
- Routine Care
- Safety

For information on individual age-specific anticipatory guidance, please download a copy of the ***Anticipatory Guidance–Provider Guide*** at https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-anticipatory-guidance.pdf.

or

visit https://www.txhealthsteps.com/static/courses/AG-ONLINE/sections/section-1-1.html to use the THSteps on-line Anticipatory Guidance Provider Guide tool that allows quick and easy access to age-specific anticipatory guidance topics.

STAR Non-Emergency Medical Transportation Program (NEMT)

Community uses Access2Care to provide non-emergency medical transportation for STAR Members.

How Access2Care Pays for the Ride

- If your patient does not have a ride and no one can drive them, Access2care can arrange and pay for their ride on the bus or with a ride-sharing service.
- If your patient does not have a car, but someone can drive them, then Access2care will pay back the driver by the mile to take the patient to the appointment and back.
- If your patient has a car but no gas money, Access2care might pay your patient ahead of time by the mile to get them to the appointment and back. For trips that require an overnight stay, Access2care might pay for overnight lodging and meals for the patient and their parent or guardian.

How Can You Help

- Remind Community's Medicaid patients about our non-emergency transportation provided by Access2Care if they miss an appointment or whenever you schedule an appointment. Patients can schedule or cancel a ride through the Access2Care Member app or call 24/7, toll-free at 1.844.572.8194.
- Please note: Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult at the medical or dental checkup.

For more information, please visit Community's Access2Care webpage for Members at https://www.communityhealthchoice.org/texas-star-medicaid-plan/member-resources/access2care-transportation/

Community's Transportation Service for CHIP Members

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

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

Wellness Services During COVID-19

The American Academy of Pediatrics 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 checkup 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 up 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

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

To learn more, please visit Community's Provider website at https://provider.communityhealthchoice.org/coronavirus/ and 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 Documentation – Essential to Medical Records

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

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

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

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

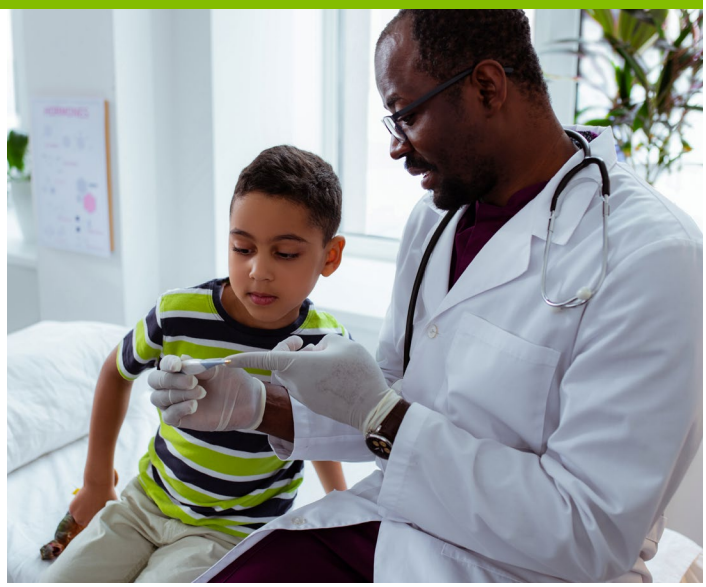
Qualified and caring THSteps Providers are vital to keeping young Texans healthy. The preventive health care you provide to young Texans is valued. It is important to reflect this care in the completeness of your medical documentation.

THSteps 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 in our online Provider Portal titled "Panel Report (Medicaid/CHIP)."



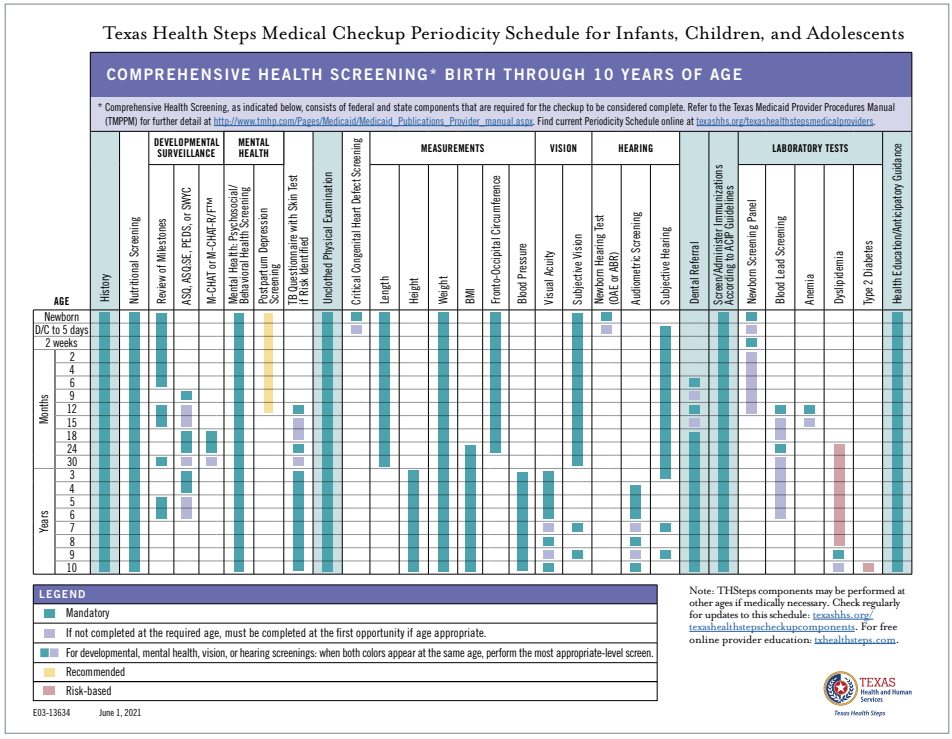
Complete before the next checkup age		
Newborn	3-5 days	2 weeks
2 months	4 months	
Complete within 60 days of these checkup ages		
6 months	9 months	12 months
15 months	18 months	24 months
	30 months	
Complete on or after the birthday but before the next birthday		
Members ages 3 through 20 need a checkup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

The Membership Panel is available on our online Provider Portal titled "Panel Report (Medicaid/CHIP)" at https://providerportal.communitycares.com/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-ste



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 texashhs.org/texashealthstepsmedicalproviders.

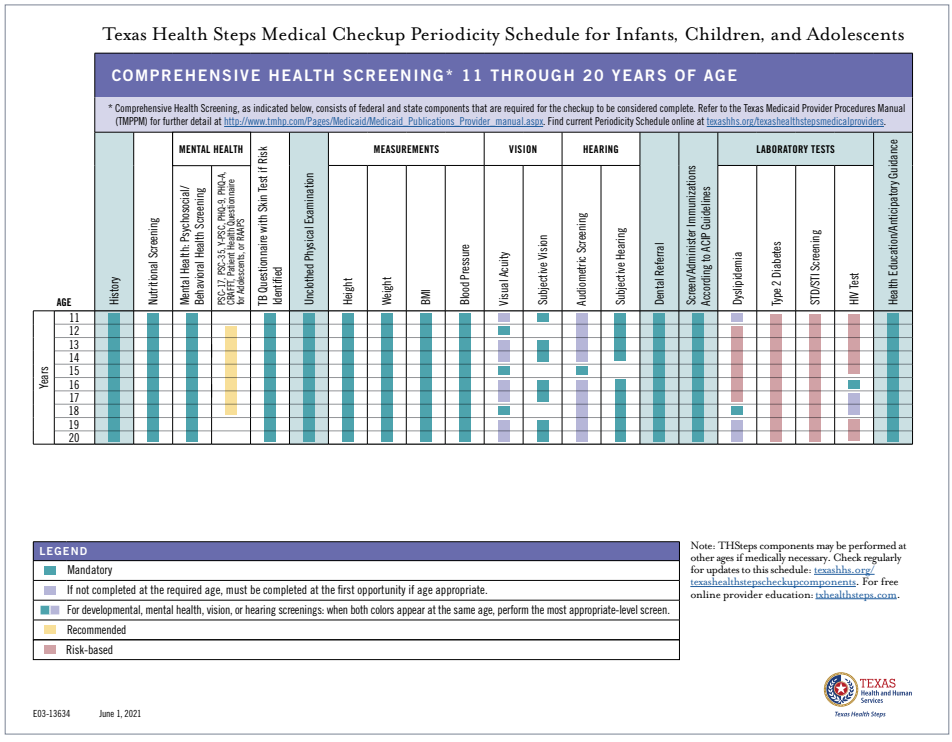
AGE	History	Nutritional Screening	DEVELOPMENTAL SURVEILLANCE: Review of Milestones	DEVELOPMENTAL SURVEILLANCE: ASQ, ASQ-SE, PEDS, or SWYC	DEVELOPMENTAL SURVEILLANCE: M-CHAT or M-CHAT-R/F™	MENTAL HEALTH: Mental Health: Psychosocial/ Behavioral Health Screening	MENTAL HEALTH: Postpartum Depression Screening	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	■								■																■				■
4	■								■																■				■
6	■								■																■				■
9	■		■	■					■																				■
12	■		■	■					■																■	■	■		■
15	■			■	■				■																				■
18	■								■																				■
24	■		■	■	■				■																			■	■
30	■								■																				■
Years 3	■		■	■	■	■		■	■			■		■			■												■
4	■								■																				■
5	■		■	■	■				■																				■
6	■								■																				■
7	■								■								■	■		■	■	■							■
8	■								■																				■
9	■								■								■	■				■							■
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: texashhs.org/texashealthstepscheckupcomponents. For free online provider education: txhealthsteps.com.

E03-13634 June 1, 2021



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 texashhs.org/texashealthstepsmedicalproviders.

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, Patient Health Questionnaire for Adolescents, or RAAPS	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	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■
12	■	■	■		■	■	■	■	■	■	■				■	■		■	■	■	■
13	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■
14	■	■	■		■	■	■	■	■	■	■				■	■		■	■	■	■
15	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
16	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■
17	■	■	■		■	■	■	■	■	■	■				■	■		■	■	■	■
18	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■
19	■	■	■		■	■	■	■	■	■	■				■	■		■	■	■	■
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: texashhs.org/texashealthstepscheckupcomponents. For free online provider education: txhealthsteps.com.

E03-13634 June 1, 2021

THSteps Medical Checkup Billing Procedure Codes

Effective August 1, 2021, TMHP updated the Texas Health Steps Quick Reference Guide. Under the column titled "Immunizations Administered," the Ebola virus vaccine (procedure code 90758) is added. To download a copy, please visit https://www.tmhp.com/sites/default/files/file-library/texas-health-steps/THSteps_QRG.pdf.

Texas Health Steps Quick Reference Guide

Remember: Use Provider Identifier • Use Benefit Code EP1

Texas Health Steps Medical Checkup Billing Procedure Codes

Texas Health Steps Medical Checkups

99381	99382	99383	99384	99385*
99391	99392	99393	99394	99395*

* For clients who are 18 through 20 years of age, use diagnosis code Z0000 or Z0001.

Texas Health Steps Follow-up Visit

Use procedure code 99211 for a Texas Health Steps follow-up visit.

ICD-10 Diagnosis Codes

Z00110	Routine newborn exam, birth through 7 days
Z00111	Routine newborn exam, 8 through 28 days
Z00129	Routine child exam
Z00121	Routine child exam, abnormal
Z0000	General adult exam
Z0001	General adult exam, abnormal

Point-of-Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

Procedure Codes	Vaccine
90632 or 90633† with (90460/90461 or 90471/90472)	Hep A
90620† or 90621† with (90460/90461 or 90471/90472)	MenB
90636 with (90460/90461 or 90471/90472)	Hep A/Hep B
90644	Hib-MenCY
90647† or 90648† with (90460/90461 or 90471/90472)	Hib
90650 or 90651† with (90460/90461 or 90471/90472)	HPV
90630, 90654, 90655†, 90656†, 90657†, 90658†, 90685†, 90686†, 90687† or 90688† with (90460/90461 or 90471/90472); 90660† or 90672† with (90460/90461 or 90473/90474); 90661, 90673, 90674, 90682 or 90756† with (90471/90472)	Influenza
90670† with (90460/90461 or 90471/90472)	PCV13
90680† or 90681† with (90460/90461 or 90473/90474)	Rotavirus
90696† with (90460/90461 or 90471/90472)	DTaP-IPV
90698† with (90460/90461 or 90471/90472)	DTap-IPV-Hib
90700† with (90460/90461 or 90471/90472)	DTaP
90702† with (90460/90461 or 90471/90472)	DT
90707† with (90460/90461 or 90471/90472)	MMR
90710† with (90460/90461 or 90471/90472)	MMRV
90713† with (90460/90461 or 90471/90472)	IPV
90714† with (90460/90461 or 90471/90472)	Td
90715† with (90460/90461 or 90471/90472)	Tdap
90716† with (90460/90461 or 90471/90472)	Varicella
90723† with (90460/90461 or 90471/90472)	DTap-Hep B-IPV
90732† with (90460/90461 or 90471/90472)	PPSV23
90733 or 90734† with (90460/90461 or 90471/90472)	MPSV4
90743, 90744†, or 90746 with (90460/90461 or 90471/90472)	Hep B
90748† with (90460/90461 or 90471/90472)	Hib-Hep B
90758 with (90471/90472)	Ebola Virus

† Indicates a vaccine distributed by TVFC

Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

Oral Evaluation and Fluoride Varnish

Use procedure code 99429 with U5 modifier.

Developmental and Autism Screening

Developmental screening with use of the ASQ, ASQ:SE, PEDS or SWYC is reported using procedure code 96110.

Autism screening with use of the M-CHAT or M-CHAT R/F is reported using procedure code 96110 with U6 modifier.

Mental Health Screening

Mental Health Screening in adolescents with the use of the PSC 17, PSC-35, Y-PSC, PHQ-9, PHQ-A (depression screen), CRAFFT, PHQ-A (Anxiety, mood, substance use) or RAAPS is reported using procedure code 96160 or 96161. Only one procedure code (96160 or 96161) may be reimbursed per client per calendar year.

Postpartum depression screening with the use of a validated screening tool including the Edinburgh Postnatal Depression Scale, PHQ-9 or Postpartum Depression Screening Scale is reported using procedure code G8431 or G8510. Only one procedure code (G8431 or G8510) may be reimbursed per client.

Modifiers

Performing Provider

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

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

Exception to Periodicity

Use with Texas Health Steps medical checkups procedure codes to indicate the reason for an exception to periodicity.

23 (Unusual Anesthesia)	32 (Mandated Services)	SC (Medically Necessary)

FQHC and RHC

Federally qualified health center (FQHC) providers must use modifier EP for Texas Health Steps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for Texas Health Steps medical checkups.

Vaccine/Toxoids

Use to indicate a vaccine/toxoid *not available* through TVFC and the number of state defined components administered per vaccine.

U1	Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available

Vaccine Administration and Preventive E/M Visits

Use with Texas Health Steps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.

25	Significant, separately identifiable evaluation

Condition Indicator Codes

One of the Condition Indicators below is required whether a referral was made or not.

Referral Status	Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

Texas Health Steps Quick Reference Guide - revised 08/01/2021 1

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, **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 4th birthday, if the child is a member of a traveling family that is leaving the area. Providers must use the CPT modifier "32" when providing accelerated services outside of the periodicity schedule.

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

If you have any patients from Community that meet these criteria, please refer them to Wellness Services at 713.295.6789. Our goal is to arrange for all healthcare services they may need before they leave for the new job.

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 31st of each calendar year. If you have any questions, please contact your Provider Engagement Representative.

Online Provider Education - Free Continuing Education (CE) Hours

Texas Health Steps' online program offers more than 60 CE-accredited courses that cover a broad array of health topics. These topics range from wellness and prevention essentials, like breastfeeding and immunization, to specialized courses about treating children with asthma, diabetes, high blood pressure, and many other chronic health conditions. **First-time users will need to register**. These 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
https://www.txvendordrug.com/providers/prescriber-education-and-training.

SERVICE AREA MAP

MEDICAL AFFAIRS

Peer-to-Peer Discussions: 713.295.2319

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