Provider Newsletter

V3-2022

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.

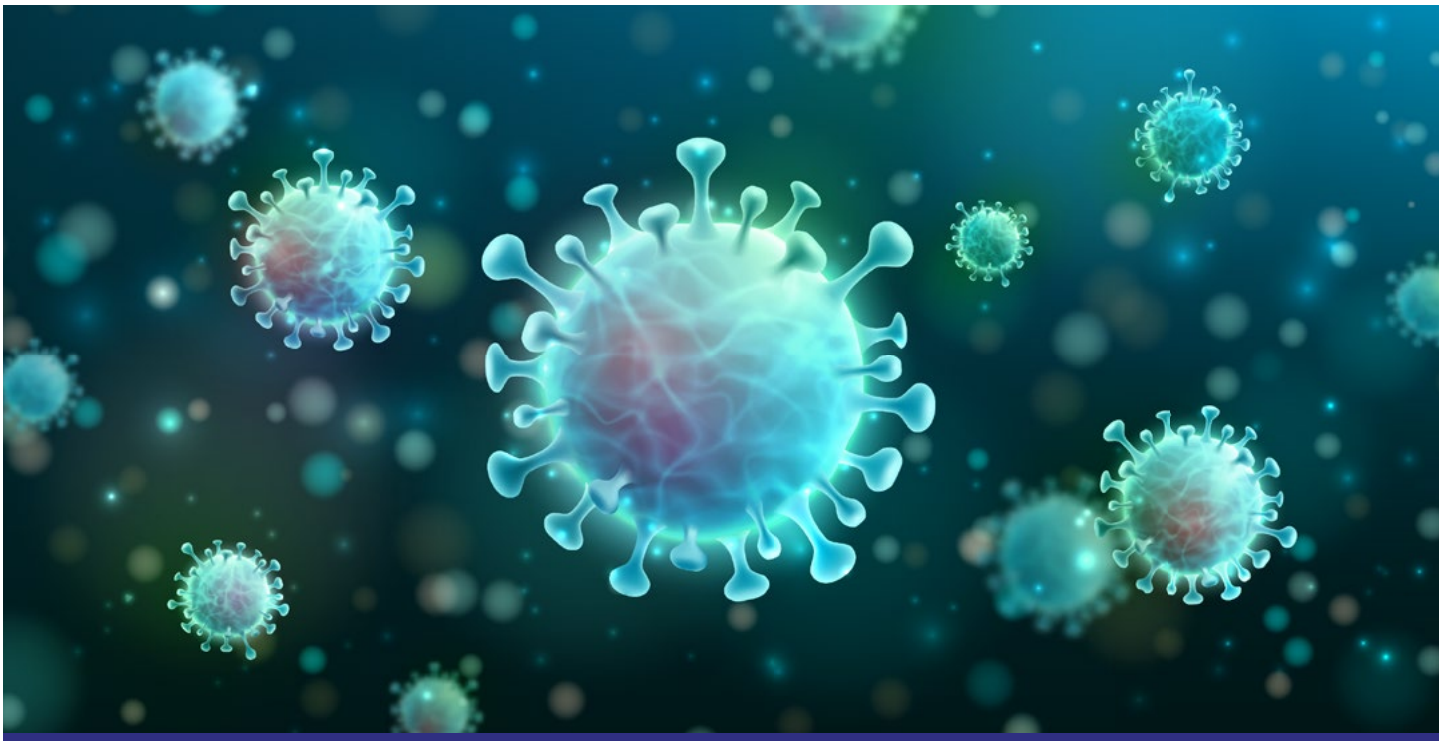
What program does this impact?

- 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.



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.

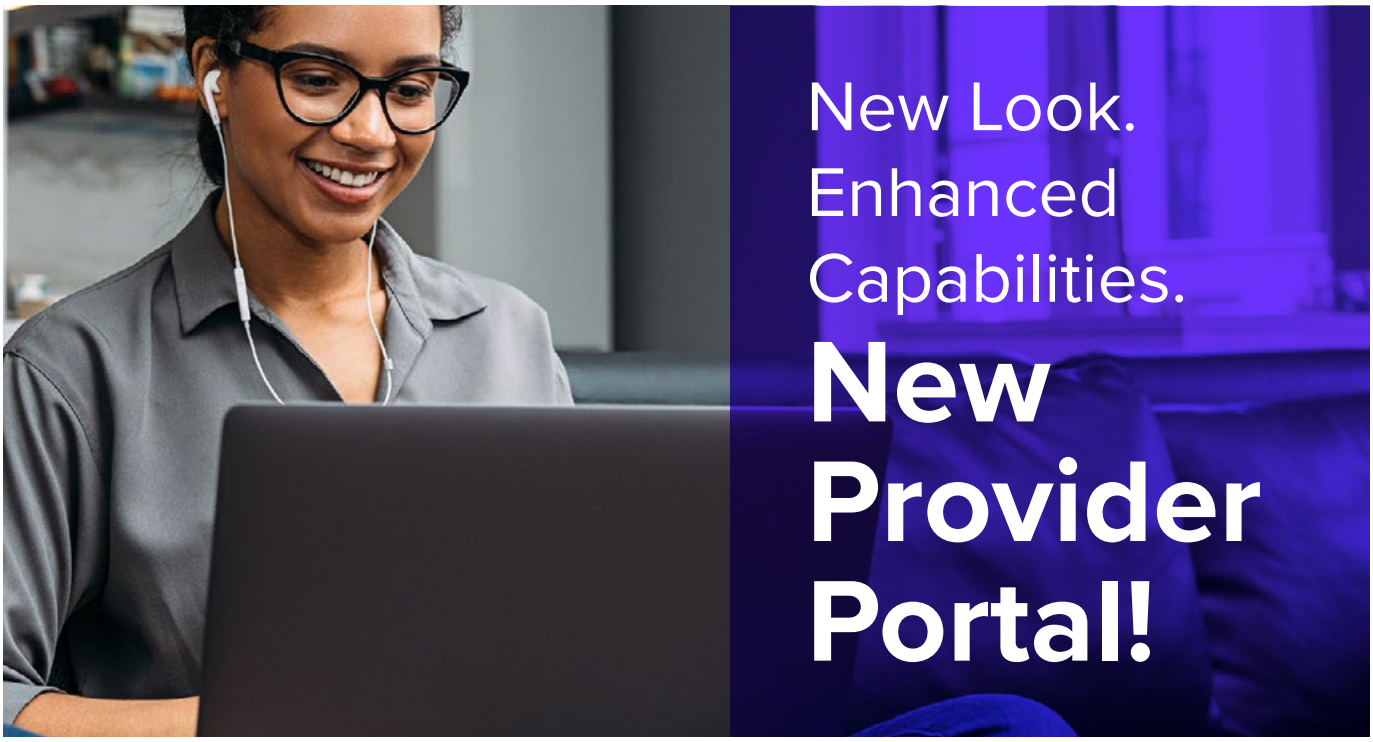
Please visit our website where you will find a page dedicated to COVID-19 with the most current information, updates, and resources: https://provider.communityhealthchoice.org/coronavirus/.

Case Management for Children and Pregnant Women

CHANGES EFFECTIVE SEPTEMBER 1, 2022

Case Management for Children and Pregnant Women is a Medicaid State Plan benefit that assists children and pregnant women in gaining access to necessary medical, social, educational, and other service needs related to the person's health condition, health risk or high-risk condition. Providers who render CPW services must be a registered nurse or licensed social worker.

Community Health Choice will provide service coordination for CPW through a case manager. The case manager is responsible for providing service coordination and care management to Members. The case manager will work in conjunction with Members and their designated representatives and Providers to determine needs through the use of assessment tools and Service & Care Planning. A case manager can be reached at 713.295.2303 or 1.855.315.5386.



Existing Provider portal users: You will receive a link to change your password and will automatically receive access to the new Provider portal.

The username for the new Provider portal must be in an email domain, which is different than the current Provider portal user name: https://providerportal.communityhealthchoice.org/Providers/Secure/Provider_Default.aspx

You will have the same access as your previous portal experience, with these enhancements:

- New self-service capabilities, including the ability to manage/maintain users, as well as granting access, adjusting access, and removing access
- Reference numbers for eligibility verifications, prior authorizations, and any questions asked via the portal
- Log history for claims manager–claim submissions, status of claims submitted, authorization history, training and attestation, therapy waitlist history, and member eligibility search history
- Some forms in automation vs. printing and faxing or uploading with many more coming soon!

Questions: Email ProviderPortalAccessRequest@CommunityHealthChoice.org

Important Reminders:

1. Please ensure to submit your claims to the appropriate Payer ID/ Claims Address:

HHSC

Electronic Payer ID: 48145

Claims Mailing Address: Community Health Choice
P.O. Box 301404
Houston, TX 77230-1404

Marketplace

Electronic Payer ID: 60495

Claims Mailing Address: Community Health Choice
P.O. Box 301424
Houston, TX 77230-1424

2. Please ensure to submit your Claims Payment Reconsiderations accordingly:

HHSC

Requests for reconsideration must be made within 120 days from the date of the Explanation of Payment (EOP). Please use the form at communityhealthchoice.org > Provider > Forms and Guides > Provider Payment Dispute Form. Include copy of Community Health Choice EOP along with all supporting documentation, e.g., office notes, authorization and practice management print screens.

Mail to: Community Health Choice
Attn: Claims Payment Reconsideration
2636 S. Loop West, Suite 125
Houston, TX 77054

Email: ProviderWebInquiries@CommunityHealthChoice.org

Marketplace

Requests for reconsideration must be made within 180 days from the date of the Explanation of Payment (EOP). Please use the form at communityhealthchoice.org > Provider > Forms and Guides > Provider Payment Dispute Form. Include copy of Community Health Choice EOP along with all supporting documentation, e.g., office notes, authorization and practice management print screens.

Mail to: Community Health Choice
Attn: Claims Payment Reconsideration
2636 S. Loop West, Suite 125
Houston, TX 77054

Email: ProviderWebInquiries@CommunityHealthChoice.org

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. • To avoid delayed payments, please ensure the appropriate units on claims submissions, untimed units should be billed as 1 unit.
Skilled Nursing Facility	Revenue Codes	Not billing with appropriate codes	Bill appropriate (subacute) level of care revenue codes

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.

Perinatal Transmission of HIV

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

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.

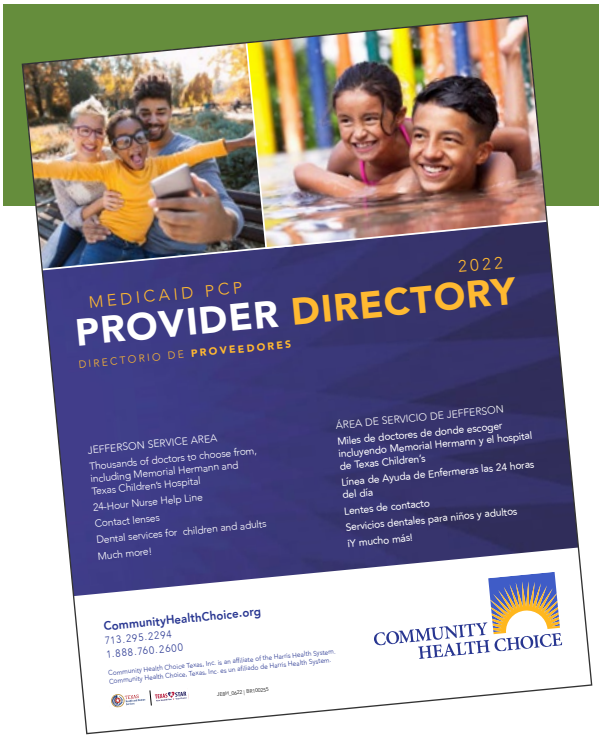
Please be aware that **all** genetic and molecular lab testing requires prior authorization with the exception of the following:

- 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.



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.

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

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.

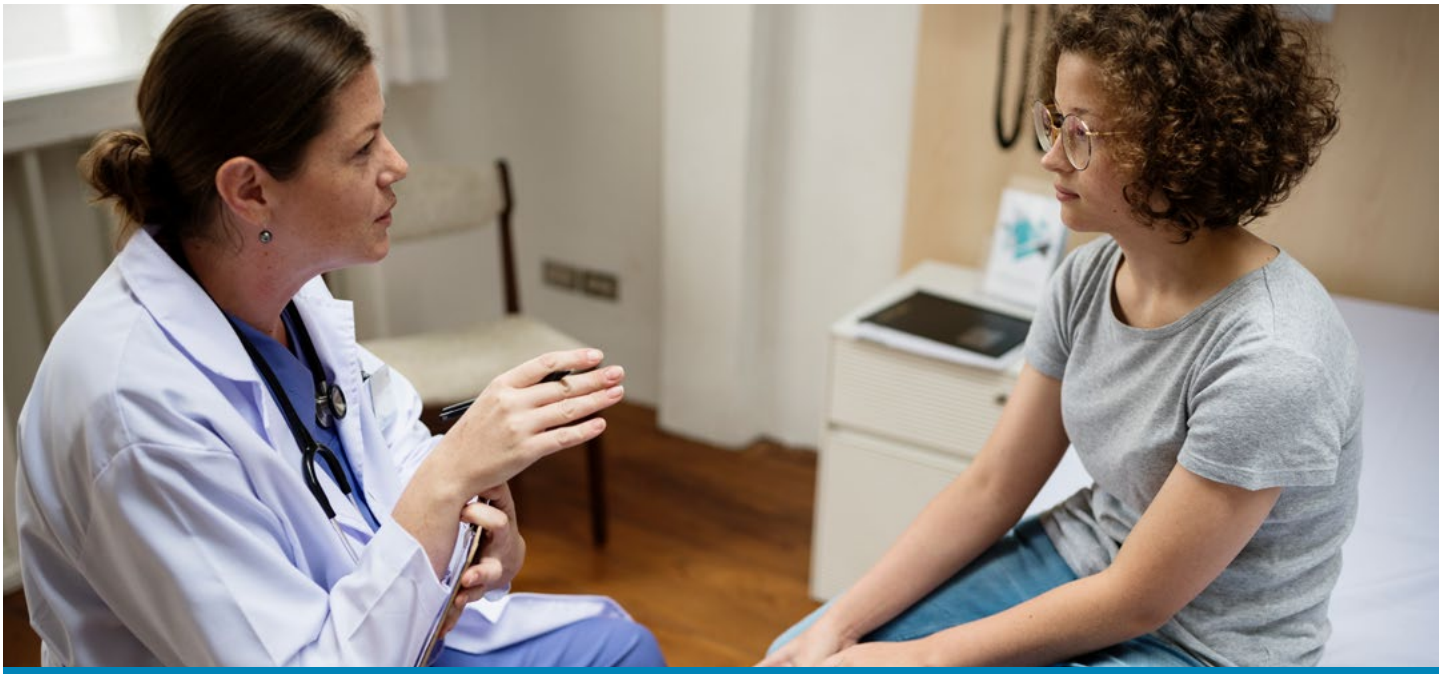
Unacceptable after-hours coverage

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



Teen Nutrition and Annual Physical

Annual physical for adolescent is important to assess their development. Pediatricians should assess adolescent development related to hormonal changes, behavior and emotional stressors, nutrition and exercise, hygiene, sleep patterns, safety, and vaccinations. This article will focus on adolescent physical assessment related to nutrition. Adolescent nutrition has gained attention in the pass years due to ever increasing adolescent obesity from lack of physical activity and poor nutrition. Unfortunately, some physicians are not comfortable in discussing weight issues with teenagers. In addition, pediatricians are limited to the time spent with the adolescent patients to discuss sensitive topics such as obesity.

Obese adolescent have low self-esteem and are prone to being teased and bullied by their peers. Some are prone to depressions or anger issues. A professional team approach headed by the pediatrician is necessary to provide a well-rounded plan of care that will yield a positive result for the adolescent. The treatment plan should focus on open discussion with the family and the adolescent to ensure cooperation of both parties. Focus on lifestyle issues rather than calorie count. To build self-esteem and gain cooperation, allow the adolescent to voice his/her preference related to the treatment plan. Parents play an important role by modeling proper eating habits and participating in physical activities. Incorporating behavioral therapy to allow the adolescent to voice his/her anxiety in a safe environment and provide appetite awareness training. Despite achieving the goal, therapy should continue until the adolescent is able to manage his weight on his own. Visits to the pediatrician to monitor the adolescent's health and weight should continue according to the pediatrician prescribed visit frequency.

Teen Vaccinations

Providers have the responsibility to inform parents and teens the importance of immunization by presenting evidence-based information about vaccine safety and potential side effects. There are various ways Providers can influence teen vaccinations:

- Refer teens to vaccine centers with programs geared to relate concerns with vaccinations.
- Brochures are also instrumental in providing information that can encourage teens to obtain their vaccinations.
- Provider office sends reminders to parents regarding required vaccinations as they come due with specific information about each vaccine.
- Providers can also refer both teens and parents to websites discussing vaccine issues, questions and answers, and other vaccine resources.

Websites:

Vaccinate Your Family

https://vaccinateyourfamily.org/which-vaccines-does-my-family-need/preteens-teens/?gclid=CjwKCAjwk_WVBhBZEiwAUHQCmfcCrB-j9fMsUkbTqAAn_dVpqs1wo09SfrSy1jPPv3ocoiO27pG-_hoC1TUQAvD_BwE

American Academy of Pediatrics

https://www.aap.org/en/patient-care/immunizations/

Quality Improvement Program Data Usage

As a participating Provider/Practitioner in the Community Health Choice Network, you agree to cooperate in Quality Improvement programs to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. Community Health Choice may use provider/practitioner performance data for quality improvement activities.

Post-Partum Care for High-Risk Mothers

Maternal care for high risk postpartum patients is difficult and complex. High-risk postpartum patients often come frnm low income households, minorities and residing in rural communities that have limited access to specialists and medical services. Those limitations lead to multiple chronic medical conditions causing higher morbidity and mortality post-delivery.

Obstetricians and/or family physicians must be pro-active in preventing complications during and after pregnancies. To achieve optimal postpartum health, physicians must educate patients to schedule more frequent visits to the doctor leading to early detection of possible complications before and after delivery. Besides screening for health issues that can complicate the pregnancy and delay postpartum recovery, physicians should screen for social determinants that can also lead to stress and depression such as:

- Food insecurity
- Lack of access to transportation
- Safe and clean housing
- Financial insecurity
- Violence and/or abuse
- Lack of education on how to properly care for the newborn baby

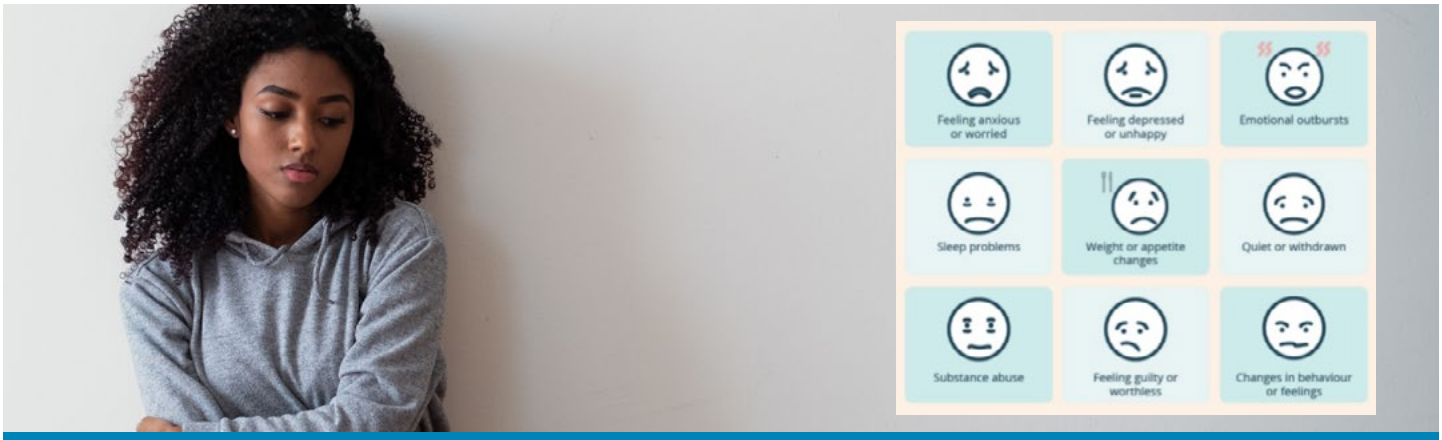
Physicians have the responsibility to refer patients to appropriate social services that can assist in providing the social and financial support for both mother and baby. Those referrals can lead to access nondinical and community-based services such as, affordable day care for the baby and mother support groups. Referral to a home visiting nurse is also helpful to monitor the high-risk mother and baby's health conditions, provide on hand education as needed and ensure both mother and baby are committing to the required clinical appointments. The visiting nurse can also facilitate continued communication with the primary physician to report the mother and baby's health conditions that may require intervention from other health specialists. In addition, creating postpartum care plans can also assist in a smooth transition from postpartum care to well-woman care.

Post-Partum Care Plan

Components of a postpartum care plan are (American College of Obstetricians and Gynecologist, May 2018)

Team Member	Role
Family and friends	• Ensures woman has assistance for infant care, breastfeeding support, care of older children • Assists with practical needs such as meals, household chores, and transportation • Monitors for signs and symptoms of complications including mental health
Primary maternal care provider (obstetrician-gynecologisct, certified nurse midwife, family physician, women's health nurse practitioner)	• Ensures patient's postpartum needs are assessed and met during the postpartum period and that the comprehensive postpartum visit is completed • "First call" for acute concerns during postpartum period • Also may provide ongoing routine well-woman care after comprehensive postpartum visit
Infant's health care provider (pediatrician, family physician, pediatrician nurse practitioner)	• Primary care provider for infant after discharge from maternity care
Primary care provider (also may be the obstetric care provider)	• May co-manage chronic conditions (hypertension, diabetes, depression) during postpartum period • Assumes primary responsibility for ongoing healthcare after comprehensive postpartum visit
Lactation support (professional IBCLC, certified counselors and educators, peer support)	• Provides anticipatory guidance and support for breastfeeding • Co-manages complications with pediatric and maternal care providers
Care coordinator or case manager	Coordinates health and social services among members of postpartum care team
Home visitor (Nurse Family Partnership, Health Start)	Provides home visit services to meet specific needs of mother-Infant dyad after discharge from maternity care
Specialty consultant (maternal-fetal medicine, internal medicine subspecialist, behavioral healthcare provider)	• Co-manages complex medical problems during postpartum period • Provides pre-pregnancy counseling for future pregnancies

Elements	Components
Care team	Name, phone number, and office or clinic address of each member of care team
Postpartum visits	Time, date, and location of postpartum vlsit(s); phone number to call to schedule or reschedule appointments
Infant feeding plan	Intended method of infant feeding, resources for community support (eg, WIC, Lactation Warm Lines, Mothers' groups), return-to-work resources
Reproductive life plan and commensurate contraception	Desired number of children and timing of next pregnancy Method of contraception, instructions for when to initiate, effectiveness, potential adverse effects, and care team member to contact with questions
Pregnancy complications	Pregnancy complicationa and recommended follow-up or test results (eg, glucose screening for gestational diabetes, blood pressure check for gestational hypertension), as well as risk reduction recommendations for any future pregnancies
Adverse pregnancy outcomes associated with ASCVD	Adverse pregnancy outcomes associated with ASCVD will need baseline ASCVD risk assessmenat, as well as discussion of need for ongoing annual assessment and need for ASCVD prevention over lifetime
Mental health	Anticipatory guidance regarding signs and symptoms of perinatal depression or anxiety; management recommendations for women with anxiety; depression, or other psychiatric issues identified during pregnancy or in the postpartum period
Postpartum problems	Recommendations for management of postpartum problems (eg, pelvic floor exercises for stress urinary incontinence, water-based lubricantf or dyspareunia)
Chronic health conditions	Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up



Special Populations and Behavioral Health

Individuals with behavioral health issues are a special population who need extra time and diligence to ensure they get the care they need.

There are several different types of behavioral health disorders. These include but are not limited to:

1. **Substance abuse**: involves using legal or illegal substances to a level of psychological or physiological dependence
2. **Eating disorders**: involves any severe and persistent disturbance in eating behaviors and distressing thoughts or emotions about food and body image
3. **Addiction**: a treatable, chronic medical disease where a person engages in compulsive behaviors due to psychological or physiological dependence
4. **Depression**: involves feelings of sadness, worthlessness, and hopelessness that interferes with your ability to work, sleep, or enjoy life
5. **Anxiety disorder**: involves feelings of worry and fear that interfere with your ability to sleep, work, and enjoy life

It is important to recognize symptoms of behavioral health issues in your patients and help them get the treatment they need. Sadly, these disorders often go undiagnosed as patient often do not know they have a problem or are afraid to speak out.

Recognizing symptoms such as sadness, anxiousness, sleep problems, changes in behaviors, weight gain or loss, lack of energy, and more, can be helpful in diagnosing your patients.

Things you can do:

1. Utilize Community Health Choice's Primary Care Provider Toolkit for guidelines and use screening tools at each visit to help diagnose issues like anxiety and depression
   - **Depression screening:** The Beck Depression Inventory (BDI), BDI interactive Tool, The Hamilton Depression Scale (HAM-D), Patient Health Questionnaire-9 (PHQ-9)
   - **Anxiety screening:** GAD-7 (For Generalized Anxiety Disorder)
2. Ask patients specific questions about their mental health and emphasize that mental health is equal to physical health
3. Encourage patients to be open about their mental health by reassuring them that this is a judgement free zone
4. Provide accessible learning materials about behavioral health disorders to patients
5. Be honest about treatment options
6. Bridge the gap between primary care and specialty care depending on patient needs
7. Show compassion as these patients are often the most vulnerable
8. Emphasize how all health information is confidential and details of mental or behavioral health issues will not be shared with anyone

Following these steps will help your patients feel safe, comfortable, and more willing to seek out help.

Seven- and 30-Day Followup After Hospitalization for Mental Illness

HOW COMMON IS MENTAL ILLNESS?

1 in 5 U.S. adults experience mental illness each year

1 in 20 U.S. adults experience serious mental illness each year

1 in 6 U.S. youth ages 6-17 experience a mental health disorder each year

50% of all lifetime mental illness begins by age 14 and 75% by age 24

Suicide is the **second leading** cause of death among people ages 10-34

Data retrieved 06/10/2022 from https://www.nami.org/mhstats.

WHAT ISSUES CAN AFFECT MENTAL ILLNESS?

- Discovering mental illness early
- Taking medications as prescribed
- Having other diseases or conditions in addition to mental illness
- Getting timely care for other health needs

WE NEED YOUR HELP TO:

PARTNER

Work with the Member to develop a treatment plan and assess their medication along with the side effects

COLLABORATE

Assist member with finding community resources for additional support, as well as offer 24/7 toll-free urgent support if the Member is experiencing thoughts of harming themselves or others

- National Suicide Prevention Lifeline – 800.273.TALK (8255)
- Dial 211 or visit 211 online
- National Alliance on Mental Illness – text 741.741 or call 800.950.NAMI (6264)

Utilize Community's Behavioral Health Case Management Program

- Member may self-refer to any in-network behavioral health Provider **No prior approval is required from primary care Providers**
- Member may call Community at 713.295.6704
- Providers may call Provider Services at 713.295.6704
- Providers may fax referral information to our dedicated behavioral health team at 713.576.0932 (inpatient) or 713.576.0930 (outpatient)

ENGAGE

- Provide Member reminder calls within 24 hours to confirm appointments
- Schedule the next follow-up appointment before the Member leaves the office
- Reach out within 24 hours if the Member does not keep scheduled appointment to schedule another appointment

WHY DO WE NEED YOUR HELP FOR MEMBER FOLLOW-UP CARE?

- To reduce the risk of readmissions
- To decrease the chance for confusion or gaps with medications
- To detect early complications or outstanding care needs
- To enhance patient- Provider relationship

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 has 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 Health Choice's Primary Care Provider 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 the 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)

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

Billing THSteps Medical Checkup and Other Services on the Same Day

A. THSteps Medical Checkup and Immunization Administration on the Same Day

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

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

B. THSteps Medical Checkup and Acute Care Visit on the Same Day

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

C. THSteps Medical Checkup and Sports and School Physical on the Same Day

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

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.

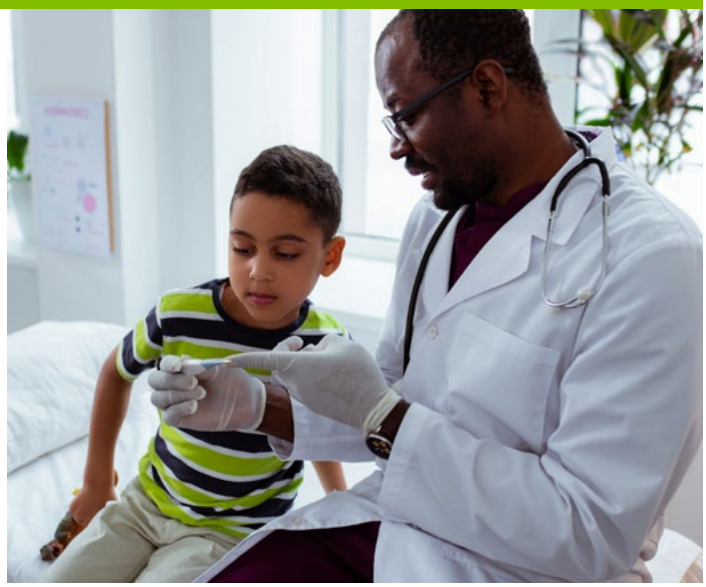
For more information, please visit Community's Access2Care webpage for Members at https://www.communityhealthchoice.org/texas-star-medicaid-plan/member-resources/access2care-transportation/

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.

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)."

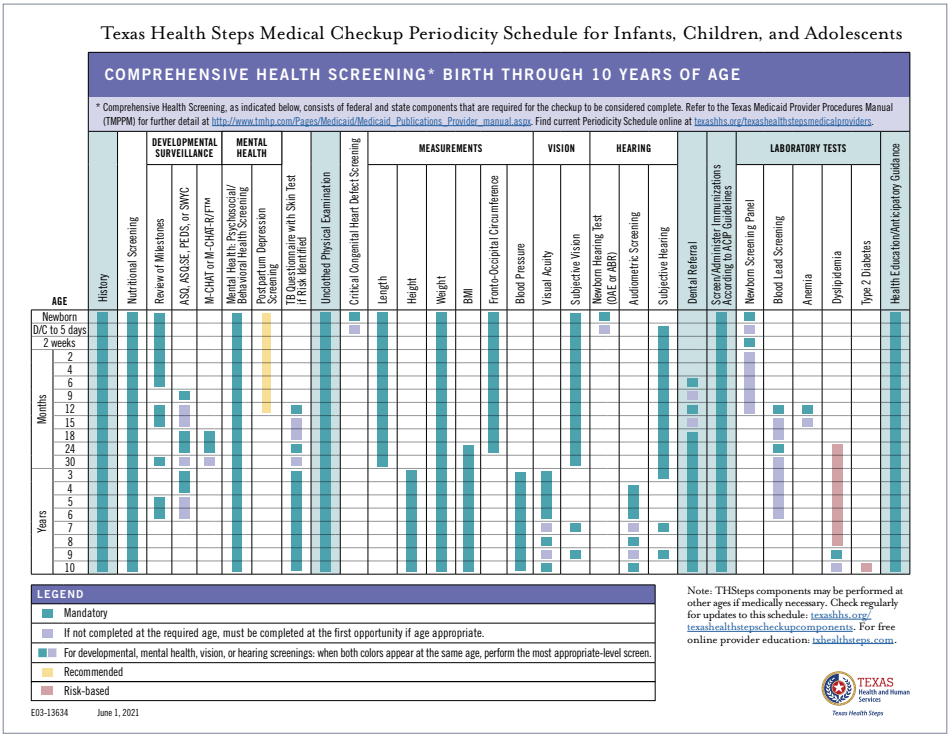
Complete before the next checkup age		
Newborn	3-5 days	2 weeks
2 months	4 months	
Complete within 60 days of these checkup ages		
6 months	9 months	12 months
15 months	18 months	24 months
	30 months	
Complete on or after the birthday but before the next birthday		
Members ages 3 through 20 need a checkup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



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

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

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

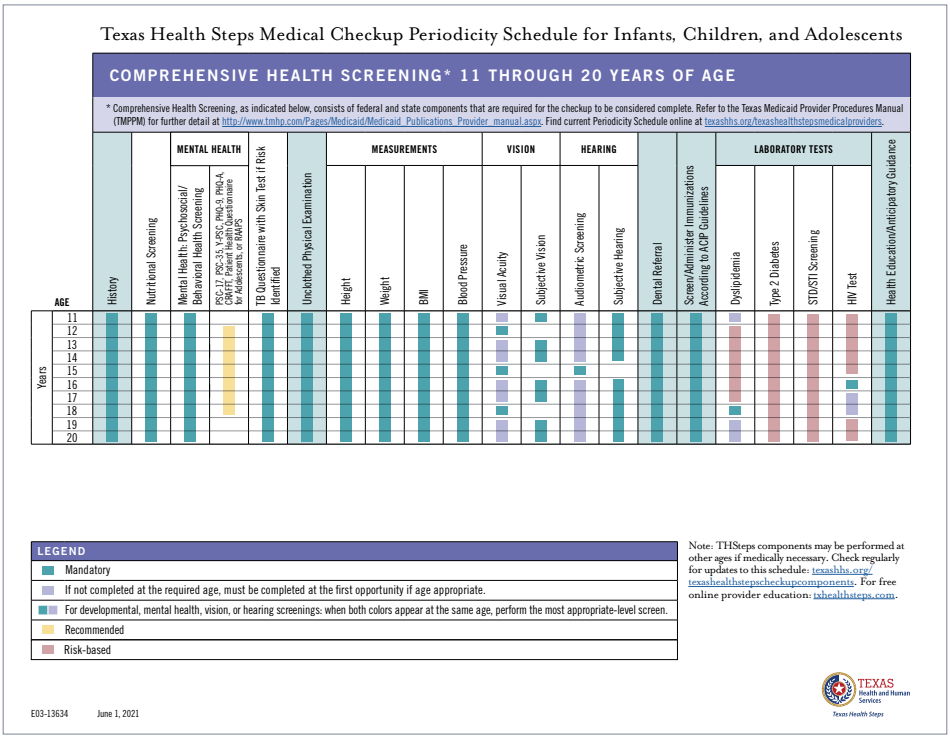
AGE	History	Nutritional Screening	DEVELOPMENTAL SURVEILLANCE: Review of Milestones	DEVELOPMENTAL SURVEILLANCE: ASQ, ASQ-SE, PEDS, or SWYC	DEVELOPMENTAL SURVEILLANCE: M-CHAT or M-CHAT-R/F™	MENTAL HEALTH: Mental Health: Psychosocial/ Behavioral Health Screening	MENTAL HEALTH: Postpartum Depression Screening	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	■		■			■			■									■						■						■
Months 4	■					■			■									■						■						■
Months 6	■					■			■									■						■						■
Months 9	■		■	■		■			■									■						■						■
Months 12	■		■	■		■		■	■									■						■	■	■	■			■
Months 15	■		■	■		■		■	■									■						■	■	■	■			■
Months 18	■		■	■	■	■		■	■									■						■	■	■	■			■
Months 24	■		■	■	■	■		■	■					■				■						■	■	■	■			■
Months 30	■		■	■	■	■		■	■									■						■	■	■	■			■
Years 3	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 4	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 5	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 6	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 7	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 8	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 9	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■
Years 10	■		■	■	■	■		■	■			■				■		■						■	■	■	■			■

LEGEND

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

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: 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	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■
Years 12	■	■	■		■	■	■	■	■	■	■				■	■	■	■	■	■	■
Years 13	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■
Years 14	■	■	■		■	■	■	■	■	■	■				■	■	■	■	■	■	■
Years 15	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 16	■	■	■		■	■	■	■	■	■	■	■			■	■	■	■	■	■	■
Years 17	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 18	■	■	■		■	■	■	■	■	■	■	■			■	■	■	■	■	■	■
Years 19	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Years 20	■	■	■		■	■	■	■	■	■	■	■			■	■	■	■	■	■	■

LEGEND

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

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: texashhs.org/texashealthstepscheckupcomponents. For free online provider education: txhealthsteps.com.

E03-13634 June 1, 2021

THSteps Medical Checkup Billing Procedure Codes

TMHP updated the Texas Health Steps Quick Reference Guide. Under the column titled "Immunizations Administered", pneumococcal vaccine procedure codes 90671 and 90677 is added. The procedure codes became benefits of Texas Medicaid for members who are 18 years of age or older. 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
90619† with (90460/90461 or 90471/90472)	MenACWY-TT
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
90647† or 90648† with (90460/90461 or 90471/90472)	Hib
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
90671 with (90471/90472)	PCV15
90677 with (90471/90472)	PCV20
90680† or 90681† with (90460/90461 or 90473/90474)	Rotavirus
90696† with (90460/90461 or 90471/90472)	DTaP-IPV
90697† or 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
90734† with (90460/90461 or 90471/90472)	MPSV4
90739, 90743, 90744†, 90746 , or 90759 with (90460/90461 or 90471/90472)	Hep B
90758 with (90471/90472)	Ebola Virus

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

† Indicates a vaccine distributed by TVFC

Texas Health Steps Quick Reference Guide - revised 09/01/2022 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.

DME Documentation

Dear Provider:

The Community Health Choice (Community) SIU (Special Investigation Unit) is responsible for the identification and investigation of potential fraud, waste, 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 regarding DME documentation requirements.

Medical records must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

Standard written orders should include but is not limited to:

- Member's name or Member identification number
- Order date
- General description of the item
- Quantity to be dispensed, if applicable
- Treating practitioner name and/or National Provider Identifier (NPI)
- Treating practitioner's signature
- Prior authorization, when applicable
- Appropriate refill
- Proof of delivery
- Continued need
- Continued use

Community's SIU reviews medical records to ensure medical documentation meets requirements per the Centers for Medicare & Medicaid Services (CMS) and the Texas Administrative Code (TAC). The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item has been met. If the information in the medial record does not adequately support the services billed, the associated claims may be denied.

Reference: Medicare Program Integrity Manual Chapter 5 – Durable Medical Equipment
https://www.cms.gov/regulations-and-Guidance/guidance/manuals/downloads/pim83c05.pdf

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/

Training on Childhood Anxiety Disorders

Texas Health and Human Services offers a free continuing education course on childhood anxiety disorders.

An estimated one-third of adolescents experience an anxiety disorder, but the majority do not receive treatment. This course provides guidance about identifying and managing childhood anxiety, including making referrals and providing ongoing care in a primary care setting.

https://www.txhealthsteps.com/618-childhood-anxiety-disorders?utm_source=courseannouncement&utm_medium=email&utm_campaign=CANX-other

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