

Provider Newsletter

V1-2023



[CommunityHealthChoice.org](https://www.CommunityHealthChoice.org)

713.295.2295 | 1.888.760.2600 (Medicaid/CHIP)

713.295.6704 (Marketplace)

713.295.5007 (HMO D-SNP)



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Feedback

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



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.

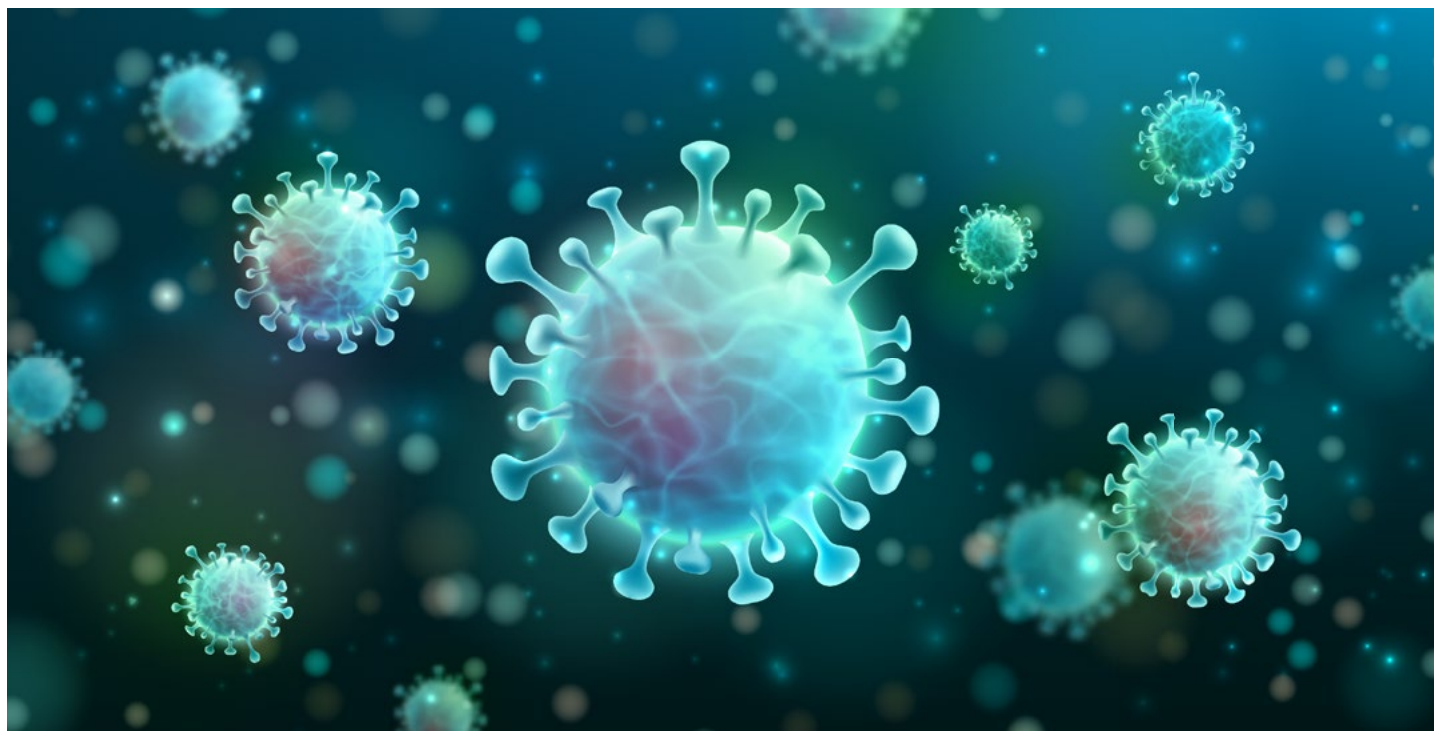
What program does this impact?

- 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/>.



Prepare our Members for the End of the Public Health Emergency

Since March 2020, HHSC Members' benefits have been auto-renewed due to the COVID-19 pandemic being classified as a public health emergency (PHE). Although a date hasn't been determined, the PHE will end eventually—maybe in early 2023. When it does end, HHSC plan recipients will:

1. Go through a “redetermination” process to see what health coverage they qualify for now.
2. Resume recertifying for their benefits every year.

Based on the most recent data, HHSC estimates as many as 3.7 million recipients will need to have their Medicaid eligibility redetermined when continuous coverage ends, with 2.97 million of these individuals extended due to the requirements to provide continuous Medicaid coverage until the end of the PHE.

Community estimates our number of affected Members at 60,000. Help us educate them.

1. Review HHSC's frequently asked questions (FAQ) below.
2. Direct them to our PHE microsite for up-to-date information: <https://www.communityhealthchoice.org/public-health-emergency/>

What is the PHE, and why is it important for my benefits?

In response to the COVID-19 pandemic, the federal government declared a public health emergency (PHE) and passed a law that allowed you to automatically keep your Medicaid coverage since March 2020.

When will automatic coverage for Medicaid end?

The timing is unknown, but HHSC may soon be directed to end Medicaid coverage for recipients who are not eligible but continued to be covered due to the PHE.

HHSC will review your information to determine if your coverage will continue. If you don't respond to renewal or information requests from HHSC, you may lose benefits when automatic coverage ends.

If you receive a notice from HHSC that says you still have benefits but are no longer eligible, you may lose benefits when automatic coverage ends.

Please complete and submit the renewal packet that is sent to you. **The best way to complete your renewal is online at YourTexasBenefits.com.** You can also submit your information by mail or fax, or by calling 2-1-1 and selecting option 2 after selecting a language.

What should I do now to ensure my Medicaid coverage continues if I am eligible?

You should respond to any request HHSC sends you. When you get a notice that your renewal is due, follow the instructions to complete and return the information. If you don't do this, you may lose your Medicaid coverage. Please complete and submit the renewal packet that is sent to you.

The best way to complete your renewal is online at YourTexasBenefits.com.

You can also submit your information by mail or fax, or by calling 2-1-1 and selecting option 2 after selecting a language.

Create a Your Texas Benefits online account or download the Your Texas Benefits mobile app to view your account information, update your contact information and respond to requests from HHSC. Visit YourTexasBenefits.com to get started. You can also sign up for electronic notices to stay informed about your case.

You must continue to report all changes and return all requested information, including renewal forms. You can report a change by going online to YourTexasBenefits.com, through the mobile app, or by calling 2-1-1 and selecting option 2 after selecting a language.

Why is it important for me to renew my coverage now?

If you are eligible, completing your renewal now will help make sure you don't lose your coverage later or have a gap in coverage. If you renew your coverage now, you will not need to renew your benefits again until your certification period ends.

How do I know if I need to renew my Medicaid coverage?

Check if it is time for you to renew by logging in to your account on YourTexasBenefits.com or the mobile app, or by calling 2-1-1 and selecting option 2 after selecting a language.

What happens after I turn in my renewal?

HHSC will review your renewal and may ask for missing information or information not available from other sources. If you remain eligible, you will receive a notice from HHSC that says your Medicaid eligibility is renewed and will continue until it is time to renew again. If we find you are not eligible or if you do not return your renewal, HHSC will continue to send you renewal packets every six months until continuous coverage ends or until you are determined eligible again. When continuous coverage ends, HHSC will review your eligibility again. If you are ineligible, your coverage will end.

Please complete and submit the renewal packet that is sent to you. **The best way to complete your renewal is online at YourTexasBenefits.com.** You can also submit your information by mail or fax, or by calling 2-1-1 and selecting option 2 after selecting a language.

If I am determined ineligible for Medicaid, do I have to apply for other benefits?

During the Medicaid renewal process, HHSC will evaluate your eligibility for other HHS programs, such as CHIP. You will receive a notice if you are moved to a different type of assistance.

What is the best way to ensure that I stay up to date on my benefits?

Create a Your Texas Benefits online account. You can view your account information, update your contact information, submit a renewal and respond to requests from HHSC. You can also sign up for electronic notices to stay informed about your case.

Visit YourTexasBenefits.com to get started.

I submitted a renewal, and I received a notice saying I'm not eligible for coverage after the PHE. I think I am eligible, what can I do?

You may appeal any case decision that is incorrect by coming into a local office or by calling 2-1-1 and selecting option 2 after selecting a language. If you aren't able to resolve your issue through the appeals process or if you have a complaint about an HHS program, service or benefit that has not been resolved to your satisfaction, you can send a question or file a complaint with the Office of the Ombudsman by doing one of the following:

- Call: 877-787-8999 (8 a.m. to 5 p.m., Central Time, Monday through Friday)
- Go online: hhs.texas.gov/ombudsman
- Fax: 888-780-8099 (toll-free)
- Mail: Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P.O. Box 13247
Austin, Texas 78711-3247

I get SNAP benefits. Will my SNAP benefits change when the PHE ends?

Beginning in April 2020, SNAP recipients began receiving the maximum benefit amount for their income size. This was called an emergency allotment. This could continue each month until the PHE ends. SNAP recipients will receive a notice the month before the emergency allotment will end.

I get TANF benefits. Will my TANF benefits change when the PHE ends?

No. If you are currently receiving TANF, your benefits will not change because of the end of continuous coverage. Is my child's CHIP coverage impacted by the end of the PHE? No. If your child is eligible for CHIP, your coverage will not change because of the end of continuous coverage.

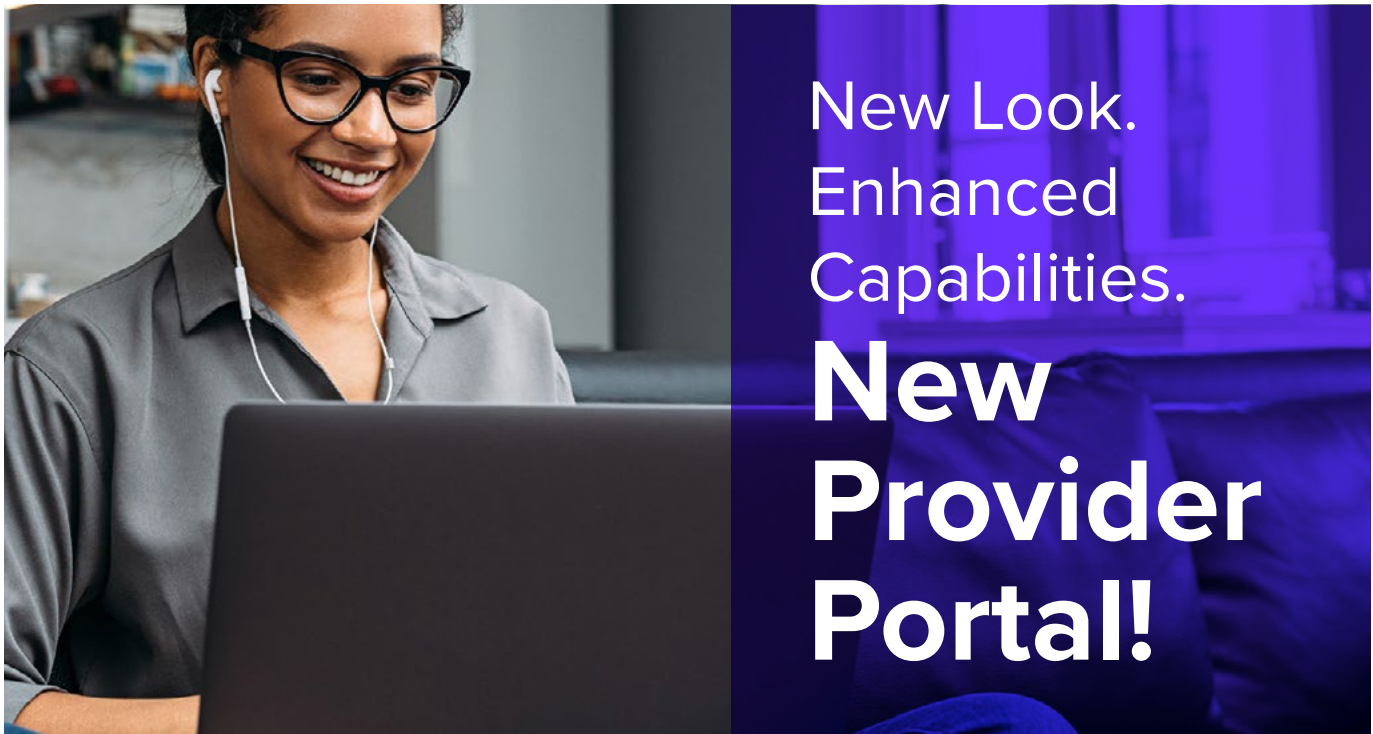


Case Management for Children and Pregnant Women

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



Provider Contact Center

Don't have time to contact us by phone? Not to worry... if you have claim and authorization questions that are not access to care it is best to email us at ProviderWebInquiries@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**

IMPORTANT UPDATE: Community will be changing the claims address for all lines of business in 2023.

Effective January 1, 2023, the new PO Box claims address for the Health Insurance Marketplace program will be:

**PO Box 981839
El Paso, TX 79998-1839**

Effective **February 15, 2023**, the new PO Box claims address for the STAR, CHIP, CHIP Perinatal and D-SNP programs will be:

**PO Box 981840
El Paso, TX 79998-1840**

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



Important Reminders

3. Please ensure to utilize Frequency Code 7 for corrected claims accordingly:

Do not submit a frequency code 7 claim when the date of service is 120 days (Medicaid) or 180 days (Marketplace) greater than the date of disposition on the original claim. Doing so may cause the whole claim to be reversed and denied for timely filing.

4. Sterilization Form

Please reference Section 2.2.8.1 in the [TMHP Manual](#) for the new form that is required to be submitted effective 9/1/2021.

5. IFSP/ECI Service

The IFSP form is no longer required, please do not send these forms with claims or via fax. We no longer require these forms in order to process claims for payment.

6. Medical Necessity (Appeals)

IF authorization was denied due to medical necessity, do not send a claim with the medical necessity appeal, and ensure you are using the appropriate form.

Provider **APPEAL** Form- to be sent to Medical Appeals Team (Do not attach a copy of claim)

<https://provider.communityhealthchoice.org/wp-content/uploads/sites/2/2020/10/Provider-Appeal-Form-Revised-09-30-2020.pdf>

7. Payment Reconsideration

Do not attach a copy of the HCFA/UB. Doing so may cause your request to be denied as a duplicate. Attach the appropriate form with correspondence or documentation.

Provider **PAYMENT** dispute form- to be sent to Claims (Do not attach a copy of claim)

<https://provider.communityhealthchoice.org/wp-content/uploads/sites/2/2022/05/Provider-Payment-Dispute-Form.pdf>

8. Exclusive to Behavioral Health

HCPCS codes billed by LMHA and CDTF providers pay to the group NPI only. Do not add a rendering provider.

CPT codes billed by LMHA and CDTF providers should have a rendering and the group NPI submitted on the claim.

Adding or omitting the incorrect NPI based on service rendered may cause a delay in payment or cause a claim to deny in error.

9. CPW Reimbursement Guidelines

Case Management for Children and Pregnant Women services are limited to one contact per day per person. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

Note: the authorization requested for the service must match what is billed.

Procedure code **G9012** is to be used for all Case Management for Children and Pregnant Women services. Modifiers are used to identify which service component is provided.

Please visit section **3.3 Services, Benefits, Limitations, and Prior Authorization** in the TMHP manual for additional details.

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	<ul style="list-style-type: none"> Billed with the incorrect payer number and member number 	Bill with the appropriate payer number and member number
	Taxonomy	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Allow 30 days between submissions. Include original claim number in box 64 of UB04 or box 22 of the CMS1500 form.
	Modifier 25	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> A more appropriate procedure or service code is available No supporting documentation Appropriate modifier missing for unlisted DME, orthotics, and prosthetics 	<ul style="list-style-type: none"> 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	Do 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 and RHCs	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
	Rendering Provider	Rendering provider is no longer required to be submitted	Submitting a claim with rendering provider information may cause a delay in payment. Please submit only the billing/group information for claims associated with FQHC and RHC services.
PT/ST/OT Providers	Modifiers	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 a Prior Authorization Catalog. 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.

Note: the authorization catalog is subject to change.



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

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.

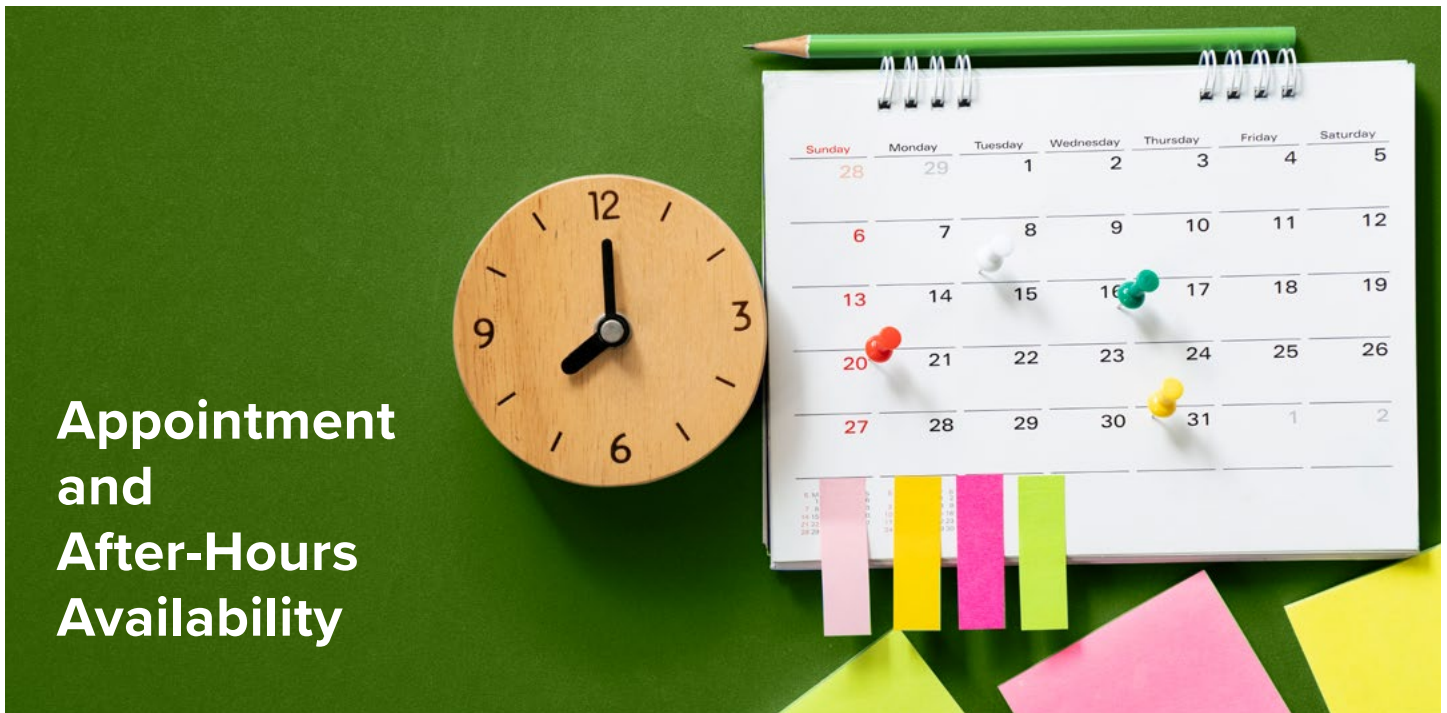
Member Panel Reports

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

Providers – Your Impact with Mental Health

Providers must be informed of the importance of reducing potentially preventable admissions in behavioral health diagnosis. One way is to educate members and provide behavioral health resources to reduce potentially preventable admissions.

Action Needed:

Providers can help address the following barriers of behavioral health diagnosis:

- The importance of maintaining follow-up scheduled appointments
- Lack of knowledge of community-based resources
- Low detection rates of mental illness in primary care
- Behavioral Health providers have limited appointments available
- PCP's lack of understanding of how to make a BH (Behavioral Health) referral
- Lack of coordination between PCP (Primary Care Physician) and BH Providers

Strategy:

Providers must engage with members with behavioral health diagnosis, especially if members don't require an emergency department level care. Common concerns include anxiety, depression, and attention deficit disorders, additionally, children with autism spectrum. Community Health offers a PCP Toolkit that contains educational materials to assist PCPs in screening and identifying resources for members with behavioral health diagnosis. This information will be available on the new provider portal. Partnership with Charlie Health can help identify members with depression diagnosis in efforts to reduce hospitalizations and readmissions.

What is the Care Management Depression Program – eligible members can be enrolled with a depressive disorder with a behavioral health case manager.

Welcome Home Packet

Community has developed a Member Discharge Toolkit to contain a Welcome Home Letter, educational flyer about the importance of completing the initial/first follow-up visit after discharge.

Community's Aftercare Program

Community's Behavioral Health Case Management team contacts members and schedules follow-up appointments with a behavioral health provider. The team confirms with the provider of appointments and educates the provider to call members and reschedule the appointment within 24 hours.

Behavioral Health Provider Training

Community's Behavioral Health Team has developed provider training materials designed to educate providers on the importance of timely follow-up care after hospitalizations for members with mental illness.

January Annual Preventative Education COVID FAQs

Q&A with most current COVID guidelines

Q: Is it safe for most people to get vaccinated against COVID-19?

A: Yes, in most circumstances. However, vaccination is not recommended if:

- There is a history of severe allergic reactions/anaphylaxis to any of the ingredients of the COVID-19 vaccine.
- Patient has a fever over 38.5°C on the day of vaccine appointment.
- Patient has confirmed or suspected COVID-19.

Q: Is it safer to frequently clean your hands and not wear gloves?

A: Wearing gloves risks transferring germs from one surface to another and contaminating hands when removing them. Wearing gloves does not replace cleaning hands.

Q: Is there a preferred COVID-19 vaccine?

A: Yes. For primary series vaccination, Moderna, Pfizer-BioNTech, and Novavax COVID-19 vaccines are recommended. For booster vaccination, Moderna and Pfizer-BioNTech are recommended.

Q: How is vaccination managed with a child who is moving from a younger age group with a lower dose formulation to an older age group with a higher dose formulation?

A: CDC recommends that people receive the age-appropriate vaccine dosage based on their age on the day of vaccination. Note: FDA authorization allows for dosing options for certain other age transitions when a child ages from a younger to older age group.

Q: What do antibody tests tell us about immunity, and should these tests influence the decision to vaccinate or revaccinate?

A: Antibody testing is not currently recommended to assess the need for vaccination in an unvaccinated person or to assess immunity to SARS-CoV-2 following COVID-19 vaccination or after SARS-CoV-2 infection. None of the currently authorized SARS-CoV-2 antibody tests have been validated to evaluate specific immunity or protection from SARS-CoV-2 infection.

Q: What is the guidance for vaccinating preterm infants?

A: In accordance with general best practices, preterm infants (infants born before 37 weeks' gestation), regardless of birth weight, should receive COVID-19 vaccination at their chronological age and according to the same schedule and guidance as for full-term infants and children.

Q: Is isolation necessary for a person with a current laboratory-confirmed SARS-CoV-2 infection and mild symptoms who are not moderately or severely immunocompromised?

A: Isolation can be discontinued at least 5 days after symptom onset and after resolution of fever for at least 24 hours and with improvement of other symptoms. It is also recommended that a well-fitting mask around others at home and in public for 5 additional days after the 5-day isolation period.

Source: <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/faq.html>

Reducing Behavioral Health PPAs

FACTS ON MENTAL ILLNESS:

Data from <https://www.nami.org/mhstats>

SIGNIFICANT IMPACTS OF MENTAL HEALTH:

- Detection of mental illness early
- Medication adherence
- Having other diseases or conditions in addition to mental illness
- Resistant to treatment due to social or cultural stigma

WE NEED YOUR SUPPORT TO COLLABORATE:

- Work with the patient to develop a treatment plan and assess their medication along with the side effects
- Assist patient 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 Complex Case Management Program
 - Patient may self-refer to any in-network Behavioral Health Provider
No prior approval is required from primary care providers
 - Patient may call Community at 713.295.6704
 - Providers may call Provider Services on 713.295.6704
 - Providers may fax referral information to our dedicated behavioral health team at 713.576.0932 (inpatient) or 713.576.0930 (outpatient)

ACCESS TO CARE-

- Schedule the next follow-up appointment before the patient leaves the office and call to reschedule as necessary for non-attendance
- See Community Provider Manual for BH Care Management Coordination. Partnership with Charlie Health- During an analysis of 2022 admissions for BH diagnoses, depression represented 56% of all BH admissions.

WHY IS MEMBER FOLLOW-UP CARE IMPORTANT?

- The importance of maintain follow-up scheduled appointments
- Lack of knowledge of community-based resources
- Low detection rates of mental illness in primary care
- Understand the importance of making a BH referral
- To reduce the risk for potentially preventable readmissions
- BH Providers have limited appointments available
- To enhance patient- provider coordination

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 aged 6-17 experience a mental disorder each year

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

Suicide is the **2nd leading** cause of death among people age 10-34



Well Child Care – Overweight and Obesity

Centers for Disease Control (CDC) and Prevention revealed that 19.7% of children between 2-19 years old are obese. At the local level, pediatricians are challenged to tackle childhood obesity along with other well child care such as vaccinations, mental health and family life which can affect childhood health. Providing a holistic care to children while attempting to combat obesity will require a team of professionals and support of outside organizations.

Obese children suffer from psychological trauma from being bullied at school and isolated from social events. To overcome the social stigma and encourage the child to lose weight without affecting self-esteem, Pediatricians and other healthcare providers must provide multidisciplinary management involving (Columbia University Department of Pediatrics, 2022):

- Individualized dietary counseling for the child and family
- Behavioral and psychological interventions
- Nutrition education for parents
- Exercise activities for children and adolescents
- Pharmacotherapy such as
 - Orlistat to prevent breakdown and absorption of fat
 - Phentermine for patients older than 16 years to control appetite
 - Metformin – for type 2 diabetes

Reference

American Academy of Pediatrics (2011). The pediatrician's role in family support and family support programs. <https://publications.aap.org/pediatrics/article/128/6/e1680/31070/The-Pediatrician-s-Role-in-Family-Support-and?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000>

Centers for Disease Control (CDC) and Prevention (2022). Childhood Obesity Facts: Prevalence of childhood obesity in the United States. <https://www.cdc.gov/obesity/data/childhood.html#:~:text=The%20prevalence%20of%20obesity%20was,more%20common%20among%20certain%20populations.>

Columbia University Department of Pediatrics (2022). Childhood Obesity: tips for pediatricians. <https://www.pediatrics.columbia.edu/education/continuing-medical-education/childhood-obesity-tips-pediatricians>

Post-Partum Care for High-Risk Mothers

Maternal care for high risk postpartum patients is difficult and complex. High-risk postpartum patients often come from 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	<ul style="list-style-type: none"> 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-gynecologist, certified nurse midwife, family physician, women's health nurse practitioner)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Primary care provider for infant after discharge from maternity care
Primary care provider (also may be the obstetric care provider)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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 visit(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 complications 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 assessment, 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 lubricant or dyspareunia)
Chronic health conditions	Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up

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.



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 this schedule:



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

The Membership Panel is available on our online Provider Portal titled “Panel Report (Medicaid/CHIP)” at https://providerportal.communitycares.com/Providers/Secure/Panel_Report.aspx



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:

- Comprehensive health and developmental history which includes nutrition screening, developmental and mental health screening and TB screening;
- Comprehensive unclothed physical examination which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening;
- Appropriate immunizations, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV;
- Appropriate laboratory tests which include newborn screening blood lead level assessment appropriate for age and risk factors, and anemia;
- Health education (including anticipatory guidance); and
- 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.

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 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.tmh.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at [texashealthstepsmedicalproviders](https://texashealthstepsmedicalproviders.texashealthsteps.com).

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

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: texashealthsteps.com. For free online provider education: texashealthsteps.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.tmh.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at [texashealthstepsmedicalproviders](https://texashealthstepsmedicalproviders.texashealthsteps.com).

AGE	History	Nutritional Screening	MENTAL HEALTH		Unchecked Physical Examination	Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACP Guidelines	LABORATORY TESTS			Health Education/Injury Prevention Guidance										
			Mental Health: Psychosocial/Behavioral Health Screening	PHQ-2/PHQ-9, PCP, PHQ-A, or PHQ-A-CHEFF Parent Health Questionnaire for Adolescents or PHQCS								TB Questionnaire with Skin Test if Risk Identified	Subjective Vision	Audiometric Screening	Subjective Hearing			Dyslipidemia	Type 2 Diabetes	STD/STI Screening		HIV Test									
11	Mandatory		Mandatory	Mandatory																											
12	Mandatory		Mandatory	Mandatory																											
13	Mandatory		Mandatory	Mandatory																											
14	Mandatory		Mandatory	Mandatory																											
15	Mandatory		Mandatory	Mandatory																											
16	Mandatory		Mandatory	Mandatory																											
17	Mandatory		Mandatory	Mandatory																											
18	Mandatory		Mandatory	Mandatory																											
19	Mandatory		Mandatory	Mandatory																											
20	Mandatory		Mandatory	Mandatory																											

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: texashealthsteps.com. For free online provider education: texashealthsteps.com.



E03-13634 June 1, 2021

THSteps Medical Checkup Billing Procedure Codes

TMHP updated the Texas Health Steps Quick Reference Guide (QRG) on February 1, 2023. Updates to the QRG include multiple vaccine procedure code changes. The updated QRG can be downloaded via

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 EPI

Texas Health Steps Medical Checkup Billing Procedure Codes

Texas Health Steps Medical Checkups	
99381	99382
99391	99392
	99393
	99394
	99385*
	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 ¹ with (90460/90461 or 90471/90472)	MenACWY-TT
90632 or 90633 ¹ with (90460/90461 or 90471/90472)	Hep A
90620 ¹ or 90621 ¹ with (90460/90461 or 90471/90472)	MenB
90636 with (90460/90461 or 90471/90472)	Hep A/Hep B
90647 ¹ or 90648 ¹ with (90460/90461 or 90471/90472)	Hib
90651 ¹ with (90460/90461 or 90471/90472)	HPV
90630, 90654, 90655 ¹ , 90656 ¹ , 90657 ¹ , 90658 ¹ , 90685 ¹ , 90686 ¹ , 90687 ¹ or 90688 ¹ with (90460/90461 or 90471/90472); 90660 ¹ or 90672 ¹ with (90460/90461 or 90473/90474); 90661, 90673, 90674, 90682 or 90756 ¹ with (90471/90472)	Influenza
90670 ¹ with (90460/90461 or 90471/90472)	PCV13
90671 ¹ with (90471/90472)	PCV15
90677 with (90471/90472)	PCV20
90680 ¹ or 90681 ¹ with (90460/90461 or 90473/90474)	Rotavirus
90696 ¹ with (90460/90461 or 90471/90472)	DTaP-IPV
90697 ¹ or 90698 ¹ with (90460/90461 or 90471/90472)	DTaP-IPV-Hib
90700 ¹ with (90460/90461 or 90471/90472)	DTaP
90702 ¹ with (90460/90461 or 90471/90472)	DT
90707 ¹ with (90460/90461 or 90471/90472)	MMR
90710 ¹ with (90460/90461 or 90471/90472)	MMRV
90713 ¹ with (90460/90461 or 90471/90472)	IPV
90714 ¹ with (90460/90461 or 90471/90472)	Td
90715 ¹ with (90460/90461 or 90471/90472)	Tdap
90716 ¹ with (90460/90461 or 90471/90472)	Varicella
90723 ¹ with (90460/90461 or 90471/90472)	DTaP-Hep B-IPV
90732 ¹ with (90460/90461 or 90471/90472)	PPSV23
90734 ¹ with (90460/90461 or 90471/90472)	MPSV4
90739, 90743, 90744 ¹ , 90746 ¹ , 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), CRAFTT, 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 <i>not available</i> 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

¹ Indicates a vaccine distributed by TVFC

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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 Customer Outreach Advocates at 713.295.2222. Our goal is to arrange for all healthcare services they may need before they leave for the new job.





Medical Record Request from the Special Investigation Unit (SIU)

Community Health Choice (Community) SIU 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.

Texas Administrative Code, Title 1, Rule §353.502(g) Failure of the provider to supply the records requested by the MCO will result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold.

Social Security Act, Title XVIII, Section 1833€ states “(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

Code of Federal Regulations, Title 42, Section 424.5(a)(6) Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.

It is important that providers cooperate by submitting all requested documentation in a timely manner. **Failure to supply the records** will be viewed as non-compliance and may result in negative action which could include: **recovery of payments for the claims under review**, referral for legal or regulatory action, payment withhold, breach of contract action, or other action as allowed.

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.



Breastfeeding

Stay up to date on current breastfeeding information and guidance and learn how you can provide support to help families meet their breastfeeding goals. This course is available at https://www.txhealthsteps.com/641-breastfeeding?utm_source=courseannouncement&utm_medium=email&utm_campaign=POST+BF-other

New Cultural Competency Training Available

Practitioners have the opportunity to earn CEUs for Cultural Competency Training. The training is offered by the U.S. Department of Health and Human Services, Office of Minority Health and is featured on the Community Health Choice Website and within the Provider Portal. There are specific training for Physicians, Nurses and Maternal Health Care providers. Please refer to the Resources tab for Cultural Competency or log-in to the Provider Portal for more details.

<https://provider.communityhealthchoice.org/>

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/>

Postpartum Health: Screening and Intervention

Learn how to identify and address factors that affect maternal health and safety in the first year after childbirth.

This course is available at https://www.txhealthsteps.com/634-postpartum-health-screening-and-intervention?utm_source=courseannouncement&utm_medium=email&utm_campaign=POST+BF-other

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

Availability: 1.800.282.4548

Gateway EDI: 1.800.969.3666

TMHP (Medicaid only): www.tmhp.com

ELECTRONIC CLAIMS-UB, CMS-1500 (MARKETPLACE)

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

Change Healthcare: 1.800.735.8254

Payer ID: 60495

PHARMACY

Navitus Health Solutions

1.877.908.6023 | 1.866.333.2757 (Medicare)

www.navitus.com

VISION SERVICES

Envolve Vision

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

DENTAL SERVICES

FCL Dental

Toll-free Member Services: 1.866.844.4251

Toll-free Provider Services: 1.877.493.6282

www.fclidental.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