Provider Newsletter

V2-2023

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.

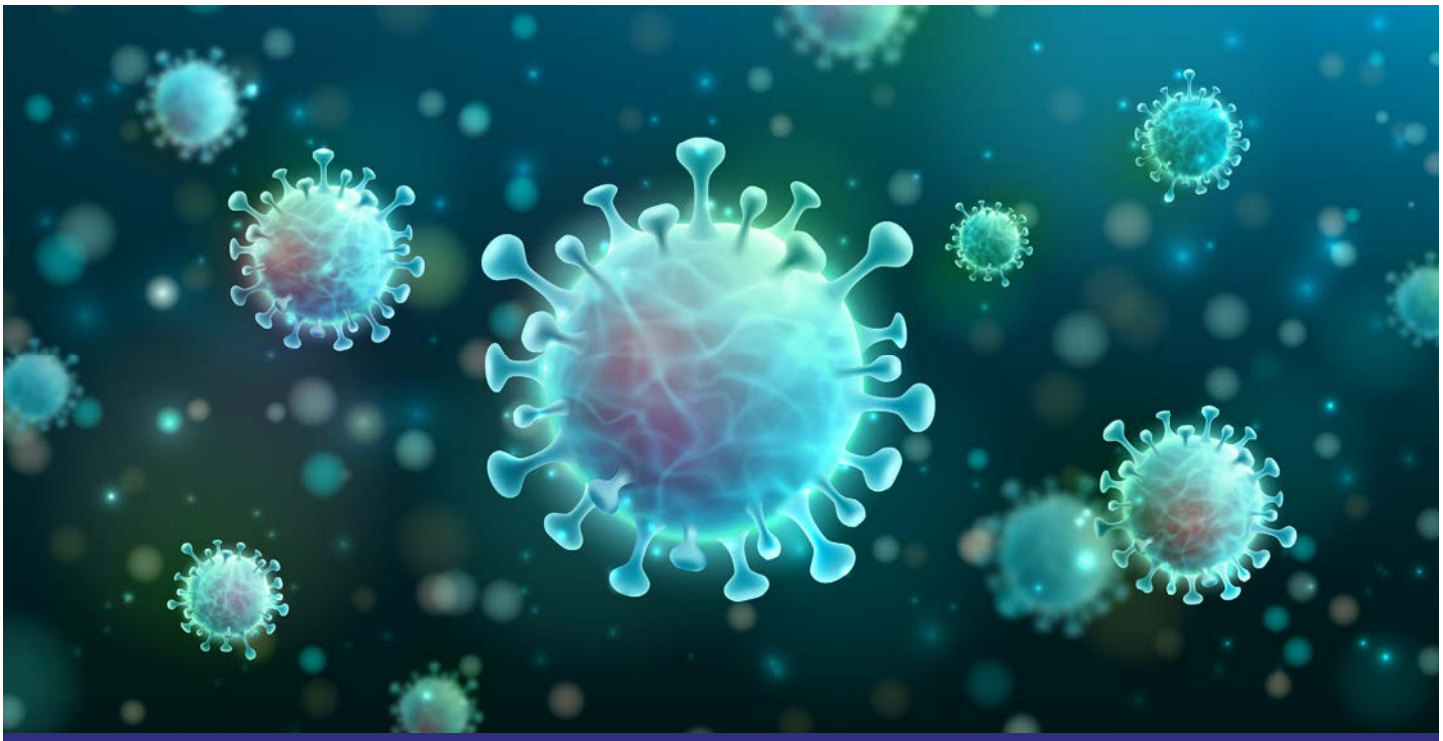
What program does this impact?

- 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, and run 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 into 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, TX 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.

Co-Pays for Some CHIP Services Resume Effective May 12, 2023

Dear Provider,

You may begin collecting CHIP co-pays on or after May 12, 2023.

During the COVID-19 public health emergency, the Texas Health and Human Services Commission (HHSC) waived co-pays for Children's Health Insurance Program (CHIP) medical office visits. This waiver ended May 11, 2023, except for mental health and substance-use disorder outpatient office visits and COVID-19-related office visits for COVID-19 vaccines, testing, and treatment.

For CHIP medical office visits scheduled on or after **May 12, 2023,** you may begin collecting co-pays.

You may not charge co-pays for mental health and substance-use disorder outpatient office visits.

Co-pays have been permanently removed for mental health and substance-use disorder outpatient office visits to comply with federal regulations.

CHIP co-pays that Members must pay are determined based on their income. CHIP co-pays do not apply to Native Americans, Alaska Natives, CHIP Perinate, and CHIP Perinatal newborn members.

Providers must adhere to co-pay guidelines outlined in the MCO Provider Manual.

If you have any questions, please contact our Provider Services line at 713-295-2295 or email us at ProviderWebInquiries@CommunityHealthChoice.org.

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.

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 be sure 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 be sure 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 be sure 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) longer 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 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 be denied 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 the 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	Do not submit IFSP forms to Community
	Rendering NPI	Including a rendering NPI may hold up claim payment or deny claim payment.	Do 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	• 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 and untimed units should be billed as one 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.

Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs)

Community Health Choice requires that Providers report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131 - 97.134 using the required forms and procedures for reporting STDs.

Providers must coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia, and HIV receive risk reduction and partner elicitation/notification counseling.

Providers must have procedures in place to protect the confidentiality of Members provided HIV/STD services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared.

Providers who provide HIV/STD services must comply with all state laws relating to communicable disease reporting requirements.

Visit the CDC website at https://www.cdc.gov/std/hiv/ for information related to treatment and screening of HIV/AIDS and STDs.

Additional Resource:

Visit the Agency for Healthcare Research and Quality for additional information at https://www.ahrq.gov/gam/index.html.

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

Invalid NPI in NPPES to Trigger Disenrollment Action

Summary of Notification:

Texas Medicaid and Healthcare Partnership (TMHP) has identified several National Provider Identifiers (NPI) as inactive in the National Plan and Provider Enumeration System (NPPES) and will be taking immediate disenrollment action that will result in a payment denial code (PDC) 64 added on to the Provider record in the Master Provider File (MPF).

Key Details:

- Providers must have an active NPI to remain active in any Texas state healthcare program. Providers should contact NPPES at 1-800-465-3203 to research and resolve any issues with the NPI status.
- TMHP will reverify the NPI status with NPPES when they release the next NPPES dissemination file, and the payment hold will be end-dated once the NPI is reinstated.
- Any claims and prior authorization requests that are submitted for dates of service on or after the disenrollment date will be denied.

Additional Information:

Providers can also refer to the current Texas Medicaid Provider Procedures Manual, General Information, Section 1, “Provider Enrollment and Responsibilities,” for more information.

Resources:

Providers may find more information on Provider Enrollment at Provider Enrollment | TMHP.

Should you have any questions, please contact our Provider Services line at 713-295-2295 or email us at ProviderWebInquiries@CommunityHealthChoice.org.

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

If you do not see that you are the PCP assigned to the Member via the Provider portal, this should not keep you from seeing the Community Member. As long as you accept the plan that the Member is enrolled in, you can proceed with seeing our Member.

This allows Members the opportunity to see a Provider for non-emergent needs should their selected PCP not be available.

Appointments 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 impairment 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

Makena Products No Longer Covered as of April 7, 2023

SUMMARY OF NOTIFICATION:

On April 6, 2023, the U.S. Food and Drug Administration (FDA) announced the final decision to withdraw approval of hydroxyprogesterone caproate (Makena).

Key Details:

Effective June 1, 2023, for dates of service on or after April 6, 2023, hydroxyprogesterone caproate (Makena) procedure code J1726 will no longer be a benefit of Texas Medicaid.

The Texas Medicaid Provider Procedures Manual, *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook,* subsection 4.1.12, "Hydroxyprogesterone Caproate," and the *Outpatient Drug Services Handbook,* subsection 6.43, "Hydroxyprogesterone Caproate," will be updated to remove references to hydroxyprogesterone caproate.

Affected claims submitted for dates of service from April 6, 2023, through June 1, 2023, may be reprocessed. Affected claims may result in recoupment

Resources:

The FDA's announcement of its withdrawal of approval for Makena may be found here: https://www.fda.gov/news-events/press-announcements/fda-commissioner-and-chief-scientist-announce-decision-withdraw-approval-makena.

Providers – Your Impact on 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 scheduled follow-up 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 a behavioral health diagnosis, especially if Members don't require emergency department level care. Common concerns include anxiety, depression, and attention deficit disorders, as well as children on the autism spectrum. Community Health offers a PCP Toolkit that contains educational materials to assist PCPs in screening and identifying resources for Members with a behavioral health diagnosis. This information will be available on the new Provider portal. Partnership with Charlie Health can help identify Members with a depression diagnosis in efforts to reduce hospitalizations and readmissions.

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

Welcome Home Packet

Community has developed a Member Discharge Toolkit containing a welcome home letter and an 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.

Reducing Behavioral Health PPAs

FACTS ON MENTAL ILLNESS:

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

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 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

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 the 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?

- To emphasize the importance of maintaining scheduled follow-up appointments
- To learn about community-based resources
- To reduce low detection rates of mental illness in primary care
- To understand the importance of making a BH referral
- To reduce the risk for potentially preventable readmissions
- Because BH Providers have limited appointments available
- To enhance patient-Provider coordination

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 prevents 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 frnm low-income households and minorities 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 to non-clinical and community-based services such as affordable daycare 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 hands-on 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 any mother and baby 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 (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 heathcare 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 health care 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 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 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

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.

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 one per rolling year). Provider must use procedure code 97169, 97170, 97171 or 97172 depending on the level of complexity when billing for sports physicals. For more information regarding the sports and physical codes, see New Sports and School Physical Procedure Codes article.

Exception-to-Periodicity Checkups

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

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

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

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

Modifiers indicate the reason for the exception to periodicity checkup:

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

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

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

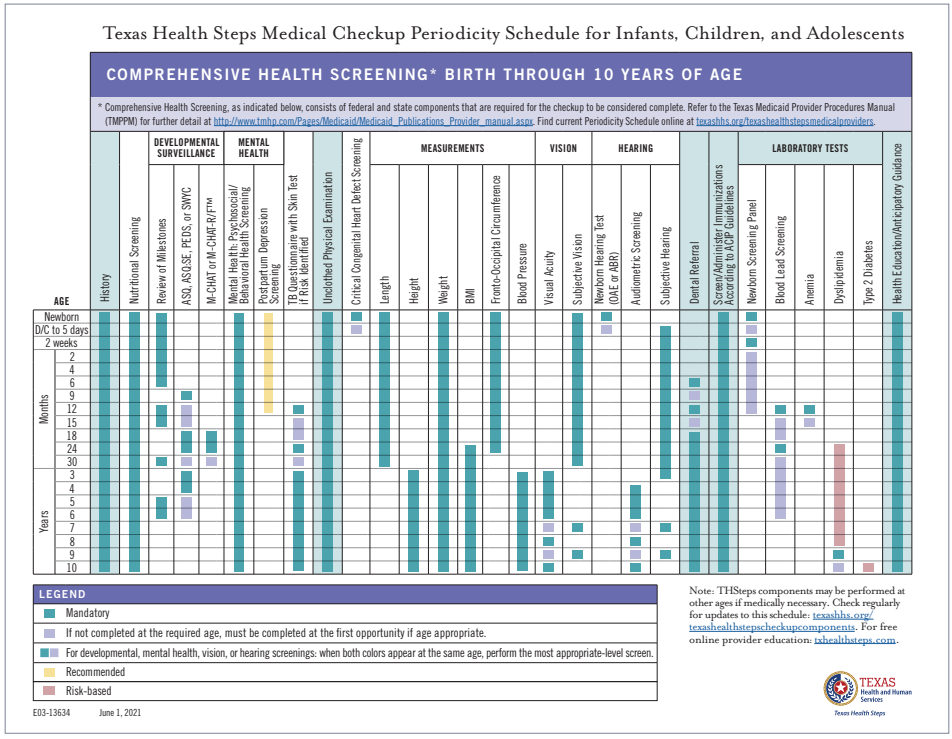
We offer free transportation for CHIP Members to doctors' appointments when no other transportation is available with prior approval by our case manager.

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.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at texashhs.org/texashealthstepsmedicalproviders.

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

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

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

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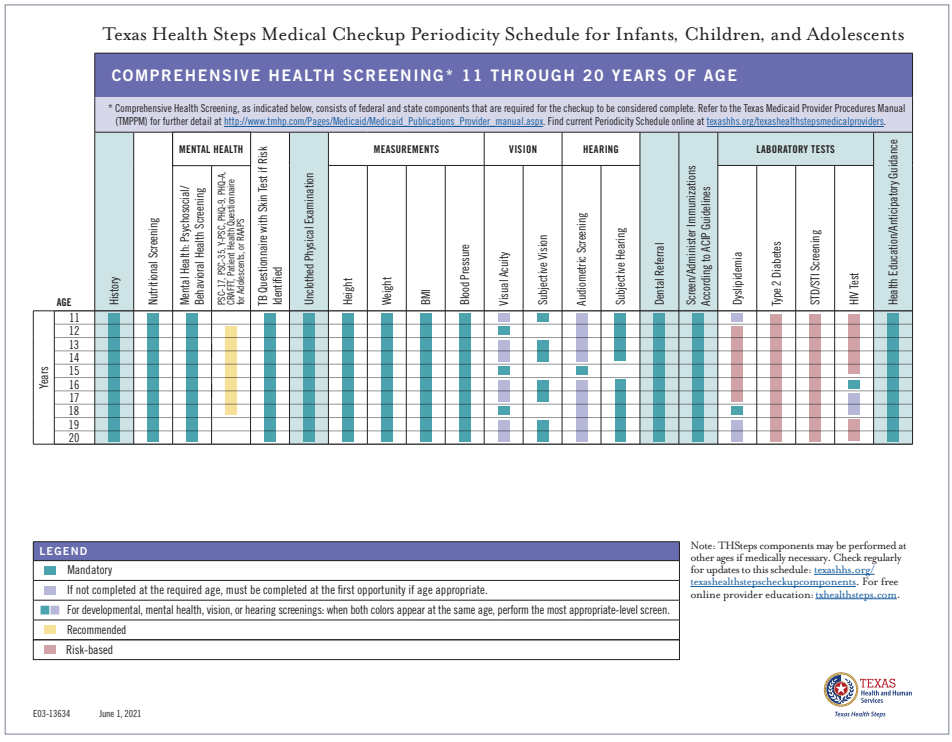

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

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

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

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

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

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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 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 02/01/2023 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.

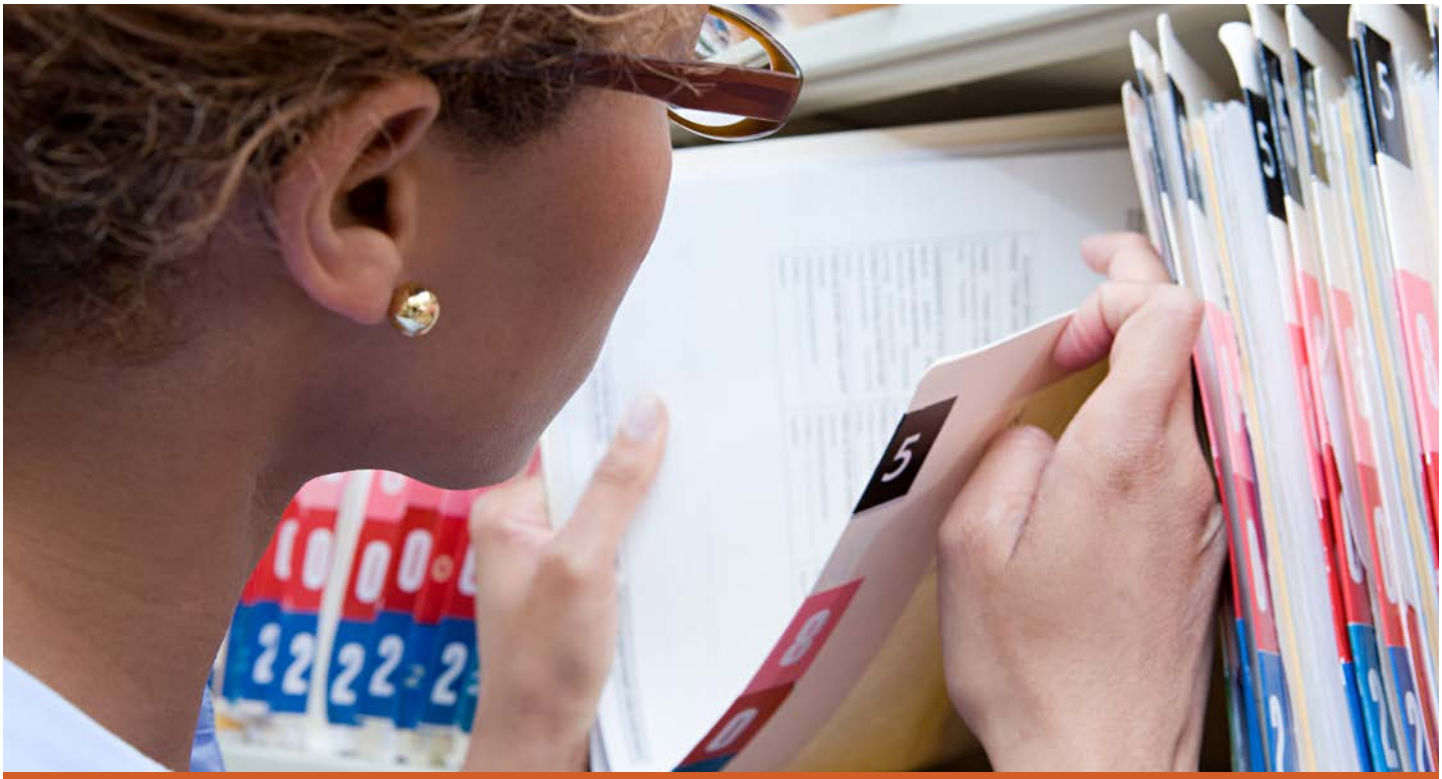
A traveling farmworker is someone who:

- 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 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 that 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 31 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 trainings for physicians, nurses, and maternal healthcare 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 Formularies 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 Health Care: 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 Health Care: 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