Provider Newsletter

V2-2025

CommunityHealthChoice.org

713.295.2295 | 1.888.760.2600 (Medicaid/CHIP)
713.295.6704 (Marketplace)
713.295.5007 (HMO D-SNP)
713.295.2300 | 1.888.435.2850 (STAR+PLUS)

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.

Community GAM Partnership

Community Health Choice is happy to announce a partnership with GAM ("Global Appropriateness Measures") to address overuse of select procedures, scans and tests using the current best available evidence and endorsement by expert physician specialists. Properly managing healthcare resources by addressing potentially unnecessary care and outlier practice patterns is a high priority for all healthcare stakeholders. This work is part of our responsibility to provide high-quality, cost-effective care for our members.

Community has taken this approach as individual physicians may not be aware of where their practices fall with respect to best evidence for these measures. The Community executive team, alongside the GAM physician consortium, will select a few measures each year to perform quality improvement initiatives around. All physicians within Community's network who perform the selected procedures will receive a report detailing their score and where they fall on the national bell curve of each measure. The bell curve helps highlight whether a physician is practicing within a normal, appropriate practice pattern range or has an "outlier" practice pattern as defined by physician specialists in that field as well as statistical standard deviations.

We expect to issue up to 8 reports on specific procedures in 2024 and 8 or more in 2025. These data will be monitored for practice pattern improvement, and a follow-up report will be sent every 12-months. This program is educational and we at Community look forward to your feedback. As always, we appreciate the great care you provide for our members.

Below is a description of the GAM program and how they select measures and analyze data:

GAM ("Global Appropriateness Measures") is a large consortium of physicians committed to advancing the science of healthcare quality by focusing on the identification and reduction of low-value medical care. By meticulously analyzing clinical practices, GAM seeks to identify clinical waste that not only strains the healthcare system but also exposes patients to unnecessary risks. The consortium's approach is rooted in evidence-based methodologies, with quality measures being developed by panels of expert physicians in each specialty. These measures serve as benchmarks to assess whether a physician's practice pattern aligns with appropriate care patterns or if they deviate into what is deemed outlier behavior.

GAM's research has demonstrated success in influencing physician behavior. Through extensive studies and publications, GAM has shown that when physicians are informed of their performance relative to their peers using clinically validated and sophisticated quality measures, 71%-90% of outlier physicians adjust their practice. This shift results in better patient care reduced healthcare costs.

The overarching mission of GAM is to be an organization of physicians for physicians, helping to create a healthcare environment that is safer, higher in quality, and more cost-effective. By focusing on reducing clinical waste and promoting adherence to respected quality measures, GAM is playing a crucial role in transforming the healthcare landscape. The consortium's work is not just about improving individual physician performance; it is about fostering a culture of accountability across the entire healthcare system, ultimately leading to better outcomes for patients and more cost- effective healthcare practices. You can find more information about the GAM physician consortium at www.gameasures.com.

June 9, 2025

PROVIDER ENROLLMENT AND MANAGEMENT SYSTEM (PEMS) GO-LIVE NOTICE - UPDATED

SUMMARY OF NOTIFICATION

Have you updated your data in the **TMHP Provider Enrollment and Management System (PEMS)?** Don't wait – stay compliant and avoid disruptions.

Please be sure to access PEMS now to register/update your data here.

FREQUENTLY ASKED QUESTIONS (FAQs)

What is PEMS? PEMS is a system designed to streamline the process of enrolling, re-enrolling, and managing provider information within the TMHP program.

- **Enrollment:** Facilitates new provider enrollment in Texas Medicaid.
- **Re-enrollment:** Handles the re-enrollment process for providers whose enrollment status has changed.
- **Re-validation:** Allows providers to revalidate their existing enrollment records before the end of their enrollment period.
- **Maintenance:** Enables providers to update and manage their enrollment information.

Need to Enroll?
For provider enrollment, visit Provider Enrollment Help | TMHP.
This helpful link provides various resources to assist enrollees in the process.

Already Enrolled?
Access your PEMS account through the TMHP website here then select ***My Account***.

Have Additional Questions?
For additional enrollment walkthrough assistance please contact one of the following:

- TMHP Contact Center (800-925-9126)
- TMHP-CSHCN Services Program Contact Center (800-568-2413)
- Send an email to provider.relations@tmhp.com to request assistance with enrollment questions.

Community Health Choice Texas, Inc. | 4888 Loop Central Drive, Ste. 600 | Houston, TX 77081

Reminder

NPPES taxonomies MUST be up to date to successfully enroll and revalidate in PEMS.

- Ensure taxonomy codes on the National Plan & Provider Enumeration System (NPPES) website remain up to date with the available taxonomy codes, used to identify applicable program selections in PEMS.
- Providers with an API still choose a taxonomy, but it will not be compared with NPPES.

February 11, 2025

REMINDER: RIDER 32 IMPLEMENTATION INFORMATION AVAILABLE

BACKGROUND

The HHSC Office of Policy and Program Development published an MCO Notice ("Rider 32 Implementation Date") in TexConnect on Dec. 5, 2024, regarding implementing House Bill 1, 88th Texas Legislature, Regular Session, 2023 (Art. II, HHSC, Rider 32).

KEY DETAILS

Rider 32 implements the transition to Medicaid-only services for dually eligible people enrolled in Medicaid managed care from a fee-for-service (FFS) to a managed care service delivery system, effective Sept. 1, 2025. This change incorporates wraparound drugs for dual eligible members into the capitation rate. Refer to the Dec. 5 MCO Notice for more information.

Community Health Choice Texas, Inc. | 4888 Loop Central Drive, Ste. 600 | Houston, TX 77081

Separate Reimbursement of Certain Inpatient High-Cost Drug and Biologics (HCCADs)

BACKGROUND

While Medicaid covers drugs and biologics administered in both inpatient and outpatient settings, those administered in an inpatient setting are usually not reimbursed separately to hospitals. Instead, they are bundled into a Diagnosis Related Group (DRG) payment reflecting all average hospital costs associated with providing care for the patient's primary diagnosis and complications. DRG payments exclude separate reimbursement for high-cost drugs or biologics, which can range from hundreds of thousands of dollars to upwards of three million dollars per dose.

KEY DETAILS

This notice contains information on implementing the Separate Reimbursement of Certain Inpatient High-Cost Drug and Biologics (HCCADs). HCCAD are drugs or biologics that HHSC has approved to be "carved out" of the All-Patient Refined Diagnosis Related Group (APR-DRG) and can be billed on an outpatient claim.

This change will take effect uniformly in both fee-for-service and managed care on June 2, 2025.

HCCAD LIST:

- HEMGENIX
- ELEVIDYS
- SKYSONA
- LYFGENIA
- ZYNTEGLO
- ROCTAVIAN
- ZOLGENSMA
- CASGEVY
- KYMRIAH
- CARVYKTI
- ABECMA
- BREYANZI
- TECARTUS
- YESCARTA

ADDITIONAL INFORMATION

The SPA language is forthcoming and will be provided in a later notice.

Implementation Plan for High-Cost Clinician Administered Drugs (HCCAD): Claims Processing Requirements

HCCAD are drugs or biologics that HHSC has approved to be "carved out" of the All-Patient Refined Diagnosis Related Group (APR-DRG) and can be billed on an outpatient claim.

The following billing guidelines apply to outpatient claims of HCCAD.

Special requirements for transmitting claims for HCCAD

1. The hospital must claim **separate payment** for the HCCAD on an **outpatient claim**. MCOs must ensure that payment to the hospital is direct reimbursement for the HCCAD. Payment for the HCCAD must not be bundled with any other service.
2. The claim for the HCCAD must be **separate** from any facility/institutional claim the hospital submits for **all other** hospital services delivered to the member during the same visit. The associated inpatient or outpatient charges with the same date(s) of service are billed separately and remain part of the APR-DRG.
3. The date of administration of the drug should be used on the HCCAD outpatient claim.
4. Along with the members name, date(s) of service, and other required information, the HCCAD claim **must** include:
    a. The **NDC qualifier** of N4
    b. The appropriate 11-digit **National Drug Code (NDC)** and corresponding **HCPCS code** for the drug; and
    c. The **number of units** of the drug administered to the member that is covered by the claim; and
    d. The **NDC unit of measurement**. There are five allowed values: F2, GR, ML, UN or ME.
5. MCOs should reimburse the hospital at the FFS rate or the actual acquisition cost from the invoice, whichever is less. MCOs must require the hospital to submit an invoice of the **actual acquisition cost** of the drug.

Additional instructions for MCOs

1. The HHSC-approved prior authorization criteria for HCCAD is **mandatory** and can be found in the Outpatient Drugs Handbook of the Texas Medicaid Provider Procedure Manual.
2. MCOs will be reimbursed non-risk for the HCCAD. The medical encounters must contain the **Financial Arrangement Code value of "20".**
3. HHSC limits the non-risk payment to the actual amounts paid to providers for the drug's ingredient cost (up to the fee-for-service reimbursement amount).
4. **Drugs administered in an inpatient setting do not qualify for 340B discounts.**

STAR+PLUS Launched September 1st, 2024

We're excited to announce that starting September 1, 2024, Community Health Choice will begin offering STAR+PLUS, a Texas Medicaid-managed care program designed to support Texans with disabilities and those aged 65 and older.

As healthcare providers, you play a vital role in delivering the services that make a meaningful difference in the lives of these individuals. Below is an overview of STAR+PLUS and how it can impact your patients and practice.

What is STAR+PLUS?

STAR+PLUS is a Medicaid program that provides comprehensive care to older adults and those with disabilities through the health plan they select. STAR+PLUS is designed to enhance the quality of life for Members by offering:

- **Comprehensive Care:** Medical, behavioral health, and long-term services and supports (LTSS).
- **Assistance with Daily Living:** Help with daily activities like bathing, dressing, and meal preparation.
- **Service Coordination:** Every Community STAR+PLUS Member is assigned a Service Coordinator to develop a personalized care plan tailored to their individual needs.
- **In-Home Care:** Supports Members in staying in their homes whenever possible, rather than entering nursing facilities.

Who Qualifies for STAR+PLUS?

Your eligible patients include individuals who are approved for Medicaid and are one or more of the following:

- Age 21 or older, getting Supplemental Security Income (SSI) benefits and able to get Medicaid due to low income
- Not getting SSI and need the type of services in STAR+PLUS Home and Community-Based Services
- Age 21 or older, getting Medicaid through what are called "Social Security Exclusion programs" and meet program rules for income and asset levels
- Age 21 or over residing in a nursing home and receiving Medicaid while in the nursing home
- In the Medicaid for Breast and Cervical Cancer program

To learn more about patient eligibility and how STAR+PLUS can benefit your practice, visit our website at CommunityHealthChoice.org/texas-starplus/.

How Providers Can Support Enrollment

While patients can enroll in STAR+PLUS on their own, providers can play a key role in educating them about their options. Here's how you can help your patients apply for STAR+PLUS:

- **Online:** Direct patients to apply at YourTexasBenefits.com. If they have questions, have them call us for help toll-free at 1.888.760.2600.
- **By Phone:** They can call 2-1-1, select their language, and press 2 to start the application process with a Texas Health and Human Services representative.
- **By Mail or Fax:** They can print an application from the Texas Medicaid website and submit it via mail or fax. Processing times may take up to 45 days.

Community Health Choice and STAR+PLUS

At Community Health Choice, we are committed to working closely with you to deliver high-quality, coordinated care to STAR+PLUS Members. Our goal is to enhance the health and well-being of these vulnerable populations, with your expertise and partnership being essential to our mission.

If you have any questions about STAR+PLUS or how to assist patients with the enrollment process, feel free to reach out to us or visit our provider portal for more details. Let's work together to ensure our patients receive the comprehensive care and support they need.

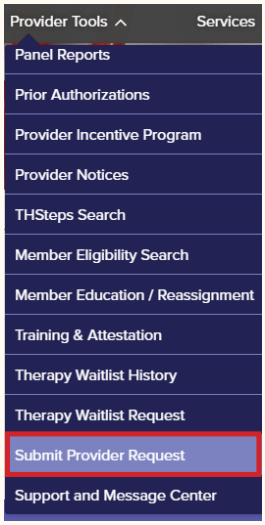
Our Provider Portal Offers Enhanced Capabilities!

Community Health Choice Provider portal offers a wide range of functions including:

- **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 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**

If you or your staff has questions or would like a personalized training regarding the portal please reach out to your Provider Relations Representative or send an email to providerrelationsinquiries@communityhealthchoice.org.

Provider Tools > Submit Provider Request



YOU NOW HAVE THE CAPABILITY TO UPDATE PROVIDER INFORMATION ONLINE:

- Address
- Name
- Phone Number
- Specialty
- Office Hours
- Age Limits
- NPI
- Panel Status
- Other

CYBER SECURITY ENHANCEMENTS: Multi-Factor Authentication implementation in August 2024

Dear Valued Provider Portal User,

In response to increasing cybersecurity threats, we are enhancing the security of your login credentials for accessing the Community Health Choice provider portal. Starting August 2024, we will be implementing Multi-Factor Authentication (MFA), also known as two-step verification.

Why You Should Never Share Your Passwords

In today's digital world, your passwords are the keys to your personal and financial information. Sharing them—even with people you trust—can put you at serious risk. Once someone else has your password, you lose control over how it's used. Whether it's your email, bank account, or social media, one mistake can lead to identity theft, financial loss, or privacy violations.

Cybercriminals often take advantage of shared credentials to spread malware, steal information, or commit fraud. Even accidental misuse by friends or family can lock you out of your accounts or expose sensitive data.

Protect yourself with these tips:

- Never share your passwords. If access is needed, look for secure alternatives like account delegation or shared access features.
- Use strong, unique passwords for every account.
- Enable two-factor authentication (2FA) wherever possible.
- Change your passwords regularly, especially if you suspect they've been compromised.

Remember, keeping your passwords private is the first step to protecting your digital life.

ProgenyHealth® Maternity Care Management Program

The ProgenyHealth® Maternity Care Management program – an innovative program designed to support your patients and ease your workload. The program is delivered by Community Health Choice for their members. The Maternity Care Management program supports patients before, during and after their pregnancy with the support of experienced Maternity Case Managers... at no additional cost to you or your patients.

The program includes:

- **Case Management** – Member support from a maternity case manager in collaboration with OB/GYNs via personalized care plans – from pregnancy through the first eight months postpartum.
- **Mobile App** – Reproductive health support from cycle tracking and conception to pregnancy and parenthood through the app.
- **Return to Work** – Help women transition back to the workplace if they choose, as well as navigate job issues, childcare, and more.
- **Intelligent Platform** – A comprehensive medical record that drives all interventions and care pathways based on evidence-based protocols and maternal risk factors.

To refer a patient, click here. Learn more about the program here and download an easy-to-understand overview of the program for your patients. The patient flyer also includes simple instructions for downloading a mobile app.

To learn more about ProgenyHealth's programs and services or if you'd prefer to enroll your patient by phone, please call **1-855-231-4730** Monday-Friday between 8:30 AM and 5:00 PM ET.

Thank you for your partnership in caring for Community Health Choice Members.

Paper Claims Address Change

August 27, 2024

COMMUNITY'S PAPER CLAIM SUBMISSION PO BOX ADDRESS CHANGE – ALL PROGRAMS

SUMMARY OF NOTIFICATION

Community is changing the claims address for all lines of business.

KEY DETAILS

Effective immediately, the new PO Box claims address for STAR, STAR+PLUS, CHIP, CHIP Perinatal and D-SNP will be:

Paper CLAIMS-UB, CMS-1500
Community Health Choice, Inc.
P.O. Box 301404
Houston, TX 77230

Effective immediately, the new PO Box claims address for Marketplace will be:

Paper CLAIMS-UB, CMS-1500
Community Health Choice, Inc.
P.O. Box 301424
Houston, TX 77230

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, Inc.
P.O. Box 301404
Houston, TX 77230-1404

Marketplace

Electronic Payer ID: 60495

Claims Mailing Address:

Community Health Choice, Inc.
P.O. Box 301424
Houston, TX 77230-1424

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
4888 Loop Central, Suite 600
Houston, TX 77081

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
4888 Loop Central, Suite 600
Houston, TX 77081

Email: ProviderWebInquiries@CommunityHealthChoice.org

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 lack of 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.

Important Reminders

6. Medical Necessity (Appeals)

IF authorization was denied due to medical necessity, do not send a claim with the medical necessity appeal and make sure 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.

10. Claims with Handwriting

Claims with handwriting are not acceptable and will be rejected by the Clearinghouse (Change Healthcare).

11. Electronic Claim Submission with Primary Insurance Payments

When a Provider submits primary insurance payments electronically, we attempt to confirm the primary information. At times this cannot be confirmed due to insufficient information, Member termed on date of service, newborns not auto enrolled, etc.

A Provider should only be submitting electronic claims with primary COB information when they have received a copy of the EOP from the primary carrier.

Submitting a claim with the guesstimate of what the primary carrier will allow/pay is not acceptable. Claim will deny requesting a copy of the Explanation of Payment.

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 or 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 have claim payment denied.	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's 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

Claims Editing Program Notification

PROVIDER COMMUNICATION
4888 Loop Central Dr. Suite 600
Houston, TX 77081

April 24, 2024

Dear Valued Provider:

Community Health Choice has been diligently enhancing its payment policies to align with industry standards. Our aim is to consistently process claims in adherence to best practices. Beginning August 1, 2024, we will implement further improvements to our claims editing programs to support correct coding and billing practices.

These additional edits will be conducted on a pre-payment basis, focusing on claims for payment policy management, coding validation, and claim pattern review. Our edits adhere to nationally recognized standards, including guidelines from the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and Texas Medicaid. Coding edits are reviewed by experienced nurses and coders certified by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA).

We believe these enhancements will help you and your billing staff better understand our claims processing decisions, given the widespread use of these policies. This letter serves as the required notification of changes to our existing coding and editing guidelines.

Following the implementation, you may notice claim denials or payment adjustments based on these enhanced editing concepts in your Explanation of Payment or electronic remittances. For more information on Community Health Choice's new claims editing program or details specific to your claim submission and payment decisions, please contact us at the phone numbers listed below for each product.

STAR and CHIP:
- Local: 713.295.2295
- Toll-free: 1.888.760.2600

Marketplace:
- Local: 713.295.6704
- Toll-free: 1.855.315.5386

Medicare DSNP:
- Local: 713.295.5007
- Toll-free 1.833.276.8306

STAR+PLUS:
- Local: 713.295.2300
- Toll-free 1.888.435.2850

Sincerely,

Laurie Levermann
Chief Operating Officer
Community Health Choice

Revisions to the Explanation of Payment

The Explanation of Payment (EOP) has been enhanced to show DPP payments including TIPPS, RAPPS, BHS and CHIRP. Please see the example below highlighting the additional payment information.

Tax ID: 123456789 **EPC Draft:** 13529272 **Payment Week:** 32 **Payment Date:** 08/10/2020 Page 1 of 1

Service Date	Procedure Description	Units	Explanation Code(s)	Total Charge	Allowed Amount	Contractual Adjustment	Other Coverage	Other Adjustments	Patient Obligation				Net Payment Amount
									Co-Ins	Co-Pay	Deductible	Non-Cov	
Claim Number: 1082357891					**Group ID**: 1234					**Check Number:** 123456			
Provider: 123456789 - Dr. Service Provider					**Patient Name:** Sample Format					**Subscriber Name:** Sample Member			
Network: Sample Network					**Patient Acct #:** 123456789					**Subscriber ID:** 123456789-2			
06/16/20	99215	1	45, 144, OSC	$100.00	$80.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$80.00
06/16/20												**B Directed Payment Program for Behavioral Health Services (DPP BHS)**	$5.00
06/16/20	86140	1	45, 253	$35.00	$35.00	$0.00	$4.77	$0.70	$1.81	$0.00	$0.00	$0.00	$32.49
06/16/20												R Rural Access to Primary and Preventive Services Program (RAPPS)	$5.00
06/16/20	85651	1	253	$25.00	$25.00	$0.00	$4.64	$0.50	$1.24	$0.00	$0.00	$0.00	$23.26
			Claim Total	$160.00	$140.00	$20.00	$9.41	$1.20	$3.05	$0.00	$0.00	$0.00	$145.75
												Interest	$0.75
												Total Net Payment	$146.50

If you have questions about the new EOPs, please reach out to your assigned Performance Improvement Manager or call **713.295.2295** Toll-free: **1.888.760.2600 (STAR)** or **713.295.2300** Toll-free: **1.888. 435.2850 (STAR+PLUS)**.

Community Health Choice Prior Authorization Process

IMPORTANT REMINDERS

To help reduce delays and ensure smooth processing, it's important to remember a few key points about the prior authorization process.

All authorization requests should be submitted using the Texas Standard Prior Authorization (TSPA) form. This form is required for every request and must be completed fully and legibly. Incomplete or hard-to-read forms may delay processing.

The Prior Authorization List (PAL) is available on the Community Health Choice website. Each line of business-Medicaid, CHIP, Marketplace and Medicare-has its own PAL. Providers should always refer to the correct PAL before submitting a request. You can find links to each PAL on the Provider Home section of our website.

Using the Prior Authorization Look-Up Tool saves time and effort. It helps you avoid submitting requests for services that don't require authorization. When services don't need authorization, this tool ensures that you'll avoid unnecessary delays or paperwork. You can find it at http://www.provider.communityhealthchoice.org/resources/priorauthorization-information.

NON-PAYABLE CODES

For Medicaid members under age 21 and durable medical equipment (DME), prior authorization is required for certain non-payable codes.

However, if a non-payable code is submitted that does not meet these Medicaid-specific criteria (age or DME), it will be administratively denied as a non-payable code.

You do not need to submit a prior authorization request for any services or codes covered under your **Gold Card Status**.

SUBMITTING AN AUTHORIZATION REQUEST

TSPA Form Submission

Submitting a legible and fully completed TSPA form is critical. This helps prevent delays and ensures our team can begin reviewing the request immediately. In addition to the form, you must include clinical documentation to support the requested service.

TSPA Form Submission *Continued*

The more complete your submission, the faster we can process it. Missing or unclear information may result in delays or denials, so double-check all submissions before sending. The essential information required to initiate the PA review process includes:

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)
- Service requested - Current Procedural Terminology (CPT), Healthcare
- Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT)
- Service requested start and end date(s)

Clinical Criteria Guidelines

When submitting your clinical documentation, make sure it meets the correct criteria based on the member's line of business:

For Medicaid/CHIP, refer to the Texas Medicaid Provider Procedures Manual (TMPPM).

For Medicare, follow guidance from Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).

For Marketplace, refer to the Evidence of Coverage (EOC).

For some services, **Community Health Choice (CHC)** has developed its own medical review guidelines, which can be found on the CHC website under Medical Review Guidelines.

Physician Peer Discussion (Peer to Peer) is offered as a reasonable opportunity before any adverse determination is made on prior authorization requests, including urgent, standard, and incomplete Medicaid requests.

Need More Support?

You can find everything you need on the Community Health Choice Provider Portal. Taking a few minutes to check these resources can save hours of processing time. If you need additional assistance, you can call or email us.

Local: 713.295.2295 | **Toll-free:** 1.888.760.2600 | **Email:** ProviderWebInquiries@CommunityHealthChoice.org

Utilization Management Hours of Operations:

Medicaid: M-F, 8 a.m.-5 p.m., CHIP/Marketplace/Medicare: M-F, 6 a.m.-6p.m., Sat/Sun/Holidays 9 a.m.-12 p.m.

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 Prior Authorization Catalog is subject to change.

Low Dose Aspirin During Pregnancy

March of Dimes, the leading organization fighting for the health of all moms and babies, has a multi-year campaign aimed at decreasing the adverse effects of preeclampsia and preterm birth through the use of low dose aspirin called **Low Dose, Big Benefits**.

According to the CDC, 80% of pregnancy-related deaths are preventable and hypertensive disorders of pregnancy, like preeclampsia, are among the leading causes of deaths, particularly for Black moms.

Preeclampsia affects 1 in 25 pregnancies in the United States. Studies show that pregnant people at an increased risk for preeclampsia who take low dose aspirin may reduce their risk of preeclampsia by 15% and their risk of preterm birth by 20%.

This campaign focuses on raising awareness of low dose aspirin to reduce the negative impacts of preeclampsia. It includes resources to educate healthcare professionals (OB-Gyns, midwives and pharmacists) on the benefits of low-dose aspirin. Resources include a video course, screening materials and guidance to prescribe low dose aspirin. There's also educational information and resources that can be provided to pregnant individuals and their families during their pregnancy journey.

For more information on low dose aspirin, go to marchofdimes.org/lowdosebigbenefits

Reference: March of Dimes Low Dose, Big Benefits Campaign Launched News Article

Texas Medicaid HepCure

A public health initiative to reduce the rate of Hepatitis C in Texas

NOTE: This information was distributed by the Texas Health and Human Services Commission

The Texas Health and Human Services Commission (HHSC) launched a public health initiative in called **Texas Medicaid HepCure** to reduce the rate of Hepatitis C virus (HCV) in Texas. HHSC removed administrative barriers to improve access to HCV treatment for all patients.

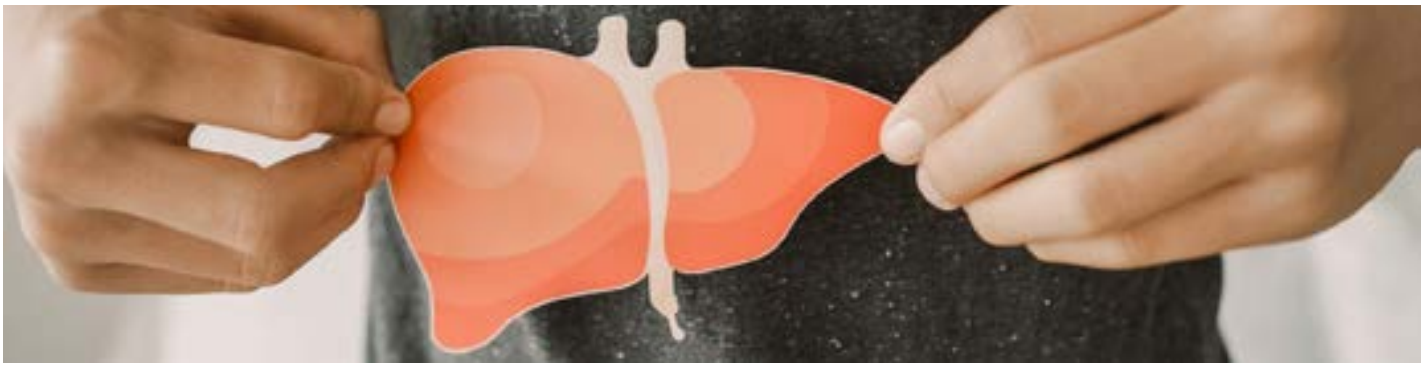
Texas Medicaid has designated MAVYRET as the preferred direct-acting antiviral (DAA) agent for treating hepatitis C infection. The product MAVYRET (glecaprevir/pibrentasvir) does not require clinical prior authorization when prescribed following Food and Drug Administration (FDA)-approved labeling. No HCV medication is required to be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist. All providers with prescriptive authority can prescribe this treatment to their patients with HCV. All Medicaid patients are eligible for DAA treatment with Mavyret, regardless of the patient's METAVIR fibrosis score. Drug screening is not required.

Background on Hepatitis C

Hepatitis C is a liver infection caused by HCV. It spreads through contact with blood from an infected person. For some people, hepatitis C is a short-term illness that resolves spontaneously, but it becomes a chronic infection for most people who become infected with HCV. Chronic HCV can result in serious, even life-threatening, health problems like cirrhosis and liver cancer.

People with HCV often have no symptoms and do not feel sick. When symptoms appear, they often are a sign of advanced liver disease. The number of persons unknowingly living with undiagnosed HCV infection is why broad population-based HCV screening is important. Screening, testing and treatment can save and prolong life.

DAA medications use molecules that target specific nonstructural proteins of the virus which results in disruption of viral replication and infection. They are oral medications taken once per day for several weeks. With cure rates above 90%, these drugs can virtually eliminate the disease. The medications can be prescribed using simplified treatment algorithms for most patients and do not require specialized clinical oversight or management.



HCV Screening and Testing

The Centers for Disease Control and Prevention (CDC) recommends that all adults ages 18 and older be screened for HCV at least once in a lifetime. Screening for HCV involves measuring antibodies to HCV in a person's serum. A reactive or positive test (detection of the antibody) is not a disease diagnosis; it only indicates that a person was previously exposed to the virus. If the antibody test is reactive, a nucleic acid test (also known as a polymerase chain reaction [PCR] test) for HCV ribonucleic acid (RNA) is needed to determine whether the person currently has active HCV infection. Often, the antibody test and the RNA test can be performed on a single blood draw, with a positive antibody test automatically reflexing to the HCV RNA test. The patient can be prescribed HCV treatment if the HCV RNA test is positive. In most instances, a simplified HCV treatment algorithm can be followed. See additional information in the "Resources for Providers" section.

Treatment Coverage

MAVYRET is an oral prescription medication for adults and children 3 and older with chronic HCV genotypes 1-6. In most cases, the treatment regimen is three pills taken once daily for eight weeks. MAVYRET treats all common HCV genotypes; therefore, a genotype test is not required before starting a patient on MAVYRET. MAVYRET is the only DAA identified as preferred on the Texas Preferred Drug List (PDL) and does not require clinical prior authorization when prescribed following FDA-approved labeling. Clinical prior authorization is still required for PDL non-preferred agents.

Follow-Up After Treatment

Patients who have received treatment should be tested for HCV RNA 12 weeks (or longer) after treatment completion. Undetectable or unquantifiable HCV RNA 12 weeks or longer after treatment completion is defined as a sustained virologic response (SVR) consistent with the cure of HCV infection.

Pregnant Persons

The CDC recommends that all pregnant persons should be screened for HCV during each pregnancy, regardless of age. This will aid providers in identifying HCV-infected pregnant persons, which can lead to treatment for the birthing person during the postpartum period. It can also help identify infants with perinatal exposure who should receive testing at a pediatric visit. There are currently no approved curative treatments available for pregnant persons or children under 3 years, but curative treatments are available for non-pregnant persons and for children 3 years and older.

Resources for Providers

HCV DAAs are safe, associated with high rates of cure, and have few side effects and contraindications. Some HCV patients may need to have their treatment managed by a specialist, such as those with hepatitis B virus or HIV co-infection, those who previously failed HCV treatment, or those with liver cancer or who have had a liver transplant. However, most cases of HCV can be treated by primary care physicians or advanced practice providers. Providers may find the following resources helpful, and can also visit txvendordrug.com/formulary/hepatitis-c-treatment for more information on Texas Medicaid HepCure and Hepatitis C:

- CDC Resources:
  - Recommended Testing Sequence for Identifying Current HCV Infection: cdc.gov/hepatitis/hcv/pdfs/hcv_flow.pdf
  - Testing Recommendations for HCV infection: cdc.gov/hepatitis/hcv/guidelinesc.htm
  - Hepatitis C Questions and Answers for Health Professionals: cdc.gov/hepatitis/hcv/hcvfaq.htm
- Prescriber Resources: www.hcv.com/provider-resources
- Texas Department of State Health Services (DSHS) Resources: https://www.dshs.texas.gov/hivstd/info/hepatitis-c

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 who have received 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 may be reached as follows:

Perinatal HIV Hotline
https://nccc.ucsf.edu
888.448.8765

24 hours, seven days a week

SYPHILIS.....Still an Epidemic? YES!

In July 2023, The Houston Health Department (HHD) declared a syphilis outbreak in Houston and Harris County.

2023 CDC STI Surveillance Report showed that after several years of increase, the 2023 data is promising. It suggests that the sexually transmitted infections (STI) epidemic may be slowing. Despite these small wins, there's still a lot of work to be done.

For total syphilis cases: In 2023, despite the increase in cases, the overall rate of reported cases per 100,000 people remained relatively stable, increasing by less than 1% as compared to 2022.

United States	2019	2020	2021	2022	2023	2023 Rate per 100,000 lives/live births
Total Syphilis	127,943	131,797	173,858	203,500	209,253	61.3
Primary/Secondary Syphilis	38,992	41,655	53,767	59,016	53,007	15.8
Congenital syphilis	1882	2162	2875	3,775	3,882	105.8
Texas						
Primary/Secondary Syphilis	2,357	2,708	3,865	4,655	4,562	15
Congenital syphilis	528	561	685	955	930	238.6

Note: total syphilis (all stages and congenital syphilis combined)

For congenital syphilis, In 2023, Texas has moved from being ranked #1 to #5.

The Houston Health Department (HHD) recommends syphilis testing to:

- Pregnant women at their initial prenatal visit, third trimester and delivery (required by state law)
- People who have had unprotected sex.
- Men with anonymous sex partners

- People with multiple sex partners
- People recently diagnosed with any other sexually transmitted disease such as gonorrhea, Chlamydia or HIV.

What can you, as a provider, do to help combat this outbreak?

1. Make sexual health a priority at every health visit.
2. Ask women AND men about their sexual practices.
3. Provide education including safe sex practices. If you talk about it, patients will.
4. Screen, test and treat annually (more often if indicated) anyone who is sexually active.
    a. Check results of testing
5. If you provide care to pregnant people, syphilis testing should occur 3 times during pregnancy.
    a. Initial prenatal visit
    b. Third trimester (between 28 and 32 weeks)
    c. At delivery
6. Report syphilis infections so sexual contacts can be located, tested, and treated.
    a. HHD's Healthcare Provider Reporting:
        *Provider eFax: 832-395-9683
        *Provider phone: 855-264-8463

Information on testing sites is available by visiting HHD's Syphilis Testing and Treatment site.

A specific Congenital Syphilis Contact by region is located on DSHS Congenital Syphilis site.

Sources:

CDC STI Statistics

CDCs 2023 STI Surveillance Report-State Ranking Tables

Texas Health and Human Services Texas Department of State Health Services 2023 Congenital Syphilis Report

Houston Health Department Syphilis Testing and Treatment

Year Long Prescription For Contraception

HB 916 requires health insurers to allow a three-month supply at once to a person who is prescribed a new, covered contraceptive drug and then a 12-month supply at once thereafter.

As of January 1, 2024, health insurers* including Medicaid that cover prescription contraceptive drugs are required to provide a year's supply of the medication at once. This does not apply to the Children's Health Insurance Plan (CHIP).**

What does this mean?

Many women struggle to maintain consistent contraceptive use with a monthly or a 3-month supply of birth control which may lead to an unplanned pregnancy. This bill allows women to obtain birth control for up to a 12-month supply at one time.

How does it work?

A health benefit plan that provides benefits for a prescription contraceptive drug must provide for an enrollee to obtain up to:

1. A three-month supply of a covered prescription contraceptive drug at one time the first time the drug is obtained. Clinically administered contraceptives are not applicable. AND
2. A 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the same drug. regardless of whether the enrollee was enrolled in the health benefit plan the first time the enrollee obtained the drug.

An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period. Pharmacists can only dispense a 12-month supply per calendar year.

***Applicable to:** Health insurers include TDI-regulated commercial plans, exchange plans, HMOs, school districts, Medicaid

****Not applicable to:** Children's Health Insurance Plan (CHIP), self-funded ERISA plans, self-funded municipal plans (except school districts)

Source:

Texas House Bill 916 passed in the 88th legislative session. Effective September 1, 2023. https://legiscan.com/TX/text/HB916/id/2814458/Texas-2023-HB916-Enrolled.html

12 Month Extension Of Postpartum Coverage

"Out of the state's profound respect for the lives of mothers and unborn children, Medicaid coverage is extended for mothers whose pregnancies end in the delivery of the child or end in the natural loss of the child." (Wording of the bill)

Effective March 1, 2024, postpartum Medicaid STAR and CHIP (Children's Health Insurance Program) coverage is extended from the current two (2) months to:

- 6 months after a pregnancy loss (following the date the woman delivers or experiences an involuntary miscarriage)
- 12 months after a live birth

This extended postpartum coverage does not apply to CHIP Perinatal (CHIP-P) recipients. CHIP-P will continue to receive CHIP-P coverage through the end of the month when their pregnancy ends plus two postpartum visits.

Why is having 12 months of postpartum Medicaid coverage important?

- Half of the people giving birth in Texas get their health care coverage through Medicaid.
- Women with chronic health conditions have a 43 percent increased likelihood of preterm birth compared to women with none.
- 30% of pregnancy-related deaths occur from 43 days to 1 year after delivery according to the CDC.
- There is an increased risk of adverse outcomes due to the lack of access to reproductive and sexual health services.

What does this mean?

As patients transition to the postpartum period, their medical needs will change. Medicaid and CHIP recipients will now have access to covered services and providers that meet these changing needs throughout the extended postpartum period.

Covered services during the 12-month postpartum period include but is not limited to:

- Preventive or routine care to receive physicals, vaccinations, and sick visits.
- Continued care from an OB/GYN for gynecological care or contraception

- Continued treatment of physical health complications from the pregnancy and/or delivery
- Possible continued or emergent behavioral health treatment, including for substance use and mental health conditions.
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and preexisting conditions

How does the recipient get coverage extended?

- Medicaid and CHIP recipients DO NOT need to apply to have their coverage extended.
- Coverage will be automatically reinstated for the remainder of the 12-month postpartum period for women who are not current Medicaid or CHIP recipients but who were enrolled in Medicaid or CHIP in Texas while pregnant and are still within their 12-month postpartum period (provided they are still residents of Texas).
- Women who are enrolled in Healthy Texas Women who are still within their 12-month postpartum period will be transitioned back to full-coverage Medicaid or CHIP for the remainder of their 12-month postpartum period.
- The Medicaid or CHIP recipients will get a notice by mail or through their "Your Texas Benefits" account (if they chose to receive notices electronically).

Exceptions to eligibility

Eligible Medicaid and CHIP recipients will receive the extended coverage through their postpartum period unless they:

- Voluntarily withdraw.
- Move out of Texas.
- Are determined ineligible because of fraud, abuse or perjury.
- Die

For more information

- Call 2-1-1 and choose Option 2.
- Visit the HHS Medicaid for Pregnant Women and CHIP Perinatal webpage.
- See attached frequently asked questions (FAQs)

Sources:

House Bill 12 (HB 12) passed in the 88th legislative session.

Susanna Trost, MPH; Jennifer Beauregard, MPH, et.al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. CDC

2022 Texas Maternal Mortality and Morbidity Review Committee (MMMRC) and the Department of State Health Services (DSHS) Biennial report

Postpartum Medicaid and CHIP Coverage Extension FAQs

The Texas Health and Human Services Commission (HHSC) extended its postpartum Medicaid coverage from two to 12 months for eligible women, effective March 1, 2024.

HHSC is also providing 12 months of postpartum CHIP (Children's Health Insurance Program) coverage. The 12 months of postpartum coverage begins the month after a pregnancy has ended.

Q: Who is eligible for the 12-month postpartum coverage?

A: Effective March 1, 2024, eligible recipients include:

- Medicaid or CHIP recipients who are pregnant or become pregnant and women who enroll because they become pregnant.
    - CHIP Perinatal (CHIP-P) recipients are not eligible for 12 months of postpartum coverage. They'll continue to receive CHIP-P coverage through the end of the month when their pregnancy ends plus two postpartum visits.
- Medicaid or CHIP recipients who were enrolled in Medicaid or CHIP while pregnant or are no longer pregnant but are still within their 12-month postpartum period.
    - Women who transitioned from Medicaid or CHIP to Healthy Texas Women (HTW) after their pregnancy ended and who are within their 12-month postpartum period will be reinstated to full coverage Medicaid or CHIP.
- Women who received services while pregnant in Texas that would have been covered by Medicaid but who apply for Medicaid after their pregnancy ends. Medicaid applicants with unpaid medical bills can apply for coverage for up to three months before their application month. This doesn't apply to CHIP applicants.

Q: I'm not a current recipient, but I'm within my 12-month postpartum period. Does my coverage start from the date my benefits were terminated until the end of my 12-month postpartum period?

A: Your Medicaid or CHIP coverage will be reinstated beginning on March 1, 2024, until the end of your 12-month postpartum period.

Q: Do I have to apply for postpartum coverage?

A: No, you don't need to apply to have your coverage extended. Coverage will be extended for current Medicaid and CHIP recipients.

Coverage will be reinstated for women who are not current Medicaid or CHIP recipients but who were enrolled in Medicaid or CHIP in Texas while pregnant and are still within their 12-month postpartum period (if they are still residents of Texas).

Women who transitioned from Medicaid or CHIP to HTW after their pregnancy ended and who are within their 12-month postpartum period will be reinstated to full coverage Medicaid or CHIP.

Only women who are not currently enrolled in Medicaid or CHIP and were not enrolled in Medicaid coverage during their pregnancy need to apply to receive this benefit. Medicaid recipients with unpaid medical bills can apply for coverage for up to three months prior to their application month. This doesn't apply to CHIP recipients.

Q: What kind of coverage is included in the 12-month postpartum period?

A: Medicaid or CHIP covered services remain available in the 12-month postpartum period. This is including but not limited to:

- Regular medical checkups.
- Prescription drugs and vaccines.
- Hospital care and services.
- X-rays and lab tests.
- Vision and hearing care.
- Access to medical specialists and mental health care.
- Treatment of special health needs and pre-existing conditions.

Q: If I'm eligible for the rest of my 12 months of postpartum coverage, how will I be notified?

A: You'll get a notice by mail or through Your Texas Benefits (if you've chosen to receive notices electronically).

All Medicaid and CHIP recipients should go to YourTexasBenefits.com or call 2-1-1 and choose Option 2, to make sure your mailing address and contact information are up to date.

Q: My pregnancy ended before the effective date of March 1, 2024, and I was previously receiving Medicaid or CHIP services. Will my coverage be extended?

A: Yes, if you are still within your 12-month postpartum period. Beginning on March 1, your coverage will be reinstated for the rest of your 12-month postpartum period.

Q: My pregnancy didn't go to term or there was a miscarriage/loss of pregnancy. Am I still eligible?

A: Yes, you're still eligible for coverage for 12 months after your pregnancy ended.

Q: If I get pregnant again during my 12-month coverage, what happens to my coverage?

A: If you report a new pregnancy while in your 12-month postpartum period, your eligibility will be reviewed for Medicaid or CHIP.

If you're eligible for Medicaid or CHIP for your new pregnancy, you'll receive coverage for the pregnancy and for 12 months after the new pregnancy ends.

Q: What happens if I report a new pregnancy in that 12-month postpartum period, but when my eligibility is reviewed, I'm no longer eligible and can't get certified for the new pregnancy?

A: You would remain enrolled in Medicaid or CHIP for your entire first 12- month postpartum period unless you:

- Voluntarily withdraw. Move out of Texas.
- Are determined ineligible because of fraud, abuse or perjury.
- Die.

Q: Will I get a new Medicaid card for my 12-month postpartum coverage?

A: If you are currently receiving Medicaid or CHIP services you won't get a new Medicaid or CHIP ID card for the 12-month postpartum coverage period.

If you previously received Medicaid or CHIP services that are being reinstated or you're newly applying for coverage, you'll get a new Medicaid or CHIP ID card.

Q: Will I receive services through my managed care organization?

A: In most cases, you'll be enrolled in your prior managed care plan. If you have questions about enrollment in managed care, contact the Enrollment Broker at 1-800-964-2777.

Q: If I'm currently on CHIP and am eligible for 12-month postpartum coverage, will I need to pay another enrollment fee to get the extended coverage?

A: If you're currently receiving CHIP services and were found eligible by HHSC to receive 12-month postpartum coverage, you won't need to pay another enrollment fee to get 12-month postpartum coverage.

Q: Will my eligibility be automatically renewed when my 12-month postpartum period ends?

A: We'll attempt to automatically renew your Medicaid or CHIP coverage about two months before your 12-month postpartum period ends.

If you aren't eligible for full coverage Medicaid or CHIP, we'll determine if you're eligible for the HTW program. If we can't automatically verify your eligibility, we'll send you a renewal packet. Your renewal application must be returned within 30 days.

Q: I have more questions, who do I contact?

A: To learn more, visit the HHS Medicaid for Pregnant Women and CHIP Perinatal webpage, or call 2-1-1 and choose Option 2.

Child Psychiatry Access Network (CPAN)

The Child Psychiatry Access Network (CPAN) is a FREE, statewide initiative, funded by the Texas legislature, to address the mental health needs of Texas children and adolescents. The network of academic hubs for South and Southeast Regions (Region 2) includes Baylor College of Medicine, The University of Texas Health Science Center at Houston, and The University of Texas Medical Branch at Galveston

Mental health is an important part of our children and adolescent's overall health and well-being. More children and youth need mental health support now more than ever before. One in five children have a mental health disorder but cannot get timely access to psychiatric care due to a shortage of child psychiatrists and other behavior health professionals. This results in families often waiting for months before their child can see a psychiatrist.

CPAN is a free service for primary care physicians (PCPs) and pediatricians who provide care for children and youth under the age of 23. This is an evidence-based clinician-to-clinician program. This program is to enhance child and youth mental health care at the PCP's and pediatrician's practice.

CPAN offers these services:

1. Consultations with a child psychiatrist to help with any mental health question including those about assessment, diagnosis, and implementation of treatments plans including psychopharmacology.
2. Guidance in developing behavior management plan.
3. Facilitated referrals to reliable mental health providers in your community.
4. Training opportunities for PCP's and pediatricians to improve the care of children and adolescents with behavioral health needs.

VISIT WEBSITE OR CALL TO ENROLL: https://tcmhcc.utsystem.edu/child-psychiatry-access-network-cpan/

Call 1 (888) 901-CPAN (2726), press 2 for South and Southeast Region and then "academic hub number" (see below) per your clinic's zip code.

1. Baylor College of Medicine
2. The University of Texas Health Science Center at Houston
3. The University of Texas Medical Branch at Galveston

If the academic hub is not known, then press "9" to get assistance in identifying your academic hub.

(View Video) https://youtu.be/tTGcgml8dPc

REFERENCE:

Texas Child Mental Health Care Consortium: https://tcmhcc.utsystem.edu/child-psychiatry-access-network-cpan/

Perinatal Psychiatry Access Network (PeriPAN)

Maternal mental health conditions are the most common complications of pregnancy and childbirth. In Texas, maternal mental health conditions affect more than 1 in 8 pregnant and postpartum women. Most of these women do not receive mental health care in a timely fashion.

Mental health conditions contribute to 21% of pregnancy-related deaths in Texas and is the cause of 17% pregnancy-related deaths. Substance use disorders contribute to 8% of pregnancy-related deaths.[1]

Texas Perinatal Psychiatry Access Network (PeriPAN) is a FREE, state-funded initiative that offers access to a multidisciplinary network of mental health experts-including a reproductive psychiatrist-for peer-to-peer consults by phone. This program is for clinicians treating pregnant women and new mothers who may be experiencing mental health distress. PeriPAN's goal is to increase the clinician's capacity to treat maternal mental health conditions for people who are pregnant, postpartum, suffering perinatal loss, or planning pregnancy.

This network of psychiatrists assists clinicians by offering:

- Prompt real-time phone-based consultation on issues such as diagnostic clarification, treatment plans, and medication management.
- Facilitated assistance to vetted referrals and resources
- Free CMEs on perinatal psychiatry subjects/reproductive mental health

PeriPAN is available to clinicians who provide care to pregnant and postpartum people including but not limited to:

- OB/Gyns
- Pediatricians
- Family Practitioners
- Other Primary Care Physicians
- Midwives
- Psychiatrists
- Psychologists

VISIT WEBSITE OR CALL TO ENROLL: https://tcmhcc.utsystem.edu/perinatal-psychiatry-access-network-peripan/

Call 1 (888) 901-CPAN (2726), press 2 for South and Southeast Region and then "academic hub number" (see below) per your clinic's zip code.

1. Baylor College of Medicine
2. The University of Texas Health Science Center at Houston
3. The University of Texas Medical Branch at Galveston

If the academic hub is not known, then press "9" to get assistance in identifying your academic hub.

(See Video): https://www.youtube.com/watch?v=9YEMxs7dXAM

REFERENCES:

Texas Child Mental Health Care Consortium: https://tcmhcc.utsystem.edu/perinatal-psychiatry-access-network-peripan/

1. Texas Maternal Mortality and Morbidity Review Committee (MMMRC) and Department of State Health Services Joint Biennial Report 2022

Electronic Visit Verification (EVV)

Visit Maintenance Unlock Request (VMUR)

A Visit Maintenance Unlock Request, when approved, allows a program provider, FMSA, CDS employer or PSO the opportunity to correct data element(s) on an EVV visit transaction(s) after the visit maintenance time frame has expired.

- Program providers, FMSA and CDS employers must complete all required visit maintenance, including entry of manual EVV visits, within ninety-five (95) days from the date of service delivery.
- After the visit maintenance time frame has expired, the EVV system locks the EVV visit transaction and program providers, FMSAs or CDS employers may only complete visit maintenance if Community approves a Visit Maintenance Unlock Request.

Reminders:

- Request must be sent via Secure Email to Community.
    - If you need assistance initiating a secure email communication, please request one at EVVProvider@CommunityHealthChoice.org.
    - The latest VMUR template provided by HHSC must be utilized for consideration.
        - Note: you can find this on our EVV provider webpage.
    - Once Community receives the VMUR request, please allow up to ten (10) business days for review.

Be sure to visit our EVV Provider Webpage for the latest updates: https://provider.communityhealthchoice.org/electronic-visit-verification/

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 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

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.

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.

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 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.
3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical Provider who can return the call within 30 minutes.

Unacceptable after-hours coverage

1. The office telephone is only answered during office hours.
2. The office telephone is answered after-hours by a recording that tells Members to leave a message.
3. The office telephone is answered after-hours by a recording that directs Members to go to an emergency room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

Prenatal Appointment Availability Requirements

Prenatal care must be provided within 14 days for initial appointment except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within 5 days or immediately if an emergency exists. Appointments for ongoing care must be available in accordance with the treatment plan as developed by the Provider.

Level/Type of Care	Time to Treatment (Calendar Days)
Low-Risk Pregnancies	14 Days
High-Risk Pregnancies	5 Days
New Member in the Third Trimester	5 Days

HEDIS Season is Upon Us!

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

Frequently Asked Questions:

1) **When is the collection period?**
   The medical record collection period has begun and will run through April 28, 2025.

2) **What will be requested?**
   The medical records for specifically identified Members that provide documentation to support HEDIS® reporting.

3) **Am I required to respond?**
   Yes, this is a required quality improvement activity in the contract with Community Health Choice.

4) **What should the record include?**
   - Member name (on each page)
   - Member date of birth
   - Member health plan ID
   - Date of service
   - Provider signature with credentials
   - Measure specific requested information and visit notes

5) **Who will request medical records?**
   Community partners with KDJ Consultants to perform HEDIS® medical record collection and data abstraction on our behalf. KDJ Consultants will request copies of chart components to be sent by secure fax for offsite review. KDJ Consultants also has the capability to provide access to a secure portal or to set up EMR access to review medical records remotely. If you would like to set up EMR access or be provided with a link to the secure portal, please contact HEDIS@CommunityHealthChoice.org so procedural details can be worked out.

We appreciate your help and prompt attention during this medical record collection process. We know that time with your patients—our Members—is valuable. We ask that you respond to the medical records request within 5-7 days.

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

Enhancing Patient Engagement: New Mammography Decision Aids Available on Our Website

We are excited to announce a set of patient decision aids (PDAs) for breast cancer screening has been added to our website!

Community Health Choice is committed to empowering our members to make informed decisions about their health and healthcare options. We understand that navigating healthcare can be challenging, and we believe that providing the right tools is essential to enhancing member engagement in the care process.

PDAs are evidence-based tools that provide clear, straightforward information about specific medical decisions, treatments, or procedures. They are designed to help you start a dialogue that can help your patients understand their healthcare options, allow them to weigh potential benefits or harms, and ultimately make choices that align best with their preferences and values.

These new decision aids can be easily accessed via our provider website. To find them, simply navigate to the **Forms & Guides** section under the provider resources tab, where you will find the **Patient Decision Aids (PDAs)** subsection.

Here you will find PDAs covering breast cancer screening options for women between the ages of **40-49, 50-74**, and **75** and older.

Thank you for your continued commitment to delivering high-quality care and supporting our members through informed choice.

Flu Vaccination Awareness for Children

Healthcare providers need to educate patients on getting the flu vaccination for the following reasons:

1. The primary goal is to protect patients from getting the flu, which can cause a range of symptoms from mild to severe, and in some cases, lead to hospitalization or death.
2. Even if a vaccinated individual contracts the flu, the vaccine can reduce the severity of the illness, leading to milder symptoms and a quicker recovery.
3. Healthcare providers play a crucial role in encouraging high-risk groups, such as the elderly, young children, and those with chronic conditions, to get vaccinated, as they are more susceptible to severe flu complications.
4. The Centers for Disease Control (CDC) recommends children to get their first dose at age 6 months and then continue to receive a flu vaccine at least once a year.

WE NEED YOUR SUPPORT TO COLLABORATE:

1. Community's new vaccine guidance page on the wellness corner for members https://www.communityhealthchoice.org/wellness-corner/vaccines/ that includes:
   - Member Scheduling Assistance and Transportation Request Form
   - Printable parent friendly vaccine schedule in English and Spanish
   - A calendar of mobile immunization events and other helpful resources for parents
   - Education on vaccines that are recommended for different age groups.
2. Practical HEDIS tips for ensuring compliance with Childhood Immunization Status (CIS) during this flu season:
   - Educate office staff to schedule flu vaccine appointments early in the season (it started October 1st in 2023).
   - Any vaccines after the age of 2 years old are considered late for HEDIS reporting so make sure members get the shot once a year and before they turn 2.
   - Review Community's 2023 HEDIS Quick Reference guide for tips on appropriate billing/coding - **Flu CPT: 90655, 90657, 90661, 90673, 90685-90689 CVX: 88, 140, 141, 150, 153, 155, 158, 161 HCPCS: G0008**
   - Submit all immunizations records to ImmTrac. For more information please visit the Texas Department of State Health Services website: https://www.dshs.texas.gov/immunization-unit/immtrac2-texas-immunization-registry
3. Have the Member call Community's wellness coaching and health literacy support line at 1-844-882-7642 or 713-295-6789. Members can receive education on vaccines, the importance of routine preventive care, and more from our team of certified Community Health Workers.

Providers – Your Impact on Mental Health

Providers must be informed of the importance of reducing potentially preventable admissions in a behavorial 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 in a behavorial 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 appointments with the Provider 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 at 713.295.6704
  - Providers may fax referral information to our dedicated behavioral health team at 713.576.0932 (inpatient) or 713.576.0930 (outpatient)

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 and 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 requires a team of professionals and the 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:

- 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 from 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 with 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, services, and Member experiences. Cooperation includes the 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.

American Heart Month

Heart disease is a leading cause of death in the United States. Women and men may have different symptoms of a heart attack:

Female Silent Symptoms:

- Indigestion
- Feeling of strained muscle in the chest or upper back
- Or prolonged excessive fatigue

Male Symptoms:

- Chest Pain, pressure, fullness
- Discomfort in other areas of your body
- Difficulty breathing and dizziness
- Nausea and cold sweats

During the patient assessment, discuss common and silent symptoms that can cause a heart attack. Direct the patient to the Center for Disease Control and Prevention (CDC) that has various resources for individuals and patients that can assist in decreasing the risk of heart disease.

https://www.cdc.gov/heartdisease/american_heart_month_patients.htm

The CDC website provides information and handouts:

- Stroke
- High Blood Pressure
- Cholesterol
- Million Hearts
- Wisewoman Program
- And other chronic disease topics related to heart disease

Diabetes Significantly Impacts Texas

The prevalence of diabetes in Texas and the nation has substantially increased over the past decade.

- Diabetes-related complications have a greater death risk than many types of cancer.
- Diagnosed diabetes costs an estimated $25.6 billion in Texas each year.
- There are 7,142,000 people in Texas with 34% of the adult population having prediabetes.
- Approximately 2,758,942 people in Texas, or 12.3% of the adult population, have diagnosed diabetes.
- Regularly assessing fasting blood sugar is essential.
    - o According to the CDC, a consistent fasting blood sugar level of 99 mg/dL or lower is normal, 100 to 125 mg/dL indicates a person may have prediabetes, and 126 mg/dL or higher indicates a person may have diabetes.
- A blood test, hemoglobin A1C (HbA1C), is also used as an indicator of diabetes. This test measures your average daily blood glucose levels over the prior 3 months.
    - o According to the CDC, a standard, non-diabetic HbA1C level is less than 5.7%. A HbA1c value of 5.7 % to 6.4 % is prediabetic, and diabetes can be diagnosed with a HbA1c of 6.5% or higher.

Late diagnosis causes several complications:

- Delays treatment
- Increases the risk for diabetes-related complications, such as diabetic ketoacidosis, blindness, heart attack, stroke, kidney failure, and amputation
- Reduces both length and quality of life

Are you effectively reducing poor health outcomes for fellow Texans with diabetes, as much as you would like?

Consider connecting with the Texas Diabetes Council (TDC) to learn more about closing common care gaps for this population.

The TDC was established in 1983 with the goal of partnering with private and public healthcare organizations to promote diabetes prevention and awareness in Texas in addition to identifying and assisting with addressing issues impacting Texans with diabetes.

The TDC is also responsible for assessing the state's diabetes prevention and treatment programs. This information is then used to create and implement the Texas Diabetes State Plan, which is updated annually, odd-numbered years.

Diabetes has a significant impact on longevity, quality of life, productivity, and healthcare expenditures for affected Texans. The Texas Diabetes State Plan of 2023 includes the following priority areas:

- Improving eye health in all persons with diabetes.
- Improving mental health in all persons with diabetes
- Reducing identified health disparities for all persons with diabetes and/or obesity
- Expanding the use of advanced diabetes technologies
- Increasing access to insulin and diabetes treatments

How can a Provider connect with the TDC?

- Email: diabetes@dshs.texas.gov
- Phone: 512-776-2834
- Website: https://www.dshs.texas.gov/diabetes/texas-diabetes-council

References:

https://www.dshs.texas.gov/diabetes/texas-diabetes-council

https://www.dshs.texas.gov/sites/default/files/txdiabetes/PDF/Texas_Diabetes_Council_2023_State_Plan_to_Prevent%20and_Treat_Diabetes_and_Obesity_Report.pdf

https://www2.diabetes.org/sites/default/files/2023-03/ADV_2023_State_Fact_sheets_all_rev_TX.pdf

TMPPM Update for OEFV Services

The Texas Medicaid & Healthcare Partnership (TMHP) has updated language in the Texas Medicaid Provider Procedures Manual (TMPPM), Children's Services Handbook, subsection 4.3.13.1, "Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home," to clarify the following requirements:

- OEFV is limited to Texas Health Steps medical checkup providers who have completed the required benefit education and are certified by the Texas Health Steps Dental Program to perform OEFV services.
  - Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.
- The primary care provider must complete the intermediate oral evaluation but can delegate all other components.

For more information, call the TMHP Contact Center at 800-925-9126.

Back to School - Sports and Physical Exams

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

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

Code	Level of Complexity	Number of Comorbidities	Number of Elements Addressed	Time Duration
97169	Low	0	1 - 2	15 Minutes
97170	Moderate	1 - 2	3 or More	30 Minutes
97171	Moderate	3 or More	4 or More	45 Minutes
97172	Re-evaluation of athletic training established plan of care requiring these components: • assessment of patient's current functional status when there is a documented change • revised plan of care using a standardized patient assessment instrument and/or measureable assessment of functional outcome with an update in management options, goals and interventions.			20 Minutes

Back to School - Immunizations

The 2025-2026 Texas Vaccine requirements for students grades K – 12 can be downloaded via

http://www.dshs.texas.gov/sites/default/files/LIDS-Immunizations/pdf/pdf_stock/6-14.pdf

2025 - 2026 Texas Minimum State Vaccine Requirements for Students Grades K - 12

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This document is not intended as a substitute for the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements by the Texas Education Code, Chapter 38.

IMMUNIZATION REQUIREMENTS

A student shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a public or private elementary or secondary school in Texas.

Vaccine Required (Attention to notes and footnotes)	Minimum Number of Doses Required by Grade Level			Notes
	Grades K - sixth (K 1 2 3 4 5 6)	Grade seventh (7)	Grades eighth-12th (8 9 10 11 12)	
Diphtheria/Tetanus/ Pertussis(DTaP/DTP/DT/ Td/Tdap)	Five doses or four doses	Three dose primary series and one booster dose of tdap / td within the last five years	Three dose primary series and one booster dose of tdap / td within the last 10 years	For K – sixth grade: five doses of diphtheria-tetanus-pertussis vaccine; one dose must have been received on or after the fourth birthday. However, four doses meet the requirement if the fourth dose was received on or after the fourth birthday.[1] For students aged 7 years and older, three doses meet the requirement if one dose was received on or after the fourth birthday.[1] For seventh grade: one dose of Tdap is required if at least five years have passed since the last dose of tetanus-containing vaccine.* For eighth – 12th grade: one dose of Tdap is required when 10 years have passed since the last dose of tetanus-containing vaccine. **Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.
Polio	Four doses or three doses			For K-12th grade: four doses of polio; one dose must be received on or after the fourth birthday.1 However, three doses meet the requirement if the third dose was received on or after the fourth birthday[1]. Polio vaccine is not required for persons eighteen years of age or older.
Measles, Mumps, and Rubella [2] (MMR)	Two doses			For K – 12th grade: two doses are required, with the first dose received on or after the first birthday. [1] Students vaccinated prior to 2009 with two doses of measles and one dose each of rubella and mumps satisfy this requirement
Hepatitis B[2]	Three doses			For students aged 11 – 15 years, two doses meet the requirement if adult hepatitis B vaccine (Recombivax®) was received. Dosage (10 mcg /1.0 mL) and type of vaccine (Recombivax®) must be clearly documented. If Recombivax® was not the vaccine received, a three dose series is required.
Varicella[2, 3]	Two doses			For K – 12th grade: two doses are required, with the first dose received on or after the first birthday.[1]
Meningococcal (MCV4)		One dose		For seventh – 12th grade, one dose of quadrivalent meningococcal conjugate vaccine is required on or after the student's 11th[1] birthday.
Hepatitis A[2]	Two doses			For K – 12th grade: two doses are required, with the first dose received on or after the first birthday.[1]

NOTE: Shaded area indicates that the vaccine is not required for the respective grade.

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.

THSTEPS Checkup Timeliness

- **New Community 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 or enrollment in the Head Start program. This is a Head Start requirement.
- **Existing Community Members** must complete a checkup in accordance with the THSteps Medical Checkup Periodicity Schedule. Follow this schedule:

Complete before the next checkup age	
Newborn	2 months
3-5 days	4 months
2 weeks	
Complete within 60 days of these checkup ages	
6 months	18 months
9 months	24 months
12 months	30 months
15 months	

Complete on or after the birthday but before the next birthday
Members ages 3 through 20 need a checkup once a year

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

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

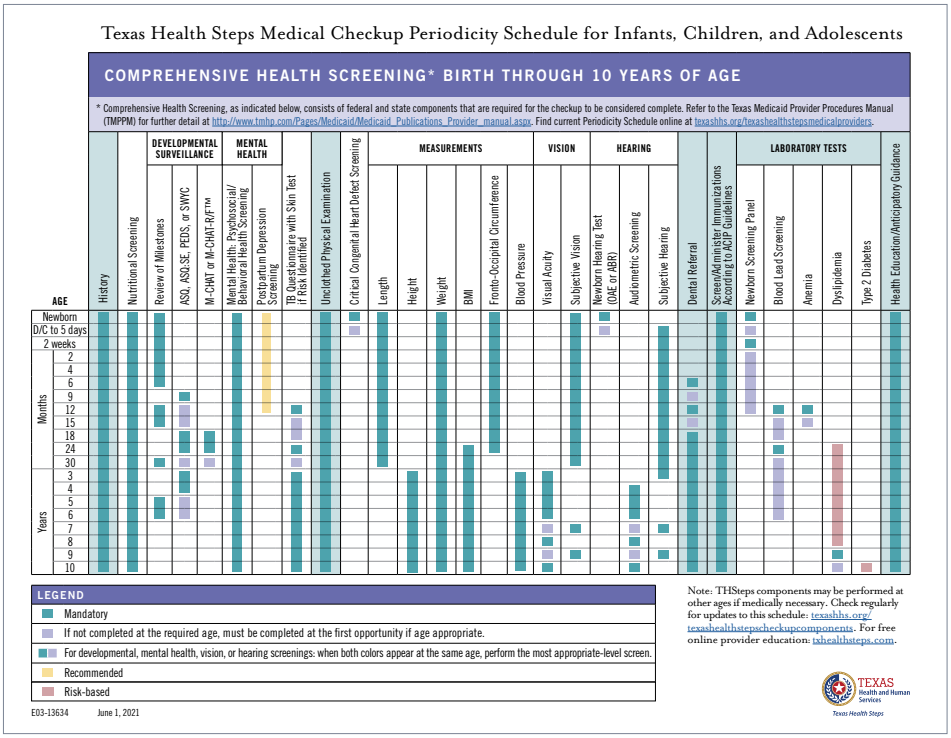
We offer free transportation for CHIP Members to doctors' appointments when no other transportation is available with prior approval by our case manager.

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: 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

DEVELOPMENTAL SURVEILLANCE: Review of Milestones; ASQ, ASQ-SE, PEDS, or SWYC; M-CHAT, or M-CHAT-R/F™

MENTAL HEALTH: Mental Health: Psychosocial/Behavioral Health Screening; Postpartum Depression Screening

TB Questionnaire with Skin Test if Risk Identified

Unclothed Physical Examination

MEASUREMENTS: Critical Congenital Heart Defect Screening; Length; Height; Weight; BMI; Fronto-Occipital Circumference; Blood Pressure

VISION: Visual Acuity; Subjective Vision

HEARING: Newborn Hearing Test (OAE or ABR); Audiometric Screening; Subjective Hearing

Dental Referral

Screen/Administer Immunizations According to ACIP Guidelines

LABORATORY TESTS: Newborn Screening Panel; Blood Lead Screening; Anemia; Dyslipidemia; Type 2 Diabetes

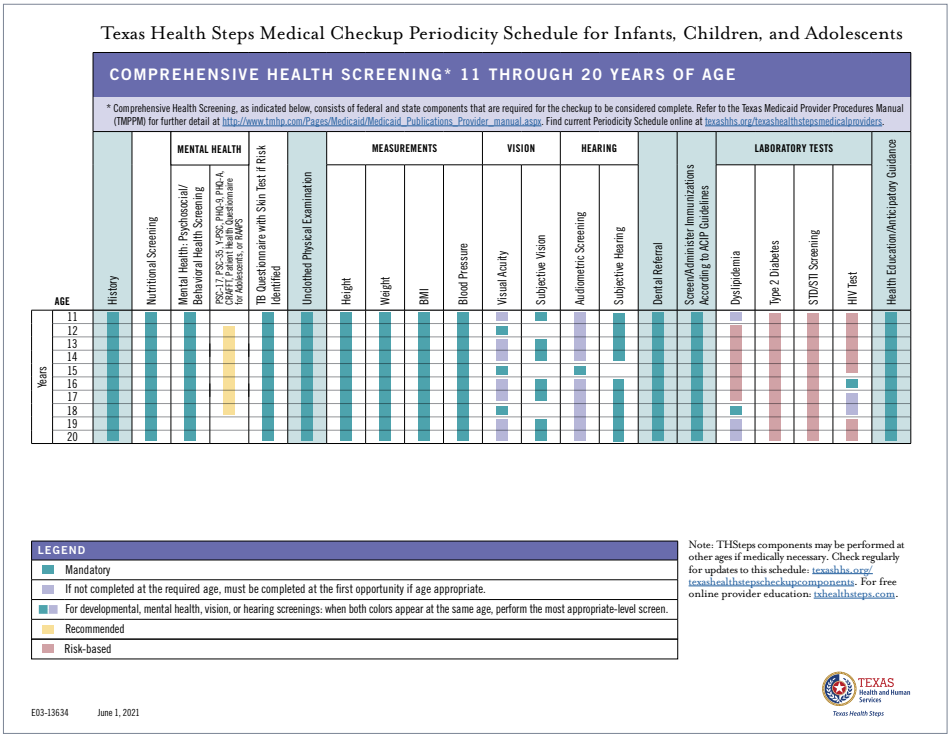
Health Education/Anticipatory Guidance

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.

TEXAS Health and Human Services — Texas Health Steps

E03-13634 June 1, 2021



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

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

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

AGE: Years 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

MENTAL HEALTH: Mental Health: Psychosocial/Behavioral Health Screening; PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, PSYCKE Patient Health Questionnaire for Adolescents, or RAAPS

TB Questionnaire with Skin Test if Risk Identified

Unclothed Physical Examination

MEASUREMENTS: Height; Weight; BMI; Blood Pressure

VISION: Visual Acuity; Subjective Vision

HEARING: Audiometric Screening; Subjective Hearing

Dental Referral

Screen/Administer Immunizations According to ACIP Guidelines

LABORATORY TESTS: Dyslipidemia; Type 2 Diabetes; STD/STI Screening; HIV Test

Health Education/Anticipatory Guidance

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.

TEXAS Health and Human Services — Texas Health Steps

E03-13634 June 1, 2021

THSteps Medical Checkup Billing Procedure Codes

TMHP updated the Texas Health Steps Quick Reference Guide (QRG) on February 1, 2025. Influenza vaccine (procedure codes 90630 and 90654) will be removed from the Immunizations Administered column as it is no longer a benefit of Texas Medicaid.

The updated guide is available at Texas Health Steps Quick Reference Guide

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

Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

Procedure Codes	Vaccine
90380† or 90381† with (96380 or 96381)	RSV
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
90623† with (90460/90461 or 90471/90472)	MenABCWY
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
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 (90460/90461 or 90471/90472)	PCV15
90677† with (90460/90461 or 90471/90472)	PCV20
90678† with (90460/90461 or 90471/90472	RSV
90680† or 90681† with (90460/90461 or 90473/90474)	Rotavirus
90684 with (90471/90472)	PCV21
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
91320† or 91322† with (90480/M0201)	COVID-19

Oral Evaluation and Flouride 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.

Tuberculin Skin Testing (TST)

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

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.

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

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.

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

† Indicates a vaccine distributed by TVFC

Texas Health Steps Quick Reference Guide - revised 02/01/2025 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.

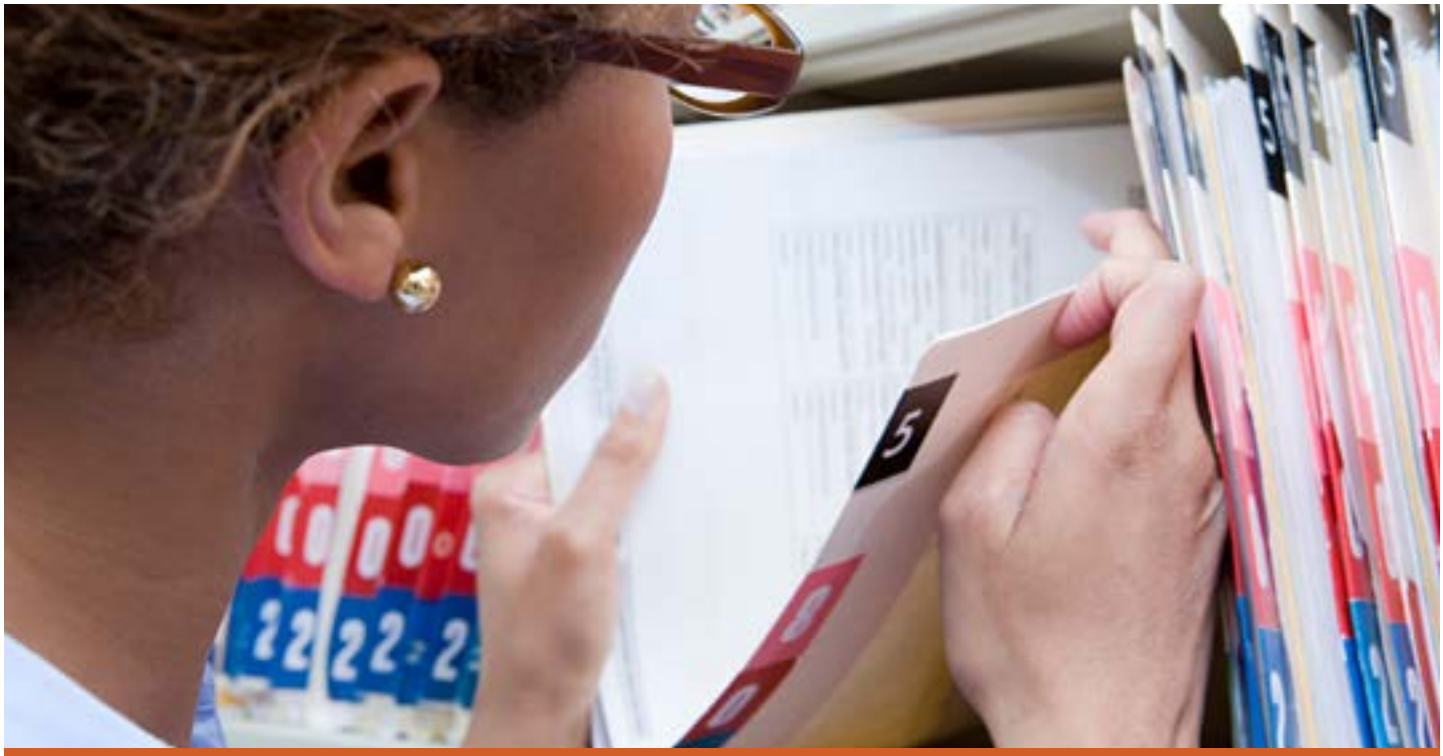
A traveling farmworker is someone who:

- 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 who 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.

Guidance on Member Allegations of Provider Discrimination Based on Immunization Status

BACKGROUND

House Bill (H.B.) 44 (88th Legislature, Regular Session, 2023) prohibits Medicaid and Childrens Health Insurance Program (CHIP) providers from refusing health care services to members because of the member's refusal or failure to obtain a vaccination or immunization.

As part of implementing H.B. 44, HHSC proposed amendments to the managed care contracts effective 09/01/2024 to the sections listed below, relating to language requiring the Managed Care Organization (MCO) or Dental Contractor to refer members alleging noncompliance with Texas Government Code §531.02119(a) to HHS Office of Ombudsman.

- Uniform Managed Care Contract (UMCC): 8.2.6 (Medicaid Member Complaint and Appeal System); and 8.4.2 (Member Complaint and Appeals)
- CHIP RSA: 8.1.5.9 (MCO Internal Member Complaint and Appeal Process)
- STAR+PLUS: 8.1.29 (Member Complaint and Appeal System)
- STAR Health: 8.1.33 (Member Complaint and Appeal System)
- STAR Kids: 8.1.29 (Member Complaint and Appeal System)
- Dental:4.1.6 (Member Complaint and Internal Appeal System)
- MMP Dual Demo: 2.11.4.1.3.1 (Grievance Administration)

During the MCO comment period of the contract amendment process, multiple MCOs requested clarification on two points:

- The process of referring allegations of provider noncompliance to the HHS Office of the Ombudsman.
- Whether these allegations will count toward the Contract Deliverable CA-1 which states, "The MCO must resolve at least 98% of Member Complaints within 30 Days from the date the Complaint is received by the MCO."

KEY DETAILS

Referral Guidance for Medicaid MCOs and Dental Contractors:

Regarding comments about the process to refer complaints of noncompliance, HHSC directs Medicaid MCOs and Dental Contractors contacted with an allegation of H.B. 44 noncompliance to refer the member to the HHS Office of Ombudsman by providing the member with the following information:

- Allegations of provider discrimination based on vaccine status are handled by HHSC and not by the MCO or DMO, as applicable.
- HHSC receives these allegations through the HHS Office of Ombudsman.
- Ways to reach the HHS Office of Ombudsman include:
  - Toll-free phone call to the Managed Care Assistance Team 1-866-566-8989. A person who has a hearing or speech disability, call 7-1-1 or 800-735-2989.
  - Online at https://hhs.texas.gov/omcat.
  - Faxing toll-free to 888-780-8099.
  - Mailing to: Texas Health and Human Services Commission, Office of the Ombudsman, MC H-700, P.O. Box 13247, Austin, Texas 78711-3247.

Referral Guidance for CHIP MCOs:

Regarding the comments about the referral process to refer complaints of noncompliance, HHSC directs CHIP MCOs and Dental Contractors contacted with an allegation of H.B. 44 noncompliance to refer the member to the MCCO Research and Resolution Team by providing the member with the following information:

- Allegations of provider discrimination based on vaccine status are handled by HHSC and not by the CHIP MCO or Dental Contractor.
- HHSC receives CHIP allegations through the MCCO Research and Resolution Team.
- The member may submit this allegation to the MCCO Research and Resolution Team using one of these methods:
  - Complaint inbox: HPM_Complaints@hhsc.state.tx.us
  - Online Portal https://texashhs.org/ManagedCareProviderComplaint
  - Fax 512-491-1958
  - Mail: Health and Human Services Commission Medicaid/CHIP, Managed Care Compliance and Operations, P.O. Box 149030 MC-0210, Austin, Texas 78714-9030

Complaint Record Guidance:

Regarding comments related to whether allegations of H.B. 44 noncompliance will count against the MCO or Dental Contractor relative to the timely resolution requirements, HHSC clarifies MCOs and Dental Contractors are not required to record allegations of HB 44 noncompliance in the Member Complaint Report submitted to HHSC. Therefore, HHSC will not count HB 44 noncompliance allegations when assessing compliance with Deliverable CA-1 which requires MCOs and Dental Contractors to resolve at least 98% of Member Complaints within 30 Days of receipt.

ADDITIONAL INFORMATION

On September 1, 2024, the Texas Medicaid & Healthcare Partnership (TMHP) will update the Texas Medicaid Provider Procedures Manual (TMPPM), Section 1.7, “Provider Responsibilities” to include a new subsection titled “Nondiscrimination for Vaccine Status.” This subsection contains the following language:

“In accordance with H.B. 44, Medicaid providers are prohibited from refusing to provide health care services to any Medicaid client based solely on the client’s refusal or failure to obtain a vaccine or immunization for a particular infectious or communicable disease unless excepted by Texas Government Code §531.02119.”

Medicaid Members with Other Insurance

Providers who participate in Texas Medicaid may not refuse services to eligible Medicaid Members due to potential other health insurance coverage. Additionally, providers are reminded that Medicaid-eligible Members cannot be held responsible for charges exceeding a third-party liability (TPL) payment for services covered by Texas Medicaid. If the TPL pays less than the Medicaid managed care amount, providers should submit a claim to Community Health Choice for any additional allowable reimbursement.

Annual Texas Health Steps Provider Training

Community requires all contracted THSteps Providers take 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 Hearing and Vision Screening Training Available

Hearing and vision screenings are required components of Texas Health Steps preventive medical checkups. This course provides helpful information about conducting age-appropriate screenings, as well as guidelines for coordinating with school-based screenings and making referrals when necessary. This course is available at https://www.txhealthsteps.com/654-hearing-and-vision-screening.

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/.

Switching to Electronic Submissions

Switching to electronic submissions can enhance the overall efficiency and effectiveness of the claims process.

There are several benefits to electronic submissions over paper forms:

- Speed and Efficiency
- Accuracy
- Tracking and Confirmation
- Cost-Effective
- Environmentally Friendly
- Accessibility
- Improved Communication

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 a 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

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 *(STAR/STAR+PLUS/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
STAR+PLUS
713.295.2300 or toll-free 1.888.435.2850