COMMUNITY HEALTH CHOICE, INC.

PROVIDER NEWSLETTER

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COMMUNITY NEWS

COMMUNITY’S EXPANDED MISSION STATEMENT

KEN JANDA, PRESIDENT AND CEO

I am thrilled to tell you that the Community Health Choice board of directors recently updated our mission statement to formally extend our vision to be more than just a non-profit managed care organization. The changes are in bold.

Our mission is to improve the health and well-being of underserved residents of Southeast Texas by opening doors to coordinated, high-quality, cost-effective health care and health-related social services.

The change is to formally acknowledge that, to improve the health of our underserved neighbors, we need to go beyond just traditional health care services and address other challenges our Members face in improving their health. Community has been partnering for years with numerous community-based organizations whose missions align with ours to help ensure that healthcare services are broadly available and affordable. Examples include: providing enrollment assistance at safety-net provider locations, providing services at health fairs, sponsoring events that support the financial sustainability of community-based organizations, and employee commitment to serve as volunteers for these organizations. In recent years, Community has provided several rounds of sizable Community Benefits grants to health care and health education organizations whose initiatives directly impact our mission. Additionally, Community annually supports health events with a purpose, such as the March of Dimes Walk for Babies and Get Up! Get Moving!

These activities will no longer be just ancillary to what we do, but a key portion of our mission.

Our commitment to a broader mission includes engaging in and supporting additional activities in three primary ways:

1. Engage in efforts to broaden our support of pregnant Members to ensure not only appropriate prenatal and postpartum care, but also parenting classes and resources, information on engaging with their children’s educational partners, and other social services.

2. Collaborate with organizations and in programs that aim to:
   a. Improve the percentage of Southeast Texas children who are able to enroll in early childhood education and pre-K programs
   b. Increase student retention and graduation rates from high school
   c. Enhance student matriculation to higher education

3. Support job training programs for our adult Members that will improve the economic status of their family and enhance their ability to support their family’s education and health needs.

These activities will be provided through:
   • Partnering with community-based Providers and other organizations, funded by our Community Benefit Program grants
   • Providing value-added services directly to our Members
   • Continuing our employee volunteer program, where we expect significant community engagement, (like serving on non-profit boards) by our entire leadership team in addition to four hours of volunteer activity for every one of our 400 employees.

We are just kicking off this exciting new chapter and would love to hear your ideas and suggestions. Send them to me at Ken.Janda@CommunityCares.com.

And thanks for all you already do to serve our Members.

Ken Janda, President and CEO
COMMUNITY NEWS

COMMUNITY’S NEW ASSOCIATE MEDICAL DIRECTOR

Community is pleased to announce that Lisa Fuller, M.D. has joined Community as an Associate Medical Director.

A native of Louisiana, Dr. Fuller obtained her M.D. from the Louisiana State University School of Medicine in 1998 and completed a pediatric residency at the LSU Health Sciences Center in New Orleans in 2001. She is board certified in pediatrics.

Dr. Fuller practiced general pediatrics in New Orleans for three years before moving to Houston because of her husband’s job. She joined the full-time faculty of Baylor College of Medicine in February 2005. In that position, she provided daily resident and medical student instruction and training in newborn medicine and pediatric inpatient care at Ben Taub Hospital, Texas Children’s Hospital, and, most recently, at San Jacinto Methodist Hospital.

Please join us in welcoming Dr. Fuller to Community.

MARCH 2016 DEADLINE: RE-ENROLLMENT REQUIREMENT FOR MEDICAID PROVIDERS

As a reminder, all Texas Medicaid Providers who were enrolled with Texas Medicaid and Healthcare Partnership (TMHP) before December 31, 2012, must re-enroll by March 24, 2016. If you rendered services through a Medicaid Managed Care Organization (MCO) or through Traditional Medicaid, you must re-enroll with Texas Medicaid to maintain your credentialing status with TMHP and the MCO.

Community relies on the information provided by the Texas State Master File, so, although you may be credentialed with Community, you should ensure that your enrollment status is updated with TMHP by:

1. Submitting a completed re-enrollment application, if you were enrolled with TMHP before January 1, 2013.
2. Receiving notification from TMHP that your application has been received and approved.

If you are unsure about your enrollment date, please contact the TMHP Contact Center at 1.800.925.9126 or visit the TMHP provider portal at www.TMHP.com.

TEXAS MEDICAID’S PROVIDER ENROLLMENT QUICK TOOLS REFERENCE GUIDE

The TMHP Provider Enrollment Tools Quick Reference Guide provides step-by-step instructions for the Texas Medicaid enrollment and re-enrollment process. It has links to provider re-enrollment training on the TMHP Learning Management System (LMS), information about provider town hall meetings, the current Texas Medicaid Provider Procedures Manual, and the re-enrollment Frequently Asked Questions.

The Provider Enrollment Quick Reference Guide covers how to:

- Create an account
- Verify provider information
- Gather documentation
- Enroll
- Get help

All current Texas Medicaid Providers who were enrolled before January 1, 2013, must re-enroll now. Failure to re-enroll may result in termination from Texas Medicaid.

For more information, call the TMHP Contact Center at 1.800.925.9126, option 2, or the TMHP-CSHCN Services Program Contact Center 1.800.568.2413.
DEFINITION OF A PROVIDER ENROLLMENT ‘COMPLETE APPLICATION’ TO BE UPDATED IN TEXAS ADMINISTRATIVE CODE (TAC)

Effective September 1, 2015, the Inspector General (IG) is required to process new Medicaid enrollment and re-enrollment applications from providers within 10 business days of receiving a completed application. The IG will be updating the definition of a complete application in Texas Administrative Code (TAC) Rule §371.1003.

Note: This rule applies for all provider enrollment applications submitted to TMHP, including, but not limited to, Texas Medicaid and the Children with Special Health Care Needs (CSHCN) services program.

Important Changes
Providers enrolling in Texas Medicaid for the first time or providers who are re-enrolling must submit the following information, along with the current required documents:

- Copies of the complete disposition on criminal history for all individuals who are required to disclose; and
- Documentation of compliance with current board or licensing orders for all individuals who are required to disclose.

Complete Applications
Applications will not be processed until all documentation is provided.

For more information, call the TMHP Contact Center at 1.800.925.9126 or the TMHP-CSHCN Services Program Contact Center at 1.800.568.2413.

To be considered complete, an application must contain:

- Complete answers to all questions, including date of birth, Social Security numbers, license numbers, and all requirements for the provider type defined in the Texas Medicaid Provider Procedures Manual
- IRS Form W-9 (if required)
- Signed and certified provider agreements
- Provider Information Form (PIF-1)
- Principal Information Form (PIF-2) on all persons required to be disclosed
- Full disclosure of criminal history, including copies of complete dispositions on all criminal history (if applicable)
- Full disclosure of all board or licensing orders, including documentation of compliance with current board orders
- Full disclosure of all corporate compliance agreements, settlement agreements, state or federal debt, and sanctions
- Documentation of an active license – The license expiration date may not be within 30 days of the application’s submission
- Completion of a pre-enrollment site visit (if required) and all required current documentation
- Documentation of fingerprints of a provider and any person with a 5 percent or greater direct or indirect ownership stake in the provider
BEHAVIORAL HEALTH

BEACON HEALTH OPTIONS PCP TOOLKIT

Beacon Health Options, Community Health Choice’s managed behavioral health partner, has developed a toolkit to assist PCPs in the diagnosis and treatment of mental health and substance use disorders.

Delivering behavioral health services in a primary care setting can help reduce the stigma and discrimination associated with mental health diagnoses. It’s also more cost-effective to treat common behavioral health disorders in primary care settings.

Primary care settings are also becoming the first line of identification for behavioral health issues, and PCPs are the center of care for many patients who have both physical and behavioral health disorders. To support PCPs, this online toolkit will assist in identifying behavioral health conditions through well-known screening tools, as well as decision support. Condition-specific fact sheets, as well as other patient-centered information, are included in the toolkit so PCPs can help their patients understand their diagnosis and take the right steps to become and stay healthy.

Conditions included in the toolkit:

- Alcohol and drugs
- Anxiety
- ADHD
- Depression, adolescent depression, and postpartum depression
- Eating disorders
- OCD
- PTSD
- Schizophrenia

The toolkit also has forms that will allow PCPs to share relevant patient information with other providers, including behavioral health providers, to facilitate better integration of care.

Beacon’s PCP toolkit is an excellent resource for PCPs as they diagnose and treat behavioral health conditions. Download it at http://beaconhealthstrategies.com/pcp_toolkit/pcp_toolkit.aspx.
PHARMACY DELIVERY METHOD FOR CLINICIAN-ADMINISTERED DRUGS

Providers dispensing physician-administered drugs in an office or outpatient setting for Medicaid Fee-For-Service (FFS) and Medicaid Managed Care Organization (MCO) clients can utilize the “white bagging” delivery method, in which the provider submits prescriptions to pharmacies and the prescription is shipped or mailed to the provider’s office. This delivery method is called “white-bagging.”

Providers should use the following steps for this delivery method:

1. The treating provider identifies a Medicaid-enrolled client;
2. The treating provider or treating provider’s agent sends a prescription to a Texas Medicaid-enrolled pharmacy and obtains any necessary prior authorizations;
3. If any prior authorization is approved, the dispensing pharmacy fills the prescription and ships an individual dose of the medication overnight, in the name of the Medicaid client, directly to the treating provider; and
4. The treating provider administers the medication to the Medicaid client in an office or outpatient setting. The provider bills for an administration fee and any medically necessary office-based evaluation and management service provided at time of administration. The provider should not bill Medicaid for the drug.

The pharmacy contacts the provider each month, prior to dispensing any refills, to ensure that the patient was administered all previously dispensed medication. Auto-refills are not allowed.

These medications cannot be used for any other patient and cannot be returned to the pharmacy for credit.

Note: Physicians using this delivery method will not have to purchase the physician-administered drug, therefore, the physician is allowed to administer the drug and should only bill for the administration of the drug.

For more information, call the TMHP Contact Center at 1.800.925.9126.

Community Health Choice and our partner, Beacon Health Options, are pleased to launch the Psychotropic Drug Intervention Program (PDIP). Our goal is to improve Member safety and health outcomes by providing clinicians with timely and relevant information, promoting communication among Providers, and ensuring efficient use of limited resources.

What is the Psychotropic Drug Intervention Program?

The PDIP combines health informatics, analytics, and clinical expertise to enhance medication adherence, promote safe, coordinated, evidence-based prescribing of behavioral health medication, and to monitor for possible overutilization of medications with abuse potential. The program is based on extensive, evidence-based research, clinical practice guidelines, and centers on the collective expertise of Beacon’s clinical team of psychiatrists, nurses, and pharmacists. Through careful clinical review of algorithmically-identified potential outlier cases, we suggest appropriate, informative interventions to you and/or your patients.

Several components of the PDIP support the specific care you provide to your patients. You will receive notifications to inform you of prescribing and medication refill patterns, identified medication-related problems or safety concerns beneficial for you to review and evaluate.

These components include, but are not limited to:

- Prescriber education about best prescribing practices through provision of timely, relevant, and evidence-based information
- Provider alerts to patient-specific potential problems in medication adherence, dosing or polypharmacy
- PCP behavioral health and prescribing decision support through telephonic availability of psychiatrists
PROVIDER INFORMATION DATA ACCURACY

Managed Care Organizations continue to see more and more State and Federal guidelines related to Provider data accuracy. The accuracy of Provider data is critical to eliminate challenges for Members attempting to access care and to ensure the timeliness and accuracy of claims payments to the Provider. Community requires its participating physician, hospital, and ancillary Providers to issue 30-day advance written notification of changes in demographic or practice information. This includes, but is not limited to, the following types of information:

- changes to Provider’s mailing or payment remit addresses, telephone or facsimile numbers, and e-mail
- changes in the Provider’s tax identification numbers, National Provider Identifiers, taxonomy, etc.
- changes in the Provider’s participation status such as retirement, leave of absence, an addition of new locations, closure of existing locations or expansion of the Provider’s service area
- the addition or departure of a physician from an existing group practice
- decisions to open or close a Provider’s panel to new or existing patients

Providers must submit notification of the above changes in writing 30 days in advance of when the changes will occur. Notification of change(s) must include the effective date and description of the change. The notification should be detailed enough to ensure that Community can process the change accurately and timely in the Provider Directory and the Claims Adjudication System.

PROVIDER CONTRACTING TEAM

Community welcomes Claudia Meadows as our new Director of Contracting. Claudia’s primary responsibility is day-to-day operations of the Contracting Department. She brings a wealth of healthcare experience to our team, including local Contract and Network Management roles with UNICARE, Great-West Healthcare, Bravo Health, and Cigna-HealthSpring. Her experience includes Commercial/Self-Insured, Medicare, as well as STAR+PLUS programs.
Community’s Provider Relations Team thanks you for another great year of support!

We greatly appreciate your active participation in our educational events as well as your feedback and constructive suggestions following the events. Thanks to your support, we continually improve these educational forums. If you were unable to attend an event this year, don’t worry! In 2016, Community will expand the means by which we offer our educational events to ensure greater flexibility for our Providers and their staff, thereby, improving the rate of participation.

Community’s Provider Engagement Platform outlines a focus on partnership and transparency in communications. As part of that effort, we committed to publish the questions and answers from each of our Provider Lunch and Learn events. Here are some of the key questions Providers asked during recent events:

Q: What if a single-specialty clinic wanted to change to a multi-specialty clinic?
A: Providers may elect to change from a single-specialty to a multi-specialty designation. This is a change in the Provider’s taxonomy and requires that the Provider notify and receive approval from Texas Medicaid. During the Medicaid enrollment process, the Provider would select the available taxonomy code list that is populated with either the multispecialty (193200000X) or single-specialty (193400000X) clinic/group taxonomy code dependent on which specialty is chosen. The multi- or single-specialty taxonomy codes for clinic/group Providers are accurate and have been approved by HHSC. The most appropriate taxonomy codes should be selected for any performing Providers that will be enrolled according to their specific performing Provider type and specialty. Additional information regarding Medicaid requirements is available at www.tmhp.com.

Upon receipt of written notification that the TMHP approved a Provider’s requested change in taxonomy, Community’s Provider Contracting team will review and make a determination regarding any required action based on the Provider’s updated information. Action might include an assessment of network need, the requirement to execute an amendment or new participating provider agreement, or might require credentialing approval.

Please read the Provider Information Data Accuracy article in this newsletter as it relates to the requirement for Provider’s to forward 30-day advance notice to Community regarding any changes in Provider’s Medicaid enrollment, billing or demographic information.

Q: What is the “hospital privileges” requirement? Is a courtesy privilege status acceptable?
A: As part of Community’s Physician Participation Criteria, Community requires that physicians maintain, or arrange coverage with a participating group that maintains, hospital privileges with at least one participating hospital. Community accepts courtesy staff privileges to meet the criteria. As a reminder, physicians may refer Members for outpatient and/or inpatient services only to hospitals that participate in Community’s Provider Network.

Q: We have Members assigned to our panel, but these Members have not been seen at our clinic. What can PCPs do to remove these Members from our panel?
A: Community incentivizes PCPs to schedule appointments with newly assigned Members within 30 days of the Members’ enrollment. Community recommends that PCPs make at least three attempts to contact paneled Members. If Member contact is unsuccessful, PCPs may request that the Member be assigned to another PCP.
Please note that Community monitors Members who receive care from a PCP other than the PCP on their ID card. Community contacts these Members to request whether or not they want to change their PCP of record to the actual PCP they have been seeing for their medical care needs.

Q: How long does the credentialing process take?
A: Managed Care Organizations have up to 90 days to process a Provider’s completed credentialing application. Community’s average time to process a completed application is significantly less, and Community maintains a goal of processing applications within 30 days from receipt of the completed application.

Community’s Provider Engagement Platform created specific Physician Network Participation Criteria (see Q1-2014 Provider Newsletter). The following is a brief overview of Community’s process for considering the addition of a physician to Community’s physician network.

• When a non-participating Provider makes an initial inquiry about joining Community’s Provider network, Community asks the Provider to complete a profile form that outlines basic demographic information about his or her practice (e.g., legal structure, specialty type, locations, etc.) and to attest to compliance with Community’s defined Provider Network Participation Criteria.

• Upon receipt of this documentation, the Network Management team completes a Network Need Assessment. The consideration of whether or not there is a Network Need is based upon access and availability, regulatory requirements, provider’s accreditation, continuity of care needs or strategic network development, as well as other demographic considerations.

• If Network Management determines a Network Need exists, Community forwards an invitation to the Provider to join Community’s Provider network, including a request for completion of required credentialing information and signature on Community’s Provider Participation Agreement, with standard language and standard compensation levels as approved by the Contracting and Provider Reimbursement Committee.

• Community maintains a formal process to consider any exceptions if a Provider fails to meet the Provider Participation Criteria, yet there is a Network Need. The exception process includes review by the Vice President of Network Management and the Senior Vice President of Medical Affairs, who will agree on a final decision as to whether or not to extend the Provider an invitation to participate in Community’s Provider Network. The invitation is contingent upon the Provider’s adherence to any of the variances identified within a given timeline.

Q: Can Providers complete the Texas Medicaid re-enrollment process via CAQH?
A: Please contact TMHP at 800.925.9126 for re-enrollment information.
2016 PROVIDER LUNCH AND LEARN SCHEDULE

January 13, 2016
April 20, 2016
July 20, 2016
October 19, 2016

In addition to the regularly-scheduled Lunch and Learn dates and times above, Community will offer additional educational opportunities and formats during 2016. We are developing webinars and panel discussions with participating physicians. In addition, as part of our Provider Engagement Platform, Community will offer educational events specifically requested by participating physicians and Providers. If you have any suggestions for educational topics, please email ProviderRelations@CommunityCares.com or call 713.295.2295.

VOLUME 3 GAME ANSWERS

Provider Word Wheels

Seven-Letter Word: HEALTHY – health, heath, heathy, hyetal, lathy, ethyl, lathe, halt, hath, late, hyla, htye, lath, yeah, heal, hay, hale, hate, hey, heat, hay, hat, they, the, eath, heth, thae, yeh, yah, thy, hah, eth, hae, het, heh, ah, he, eh, ha

Seven-Letter Word: OUTCOME – out, come, comet, comte, moot, mote, moue, mute, come, tome, toom, meou, coot, cote, tom, toe, oot, mot, moo, coo, too, moc, cot, to, om, oe, mo

Seven-Letter Word: QUALITY – qua, quail, quit, quilt, quai, litu, quay, tau, uta, tui

Seven-Letter Word: IMPROVE – rove, more, pier, improv, prime, moper, mover, prove, primo, proem, moire, viper, vireo, over, vier, rive, rev, rei, ore, peri, perm, repo, prom, omine, ripe, romp, rope, rip, per
PROVIDER RELATIONS

BEACON BEHAVIORAL HEALTH DISCHARGE PLANNING

HEDIS Requirements
Beacon Health Options is the company that manages the behavioral health for Community Health Choice Members. They hold NCQA accreditation as a managed behavioral health organization (MBHO). As an accredited MBHO, they take pride in reporting measures based on the Healthcare Effectiveness Data and Information Set (HEDIS).

HEDIS tracks the aftercare follow-ups that are established for Members 6 years of age and older, who have been released from an inpatient psychiatric hospital. The Member must have:

- A mental health diagnosis
- An aftercare appointment scheduled between the 7th day of discharge and the 30th day of discharge (21 days post discharge) with a mental health professional

Follow-up after Inpatient Hospitalization
Effective discharge planning begins at the time of admission. By beginning the process at the time of admission, it allows the discharge planner the time to find a provider that best fits the needs of the Member.

Members who receive prompt follow-up care after inpatient treatment are more likely to continue engaging in outpatient care. In addition, when a Member actively participates in their outpatient treatment, he/she is 2.5 times less likely to be re-hospitalized.

Due to the lack of available psychiatrists in Texas, we recommend you schedule the Member’s 7th day aftercare appointment with a therapist. We also suggest that their outpatient treatment continue with a psychiatric appointment within 14 days of discharge for adults and within 30 days of discharge for children.

How can we help?
The 7 and 30-day aftercare appointments should be scheduled with a Beacon provider. If you need assistance securing an aftercare appointment within 7 days of a Member’s discharge, call Beacon’s Member services or Aftercare Department at 1.855.371.8095.
REMINDER: POSTPARTUM DELIVERY CODING

Community outlined a number of changes to ensure compliance with quality performance metrics outlined by the Texas Department of Health and Human Services (HHSC).

In order to ensure appropriate documentation of timely postpartum visits, in November 2013, we informed participating providers that Community would no longer accept or issue payment for global delivery and postpartum services. We continue to thank each of you for recognizing the need for revising the billing methodology and supporting continued efforts to document the quality of care provided to our Members.

While the decision to no longer allow the billing of the global delivery and postpartum service code improved results, this change was insufficient for moving performance to a level that achieves the HEDIS metrics utilized by HHSC.

As a reminder, the standard of care is that the comprehensive postpartum review and examination should occur at 4 – 6 weeks after delivery. HEDIS measurements for this are slightly more relaxed, allowing the visit to occur any time between 21 to 56 days.

*Neither Community, nor you as the Provider, receive credit for the HEDIS measured comprehensive postpartum visit when this service is provided before the 21st or after the 56th day.*

As of June 2, 2015, Community only issues compensation for CPT code 59430 when billed between the 21st and 56th day following the delivery. Claims payment will not be issued for postpartum services billed with CPT 59430 outside of this date range. As a reminder, participation agreements with Community require that Members be held harmless for any services rendered by participating providers; therefore, Members may not be billed for covered services under any circumstance.

Problem or sick visits that occur at any time postpartum should be billed using standard CPT evaluation and management codes (99212-99215). Visits for suture, staple removal or other wound care issues during the global postoperative period following a C-section are not considered problem visits and are not considered postpartum visits; therefore, they are not eligible for payment as separate visits.

Using a C-section delivery as an example…

1. Delivery should be billed with the appropriate delivery code.
2. Each hospital day prior to the discharge day should be billed as a hospital postpartum day.
3. The last day should be billed as the discharge day.
4. An office visit for staple removal should not be billed.
5. A visit for postpartum depression screening or breastfeeding issues should be billed as a problem visit using the appropriate E&M code.
6. At 21 to 56 days, the patient should receive her postpartum visit, billed with the CPT code 59430.
THSTEPS MEDICAL CHECKUPS AND ICD-10 CODES

Effective October 1, 2015, for dates on and after October 1, 2015, the ICD-9-CM diagnosis and surgical codes will no longer be accepted by Community. Providers must include ICD-10-CM diagnosis codes when submitting prior authorizations and claims to Community.

How does this affect THSteps? There are new codes for the THSteps Well Visit, Lead Testing, and Immunization diagnosis codes.

<table>
<thead>
<tr>
<th>Age-Appropriate CPT Codes</th>
<th>Modifier</th>
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<tbody>
<tr>
<td>• New Members: 99381 – 99385</td>
<td>AM, SA, TH, U7, EP (FQHCs), 25 (Vaccines)</td>
</tr>
<tr>
<td>• Existing Members: 99391 – 99395</td>
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</tbody>
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Exception-to-Periodicity Checkup Modifier

Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances.

Exception-to-periodicity checkups are complete medical checkups, which are medically necessary, and might cause the total number of checkups to exceed the number allowed for the Member’s age range if the Member were to have all regularly-scheduled checkups. An exception-to-periodicity checkup is allowed when:

• Medically necessary, for example, for a client with developmental delay, suspected abuse, or other medical concerns or a client in a high-risk environment, such as living with a sibling with elevated blood lead.
• Required to meet State or Federal exam requirements for Head Start, day care, foster care or pre-adoption.
• When needed before a dental procedure requiring general anesthesia.

As noted in the Periodic Checkup Age Range table, the number of checkups is set for each age range.

This may avoid an exception-to-periodicity checkup and allow flexibility for the Provider and family to schedule a checkup including before the child’s birthday.

If a client is due for a medical checkup, a checkup outside of the regular THSteps schedule must be billed as a regular checkup rather than an exception to periodicity.

The checkup is considered complete when all the required components are documented in the client’s medical record or supporting documentation, which details the reason a component(s) was not completed. A plan to complete the component(s) if not due to reasons of conscious or parental concerns must be included in the documentation.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>Medically necessary service or supply</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier “23” to the procedure code of the basic service.</td>
</tr>
<tr>
<td>32</td>
<td>Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier “32” to the basic procedure.</td>
</tr>
</tbody>
</table>
THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

**Diagnosis Codes**

<table>
<thead>
<tr>
<th>Diagnosis Code (ICD-9)</th>
<th>Diagnosis Code (ICD-10)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20.2</td>
<td>Z00.121, Z00.129</td>
<td>Routine infant or child health check</td>
</tr>
<tr>
<td>V20.3</td>
<td>Z00.110, Z00.111</td>
<td>Newborn health supervision</td>
</tr>
<tr>
<td>V70.0</td>
<td>Z00.00, Z00.01</td>
<td>Routine general medical examination at health care facility</td>
</tr>
<tr>
<td>V70.3</td>
<td>Z02.0, Z02.2, Z02.4, Z02.5, Z02.6, Z02.82, Z02.89</td>
<td>Other general medical examination for administrative purposes</td>
</tr>
<tr>
<td>V70.5</td>
<td>Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.89</td>
<td>Health examination of defined subpopulation</td>
</tr>
<tr>
<td>V70.6</td>
<td>Z00.8</td>
<td>Health examination in population survey</td>
</tr>
<tr>
<td>V70.8</td>
<td>Z00.5, Z00.70, Z00.71, Z00.8</td>
<td>Other specified general medical examination</td>
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<tr>
<td>V70.9</td>
<td>Z00.8</td>
<td>Unspecified general medical examination</td>
</tr>
</tbody>
</table>

**THSteps Well Visit ICD-10 Codes:** Z00.121 or Z00.129

**Lead Testing ICD-10 Codes:**

T560X1A, T560X1D, T560X1S, T560X2A, T560X2D, T560X2S, T560X3A, T560X3D, T560X3S, T560X4A, T560X4D, T560X4S, Z77011

**Preventive Immunization ICD-10 Codes:** Z23

See Z28 code range if you cannot administer the immunization.

Providers must continue to use CPT and HCPCS codes for professional and outpatient procedures and services.

For more information, please see the Texas Medicaid Provider Procedures Manual at [www.tmhp.com](http://www.tmhp.com).
CARE MANAGEMENT

CHILDBIRTH CLASSES FOR PREGNANT MEMBERS

Community offers a FREE, one-day childbirth class. This informative and interactive class is only for our Members. We hold classes on multiple days and in multiple locations—including our office—in the Harris service area.

Our Lamaze instructor, Marisa Pena-Alfaro, has more than 20 years of experience and conducts classes in English and Spanish. Moms who attended have had a greater likelihood of:

• Full-term babies
• Vaginal versus C-section deliveries
• Success with breastfeeding

Community Members can R.S.V.P. online at CommunityCares.com or call 713.295.5001 or toll-free at 1.855.806.8319. If they need a ride to the class, they can also call three days in advance to schedule.

We assist with transportation to and from the class, if the Member contacts us at least three days in advance.

Childbirth Classes Benefit our Providers!

Encourage your pregnant Community Members to become one of Community’s healthy moms!

The class may answer questions that they did not ask during their visit with you. It may also lead to better communication at subsequent visits. Additionally, if the mom has a better outcome, it may increase your bonus.

MEMBER TESTIMONIAL

Thank you for all the information that you gave me during the Childbirth class and after. I called you some days ago because my doctor told me he wanted to do a C-section because my baby was in a breach position at week 37. I followed your advice and started crawling, and my baby turned into the right position at 38 weeks.

Still, they wanted to induce me. I told them that I wanted to wait, and my baby was born naturally at 38 weeks and 4 days. I arrived at the hospital at 8 centimeters, having contractions every 3 minutes. I didn’t need any analgesia or anesthesia. I just kept on doing the breathing and visualization techniques.

I thought that my labor wasn’t going to last more than four hours, and I was right! We arrived at the hospital at 5:30 a.m., and my baby was born at 9:21 a.m. Thank God everything was perfect. It was an unforgettable and wonderful experience, giving birth completely natural. I’m so happy and feel so satisfied.

Our brains are so powerful. If I was able to do it, many other women will be able to do it as well.

Thank you Marisa!

Dalia Montalvo, proud mother of Gael Garcia Montalvo
CRITERIA FOR APPROVAL OF 17P INJECTIONS

Has your patient previously delivered a preterm infant spontaneously between 20 and 36.6 weeks of gestation?

If so, you can start them on weekly 17P injections! We can get them approved and set up to begin their injections at 16 weeks, two weeks prior to the start date.

All you need to submit to us is a clinical documentation supporting request, which includes:

- previous preterm delivery (number of weeks gestation), year of delivery and reason for preterm birth (PROM or preterm labor)
- an induction for any reason other than PROM or advanced dilatation does not qualify member to receive 17P injections

Call Care Management at 713.295.2303 or fax clinicals to 713.295.7028.

HEAD START PROGRAM – CELEBRATING 50TH ANNIVERSARY

What is Head Start?

Head Start is a Federal program that promotes the school readiness of children from birth to age five from low-income families by enhancing their cognitive, social, and emotional development. Head Start programs provide a learning environment that supports children’s growth in many areas such as language, literacy, and social and emotional development. Head Start emphasizes the role of parents as their child’s first and most important teacher. These programs help build relationships with families that support family well-being and many other important areas.

Many Head Start programs also provide Early Head Start, which serves infants, toddlers, and pregnant women and their families who have incomes below the Federal poverty level.

General Program Requirements

For this benefit program, individuals must be a Texas resident and must have an annual income (before taxes) that is below the following amounts:

<table>
<thead>
<tr>
<th>Household Size *</th>
<th>Maximum Income Level (Per Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,770</td>
</tr>
<tr>
<td>2</td>
<td>$15,930</td>
</tr>
<tr>
<td>3</td>
<td>$20,090</td>
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<tr>
<td>7</td>
<td>$36,730</td>
</tr>
<tr>
<td>8</td>
<td>$40,890</td>
</tr>
</tbody>
</table>

*For households with more than eight people, add $4,160 per additional person. Always check with the appropriate managing agency to ensure the most accurate guidelines.

References:
Providers are required to administer a complete Texas Health Steps (THSteps) medical checkup for Members from birth through age 20.

The required components of a complete THSteps medical checkup are:

- Comprehensive health and developmental history
  - Nutritional assessment
  - Developmental assessment including the use of standardized screening tools
  - Autism screening using the M-CHAT
  - Mental health assessment
  - Tuberculosis screening with skin test based on risk
- Comprehensive unclothed physical examination
  - Oral Evaluation and Fluoride Varnish (OEFV) for children from 6 to 35 months of age
  - Measurements
  - Vision and hearing screening
- Laboratory tests including blood lead screening and other tests appropriate for age and risk
- Immunizations appropriate for age
- Health education/anticipatory guidance
- Dental referral beginning at 6 months of age until a dental home has been established
  - To locate a participating THSteps dentist, please call the Member’s DHMO
- Referral to case management services (Case Management for Children and Pregnant Women, Comprehensive Care Program (CCP), etc.)

For more information on THSteps checkup components, please visit:
https://www.dshs.state.tx.us/thsteps/providers.shtm
THSTEPS PROVIDER OUTREACH REFERRAL SERVICE & HOW IT WORKS

The THSteps Provider Outreach Referral Service (MAXIMUS) is utilized by any THSteps provider who requests outreach and follow-up for a Texas Health Steps patient who needs assistance:

- Scheduling a follow-up appointment
- Rescheduling a missed appointment
- Scheduling transportation to an appointment
- With other outreach services

This outreach service is administered by the THSteps program and provides necessary outreach and follow-up with THSteps patients by contacting them to:

- Schedule a follow-up appointment
- Reschedule a missed appointment
- Assist with scheduling transportation to the appointment
- Assist with other patient-related outreach services.

Download the instructions and the THSteps Provider Outreach Referral Form: [http://www.dshs.state.tx.us/thsteps/POR.shtm](http://www.dshs.state.tx.us/thsteps/POR.shtm)

THSTEPS CHECKUP DUE DATES

For new Community Medicaid Members, a THSteps checkup should be offered within 14 days of enrollment for newborns and within 90 days of enrollment for all other Members. Members participating in Head Start program should receive their checkup no later than 45 days after enrolling into Head Start or Community Health Choice.

Existing Community Medicaid Members should have a checkup based on their age range:

- **Ages birth through 30 months:**
  - Due before the next checkup: newborn, 3-5 days, 2 weeks, 2 months, 4 months, and 6 months
  - Due within 60 days of the periodicity date: 9 months, 12 months, 15 months, 18 months, 24 months and *30 months.

* Please note that the 30-month checkup is a required checkup according to the THSteps Medical Checkup Periodicity Schedule.

- **Ages 3-20 years:**
  - A checkup should be completed on or near the child’s birthday—within 60 days after the birthday. It’s considered timely if it occurs within 364 calendar days after the child’s birthday in a non-leap year, or 365 calendar days after the child’s birthday in a leap year.

Download the updated THSteps Medical Checkup Periodicity Schedule at [http://www.dshs.state.tx.us/thsteps/providers.shtm](http://www.dshs.state.tx.us/thsteps/providers.shtm)
CHIL​DREN 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:

- Has been so employed in this capacity within the last 24 months
- Established a temporary abode for the purposes of such employment

Their children 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. 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.

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.

If you have any patients from Community that meet this criteria, please refer them to Thuy Pham, THSteps Program Lead, at 713.295.6745. Our goal is to arrange for all health care services they may need before they leave for the new job.

COMMUNITY’S TRANSPORTATION SERVICE FOR CHIP MEMBERS

We offer free transportation for CHIP Members to doctor appointments when no other transportation is available and when approved 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.
TEXAS HEALTH STEPS

HHSC’S MEDICAL TRANSPORTATION PROGRAM FOR MEDICAID MEMBERS

Medicaid provides transportation at no cost for THSteps patients and most others who use Medicaid medical and dental services. Children younger than age 14 must be accompanied by the parent, guardian or other authorized adult at the medical or dental checkup.

How Medicaid Pays for the Ride

If your patient...

• Does not have a ride and no one can drive them, Medicaid can arrange and pay for their ride on the bus or with a ride sharing service.

• Does not have a car, but someone can drive them, then Medicaid will pay back the driver by the mile to take the patient to the appointment and back.

• Has a car, but no gas money, Medicaid might pay your patient ahead of time by the mile to get to the appointment and back. For trips that require an overnight stay, Medicaid might pay for overnight lodging and meals for the patient and their parent or guardian.

Advantages for Health Care Professionals

• Medicaid rides help patients miss fewer appointments, reducing no-shows and the need to overbook appointments.

• With a single call to Medicaid’s transportation hotline, your office or patient can arrange travel for an entire month for ongoing appointments such as renal dialysis for kidney disease.

How You Can Help

• Tell Medicaid patients about free ride service when you schedule appointments.

• Remind patients about Medicaid free rides if they miss an appointment.

• Provide the Medicaid free ride phone number: 1.855.687.4786. It is answered Monday through Friday, 8:00 a.m. to 5:00 p.m. Patients should call at least 2 workdays before the appointment (the sooner, the better).

Learn more: http://www.txhealthsteps.com/cms/?q=node/88
CURRENT THSTEPS NOTICES

Effective for dates of service on or after November 1, 2015, HHSC will implement benefit criteria changes for THSteps preventive care medical checkups.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes Z0000 and Z0001 will be added as payable diagnosis codes for procedure codes 99385 and 99395.

THSteps preventive care medical checkups are not a benefit as a telemedicine or telehealth service.

Screenings
The THSteps Medical Checkups Periodicity Schedule were updated on November 1, 2015, with changes to the following laboratory requirements:

- **Anemia screening**: Removal of the mandatory screenings for all clients who are 18 months of age and for females who are 12 years of age. The only mandatory screening will be for clients who are 12 months of age.

- **Human Immunodeficiency Virus (HIV) screening**: Addition of one mandatory screening for clients who are 16 through 18 years of age, regardless of risk. This is in addition to the current risk-based screening for clients who are 11 through 20 years of age.

- **Dyslipidemia Screening (previously hyperlipidemia screening)**: Addition of one mandatory screening for clients who are nine through 11 years of age, and once again for clients who are 18 through 20 years of age, regardless of risk. These are in addition to the current risk-based screening for clients who are 24 months through 20 years of age.

Providers must refer to the current version of the THSteps Medical Checkups Periodicity Schedule available on the Department of State Health Services (DSHS) Web site at www.dshs.state.tx.us/thsteps/providers.shtm.

Autism Screening
The Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT R/F) may also be used to complete the required autism screening at 18 and 24 months of age.

Dyslipidemia Screening
Addition of one mandatory screening for clients who are 9 through 11 years of age, and once again for clients who are 18 through 20 years of age, regardless of risk. These are in addition to the current risk-based screening for clients who are 24 months through 20 years of age.

Newborn Screening
State-mandated newborn screening for critical congenital heart disease (CCHD) is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 33, §§ 33.011, and the Texas Administrative Code (TAC), Title 25, Part 1, Chapter 37, Subchapter E, §§ 37.75 - 37.79.
Mental Health Screening

Mental health screening using one of the following validated, standardized mental health screening tools recognized by THSteps is required once for all clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)

Procedure code 99420 will be a benefit for clients who are 12 through 18 years of age when services are provided by THSteps medical and federally qualified health center providers in the office setting. Procedure code 99420 must be submitted for mental health screenings when one of the validated, standardized mental health screening tools recognized by THSteps is used.

Mental health screening at other checkups does not require the use of a validated, standardized mental health screening tool.

Procedure code 99420 must be submitted on the same date of service by the same provider as procedure code 99384, 99385, 99394 or 99395, and will be limited to once per lifetime.

The client’s medical record must include documentation identifying the tool that was used, the screening results, and any referrals.

POSTPARTUM CHECKUPS FOR MOM AND BABY: A TAG-TEAM APPROACH

Providers, please help us encourage our Members to go to their postpartum appointments! Stress to them that these follow-up appointments are extremely necessary and beneficial to mom and baby. We offer this tag-team approach.

Primary Care Providers:

Pregnant Members under 21 still need comprehensive care visit, in addition to prenatal visits. Refer her to an OB/GYN, if she has not gotten one yet. During her newborn’s 4-week checkup, stress to her the importance of scheduling a postpartum appointment.

OB/GYNs:

Please stress the importance of a postpartum appointment for 4 to 6 weeks after delivery when you see mom and baby in the hospital room and during the first office visit after delivery. Ask your front-office staff to offer to schedule one when mom checks in. In addition, educate mom on the importance of newborn checkups towards the end of her pregnancy and during her postpartum appointments. Refer mom to a pediatrician for her newborn, if she has not gotten one yet.
CONTACT INFORMATION

MEDICAL AFFAIRS
Peer-to-Peer Discussions
713.295.2319
Senior Vice President
Fred Buckwold, M.D.
Medical Director
Lisa Fuller, M.D.
Associate Medical Director

Utilization Management
Phone: 713.295.2221
Fax: 713.295.2283 or 84

Care Management: Asthma, Diabetes, High-Risk Pregnancy
713.295.2303

Diabetic Supplies/Outpatient Perinatal
Fax: 713.295.7028
Toll-free fax: 1.844.247.4300

CLAIMS
• Inquiries
• Adjudication
CommunityCares.com or 713.295.2295

Community will accommodate three claims per call.

MAILED CLAIMS
To the attention of: Corrected Claims
Community Health Choice, Inc.
P.O. Box 301404
Houston, TX 77230

REFUND LOCKBOX
Amegy Bank
P.O. Box 4605
Houston, TX 77210-4605

ELECTRONIC CLAIMS
(CHIP & STAR)
Submit directly through Community’s online claims portal:
CommunityCares.com > Provider Tools > Claims Center
Fayer ID: 48145
Emdeon 1.800.735.8254
SSI 1.800.820.4774
Availity 1.800.282.4548
TKSoftware 1.402.593.6542
RelayHealth 1.563.585.4411
Gateway EDI 1.800.969.3666
Practice Insight 713.333.6000
TMHP (STAR only) www.tmhp.com

ELECTRONIC CLAIMS-UB,
CMS-1500 (HIM)
Submit directly through Community’s Online Claims Portal:
CommunityCares.com > For Providers > Provider Tools > Claims Center
Emdeon: 1.800.735.8254
Fayer ID: 60495

PHARMACY
Navitus Health Solutions
1.877.908.6023
www.navitus.com

BEHAVIORAL HEALTH
Beacon Health Options
1.877.343.3108
www.beaconhealthstrategies.com

ADVERSE DETERMINATIONS & APPEALS
Community Health Choice, Inc.
Attn: Appeals
2636 South Loop West, Suite 900
Houston, TX 77054

All appeals must be in writing and accompanied by medical records.

MEMBER SERVICES & SPECIALIST SCHEDULING
713.295.2294 or 1.888.760.2600

PROVIDER RELATIONS
For general questions or to submit your updates:
• CommunityCares.com
• ProviderRelations@CommunityCares.com
• Contact your Provider Relations Representative.

SERVICE AREA MAP

- Harris Service Area
- Jefferson Service Area