COMMUNITY HEALTHCARE

Provider Newsletter | Spring/Summer 2022

ADHD: Diagnosis and the Provider's Role | Long-Term Services & Supports: Important Policy Updates | Caring For Our Most Vulnerable Members

The End of the Public Health Emergency & Its Impact on Health Benefits

RenewMyTexasBenefits.com

ON PAGE 6, LEARN WHAT YOU CAN DO TO EDUCATE AND EMPOWER YOUR PATIENTS, HELPING THEM TAKE THE NEEDED STEPS TO KEEP THEIR HEALTH CARE COVERAGE.

COMMUNITY FIRST HEALTH PLANS

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VISIT OUR WEBSITE OR CALL AT:
CommunityFirstHealthPlans.com
(210) 227-2347 or
toll-free (800) 434-2347

Follow Community First Health Plans on social media for all the latest updates!

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UTILIZATION MANAGEMENT:
THE PROCESS BEHIND THE DECISION

Community First Health Plans utilizes evidence-based criteria and clinical guidelines to make Utilization Management (UM) decisions. The criteria are applied in a fair, impartial, and consistent manner that serves the best interest of our Members.

Community First approves or denies services based on whether the service is medically needed and a covered benefit. Criteria used to make a determination are available upon request.

Service Review. A service review for authorization will occur before a Member receives care. All requests are reviewed by our experienced clinical staff. Service requests that fall outside of standard criteria and guidelines are reviewed by our physician staff for plan coverage and medical necessity.

If care is received that was not authorized in advance (for emergency services), a service review will occur before the claim is processed. Please note that a service review that happens after (emergency) services are received does not guarantee payment of claims.

Generally, your office staff will request prior authorization from Community First before providing care. You have a responsibility to make sure you are following Community First rules for providing care.

Out-of-Network Care. Requests for out-of-network services involve an evaluation of whether the necessary and covered services can be provided on time by a network Provider. Community First does not cover out-of-network care without prior approval.

Hospital Care. Community First also reviews care our Members receive while in the hospital. We assist hospital staff in making sure our Members have a smooth transition home or to their next care setting.

Appeals. The Member, the Member's representative, or a physician acting on behalf of the Member may appeal a decision denying a request for services. Members can file an appeal through the Community First appeals process.

More Information. To obtain more information about UM criteria used to make decisions about your patient's health care, contact Population Health Management. Call (210) 358-6050 and press "3" for authorizations, Monday through Friday from 8 a.m. to 5 p.m.

Our UM staff is also available to assist you with any questions you may have regarding processing a request for services. Calls or communications received after hours will be addressed by the next business day. Should our staff attempt to reach you, they will provide you with their full name and title at Community First Health Plans.

Our Commitment: Focused Care For Our Most Vulnerable Members

STAR Kids Members, our most vulnerable Members, are enabled to maximize their health and well-being when both Providers and managed care organizations work together. Based on this foundation, the Texas Health and Human Services Commission (HHSC) has selected two Member perception questions administered through the Consumer Assessment of Healthcare Providers & Systems (CAHPS) and the National Survey on Children's Health as part of the 2022 Pay-for-Quality measures.

The questions are as follows:

1. **Percentage of caregivers of Members under the age of 18 who said someone helps arrange or coordinate their Member's childcare; and**

2. **Percentage of caregivers of Members under 18 years who said in the last six months it was always easy to get special medical equipment or devices, special therapy, and/or treatment and counseling for the Member child.**

As the Member's primary care provider or specialist, we ask that you help our Members navigate the health care system and troubleshoot their questions or concerns. Our Service Coordinators are committed to doing the same. Together, we can ensure a focused, Member-centric approach to delivering high-value health care.

In addition, we request your support in encouraging STAR Kids Members to participate in the **STAR Kids Screening and Assessment Instrument (SAI)**, which provides eligibility for Long-Term Services and Supports (LTSS). The SAI also helps Community First ensure that necessary services are in place, preventing gaps in care and unplanned hospitalizations while reinforcing Provider care plans.

Please be aware that if the Member elects to participate in the SAI via telephone instead of telehealth and/or in person, HHSC requires all managed care organizations to contact the Member's Provider to validate the information collected. In these limited situations, our staff will contact your office for assistance.

Community First would like to thank all of our valued Providers for working collectively to ensure the health and safety of our Members in the STAR Kids program.

ADHD: DIAGNOSES & THE PROVIDERS' ROLE

Mental disorders among children can impact how they learn, behave, or handle their emotions, causing distress and difficulties completing daily tasks. One of the most commonly diagnosed childhood mental disorders is attention-deficit/hyperactivity disorder (ADHD), affecting 9.4 percent of children ages 2-17 (approximately 6.1 million).

The American Academy of Pediatrics (AAP) guidelines for diagnosis and evaluation of ADHD recommends that primary care providers complete these steps:

- Evaluate children and adolescents ages 4 to 18 years for ADHD if they have academic or behavioral problems and show inattention, hyperactivity, or impulsivity.
- Get reports on the child's symptoms from parents or guardians, school staff, and mental health workers involved with their care. Gather information from the child or adolescent as well.
- Use rating scales and other sources to document the symptoms and ensure that DSM-5 criteria are met.
- Rule out any other possible conditions that can cause similar symptoms.
- Screen for other conditions that might coexist with ADHD, including emotional or behavioral disorders (i.e., anxiety, depression, and behavior problems), developmental disorders (i.e., learning and language disorders or autism spectrum disorder), and physical conditions (i.e., tics, sleep disorders, or apnea).
- Refer children to a specialist if co-occurring conditions are detected and/or the Provider is inexperienced in treating or diagnosing.

After a child is diagnosed, AAP guidelines recommend follow-up appointments at least monthly until the child's ADHD symptoms are stabilized. Once the child is stable, an office visit every three to six months allows for reassessment of learning and behavior.

Community First's Pharmacy Department recently launched a new initiative with the goal of improving follow-up care for children prescribed an ADHD medication. We are collaborating with Providers to increase the percentage of Members ages 6 to 12 who have one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase after filling a new ADHD medication.

Providers play a critical role in conveying the efficacy of pharmacotherapy to their patients. By providing timely follow-up care, Providers can monitor their patients closely for potential adverse events and improvements in clinical symptoms.

As a reminder, Community First can help Providers find behavioral health services for Members if needed. Our specially trained Service Coordinators and Care Managers are available to help.

Community First behavioral health services do not require a referral from a PCP or a pre-authorization for outpatient services, including an initial assessment or individual, family, or group counseling.

SOURCES:

https://www.cdc.gov/ncbddd/adhd/guidelines.html

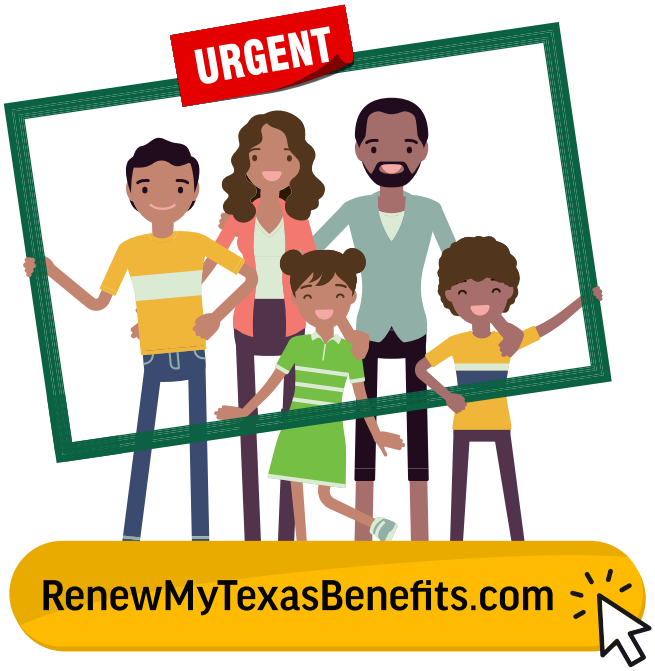
https://publications.aap.org/pediatrics/article/144/4/e20192528/81590/

PROUD TO BE LOCAL

PROUD TO BE YOUR PLAN.

COMMUNITY FIRST HEALTH PLANS

The End of the Public Health Emergency & Its Impact on Health Benefits



Based on the most recent data, HHSC estimates as many as 3.7 million individuals will need to have their Medicaid eligibility redetermined when continuous coverage ends, with 2.97 million of these individuals extended due to the requirements to provide continuous Medicaid coverage until the end of the PHE. This number continues to grow based on Members continuing to reach the end of their current eligibility periods.

With the end of the COVID-19 Public Health Emergency (PHE) on the horizon, millions of Americans' health care coverage will be impacted. As a part of the PHE, a law was passed allowing Medicaid and CHIP recipients to keep their health care coverage, circumventing the recertification or "renewal" process. **When the PHE ends, individuals covered by Medicaid or CHIP will need to take action in order to keep their health care benefits.**

It's essential to begin informing patients about the renewal process NOW. Here are a few common questions you might receive from your patients about the end of the PHE and how you can answer them:

1. **What is the PHE?**
   In March 2020, the federal government declared a Public Health Emergency (PHE) due to the COVID-19 pandemic and passed a law allowing Medicaid/CHIP recipients to receive continuous coverage without renewing. When the PHE ends, you will need to take action to renew your Medicaid/CHIP benefits.

2. **Why is this important? What happens if I don't take any action?**
   If you do not take any action, you might lose your Medicaid coverage. It is extremely important to report any changes in your contact information and/or income to Texas Health & Human Services Commission (HHSC) and respond quickly to any notices you receive from them.

3. **What happens if I don't get a notice from HHSC?**
   If you have moved recently, HHSC might not have your new contact information. If an old address is on file or there has been a mistake, call 2-1-1 and choose option 2 or update your information at YourTexasBenefits.com.

4. **What can I do to keep my Medicaid/CHIP benefits?**
   You will need to go through the recertification ("renewal") process. During this process, HHSC will determine if you are still eligible to keep receiving your health care benefits.

5. **Is the renewal process difficult?**
   Not at all. You can renew by mail, online at YourTexasBenefits.com, or via the Your Texas Benefits mobile app. Here are a few documents you might need while renewing:

   a. Bank account statements
   b. Pay stubs
   c. Child support or alimony you get or pay
   d. Social Security benefits
   e. Childcare costs

6. **Is there anything I can do now to keep my benefits?**
   You can start preparing for the renewal process now by taking the following steps:

   a. Create an account at YourTexasBenefits.com or log in if you have one already.
   b. Check if it's time to renew by clicking "Manage" and finding the case that says "Ready for Renewal."
   c. Check your mail and email for notices or forms from HHSC. **If HHSC is requesting more information from you, respond right away!**
   d. Report any changes – like your mailing address, contact information, income, etc. – to HHSC as soon as possible either online at YourTexasBenefits.com, via the app, or by calling 2-1-1.

7. **How often do I have to renew?**
   You'll need to go through the renewal process every 12 months. You can sign up for renewal alerts at YourTexasBenefits.com or on the mobile app.

8. **I still have questions. Where can I get more help and information?**

> Visit RenewMyTexasBenefits.com for more information or to make an appointment for in-person or phone assistance.

> Call Community First's bilingual Member Services Department at (210) 227-2347.

> Call HHSC at 2-1-1 and choose option 2.

As a Provider, you might have questions about the PHE and its impact on your patients' health care coverage. Refer to the questions below.

1. **How do I verify my patient's Medicaid coverage?**
   You can verify client eligibility for Medicaid through the Texas Medicaid & Healthcare Partnership's (TMHP) TexMedConnect portal. You can also call 2-1-1. Press option 2 after the language prompt, and then option 2 again. Be prepared to provide your National Provider Identifier (NPI).

2. **If my patient is uninsured, where can they go for coverage?**
   If your patient was found ineligible for Medicaid, their case has been automatically sent to the federal marketplace to be considered for coverage options. For more information about this visit, Healthcare.gov.

If your patient was disenrolled because they never responded to HSSC or didn't complete their renewal application, they will not be transferred to the marketplace. This is because HHSC was not able to confirm their eligibility for Medicaid. In this case, they should submit their renewal for benefits.

3. **What is Prior Medicaid Coverage, and how does someone apply?**
   When a person applies for Medicaid coverage through HHSC, they can apply for Medicaid benefits for up to the three months prior to the month of application if they have unpaid medical bills in those three months. People can apply for Medicaid coverage by submitting Form H1113, Application for Prior Medicaid Coverage. Please refer patients to the Texas Works Handbook for more information.

Community First has created materials to assist all Medicaid/CHIP Members through the renewal process. Please contact your Provider Relations Representative or call 210-358-6294 if you would like to display these materials in your office or provide them to your patients.

CARE MANAGEMENT:
HOW WE CAN HELP YOUR PATIENTS

What is Care Management?
Care Management is a key component of Community First's Population Health Management (PHM) strategy. The Care Management Program provides comprehensive, personalized Care Management services and goal setting for Members who have complex medical needs and require a wide variety of resources to manage their health and improve their quality of life.

Community First embraces a holistic approach to managing quality of life by treating every Member as a whole. Within this holistic approach, our interdisciplinary team relies on experienced professionals from diverse backgrounds including social work, nursing, mental health, home care, and home health.

What is a Care Manager?
Care Managers serve as the primary point of contact and collaborate with the Member, their family members, and all relevant service providers to help the Member understand their condition and how to best take care of themselves. Our Care Managers are trained Registered Nurses or social workers.

Our Care Management teams also provide the Member with resources that can help them get the best care possible utilizing the right Providers, in the right setting, and in the right time frame.

What services does Care Management include?
Care Management services include the following:

- Complex Care Management.
- Systematic assessment of the patient's medical, functional, and psychosocial needs.
- System-based approaches to ensure timely receipt of all recommended preventive care services.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of patient self-management of medications.
- Coordination of care with home and community-based clinical service providers.

Care Coordination and Service Management:
Care Coordination and Service Management are essential, ongoing sub-components of Community First 's Care Management Program. In these sub-components, Providers working with a particular Member share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep Members and their families informed and to ensure that effective referrals and transitions take place.

What services does Care Coordination and Service Management include?

- Oversight of transitions between and among health care providers and settings.
- Referrals to other clinicians.
- Follow-up after an emergency department visit or facility discharge.
- Community First's Care Management team is committed to working with our Members, their family, doctors, and other members of their health care team to improve the Member's overall health and to obtain the services they need.

Care Management Referral
If you would like to refer a Member who could benefit from Care Management, please complete the Care Management referral form.

Visit CommunityFirstHealthPlans.com/Providers.

1. Click on the health plan you service.
2. Select "Provider Resources" under the Provider dropdown menu.
3. Select Provider Forms.
4. Complete and email the form to caremanagementhelp@cfhp.com.

A Care Manager will then contact the Member to discuss their individual health care needs.

If you would like to learn more about our Care Management Services, please call Community First Population Health Management at (210) 358-6050.

COMMUNITY FIRST FOOD PANTRIES

Growing, Expanding, Serving More Communities

Over the past year, we have installed 15 Community Food Pantries throughout our service area... and counting! Our Food Pantries are designed to help in the fight against food insecurity by supplying food and other items without barriers for those in immediate need.

What is a Community First Food Pantry?

Our Food Pantries have several unique features, including:

- Free-standing, weather-proof, most located outdoors
- Most offer 24/7 access
- No cost, no registration, no sign-up

What items are in the Food Pantries?

Some items you may find in our Food Pantries include:

- Peanut butter
- Cereal
- Tuna
- Beans
- Rice
- Macaroni & cheese
- Chili and soups
- Baby food and diapers
- Canned lunch meats
- Pet food
- Full meals (can/box)
- Pop-top food items
- Seasonal items like sunscreen, school supplies, and toys

Where can I find a Food Pantry?

If you have a patient or know someone in need, you can find a map of Food Pantry locations at CommunityFirstHealthPlans.com/Food-Pantry.

How can I help?

If you or your team is interested in helping us stock our Food Pantries, please visit the location of your choice, place items inside the pantry, and close the doors before you go.

We are also looking for Provider groups and other organizations to take our #StuffThePantry Challenge by committing to donating to one of our Food Pantries on a weekly or monthly basis.

PROVIDING MEMBER-CENTRIC CARE

Community First Health Plans uses a Member-Centric Population Health Management (PHM) strategy that allows us to focus on care that addresses each Members' preferences, needs, and values. The framework of this strategy identifies the needs of our community, stratifies these needs for intervention, and focuses on the transition to value-based care in our contracted network.

The tools in our PHM strategy include the following:

Health Assessments. Health Assessments collect important information about Members, including their health literacy, risks and health behaviors, demographics, values, and special needs. Health Assessments also help us connect with our Members at all stages of life (i.e., early childhood, adolescence, adulthood, and old age), and better understand how they approach conditions and want to receive information.

Risk Stratification. Risk Stratification arranges Members into meaningful categories for personalized intervention targeting. This includes everyone in our Member population, from low-risk to high-risk. Most health care costs are incurred by a minority of the population so it is important to strategize as to where to target investments that can yield the highest return, both in improved health outcomes and cost reductions.

Enrollment and Engagement. Enrollment and engagement include coordination of care across all settings for every Member. Engaging Members in their health care helps them to appropriately access care and services. Enrollment and engagement include self-determined participation in intervention-directed activities that are in alignment with the Members' goals.

Person-Centered Interventions. Person-centered clinical and wellness interventions include a broad range of approaches and activities tailored to improve the health and well-being of an individual. These interventions can direct resources toward the areas of greatest population risk and opportunities for health improvement. This includes disease management, medication adherence, lifestyle management, and ongoing behavioral health coaching and education.

Providers play a key role in our overall strategy, including promoting healthy habits and increasing Member engagement in our Health & Wellness Programs. Our current Health & Wellness Programs include:

- **ASTHMA MATTERS**
  Asthma Management Program
- **DIABETES IN CONTROL**
  Diabetes Management Program
- **HEALTHY MIND**
  Behavioral Health Program
- **HEALTHY LIVING**
  Healthy Lifestyle Program
- **HEALTHY EXPECTATIONS MATERNITY PROGRAM**
- **HEALTHY HEART**
  Blood Pressure Management Program

To read more about these programs, please turn to page 14.

If you identify a Member that may benefit from engaging in any of our Health & Wellness Programs, please contact our Health Promotion and Wellness team at (210) 358-6349 or email healthyhelp@cfhp.com.

Provider Education & Training:
New Opportunities Now Available!

COMMUNITY FIRST U
VIRTUAL LEARNING INSTITUTE *for* PROVIDERS

Community First Health Plans is committed to supporting our network of Providers by providing needed support, information, tools, and resources. We are continuously working on expanding the educational opportunities available.

Below, you will find information about two of our newest initiatives designed to help you learn more about Community First and navigate our processes and procedures more efficiently. We invite you and your staff to take advantage of these resources.

Community First *U*
Virtual Learning Institute for Providers

Community First *U* is located on the secure Provider Portal. Log in to the portal with your username and password (or create an account if you have not done so already) to access guides divided into two categories:

Informational Guides
Alternate Payment Model
Billing Code References
Cultural Competency
Disease and Care Management Programs
Nurse Advice Line
Provider Newsletters
Recredentialing
Texas Health Steps
Outages Notice
Learning Guides
Authorizations in JIVA
NDC Lookup
Payspan
Website, Provider Portal & Provider Resources
Claim Submission Tips

Community First *U* guides are available to view, download, or print from your computer or mobile device.

Provider Educational Sessions

Our Provider Educational Sessions are live, virtual education sessions conducted by our Provider Relations Department. These sessions are an excellent opportunity for both new and existing Providers and their office staff to learn more about Community First.

3rd Friday of Every Month

- **Provider Onboarding (1:30 p.m.)** – a history of Community First, our service area, membership, authorizations/claims, and more (this session serves as an initial onboarding required for all new Community First Providers and a refresher for existing Providers.)
- **Provider Forum (2:30 p.m.)** – a monthly overview of important news and updates relevant to Community First Providers.

4th Friday of Every Month

- **Provider Portal Overview (1:30 p.m.)** – how to access, navigate, and utilize the tools on the portal, including claim status search, claim & eligibility look up, and claim appeal submissions.
- **LTSS/EVV Overview (2:30 p.m.)** – an overview of the STAR Kids program, LTSS, EVV, and more.

It's easy to sign up for the virtual session of your choice. Visit CommunityFirstHealthPlans.com/Provider-Educational-Sessions, view the schedule of upcoming sessions, and complete the online Provider Education Registration form. (If you are already logged in to the Provider Portal, you can sign up for upcoming sessions by clicking on the Community First *U* "Educational Sessions" tab.)

We are constantly striving to expand our resources and tools for Providers, so we welcome any feedback and suggestions you may have. Please call your Provider Relations Representative directly or contact our Provider Relations Department at (210) 358-6294 or ProviderRelations@cfhp.com.

Dates *for* Provider Educational Sessions:

JULY:

July 15: Provider Onboarding @ 1:30 | Provider Forum @ 2:30

July 22: Provider Portal Overview @ 1:30 | LTSS/EVV Overview @ 2:30

AUGUST:

Aug 19: Provider Onboarding @ 1:30 | Provider Forum @ 2:30

Aug 26: Provider Portal Overview @ 1:30 | LTSS/EVV Overview @ 2:30

SEPTEMBER:

Sept 16: Provider Onboarding @ 1:30 | Provider Forum @ 2:30

Sept 23: Provider Portal Overview @ 1:30 | LTSS/EVV Overview @ 2:30

OCTOBER:

Oct 21: Provider Onboarding @ 1:30 | Provider Forum @ 2:30

Oct 28: Provider Portal Overview @ 1:30 | LTSS/EVV Overview @ 2:30

NOVEMBER:

(November and December dates shifted to 2nd and 3rd Friday due to holiday season)

Nov 11: Provider Onboarding @ 1:30 | Provider Forum @ 2:30

Nov 18: Provider Portal Overview @ 1:30 | LTSS/EVV Overview @ 2:30

DECEMBER:

Dec 9: Provider Onboarding @ 1:30 | Provider Forum @ 2:30

Dec 16: Provider Portal Overview @ 1:30 | LTSS/EVV Overview @ 2:30

Sign Up at CommunityFirstHealthPlans.com/Provider-Educational-Sessions

COMMUNITY FIRST HEALTH PLANS

HEALTH & WELLNESS PROGRAMS

A Prescription for Wellness

Community First Health Plans has a family of dedicated programs designed to help our Members improve their health, help control a chronic condition, and experience a healthy pregnancy. Our Health & Wellness programs were designed to provide the guidance they need to achieve better health outcomes.

Community First's Health & Wellness Programs include:

Asthma Matters

Asthma Management Program

- Education about the causes or triggers of asthma
- Tips to achieve normal or near-normal lung function
- Advice on how to participate in physical activity without symptoms
- Ways to decrease the frequency and severity of flare-ups

Qualifying Members may also receive a peak flow meter and up to $10 in gift cards for health-related items.*

Diabetes in Control

Diabetes Management Program

- Diabetes education classes
- Information on how to control blood sugar
- Tips for talking to Providers
- Blood sugar testing and supplies
- One-on-one access to a Health Educator
- Referral to YMCA Diabetes Prevention Program including a complimentary four-month YMCA membership*

Qualifying Members may also receive up to $50 in gift cards for health-related items.*

Healthy Expectations Maternity Program

- One-on-one contact with a Health Educator
- Prenatal and postpartum education
- Home visits for high-risk pregnancies
- Virtual Mommy & Me baby shower

Qualifying Members may also receive gift cards for attending pre and postnatal checkups, reimbursement for birthing classes or toward a pregnancy pillow, and more.*

Healthy Mind

Behavioral Health Program

- Help determining the type of behavioral health assistance needed
- Information to help choose the right professional counselor or doctor
- Care Management for high-risk Members

Healthy Living

Lifestyle Management Program

- One-on-one contact with a Health Educator
- Referral to YMCA Weight Loss Program including a complimentary 4-month YMCA membership*
- Care Management for high-risk Members
- Access to Zumba and other fitness classes at no-cost

Healthy Heart

Blood Pressure Management Program

- One-on-one contact with a Health Educator
- Referral to YMCA High Blood Pressure Self-Monitoring Program, including a free blood pressure cuff*
- Care Management for high-risk Members

How to Join

If you have a patient who could benefit from participating in one or more of our Health & Wellness Programs, we encourage you to contact Population Health Management at (210) 358-6055 or email healthyhelp@cfhp.com.

You can also refer them to the program(s) that fits their needs. To join, instruct the Member to:

- Take our online Health Assessment and/or Pregnancy Health Assessment available on our website at CommunityFirstHealthPlans.com/Health-and-Wellness-Programs/ or on the Member Portal, or
- Email healthyhelp@cfhp.com, or
- Call (210) 358-6055 to speak with a Health Educator.

All Health & Wellness Programs are provided at no cost, and Members can opt out of a program at any time. Community First also offers Members free virtual education classes and a family of scholarship programs.

Community First strives to provide the best quality services to our Members. A referral to our family of Health & Wellness programs helps us complement your efforts as a caring, engaged Provider.

**Limits and restrictions apply.*

PHARMACY BENEFITS:
WHAT YOU NEED TO KNOW

Below, you will find a compilation of important information about Community First Health Plans' pharmacy benefits and key changes to the 2022 CDC Immunization Schedules. Please review carefully.

Pharmacy Benefit Program

Community First Health Plans offers Members prescription drug benefits through our pharmacy benefits partner, Navitus Health Solutions.
Take the following steps to log in to the Navitus Provider Portal.

1. Visit Prescribers.Navitus.com.
2. Click "Sign In" located on the upper right hand corner of your screen.
3. Enter your NPI number and state.

Once logged in, Providers can access the following information:

- List of covered drugs, also called a formulary, and other information including drug tiers and quantity limits.
- Updates to the formulary.
- Prior authorization forms and clinical criteria used for certain medications.
- Information on how to request a formulary exception.
- List of network pharmacies and specialty pharmacies.

Preferred Drug List

The Texas Vendor Drug Program publishes a Preferred Drug List (PDL) for Medicaid Members every January and July. This list contains preferred covered medications and requirements for using non-preferred medications.

For the most up-to-date version of the Medicaid PDL, please visit Medicaid Pharmacy Prior Authorization and PDL.

To obtain a paper copy, please contact Member Services at (210) 227-2347.

CLAIMS CORNER

Please review the following information for important claims updates.

New Paper Claims Mailing Address

Community First Health Plans has changed servicing vendors for mailed-in paper claims and paper claim appeals. Effective June 1, 2022, Providers who choose to submit paper claims or claim appeals via USPS will need to update the mailing address to the following:

Community First Health Plans
P.O. Box 240969
Apple Valley, MN 55124

New Claims Appeal Form

Providers have the right to appeal the denial of a claim by Community First. To file an appeal, Providers should submit the Community First Claims Appeal Form and a copy of the EOP, along with any information related to the appeal.

For efficient processing, please fill out the Claims Appeal Form electronically using our secure Provider Portal. For assistance navigating the portal or to create an account, please email ProviderRelations@cfhp.com or call (210) 358-6294 to contact our Provider Relations Department.

If you prefer to fill out this form by mail, please download our paper Claims Appeal Form.

Providers using the paper form should mail it to the address below beginning on June 1, 2022:

Community First Health Plans
P.O. Box 240969
Apple Valley, MN 55124

Please Note: Appeals submitted without the Claims Appeal Form or with inaccurate information will be rejected, and will receive a rejection notification from our Provider Relations Department.

New Claims Editing Software

On April 1, 2022, Community First implemented Optum Claims Editing Softward (CES), a pre-payment auditing process to help identify frequent coding errors. Coding edits are based on Current Procedural Terminology (CPT), Medicaid guidelines, industry standard National Correct Code Initiative (NCCI) policy and guidelines, and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

The new CES identifies frequent correct coding billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims

- Services included in global care
- Incorrect coding of services rendered

All edits within the CES comply with national coding standards and are most likely part of the normal billing practice of providers. All claims must follow the proper coding guidelines. This requires the usage of correct modifiers, correct place of service codes, and correct usage of ICD-10 codes in the primary diagnosis field.

The CES was implemented to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Community First reimbursement uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. Reference to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Ensure your billing systems are up to date with Texas state standards to ensure your claims are processed efficiently and paid quickly.

For additional information, please contact Provider Relations at (210) 358-6294 or ProviderRelations@cfhp.com.

TO ASSIST YOU IN THIS TRANSITION, THE FOLLOWING ARE COMMON SCENARIOS THAT MAY HELP YOU UPDATE YOUR SYSTEMS TO ENSURE TIMELY CLAIMS FILING AND QUICK PAYMENT.

Modifier 26 - Professional Component

The total service/procedure described by a single CPT code is comprised of two distinct portions: a **professional component** (designated by Modifier 26), and a **technical component** (designated by modifier TC).

- The **professional component** of a diagnostic service/procedure is provided by the physician and may include supervision, interpretation, and a written report.
- The **technical component** of a diagnostic service/procedure accounts for equipment, supplies, and clinic staff, such as technicians. Fees for the technical component generally are reimbursed to the facility of practice that provides or pays for the equipment and supplies.

To identify professional service only for a service that includes both professional and technical components, append modifier 26 to the appropriate CPT code. Please note that this modifier is appropriate when the physician supervises/or interprets a diagnostic test.

Do not append modifier 26 if there is a dedicated code to describe only the professional/physician component of a given service. (For example, 93010 Electrocardiogram, routing ECG with at least 12 leads; interpretation and report only.)

Understanding the correct and appropriate use of this modifier 26 will be key to filing clean claims and avoiding denials for duplicate billing or incorrect use of modifier.

Inappropriate Diagnosis Codes

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, developed through a collaboration of Centers for Medicare and Medicaid services (CMS), the National Center for Health Statistics (NCHS), and the Department of Health and Human Services (DHHS), provides clear direction on the coding and sequencing of diagnosis codes.

Use the chart below to review examples of factors influencing health status.

Examples of Factors Influencing Health Status (Category of codes beginning with Z)	
CATEGORY	**INSTRUCTIONS**
Z15.03-Z15.09, Z15.81, Z5.89	
Category Z16	Sequence the infection code first
Category Z17	Sequence the malignant neoplasm of breast code first
Category Z19	Sequence the malignant neoplasm code first
Code Z33.1	Code Z33.1
Category Z3A	Sequence first complications of pregnancy, childbirth, and the puerperium (000-09A), followed by a code from Category Z3A to identify the specific week of the pregnancy.
Codes Z55-Z65	These codes should only be reported as secondary diagnoses
Codes Z68.1-Z68.24, Z68.51-Z68.54	BMI codes that should only be reported as secondary diagnoses.
Category Z91.1	Sequence the underdosing of medication (T36-T50) first
Category Z91.13	Sequence the underdosing of medication (T36-T50) first
Code Z91.83	Sequence the underlying disorder first

ICD-10 codes found on the Factors Influencing Health Status Category List (category of codes beginning with Z) will be denied when billed as the Primary Diagnosis Codes.

The Use of Modifier 59 In Therapy Billing

Modifier 59 allows PTs to charge for two separate services that have been paired by the National Correct Coding Initiative (NCCI) as one. However, there are many other factors that affect its use and may cause errors.

- **The NCCI identified certain procedures that therapists often perform together in the same treatment period as edit pairs.** Should you charge for any two CPT codes that make up an edit pair, the payer will automatically pay for only one of those services. This is unless those services were provided wholly separate from each other and modifier 59 is applied to one of the codes.
- **Modifier 59 signifies separate payment for code pairs that are considered to have just one payment.** For example, code 97110, which indicates therapeutic procedure on one or more ears (each for 15 minutes) links to several other codes to perform edit pairs. To be able to charge for 97110 as well as its partner code in an edit pair separately, the services need to have been performed in different time periods (different 15-minute periods in this case) and have modifier 59 attached to the linking code.
- **Modifier 59 as intended primarily for surgical procedures but does affect physical, occupational and speech therapy billing and is widely recognized.** There are certain conditions necessary for this modifier to be effective. First, is that you use it with an existing edit pair. Some codes represent mutually exclusive procedures and can therefore never be billed with another code.

For a guide on how and where to look up edit pairs, visit CMS.gov/Medicare/Coding/NCCI-Coding-Edits.

Improper Use of Place of Service Codes

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The place of service code helps the insurer to ascertain the place where the medical service was rendered.

Matching of the current location of service codes to the procedural codes is crucial while reimbursing claims. If the place of service code does not correlate with treatment code(s), the claim will be denied.

All home modification services must be billed with location 12, as the treatment is occurring in the patient's home.

For a complete list of service codes, please visit CMS.gov/Medicare/Coding/Place-of-Service-Codes.

EDC Analyzer

The information below is for Providers who bill on a UB-04 claim form, or its electronic equivalent, or it's successor form. This applies to all products and all network and non-network facility emergency departments (including hospital emergency departments) and free-standing emergency departments.

Community First reimburses UB claims billed with Evaluation and Management (E/M) codes Level 4 (99284/G0383) and Level 5 (99285/G0384) for services rendered in an emergency department.

CMS indicates facilities should bill appropriately and differentially for outpatient visits, including emergency department visits. To that end, CMS coding principles applicable to emergency department services provide that facility coding guidelines should:

- follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code,
- be based on hospital facility resources and not based on physician resources, and
- not facilitate upcoding

Community First will utilize the Optum Emergency Department Claim (EDC) Analyzer to determine the emergency department E/M level to be reimbursed for certain facility claims. The EDC Analyzer applies an algorithm that takes three factors into account to determine a Calculated Visit Level for the emergency department E/M services rendered.

The three factors used in the calculation are:

1. **Presenting problems** as defined by the ICD-10 reason for visit (RFV) diagnosis.
2. **Diagnostic services performed** based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e., Lab, X-Ray, EKG/RT/Other Diagnostic, CT/MRI/Ultrasound)
3. **Patient complexity and co-morbidity** based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Facilities may experience denials to the levels 4 or 5 E/M codes submitted on the UB-04. In the event you receive a denial, the facility may submit a corrected claim, which Community First will adjudicate based on the new charges and/or additional coding that supports the E/M Level.

Community First will continue to provide guidance and resources as we transition to our new CES.

For questions or comments, contact Community First Provider Relations at (210) 358-6294 or email ProviderRelations@cfhp.com.

Long-Term Services & Supports: Important Policy Updates

Long-Term Services and Supports (LTSS) encompasses services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance performing routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Who Qualifies for LTSS?

Community First STAR Kids Members ages 0-20 who either:

- receive SSI,
- receive disability-related Medicaid services, and/or
- are enrolled in the Medically Dependent Children's Program (MDCP).

Waiver Programs

Children or youth currently enrolled in an Individual Developmental Disabilities/Individuals with Intellectual Disabilities (IDD/IID) waiver such as CLASS, DBMD, HCS, or Texas Home Living will be required to enroll in a STAR Kids health plan in their area in order to receive acute care services. All LTSS are provided through their waiver program.

What is EVV?

EVV stands for Electronic Visit Verification. EVV is a computer-based system that verifies the occurrence of authorized personal attendant service visits by electronically documenting the precise time a service delivery visit begins and ends.

Texas requires EVV for certain Medicaid-funded home and community-based services provided through the Texas Health and Human Service Commission (HHSC) and managed care organizations.

What's New?

- HHSC implemented EVV for 90 percent of personal care services (PCS) in 2016. To comply with the Federal 21st Century Cures Act, Section 12006, Texas implemented EVV for the remaining 10 percent on January 1, 2021.
  - PCS Required to Use EVV (pdf) lists the specific services considered PCS required to use EVV in Texas. The services are separated into two groups: State-Required PCS and Cures Act PCS.
- The Cures Act requires states to implement EVV for Medicaid home health care services by January 1, 2023. Home health care services are covered services, equipment, appliances, and supplies that are provided to qualified Medicaid recipients at their place of residence by home health agency staff, providers of durable medical equipment, or expendable medical supplies.
  - HHSC plans to implement EVV for Medicaid Home Health Care Services on January 1, 2024.
  - HHSC is in the early stages of meeting the federal requirement, including identifying the specific home health care services that will be required to use EVV in Texas. HHSC refers to these services as "Cures Act Home Health Care Services" or "Cures Act HHCS." 21st Century Cures Act will be updated with more information as the project progresses.

On June 1, 2022, HHSC published information to describe the changes made to the EVV Policy Handbook. You can view these revisions at HHS.Texas.gov/Regulations/Handbooks.

- EVV claims matching for all Service Group 21 Home and Community-based Services and Service Group 22 Texas Home Living billing code combinations resumes July 1, 2022.
- Payers will begin conducting EVV Usage Reviews for Consumer Directed Services employers for dates of service on or after September 1, 2022.

To receive important LTSS and EVV updates, please subscribe to our Provider eNewsletter or visit Medicaid.CommunityFirstHealthPlans.com/Providers/EVV/.

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IMMUNIZATIONS FOR ADOLESCENTS

Providers should always make immunization recommendations for adolescents by (1) determining needed vaccines based on age; (2) determining appropriate intervals for catch-up, if needed; (3) assessing for medical indications; and (4) reviewing special situations.

HEDIS® Measure Combo 2 (IMA 2)

HEDIS® Measure Combo 2 (IMA 2) assesses adolescents 13 years of age who receive the following vaccinations by their 13th birthday:

- One Meningococcal vaccine (MCV) given on or between 11th and 13th birthday.
  - Serogroup B (MenB) will not meet compliance.
- One tetanus, diphtheria, and pertussis (Tdap) given on or between 10th and 13th birthday.
- HPV vaccines given between their 9th and 13th birthday.
  - Two-dose vaccination series with at least 146 days between the doses with different dates of service between 9th and 13th birthday (male and female), or
  - At least three HPV vaccines with different dates of service between 9th and 13th birthday (male and female).

Description	CPT
MCV	90734
Tdap	90715
HPV	90649, 90650, 90651

Primary care providers, please note: IMA 2 is a 2022 PCP Incentive Program metric for STAR and CHIP lines of business. Eligible PCPs may earn incentive rewards for improvement in administrative rates (based on appropriate billing/claims) on a quarterly basis.

IMA PROVIDER TIPS

Immunization Records

- Record date(s) and immunization(s) provided at other practices (including out of state) and the health department in the patient's medical record.
- Record all immunizations in Texas Immunization Registry ImmTrac2.
  - Community First receives records from the state as a part of routine HEDIS reporting.
- Be sure to code/bill all immunizations given.
  - Documentation of physician orders, CPT codes, or billing charges is NOT compliant.
- During HEDIS medical record requests, provide all sources of immunizations from medical record: administration/vaccine log, school certificate, and state registry documentation.

Immunization Recommendations

- Use each visit to review vaccine schedule and catch up on missing immunizations.
- Schedule 13-year-old patient well-visits before the patient's 13th birthday.
  - Patient will NOT be compliant for HEDIS if final HPV dose is given after 13th birthday.
- Recommend the HPV vaccine the same way (and on the same day) you recommend other adolescent vaccines.
  - Discuss HPV in terms of cancer prevention and explain that the HPV vaccine is most effective before sexual activity begins.
  - List HPV in between other vaccines being received as a preteen bundle. (For example: Tdap, HPV, and then MCV.)
  - Hardwire scheduling of second (or third) HPV appointments and reminders.
  - Administer first HPV vaccine at 9-10 years old instead of later to help increase compliance.

Visit HPV Educational Materials to access additional resources to help relay to Members the importance of the HPV vaccine.

Source:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

KEY 2022 CDC IMMUNIZATION SCHEDULE CHANGES

1. Child and Adolescent Immunization Schedules

- **Dengue** note was added to provide guidance for areas with endemic dengue and pre-vaccination laboratory testing.
- The **Hib** note now includes recommendations for using Vaxelis for routine and catch-up vaccination.
- The **hepatitis A** note now clarifies the recommended age for routine vaccination.
- The **hepatitis B** now clarifies the recommendation for post-vaccination serologic testing and revaccination
- The **HPV** note now clarifies the number of doses for immunocompromised persons.
- Information on contraindications and precautions for influenza vaccines was moved to the newly created appendix in the **influenza** note.
- The **MenACWY** note now include language stating MenACWY vaccines may be administered simultaneously with MenB vaccines if indicated, but at a different anatomic site, when feasible.
- The **MMR** note now includes information on recommendations for use of MMRV.
- **The Varicella** note now includes information on recommendations for use of MMRV.

2. Adult Immunization Schedules

- The **hepatitis B** note now states that HepB vaccine is universally recommended for all adults ages 19-59. The 2-, 3-, or 4- dose regimens and the risk-based recommendations for adults 60 and older are now listed. A note was added to state "anyone age 60 years or older who does not meet risk-based recommendations may still receive HepB vaccination."
- The **HPV** note was edited to increase clarity in the "Routine Vaccination" and "Special Situations" sections.
- The "Shared Clinical Decision-Making" section of the **HepB** note was revised to include HepB vaccines in persons with diabetes ages 60 and up.
- Information on contraindications and precautions for influenza vaccines was moved to the newly created appendix in the **influenza** note. The language was edited to clarify the age as "19 years or older," to be consistent with the schedule.
- The **MenB** note now states, "*MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, when feasible.*"
- The MMR "special situations" section in the **MMR** note now includes CD4 percentages in addition to CD4 counts in the HIV infection bullet to harmonize language with the child/adolescent schedule.
- The "Routine Vaccination" section in the **pneumococcal** note now states that anyone ages 65 and up "*who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used, this should be followed by a dose of PPSV23.*" The "Special Situations" section now states that anyone "*aged 19 through 64 years with certain underlying medical conditions or other risk factors who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used, this should be followed by a dose of PPSV23.*" Guidance for dosing intervals between PCV15 and PPSV23 and for patients who have previously received PCV13 or PPSV23 in the past is also included. Notes are added listing all underlying medical conditions or risk factors that would make those aged 19-64 eligible to receive pneumococcal vaccination.
- The "Special Situations" section in the **Varicella** note now includes CD4 percentages in addition to CD4 counts in the HIV infection bullet.
- The "Special Situations" section pregnancy bullet in the **Zoster** note now states "There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy." Additionally, the immunocompromising conditions bullet now states "*RZV is recommended for use in persons aged 19 years and older who are (or will be) immunodeficient or immunosuppressed because of disease or therapy.*"

Source: https://www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html

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Non-Discrimination Notice

Community First Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Community First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Community First Health Plans provides free auxiliary aids and services to people with disabilities to communicate effectively with our organization, such as:

Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, and other written formats)

Community First Health Plans also provides free language services to people whose primary language is not English, such as:

Qualified interpreters
Information written in other languages

If you need these auxiliary services, please contact Community First Member Services at 1-800-434-2347. TTY (for hearing impaired) at 210-358-6080 or toll free 1-800-390-1175.

If you wish to file a complaint regarding claims, eligibility, or authorization, please contact Community First Member Services at 1-800-434-2347.

If you feel that Community First Health Plans failed to provide free language services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can contact the Chief Compliance & Quality Officer by phone, fax, or email at:

Susan Lomba
Chief Compliance & Quality Officer
Phone: 210-510-2463, TTY number: 1-800-390-1175
Fax: 210-358-6014
Email: slomba@cfhp.com

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

You may also file a complaint by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD number: 1-800-537-7697

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html

Aviso de no discriminación

Community First Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual. Community First Health Plans no excluye o trata de manera diferente a las personas debido a raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual.

Community First Health Plans proporciona asistencia y servicios gratuitos a personas con discapacidades para comunicarse efectivamente con nuestra organización, como:

Intérpretes calificados de lenguaje de señas
Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Community First Health Plans también ofrece servicios gratuitos lingüísticos a personas cuyo idioma principal no es el inglés, como:

Intérpretes calificados
Información escrita en otros idiomas

Si necesita recibir estos servicios auxiliares, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347. TTY (para personas con problemas auditivos) al 210-358-6080 o al número gratuito 1-800-390-1175.

Si desea presentar una queja sobre reclamos, elegibilidad, o autorización, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347.

Si cree que Community First Health Plans no proporcionó servicios lingüísticos gratuitos o fue discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual, puede comunicarse con la directora del calidad y cumplimiento por teléfono, fax, o correo electrónico al:

Susan Lomba
Directora de calidad y cumplimiento
Teléfono: 210-510-2463, línea de TTY gratuita: 1-800-390-1175
Fax: 210-358-6014
Correo electrónico: slomba@cfhp.com

También puede presentar un queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del portal de quejas de derechos civiles, disponible en:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

También puede presentar una queja por correo o por teléfono al:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
Teléfono: 1-800-368-1019, línea de TDD gratuita: 1-800-537-7697

Los formularios de queja están disponibles en:
http://www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-434-2347 (TTY: 1-800-390-1175).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-434-2347 (TTY: 1-800-390-1175).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-800-434-2347 (TTY:1-800-434-2347)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 (TTY: 1-800-390-1175)번으로 전화해 주십시오.

ر ق م 1-800-434-2347 ق م ب ر ا ت ص ل با ل م ج ا ن . ل ك ف ت ت و ی ة ا ل ل غ و ع د ة ا ل م س ا خ د م ا ت ف إ ن ا ل
ل غ ة ، ا ذ ا ك ر ت ت ح د ث ك ن ت إ ذ ا م ل ح ظ ة : 1-800-390-1175 : و ا ل ا ل ص م ه ا ت

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ا گ ر د ا ر : خ ب ر 1-800-434-2347 (TTY: 1-800-390-1175).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-434-2347 (TTY: 1-800-390-1175).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347 (ATS: 1-800-390-1175).

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注意事項：日本語を話される場合，無料の言語支援をご利用いただけます. 1-800-434-2347 (TTY:1-800-390-1175)まで、お電話にてご連絡ください.

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