



# First Things First

For Physicians and Providers

## CHIP Perinatal Clients at or Below 185 Percent Federal Poverty Level

### Important Changes in Application Process for Emergency Medicaid

The Texas Health and Human Services Commission is changing the process many expectant mothers use to get perinatal services provided through the Children's Health Insurance Program (CHIP). The change involves the form that must be filled out to ensure the hospital is paid facility fees for labor and delivery for women getting CHIP perinatal coverage whose income is at or below 185 percent of the federal poverty level.

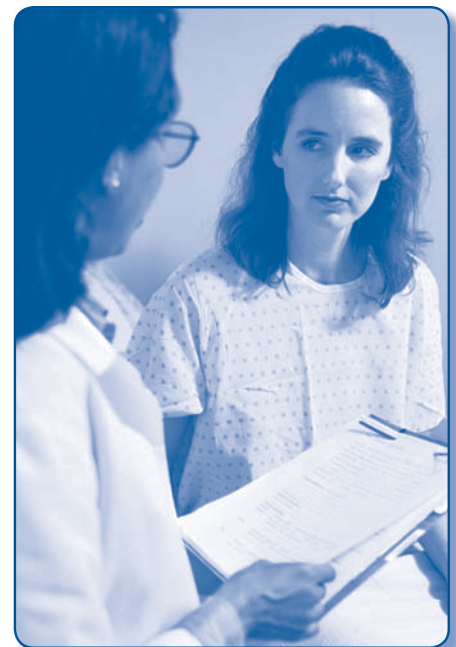
Currently, women in this income range must apply for Emergency Medicaid to cover their hospital labor and delivery fees. This can cause a problem for the hospital if the mother has new income that puts her over the Medicaid limit. **Beginning August 1, 2008**, HHSC will instead require the expectant mother's provider to fill out Form 3038, the Emergency Medical Services Certification. The expectant mother will receive this form from HHSC a month before her due date, along with a letter reminding her to send information about the birth of her child after delivery. The letter will instruct the woman to take the form to her provider, have the provider fill out the form, then mail the form back to HHSC in a pre-addressed, postage-paid envelope. In many cases this activity will happen after delivery when the mother is being discharged from the hospital.

Once HHSC receives the completed Form 3038, Emergency Medicaid coverage will be added for the mother for the period of time identified by the healthcare provider. Form 3038 is the same form currently required to complete Emergency Medicaid certification.

It is important to understand that in this new arrangement, the CHIP perinatal mother will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid. Instead, HHSC will determine the woman's eligibility for Emergency Medicaid by using income and other information the mother to-be provided when she originally applied for CHIP perinatal coverage, as well as information included on the Form 3038.

In cases where a woman fails to send back the Form 3038 within a month after her due date, HHSC will send her another Form 3038 with a postage-paid envelope. If the woman fails to submit the second form, and the hospital cannot locate a Type Program 30 for her in the TMHP online provider look-up system, then the hospital can bill her for facility fees incurred during her stay.

For more information on this change, contact Lisa Bartels, HHSC Office of Family Services, at [lisa.bartels@hhsc.state.tx.us](mailto:lisa.bartels@hhsc.state.tx.us).



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If you have any questions, please call Network Management at (210) 358-6030, 1-800-434-2347

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## From the Coding and Documentation Department

It is the expectation of Health & Human Services Commission (HHSC) and the Office of Inspector General (OIG) that Community First Health Plans (CFHP) makes every effort to prevent and reduce fraud, abuse or waste in the delivery of services in the Medicaid and/or CHIP programs. To meet these expectations, CFHP will be conducting compliance audits beginning in August. These audits will require access to medical record documentation, appointment schedules or other necessary documents to validate coding and documentation compliance.

A representative from the Coding and Documentation Department will be visiting various offices to either request records or to make copies and/or scan medical records related to the compliance audits. Your cooperation is appreciated, and we will make every effort to schedule the visits in a manner that will not conflict with office work flow.

Once the compliance audit is completed a compliance notification letter will be mailed with the results and any corrective actions if necessary.

### Compliance Matters

CFHP adheres to the Texas Administrative Code, Title 22, Part 9, Charter 165, Rule §165.1, regarding the amendment of medical records: "Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction."

For review purposes, the Coding and Documentation Department does not accept amended documentation of existing records under any circumstances. Examples of falsifying records or amending documentation of existing records include:

- Creation of new records when records are requested
- Adding or supplementing portions of records to existing records when records are requested
- Back-dating entries
- Pre-dating entries
- Post-dating entries
- Writing over entries

### Coding and Documentation Tips

The Coding and Documentation Department reviews claims frequently appealed for the removal of impacted cerumen. Many times, proper documentation does not support the billing of 69210.

Below are excerpts taken from the CPT Assistant and the American Medical Association regarding proper documentation and billing of 69210.

CPT Assistant states the following regarding 69210 (Impacted cerumen removal): Year: 2005 / Issue: July/ Pages: 13-16

### Surgery: Auditory System

In collaboration with the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), we present the following discussion which provides some typical coding scenarios with regard to the appropriate use and application of CPT codes related to ear wax removal:

- The patient presents to the office for the removal of "ear wax" by the nurse via irrigation or lavage.
- The patient presents to the office for the removal of "ear wax" by the primary care physician via irrigation or lavage.
- The patient presents to the office for "ear wax" removal as the presenting complaint. This is described as impacted cerumen because it completely covers the eardrum and the patient has hearing loss. The impacted cerumen is removed by the primary care physician or otolaryngologist with magnification provided by an otoscope or operating microscope and instruments such as wax curettes, forceps, and suction.

**Question:** Are these procedures appropriately reported with CPT code 69210, removal impacted cerumen (separate procedure), one or both ears?

**AMA Comment:** A major element in determining whether code 69210 should be reported is understanding the definition of impacted cerumen. By definition of the AAO-HNS, "If any one or more of the following are present, cerumen should be considered 'impacted' clinically:

- Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.

# NCQA Announces New HEDIS 2009 Measures

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures that was created and is maintained by the National Committee for Quality Assurance (NCQA). Overall, HEDIS promotes the ability for purchasers and consumers to compare health plans on key performance measures.

In the spring of 2008, NCQA provided a draft document for public comment regarding the addition of new HEDIS 2009 measures. These measures will cover medical record and claims data from the year 2008.

The new proposed measures are:

| Measure   | Description   | Product Line                   |
|---|---|--------------------------------|
| <b>Adult Body Mass Index (BMI) Assessment (BAA)</b>                               | The percentage of members 18–74 years of age who had an outpatient office visit and who had their body mass index (BMI) documented.   | Commercial, Medicaid, Medicare |
| <b>Weight Assessment and Counseling for Nutrition and Physical Activity (BCA)</b> | The percentage of members 2–17 years of age who had an outpatient office visit and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> <li>• BMI percentile assessment</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> | Commercial, Medicaid           |

Source: <http://www.ncqa.org/tabid/661/Default.aspx>

*Continued from page 2*

- **Inflammatory considerations:** Associated with foul odor, infection, or dermatitis.
- **Quantitative considerations:** Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.”

Other issues may also require consideration. Removing wax that is not impacted does not warrant the reporting of CPT code 69210. Rather, that work would appropriately be captured by an evaluation and management (E/M) code regardless of how it is removed. If, however, the wax is truly impacted, then its removal should be reported with 69210 if performed by a physician using, at minimum, an otoscope and instruments such as wax curettes or, in the case of many otolaryngologists, with an operating microscope and suction plus specific ear instruments (e.g., cup forceps, right angles). Accompanying documentation should indicate the time, effort, and equipment required to provide the service. Add-on code 69990, microsurgical techniques requiring use of operating microscope (list separately in addition to code

for primary procedure) should not be reported if the operating microscope is used for cerumen removal. In this later instance, however, code 92504, binocular microscopy (separate diagnostic procedure), may be reported.

Therefore, based on this information, scenarios 1 and 2 would not be reported with code 69210. These scenarios would be captured by the appropriate E/M code. Scenario 3, however, should be reported with code 69210 because both criteria were met; the patient had cerumen impaction and the removal required physician work using at least an otoscope and instrumentation rather than simple lavage.

- **2008 CPT Definition:** Removal impacted cerumen (separate procedure), one or both ears.
- **Procedure Description:** Under direct visualization, the physician removes impacted cerumen (ear wax) using suction, a cerumen spoon, or delicate forceps. If no infection is present, the ear canal may be irrigated.

## **New Recommendations for Pediatric Preventive Healthcare**

Community First Health Plans follows the components of the Texas Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT or THSteps) as well as the American Academy of Pediatrics (AAP) periodicity schedule for pediatric preventive health care. CFHP wants to ensure that all participating physicians who provide pediatric preventive care are aware of recent changes that the AAP made to the periodicity schedule. These changes include additional visits at ages 30 months, seven (7) years, and nine (9) years. CFHP recognizes the importance of these exams and encourages all providers to begin incorporating this new schedule into their practice. To support this effort, CFHP provides reimbursement for these new age category visits. Please remember that reimbursement is made to providers performing a complete medical checkup which includes all required screenings, a comprehensive unclothed physical exam, laboratory tests, immunizations and anticipatory guidance based on the child's age. These updates, along with additional recommendations made by AAP, will be incorporated into CFHP's Preventive Health Guidelines. You may access the AAP Web site at <http://practice.aap.org> for the complete periodicity schedule.

## **Texas Health Steps**

Texas Health Steps (THSteps) medical checkups are an opportunity for a child or adolescent to receive a comprehensive medical checkup. All components of the medical checkup must be completed for the provider to submit a claim.

Labs obtained as part of the THSteps visit must be sent to the state designated location. See Chapter 43 of the 2008 Texas Medicaid Provider Procedure Manual for details. By contract, CFHP must require that contracted providers follow this process.

## **Immunization Tools Available on the CDC Web site**

The Centers for Disease Control and Prevention (CDC) has several immunization tools available free to help your practice with managing childhood immunizations.

- The "Instant Childhood Immunization Scheduler" is a downloadable program that allows you to enter a child's birthdate (6 years of age or under) to create a printable schedule of recommended immunizations.
- The "Catch-up Immunization Scheduler" is a new tool that is similar to the "Instant Childhood Immunization Scheduler." The downloadable tool is particularly helpful for identifying missed or skipped immunizations for children younger than 6 years.

The tools are available at:

<http://www.cdc.gov/vaccines/programs/default.htm>  
under Tools/Software topic.



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