



El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

ANCILLARY PROVIDER SPECIALTY TRAINING

Thursday, October 29, 2020

2:00pm - 3:30pm

LIVE WEBINAR

EVENTBRITE LINK: <https://ancillarytrainingoct2020.eventbrite.com>

Password: elpasohealth

Complete our survey for a chance to win!

Prize Bag Includes :

- El Paso Health Beach Bag
- El Paso Health Blanket
- EOS Lotion
- EOS Lip Balm
- El Paso Health Pens
- El Paso Health Masks (2) Black & Blue
- El Paso Health Mouse Pad / Phone Holder
- \$20.00 Gift Card

<https://www.surveymonkey.com/r/B3SQ9J>



Please return your survey to be included in the drawing.

Agenda

- Provider Relations & Contracting - [Updates and Reminders](#)
- Member Services – [MS Overview](#)
- Health Services – [Updates and Reminders](#)
- Complaints and Appeals – [C&A Process](#)
- Claims - [Reminders](#)



El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

THE HEALTH PLANS OF EL PASO FIRST

Provider Relations/Contracting Updates and Reminders

Liliana Jimenez

Provider Relations Representative

COVID-19 Updates

- HHSC is extending Medicaid, CHIP, and CHIP Perinatal coverage during the public health emergency declaration.
- In response to the COVID-19 pandemic, office visit co-payments for all CHIP members for services provided from March 13, 2020, through November 30, 2020 are waived.
- Providers must not collect office visit co-payments for CHIP members during this time. El Paso Health will reimburse the provider the full rate for services including member cost sharing.
- Co-payments are not required for covered services delivered via telemedicine or telehealth to CHIP members. HHSC encourages the use of teleservices in lieu of in-person office visits, as appropriate.
- Co-pays do not apply to Medicaid Members.


COVID-19 Update: Waiver of CHIP Co-Payment

HHSC is waiving in office face to face visit co-payments for all CHIP members for services provided from March 13, 2020 through November 30, 2020.

- El Paso Health will reimburse the provider the full rate for services including any member cost sharing.
- Providers must attest that an office visit co-payment was not collected from the member by submitting the [attestation form](#).
- Please submit member listing with the following information: member name, member ID, DOS, claim number and co-payment amount.
- Forms will be accepted via email at providerservicesdg@elpasohealth.com or via mail at the following address:

El Paso Health
Attention: Provider Relations
1145 Westmoreland Dr.
El Paso, TX 79925

DME Supplies Form



DME SUPPLIES FORM: Please indicate the Durable Medical Equipment and/or Medical Supply that you provide. Please also indicate if these items can be picked up, delivered, or mail ordered.

Date: _____

Provider/Group Name: _____

Address: _____

Phone: _____ Fax: _____

Contact: _____

Hours of Operation: _____

DME Supplies	Yes	Pick Up	Delivery	Mail Order
Apnea Monitors Child/Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bandages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathroom Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canes/Crutches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPAP/BiPAP Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creams/Washes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decubitus Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enteral Supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Beds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence Supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needles/Syringes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional Supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ostomy Supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen/Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction/Trapeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walkers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair-Manual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair-Power	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair-Rental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair-Repairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair Seating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: Please describe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DME form 9/14/2017


- Please indicate the Durable Medical Equipment and/or Medical Supply that you provide. Please indicate if these items can be picked up, delivered, or mail ordered.
- This DME Supplies form can be found on our website at www.elpasohealth.com under Providers- Provider Forms- Credentialing Packet Forms.
- Completed forms will be accepted via email at providerservicesdg@elpasohealth.com or by fax to 915-225-6762.

Provider Directory Review

HHSC performs random audits to ensure accuracy of our Provider Directories.

- An internal review is done by our Provider Relations Department on a monthly basis.
- Provider Directories are available in the following formats:
 - Print: available for pick up at our office or mailed to members upon request
 - [Online](#): a PDF version is available for viewing or for printing on our website
 - [Provider Search](#): an interactive search option is available on our website
- The following elements are reviewed and updated as necessary:
 - provider name
 - address
 - workdays
 - age limitations, if any
 - program participation
 - phone and fax number
 - languages spoken
 - new patient restrictions
- Updates and discrepancies may be corrected using the [Provider Demographic Form](#).

Provider Demographic Form

 **El Paso Health**
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

915.532.3778 • Fax: 915.298.7870 • contracting_dept@elpasohealth.com

PROVIDER DEMOGRAPHIC FORM

Group/Facility Name: _____
Group/Facility Specialty: _____
Tax ID: _____ Group NPI: _____ Group TPI: _____

Program Participation: Medicaid CHIP CHIP Perinatal Preferred Administrators Health Care Options

Please check off provider type: PCP Specialist PCP/Specialist Hospital Based

Last Name: _____ First Name: _____ Middle: _____
Individual NPI: _____ API: _____ TPI: _____ EPSDT: _____
Specialty: _____ Subspecialty: _____ Medical License: _____

Professional Category: MD DO FNP ACNP PA CRNA Other: _____

Primary Practice Address: _____
City, State, ZIP: _____ Office Hours/Days: _____
Phone: _____ Fax: _____ Website URL: _____

Secondary Location: _____ City, State, ZIP: _____
Office Hours/Days: _____ Phone: _____ Fax: _____
Taxonomy number: _____ Additional Taxonomy Numbers: _____

Languages Spoken: English Spanish American Sign Language (ASL) Other: _____

Accepting New Patients: Yes No Established Only Age Range: _____

Practice Limitations: Male only Female Only None Other: _____

CLIA Type: _____ Radiology Certificate: Yes No N/A

Completed cultural diversity training? Yes No

Do you offer: Telemedicine Telehealth Telemonitoring Targeted Case Management

Does this office meet American Disabilities Act (ADA) accessibility requirements? Yes No

Billing Information (Must Reflect W-9): _____
Doing Business As: _____
Pay to Address: _____ Tax ID: _____
Primary Contact: _____ Phone: _____ Email: _____
Reason for submission: _____


- Our [Provider Demographic Form](#) is used when updating any practice information.
- The Provider Demographic Form can be found on our website at www.elpasohealth.com under Providers- Provider Forms- Credentialing Packet Forms.
- The completed form may be returned using one of the following:
 - Email: contracting_dept@elpasohealth.com
 - Fax: 915-298-7870

Electronic Usages

El Paso Health is encouraging electronic forms of communication during the COVID-19 pandemic. The following items are currently available via electronic platforms:

- Remittance Advice (RA) Reports via our Provider Web Portal
 - Must have an Administrative account in order to access RAs.
 - Standard users may contact Provider Relations at 915-532-3778 to request Administrative user rights.
- Electronic Remittance Advice (835) files via your clearinghouse
 - Submit our [Electronic Remittance Advice \(835\) Request Form](#) to enroll.
- Electronic Claims Submission
- Upload appeals via our Provider Web Portal
- Submit prior authorizations and prior authorization amendments via our Provider Web Portal
- Direct Payments (ACH) to your financial institution
 - Submit our [EFT Form](#) to enroll.

Electronic Remittance Advice (835) Request Form

 **El Paso Health**
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

Electronic Remittance Advice (835) Request Form
915.532.3778 ext. 1507 • Fax: 915.225.6762

BILLING PAY TO PROVIDER INFORMATION (PLEASE INCLUDE W9)

Official Business Name: _____
Doing Business As: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Federal Tax ID: _____ Group NPI: _____
Primary Contact: _____ Phone: _____ Email: _____

PROVIDER INFORMATION

Primary Service Location: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Website URL: _____

CLEARINGHOUSE INFORMATION

Clearinghouse Name: _____ Phone: _____
*Availity Customer ID# (Genkey): _____ Billing Submitter Number: _____
Software Vendor Name: _____ Phone: _____
**Genkey is required for Availity.*

AUTHORIZATION STATEMENT SIGNATURE

Provider (enter provider/provider representative name) _____ hereby appoints (enter vendor name) _____ to act as the authorized agent for the purpose of retrieving the 835 electronically from El Paso Health.
Provider/Provider Representative Signature: _____ Date: _____

EL PASO HEALTH PAYER IDS

El Paso First Health Plans Premier Plan STAR Medicaid HMO	Availity/ Trizetto Provider Solutions Payer ID: EPF02
El Paso First Health Plans CHIP	Availity/ Trizetto Provider Solutions Payer ID: EPF03
El Paso First Health Plan HCO Healthcare Options	Availity/ Trizetto Provider Solutions Payer ID: EPF37
Preferred Administrators	Availity/ Trizetto Provider Solutions Payer ID: EPF10
Preferred Administrators Children's Hospital	Availity/ Trizetto Provider Solutions Payer ID: EPF11

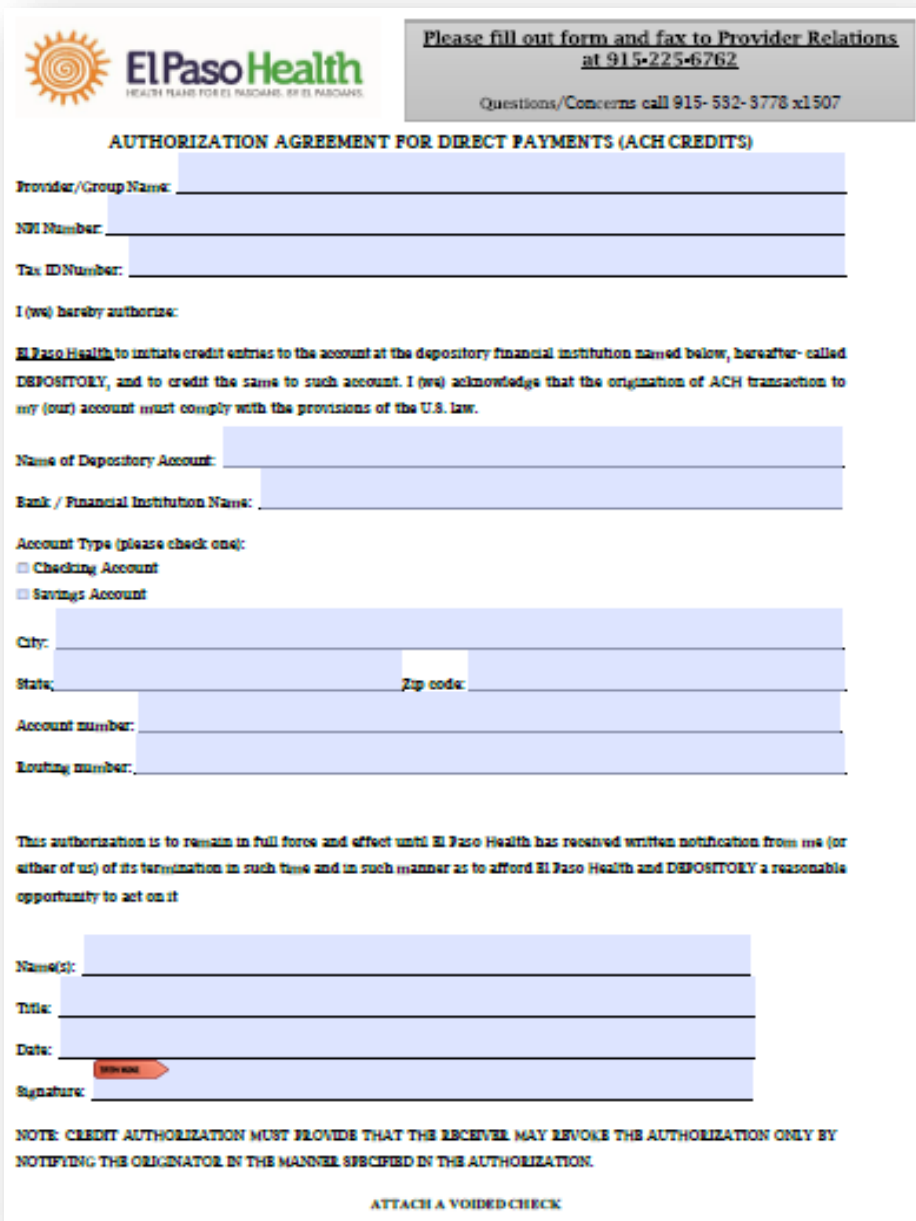
CONFIRMATION OF TEST FILE


After submission of the Electronic Remittance Advice Request Form, a test file will be sent to ensure the successful transmission of the 835 file. Please enter the contact information for the representative that will be able to confirm receipt of the test file. Please note that the test file must be confirmed before the process can be completed. Failure to confirm the test file within 30 calendar days will cause the request to be closed and a new request will need to be submitted.

Contact Name: _____ Phone: _____ Email: _____

- Our [Electronic Remittance Advice \(835\) Request Form](#) is used to retrieve 835 files via your clearinghouse.
- The Electronic Remittance Advice (835) Request Form can be found on our website at www.elpasohealth.com under Providers- Provider Forms- Misc. Forms.
- The completed form may be faxed to: 915-225-6762.

EFT Form



 **El Paso Health**
HEALTH PLANS FOR EL PASOANS, BY EL PASOANS

Please fill out form and fax to Provider Relations
at 915-225-6762

Questions/Concerns call 915-532-3778 x1507

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH CREDITS)

Provider/Group Name: _____
NPI Number: _____
Tax ID Number: _____

I (we) hereby authorize:
El Paso Health to initiate credit entries to the account at the depository financial institution named below, hereafter called **DEPOSITORY**, and to credit the same to such account. I (we) acknowledge that the origination of ACH transaction to my (our) account must comply with the provisions of the U.S. law.

Name of Depository Account: _____
Bank / Financial Institution Name: _____

Account Type (please check one):
 Checking Account
 Savings Account

City: _____
State: _____ Zip code: _____
Account number: _____
Routing number: _____

This authorization is to remain in full force and effect until El Paso Health has received written notification from me (or either of us) of its termination in such time and in such manner as to afford El Paso Health and DEPOSITORY a reasonable opportunity to act on it

Name(s): _____
Title: _____
Date: _____
Signature: _____

NOTE: CREDIT AUTHORIZATION MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR BY THE MANNER SPECIFIED IN THE AUTHORIZATION.

ATTACH A VOIDED CHECK

- Our [EFT Form](#) is used to initiate credit entries to your financial institution. This will eliminate the need for a paper check for our STAR and CHIP product lines.
- Please remember to attach a voided check or a letter from your financial institution confirming your account information.
- The EFT Form can be found on our website at www.elpasohealth.com under Providers- Provider Forms- Misc. Forms.
- The completed form may be faxed to: 915-225-6762.

Credentialing Updates COVID-19

- Increase the period for organizations to complete participating provider re-credentialing from 36 months by an additional 90 days.
- Accept an application that is signed and updated up to 210 days.

Contracting & Credentialing Contact Information

For any questions please contact us directly at the email or phone number below.

A Contracting and Credentialing Representative will respond to your inquiry within 48

Contracting_Dept@elpasohealth.com

915-532-3778

Contact Information

Liliana Jimenez
Provider Relations Representative
(915) 298-7198 ext. 1018
ljimenez@elpasohealth.com

Provider Relations Department
(915) 532-3778
ProviderServicesDG@elpasohealth.com



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Member Services Overview

Edgar Martinez

Director of Member Services

Transportation Services

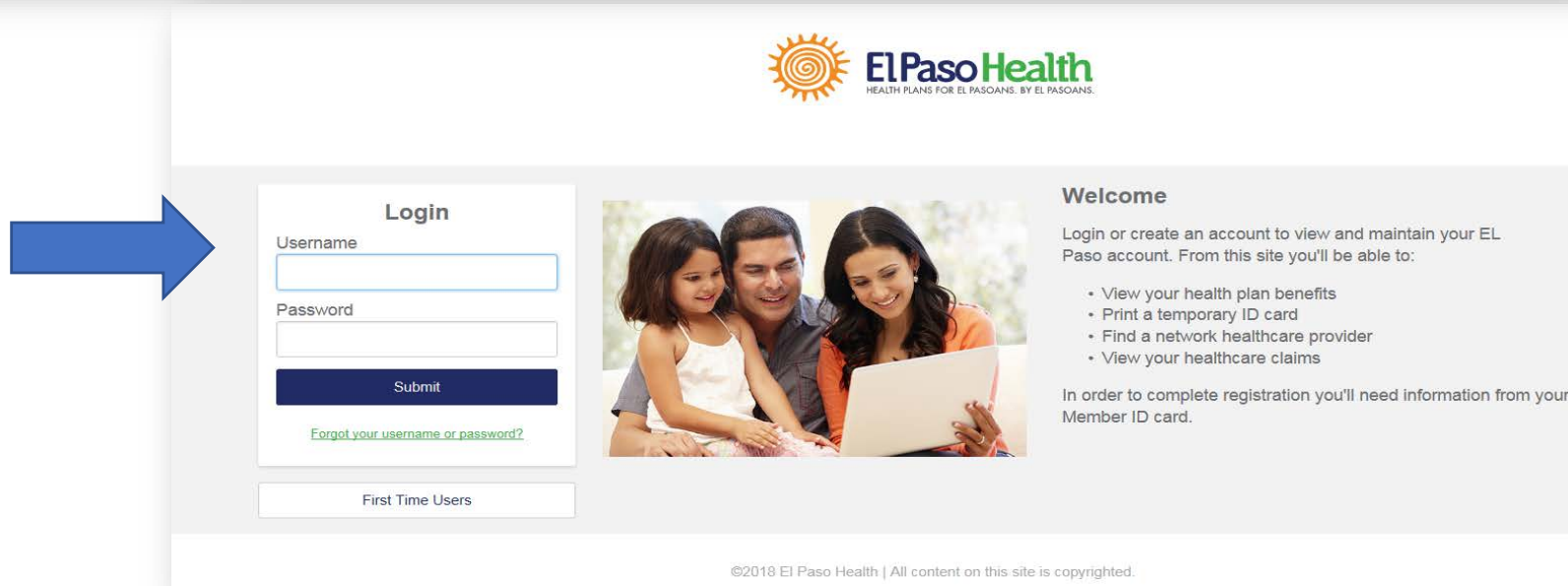
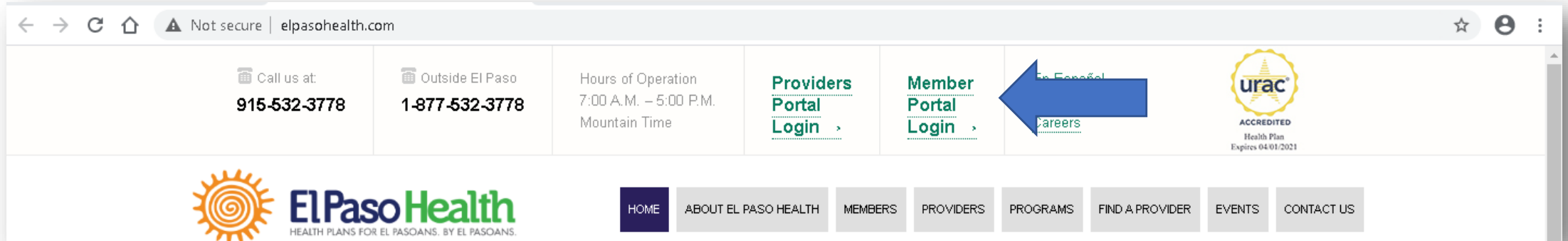
El Paso Health offers Medicaid and CHIP Members a free taxi ride service to doctor visits or health education classes.



To schedule a transportation request for a doctor's appointment or health education class, call the El Paso Health Member Services Line 48 hours before the appointment at 1-877-532-3778 and a Call Center Representative will assist with scheduling the taxi ride.

STAR and CHIP Member Portal

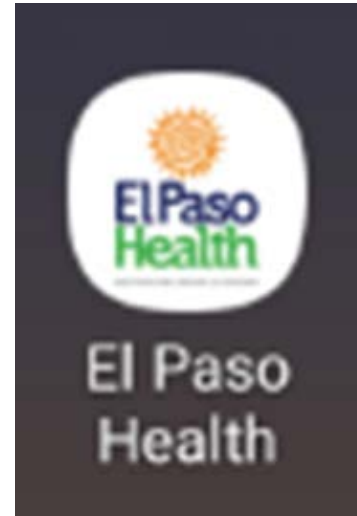
Members can access the Member Portal on our website at www.elpasohealth.com, by clicking on the Member Portal Login.



El Paso Health Mobile App

On the El Paso Health App, you can:

- View and print a temporary ID
- View eligibility information
- Find a Provider
- Request a PCP change
- View wellness information
- View authorizations
- View claims
- Ask a Question



FIRSTCALL Medical Advice Infoline

What is the FIRSTCALL Medical Advice Infoline?

- FIRSTCALL Medical Advice Infoline is for El Paso Health Members, provided at no-cost.
- When Members call FIRSTCALL, they will receive immediate information to take care of their medical or health concerns
- The call will be answered by a bilingual nurse or pharmacist.



FIRSTCALL
MEDICAL ADVICE INFOLINE

Available 24 Hours/7 Days A Week

CALL 1-844-549-2826

For Members of  **El Paso Health**

Behavioral Health Services Hotline

El Paso Health offers Medicaid and CHIP Members, 24 hours a day, 7 days a week Behavioral Health crisis hotline. The Behavioral Health crisis hotline staff is bilingual and interpreter services are also available.



BEHAVIORAL HEALTH
CRISIS LINE

STAR 1-877-377-6147

CHIP 1-877-377-6184

The crisis line for help with behavioral health is open 24 hours a day, 7 days a week. Call if you need assistance.

Questions

Edgar Martinez

Director of Member Services

915-532-3778 ext. 1064



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Health Services Overview

Edna Lerma, LPC
Care Coordination Manager

Vianka Sanchez, M.S., CCC-SLP
Manager, Therapy Utilization Program

Items To Be Covered:

- COVID-19 Authorization Extensions
- Prior Auth Tool
- Case Management Program
- DME Authorization Requirements
- PA Reminders
- New: Therapy Request Checklist

COVID-19 Extensions

- 90 Day Extensions continue, submit a fax cover letter with:
 - a) Authorization number
 - b) Member ID number
 - c) Clearly stated you are requesting COVID 90-Day Extension
 - d) Do NOT send original documentation again, not necessary
- 90 Day Extension for DOS, Units, Frequency VS New PA Requests
- MUST be submitted by the rendering Provider
- Other COVID-19 Extensions
 - a) COVID-19 extension currently to the end of November
 - b) Tele health waivers continue
 - c) Document flexibilities continue

Prior Authorization Tool

For STAR and CHIP ONLY

How To Access: www.elpasohealth.com

- Provider Tab, and then on drop down click on Prior Auth Tool Tab
- Answer the 4 yes/no questions and enter the CPT codes
 - CPT codes entered are for HCPCS claims, not revenue codes
- Immediate response either....
 - Authorization required in Red OR
 - No Authorization required in Green
 - Conditions to Authorization in Yellow

Prior Auth Tool

Please answer all of the following questions to determine if an authorization is needed:

Types of Services	Yes	No
Are services being provided by an out-of-network Provider?	<input type="radio"/>	<input type="radio"/>
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving oral surgery services?	<input type="radio"/>	<input type="radio"/>
Is the member receiving plastic and reconstructive surgeon services?	<input type="radio"/>	<input type="radio"/>

Prior Authorization Example

Authorization Required:

92507 - TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); INDIVIDUAL

Authorization is required.

No Authorization
Required:

92523 - Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)

No authorization is required.

No Authorization Required, unless the following condition is met:

20550 - INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG, PLANTAR "FASCIA")

No authorization is required, unless the following condition is met

Conditions: performed at any POS other than office. Example: ASC, Hospital, Endoscopy Ctr, etc.

Case Management Program

EPH offers a comprehensive case management program for Members with the following conditions:

- High Risk pregnancies
- Behavioral health conditions
- Chronic/complex medical conditions
- Asthma
- Diabetes
- Heart Disease
- Obesity

Case Management Program

Upon enrollment in one of the Case Management program, Members will receive:

- A comprehensive, holistic assessment to identify their needs
- A service plan that will identify their needs, strengths and goals
- Referrals to community agencies and non-capitated services
- Assistance with coordination of care (medical, behavioral, social determinants of health)

DME Requirements

- Include supportive clinical documentation ONLY
- TMPPM Rental Requirements
- Orders valid for 6 months only,
- DME under \$300 DO NOT require prior authorization
- DME requests for AAC devices must have comprehensive evaluation
- DME requests must be ordered by a physician, not a PA or NP

Introducing: Therapy Request Checklist

Specific guidelines for submitting ST/PT/OT prior authorization requests

including:

- Initial and reevaluation requirements to assist therapists in documentation requirements
- List of documentation requirements to reduce/eliminate additional Info requests
- Elements of valid physician orders
- Supplemental Information
- Providers DO NOT SUBMIT THE CHECKLIST: to be used as a resource only

<http://www.elpasohealth.com/forms/EPH-PR-THERAPY%20REQUEST%20CHECKLIST.pdf>

Therapy Request Checklist

Physician Order Elements

The elements on any of the three options listed below **MUST** contain all of the following...

A) Frequency B) Duration C) Signature from referring PCP or Specialist

The **OPTIONS** are as follows...

- 1) Texas Standard Prior Authorization Request Form for Health Services **OR**
- 2) Physician Order **OR**
- 3) Physician signed Plan of Care

Therapy Request Checklist

Components

INITIAL EVALUATION AND REQUEST FOR THERAPY VISITS:

- Per TMPPM 6.3.5 PT,OT,ST Reimbursement Guidelines: Procedure codes for initial evaluations are payable once every three years to the same rendering provider.
- Acute services, PT, OT, ST re-evaluations may be reimbursed once every 60 days to to any provider when a recertification of services is planned.
- Must submit...
 - Physician Order
 - THSteps OR clinical note from PCP/Specialist
 - Therapy Evaluation signed by physician and therapist: elements described in TMPPM 5.2.1.1

Therapy Request Checklist

Components

RE-EVALUATION AND THERAPY CONTINUATION :

Must submit...

- Physician Order
- THSteps OR clinical note from PCP/Specialist
- Therapy Re-Evaluation signed by physician and therapist: elements described in TMPPM 5.2.4 for Acute and TMPPM 5.2.5 for Chronic, including
 - Updated or new functional and measurable short and long term goals with time frames
 - Previous authorizations goals and progress MUST be included
 - Raw scores must be included with Standard Scores and Standard Deviations
 - Documentation of reasons why continued therapy is needed
 - Prognosis with clearly defined discharge criteria
 - Documentation of clients participation/adherence in treatment
 - Adherence to home treatment program
 - Functional status of member

Therapy Request Checklist

Components

SUPPLEMENTAL INFORMATION:

- NOT REQUIRED, but assist with authorization reviews and approvals
 - HX of previous therapy
 - Feeding/Swallowing evaluation : Growth charts from PCP
 - Therapy attendance during the previous authorization period: actual number of visits

Finally, Things To Remember...

Quick Update

- 180 Day Rule , TMPPM 5.2.5
- Health X Web Portal: THE BENEFITS
- Submission Day is Day 0
- Stat vs Standard requests
- Change of Provider letters
- Peer to Peer requests
- Initial versus Re-eval codes on PA request
- Non payable codes (ex: 97010); Timed and Untimed Codes;
- Diagnosis Codes as related to therapy request
- Double check!

Contact Information

Vianka Sanchez, M.S., CCC-SLP
Manager, Therapy Utilization Program
vsanchez@elpasohealth.com

Edna Lerma, LPC
Care Coordination Manager
elerma@elpasohealth.com



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Complaints and Appeals Process

Corina Diaz

Complaints and Appeals Manager

Complaints and Appeals Process

- All Complaints and Appeals must be submitted in writing
 - Fax: 915-298-7872
 - Secure FTP site through our Web Portal
 - Mail:

El Paso Health
Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, Texas 79925
- Include detailed and any supporting information, example:
 - Copy of Remittance Advice
 - Medical records (if necessary)
 - Proof of Timely Filing
 - Etc.

Complaints and Appeals Process

- Provider will receive
 - Acknowledgment letter no later than five (5) business days
 - Resolution letter within thirty (30) calendar days
- Appeals must be received within 120 days from the notice of the denial

Web Portal

Provider Appeals

You are currently logged in as

[Messages \(0\)](#) [Profile](#) [Logout](#)

Home

Eligibility and Benefits

Claims and Payment

Authorizations

Reports

Welcome to the **Provider Portal**

This site provides quick access to member eligibility and benefits, claims payment details, and more!

Provider Name:

Provider Phone:



Quick Links

Submit Claims

Submit Claim Attachments

Provider Appeals

Amended Authorizations

Provider Overpayments

Contact Us

If you have questions or need assistance, contact the Provider Relations Department at:

915-532-3778 ext 1507

Toll-Free: 1-877-532-3778 ext 1507


Our customer service hours are Monday through Friday between 8:00 am and 5:00 pm MST.

Fax Number: 915-225-6762

Web Portal

Provider Appeals

+ Add Attachments

 From:
To:
Subject:

Today's Date:
Contact Name (First & Last name):
Mailing Address:
Phone Number:
Provider Name:
Provider NPI Number:
Member Name:
Member ID:
Date of Service:
Claim Number:

Reason for Appeal: (Please put an "x" in the appropriate box)

Authorization Issue
 Past Timely Filing
 Requesting Payment/Additional Payment
 Other (Use comments section to give detailed explanation)

Comments:

Your appeal will be acknowledged in writing within 5 business days and you will receive a resolution letter within 30 calendar days. If you have any further questions or need additional assistance, please contact the Provider Care Unit at 915-532-3778 extension 1504 or 1-877-532-3778 extension 1504.

Sample

Acknowledgment Letter

July 27, 2020

PROVIDER GROUP
TEMP PROVIDER MD
ATTN: OFFICE MANAGER
2501 N MESA
EL PASO, TX 79902

RE: Jane Doe
Member ID: 55555555
Date of Service: 04/11/20
Appeal Received on: 07/22/20
Case #: AGI000000020513

Dear Office Manager:

Thank you for taking the time to let us know about your appeal. At any time, the Health and Human Services Commission may review documentation we retain regarding the appeal and the action taken on it. We will look into your appeal and send you a letter with our findings no later than thirty (30) days from the date we received the appeal.

Sample

Resolution Letter

August 19, 2020

PROVIDER GROUP
TEMP PROVIDER MD
ATTN: OFFICE MANAGER
2501 N MESA
EL PASO, TX 79902

RE: Jane Doe
Member ID: 555555555
Date of Service: 04/11/20
Appeal Received on: 07/22/20
Case #: AGI000000020513

Dear Office Manager:

The review of information submitted and received by El Paso Health regarding the denial of payment for claim # 00000000000 has been completed. The decision has been made to uphold *or* reprocess your claim.

You have the right to a second level appeal. Your appeal must be filed within 120 days of this resolution or the latest Provider Remittance Advice Notification. If you have additional information and/or documentation regarding this case that has not been previously considered, or if you wish that El Paso Health reconsider the decision, you may submit a letter appealing this decision to:

El Paso Health
Attn: Complaint and Appeals Department
1145 Westmoreland
El Paso, Texas 79925

Members

Billed/Balance Billed

STAR and CHIP Members must

NOT

be billed or balanced billed for covered services.

Contact Information

Corina Diaz

Complaints and Appeals Manager

cdiaz@elpasohealth.com

(915) 532-3778 ext. 1092



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Claims - Reminders

Patricia Diaz

Director of Claims

Reminders

Claims Processing

- Timely filing deadline
 - 95 days from date of service
- Corrected claim deadline
 - 120 days from date of EOB

Telemedicine

- Modifier 95 – used to indicate remote delivery has occurred
- Claims submitted on a CMS-1500
 - Place of Service (POS) 02
 - Only when services are delivered remotely
- Claims submitted on a UB-04 CMS-1450
 - Corresponding Type of Bill by provider type

Note: Services submitted on a CMS-1500 will deny if claim is submitted only with modifier 95 and POS 02 is not present or vice versa

Top Denial Reasons

- Missing/incomplete/invalid treatment authorization code
- Precertification/authorization exceeded.
- Diagnosis is inconsistent with the procedure
- Procedure code/bill type is inconsistent with the POS
- Time Limit for Filing has expired

Electronic Claims

Payer ID Numbers

Claims are accepted from:

- Availity
- Trizetto Provider Solutions, LLC. (*formerly Gateway EDI*)

Payer ID Numbers:

El Paso Health - STAR	EPF02
El Paso Health - CHIP	EPF03
Preferred Admin. UMC	EPF10
Preferred Admin. EPCH	EPF11
Healthcare Options	EPF37

Contact Information

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Prize Bag Includes :

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- El Paso Health Blanket
- EOS Lotion
- EOS Lip Balm
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- \$20.00 Gift Card

<https://www.surveymonkey.com/r/B3SQ9J>



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