Welcome Providers!

Quarterly Provider Orientation

June 5, 2013
El Paso First Health Plans

2012 Provider Survey

Irma Herrera, MBA
Director of Provider Relations & Credentialing
Provider Survey

- Contract with Institute for Policy & Economic Development at UTEP.
- Purpose is to obtain feedback about our performance within the last 12 months.
- 985 Providers were sent surveys by mail
- 165 Providers Responded
- Top respondent type were Medical Doctors
- Top three respondent specialties included Behavioral Health, OB/GYN & Pediatrics
Key Survey Findings

1. Overall feeling EP1st members are satisfied: 70% (2012) vs 71% (2011)
2. Aware Health Services has case managers: 70% (2012) vs 70% (2011)
3. Newsletter has relevant topics & helpful: 66% (2012) vs 67% (2011)
4. Provider registered to receive direct deposit: 46% (2012) vs 46% (2011)
6. PR Reps knowledge of benefit plans: 71% (2012) vs 74% (2011)
8. Comparison to other Medicaid Payers: 69% (2012) vs 69% (2011)
Overall Satisfaction with Departments

- Overall satisfaction with El Paso First: 73% (2012), 79% (2011)
- Member Services Department: 70% (2012), 74% (2011)
- Health Services Department: 65% (2012), 70% (2011)
- Clearing House Department: 74% (2012), 79% (2011)
- Provider Care Unit: 75% (2012), 77% (2011)
- Claims Processing Department: 69% (2012), 66% (2011)
- Provider Relations Department: 70% (2012), 78% (2011)
Satisfaction

Overall satisfaction with El Paso First

2012: 79%
2011: 73%
2010: 74%
2009: 65%
2008: 73%
After the Results

- Survey is presented to Management and Board of Directors
- Departments evaluate their areas of improvement
- Develop action items to meet improvement goals
Email us at: providerservices@epfirst.com
or
call us at
915-298-7198 ext 1507

Irma L. Herrera
iherrera@epfirst.com
298-7198 ext. 1018
Resources for OB/GYN Providers

Stacy Arrieta
OB Provider Relations Representative
Pregnant Members OB Program

- **Free car seat** for pregnant Members who complete a pregnancy class. STAR / CHIP Perinate
- **Free phone**, through Assurance Wireless, with limited calls and text message capabilities from El Paso First for health related activities for members that qualify for the Lifeline Assistance Program.
- **Home visits** to new mothers who are high risk.
- **$25 Cinemark movie gift card or $25 Wal-Mart gift card** for pregnant Members that complete a prenatal visit and attend one pregnancy class.
Pregnant Members OB Program

Your assistance is greatly appreciated by completing the back portion of the postcard with the member ID, date of service and the Provider’s name, address and signature or office stamp.
El Paso First hosts monthly baby showers for our STAR / CHIP Perinate pregnant members the third week of every month.

- Wednesdays at 10am in Spanish and Thursdays at noon in English.
Memo

To: Providers
From: Preferred Administrators
Date: September 26, 2012
Re: Global Billing

Effective October 1, 2012 providers will be required to bill using the global method. In the case of confirmed pregnancy diagnosis prior to October 1, 2012 Providers are to continue to bill fee for service.

The following guidelines must be followed when submitting OB service claims for members of Preferred Administrators or there will be an increased likelihood that the claim will be denied and/or adjusted by Preferred Administrators.

Global Billing
The intent of global billing (CPT-4 codes 59400, 59510, 59610, and 59618) is to offer a convenient means of billing for providers who render total obstetrical care to a woman throughout her pregnancy. Global obstetrical (OB) billing consists of antepartum care, delivery and postpartum care, including the following:

- Hospital admission
- Patient history
- Physical examination
- Labor management
- Postpartum office visit
- Vaginal or cesarean section delivery
- Vaginal or cesarean section delivery, after previous cesarean delivery
- Hospital discharge
- All applicable postoperative care

Services that are not separately reimbursable on a global basis include:

- Antepartum consultations paid to the same provider, for dates of service either within the from through period of the global billing or within 270 days prior to the global OB delivery date
Questions?

Stacy Arrieta
Provider Relations Representative
298-7198 ext. 1059
sarrieta@epfirst.com
First Steps
Case Management Program

Edna Martinez
OB Case Manager

FIRST steps of EL PASO FIRST
Case Management Program

How we can help you?

- Coordinate transportation for our members to and from your office.
- Guide your patient to access medical/psychiatric/and dental services.
- Coordinate specialized care for your El Paso First patients.
- Educate our members on how to access available community resources.
Case Management Continued

Examples

- El Paso First prenatal class
- Hospital prenatal classes
- WIC
- Baby Café
- Child Care Services
- Transportation Assistance
- Car Seat Assistance
- Community referrals to assist with basic needs
- Referral to Nurse Family Partnership Program for first time moms
Welcome to our new website!

In an effort to better serve you we changed our image and hope you find it easier to navigate.

**Vision:** Your community partner leading the way to quality healthcare through service and innovation...because we CARE.

**Mission:** El Paso First Health Plans promotes community health by providing access to quality healthcare for children, families and individuals who need it most. We partner and collaborate with community providers and advocates to foster a culture of excellence.

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**Members**
- CHIP
- CHIP Perinatal
- Healthcare Options
- Premier Plan Star Medicaid
- Preferred Administrator
- Helpful Links

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**Providers**
- Web Portal
- Forms
- Texas Health Care Resources
- Behavioral Health Providers
- Important Updates
- Clinical Practice Guidelines

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El Paso First is located at
1145 Westmoreland Drive
El Paso, TX 79925-5615

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Paper Claim submissions will continue to go to:
El Paso First Health Plans - Claims
P.O. Box 971370
El Paso, TX 79997-1370

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Our General Correspondence address has not changed.
P.O. Box 971100
El Paso, TX 79997-1100
## Providers - Forms

### Web Portal Forms

### Health Services Forms
- Letter & High Risk Form
- Case Management Referral
- Fax Cover for Pregnant Woman Visit
- Notification of Pregnancy
- Pre-Authorization Flyer-STAR/CHIP
- Pre-Authorization Flyer-Health Care Options (HCO)
- Pre-Authorization Flyer-Preferred Administrators
- Pre-Certification Form-Behavioral Health
- Pre-Certification Checklist
- Pre-Certification Form-Outpatient/Scheduled Procedures
- Pre-Certification Form-Out of Area/Inpatient Notification

### Complaints and Appeals Forms

### Members Services Forms

### Claims Forms

### Credentialing Packet Forms

### Misc. Forms
AUTHORIZATIONS

PRIOR AUTHORIZATION FORM
HIGH RISK PREGNANCY

Please attach clinical documentation.

Date: ____________________________

To: Edna Martinez
OB Case Manager

Fax: 915.298.7866

From: ____________________________

Fax: ____________________________

Approved DOS: ____________________________
No. of Pages: ____________________________
(including cover sheet)

Authorization No.: ____________________________

Member Information

Name: ____________________________

DOB: ____________________________

Phone No.: ____________________________ Health Plan ID#: ____________________________

Expected due date: ____________________________ IC9-Codes: ____________________________

Patient has been diagnosed with any of the following conditions:

☐ Pre-term delivery (<37 weeks/previous pregnancy)
Year and Gestation age of PTL: ____________________________

☐ Multiple Gestation

☐ Gестиy Complicating Pregnancy
BMI > 35 Weight: ____________________________

☐ Young primigravida < 16

☐ Hx of Mental Disorders
Specify: ____________________________

☐ Anticonvulsant

☐ Toxic Habits (Alcohol/Drug use)
Specify: ____________________________

☐ ILGR

☐ Placenta previa (persistent in 3rd trimester)

☐ GDM (Type 1/II)
Hypertensive disorders of pregnancy
Recent 3/F:

☐ Hypertension detected

☐ Birth defect detected

☐ Advanced Maternal Age
Specify: ____________________________

☐ Late prenatal care (after 20 weeks)

☐ Other: ____________________________

EL PASO FIRST
healthplans inc.

Pre-certification Fax Form for
OUTPATIENT/SCHEDULED Procedures
Fax No. 915-298-7866 Pre-Cert No. 915-832-3778 X 1500

DATE OF REQUEST: ____________________________ PROVIDER'S NAME: ____________________________ NPI #: ____________________________

CONTACT PERSON: ____________________________ PHONE NO.: ____________________________ FAX NO.: ____________________________

SERVICE LOCATION: ____________________________ MAIL ADDRESS: ____________________________

MEMBER INFORMATION

NAME: ____________________________ MEMBER ID. NO.: ____________________________ SSI: (Circle if SSI)

DOB: ____________________________ Member Phone: ____________________________ PCP: ____________________________

REFER TO INFORMATION (PROVIDER/FACILITY PERFORMING SERVICE IF DIFFERENT FROM ABOVE)

PROVIDER'S NAME: ____________________________ NPI #: ____________________________

CONTACT PERSON: ____________________________ PHONE NO.: ____________________________ FAX NO.: ____________________________

SERVICE LOCATION: ____________________________ MAIL ADDRESS: ____________________________

PROCEDURE INFORMATION

TYPE OF SETTING: [ ] OFFICE VISIT [ ] OFFICE VISIT WITH TREATMENT
[ ] OFFICE VISIT WITH TREATMENT [ ] LABS [ ] RADIOLOGY

[ ] THERAPY (OT, PT, ST) [ ] SURGICAL [ ] DENTAL [ ] HOME HEALTH [ ] PODIATRY

[ ] INPATIENT/SCHEDULED SERVICES [ ] DIABETES/ASTHMA EDUCATION [ ] OTHER

EXPECTED DATE OF PROCEDURE:

PRIMARY DIAGNOSIS CODES (ICD-9):

1. ____________________________ 2. ____________________________ 3. ____________________________ 4. ____________________________ 5. ____________________________ 6. ____________________________

CPT PROCEDURE CODES: ____________________________

1. ____________________________ 2. ____________________________ 3. ____________________________ 4. ____________________________ 5. ____________________________ 6. ____________________________

$SI ONLY

1. ____________________________ 2. ____________________________ 3. ____________________________ 4. ____________________________ 5. ____________________________ 6. ____________________________

PLAN OF TREATMENT/PERTINENT CLINICAL HISTORY AND PHYSICAL EXAM

(INCLUDE PREVIOUS MEDICAL MANAGEMENT LAB AND OTHER RESULTS):

FOR EL PASO FIRST USE ONLY

REVIEWED BY: ____________________________ DATE: ____________________________ APPROVED: YESS NO

REFERENCE NO.: ____________________________

The information submitted in this form is the property of FirstHealth. No person shall use, disclose, or reproduce the information in whole or in part for unauthorized purposes. Falsification of information in this form constitutes fraudulent conduct in violation of applicable laws and regulations.
High Risk Authorization

- Upon identification of a member with a high risk diagnosis, provider should submit High Risk PA Form.
  - This will prompt our OB Unit to contact member and begin Case Management process.
OB CASE MANAGER

Edna Martinez
OB CASE MANAGER
915-298-7198 ext. 1078
martineze@epfirst.com
**ER Reports**

- **Purpose**
  - Assist Primary Care Providers on identifying members from their panel that go to the ER to seek care
  - Encourage Providers to educate their identified members on true emergencies, after hours availability, night clinics or provide other options
  - Educate Members on the Medical Home concept

- **Content**
  - Member name, ID number, Age, DOB, Phone number, Address, ER DOS, ER Location, Diagnosis.

- **Mailed**
  - Mailed monthly along with Rosters
## SAMPLE ER REPORT

<table>
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<tr>
<th>Member #</th>
<th>Member Name</th>
<th>Age</th>
<th>DOB</th>
<th>Phone</th>
<th>Address</th>
<th>ER DOS</th>
<th>ER Pay To</th>
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<td>11111111</td>
<td>Baby Boy</td>
<td>0</td>
<td>12/14/07</td>
<td>915-XXX-XXXX</td>
<td>1145 Westmoreland Dr. El Paso, Tx 799XX</td>
<td>3/1/10</td>
<td>XY Medical Center</td>
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<tr>
<td>11111111</td>
<td>Baby Girl</td>
<td>1</td>
<td>1/13/07</td>
<td>915-XXX-XXXX</td>
<td>1145 Westmoreland Dr. El Paso, Tx 799XX</td>
<td>3/1/10</td>
<td>XY Medical Center</td>
</tr>
<tr>
<td>11111111</td>
<td>Baby Girl</td>
<td>4</td>
<td>2/3/04</td>
<td>915-XXX-XXXX</td>
<td>1145 Westmoreland Dr. El Paso, Tx 799XX</td>
<td>3/1/10</td>
<td>XY Medical Center</td>
</tr>
<tr>
<td>11111111</td>
<td>Baby Boy</td>
<td>14</td>
<td>7/14/93</td>
<td>915-XXX-XXXX</td>
<td>1145 Westmoreland Dr. El Paso, Tx 799XX</td>
<td>3/1/10</td>
<td>XY Medical Center</td>
</tr>
<tr>
<td>11111111</td>
<td>Baby Girl</td>
<td>0</td>
<td>8/1/07</td>
<td>915-XXX-XXXX</td>
<td>1145 Westmoreland Dr. El Paso, Tx 799XX</td>
<td>3/1/10</td>
<td>XY Medical Center</td>
</tr>
</tbody>
</table>

**Diagnosis:**
- Acute Pharyngitis
- 780.60 Fever, unspecified
- 462 Acute Pharyngitis
- V28.89 Other specified antenatal screening
Initial Credentialing – new to the network

✓ Demographic form
✓ W9
✓ Texas Standardized Credentialing Applications (TSCA 07)
✓ Facility Application
✓ El Paso First Checklists
✓ Missing/incomplete information requests will be attempted via emails, faxes, and by phone on a weekly basis.
✓ Incomplete application cannot be held for more than 30 days and will be returned by certified mail

Credentialing and Peer Review Committee (CPRC) meet every 1st Wednesday of each month
Board of Directors (BOD) signature approval meet every 2nd Thursday of each month

CPRC and BOD meetings dates are subject to change
Recredentialing is a requirement every 3 years

- 1	extsuperscript{st} Request 90 day notification of recredentialing expiration date claims denial if application is not received.

- 2	extsuperscript{nd} Request 60 day notification of recredentialing expiration date claims denial if application is not received.

- 3	extsuperscript{rd} Final Request 30 day sent certified mail indicating expiration date and claims denial if date of expiration is exceeded.

Any applications received after date of expiration will be considered as new and initial applications and claims will deny until process is finalized.
HealthCare Options

Rene Duran
HealthCare Options
Provider Relations Representative
El Paso First Health Plans, Inc.
Effective June 1, 2010 University Medical Center of El Paso ("UMC") developed an indigent care collaborative with private hospitals in El Paso County. Under this collaborative, UMC worked with Las Palmas Medical Center and Del Sol Medical Center ("LPDS") to create a non-profit organization that will fund the services provided to HCO members. This new non-profit entity is El Paso County Clinical Services, Inc. ("EPCCS").
Program Overview

Overview

- Developed by UMC Hospital to provide medical services to El Paso’s indigent population.
- Covered benefits have been enhanced to give members improved access to healthcare.
Program Overview cont.

- 14,000 + Members
- Managed Care environment
- Primary Care home for indigent
- Increased levels of primary care
- Member access to preventative care and disease management programs
- Reduction in escalation of illnesses
- Reduction in ER visits
Program Features

- Covered Primary, Preventive and Specialty care services are provided through the HCO Network providers.
- Eligible members choose a PCP to manage their healthcare.
- Inpatient care and pharmacy benefits are provided by UMC Hospital as the County Hospital with responsibility for care of the uninsured and indigent.
- Affordable Co-pays
Eligibility

- Determined by UMC Hospital – Enrollment Services Unit
- Must meet income and resident requirements
- May not be eligible for any other insurance coverage such as Medicaid or Private Insurance.
Applicants must bring:

- Proof of Income (W-2, pay stubs, tax return, bank statement, or other indicator of income such as Food Stamps, WIC, Unemployment Compensation, etc.)

- Proof of Residency (Mail addressed to patient, TX Driver’s License, Property Tax Receipts, Mortgage Payment Receipts, Utility Receipts, and Other Official Identifications.)

- Must have services pending at UMC, i.e. lab, x-rays etc.
How to Apply

Applications are **only** accepted at:

UMC Hospital
(Walk-Ins)

or

UMC Clinics
(Appointments only)

Enrollment Services Unit
Monday-Friday 8:00 AM to 6:00 PM
Re-enrollment Process

- Coverage is continuous for a period of 12 months.
- Members are required to re-apply to maintain their benefits.
- A member due for re-enrollment will receive a notification 2 months prior to their termination date with instructions for re-enrollment.
Member ID Card

HealthCare

Options of El Paso

EPCCS
El Paso County Clinical Services, Inc.

1045230  Effective: 06/01/2010
Term Date: 05/31/2011

DUCK, DONALD
DOB: 04/05/1938  Not Transferable

DREW, DEAN

(915) 520-2170

$15 PCP/Specialist

El Paso First
Health Plans Inc.
532-3778

El Paso First
Health Plans Inc.
Termination

A member can be terminated from the HealthCare Options program if the member:

- does not re-apply
- has other health insurance coverage
- has moved out of the service area
Covered Benefits

- Please refer to schedule of benefits for detailed information on covered services.
- Services limited to IN-NETWORK providers.
HCO Network Providers

Provider Directories have been developed specifically for HCO Network.

- Members must choose a PCP within the HCO Network.
- Unlimited PCP changes can be made, contact El Paso First to make changes.
- Specialty Care requires a referral from the members PCP.
- Laboratory Services for covered benefits must be referred to UMC Hospital.
- UMC is the ONLY participating Hospital for the HCO Program.
Network Pharmacies

- Prescriptions must follow the UMC Hospital Formulary
- Prescriptions can **ONLY** be filled at any of these locations

<table>
<thead>
<tr>
<th>Pharmacy</th>
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<th>Phone</th>
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<tr>
<td>UMC Pharmacy</td>
<td>4824 Alberta</td>
<td>915-521-7705</td>
</tr>
<tr>
<td></td>
<td>El Paso, Texas 79905</td>
<td></td>
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<tr>
<td>UMC Pharmacy</td>
<td>9849 Kenworthy</td>
<td>915-745-4247</td>
</tr>
<tr>
<td></td>
<td>El Paso, Texas 79924</td>
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<tr>
<td>UMC Pharmacy</td>
<td>300 S. Zaragoza, Bldg B</td>
<td>915-860-4039</td>
</tr>
<tr>
<td></td>
<td>El Paso, Texas 79907</td>
<td></td>
</tr>
</tbody>
</table>
Referrals

- Members PCP must initiate referral for specialty care services.
- In network specialist to specialist referrals are allowed with an auth. Any request from a specialist for a member to see an out of network specialist requires an authorization.
- Prior Authorizations: only requests that are not to be performed at UMC or Texas Tech require an auth.
- Out of network referrals must be coordinated through Health Services at (915)532-3778.
Prior Authorizations

- Authorizations for OUTPATIENT/Scheduled procedure requests, INPATIENT notifications and Clinical Information must be directed to Health Services Department if out of network. If covered benefit, all procedures/services at UMC and/or Texas Tech, do not require an authorization.

- All Prior Authorizations must be submitted by Fax to:
  - (915)298-7866 – Outpatient/Scheduled Procedures
  - (915)298-5278 – Inpatient Notifications
  - 72 hour turnaround time applies to all Prior Authorization Requests
Taking Care of Our Providers

El Paso First Health Plans has a quality claims processing and customer service TEAM.

- The EPCCS check is processed once a week (Thursday).
- Claims must be received by El Paso First within 95 days from DOS.
- Corrected claims must be re-submitted within 120 days from the R.A. (Remittance Advice).
Rene Duran
HealthCare Options
Provider Relations Representative
915-298-7198 ext. 1037
rduran@epfirst.com
Texas Health Steps Updates

• The Texas Health Steps Medical Checkup Periodicity Schedule for infants, children, and adolescents (birth through 20 years of age) has been revised to reflect policy updates effective December 1, 2011.
  • This PDF document is available for download in both color and black & white: [http://www.dshs.state.tx.us/thsteps/providers.shtm](http://www.dshs.state.tx.us/thsteps/providers.shtm)

• Tuberculin skin testing changed to TST.

• ECI referral language changed from *2 business days* to *as soon as possible but in no case longer than 7 days after identification*.

• All blood lead levels in clients 14 years or younger shall be reported to DSHS. Reports shall include all information as required on the Texas Child Blood Lead Level Reporting Form, F09-11709 or Point of-Care Blood Lead Testing report, Form Pb-111, which can be found at [http://www.dshs.state.tx.us/lead/providers.shtm](http://www.dshs.state.tx.us/lead/providers.shtm), or by calling 1-800-588-1248.
  • Codes 87490 and 87590 have been removed (Chlamydia/gonorrhea testing) as the testing method is no longer available.

THSteps Modules for RNs updated.
Child Health Record Forms for Texas Health Steps checkups

- 2 Month Child Health Record form have been edited to remove Meningococcal and Influenza, and add Rotavirus (RV).

- There are forms for each age visit, from up to 5 days through 20 years.
  - The forms are posted on the DSHS website:
    http://www.dshs.state.tx.us/thsteps/childhealthrecords.shtm

- Please keep in mind that these forms are not mandatory but recommended. Just remember that DOCUMENTATION is essential!
Updated Referral Form

Beginning April 1, 2013, the Texas Health Steps Provider Outreach Referral Form should be used by all Texas Health Steps providers to replace the Texas Health Steps Missed Appointment Referral Form.
Intermediate Oral Evaluation with Fluoride Varnish Application

- Texas Health Steps enrolled physicians, physician assistants, and advanced practice nurses.
- An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients 6 months of age through 35 months of age.
- The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup visit and is limited to 6 services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202.
Contact Information

Maritza Lopez-THSteps Coordinator
E-mail: mlopez@epfirst.com
Phone: (915)298-7198 extension 1071

Lluvia Acuña-Migrant Outreach Coordinator
E-mail: lacuna@epfirst.com
Phone: (915)298-7198 extension 1075

Adriana Cadena-C.A.R.E. Unit Manager
E-mail acadena@epfirst.com
Phone: (915) 298-7198 extension 1127
Reference Guide to Effective Claims Submission

Sonia Lopez, BS, CPC
Director of Claims
Governing Resource Website

- Texas Medicaid and Healthcare Partnership [http://www.tmhp.com/Pages/default.aspx](http://www.tmhp.com/Pages/default.aspx)
- (TDI) Texas Department of Insurance [http://www.tdi.texas.gov/](http://www.tdi.texas.gov/)
- Texas Health and Human Services Commission [http://www.hhsc.state.tx.us/about_hhsc/reports/search/search_dateorder.asp](http://www.hhsc.state.tx.us/about_hhsc/reports/search/search_dateorder.asp)
Governing Resource Website

- National Correct Coding Initiative (NCCI)

Clinical Laboratory Improvement Amendments (CLIA)
- U.S Food and Drug Administration  FDS
  http://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm
Billing Resource Website

- American Academy of Professional Coders (AAPC) [www.aapc.com](http://www.aapc.com)
- American Association of Medical Assistants (AAMA) [www.aama-ntl.org](http://www.aama-ntl.org)
- American health Information Management Association (AHIMA) [www.ahima.org](http://www.ahima.org)
- American Medical Billing Association (AMBA) [www.ambanet.net](http://www.ambanet.net)
- Medical Association of Billers (MAB) [www.E-medbill.com](http://www.E-medbill.com)
FIGURE 2-1. Timeline of dates and significant events in healthcare reimbursement.
Important Claim
Submission Elements
Billing Pay–Federal Tax Information

LOOP 2010AA

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<td>Provider SSN# or EIN#</td>
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## Bill Pay Information

### LOOP 2010AA

Submit Group NPI Only in Loop 2010AA

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<tr>
<td>33a</td>
<td>Billing Provider NPI</td>
<td>2010AA/NM1/85/09 (08 = XX)</td>
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<tr>
<td>33b</td>
<td>Billing Provider Legacy Number or PIN (No longer reported.)</td>
<td>No longer used, effective 5/23/08</td>
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Rendering Provider LOOP 2310B

Submit Rendering’s INDIVIDUAL NPI Only in

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<td>Rendering Provider Legacy Number (shaded area) (No longer reported.)</td>
<td>Not used</td>
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<tr>
<td></td>
<td>NPI of rendering provider (unshaded area)</td>
<td>2310B or 2420A, NM1/82, 09 (08=XX)</td>
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## Referring Provider – Information

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<td>Onset of current illness or injury</td>
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<td>2310A or 2420F, NM1/DN, 03</td>
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<tr>
<td></td>
<td>(17B MUST be reported when a service was ordered or referred by a physician.)</td>
<td>2310A or 2420F, NM1/DN, 09</td>
</tr>
</tbody>
</table>
## Diagnosis Indicators

<table>
<thead>
<tr>
<th>CMS-1500 Item #</th>
<th>Description</th>
<th>ANSI 837 v5010 Loop, Segment, Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>24e</td>
<td>Diagnosis Pointer</td>
<td>2400, SV1, 07-1</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis 1</td>
<td>2300, HI, 01-2</td>
</tr>
</tbody>
</table>

### REMEMBER!

If more than one pointer number is reported, the first-listed code is the reason the patient sought care from the provider.

![Diagram of diagnosis code](image-url)
National Correct Coding Initiative
NCCI Code Edit

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>Imadm any route 1st</td>
<td>Multiple Procedure: None, Bilateral Surgery: None, Assistant at Surgery: None, Team Surgery: None, Co-Surgeons: None, PC/TC: MD Service, MD Supervision: N/A, Global Surgery: N/A (XXX), Code Status: Active, Surgical Splits: Pre 0% Intra 0% Post 0%</td>
</tr>
</tbody>
</table>

During 2011 Apr-Jun, Code 90460 is Considered a Complementary Code.
What is National Correct Coding Initiative (NCCI)?


How to Use THE NATIONAL CORRECT CODING INITIATIVE (NCCI) TOOLS
# Modifier Indicator Table

<table>
<thead>
<tr>
<th>MODIFIER INDICATOR</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Not Allowed)</td>
<td>There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.</td>
</tr>
<tr>
<td>1 (Allowed)</td>
<td>The modifiers associated with NCCI are allowed with this code pair when appropriate.</td>
</tr>
<tr>
<td>9 (Not Applicable)</td>
<td>This indicator means that an NCCI edit does not apply to this code pair. The edit for this code pair was deleted retroactively.</td>
</tr>
</tbody>
</table>
Figure 3 shows part of the Column 1/Column 2 table for the Medicine Evaluation and Management Services Service Type with our example code 99215 in Column 1.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Existence Prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>48889</td>
<td>99215</td>
<td>G0101</td>
<td>19980401</td>
<td>19980401</td>
<td>9</td>
</tr>
<tr>
<td>48890</td>
<td>99215</td>
<td>G0102</td>
<td>20000605</td>
<td>*</td>
<td>0</td>
</tr>
<tr>
<td>48891</td>
<td>99215</td>
<td>G0104</td>
<td>19980401</td>
<td>19980401</td>
<td>9</td>
</tr>
<tr>
<td>48892</td>
<td>99215</td>
<td>G0105</td>
<td>19980401</td>
<td>19980401</td>
<td>9</td>
</tr>
<tr>
<td>48893</td>
<td>99215</td>
<td>G0106</td>
<td>19980401</td>
<td>19980401</td>
<td>9</td>
</tr>
<tr>
<td>48894</td>
<td>99215</td>
<td>G0107</td>
<td>19980401</td>
<td>19980401</td>
<td>9</td>
</tr>
</tbody>
</table>
TOP DENIALS

- Duplicate Claim
- Claim Submission Window Exceeded
- Member has no enrollment
- Invalid NPI Number
- Benefit Requires Authorization
- Member does not meet Age Criteria
Elements on a CMS-1500
CMS -1500

HEALTH INSURANCE CLAIM FORM

Member Information
- Coordination of Benefits
- Provider Information
- Practice Information

Code Rules
- Unique ID - (TPI or CH) Numbers

Indicators and Date of Onset

Valid Member ID

COB

If Box 10 = Yes Or Pregnancy Date
Date Required

Referring Provider Name & NPI or Unique ID
required

Valid ICD-9

Authorization No. Only

Valid CP/E Modifiers

DX Poisoner

Name and address where payments will be mailed.

Provider Name

Practice Name or Facility Where service are rendered

Unique ID

NPI

EPSDT or Family Planning
(Y or N)

If Box 11 d = Yes
Pay Amount Required
Attached EOB
From Prime Inst Required

Verification of Authorization

• The Authorization Number should be in BOX 23
• The authorization Number are 10 Characters Long with Prefix of Zero.

  EXAMPLE: 0000123456

*****************************************************************************

DO NOT SEND:

• CLIA Numbers: 45D0123456
• Auth Not Needed
• NOT on 1st VISIT
• EXPIRED
• 117044
• 45D0123456 0000123456
Verification of Authorization

When authorization is required Do Not leave Box 23 Blank.
Terms and Definitions

Remittance Advice (RA)
A notice sent by the insurance company that contains payment information about a claim.

Explanation of Benefits (EOB)
A detail notice sent by the insurance company to a member with the result of a processed claim and member responsibility.

Clearinghouse Real Time Response Report
A centralized claims processing for providers and health plans.

Clearinghouse Response/Report
A detail notice sent by the Clearinghouse to a provider that contains claims submission acceptance/rejection.
How to read a Remittance Advice (RA)

Texas Health Insurance

John Doe  
PO BOX 000  
Kalamazoo, MI 49065-0671

Enrollee: John Doe  
Patient: Jane Doe  
Patient #: 99999999  
SSN #: 999-88-9999  
Provider Name: Sample Hospital  
Claim#: 99999999-04  
Date: 12/20/2000

Dates of Service | Service Code | Total Amount | Not Covered | Reason Code | Discount Amount | Covered By Plan | Deductible Amount | Co-Pay Amount | Balance | Paid At | Payment Amount |
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
06/27/2012 | MD | $35000.00 | $10000.00 | 03 | $1000.00 | $2500.00 | 00.00 | $800.00 | $900.00 | 20% | $2000.00 |

Other Insurance Credits or Adjustments  
Total Net Payment: $2000.00

Total Patient Responsibility: $500.00

Payment To: Sample Hospital  
Check No. 20407187  
Amount: $2000.00

Charges not eligible, which could be a discount written off by the provider, or a charge the patient is responsible to pay.

The amount applied to the deductible on this claim. This could include an amount applied to your deductible, a co-pay amount paid to a provider, coinsurance (your %) a charge excluded by the plan, or a charge previously considered.

The total amount applied to the deductible year-to-date for the claimant and for the family.

Service Code  
Reason Code Description  
03 EXCEEDS FEE SCHEDULE  
An explanation by line number of the reasons certain charges were excluded.
How to read a Explanation of Benefits (EOB)

THE KEYSTONE PLAN

P.O. BOX 900
ALFRED, NY 14802-0900
(800) 555-5000

MARY SUE PATIENT
100 MAIN ST
ALFRED, NY 14802

EXPLANATION
OF BENEFITS

SERVICE DETAIL

<table>
<thead>
<tr>
<th>PATIENT/RELAT CLAIM NUMBER</th>
<th>PROVIDER SERVICE</th>
<th>DATE OF SERVICE</th>
<th>AMOUNT CHARGED</th>
<th>AMOUNT NOT COVERED</th>
<th>AMOUNT ALLOWED</th>
<th>GTPAY/ DEDUCTIBLE</th>
<th>%</th>
<th>PLAN BENEFITS</th>
<th>REMARK CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENROLLEE 5629587</td>
<td>D MILLER</td>
<td>OFFICE VISITS 04/05/YYYY</td>
<td>40.25</td>
<td>40.25</td>
<td>8.00</td>
<td>100</td>
<td>32.25</td>
<td>D1</td>
<td>PLAN PAYS</td>
</tr>
</tbody>
</table>

*THERE IS A COPY OF INFORMATION SENT TO THE PROVIDER. THANK YOU FOR USING THE PROVIDER PROGRAM.

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE *SERVICE DETAIL* SECTION UNDER THE HEADING *REMARK CODE*.

(D1) THANK YOU FOR USING A NETWORK PROVIDER. WE HAVE APPLIED THE NETWORK CONTRACTED FEE. THE MEMBER IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED BY THE CONTRACT.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

D MILLER $32.25

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>MEDICAL/SURGICAL OUT OF POCKET</th>
<th>MEDICAL/SURGICAL DEDUCTIBLE</th>
<th>PHYSICAL MEDICINE DEDUCTIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENROLLEE</td>
<td>ANNUAL DEDUCT TO-DATE</td>
<td>ANNUAL MAXIMUM TO-DATE</td>
<td>ANNUAL DEDUCT TO-DATE</td>
</tr>
<tr>
<td></td>
<td>$249.00</td>
<td>$121.64</td>
<td>$250.00</td>
</tr>
</tbody>
</table>

THIS CLAIM WAS PROCESSED IN ACCORDANCE WITH THE TERMS OF YOUR EMPLOYEE BENEFITS PLAN. IN THE EVENT THIS CLAIM HAS BEEN DENIED, IN WHOLE OR IN PART, A REQUEST FOR REVIEW MAY BE DIRECTED TO THE KEYSTONE PLAN AT THE ALFRED ADDRESS OR PHONE NUMBER SHOWN ABOVE. THE REQUEST FOR REVIEW MUST BE SUBMITTED WITHIN 60 DAYS AFTER THE CLAIM PAYMENT DATE, OR THE DATE OF THE NOTIFICATION OF DENIAL OF BENEFITS. WHEN REQUESTING A REVIEW, PLEASE State WHY YOU BELIEVE THE CLAIM DETERMINATION OR PRE-CERTIFICATION IMPROPERLY REDUCED OR DENIED YOUR BENEFITS. ALSO, SUBMIT ANY DATA OR COMMENTS TO SUPPORT THE APPEAL.

THIS IS NOT A BILL.
clearinghouse real time response report

real-time response report from thin - 1st level reporting

redi-link blue claim acceptance response

response date: 2000/12/05  response type:  response time: 11:05:13

sender: xclv00  thin - clearinghouse
payor: pmixed  multiple payers

format: nsf

submitter id: s00000

file id: a04880

status: accepted/prod

charges: $880.00
charges: $236.00

provider id: 123456789

batch id: b05492 0001

status: accepted/prod

charges: $880.00
charges: $236.00

patient: doe

pcn: willia0005

status: rejected

charges: $236.00
payer: p60054

insured: doe

id: zga44046852501

11/27

msg-304  claim type does not match the file type

dao-05

end of report

1. date and time file was received by thin.
2. key to reading responses. sender determines who is acknowledging receipt of claims.
3. sender can be thin, payer contractor, payer.
4. the payer identifies the insurance company.
5. format is the claim type: nsf=professional
6. and ub92=institutional
7. submitter id
8. total claims and charges for this file.
9. total claim rejects and charges for this file.
10. batch status: accepted or rejected & test or production.
11. patient and insured’s name. (last, first)
12. patient control number assigned by your system.
13. claim status: accepted or rejected.
14. first/earliest date of service.
15. total charges for the claim.
16. payer id number - refer to thin payer list for name.
17. messages (r=reject, w=warning, i=informational)
18. record and field where error occurred within claim.
19. end of report.
Questions?
Quality Improvement
June 2013

Kathleen Thompson MPH, CHES, Director of Quality Improvement
Christina Casas RN, QI Nurse
Angelica Baca, QI Coordinador
What is Quality Improvement

Quality Improvement is the continuous monitoring of care provided to members to improve outcomes and experiences by providing coordinated care that supports evidenced-based practice and patient-centeredness.

• Systematic,
• Data-Driven, and
• Multidisciplinary
What is HEDIS

- Healthcare Effectiveness Data and Information Set
- Most widely used healthcare quality *tool*
- HEDIS 2013 includes 5 domains of care that includes 76 measures
Domains / Indicators of Quality Care

Access & Availability:
- How many members had access to a provider in a given year?
- Were providers available after-hours for members?

Prevention Measures:
- How many women had their Breast Cancer Screening in a given year?

Utilization Measures:
- How many Well-child Visits occurred in 2012?

Quality of Care Concerns & Member complaints:
- How many members complaint did we receive?
- Potential Adverse Events?

Member Experiences with Care (Surveys)
Providers Experience's with Plan (Surveys)
HEDIS Data Collection

Administrative
• Claims, encounters, enrollment, provider systems (pharmacy and labs)

Hybrid:
• Administrative and medical record data retrieval.

Surveys
• Survey such as the CAHPS
Overall Quality Assessment Program

Health Care Performance, Effectiveness
HEDIS®
From Administrative Claims/Encounter and Medical Records (hybrid)

Member Experiences & Satisfaction
CAHPS® Survey

Preventable and costly care
Potentially Preventable Events

Health Plan Structure and Processes of Care
Source: CMS Protocols
Data Type: MCO Administrator Interviews, QAPIs

Focused Studies / Medical Record Reviews

Quality Assessment

Data is used to identify opportunities for improvement

Performance Improvement Projects (PIPS) and other activities to improve process, care, health outcomes, and satisfaction are developed

REPEAT Yearly
2013 Medical Record Review & HEDIS Hybrid

- Children's Immunization Status (CIS)
  - Complete
- Weight, Counseling and Nutrition (WCC)
  - Complete
- Controlling Blood Pressure (CBP)
  - In Progress
- Comprehensive Diabetes HgA1c<8, LDL<100 (CDC)
  - In Progress
STAR Childhood Immunizations
(Combo 4, Hybrid)
Rates with denominators <30 excluded

<table>
<thead>
<tr>
<th>Plan</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR</td>
<td>45.00%</td>
</tr>
<tr>
<td>A</td>
<td>39.42%</td>
</tr>
<tr>
<td>B</td>
<td>41.36%</td>
</tr>
<tr>
<td>C</td>
<td>48.91%</td>
</tr>
<tr>
<td>D</td>
<td>47.20%</td>
</tr>
<tr>
<td>E</td>
<td>47.69%</td>
</tr>
<tr>
<td>ElPasoFirst</td>
<td>52.55%</td>
</tr>
<tr>
<td>F</td>
<td>50.36%</td>
</tr>
<tr>
<td>G</td>
<td>45.74%</td>
</tr>
<tr>
<td>H</td>
<td>38.44%</td>
</tr>
<tr>
<td>I</td>
<td>55.00%</td>
</tr>
<tr>
<td>J</td>
<td>31.80%</td>
</tr>
<tr>
<td>K</td>
<td>38.56%</td>
</tr>
<tr>
<td>L</td>
<td>50.69%</td>
</tr>
</tbody>
</table>

HEDIS® P50 (%) 31.00
STAR Weight Assessment for Children for Nutrition and Physical Activity for Children/Adolescents

![Graph showing percentages for different providers.]

<table>
<thead>
<tr>
<th>Provider</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR</td>
<td>23.18%</td>
</tr>
<tr>
<td>A</td>
<td>21.17%</td>
</tr>
<tr>
<td>B</td>
<td>20.19%</td>
</tr>
<tr>
<td>C</td>
<td>21.41%</td>
</tr>
<tr>
<td>D</td>
<td>23.60%</td>
</tr>
<tr>
<td>E</td>
<td>26.03%</td>
</tr>
<tr>
<td>F</td>
<td>9.49%</td>
</tr>
<tr>
<td>El Paso First</td>
<td>45.99%</td>
</tr>
<tr>
<td>G</td>
<td>21.17%</td>
</tr>
<tr>
<td>H</td>
<td>22.87%</td>
</tr>
<tr>
<td>I</td>
<td>19.95%</td>
</tr>
<tr>
<td>J</td>
<td>21.30%</td>
</tr>
<tr>
<td>K</td>
<td>22.00%</td>
</tr>
<tr>
<td>L</td>
<td>26.20%</td>
</tr>
</tbody>
</table>

HEDIS® P50 (%) N/A
## Performance Improvement Projects 2013 – (See handout)

<table>
<thead>
<tr>
<th>STAR</th>
<th>CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Utilization ED Utilization <em>(asthma, diabetes, gastroenteritis, perforated appendix)</em></td>
<td>Well-Child Visits 3-6 years of age</td>
</tr>
<tr>
<td>Weight, Counseling for Nutrition and Physical Activity <em>(Prevent, intervene, treat obesity)</em></td>
<td>Weight, Counseling for Nutrition and Physical Activity <em>(Prevent, intervene, treat obesity)</em></td>
</tr>
<tr>
<td>Prenatal and Postpartum Care</td>
<td>Adolescent Well-Child</td>
</tr>
</tbody>
</table>
Questions

We are here to help you!!

If you have questions or concerns please contact the Quality Department

Kathleen Thompson, QI Director
kthompson@epfirst.com
915.298.7198 ext 1043
Pre-Authorization

• Prior authorization flyer identifies authorization requirements
• Submit required documentation
  – (i.e. Title XIX forms, TP1, TP2 forms)
• Submit supporting clinical information
  – (i.e. evaluation, plan of care)
Pre-Authorization Form

• Submit complete and legible pre-certification form
  – Include date of service
• Enter applicable CPT Codes and ICD-9 Codes
• Complete the member’s identifying information
  - Name  - Date of birth  - Identification number

EL PASO FIRST Health Plans inc.
Amendments

• When requesting an amendment, please include the following:
  – Original authorization number
  – Clinical information to support the amendment
Notifications

Partial Approval
• The Medical Director has approved services with a modification from the original request.
• The provider receives a fax notifying him/her of the approval.
• Provider has the opportunity to request a peer to peer discussion.

Administrative Denial
• Requested services were not approved.
• Example:
  – No clinical information is submitted within the requested time frame
  – Service is not a covered benefit
• The provider receives a fax notifying him/her of the denial and a formal denial letter with appeal rights.
Case Management and Disease Management

- Licensed social workers and nurses:
  - Initiate service coordination for local and out of town services
  - Link individuals with local community resources
  - Learn about each member’s unique needs
  - Assist in management of chronic conditions such as asthma and diabetes
Health Services

Contact Information

- Janel Lujan, LMSW
  Director of Health Services
  - Extension 1090

- Dolores Herrada, RN, CCM
  Clinical Supervisor
  - Extension 1007

- Irma Vasquez
  Administrative Supervisor
  - Extension 1042

- Mabel Toscano, RN
  Prior Authorization Coordinator
  - Extension 1212

- Crystal Moran, MPH
  Disease Management Coordinator
  - Extension 1175
Assigning PCP’s to Newborns

Edgar Martinez
Director of Member Services
Assigning PCP’s to Newborns

The Enrollment Specialist will review the P35 Newborn Report (TP45) on a daily basis to identify new members that have been enrolled in QNXT without an assigned PCP. (Some do have a PCP already)
Assigning PCP’s to Newborns

If no PCP is listed on the P35 Newborn Report the enrollment specialist will research QNXT. (Review the mother’s account on file to see if she already selected a pcp, search for siblings, call mother to get pcp name, if not PCP will be assigned based on members zip code).
Assigning PCP’s to Newborns

Depending on which date of the month the enrollment specialists are working the pcp assignment will take from 16 to 45 days. (Assignment/changes before cut off date are effective the following month after cut off date they will be effective in 2 months).
Questions?

If you have questions please contact the Member Services Department

Edgar Martinez, MBA
edmartinez@epfirst.com
915.298.7198 ext 1064
Thank You for Attending Providers!