Quarterly Provider Orientation

February 29, 2012

Welcome Providers!!
Pharmacy Benefit Manager Introduction

- Navitus is the Pharmacy Benefits Manager (PBM) contracted by El Paso First Health Plans, Inc., to manage our Members’ pharmacy benefits effective **March 1, 2012.**

- A **Pharmacy Benefit Manager (PBM)** directs prescription drug programs and processes prescription claims by negotiating drug costs with manufacturers, contracting with pharmacies and building and maintaining drug formularies. These cost-saving strategies help lower drug costs and promote member health.

- **Mission:** Navitus Health Solutions is a pharmacy benefit manager committed to lowering drug costs, improving health and delivering superior service in a manner that inspires trust and confidence.
Navitus Services

For the Texas STAR and CHIP, Navitus provides:

• Provider (Pharmacy and Prescriber) Hotline Customer Service
• Mail order availability and savings
• Pharmacy network including retail, mail order, and specialty pharmacies
• Prior Authorization processing
• Provider and pharmacy education through health fairs, newsletters, website, Pharmacy Handbook, and mailings
• Point of Sale (POS) claims processing

These services are currently administered under the Vendor Drug Program. The formulary and benefits are not changing with the transition to Navitus.
Pharmacy Provider Responsibilities

• Pharmacy Providers participating in the El Paso First Health Plan’s Provider Network will adhere to the Formulary and Preferred Drug List (PDL) mandated by the Health and Human Services Commission (HHSC).

• Pharmacy Providers will work in coordination with the Member’s prescribing physician to ensure that El Paso First Health Plan Members receive the correct medications in accordance with all clinical protocols and administrative policies.

• Pharmacy Providers will ensure that El Paso First Members receive all medications they are eligible to receive as prescribed by the Members’ physician.

• Pharmacy Providers will ensure that the coordination of benefits occurs when a Member also receives Medicare Part D services or other insurance benefits.
Provider and Member Hotlines

• Navitus Texas STAR and CHIP Provider Hotline:
  1-877-908-6023
  – Option 1 = If you are calling from a Pharmacy
  – Option 2 = If you are calling from a Provider’s Office (includes Prior Authorization)
  – Option 3 = If you know your party’s extension
  – Option 4 = If you are an MCO requiring support
  – Option 5 = All other inquiries

• Website: www.navitus.com

• Navitus handles all pharmacy and provider calls for pharmacy benefit including prior authorization requests. Their call center is available 24/7, excluding Thanksgiving and Christmas, with call centers in Appleton, WI and Austin, TX.

• El Paso First handles all member calls through our Member Services Hotline: 915-532-3778 or toll free 1-877-532-3778
To access the formulary and find a list of covered drugs.
VDP formulary drug search for covered drugs
Process for requesting a prior authorization (PA) for Pharmacy

- The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC. Information regarding the formulary and the specific prior authorization criteria can be found at the Vendor Drug Website, ePocrates, and SureScripts for ePrescribing.
- Prescribers can access prior authorization forms online via www.navitus.com under the “Providers” section or have them faxed by Customer Care to the prescriber’s office. Prescribers will need their NPI and State to access the portal. Completed forms can be faxed 24/7 to Navitus at 920-735-5312. Prescribers can also call Navitus Customer Care at 877-908-6023.
- Providers can select the prescriber option and speak with the Prior Authorization department between 8a-6p M-F Central Time to submit a PA request over the phone. After hours, providers will have the option to leave a voicemail message. Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The provider will be notified by fax regarding the outcome or verbally if an approval can be established during a phone request.
**Important**: PDL PA edits do not apply to CHIP. The PA forms (Clinical PA criteria) will not be posted to Navitus’ website until 03/01/12. The criteria is the same as VDP today and are available on the VDP site if needed.

- Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will undergo an automated review to determine if the necessary criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the process identified previously should be followed.

- When a Prior Authorization is required and the provider is not available to submit the PA request, HHSC requires pharmacies to dispense a 72 hour supply as long as the member will not be harmed if the PA is denied and therapy will be discontinued.
Emergency Prescription Supply

• A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

• A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler as a 72-hour emergency supply.
Complaints & Appeals

- All member complaints and appeals, including those submitted by a member or on behalf of a member by a pharmacy or provider, are managed by El Paso First.
  - Regardless of who is submitting the complaint or appeal, the first question is, “Is this from, related to, or on behalf of a member?”.
    - If yes, El Paso First manages the process.
      - If Navitus’ call center receives the complaint/appeal, the call will be warm transferred to El Paso First.
      - If El Paso First receives the complaint/appeal, they will follow their process.
    - If no, meaning it is a provider or pharmacy with a complaint or appeal not related to a member, then Navitus’ Grievance and Appeal Coordinator will manage the process.
Eligibility Roles

• All Medicaid Members will be re-issued another Medicaid ID card 30-45 days after March 1, 2012.

• All eligibility issues are managed by El Paso First.

• If Navitus is made aware of an eligibility issue or discrepancy, Navitus will fax an Immediate Eligibility form to the designated El Paso First contact for review. This contact was identified during the implementation process for each plan.

• If HHSC or El Paso First identifies an error with the pharmacy eligibility, the correction will be made in the pharmacy claim processing system overnight when the corrected file is sent to Navitus.

• If an urgent change is required, a designated contact at El Paso First will have access to modify eligibility.
Eligibility fax sample

<table>
<thead>
<tr>
<th>URGENT:</th>
<th>(Prescription needed ASAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-URGENT:</td>
<td>(Prescription needed next business day)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAX RECIPIENT(S):</th>
<th>MCO CONTACT NAME #1</th>
<th>MCO FAX:</th>
</tr>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>MCO CONTACT NAME #2</th>
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<table>
<thead>
<tr>
<th>MEMBER LAST NAME:</th>
<th>MEMBER FIRST NAME:</th>
<th>MEMBER MI:</th>
<th>GENDER:</th>
<th>MEMBER DOB:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent Information:</th>
<th>SPOUSE</th>
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<th>OTHER</th>
<th>Check all that apply</th>
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<tr>
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<table>
<thead>
<tr>
<th>Notes:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>CALLBACK NAME/RELATIONSHIP:</th>
<th>CONTACT PHONE:</th>
</tr>
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<tr>
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<td>### - ### - ####</td>
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**IMMEDIATE/MANUAL ELIGIBILITY REQUEST**

**NAVITUS HEALTH SOLUTIONS**

**EL PASO FIRST Health Plans, Inc.**
Eligibility FAQ

Q. What if a member paid the wrong co-pay (CHIP only) because they were showing in the wrong group?
A. Once the eligibility is corrected, the pharmacy can reprocess the claim and reimburse the member the difference.

Q. What if the member states they are eligible, but the system shows they are termed (or shows other insurance incorrectly, wrong group, etc.)?
A. All eligibility issues are researched and resolved by El Paso First. Changes are made to the eligibility files sent to Navitus. If the member does not show active coverage, they will not be able to have claims processed.

Q. What if the claim is rejecting because the wrong date of birth or gender are on the member’s profile?
A. The pharmacy needs to submit the claim with the information on file or wait for the eligibility file to be corrected. If Navitus is made aware of the discrepancy, it will notify El Paso First to research.
Eligibility FAQ

Q. How will Navitus notify El Paso First of an eligibility issue?
A. Navitus sends an Immediate Eligibility form to the El Paso First contact identified as part of the implementation process.

Q. Where will El Paso First verify eligibility when a member calls?
A. El Paso First should verify eligibility the same way they do today. As part of training by Navitus, El Paso First will learn how to verify member eligibility in the pharmacy system as well. Since files are sent daily, there should not be discrepancies between the two.

Q. What if changes need to be made to the member’s eligibility in Navitus’ system?
A. Identified representatives from each plan will be trained on making eligibility changes to the claim processing system for immediate needs. Changes will be overwritten when the daily file loads.

Q. How will newborn claims be processed before they have a permanent ID?
A. EPF will issue a Proxy ID number to the newborn, which will be entered in the Navitus system. Pharmacies can use this number to submit claims to Navitus. Proxy ID will consist of mother's ID and an "A" for a female child and "B" for a male child.
Q. How can pharmacies verify eligibility?

Vendor Drug’s EVP eligibility portal will not work for MCO members; it will show they are not eligible per HHSC. Pharmacies can call the Provider Hotline at Navitus, or call El Paso First Health Plans at 1-877-532-3778, access our web portal, or use HealthX.

Q. How often does Navitus receive eligibility files?

A. Navitus receives eligibility files from each plan daily. Some are M-F and others are 7 days a week.
Pharmacy Networks
Q. How do I know who is a participating pharmacy?


Navitus will have a complete Texas Medicaid/CHIP pharmacy directory available at www.navitus.com> Providers. All directories are searchable PDFs and are updated every two weeks. Members can use any participating pharmacy on these lists. Open the list, press Ctrl + F to open the search window and enter the city, zip, pharmacy name, etc. Click the left and right arrows by the search box to move between results.

- The complete participating pharmacy directory will not be available on Navitus’ website until 03/01/12.
Mail order FAQs

Q. Who is the mail order pharmacy and how do member’s get started?
A. Wellpartner is the mail order vendor. Members should call 1-877-935-5797 9:30 AM to 7:30 PM, CT Mon – Fri to set up an account. Payment is required before shipping for CHIP members only. Visa, MasterCard, Discover, American Express or check by phone is accepted. Members should enroll at least 14 days before they need their medications to allow time for processing and shipping. Delivery is free.

Q. Do members have to use mail order?
A. No, mail order use is voluntary.

Q. What is the day supply allowed through mail order?
A. Members can get up to a 90 day supply of medications through mail order barring any formulary restrictions. CHIP members need to pay 3 months of co-pays.

Q. How do prescribers send prescriptions to mail order?
A. Prescribers can fax prescriptions to 1-866-624-5797 or call 1-866-935-5797.

Q. What if there are problems with the order?
A. All issues should be directed to Wellpartner for resolution.
Specialty FAQs

Q. Who is the Specialty pharmacy and how do members get started?
A. Walgreens Specialty is the Specialty pharmacy. This is different than your corner Walgreens and mails the prescriptions. Members should call 1-800-218-1488 M-F 7a-7p CT or 7a-2p Sat to set up their account. Check, money order, or credit card are accepted forms of payment. Delivery is via Fed Ex and UPS and is free.

Q. Do members have to use Specialty pharmacy?
A. No, Specialty use is voluntary.

Q. What is the day supply allowed through the Specialty pharmacy?
A. Members can get up to a 34 day supply from the Specialty pharmacy.

Q. How do prescribers send prescriptions to the Specialty pharmacy?
A. Prescribers can fax prescriptions to 1-800-830-5292 or call 1-800-218-1488.

Q. What if there are problems with the Specialty pharmacy?
A. All issues should be directed to Walgreens Specialty for resolution.
Contracting FAQs

Q. How does a pharmacy contract with Navitus?
A. Before a pharmacy can be contracted with Navitus, they must first contract with Vendor Drug Program. Pharmacies can see if they're contracted with VDP by going to www.txvendordrug.com under Providers > Find a Provider. To contract with Vendor Drug, pharmacies can call the Vendor Drug Pharmacy Help Desk at 800-435-4165: M-F, 8:30am – 5:15pm (CT). Unique processes apply for out of state pharmacies that can be expedited for emergency situations. Information and forms are available on the Vendor Drug website. Once the pharmacy is contracted by Vendor Drug, then a separate Navitus contract is required. Pharmacies should contact Navitus' Networks department at 608-729-1577 or can call the Provider Hotline to be connected.

Q. Can an out of network pharmacy be overridden?
A. No, member must use pharmacies that are contracted with Navitus and the Texas Vendor Drug Program. In an emergent situation, a pharmacy can quickly be granted a temporary contract with Vendor Drug using the process above. Once the pharmacy is contracted with Vendor Drug, the pharmacy can then submit a manual claim to Navitus for the emergency fill. The pharmacy can determine whether to fully contract with Navitus and Vendor Drug after the urgent need is resolved.
Q. What information does the pharmacy need to submit a claim to Navitus?
A. Pharmacies need to submit the BIN (610602), PCN (MCD), the member’s ID number and Group number from their health plan ID card, the member’s date of birth and gender.

Q. How does the pharmacy submit a claim for a 72-hour emergency fill for a PA drug?
A. The pharmacy should enter ‘8’ in “Prior Authorization Type Code” (Field 461-EU), ‘801’ in Prior Authorization Number Submitted (Field 462-EV) and ‘3’ in “Days Supply” in the claim segment of the billing transaction (Field 405-D5). The quantity submitted in “Quantity Dispensed” (Field 442-E&) should not exceed the quantity necessary for a three-day supply. It is permissible that a pharmacy can dispense product packages in fixed dosage forms which are unbreakable (e.g. inhalers, nebulized medications), as a 72-hour supply. Place ‘3’ in “Days Supply” but enter the full quantity dispensed. Important: If a pharmacy is not complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of Inspector General and Navitus' Networks department at 608-729-1577 for review.

Q. How can pharmacies get more information on claim submission?
A. Pharmacies can contact Navitus’ Provider Hotline at 877-908-6023 or can visit www.navitus.com under the Providers menu to access the Pharmacy Handbook which includes a great deal of information on claim processing. Navitus sends Payor Sheets to pharmacies which instructs them how to process claims for Navitus.
Dispensing FAQs

Q. What if a pharmacy refuses to break the box to fulfill a script written for a quantity that is different than the package size?
A. Pharmacies should dispense the day supply prescribed whenever possible. Members can use a different participating pharmacy who will dispense appropriately, including mail order. If the package cannot be broken, the pharmacy should dispense the amount closest to the allowed day supply without exceeding it when possible. For example, if two inhalers will last a member 40 days, the pharmacy should dispense one inhaler for a 20 day supply instead of exceeding the 34 day supply limit. If one inhaler will last 40 days, then the pharmacy should bill one inhaler for a 34 day supply or contact Navitus for an override.

Q. What if Navitus’ claim system is down?
A. Pharmacies should call Navitus to receive copay information for the medications being dispensed, dispense the medication, and submit the claim when processing resumes.

Q. How will lock-ins be handled?
A. This is still under review. If Navitus is notified by HHSC or the MCO that a member is to be “locked-in” to a pharmacy or provider, this can be done in Navitus’ claim processing system.
Conclusion

• A pharmacy network is comprised of pharmacies that agree to contract rates. Pharmacies must also be contracted with Vendor Drug.

• Navitus educates pharmacies on claim submission through payor sheets, Pharmacy Handbooks, face-to-face training and newsletters.

• Members will have the option to use retail, mail order, and Specialty pharmacies to meet their medication dispensing needs.

• Par pharmacies can be found by accessing the pharmacy directory by service area on the MCO’s websites or the complete directory on Navitus’ website.

• To submit a claim for a specific member, the pharmacy will need the BIN, PCN, Group, Member ID, and the member’s date of birth and gender. The member information must match the member’s record in the claim processing system.

• Pharmacies should contact Navitus with any claim processing or contracting inquiries.
Pharmacy Quick Reference Guide

Navitus Health Solutions is El Paso First’s Pharmacy Benefit Manager for STAR/CHIP/CHIP Perinate members.

Navitus will handle ALL Provider (Prescriber and Pharmacy calls and is available 24/7/365 except Thanksgiving and Christmas from 8 am to 6 pm Central time) and can assist you with:

- Prior Authorizations
- Mail order/ Specialty Pharmacy services
- Point of sale (POS) Claims processing
- Contracting/Credentialing

Navitus Provider Hotline: **1-877-908-6023**

| Website: | [www.navitus.com](http://www.navitus.com) |
| Navitus BIN#: | 610602 PCN: MCO Rx Group: EPF |
| Prescriptions for mail order fax: | 1-866-624-5797 or call 1-866-935-5797 |
| Prescriptions for Specialty pharmacy fax: | 1-800-830-5292 or call 1-800-218-1488 |
| Prior Authorization Fax number: | 1-920-735-5312 |
| Clinical PA Criteria: | [www.navitus.com](http://www.navitus.com) (PDL PA edits do not apply to CHIP) |

- To verify eligibility: Pharmacies can call the Provider Hotline at Navitus, or call El Paso First Health Plans at 1-877-532-3778, access our web portal, or use HealthX.
- If a pharmacy is not complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of Inspector General and Navitus’ Networks department at 608-729-1577 for review.
Questions
Waste, Fraud & Abuse

New State Mandated Requirements
Delivery Induction Audits

• Implementation date
  – Effective December 2011

• Purpose
  – Ensure medical necessity for:
    • All delivery inductions and Cesarean Sections before 39 weeks.

• Process
  – SIU system generated random selection of 15 monthly claims with modifiers U1, U2 and U3
  – El Paso First sends a letter to the Provider requesting medical records with a 15 day turnaround
  – El Paso First receives the medical records and the Medical Director reviews medical necessity of the induction.
  – El Paso First will notify Provider of findings which may include recoupment.
Member Medical Services Verifications

- Implementation date
  - Effective December 2011
- Purpose
  - Ensure services were rendered as billed
- Process
  - SIU system generated random selection of 15 claims per week
  - Mandated total 60 calls per month
  - El Paso First’s SIU Auditor telephonically contacts the member and inquires if he/she received services for the identified date of service.
  - El Paso First’s SIU Auditor will document on QNXT by choosing the most appropriate below attribute:
    - Verified, services rendered
    - Not verified, services not rendered
    - Phone number disconnected
- NOTE: If services are not verified as rendered, a Provider preliminary investigation will be initiated
Continuing Coding/Billing Reviews

• Texas enacted House Bill 2292 requires all managed care payers to establish a Special Investigations Unit
  – To prevent and reduce waste, fraud and abuse
• This law requires El Paso First Health Plans to establish a plan to monitor and improve the accuracy of claims payments made to Providers
  – El Paso First will educate Providers making minor coding violations
  – El Paso First will recoup all identified overpayments up to $100,000
• TAC 353.501-353.505 enforces the investigative process for MCOs to follow
Compliance – Special Investigations Unit

• Rocio Chavez, BSHCA, CHC
  Compliance Director
  298-7198 ext. 1032
  rchavez@epfirst.com

• Laura Wilson, BSHCS, CCS-P
  Special Investigations Claims Auditor
  298-7198 ext. 1169
  lwilson@epfirst.com
Provider Relations Department
New Provider Manual


• The most important updates include
  – Pharmacy information on our Pharmacy Benefit Manager: Navitus
    • Prior Authorization process
    • 72-hour override
  – New CHIP cost sharing and co-pay updates
  – Helpful attachments that include pre-authorization forms that you use very often.

• You can download this electronic version to your desktop to look up any information that pertains to your practice as well as to access the rights and responsibilities you have by being part of our Provider Network.
Provider Relations Department

Provider Relations Department Services:

• Provider Relations Representatives are the liaison between the community providers, health plan & HHSC

• Site Visits
  – Education visits
  – Credentialing visits
  – Quarterly site visits

• Follow up on issues/concerns
  – Claims, Eligibility, Authorizations
  – Collaborate with other Departments

• Provide Contracts
  – Provider joining the Network or Group
  – Provider obtained TPI#

• Guidance during Credentialing process

• Demographic Changes & Updates

• Provide other Resources

For more information contact your assigned Provider Relations Representative or the Provider Relations Department at 532-3778 ext.1507.
Texas Health Steps Updates

Maritza Lopez & Michelle Anguiano
Updates effective December 1, 2011

Effective for dates of service on or after **December 1, 2011**, the benefit criteria for Texas Health Steps preventive medical checkups will change for Texas Medicaid.

1. A new checkup and a new evaluation and management visit performed on the same day may both be reimbursed as new patient visits if the client meets the requirements as a new patient.

2. In accordance to the National Corrective Coding Initiative (NCCI) guidelines, procedure code 99211 will not be separately reimbursed when billed with a vaccine administration code.

3. Dental referrals must be made starting at six months, and every six months afterward until the parent confirms a dental home has been established.

4. Registered nurses (RNs) without clinical nurse specialist (CNS), nurse practitioner (NP), or certified nurse midwife (CNM) certification may provide medical checkups only under direct physician supervision, meaning the physician is either on site during the checkup or immediately available to furnish assistance and direction to the RN during the checkup.
Updates effective December 1, 2011

5. The ages for anemia screening:
   - 12 months of age
   - Once between 18 and 24 months of age
   - For females, once between 12 and 16 years of age

6. Hemoglobin type is now included in the newborn screening rather than listed separately on the periodicity schedule.

7. Hearing screening - additional audiometric screening at 15 years of age

8. The checkup previously listed on the periodicity schedule as “3-5 days” will now be listed as “discharge to 5 days,” or “DC, to 5 days.”
   - **Newborn Examination** -. Procedure codes 99460, 99461, and 99463 should not be billed with modifier 52. The descriptions of these newborn exam codes reflect the completion of all the Texas Health Steps checkup components.
   - **Screenings** - Additional parental or guardian consent may be required.
9. **Hearing Screening** - Due to the implementation of the state-mandated newborn hearing screening, the Hearing Checklist for Parents is no longer required.

10. **Tuberculosis (TB) Screening** - The TB risk screening tool must be administered annually to all clients who are 12 months of age and older.

11. **Lead Poisoning** - Blood lead testing must be performed during the 12- and 24-month checkups, as indicated on the periodicity schedule. Blood lead testing (procedure code 83655) may be reimbursed to Texas Health Steps medical providers when it is performed in the provider’s office using point-of-care testing.

12. **Laboratory Testing** - To meet the laboratory testing requirement(s), providers can use documented laboratory results that are obtained within the preceding 30 days for clients who are birth through 2 years of age, and the preceding 90 days for clients who are 3 years of age and older.

**NOTE:** A new periodicity schedule will be revised and posted on the DSHS website effective December 1, 2011 to reflect these changes.
New Child Health Record Forms for medical checkups

• As part of the Frew corrective action plan for the checkup completeness study, DSHS developed a new child health records for THSteps checkups.

• The forms were just posted on the DSHS website: http://www.dshs.state.tx.us/thsteps/childhealthrecords.shtm

• There is now a form for each age visit, from up to 5 days through 20 years. The forms reflect the recommendations of physicians who used them in a pilot project last October as well as suggestions from DSHS’ Performance Improvement Process (PIP) physician advisory group.

• Please keep in mind that these forms are not mandatory but recommended. Just remember that DOCUMENTATION is essential!
Online Provider Education

• New module on Injury Prevention
• The courses currently being offered are:
  – Oral Evaluation and Fluoride Varnish
  – Developmental/Mental Screening
  – Adolescent Health Screening
  – Introduction to the Medical Home
  – Immunization
  – Medicaid Children’s Services
  – And many more...

For more information please go to http://www.txhealthsteps.com/
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.
Comparison Chart of Providers and OEFV Certificate

Oral Evaluation and Fluoride Varnish Certifications

- YES: 72%
- NO: 28%
ImmTrac Registry

• Free service
• Stores child’s immunization information electronically
• One centralized system
• Consent is during birth registration process OR completion of consent form
• For more information please log on to http://www.dshs.state.tx.us/immunize/immtrac/default.shtm
TVFC Updates

• Available at no cost to Providers
• As part of providing comprehensive care package to patients
• Updated policy
  – Children birth through 18 years of age who meet at least one of the following criteria are eligible to receive TVFC vaccine from any TVFC-enrolled Provider.
  – Criteria:
    • Medicaid eligible
    • Uninsured
    • America Indian or Alaskan Native
    • Underinsured: “A child who has commercial health insurance, but coverage does not include vaccines; a child whose insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, that child is categorized as underinsured.”

• New TVFC Standardized Forms
  – Patient Eligibility Screening Record-C110
  – TVFC Patient Decision Screening Tree
  – Patient Referral Form for Vaccination from local Health Department or Public Health Clinics

• For more information on TVFC please log on to http://www.dshs.state.tx.us/immunize/tvfc/default.shtm
Developmental Screening Tools

Effective September 1, 2011, the THSteps medical checkup will be considered complete only if providers use the Modified Checklist for Autism for Toddlers (M-CHAT) tool for the autism screening and one of the following tools for the developmental screening:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)
- Parents’ Evaluation of Developmental Status (PEDS)

The tools must be used at the ages indicated in the following table:

<table>
<thead>
<tr>
<th>Ages</th>
<th>Developmental Screening Tools (Procedure code 96110)</th>
<th>Autism Screening Tool (Procedure code 96110 with modifier U6)</th>
</tr>
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<tbody>
<tr>
<td>9 months</td>
<td>ASQ or PEDS</td>
<td>N/A</td>
</tr>
<tr>
<td>18 months</td>
<td>ASQ or PEDS</td>
<td>M-CHAT</td>
</tr>
<tr>
<td>24 months</td>
<td>ASQ or PEDS</td>
<td>M-CHAT (only if the screening is not completed at 18 months, or with provider/parental concerns)</td>
</tr>
<tr>
<td>3 years</td>
<td>ASQ, or ASQ:SE, or PEDS</td>
<td>N/A</td>
</tr>
<tr>
<td>4 years</td>
<td>ASQ, or ASQ:SE, or PEDS</td>
<td>N/A</td>
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Developmental Screening Billing

**NOTE:** Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, *with the exception* of developmental and autism screening.
Assistance required on the Happy Birthday Reminder Card

Please complete back portion with DOS, member ID#, Provider name/stamp.
Accelerated Services for Children of Migrant Farm Workers

- State initiative to provide a THSteps checkup and accelerated services to children of migrant farm workers due to the uniqueness of this population.
- Collaborating with the Migrant Outreach Coordinator to educate our providers about these services.
- If you have any patients from El Paso First that meet this criteria please refer them to Llivia Acuña, Migrant Outreach Coordinator at 915-532-3778 ext 1075.
Migrant Postcard
Contact Information

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

– Michelle Anguiano-C.A.R.E. Unit Manager
  • E-mail manguiano@epfirst.com
  • Phone: (915) 298-7198 extension 1053
Claims Department

Sonia Lopez
Claims Director
Expediting Your Paper Claims Submission
Medical Record Reviews

General Requirements & Data Fields

Attachment Claims & Corrected Claims

Multiple Claim Submission
General Requirements

- Use original claim forms (Red and White) CMS 1500
  - Don’t use copies of claim forms.
- Detach claims at perforated lines before mailing.
- Don’t fold claim forms, corrected claims, appeals, or correspondence.
- Don’t use labels, stickers, or stamps on the claim form.
- Don’t send duplicate copies of information.
- Don’t mail claims with correspondence for other departments such as Complaints and Appeals.
  - Use 8 x 11 inch paper.
  - Don’t use paper smaller or larger than 8 x 11 inches
Data Fields

• Print claim data within defined boxes on the claim form.
• Use black ink, but not a black marker.
• Don’t use red ink or highlighters.
• Use all capital letters.
• Use a laser printer for best results.
• Print using 10-pitch (12-point) Courier font, 10 point.
  – Don’t use proportional fonts, such as Arial or Times Roman.
  – Don’t use a dot matrix printer, if possible.
  – Don’t use dashes or slashes in date fields.
Attachments

- Use paper clips or staple claims or appeals if they include attachments. Don’t use glue, or tape.
- Place the claim form on top when sending New claims, followed by any medical records or other attachments.
- Ensure all Remittance Advice from Primary Carriers are attached and include the denial descriptions.
- Submit claim correct claims with a Corrected Claim form located on the El Paso First Website. [www.epfirst.com](http://www.epfirst.com)

Multiple Claim Submission

- Paper clip or staple multiple claims.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
Remember To:

Review Your Claim
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

The Authorization Number should be in **BOX 23**

When authorization is required do not leave Box 23 Blank.

| 14. DATE OF CURRENT: MM DD YY | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE |
| 17a. |
| 17b. NPI |
| 19. RESERVED FOR LOCAL USE |
| 20. OUTSIDE LAB? YES NO |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____ 4. _____ |
| 22. MEDICAID RESUBMISSION CODE ORIG. REF. NO. |
| 23. PRIOR AUTHORIZATION NUMBER |
Hysterectomies
El Paso Health Plans, Inc. (El Paso First) will reimburse hysterectomies for medical necessity.

At the time of authorization, reimbursement for an Assistant Surgeon will be allowed when medically necessary and must be billed with the appropriate modifier.

El Paso First does not reimburse hysterectomies performed for the sole purpose of sterilization.

Providers may use any of the following procedure codes to submit claims for hysterectomy procedures:

51925 58150 58152 58180 58200 58210 58240 58260 58262 58263 58267 58270 58275 58280 58285 58290 58291 58292 58293 58294 58541 58542 58543 58544 58548 58550 58552 58553 58554 58570 58571 58572 58573 59135 59525
Helpful Link for 5010 Version
The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) upgrade to Version 5010 was effective January 1, 2012.

If you are experiencing issues with your claims submissions we encourage you to contact your clearinghouse and/or billing services to review the companion referencing 5010 transactions.

For further information, please refer to the following link:
https://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
Questions?

Sonia Lopez, BS, CPC
Director of Claims
(915) 532-3778 Ext: 1097

Provider Care Unit Extension Numbers:
1527 – Medicaid
1512 – CHIP
1509 – Preferred Administrators
1504 – HCO
Member Services Department
CHIP Co-pay and Cost Sharing increases

Starting March 1, 2012, CHIP co-payments and cost-sharing cap will go up for medical and prescription drug (generic and brand name) services.

<table>
<thead>
<tr>
<th>CHIP Cost-Sharing</th>
<th>Effective March 1, 2011 through February 29, 2012</th>
<th>Increases Effective March 1, 2012 ***</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Co-Pays (per visit, per child):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At or below 100% of FPL*</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>1.25% of family’s income**</td>
<td>5% of family’s income**</td>
</tr>
<tr>
<td>Above 100% up to and including 150% of FPL*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient</td>
<td>$25</td>
<td>$35</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>1.25% of family’s income**</td>
<td>5% of family’s income**</td>
</tr>
<tr>
<td>Above 150% up to and including 185% of FPL*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$12</td>
<td>$20</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$8</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$25</td>
<td>$35</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>2.25% of family’s income**</td>
<td>5% of family’s income**</td>
</tr>
<tr>
<td>Above 185% up to and including 200% of FPL*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$16</td>
<td>$25</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$8</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$25</td>
<td>$35</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient</td>
<td>$100</td>
<td>$125</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>2.25% of family’s income**</td>
<td>5% of family’s income**</td>
</tr>
</tbody>
</table>

* The federal poverty level (FPL) refers to income guidelines established annually by the federal government.
** Per 12-month term of coverage.
*** Effective March 1, 2012, CHIP members will be required to pay an office visit co-payment for each non-preventive dental visit.
New ID cards with Pharmacy information

• All EPF members will receive a new El Paso First ID card with the new Pharmacy information required to submit claims to Navitus.

• Please remember that all Medicaid members will be issued a new Your Texas Medicaid Benefits plastic card but members will receive it on late March or April.

• To verify eligibility for one of our members
  – Call our Member Services Department Monday through Friday from 7 am to 5 pm at 915-532-3778,
  – Use our Web portal,
  – Use our Health X system.
Overview of El Paso Children’s Hospital (EPCH)

Effective February 5, 2012, Preferred Administrators began providing medical benefits for the Associates of the El Paso Children’s Hospital.
New Plan Information

• Name of Plan- El Paso Children's Hospital Employee Health Benefit Plan
  Address- 4845 Alameda Avenue
  El Paso, TX 79995
  Phone Number- 915-521-7148

• Plan Year-The initial year will be February 5th – September 30th. Thereafter the Plan Year will be October 1st – September 30th

• Third Party Administrator- Preferred Administrators
BENEFITS FOR EPCH

• Co-Pays same as UMC
• Deductibles same as UMC
• Accumulators same as UMC
• Maximum Out of Pockets same as UMC
• Co-Insurance same as UMC

-Any transferred employees from UMC to EPCH prior to February 5th will be grandfathered their deductibles, accumulators, maximum out of pocket and co-insurance
Benefit Changes for EPCH

- Benefits will be same as UMC except for Behavioral
- Behavioral Benefits will have no Max Limits or Maximum Visits
- Domestic Partners will be eligible for Medical Insurance with EPCH
- What is a Domestic Partner? Domestic Partner is a person of the same or opposite sex (gender) who has the same principal place of residence as the employee and both the employee and domestic partner meet EPCH requirements
EPCH Member ID Card

- EPCH ID Number will be different and it will also begin with HP
- Group Number- EPCH01
- Pharmacy- RX Solutions now OPTUMRx
Authorizations

• All Authorizations will be processed by Health Services
• Authorization Flyer will remain the same as before under Preferred Administrators until next Fiscal Year
• Authorization Forms will remain the same
• Authorization Queue for EPCH ext. 1538
• Authorization Fax will remain the same
• Authorization Appeals will remain the same
Provider Network

• Preferred Provider Networks
  (1) El Paso Children’s Hospital and University Medical Center of El Paso and Texas Tech Physicians
  (2) Preferred Administrators Network in El Paso and other providers contracted by Preferred Administrators Network on behalf of this Plan

• Wrap Network-Texas True Choice and Beech street
Claims Billing

PROVIDER CLAIM SUBMISSION:
• All El Paso and Outside Area Providers
  – All Paper Claims need to be sent to:
    Preferred Administrators
    P.O. Box 971370
    El Paso, TX 79997
• All Electronic Claims need to be sent to:
  Avality:EPF11
Pharmacy

• EPCH will have RX Solutions as their PBM
  -Any transferred employee from UMC to EPCH prior to February 5th will be grandfathered their deductibles.

Prescription Solutions Contact Numbers
- Customer Service Phone Number 1-800-788-7871
- Prior Authorization Department 1-800-711-4555
- Mail Order Pharmacy 1-800-562-6223
- RX Website https://www.prescriptionsolutions.com
Questions?

Thank you for attending!