

EL PASO FIRST
Health *Plans, inc.*



Quarterly Provider Orientation

May 24, 2012

Welcome Providers!!

Provider Relations Department Updates

Irma Herrera

Provider Relations and Credentialing Director



Collection of Medical Records

- HHSC contracted an independent organization to validate encounter data.
 - Institute for Child Health Policy (ICHIP) is performing this service for HHSC.
- Providers are randomly selected
- El Paso First is collecting medical records for ICHIP review.
- Four phases of request being made
 - 1st Phase- Comprehensive Diabetes Care
 - 2nd Phase- Childhood Immunization Status
 - 3rd Phase- Diabetes & Hypertension
 - 4th Phase- Pending
- Records are to be submitted within 15 business days after the date of receipt of request
- Reminders are being faxed to be compliant with deadlines
- Provider Relations Representatives are available to pick up medical records
- If you have any questions, please contact your Provider Relations Representative or the Provider Relations Department at 532-3778, press option 4 and dial 1507.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

RE: Request to Provide Records

Dear Medicaid/CHIP Provider of Texas:

Thank you for serving as a Medicaid/CHIP managed care provider. As required by federal regulations, the Health and Human Services Commission (HHSC) has contracted with an independent External Quality Review Organization (EQRO) to validate encounter data. The Institute for Child Health Policy (ICHP) at the University of Florida is under contract with HHSC to perform this service as the State's EQRO.

This letter is your notification that the health plans are collecting medical records for ICHP's review. Under the terms of your Provider contract, you have agreed to provide documents to the health plan and to the EQRO in its role as an independent verification and validation contractor acting on behalf of HHSC. Ref: HHSC Uniform Managed Care Manual, Chapter 8.1 Provider Contract.

Please be advised that you are permitted to share health record information in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) because you qualify as a business associate of HHSC, as does ICHP. You are required to share this information because of provisions in your contract with the participating Medicaid/CHIP Managed Care Organization. Please note that clients give consent for this activity as part of their Medicaid/CHIP enrollment.

If the billing information lists the Group Practice billing address, the health information request will be sent to the provided billing address. The Group Practice will need to forward the health information request to the appropriate Group Practice site, where the patient was seen. If a provider does not send the health information by the deadline, the enrollee's case will be deemed non-compliant with the guidelines when the compliance rate is determined. Records shall be furnished by the physician within 15 business days after the date of the receipt of the request. (Texas Administrative Code, Title 22, Part 9, Chapter 165, Rule §165.2)

Your participation in this process is essential. Your prompt attention to the record request is greatly appreciated. Should you have any questions, please contact El Paso First Health Plans at 915-532-3778.

Sincerely,

Handwritten signature of Scott Schalchlin in black ink.

Scott Schalchlin
Director, Health Plan Operations
Medicaid/CHIP Division
Texas Health and Human Services Commission

Handwritten signature of Elizabeth Shenkman in black ink.

Elizabeth Shenkman, Ph.D.
Texas EQRO Director
University of Florida- Institute for Child Health Policy

C.A.R.E. Unit & Department of Public Health Educational Efforts

Michelle Anguiano
C.A.R.E Unit Manager



Reporting Communicable Diseases Kit

- Healthcare Providers and other agencies are required to report cases or notifiable conditions to the City of El Paso Department of Public Health.
- On-line Disease Reporting System called “Confidential Morbidity Reporting”
- One DVD per office
- Please review the *Notifiable Conditions Reporting Protocol*

Pertussis and Cocooning Advisory and Handbook

Dedicated to Outstanding Customer Service for a Better Community

SERVICE SOLUTIONS SUCCESS

Health Advisory

To: All El Paso Area Medical Providers
From: Hector Ocaranza, M.D.
Health Authority
Bruce Parsons, Assistant Director
City of El Paso Department of Public Health
Date: May 14, 2012
Subject: Pertussis Intervention

The City of El Paso Department of Public Health is asking for your cooperation in reducing the number of pertussis cases in our region. The department has investigated a total of 14 cases so far this year, as compared to six cases identified in all of 2011. In an effort to prevent the overwhelming number of cases seen in other areas of the state and in other parts of the country, we are asking for your partnership in combating this disease. As you know, vaccination is the best way to prevent the disease and so the following is a list of ways you can support our efforts.

- Promote the vaccine for all expectant mothers, and adult members of the household who will come in contact with the newborn child
- Encourage all adult clients to be vaccinated against pertussis
- Educate the family about the signs and symptoms of the disease

Recently the Centers for Disease Control and Prevention (CDC) recommended a strategy called Cocooning to protect infants against pertussis and other infectious diseases. Cocooning is a practice of vaccinating all close contacts of infants to protect the newborn from disease. By getting a pertussis-containing vaccine (Tdap), adults and adolescents remain disease free, thereby protecting infants from pertussis. Please find attached the Pertussis Cocooning Handbook and make it available to your staff.

Background

Pertussis symptoms appear five to twenty-one days after infection. Usually only close contacts of people with pertussis become infected.



5115 El Paso Drive - El Paso, Texas 79905 - (915) 771-5702
Where Health Knows No Borders



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John F. Cook

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Susie Byrd

District 3
Emma Acosta

District 4
Carl L. Robinson

District 5
Dr. Michiel R. Noe

District 6
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Pertussis begins with cold-like symptoms (sneezing and a runny nose) and a cough that gradually becomes worse. After one to two weeks, the cough usually occurs in strong "coughing fits." In young children, this is often followed by a whooping noise as they try to catch their breath.

After coughing, a person may have difficulty catching their breath, vomit, or become blue in the face from lack of air. Between coughing spells, the person may appear well. There is generally no fever. The cough is often worse at night and cough medicines usually do not help reduce the coughing. Coughing fits can last six weeks or longer. Adults, teens, and vaccinated children often have milder symptoms, similar to bronchitis or asthma.

It is important to remember that people with pertussis are contagious until they have completed 5 days of antibiotics. According to the Department of State Health Services, children who have pertussis are not permitted to return to school until they have completed 5 days of antibiotics. Persons who are diagnosed with pertussis should be advised by their health care provider to remain home until 5 days of antibiotics are completed.

In order to help contain the spread of pertussis, all household and close contacts of someone diagnosed with pertussis should also receive antibiotics and a pertussis-containing vaccine (such as Tdap) even if they are not coughing. Close contact is generally defined as being within 1-2 feet of someone with pertussis for 1-2 hours.

Thank you for your attention to this matter and for your continued cooperation in making sure health is a top priority in El Paso.

Sincerely,

Hector Ocaranza, M.D.
Health Authority

Bruce Parsons
Public Health Assistant Director



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Pertusis Cocooning Handbook

- The purpose is to ask OB GYNs, Family Medicine Providers, Pediatricians and Hospital-based doctors to implement cocooning strategies in their practices.
- Vaccinating adult and adolescent patients and family members with the Tdap vaccine to protect the infant they have contact with as well.
- Copies are available upon request or via our website (www.epfirst.com) under Texas Health Steps Resources.



Texas Health Steps Tools & Guides

Maritza Lopez
THSteps Coordinator



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.

Auto-dialer & Post cards

- To remind our Medicaid members they are due for a Texas Health Steps (THSteps) checkup.
- Use the PCP's name to program the auto-dialer and post cards
- Mail THSteps reminder postcards with the Doctor's name printed to his/her membership on a monthly basis

Texas Health Steps Postcards

Just a reminder

Our records show that your son/daughter is due for their **FREE** Texas Health Steps medical checkup.

Please call

at
to make an appointment today!



Sólo un recordatorio

Nuestros archivos indican que a su hijo le toca el examen médico **GRATIS** de Pasos Sanos de Texas.

Por favor, ¡llame hoy mismo a

al
para hacer una cita!



It's Time Es Hora



El Paso First Health Plans, Inc.
PO Box 971100
El Paso, TX 79997-1100

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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...**

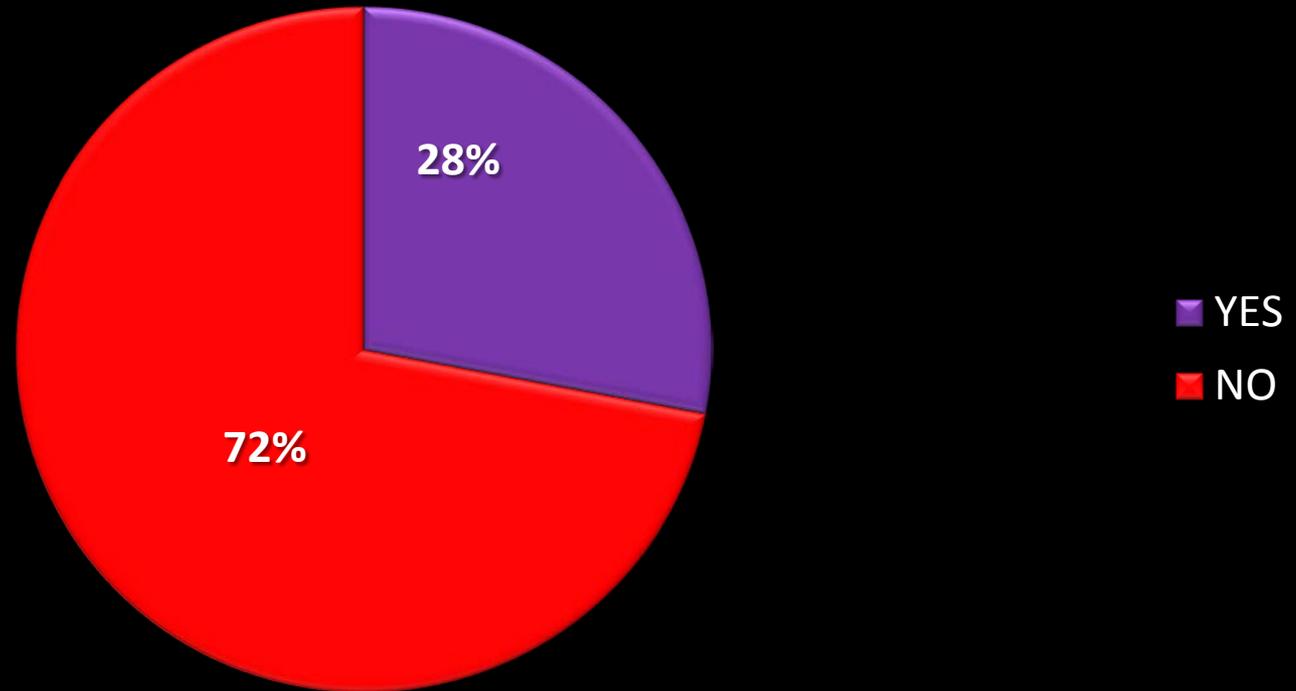
For more information please go to <http://www.txhealthsteps.com/>

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



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:

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

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

EL PASO FIRST
premierplan
PO BOX 971100
El Paso, TX
79997-1100

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To be filled out by the Provider ONLY:
I had my THSteps checkup on (date) _____
and discussed concerns I had about my health.
I also had the following as part of my checkup:

- Unclothed Physical
- Health and Development History
- Physical Exam
- Immunizations
- Lab Test
(including lead blood level assessment)
- Health Education

Doctor's name, address, and signature or office stamp:

Patient Medicaid ID number:

Please fax this completed form to:
El Paso First Health Plans at **915.532.2296** in order
to mail the member a \$10.00 gift card and enter
them in a monthly drawing for a \$100.00 gift card.

TEXAS STAR
Member of the Texas Health Care System

¡Feliz Cumpleaños!
Happy Birthday!

EL PASO FIRST
premierplan

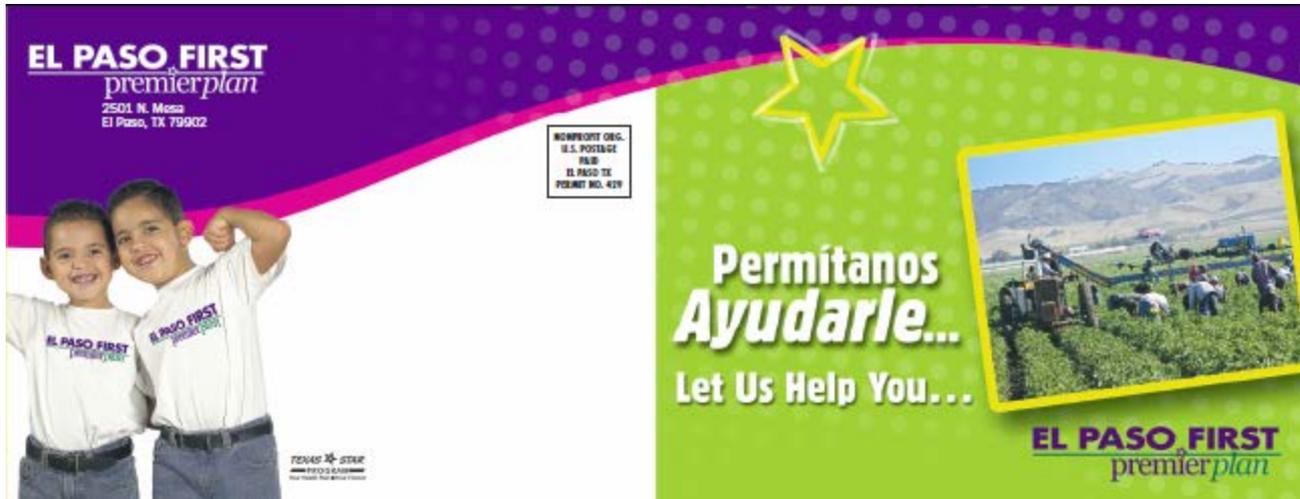


Please complete back portion with
DOS, member ID#, Provider name/stamp.

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 Lluvia Acuña, Migrant Outreach Coordinator at 915-532-3778 ext 1075.

Migrant Postcard



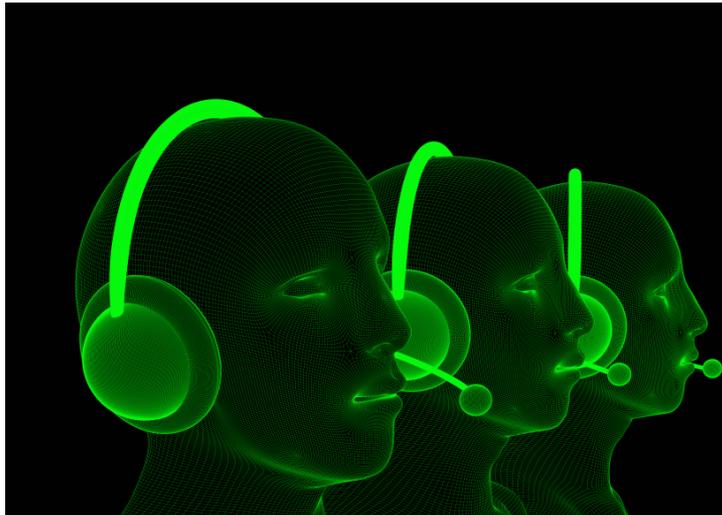
| Estimado miembro, permitanos ayudarle: | Dear member, let us help you: |
|---|---|
| <p>El Plan Premier de El Paso First tiene servicios especiales de Medicaid para niños de trabajadores temporales del campo, por eso nos gustaria saber lo siguiente:</p> | <p>El Paso First Premier Plan has special Medicaid services for the children of seasonal farm workers and we would like to know the following:</p> |
| <p>¿Es usted un trabajador temporal del campo? Si <input type="radio"/> No <input type="radio"/></p> | <p>Are you a seasonal worker? Yes <input type="radio"/> No <input type="radio"/></p> |
| <p>¿En la plaza de cebolla, chile, lechuga, tomate, uvas, nueces, etc...? Si <input type="radio"/> No <input type="radio"/></p> | <p>Picking onions, chile, lettuce, tomatoes, grapes, pecans, etc...? Yes <input type="radio"/> No <input type="radio"/></p> |
| <p>¿Empacando o procesando vegetales, frutas, pescado, pollo, etc...? Si <input type="radio"/> No <input type="radio"/></p> | <p>Packing or processing vegetables, fruits, fish, chicken, etc...? Yes <input type="radio"/> No <input type="radio"/></p> |
| <p>¿En lechugas, pesca, o manzana, etc...? Si <input type="radio"/> No <input type="radio"/></p> | <p>In dailies, fisheries, or slaughtering, etc...? Yes <input type="radio"/> No <input type="radio"/></p> |
| <p>Si contesto SI a alguna de las preguntas, por favor comuniquese con Lujvia Acuña, Coordinadora Migrante, al (915) 532-3778. Le ayudaremos a recibir servicios rápidos. ¡Gracias por su tiempo!</p> | <p>If you answered YES to any of these questions, please contact Lujvia Acuña, Migrant Coordinator at (915) 532-3778. We will help you receive accelerated services. Thank you for your time!</p> |
| <p>Sinceramente, Plan Premier de El Paso First</p> | <p>Sincerely, El Paso First Premier Plan</p> |

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

Member Services Department

Edgar Martinez
Member Services Director



CHIP Updates

- CHIP Network Providers and Out-of-Network Providers may collect co-payments authorized in the CHIP State Plan from CHIP Members.
- Providers are responsible for collecting all Member co-payments at the time of service.
- Copayments that families must pay vary according to their income level.
- Copayments do not apply, at any income level, to Covered Services that qualify as well-baby and well-child care services, preventive services, or pregnancy-related services as defined by 42 C.F.R. §457.520 and SSA § 2103(e)(2). Also, cost sharing does not apply to CHIP Perinatal Members.

CHIP Co-payments

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

* 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.

Automated Telephone System

- El Paso First is always looking at ways to simplify your life, so here is a short-cut on how to get to the appropriate phone extensions much faster:
 - Step 1: call 532-3778
 - Step 2: press 3 for Providers
 - Step 3: Press 1 for eligibility, Press 2 for claims, Press 3 for Authorizations or Press 4 for HealthX
 - Last Step: Press the number for the program you are calling about. (i.e. Medicaid, CHIP, HCO...) and this should get you to the appropriate phone extensions.
- If you plan not to follow these steps, it might just take you a little **more time** to get where you want to go.

Claims Department

Sonia Lopez
Claims Director



Availity Payer ID Number

| Product Line | Payer ID Number |
|--|-----------------|
| Premier (STAR) | EPF02 |
| CHIP | EPF03 |
| Preferred Admin TPA= UMC | EPF10 |
| Preferred Admin TPA=Children's | EPF11 |
| Healthcare Options/ Care Management | EPF37 |

NOTICE EFFECTIVE MARCH 1, 2012

- CHIP and CHIP Perinatal members remain eligible until the end of their 12 months certified period even if a third party payer has been reported.
- Coordination of Benefits will apply to CHIP and CHIP Perinatal Claims.
- If a claim with Primary Insurance for a CHIP member is submitted **WITHOUT** an EOB from primary carrier the claims will be **denied**.
- If a claim with Primary Insurance for a CHIP member is submitted **with an EOB from primary carrier indicating payment from the primary carrier, we will coordinate benefits for the remaining balance. The COB process will mirror how Medicaid COB claims are processed.**
- El Paso First Health Plans **will be responsible for the remainder of the claim if a third party does not cover the full 100% of the Medicaid allowable amount billed.**

SAMPLE:

| | |
|-------------------------------|------------------------------|
| <i>Claim Charges :</i> | <i>\$1500.00</i> |
| <i>Primary Carrier Allows</i> | <i>\$1300.00</i> |
| <i>Primary Carrier Pays</i> | <i>\$1040.00 paid at 80%</i> |
| <i>Member Responsible:</i> | <i>\$ 260.00</i> |

| | |
|----------------------------|------------------|
| <i>CHIP Allowed Amount</i> | <i>\$1000.00</i> |
| <i>CHIP Pay Amount</i> | <i>\$ 260.00</i> |

NOTICE EFFECTIVE JULY 1, 2012

In order to expedite the process of your claims effective July 1, 2012, El Paso First Health Plans will be requiring valid NPI numbers on ALL claims for the following product lines of business.

- **El Paso First Premier (STAR)**
- **El Paso First CHIP**
- **Preferred Administrators (TPA)**
- **Health Care Options (HCO)**

NOTICE EFFECTIVE AUGUST 21, 2012

- Effective **August 21, 2012**, if you need to provide a flu or HPV vaccine to a **STAR or CHIP** member that is **18 years and older**, we need you to please request a pre-authorization for this service.
- The claims you have submitted without a prior authorization are being manually processed so no action is needed from you regarding these claims.
- However, effective **August 21, 2012**, any claims submitted with that date of service or forward without a prior authorization number on the claim for the administration of HPV or flu vaccines for STAR or CHIP members 18 and over, will be **denied**.
- In the event you have one of our members in the office and you need to administer the HPV or flu vaccine, please submit your pre-authorization and label it “STAT” so we can expedite our review.

National Provider Identifier (NPI)

- The National Provider Identifier (NPI) is a standard required under HIPAA.
- The NPI is a unique, 10-digit identification number for health care providers.
- Under HIPAA, the Provider must submit claims with NPI numbers.

<http://www.cms.gov/>

Attest Your NPI Number

Texas Medicaid requires for providers to attest their NPI numbers with Texas Health Partnership (TMHP).

<http://www.tmhp.com/Pages/default.aspx>

Submission Requirements for Scanned and EDI Claims

In order to support our scanning requirements, NPI numbers are required.

HIPAA 5010 requirements require NPI numbers to be submitted in their appropriate loops.

NPI validation Rules for Electronic Claims

Professional 837P:

- Loop 2010AA = [Billing Pay TO]
- Loop 2310B = [Rendering Providers]

Institutional 837I:

- Loop 2010AA = [Billing Pay TO]
- Loop 2310C = [Attending Physician]

Note: NO P.O. Box should be submitted on billing Pay To field.

NPI Validation Rules

Professional Claim: (Box 24J) Rendering NPI;

- **(Box 31) Provider Name must match the submitted NPI number on (Box 24J).**

Professional Claim: (Box 33) Pay To Information; (Box 33a) Pay To NPI #

Institutional Claim: (Box 56) Pay To NPI;

- **(Box 1a) Pay To Name Institutional Claims:**
- **(Box 76) Attending Physician NPI No.**

Scanning Requirements



Scanning Requirements

Format:

- **Submit Claims in Red and White Forms**
- **Black Ink**
- **Print Size : 10 –pitch font (12-point)**
- **Courier font, 10 point**

Scanning Requirements

Don'ts

- Do **not** use proportional fonts, such as Arial or Times Roman.
- Do **not** use a dot matrix printer, if possible.
- Do **not** use dashes or slashes in date fields.
- Do **not** send hand written claims.
- Signature Stamp is **not** required in Box 31 of a CMS1500.

UB04 Field Requirement

| UB04 Field | Description | Requirement |
|-------------------|--|--------------------|
| 1 | Facility Name and address | Required |
| 3 | Patient Control number | Required |
| 5 | Federal Tax ID No. | Required |
| 8B | Patient's last name and first | Required |
| 10 | Patient's Date of Birth | Required |
| 11 | Patient's sex | Required |
| 42 | Valid Revenue Codes | Required |
| 44 | Valid HCPCS codes | Required |
| 45 | Service Dates in 8 digit format (mm/dd/ccyy) | Required |
| 46 | Service Units | Required |
| 47 | Total charges must balance | Required |
| 56 | NPI No. to rendering facility | Required |
| 58 | Insured's Name | Required |
| 66 | Valid Diagnosis Codes | Required |
| 69 | Valid Diagnosis Codes | Required |
| 74 | Valid Procedure Codes | Required |
| 76 | Attending Physicians NPI No. | Required |
| 77 | Operating Provider's NPI No. | Required |

CMS1500 Field Requirement

| CMS 1500 Field | Description | Requirement |
|---------------------------|--|--------------------|
| 1 | Member I.D. | Required |
| 2 | Patient's Last name, First name, and Middle Initial | Required |
| 3 | Patient's eight-digit birth date (MM DD CCYY) | Required |
| 3 | Patient's sex | Required |
| 17 | Referring Provider Name | Required |
| 17b | Referring Provider NPI No. | Required |
| 21 | Valid Diagnosis codes | Required |
| 24 | Service Date eight-digit (MM/DD/CCYY) | Required |
| 24b | Valid Place of service code(s) | Required |
| 24d | Valid Procedure code and modifiers if applicable | Required |
| 24e | Diagnosis Pointers must be on claims | Required |
| 24g | Number of day(s) or unit(s) | Required |
| 24g | Texas Health Steps indicator | Required |

CMS1500 Field Requirement

| CMS 1500 Field | Description | Requirement |
|---------------------------|--|--------------------|
| 24j | Rendering Provider NPI No. | Required |
| 25 | Federal Tax ID No. for Practice | Required |
| 28 | Total Charges must balance | Required |
| 30 | Total Charges must balance | Required |
| 31 | Provider Printed Name and Title (No Signature Stamp) | Required |
| 32 | Service Facility Name and Address | Required |
| 32a | Service Facility NPI No. | Required |
| 33 | Billing Provider Name and Address | Required |
| 33a | Billing Provider NPI No. | Required |

Multiple Claim Submission

- Paper clip or staple multiple claims.
- Number the pages when sending multiple claims for the same member same date of service (e.g., 1 of 2, 2 of 2).
- Don't total the billed amount on each claim form when submitting multi-page claims for the same member same date of service.
- Total should be on the last claims Box 28 & 30.

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 | | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 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. | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | |
| | | 17b. NPI | | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 19. RESERVED FOR LOCAL USE | | | | 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | |
| 1. _____ | | 3. _____ | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | | | | |
| 2. _____ | | 4. _____ | | | | | | |
| 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | |

CMS 1500

EL PASO FIRST healthplans, inc.

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 6/9/06

1. MEDICARE MEDICAID CHAMPION OTHER 19. INSURER'S ID NUMBER **Valid Member ID**

2. PATIENT'S NAME (Last, First, Middle Initial) 3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURANCE (Include Medicare, Medicaid, etc.) 9. PATIENT'S EMPLOYMENT (Current or Previous) 10. INSURED'S DATE OF BIRTH SEX 11. INSURED'S POLICY # GROUP OR PEOA NUMBER

12. EMPLOYER'S NAME OR SCHOOL NAME 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN **COB**

16. PATIENTS OR AUTHORIZED PERSONS SIGNATURE 17. DATE OF SERVICE 18. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE 20. OUTSIDE LAST CHARGE

21. ICD-9 CODE **Valid ICD-9** 22. MEDICARE REVISION/CHG CODE 23. PRIOR AUTHORIZATION **Authorization No. Only**

24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY 25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. PAYEE ASSIGNMENT 28. TOTAL CHARGE 29. BILLING FORWARD

25. SIGNATURE OF PHYSICIAN OR SUPPLIER 26. PRACTICE NAME OR FACILITY WHERE SERVICE ARE RENDERED 27. NAME AND ADDRESS WHERE PAYMENTS WILL BE MAILED

NUCC Instruction Manual available at: www.nucc.org APPROVED CMB-0938-0950 FORM CMS 1500 (06/05)

If Box 10 = Yes Or Pregnancy Date
Date Required

Referring Provider Name & NPI or Unique ID required

EPSDT Condition Indicator

Valid CPT Modifiers

DX Pointer

Practice TIN #

Provider Name

Practice Name or Facility Where service are rendered

Name and address where payments will be mailed.

EPSDT or Family Planning (Y or N)

Unique ID

NPI

If Box 11 d = Yes

Pay Amount Required

Attached EOB From Prime Ins Required

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

- Code Rules
- Unique ID -(TPI or CH) Numbers
- Indicators and Date of Onset
- NPI
- Unique ID

How to Submit a Corrected Claim



Corrected Claim Form



Corrected Claim Form

| | |
|----------------|-----------------|
| Provider Name: | Date: |
| Member Name | Member ID |
| Claim Number: | Date of Service |

Reason for Corrected Claim:
(Please check appropriate box)

Correct Member Demographic

Correct Billing Code (HCPC, CPT, Revenue Code or DRG)

Correct Billing Modifier

Correct Diagnosis Code (ICD9)

Correct Provider Billing Information

Recoupment Request (Claim billed in error) Please provide claim number: _____

Proof of timely filing (Please attach Remittance Advice or EDI Report)

Other Insurance Payment (Attach EOB)

Other (Use comments section to give detailed explanation)

Comments:

CLAIMS DENIALS

Can I send my corrected claim electronically?

Yes,

Only ZERO Paid Denied Claims may be sent electronically within 95 day timely filing.

No,

Claims with partial payments should be submitted on a paper with a copy of the Remittance Advice and a Corrected Claim Form.



Corrected and Attachments



- Place the claim form on top when sending new Claims, followed by any medical records or other attachments.
- Submit corrected claims with a *Corrected Claim Form* located on the El Paso First Website at www.epfirst.com
- Attachments to claims must be paper clipped or stapled.
- Ensure all Remittance Advice from Primary Carriers are attached and include the denial descriptions.

Deadlines and Penalties



Claims Filing Deadlines

- 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).
- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of the disposition by the other insurance carrier.
- It is strongly recommended providers who submit paper claims keep a copy of the documentation they send. It is also recommended paper claims be sent by certified mail with return receipt requested & a detailed listing of the claims enclosed.

Provider Notification

- Proof of Timely Filing Documents
- Returned Claims (W-9, Purple or Green Forms)
- Rejected Claims (Electronic Claim Rejection)
- Remittance Advice- (RA) from Primary Carrier or El Paso First

Additional Information Rejection Form



Thank you for participating with El Paso First Health Plans. We value your partnership with our organization and would like to assist you with the adjudication of your claims. However, the attached claim you have submitted is either missing required information or contains invalid values. In accordance with CMS & Texas Insurance regulations (under 21.2607 Effect of Filing Clean Claim) your claim is being returned as incomplete. Please review the item(s) on this form and resubmit the claim with the necessary information within 120 days of the date of this notice.

Additional Information Request for UE-04

| | | |
|----------------------|--------------------|---------------------|
| Receipt Date: | Return Date: | |
| Member ID # | Member DOB | |
| From Date of Service | To Date of Service | |
| Claims Reviewer ID: | Adjudicator ID: | Approval Signature: |

The claim(s) cannot be processed due to the following reason(s):

We are unable to identify eligibility with the information submitted. Please resubmit with a copy of the Participant's Card.

Newborn full name and plan identification number is required. Please contact our enrollment department for assistance.

Facility Name and/or Address does not match our records or is incomplete on the claim form.

The patient's control number is incomplete.

The Bill Type is inconsistent, invalid or incomplete with procedures.

Federal Tax No. does not match our records or is incomplete.

Covered Dates for Inpatient does not match our records or is incomplete.

Patient's Name does not match our records or is incomplete.

Patient's Address does not match our records or is incomplete.

Patient's Date of Birth does not match our records or is incomplete.

Patient's sex does not match our records or is incomplete.

Inpatient Admission Date does not match our records or is incomplete.

Admission Hour is invalid or incomplete.

Type of Admission is invalid or incomplete.

Inpatient Source of Admission is invalid or incomplete.

Discharge Hour is invalid or incomplete.

Discharge status is invalid or incomplete.

Condition Codes is invalid or incomplete.

Occurrence Codes are inconsistent, invalid or incomplete.

Occurrence Span codes and Dates are invalid or incomplete.

For any questions regarding this claim(s) please contact our Provider Care Unit (915) 532-3778. 1



Thank you for participating with El Paso First Health Plans. We value your partnership with our organization and would like to assist you with the adjudication of your claims. However, the attached claim you have submitted is either missing required information or contains invalid values. In accordance with CMS & Texas Insurance regulations (under 21.2607 Effect of Filing Clean Claim) your claim is being returned as incomplete. Please review the item(s) on this form and resubmit the claim with the necessary information within 120 days of the date of this notice.

Additional Information Request for Professional Claims

| | | |
|-----------------------|---------------------|---------------------|
| Receipt Date: | Return Date: | |
| Member ID#: | Member DOB: | |
| From Date of Service: | To Date of Service: | |
| Claims Reviewer ID: | Adjudicator ID: | Approval Signature: |

The claim(s) cannot be processed due to the following reason(s):

We are unable to identify eligibility with the information submitted. Please resubmit with a copy of the Participant's card.

Newborn full name and plan identification number is required. Please contact our enrollment department for assistance.

The member ID number does not match our records or is incomplete on the claim form.

The patient's last name, first name, and middle initial, does not match our records or is incomplete.

The patient's eight-digit birth date (MM | DD | CCYY) and sex does not match our records or is incomplete.

The insurance primary to El Paso First, either through the patient's parent or spouse, does not match our records.

The patient's mailing address and telephone number does not match our records or is incomplete.

The relation to patient does not match our records or is incomplete.

The insured's address and telephone number does not match our records or is incomplete.

The insured's name does not match our records or is incomplete.

The policy and/or group number of the insured does not match our records or is incomplete.

The insured's eight-digit birth date (MM | DD | CCYY) and sex does not match our records.

Leave blank if the Payer ID is entered in Item 9d.

The nine-digit Payer ID number of the insurer does not match our records or is incomplete.

The patient's condition related does not match our records or is incomplete.

The boxes must be completed. If there is no insurance primary to El Paso First, leave blank.

The insured's eight-digit birth date (MM | DD | CCYY) does not match our records or is incomplete.

The insured's employer's name does not match our records or is incomplete.

The nine-digit Payer ID number of the primary insured does not match our records or is incomplete.

The records show there is other insurance involved, please attach a corresponding explanation of benefits.

Proof of assignment of benefits is needed.

For any questions regarding this claim(s) please contact our Provider Care Unit (915) 532-3778. 1

Claim Notification Form



Claim Notification

Servicing Name: _____ Submission Date: _____

Member Name: _____ Member DOB: _____

Member ID Number: _____ Date of Service: _____

To whom it may concern,

Thank you for providing services to an El Paso First member. This notice is an acknowledgement of receipt for your claim. Your claim has been referred to our claim resolution team for further review. If our team should need further information you will be contacted in addition to this notice. Should you have any questions feel free to contact our claims department at (915) 532-3778, and speak with one of our claims resolutions team member.

We are in need of further information to process your claim. Please provide the following information within 30 days from submission date of this letter:

Your claim has been reviewed and it has been determined that the supporting documentation does not justify reimbursement from El Paso First. Please forward claims to the appropriate health plan. _____

We have reviewed your claim and payment has been approved. Your claim has been forwarded to our finance department for a check release. A check will be mailed separately from this letter. Should you not receive a check within (15) days from the date of this letter, please contact our office.

Thank You,

Sonia Lopez

Sonia Lopez
Claims Director

Delay in ICD-10

Delay by 1 year:

- ICD-10 compliance date for diagnosis coding (ICD-10-CM) and
- Inpatient hospital procedure coding (ICD-10-PCS) to October 1, 2014

Survey Questions

- ICD-10 – is one year enough?
- Will more than one year have cost impact?
- Will more than one year impact momentum?

Provider Care Unit

Contact us at 532-3778

When calling you will reach a Claims specialist who will:

- Give claim status calls.
- Resolve or answer claim questions.
- Answer Electronic claims submission rejections or questions.
- Assist with claims disputes.

Please note you have the right to appeal any disposition of a claim through a formal appeal. Written request must be mailed to:

El Paso First Health Plans, Inc
Attn: Complaints and Appeals Department
PO BOX 971370, El Paso, Texas 79997-1370

Within 120 days from the date of your Provider Remittance Advice.

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



Questions?

Thank you for
attending!

