

# EL PASO FIRST

*Health Plans, inc.*

Dear Provider:

El Paso First Health Plans, Inc. is excited to announce a new initiative designed to help better serve our members with high risk pregnancies, while concurrently facilitating the process of delivering care for our providers. Starting August 1<sup>st</sup>, 2011 prior authorization for ultrasounds performed on members who have been identified as being at high risk for complications of pregnancy will no longer be required.

Identification of a member requires the submission of the, "High Risk Pregnancy Notification," form to El Paso First via facsimile. Upon receipt of the notification form, the Prior Authorization Unit will enter an authorization into the health plans computer information management system, which will allow the subsequent claims for the ultrasounds to process for payment without any further administrative requirements from the provider.

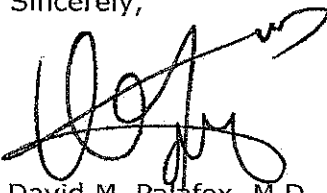
The limit of four ultrasounds for members who are not at high risk will remain in place. If additional ultrasounds are performed without prior submission of the high risk identification form or prior authorization for the fifth ultrasound, the claim will deny in accordance with current utilization management policies.

It is the intent of this revision in policy to identify members who are at high risk for complications related to pregnancy more efficiently, thus expediting their enrollment into El Paso First's High Risk Pregnancy Case Management Program, while at the same time facilitating the delivery of care by their providers.

A copy of the, "High Risk Pregnancy Notification Form," has been attached to this letter of notification. El Paso First has devoted a portion of our next quarterly Provider Orientation Program to review this process in greater detail. The Provider Orientation is scheduled on July 14<sup>th</sup>, 2011 at 8:30 a.m. If you have any questions regarding this initiative prior to our quarterly Provider Orientation Program, please contact your provider representative or the Health Services Department.

El Paso First appreciates the excellent care you provide for our members and is hopeful this process improvement will lead to the provision of timely care with less administrative requirements.

Sincerely,



David M. Palafox, M.D.  
Medical Director

# PRIOR AUTHORIZATION FORM HIGH RISK PREGNANCY



Please attach clinical documentation. Date: \_\_\_\_\_

To: **Edna Martinez** Fax: 915.298.7866  
OB Case Manager

From: \_\_\_\_\_ Fax: \_\_\_\_\_

Approved DOS: \_\_\_\_\_ No. of Pages: \_\_\_\_\_

Authorization No.: \_\_\_\_\_ (including cover sheet)

## Member Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_ Health Plan ID#: \_\_\_\_\_

Expected due date: \_\_\_\_\_ IC9-Codes: \_\_\_\_\_

Patient has been diagnosed with any of the following conditions:

- |   |  |
|---|--|
| <input type="checkbox"/> Pre-term delivery (<37 weeks/previous pregnancy)<br>Year and Gestation age of PTL: _____ | <input type="checkbox"/> GDM (Type I/II)<br>HgA1C: _____                                       |
| <input type="checkbox"/> Multiple Gestation   | <input type="checkbox"/> Hypertensive disorders of pregnancy<br>Recent B/P: _____              |
| <input type="checkbox"/> Obesity Complicating Pregnancy<br>BMI > 35 Weight _____                                  | <input type="checkbox"/> Birth defect detected<br>Specify: _____                               |
| <input type="checkbox"/> Young primigravida < 16  | <input type="checkbox"/> Advanced Maternal Age<br>Age 35 for singleton<br>Age 33 for multiples |
| <input type="checkbox"/> HX of Mental Disorders<br>Specify: _____<br>Medication: _____                            | <input type="checkbox"/> Late prenatal care (after 20 weeks)                                   |
| <input type="checkbox"/> Toxic Habits (Alcohol/Drug use)<br>Specify: _____  | <input type="checkbox"/> HIV/HSV/ Hepatitis  |
| <input type="checkbox"/> IUGR   | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Placenta previa (persistent in 3 <sup>rd</sup> trimester)                                |  |

## Information

Physician's Name: \_\_\_\_\_

Office contact person: \_\_\_\_\_

Phone No.: (       ) \_\_\_\_\_

***If you have any questions please contact the OB Case Management program  
at (915) 532-3778 extension 1500.***