Welcome Providers!

Quarterly Provider Orientation

August 22, 2013

EL PASO FIRST Health Plans inc.

DME / Ancillary & Behavioral Health Providers

Vianey Licon
Provider Relations Representative
915 532 3778 ext 1021
vlicon@epfirst.com

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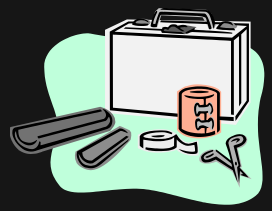
DME Supply List

- *In order to better assist our providers and members to obtain their particular DME needs, EP1st has implemented this check off list.*



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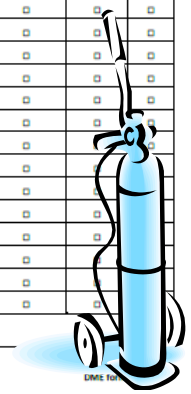
DME SUPPLIES FORM: *In order to better assist our providers and members to obtain their particular DME need please check off the DME items and services your agency is able to provide. If you have any questions please contact Provider Relations at 915-532-3778 press 4 and ext. 1507.*

Provider/Group Name:

DME Supplies	Services Provided	Hours of Operation	After Hours	House Calls	Deliveries	Pick Up	Mail Order
	☐	M-F 8am-5pm	Answering Msg	☐	☐	☐	☐
Apnea Monitors	☐			☐	☐	☐	☐
Bandages(wound care)	☐			☐	☐	☐	☐
Bathroom Equipment	☐			☐	☐	☐	☐
Breast Pumps	☐			☐	☐	☐	☐
Canes/Crutches	☐			☐	☐	☐	☐
CPAP/BiPAP Units/Supp	☐			☐	☐	☐	☐
Creams/Washes	☐			☐	☐	☐	☐
Decubitus Care	☐			☐	☐	☐	☐
Diabetic Supplies	☐			☐	☐	☐	☐
Enteral Supplies	☐			☐	☐	☐	☐
Hospital Beds	☐			☐	☐	☐	☐
Incontinence Supplies	☐			☐	☐	☐	☐
Mattress Replacement Sys	☐			☐	☐	☐	☐
Needles/Syringes	☐			☐	☐	☐	☐
Nutritional Supplements	☐			☐	☐	☐	☐
Orthopedic Footwear	☐			☐	☐	☐	☐
Orthotic Devices	☐			☐	☐	☐	☐
Ostomy Supplies	☐			☐	☐	☐	☐
Oxygen/Respiratory	☐			☐	☐	☐	☐
Spinal Stimulator	☐			☐	☐	☐	☐
TENS	☐			☐	☐	☐	☐
Traction/Trapeze	☐			☐	☐	☐	☐
Uterine Monitor	☐			☐	☐	☐	☐
Walkers	☐			☐	☐	☐	☐
Wheelchairs-Manual	☐			☐	☐	☐	☐
Wheelchairs-Power	☐			☐	☐	☐	☐
Wheelchairs-Rental	☐			☐	☐	☐	☐
Wheelchairs-Repairs	☐			☐	☐	☐	☐
Wheelchair Seating	☐			☐	☐	☐	☐
Urology Supplies	☐			☐	☐	☐	☐
Pharmacy	☐			☐	☐	☐	☐
Wound Vac Supplies	☐			☐	☐	☐	☐
Wound Care Supplies	☐			☐	☐	☐	☐
Other: Please indicate							



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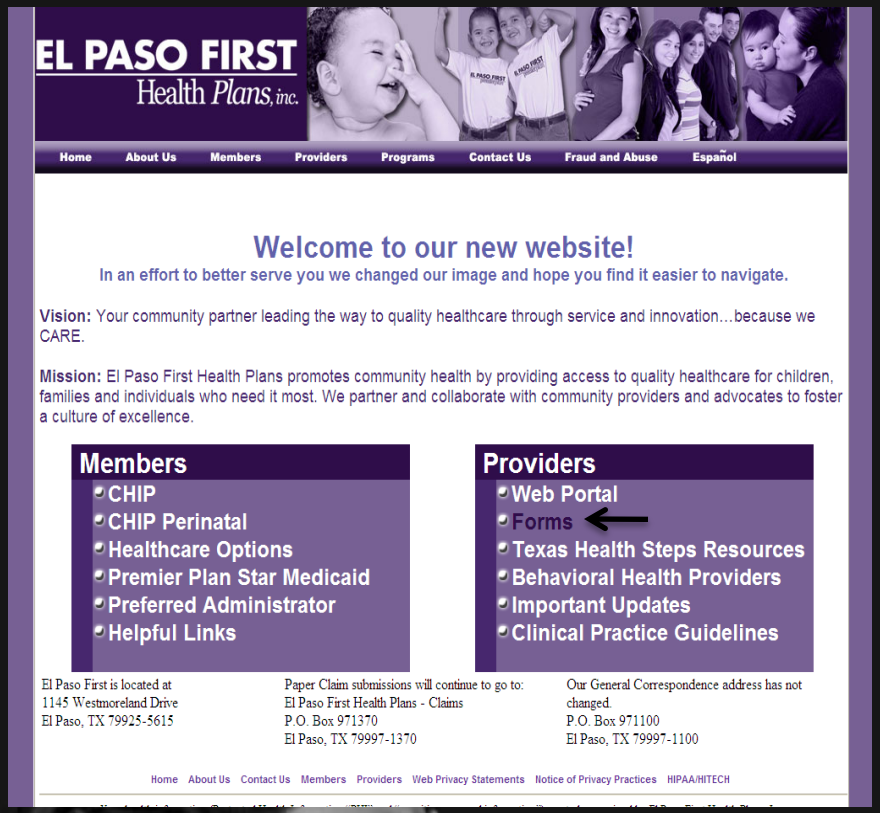
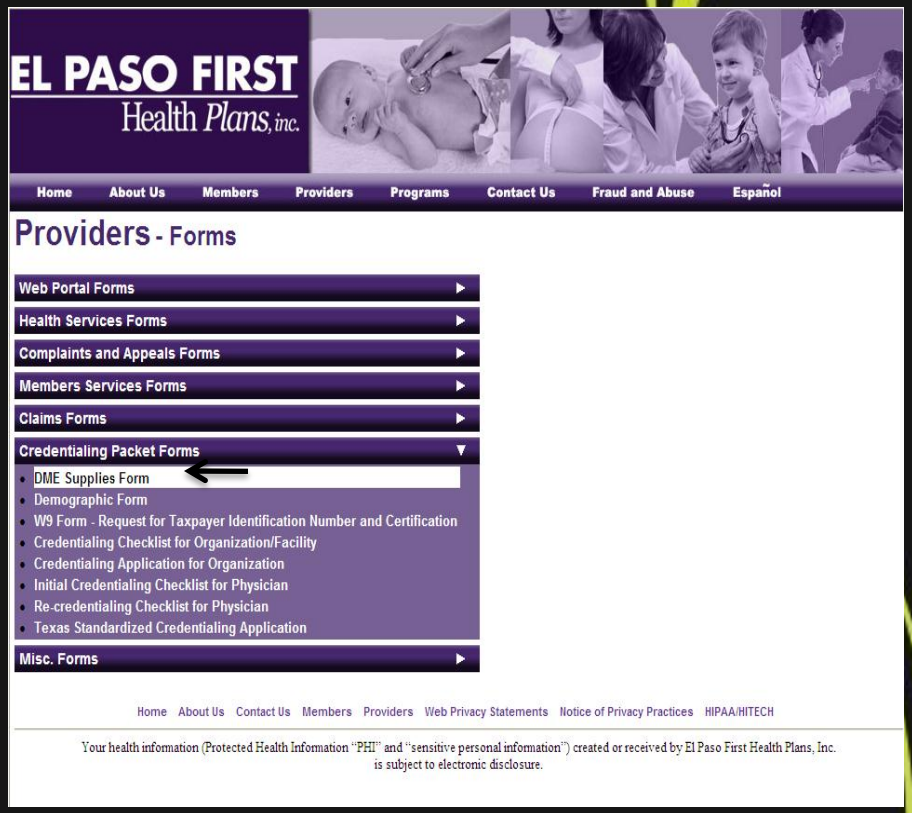
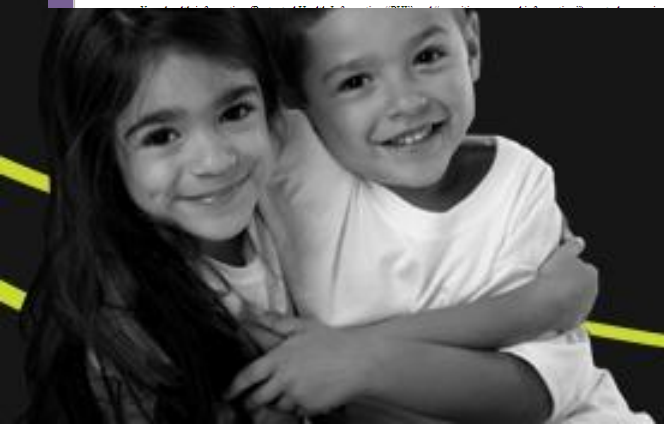
Go to our website www.epfirst.com







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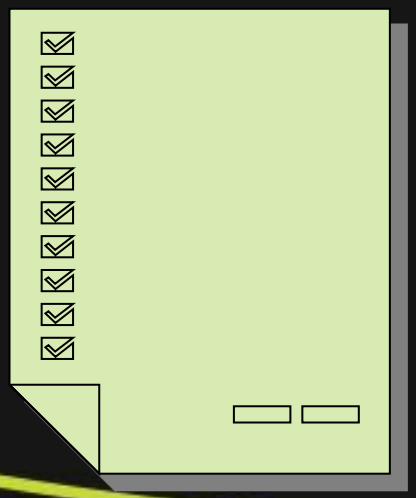
Feedback

- Topics
- What you want to know?
- Questions?



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Texas Health Steps

Maritza Lopez
Texas Health Steps Coordinator

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THSteps Laboratory Specimens

- All required laboratory testing for THSteps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:
  - Specimens collected for type 2 diabetes, hyperlipidemia, HIV, and syphilis screening
    - may be sent to the laboratory of a provider's choice or to the DSHS Laboratory in Austin if submission requirements can be met.
  - Blood lead testing by point-of-care screening.
- Laboratory specimens must be accompanied with the DSHS Laboratory Specimen Submission Form

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Lead Screening

- Blood lead testing must be performed during the 12- and 24-month checkups

- Environmental lead risks may be addressed during other visits using the Risk Assessment for Lead Exposure Questionnaire, Form Pb-110. Use of the form, which is available in the forms section of the DSHS website at www.dshs.state.tx.us/thsteps/forms.shtm

- The initial lead testing may be performed using a venous or capillary specimen
    - Specimens must either be sent to the DSHS lab or the test must be performed in the provider's office using point-of-care testing.

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Lead Screening

- Providers who perform point of care lead testing must be (CLIA)-certified. Procedure code 83655 is a CLIA-waived test and must be submitted with modifier QW.

- 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*, or by calling 1-800-588-1248.

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Tuberculosis(TST) Screening

- The TB risk screening tool must be administered annually to all clients who are 12 months of age and older.
  - The TB risk screening tool is available in the forms section of the DSHS website at www.dshs.state.tx.us/thsteps/forms.shtm.
  - Providers must administer a TB skin test if the screening tool indicates that there is a risk for possible exposure
  - Providers must obtain their own supply of purified protein derivative (PPD).
  - A TB skin test (procedure code 86580) may now be submitted for reimbursement when it is performed as part of a Texas Health Steps medical checkup visit.

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Hemoglobin Screening

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

- The newborn screening should be obtained up to 12 months of age if not previously obtained, the results are not available, or in special circumstances, such as adoption, if there is no record of previous test results.
    - The specimen may be sent to the DSHS laboratory (using the form G1B) or the client may be sent to a laboratory of the Provider's choice.

- Providers must use their acute care provider number when ordering a medically necessary hemoglobin electrophoresis test.

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CHIP Well Child Visits

- Well Child visits must be performed once per calendar year.
- No co-pay.
- Laboratory testing must be sent to laboratory of provider's choice not DSHS.
- Well child visits do not require:
  - Oral Evaluation and Fluoride Varnish Application
- Providers can conduct Developmental/ MCHAT Screenings but are not required to do as often as Medicaid.

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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.

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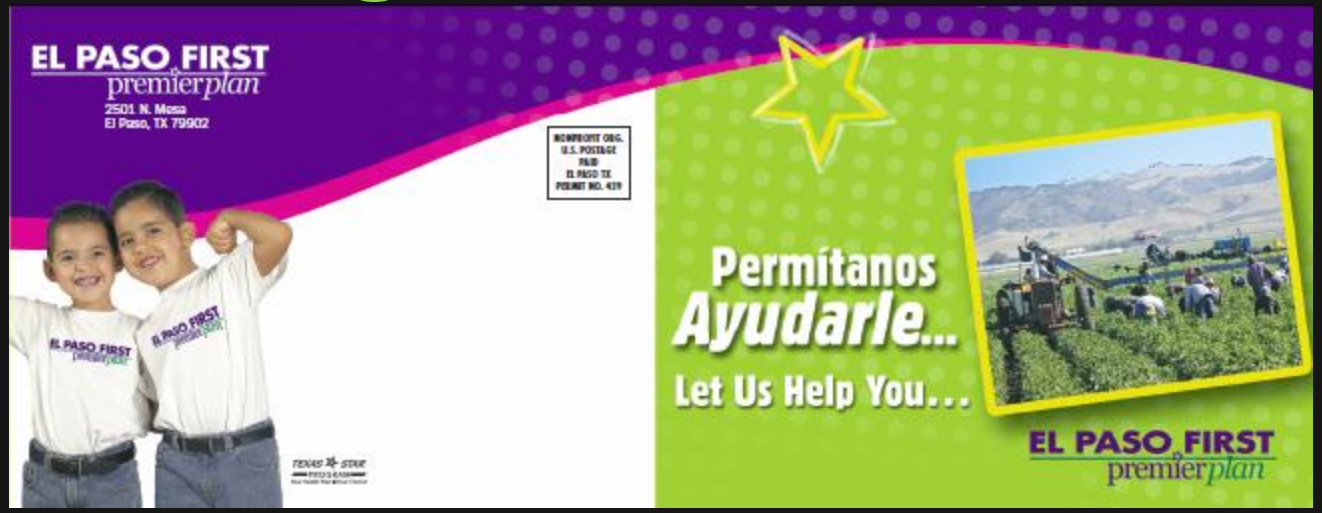
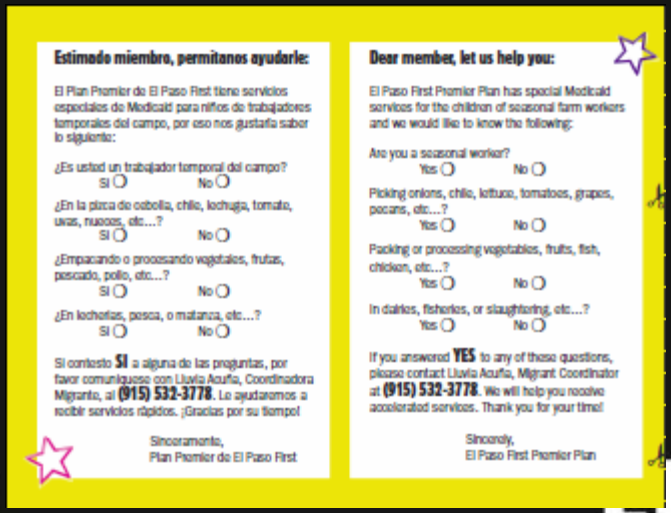
Migrant Postcard





Estimado miembro, permítanos ayudarle:

El Plan Premier de El Paso First tiene servicios especiales de Medicaid para niños de trabajadores temporales del campo, por eso nos gustaría saber lo siguiente:

¿Es usted un trabajador temporal del campo?
Sí ○ No ○

¿En la pisca de cebolla, chile, lechuga, tomate, uvas, nueces, etc...?
Sí ○ No ○

¿Empacando o procesando vegetales, frutas, pescado, pollo, etc...?
Sí ○ No ○

¿En lecherías, pesca, o matanza, etc...?
Sí ○ No ○

Si contesto **SI** a alguna de las preguntas, por favor comuníquese con Lluvia Acuña, Coordinadora Migrante, al **(915) 532-3778**. Le ayudaremos a recibir servicios rápidos. ¡Gracias por su tiempo!

Sinceramente,
Plan Premier de El Paso First

Dear member, let us help you:

El Paso First Premier Plan has special Medicaid services for the children of seasonal farm workers and we would like to know the following:

Are you a seasonal worker?
Yes ○ No ○

Picking onions, chile, lettuce, tomatoes, grapes, pecans, etc...?
Yes ○ No ○

Packing or processing vegetables, fruits, fish, chicken, etc...?
Yes ○ No ○

In dairies, fisheries, or slaughtering, etc...?
Yes ○ No ○

If you answered **YES** to any of these questions, please contact Lluvia Acuña, Migrant Coordinator at **(915) 532-3778**. We will help you receive accelerated services. Thank you for your time!

Sincerely,
El Paso First Premier Plan

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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

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Health Services Department

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Pre-Authorization

- Prior authorization flyer identifies authorization requirements
- Submit required documentation
  - (i.e. Title XIX forms, TP1, TP2 forms, CCP form)
- Submit supporting clinical information
  - (i.e. evaluation, plan of care)

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Prior Authorization Flyers

El Paso First Provider Forms

- STAR and CHIP
- TPA
- HCO

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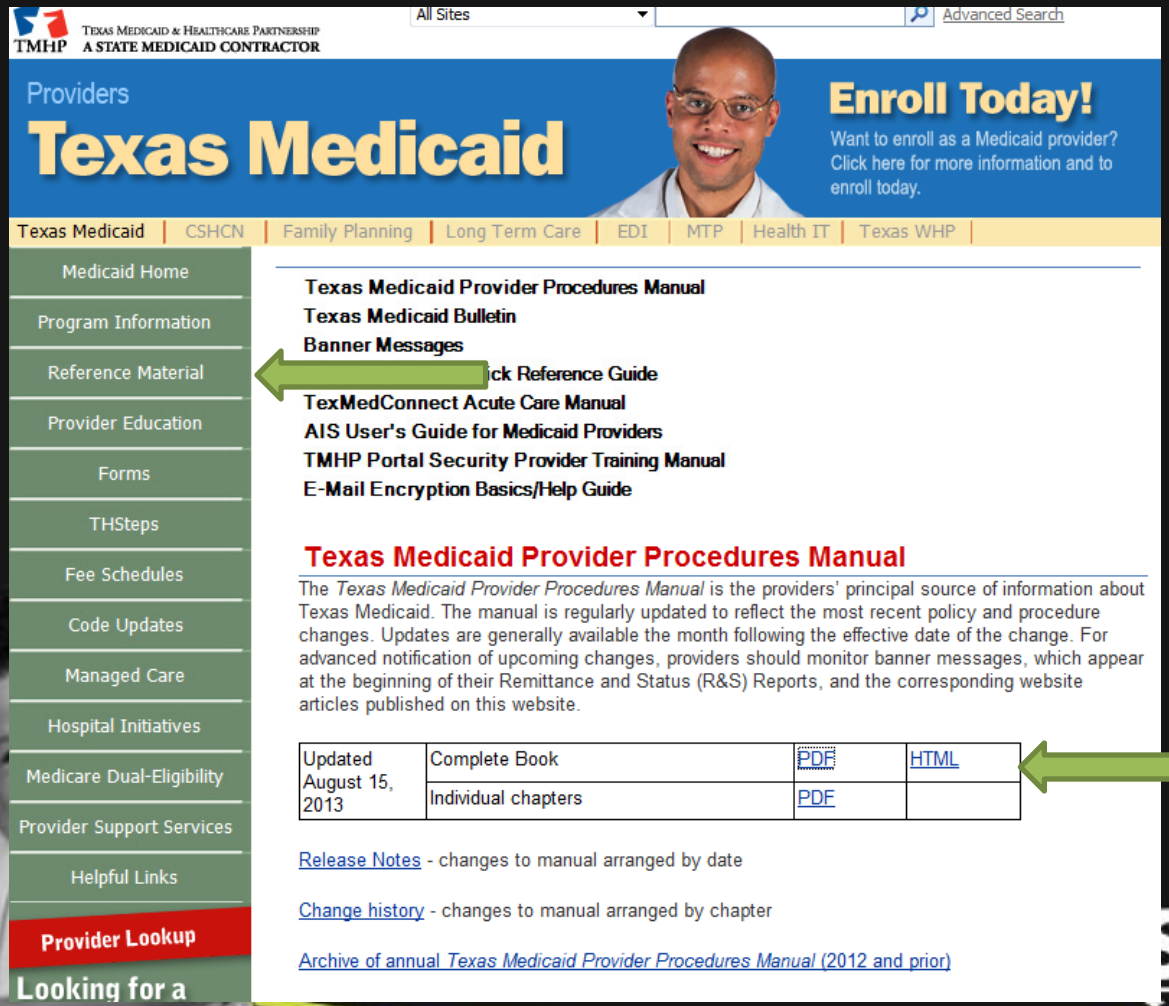
TP-1, TP-2, Title XIX, CCP Form

Welcome to TMHP



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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

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Amendments

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

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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:
  - 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.

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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

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Health Services Contact Information

- **Janel Lujan, LMSW**
  Senior Director of Operations
  – Extension 1090

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

- **Jose Acosta, RN**
  UR Coordinator
  - Extension 1080

- **Irma Vasquez**
  Administrative Supervisor
  – Extension 1042

- **Mabel Toscano, RN**
  Prior Authorization Coordinator
  – Extension 1212

- **Crystal Moran, MPH**
  Disease Management Coordinator
  - Extension 1175

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ACCESSIBILITY AND AVAILABILITY

Quality Improvement Department

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Background

- In accordance with the Texas Health and Human Services Commission and the Texas Department of Insurance mandates, El Paso First Health Plans, Inc. is required to monitor its Primary Care Providers on an annual basis for office accessibility compliance and 24-hour availability.

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Definitions

- **Office Accessibility** –members must be able to schedule an appointment for covered services within the time frames mandated by TDI and HHSC.
- **After-hours Availability** - PCP and Behavioral Health Providers must be available 24/7 as mandated by TDI and HHSC.

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Office Accessibility Standards for Emergency and Urgent Care

- Emergency Services must be provided upon member presentation at the service delivery site.
- Urgent Care, including specialty urgent care, must be provided within 24 hours of request.

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Office Accessibility Standards for Routine Care & Behavioral Health

- Routine Primary Care must be provided within 14 days of request.
- Routine Specialty Care referrals must be provided within 30 days of request.
- Initial Outpatient Behavioral Health visits must be provided within 14 days of request.

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Office Accessibility Standards for Prenatal Care

- Prenatal Care must be provided within 14 days of request.
- Prenatal Care for High-Risk Pregnancies and New Members in the 3rd Trimester must be offered within 5 days or immediately if an emergency exists.

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Office Accessibility for Preventive Health

- Preventive Health Services for Adults must be provided within 90 days of request.
- Preventive Health Services for Children:
  - For members under age 20 as soon as practicable.
  - For newborn members, no later than 14 days
  - For all other eligible members no later than 90 days.

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Office Appointment Accessibility Form

- Visits from Provider Relations Reps for completion of the Office Appointment Accessibility Form:
  - Accepting new patients
  - Appointment wait times for patients
  - Average number of patients seen at your office on daily basis
  - Office accessibility, days and hours office open
  - Disability, language and diverse background accommodations
  - After hours availability: physician's direct contact #, nurse triage or answering service

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Office Accessibility Wait Time

- TDI and HHSC have also established that a member wait at the office should not be longer than 15 minutes to be taken to the exam room.

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After-Hours Availability

- The QI Department monitors PCP after-hours availability on an annual basis.
- After-hours are 05:00 pm to -08:30 am, Monday through Friday and all day Saturday and Sunday.
- The QI Nurse Auditor, following a script, conducts the after hour calls. Calls are identified as "annual after-hour survey calls".
- Depending on the recording and call-back time, calls are classified either compliant or non-compliant.

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Compliant After-Hour Calls

- Answering services meets the language requirement of the major population groups and must be able to contact the Provider or other designated medical practitioner.
- Recording must also meet the language requirements and directs member to call another phone number to reach the Provider or other designated medical practitioner. Other phone number must be answered by someone at the time of the call.
- Call is transferred to an on-call person and also meets the language requirements. Person on-call must be able to reach the Provider or other designated medical practitioner to return call to member.
- Once the Provider or other designated medical practitioner is paged, the call **must** be returned within 30 minutes.

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Non-Compliant After-Hour Calls

- Office telephone is answered only during office hours.
- Office telephone is answered by a recording instructing the member to leave a message.
- Office telephone is answered by a recording that tells the member to go to the Emergency Room for services needed.
- Office telephone is answered by a recording advising the member that a fee will be charged for any after-hour calls returned by the provider.
- Returning after-hour calls past 30 minutes.

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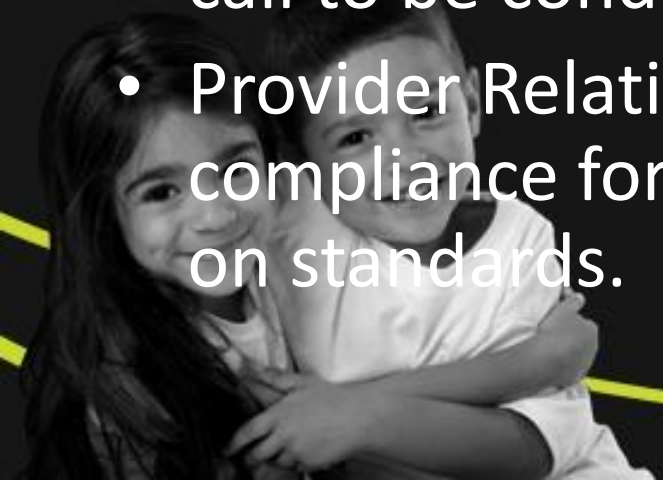
Handling of Non-Compliant After-Hour Survey Calls

- Provider notified of non-compliance with the after-hours availability standards via Certified letter.
- Copy of the Accessibility and Availability Standards enclosed with letter.
- Notification of after-hours availability re-survey call to be conducted within next few months.
- Provider Relations Department notified of non-compliance for purpose of additional education on standards.



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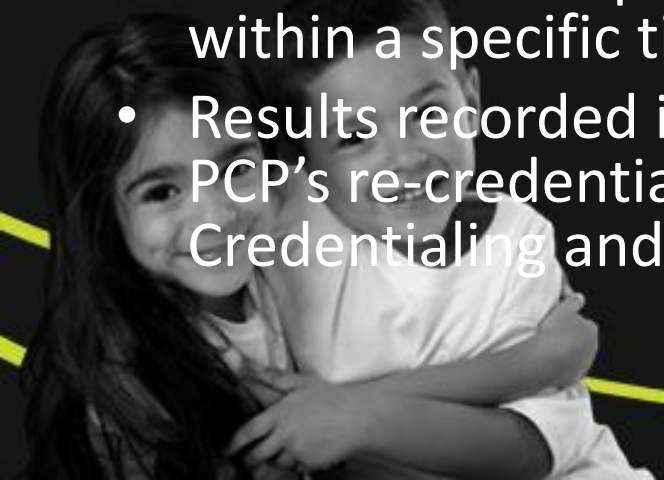
2nd Non-Compliant Survey Call

- Results reviewed by the Medical Director and the Quality Improvement Committee.
- The QIC may recommend appropriate measure be taken to address and correct the issues.
- The QIC reviews and approves sub-committee recommendations
- Corrective action plans may take place immediately to amend shortcomings and may include the following measures: new policies, additional education, resurveying within a specific timeframe.
- Results recorded in the physician profile sheets during the PCP's re-credentialing file to be reviewed by the Credentialing and Peer Review Committee.



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Tips for Preventing Non-Compliant Availability Telephone Surveys

- Update your business and after-hour telephone numbers with El Paso First. The telephone number we have on record is the one we call and is given out to members.
- If using an answering service, provide the answering service with the correct contact information – telephone number and/or name of the provider that is on-call.
- Switching the telephone to the after-hours recording.

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Acknowledgements

- El Paso First recognizes that the Provider's time is extremely valuable and cooperation in this State mandate is greatly appreciated.
- Your partnership is paramount in the success of our Quality Improvement initiatives and requirements mandated by TDI and HHSC.
- El Paso First thanks you for your commitment in improving the quality of service offered to the community.

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Contact Information

- Should you have any questions regarding Accessibility and Availability, please contact:

Don Gillis - Quality Improvement Director at ext 1231

or

Quality Improvement Department at 532-3778 ext 1106 or 1159

or

Your designated Provider Relations Representative at 532-3778 ext. 1507

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Claims

Sonia Lopez, BS, CPC
Director of Claims

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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.

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Top 6 Denials

1. Diagnosis Pointer Required on service Line for Diagnosis Codes
2. Prior authorization dates do not match claim
3. No COB Information received with a Secondary Enrollment
4. Submission Window Exceeded for Claim
5. No enrollment exists for claim start date
6. Invalid NPI number for provider

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Top 4 EDI Clearinghouse Rejections

1. Rendering Provider Taxonomy Code missing or invalid.
2. National Provider ID (NPI) is required for this payer.
3. Invalid Diagnosis code
4. Composite Diagnosis Code Pointer should not be used.

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Important Claim Submission Elements

Billing Pay–Federal Tax Information LOOP 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
25	Provider SSN# or EIN#	2010AA , REF, 02 (REF01=EI or SY)

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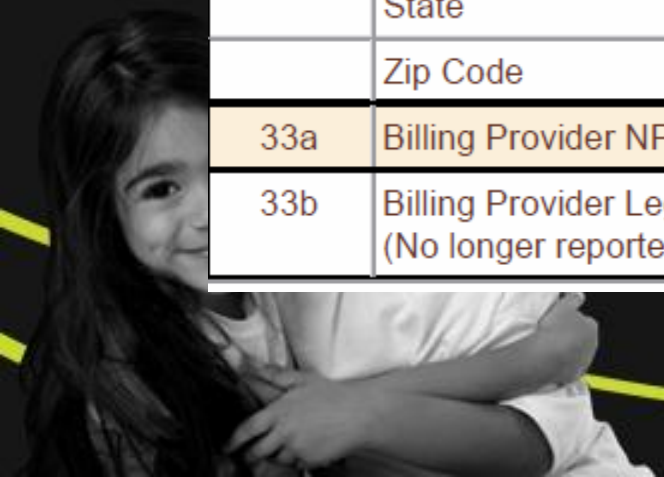
Bill Pay Information
LOOP 2010AA

Submit Group NPI Only in Loop 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
33	Organization Name	2010AA, NM1/85, 03
	Provider's Last Name	2010AA, NM1/85, 03
	Provider's First Name	2010AA, NM1/85, 04
	Address	2010AA, N3, 01
	City	2010AA, N4, 01
	State	2010AA, N4, 02
	Zip Code	2010AA, N4, 03
33a	Billing Provider NPI	2010AA/NM1/85/09 (08 = XX)
33b	Billing Provider Legacy Number or PIN (No longer reported.)	No longer used, effective 5/23/08



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Rendering Provider LOOP 2310B

Submit Rendering's INDIVIDUAL NPI Only in

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
31	Provider Signature Indicator	2300, CLM, 06
24j	Rendering Provider Legacy Number (shaded area) (No longer reported.)	Not used
	NPI of rendering provider (unshaded area)	2310B or 2420A, NM1/82, 09 (08=XX)

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Referring Provider –Information LOOP 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
17	Onset of current illness or injury	2300 or 2400, DTP/431, 03
	Referring Provider Last Name	2310A or 2420F, NM1/DN, 03
	Referring Provider First Name	2310A or 2420F, NM1/DN, 04
	Ordering Provider Last Name	2420E, NM1/DK, 03
	Ordering Provider First Name	2420E, NM1/DK, 04
17a	Ordering Provider Secondary Identifier, no longer reported	Not Used
	Referring Provider Secondary Identifier, no longer reported	Not Used
17b	Ordering Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2420E, NM1/DK, 09
	Referring Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2310A or 2420F, NM1/DN, 09

Diagnosis Indicators

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
24e	Diagnosis Pointer	2400, SV1, 07-1
21	Diagnosis 1	2300, HI, 01-2

REMEMBER!

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 794 02
2. 413 1
3. 850 0
4. E8844

E. DIAGNOSIS POINTER: 1

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Verification of Authorization

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

EXAMPLE: 0000123456

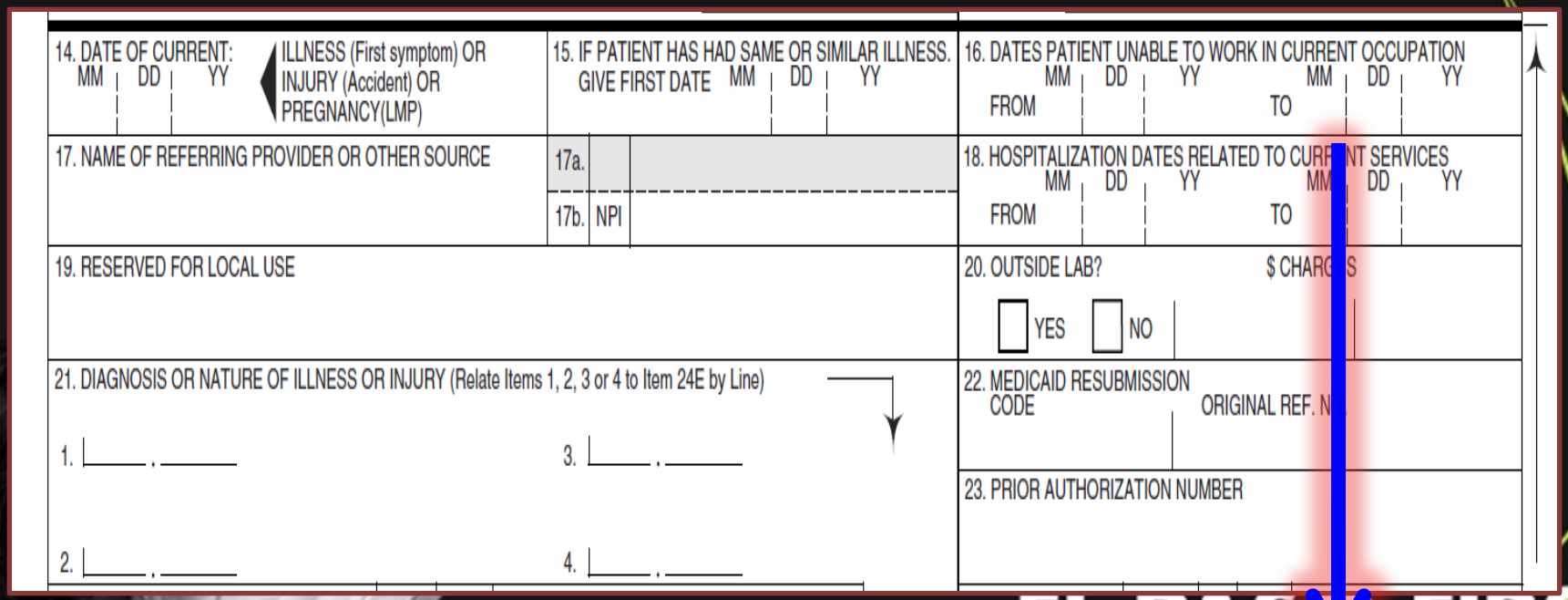
****

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.



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 MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

EL PASO FIRST Health Plans inc.

Timely Filing

- 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.

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Provider Notification for Additional Information

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

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Proof of Timely Filing

Note: Office notes indicating claims were submitted on time or system screen prints of claim submissions are not considered proof of timely filing.

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Proof of Timely Filing

Submit a copy of an Electronic Claims Report that includes the following information:

- ✓ Batch submission ID and date
- ✓ Individual claim that is being appealed
- ✓ EL Paso First -assigned batch ID number

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Availity Customer ID: 0009999

Availity Electronic Batch Report

Date Received:	2007-04-04	Time Received:	16.17.07.475
Availity Batch ID:	2007121406081000	File Control Number:	000002303

Payer:	BCBSF	Payer ID:	00590
Received Claims:	4	Charges:	3,692.00
Accepted Claims:	2	Charges:	168.00
Rejected Claims:	2	Charges:	3,524.00

Patient Name:	DOE, NIDAL		
From Date:	20061231	To Date:	20061231
Patient Control Number:	0234600999	Charge:	3024.00
Provider Billing ID:	73-3559599	Clearinghouse Trace #:	456123
Payer Claim #:	123456789012345	Availity Trace #:	012345678912345

Error Initiator: HIPAA Message Type: R Error Code: NA

Error Message: Value of element NM109 is incorrect. Expected value is National Provider ID (format is '10 digits with optional '80840' prefix and last check digit') when NM108 = 'XX'. Segment NM1 is defined in the guideline at position 250. Invalid data: 1234567890

Loop: 2010AA Segment ID: NM1 Element #: 09

Patient Name:	DOE, JANE		
From Date:	20061231	To Date:	20061231
Patient Control Number:	0234600988	Charge:	500.00
Provider Billing ID:	73-3559599	Clearinghouse Trace #:	123456789
Payer Claim #:	123456789012345	Availity Trace #:	012345678912345

Error Initiator: BCBSF Message Type: I Error Code: NA

Error Message: Prov. ID reported from Payer is 0000123ABC

Loop: NA Segment ID: NA Element #: NA

Error Initiator: BCBSF Message Type: W Error Code: NA

Error Message: Paid amt does not match service line amt

Loop: NA Segment ID: SVD Element #: 02

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Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

File Roll-Up Section displays header and detail areas of a claim record. Patient and Payer information is displayed.

Page Footer Section displays report # and page number(s) of the report.

```
                    Emdeon Business Services Division
                   XXXXXXXX Claims Distribution System

                       File Detail Summary Report
                            FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
Emdeon Ref: 5634                                   Run Date: MM/DD/YY
Report #: RPT-04A
Acct  ID: 123

File Control #: P23456
Submitter ID: 123456789
Submitter Name: Vendor Systems

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

                              DISCLAIMER

ACCEPTED CLAIMS HAVE BEEN FORWARDED TO THE PAYER BY EMDEON BUSINESS SERVICES
DIVISION. ADDITIONAL CLAIM STATUS REPORTS MAY FOLLOW IF AVAILABLE FROM THE
PAYER. THIS IS NOT A GUARANTEE OF PAYMENT.

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

Customer ID/Sub: 987654321 abcd            NPI: 1234567890
Customer Name: Prov/Group Name

                               FILE ROLL-UP

Patient Name                Patient         Date of   Total   Payer Name/ID Status
                           Control #        Service   Charges

Childs M J           39145278912547856364 012700    176.95 Payer One    12345 AE
Gagnon J             39143268973247658365 012800   1176.00 Payer Two    60054 RE
Osborn J             39145278955467289367 012500    276.00 Payer Three  SMTX0 TE
Osborn J             39145278963098426368 012700    176.00 Payer One    12345 AP

Customer ID/Sub: 987654321 efgh            NPI: 1234567890
Customer Name: Prov/Group Name

                               FILE ROLL-UP

Patient Name                Patient         Date of   Total   Payer Name/ID Status
                           Control #        Service   Charges

Bolders M J          39145278961234531363 012700    176.00 Payer One    12345 AE
Garrett J            39143268971234504366 012800   1176.00 Payer Two    60054 RE
Osborn J             39145278951234507369 012500    276.00 Payer Three  SMTX0 TE
Sims   J             39145278961234508362 012700    176.95 Payer One    12345 AP

RPT-04A                                                          Page 1
```

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Claim Resubmission

Can I send my corrected claim electronically?

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

No,
Claims with partial payments should be submitted on paper with a copy of the Remittance Advice and a Corrected Claim Form.

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Corrected Claim Form

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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:

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Revised CMS 1500 Paper Claim Form: Version 02/12

The National Uniform Claim Committee (NUCC), an industry organization in which CMS participates, maintains the CMS 1500 claim form and periodically revises it according to industry needs. The NUCC recently revised this form (version 02/12). The NUCC changed the form to adequately accommodate and implement ICD-10-CM diagnosis codes, although the form does include other changes as well.

- More information is available on the NUCC website. http://www.nucc.org/

- On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised CMS 1500 claim form, version 02/12, OMB control number, 0938-1197. The CMS 1500 claim form is the required format for submitting claims to Medicare on paper.

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Features of the Revised From

The revised form, among other changes, notably adds the following functionality:

- **Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.**
- **Expansion of the number of possible diagnosis codes to 12.**
- **Qualifiers to identify the following provider roles (on item 17):**
  - **Ordering**
  - **Referring**
  - **Supervising**

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Tentative Timelines

- **• January 6, 2014:** Medicare begins receiving and processing paper claims submitted on the revised CMS 1500 claim form (version 02/12).

- **• January 6 through March 31, 2014**: Dual use period during which Medicare continues to receive and process paper claims submitted on the old CMS 1500 claim form (version 08/05).

- **April 1, 2014: ONLY Revised CMS 1500 claim form (version** 02/12).

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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

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Questions?

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Member Services

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Medicaid - Value Added Services

- Help getting a ride to doctor visits or health classes for Members who need a ride
- Extra dental services up to $295 (initial checkup, x-rays, and a routine cleaning) for Members age 21 and older
- Up to $125 above the Medicaid benefit for contact lenses, lenses, and frames
- Welcome Packet: A $15 value of over-the-counter items if the request form is completed and mailed back within 30 days of enrollment
- One free cell phone per household and free calls or texts from El Paso First for related health activities.
- 1 free car seat per pregnancy for pregnant Members who complete a pregnancy class
- $10 gift card for health related items for pregnant Members completing one pregnancy visit within 30 days of enrollment and going to one pregnancy class

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Medicaid - Value Added Services

- Home visits to high risk pregnant Members
- 4 extra food counseling services, above the Medicaid benefit, for Members age 20 and younger
- Up to $25 for any sport registration activity fee, once every 12 months
- $15 gift card for health items for Members age 20 and younger completing a timely Texas Health Steps visit
- Gifts of a digital thermometer, a pedometer (per family per year), an emergency aid booklet (per family per year) and a school supply kit for new Members if requested within 30 days of receiving welcome packet
- $15 gift card for health items for postpartum Members completing one postpartum visit within 21-56 days after delivery

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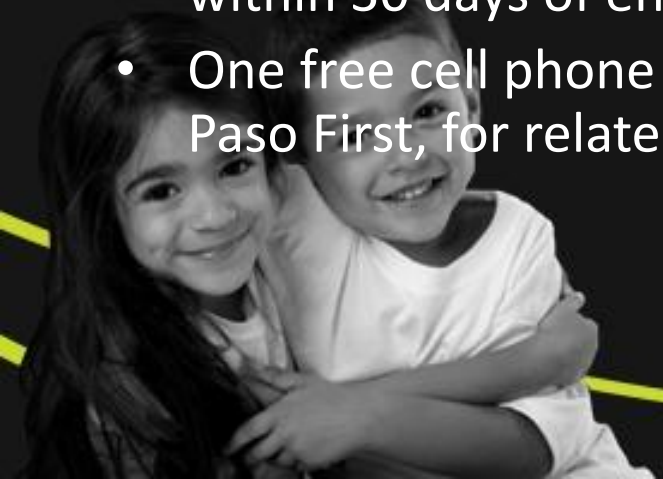
CHIP - Value Added Services

- Help getting a ride to doctor visits or health classes for CHIP and CHIP Perinate Members
- Extra dental services up to $295 above the CHIP benefit (initial checkup, x-rays, and cleaning) for CHIP Members
- 25% off lenses and frames above the CHIP benefit for CHIP Members
- 20% off certain contact lenses above the CHIP benefit for CHIP Members
- Welcome Packet: A $15 value of over-the-counter items for new CHIP Members if the request form is completed and mailed back within 30 days of enrollment
- One free cell phone per household and free calls or texts from El Paso First, for related health activities.



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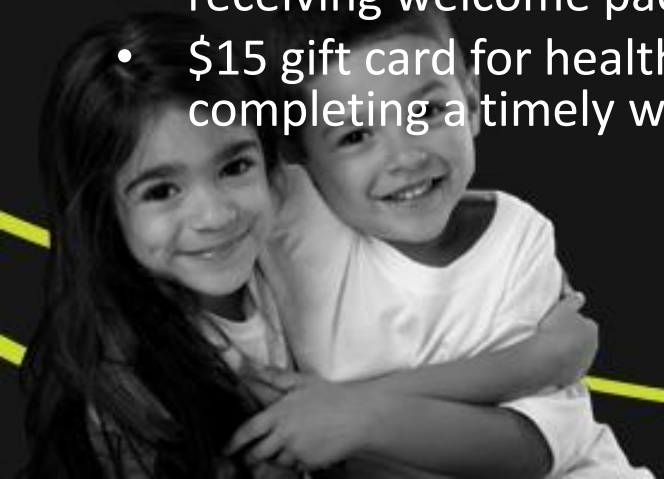
Health Plans inc.

CHIP - Value Added Services

- Free car seat for pregnant Members who complete a pregnancy class
- $15 over-the-counter prenatal vitamins packet for new CHIP Perinatal Members if request form is completed and mailed back within 30 days of enrollment
- Home visits to new high risk pregnant Members
- 4 extra food counseling services, above the CHIP benefit, for CHIP Members age 18 and younger
- Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members
- Gifts of a digital thermometer, a pedometer (per family per year), an emergency aid booklet (per family per year) and a school supply kit for new CHIP and CHIP Perinatal Members if requested within 30 days of receiving welcome packet
- $15 gift card for health items for Members age 3 to 6 and 12 to 19 completing a timely well-child checkup



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CHIP-to-TIERS

- HHSC is in the early stages of a transition that will bring the processing of CHIP applications into the state's TIERS eligibility system. The transition is targeted for Oct. 1, 2013
- The CHIP-to-TIERS transition should not disrupt the processing of children's health insurance applications.
- Effective October 1, 2013, the all CHIP ID numbers will be changing from an alpha numeric format (i.e. A123456789) to a numeric format (i.e. 123456789). El Paso First Health Plans will be issuing new ID cards to all its CHIP members at the end of September 2013.

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CHIP-to-TIERS Rosters

PEDIATRICS R US

EL SO, TX 902

ALL LOCATIONS

El Paso First Health Plans, Inc.
CHIP to TIERS Crosswalk
October 2013

NEW CHIP Member#	Legacy CHIP Member#	Member Name	DOB	Phone	Address	Effective	Well Child Visit	PCPName
New Members								
50000001	M1234567	MICKEY MOUSE	6/21/02	915-555-5550	100 CARS DR EL PASO, TX 79936	10/01/13	DUE	DONALD DUCK, MD
60000002	J1234567	MINNIE MOUSE	4/6/09	915-555-5501	200 CASTLE DR EL PASO, TX 79932	07/01/13	DUE	DONALD DUCK, MD
Member Count		2						
Existing Members								
60000003	D1234567	DAISY DUCK	6/30/95	915-555-5502	1234 DISNEY AVE EL PASO, TX 79936	02/01/13	COMPLETE	DONALD DUCK, MD
Member Count		1						
Total Member Count		3						

This report contains confidential information and is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. The information is proprietary and must not be sold, transferred or otherwise disclosed without the expressed consent from El Paso First Health Plans, Inc.

Authorized users are allowed access to this information for the sole purpose of conducting business with El Paso First Health Plans, Inc. It will be your responsibility to ensure that controls are in place to protect the information from unauthorized access and/or disclosure. When you are finished with the information the report must be destroyed using a method that ensures complete destruction of all confidential information.

Preferred Administrators

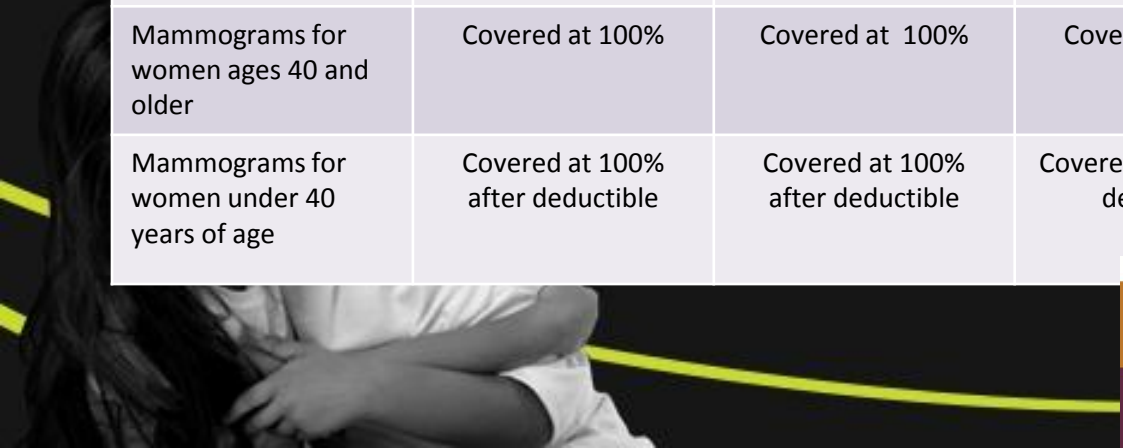
Updates on Benefits for Fiscal Year

October 1, 2012 – September 30, 2013

Preferred
ADMINISTRATORS

UMC and EPCH Benefits

Benefit Description	UMC/EPCH	Texas Tech	PPO	Out-of-Network
UMC/Medical Office Visits	$15.00 Co-pay	$25.00 Co-pay	$35.00 Co-pay	60% after deductible
EPCH/Medical Office Visits	$10.00 Co-pay	$20.00 Co-pay	$30.00 Co-pay	60% after deductible
Diagnostic X-Ray, Pathology	100% after deductible	100% after deductible	75% after deductible	60% after deductible
HPV for Female and Males (Ages 9 up to 26)	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered
Pregnancy for Covered Associates and Dependents	Covered under Global Maternity	Covered under Global Maternity	Covered under Global Maternity	Covered under Global Maternity
Annual Well Women's Exam. One per Fiscal Year	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered
Mammograms for women ages 40 and older	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered
Mammograms for women under 40 years of age	Covered at 100% after deductible	Covered at 100% after deductible	Covered at 75% after deductible	60% after deductible



Preferred ADMINISTRATORS

UMC/EPCH Deductibles and MOP

Deductible per Fiscal Year	UMC /Texas Tech/EPCH	PPO Providers	Out –of-Network
Per Covered Participant	$100.00	$1,000	$1,500
Max Family Deductible	$300.00	$3,000	$4,500

Out-of-Pocket Max Per Fiscal Year	UMC /Texas Tech/EPCH	PPO Providers	Out –of-Network
Per Covered Participant	N/A	$3,600	$Unlimited
Max Family Deductible	N/A	$10,800	$Unlimited
Annual Maximum Per Covered Participant $2,000,000			

Preferred ADMINISTRATORS

Difference between benefits for UMC and EPCH

University Medical Center of El Paso (UMC)

- Office Co-Pays $15/25/35
- Inpatient Co-Pays $250/750
- Does not have Domestic Partners
- Behavioral Max 30 Visits and Lifetime Max $25,000
- Does not combine max benefit for Occupational, Physical, and Speech Therapy

El Paso Children's Hospital (EPCH)

- Office Co-Pays $10/20/30
- Inpatient Co-Pays $150/200
- Covers Domestic Partners
- No Behavioral Max
- Max Combination Benefit for Occupational, Physical, and Speech Therapy of 30 visits per Fiscal Year

Preferred ADMINISTRATORS

Prior Authorization Flyer

FORM REVISION DATE: 11/06/12 EFFECTIVE DATE: 12/01/2012

Preferred ADMINISTRATORS

OUTPATIENT FAX NUMBER: 915-298-7866

PROCEDURES & SERVICES REQUIRING PREAUTHORIZATION/NOTIFICATION

INPATIENT FAX NUMBER: 915-298-5278

All Pre-certification Requests must be individually FAXED

Pre-authorization is based on information provided to Preferred Administrators at the time of request, and does not guarantee payment of benefits nor verify eligibility. Payment for services is subject to all terms, conditions, limitations and exclusions related to the member's eligibility and subsequent medical review. Regardless of pre-authorization status, medical decisions concerning a course of treatment are solely between the physician and the patient.

Please contact TPA administration to verify payment, eligibility, and benefits.

Preferred ADMINISTRATORS

Preferred Administrators appreciates the care you provide for our members.

Please notify Preferred Administrators AS SOON AS POSSIBLE to begin the pre-authorization process.

A 72-Hour advance notice allows us to review the request for services and respond in a timely manner.

Preferred ADMINISTRATORS

Behavioral Health (Initial evaluation does not require pre-authorization)
Chiropractic Services (Initial evaluation does not require pre-authorization)
Diagnostic Tests Related to Potential Organ Transplantation
Dialysis Services
Durable Medical Equipment
Note: All DME rentals exceeding 2 months require pre-authorization
DME maximum up to 12 months, not to exceed purchase price.
Elective Admissions
Growth Hormones
Home Health Services (Initial evaluation does not require pre-authorization)
Inpatient Admissions
Note: Preferred Administrators must be notified of all urgent/emergent admissions
Laser Surgeries
Intense Allergy Desensitization
Non-Emergent Admission
Obstetrical Ultrasounds
Note: Member is allowed four ultrasounds without obtaining pre-authorization
Occupational Therapy (Initial evaluation does not require pre-authorization)
Oral, Injectable or IV Drug Administration over $500
Note: This includes oral, Injectable or IV provided in a physician's office
Oral Surgery
Orthotics and Prosthetics (Adult and Children)
Outpatient Chemo-Therapy and Infusion
Out-of-Network / Non-Participating Facility, Provider, or Vendor
Outpatient Procedures
Outpatient Surgery
PET Scans
Physical Therapy (Initial evaluation does not require pre-authorization)
Podiatry Services (Excluding debridement of nails, avulsion of nail plate, excision of nail and wedge excision of skin of nail)
Radiation Therapy
Specialty Medicine - All specialty medicines require pre-authorization
Note: Please go to www.preferredadmin.net for complete list of specialty medicines
Speech Therapy (Initial evaluation does not require pre-authorization)
Synagis
Transplants
Transportation (Air transport and non-emergent ambulance)

Preferred ADMINISTRATORS

All out-of-network services provided by non-participating facility, provider or vendor require pre-authorization

No authorization is required for the initial visit for the following:
Behavioral Health
Chiropractic Services
Home Health Services
Occupational Therapy
Physical Therapy
Speech Therapy

*PODIATRIC PROCEDURES
The following CPT codes do not require authorization for in- office procedures

11720
11721
11730
11732
11750
11765

Preferred ADMINISTRATORS

*Please see additional information on side bar

Please Note: EMERGENCY SERVICES do NOT require pre-authorization. All other services requiring pre-authorization must be approved in advance by the plan Medical Director or their designee.

Note: It is the Provider's responsibility to request a prior authorization for services listed on the flyer.

Preferred ADMINISTRATORS

Wrap Network

For members residing <u>inside</u> El Paso's network service region:

- The PHCS & Multiplan logos will be placed on the back of the members card it will show the contact information.
- Outside (STATE/AREA) contact 800-678-7427 or multiplan.com for a PHCS provider or, if not available, a MultiPlan provider.

For members residing <u>outside</u> El Paso's network service region:

- The PHCS logo is placed on the front of the card, and the Multiplan logo will be placed on the back of the card
- Language requested (on back of card): To locate PHCS provider, please contact 800-922-4362 or multiplan.com

Preferred
ADMINISTRATORS

Wrap Network

- How to look up a Provider participating with MultiPlan:
  - **Step 1.** To locate a Provider outside of the El Paso County click below:

    http://www.multiplan.com/
  - **Step 2.** Click on *Providers* and then *Search for a Doctor or Facility*
  - **Step 3.** Click on the logo that is in front or back of the ID card
  - **Step 4.** Search by location, doctor, hospital or facility name

Preferred ADMINISTRATORS

Female Preventive Services Covered at 100%
Effective 10/1/2012

1. **Gestational diabetes screening**
2. **HPV DNA testing**
3. **STI counseling**
4. **HIV screening and counseling**
5. **Contraception to include Voluntary Sterilization and Covered Contraceptives to include Female Generic Prescription Drugs and contraceptive counseling**
6. **Interpersonal and domestic violence screening and counseling**
7. **Breastfeeding support, supplies, and counseling**

Preferred
ADMINISTRATORS

Important Note to Remember!

Preferred Administrators Network physicians who provide services at UMC or EPCH, will have professional services paid at the contracted rate.

The Member's responsibility will be at the UMC/EPCH/Texas Tech benefit coverage level.

Effective October 1, 2012, Tenet and its affiliates are considered an out of network Provider.

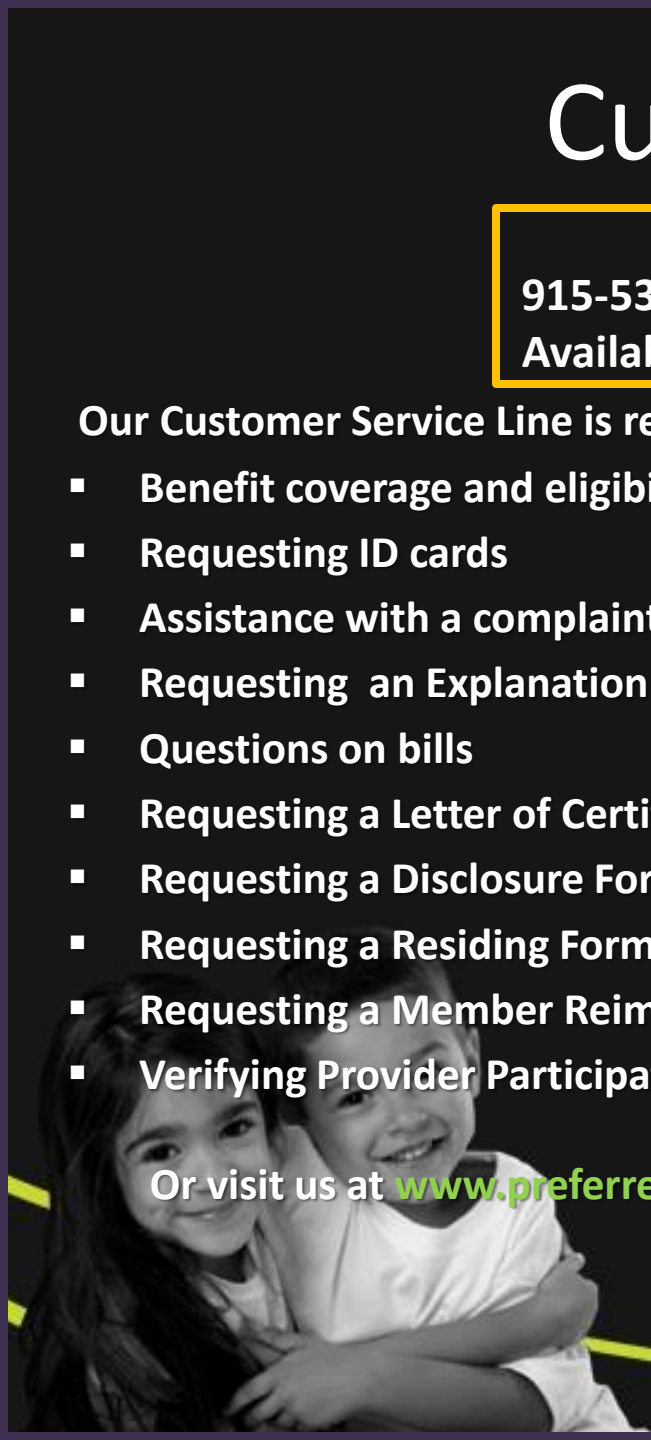
Preferred
ADMINISTRATORS

Customer Service

Customer Service Line:
915-532-3778 press 4 and then extension 1529
Available Monday to Friday from 7 am to 5 pm

Our Customer Service Line is ready to assist you with the following inquiries:

- **Benefit coverage and eligibility questions**
- **Requesting ID cards**
- **Assistance with a complaint/appeal**
- **Requesting an Explanation of Benefits (EOB)**
- **Questions on bills**
- **Requesting a Letter of Certificate of Coverage**
- **Requesting a Disclosure Form**
- **Requesting a Residing Form to update a dependent's address**
- **Requesting a Member Reimbursement Form**
- **Verifying Provider Participation**



Or visit us at www.preferredadmin.net to access the Member Handbook, Provider Directory, OptumRx formulary and more.

Preferred
ADMINISTRATORS

Contact Information

Veronica Maldonado-TPA Coordinator
vmaldonado@epfirst.com
298-7198 ext 1073

Michelle Anguiano-Director of TPA
manguiano@epfirst.com
298-7198 ext 1053

Preferred
ADMINISTRATORS

Thank You for Attending Providers!

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Health Plans inc.