About Your Health
Provider Newsletter
Spring • 2026
El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.
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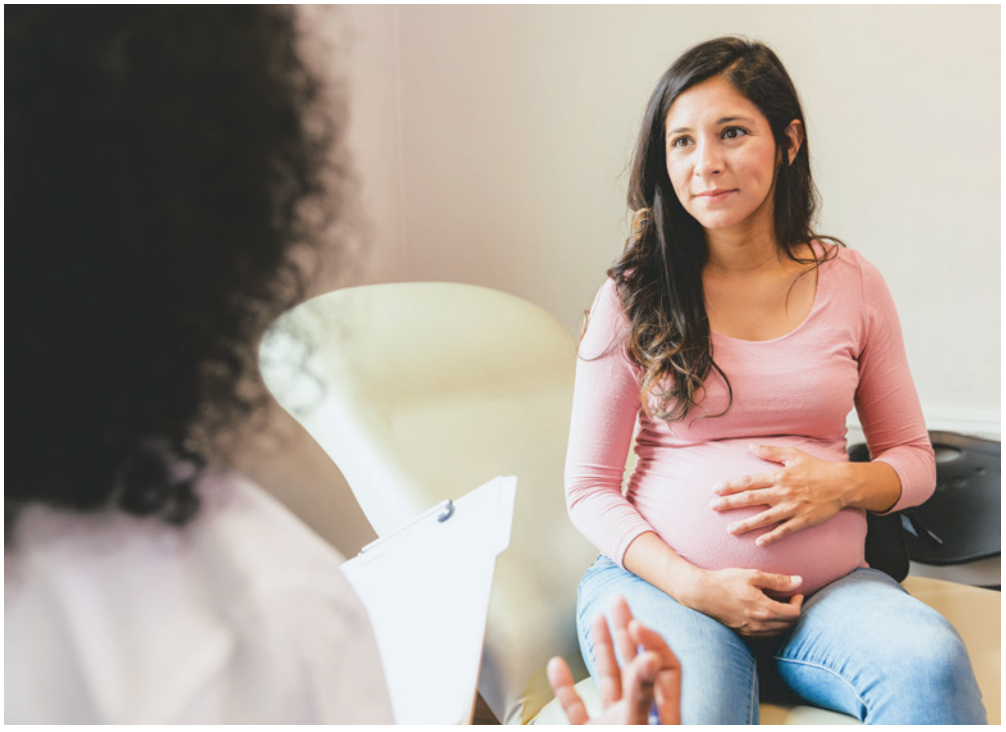
Preeclampsia: Preventing harm

Preeclampsia complicates between 5% and 8% of all births in the United States. It's also the cause of about 15% of premature deliveries.

Most health-care Providers traditionally adhered to a rigid diagnosis of preeclampsia based on blood pressure and protein in the urine (proteinuria) prior to the new guidelines. However, according to those guidelines, released by the American College of Obstetricians and Gynecologists, the diagnosis of preeclampsia no longer requires the detection of high levels of protein in the urine.

Evidence shows that problems with the kidneys and liver can occur without signs of protein in the urine. The amount of protein in the urine does not predict how severely the disease will progress. A woman's condition can progress to severe preeclampsia very quickly.

The rate of preeclampsia in the U.S. has increased 25% in the last 2 decades and is a leading cause of maternal and infant illness and death. Preeclampsia can be made worse by delays in diagnosis or management, seriously harming or killing both the mother and baby before, during, or after birth.



Working together

During El Paso Health monthly Baby Showers, a team of nurses will check the member's blood pressure, educate about signs and symptoms of preeclampsia and postpartum risks, demonstrate how to take a blood pressure, and provide a blood pressure log tracker for each member.

If you have a patient who needs a blood pressure device for home monitoring, El Paso Health can provide one as part of our value-added services. Our case managers can be reached by calling **915-532-3778** or toll-free at **1-877-532-3778**. Providers may also complete a Case Management Referral Form and indicate that the member has a high-risk pregnancy with a diagnosis of preeclampsia. The form may be found at **elpasohealth.com/documents/casemanagementreferralform.pdf**.

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Avoid denials and recoupments with these documentation basics

Strong documentation protects your practice and supports accurate Medicaid billing. Recent reviews show that small documentation gaps often lead to denials and payment recoveries. A few simple habits can help reduce that risk.

The most common issues we see:

Missing Provider signatures or credentials. Every clinical entry must be signed and clearly show the Provider's name and credentials. This supports the service billed and identifies who rendered the care.

Late documentation or post-payment signatures. Notes should be completed at the time of service or shortly after. Adding signatures or making changes long after the visit, especially after a claim is paid, raises compliance concerns and may result in unsupported services.

Missing start and end times for time-based services. Therapy and many behavioral health services require clear time documentation. Appointment schedules or check-in logs do not replace clinical notes and cannot support billed time.

Outdated or missing plans of care. Physical therapy, occupational therapy, and speech therapy services must follow an active, signed plan of care. Expired or incomplete plans may result in denied claims.

Inconsistencies between the medical record and the claim. Dates of service, rendering Provider information, and service details must match what is submitted for payment. Even small differences can trigger denials or recoupments.

Taking a few extra minutes to review documentation before billing can help prevent recoupments and support Medicaid program integrity. Provider Relations or Compliance teams are available to help.

PEMS+PLUS coming soon

The current PEMS system will be replaced by PEMS+PLUS, allowing Providers to submit credentialing information during enrollment, reenrollment, or maintenance requests for Texas Medicaid, managed care organizations (MCOs), and dental maintenance organizations (DMOs).

What this means for you

Currently, Providers must submit credentialing information separately to MCOs or DMOs after enrolling with Texas Medicaid. The updated PEMS will simplify this process, allowing Providers to complete credentialing directly through the system, speeding up enrollment and increasing efficiency.

Key updates to PEMS

Credentialing tab. A new tab will allow Providers to easily submit credentialing information.

Attestation requirement. Providers will only need to attest if they wish to credential with an MCO or DMO during enrollment or maintenance.

Concurrent process. Providers initiating credentialing during enrollment must complete the application before submitting both Medicaid and credentialing applications.

Maintenance requests. Providers can request credentialing post-enrollment via a new maintenance request option.

Credentialing process

Providers will submit credentialing applications electronically, including required documentation (e.g., education, licensure, certifications). New Providers can credential during initial enrollment, and existing Providers can initiate or complete credentialing via the maintenance request option.

Important note: Credential verification organizations will still verify all submitted information to ensure compliance with credentialing standards.

For more details, visit the Texas Medicaid & Healthcare Partnership website, **tmhp.com**.

Understanding Medicaid vs. Medicare Advantage claims

While many claims submission requirements are similar, there are key differences between Medicaid and Medicare Advantage (MA) that can affect how claims are processed and paid. Understanding these distinctions can help reduce delays and denials.

Medicaid claims

Medicaid benefits and coverage are governed by state and federal regulations, which may vary by program.

Eligibility: Member eligibility may change month to month and should be verified on the date of service.

Authorizations: Many services require prior authorization, and claims must align exactly with the approved services and units.

Timely filing: Timely filing limits are strictly enforced and vary by program.

Cost share: Most Medicaid members have little to no cost share; co-pays and deductibles are limited by state guidelines.

Coordination of benefits: Medicaid is often the payer of last resort, which may require additional documentation.

Medicare Advantage claims

MA plans follow guidelines from the Centers for Medicare & Medicaid Services (CMS) and plan-specific policies.

Eligibility: Eligibility is generally stable, but benefit plans may change annually.

Authorizations: Prior authorization requirements are plan-specific and must meet CMS coverage rules.

Timely filing: Timely filing limits apply and are outlined in the Provider contract and plan policy.

Cost share: Members may have co-pays, co-insurance, or deductibles, depending on their benefit plan.

Risk adjustment: Accurate diagnosis coding is essential, as MA claims support CMS risk adjustment and member care planning.

Tips for both programs

- Verify eligibility and benefits prior to service.
- Ensure that services billed match the authorization (when required).
- Submit clean claims with accurate coding and supporting information.
- Review evidence of benefits statements regularly, and address discrepancies promptly.

We're here to support you

Our goal is to partner with you to ensure accurate, timely claims processing for both Medicaid and MA members. For detailed requirements, please refer to the Provider Manual or contact us.

Special services for children of traveling farmworkers

El Paso Health has special Medicaid services for the children of traveling farmworkers. The services include assistance with scheduling their upcoming Texas Health Steps exams, as well as vision, mental health, and transportation benefits for them.

El Paso Health is also assisting members with community resources such as housing, food security, utility assistance, and child care assistance.

If you have any questions or would like to receive more information about these services for children of traveling farmworkers or would like the program coordinator to provide an in-service to your staff, please call the Outreach Coordinator at **915-532-3778, ext. 1075**.

Enhancing your experience when calling Member Services

At El Paso Health, we value our Provider partners and want every interaction you have with our Member Services team to be smooth, efficient, and helpful. To support your office staff and ensure the best possible experience, we've put together some helpful tips and reminders.

Make the most of our available resources

Before calling Member Services, consider checking the tools already at your fingertips:

- El Paso Health website
- Provider Manual
- Provider portals

These resources often contain the information you need and can help you avoid longer wait times on high-volume call days.

Set up and optimize your office portal account

If your office has not yet created a portal account, now is a great time to do so. To ensure smooth access:

- Create your office portal account.
- Confirm that all designated staff have the correct roles and permissions for full viewing capabilities.

This helps your team quickly find member and claim information without needing to call in.

Phone numbers by line of business

Please share these numbers with your staff and any billing agencies you work with.

Line of business	Phone number
STAR+PLUS	**1-833-742-3127**
STAR CHIP	**1-877-532-3778**
Medicare Advantage D-SNP	**1-833-742-3125**
Medicare Advantage MAPD	**1-833-742-2121** (Total and Give Back plans)

If you'd like help setting up portal access or have questions about these tips, feel free to reach out and call the number that pertains to the line of business you are calling about.

Use the best numbers and prompts

Reaching the right department first saves everyone time. When calling Member Services:

- Double-check that you are dialing the correct phone number.
- Select the appropriate prompts to reach the correct department.
- Avoid dialing the operator unless necessary, as this may prolong your call and lead to additional transfers.

If you use a billing agency

Some Providers rely on outside billing agencies to contact us on their behalf. To ensure that we can assist them efficiently, please make sure your billing partners have:

- Member ID and member name.
- Your practice information (for verification and authorization).
- Claim numbers and any relevant details.
- The correct phone numbers for each line of business.

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Member Services 1-877-532-3778

ABOUT YOUR HEALTH is published as a service for members of the EL PASO HEALTH Provider network.

EL PASO HEALTH Executive Offices are located at 1145 Westmoreland Drive, El Paso, TX 79925, **915-532-3778** or **1-877-532-3778**, **elpasohealth.com**.

Information in ABOUT YOUR HEALTH comes from a wide range of medical experts. If you have any concerns or questions about specific content in this newsletter, call **1-877-532-3778**. Models may be used in photos and illustrations.

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