



Welcome Providers!

OB Specialty Training
July 24, 2014

EL PASO FIRST
Health Plans, inc.

Agenda

- Welcome & Introductions
- Credentialing / Recredentialing - Provider Relations
- Telemedicine - Provider Relations
- OB Authorization Process - Health Services
- Gestational Diabetes Coverage for Medicaid and CHIP Perinatal - Health Services
- Breast Pump Process for Medicaid - Health Services
- HEDIS Measures - Quality Improvement
- Value Added Services - Member Services

Provider Relations

Stacy Arrieta

Provider Relations Representative

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Credentialing

- Initial Credentialing – new to the network
- Demographic form
- W9
- Texas Standardized Credentialing Applications (TSCA 07) Facility Application
- El Paso First Checklists
- Missing/incomplete information requests will be attempted via emails, faxes, and by phone on a weekly basis.
- Incomplete application cannot be held for more than 30 days and will be returned by certified mail
- Credentialing and Peer Review Committee (CPRC) meet every 1st Wednesday of each month
(CPRC meeting dates are subject to change)

Recredentialing

Recredentialing is a requirement every **3 years**

- 1st Request 90 day notification of recredentialing expiration date claims denial if application is not received.
- 2nd Request 60 day notification of recredentialing expiration date claims denial if application is not received.
- 3rd Final Request 30 day sent certified mail indicating expiration date and claims denial if date of expiration is exceeded.

Any applications received after date of expiration will be considered as new and initial applications and claims will deny until process is finalized.

Contact Provider Relations

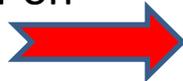
- ✓ Changes in address locations
- ✓ If you are adding or terming a provider
- ✓ Billing company changes
- ✓ NPI/TPI updates
- ✓ Phone and fax updates, etc.

Any changes you consider we may need in order to update our system and your records

Demographic Form

IMPORTANT

The information on the W-9 must match the provider billing information on the demographic form



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Health Plans, Inc. Telephone: (915) 532-3778, Fax: (915) 225-6762

IMPORTANT: Completion of this form is not considered a binding contract with El Paso First. For more information on contract plans for participation please contact your Provider Relations Representative.

Demographic Information Form			
Please Check off Health Plan Participation (Contract):		Please check off Specialty Type:	
<input type="checkbox"/> Medicaid/Premier Plan	<input type="checkbox"/> HCO	<input type="checkbox"/> PCP	<input type="checkbox"/> Allied Health (PT,OT, ST, LPC)
<input type="checkbox"/> CHIP	<input type="checkbox"/> TPA (Preferred Admin)	<input type="checkbox"/> Specialist	
<input type="checkbox"/> CHIP Perinate		<input type="checkbox"/> Ancillary (DME, Home Health, Facility)	
Group/Facility Name			
Group NPI:		Group Tax-ID:	
Group TPI:			
Provider Name (Last, First, Middle):		Professional Category:	
		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CRNA <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> LPC	
		<input type="checkbox"/> Other:	
Individual NPI:		Individual TPI: <input type="checkbox"/> Pending (in process)	
Primary Specialty:		Sub-Specialty:	
Medical License:		If applicable EPSDT Number:	
Languages Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish		Accepting New Patients	
<input type="checkbox"/> Other		Established Patients Only	
Practice Limitations: <input type="checkbox"/> Male Only <input type="checkbox"/> Female Only <input type="checkbox"/> Age Range () <input type="checkbox"/> Other			
Office Days/Hours:		CLIA: <input type="checkbox"/> Waiver <input type="checkbox"/> Certificate	
After Hours:		Laboratory: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provider Billing Information			
W-9 must be submitted along with Demographic Information Form			
Official Business Name (as it appears on W-9/IRS Documentation)			
Doing Business As (if different from above) <i>**this information must match Box #33 on claim form</i>			
Billing Address, City State and Zip Code:			
Tax ID Number:			
Primary Practice Location		Secondary Practice Location	
Address:		Address:	
City, Zip Code:		City, Zip Code:	
Phone Number: () () ()		Phone Number: () () ()	
Fax: () () ()		Fax: () () ()	
Primary Contact Person: First and Last name		Phone Number () () ()	
		email address:	
For EP First Staff Only:			
Verifications: <input type="checkbox"/> W-9 <input type="checkbox"/> NPPES <input type="checkbox"/> TPI Look Up <input type="checkbox"/> Provider Letter <input type="checkbox"/> Other			
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> PCP/Specialist <input type="checkbox"/> Specialist <input type="checkbox"/> Ancillary <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Hospitalist			
Contract Type: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Attachment D <input type="checkbox"/> Attachment B/C <input type="checkbox"/> Attachment F <input type="checkbox"/> Facility			
<input type="checkbox"/> LOA <input type="checkbox"/> Ancillary <input type="checkbox"/> After Hours			
Credentiaing: Provider Credentialed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Required			
Credentiaing: Credential Site Visit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Required			
Actions: Add: <input type="checkbox"/> To Network <input type="checkbox"/> To Group <input type="checkbox"/> Program			
TERM: <input type="checkbox"/> From Network <input type="checkbox"/> From Group REASON: _____			
<input type="checkbox"/> STAR <input type="checkbox"/> CHIP <input type="checkbox"/> CHIP Perinate <input type="checkbox"/> HCO <input type="checkbox"/> CM <input type="checkbox"/> TPA Effective Date: ____/____/____			
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating			
Comments: _____			

Where to locate forms

www.epfirst.com



Welcome to our new website!

In an effort to better serve you we changed our image and hope you find it easier to navigate.

Vision: Your community partner leading the way to quality healthcare through service and innovation...because we CARE.

Mission: El Paso First Health Plans promotes community health by providing access to quality healthcare for children, families and individuals who need it most. We partner and collaborate with community providers and advocates to foster a culture of excellence.

Members

- CHIP
- CHIP Perinatal
- Healthcare Options
- Premier Plan Star Medicaid
- Preferred Administrator
- Helpful Links

Providers

- Web Portal
- Forms
- Texas Health Steps
- Resources
- Behavioral Health Providers
- Important Updates
- Clinical Practice Guidelines





Providers - Forms

- [Web Portal Forms](#) ▶
- [Health Services Forms](#) ▶
- [Complaints and Appeals Forms](#) ▶
- [Members Services Forms](#) ▶
- [Claims Forms](#) ▶
- [Credentialing Packet Forms](#) ▼
 - DME Supplies Form
 - Demographic Form
 - W9 Form - Request for Taxpayer Identification Number and Certification
 - Credentialing Checklist for Organization/Facility
 - Credentialing Application for Organization
 - Initial Credentialing Checklist for Physician
 - Re-credentialing Checklist for Physician
 - Texas Standardized Credentialing Application
- [Misc. Forms](#) ▶





Provider Surveys

- Provider Surveys will be delivered to Provider offices in the up coming months.
- Tell us how we're doing!
- Your feedback is appreciated.

Telemedicine

Cynthia Moreno
Provider Relations
Coordinator

EL PASO FIRST
Health Plans, inc.

What is Telemedicine?

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.



What is Telehealth?

Telehealth is the more general term and means the electronic transfer of medical information for the purpose of patient care.



What is Telemonitoring?

Telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency or a hospital.

How does it work?

Transfer of medical data requires the use of advanced including the following:

- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture and store-and forward.
- Other technology that facilitates access to health-care services or medical specialty expertise.

Telephone or faxes are not considered forms of telehealth/telemedicine.



Distant Site and Patient Site

Distance Site - *is the location of the provider rendering the service.*

Telemedicine Providers Include:

- Physician
- Certified Nurse Specialist
- Nurse Practitioner
- Physicians Assistant
- Certified Nurse Midwife



Telehealth Providers Include:

- Licensed professional counselor
- Licensed marriage and family therapist
- Licensed clinical social worker
- Psychologist
- Licensed psychological associate
- Provisionally licensed psychologist
- Licensed dietician

Patient Site - *is where the client is physically located while the service is rendered.*

The patient-site must be one of the following:

- *Established medical site*
- *State mental health facility*
- *State supported living center*

Texas Medicaid Benefit

Telemedicine (distant site) procedure codes

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site telemedicine providers:

Procedure Codes					
90791	90792	90832	90833	90834	90836
90837	90838	90951	90952	90954	90955
90957	90958	90960	90961	99201	99202
99203	99204	99205	99211	99212	99213
99214	99215	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255
G0406*	G0407*	G0408*	G0425	G0426	G0427
M0064					
*Procedure codes are limited to one service per day.					
Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health." Procedure codes 90833, 90836, and 90838 are add-on codes and must be billed with a primary E/M procedure code in order to be reimbursed.					

Telemedicine (Patient Site) providers enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, PA, physicians, and outpatient hospital providers.

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site telehealth providers:

Procedure Codes							
90791	90832	90834	90837	97802	97803	97804	S9470
Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Section 4, "Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)" and Section 6, "Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers" of the <i>Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks)</i> .							

Telehealth (Patient Site)
The facility fee procedure code Q3014) is not a benefit for telehealth services. Charges for other services that are performed at the patient site may be submitted separately.

What are the benefits?

- Improved access – allows for patient accessibility and providers to extend their reach beyond their offices.
- Cost efficiencies - reduce healthcare cost, increase efficiency via better management of chronic diseases, shared health professional staffing, reduced travel times, and fewer or shorter hospital stays.
- Improved Quality - Studies have shown that the quality of healthcare services delivered via telemedicine are as good those given in traditional in-person consultations.
- Patient Demand -Reduces travel time and related stresses for the patient. Offer patients access to providers that might not be available otherwise, as well as medical services without the need to travel long distances.

TMHP – Texas Medicaid provider procedures manual: Vol 2 <http://www.tmhp.com/Pages/default.aspx>

Texhealth Resource Center TexLa - <http://texlatrc.org/Links.aspx>

American Telemedicine Association <http://www.americantelemed.org/about-telemedicine/faqs>

Medicaid.gov - <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

Health Resources and Services Administration Rural -

<http://www.hrsa.gov/ruralhealth/about/telehealth/telehealth.html>

Contact Information

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Provider Relations Department
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OB Authorization Process

Edna E. Lerma, LPC
Clinical Supervisor

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OB High Risk Authorizations

PRIOR AUTHORIZATION FORM HIGH RISK PREGNANCY

EL PASO FIRST
healthplans, inc.

Please attach clinical documentation. Date: _____
 To: _____ Fax: (915) 298-7866
 From: _____ Fax: _____
 Approved DOS: _____ No. of Pages: _____
 Authorization No.: _____ (including cover sheet)

Member Information

Name: _____ DOB: _____
 Phone No.: () _____ Health Plan ID# _____
 Expected due date: _____ ICD9-Codes: _____

Patient has been diagnosed with any of the following conditions:

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

Provider Information

Physician's Name: _____
 Office contact person: _____
 Phone No.: () _____

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

Upon identification of a member with a high risk diagnosis, provider should submit High Risk PA Form.

Please submit documentation that clearly indicates medical necessity for High Risk diagnosis.

Once PA is approved this will allow provider to administer medically necessary ultrasounds through a specific date range

Ultrasounds codes will range from CPT Code 76801 - 76819

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Ultrasound Authorization Requirements

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Pre-certification Fax Form for
OUTPATIENT/SCHEDULED Procedures
Fax No. 915-298-7866 Pre-Cert No. 915-532-3778 X 1500

PLEASE NOTE: All services requiring pre-certification (other than an emergency, SSI) must be approved in advance by a MUD (Medical Underwriter). Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.

PROVIDER'S INFORMATION (PROVIDER/FACILITY SUBMITTING AUTH REQUEST)			
DATE OF REQUEST:	PROVIDER'S NAME:		
IPI #	NPI #		
CONTACT PERSON:	PHONE NO.	FAX NO.	
SERVICE LOCATION:	MAIL ADDRESS:		

MEMBER'S INFORMATION			
NAME:	MEMBER I.D. NO.:	SSI (Circle if SSI)	
DOB:	Member Phone:	PCP:	

REFER TO INFORMATION (PROVIDER/FACILITY PERFORMING SERVICE IF DIFFERENT FROM ABOVE)			
PROVIDER'S NAME:	IPI #	NPI #	
CONTACT PERSON:	PHONE NO.	FAX NO.	
SERVICE LOCATION:	MAIL ADDRESS:		

PROCEDURE INFORMATION			
<input type="checkbox"/> OFFICE VISIT <input type="checkbox"/> OFFICE VISIT W/TREATMENT <input type="checkbox"/> LABS <input type="checkbox"/> RADIOLOGY <input type="checkbox"/> THERAPY (OT, PT, ST) <input type="checkbox"/> SURGICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> HOME HEALTH <input type="checkbox"/> PODIATRY <input type="checkbox"/> INPATIENT SCHEDULED SERVICES <input type="checkbox"/> DIABETES/AS/THW EDUCATION <input type="checkbox"/> OTHER			
EXPECTED DATE OF PROCEDURE: _____			
<u>PRIMARY DIAGNOSIS CODES (ICD-9)</u>	<u>CPT PROCEDURE CODES</u>	<u>SSI ONLY</u>	
		<u>TYPE OF SERVICE</u>	<u>MODIFIER</u>
1. _____	1. _____	1. _____	_____
2. _____	2. _____	2. _____	_____
3. _____	3. _____	3. _____	_____
4. _____	4. _____	4. _____	_____
5. _____	5. _____	5. _____	_____

PLAN OF TREATMENT/PERTINENT CLINICAL HISTORY AND PHYSICAL EXAM (INCLUDE PREVIOUS MEDICAL MANAGEMENT, LAB AND X-RAY RESULTS):

FOR EL PASO FIRST USE ONLY			
REVIEWED BY: _____	DATE: _____	APPROVED: YES	NO
REFERENCE NO. _____			

THIS PRE-CERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS NOR VERIFY ELIGIBILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEMBER'S CONTRACT. REGARDLESS OF A DETERMINATION, MEDICAL DECISIONS REGARDING A COURSE OF TREATMENT ARE SOLELY BETWEEN THE PHYSICIAN AND THE PATIENT.

- First four ultrasounds do not require an authorization.
- Please submit PA form along with supporting clinical documentation to support your request.

J1725

Providers must submit claims for a compounded drug using procedure code J1725

9.2.39.4 17-Alpha Hydroxyprogesterone Caproate

- 17-alpha hydroxyprogesterone caproate is a benefit of Texas Medicaid for clients who are 10 through 55 years of age.
- 17-alpha hydroxyprogesterone caproate is administered intramuscularly at a dose of 250 mg once a week (every 7 days) and is indicated when all of the following criteria are met:
 - The client's treatment is initiated between 16 weeks, 0 days and 20 weeks, 6 days gestation.
 - The client's treatment may continue, as medically indicated, through 36 weeks, 6 days gestation or delivery, whichever occurs first.
 - The client has a singleton pregnancy.
 - The client has had a prior, singleton, spontaneous, preterm delivery before 37 weeks gestation.

PLEASE NOTE

Although this is a drug, it is not a pharmacy benefit. This is a physician-administered drug.

Provider Tool Link



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First Steps OB Case Management Program

Prenatal-Postpartum Care Visit Verification

Please complete the visit information below.
***=Required Information**

Physician/Nurse Practitioner Name *:

Member's ID Number *:

Member's Name *:

Member's Birth Date(mm/dd/yyyy) *:

Expected Date of Delivery *:

Date of First Prenatal Visit:

Date of Postpartum Visit:

Is the member experiencing barriers to prenatal/postpartum care? Yes No

• First Steps Program for Healthy Babies
- Our First Steps Case Management Program is designed to assist you in providing timely, quality health care to all of your patients. Our case managers collaborate with you and your office staff to ensure expectant mothers, who are enrolled in our health plan, receive prenatal and post partum care. You may complete the case management referral form and one of our nurses or social workers will contact the member.

First Step Forms

- [Letter & High Risk Form](#)
- [Pre-Certification Form-Outpatient/Scheduled Procedures](#)
- [Case Management Referral Form](#)

[Home](#) [About Us](#) [Contact Us](#) [Members](#) [Providers](#) [Web Privacy Statements](#) [Notice of Privacy Practices](#) [HIPAA/HITECH](#)

Your health information (Protected Health Information "PHI" and "sensitive personal information") created or received by El Paso First Health Plans, Inc. is subject to electronic disclosure.

Coming soon...

STAR

Gestational Diabetes Benefits

- Oral Medication/Insulin
- Request for DME (lancets, strips, monitor) is a covered benefit (no auth required if limit is not exceeded) check Medicaid Guidelines for max allowed
- Preferred glucometers and test strips:
 - TRUEresult glucometer with TRUEresult test strips
 - Freestyle Lite, Freedom Lite, and Precision Xtra Systems and test strips from Abbott Diabetes Care.
- Diabetes Education Classes (*authorization required*)
 - El Paso Diabetes Association
 - UMC of El Paso Diabetes Management Program

CHIP Perinate Gestational Diabetes Benefits

COVERED

- Oral Medication/Insulin
- Diabetes Education Classes (*auth required*)
 - El Paso Diabetes Association
 - UMC of El Paso Diabetes Program

NOT A COVERED BENEFIT

- Durable medical equipment or other medically related remedial devices (does NOT cover testing strips, lancets, monitor)
- EP First can HELP – resources available in the community.

Call us!

Diabetes Education

El Paso Diabetes
Association

1220 Montana Avenue

El Paso, Texas 79905
(915) 532-6280

UMC of El Paso
Diabetes Management
Program

4815 Alameda Avenue
El Paso, Texas 79905
(915) 521-7861

Sterilization Consent Form

Guidelines for STAR ONLY

As per 2014 Texas Medicaid Provider and Procedures Manual Section 2.2.8.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

To be eligible for a sterilization procedure the client must be 21 years of age or older and must complete and sign a Sterilization Consent Form within at least 30 days of the date of the surgery but no more than 180 days.

Sterilization Consent Form (FAX consent form to 1-512-514-4229)		
Client Medicaid or Family Planning Number: _____	Date Client Signed: ____/____/____	(month/day/year)
Choose one: <input type="checkbox"/> This is an initial submission of the Sterilization Consent Form. <input type="checkbox"/> This is a corrected Sterilization Consent Form.		
Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.		
Consent to Sterilization		
I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.		
I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.		
I understand that I will be sterilized by an operation known as a _____ (specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.		
I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.		
I am at least 21 years of age and was born on ____ (month) ____ (day) ____ (year). I, _____ hereby consent of my own free will to be sterilized by _____ (doctor or clinic) by a method called _____ (specify type of operation).		
My consent expires 180 days from the date of my signature below.		
I also consent to the release of this form and other medical records about the operation to Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.		
Client's Signature: _____	Date of Signature: ____/____/____	(month/day/year)
Race and Ethnicity Designation (You are requested to supply the following information, but it is not required.)		
Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino Race (mark one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		
Interpreter's Statement		
If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.		
Interpreter's Signature: _____	Date of Signature: ____/____/____	(month/day/year)
Statement of Person Obtaining Consent		
Before _____ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation: _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.		
Signature of person Obtaining Consent: _____	Date of Signature: ____/____/____	(month/day/year)
Facility Name: _____	Facility Address: _____	
Physician's Statement		
Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on ____/____/____ (date of sterilization), I explained to him/her the nature of the sterilization operation: _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.		
Choose one of the two statements below as applicable:		
<input type="checkbox"/> (1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed. (Note: Use this option except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form.)		
<input type="checkbox"/> (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of one of the following circumstances. If you chose option #2, check the applicable box below and fill in the information requested:		
<input type="checkbox"/> (2a) Premature delivery - Individual's expected date of delivery: ____/____/____ (month, day, year)		
<input type="checkbox"/> (2b) Emergency abdominal surgery (describe circumstances): _____		
Physician's Signature: _____	Date of Signature: ____/____/____	(month/day/year)
Paperwork Reduction Act Statement		
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0987-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OO/OPRA, 200 Independence Ave., S.W., Suite 917 H, Washington, D.C. 20201, Attention: PRA Reports Clearance Officer. [HHS-687]		
All Fields in This Box Required for Processing		
TR: _____	NPI: _____	Taxonomy: _____
Provider/Clinic Telephone: _____	Provider/Clinic Fax Number: _____	Benefit Code: _____
Program (Check one): <input type="checkbox"/> DBHS Family Planning Program <input type="checkbox"/> XX (Medicaid)		

Effective Date: 01/15/2012 Revised Date: 03/11/2014

Breast Pump

Texas Medicaid Provider and Procedures Manual Section 2.2.8

- Authorization is required
- A manual or non hospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity.
- The purchase of a breast pump is limited to one every three years.
- Providers must use procedure code E0602 or E0603 when billing for the purchase of a manual or non hospital-grade electric breast pump.

Women, Infants and Children WIC Program

Breastfeeding Support

- Clients receive encouragement and instruction in breastfeeding. In many cases, breastfeeding women are provided breast pumps free of charge.
- WIC helps clients learn why breastfeeding is the best start for their baby, how to breastfeed while still working, Dad's role in supporting breastfeeding, tips for teens who breastfeed, how to pump and store breast milk, and much more.

Health Services Contact Info

(915) 532-3778

Janel Lujan, LMSW

Senior Director of Operations

- Extension 1090

Dolores Herrada, RN, CCM

Health Services Director

-Extension 1007

Edna E. Lerma, LPC

Clinical Supervisor

- Extension 1078

Irma Vasquez

Administrative Supervisor

-Extension 1042

HEDIS OB Specialty Training

Angelica Baca, MSTAT

QI Data Specialist

EL PASO FIRST
Health Plans, inc.

HEDIS OB Specialty Training

- 2014 Pay for Quality – HEDIS PPC
- Calendar Year 2013 Interim Results
- Changes in 2015
- Postpartum Claims
- HEDIS Hybrid Prenatal Care and Postpartum (PPC) Requirements

2014 Pay for Quality - PPC

- **Timeliness of Prenatal Care.** The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

2014 Pay for Quality - PPC

- PPC – Prenatal and Postpartum are scored as hybrid measures.
- Final rates will be available in August 2014.

Calendar Year 2013 Interim Results

Administrative – Claims Only - Results

STAR					
Measure	Population Name	CY 2012 Rate	CY 2013 Rate	CY 2013 Percentile	% Points Change
PPC - Prenatal	El Paso First	83.50%	82.97%	> 25th	-0.53%
PPC - Postpartum	El Paso First	58.49%	47.80%	< 10th	-10.69%

Medicaid HEDIS 2013 Audit Means, Percentiles and Ratios						
Name	SubmeasureName	P10 (%)	P25 (%)	P50 (%)	P75 (%)	P90 (%)
PPC	Prenatal Care	70.59	79.85	85.88	89.72	92.82
PPC	Postpartum Care	50.69	57.91	63.99	70.20	73.83

Changes in 2015

- In 2015 El Paso First will create samples and chases.
- Administrative data will be considered before medical record is requested.
- Denied claims will count toward individual OB rates.
- Submitting Postpartum claims will result in less records requested for PPC measures.

Postpartum Claims

From 2014 HEDIS specs:

“Include all paid, suspended, pending and denied claims. To count services in the medical record, documentation in the medical record must indicate the date when the procedure was performed and the result or finding (when applicable).”

HEDIS Hybrid Prenatal Care (PPC)

Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present.

- *Documentation must include*
 - *Note indicating date of prenatal care visit*
 - *And evidence of ONE of the following*
 - A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flow sheet may be used)
 - Evidence that a prenatal care procedure was performed
 - Documentation of LMP or EDD in conjunction with *either* of the following.
 - Prenatal risk assessment and counseling/education.
 - Complete obstetrical history.

HEDIS Hybrid Postpartum Care (PPC)

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery.

- Documentation must include
 - a note indicating the date of the postpartum visit
 - and *ONE* of the following.
 - Pelvic exam.
 - Evaluation of weight, BP, breasts AND abdomen.
 - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
 - Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.

Contact Information

Quality Improvement Department
(915) 532-3778 ext. 1231

SFY 2015 Value Added Services

Edgar Martinez
Director of Member Services

EL PASO FIRST
Health Plans, inc.

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 through Project Vida
- Up to \$125 above the Medicaid benefit for contact lenses, lenses, and frames
- Welcome Packet: A \$25 value of over-the-counter items if the request form is completed and mailed back within 30 days of enrollment
- Free calls or texts from El Paso First for related health activities. One free cell phone per household from the Lifeline Assistance Program for those who qualify.
- 1 free car seat per pregnancy for pregnant Members who complete a pregnancy class
- \$10 gift card for health related items for pregnant Members

Effective September 1, 2014

days of enrollment

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, 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

Effective September 1, 2014

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 \$25 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.

Effective September 1, 2014

CHIP - Value Added Services

- Free car seat for pregnant Members who complete a pregnancy class
- \$25 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, 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

Effective September 1, 2014

Thank You!

Any Questions!

Edgar Martinez

Director of Member Services ext. 1064

Antonio Medina

Enrollment & Member Service Supervisor ext. 1034

Juanita Ramirez

Member Services & Enrollment Supervisor ext. 1063

Preferred Administrators Updates

Michelle Anguiano

Director of TPA Account Management

EL PASO FIRST
Health Plans, inc.

Preferred Administrators Updates

- Contraceptives
 - List of contraceptives covered at 100% if not on the list, co-pay and co-insurance will apply.
 - IUDs are a medical ***not*** a pharmacy benefit (insertion and removal do not need a prior authorization)

List of \$0 Cost Share Contraceptive Medications & Products
Please note this list is subject to change

Hormonal Contraceptives			
Altavera	Enpresse	Microgestin 1.5/30	Quasense
Alyacen 1/35	Errin	Microgestin 1/20	Reclipsen
Alyacen 7/7/7	Falmina	Microgestin Fe 1.5/30	Solia
Amethia	Gianvi	Microgestin Fe 1/20	Spryntec
Amethia Lo	Gildess Fe 1.5/30	Mononessa	Sronyx
Amethyst	Gildess Fe 1/20	Myzila	Syeda
Apr	Heather	Necon 0.5/35	Tilia
Aranelle	Introvale	Necon 1/35	Tri-legest
Aviane	Jolessa	Necon 1/50	Trinessa
Azurette	Joliette	Necon 10/11	Tri-previfem
Balziva	Junel 1.5/30	Necon 7/7/7	Tri-sprintec
Briellyn	Junel 1/20	Nora-be	Trivora
Camila	Junel Fe 1.5/30	Norethindrone	Velivet
Camrese	Junel Fe 1/20	Notrel (21)	Vestura
Camrese Lo	Kariva	Notrel(28)	Viorele
Cazant	Kelnor	Notrel (28) 0.5/35	Wera
Cesia	Leena	Notrel 7/7/7	Wymzya
Cryelle	Lessina	Nuvaring	Zarah
Cyclafem 1/35	Levonest	Ocella	Zenchant
Cyclafem 7/7/7	Levora	Ogestrel	Zenchant Fe 0.4MG
Dasetta 1/35	Loryna	Orsythia	Zeosa
Dasetta 7/7/7	Low-ogestrel	Philith	Zovia 1/35E
Depo-Sq	Lutera	Portia	Zovia 1/50E
Elinest	Marlissa	Prentif	
Emoquette	Medroxyprogesterone	Previfem	

Emergency Contraceptives
Ella
Next Choice 0.75MG
Next Choice 1.5MG

Diaphragms
Omniflex
Ortho Coil
Ortho Flat
Ortho Flex
Wide-Seal

Preferred Administrators Updates

- Breast pump process
 - Obtain it through a DME or
 - Member Reimbursement up to \$200 for a non-hospital grade double electric breast pump purchased at retail or up to \$50 for supplies if the member has a device.
 - Must complete *Member Reimbursement Form* and attach RX and receipt.

Preferred ADMINISTRATORS

Home
Members
Providers
Contact Us

Members

The Member area is an easy-to-navigate page where you can perform the following functions:

- View Enrolled Family Members
- View Submitted Claims
- View Available Benefits
- View Demographics
- Change PCP
- View Authorizations
- And, much, much more

[Member Login Screen](#)
[Member Registration](#)
[Flex Spending Account/HRA](#)
[Notice of Privacy Practices](#)
[NOTICE TO ALL MEMBERS - FAQ's regarding TENET](#)
[UMC Breast Pump Amended Benefit Letter.pdf](#)
[EPCH Breast Pump Amended Benefit Letter.pdf](#)
[Preferred Administrators Contraceptives Benefit.pdf](#)

Contact Information

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**Thank You for
Attending
Providers!**

EL PASO FIRST
Health Plans, inc.
