

Welcome Providers!

Behavioral Health Specialty
Training

July 10, 2014



8001EPF061714

EL PASO FIRST
Health *Plans* inc.

Agenda

- Welcome & Introductions
- Credentialing / Recredentialing - Provider Relations
- Telemedicine - Provider Relations
- Behavioral Health Authorization Process - Health Services
- Health and Behavior Assessment and Intervention Services (HBAI) - Health Services
- Mental Health Rehabilitative Services and Targeted Case Management (TCM) - Health Services
- Accessibility and Availability - Quality Improvement
- Medical Transportation Program & Eligibility - Member Services



Provider Relations

Cynthia Moreno

Provider Relations Coordinator



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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)

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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.

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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.

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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 TPI:	Group Tax-ID:	
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"/>	
<input type="checkbox"/> Other		Established Patients Only <input type="checkbox"/>	
Practice Limitations: <input type="checkbox"/> Male Only <input type="checkbox"/> Female Only		Age Range () 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) ***this information must match Box #33 on claim form*

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: W-9 NPPES TPI Look Up Provider Letter Other

Provider Type: PCP PCP/Specialist Specialist Ancillary Behavioral Health Hospitalist

Contract Type: Individual Group Attachment D Attachment B/C Attachment F Facility LOA Ancillary After Hours

Credentialing: Provider Credentialed Yes No Not Required
 Credential Site Visit Yes No Not Required

Actions: Add: To Network To Group Program
 TERM: From Network From Group REASON: _____

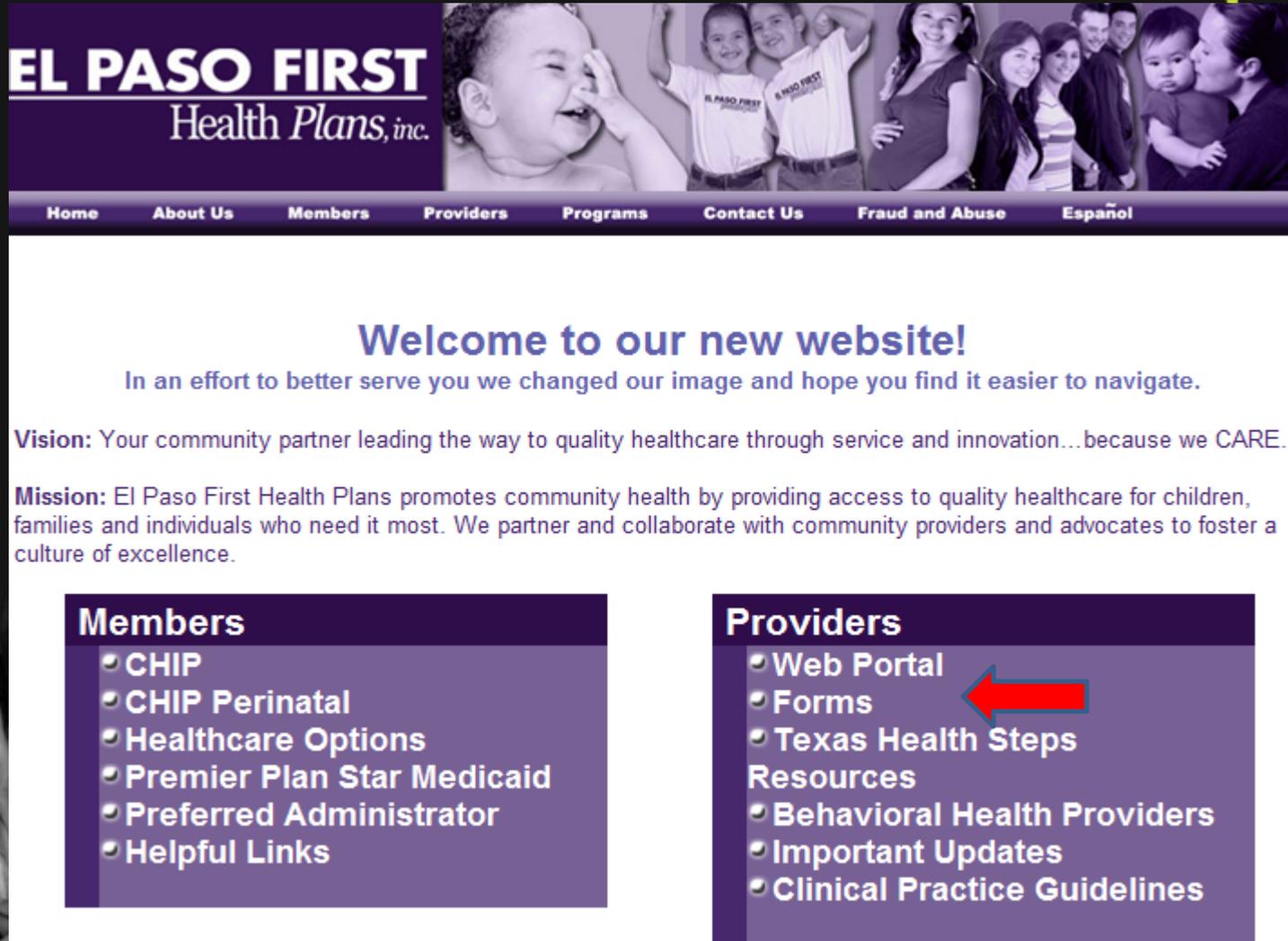
STAR CHIP CHIP Perinate HCO CM TPA Effective Date: ____/____/____

Participating Non-Participating

Comments: _____

Where to locate forms

www.epfirst.com



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Health Plans, inc.

Home About Us Members Providers Programs Contact Us Fraud and Abuse Español

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](#) ▶



Telemedicine

Cynthia Moreno

Provider Relations Coordinator



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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

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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.

Telehealth (distant site) procedure codes

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 *Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks)*.

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>

1. 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>

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Contact Information

Cynthia Moreno

Provider Relations Coordinator

cmoreno@epfirst.com

915-532-3778 ext. 1044

Provider Relations Department

915-532-3778 ext. 1507



EL PASO FIRST
Health Plans *inc.*

Behavioral Health Authorization Process

Diana Gonzalez, LVN
Case Manager



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Health Plans *inc.*

Prior Authorization Process

- Provider Faxes El Paso First
 - Pre-certification form is submitted for all outpatient/inpatient requests
 - Fax number: (915) 298-7866 Outpatient
- Online: (Via Provider Web Portal)
- Telephone:(915) 532-3778 Ext. 1500 or
(877) 532-3778 Ext. 1500



BHS-OTR-Page 2

Pre-certification Fax Form for OUTPATIENT/INPATIENT Behavioral Health

Member's Name: _____ Member I.D. _____

Treatment Plan. Note specific progress for each goal

Goal	Current Progress	Target Date

<p>Anxiety/Phobia</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic Attack <input type="checkbox"/> Phobic Responses <input type="checkbox"/> Excessive Worry <input type="checkbox"/> PTSD	<p>Risk Factors</p> <input type="checkbox"/> Social Isolation <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Aggression <input type="checkbox"/> Oppositional/Defiant <input type="checkbox"/> Self injurious <input type="checkbox"/> Recent Suicide attempts <input type="checkbox"/> Past Suicide attempts	<p>Sleep Patterns</p> <input type="checkbox"/> Hypersomnia <input type="checkbox"/> Insomnia <input type="checkbox"/> Awakenings <input type="checkbox"/> Traumatic Dreams	<p>Eating Patterns</p> <input type="checkbox"/> Increase Appetite <input type="checkbox"/> Decrease Appetite <input type="checkbox"/> Binge Eating <input type="checkbox"/> Self-induced Vomiting	<p>Substance Abuse</p> <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Active <input type="checkbox"/> Remission
<p>Mood</p> <input type="checkbox"/> Anger <input type="checkbox"/> Apathy <input type="checkbox"/> Blunted/Flat Affect <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Elevated/Expansive <input type="checkbox"/> Grandiosity <input type="checkbox"/> Hopelessness <input type="checkbox"/> Irritable <input type="checkbox"/> No Self Esteem <input type="checkbox"/> Tearfulness <input type="checkbox"/> Mood in swings/lability <input type="checkbox"/> Previous Suicide attempt	<p>Cognition</p> <input type="checkbox"/> Decrease Concentration <input type="checkbox"/> Distractibility <input type="checkbox"/> Impaired Abstract Thinking <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Hallucinations	<p>Thought Content</p> <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Loose Association <input type="checkbox"/> Hypertalkative <input type="checkbox"/> Pressured Speech <input type="checkbox"/> Racing Thoughts <input type="checkbox"/> Delusions <input type="checkbox"/> Grandiosity <input type="checkbox"/> Paranoid Ideation <input type="checkbox"/> Suicidal Ideation	<p>Functionality</p> <input type="checkbox"/> Obsessions/Compulsions <input type="checkbox"/> Social Withdrawal <input type="checkbox"/> Impaired ability to function at: <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Obsessions/Compulsions <input type="checkbox"/> Social Withdrawal <input type="checkbox"/> Risk-taking <input type="checkbox"/> Anti-social <input type="checkbox"/> Hypersexual	<p>Activity</p> <input type="checkbox"/> Decrease in Energy <input type="checkbox"/> Psychomotor Retardation <input type="checkbox"/> Restlessness <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Impulsiveness <input type="checkbox"/> History of aggression

THIS PRECERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS. 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.



BHS-OTR-Page 3

Pre-certification Fax Form for OUTPATIENT/INPATIENT Behavioral Health

Member's Name: _____ Member I.D. _____

Suicidal: Yes No Explain: _____

Homicidal: Yes No Explain: _____

Emotional Trauma: Yes No Explain: _____

Sexual Trauma: Yes No Explain: _____

Physical Trauma: Yes No Explain: _____

Indicate number of sessions being requested to include CPT Code/Revenue Code and frequency.

CPT CODES	UNITS	FREQUENCY	REV CODE	UNITS
<input type="checkbox"/> INITIAL EVAL	_____	_____	<input type="checkbox"/> 124	_____
<input type="checkbox"/> INDIVIDUAL THERAPY	_____	_____	<input type="checkbox"/> 905	_____
<input type="checkbox"/> 90847 FAMILY THERAPY WITH MEMBER	_____	_____	<input type="checkbox"/> 906	_____
<input type="checkbox"/> 90853 GROUP THERAPY	_____	_____	<input type="checkbox"/> 912	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/> 913	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Other	_____

For El Paso First's Use Only

Approved Denied Partial Approval Comments: _____

MD Signature: _____

THIS PRECERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS. 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.



Prior Authorization Process

- El Paso First begins review process to ensure medical necessity as per Milliman Care Guidelines and/or Texas Medicaid
 - If reviewer is unable to identify medical necessity based on the information submitted, authorization is sent to medical director for further review and determination.



STAR

EL PASO FIRST Health Plans, inc.

1145 Westmoreland Drive
El Paso, Texas 79925
Phone (915) 532-3778
Fax (915) 298-7866

REQUEST FOR ADDITIONAL INFORMATION (BH)

DATE: _____ **NO. OF PAGES:** 1
TO: _____
Attention: _____ **FAX NO.:** _____
FROM: Health Services – BH Pre-Auth Unit **PA NO.:** _____
PHONE: 532-3778 Ext. 1500 PREMIER PLAN CALL LINE
RE: Member Name: _____
ID No. _____ Date of Birth _____

REFERENCE NO. _____

Additional documentation is required to continue processing your authorization request.
Please submit the following information:

Current Symptoms Frequency of Contact Response to Past Treatment

Other: _____

El Paso First requires that requests for additional information be submitted within seven (7) days of request. This information must be received by _____. If the information is not received by this date, medical determination will be made based on the information originally submitted.

THE DOCUMENTS ACCOMPANYING THIS TRANSMISSION CONTAIN CONFIDENTIAL HEALTH INFORMATION THAT IS LEGALLY PRIVILEGED. THIS INFORMATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. THE AUTHORIZED RECIPIENT OF THIS INFORMATION IS PROHIBITED FROM DISCLOSING THIS INFORMATION TO ANY OTHER PARTY UNLESS REQUIRED TO DO SO BY LAW OR REGULATION AND IS REQUIRED TO DESTROY THE INFORMATION AFTER ITS STATED NEED HAS BEEN FULFILLED. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR ACTION TAKEN IN RELIANCE ON THE CONTENTS OF THESE DOCUMENTS IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY AND ARRANGE FOR THE RETURN OR DESTRUCTION OF THESE DOCUMENTS.

Revised: 10/01/2013

EL PASO FIRST
Health Plans inc.



BHS Notification STAR & CHIP

NOTIFICATION OF APPROVAL

DATE: _____ **NO. OF PAGES:** _____
TO: _____
 Attention: _____ **FAX NO.:** _____
FROM: Health Services – Pre Auth Unit **PA NO.:** _____
PHONE: 532-3778 Ext. 1500 (STAR) Ext. 1536 (CHIP/CHIP PERINATE) Ext. 1537 (HCO)
RE: Member Name: _____
 ID No. _____ Date of Birth _____

AUTHORIZATION NO. 0000 _____

The following services have been approved:

<u>CPT CODE</u>	<u>UNITS</u>	<u>CPT CODE</u>	<u>UNITS</u>	<u>CPT CODE</u>	<u>UNITS</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

DOS: _____ **TO:** _____ **PLACE OF SERVICE:** _____
Comments: _____

THE DOCUMENTS ACCOMPANYING THIS TRANSMISSION CONTAIN CONFIDENTIAL HEALTH INFORMATION THAT IS LEGALLY PRIVILEGED. THIS INFORMATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. THE AUTHORIZED RECIPIENT OF THIS INFORMATION IS PROHIBITED FROM DISCLOSING THIS INFORMATION TO ANY OTHER PARTY UNLESS REQUIRED TO DO SO BY LAW OR REGULATION AND IS REQUIRED TO DESTROY THE INFORMATION AFTER ITS STATED NEED HAS BEEN FULFILLED. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR ACTION TAKEN IN RELIANCE ON THE CONTENTS OF THESE DOCUMENTS IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY AND ARRANGE FOR THE RETURN OR DESTRUCTION OF THESE DOCUMENTS.

Revised: 10/01/2013



BHS-Fax Adverse Determination-CHIP

EL PASO FIRST
Health Plans, inc.

1145 Westmoreland Drive
El Paso, Texas 79925
Phone (915) 532-3778
Fax (915) 298-7866

NOTIFICATION OF REVIEW

DATE: _____ NO. OF PAGES: 1
TO: _____
Attention: _____ FAX NO: _____
FROM: Health Services – Pre-Cert Unit PA NO. _____
PHONE: 532-3778 Ext. 1536 (CHIP/CHIP PERINATE)
RE: Member Name: _____
ID No. _____ Date of Birth _____

REFERENCE NO. _____

DOS: _____ TO _____ PLACE OF SERVICE: _____

A denial or partial denial is pending for the services listed below:

<u>CPT CODE</u>	<u>UNITS</u>	<u>CPT CODE</u>	<u>UNITS</u>	<u>CPT CODE</u>	<u>UNITS</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

El Paso First is required under Texas Law to make a determination within three (3) days from the date of a request. An adverse determination is pending for this request. Before moving forward with the adverse determination, El Paso First is providing you with the opportunity to discuss the clinical rationale for the decision.

We ask that you please contact the Pre-Cert Unit at _____ by **<include time-24 hours from receipt>** today for the opportunity for the peer-to-peer conference. Should we not hear from you, a Notice of Adverse Determination will be issued within three (3) days from the date of the request made on **<date of receipt>**. This notice will provide you with your appeal rights, and include your right to request an Independent Review Organization (IRO) and a description of how to obtain one.

THE DOCUMENTS ACCOMPANYING THIS TRANSMISSION CONTAIN CONFIDENTIAL HEALTH INFORMATION THAT IS LEGALLY PRIVILEGED. THIS INFORMATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. THE AUTHORIZED RECIPIENT OF THIS INFORMATION IS PROHIBITED FROM DISCLOSING THIS INFORMATION TO ANY OTHER PARTY UNLESS REQUIRED TO DO SO BY LAW OR REGULATION AND IS REQUIRED TO DESTROY THE INFORMATION AFTER ITS STATED NEED HAS BEEN FULFILLED. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR ACTION TAKEN IN RELIANCE ON THE CONTENTS OF THESE DOCUMENTS IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY AND ARRANGE FOR THE RETURN OR DESTRUCTION OF THESE DOCUMENTS.

Revised: 10/01/2013

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BHS-Fax Adverse Determination-STAR

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1145 Westmoreland Drive
El Paso, Texas 79925
Phone (915) 532-3778
Fax (915) 298-7866

NOTIFICATION OF REVIEW

DATE: _____ NO. OF PAGES: 1
TO: _____
Attention: _____ FAX NO: _____
FROM: Health Services – Pre-Cert Unit PA NO. _____
PHONE: 532-3778 Ext. 1500 PREMIER PLAN
RE: Member Name: _____
ID No. _____ Date of Birth _____

REFERENCE NO. _____

DOS: _____ TO _____ PLACE OF SERVICE: _____

A denial or partial denial is pending for the services listed below:

<u>CPT CODE</u>	<u>UNITS</u>	<u>CPT CODE</u>	<u>UNITS</u>	<u>CPT CODE</u>	<u>UNITS</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

El Paso First is required under Texas Law to make a determination within three (3) days from the date of a request. An adverse determination is pending for this request. Before moving forward with the adverse determination, El Paso First is providing you with the opportunity to discuss the clinical rationale for this decision.

We ask that you please contact the Pre-Cert Unit at _____ by **<include time-24 hours from receipt>** today for the opportunity for the peer-to-peer conference. Should we not hear from you, a Notice of Adverse Determination will be issued within three (3) days from the date of the request made on **<date of receipt>**. This notice will provide you with your appeal rights, and include your right to request a State Fair Hearing and a description of how to obtain one.

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Revised: 10/01/2013

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PRECERTIFICATION UNIT REVIEW

DATE: _____ **NO. OF PAGES:** 1
TO: _____
Attention: _____ **FAX NO:** _____
FROM: Health Services – Pre-Cert Unit
PHONE: 532-3778 Ext. 1500 PREMIER PLAN Ext. 1536 CHIP/CHIP PERINATE PLAN
RE: Member Name: _____ SSI
ID No. _____ Date of Birth _____

REFERENCE NO. 0000
DOS: _____ **TO** _____ **PLACE OF SERVICE:** _____

Your authorization request is being returned to you. Upon review, it was determined that:

- The member's eligibility is or will become termed with El Paso First for the DOS requested.
- No auth is required for the requested services; auth request has been closed.
- This request is a duplicate request; there is already an auth on file for the same CPT Code(s)
- The services requested can be performed by an in-network provider.
- This is a retro authorization; prior authorization is required for elective or scheduled services.
- The service requested is not a covered benefit under the Member's Plan.
- Non-compliance with UM Process: _____

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Revised: 10/01/2013

BHS-Fax
Administrative
General
Notification
STAR & CHIP



FAQ'S

- If member is receiving services with another provider please submit a written letter indicating change of provider
- For Preferred Administrators (UMC/El Paso Children's Hospital Employees) please verify benefit coverage.



Questions/Comments

Please Contact : Diana Gonzalez, LVN Case Manager
915-298-7198 ext. 1082

Aurora Arias, LBSW Case Manager
915-298-7198 ext. 1131

Edna Lerma, LPC
Clinical Supervisor
915-298-7198 ext. 1078



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Health and Behavior Assessment and Intervention Services (HBAI)

Edna Lerma, LPC
Clinical Supervisor



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Health and Behavior Assessment and Intervention (HBAI) Services

- As of July 1, 2014 El Paso First will implement a new benefit in Texas Medicaid
- No authorization is required
- HBAI services are for Medicaid clients who are 20 years of age and younger
 - Have an underlying physical illness or injury
 - Member has a documented need for psychological evaluation
 - (Other Specific Criteria Apply)



HBAI

HBAI services are provided by a licensed professional of the healing arts (LPHA) who is co-located in the same office as the client's primary care provider (PCP).

- Physician Assistant (PA)
- Nurse Practitioner
- LPC/LMFT
- LCSW
- Physician (D.O./M.D.)



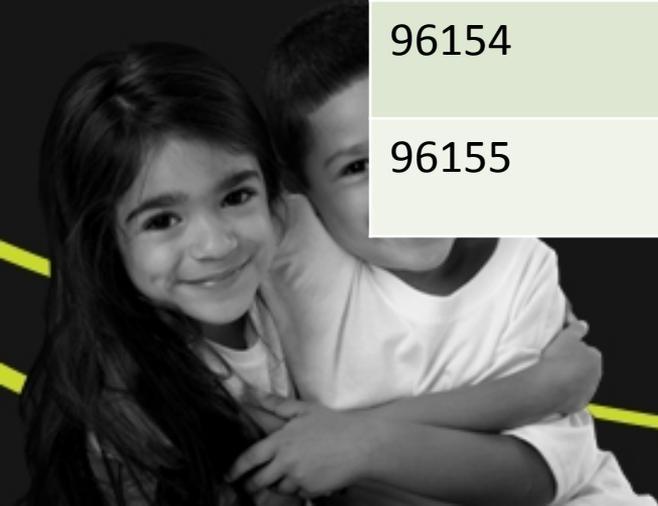
HBAI - Benefits

- A health and behavior assessment (96150) and reassessment (96151)
- Treatment services which could consist of cognitive, behavioral, social, or psychological interventions designed to ameliorate specific disease related problems.



Benefits Cont.

Codes	Service
96150	Assessment
96151	Reassessment
96152	Individual
96153	Group
96154	Client w/family
96155	Family w/o client



Mental Health Rehabilitative Services and Targeted Case Management (TCM)

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MH Rehabilitative Services and Targeted Case Management (TCM)

Services are available to Medicaid recipients only who are assessed and determined to have:

- A severe and persistent mental illness (SPMI) such as schizophrenia, major depression, bipolar disorder or another severely disabling mental disorder
- Children and adolescents ages 3 through 17 years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance (SED)



Prior Authorization

- El Paso First will require prior authorization for the following services:
 - Rehabilitative Services
 - Medication Training and Support
 - Skills Training and Development
 - Targeted Case Management



Targeted Case Management (TCM)

- Must be face to face
- Include regular, annual, monitoring of service effectiveness
- Proactive crisis planning and management for individuals
 - Case Managers will refer to Local Mental Health authorities if member loses eligibility



Rehabilitative Services

- Crisis Intervention Services
- Medication Training and Support Services
- Psychosocial Rehabilitative Services
- Skills Training and Development Services
- Day Program for Acute Needs



Medication Training and Support - Adult -

Service	Procedure Code	Modifier 1	Unit
Individual services	H0034		15 min
Group Services	H0034	HQ	15 min



Medication Training and Support - Child/Adolescent -

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Individual services	H0034	HA		15 min
Group Services	H0034	HA	HQ	15 min



Medication Training and Support - Crisis Intervention -

Service	Procedure Code	Modifier 1	Unit
Adult services	H2011	HA	15 min
Child/Adol Services	H2011	HA	15 min



- Children/Adolescent - - Skills Training and Development-

Service	Procedure Code	Modifier 1	Unit
Individual	H2014	HA	15 min
Group	H2014	HQ	15 min



Psychosocial Rehabilitative Services

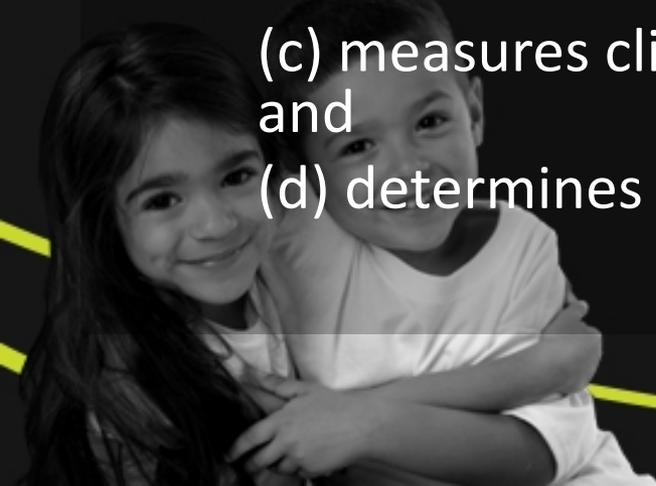
Service	Procedure Code	Modifier 1	Modifier 2	Unit
Individual	H2017			15 min
Individual by RN	H2017	TD		15 min
Group	H2017	HQ		15 min
Group by RN	H2017	HQ	TD	15 min
Crisis	H2017	ET		15 min

Targeted Case Management Codes

Service	Procedure Code	Modifier	Limitations	Unit
Routine MH TCM Adult	T1017	TF	32 units (restrictions apply)	15 min
Routine CM (Child/ Adol)	T1017	TF, HA	32 units (restrictions apply)	15 min
Intensive CM (Child/ Adol)	T1017	TG, HA	32 units (restrictions apply)	15 min

Texas Resilience and Recovery Utilization Management Guidelines

- El Paso First Health Plan is required to utilize the current DSHS utilization management guidelines
- The Texas Resilience and Recovery System or public mental health service design in Texas
 - includes the following components:
 - (a) establishes who is eligible to receive services through a uniform assessment,
 - (b) establishes ways to manage the use of services as outlined in the Utilization Management (UM) Guidelines
 - (c) measures clinical outcomes or the impact of services, and
 - (d) determines how much these services should cost.



ANSA/CANS

- El Paso First will contract with provider entities that will assess member's needs for services by administering Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS)
- Providers must be trained and certified to administer the ANSA and CANS assessment tools
- Provider entities must attest to El Paso First that the organization has the ability to provide, either directly or through sub-contract, Members with the full array of RRUMG services.



Levels of Care

- Level of care 0: Crisis Services
- Level of care 1M (Medication Management)
- Level of care 1S (Skills Training)
- Level of care 2: Basic Services Including Counseling
- Level of care 3: Intensive Services with Team Approach
- Level of care 4: Assertive Community Treatment (ACT)
- Level of care 5: Transitional Services



Questions/Comments

Please Contact Us:

Diana Gonzalez, LVN Case Manager
298-7198 ext. 1082

Aurora Arias, LBSW Case Manager
298-7198 ext. 1131

Edna Lerma, LPC
Clinical Supervisor
915-298-7866 ext. 1078



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ACCESSIBILITY AND AVAILABILITY

Patricia S Rivera, RN

QI Nurse Auditor

Quality Improvement Department



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Background

- HHSC UMCC states
 - The MCO is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members.
 - The MCO must enforce access and other Network standards required by the Contract and take appropriate action with noncompliant Providers.

Definitions

- **Office Accessibility** –members must be able to schedule an appointment with PCP and Behavioral Health Providers for covered services within the time frames mandated by TDI and HHSC.
- **After-hours Availability** - PCPs and OB/GYN (that are PCPs) must be available 24/7 as mandated by TDI and HHSC. If the Provider delegates this duty, the covering Provider must also be available 24/7.

Office Accessibility Standards

- Initial Outpatient Behavioral Health visits must be provided within 14 days of request.



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 number, nurse triage or answering service

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.



Non-Compliant Accessibility Survey

- Medical Director will send letter detailing the reason for the non-compliance.
- The QI Dept will forward results of the office appointment surveys to PR and Credentialing Depts.
- Non-compliant Providers will receive education from PR and Credentialing Depts.
- Non Compliant Provider will be re-surveyed within 3 to 6 months.

2nd Non-Compliant Survey

- Medical Director will send second letter detailing the reason for the non-compliance.
- Medical Director will call Provider.
- QI Nurse Auditor will present Providers who fail the re-survey to the Committee for Peer Review and Credentialing.
- Results are recorded in the physician profile sheets utilized during re-credentialing.

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.

Contact Information

- Should you have any questions regarding Accessibility and Availability, please contact:
 - Your designated Provider Relations Representative at 532-3778 ext. 1507
 - The Quality Improvement Department at 532-3778 ext 1106 or 1231
 - Our Medical Director, David Palafox, MD, at 532-3778 ext 1031

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Medical Transportation Program & Eligibility

Edgar Martinez

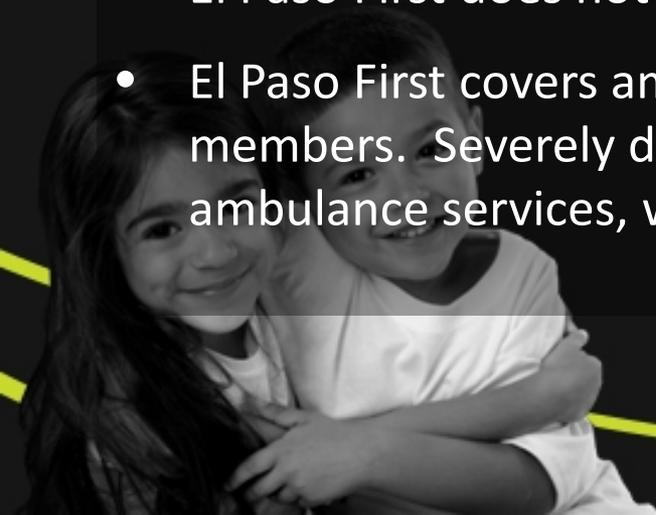
Director of Member Services



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Transportation - El Paso First

- Transportation is available for medical appointments and health education classes.
- If a member needs a ride to a doctor's office, please call our Member Services Department at 915-532-3778 or 1-877-532-3778.
- Transportation must be requested at least 48 hours in advance.
- Transportation is available through bus tokens or through UMC Guest Services Shuttle. Taxi cabs are available on a case by case basis.
- El Paso First does not reimburse members for mileage.
- El Paso First covers ambulance services in emergency situations for all members. Severely disabled members, whose condition requires ambulance services, will also be covered.



Medical Transportation Program

- Transportation is also available from the Medical Transportation Program (MTP).
- If a member needs a ride to a doctor's office, please call MTP at 1-877-633-8747 Monday – Friday 8:00 a.m. to 5:00 p.m. Central Time.
- Transportation must be requested at least two days in advance.
- MTP also pays for members to have a friend, relative, or another individual give them a ride when the member doesn't have a car or gas money. MTP pays these drivers as Individual Contractors by the mile (at the rate set by legislature for state employees).

Eligibility

- Eligibility for all El Paso First members is determined by HHSC.
- It is important to verify eligibility every month.
- To obtain eligibility, please call our Member Services Department at 915-532-3778 or 1-877-532-3778.
- The following diagram will assist you in navigating through the automated telephone system in a more accurate manner.



Thank you for calling El Paso First Health Plans.

Gracias por llamar al plan de salud El Paso First.

- Para asistencia en Espanol, oprima el 1.
- If you are a member, parent of guardian of member press 2.
- **If you are a provider press 3.**
- If you know your party's extension press 4.
- If you would like to hear the menu again press Pound (#)
- For all other calls please remain on the line and an operator will assist you.

Provider Menu

- To verify **Eligibility** through a **Member Services Representative press 1.**
- If you are calling about a **Claim** and would like to speak to a **PCU representative press 2.**
- If you are calling about an **Authorization** and would like to speak to an **Utilization Review Technician press 3.**
- If you would like to be transferred to the **El Paso First Health X** automated eligibility, claims and authorization status services **press 4.**
- To hear the menu again press pound (#).
- For all other calls, please remain on the line and an operator will assist you.

1↓

Provider Member Services Menu

If you are calling about a:

- **Medicaid Member press 1.**
- **Chip Member or Chip Perinate Member press 2.**
- **Health Care Options Member press 3.**
- **Preferred Administrators member press 4.**
- To hear the menu again press pound (#).
- For all other calls, please remain on the line and an operator will assist you.

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Provider Claims Menu

If you are calling about a:

- **Medicaid Member press 1.**
- **Chip Member or Chip Perinate Member press 2.**
- **Health Care Options Member press 3.**
- **Preferred Administrators member press 4.**
- To hear the menu again press pound (#).
- For all other calls, please remain on the line and an operator will assist you.

3↓

Provider Health Services Menu

If you are calling about a:

- **Medicaid Member press 1.**
- **Chip Member or Chip Perinate Member press 2.**
- **Health Care Options Member press 3.**
- **Preferred Administrators member press 4.**
- To hear the menu again press pound (#).
- For all other calls, please remain on the line and an operator will assist you.



Eligibility

Here is a quick reference chart to guide you to the correct extension.

El Paso First Health Plans Phone Queues	Extension
Eligibility Dept. CHIP - Provider	1517
Eligibility Dept. Medicaid - Provider	1514
Eligibility Dept. Preferred Administrators - Provider	1529
Claims Dept. - Provider Care Unit	1504
Claims Dept. - CHIP	1512
Claims Dept. - Health Care Options	1504
Claims Dept. - Medicaid	1527
Claims Dept. - Preferred Administrators	1509
Prior Authorization Dept. - Medicaid	1500
Prior Authorization Dept. - CHIP	1536
Prior Authorization Dept. – Health Care Options	1537
Prior Authorization Dept. – Preferred Administrators	1538
Provider Relations Department	1507



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



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**Thank You for
Attending Providers!**



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