Welcome Providers

ICD-10 Readiness Training

July 16, 2015

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

CHIP We've got your kids covered.

EL PASO FIRST Health Plans, inc.

Agenda

- **AHIMA Presentation: ICD-10 Readiness**
- **Provider Relations**: ICD-10 Transition
- **Claims**: Claim Submission Guidelines
- **Health Services**: Authorization Expectations

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ICD-10 Transition

Cynthia Moreno
Provider Relations Supervisor

EL PASO FIRST
Health Plans, inc.

Timeline

- July 1, 2015 – September 1, 2015: Provider claims and authorization testing.
- October 1, 2015: ICD-10 go live date.

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Transition Expectations

- All providers must use ICD-10 starting 10/01/2015
- No grace period for implementation.
- Exception projects will not be considered.

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ICD-10 Resources

- El Paso First ICD-10 mapping tool available on the Web Portal.
- Mapping tool applies to El Paso First only.
- Providers may call the following departments:
  - Claims Provider Care Unit
  - Health Services Prior Authorization
  - Provider Relations Representative

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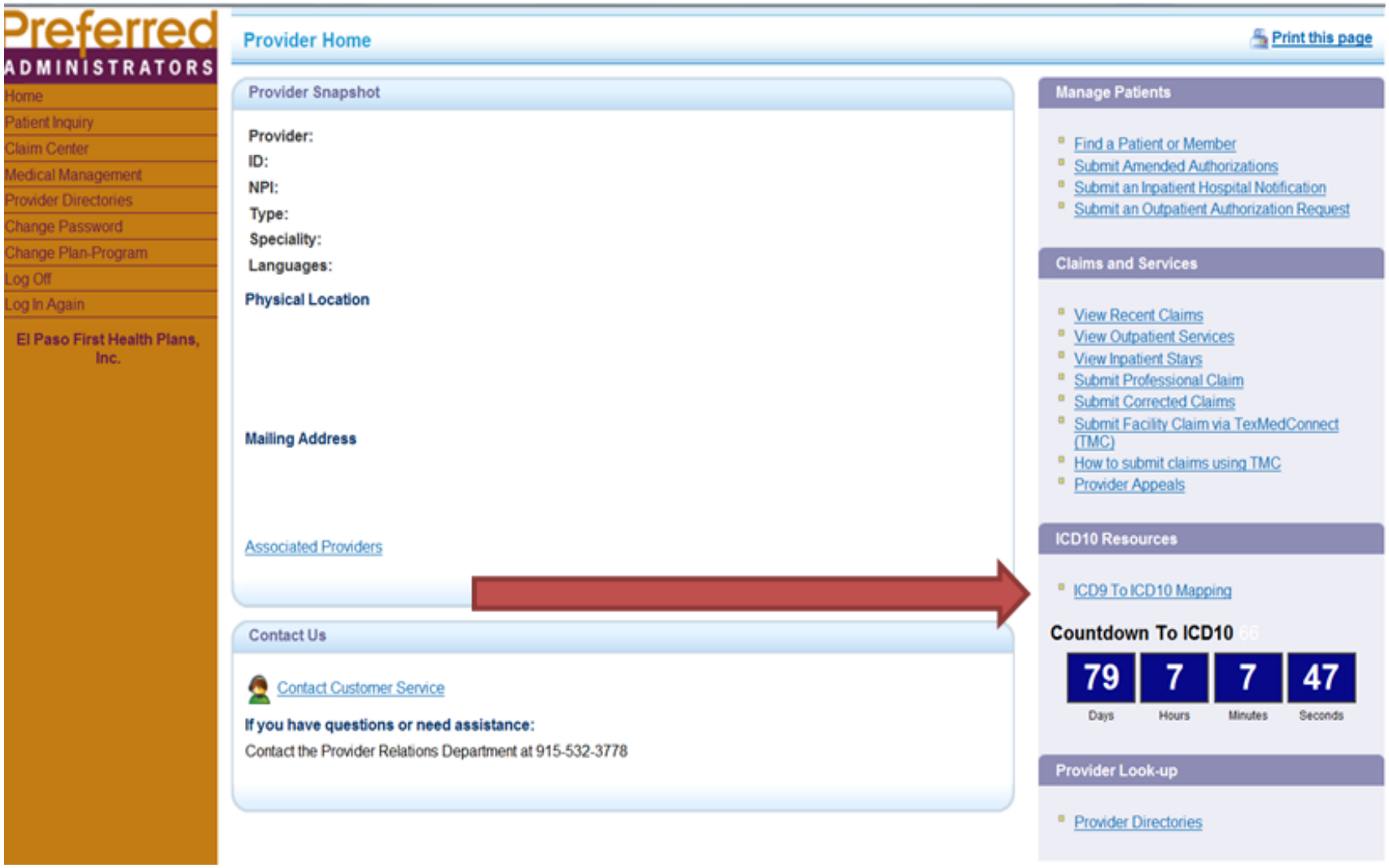
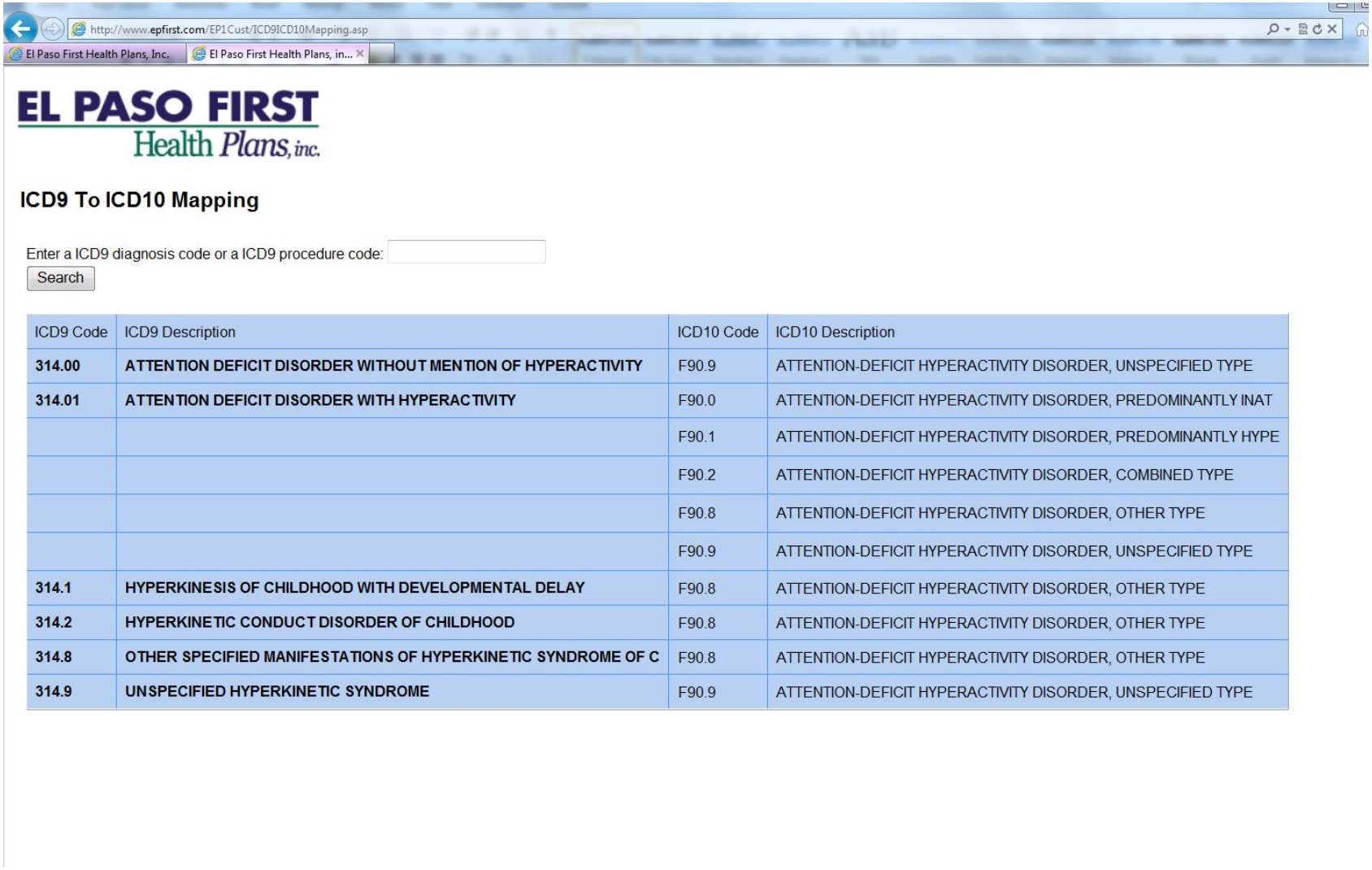
Web Portal Mapping Tool



ICD 9 to ICD 10 Mapping



ICD9 Code	ICD9 Description	ICD10 Code	ICD10 Description
314.00	**ATTENTION DEFICIT DISORDER WITHOUT MENTION OF HYPERACTIVITY**	F90.9	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE
314.01	**ATTENTION DEFICIT DISORDER WITH HYPERACTIVITY**	F90.0	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, PREDOMINANTLY INAT
		F90.1	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, PREDOMINANTLY HYPE
		F90.2	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, COMBINED TYPE
		F90.8	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, OTHER TYPE
		F90.9	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE
314.1	**HYPERKINESIS OF CHILDHOOD WITH DEVELOPMENTAL DELAY**	F90.8	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, OTHER TYPE
314.2	**HYPERKINETIC CONDUCT DISORDER OF CHILDHOOD**	F90.8	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, OTHER TYPE
314.8	**OTHER SPECIFIED MANIFESTATIONS OF HYPERKINETIC SYNDROME OF C**	F90.8	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, OTHER TYPE
314.9	**UNSPECIFIED HYPERKINETIC SYNDROME**	F90.9	ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE

Contact Information

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Provider Relations Supervisor
cmoreno@epfirst.com
915-532-3778 ext. 1044

Provider Relations Department
915-532-3778 ext. 1507

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Claim Submission Guidelines

Adriana Villagrana
Claims Manager

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Billing Expectations

- Providers expected to use ICD-10 coding
  - Effective for dates of service on and after 10/01/15
  - No grace period for compliance
- Clearinghouses will reject claims with incorrect diagnosis code
- EPF will deny claims with incorrect diagnosis code

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Inpatient Claims

- Claims must be coded according to date of discharge
  - ICD-9 for date of discharge on or before 09/30/2015
  - ICD-10 for date of discharge on or after 10/01/2015

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Professional & Outpatient Claims

- Claim for DOS on or before 09/30/2015 submitted on one claim
- Claim for DOS on or after 10/01/2015 submitted on separate claim

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Example

	DOS From	DOS To	POS	CPT	Mod 1	Mod 2	Mod 3	Diagnosis	Charges	Units	NDC
1	06/17/2015	06/17/2015	11	97110	GP			1, 2, 3, 4	$184.00	4.00	
2	06/17/2015	06/17/2015	11	G8978	GP	CK		1, 2, 3, 4	$0.00	1.00	
3	06/17/2015	06/17/2015	11	G8979	GP	CI		1, 2, 3, 4	$0.00	1.00	
4	06/18/2015	06/18/2015	11	97110	GP	AT		1, 2, 3, 4	$184.00	4.00	

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ICD-10 Claim Testing

- Providers may contact Availity and Trizetto Provider Solutions (formerly Gateway EDI).
  1. Submit test claims to the clearinghouse
  2. Notify El Paso First PR Representative about test claims
- Paper claims may be sent to EPF

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Contact Information

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Claims Manager
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Provider Care Unit Extension Numbers:

- 1527 – Medicaid
- 1512 – CHIP
- 1509 – Preferred Administrators
- 1504 – HCO

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Authorization Expectations

Edna Lerma

HS Clinical Supervisor

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Authorization Expectations Overview

- Texas Standardized Prior Authorization Form for medical and pharmacy benefits
- ICD-10 authorization requests

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Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. Do not send this form to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: When an issuer requires prior authorization of a health care service, use this form to request authorization by fax or mail. An issuer may also provide an electronic version of this form on its website that you can complete and submit electronically, via the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I. An issuer may have already entered this information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV.

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

***Note:** Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before faxing or mailing your request.*

If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

Texas Department of Insurance | 333 Guadalupe | Austin, Texas 78701 | (800) 578-4677 | www.tdi.texas.gov | @TexasTDI

- New Texas Standard PA Form Effective September 1, 2015
- Applies to all Health Care Services

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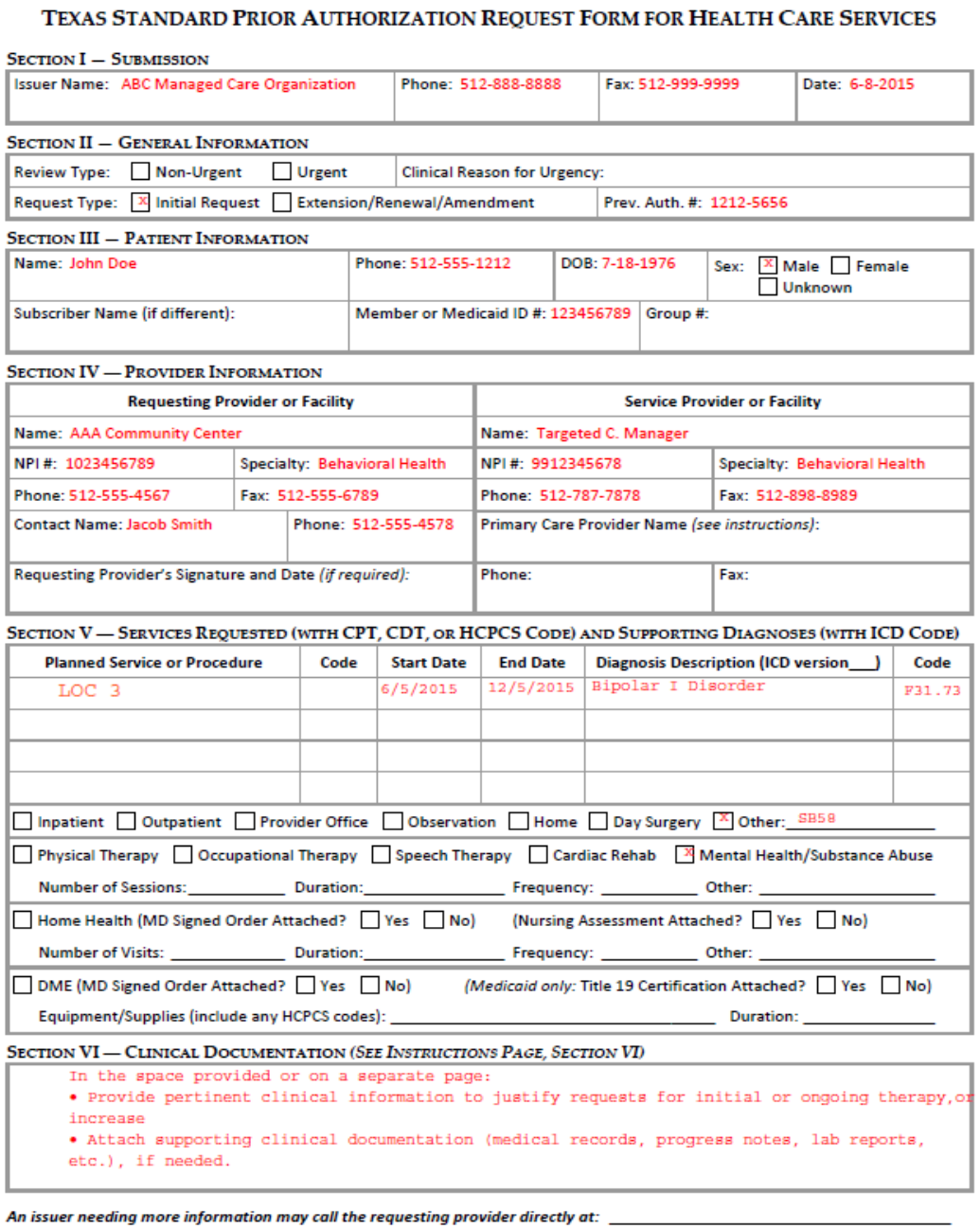

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name: ABC Managed Care Organization	Phone: 512-888-8888	Fax: 512-999-9999	Date: 6-8-2015

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☒ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #: 1212-5656

SECTION III — PATIENT INFORMATION

Name: John Doe	Phone: 512-555-1212	DOB: 7-18-1976	Sex: ☒ Male ☐ Female ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #: 123456789	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: AAA Community Center		Name: Targeted C. Manager	
NPI #: 1023456789	Specialty: Behavioral Health	NPI #: 9912345678	Specialty: Behavioral Health
Phone: 512-555-4567	Fax: 512-555-6789	Phone: 512-787-7878	Fax: 512-898-8989
Contact Name: Jacob Smith	Phone: 512-555-4578	Primary Care Provider Name *(see instructions)*:	
Requesting Provider's Signature and Date *(if required)*:		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code
LOC 3		6/5/2015	12/5/2015	Bipolar I Disorder	F31.73

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☒ Other: SB58

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☒ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) *(Medicaid only:* Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION *(SEE INSTRUCTIONS PAGE, SECTION VI)*

In the space provided or on a separate page:
- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increase
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

An issuer needing more information may call the requesting provider directly at: _____

NOFR001 | 0115

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Effective 9/1/2015
Texas Standard PA Request Form must be submitted for ALL Health Care Services

ATTENTION
Beginning 10/1/2015 ONLY ICD-10 Codes will be accepted.

Effective 10/1/2015
ALL requests must be submitted using new **Texas Standard PA Request Form** along with ICD-10 codes

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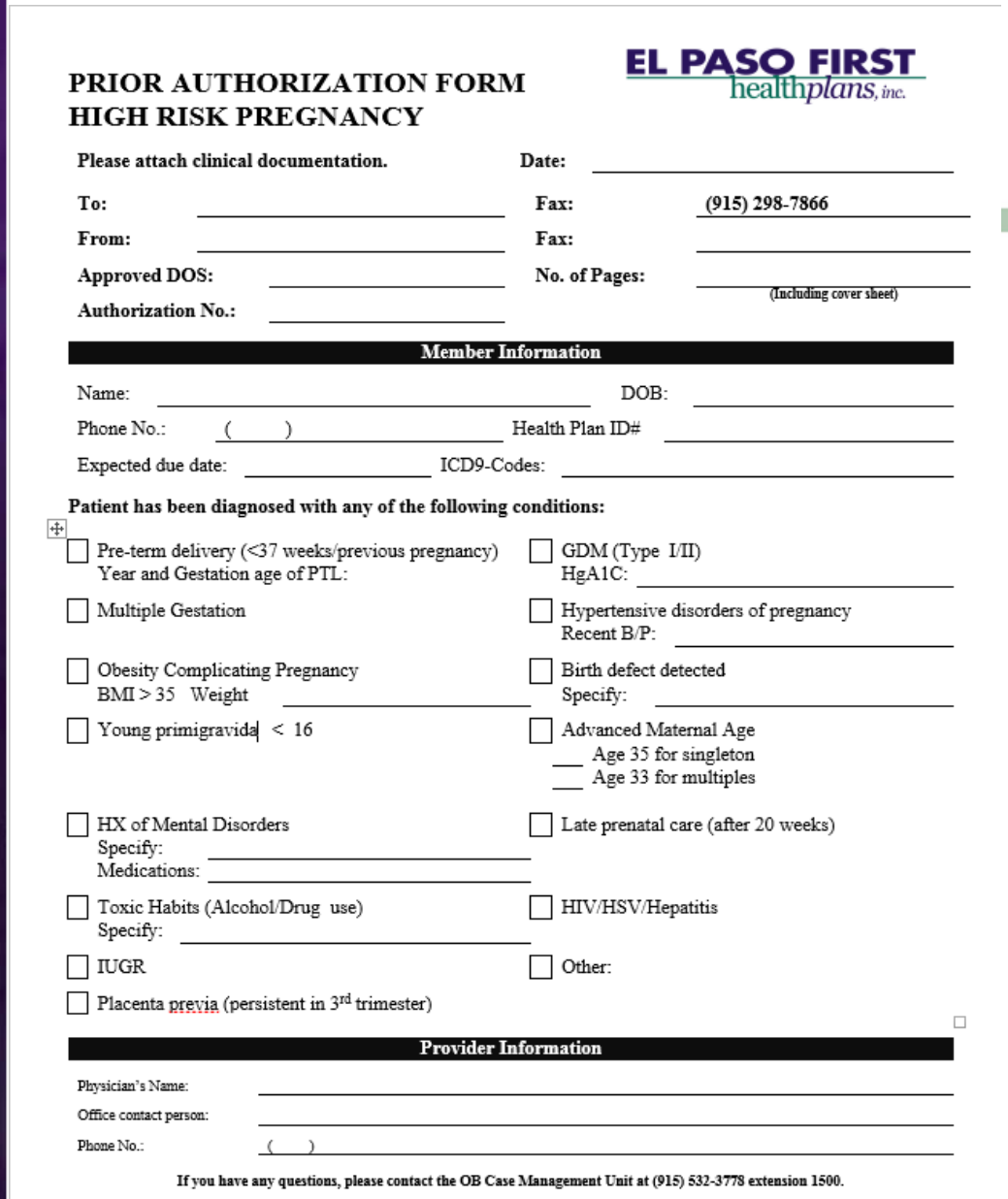

PRIOR AUTHORIZATION FORM
HIGH RISK PREGNANCY

EL PASO FIRST healthplans, inc.

Please attach clinical documentation. **Date:** _____

To: _____ **Fax:** (915) 298-7866

From: _____ **Fax:** _____

Approved DOS: _____ **No. of Pages:** _____ (Including cover sheet)

Authorization No.: _____

Member Information

Name: _____ DOB: _____

Phone No.: ( ) _____ Health Plan ID# _____

Expected due date: _____ ICD9-Codes: _____

Patient has been diagnosed with any of the following conditions:

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

OB providers will continue to use this form when requesting authorization for High Risk Members.

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Pharmacy Prior Authorization

- Texas Department of Insurance (TDI) adopted a standardized form to prior authorize prescription drug benefits.
- The standardized PA form will be used by all health plans.

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Texas Standardized Prior Authorization Request Form For Prescription Drug Benefits

Clear Form | Print

Section I — Submission

Submitted to:	Phone:	Fax:	Date:

Section II — Review

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:	
BIN # (if available):	PCN (if available):	Rx ID # (if available):	

Section IV — Prescriber Information

Name:	NPI #:	Specialty:	
Address:	City:	State:	ZIP Code:
Phone: / Fax:	Office Contact Name:	Contact Phone:	

Section V — Prescription Drug Information

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated: _____)

For Provider Administered Drugs Only:

HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____

Section VI — Prescription Compound Drug Information

Compound Drug Name:

Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

Section VII — Prescription Device Information

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

Section VIII — Patient Clinical Information

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

Section IX — Justification (See Instruction Page Section IX)

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Pharmacy Prior Authorization

- PA Request Form for Prescription Drug Benefits must be submitted to our pharmacy benefit manager, Navitus.
- Information regarding medications that require authorization can be found at http://www.navitus.com/Texas-Medicaid-Star-Chip/Texas-Medicaid-Star-Chip-Main.aspx and www.txvendordrug.com

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Contact Information

Please contact Health Services for any questions regarding PA and ICD-10

915-532-3778 ext. 1500

All forms discussed in the presentation will be available on our website.

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Thank You for Attending Providers!

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