Welcome Providers!

Provider Quarterly Orientation

May 15, 2014

EL PASO FIRST
Health Plans inc.

Agenda

- Welcome & Introductions
- PCP Supplemental Payment - Provider Relations
- STAR Texas Health Steps Updates - C.A.R.E. Unit
- Case Management- Health Services
- New CMS-1500 - Claims
- Special Investigations Unit – Compliance
- Complaints & Appeals Process – Compliance
- CHIP Member Cost Sharing – Member Services

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Provider Relations Department

Irma L. Herrera

Director of Provider Relations & Credentialing

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PCP Supplemental Payment

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Memo

To: Providers

From: El Paso First Health Plans

Date: April 10, 2014

Re: PCP Rate Increase Supplemental Payment Update

The Affordable Care Act (ACA) grants a rate increase for certain primary care Medicaid services provided during 2013 and 2014. HHSC will issue quarterly supplemental payments to providers to cover the difference between the regular Medicaid rate for the service and the temporary increase. In January, HHSC was scheduled to issue payments directly to the health plans and the health plans are expected to pass the payment to the appropriate Provider. Payments to a billing Provider group (such as a group practice, facility, or institution) are required to pass down the full supplemental payment from the billing Provider group to the eligible and identified Provider. Provider groups who believe they are exempt from this HHSC requirement must provide documentation supporting their declaration.

To be eligible to receive supplemental payments, providers must complete and submit an attestation form to TMHP. The form is available on the TMHP website:
http://www.tmhp.com/Provider_Forms/Medicaid/ACA%20Primary%20Care%20Attestation.pdf

Only physicians who meet the specialty and board certification or Medicaid billing volume requirements described on the attestation form are eligible for supplemental payments. Physicians who complete the form by April 1, 2014 will qualify for rate increase payments for services provided since January 1, 2013. Those who complete the form after April 1, 2014 will get the rate increase payments only for services provided from the date they complete the form.

TMHP has published a list of Providers who have the required attestation form on file. As new attestation forms are processed TMHP will continue to update the list.
http://www.tmhp.com/TMHP_File_Library/ACA/PCP%20Attestation%20List.pdf

Please contact your Provider Relations Representative or Provider Relations Department at 915-532-3778 ext. 1507 for general questions. For all other detailed questions or concerns regarding this process or amounts to be paid, please contact TMHP Contact Center at 1-800-925-9126.

Contact Information

Irma L. Herrera

Director of Provider Relations & Credentialing

iherrera@epfirst.com

(915) 532-3778 ext. 1018

Provider Relations Department

(915) 532-3778 ext. 1507

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Texas Health Steps Updates & Reminders

STAR Members

Maritza Lopez
Texas Health Steps Coordinator

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THSteps Updates

Effective April 1, 2014

- Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program will enforce the National Correct Coding Initiative (NCCI) procedure-to-procedure edits for claims with immunization administration, preventive medicine evaluation, and management (E/M) procedure codes billed on the same day.

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THSteps Updates

Effective April 1, 2014, Changes in Claims Filing for Vaccine Administration and Preventive Medicine E/M Visits

- For claims that are submitted with procedure codes for an immunization administration and a preventive medicine E/M visit, providers may append modifier 25 to the preventive medicine E/M procedure code to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.

- Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

- If a claim for a preventive medicine E/M service is denied, the claim may be appealed with modifier 25 appended to the preventive medicine procedure code.

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THSteps Updates

THSteps Preventive Care Medical Checkup Requirement to Change for Elevated Blood Levels

- As of December 1, 2013, the elevated blood lead level requirement has been reduced from 10 mcg/dL **to <u>5 mcg/dL.</u>**

- For an elevated blood lead level of 5 mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen.
  - The confirmatory specimen may be sent to the Department of State Health Services (DSHS) Laboratory, or the client or specimen may be sent to a laboratory of the provider's choice.

Information related to blood lead screening and reporting for clients who are 15 years of age and older is available on the DSHS Blood Lead Surveillance Group's website at www.dshs.state.tx.us/lead/providers.shtm.

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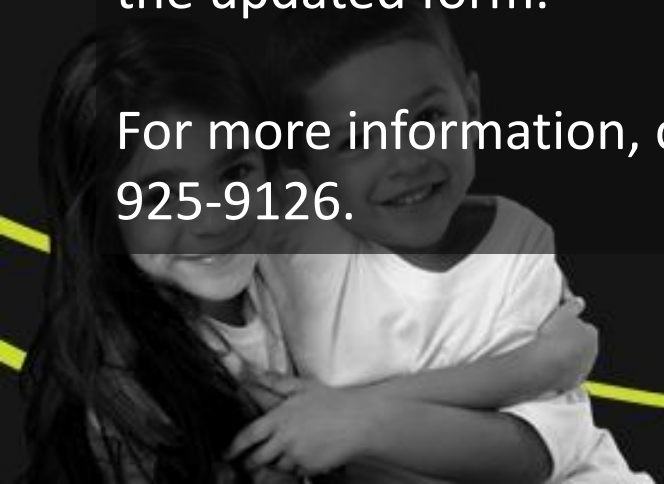
THSteps Updates

Updated TXCLPPP Reference for Follow-up Blood Lead Testing and Medical Case Management Now Available

The Texas Childhood Lead Poisoning Prevention Program (TXCLPPP) Reference for Follow-up Blood Lead Testing and Medical Case Management (Pb-109) is now available on the Texas Department of State Health Services (DSHS) website. The January 2014 release of the *Texas Medicaid Provider Procedures Manual, Children's Services Handbook* will include the updated form.

For more information, call the TMHP Contact Center at 1-800-925-9126.



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THSteps Updates

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

Request for Medicaid Records

<<prov_contact_name>>
<<prov_name>>
<<prov_addr_line_1>>
<<prov_addr_line_2>>
<<prov_addr_citys>>, <<prov_addr_state>>, <<prov_addr_postalcode>>

Dear <<prov_contact_name>>:

The Texas Health and Human Services Commission (HHSC) has contracted with Altarum Institute and UniMed Direct to comply with the requirements of a federal court order in a class action lawsuit, *Frew v. Janek, et al. (Frew)*, Civil Action No.3:93CV65. These independent organizations have been selected to conduct a court-ordered study about the completeness of medical checkups in the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, known also as Texas Health Steps (THSteps) in Texas. A copy of the *Frew* court's order is located on HHSC's website: http://www.hhs.state.tx.us/MotionCorrectiveActions/CA_Docs/3Checkups.pdf

Under the terms of your Provider Enrollment Contract and the Texas Medicaid Provider Procedures Manual, you have agreed to provide any documents required by HHSC. This request is an authorized health oversight activity under the Health Insurance Portability and Accountability Act, Section 164.512(d) that allows disclosure of protected health information without patient consent or authorization. Please consider any request pertaining to this matter from Altarum Institute and UniMed Direct in the same manner as you would treat a request from HHSC. Hence, you are not entitled to reimbursement for the cost of submitting the medical records requested herewith.

Enclosed is a list of all patients in your care whose medical records are being requested. For each patient listed, there is a cover sheet containing instructions for completion and return of the requested record. Also enclosed is a Required Records Checklist that identifies all elements of medical records being requested. Lastly, we request your completion of a short survey about your knowledge and provision of Medicaid THSteps care, why checkup elements are most commonly missed or not documented, and your insights to help improve checkup completeness.

Please submit all requested documentation on or before <<**Insert Date Due**>>. Please mail the survey separately in the postage paid envelope provided. If the record(s) requested are located at a different site, please forward this letter and all attachments accordingly. Should you have questions regarding this request, contact Jo Ann Roznovak, Frew Compliance Lead - Medicaid Managed Care, HHSC at (512) 462-6377.

Sincerely,

Kay Ghahremani
Associate Commissioner for Medicaid and CHIP

Enclosures
Medical Record Request Cover Sheet(s)
Required Records Checklist
Medicaid THSteps Provider Survey

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

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Overview:
Program for Children of Farm Workers who Travel for Work

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Accelerated Services for Children of Farm Workers who Travel for Work

- State initiative to provide a THSteps checkup and accelerated services to children of farm workers who travel for work due to the uniqueness of the population.
- Coordinate with the Migrant Outreach Coordinator for provider education on these services.

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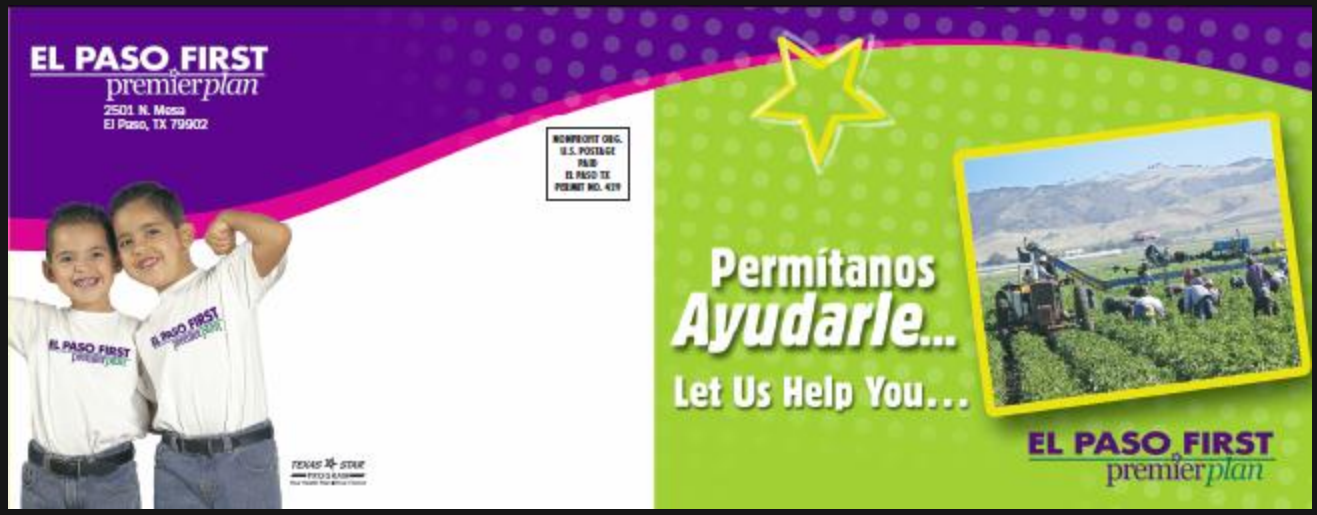
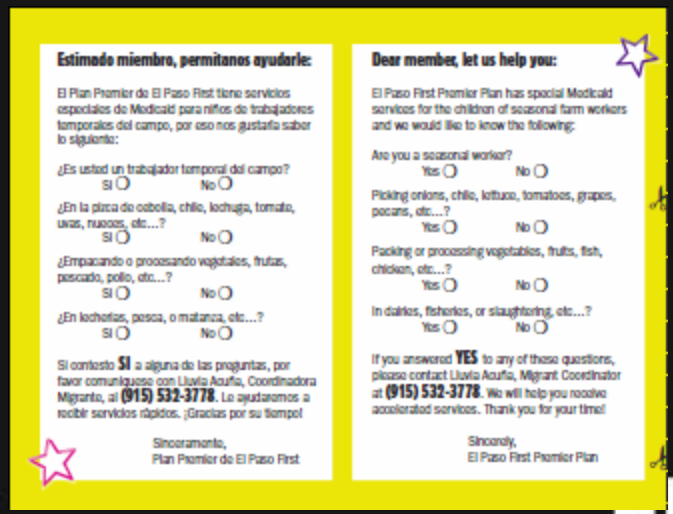
Postcard





Estimado miembro, permítanos ayudarle:

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

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

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

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

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

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

Sinceramente,
Plan Premier de El Paso First

Dear member, let us help you:

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

Are you a seasonal worker?
Yes ○ No ○

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

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

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

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

Sincerely,
El Paso First Premier Plan

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Contact Information

Maritza Lopez-THSteps Coordinator

mlopez@epfirst.com

(915) 532-3778 ext. 1071

Lluvia Acuña-Migrant Outreach Coordinator

lacuna@epfirst.com

(915) 531-3778 ext. 1075

Adriana Cadena-C.A.R.E. Unit Manager

acadena@epfirst.com

(915) 532-3778 ext. 1127

EL PASO FIRST Health Plans inc.

Health Services Department

Grisel Muñoz, RN, BSN
Medical Case Manager

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Purpose of Our Case Management

- Facilitates the achievement of the member's **wellness** & **autonomy**
- Links members with appropriate providers & resources in
  - Care settings
  - Continuum of health & human services
- Identifies new problems before they become serious

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Why does El Paso First Provide Case Management?

- To assist the client to return back to an optimum level of:
  - Wellness
  - Self-care management
  - Functional capability

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Types of Case Management

El Paso First Health Plans (EPF) offers the following types of Case Management:

- Medical Case Management
- Neonatal Intensive Care Case Management
- High-risk Obstetric Case Management
- Disease Management
- Catastrophic Case Management
- Behavioral Health Case Management

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Case Management Process

Case Managers at EPF:

- Initiate the Case Management Process by:
  - **Telephonically interviewing the member/care giver to perform needs-assessment**
  - **Creating & adhering to a service plan that details required interventions and member's goals**
- Continuously follow-up with members to evaluate progress & modify service plan as needed
- Terminate Case Management once goals or needs are met

* If warranted, Case Managers will conduct home visits to better assist members.

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El Paso First Service Coordination

EPF Case Managers coordinate services to connect or facilitate collaboration between the member and the following health & human resources:

- Primary Care Providers
- Specialists
- Therapy or nursing services
- Hospitals/clinics
- Associations/Support Groups

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El Paso First Service Coordination

Case Managers refer members to the following human services when applicable:

- Specialty Case Management Services
  - Early Childhood Interventions
  - Children & Pregnant Women Case Management
  - Special Health Care Needs (SHCN) Program
- Crisis Centers

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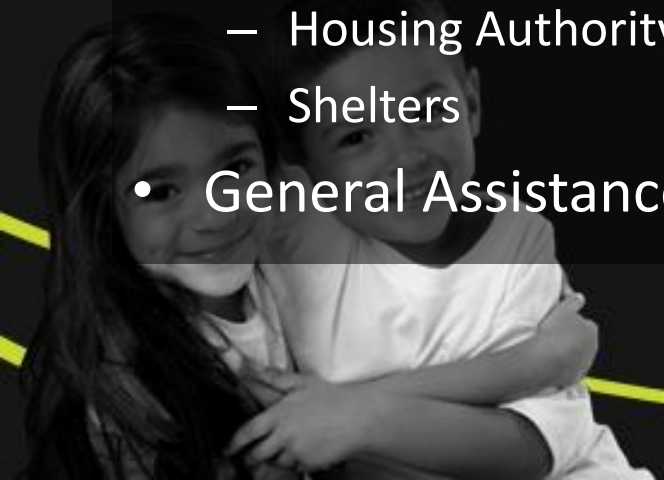
El Paso First Service Coordination

- Food & Nutrition Services
  - Food Stamps
  - WIC
  - Community Food Banks
- Transportation
  - Medical Transportation Program
  - EPF Transportation
- Housing & Shelter Services
  - Housing Authority
  - Shelters
- General Assistance Services



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How do we receive referrals?

- Hospital case managers, social workers
- Physician Referrals
- Member self-referrals
- Health plan initiated referrals

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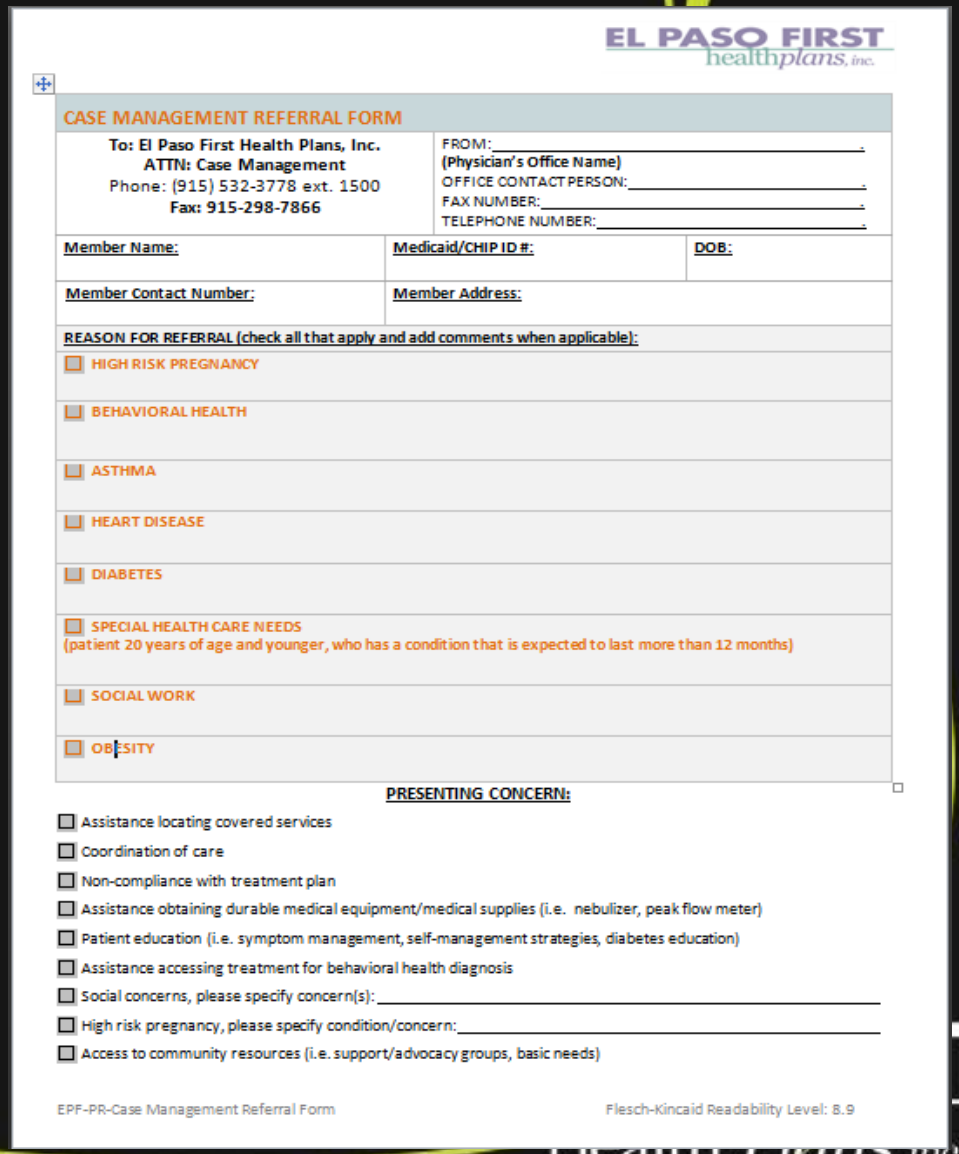
How To Refer a Member

Identification of members requiring disease management is important for the most proper care and enhancement of health status.

Please help us identify those who are in need of these services! We are taking referrals by phone and fax as referral methods. This form will be faxed to all providers to use.

To refer someone by phone, please call (915)532-3778, x1500.

Fax: 298-7866



EL PASO FIRST healthplans, Inc.

CASE MANAGEMENT REFERRAL FORM

To: El Paso First Health Plans, Inc. **ATTN: Case Management** Phone: (915) 532-3778 ext. 1500 **Fax: 915-298-7866**	FROM: _____ (Physician's Office Name) OFFICE CONTACT PERSON: _____ FAX NUMBER: _____ TELEPHONE NUMBER: _____

Member Name:	Medicaid/CHIP ID #:	DOB:
Member Contact Number:	Member Address:	

REASON FOR REFERRAL (check all that apply and add comments when applicable):

- ☐ HIGH RISK PREGNANCY
- ☐ BEHAVIORAL HEALTH
- ☐ ASTHMA
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ SPECIAL HEALTH CARE NEEDS (patient 20 years of age and younger, who has a condition that is expected to last more than 12 months)
- ☐ SOCIAL WORK
- ☐ OBESITY

PRESENTING CONCERN:

- ☐ Assistance locating covered services
- ☐ Coordination of care
- ☐ Non-compliance with treatment plan
- ☐ Assistance obtaining durable medical equipment/medical supplies (i.e. nebulizer, peak flow meter)
- ☐ Patient education (i.e. symptom management, self-management strategies, diabetes education)
- ☐ Assistance accessing treatment for behavioral health diagnosis
- ☐ Social concerns, please specify concern(s): _____
- ☐ High risk pregnancy, please specify condition/concern: _____
- ☐ Access to community resources (i.e. support/advocacy groups, basic needs)

EPF-PR-Case Management Referral Form — Flesch-Kincaid Readability Level: 8.9

Helping our members.

EPF Case Management team assisted a member with a history of Lupus, Rheumatoid Arthritis, chronic uncontrolled pain, & hypothyroidism. The member frequented the emergency room due to pain, fatigue, muscle weakness, drowsiness and did not see their doctor frequently. The member was unable to meet basic needs.

Interventions:

- Arranged appointments with an Endocrinologist, Rheumatologist, & Pain Specialist.
- Linked member to community services that helped meet her basic needs such as MTP, Food Stamps Program, Community Food Pantries, Project Bravo, & Assurance Wireless.
- Educated on when to use the emergency room and when to go to the doctor

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Health Plans inc.

Health Services Contact Info

(915) 532-3778

Janel Lujan, LMSW
Senior Director of Operations
- Extension 1090

Irma Vasquez
Administrative Supervisor
-Extension 1042

Dolores Herrada, RN, CCM
Health Services Director
-Extension 1007

Grisel Muñoz, RN, BSN
Medical Case Manger
- Extension 1138

Jose Acosta, RN
UR Coordinator
- Extension 1080

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New CMS-1500 Overview

Julie Zubia
Claims Processing Supervisor

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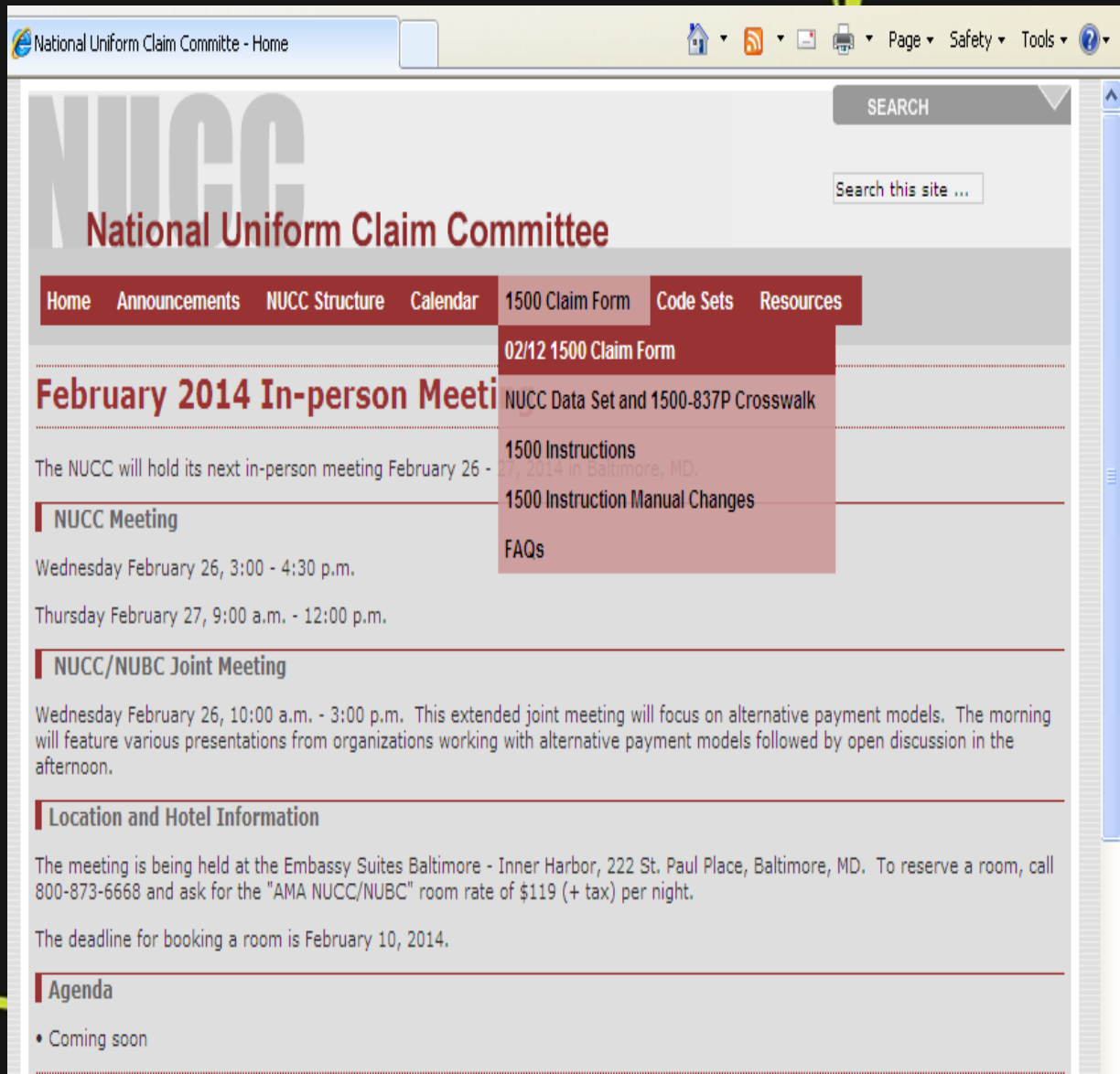
National Uniform Claim Committee

www.nucc.org



EFFECTIVE 4-1-2014

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

CARRIER BLOCK

DESCRIPTION: The payer is the carrier, health plan, third-party administrator, or other payer that will handle the claim. This information directs the claim to the appropriate payer.


HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
PICA
PICA

1st Line – Name
2nd Line – First line of address
3rd Line – Second line of address, if necessary
4th Line – City, State (2 characters) and ZIP Code

Line	Descriptor	Type	Bytes	Columns
4	Payer Name	A/N	41	38-78
5	Payer Address 1	A/N	41	38-78
6	Payer Address 2	A/N	41	38-78
7	Payer City State and ZIP	A/N	41	38-78

For an address with three lines, enter it in the following format:

1st Line – Name
2nd Line – Line of address
3rd Line – Leave blank
4th Line – City, State (2 characters) and ZIP Code

Line	Descriptor	Type	Bytes	Columns
4	Payer Name	A/N	41	38-78
5	Payer Address	A/N	41	38-78
6	Leave blank			
7	Payer City State and ZIP	A/N	41	38-78

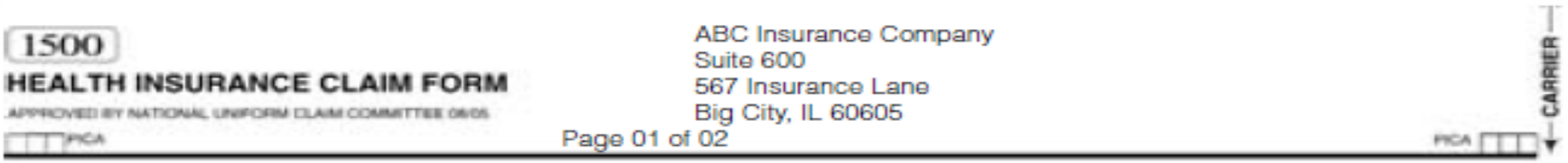
Multiple Page Claims

When printing page numbers on multiple page claims print the page numbers in the Carrier Block on Line 8 beginning at column 32.

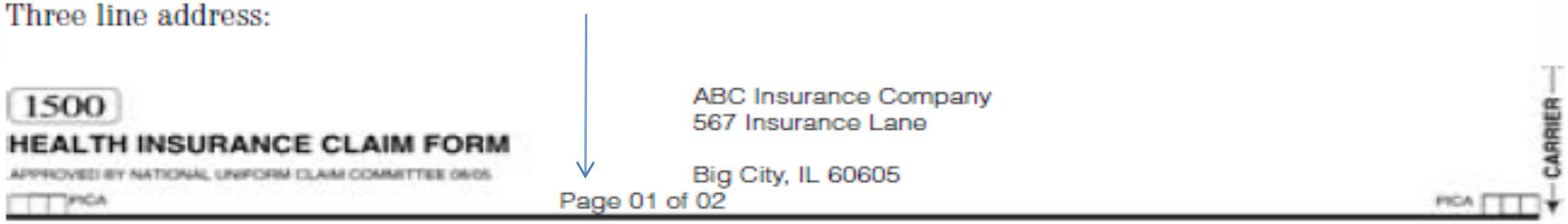
Page numbers are to be printed as:
Page XX of YY

Example:

Four line address:



Three line address:



PATIENT AND INSURED INFORMATION

Note: **If the patient can be identified by a unique Member Identification Number, the patient is considered to be the "insured". The patient is reported as the insured in the insured data fields.**

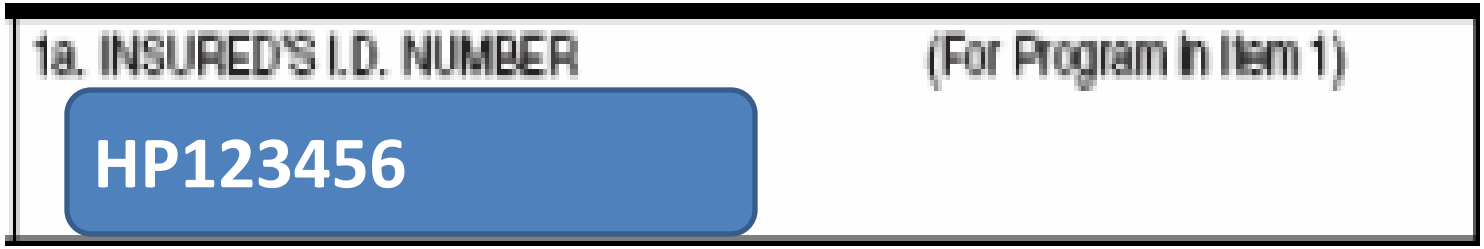
EL PASO FIRST Health Plans inc.

Insured's ID Number Box 1a

NOTE: Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted.

If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field.

EXAMPLE:



Date of Onset

ITEM NUMBER 14

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			
MM	DD	YY	QUAL.

TITLE: Date of Current Illness, Injury, or Pregnancy (LMP)

INSTRUCTIONS: Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

Enter the applicable qualifier to identify which date is being reported.

431	Onset of Current Symptoms or Illness
484	Last Menstrual Period

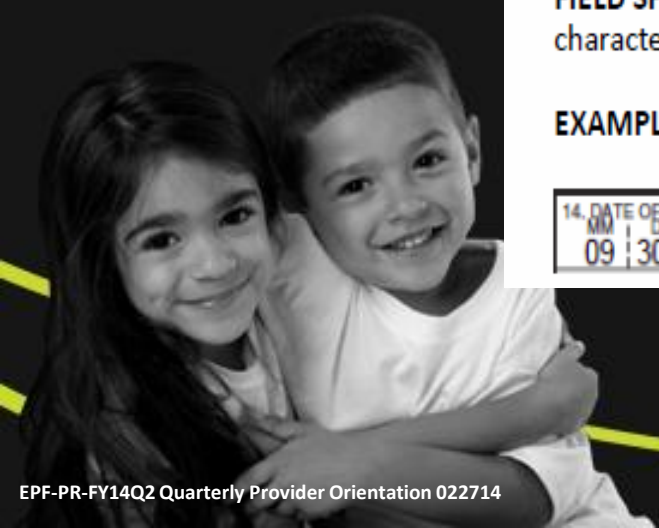
Enter the qualifier to the right of the vertical, dotted line.

DESCRIPTION: The "Date of Current Illness, Injury, or Pregnancy" identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.

FIELD SPECIFICATION: This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, 4 characters under YY, and 3 characters to the right of the vertical, dotted line.

EXAMPLE:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			
MM	DD	YY	QUAL.
09	30	2005	431



EL PASO FIRST Health Plans inc.

Other Date

(related to patient's condition or treatment)

ITEM NUMBER 15

15. OTHER DATE QUAL		MM	DD	YY

TITLE: Other Date

INSTRUCTIONS: Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format.

Enter the applicable qualifier to identify which date is being reported.

454	Initial Treatment
304	Latest Visit or Consultation
453	Acute Manifestation of a Chronic Condition
439	Accident
455	Last X-ray
471	Prescription
090	Report Start (Assumed Care Date)
091	Report End (Relinquished Care Date)
444	First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

DESCRIPTION: The "Other Date" identifies additional date information about the patient's condition or treatment.

FIELD SPECIFICATION: This field allows for the entry of the following: 3 characters between the vertical, dotted lines, 2 characters under MM, 2 characters under DD, and 4 characters under YY.

EXAMPLE:

15. OTHER DATE QUAL	454	MM 09	DD 25	YY 2005

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Referring Provider & Qualifiers

ITEM NUMBER 17

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

TITLE: Name of Referring Provider or Other Source

INSTRUCTIONS: Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

DESCRIPTION: The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported.

FIELD SPECIFICATION: This field allows for the entry of 2 characters to the left of the vertical, dotted line and 24 characters to the right of the dotted line.

EXAMPLE:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN Jane A Smith MD

Referring Provider ID No.

ITEM NUMBER 17a AND 17b (Split Field)

17a.		
17b.	NPI	

TITLE 17a: Other ID#

INSTRUCTIONS 17a: The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only.)

DESCRIPTION: The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.

FIELD SPECIFICATION: This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.

TITLE 17b: NPI #

INSTRUCTIONS 17b: Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

DESCRIPTION: The NPI number refers to the HIPAA National Provider Identifier number.

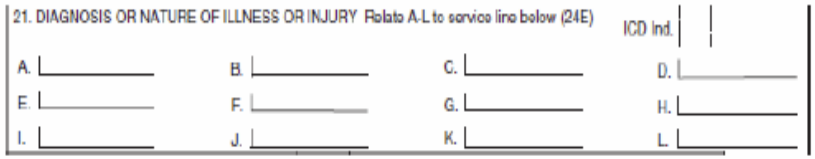
FIELD SPECIFICATION: This field allows for the entry of a 10-digit NPI number.

EXAMPLE:

17a.	G2	ABC1234567890
17b.	NPI	0123456789

ICD – (9 or 10) Codes

ITEM NUMBER 21



TITLE: Diagnosis or Nature of Illness or Injury

INSTRUCTIONS: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9	ICD-9-CM
0	ICD-10-CM

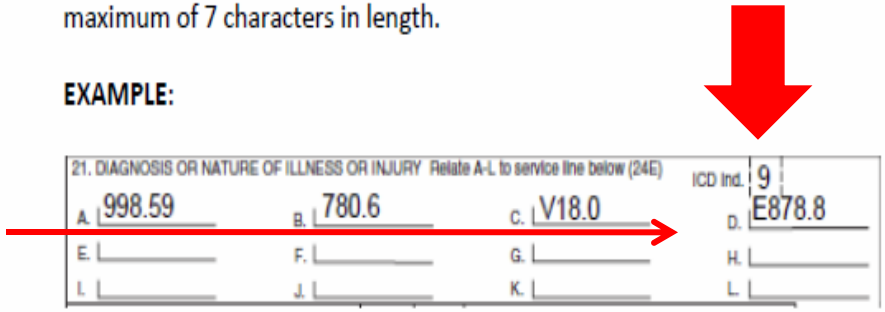
Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

DESCRIPTION: The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

FIELD SPECIFICATION: This field allows for the entry a 1 character indicator and 12 diagnosis codes at a maximum of 7 characters in length.

EXAMPLE:



DX Submission for Multiple Page Claims

When reporting line item services on multiple page claims:

1. Only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages.
2. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim.

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Diagnosis Pointers

SECTION 24

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1														NPI	
2														NPI	

TITLE: Diagnosis Pointer [lines 1–6]

INSTRUCTIONS: In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.

Enter letters left justified in the field. Do not use commas between the letters.

DESCRIPTION: The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.

FIELD SPECIFICATION: This field allows for the entry of 4 characters in the unshaded area.

ITEM NUMBER 24E

E. DIAGNOSIS POINTER

EXAMPLE:

E. DIAGNOSIS POINTER
ABCD

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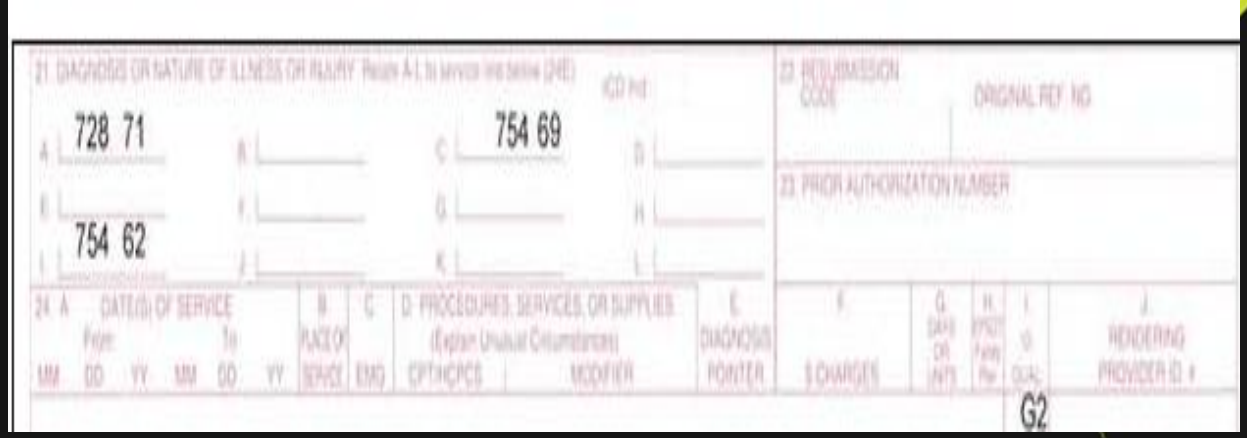
Incorrect Diagnosis Submission



Correct Submission Format

Correct format for box 21 and 24e of the 1500 claim form version 02/12

List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Use the highest level of specificity.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind. 9
A. 998.59	B. 780.6	C. V18.0	D. E878.8
E.	F.	G.	H.
I.	J.	K.	L.

Relate lines A - L to the lines of service in 24E by the letter of the line.

E. DIAGNOSIS POINTER
ABCD

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Claim Correction Resubmission Information

ITEM NUMBER 22

22. RESUBMISSION CODE	ORIGINAL REF. NO.

TITLE: Resubmission and/or Original Reference Number

INSTRUCTIONS: List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code).

When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

7	Replacement of prior claim
8	Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

DESCRIPTION: "Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

FIELD SPECIFICATION: This field allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. area.

EXAMPLE:

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	ABC1234567890

Replacement Claim Number

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Provider Care Unit Extension Numbers:

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

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Questions?

Irma L. Herrera
Director of Provider Relations & Credentialing
ext. 1018
iherrera@epfirst.com

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Special Investigations Unit- Compliance

Alma Meraz –Special Investigations Unit
Claims Auditor

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Monthly Random Medical Records Reviews

- Texas enacted bill 2292 to require all Managed Care Organizations like El Paso First to establish a plan to prevent waste, fraud and abuse
- 5-7 providers are randomly selected on a monthly basis
  - Edits, billing patterns, Health Plan request
- The process involves the review of paid claims and if necessary a request for records

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- A Business Records Affidavit is required
- El Paso First will send out a notification letter with the findings at the end of the review
  - Will include detailed spreadsheets with claim recoupment information
- You have the right to dispute the findings

  (within 30- days of receipt of the notice)
- The Recoupment process
  - Per the Office of the Inspector General's directive El Paso First will recoup via claims adjustments

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39 Week OB Reviews

- Random selection of 15 providers a month
- Records are requested and reviewed
- Ensures medical necessity of inductions and/or c-sections
- Reviews proper utilization of modifiers U1, U2 and U3

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Member Services Verification

- Random selection of 60 members a month
- Courtesy phone calls to verify services were rendered as billed
- If not verified by member, records are requested
- The Provider will be notified of findings

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Contact Information

Alma Meraz

Special Investigations

Unit Claims Auditor

915-298-7198 ext. 1039

ameraz@epfirst.com

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Complaints and Appeals Process

Raquel Payan
Compliance Supervisor

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Complaints & Appeals Process

- All Complaints and Appeals must be submitted in writing
- Appeals must be received within 120 days from the notice of the denial
- Complaints or Appeals must include detailed and supporting information:

  -Corrected Claim
  -Copy of Remittance Advice
  -Medical records/Operative Report
  -Proof of Timely Filing
  -Provider attested letter TPI/NPI

- Complaints must be addressed to:

  Complaints and Appeals Unit
  1145 Westmoreland
  El Paso, Texas 79925

* NOTE: Member's must not be billed or balance billed

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Compliance

Raquel Payan
Compliance Supervisor
rpayan@epfirst.com
(915) 532-3778 ext. 1092

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Member Cost-Sharing CHIP Members

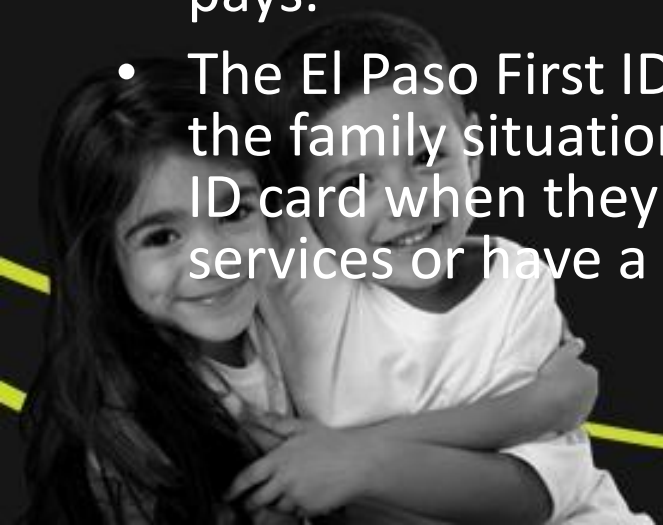
Edgar Martinez

Director of Member Services

EL PASO FIRST Health Plans inc.

WHAT IS COST-SHARING (CO-PAYMENTS)? HOW MUCH ARE THEY AND WHEN DO THEY APPLY?

- Co-payments for medical services or prescription drugs are paid to the health care provider at the time of service.
- For CHIP members, there is no cost-sharing on benefits for well-baby and well-child services, immunizations, preventive services, or pregnancy-related assistance.
- Additionally, CHIP Perinatal members and CHIP members who are American Indian or Alaskan Native are exempt from all cost-sharing obligations, including enrollment fees and co-pays.
- The El Paso First ID card lists the co-payments that apply to the family situation. Members are educated to present their ID card when they receive office visit or emergency room services or have a prescription filled.



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Cont.

- It is important for CHIP members to keep track of their CHIP related expenses. This will help the member know when they have reached their annual co-pay maximum cap.
- When members reach their annual cap, they are informed to contact HHSC at 1-800-647-6558. HHSC will contact us, El Paso First, and we will issue a new ID card to the member. The new card will show that no co-payments are due when services are rendered.
- Some medical and pharmacy services will require prior authorization and/or physician prescription to render the services.

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Cont.

The table below lists the CHIP copayment schedule. It is listed according to a family's income.

Federal Poverty Levels	Office Visit	Non-Emergency Emergency Room Visit	Prescription Generic Drugs	Prescription Brand Name Drugs	Facility Co-pay, Inpatient (per admission)	Annual Co-pay Maximum
Native Americans	$0	$0	$0	$0	$0	None
At or Below 100%	$3	$3	$0	$3	$15	5% of family's income
101%–150%	$5	$5	$0	$5	$35	5% of family's income
151%–185%	$20	$75	$10	$35	$75	5% of family's income
186%–200%	$25	$75	$10	$35	$125	5% of family's income

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Member Services Contact Information

- **Edgar Martinez, MBA**
  Director of Member Services
  (915) 532-3778 ext. 1064

- **Juanita Ramirez**
  Member Services Supervisor
  (915) 532-3778 ext. 1063

- **Antonio Medina**
  Enrollment Services Supervisor
  (915) 532-3778 ext. 1034

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EXTRA! EXTRA!

- SAVE THE DATE -

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Thank You for Attending Providers!

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