Welcome Providers!

Quarterly Provider Orientation

June 5, 2013

EL PASO FIRST
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El Paso First Health Plans

2012 Provider Survey

Irma Herrera, MBA

Director of Provider Relations & Credentialing
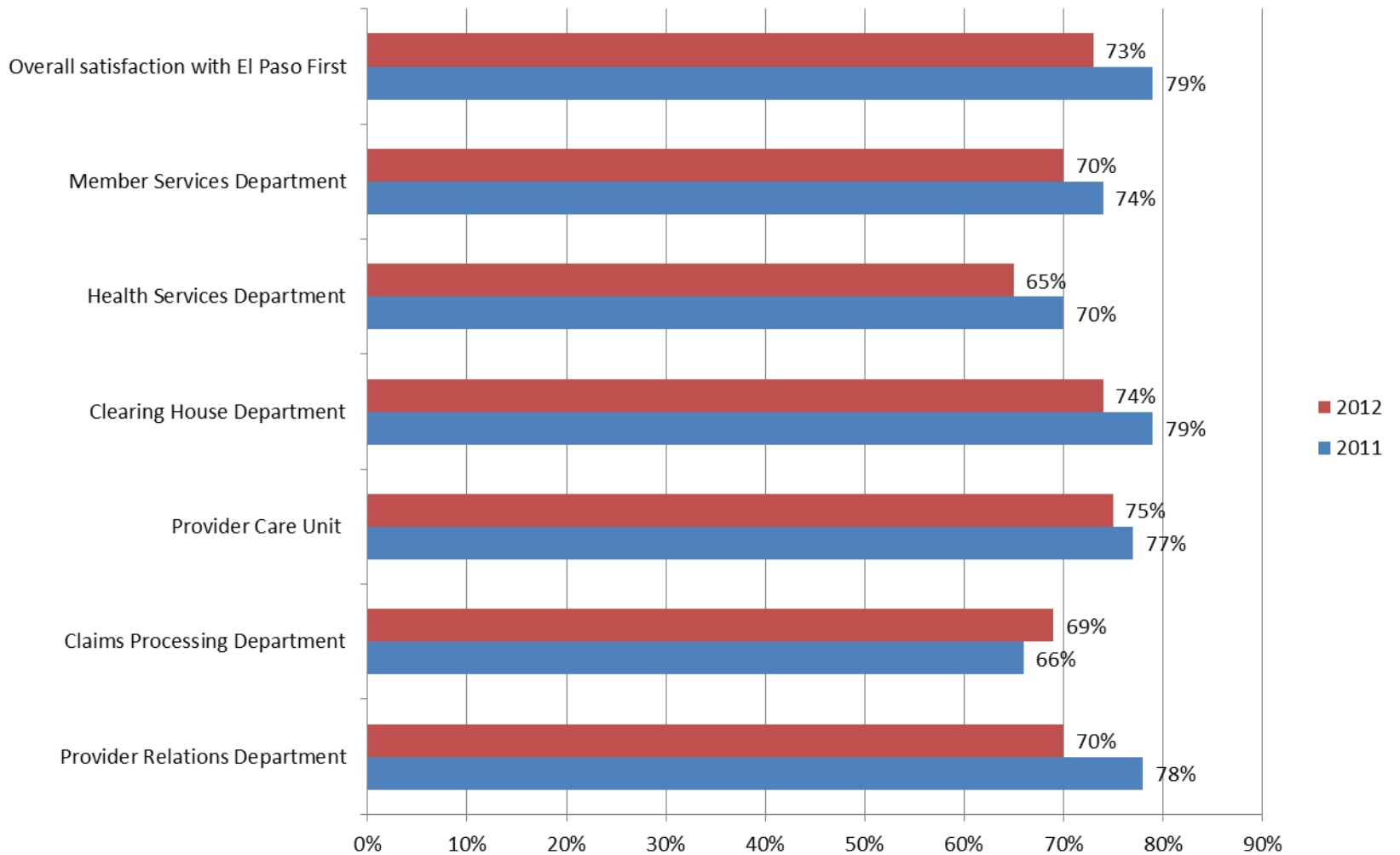
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Provider Survey

◦ Contract with Institute for Policy & Economic Development at UTEP.

◦ Purpose is to obtain feedback about our performance within the last 12 months.

◦ 985 Providers were sent surveys by mail

◦ 165 Providers Responded

◦ Top respondent type were Medical Doctors

◦ Top three respondent specialties included Behavioral Health, OB/GYN & Pediatrics

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Key Survey Findings
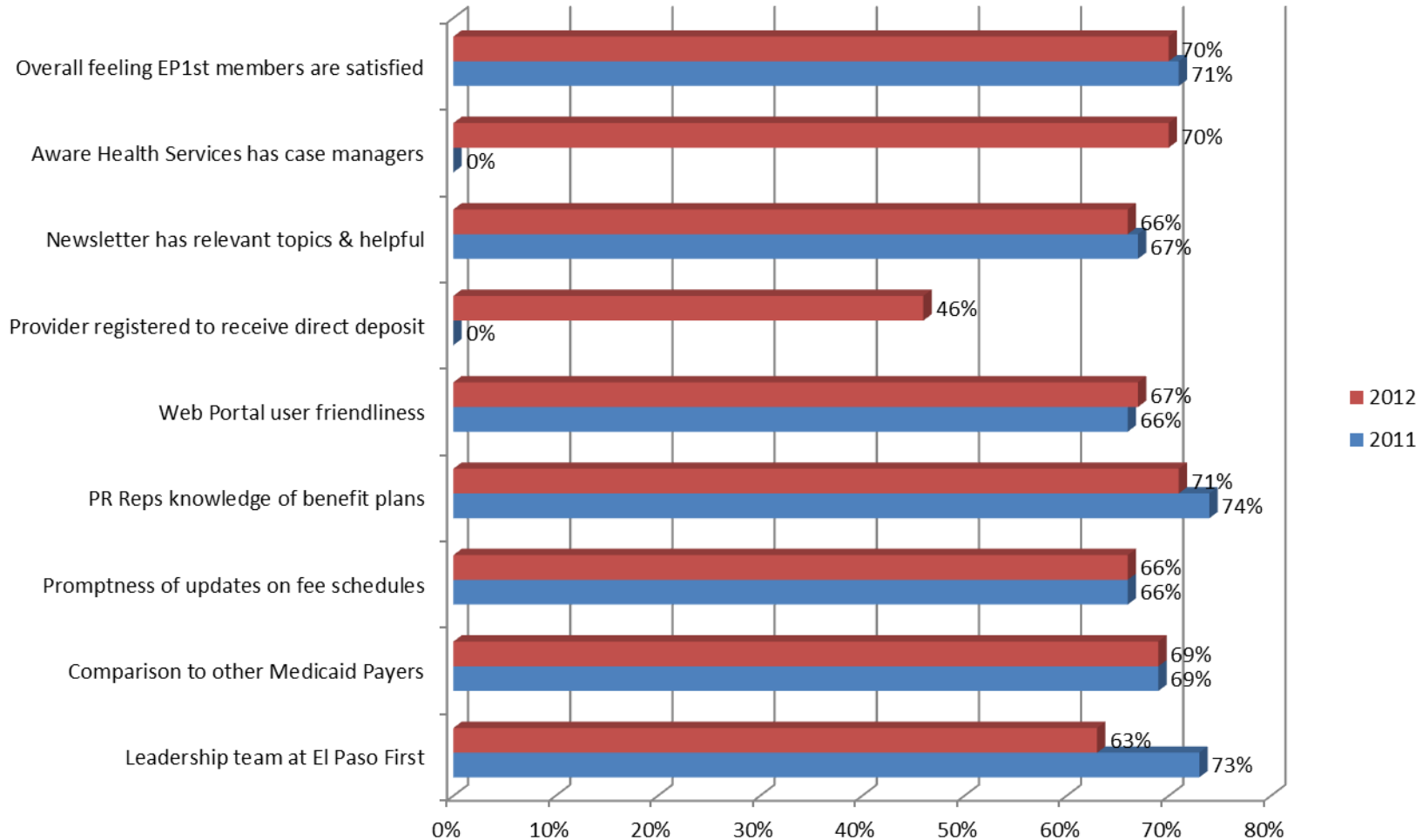
Overall Satisfaction with Departments

Satisfaction

Overall satisfaction with El Paso First

Year	Satisfaction
2012	79%
2011	73%
2010	74%
2009	65%
2008	73%
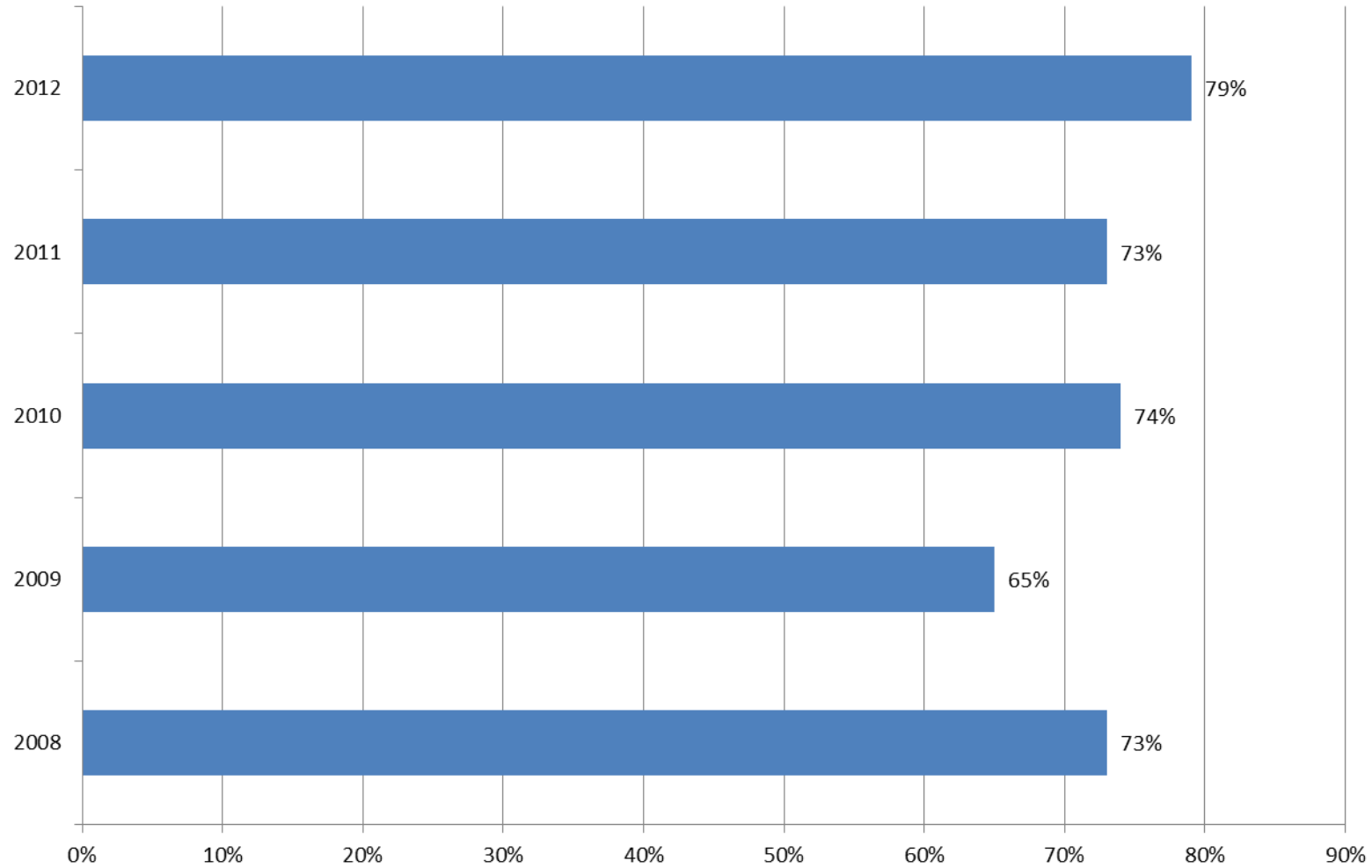
After the Results

◦ Survey is presented to Management and Board of Directors

◦ Departments evaluate their areas of improvement

◦ Develop action items to meet improvement goals

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Irma L. Herrera
iherrera@epfirst.com
298-7198 ext. 1018

Email us at:
providerservices@epfirst.com

or
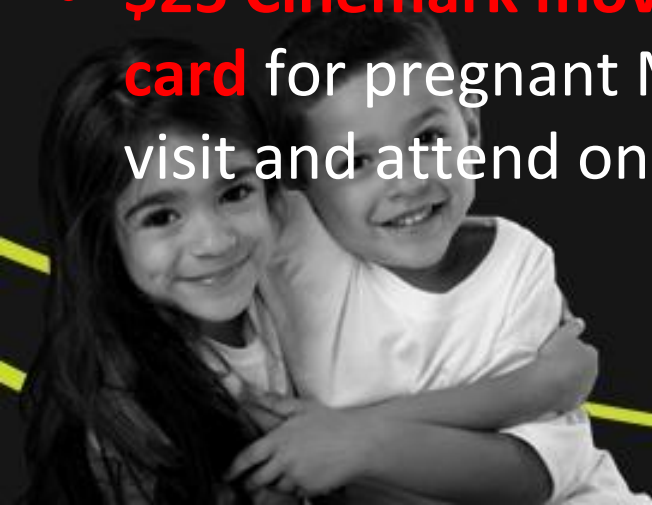call us at
915-298-7198 ext 1507

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Pregnant Members OB Program

- **Free car seat** for pregnant Members who complete a pregnancy class. STAR / CHIP Perinate

- **Free phone**, through Assurance Wireless, with limited calls and text message capabilities from El Paso First for health related activities for members that qualify for the Lifeline Assistance Program.

- **Home visits** to new mothers who are high risk.

- **$25 Cinemark movie gift card or $25 Wal-Mart gift card** for pregnant Members that complete a prenatal visit and attend one pregnancy class.

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Pregnant Members OB Program

Your assistance is greatly appreciated by completing the back portion of the postcard with the member ID, date of service and the Provider's name, address and signature or office stamp.

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Baby Showers

- El Paso First hosts monthly baby showers for our STAR / CHIP Perinate pregnant members the third week of every month.

- Wednesdays at 10am in Spanish and Thursdays at noon in English.

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Preferred
ADMINISTRATORS

Memo

To: Providers

From: Preferred Administrators

Date: September 26, 2012

Re: Global Billing

Effective October 1, 2012 providers will be required to bill using the global method. In the case of confirmed pregnancy diagnosis prior to October 1, 2012 Providers are to continue to bill fee for service.

The following guidelines must be followed when submitting OB service claims for members of Preferred Administrators or there will be an increased likelihood that the claim will be denied and/or adjusted by Preferred Administrators.

Global Billing
The intent of global billing (CPT-4 codes 59400, 59510, 59610, and 59618) is to offer a convenient means of billing for providers who render total obstetrical care to a woman throughout her pregnancy. Global obstetrical (OB) billing consists of antepartum care, delivery and postpartum care, including the following:

- Hospital admission
- Patient history
- Physical examination
- Labor management
- Postpartum office visit
- Vaginal or cesarean section delivery
- Vaginal or cesarean section delivery, after previous cesarean delivery
- Hospital discharge
- All applicable postoperative care

Services that are not separately reimbursable on a global basis include:

- Antepartum consultations paid to the same provider, for dates of service either within the from-through period of the global billing or within 270 days prior to the global OB delivery date

Questions ?

Stacy Arrieta
Provider Relations
Representative
298-7198 ext. 1059
sarrieta@epfirst.com

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First Steps
Case Management Program

Edna Martinez

OB Case Manager

Case Management Program

How we can help you?

- Coordinate transportation for our members to and from your office.

- Guide your patient to access medical/psychiatric/and dental services.

- Coordinate specialized care for your El Paso First patients.

- Educate our members on how to access available community resources.

Case Management Continued

Examples

- El Paso First prenatal class

- Hospital prenatal classes

- WIC

- Baby Café

- Child Care Services

- Transportation Assistance

- Car Seat Assistance

- Community referrals to assist with basic needs

- Referral to Nurse Family Partnership Program for first time moms

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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

El Paso First is located at
1145 Westmoreland Drive
El Paso, TX 79925-5615

Paper Claim submissions will continue to go to:
El Paso First Health Plans - Claims
P.O. Box 971370
El Paso, TX 79997-1370

Our General Correspondence address has not changed.
P.O. Box 971100
El Paso, TX 79997-1100

Providers - Forms

Web Portal Forms ▶

Health Services Forms ▼

- Letter & High Risk Form
- Case Management Referral
- Fax Cover for Pregnant Woman Visit
- Notification of Pregnancy
- Pre-Authorization Flyer-STAR/CHIP
- Pre-Authorization Flyer-Health Care Options (HCO)
- Pre-Authorization Flyer-Preferred Administrators
- Pre-Certification Form-Behavioral Health
- Pre-Certification Checklist
- Pre-Certification Form-Outpatient/Scheduled Procedures
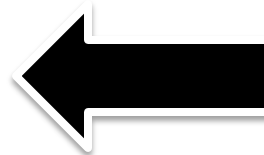- Pre-Certification Form-Out of Area/Inpatient Notification

Complaints and Appeals Forms ▶

Members Services Forms ▶

Claims Forms ▶

Credentialing Packet Forms ▶

Misc. Forms ▶

Authorizations

PRIOR AUTHORIZATION FORM HIGH RISK PREGNANCY

FIRST *steps* of EL PASO FIRST

Please attach clinical documentation.	Date:

To: **Edna Martinez**
OB Case Manager   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: _____   IC9-Codes: _____

Patient has been diagnosed with any of the following conditions:

- Pre-term delivery (<37 weeks/previous pregnancy) Year and Gestation age of PTL: _____
- Multiple Gestation
- Obesity Complicating Pregnancy BMI > 35   Weight: _____
- Young primigravida < 16
- HX of Mental Disorders Specify: _____ Medication _____
- Toxic Habits (Alcohol/Drug use) Specify: _____
- IUGR
- Placenta previa (persistent in 3rd trimester)

- GDM (Type I/II) HgA1C: _____
- Hypertensive disorders of pregnancy Recent B/P: _____
- Birth defect detected Specify: _____
- Advanced Maternal Age
  - Age 35 for singleton
  - Age 33 for multiples
- Late prenatal care (after 20 weeks)
- HIV/HSV/ Hepatitis
- Other: _____

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

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

PROVIDER'S INFORMATION (PROVIDER/FACILITY SUBMITTING AUTH REQUEST)

DATE OF REQUEST: _____ PROVIDER'S NAME: _____
TPI # _____ NPI # _____
CONTACT PERSON: _____ PHONE NO. _____ FAX NO. _____
SERVICE LOCATION: _____ MAIL ADDRESS: _____

MEMBER'S INFORMATION

NAME: _____ MEMBER I.D. NO.: _____ **SSI** (Circle if SSI)
DOB: _____ Member Phone: _____ PCP: _____

REFER TO INFORMATION (PROVIDER/FACILITY PERFORMING SERVICE IF DIFFERENT FROM ABOVE)

PROVIDER'S NAME: _____ TPI # _____ NPI # _____
CONTACT PERSON: _____ PHONE NO. _____ FAX NO. _____
SERVICE LOCATION: _____ MAIL ADDRESS: _____

PROCEDURE INFORMATION

TYPE OF SETTING:
- OFFICE VISIT
- OFFICE VISIT W/TREATMENT
- LABS
- RADIOLOGY
- THERAPY (OT, PT, ST)
- SURGICAL
- DENTAL
- HOME HEALTH
- PODIATRY
- INPATIENT SCHEDULED SERVICES
- DIABETES/ASTHMA EDUCATION
- OTHER

EXPECTED DATE OF PROCEDURE: _____

PRIMARY DIAGNOSIS CODES (ICD-9)	CPT PROCEDURE CODES	SSI ONLY TYPE OF SERVICE	MODIFIER
1.	1.	1.	
2.	2.	2.	
3.	3.	3.	
4.	4.	4.	
5.	5.	5.	

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

FOR EL PASO FIRST USE ONLY

REVIEWED BY: _____ DATE: _____ APPROVED: YES NO
REFERENCE NO. _____

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

High Risk Authorization

- Upon identification of a member with a high risk diagnosis, provider should submit High Risk PA Form.
    - This will prompt our OB Unit to contact member and begin Case Management process.

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OB CASE MANAGER

Edna Martinez

OB CASE MANAGER

915-298-7198 ext. 1078

martineze@epfirst.com

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Corina Diaz

## Provider Relations Representative

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ER Reports

- Purpose
  - Assist Primary Care Providers on identifying members from their panel that go to the ER to seek care
  - Encourage Providers to educate their identified members on true emergencies, after hours availability, night clinics or provide other options
  - Educate Members on the Medical Home concept
- Content
  - Member name, ID number, Age, DOB, Phone number, Address, ER DOS, ER Location, Diagnosis.
- Mailed
  - Mailed monthly along with Rosters

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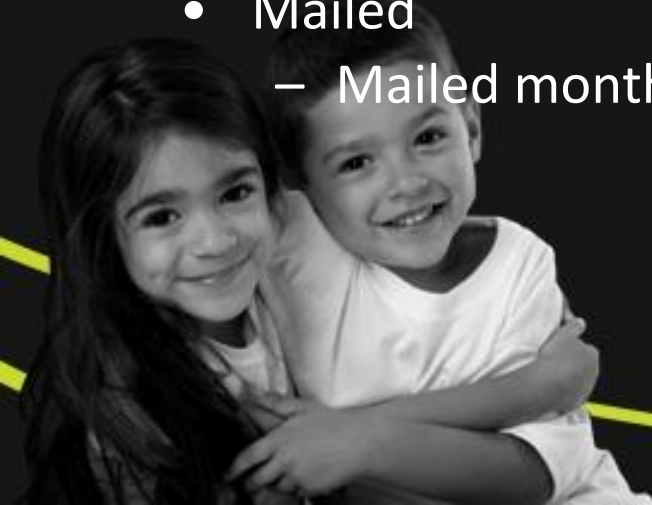
SAMPLE ER REPORT

PROVIDER MD, PA
EL PASO, TX 799XX

El Paso First Health Plans, Inc.
ER Utilization
Paid dates Between XX/1/2010 and XX/1/2010

Member #	Member Name	Age	DOB	Phone	Address	ER DOS	ER Pay To
Provider: Dr. X							
111111111	Baby Boy	0	12/14/07	915-XXX-XXXX Diagnosis: 462 Acute Pharyngitis	1145 Westmoreland Dr. El Paso, Tx 799XX	3/1/10	XY Medical Center
111111111	Baby Girl	1	1/13/07	915-XXX-XXXX Diagnosis: 462 Acute Pharyngitis	1145 Westmoreland Dr. El Paso, Tx 799XX	3/1/10	XY Medical Center
111111111	Baby Girl	4	2/3/04	915-XXX-XXXX Diagnosis: 780.60 Fever, unspecified	1145 Westmoreland Dr. El Paso, Tx 799XX	3/1/10	XY Medical Center
111111111	Baby Boy	14	7/14/93	915-XXX-XXXX Diagnosis: 462 Acute Pharyngitis	1145 Westmoreland Dr. El Paso, Tx 799XX	3/1/10	XY Medical Center
111111111	Baby Girl	0	8/1/07	915-XXX-XXXX Diagnosis: V28.89 Other specified antenatal screening	1145 Westmoreland Dr. El Paso, Tx 799XX	3/1/10	XY Medical Center

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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

Board of Directors (BOD) signature approval meet every 2nd Thursday of each month

CPRC and BOD meetings 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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HealthCare Options

Rene Duran

HealthCare Options

Provider Relations Representative

El Paso First Health Plans, Inc.

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EPCCS/HCO

Effective June 1, 2010 University Medical Center of El Paso ("UMC") developed an indigent care collaborative with private hospitals in El Paso County. Under this collaborative, UMC worked with Las Palmas Medical Center and Del Sol Medical Center ("LPDS") to create a non-profit organization that will fund the services provided to HCO members.   This new non-profit entity is El Paso County Clinical Services, Inc. ("EPCCS").

Program Overview

<u>Overview</u>

  ➢ Developed by UMC Hospital to provide medical services to El Paso's indigent population.

  ➢ Covered benefits have been enhanced to give members improved access to healthcare.

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Program Overview cont.

- ➤ **14,000** + Members
- ➤ Managed Care environment
- ➤ Primary Care home for indigent
- ➤ Increased levels of primary care
- ➤ Member access to preventative care and disease management programs
- ➤ Reduction in escalation of illnesses
- ➤ Reduction in ER visits

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Program Features

➢ Covered Primary, Preventive and Specialty care services are provided through the HCO Network providers.

➢ Eligible members choose a PCP to manage their healthcare.

➢ Inpatient care and pharmacy benefits are provided by UMC Hospital as the County Hospital with responsibility for care of the uninsured and indigent.

➢ Affordable Co-pays

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Eligibility

➢ Determined by UMC Hospital –Enrollment Services Unit

➢ Must meet income and resident requirements

➢ May not be eligible for any other insurance coverage such as Medicaid or Private Insurance.

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Applicants must bring:

➢ Proof of Income (W-2, pay stubs, tax return, bank statement, or other indicator of income such as Food Stamps, WIC, Unemployment Compensation, etc.)

➢ Proof of Residency (Mail addressed to patient, TX Driver's License, Property Tax Receipts, Mortgage Payment Receipts, Utility Receipts, and Other Official Identifications.)

➢ Must have services pending at UMC, i.e. lab, x-rays etc.

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How to Apply

Applications are <u>only</u> accepted at:

UMC Hospital

(Walk-Ins)

or

UMC Clinics

(Appointments only)

Enrollment Services Unit

Monday-Friday 8:00 AM to 6:00 PM

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Re-enrollment Process

➢ Coverage is continuous for a period of 12 months.

➢ Members are required to re-apply to maintain their benefits.

➢ A member due for re-enrollment will receive a notification 2 months prior to their termination date with instructions for re-enrollment.

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Member ID Card

Termination

- A member can be terminated from the HealthCare Options program if the member:

    - does not re-apply

    - has other health insurance coverage

    - has moved out of the service area

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Covered Benefits

➢ Please refer to schedule of benefits for detailed information on covered services.

➢ Services limited to IN-NETWORK providers.

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HCO Network Providers

Provider Directories have been developed specifically for HCO Network.

- ➢ Members must choose a PCP within the HCO Network.
- ➢ Unlimited PCP changes can be made, contact El Paso First to make changes.
- ➢ Specialty Care requires a referral from the members PCP.
- ➢ Laboratory Services for covered benefits must be referred to UMC Hospital.
- ➢ UMC is the ONLY participating Hospital for the

  HCO Program.

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Network Pharmacies

- Prescriptions must follow the UMC Hospital Formulary

- Prescriptions can **ONLY** be filled at any of these locations ▶

UMC Pharmacy **4824 Alberta** **El Paso, Texas 79905** **915-521-7705**
UMC Pharmacy **9849 Kenworthy** **El Paso, Texas 79924** **915-745-4247**
UMC Pharmacy **300 S. Zaragoza, Bldg B** **El Paso, Texas 79907** **915-860-4039**

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Referrals

- Members PCP must initiate referral for specialty care services.

- In network specialist to specialist referrals are allowed with an auth. Any request from a specialist for a member to see an out of network specialist requires an authorization.

- Prior Authorizations: only requests that are not to be performed at UMC or Texas Tech require an auth.

- Out of network referrals must be coordinated through Health Services at **(915)532-3778**.

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Prior Authorizations

- Authorizations for OUTPATIENT/Scheduled procedure requests, INPATIENT notifications and Clinical Information must be directed to Health Services Department if out of network. If covered benefit, all procedures/services at UMC and/or Texas Tech, do not require an authorization.

- All Prior Authorizations must be submitted by Fax to :
  - **(915)298-7866** – Outpatient/Scheduled Procedures
  - **(915)298-5278** – Inpatient Notifications
  - 72 hour turnaround time applies to all Prior Authorization Requests

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Taking Care of Our Providers

**El Paso First Health Plans
has a quality claims processing and customer service
TEAM.**

➢ The EPCCS check is processed once a week (Thursday).

➢ Claims must be received by El Paso First within 95 days from DOS

➢ Corrected claims must be re-submitted within 120 days from the R.A. (Remittance Advice)

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Rene Duran

HealthCare Options

Provider Relations Representative

915-298-7198 ext. 1037

rduran@epfirst.com

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Texas Health Steps
Tools & Updates

as Health Steps Updates

- The Texas Health Steps Medical Checkup Periodicity Schedule for infants, children, and adolescents (birth through 20 years of age) has been revised to reflect policy updates effective December 1, 2011.
  - This PDF document is available for download in both color and black & white: http://www.dshs.state.tx.us/thsteps/providers.shtm

- Tuberculin skin testing changed to TST.

- ECI referral language changed from *2 business days* to *as soon as possible but in no case longer than 7 days after identification.*

- All blood lead levels in clients 14 years or younger shall be reported to DSHS. Reports shall include all information as required on the Texas Child Blood Lead Level Reporting Form, F09-11709 or Point of-Care Blood Lead Testing report, Form Pb-111, which can be found at *http://www.dshs.state.tx.us/lead/providers.shtm*, or by calling 1-800-588-1248.
  - Codes 87490 and 87590 have been removed (Chlamydia/gonorrhea testing) as the testing method is no longer available.

  - THSteps Modules for RNs updated.

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Child Health Record Forms for Texas Health Steps checkups

- 2 Month Child Health Record form have been edited to remove Meningococcal and Influenza, and add Rotavirus (RV).

- There are forms for each age visit, from up to 5 days through 20 years.
    - The forms are posted on the DSHS website: http://www.dshs.state.tx.us/thsteps/childhealthrecords.shtm

- Please keep in mind that these forms are **not mandatory** but *recommended.* Just remember that **DOCUMENTATION** is essential!

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Updated Referral Form

TEXAS HEALTH STEPS
PROVIDER OUTREACH REFERRAL FORM
FAX: 512-533-3867

- Complete this form and submit by fax.
- Use only ONE FORM PER HOUSEHOLD, up to 2 patients.
- You will receive notification once your referral is processed.

Provider Information Date: _____

Provider/Clinic Name:		Contact Name:	
Office Address:	City:	County:	Zip Code:
Phone Number:	Fax Number:		

Provider Type: ☐ Medical ☐ Dental ☐ Orthodontic ☐ Case Management ☐ Other:

Parent/Guardian Information

| Parent/Guardian Name: | Phone Number: | Mobile Number: |
| Address: | City: | County: | Zip Code: |

Language Preference: ☐ English ☐ Spanish ☐ Other:

Patient #1 Information

| Patient Name: | Date of Birth: | Medicaid ID: |

Appointment Type: ☐ THSteps Checkup ☐ THSteps Followup ☐ Sick Visit ☐ Lead ☐ Other:

Reason for referral (*check all that apply*)
☐ Patient missed appointment, date: ☐ Assistance needed scheduling appointment.
☐ Follow-up appointment for additional lead testing. ☐ Provide updated patient address (*Case Management Only*)
☐ Assist with transportation to appointment. ☐ Other, see comments.

Comments:

Outreach Services Results (SSU Use Only)
☐ Appointment scheduled; date/time: ☐ Patient provided education about appointment etiquette.
☐ Patient assisted with transportation to appointment. ☐ Patient will contact provider directly.
☐ No action taken; patient declined assistance. ☐ No action taken; patient no longer eligible for Medicaid.
☐ Unable to locate patient; letter mailed to patient. ☐ Other:

Comments to Provider:

Patient #2 Information

| Patient Name: | Date of Birth: | Medicaid ID: |

Appointment Type: ☐ THSteps Checkup ☐ THSteps Followup ☐ Sick Visit ☐ Lead ☐ Other:

Reason for referral (*check all that apply*)
☐ Patient missed appointment, date: ☐ Assistance needed scheduling appointment.
☐ Follow-up appointment for additional lead testing. ☐ Provide updated patient address (*Case Management Only*)
☐ Assist with transportation to appointment. ☐ Other, see comments.

Comments:

Outreach Services Results (SSU Use Only)
☐ Appointment scheduled; date/time: ☐ Patient provided education about appointment etiquette.
☐ Patient assisted with transportation to appointment. ☐ Patient will contact provider directly.
☐ No action taken; patient declined assistance. ☐ No action taken; patient no longer eligible for Medicaid.
☐ Unable to locate patient; letter mailed to patient. ☐ Other:

Comments to Provider:

EF03-14040 02/2013

TEXAS Department of State Health Services

Beginning April 1, 2013, the Texas Health Steps Provider Outreach Referral Form should be used by all Texas Health Steps providers to replace the Texas Health Steps Missed Appointment Referral Form

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Intermediate Oral Evaluation with Fluoride Varnish Application

- Texas Health Steps enrolled physicians, physician assistants, and advanced practice nurses.

- An intermediate oral evaluation with fluoride varnish application (procedure code **99429**) is a benefit for clients 6 months of age through 35 months of age.

- The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup visit and is limited to 6 services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202.

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Contact Information

Maritza Lopez-THSteps Coordinator

E-mail: mlopez@epfirst.com

Phone: (915)298-7198 extension 1071

Lluvia Acuña-Migrant Outreach Coordinator

E-mail: lacuna@epfirst.com

Phone: (915)298-7198 extension 1075

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

E-mail acadena@epfirst.com

Phone: (915) 298-7198 extension 1127

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Governing Resource Website

- **Centers for Medicare and Medicaid http://www.cms.gov/**

- **Texas Medicaid and Healthcare Partnership http://www.tmhp.com/Pages/default.aspx**

- **(TDI) Texas Department of Insurance http://www.tdi.texas.gov/**

- **Texas Health and Human Services Commission http://www.hhsc.state.tx.us/about_hhsc/reports/search/search_dateorder.asp**

- **Texas Medical Association http://www.texmed.org/Template.aspx?id=23886**

- **U.S. Department of Labor, Bureau of Labor Statistics (BLS) http://www.bls.gov**

- **National Plan & Provider Enumeration System https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do**

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Governing Resource Website

- **National Correct Coding Initiative (NCCI)**
  http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/

  Clinical Laboratory Improvement Amendments (CLIA)
- **U.S Food and Drug Administration FDS**
 http://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm

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Billing Resource Website

- **American Academy of Professional Coders (AAPC)** www.aapc.com

- **American Association of Medical Assistants (AAMA)** www.aama-ntl.org

- **American health Information Management Association (AHIMA)** www.ahima.org

- **American Medical Billing Association (AMBA)** www.ambanet.net

- **Medical Association of Billers (MAB)** www.E-medbill.com
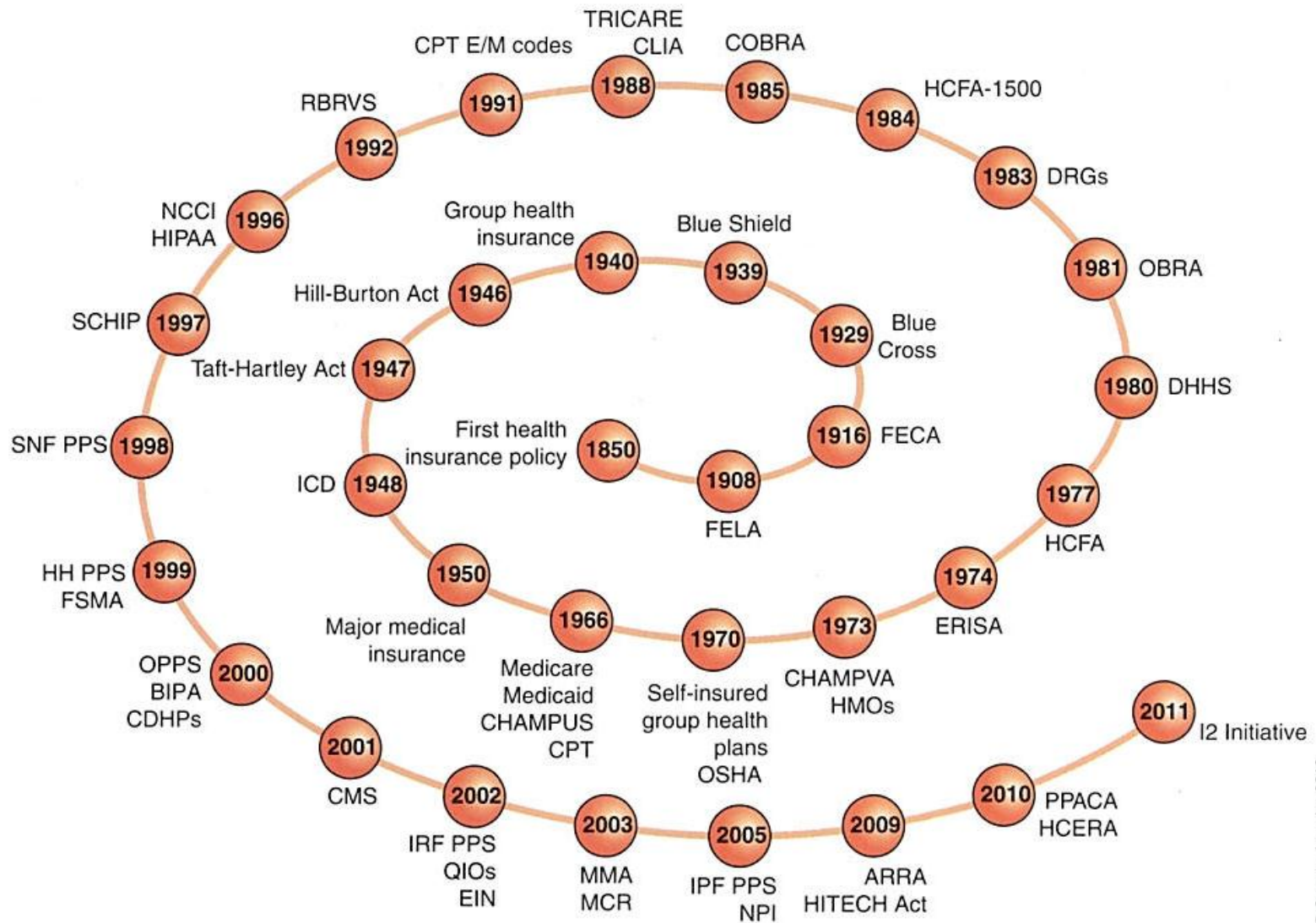
FIGURE 2-1 Timeline of dates and significant events in healthcare reimbursement.

© Cengage Learning 2013

Important Claim Submission Elements

Billing Pay–Federal Tax Information LOOP 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
25	Provider SSN# or EIN#	2010AA , REF, 02 (REF01=EI or SY)

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Bill Pay Information LOOP 2010AA

Submit Group NPI Only in Loop 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
33	Organization Name	2010AA, NM1/85, 03
	Address	2010AA, N3, 01
	City	2010AA, N4, 01
	State	2010AA, N4, 02
	Zip Code	2010AA, N4, 03
33a	Billing Provider NPI	2010AA/NM1/85/09 (08 = XX)
33b	Billing Provider Legacy Number or PIN (No longer reported.)	No longer used, effective 5/23/08

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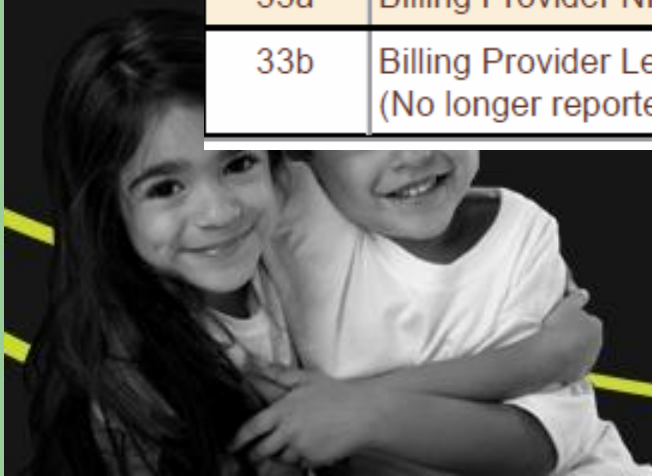
Rendering Provider LOOP 2310B

Submit Rendering's INDIVIDUAL NPI Only in

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
31	Provider Signature Indicator	2300, CLM, 06
24j	Rendering Provider Legacy Number (shaded area) (No longer reported.)	Not used
	NPI of rendering provider (unshaded area)	2310B or 2420A, NM1/82, 09 (08=XX)

Referring Provider –Information LOOP 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
17	Onset of current illness or injury	2300 or 2400, DTP/431, 03
	Referring Provider Last Name	2310A or 2420F, NM1/DN, 03
	Referring Provider First Name	2310A or 2420F, NM1/DN, 04
	Ordering Provider Last Name	2420E, NM1/DK, 03
	Ordering Provider First Name	2420E, NM1/DK, 04
17a	Ordering Provider Secondary Identifier, no longer reported	Not Used
	Referring Provider Secondary Identifier, no longer reported	Not Used
17b	Ordering Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2420E, NM1/DK, 09
	Referring Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2310A or 2420F, NM1/DN, 09

Diagnosis Indicators

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
24e	Diagnosis Pointer	2400, SV1, 07-1
21	Diagnosis 1	2300, HI, 01-2

REMEMBER!

If more than one pointer number is reported, the first-listed code is the reason the patient sought care from the provider.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 794 02   3. 850 0

2. 413 1   4. E8844

E. DIAGNOSIS POINTER

1

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National
Correct Coding Initiative

NCCI Code Edit

What is National Correct Coding Initiative (NCCI)?

http://www.cms.gov/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf

How to Use
THE NATIONAL CORRECT CODING INITIATIVE (NCCI) TOOLS

Modifier Indicator Table

Modifier Indicator Table

MODIFIER INDICATOR	DEFINITION
0 (Not Allowed)	There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.
1 (Allowed)	The modifiers associated with NCCI are allowed with this code pair when appropriate.
9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this code pair. The edit for this code pair was deleted retroactively.

Column1/Column 2 Edits

Figure 3 shows part of the Column 1/Column 2 table for the Medicine Evaluation and Management Services Service Type with our example code 99215 in Column 1.

	A	B	C	D	E	F
1			Column1/Column 2 Edits			
	①	②	③	④	⑤	Modifier ⑥ 0=not allowed 1=allowed 9=not applicable
2	Column 1	Column 2	existence prior to 1996	Effective Date	Deletion Date *=no data	
48889	99215	G0101		19980401	19980401	9
48890	99215	G0102		20000605	*	0
48891	99215	G0104		19980401	19980401	9
48892	99215	G0105		19980401	19980401	9
48893	99215	G0106		19980401	19980401	9
48894	99215	G0107		19980401	19980401	9

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TOP DENIALS

- Duplicate Claim

- Claim Submission Window Exceeded

- Member has no enrollment

- Invalid NPI Number

- Benefit Requires Authorization

- Member does not meet Age Criteria

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Elements on a CMS-1500

CMS -1500

CMS-1500 Health Insurance Claim Form with annotations:

- Valid Member ID
- COB
- If Box 10 = Yes Or Pregnancy Date Date Required
- COB
- Referring Provider Name & NPI or Unique ID required
- Valid ICD-9
- EPSDT or Family Planning (Y or N)
- Authorization No. Only
- Valid CPT Modifiers
- DX Pointer
- Unique ID
- NPI
- If Box 11 d = Yes Pay Amount Required Attached EOB From Prime Ins Required
- Practice TIN #
- Name and address where payments will be mailed.
- Provider Name
- Practice Name or Facility Where service are rendered
- NPI
- Unique ID

Legend:
- Member Information
- Coordination of Benefits
- Provider Information
- Practice Information
- Code Rules
- Unique ID –(TPI or CH) Numbers
- Indicators and Date of Onset

Verification of Authorization

- **The Authorization Number should be in BOX 23**
- **The authorization Number are 10 Characters Long with Prefix of Zero.**

EXAMPLE: 0000123456

****

DO NOT SEND:

- CLIA Numbers: 45D0123456
- Auth Not Needed
- NOT on 1st VISIT
- EXPIRED
- 117044
- 45D0123456 0000123456

Verification of Authorization

When authorization is required Do Not leave Box 23 Blank.

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Terms and Definitions

Remittance Advice (RA)

A notice sent by the insurance company that contains payment information about a claim.

Explanation of Benefits (EOB)

A detail notice sent by the insurance company to a member with the result of a processed claim and member responsibility.

Clearinghouse Real Time Response Report

A centralized claims processing for providers and health plans.

Clearinghouse Response/Report

A detail notice sent by the Clearinghouse to a provider that contains claims submission acceptance/rejection.

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How to read a Remittance Advice (RA)

How to read a Explanation of Benefits (EOB)

THE KEYSTONE PLAN

P.O. BOX 900
ALFRED, NY 14802-0900
(800) 555-9000

DATE: 04/05/YY
ID #: BLS123456789
ENROLLEE: MARY SUE PATIENT
CONTRACT: 300500
BENEFIT PLAN: STATE OF NEW YORK

MARY SUE PATIENT
100 MAIN ST
ALFRED, NY 14802

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	AMOUNT NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	%	PLAN BENEFITS	REMARK CODE
ENROLLEE 5629587	D MILLER OFFICE VISITS	04/05/YYYY	40.25		40.25	8.00	100	32.25*	D1
						PLAN PAYS		32.25	

*THIS IS A COPY OF INFORMATION SENT TO THE PROVIDER. THANK YOU FOR USING THE PARTICIPATING PROVIDER PROGRAM.

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(D1) THANK YOU FOR USING A NETWORK PROVIDER. WE HAVE APPLIED THE NETWORK CONTRACTED FEE. THE MEMBER IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED BY THE CONTRACT.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
D MILLER $32.25

PATIENT NAME	MEDICAL/SURGICAL DEDUCTIBLE		MEDICAL/SURGICAL OUT OF POCKET		PHYSICAL MEDICINE DEDUCTIBLE	
	ANNUAL DEDUCT	YYYY YEAR TO-DATE	ANNUAL MAXIMUM	YYYY YEAR TO-DATE	ANNUAL DEDUCT	YYYY YEAR TO-DATE
ENROLLEE	$249.00	$249.00	$1804.00	$121.64	$250.00	$0.00

THIS CLAIM WAS PROCESSED IN ACCORDANCE WITH THE TERMS OF YOUR EMPLOYEE BENEFITS PLAN. IN THE EVENT THIS CLAIM HAS BEEN DENIED, IN WHOLE OR IN PART, A REQUEST FOR REVIEW MAY BE DIRECTED TO THE KEYSTONE PLAN AT THE ALFRED ADDRESS OR PHONE NUMBER SHOWN ABOVE. THE REQUEST FOR REVIEW MUST BE SUBMITTED WITHIN 60 DAYS AFTER THE CLAIM PAYMENT DATE, OR THE DATE OF THE NOTIFICATION OF DENIAL OF BENEFITS. WHEN REQUESTING A REVIEW, PLEASE STATE WHY YOU BELIEVE THE CLAIM DETERMINATION OR PRE-CERTIFICATION IMPROPERLY REDUCED OR DENIED YOUR BENEFITS. ALSO, SUBMIT ANY DATA OR COMMENTS TO SUPPORT THE APPEAL.

THIS IS NOT A BILL.

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Clearinghouse Real Time Response Report

Questions?

Quality Improvement
June 2013

Kathleen Thompson MPH, CHES, Director of Quality Improvement

Christina Casas RN, QI Nurse

Angelica Baca, QI Coordinador

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What is Quality Improvement

Quality Improvement is the continuous monitoring of care provided to members to improve outcomes and experiences by providing coordinated care that supports evidenced-based practice and patient – centeredness.

- Systematic,

- Data-Driven, and

- Multidisciplinary

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What is HEDIS

- Healthcare Effectiveness Data and Information Set
- Most widely used healthcare quality _tool_
- HEDIS 2013 includes 5 domains of care that includes 76 measures

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Domains / Indicators of Quality Care

Access & Availability:

How many members had access to a provider in a given year?

Were providers available after-hours for members?

Prevention Measures:

How many women had their Breast Cancer Screening in a given year?

Utilization Measures:

How many Well-child Visits occurred in 2012?

Quality of Care Concerns & Member complaints:

How many members complaint did we receive?

Potential Adverse Events ?

Member Experiences with Care (Surveys)

Providers Experience's with Plan (Surveys)

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HEDIS Data Collection

Administrative

- Claims, encounters, enrollment, provider systems (pharmacy and labs)

Hybrid:

- Administrative and medical record data retrieval.

Surveys

- Survey such as the CAHPS

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Overall Quality Assessment Program

Health Care Performance, Effectiveness
HEDIS®
From Administrative Claims/Encounter and Medical Records (hybrid)

Member Experiences & Satisfaction
CAHPS® Survey

Preventable and costly care
Potentially Preventable Events

Health Plan Structure and Processes of Care
Source: CMS Protocols
Data Type: MCO Administrator Interviews, QAPIs

Focused Studies / Medical Record Reviews

Quality Assessment

Data is used to identify opportunities for improvement

Performance Improvement Projects (PIPS) and other activities to improve process, care, health outcomes, and satisfaction are developed

REPEAT Yearly

2013 Medical Record Review & HEDIS Hybrid

- Children's Immunization Status (CIS)
  - *Complete*
- Weight, Counseling and Nutrition (WCC)
  - *Complete*
- Controlling Blood Pressure (CBP)
  - In Progress
- Comprehensive Diabetes HgA1c<8, LDL<100 (CDC)
  - In Progress

STAR Childhood Immunizations
(Combo 4, Hybrid)
Rates with denominators <30 excluded

	Rate
STAR	45.00%
A	39.42%
B	41.36%
C	48.91%
D	47.20%
E	47.69%
ElPasoFirst	52.55%
F	50.36%
G	45.74%
H	38.44%
I	55.00%
J	31.80%
K	38.56%
L	50.69%

HEDIS® P50 (%)
31.00
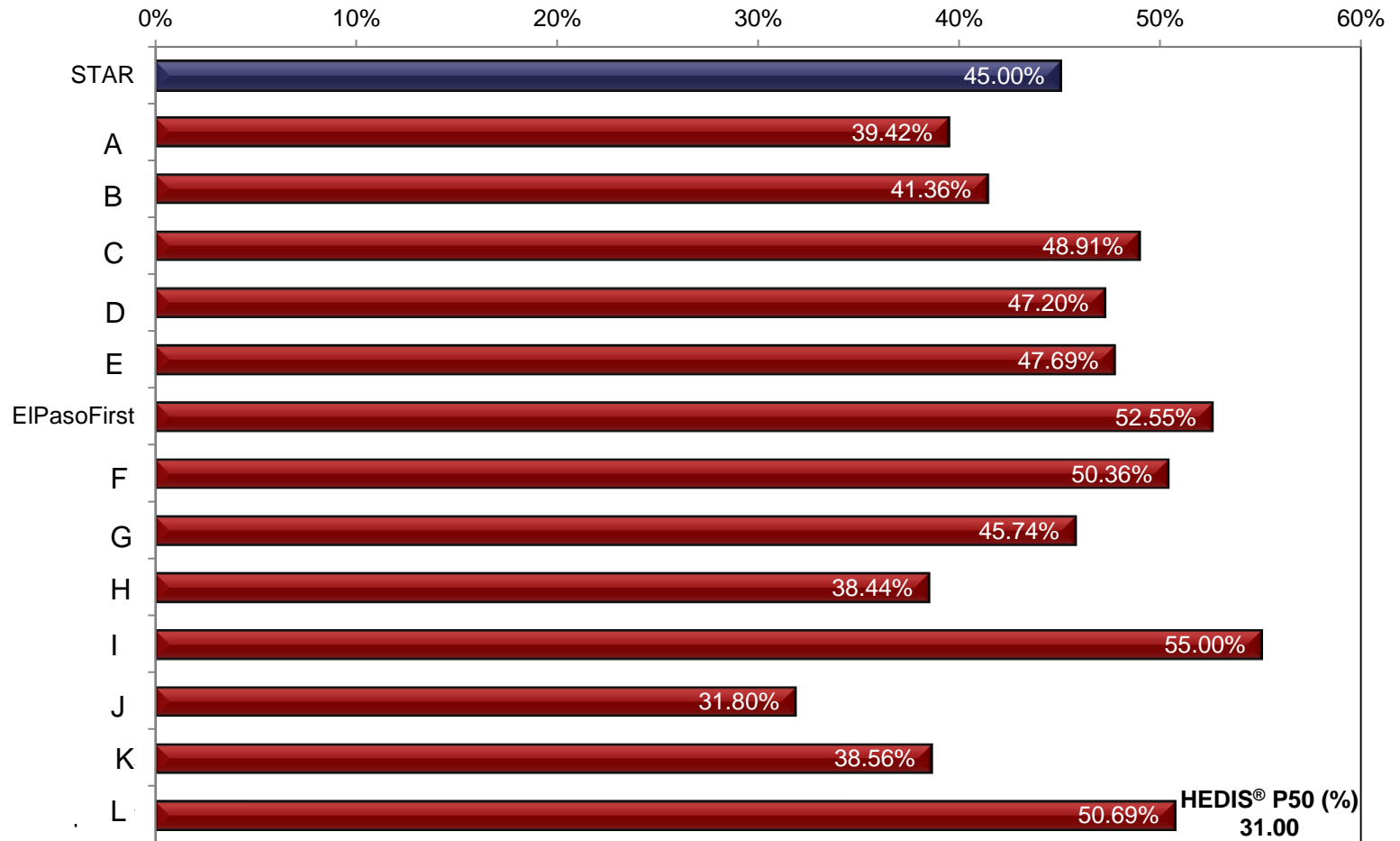
STAR Weight Assessment for Children for Nutrition and Physical Activity for Children/Adolescents

	Percentage
STAR	23.18%
A	21.17%
B	20.19%
C	21.41%
D	23.60%
E	26.03%
F	9.49%
El Paso First	45.99%
G	21.17%
H	22.87%
I	19.95%
J	21.30%
K	22.00%
L	26.20%

HEDIS® P50 (%)
N/A
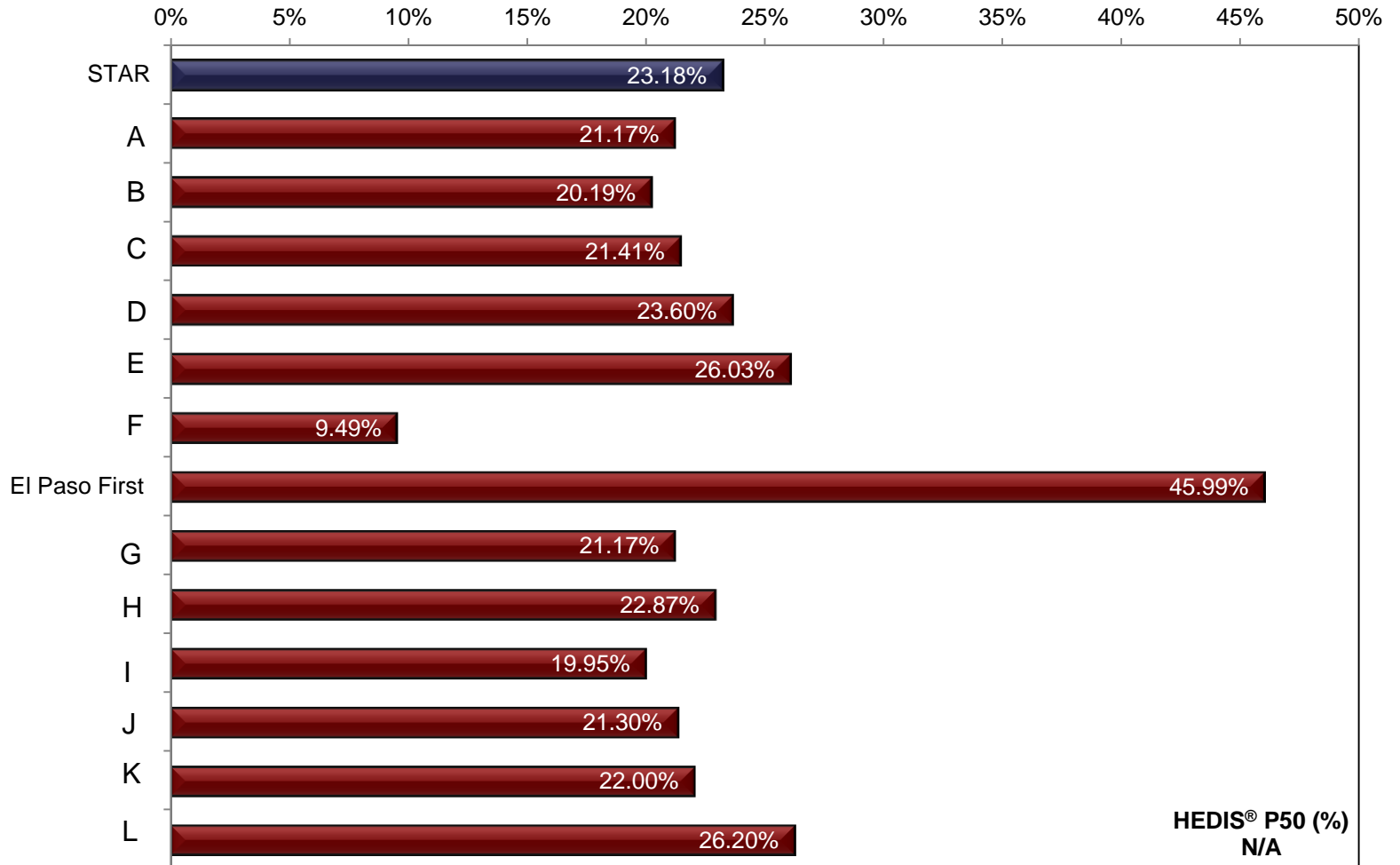
Performance Improvement Projects 2013 – (See handout)

STAR	CHIP
Reduce Utilization ED Utilization (*asthma, diabetes, gastroenteritis, perforated appendix*)	Well-Child Visits 3-6 years of age
Weight, Counseling for Nutrition and Physical Activity (Prevent, intervene, treat obesity)	Weight, Counseling for Nutrition and Physical Activity (Prevent, intervene, treat obesity)
Prenatal and Postpartum Care	Adolescent Well-Child

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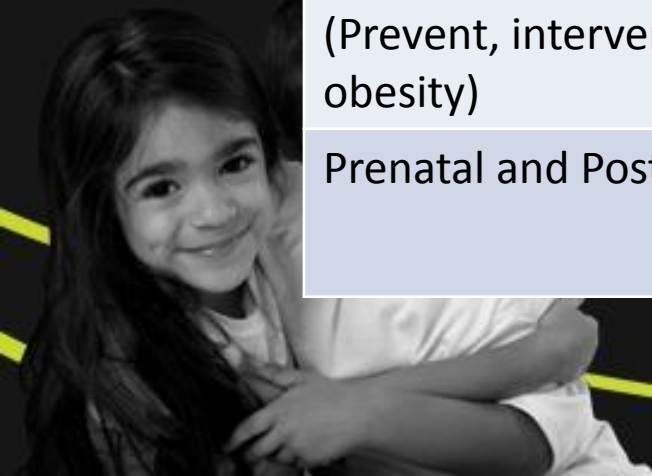
Questions

We are here to help you!!

If you have questions or concerns please contact the Quality Department

Kathleen Thompson, QI Director
kthompson@epfirst.com

915.298.7198 ext 1043

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Health Services Department

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Pre-Authorization

- Prior authorization flyer identifies authorization requirements
- Submit required documentation
  - (i.e. Title XIX forms, TP1, TP2 forms)
- Submit supporting clinical information
  - (i.e. evaluation, plan of care)

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Pre-Authorization Form

- Submit complete and legible pre-certification form
  - Include date of service
- Enter applicable CPT Codes and ICD-9 Codes
- Complete the member's identifying information

  - Name   - Date of birth   - Identification number

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Amendments

- When requesting an amendment, please include the following:
  - Original authorization number
  - Clinical information to support the amendment

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Notifications

Partial Approval

- The Medical Director has approved services with a modification from the original request.
- The provider receives a fax notifying him/her of the approval.
- Provider has the opportunity to request a peer to peer discussion.

Administrative Denial

- Requested services were not approved.
- Example:
  - No clinical information is submitted within the requested time frame
  - Service is not a covered benefit
- The provider receives a fax notifying him/her of the denial and a formal denial letter with appeal rights.

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Case Management and Disease Management

- Licensed social workers and nurses:
  - Initiate service coordination for local and out of town services
  - Link individuals with local community resources
  - Learn about each member's unique needs
  - Assist in management of chronic conditions such as asthma and diabetes

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Assigning PCP's to Newborns

The Enrollment Specialist will review the P35 Newborn Report (TP45) on a daily basis to identify new members that have been enrolled in QNXT without an assigned PCP. *(Some do have a PCP already)*

EP1st Daily P35 Newborn Report (TP45) — Delivered to Member Services

Medicaid ID	Name	SSN	Address	Phone	Risk Group	Enroll Start	Enroll End
		000-00-0000	TX 79927-0000		000006	04/26/2013	99/99/9999
DOB:	Sex: F	Case Name:	EL PASO PCP TPI: 999999999	PCP NPI: APCCNEWB01	PO BOX 200645		
		000-00-0000	TX 79928-0000		000006	05/02/2013	99/99/9999
DOB:	Sex: M	Case Name:	EL PASO PCP TPI: 999999999	PCP NPI: APCCNEWB01	PO BOX 200645		
		000-00-0000	TX 79903-0000		000006	04/22/2013	99/99/9999
DOB:	Sex: M	Case Name:	EL PASO PCP TPI: 999999999	PCP NPI: APCCNEWB01	PO BOX 200645		
		000-00-0000	TX 79849-0000		000006	04/06/2013	99/99/9999
DOB:	Sex: M	Case Name:	SAN ELIZARIO PCP TPI: 999999999	PCP NPI: APCCNEWB01	PO BOX 200645		

Total Newborns: 4

Report Run: 5/6/2013

Page 1 of 1

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Assigning PCP's to Newborns

If no PCP is listed on the P35 Newborn Report the enrollment specialist will research QNXT. *(Review the mother's account on file to see if she already selected a pcp, search for siblings, call mother to get pcp name, if not PCP will be assigned based on members zip code).*

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Assigning PCP's to Newborns

Depending on which date of the month the enrollment specialists are working the pcp assignment will take from 16 to 45 days.

(Assignment/changes before cut off date are effective the following month after cut off date they will be effective in 2 months).

May 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1	2	3	4
5	6	7	8	9	10	11
12	13	14 **Cut-off date**	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

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Questions?

If you have questions please contact the
Member Services Department

Edgar Martinez, MBA
edmartinez@epfirst.com
915.298.7198 ext 1064

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Thank You for Attending Providers!

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