Welcome OB Providers

OB Specialty Training

August 28, 2013

EL PASO FIRST Health Plans inc.

Agenda

- CHIP Perinatal Overview
- First Steps Case Management Program
- Preferred Administrators Benefits
- Accessibility & Availability Surveys
- ICD-10 Implementation Updates
-

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CHIP Perinatal Overview

- Description of CHIP Perinatal
- Eligibility
- Covered Benefits
- This information is communicated to our members via the *Member Handbook* that you can access on-line at:
  http://www.epfirst.com/pdf/perinatal_members_Handbook.pdf.

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CHIP Perinatal Description

CHIP Perinatal provides prenatal care to the pregnant woman of the unborn child who is not eligible for Medicaid and is at or below 200% of Federal Poverty Level (FPL).

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How much do you know about CHIP Perinatal?

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How long is the Member covered under the CHIP Perinatal program?

Twelve months of continuous coverage for the unborn child from the time that eligibility is determined.

No waiting period for coverage. The 30 day waiting period that applies to traditional CHIP does not apply for CHIP Perinatal.

No out of pocket fees to members. Co-payments *that apply to traditional CHIP do not apply to CHIP Perinatal.*

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Eligibility: Who qualifies?

A. Uninsured

B. Does not qualify for Medicaid

C. Texas resident

D. Meets certain income requirements

E. All of the above.

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Eligibility: Who qualifies?

- Uninsured
- Does not qualify for Medicaid
- Texas resident
- Meets certain income requirements.

Households with

- Income greater than 185% FPL, and at or below 200% FPL.
- Income below 200%, but do not qualify for Medicaid because of immigration status.

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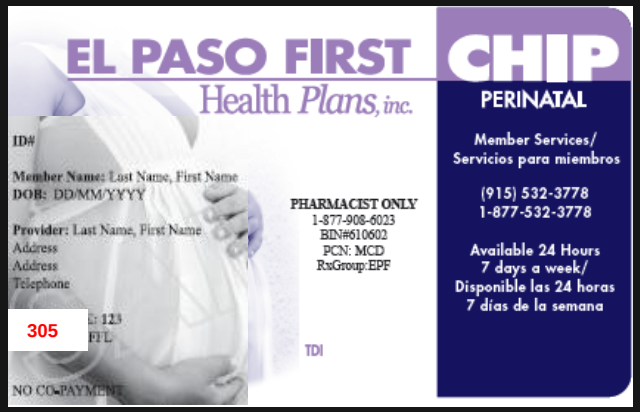
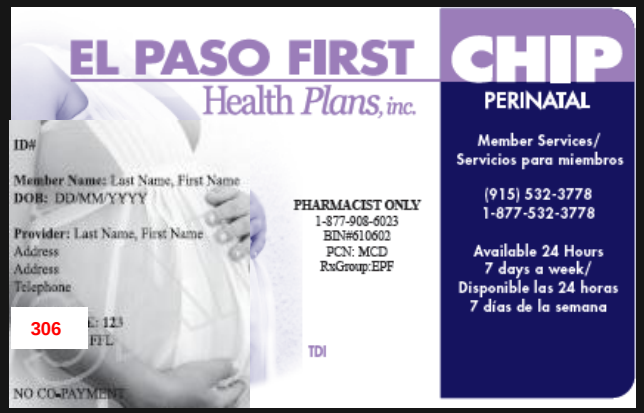
CHIP Perinatal ID Card - Member





For Hospital Facility billing for members with FPL 0-185% please bill to:
Texas Medicaid and Healthcare Partnership Claims • P.O. Box 200555 • Austin, Texas 78720-0555
For Members with FPL above 185% to 200% and for **Professionals/Other services billing**, please bill to:
El Paso First Health Plans • P.O. Box 971370 • El Paso, Texas 79997-1370

MEDICINE: Present this card at drug stores with prescription from your doctor. Call El Paso First Health, Plans, Inc. at 1-877-532-3778 if you have questions or problems getting your medicine.
DIRECTIONS FOR WHAT TO DO IN AN EMERGENCY: In case of emergency call 911 or go to the closest emergency room.

MEDICINA: Presente esta tarjeta de identificación en la farmacia junto con la receta de su doctor. Llame El Paso First Health Plans, Inc al 1-877-532-3778 si tiene preguntas o problemas para obtener la medicina.
INSTRUCCIONES EN CASO DE EMERGENCIA: En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana.

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What is the difference between rate 305 and 306?

Rate Code: 305 is for members below 185% FPL

Member will need to apply for Emergency Medicaid to pay for the hospital facility services.

For Hospital Facility Services bill TMHP.

For Professional Services bill El Paso First Health Plans.

Rate Code: 306 is for members above 186% FPL.

For Professional and Facility Services bill El Paso First Health Plans.

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What are the Mother's Benefits?

A. Up to 20 prenatal visits (more if medically necessary)

B. Limited pharmacy, limited laboratory testing, assessments, education and counseling. All these services must be related to the pregnancy.

C. Hospital facility charges and professional services charges related to the delivery.

D. Two postpartum visits for the mother within 60 days after delivery.

E. All of the above.

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CHIP Perinatal Benefits - Mother

Up to 20 prenatal visits (more if medically necessary)

- First 28 weeks of pregnancy — one visit every four weeks.
- 28 to 36 weeks of pregnancy — one visit every two to three weeks.
- 36 weeks to delivery — one visit per week.
- Additional prenatal visits allowed if medically necessary (authorization required).

– Limited pharmacy, limited laboratory testing, assessments, education and counseling. All these services must be related to the pregnancy.

– Hospital facility charges and professional services charges related to the delivery. *Preterm labor that does **not** result in a birth and false labor are not covered benefits.*

– Two postpartum visits for the mother within 60 days after delivery.

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True / False – Physician Professional Services

Medically necessary physician services are not **limited to prenatal and postpartum care and/or the delivery.**

False

Medically necessary physician services are **limited to prenatal and postpartum care and/or the delivery.**

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True / False – Physician Professional Services cont.…

Physician office visits, in-patient, out-patient services, Laboratory, imaging and pathology services, including technical component and/or professional interpretation are covered services.

True

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True / False – Physician Professional Services

Medically necessary medications, biologicals and materials administered in Physician's office are not covered benefits.

False

Medically necessary medications, biologicals and materials administered in Physician's office are covered benefits.

Note Limitations:

- Specialty Services require a referral/authorization.
- All services must be related to the care of the unborn child.

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Physician Professional Services

- Medically necessary physician services are **limited to prenatal and postpartum care and/or the delivery.**
- Physician office visits, in-patient and out-patient services.
- Laboratory, imaging and pathology services, including technical component and/or professional interpretation.
- Medically necessary medications, biologicals and materials administered in Physician's office.
- **Limitations:**
  - Requires a referral/authorization for specialty services
  - All services must related to the care of the unborn child.

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Physician Surgical Services – What's covered?

- Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.
- Administration of anesthesia by Physician (other than surgeon) or CRNA.
- Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.
- Hospital-based Physician services (including Physician performed technical and interpretive components).
- Services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).

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Inpatient Benefits – True / False

Inpatient benefits include:

- Services associated with miscarriage or non-viable pregnancy are a covered benefit.
- Dilation and curettage (D & C procedures).
- Appropriate provider administered medications.
- Ultrasounds

True

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Pregnancy-Related Laboratory Tests Covered by CHIP Perinatal

- Non-stress testing, contraction stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy
- Complete blood count (CBC)
- Urinanalysis for protein glucose every visit
- Blood type
- RH antibody screen (repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated)
- Rubella antibody titer
- Serology for syphilis, hepatitis B surface antigen
- Cervical cytology
- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test

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Laboratory Tests continued

- Human Immunodeficiency Virus (HIV) antibody screen
- Chlamydia test,
- Multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks)
- Screen for gestational diabetes at 24-28 weeks of pregnancy

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Benefits NOT Covered

- Hospital care not related to delivery.
- ***False Labor***
- Mental health
- Diabetic supplies
- Durable Medical Equipment (wheel chairs, crutches, etc.)
- Family Planning
- Colposcopy

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Helpful Websites

TMHP general inquiries hotline and website:
1-800-925-9126;
http://www.tmhp.com/Medicaid/default.aspx
CHIP Perinatal:
http://www.hhsc.state.tx.us/chip/perinatal/index.htm
Billing Processes:
http://www.hhsc.state.tx.us/chip/perinatal/NewbornClaimsInstructions.pdf
Vital Statistics Instructions:
http://www.hhsc.state.tx.us/chip/perinatal/VitalStatisticsInstructions_062807.pdf
El Paso First:
http://www.epfirst.com

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Questions ?

Stacy Arrieta

Provider Relations Representative

298-7198 ext. 1059

sarrieta@epfirst.com

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First Steps
Case Management Program

Edna Martinez and Melissa Delgado

OB Case Managers

Jesse Salomon

Community Outreach Worker

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First Steps
Case Management Program

- A comprehensive, member driven, person centered approach to assess our members individual needs and assist in identifying their unique goals.

  Our goal -
- Is to have our members at the center of decision making when it comes to their treatment plans, goals, and medical care.
- Members are encouraged to exercise choice and to direct what supports and/or service coordination is needed.

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How will members be identified?

Every member will be assessed

- CM will assist member in coordinating prenatal care.
- If member calls and schedules appointment with provider please schedule appointment for member and refer back to El Paso First Health Plans, so that we may document appointment date and time and provide member with additional benefit information.

- Case Management process will be followed depending on members identified needs
- Collaboration between Case Manager and Provider is key to successful treatment for high risk members.

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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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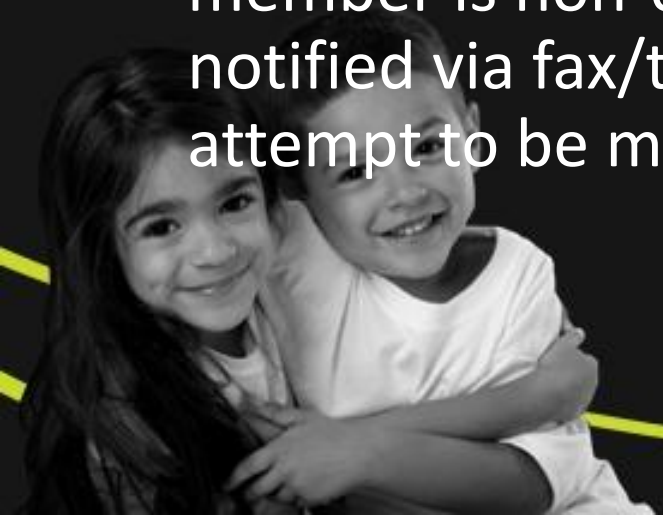
Hospital Delivery Notification

- Upon receipt of hospital delivery notification OB Unit will make contact with member to assist in scheduling postpartum visit.
- Incentive will be given to member if member complies with postpartum visit (as of September 1st, 2013)
- Collaboration between OB Unit and Provider is essential to ensure member complies with postpartum visit, if member is non-compliant, El Paso First should be notified via fax/telephone/online in order for an attempt to be made to reach the member.



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Intake Process

Provider submits PA form to El Paso First

- Pre-certification form is submitted via fax
- Fax number: 298-7866

El Paso First begins review process

- Clinical information
- Treatment goals
- CPT Codes, units and frequency

Medical director makes determination

- Final determination based on medical necessity
- Provider will receive a fax with decision

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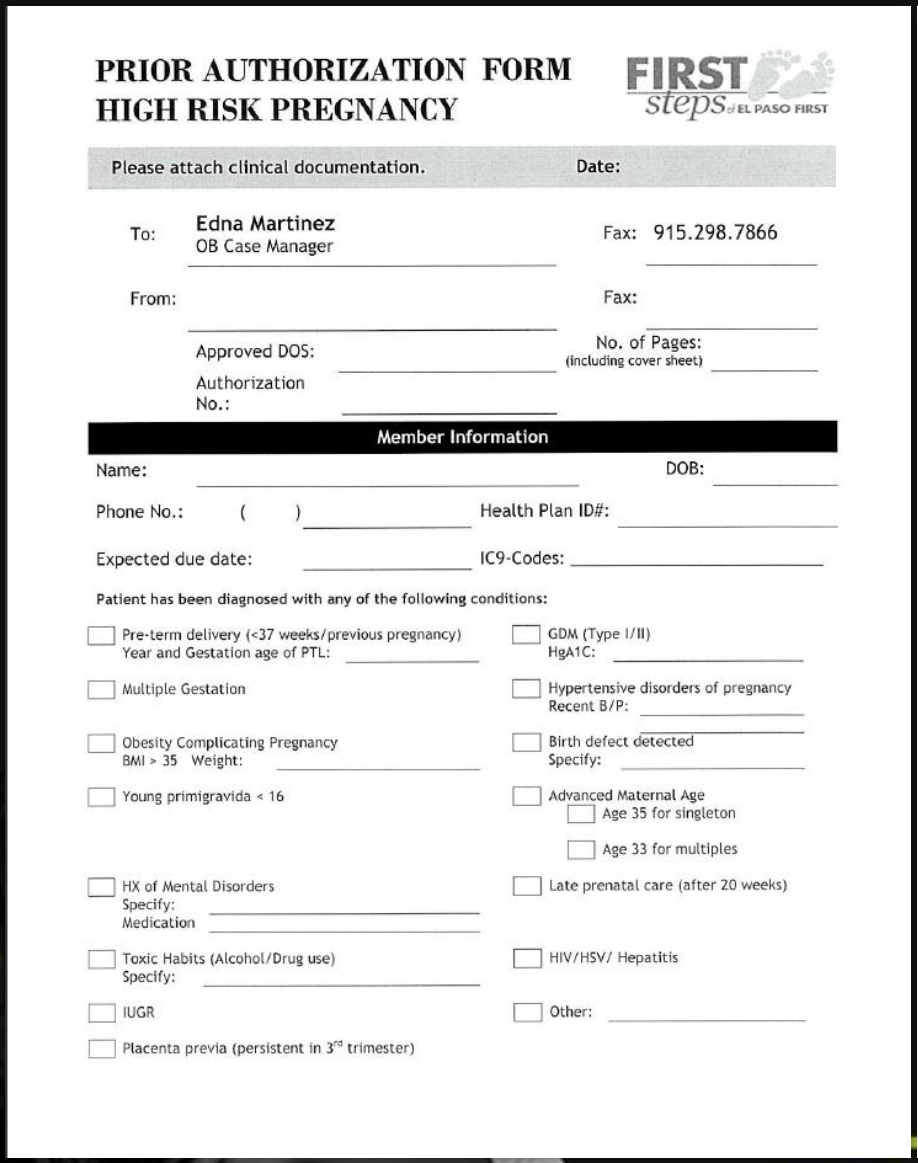
Authorizations



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

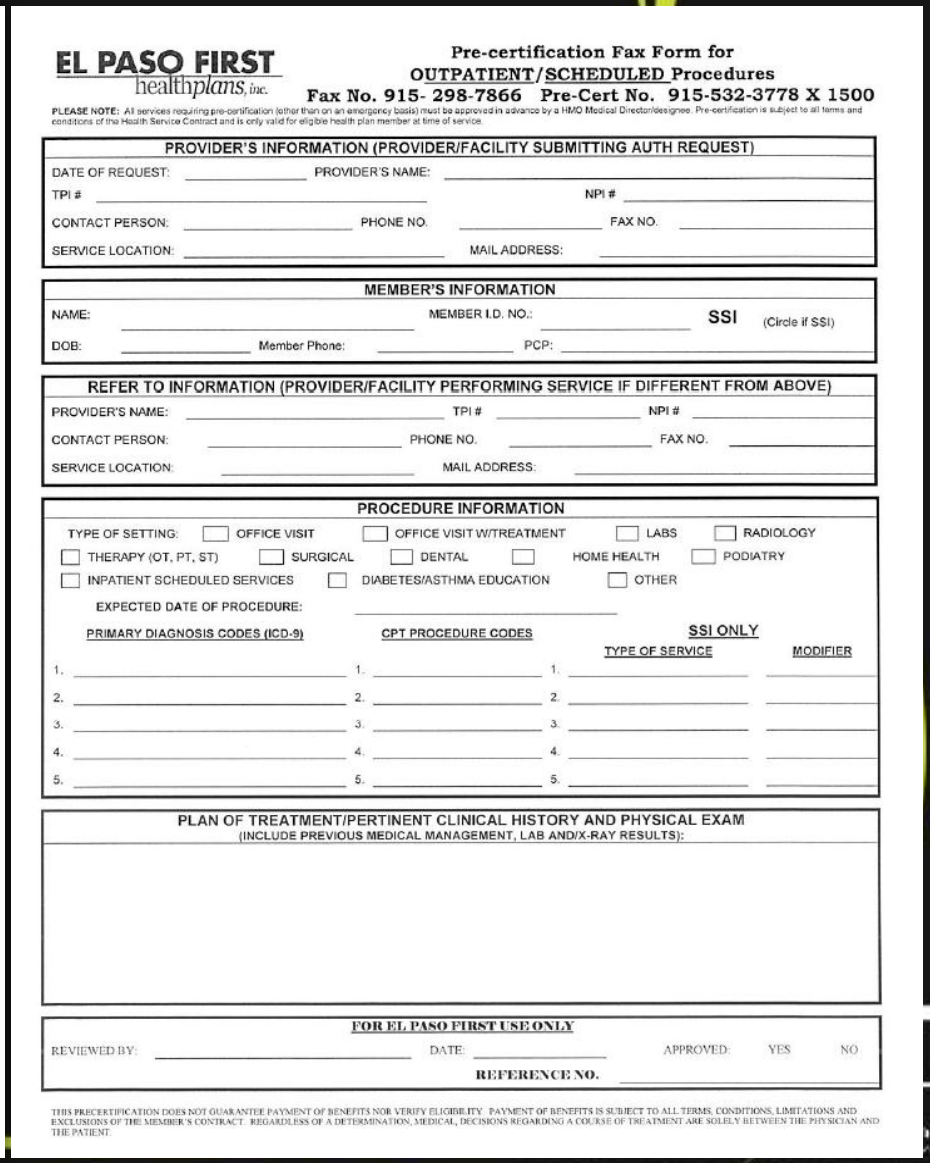
Name: DOB:

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:



EL PASO FIRST healthplans, inc.

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	SSI ONLY MODIFIER
1.	1.	1.	
2.	2.	2.	
3.	3.	3.	
4.	4.	4.	
5.	5.	5.	

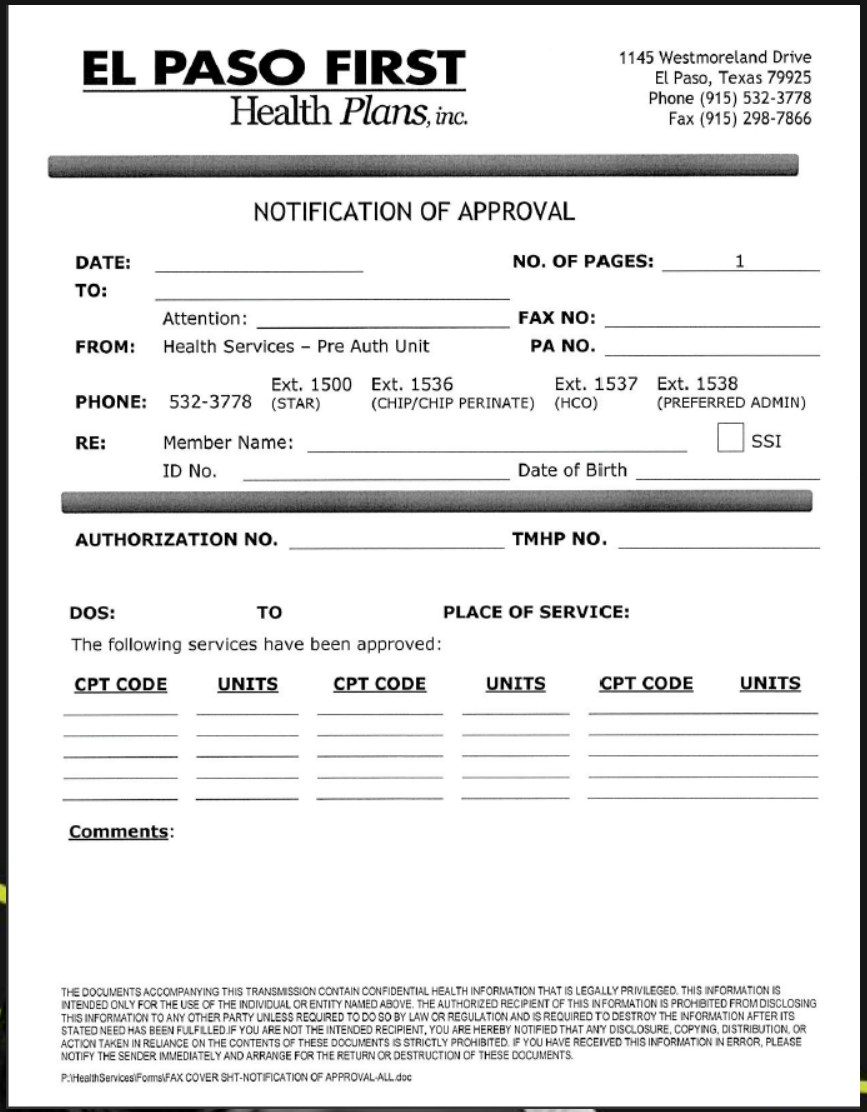
PLAN OF TREATMENT/PERTINENT CLINICAL HISTORY AND PHYSICAL EXAM
(INCLUDE PREVIOUS MEDICAL MANAGEMENT, LAB AND/X-RAY RESULTS):

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.

Health Services Forms
Notification of Approval



EL PASO FIRST
Health Plans, inc.

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

NOTIFICATION OF APPROVAL

DATE: _____ **NO. OF PAGES:** 1

TO: _____

Attention: _____ **FAX NO:** _____

FROM: Health Services – Pre Auth Unit **PA NO.** _____

PHONE: 532-3778 Ext. 1500 (STAR) Ext. 1536 (CHIP/CHIP PERINATE) Ext. 1537 (HCO) Ext. 1538 (PREFERRED ADMIN)

RE: Member Name: _____ ☐ SSI

ID No. _____ Date of Birth _____

AUTHORIZATION NO. _____ **TMHP NO.** _____

DOS: **TO** **PLACE OF SERVICE:**

The following services have been approved:

CPT CODE	UNITS	CPT CODE	UNITS	CPT CODE	UNITS

Comments:

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

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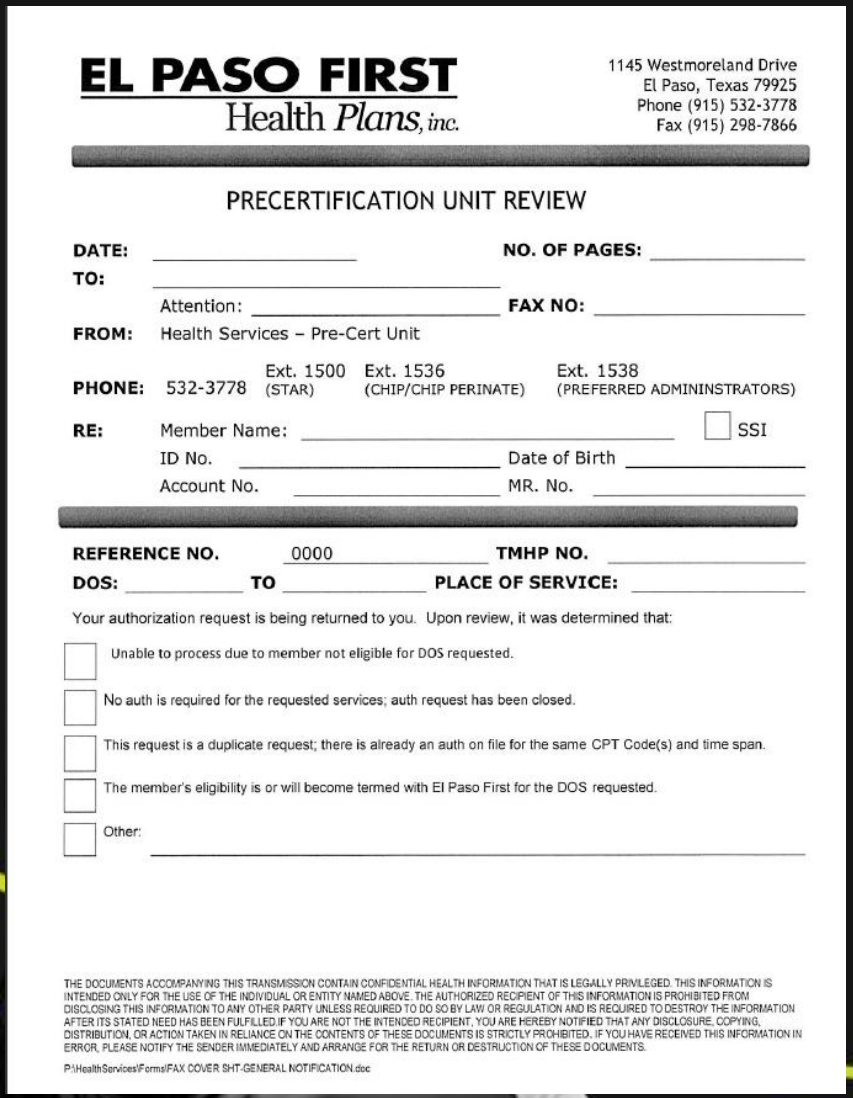
Health Services Forms
Precertification Unit Review



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Phone (915) 532-3778
Fax (915) 298-7866

PRECERTIFICATION UNIT REVIEW

DATE: _____ **NO. OF PAGES:** _____

TO: _____

Attention: _____ **FAX NO:** _____

FROM: Health Services – Pre-Cert Unit

PHONE: 532-3778 Ext. 1500 (STAR) Ext. 1536 (CHIP/CHIP PERINATE) Ext. 1538 (PREFERRED ADMININSTRATORS)

RE: Member Name: _____ ☐ SSI

ID No. _____ Date of Birth _____

Account No. _____ MR. No. _____

REFERENCE NO. 0000 **TMHP NO.** _____

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

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

☐ Unable to process due to member not eligible for DOS requested.

☐ No auth is required for the requested services; auth request has been closed.

☐ This request is a duplicate request; there is already an auth on file for the same CPT Code(s) and time span.

☐ The member's eligibility is or will become termed with El Paso First for the DOS requested.

☐ Other: _____

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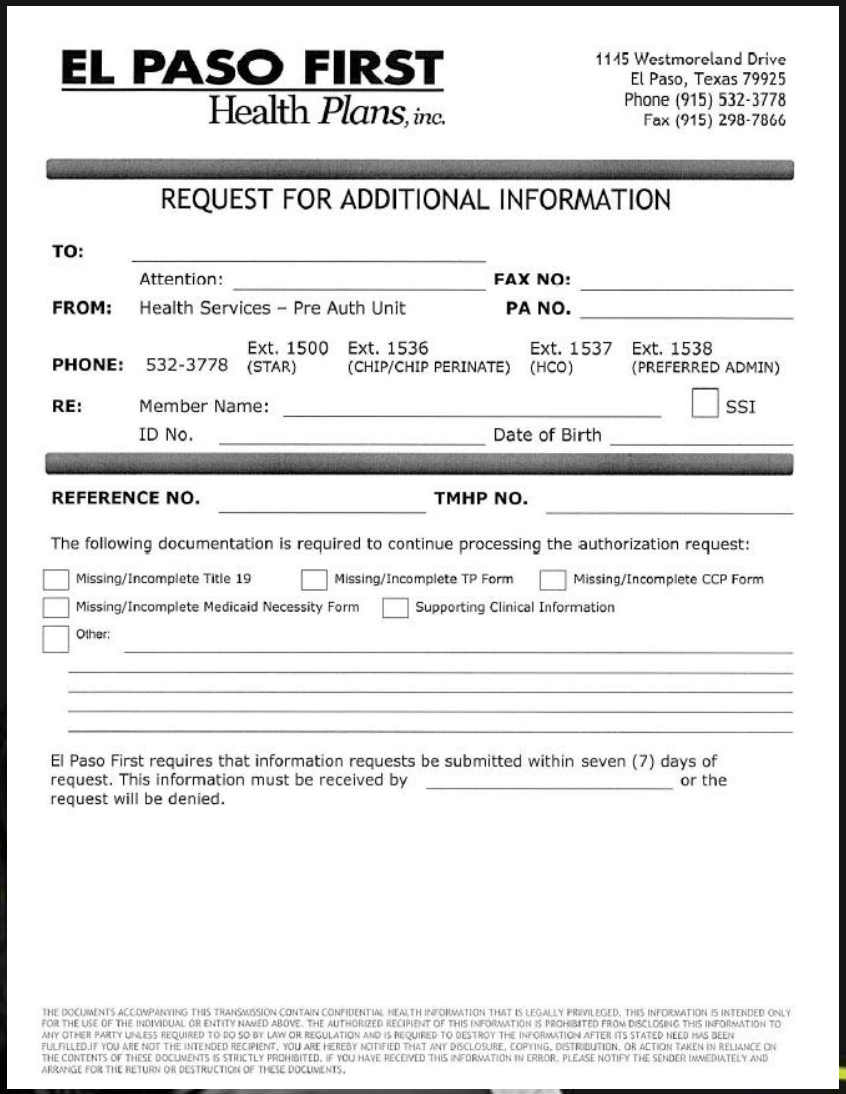
Health Services Forms
Request for Additional Information



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Fax (915) 298-7866

REQUEST FOR ADDITIONAL INFORMATION

TO: _____

Attention: _____ **FAX NO:** _____

FROM: Health Services – Pre Auth Unit **PA NO.** _____

PHONE: 532-3778 Ext. 1500 (STAR) Ext. 1536 (CHIP/CHIP PERINATE) Ext. 1537 (HCO) Ext. 1538 (PREFERRED ADMIN)

RE: Member Name: _____ ☐ SSI

ID No. _____ Date of Birth _____

REFERENCE NO. _____ **TMHP NO.** _____

The following documentation is required to continue processing the authorization request:

☐ Missing/Incomplete Title 19 ☐ Missing/Incomplete TP Form ☐ Missing/Incomplete CCP Form

☐ Missing/Incomplete Medicaid Necessity Form ☐ Supporting Clinical Information

☐ Other: _____

El Paso First requires that information requests be submitted within seven (7) days of request. This information must be received by _____ or the request will be denied.

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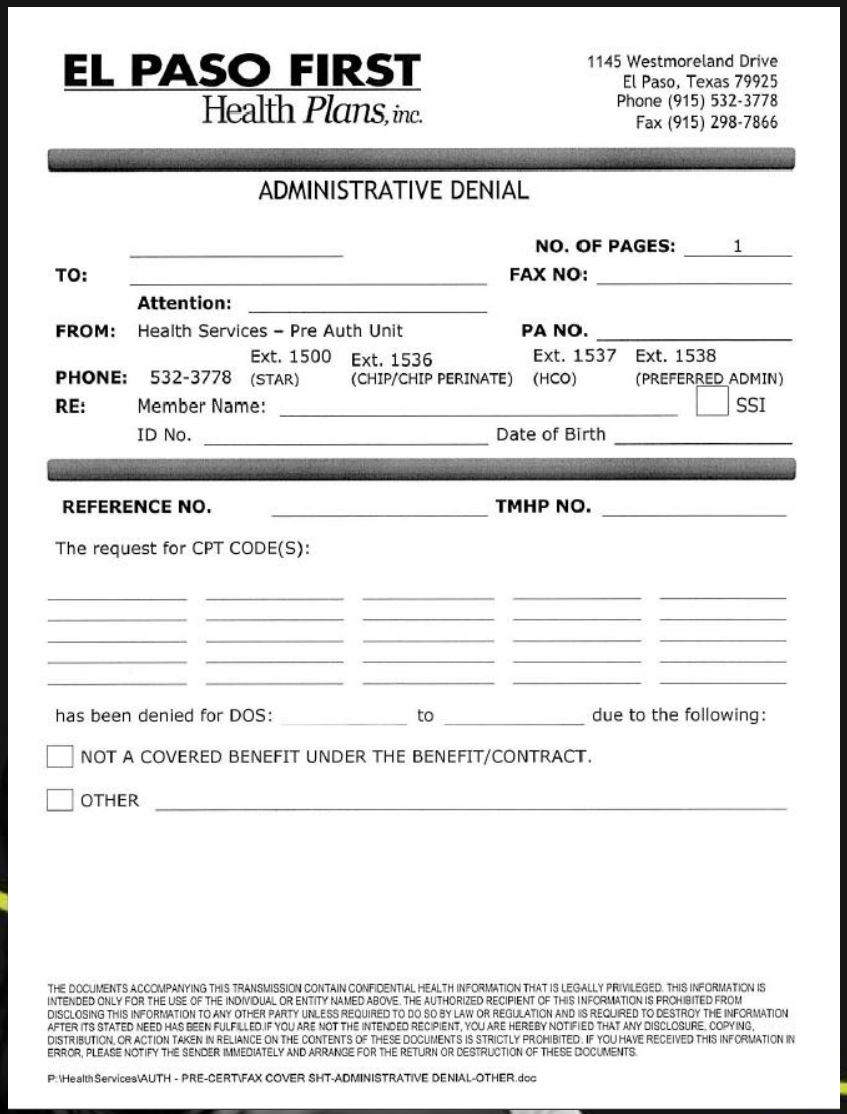
Health Services Forms
Administrative Denial



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ADMINISTRATIVE DENIAL

NO. OF PAGES: 1

TO: _____ **FAX NO:** _____

Attention: _____

FROM: Health Services – Pre Auth Unit **PA NO.** _____

PHONE: 532-3778 Ext. 1500 (STAR) Ext. 1536 (CHIP/CHIP PERINATE) Ext. 1537 (HCO) Ext. 1538 (PREFERRED ADMIN)

RE: Member Name: _____ ☐ SSI

ID No. _____ Date of Birth _____

REFERENCE NO. _____ **TMHP NO.** _____

The request for CPT CODE(S):

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

has been denied for DOS: _____ to _____ due to the following:

☐ NOT A COVERED BENEFIT UNDER THE BENEFIT/CONTRACT.

☐ OTHER _____

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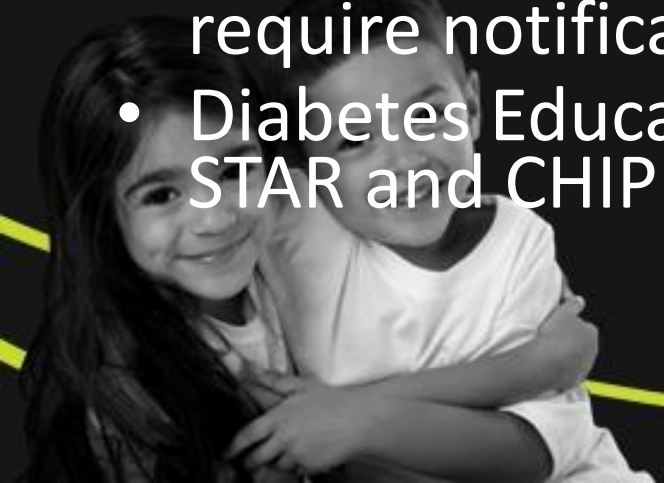
Frequently Asked Questions

- First **FOUR** ultrasounds **DO NOT** require a prior authorization
- Alpha Hydroxyprogesterone injections (17p) are a covered benefit for all Product Lines (STAR, CHIP Perinatal and Preferred Administrators members) – auth required -
- NST (59020 and 59025) DO NOT require a prior authorization
- Referral to a high risk specialist – DOES NOT require notification
- Diabetes Education classes are a benefit for both STAR and CHIP Perinate members



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STAR Medicaid - Family Planning

- Family planning annual exams (annual pap smears) – no auth required
- Laboratory procedures – no auth required
- Radiology services – non ob related radiology services no auth required
- Contraceptive devices and related procedures – no auth required
- Sterilization and sterilization-related procedures (i.e., tubal implants, tubal ligation, vasectomy, and anesthesia for sterilization) – auth required for STAR and Preferred Administrators
  - Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form for STAR members.

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Hysterectomy

- Pre-certification required for STAR and Preferred Administrators
  - Clinical documentation
    - Doctors Notes
    - Labs
    - Treatment History
    - Ultrasound results
    - 3 day notice prior to procedure

*Not covered under CHIP and CHIP-Perinatal

Please include hysterectomy acknowledgement form for STAR members.

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Diabetes Education & Supplies

- Covered/Non-covered services

El Paso Diabetes Association

1220 Montana Avenue
El Paso, Texas 79905
(915) 532-6280

UMC of El Paso Diabetes Management Program

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

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CHIP Perinatal

COVERED

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

NOT A BENEFIT

Durable medical equipment or other medically related remedial devices (does NOT cover testing strips, lancets, monitor).

EP First can HELP – resources available in the community.

Call us!

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STAR

COVERED BENEFITS

- Two preferred diabetes glucose meters and test strip lines have been implemented since November 2012:

  TRUEresult® System with TRUEtest Test Strips *from Nipro Diagnostics, Inc.*

  FreeStyle Lite®, FreeStyle Freedom Lite® and Precision Xtra® Systems and test strips *from Abbott Diabetes Care*

- ✓ If you have any questions or concerns regarding this formulary change notification, please contact Navitus Health Solutions Customer Care toll-free at 1-877-908-6023 (toll free) or visit www.navitus.com.
- Oral Medication/Insulin
- Request for DME (lancets, strips, monitor) is a covered benefit (no auth required if limit is not exceeded) check Medicaid Guidelines for max allowed
- Diabetes Education Classes (*authorization required*)
  - El Paso Diabetes Association
  - UMC of El Paso Diabetes Program

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Preferred Administrators

COVERED – Pharmacy Benefit

- Oral Medication/Insulin
- DME (lancets, strips, monitor) is a covered benefit (*no auth required)*
- Go to preferredadmin.net
  - Select link for Prescription Solutions
  - Formulary (Search for covered medication and DME)
- Diabetes Education Classes
  - El Paso Diabetes Association (*auth required*)
  - UMC of El Paso Diabetes Program (*no auth required*)

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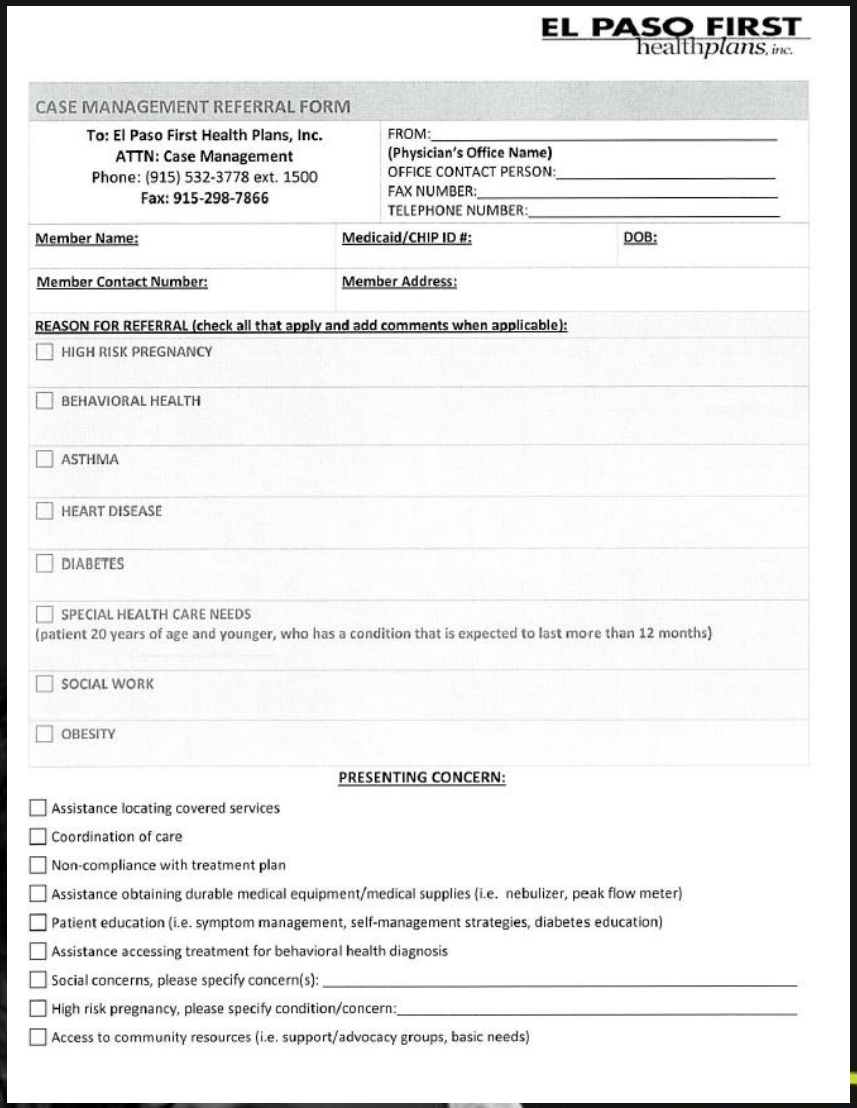
Case Management Referral Form



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)

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Questions?

Melissa Delgado
OB Case Manager
298-7198 ext. 1168
mdelgado@epfirst.com

Edna Martinez
OB Case Manager
298-7198 ext. 1078
martineze@epfirst.com

Jesse Salomon
Community Outreach
Health Worker
298-7198 ext. 1161
jsalomon@epfirst.com

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Texas Health Steps

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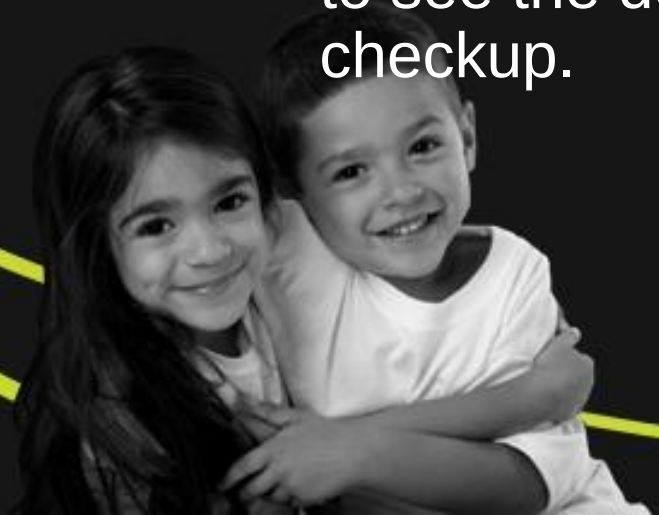
Texas Health Steps

These checkups will:

- Help make sure children are growing right.
- Help make sure children's teeth are healthy.
- Help find problems early, if there are any.
- Tell parents what to expect as their child gets older.
- Once the child turns six months old, he or she needs to see the dentist every six months for a dental checkup.



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Texas Health Steps

Texas Health Steps Checkups need to be done at these ages:					
3-5 Days	1-2 Weeks	2 Months	4 Months	6 Months	9 Months
12 Months	15 Months	18 Months	24 Months	30 Months	3 Years
4 Years	5 Years	6 Years	7 Years	8 Years	9 Years
10 Years	11 Years	12 Years	13 Years	14 Years	15 Years
16 Years	17 Years	18 Years	19 Years	20 Years	

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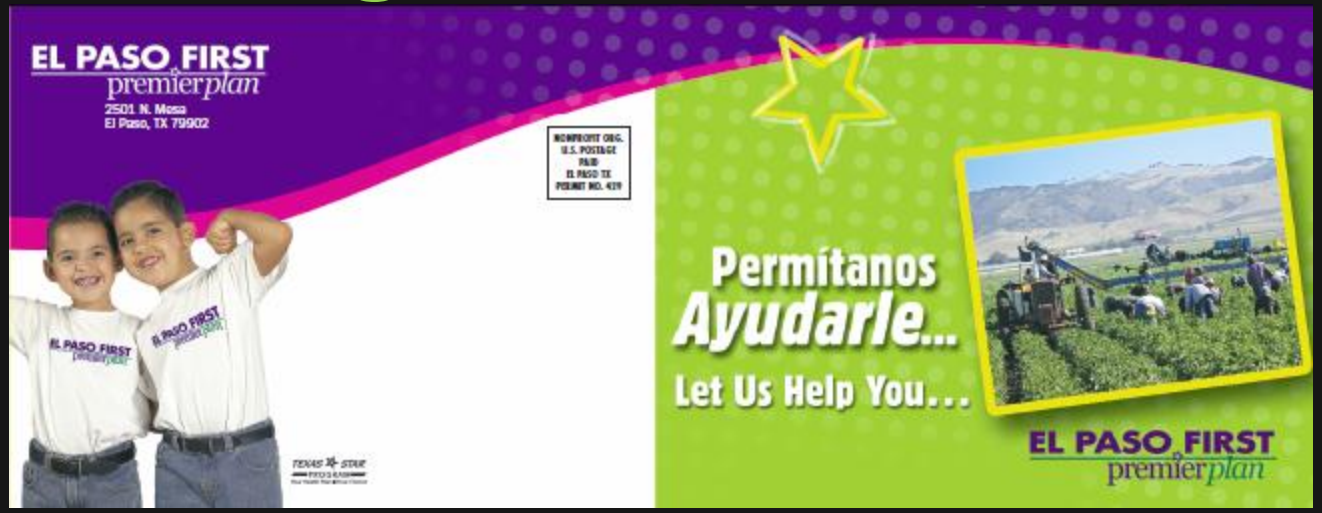
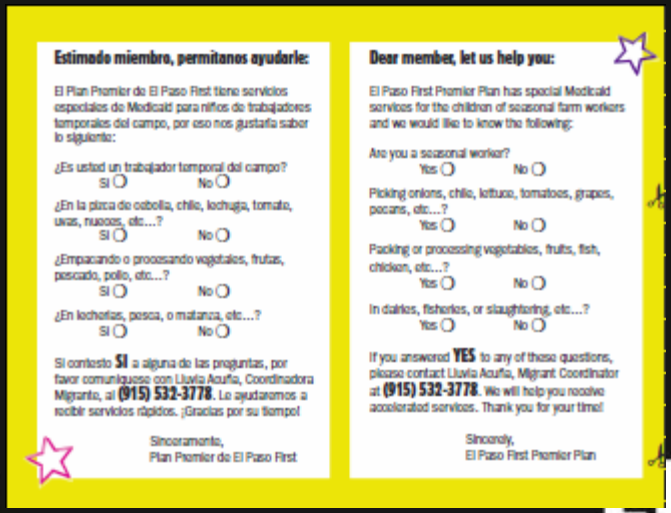
Migrant Postcard





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

EL PASO FIRST
Health Plans inc.

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

EL PASO FIRST Health Plans inc.

ACCESSIBILITY AND AVAILABILITY

Quality Improvement Department

EL PASO FIRST
Health Plans inc.

Background

- In accordance with the Texas Health and Human Services Commission and the Texas Department of Insurance mandates, El Paso First Health Plans, Inc. is required to monitor its Primary Care Providers on an annual basis for office accessibility compliance and 24-hour availability.

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Definitions

- **Office Accessibility** –members must be able to schedule an appointment for covered services within the time frames mandated by TDI and HHSC.
- **After-hours Availability** - PCP and Behavioral Health Providers must be available 24/7 as mandated by TDI and HHSC.

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Office Accessibility Standards for Emergency and Urgent Care

- Emergency Services must be provided upon member presentation at the service delivery site.
- Urgent Care, including specialty urgent care, must be provided within 24 hours of request.

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Office Accessibility Standards for Routine Care & Behavioral Health

- Routine Primary Care must be provided within 14 days of request.
- Routine Specialty Care referrals must be provided within 30 days of request.

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Office Accessibility Standards for Prenatal Care

- Prenatal Care must be provided within 14 days of request.
- Prenatal Care for High-Risk Pregnancies and New Members in the 3rd Trimester must be offered within 5 days or immediately if an emergency exists.

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Office Accessibility for Preventive Health

- Preventive Health Services for Adults must be provided within 90 days of request.
- Preventive Health Services for Children:
  - For members under age 20 as soon as practicable.
  - For newborn members, no later than 14 days
  - For all other eligible members no later than 90 days.

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Office Appointment Accessibility Form

- Visits from Provider Relations Reps for completion of the Office Appointment Accessibility Form:
  - Accepting new patients
  - Appointment wait times for patients
  - Average number of patients seen at your office on daily basis
  - Office accessibility, days and hours office open
  - Disability, language and diverse background accommodations
  - After hours availability: physician's direct contact #, nurse triage or answering service

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Office Accessibility Wait Time

- TDI and HHSC have also established that a member wait at the office should not be longer than 15 minutes to be taken to the exam room.

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After-Hours Availability

- The QI Department monitors PCP after-hours availability on an annual basis.
- After-hours are 05:00 pm to -08:30 am, Monday through Friday and all day Saturday and Sunday.
- The QI Nurse Auditor, following a script, conducts the after hour calls. Calls are identified as "annual after-hour survey calls".
- Depending on the recording and call-back time, calls are classified either compliant or non-compliant.

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Compliant After-Hour Calls

- Answering services meets the language requirement of the major population groups and must be able to contact the Provider or other designated medical practitioner.
- Recording must also meet the language requirements and directs member to call another phone number to reach the Provider or other designated medical practitioner. Other phone number must be answered by someone at the time of the call.
- Call is transferred to an on-call person and also meets the language requirements. Person on-call must be able to reach the Provider or other designated medical practitioner to return call to member.
- Once the Provider or other designated medical practitioner is paged, the call **must** be returned within 30 minutes.

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Non-Compliant After-Hour Calls

- Office telephone is answered only during office hours.
- Office telephone is answered by a recording instructing the member to leave a message.
- Office telephone is answered by a recording that tells the member to go to the Emergency Room for services needed.
- Office telephone is answered by a recording advising the member that a fee will be charged for any after-hour calls returned by the provider.
- Returning after-hour calls past 30 minutes.

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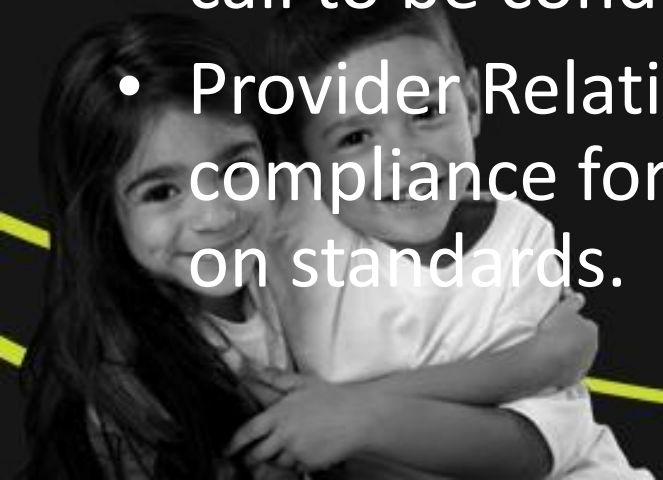
Handling of Non-Compliant After-Hour Survey Calls

- Provider notified of non-compliance with the after-hours availability standards via Certified letter.
- Copy of the Accessibility and Availability Standards enclosed with letter.
- Notification of after-hours availability re-survey call to be conducted within next few months.
- Provider Relations Department notified of non-compliance for purpose of additional education on standards.



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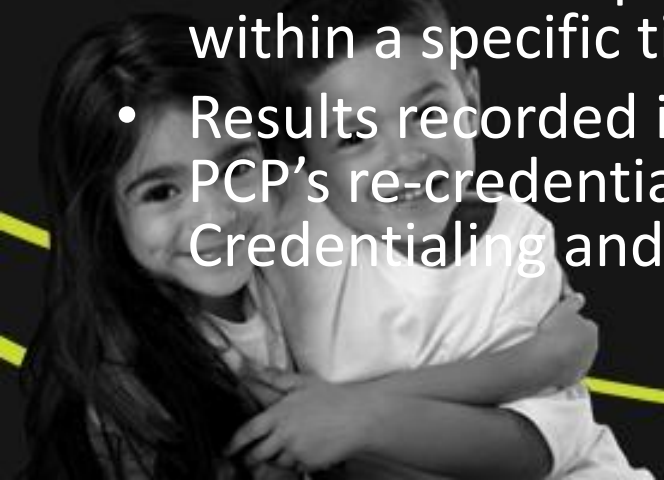
2nd Non-Compliant Survey Call

- Results reviewed by the Medical Director and the Quality Improvement Committee.
- The QIC may recommend appropriate measure be taken to address and correct the issues.
- The QIC reviews and approves sub-committee recommendations
- Corrective action plans may take place immediately to amend shortcomings and may include the following measures: new policies, additional education, resurveying within a specific timeframe.
- Results recorded in the physician profile sheets during the PCP's re-credentialing file to be reviewed by the Credentialing and Peer Review Committee.



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Tips for Preventing Non-Compliant Availability Telephone Surveys

- Update your business and after-hour telephone numbers with El Paso First. The telephone number we have on record is the one we call and is given out to members.
- If using an answering service, provide the answering service with the correct contact information – telephone number and/or name of the provider that is on-call.
- Switching the telephone to the after-hours recording.

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Acknowledgements

- El Paso First recognizes that the Provider's time is extremely valuable and cooperation in this State mandate is greatly appreciated.
- Your partnership is paramount in the success of our Quality Improvement initiatives and requirements mandated by TDI and HHSC.
- El Paso First thanks you for your commitment in improving the quality of service offered to the community.

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Contact Information

- Should you have any questions regarding Accessibility and Availability, please contact:

Don Gillis - Quality Improvement Director at ext 1231

or

Quality Improvement Department at 532-3778 ext 1106 or 1159

or

Stacy Arrieta - Provider Relations Representative at 532-3778 ext. 1059

EL PASO FIRST Health Plans inc.

Claims

Sonia Lopez
Director

EL PASO FIRST
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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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Top 6 Denials

1. Diagnosis Pointer Required on service Line for Diagnosis Codes
2. Prior authorization dates do not match claim
3. No COB Information received with a Secondary Enrollment
4. Submission Window Exceeded for Claim
5. No enrollment exists for claim start date
6. Invalid NPI number for provider

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Top 4 EDI Clearinghouse Rejections

1. Rendering Provider Taxonomy Code missing or invalid.
2. National Provider ID (NPI) is required for this payer.
3. Invalid Diagnosis code
4. Composite Diagnosis Code Pointer should not be used.

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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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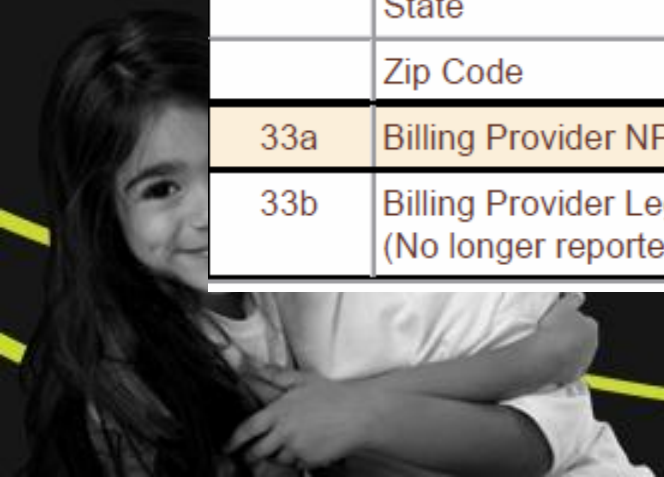
Bill Pay Information
LOOP 2010AA

Submit Group NPI Only in Loop 2010AA

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
33	Organization Name	2010AA, NM1/85, 03
	Provider's Last Name	2010AA, NM1/85, 03
	Provider's First Name	2010AA, NM1/85, 04
	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)

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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
2. 413 1
3. 850 0
4. E8844

E. DIAGNOSIS POINTER: 1

EL PASO FIRST Health Plans inc.

Verification of Authorization

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

EXAMPLE: 0000123456

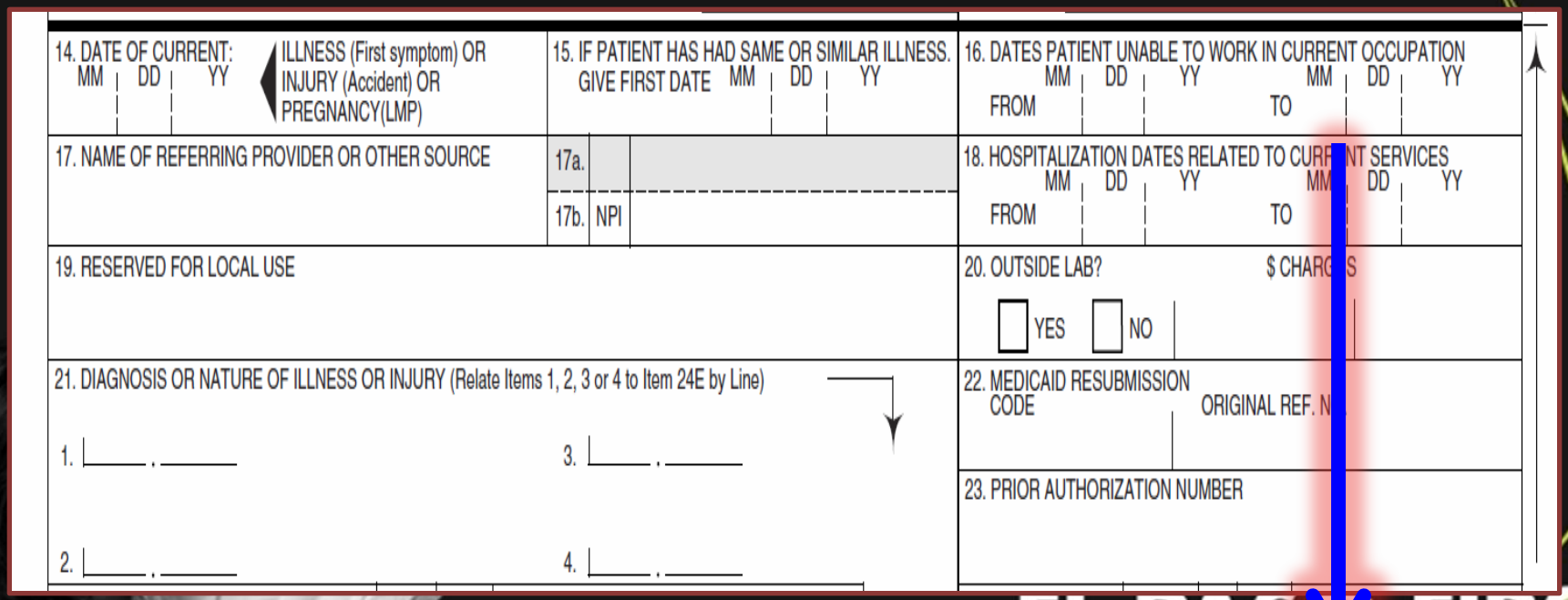
****

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.



14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

EL PASO FIRST Health Plans inc.

Timely Filing

- 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)
- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of the disposition by the other insurance carrier.
- It is strongly recommended providers who submit paper claims keep a copy of the documentation they send. It is also recommended paper claims be sent by certified mail with return receipt requested & a detailed listing of the claims enclosed.

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Provider Notification for Additional Information

- Proof of Timely Filing Documents
- Return Claims (W-9, Purple or Green Forms)
- Rejected Claims (Electronic Claim Rejection)
- Remittance Advice- (RA) form Primary Carrier or El Paso First

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Proof of Timely Filing

Note: Office notes indicating claims were submitted on time or system screen prints of claim submissions are not considered proof of timely filing.

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Proof of Timely Filing

Submit a copy of an Electronic Claims Report that includes the following information:

- ✓ Batch submission ID and date
- ✓ Individual claim that is being appealed
- ✓ EL Paso First -assigned batch ID number

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Availity Customer ID: 0009999

Availity Electronic Batch Report

Date Received:	2007-04-04	Time Received:	16.17.07.475
Availity Batch ID:	2007121406081000	File Control Number:	000002303

Payer:	BCBSF	Payer ID:	00590
Received Claims:	4	Charges:	3,692.00
Accepted Claims:	2	Charges:	168.00
Rejected Claims:	2	Charges:	3,524.00

Patient Name:	DOE, NIDAL		
From Date:	20061231	To Date:	20061231
Patient Control Number:	0234600999	Charge:	3024.00
Provider Billing ID:	73-3559599	Clearinghouse Trace #:	456123
Payer Claim #:	123456789012345	Availity Trace #:	012345678912345

Error Initiator: HIPAA Message Type: R Error Code: NA

Error Message: Value of element NM109 is incorrect. Expected value is National Provider ID (format is '10 digits with optional '80840' prefix and last check digit') when NM108 = 'XX'. Segment NM1 is defined in the guideline at position 250. Invalid data: 1234567890

Loop: 2010AA Segment ID: NM1 Element #: 09

Patient Name:	DOE, JANE		
From Date:	20061231	To Date:	20061231
Patient Control Number:	0234600988	Charge:	500.00
Provider Billing ID:	73-3559599	Clearinghouse Trace #:	123456789
Payer Claim #:	123456789012345	Availity Trace #:	012345678912345

Error Initiator: BCBSF Message Type: I Error Code: NA

Error Message: Prov. ID reported from Payer is 0000123ABC

Loop: NA Segment ID: NA Element #: NA

Error Initiator: BCBSF Message Type: W Error Code: NA

Error Message: Paid amt does not match service line amt

Loop: NA Segment ID: SVD Element #: 02

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

File Roll-Up Section displays header and detail areas of a claim record. Patient and Payer information is displayed.

Page Footer Section displays report # and page number(s) of the report.

```
                    Emdeon Business Services Division
                    XXXXXXXX Claims Distribution System

                       File Detail Summary Report
                                 FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
Emdeon Ref.: 5634                                    Run Date: MM/DD/YY
Report #: RPT-04A
Acct  ID: 123

File Control #: P23456
Submitter ID: 123456789
Submitter Name: Vendor Systems

*******************************************************************************

                                DISCLAIMER

ACCEPTED CLAIMS HAVE BEEN FORWARDED TO THE PAYER BY EMDEON BUSINESS SERVICES
DIVISION. ADDITIONAL CLAIM STATUS REPORTS MAY FOLLOW IF AVAILABLE FROM THE
PAYER. THIS IS NOT A GUARANTEE OF PAYMENT.

*******************************************************************************

Customer ID/Sub: 987654321 abcd            NPI: 1234567890
Customer Name: Prov/Group Name

                                FILE ROLL-UP

Patient Name              Patient          Date of   Total    Payer Name/ID Status
                         Control #         Service  Charges

Childs M J          39145278912547856364 012700    176.95 Payer One    12345 AE
Gagnon J            39143268973247658365 012800   1176.00 Payer Two    60054 RE
Osborn J            39145278955467289367 012500    276.00 Payer Three  SMTX0 TE
Osborn J            39145278963098426368 012700    176.00 Payer One    12345 AP

Customer ID/Sub: 987654321 efgh            NPI: 1234567890
Customer Name: Prov/Group Name

                                FILE ROLL-UP

Patient Name              Patient          Date of   Total    Payer Name/ID Status
                         Control #         Service  Charges

Bolders M J         39145278961234531363 012700    176.00 Payer One    12345 AE
Garrett J           39143268971234504366 012800   1176.00 Payer Two    60054 RE
Osborn J            39145278951234507369 012500    276.00 Payer Three  SMTX0 TE
Sims  J             39145278961234508362 012700    176.95 Payer One    12345 AP

RPT-04A                                                              Page 1
```

Claim Resubmission

Can I send my corrected claim electronically?

Yes,
Only ZERO Paid Claims may be sent electronically within 95 day timely filing.

No,
Claims with partial payments should be submitted on paper with a copy of the Remittance Advice and a Corrected Claim Form.

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Health Plans inc.

Corrected Claim Form

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Corrected Claim Form

Provider Name:	Date:
Member Name	Member ID
Claim Number:	Date of Service

Reason for Corrected Claim:
(Please check appropriate box)

- ☐ Correct Member Demographic
- ☐ Correct Billing Code (HCPC, CPT, Revenue Code or DRG)
- ☐ Correct Billing Modifier
- ☐ Correct Diagnosis Code (ICD9)
- ☐ Correct Provider Billing Information
- ☐ Recoupment Request (Claim billed in error) Please provide claim number:_____
- ☐ Proof of timely filing (Please attach Remittance Advice or EDI Report)
- ☐ Other Insurance Payment (Attach EOB)
- ☐ Other (Use comments section to give detailed explanation)

Comments:

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Revised CMS 1500 Paper Claim Form: Version 02/12

The National Uniform Claim Committee (NUCC), an industry organization in which CMS participates, maintains the CMS 1500 claim form and periodically revises it according to industry needs. The NUCC recently revised this form (version 02/12). The NUCC changed the form to adequately accommodate and implement ICD-10-CM diagnosis codes, although the form does include other changes as well.

- More information is available on the NUCC website. http://www.nucc.org/

- On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised CMS 1500 claim form, version 02/12, OMB control number, 0938-1197. The CMS 1500 claim form is the required format for submitting claims to Medicare on paper.

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Features of the Revised From

The revised form, among other changes, notably adds the following functionality:

- **Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.**
- **Expansion of the number of possible diagnosis codes to 12.**
- **Qualifiers to identify the following provider roles (on item 17):**
  - **Ordering**
  - **Referring**
  - **Supervising**

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Tentative Timelines

- **• January 6, 2014:** Medicare begins receiving and processing paper claims submitted on the revised CMS 1500 claim form (version 02/12).

- **• January 6 through March 31, 2014**: Dual use period during which Medicare continues to receive and process paper claims submitted on the old CMS 1500 claim form (version 08/05).

- **April 1, 2014: ONLY Revised CMS 1500 claim form (version** 02/12).

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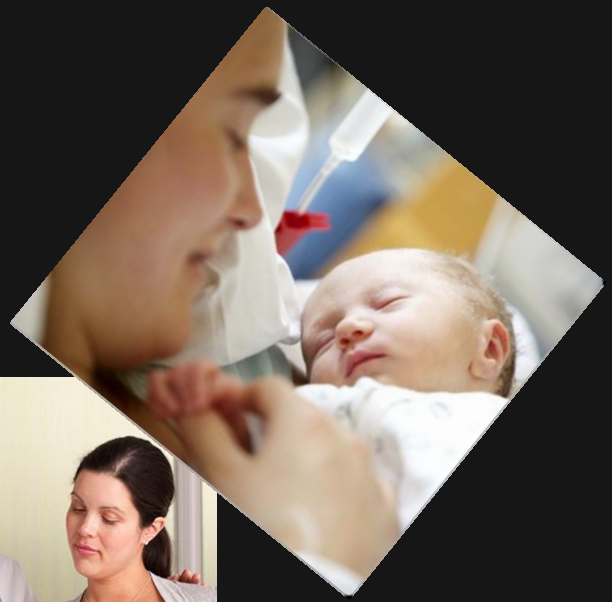
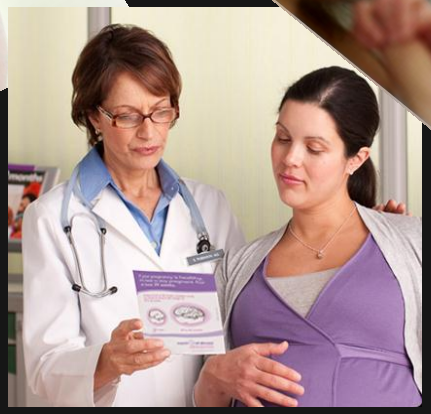
TPA Global Billing





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What Does Global Service Mean in Insurance Billing?

A "global service" in medical billing is for instances in which a medical provider can bill one HCPCS or CPT procedure code for services that could other wise be billed individually.

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Obstetrical (OB) Global Billing

The intent of OB 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.

Effective October 1, 2012

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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

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Services not separately reimbursable :

- 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.

- Hospital visits that are related to the OB delivery.

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Services not separately reimbursable :

- Postpartum consultations that are related to the delivery, paid to the same provider and within the 45-day follow-up period of the global OB delivery date.

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Completing the CMS-1500

- The “from-through” billing format (called “from-to” on the *CMS-1500*) “from” date of service and the “through” or “to” date of service is the date of the delivery.

- Enter a quantity of “1” in the *Days or Units* field (Box 24G).

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On Call Provider
Delivery Not Performed

- The claims should be split.
- A claim should be submitted for the provider who performs the antepartum Care.
- A second claim will be submitted by the provider performing the delivery.
- The provider performing the postpartum care will submit a separate claim with the appropriate modifier if he/she did not perform the delivery.

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Hiring Substitute Doctor

Occasionally circumstances prevent the primary physician from performing the delivery. In these circumstances, global billing is allowed only when the primary physician who provides the antepartum and postpartum care employs another doctor to perform the delivery. The delivering physician may not bill Preferred Administrators for the delivery or any other maternity service.

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Transfer Care

- Providers who accept transfer patients are not restricted in the number of visits for which they may be reimbursed up to the delivery.
- Providers who accept a transfer patient must bill appropriate global antepartum codes.
- Providers must render total obstetrical care during the recipient's remaining pregnancy in order to bill globally.

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Minimum Requirements
Four OB Visits

- Providers who bill for global obstetrical care must render services during at least four antepartum OB visits.
- The initial pregnancy-related office visit may be counted as one of the four visits.
- If fewer than four visits are rendered, providers must bill services on a per-visit basis.

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Verifying Eligibility

To be reimbursed for global claims, Providers must verify the recipient's eligibility for services during the month of delivery.

For eligibility, please call 915-532-3778 Press 4 ext 1529.

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Billing Limitations

Global claims are subject to the 1 year timely filing, based on the delivery date.

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Coordination of Benefits (COB)

TPA

From Date	To Date	POS	CPT/HCPCS	Modifier	Dx Pointer	Charge Amt	Primary Carrier Allowed Amount	Primary Carrier Payment	Epfirst Allowed Amount	Primary Carrier Patient Responsible
9/27/2012	9/27/2012	21	59400		1	$3,500.00	$2,500.00	$2,000.00	$3,000.00	$500.00
						$3,500.00	$2,500.00	$2,000.00	$3,000.00	$500.00

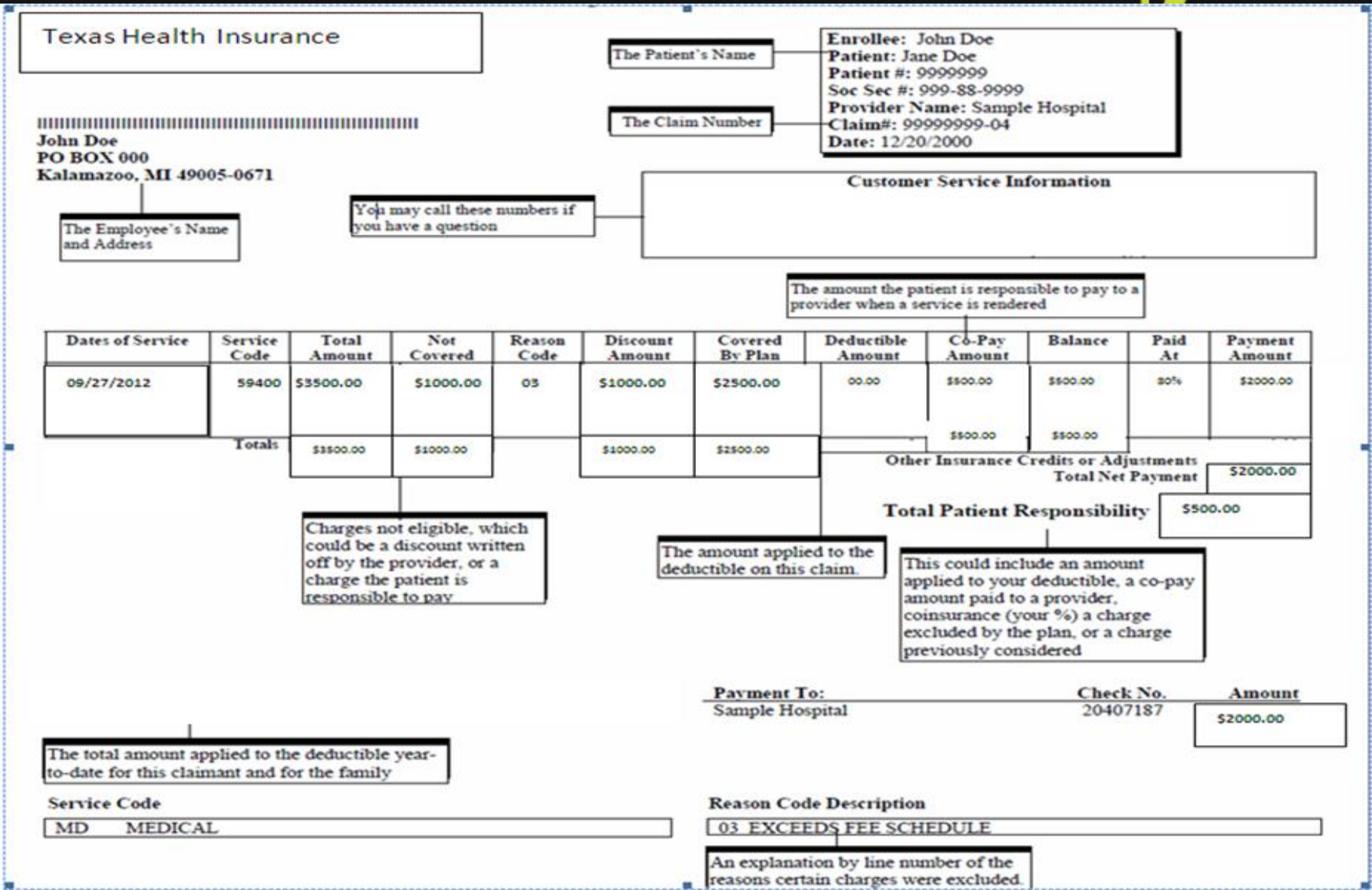
Primary Carrier EOB is Required

Subtract the Primary Carrier from the EPFirst Allowed amount.

Preferred Administrators Allowed Amount	$3,000.00		
Primary Carrier Payment	-$2,000.00		
Difference	$1,000.00	$500.00	Patient Responsibility

Pay the lesser of the two

Primary Carrier Explanation of Benefits (EOB)



CHIP/STAR

Coordination of Benefits (COB)

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Coordination of Benefits (COB)

CHIP/STAR

- Claims are billed Fee for Service.
  - **Fee**-for-**service** (FFS) is a payment model where services are unbundled and paid for separately.
- Primary Carrier Explanation of Benefits is required.

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Coordination of Benefits (COB)

From Date	To Date	POS	CPT/HCPCS	Modifier	Dx Pointer	Charge Amt	Primary Carrier Allowed Amount	Primary Carrier Payment	Epfirst Allowed Amount	Primary Carrier Patient Responsible
9/27/2012	9/27/2012	21	59410	U2	1	$3,500.00	$2,500.00	$2,000.00	$3,000.00	$500.00
						$3,500.00	$2,500.00	$2,000.00	$3,000.00	$500.00

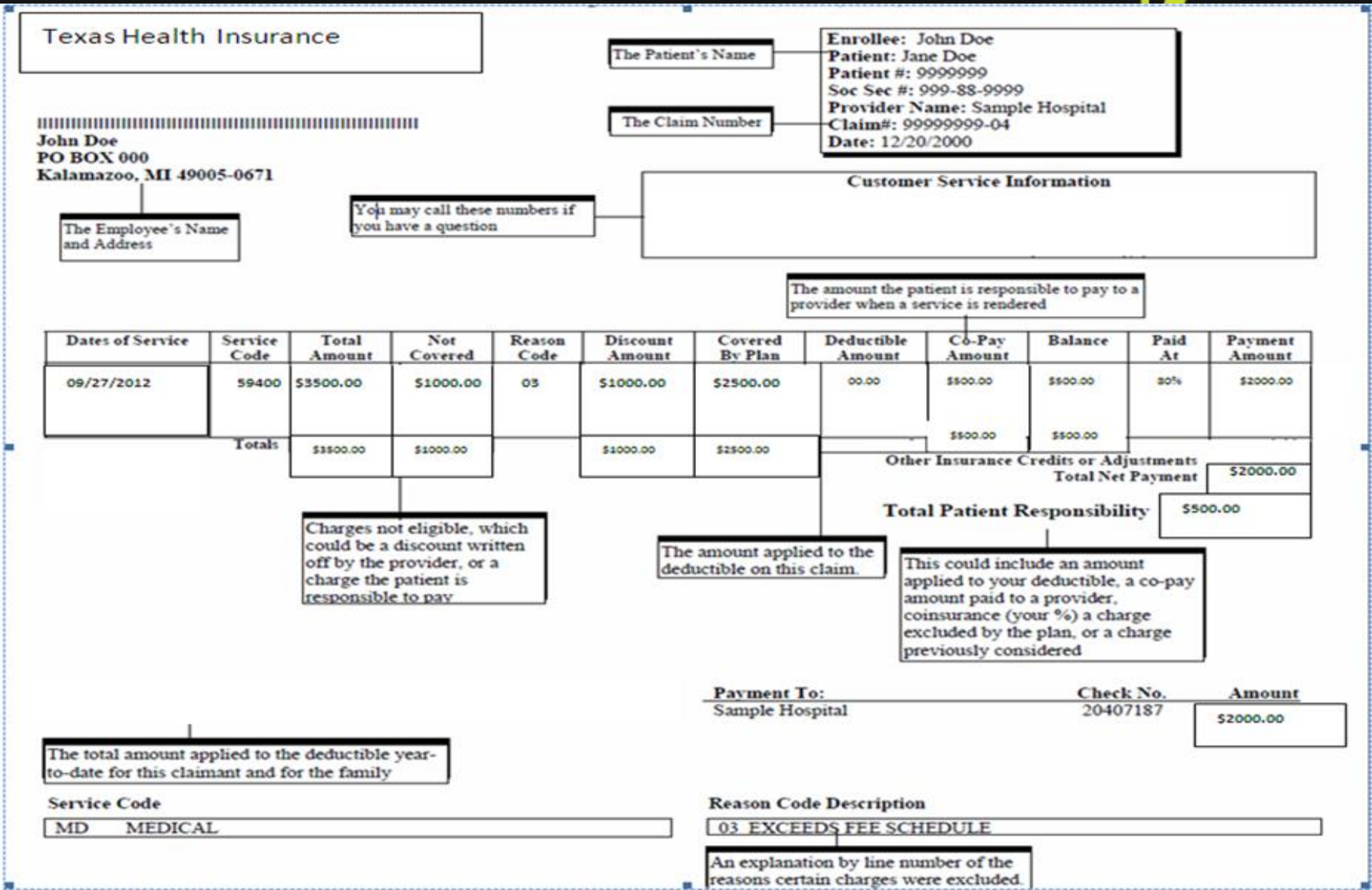
Primary Carrier EOB is Required

Subtract the Primary Carrier from the EPFirst Allowed amount.

EpFirst Allowed	$3,000.00	
Primary Carrier Payment	-$2,000.00	
Difference	$1,000.00	$500.00 Patient Responsibility

Pay the lesser of the two amounts.

Primary Carrier Explanation of Benefits (EOB)



Coordination of Benefits (COB)

CHIP/STAR

From Date	To Date	POS	CPT/HCPCS	Modifier	Dx Pointer	Charge Amt	Primary Carrier Allowed Amount	Primary Carrier Payment	Epfirst Allowed Amount	Primary Carrier Patient Responsible
1/1/2012	1/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
2/1/2012	2/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
3/1/2012	3/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
4/1/2012	4/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
5/1/2012	5/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
6/1/2012	6/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
7/1/2012	7/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
9/1/2012	9/1/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
9/10/2012	9/10/2012	11	99213	TH	1	$150.00	$100.00	$80.00	$130.00	$20.00
9/27/2012	9/27/2012	21	59410	U2	1	$3,500.00	$2,500.00	$2,000.00	$3,000.00	$500.00
						$4,850.00	$3,400.00	$2,720.00	$4,170.00	$680.00

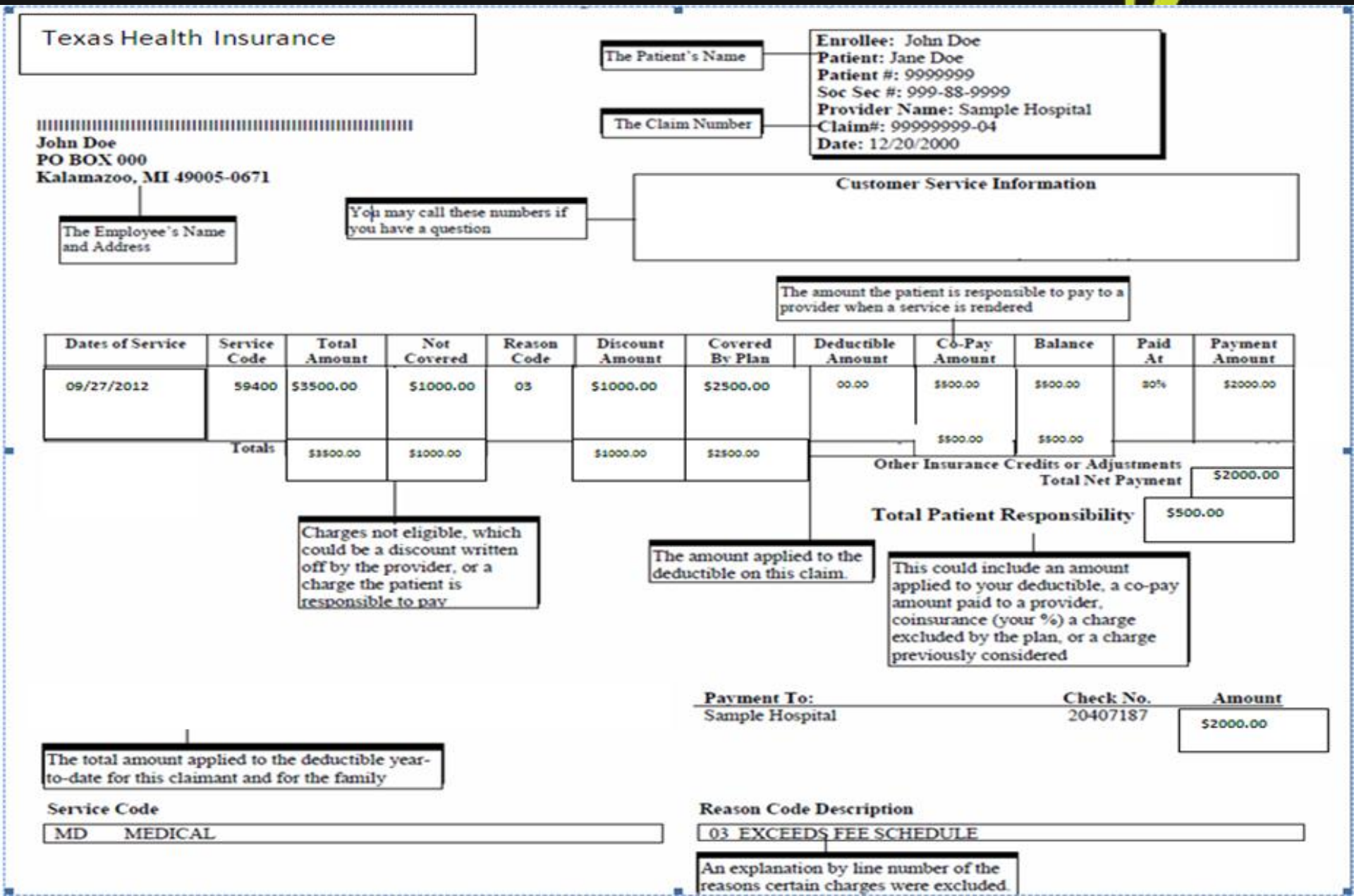
Primary Carrier EOB is Required

Subtract the Primary Carrier from the EPFirst Allowed amount.

EpFirst Allowed	$4,170.00	
Primary Carrier Payment	-$2,720.00	
Difference	$1,450.00	$680.00 Patient Responsibility

Pay the lesser of the two amounts.

Primary Carrier Explanation of Benefits (EOB)



Sonia Lopez, BS, CPC
Director of Claims
(915) 532-3778 Ext: 1097

Provider Care Unit Extension Numbers:

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

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Questions?

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Member Services

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Medicaid - Value Added Services

- Help getting a ride to doctor visits or health classes for Members who need a ride
- Extra dental services up to $295 (initial checkup, x-rays, and a routine cleaning) for Members age 21 and older
- Up to $125 above the Medicaid benefit for contact lenses, lenses, and frames
- Welcome Packet: A $15 value of over-the-counter items if the request form is completed and mailed back within 30 days of enrollment
- One free cell phone per household and free calls or texts from El Paso First for related health activities.
- 1 free car seat per pregnancy for pregnant Members who complete a pregnancy class
- $10 gift card for health related items for pregnant Members completing one pregnancy visit within 30 days of enrollment and going to one pregnancy class

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Medicaid - Value Added Services

- Home visits to high risk pregnant Members
- 4 extra food counseling services, above the Medicaid benefit, for Members age 20 and younger
- Up to $25 for any sport registration activity fee, once every 12 months
- $15 gift card for health items for Members age 20 and younger completing a timely Texas Health Steps visit
- Gifts of a digital thermometer, a pedometer (per family per year), an emergency aid booklet (per family per year) and a school supply kit for new Members if requested within 30 days of receiving welcome packet
- $15 gift card for health items for postpartum Members completing one postpartum visit within 21-56 days after delivery

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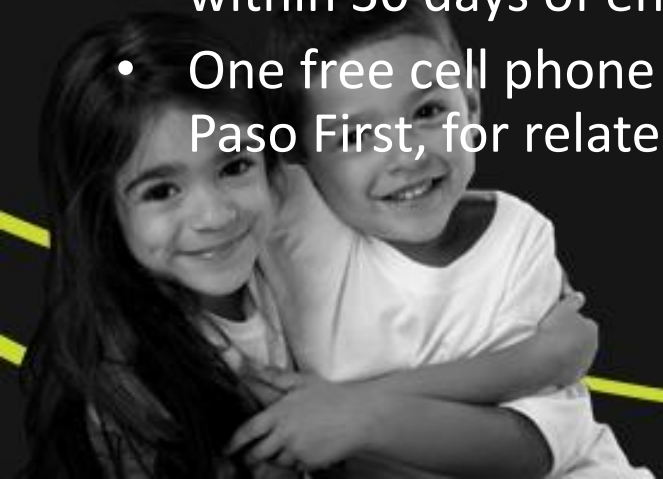
CHIP - Value Added Services

- Help getting a ride to doctor visits or health classes for CHIP and CHIP Perinate Members
- Extra dental services up to $295 above the CHIP benefit (initial checkup, x-rays, and cleaning) for CHIP Members
- 25% off lenses and frames above the CHIP benefit for CHIP Members
- 20% off certain contact lenses above the CHIP benefit for CHIP Members
- Welcome Packet: A $15 value of over-the-counter items for new CHIP Members if the request form is completed and mailed back within 30 days of enrollment
- One free cell phone per household and free calls or texts from El Paso First, for related health activities.



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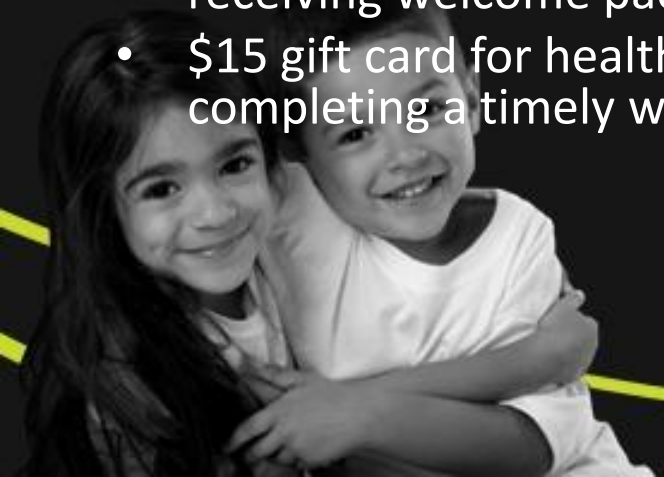
Health Plans inc.

CHIP - Value Added Services

- Free car seat for pregnant Members who complete a pregnancy class
- $15 over-the-counter prenatal vitamins packet for new CHIP Perinatal Members if request form is completed and mailed back within 30 days of enrollment
- Home visits to new high risk pregnant Members
- 4 extra food counseling services, above the CHIP benefit, for CHIP Members age 18 and younger
- Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members
- Gifts of a digital thermometer, a pedometer (per family per year), an emergency aid booklet (per family per year) and a school supply kit for new CHIP and CHIP Perinatal Members if requested within 30 days of receiving welcome packet
- $15 gift card for health items for Members age 3 to 6 and 12 to 19 completing a timely well-child checkup



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CHIP-to-TIERS

- HHSC is in the early stages of a transition that will bring the processing of CHIP applications into the state's TIERS eligibility system. The transition is targeted for Oct. 1, 2013
- The CHIP-to-TIERS transition should not disrupt the processing of children's health insurance applications.
- Effective October 1, 2013, the all CHIP ID numbers will be changing from an alpha numeric format (i.e. A123456789) to a numeric format (i.e. 123456789). El Paso First Health Plans will be issuing new ID cards to all its CHIP members at the end of September 2013.

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CHIP-to-TIERS Rosters

PEDIATRICS R US

EL SO, TX 902

El Paso First Health Plans, Inc.
CHIP to TIERS Crosswalk

ALL LOCATIONS

October 2013

NEW CHIP Member#	Legacy CHIP Member#	Member Name	DOB	Phone	Address	Effective	Well Child Visit	PCPName
New Members								
50000001	M1234567	MICKEY MOUSE	6/21/02	915-555-5550	100 CARS DR EL PASO, TX 79936	10/01/13	DUE	DONALD DUCK, MD
60000002	J1234567	MINNIE MOUSE	4/6/09	915-555-5501	200 CASTLE DR EL PASO, TX 79932	07/01/13	DUE	DONALD DUCK, MD
Member Count		2						
Existing Members								
60000003	D1234567	DAISY DUCK	6/30/95	915-555-5502	1234 DISNEY AVE EL PASO, TX 79936	02/01/13	COMPLETE	DONALD DUCK, MD
Member Count		1						
Total Member Count		3						

Preferred Administrators

Updates on Benefits for Fiscal Year

October 1, 2012 – September 30, 2013

Preferred
ADMINISTRATORS

UMC and EPCH Benefits

Benefit Description	UMC/EPCH	Texas Tech	PPO	Out-of-Network
UMC/Medical Office Visits	$15.00 Co-pay	$25.00 Co-pay	$35.00 Co-pay	60% after deductible
EPCH/Medical Office Visits	$10.00 Co-pay	$20.00 Co-pay	$30.00 Co-pay	60% after deductible
Diagnostic X-Ray, Pathology	100% after deductible	100% after deductible	75% after deductible	60% after deductible
HPV for Female and Males (Ages 9 up to 26)	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered
Pregnancy for Covered Associates and Dependents	Covered under Global Maternity	Covered under Global Maternity	Covered under Global Maternity	Covered under Global Maternity
Annual Well Women's Exam. One per Fiscal Year	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered
Mammograms for women ages 40 and older	Covered at 100%	Covered at 100%	Covered at 100%	Not Covered
Mammograms for women under 40 years of age	Covered at 100% after deductible	Covered at 100% after deductible	Covered at 75% after deductible	60% after deductible

Preferred ADMINISTRATORS

UMC/EPCH Deductibles and MOP

Deductible per Fiscal Year	UMC /Texas Tech/EPCH	PPO Providers	Out –of-Network
Per Covered Participant	$100.00	$1,000	$1,500
Max Family Deductible	$300.00	$3,000	$4,500

Out-of-Pocket Max Per Fiscal Year	UMC /Texas Tech/EPCH	PPO Providers	Out –of-Network
Per Covered Participant	N/A	$3,600	$Unlimited
Max Family Deductible	N/A	$10,800	$Unlimited
Annual Maximum Per Covered Participant $2,000,000			

Preferred ADMINISTRATORS

Difference between benefits for UMC and EPCH

University Medical Center of El Paso (UMC)

- Office Co-Pays $15/25/35
- Inpatient Co-Pays $250/750
- Does not have Domestic Partners
- Behavioral Max 30 Visits and Lifetime Max $25,000
- Does not combine max benefit for Occupational, Physical, and Speech Therapy

El Paso Children's Hospital (EPCH)

- Office Co-Pays $10/20/30
- Inpatient Co-Pays $150/200
- Covers Domestic Partners
- No Behavioral Max
- Max Combination Benefit for Occupational, Physical, and Speech Therapy of 30 visits per Fiscal Year

Preferred ADMINISTRATORS

Prior Authorization Flyer

FORM REVISION DATE: 11/06/12 EFFECTIVE DATE: 12/01/2012

Preferred ADMINISTRATORS

OUTPATIENT FAX NUMBER: 915-298-7866

PROCEDURES & SERVICES REQUIRING PREAUTHORIZATION/NOTIFICATION

INPATIENT FAX NUMBER: 915-298-5278

All Pre-certification Requests must be individually FAXED

Pre-authorization is based on information provided to Preferred Administrators at the time of request, and does not guarantee payment of benefits nor verify eligibility. Payment for services is subject to all terms, conditions, limitations and exclusions related to the member's eligibility and subsequent medical review. Regardless of pre-authorization status, medical decisions concerning a course of treatment are solely between the physician and the patient.

Please contact TPA administration to verify payment, eligibility, and benefits.

Preferred Administrators appreciates the care you provide for our members.

Please notify Preferred Administrators AS SOON AS POSSIBLE to begin the pre-authorization process.

A 72-Hour advance notice allows us to review the request for services and respond in a timely manner.

Behavioral Health (Initial evaluation does not require pre-authorization)
Chiropractic Services (Initial evaluation does not require pre-authorization)
Diagnostic Tests Related to Potential Organ Transplantation
Dialysis Services
Durable Medical Equipment
Note: All DME rentals exceeding 2 months require pre-authorization
DME maximum up to 12 months, not to exceed purchase price.
Elective Admissions
Growth Hormones
Home Health Services (Initial evaluation does not require pre-authorization)
Inpatient Admissions
Note: Preferred Administrators must be notified of all urgent/emergent admissions
Laser Surgeries
Intense Allergy Desensitization
Non-Emergent Admission
Obstetrical Ultrasounds
Note: Member is allowed four ultrasounds without obtaining pre-authorization
Occupational Therapy (Initial evaluation does not require pre-authorization)
Oral, Injectable or IV Drug Administration over $500
Note: This includes oral, Injectable or IV provided in a physician's office
Oral Surgery
Orthotics and Prosthetics (Adult and Children)
Outpatient Chemo-Therapy and Infusion
Out-of-Network / Non-Participating Facility, Provider, or Vendor
Outpatient Procedures
Outpatient Surgery
PET Scans
Physical Therapy (Initial evaluation does not require pre-authorization)
Podiatry Services (Excluding debridement of nails, avulsion of nail plate, excision of nail and wedge excision of skin of nail)
Radiation Therapy
Specialty Medicine - All specialty medicines require pre-authorization
Note: Please go to www.preferredadmin.net for complete list of specialty medicines
Speech Therapy (Initial evaluation does not require pre-authorization)
Synagis
Transplants
Transportation (Air transport and non-emergent ambulance)

All out-of-network services provided by non-participating facility, provider or vendor require pre-authorization

No authorization is required for the initial visit for the following:
Behavioral Health
Chiropractic Services
Home Health Services
Occupational Therapy
Physical Therapy
Speech Therapy

*PODIATRIC PROCEDURES
The following CPT codes do not require authorization for in- office procedures

11720
11721
11730
11732
11750
11765

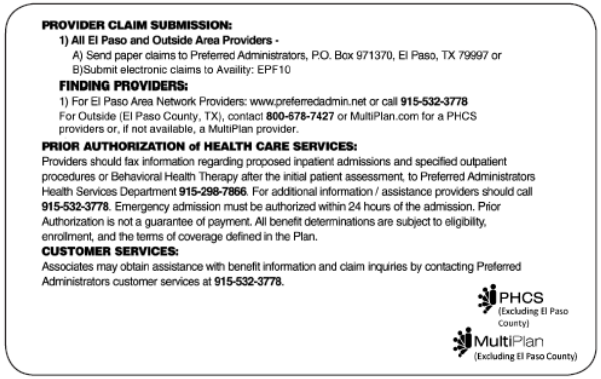
*Please see additional information on side bar

Please Note: EMERGENCY SERVICES do NOT require pre-authorization. All other services requiring pre-authorization must be approved in advance by the plan Medical Director or their designee.

Note: It is the Provider's responsibility to request a prior authorization for services listed on the flyer.

Preferred ADMINISTRATORS

Wrap Network



For members residing <u>inside</u> El Paso's network service region:

- The PHCS & Multiplan logos will be placed on the back of the members card it will show the contact information.
- Outside (STATE/AREA) contact 800-678-7427 or multiplan.com for a PHCS provider or, if not available, a MultiPlan provider.

For members residing <u>outside</u> El Paso's network service region:

- The PHCS logo is placed on the front of the card, and the Multiplan logo will be placed on the back of the card
- Language requested (on back of card): To locate PHCS provider, please contact 800-922-4362 or multiplan.com

Preferred
ADMINISTRATORS

Wrap Network

- How to look up a Provider participating with MultiPlan:
  - **Step 1.** To locate a Provider outside of the El Paso County click below:

    http://www.multiplan.com/
  - **Step 2.** Click on *Providers* and then *Search for a Doctor or Facility*
  - **Step 3.** Click on the logo that is in front or back of the ID card
  - **Step 4.** Search by location, doctor, hospital or facility name

Preferred ADMINISTRATORS

Female Preventive Services Covered at 100%
Effective 10/1/2012

1. **Gestational diabetes screening**
2. **HPV DNA testing**
3. **STI counseling**
4. **HIV screening and counseling**
5. **Contraception to include Voluntary Sterilization and Covered Contraceptives to include Female Generic Prescription Drugs and contraceptive counseling**
6. **Interpersonal and domestic violence screening and counseling**
7. **Breastfeeding support, supplies, and counseling**

Preferred
ADMINISTRATORS

Obstetrical (OB) Global Billing

The intent of OB global billing is to offer a convenient means of billing for providers who render total obstetrical care to a woman throughout her pregnancy.

Effective October 1, 2012

Preferred ADMINISTRATORS

Global obstetrical (OB) billing consists of Antepartum Care, Delivery and Postpartum care, including the following:

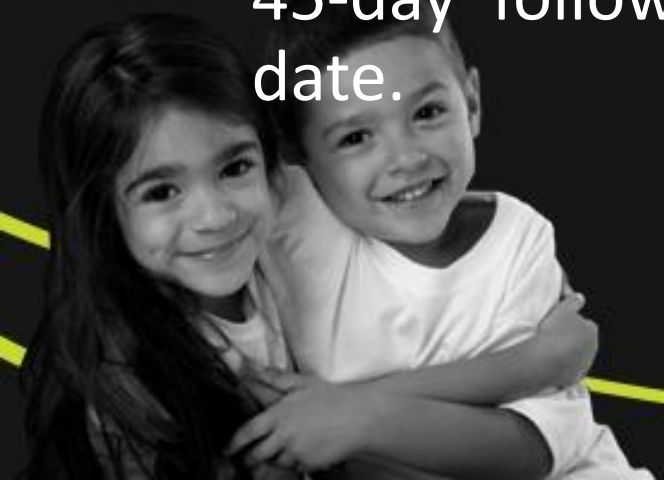
- Hospital admission
- Patient history
- Physical examination
- Labor management
- Postpartum office visit
- Vaginal or cesarean section delivery
- Vaginal or cesarean section delivery, after previous cesarean delivery
- Hospital discharge
- All applicable postoperative care

Note: Ultrasounds and labs are <u>not</u> part of global billing. They are

Preferred ADMINISTRATORS

Services not separately reimbursable :

- 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.
- Hospital visits that are related to the OB delivery.
- Postpartum consultations that are related to the delivery, paid to the same provider and within the 45-day follow-up period of the global OB delivery date.



Preferred ADMINISTRATORS

Covered Pharmacy OB Benefits

- Oral Medication/Insulin
- DME (lancets, strips, monitor) is a covered benefit (*no auth required)*
- Go to preferredadmin.net
  - Select link for OptumRx
  - Formulary (Search for covered medication and DME)
- Diabetes Education Classes
  - El Paso Diabetes Association (*auth required*)
  - UMC of El Paso Diabetes Program (*no auth required*)

Preferred ADMINISTRATORS

Important Note to Remember!

Preferred Administrators Network physicians who provide services at UMC or EPCH, will have professional services paid at the contracted rate.

The Member's responsibility will be at the UMC/EPCH/Texas Tech benefit coverage level.

Effective October 1, 2012, Tenet and its affiliates are considered an out of network Provider.

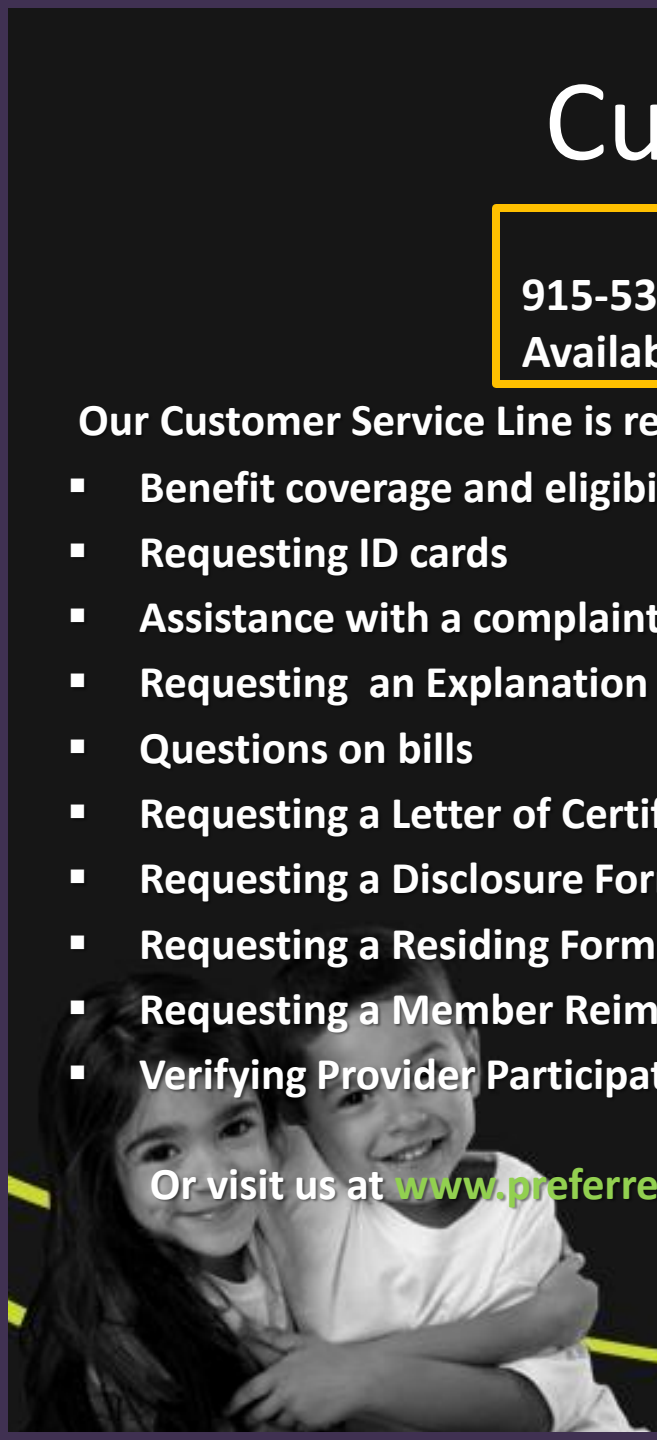
Preferred
ADMINISTRATORS

Customer Service

Customer Service Line:
915-532-3778 press 4 and then extension 1529
Available Monday to Friday from 7 am to 5 pm

Our Customer Service Line is ready to assist you with the following inquiries:

- **Benefit coverage and eligibility questions**
- **Requesting ID cards**
- **Assistance with a complaint/appeal**
- **Requesting an Explanation of Benefits (EOB)**
- **Questions on bills**
- **Requesting a Letter of Certificate of Coverage**
- **Requesting a Disclosure Form**
- **Requesting a Residing Form to update a dependent's address**
- **Requesting a Member Reimbursement Form**
- **Verifying Provider Participation**



Or visit us at www.preferredadmin.net to access the Member Handbook, Provider Directory, OptumRx formulary and more.

Preferred
ADMINISTRATORS

Contact Information

Veronica Maldonado-TPA Coordinator
vmaldonado@epfirst.com
298-7198 ext 1073

Michelle Anguiano-Director of TPA
manguiano@epfirst.com
298-7198 ext 1053

Preferred
ADMINISTRATORS

Thank You for Attending Providers!

EL PASO FIRST Health Plans inc.