Welcome Providers!

Provider Specialty Training

October 24, 2013

EL PASO FIRST
Health Plans inc.

Agenda

- Welcome and Introductions
- Affordable Care Act Updates
- Preferred Administrators Benefit Changes
- Health Care Options Overview & Updates

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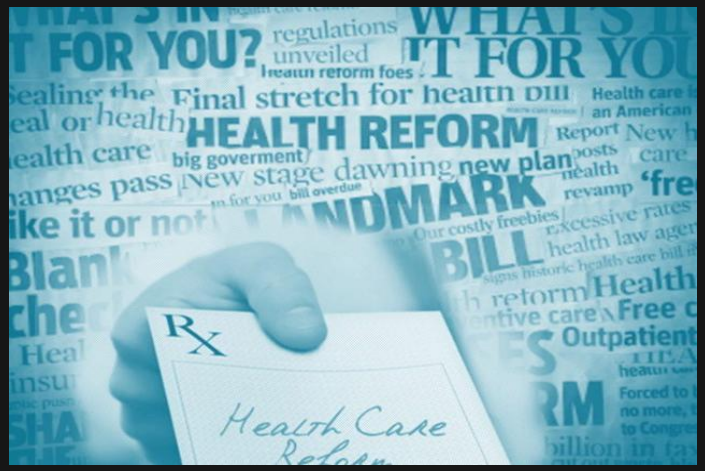
Affordable Care Act Updates



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Background

- The Patient Protection and Affordable Care Act was signed into law on March 30, 2010, in order to increase the rate of health insurance coverage for Americans and reduce the overall cost of health care.

- The Insurance Exchanges are established to facilitate purchase of health insurance coverage for all Americans starting October 1, 2013 through an electronic health insurance marketplace and Texas will participate in a federally-facilitated marketplace or exchange

- Navigators will play a vital role in helping consumer establish eligibility and enroll in the health insurance marketplace.

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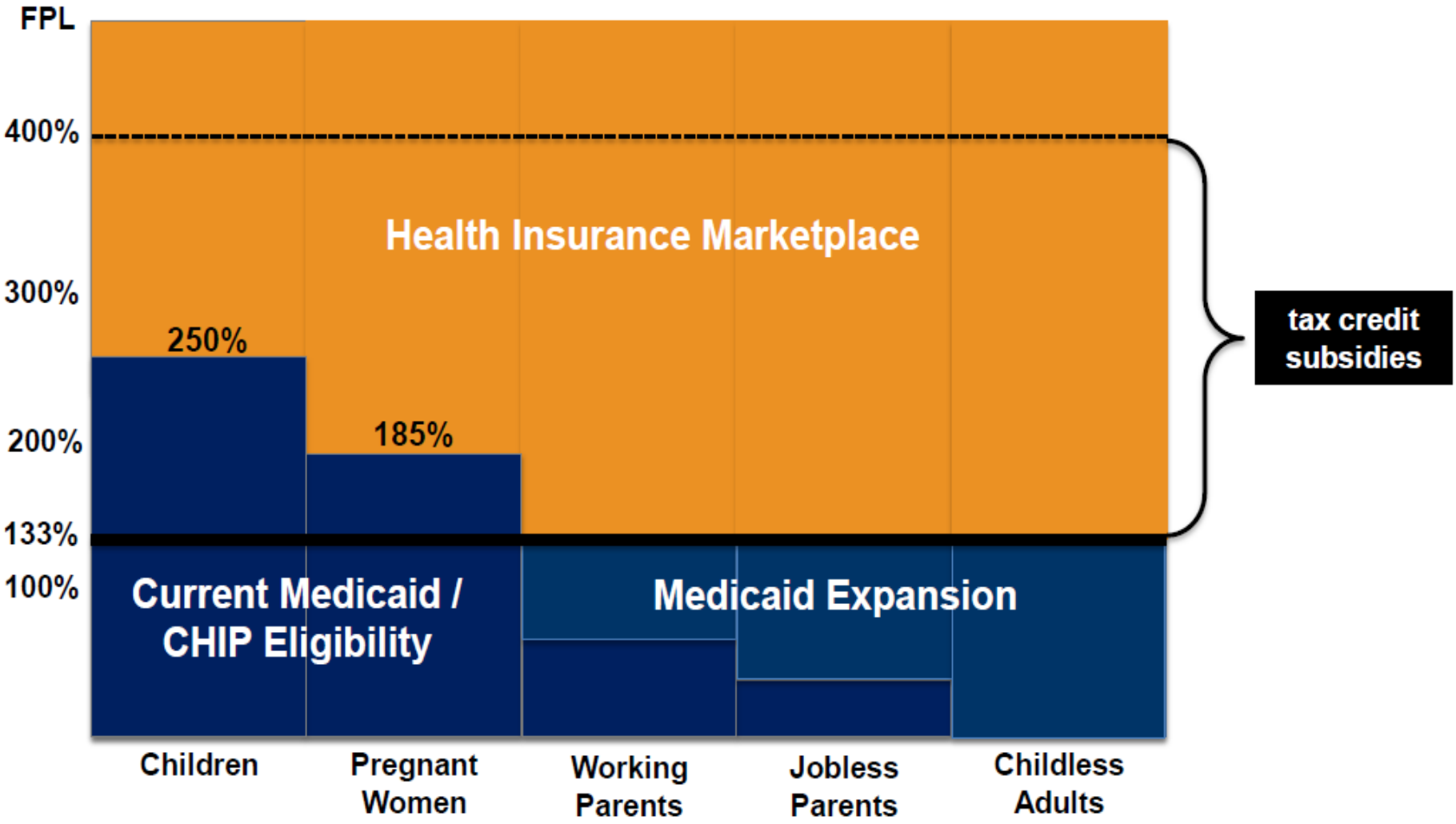
Coverage Landscape in 2014



Medicaid and CHIP coverage, based on 2012 eligibility levels in a typical state
Source: Kaiser Commission on Medicaid and the Uninsured

Health Insurance Marketplace

What is the Health Insurance Marketplace?

- The Marketplace is designed to help you find health insurance that meets your needs and fits your budget.
- The Marketplace offers “one-stop shopping” to find and compare private health insurance options.
- You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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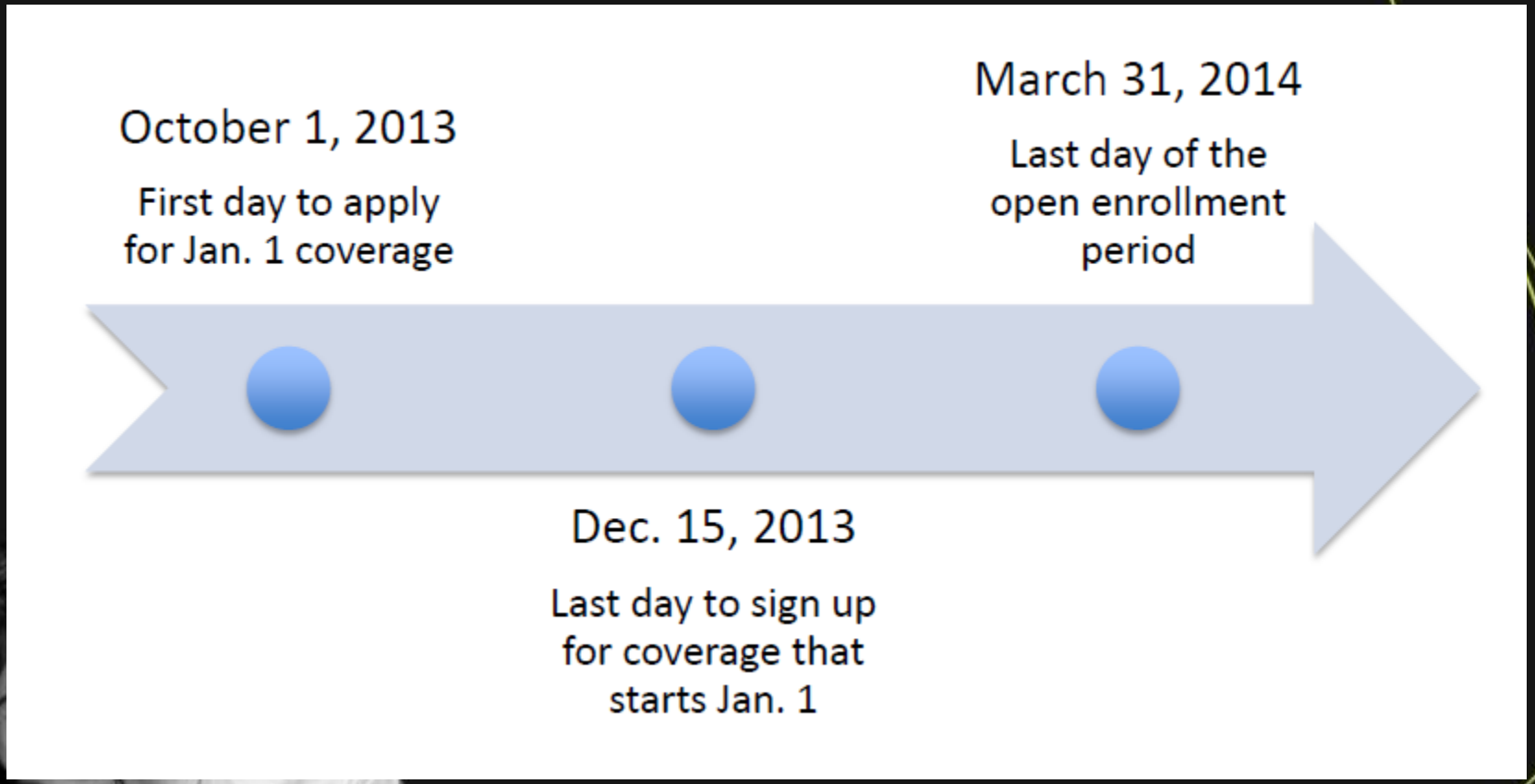
Open Enrollment



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Open Enrollment

- Plan selection date determines when coverage will take effect.
- Coverage will start on schedule only if the enrollee pays the first month's premium on time.
- Deadlines for the first month's premium are typically set by the insurer.
- Coverage may be cancelled if the first month's premium is late.

Plan Selection Date	Coverage Effective Date
Nov. 1, 2013	Jan. 1, 2014
Dec. 15, 2013	Jan. 1, 2014
Dec. 31, 2013	Feb. 1, 2014
March 31, 2014	May 1, 2014

Plans Available

When you compare Marketplace insurance plans, they're put into 4 categories based on how you and the plan can expect to share the costs of care:

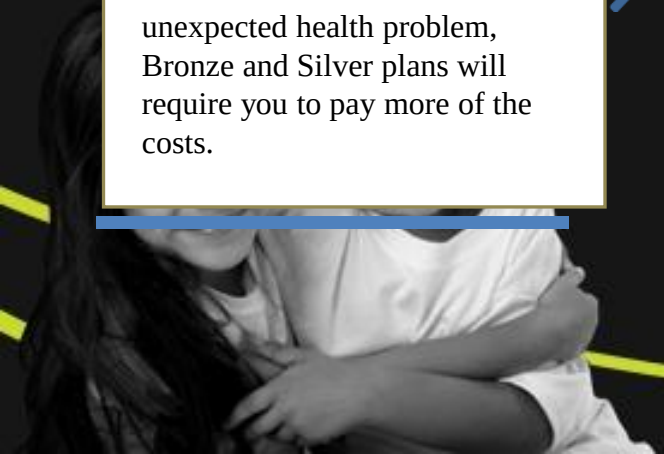
Do you expect a lot of doctor visits or need regular prescriptions?

If you do, you may want a Gold or Platinum plan.

If you don't, you may prefer a Bronze or Silver plan. But keep in mind that if you get in a serious accident or have an unexpected health problem, Bronze and Silver plans will require you to pay more of the costs.

- With a Bronze plan, you'll likely pay a lower premium, but you'll pay a higher share of costs when you get care.
- Silver- If you expect a lot of doctor visits
- Gold- If you expect a lot of Doctor visits and regular presriptions
- Platimum- Platinum plans will likely have the highest monthly premiums and lowest out-of-pocket costs. The plan will pay more of the costs if you need a lot of medical care.

Bronze	Silver	Gold	Platinum
60/40%	70/30%	80/20%	90/10%



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Open Enrollment

- **Catastrophic plans** — Except for coverage of three primary care visits and preventive care, these plans provide no coverage of Essential Health Benefits, until the beneficiary has incurred cost-sharing expenses equal to the annual out-of-pocket limit ($6,400 for 2014). Only individuals under 30 years of age or who are exempt from the mandate to purchase coverage, may enroll in catastrophic

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Essential Health Benefits

Essential health benefits must include items and services within at least the following 10 categories:

1- Ambulatory patient services
2- Emergency services
3- Hospitalization
4- Maternity and newborn care
5- Mental health and substance use disorder services, including behavioral health treatment
6- Prescription drugs
7- Rehabilitative and habilitative services and devices
8- Laboratory services
9- Preventive and wellness services and chronic disease management
10- Pediatric services, including oral and vision care

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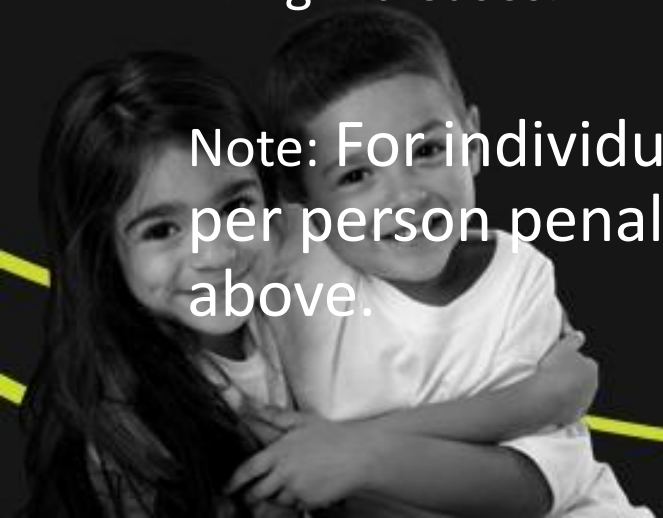
Individual Tax Mandate

- 2014: The higher of $95 per person OR 1.0% of taxable income.
- 2015: The higher of $325 per person OR 2.0% of taxable income.
- 2016: The higher of $695 per person OR 2.5% of taxable income.
- After 2016: The same as 2016, but adjusted annually for cost-of-living increases.

Note: For individuals under 18 years old, the applicable per person penalty is one-half of the amounts listed above.



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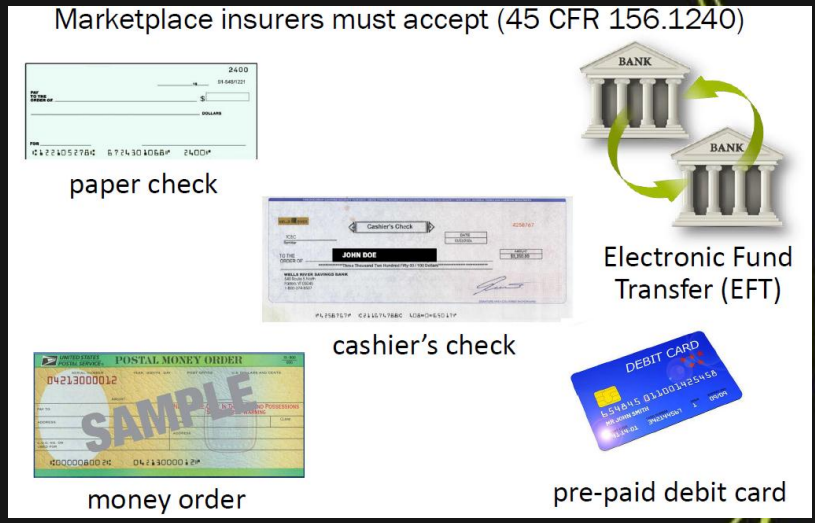
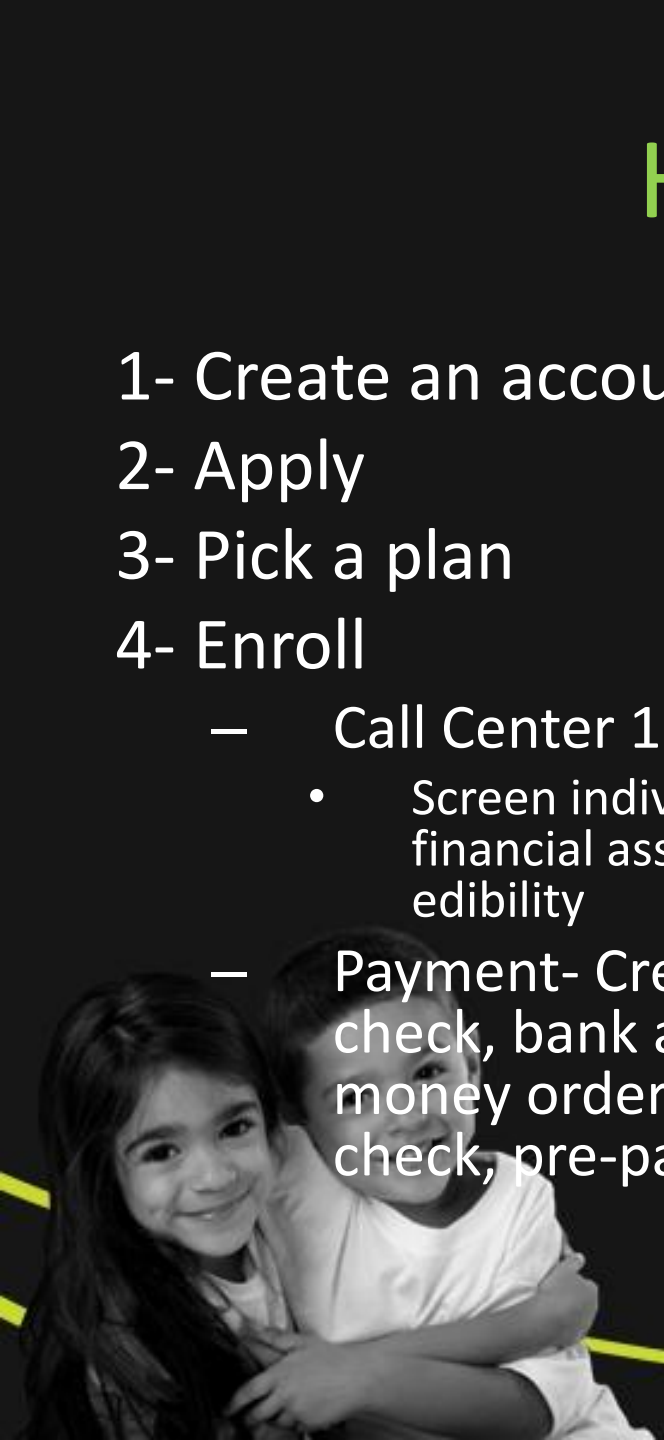
How to Enroll

1- Create an account
2- Apply
3- Pick a plan
4- Enroll
   - Call Center 1800-318-2596
     - Screen individuals for other financial assistance and edibility
   - Payment- Credit Card, paper check, bank accounts, money order, cashier's check, pre-paid debit card





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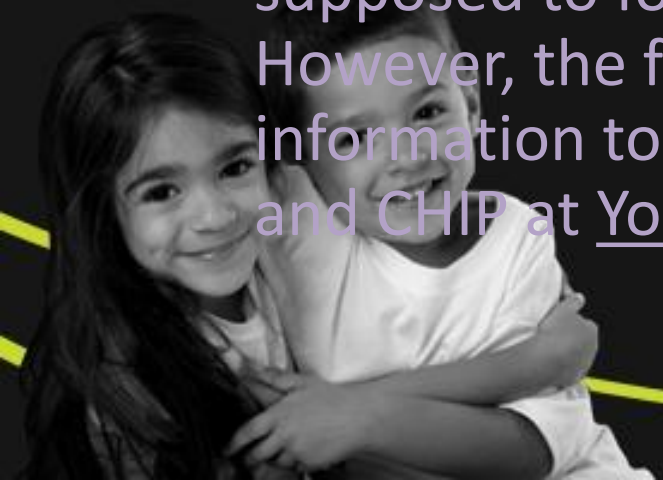
Important Note

People with Medicare do not go into the Marketplace. Medicare's Open Enrollment runs from *October 15 to December 7*, for January 1 effective date.

Families with children who may qualify for Medicaid or CHIP should apply for children's coverage through the state to avoid a delay in getting help. If someone applies through the new federal Marketplace and is eligible for Medicaid or CHIP, the federal government is supposed to forward the information to the state. However, the federal system isn't ready to send information to states. Families can apply for Medicaid and CHIP at YourTexasBenefits.com.



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Health Insurance Marketplace Coverage Options

- What if I'm interested in Marketplace Coverage?
- Go to www.healthcare.gov to review the plans available in Texas or call 1-800-318-2596

Health Insurance Marketplace

Preferred Administrators

Benefits for Fiscal Year

October 1, 2013 – September 30, 2014

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UMC Benefit Changes

- No annual behavioral maximum dollar amount. However, maximum amount of 30 visits per fiscal year still applicable.
- No annual medical and pharmacy lifetime maximum dollar amount.
- Children until age 26 can continue to be eligible to have coverage under parent's insurance, even if they were eligible for other employer – sponsored coverage.

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UMC Deductibles and Max Out of Pocket

Medical Plan Benefits	University Medical Center of El Paso, EPCH	Texas Tech	Preferred Provider Organization/PPO Wrap Network	Non-Contracted Providers
Benefit Plan Limits per Fiscal Year October 1, 2013 – September 30, 2014				
Deductible Per Fiscal Year	Individual $100.00 Maximum Family $300		Individual $1,000 Maximum Family $3,000	Individual $1,500 Maximum Family $4,500
Max Out of Pocket Per Fiscal Year (Does not include any applicable deductibles or co-pays)	N/A		Individual $4,000 Maximum Family $12,000	Individual/ Unlimited Family/ Unlimited
Co-Insurance	N/A		75% after deductible	40% after deductible

For a complete list of covered and excluded benefits, please refer to the Member Handbook at www.preferredadmin.net

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EPCH Benefit Changes

- No annual behavioral maximum dollar amount.
- No annual medical and pharmacy lifetime maximum dollar amount.
- Children until age 26 can continue to be eligible to have coverage under parent's insurance, even if they were eligible for other employer – sponsored coverage.

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EPCH Benefit Changes

- PPO Office Visit co-pay
  - PPO co-pay for office visit increased to $35
- Deductibles
  - PPO: From $1,000 to **$2,500-individual and**
  - From $3,000 to **$5,000-family**
  - Out of Network: From $1,500 to **$3,000-individual and from $4,500 to $6,000-family**
- Max out of pocket
  - PPO Max out of pocket will now include deductibles and co-pays.
  - Increased from $4,000 to **$6,000 per individual.**

For a complete list of covered and excluded benefits, please refer to the Plan Document at www.preferredadmin.net

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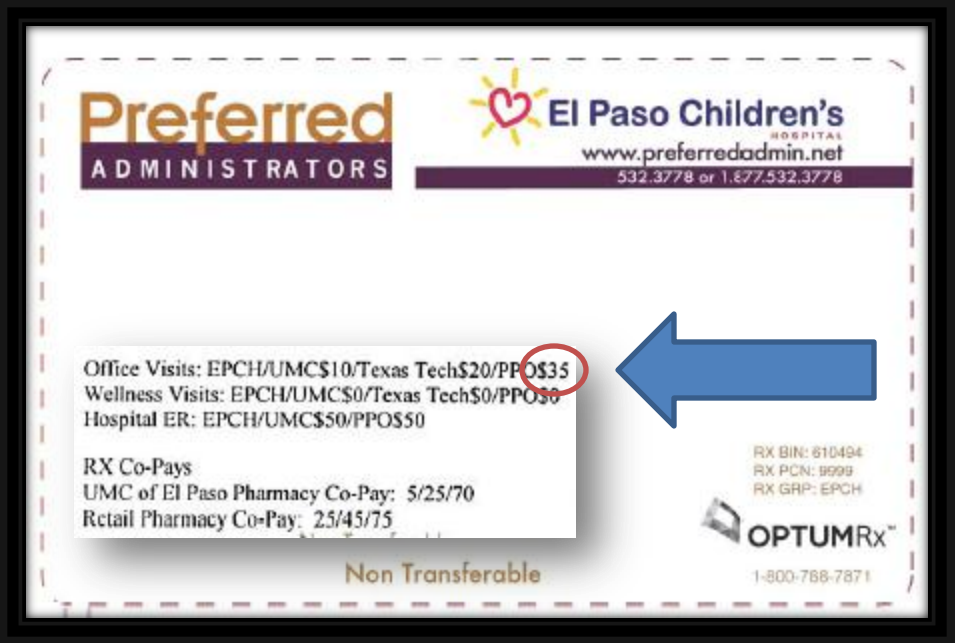
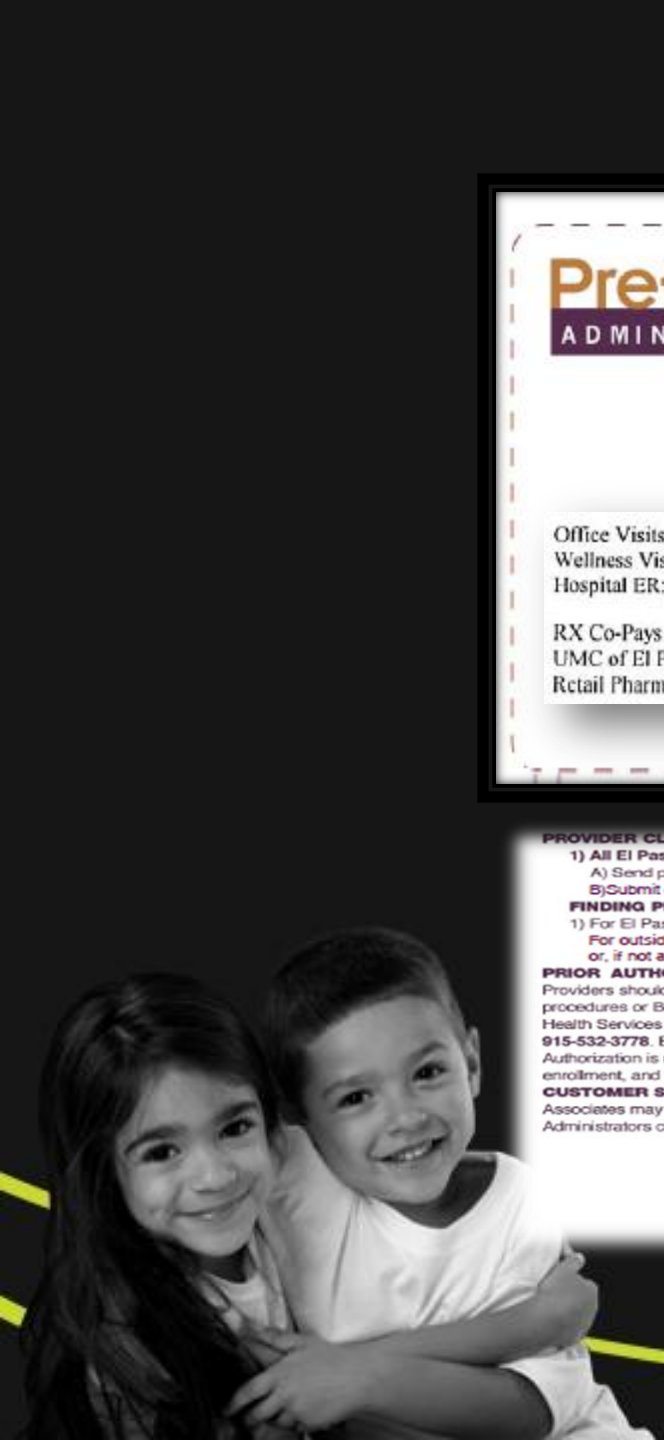
EPCH ID Cards





PROVIDER CLAIM SUBMISSION:

1) All El Paso and Outside Area Providers -

A) Send paper claims to Preferred Administrators, P.O. Box 971370, El Paso, TX 79997 or

B)Submit electronic claims to Availity: EPF11

FINDING PROVIDERS:

1) For El Paso Area Network Providers: www.preferredadmin.net or call **915-532-3778**

For outside (El Paso County, TX) contact 800-678-7427 or MultiPlan.com for a PHCS provider or, if not available, a MultiPlan provider.

PRIOR AUTHORIZATION of HEALTH CARE SERVICES:

Providers should fax information regarding proposed inpatient admissions and specified outpatient procedures or Behavioral Health Therapy after the initial patient assessment, to Preferred Administrators Health Services Department **915-298-7866**. For additional information / assistance providers should call **915-532-3778**. Emergency admission must be authorized within 24 hours of the admission. Prior Authorization is not a guarantee of payment. All benefit determinations are subject to eligibility, enrollment, and the terms of coverage defined in the Plan.

CUSTOMER SERVICES:

Associates may obtain assistance with benefit information and claim inquiries by contacting Preferred Administrators customer services at **915-532-3778**.

PHCS
(Excluding El Paso County)

MultiPlan
(Excluding El Paso County)

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Special EPCH/UMC/TT Benefit Coverage

When the following services are not available at EPCH, UMC, or Texas Tech, benefit coverage through a PPO or Out of Network provider will be paid at the schedule of benefit level of EPCH, UMC and Texas Tech:

- 1. **Radiation Therapy** (Adult and Children)
- 2. **PET Scans**
- 3. **Electrophysiology Lab**
- 4. **Adult Allergy/Immunology-** limited to patient management (physicians visit), treatment and diagnostics in the physician's office.
- 5. **Cystic Fibrosis Treatments-** limited to patient management (physicians visit), treatment and diagnostics in the physician's office.
- 6. **Ophthalmology Services-** limited to the medical diagnosis for the treatment of an eye disorder and outpatient surgery.
- 7**. Pain Management-** limited to patient management (physicians visit), treatment and diagnostics in the physician's office.
- 8. **Urology-** limited to patient management (physicians visit), treatment and diagnostics in the physician's office.

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Special EPCH/UMC/TT Benefit Coverage

- Any service not mentioned on the previous list will be covered at the appropriate benefit level per the schedule of benefits.

- These services will be covered under the appeal process after services are provided and paid at the current benefit level. If prior authorization is not obtained, the EPCH/UMC and Texas Tech level of coverage will not be applied. If the service becomes available at EPCH, UMC or Texas Tech, services must be provided there to attain the higher level of reimbursement.

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Wrap Network

- Wrap Network- Preferred Administrators has a contract with MultiPlan and PHCS (Private Health Care Systems) so they can contract provider networks outside of our area geographical area. All claims are still processed by our Claims Dept, but they use a pricing tool to verify if provider is contracted with MultiPlan and PHCS. To verify if a provider is participating, you can verify online at:

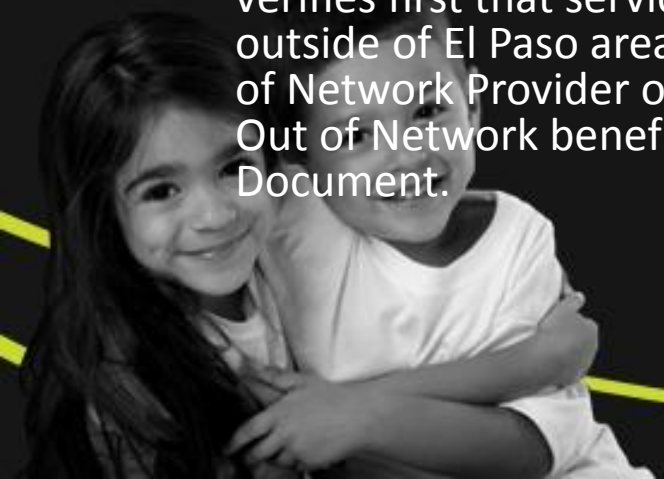
  www. Multiplan.com or call 800-922-4362

- Criteria must be met to receive PPO Benefits and services with one of our MultiPlan and PHCS providers.

  -Member resides outside of the area of El Paso area

  -Member has an emergency outside of El Paso area

  -Member needs requires services to be done outside of the area because services are not performed locally. Our Health Services Department verifies first that services can not be done locally, prior to approving services outside of El Paso area. If member chooses to receives services from an Out of Network Provider outside of our area; the member will be responsible for Out of Network benefit as explained in our Member Handbook/Plan Document.



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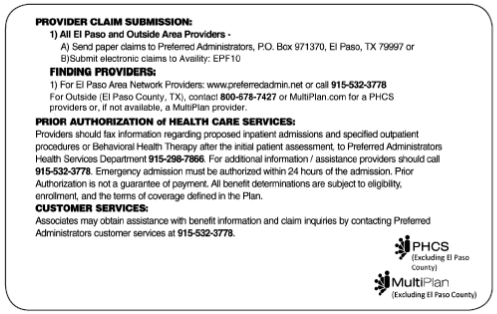
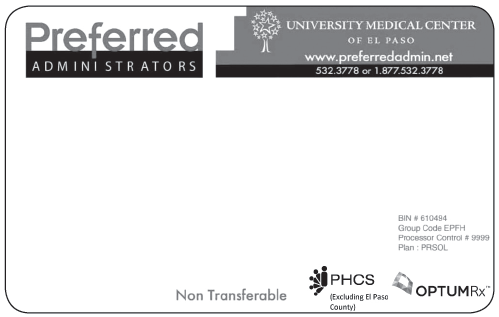
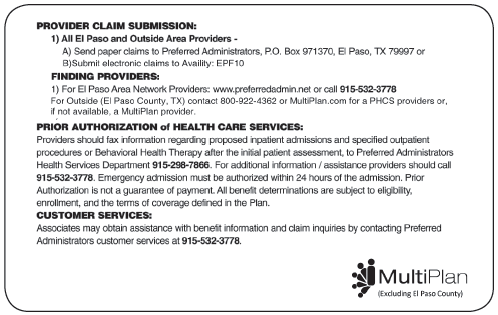
ID Cards and Wrap Network



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

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Interlink Transplant Network

- Interlink is a national network and an established leader in the transplant network industry, often referred to as being one of the most used and respected transplant networks in the United States.

- http://transplantcare.interlinkhealth.com/

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Prior Authorization Flyer

Preferred ADMINISTRATORS

PROCEDURES & SERVICES REQUIRING PRIOR AUTHORIZATION/NOTIFICATION

ALL REQUESTS MUST BE INDIVIDUALLY FAXED

Inpatient Fax Number
915-298-5278

Outpatient Fax Number
915-298-7866

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.

Inpatient Admissions

- Acute Hospital
- Surgical
- Non-Surgical
- Rehab
- Hospice
- Maternity and Newborn
- Behavioral Health
- Elective Admissions/Surgery

Outpatient Therapy

- Physical Therapy*
- Speech Therapy*
- Occupational Therapy*
- Chiropractic*
- Behavioral Health*
- Radiation Therapy
- Chemotherapy
- Infusion Therapy
- Dialysis
- Home Health*

Radiology/Diagnostic Imaging

- PET Scans
- Obstetrical Ultrasounds (Member is allowed 4 ultra-sounds without obtaining pre-authorization)

No authorization required for MRI, MRA, EKG, CT scans or X-Rays

Outpatient Procedures

- Ambulatory Surgical Center
- Endoscopy Center
- Cardiac Catheter Center
- Outpatient Hospital
- Wound Clinic

Pharmacy Medical

- Growth Hormones
- Synagis
- Oral Injectable or IV Drug Administration over $500
  Note: This includes oral, injectable, or IV provided in a Physician's office
- Specialty Medicines
  Note: Please go to www.preferredadmin.net for a complete list of specialty medicines.

Durable Medical Equipment ($500 and over)

- All DME rentals exceeding 2 months. Maximum up to 12 months, not to exceed purchase price.

Other Services

- Allergy Immunotherapy
- Laser Surgeries
- Oral Surgery
- Orthotics and Prosthetics ($200 and over for Adult and Children)
- Podiatry (Except for debridement of nails, avulsion of nail plate, excision of nail and wedge excision of skin of nail)
- Transplants (To include evaluation services by Transplant Facility)
- Transportation (Air transport and Non-Emergent Ambulance)

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

*No authorization is required for **initial evaluation** 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

Last Revision August 2013

Effective October 1, 2013

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

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Important Note to Remember!

Preferred Administrators Network physicians, who provide services at UMC or EPCH, will have professional services paid at the contracted rate. Member's responsibilities will be UMC/EPCH/Texas Tech benefit coverage level.

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

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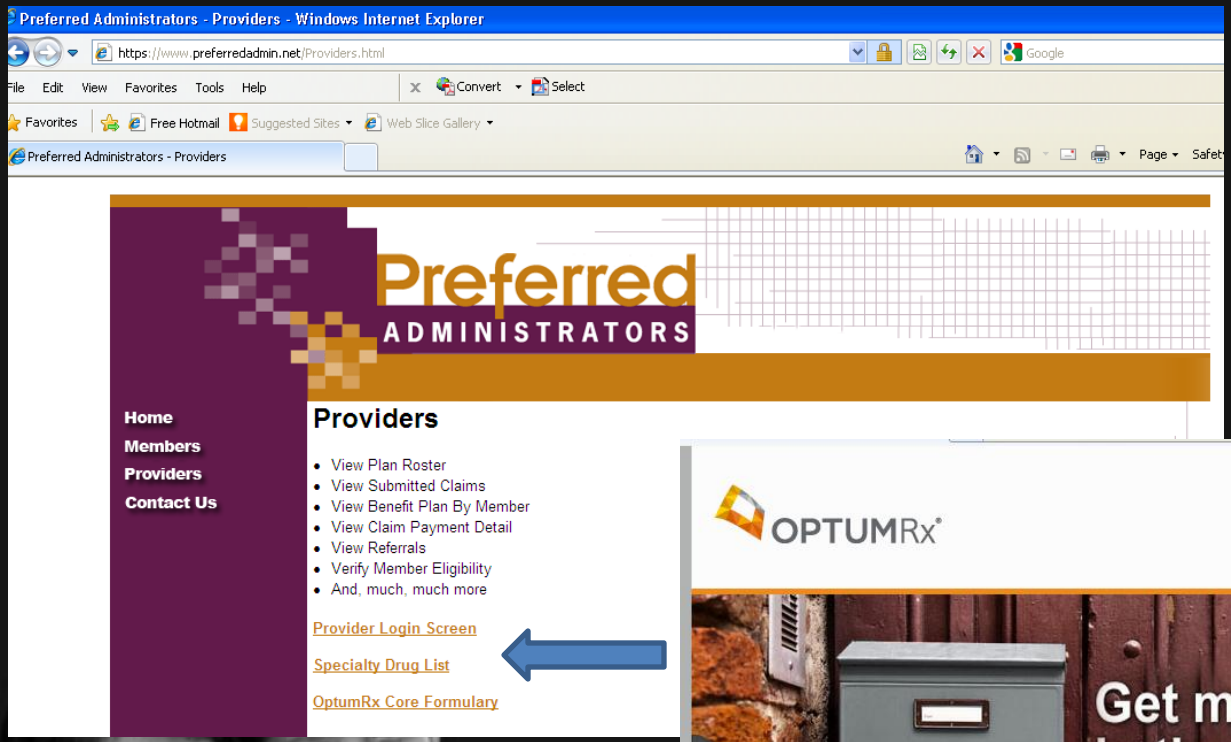
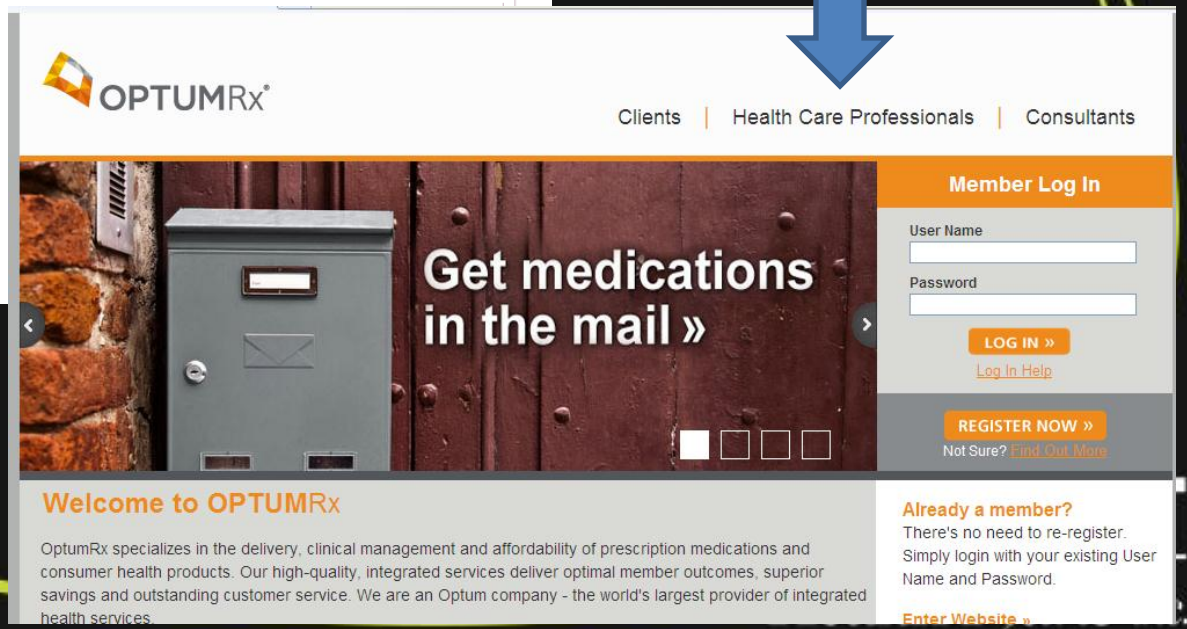
OptumRx
(Pharmacy Benefit Manager)



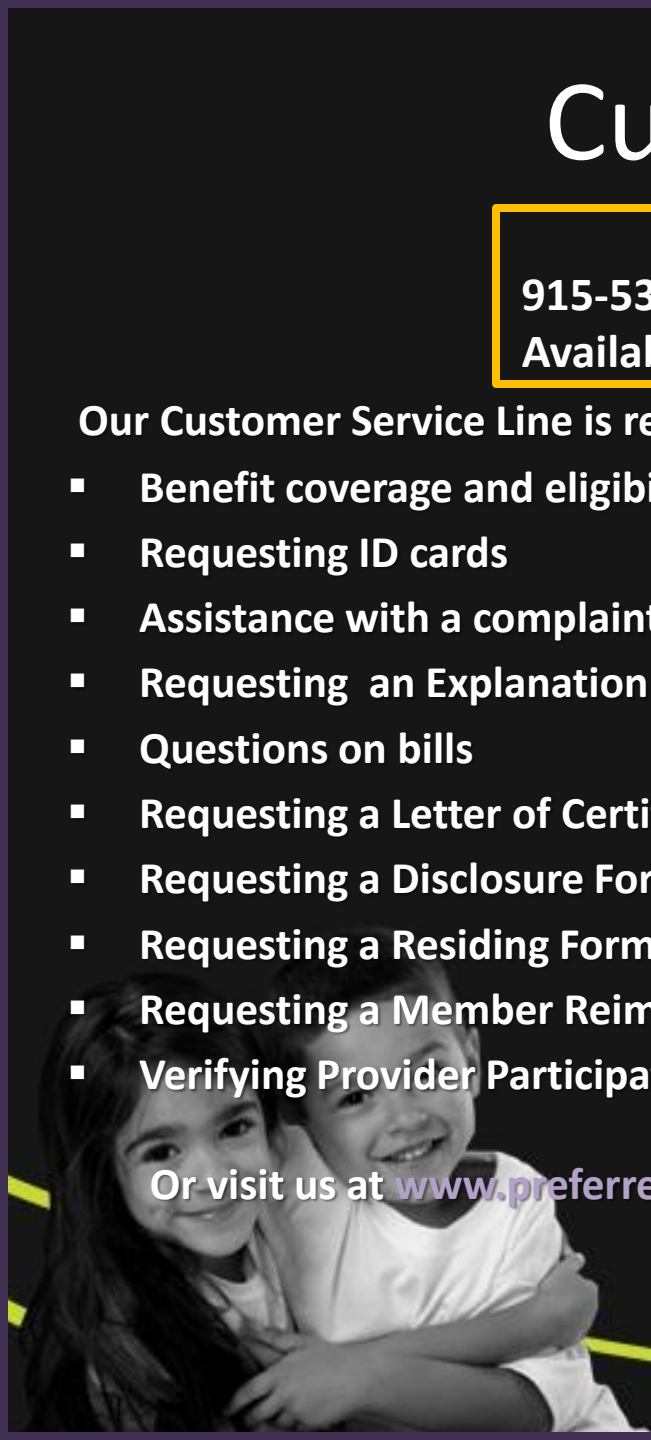


Customer Service

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.

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Contact Information

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

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

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OB Information
Preferred Administrators

Preferred
ADMINISTRATORS

Reminders
Global Billing

Preferred ADMINISTRATORS

Memo

To: Providers

From: Preferred Administrators

Date: June 28, 2013

Re: Global Billing Reminder

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 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 ante partum 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
- 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.

Outpatient Providers: Completing the CMS-1500	OB services rendered in an inpatient setting must be billed on a *CMS-1500* claim form. OB services billed by outpatient providers for global OB services on a *UB-04* claim form will be denied.
Global Billing Requires 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 less than four visits are rendered, providers must bill services on a per-visit basis.
Plans To but Does Not Perform Delivery	If a provider plans to bill a global fee, but then does not perform the delivery, the antepartum visit must be billed separately using appropriate global antepartum codes.
Hiring Substitute Doctor to Deliver	Occasionally circumstances prevent the primary physician from performing the delivery. In these circumstances, global billing is allowed only when the primary physician who gives antepartum and postpartum care employs another doctor to perform the delivery and the delivering physician does not bill Preferred Administrators for the delivery or any other maternity service.
"From-Through" Billing	Global OB claims must be billed in the "from-through" billing format (called "from-to" on the *CMS-1500*). The "from" date of service and the "through" date of service on the CMS-1500 is the delivery date. Enter a quantity of "1" in the *Days or Units* field (Box 24G).
Verifying Eligibility	To be reimbursed for global claims, providers must verify the recipient's eligibility for services during the month of delivery.
Billing Limit	Global claims are subject to 1 year timely filing based on the delivery date.
Transfer of Care	Providers must render total obstetrical care during the recipient's entire pregnancy in order to bill globally. Providers who accept a transfer patient must bill appropriate global antepartum codes. Providers who accept transfer patients are not restricted in the number of visits for which they may be reimbursed.

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Breast Pump Benefit

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TPA Benefit for Women
(Breast Feeding Support and Supplies)
Effective 10/1/12

Memo

To: DME and OB GYN Providers

Date: January 28, 2013

Re: Breast Pump Coverage Effective 10/1/12

TPA Benefit for Women (Breast Feeding Support and Supplies)

Effective October 1, 2012, breast pumps and their supplies became a benefit for women as part of preventive care services. A Prior Authorization will be required for all electric and manual breast pumps. Since there are no reimbursement fees for these services, ***an invoice is required***. Reimbursement will be coordinated between our Case Managers, Contracting Unit and the DME Provider. Please refer to the terms below regarding this benefit.

The purchase of an electric pump (non-hospital grade)

A purchase will be covered once every five years following the date of the birth. If an electric pump was purchased within the previous period, the purchase of an electric pump will not be covered until a five-year period has elapsed from the last purchase of an electric pump.

The purchase of a manual breast pump

A purchase will be covered once every five years following the date of the birth. If a manual pump was purchased within the previous period, the purchase of a manual pump will not be covered until a five-year period has elapsed from the last purchase of an electric pump.

- 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.

Outpatient Providers: Completing the CMS-1500	OB services rendered in an inpatient setting must be billed on a *CMS-1500* claim form. OB services billed by outpatient providers for global OB services on a *UB-04* claim form will be denied.
Global Billing Requires 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 less than four visits are rendered, providers must bill services on a per-visit basis.
Plans To but Does Not Perform Delivery	If a provider plans to bill a global fee, but then does not perform the delivery, the antepartum visit must be billed separately using appropriate global antepartum codes.
Hiring Substitute Doctor to Deliver	Occasionally circumstances prevent the primary physician from performing the delivery. In these circumstances, global billing is allowed only when the primary physician who gives antepartum and postpartum care employs another doctor to perform the delivery and the delivering physician does not bill Preferred Administrators for the delivery or any other maternity service.
"From-Through" Billing	Global OB claims must be billed in the "from-through" billing format (called "from-to" on the *CMS-1500*). The "from" date of service and the "through" date of service on the CMS-1500 is the delivery date. Enter a quantity of "1" in the *Days or Units* field (Box 24G).
Verifying Eligibility	To be reimbursed for global claims, providers must verify the recipient's eligibility for services during the month of delivery.
Billing Limit	Global claims are subject to 1 year timely filing based on the delivery date.
Transfer of Care	Providers must render total obstetrical care during the recipient's entire pregnancy in order to bill globally. Providers who accept a transfer patient must bill appropriate global antepartum codes. Providers who accept transfer patients are not restricted in the number of visits for which they may be reimbursed.

Preferred ADMINISTRATORS

Preventative Care Benefits for Women

Preferred ADMINISTRATORS

New Preventive Care Benefits for Women

The following are eight new preventive care services that our TPA plan will be covering at 100% effective 10/ 1/12. These new services will be free to women as summarized by HHS on HealthCare.gov

"**Well-woman visits:** This will include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their health care providers determine they are necessary. These visits will help women and their health care providers determine what preventive services are appropriate, and set up a plan to help women get the care they need to be healthy.

Gestational diabetes screening: This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes. It will help improve the health of mothers and babies because women who have gestational diabetes have an increased risk of developing type 2 diabetes in the future. In addition, the children of women with gestational diabetes are at significantly increased risk of being overweight and insulin-resistant throughout childhood.

HPV DNA testing: Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.

STI counseling: Sexually-active women will have access to annual counseling on sexually transmitted infections (STIs). These sessions have been shown to reduce risky behavior in patients, yet only 28 percent of women aged 18-44 years reported that they had discussed STIs with a doctor or nurse.

HIV screening and counseling: Sexually-active women will have access to annual counseling on HIV. Women are at increased risk of contracting HIV/AIDS. From 1999 to 2003, the Centers for Disease Control and Prevention reported a 15% increase in AIDS cases among women, and a 1% increase among men.

Contraception and contraceptive counseling: Women will have access to all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs. Most workers in employer-sponsored plans are currently covered for contraceptives. Contraception has additional health benefits like reduced risk of cancer and protection against osteoporosis.

Breastfeeding support, supplies, and counseling: Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. Breastfeeding is one of the most effective preventive measures mothers can take to protect their health and that of their children. One of the barriers for breastfeeding is the cost of purchasing or renting breast pumps and nursing related supplies.

Interpersonal and domestic violence screening and counseling: Screening and counseling for interpersonal and domestic violence should be provided for all adolescent and adult women. An estimated 25% of women in the United States report being targets of intimate partner violence during their lifetimes. Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women."

Preferred ADMINISTRATORS

Contact Information

Stacy Arrieta

Provider Relations Representative

298-7198 ext. 1059

sarrieta@epfirst.com

Preferred ADMINISTRATORS

HealthCare Options

Rene Duran

HealthCare Options

Provider Relations Representative

HealthCARE OPTIONS of EL PASO

What is Health Care Options?

- Health Care Options is a benefit program (not an insurance program) that provides care and medication for individuals who are not enrolled or do not qualify for any other public or private insurance program.
- HealthCare Options will pay for basic health care services for individuals who are determined eligible for coverage.
- Primary, preventive and specialty care services that are provided through the HCO Network providers.
- ER and Inpatient hospital care and pharmaceuticals are provided by University Medical Center (UMC).

HealthCARE OPTIONS of EL PASO

Program Overview

- **15,000** + 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

HealthCARE OPTIONS of EL PASO

Eligibility

- Determined by UMC Hospital –Enrollment Services Unit
- Must meet income and resident requirements
  - Family income must be at 100% of federal poverty level or less.
  - Must live in El Paso and at least one member of your family must have a social security number to apply.
- May not be eligible for any other insurance coverage such as Medicaid or Private Insurance.
- Must have services pending at UMC, i.e. lab, x-rays etc.

HealthCARE OPTIONS of EL PASO

How to Apply

Applications are only accepted at:

UMC Hospital

(Walk-Ins)

or

UMC Clinics

(Appointments only)

Enrollment Services Unit

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

HealthCARE OPTIONS of EL PASO

Re-enrollment Process

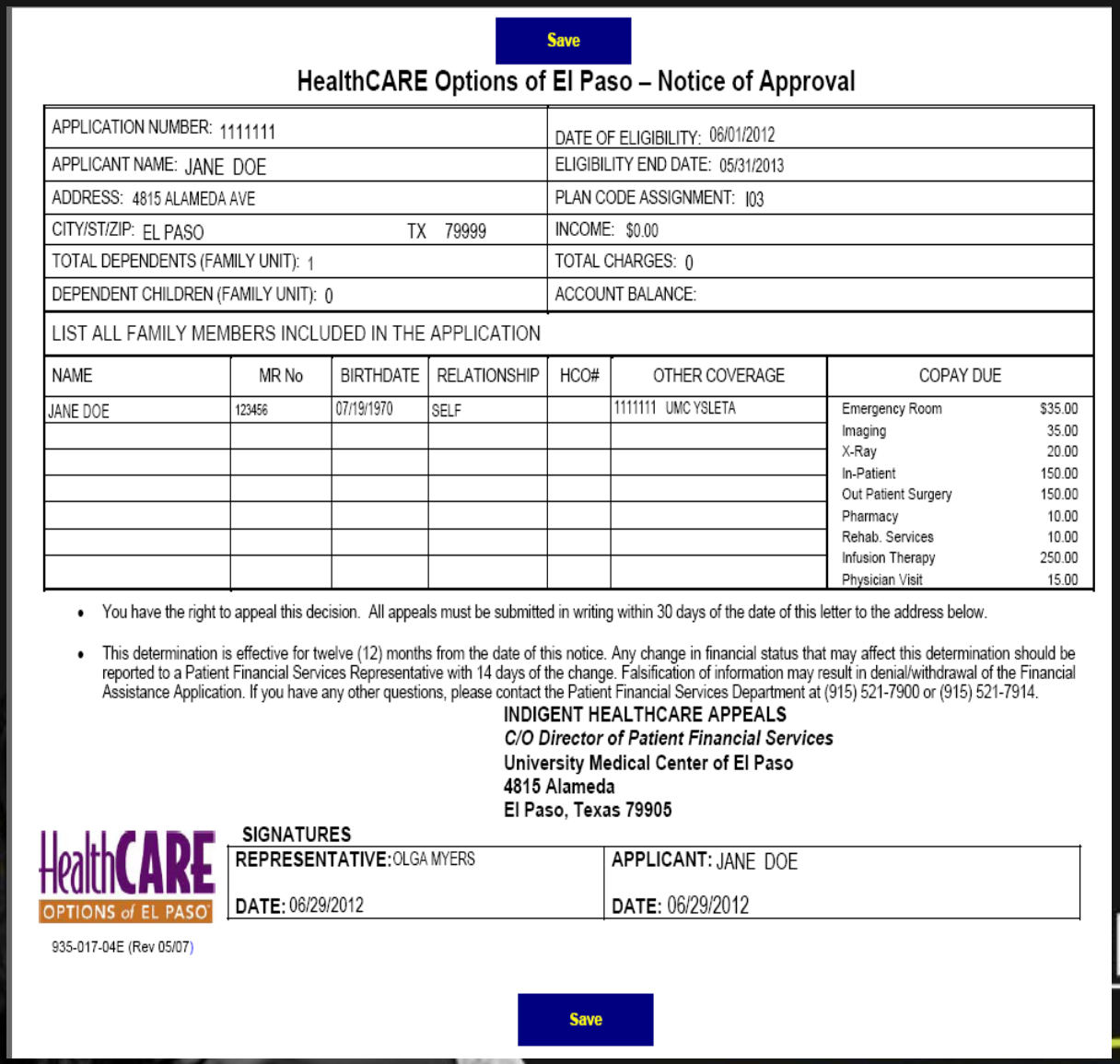
- Coverage is continuous for a period of 12 months.
- Members are required to re-apply to maintain their benefits.
- A member due for re-enrollment will receive a notification 2 months prior to their termination date with instructions for re-enrollment.

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

HealthCARE OPTIONS of EL PASO

UMC Approval Form



Save

HealthCARE Options of El Paso – Notice of Approval

APPLICATION NUMBER: 1111111	DATE OF ELIGIBILITY: 06/01/2012
APPLICANT NAME: JANE DOE	ELIGIBILITY END DATE: 05/31/2013
ADDRESS: 4815 ALAMEDA AVE	PLAN CODE ASSIGNMENT: I03
CITY/ST/ZIP: EL PASO TX 79999	INCOME: $0.00
TOTAL DEPENDENTS (FAMILY UNIT): 1	TOTAL CHARGES: 0
DEPENDENT CHILDREN (FAMILY UNIT): 0	ACCOUNT BALANCE:

LIST ALL FAMILY MEMBERS INCLUDED IN THE APPLICATION

NAME	MR No	BIRTHDATE	RELATIONSHIP	HCO#	OTHER COVERAGE
JANE DOE	123456	07/19/1970	SELF		1111111 UMC YSLETA

COPAY DUE	
Emergency Room	$35.00
Imaging	35.00
X-Ray	20.00
In-Patient	150.00
Out Patient Surgery	150.00
Pharmacy	10.00
Rehab. Services	10.00
Infusion Therapy	250.00
Physician Visit	15.00

- You have the right to appeal this decision. All appeals must be submitted in writing within 30 days of the date of this letter to the address below.
- This determination is effective for twelve (12) months from the date of this notice. Any change in financial status that may affect this determination should be reported to a Patient Financial Services Representative with 14 days of the change. Falsification of information may result in denial/withdrawal of the Financial Assistance Application. If you have any other questions, please contact the Patient Financial Services Department at (915) 521-7900 or (915) 521-7914.

INDIGENT HEALTHCARE APPEALS
C/O Director of Patient Financial Services
University Medical Center of El Paso
4815 Alameda
El Paso, Texas 79905

HealthCARE OPTIONS of EL PASO

SIGNATURES

REPRESENTATIVE: OLGA MYERS **DATE:** 06/29/2012	**APPLICANT:** JANE DOE **DATE:** 06/29/2012

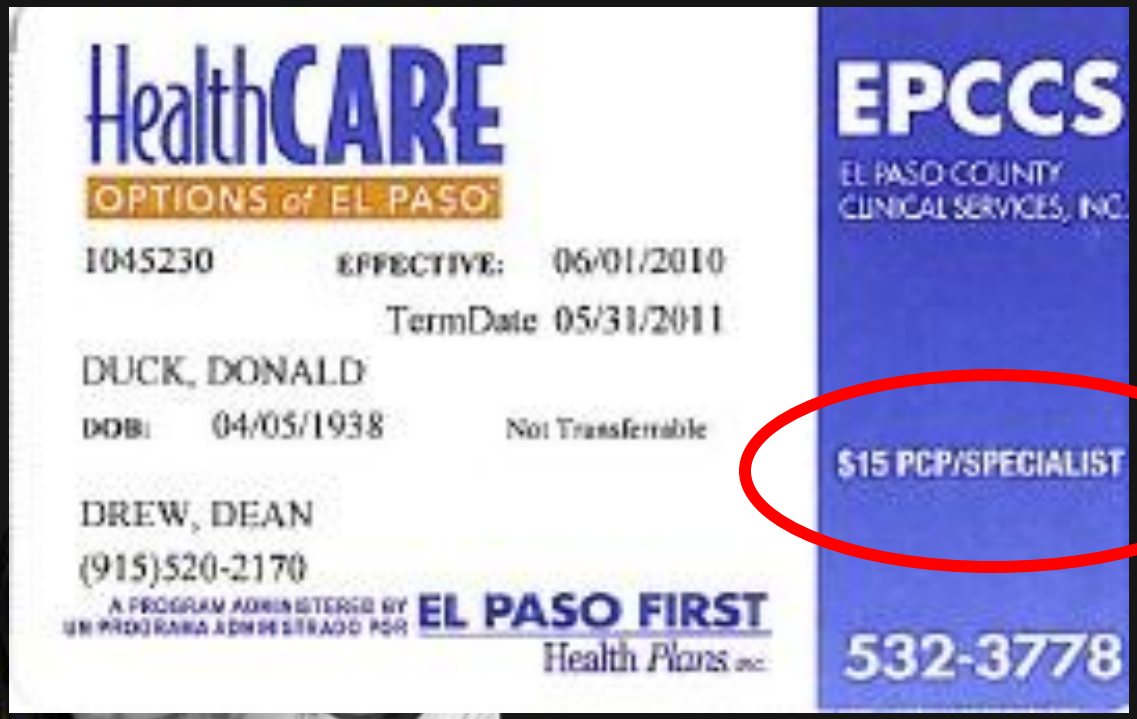
935-017-04E (Rev 05/07)

Save

- This is just an approval form but it is important to remember that ***HCO members must wait until they receive their ID card to seek services***.
- Providers must verify eligibility before rendering services.

HealthCARE OPTIONS of EL PASO

Health Care Options ID Card



Co-pay info

HealthCARE
OPTIONS of EL PASO

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.

HealthCARE OPTIONS of EL PASO

Health Care Options Covered Benefits

Services limited to IN-NETWORK providers.

- Medical visits for Primary Care, Chronic Care and Urgent needs
- Annual Physical Exams
- Cardiac Services
- Casts, splints, dressings
- Chemotherapy
- Diabetic supplies
- Diagnostic Imaging
- Education
- Emergency Medical Services at UMC
- Gynecological Services/ Pap smears
- Immunizations and Inoculations
- Inpatient Hospital Services at UMC

HealthCARE OPTIONS of EL PASO

Health Care Options Covered Benefits

- Laboratory
- Observation
- Outpatient Surgery Including anesthesia
- Physician/Professional Services
- Podiatry/Foot Care
- Physicians specialist visits authorized by PCP
- Prescriptions /Pharmacy
- Radiation Oncology
- Reconstructive Surgery
- Rehabilitation Services
- Retinal/ Ophthalmology Services
- Urology Services

HealthCARE OPTIONS of EL PASO

HCO Co-pays

Doctor visit (PCP/Specialist) $15.00

Prescription $8.00 ($5 dispensing fee for all meds under pharmaceutical company assistance)

ER visit $35.00

X-rays $20.00

Imaging services $35.00

Inpatient/outpatient visit $150.00

Labs $6 co-pay,

Rehab services $10 co-pay per visit
(physical, occupational, speech)

Infusion services $36 per visit.

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Network Pharmacies

Prescriptions must follow the UMC Hospital Formulary Prescriptions can **ONLY** be filled at any of these locations

UMC Main Pharmacy
4824 Alberta
El Paso, Texas 79905
915-521-7705

UMC Northeast Pharmacy
9849 Kenworthy
El Paso, Texas 79924
915-745-4247

UMC Ysleta Pharmacy
300 S. Zaragoza, Bldg B
El Paso, Texas 79907
915-860-4039

UMC East Pharmacy
1485 George Dieter Dr, Ste 107
El Paso, TX 79936
(915) 521-7087

UMC Fabens Pharmacy
101 Potasio
Fabens, Tx 79838
(915) 521-2271

HealthCARE OPTIONS of EL PASO

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**.

HealthCARE OPTIONS of EL PASO

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

HealthCARE OPTIONS of EL PASO

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)

HealthCARE OPTIONS of EL PASO

Rene Duran

HealthCare Options

Provider Relations Representative

915-298-7198 ext. 1037

rduran@epfirst.com

HealthCARE OPTIONS of EL PASO

Questions ?

Thank you for being our community partner!

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Health Services Department

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Prior Authorization Flyers

- Prior authorization flyer identifies authorization requirements for the following plans:

- Preferred Administrators
- HCO-Health Care Options

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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	units
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.

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Pre-Certification Fax Form

- Form should be complete and legible.
- Enter applicable CPT Codes and ICD-9 Codes
- Complete the member's identifying information

  - Name - Date of birth - Identification number

**Please f/u with HS department at 915-532-3778 ext 1500 if authorization status is not received within 72 hours.

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Amendments

- An amendment is submitted when a change to the original authorization is being requested ex: POS, DOS, CPT code(s)
- The following is required:
  - Original approved pre-certification form with authorization number
  - Include the change in “Comments” section
  - Clinical information to support the amendment

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Case Management

- Nurses and licensed social workers:
  - Initiate service coordination for local and out of town services.
  - Identify member's unique needs and link them with local community and medical resources.
  - Collaborate with providers in achieving optimal patient outcomes.

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Health Services Contact Information

- **Janel Lujan, LMSW**
  Senior Director of Operations
  532-3778 ext. 1090

- **Dolores Herrada, RN, CCM**
  Clinical Supervisor
  532-3778 ext. 1007

- **Irma Vasquez**
  Administrative Supervisor
  532-3778 ext. 1042

- **Jose Acosta, RN**
  UR Coordinator
  532-3778 ext. 1080

Crystal M. Arrieta, MPH
Disease Management Coordinator
532-3778 ext. 1175

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Claims

Sonia Lopez
Director

EL PASO FIRST
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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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Referring Provider

ITEM NUMBER 17a AND 17b (Split Field)

17a.		
17b.	NPI	

EXAMPLE:

17a.	G2	ABC1234567890
17b.	NPI	0123456789

TITLE 17a: Other ID#

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

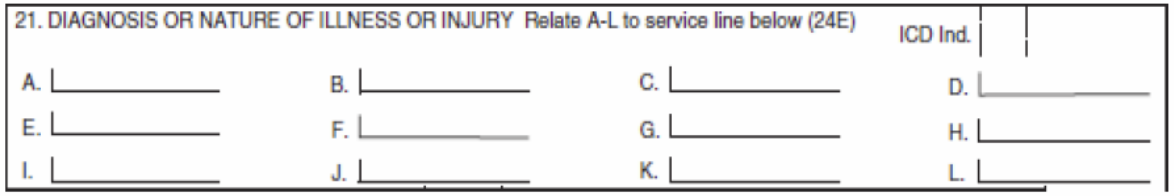
The NUCC defines the following qualifiers used in 5010A1:

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

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

Diagnosis Fields

ITEM NUMBER 21



TITLE: Diagnosis or Nature of Illness or Injury

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

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

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

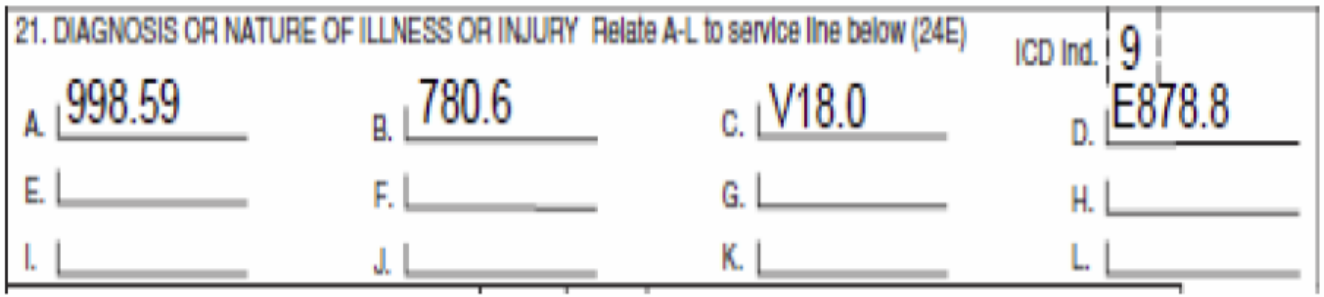
Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Example Diagnosis Submission

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

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

EXAMPLE:



Member Services

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Appeal Process for Members

- Preferred Administrators' appeal process was established to assist customers who are being balance billed by Providers and if necessary assist them in filing a formal complaint.
- When a customer is being balance billed by a Provider, a Preferred Administrators Customer Service Representative will do extensive research to find out the reason why they are being balance billed.

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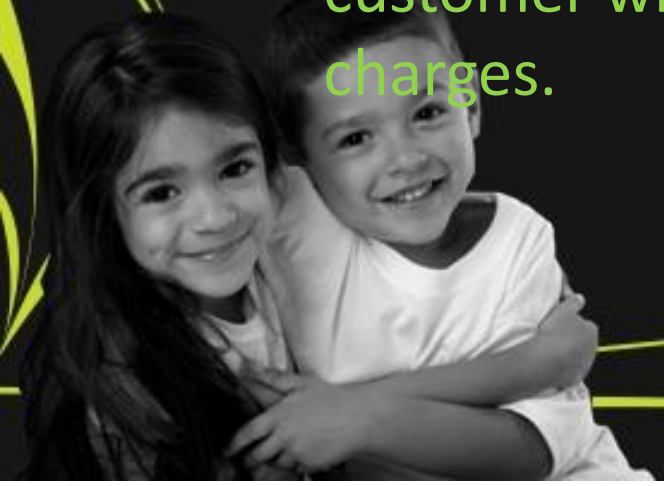
Appeal Process for Members

- A Preferred Administrators Customer Service Representative will contact the Provider and explain why the member is not responsible for the charges.
- If the customer is responsible for the charges, a Preferred Administrators Customer Service Representative will explain and educate the customer why they are responsible for the charges.



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Appeal Process for Members

- Balance billing does not include charges for deductibles, co-payments, or co-insurance.

Please note:

- Members will be responsible for non-covered services as well as out-of-network charges.

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Contact information

- For more information on Preferred Administrators, please contact our Customer Service Department Monday to Friday from 7 am to 5 pm at 915-532-3778 press 4 and then extension 1529.

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Thank You for Attending Providers!

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