

Welcome Providers



Thursday May, 27, 2010

EL PASO FIRST
healthplans, inc.

EL PASO FIRST
healthplans, inc.

Compliance Director

Special Investigations Unit Claims Auditor

El Paso First Health Plans, Inc.

Rocio Chavez

1145 Westmoreland, El Paso, Texas 79925

Phone numbers (915) 298-7198 x1032 or toll free: (877) 532-3778

Fax: (915) 298-9220

rchavez@epfirst.com

El Paso First Health Plans, Inc.

Nancy Brown

1145 Westmoreland, El Paso, Texas 79925

Phone numbers (915) 298-7198 x1169 Fax: (915) 298-9220

nbrown@epfirst.com

Reducing Waste, Abuse and Fraud in Managed Care

- Texas HB2292 (2003) requires Managed Care Organizations to establish a Special Investigative Unit (SIU) and adopt a plan to prevent and reduced Waste, Abuse and Fraud in Medicaid manage care.
- In 2004 the Texas Health and Human Services Commission amended our contracts to incorporate and implement these requirements.
- June 2004, El Paso First Health Plans, Inc. entered into a contract with Allied Management Group (AMG) to develop and administer our SIU.



Waste, Abuse, and Fraud Definitions

- **Waste**
Practices that spend carelessly and /or allow inefficient use of resources, items or services.
- **Abuse**
Practices that are inconsistent with sound fiscal, business, or medical practices and that result in unnecessary program cost or in reimbursement for services that are not medically necessary; do not meet professionally recognized standards for health care; or do not meet standards required by contract, statute regulation, previously sent interpretations of any of the items listed, or authorized governmental explanations of any of the foregoing.
- **Fraud**
Any act that constitutes fraud under applicable federal or state law including any intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to that person or some other person.

AMG

- **Data Analysis**
- **Edits**
- **Identifies Outliers**
- **Preliminary Investigations**
- **Extensive Investigation**



Data Matching, Trending, and Statistical Analysis

- Peer-to-peer Provider comparisons by cost of service
- Peer-to-peer Provider comparisons by service type within a geographic area
- Peer-to-peer Provider comparisons by diagnosis types (DX up coding)
- Comparison analysis of procedures which are commonly over-abused

Edits

- Phantom Billing- billing for services not rendered
- Up coding- billing for a higher level procedure because it pays more
- Unbundling- billing for individual services that are part of a composite billing code
- Duplicate billing
- Billing for services that are incidental to the E&M
- Billing for services performed by another provider of the same specialty in the same clinic
 - Don't sign it if you didn't do it

Nationally Recognized Coding Guidelines
CPT –AMA – NCCI - CMS



Outliers

When data has been identified as an outlier the SIU conducts a preliminary investigation to ascertain if the services and detected outcomes are reasonable.

An extensive review may be indicated.

Preliminary Investigation

The purpose of a preliminary investigation is to determine if a reported Hotline allegation or a Provider identified as suspicious during the claims payment review, claims analysis, or data analysis process has a basis for further investigation.

Extensive Investigations / Further Review

Based on the preliminary investigation and the SIU findings, if there are suspicious indicators of possible waste, abuse, and/or fraud, the MCO will direct the SIU to conduct a further review of the Provider. This is considered an “extensive investigation”.

Extensive Investigation: Medical Record Request - Provider

- The SIU selects a minimum of 50 Recipients or 15% of the Provider's claims from the data files.
- Request to the Provider for medical records and Recipient financial history printed from Provider's billing system.

(This includes Superbills)

Extensive Investigation: Provider's Refusal to Make Copies

If the Provider fails or refuses to supply the medical records requested Section §353.502(g) states that:

“Failure of the Provider to supply the records requested by the MCO will result in the Provider being reported to the HHSC-OIG as refusing to supply records upon request and the Provider may be subject to sanctions or immediate payment hold.”

Provider Education

- Education letter
- Education letter with recoupment amount
- Claims correction request
- Follow up on additional report information from providers

Further Action

If it is determined, upon completion of the preliminary investigation and medical records review, that a Provider has committed possible acts of waste, abuse and/or fraud, MCO shall report the Provider to HHSC-OIG if a 15% error rate or \$5,000 overpayment is found.

Newsletter

CLAIMS RECOUPMENT DUE TO MEDICAL RECORDS REVIEW

Notification

El Paso First Health Plans Inc. (EPF) appreciates the care you provide for our members. Routinely we must make our providers aware of the federal and state governments' efforts to reduce waste, abuse, or fraud in all government funded healthcare programs. This includes the CHIP and Star programs. EPF conducts most reviews prospectively, during claims processing. However, we identify some errors during retrospective medical records review. EPF has contracted Allied Management Group (AMG) to conduct prospective, retrospective, and medical records reviews and claims analysis to determine if there was an overpayment of claims.

Process

If EPF finds an error during a prospective review of your claim, your claim will be denied. If AMG reviews your medical records during a retrospective review and identifies an overpayment, EPF will document the findings and the overpayment amount. You will receive a detailed explanation of the findings from EPF and you will have 30 calendar days to submit a corrected claim. If EPF does not receive a corrected claim during the 30 calendar days, we will recoup the entire line item amount for the claim in question. Furthermore, if AMG did not receive your medical records during the initial medical records request, we will not accept a corrected claim.

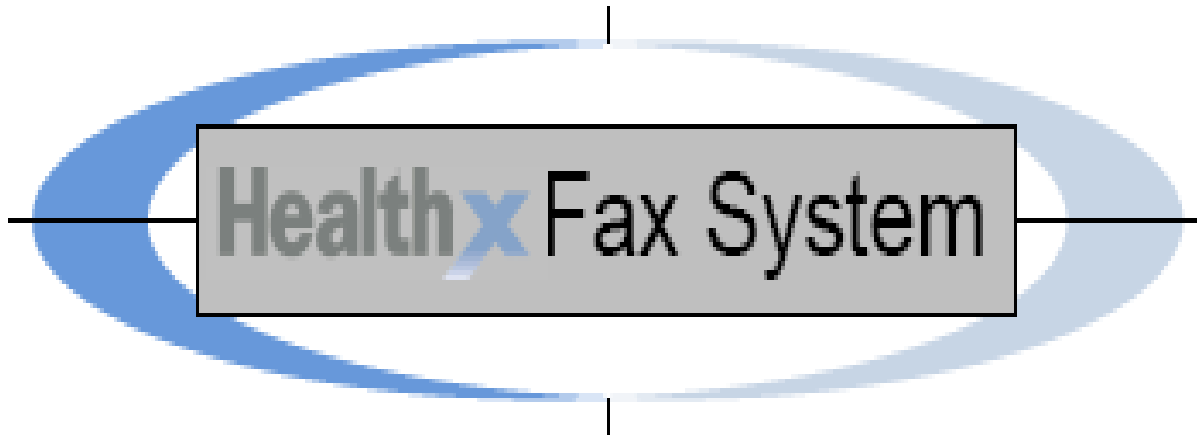
Outcome

If waste, fraud, or abuse is identified, your case may be referred to the Texas Health and Human Services Commission, Office of Inspector General (OIG). As per the OIG, EPF can only recoup claims overpayment up to the set dollar amount of \$5,000.00. If the amount is at or above \$5,000 claims overpayment or if the error rate of billing incorrectly is at or above 15%, EPF is required to report the case to the OIG for further action. EPF is required to recover all claims overpayments via claims adjustment and is not able to accept a refund check.

Reporting Possible Fraud

- **El Paso First Hotline**
 - Call the “**Hotline**” toll free number at:
1 (866) 356-8395
- **El Paso First Web-site**
 - Enter the allegation into El Paso First’s web-site at:
epfirst.com





Call 915-225-5463

Eligibility Verification
Claims Information
Authorization Information
24 hours a day 7 days a week



STAR/Premier Plan
CHIP and
CHIP Perinate



Health Care Options
Indigent Program



Third Party
Administrator
Commercial Plan

Call automated fax service at
(915) 225-5463

Healthx Fax System

EL PASO FIRST
healthplans, inc.

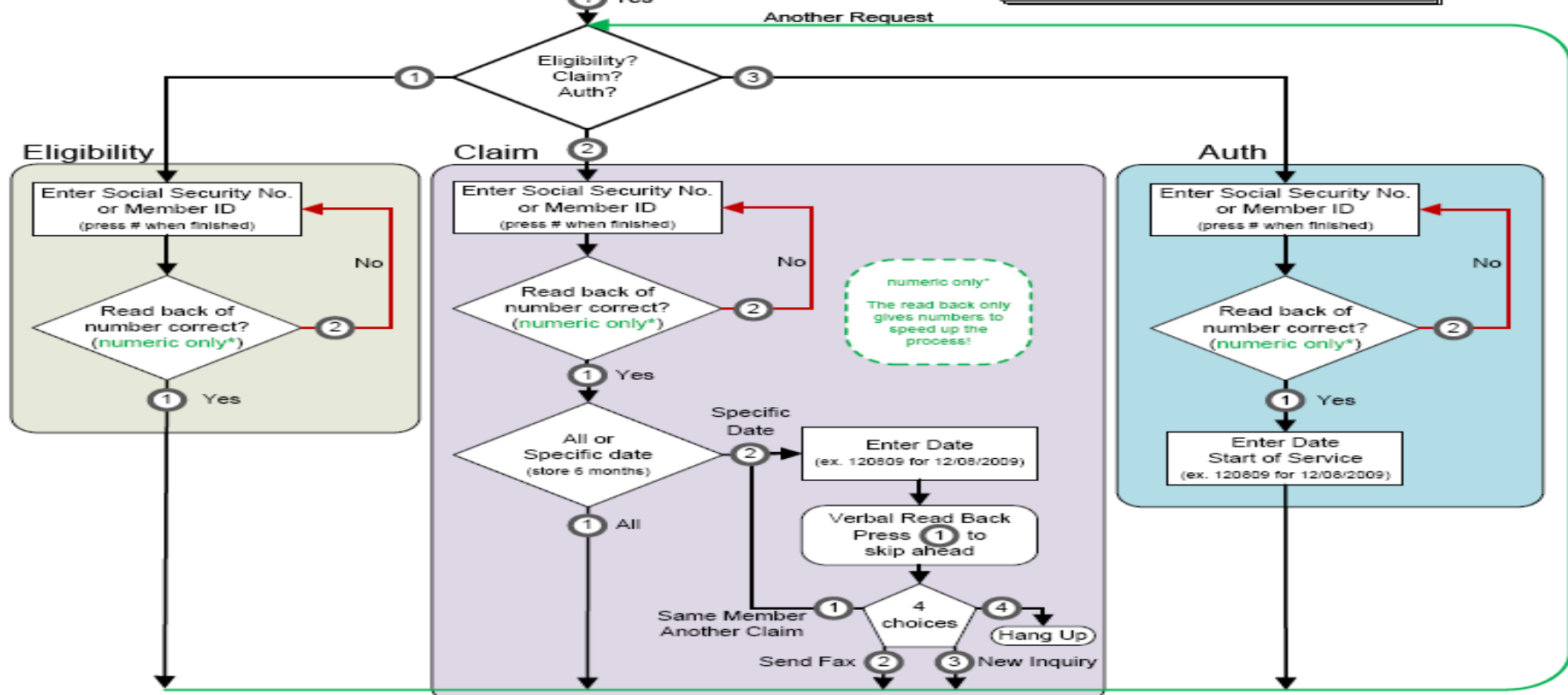
Preferred
ADMINISTRATORS

HealthCARE
OPTIONS of EL PASO

Questions

Contact Provider Relations
at
915 532-3778 ext.1507

Hang up to end session



EL PASO FIRST *healthplans, inc.*

Eligibility Fax – CHIP Example

IMPORTANT NOTICE

This is a summary of eligibility, not a guarantee of payment of a final determination of current eligibility. The information provided is as of this date, and we do not assume any obligation to notify you of any changes in eligibility. Not every charge or type of service is covered under this plan. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service. This includes any limitation or exclusion relating to preexisting conditions, medical necessity or usual and reasonable charges. The information provided is based on the latest information we have available.

Confidentiality & Privacy Notice:

Information on this facsimile is for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable State or Federal Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication in error, please notify us immediately by telephone.

Tracking: 131 Deliver to: (915) 532-2286 Tax Id#: 349876543 Eligibility As Of: 11/03/2009

Member Information

Plan Sponsor: CHIP Program
Member ID #: A01234506
Member Name: JOSE DOE JR
Address: 2501 N Mesa
Apt 120
El Paso, TX 79902
Date of birth: 06/11/2004
SSN: 123456789
Gender: Male
Rate Group: COPAYS: OFF: \$7.00 ER: \$50.00 INPATIENT: \$50.00 RX: 5.00/20.00
PCP: WHATEVER, ROBERT
Effective Date: 11/03/2009
Term Date: 01/31/2010

Claims Fax – STAR\CHIP\CHIP Perinatal example



This is a summary of action taken on your submitted claim. This fax is a summary only, and DOES NOT GUARANTEE PAYMENT. Payments payable are subject to all plan provisions. You have the right to appeal any disposition of a claim. Your appeal must be received within 120 days from the date on your Provider Remittance Advise. Please mail your appeals to El Paso First Health Plans, Inc. Attn: Complaint and Appeals Department, P.O. box 971370, El Paso, Texas 79997-1370. If the Plan Participant believes the information provided is inaccurate, please call our Customer Service Department at 915 532-3778 for confirmation or further explanation

Tracking: 131

Deliver to: (915) 532-2286

Tax Id#: 349876543

Information On: 11/03/2009

The Doctors Group
321 First St.
Suite A
El Paso, TX 79901

TIN# (9876543210)

Member Name: John Wayne

Member Number: XXXXX1201

Plan Name: Premier Plan (MEDICAID-STAR Program)

Patient Control Number: 11223344

Date Of Service	Billed Amount	Not Allowed	Contracted Amount	Co-Pay Amount	Deductible Amount	Co-Insurance Amount	Interest Amount	Payment Amount	COB Amount
Claim Number: 09103G00027		Claim Status: PAID			Rendering Provider: Dr. Joe Somebody				
01/01/2009 - 01/01/2009	\$150.00	\$25.00	\$125.00	\$30.00				\$95.00	
01/01/2009 - 01/01/2009	\$35.00	\$35.00							
Remark codes: B12 Included with another procedure.									
01/01/2009 - 01/01/2009	\$25.00	\$10.00	\$15.00					\$15.00	
Some type of claim comment									

Check Number# 2009001

Paid Date: 01/10/2009

Date Of Service	Billed Amount	Not Allowed	Contracted Amount	Co-Pay Amount	Deductible Amount	Co-Insurance Amount	Interest Amount	Payment Amount	COB Amount
Claim Number: 09103G00031		Claim Status: PENDING			Rendering Provider: Dr. Joe Somebody				
01/01/2009 - 01/01/2009	\$150.00	\$25.00	\$125.00	\$30.00				\$95.00	
01/01/2009 - 01/01/2009	\$35.00	\$35.00							
Remark codes: B12 Included with another procedure.									
01/01/2009 - 01/01/2009	\$25.00	\$10.00	\$15.00					\$15.00	
Some type of claim comment									
	\$150.00	\$25.00	\$125.00	\$30.00				\$95.00	

Check Number# 0000000

Paid Date:

Date Of Service	Billed Amount	Not Allowed	Contracted Amount	Co-Pay Amount	Deductible Amount	Co-Insurance Amount	Interest Amount	Payment Amount	COB Amount
Claim Number: 09103G00042		Claim Status: PENDING			Rendering Provider: Dr. Joe Somebody				
01/01/2009 - 01/01/2009	\$150.00	\$25.00	\$125.00	\$30.00				\$95.00	
01/01/2009 - 01/01/2009	\$35.00	\$35.00							
Remark codes: B12 Included with another procedure.									
01/01/2009 - 01/01/2009	\$25.00	\$10.00	\$15.00					\$15.00	
Some type of claim comment									
	\$150.00	\$25.00	\$125.00	\$30.00				\$95.00	

Check Number# 0000000

Paid Date:

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Information on this facsimile is for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable State or Federal Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication in error, please notify us immediately by telephone.

FACSIMILE TRANSMITTAL

THIS IS A SUMMARY OF BENEFITS TO ALL PLAN PROVISIONS AND THE ELIGIBILITY STATUS IN FORCE AT THE TIME THE SERVICES ARE RENDERED. THE ELIGIBILITY INFORMATION PROVIDED IS THE MOST ACCURATE DATA AVAILABLE TO US AS OF THIS DATE, BUT MAY NOT REFLECT ANY UNDISCLOSED OR UNREPORTED CHANGES IN STATUS. BENEFITS PAYABLE ARE SUBJECT TO ALL PLAN PROVISIONS FOR COVERED EXPENSES AND PLAN EXCLUSIONS. THIS FAX IS A SUMMARY ONLY, AND DOES NOT GUARANTEE PAYMENT OR ELIGIBILITY. IF THE PLAN PARTICIPANT BELIEVES THE INFORMATION PROVIDED IS INACCURATE, PLEASE CALL OUR HEALTH SERVICES DEPARTMENT AT 1-800-532-3778 X1500 FOR CONFIRMATION OR FURTHER EXPLANATION.

Tracking: 131 Deliver to: (915) 532-2286 Tax Id#: 349876543

Information On: 11/03/2009

Auth Status:

MEMBER ID: 123456789
MEMBER NAME: JOHN DOE
DOB: 01/01/01
STATUS: APPROVED
AUTH NO: 00000055555
DOS: 09-01-09 12/01/09
CPT CODES: 90806 - 12 UNITS
 90847 - 6 UNITS
POS: PASO DEL NORTE SURGERY CENTER
TYPE OF SERVICE: "AUTH TEMPLATE"
PROVIDER : MARIA ACOSTA
TAX ID: 74859649

PLEASE CALL 1-800-532-3778 EXT 1500 FOR AUTH STATUS



Texas Health Steps Updates

By Michelle Anguiano
Provider Relations
THSteps Coordinator
El Paso First Health Plans, Inc.



New versus Established Patients

- A new patient is one that has not received any professional services within the preceding 3 years from the provider of the same specialty who belongs to the same group practice.
- As an exception, a new preventative care medical checkup (procedure codes S-99381, S-99382, S-99384, and S-99385) may be billed when no prior checkups have been billed by the same provider or provider group even if an acute care new patient E/M service was previously performed by the same provider.

(TMHP Provider Procedures Manual Section 36-103)

New versus Established Patients

- An additional checkup will be allowed only when the client has not received any professional services in the preceding three years from the same provider or another provider who belongs to the same group practice, because subsequent acute care visits after the new patient THSteps checkup continues the established relationship with the provider.
- If a new patient checkup has been billed within the preceding three years, subsequent checkups and acute care visits billed as new patient services will be denied when billed by the same provider or provider group.

(TMHP Provider Procedures Manual Section 36-103)

New versus Established Patients

- For a client that is a new patient, an acute care and checkup visit may be reimbursed on the same date of service by the same provider or group. The checkup visit must be billed as a new patient checkup and the acute care as an established visit.
- Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit.
- An acute E/M visit for an insignificant or trivial problem or abnormality billed on the same date of service as a checkup or exception to periodicity checkup is subject to recoupment.

(TMHP Provider Procedures Manual Section 36-103)

Exceptions to Periodicity

- Exceptions are based on medical need such as
 - developmental delay,
 - environmental risk,
 - suspected abuse,
 - or state and federal requirements for Head Start, day care, foster care or adoption,
 - or for dental services under general anesthesia
 - If the client will not be available at the time the next checkup is due such as the case of children of migrant farm workers
 - If the provider is aware that the child is not due for a checkup based on age and the date of the last checkup or their Medicaid 3087 form does not state that the client is due the visit must be submitted as an exception to periodicity.

(TMHP Provider Procedures Manual 43-9)

Exceptions to Periodicity

- When billing for an exception to periodicity visit, provider must also include the most appropriate exception to periodicity modifiers.
- Claims for periodic THSteps medical checkups exceeding periodicity that do not include one for these modifiers will be denied as exceeding periodicity.

Exception-to-periodicity modifiers are as follows:

Modifier	Description
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier "-23" to the procedure code of the basic service or by use of the separate 5-digit modifier code 09923.
32	Mandated Services: Services related to <i>mandated</i> consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier "-32" to the basic procedure or the service may be reported by use of the 5-digit modifier code 09932.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-26 for billing instructions.

THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

Developmental Screening Tools (ASQ and PEDS)

- These screening tools will become mandatory in 2011.
- If purchased and used now providers will receive an additional reimbursement.
- Through August 31, 2011, providers may choose to use a standardized screening tool that is not listed in the Required Screening Ages and Tools table to complete the requirements of a medical checkup visit; however, providers may not submit a claim for a tool that is not listed in the following table.
- Links for these tools are available at <http://www.epfirst.com/ProvidersEPSTD.html>

Required Screening Ages and Tools		
Screening Ages	Developmental Screening Tools	Autism Screening Tools
9 months	Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS)	
1 year	ASQ or PEDS (if not completed at 9 months or with provider/parental concern)	
18 months	ASQ or PEDS	Modified Checklist for Autism for Toddlers (MCHAT)
24 months	ASQ or PEDS	
30 months	ASQ or PEDS (if not completed at 24 months or with provider/parental concern)	
3 years	ASQ, Ages and Stages Questionnaire-SE (ASQ-SE), or PEDS	
4 years	ASQ, ASQ-SE, or PEDS	

El Paso First THSteps Tools

- Happy Birthday Card
- Outbound calls
- Monthly Members Due List
 - Members should be scheduled within 60 days of their due date **NOT** before or the same day.
- Missed Appointment Referral Sheet
 - Reduce the number of missed appointments
 - Assist provider office staff with the issues missed appointments may create.

Online Provider Education

- The courses currently being offered are:
 - Pediatric Referral Guidelines
 - Genetic Screening
 - Case Management
 - Oral Health
 - Developmental/Mental Screening
 - Prevention & Wellness
 - Adolescent Health
 - Overview of Best Practices and Children's Services
 - Sensory Screening
 - Laboratory Services
 - Acute & Chronic Mental Conditions
 - Pharmacy

For more information please go to <http://www.txhealthsteps.com/>

Oral Evaluation and Fluoride Varnish Trainings

Who is eligible to provide this service?

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

Certification

- These providers must attend the OEFV training offered by the Department of State Health Services Oral Health Program to become certified to bill for this service. Link to [training](#) or scroll to the bottom of this page.
- The certification code is placed on the Texas Health Steps TPI under which the provider bills their Texas Health Steps medical checkups.

What is included in this visit?

- Intermediate oral evaluation.
- Fluoride varnish application.
- Dental Anticipatory guidance.
- Referral to a dental home.*

*This service must be performed in conjunction with a Texas Health Steps medical checkup.



Oral Evaluation and Fluoride Varnish Trainings

How is this service billed to Texas Medicaid?

- In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier.
- Must be billed with one of the following medical checkup codes:
 - 99381
 - 99382
 - 99391
 - 99392
- Reimbursed at \$34.16 in addition to the Texas Health Steps checkup reimbursement.
- Federally qualified health centers and Rural Health Centers do not receive additional encounter reimbursement.

What documentation is needed?

- Must document all components of OEFV on the documentation form provided during the training.
- Keep record of the referral to a dental home.

To register please go to: http://www.dshs.state.tx.us/dental/OEFV_Training.shtm

Accelerated Services for Children of Migrant Farm Workers

- State initiative to provide a THSteps checkup and accelerated services to children of migrant farm workers due to the uniqueness of this population.
- Collaborating with the Migrant Outreach Coordinator to educate our providers about these services.
- If you have any patients from El Paso First that meet this criteria please refer them to Lluvia Acuña, Migrant Outreach Coordinator at 915-532-3778 ext 1075.



Texas Department of State Health Services

Texas Health Steps

Medical Components Workshop 2010



Save the Date!



When: August 6, 2010

Where: ESC Region 19 Head Start
11670 Chito Samaniego
El Paso, Texas 79936

Time: 7:00 AM – 5:00 PM

RSVP and enjoy breakfast, lunch, giveaways and more!

*Relax and enjoy yourself while you learn more about
Texas Health Steps Medical Components.*

Various vendors will be available to answer questions.

Agenda and registration form will follow!!

REGISTER ONLINE NOW @:

www.dshs.state.tx.us/thsteps



Texas Health Steps
1-877-847-8377



www.dshs.state.tx.us/thsteps

Contact Information

- If you have any questions or concerns please contact me at:
 - E-mail: manguiano@epfirst.com
 - Phone: (915)298-7198 extension 1053.



Health Services

Pre Authorization Updates



**OUTPATIENT
FAX NUMBER:
915-298-7866**

**PROCEDURES & SERVICES REQUIRING
PREAUTHORIZATION/NOTIFICATION**

**INPATIENT
FAX NUMBER:
915-298-5278**

Please FAX all Pre-certification for OUTPATIENT/SCHEDULED PROCEDURE

Pre-authorization is based on information provided to El Paso First 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.

MEDICAID FEE SCHEDULE IS AVAILABLE ON LINE AT: www.tmhpo.com/default.aspx

	STAR	SSI	CHIP
Behavioral Health* (Initial evaluation does not require pre-authorization)	X	X	X
Chiropractic Services	X	X	X
CT Scans		X	
Durable Medical Equipment (Over \$300.00 (line item allowable rate) <i>Note: All DME rentals exceeding 2 months require pre-authorization</i>	X	X	X
Elective Admissions	X	X	X
Growth Hormones	X	X	X
Hearing Aids*	X	X	X
Home Care	X	X	X
Inpatient Admissions <i>Note: El Paso First must be notified of all inpatient admissions within 24 hrs or next business day on all urgent/emergent admissions.</i>	X	X	X
Laser Surgeries	X	X	X
MR/MRA		X	
Non-Emergent Admission	X	X	X
Nutrition Counseling	X	X	X
OB Ultrasounds <i>Note: Member is allowed three ultrasounds without obtaining pre-authorization.</i>	X	X	X
Oral Surgery	X	X	X
Orthotics and Prosthetics (Over \$200.00 (line item allowable rate)	X	X	X
Out-of-Network / Non-Participating Facility, Provider, or Vendor	X	X	X
Outpatient Procedures (excluding tonsillectomy, adenoidectomy)	X	X	X
PET Scans	X	X	X
Podiatric Procedures*	X	X	X
Dialysis Services	X	X	X
Sleep Studies	X	X	X
Specialist-to-Specialist Referrals	X	X	X
Synagis			X
Therapy Services*	X	X	X
Transplants	X	X	X
Transportation (Air Transport and Non-emergent Ambulance)	X	X	X
High Cost Medications Injectable/ Infusion (Over \$500.00)	X	X	X

***BH:**
No authorization required for the following CPT codes until the 8th visit:

90862
90807
90806

***HEARING AIDS:**
Star members under 21 must obtain approval from www.tmhpo.com/c18/hearing-services.com

***THERAPY SERVICES:**
For SSI members authorization is required for initial evaluation

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

11720; 11721; 11730; 11732;
11732; 11752

No Authorization required for outpatient chemotherapy



El Paso First appreciates the care you provide for our members.

Please notify El Paso First AS SOON AS POSSIBLE to begin the pre-authorization process.

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

X - PREAUTHORIZATION or NOTIFICATION REQUIRED

NCB - NOT A COVERED BENEFIT

ALL SSI REQUIREMENTS ARE THE SAME AS THOSE STATED IN THE TEXAS MEDICAID PROVIDER PROCEDURES MANUAL.

MEDICAID GUIDELINES APPLY TO ALL DME ORTHOTICS AND PROSTHETICS



All services or procedures that are not a covered benefit according to the Texas Medicaid Provider Procedures Manual are a non-covered benefit for El Paso First Members (Unless it is a Value Added Service)

All out-of-network services provided by non-participating facility, provider or vendor require pre-authorization
***Please see additional information on side bar**



**OUTPATIENT
FAX NUMBER:
915-298-7866**

**UMC/ TEXAS TECH
PROCEDURES & SERVICES REQUIRING
PREAUTHORIZATION/NOTIFICATION**

**EL PASO FIRST
PHONE NUMBER:
915-532-3778**

Please FAX all Pre-certification for OUTPATIENT/SCHEDULED PROCEDURE

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

**X –PREAUTHORIZATION
or NOTIFICATION
REQUIRED**

**NCB – NOT A COVERED
BENEFIT**



Pre-authorization required for the following services performed at UMC/Texas Tech	HCO
Behavioral Health	NCB
Chiropractic Services	NCB
CT Scans	
Durable Medical Equipment	NCB
Elective Admissions	
Growth Hormones	NCB
Hearing Aids	NCB
Home Care	NCB
Inpatient Admissions	
Laser Surgeries	
MR/MRA	
Non-Emergent Admission	
Nutrition Counseling	NCB
Obstetrical Services	NCB
Oral Surgery	NCB
Orthotics and Prosthetics	NCB
Out-of-Network / Non-Participating Facility, Provider, or Vendor	NCB
Outpatient Procedures	
PET Scans	
Radiation Treatment (Out of Network)	X
Chemotherapy (Out of Network)	X
Podiatric Procedures	
Dialysis Services	NCB
Sleep Studies	NCB
Eye Care Services (Out of network)	X
Symagis	NCB
Therapy Services	
Transplants	NCB
Transportation (Air Transport and Non-emergent Ambulance)	NCB
All Medications/ Injectable/ Infusion *Only available at UMC pharmacy*	

**ALL SERVICES PERFORMED OUTSIDE OF THE
UMC/TEXAS TECH NETWORK ARE
NON-COVERED BENEFITS**



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915-298-7866**

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PREAUTHORIZATION/NOTIFICATION**

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

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

X – PREAUTHORIZATION or NOTIFICATION REQUIRED

NCB – NOT A COVERED BENEFIT



	PREF ADM
Behavioral Health (Initial evaluation does not require pre-authorization)	X
Chiropractic Services	X
CT Scans	
Durable Medical Equipment <i>Note: All DME rentals exceeding 2 months require pre-authorization</i>	X
Elective Admissions	X
Growth Hormones	X
Hearing Aids	NCB
Home Care	X
Inpatient Admissions <i>Note: Preferred Administrators must be notified all inpatient admissions within 24 hours or next business day on all urgent/emergent admissions.</i>	X
Laser Surgeries	X
MR/MRA	
Non-Emergent Admission	X
Nutrition Counseling	
OB Ultrasounds <i>Note: Member is allowed three ultrasounds without obtaining pre-authorization</i>	X
Oral Surgery	X
Orthotics and Prosthetics	X
Out-of-Network / Non-Participating Facility, Provider, or Vendor	X
Outpatient Procedures	X
PET Scans	X
Podiatric Procedures*	X
Dialysis Services	X
Sleep Studies	X
Specialist-to-Specialist Referrals	
Synagis	X
Therapy Services	X
Transplants	X
Transportation (Air Transport and Non-emergent Ambulance)	X
High Cost Medications (over \$500.00)	X



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

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

- 11720
- 11721
- 11730
- 11732
- 11760
- 11766



*Please see additional information on side bar

PCU

Provider
Care
Unit



Provider Care Unit and How It Works

Contact us at 532-3778



When calling you will reach a Claims specialist who will:

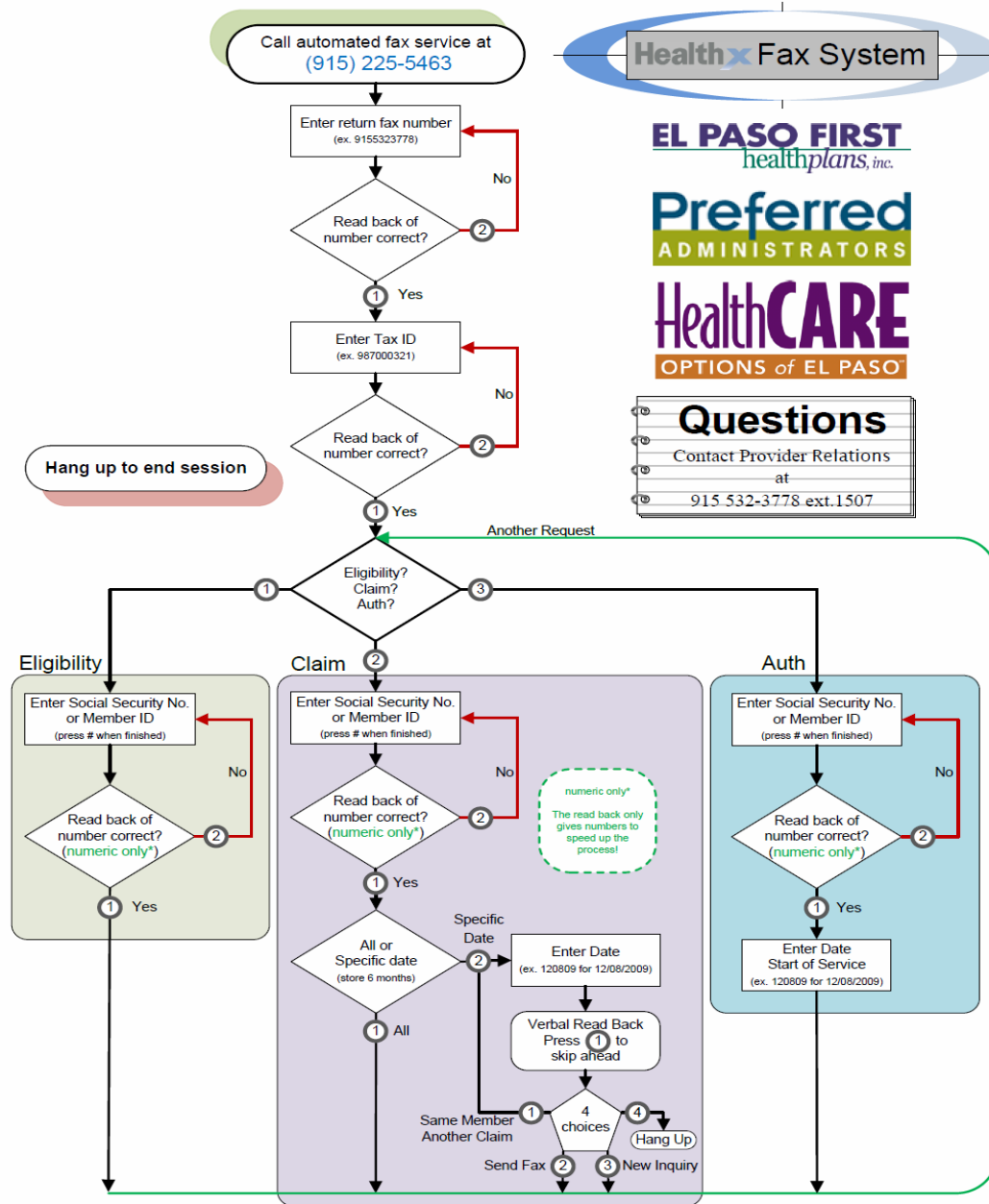
- Give claim status calls.
- Resolve or answer claim questions.
- Answer Electronic claims submission rejections or questions.
- Assist with claims disputes.

Please note you have the right to appeal any disposition of a claim through a formal appeal. Written request must be mailed to:

El Paso First Health Plans, Inc
Attn: Complaints and Appeals Department
P O BOX 971100, El Paso, Texas 79997-1370

Within 120 days from the date of your Provider Remittance Advice.

Claims Status By Phone



Claims Department

Billing Coordination of Benefits (COB)



Coordination of Benefits (COB) Applies

- Both spouses cover their family through their employers
- Both spouses are covered by the same insurance carrier but work for different employers.
- Member is Federal Medicare eligible
- Member is retired from one job and actively employed elsewhere
- Member is injured in an automobile accident
- Member is injured on the job or school
- The primary subscriber has more than one employer

Reimbursement Guidelines STAR

El Paso First as Secondary

- El Paso First is subject to follow the requirements related to COB for secondary payers in the Texas Insurance Code Section 843.379(e) and (f).
- If the amount paid by a third party health insurer is less than the amount payable for the services by El Paso First, providers may bill El Paso First for the difference between the amount paid by the third party carrier and the El Paso First allowable amount if the claim is filed timely and is in accordance with all the filing guidelines.

Reimbursement Guidelines STAR

El Paso First as Secondary

El Paso First is the secondary (or tertiary) plan, El Paso First will reimburse per COB Processing by calculating the difference between El Paso First's Maximum Allowed Amount and the primary carrier's payment paying the lesser of the two.

For Example: We processed the claim to pay the patient responsibility which is less than the Medicaid allowable.

- Prim Allowed Amount: \$248.00
- Prim Ins Paid: \$100.00
- Prim Ins. Patient Resp/Deductible: \$148.00
- Medicaid Allowable: \$162.00
- EPFirst Paid: \$62.00

Reimbursement Guidelines STAR

El Paso First as Secondary

El Paso First is the secondary (or tertiary) plan when primary carrier applies all coverage to Deductible/Coinsurance, El Paso First will reimburse per COB Processing by comparing the difference between El Paso First's Maximum Allowed Amount and the primary carrier's patient responsibility owed then paying the lesser of the two.

For Example: We processed the claim to pay the patient responsibility which is less than the Medicaid allowable.

- Bill Amount: \$248.00
- Prim Ins. Patient Resp: \$46.82
- Medicaid Allowable: \$162.00
- EPFirst Paid: \$46.82

Reimbursement Guidelines STAR

El Paso First as Secondary

Medicare/Medicaid Coverage: (Medicare Qualified Beneficiaries - QMBS)

Medicare/Medicaid Eligible Status:

- The payable period for Medicaid/Medicare eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice.

El Paso First is only required to pay for coinsurance and/or deductibles for QMBs.

Reimbursement Guidelines STAR

El Paso First as Secondary

Claims that may be submitted:

- Providers must submit Medicare-Paid claims to El Paso First for the coinsurance and deductible.
- Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.
- All claims denied by Medicare for administrative reasons must be appealed to Medicare before they are sent to El Paso First.
- An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to El Paso First for consideration.

Reimbursement Guidelines STAR

El Paso First as Secondary

Deductibles: El Paso First will consider deductibles for reimbursement when the original third party carrier applied the payment amount directly to the member's deductible. The explanation of benefits must reflect the applicable payment by the other carrier (third party pay carrier) and a completed signed claim copy must be submitted to El Paso First for consideration.

Reimbursement Guidelines CHIP

El Paso First CHIP as Primary

- El Paso First follows the Chip method of benefit coordination. If it is determined that El Paso First members are enrolled in the CHIP program the COB status guidelines do not coordinate.
- If the claims are submitted with COB information there is no other coverage following standard processing guidelines. Service do not qualify for Coordination of Benefits, claims will be denied to with denial reason:
 - D0000- Claim not covered by this payer /contractor you must send the claims to the correct payer / contractor.

El Paso First CHIP as Secondary

CHIP member's on the El Paso First CHIP program should only have CHIP coverage and no other health coverage.

Reimbursement Guidelines CHIP

EXCEPTION to Third Party Liability:

- Possible school accident and the member has school insurance, the initial claim will be automatically processed as COB coverage.
- Sent to Third Party Recovery department for Primary carrier verification and system setup.
- If the TPR Department does not receive the proper verification the claims will be denied with Denial Reason:

❖ **D09- Paid by other Insurance**

Questions?



*Thank you for your
attendance!*