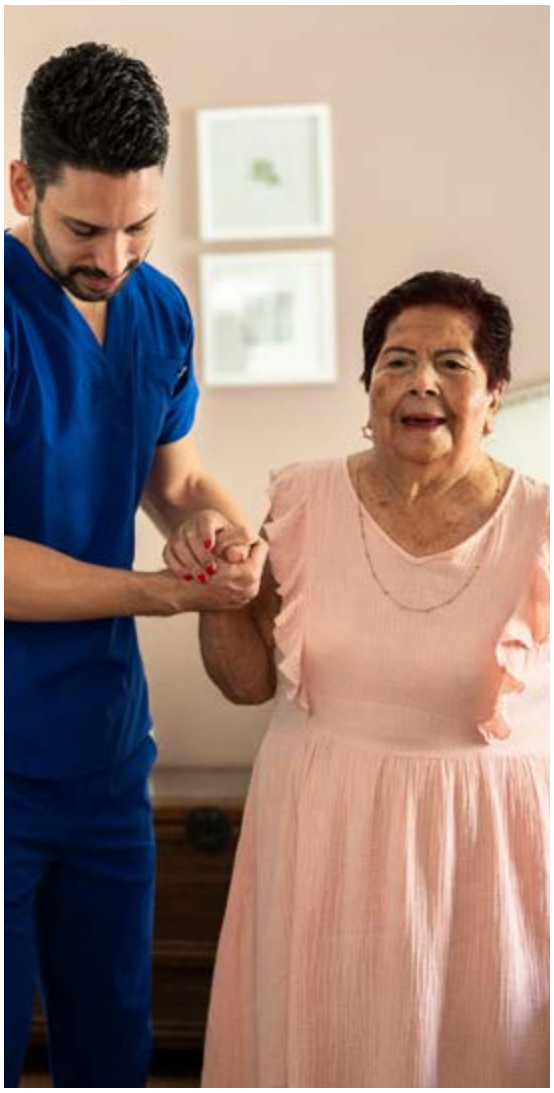
El Paso Health



Nursing Facility Provider Manual

CALL TOLL FREE **1-833-742-3127**

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TEXAS STAR PLUS Your Health Plan ★ Your Choice

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Service Area:
El Paso and Hudspeth Counties
(STAR+PLUS)

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EPHPSP8262401

9/2024

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EL PASO HEALTH IS PLEASED TO WELCOME YOU INTO OUR PROVIDER NETWORK.

El Paso Health is pleased to welcome you into our Provider network. This Provider Manual contains information about El Paso Health policies and procedures and specific "how to" instructions for Nursing Facility Providers. As changes occur, El Paso Health will update the Nursing Facility Provider Manual available to you on our website.

It is the intention of El Paso Health, in the development of this Nursing Facility Provider Manual, to help you navigate the process of providing and billing for healthcare services to El Paso Health STAR+PLUS Members. This Manual describes the services covered by El Paso Health, your responsibilities in providing services and how to bill for your services.

While we strive to streamline operational procedures, in many cases our policies and procedures are shaped by our Health and Human Services Commission (HHSC) contract requirements. El Paso Health has contracted with HHSC to provide services to STAR+PLUS program. If you are interested in obtaining a copy of El Paso Health contract with HHSC, contact Provider Relations at 1-833-742-3127.

Our goal is to make working with El Paso Health as easy as possible for all providers. We welcome suggestions and comments on our policies and procedures and on the NF Provider Manual itself. Comments or suggestions can be submitted to:

El Paso Health ATTN:
Provider Relations, 1145 Westmoreland Dr.
El Paso, TX 79925
1-833-742-3127
Email: ProviderRelationsDG@elpasohealth.com

Provider Relations is always available to answer any of your questions. Please see the Quick Reference Guide included in this Manual for additional contact information.

Background

El Paso Health is a Texas Health Maintenance Organization (HMO) established by the El Paso County Hospital District to enter into contract with HHSC for the purpose of improving access to medical care for STAR+PLUS recipients. We, at El Paso Health, are pleased that you are a participating Provider and that you share our commitment to improving the health of the El Paso community.

Quick Reference Guide

El Paso Health subcontracts with qualified companies for specialized services to our Members. The subcontracted vendors are listed below and the telephone numbers where each subcontractor can be reached for questions are listed in the Quick Reference Phone List.

The following list of phone numbers is provided for your reference and convenience.

Quick Reference Phone List

El Paso Health Quick Reference Phone List	**Telephone Number**
STAR+PLUS Program Help Line	1-833-742-3127
HHSC Office of the Ombudsman – (Provider Resolution)	1-877-787-8999
HHSC – Office of Inspector General (Medicaid Fraud & Abuse)	800-436-6184
DSHS – El Paso Regional Office	915-834-7675
Service Coordinator Hot-line	1-833-742-3127
Nursing Facility Provider Relations Representitive	1-833-742-3127
First Call Medical Advice Infoline (STAR+PLUS)	1-844-549-2826
Non-Emergency Medical Transportation (NEMT)	1-855-584-3530
Behavioral Health Crisis Line Toll Free Number (STAR+PLUS)	1-877-377-2950
Vision Services – Provider and Member (STAR+PLUS)	1-833-742-3127
Dental Services – Provider and Member (STAR+PLUS)	**Medicaid** DentaQuest 1-800-516-0165 MCNA Dental 1-800-494-6262 UnitedHealthCare 1-877-901-7321
Pharmacy (Navitus) – Provider (STAR+PLUS)	1-877-908-6023
Pharmacy – Member (STAR+PLUS)	1-877-742-3127
El Paso Health PR Nursing Facility Representative	1-833-742-3127 email EPH_NF@elpasohealth.com

PROGRAM OBJECTIVES

Objectives of the STAR+PLUS Program:

- Promote a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction.
- Improve health outcomes by ensuring the quality of health care provided to members and by promoting wellness and prevention.
- Achieve cost effectiveness without compromising access and quality.
- Integrate acute and Long-term care services for the STAR+PLUS members.
- Coordinate Medicare services for STAR+PLUS members who have SSI-Medicare and Medicaid
- Provide timely claims payment

STAR+PLUS Program Overview

STAR+PLUS is a Texas Medicaid program for adults who have disabilities or are age 65 or older. Adults in STAR+PLUS get Medicaid healthcare and long-term services and support through a health plan that they choose. Adults with complex medical needs can choose to live and receive care in a home setting instead of a nursing facility.

Goals of the STAR+PLUS Program are to:

- Promote a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction;
- Improve health outcomes by ensuring the quality of health care provided to members and by promoting wellness and prevention;
- Achieve cost effectiveness without compromising access and quality;
- Integrate acute and long-term care services for the STAR+PLUS members;
- Coordinate Medicare services for STAR+PLUS members who have SSI-Medicare and Medicaid; and
- Provide timely claims paymen

Role of Nursing Facilities

Nursing Facility providers provide institutional care to Medicaid recipients whose medical condition regularly requires skills of licensed nurses. Nursing homes provide for the medical, social and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid program or Medicare Part D), medical supplies and equipment and personal needs items.

Role of Primary Care Provider

The PCP is responsible for establishing the "Medical Home" for those Members who have selected them. The "medical home" concept establishes a patient-Provider relationship to ultimately provide better health outcomes. Primary care includes ongoing responsibility for preventive healthcare, health maintenance, treatment of illness and injuries, and the coordination of access to in-network specialty providers, network Facilities and/or other medically necessary services. Please refer to authorization catalog or prior authorization tool for a list of services and procedures requiring a pre-authorizations/ pre-certification.

PCP's may provide Behavioral Health related services within the scope if their practice. PCP's must also be available for urgent or emergency care, directly or through on-call arrangement, 24 hours a day, 7 days a week.

- Provider types who are eligible to serve as a PCP include:
- Pediatricians
- Family/General Practitioners

- Internal Medicine
- Obstetrician/Gynecologists (OB/GYN)
- Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (Practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics Gynecology)
- Certified Nurse-Midwives
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Specialist Physicians (Willing to provide medical homes to Members who have special needs)

Role of Specialty Care Provider

A Specialty Care Provider partners with the PCP to deliver specialty care to Members. El Paso Health operates a closed specialty network. This means that PCPs must refer Members to El Paso Health Network specialists and facilities only. A key component of the specialist responsibility is to maintain ongoing communication with the Members PCP. The Members PCP must initiate a referral to the specialty care Provider that outlines the necessary treatment for the Member. If the Member's condition requires urgent care, the specialist should see the Member within 24 hours. For routine care, the specialist should see the Member within two weeks. Specialty care providers and facilities are responsible for ensuring the necessary pre-authorizations/pre- certification has been obtained prior to providing services.

Some specialties may include:

- Cardiology
- Dermatology
- Obstetrician/Gynecologists (OB/GYN)
- Orthopaedic Surgery
- Hematology

Referrals are good for a limited number of days as specified by the Member's PCP. If additional treatment is needed, the Specialty Care Provider must coordinate with the Member's PCP.

Note: If a specific specialty, facility or contractor does not appear in the network the PCP should contact the El Paso Health's Utilization Management Department for authorization to refer to an out-of-network Provider.

Members have the right to select and have access to, without a Primary Care Provider referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery.

Specialist as PCP

Specialty providers may function as PCPs for Members with disabilities, special health care needs, chronic or complex special healthcare needs or a life threatening illness. The specialty Provider must agree to perform all PCP duties required under the contract and the duties must be within the scope of the specialist's license. A request for a specialist to serve as a PCP must include the following information to the Medical Director.

- Specific medical need for Member to utilize the specialist as a PCP.
- Written statement signed by the Specialist accepting responsibility for the coordination of all of the Members healthcare needs.
- Complete"Specialist as a PCP Form". Signature of the Member is required on the form.
- Specialist must also be willing to contract as a PCP as well as meet all of El Paso Health credentialing requirements.
- Specialist must also be willing to accept responsibility for coordination of all of the Members healthcare needs.

The Medical Director will review all documentation submitted to determine the clinical appropriateness of the request. Written notification of a denial to serve as the Members PCP will be mailed within 30 Days. Denials of such request may be appealed following the process outlined under Adverse Determination Appeal Process, **Section 9**; or under Provider Complaints/Appeals Process, **Section 10** of this manual.

Role of El Paso Health Service Coordinator

Service Coordination is a special program offered by El Paso Health to help members manage their health, long-term and behavioral health care needs. EPH will furnish a Service Coordinator to all STAR+PLUS Members in the Nursing Facility. EPH will ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, Long-term Services and Supports, and Behavioral Health Services. The Service Coordinator will work as a team with the PCP to coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services. All Care coordinator staff members can assist with basic inquires. If additional follow up is needed, the assigned Service Coordinator will contact the provider or member within 24 hours. We provide a single identified person as a service coordinator to all El Paso Health STAR+PLUS members, not limited to level 1, 2, and 3. The member will be notified by letter of the name and direct telephone number of their assigned personal service coordinator.

Role of Pharmacy

Pharmacist responsibilities include a range of care for patients, from dispensing medications to monitoring patient health and progress to maximize their response to the medication. Pharmacists also educate consumers and patients on the use of prescriptions and over-the-counter medications, and advice physicians, nurses, and other health professionals on drug decisions. Pharmacists also provide expertise about the composition of drugs, including their chemical, biological, and physical properties and their manufacture and use. They ensure drug purity and strength and make sure that drugs do not interact in a harmful way. Pharmacists are drug experts ultimately concerned about their patients' health and wellness.

Pharmacy Provider Responsibilities

Pharmacy Providers participating in the El Paso Health's Provider Network will adhere to the Formulary and Preferred Drug List (PDL) mandated by the Health and Human Services Commission (HHSC).

- Pharmacy Providers will work in coordination with the Member's prescribing physician to ensure that El Paso Health Members receive the correct medications in accordance with will all clinical protocols and administrative policies.
- Pharmacy Providers will ensure that El Paso Health Members receive all medications they are eligible to receive as prescribed by the Members' physician.
- Pharmacy Providers will ensure that the coordination of benefits occurs when a Member also receives Medicare Part D services or other insurance benefits. El Paso Health Members have the right to obtain medications from any pharmacy participating in the El Paso Health network.

Network Limitations

El Paso Health members must receive covered Medicaid services from El Paso Health's contracted network providers. There may be exceptions where a provider is not accessible within El Paso Health's contracted network of providers. To ensure appropriate receipt of covered service, a non-contracted or "out-of-network" provider may be approved on an exception basis.

Please note: All out-of-network services require prior authorization

COVERED SERVICES AND BENEFITS

STAR+PLUS Medicaid Covered Benefits El Paso Health covers all medically necessary Medicaid covered services with no pre-existing condition limitations. Some services require prior authorization. For the most updated list of Medicaid covered benefits for STAR+PLUS, please refer to the Texas Medicaid Provider Procedures Manual, which can be accessed on-line at: http://www.tmhp.com. For El Paso Health prior authorization guidelines please refer to the Prior Authorization Review Guide available at www.elpasohealth.com.

Nursing Facility Unit Rate

Nursing Facility Unit Rate means the types of services included in the Department of Aging and Disability Services (DADS) daily rate for Nursing Facility Providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable Nursing Facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services.

Nursing Facility Add-on Services

Nursing Facility Add-on Services means the types of service that are provided in the facility setting by the Provider or another Network Provider, but are not included in the NF Unit Rate, including but not limited to emergency dental services; physician ordered rehabilitation services; customized power wheel chairs; and augmentative communication devices.

Nursing Facility Unit Rate means the types of services included in the Department of Aging and Disability Services (DADS) daily rate for Nursing Facility Providers, such as:

- room and board
- medical supplies and equipment
- personal needs items
- social services
- over-the-counter drugs

The Nursing Facility Unit Rate also includes applicable Nursing Facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services.

Ventilator Care add-on service: To qualify for supplemental reimbursement, a Nursing Facility Member must require artificial ventilation for at least six consecutive hours daily and the use must be prescribed by a licensed physician.

Tracheostomy Care add-on service: To qualify for supplemental reimbursement, a Nursing Facility Member must be less than 22 years of age; require daily cleansing, dressing, and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

PT, ST, OT add-on services: Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility Members who are not eligible for Medicare or other insurance. The cost of therapy services for Members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the Member's functioning will improve measurably in 30 days.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the Member's clinical record.

Customized Power Wheelchair (CPWC): To be eligible for a CPWC, a Member must be:

- Medicaid eligible;
- age 21 years or older;
- residing in a licensed and certified NF that has a Medicaid contract with DADS;
- eligible for and receiving Medicaid services in a NF;
- unable to ambulate independently more than 10 feet;
- unable to use a manual wheelchair;
- able to safely operate a power wheelchair;
- able to use the requested equipment safely in the NF;
- unable to be positioned in a standard power wheelchair;
- undergoing a mobility status that would be compromised without the requested CPWC; and
- certified by a signed statement from a physician that the CPWC is medically necessary.

Augmentative Communication Device (ACD): An ACD is a speech-generating device system. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

Note: For Nursing Facility add-on therapy services, EPH will accept claims received from:

(1) the Nursing Facility on behalf of employed or contracted therapists; and
(2) directly from contracted therapists who are contracted with the MCO. All other Nursing Facility add-on providers must contract directly with and directly bill the MCO. Nursing facility add-on providers (except Nursing Facility add-on therapy services providers) must refer to the STAR+PLUS Provider Manual for information including credentialing and re-credentialing.

El Paso Health Service Coordinator for NF Members

Service Coordination is a special program offered by El Paso Health to help members manage their health, long-term and behavioral health care needs. El Paso Health will furnish a Service Coordinator to all STAR+PLUS Members in the Nursing Facility. El Paso Health will ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, Long-term Services and Supports, and Behavioral Health Services.

The Service Coordinator will work as a team with the PCP to coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services. All Care coordinator staff members can assist with basic inquires. If additional follow up is needed, the assigned Service Coordinator will contact the provider or member within 24 hours. To contact El Paso Health care coordinator team call 1-833-742-3127.

The Service Coordinator will be responsible for:

- Coordinating services when a member transitions into a Nursing Facility
- Partnering with the member, family, NF Care Coordinator/staff and others in the development of a service plan, including services provided through the NF, add-on services, acute medical services, behavioral health service and primary or specialty care. The approval of additional services outside of the NF daily unit rate is based on medical necessity and benefit structure.
- Participating in Nursing Facility care planning meetings telephonically or in person, provided the member does not object.
- Comprehensively reviewing the member's service plan, including the Nursing Facility plan of care, at least annually, or when there is a significant change in condition.
- Evaluating members living in nursing facilities at least quarterly. Visit to include, at minimum, a review of the member's service plan, clinical record and when possible, a person-centered discussion with the member about the services and supports the member is receiving, any unmet needs or gaps in the person's service plan, and any other aspect of the member's life or situation that may need to be addressed. Additionally, during the visit the SC will interact with nursing

facility staff as needed to assure the resident's needs and concerns are being addressed.

- Assisting with the collection of applied income when a NF has documented unsuccessful efforts, per HHSC-mandated NF requirements. The SC will reach out to the responsible party who controls the funds and explain the importance of paying the applied income, as it could put the resident at risk of being discharged and/or being relocated for nonpayment to the NF.
- Cooperating with representatives of regulatory and investigating entities including HHSC Regulatory Services, the LTC Ombudsman Program, HHSC trust fund monitors, Adult Protective Services, the Office of the Inspector General, and law enforcement.
- Fulfilling requirements of the Texas Promoting Independence Initiative (PII). The quarterly in-person visits required of the Service Coordinator can include assessments, and the Service Coordinator can serve as the point of contact for an individual referred to return to the community under PII.
- Coordinating with the NF discharge planning staff to discharge and transition from the NF. Transitional Assistance Services (TAS): assists individuals who are nursing facility residents to discharge to the community and set up household. A maximum of $2500 is available on a one-time basis to help defray the costs associated with setting up a household. TAS include, but are not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.
- Notifying the NF within 10 ten days of a change in the Service Coordinator
- Returning a call from the NF within 24 hours after the call is placed by the NF.

The Nursing Facility Staff are responsible for:

- Inviting the Service Coordinator to provide input for the development of the NF care plan, subject to the member's right to refuse, by notifying the SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on the SC participation
- Notifying the SC within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, long term care services and supports provider, noncontracted bed, another nursing or long-term care facility. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC if a member is admitted into hospice care
- Notifying within one business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization or emergency department visit. Additionally, the SC should be notified of the development of a wound (decubitus, etc.) Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.

Discharge and Transition Planning

Coordinating with the SC to plan discharge and transition from the Nursing Facility

- Notifying the SC within one business day of an emergency room visit. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC within 72 hours of a member's death. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC of any other important circumstances such as relocation of residents due to a natural disaster, fire, or other event that would require relocation. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC if the facility initiates an involuntary discharge of a member, including involuntary discharge for non-payment of charges, clinical needs, clinical compliance or behavioral issues.
- Providing the SC access to the facility, Nursing Facility staff and the member's medical information and records

Nursing Facility Services Coordination Staff are responsible:

To invite the Service Coordinator to provide input for the development of the NF care plan, subject to the member's right to refuse, by notifying the SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on the SC participation.

To provide notice to the MCO's designated Service Coordinator via phone, facsimile, email, or other electronic means no later than one business day after the following events:

- an admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long-term care facility
- Notifying within one business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization or emergency department visit
- Nursing Facility initiates an involuntary discharge of a Member from a facility for non-payment of charges, clinical needs, clinical compliance or behavioral issues
- Providing the SC access to the facility, Nursing Facility staff and the member's medical information and records

Claims Processing Guidelines

Prompt Payment Requirements

El Paso Health will adjudicate both paper and electronic clean claims:

1. by Claim Type,
2. by Program, and
3. by Service Area.

The statutory payment period by which a clean claim must be paid begins to run upon the receipt date of a clean claim, including a corrected clean claim. Clean claims received by El Paso Health are adjudicated in adherence to the following performance requirements and timeframes set by HHSC:

1. 30 Days of receipt to 10 days of receipt. (whether paper or electronic)
2. 99% of all Clean Claims within 90 Days of receipt.
3. 98% of all Appealed Claims within 30 Days of receipt.
4. 100% of all claims, including Appealed Claims, within 24 months from Date of Service (DOS).

Timeframes are based on calendar days and are subject to change due to updates in HHSC requirements, federal and state laws, rules, or regulations.

Payment of a clean claim is considered to have been paid on the date of:

1. Date of issue of a check for payment and its corresponding Remittance Advice to the Provider.
2. Electronic transmission, if claim paid electronically.
3. Delivery of the claim payment, if payment is made through a commercial carrier, such as UPS or Federal Express.
4. Receipt by the Provider, if payment is made other than steps one through three. El Paso Health is not required to pay any claims to providers who:
5. 5. 98% of all claims within 30 days of an accepted 837 encounter with an ICN.

El Paso Health is not required to pay any claims to providers who:

1. Are excluded or suspended from the Medicaid Programs for fraud, waste, and abuse, or
2. Are on payment hold under the authority of HHSC or its authorized agents or have pending accounts receivable with HHSC.
3. If the provider's claim for Nursing Facility unit rate does not comply with all clean claim criteria as described in UMCM Chapter 2.3, "Nursing Facility Claims Manual" and as noted below.

- The Nursing Facility resident must be Medicaid eligible for the dates of service billed;

- The Nursing Facility resident must be in the Nursing Facility for the dates of service billed;
- The Nursing Facility resident must have a current Medical Necessity determination for the dates of service billed; and
- The Nursing Facility Provider had to be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).

Payment of clean claims to providers who render Medically Necessary Covered Services to Members, for whom a capitation has been paid to El Paso Health, shall be done in an accurate and timely manner, as per our contract.

El Paso Health is subject to remedies, including liquid damages and reasonable attorney fees and taxes, if it fails to process and finalize clean claims or a portion of a clean claim within the statutory 10 Day timeframe and performance requirements. This interest rate is calculated at an annual 18% rate.

If due to a catastrophic event, El Paso Health is unable to meet the statutory timeframes for claim processing and adjudication, the deadlines may be extended. However, El Paso Health must notify TDI and HHSC within five (5) Days of the catastrophic event. Within ten (10) Days after returning to normal business operations, El Paso Health must send a certification of the catastrophic event to TDI in order to be in compliance. A valid certification of occurrence will toll the applicable deadlines for the number of days identified as the date of the catastrophic event. accrued daily, for the period of time the clean claim remains unadjudicated. If the Provider agreement specifies a contracted penalty rate, then that provision controls and the Provider must be paid the contracted penalty rate.

Out Of Network Provider

Nursing Facilities that have not signed a contract to provide care for El Paso Health members are considered out-of-network. In such cases where an out-of-network Nursing Facility provides care to an El Paso Health member, El Paso Health will reimburse the out-of-network, in-area service provider the Medicaid fee-for-service (FFS) rate whereby El Paso Health will pay for services rendered, less five percent per rules found in 1 Texas Administrative Code (TAC) § 353.4 with the exception to the Medicare coinsurance program. Out of Network providers are subject to non-participating provider authorization and reimbursement guidelines.

Requirements

Under the HIPAA provisions, El Paso Health will only accept 5010 ANSI X12N electronic files. El Paso Health requires all electronic files to contain Taxonomy Codes. The Provider Taxonomy code set is an external non-medical data code set designed for use in an electronic environment, specifically within the ANSI ASC X12N healthcare transaction. These codes may be obtained from X12.

The implementation guides may be obtained from:

X12, PMB 161,
5284 Randolph Road
Rockville, MD,20852-2116
Telephone (301) 949-9740
Fax (301) 949-9742 https://x12.org/products

Under HIPAA guidelines, El Paso Health will only accept HCPCS, CPT-4, ICD-10, and ICD-9 codes approved by CMS for claims reimbursement.

Under CMS guidelines, El Paso Health will accept place-of-service codes approved by CMS. El Paso Health adheres to the following 28 TAC Chapter 21, Subchapter T, "Submission of Clean Claims" amendments to §§21.2802, 21.2807, 21.2815, and 21.2821.

These amendments:

1. ensure that carriers are aware of the responsibility to process a clean claim submitted together with deficient claims;
2. ensure that penalties are calculated consistently and in accordance with statutory requirements; and
3. provide consistency in reporting dates and clarify the reporting period for the required verification data report.

Documentation Requirements

Providers must include the following required documentation with the claim submission:

National Provider Identifier (NPI) Requirements

The National Provider Identifier (NPI) final rule, Federal Register 45, Code of Federal Regulations (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in Health Insurance Portability and Accountability Act (HIPAA)-covered transactions.

An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES). Providers must verify the NPI number associated with their Provider name and specialty before beginning the online attestation process. Provider must ensure to attest all NPI numbers for the practice name and individual name Taxonomy Code Requirements.

Taxonomy Code

The Health Care Provider Taxonomy Code Set is an external, non-medical collection of alphanumeric codes designed to classify health-care providers by Provider type and specialty. Providers may have more than one taxonomy code. (Taxonomy codes can be obtained from the X12 website at https://x12.org/products). Providers must verify the taxonomy code associated with their Provider type and specialty before beginning the online attestation process.

Diagnosis Codes (ICD-10-CM/PCS)

El Paso Health requires the International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM/PCS).

This coding system is published by the U.S. Department of Health and Human Services, and is available from:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Diagnosis Codes (ICD-10)

The ICD-10 classification system was developed by the National Center for Health Statics (NCHS) as a clinical modification to the ICD-10 system developed by the World Health Organization (WHO). The ICD-10 draft and crosswalk between ICD-9 and ICD-10 are available on the CMS website. Compliance with ICD-10 CM and ICD-10 PCS as a replacement for ICD-9 was implemented on 10/01/2015.

CPT-Code

El Paso Health requires that providers use the Current Procedural Terminology (CPT), which contains a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

These codes are used for the following services:

- Evaluation and Management
- Texas Health Steps
- Anesthesia
- Surgery
- Pathology and Laboratory
- Radiology (Including Nuclear medicine, diagnosis ultrasound)
- Medicine

Modifier Requirements

A Current Procedural Terminology (CPT) code set modifier is a two-digit code reported in addition to the CPT services or procedure code that indicates the service or procedure was modified in some way. Modifiers are essential tools in the coding process. The American Medical Association (AMA) developed modifiers to be used with its CPT codes set to explain various aspects of coding. Modifiers are used to enhance a code narrative to describe the circumstances of each procedure or service and how it individually applies to the patient and payers. A modifier provides the means by which a rendering physician may indicate that a service or procedure has been performed, or has been altered by some specific circumstances, but not changed in its definition or code. The lack of modifiers or the improper use of modifiers can result in claims delays or denials from El Paso Health. Most procedure codes do not require a modifier, but are required for some services submitted on professional claims and outpatient hospital claims.

Modifiers are used as a method to report:

- A service or procedure that has been modified but not changed in its identification or definition
- Special circumstances or conditions of patient care
- Repeat or multiple procedures
- Cause for higher or lower costs while protecting charges history data
- Assistant surgeon services
- Anesthesia service
- Interpretation service
- Technical component service
- Professional component for a procedure or service
- Service or procedure performed bilaterally
- Multiple services performed
- Reduction or elimination of a procedure by the same Provider
- Service performed by more than one physician

Refer to LTSS Billing Matrix, NF Section

Please reference to the most current LTSS Crosswalk for the list of codes and modifiers located in the HHS MMC: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/long-term-carebill-code-crosswalks

Claim Filing Deadlines

1. Claims must be received by El Paso Health within 365 Days from the date of service (DOS). If a claim is not received by El Paso Health within 365 Days, El Paso Health must deny the claim.
2. If the provider files with the wrong health plan or the wrong HHSC portal within the 365-day submission requirement and produces documentation to that effect, El Paso Health will honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the claim with El Paso Health by the later of: (1) 365 days after the date of service, or (2) 95 days after the date on the R&S Report or explanation of payment from the other carrier or contractor.

3. When a service is billed to a third-party insurance resource other than El Paso Health, the claim must be refiled and received by El Paso Health by the later of (1) 365 days after the date of service, or (2) 95 days after the date on the R&S Report or explanation of payment from the other carrier or contractor. El Paso Health will require that the provider file their claim with a copy of the third-party payor's R&S Report or explanation of payment.

National Drug Code (NDC) Claims Filing

Each NDC must be reported as an 11-digit code unique to the manufacturer of the specific drug or product administered to the beneficiary, using a 5-4-2 format (i.e., 5 digits, followed by 4 digits, followed by 2 digits [99999999999]). Some NDCs may be in a 10-digit format. The chart below illustrates how to convert the NDC code into an 11-digit format by the addition of a zero (0).

Hyphens in the example below are for illustration only.

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99
5-3-2	99999-999-99	5-4-2	99999-**0**999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-**09**

Authorization Requirements

El Paso Health cannot issue a prior authorization for service requests for Members not enrolled with El Paso Health. To determine Member eligibility, the Provider must contact the Member Services Department for verification of eligibility status.

To determine whether a service requires authorization, the Provider should refer to the Precertification Flyer located on the El Paso Health website at www.elpasohealth.com under Provider Forms. The Provider may also contact El Paso Health's Intake Unit at 1-833-742-3127 for questions about services requiring prior authorization.

An authorization can be submitted telephonically at 1-833-742-3127, by fax 915-298-7866, or electronically through the El Paso Health Web Portal at http://www.elpasohealth.com.

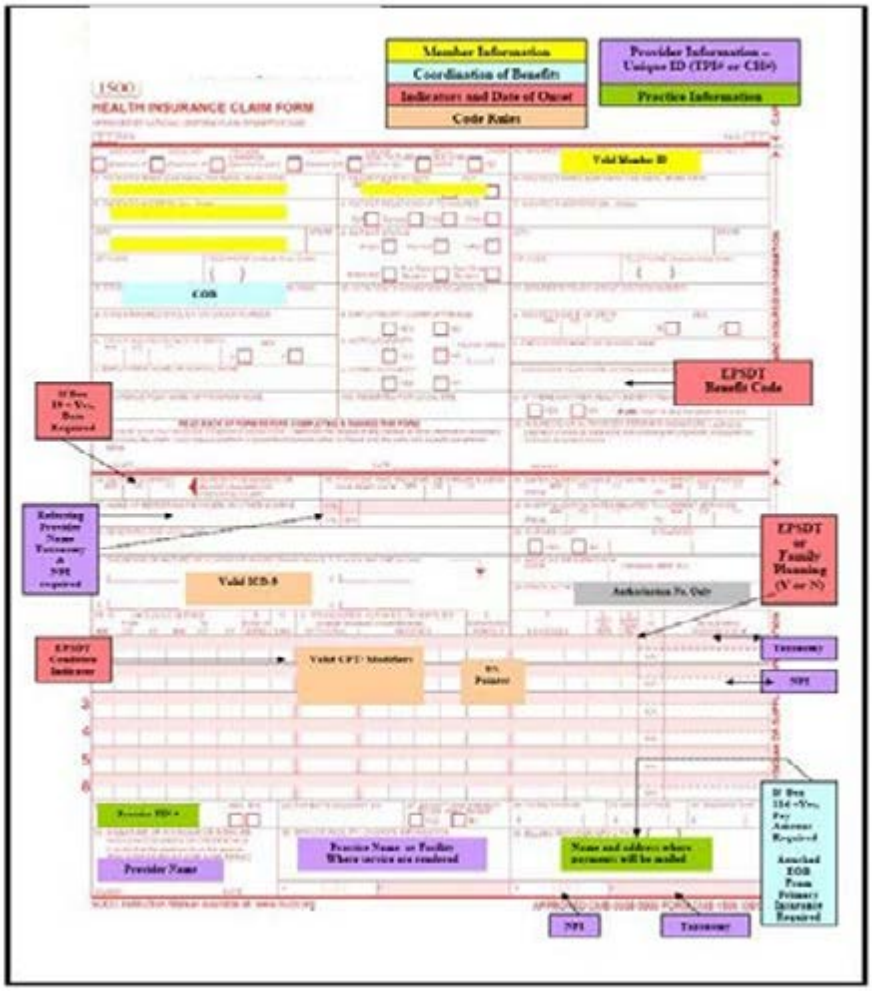
Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 Days from the add date of the client's retroactive eligibility in TMHP's system to obtain authorization for services that have already been performed.

For Coordination of Benefits (COB), El Paso Health pre-certification requirements will apply.

All claims for services that require authorization must be submitted with the correct and complete authorization number in the appropriate field of the claim or the Provider may risk a claim denial.

How To File A Claim Cms 1500 Claim Form

The CMS 1500 claim form is used to bill professional services, freestanding and ambulatory surgical centers, ambulance, independent laboratories and durable medical equipment.



*Form guide may be obtained on the El Paso Health Website at www.elpasohealth.com.

NEMT Services Claim Submission Instructions

For Non-Emergency Medical Transportation (NEMT) services please bill:

Access2Care
Attn: Claims Submission
6363 S. Fiddlers Green Circle, Suite 1400
Greenwood Village, CO 80111

For any Non-Emergency Medical Transportation (NEMT) claims related questions, please contact Access2Care 1-844-572-8196. Provider Signature on Claim= [Box 31 of the CMS 1500]

Provider Signature on Claim= [Box 31 of the CMS 1500]

The Provider's full name and credential must be populated in Box 31 of the CMS 1500. Example: John Doe, MD along with a signature. Claims prepared by computers billing services or office based computers may populate "Signature on File" in the signature along with the Provider's full name in the CMS1500 (box 31). If the claim is prepared by a billing service, the billing service must retain a letter

on file from the Provider authorizing that the billing service may submit claims for the providers. For further information please refer to the Texas Medicaid Provider Procedures Manual.

Claims with Attachments

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to the documentation needed to adjudicate the claims. Example:

- Providers filing for coinsurance, deductible, or both must attach the primary carrier explanation of benefits along with denial remarks

Multipage Claim Forms

If a claim is split the Provider must ensure that the claim is split at a logical break and all pages must contain the required information. For example, the Provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim. Hospitals are required to submit all charges including HCPCS codes when required with the Revenue Codes.

Electronic Claim Submission and Response Reports

El Paso Health has the capability to receive ANSI X12N 837I and 837P health claims. To enroll, contact El Paso Health to obtain a companion guide at:

El Paso Health Provider Relations Department

1-833-742-3127

Or via e-mail at: Helpdesk@elpasohealth.com

A clearinghouse is an electronic claims and information network available to all providers and their billing agents in the El Paso health care community that enables physicians' hospitals and ancillary providers to file patient claims electronically to El Paso Health. Filing electronic claims directly to a clearinghouse will allow for the reduction in administrative costs, accelerate claims payment, increase accuracy, and simplify daily administration.

Note: All clearinghouse entities provide their individual Payer Identification numbers. For more information or to obtain the Payer Identification numbers, log onto the El Paso Health website (www.elpasohealth.com) for a Companion Guide.

The Companion Guide assists trading partners in clarifying El Paso Health' specified values in order to facilitate implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA directed the Secretary to adopt standards for each transaction. These standards enable health information to be exchanged electronically and adopt specifications for implementing each transaction. HIPAA Implementation Guides were published for this purpose and should be used by all affected legal entities.

Recommendations for a clean testing process:

- It is important to make sure the four payer ID's have been entered into your computer system. A list of available Payer IDs can be located in the companion manual.
- It is important to provide a "good, clean" 837(I or P) 4010A1 test file which meets all HIPAA specifications.
- It is important to provide a unique NPI number for all 837 submissions at the corresponding Provider and facility loops that are submitted within the transaction.
- It is recommended that the Provider's social security number or Federal Tax Id Number (TIN) is included as a secondary identifier in REF02 loop 2010AA for validation purposes.
- It is required to address all grey areas in the El Paso Health 837P Companion Guide. All grey areas have an attachment note that provides additional formatting information.
- It is required to provide the proper Taxonomy codes per specialty. To accommodate our providers, we are only requiring the Header Taxonomy number to be reported. A list of all header taxonomy numbers can be obtained in our Electronic Claims Submission companion manual or at:

X12

Publishes X12 Implementation Guides and offers training on EDI standards, etc

https://x12.org/products

Note: Our contracted clearinghouse will reject any claims that do not contain proper Rendering Provider Taxonomy Numbers and/or Rendering Providers Unique Identifiers.

Once the testing process is complete, El Paso Health will notify your office of the exact date electronic claims processing may begin. If you have any questions, feel free to contact EDI Development Department / Provider Relations at 8333-742-3712.

CMS 1500 Professional Claims

The HIPAA Electronic claims format is designed to list 50-line items. The total number of details allowed for electronic claims by the El Paso Health claims processing system is 28. If the services provided exceed 28 line items on an approved electronic claims format, or the Provider must submit another claim for the additional line items.

UB-04 CMS-1450 Institutional Claims

The HIPAA Electronic claims format is designed to list 61 line items. The total number of details allowed for electronic claims by the El Paso Health claims processing system is 28. If the services provided exceed 28 line items on an approved electronic claims format the Provider must submit another claim for the additional line items. It is recommended that the Provider merge like revenue codes together to reduce the lines to 28 or less or payment may be delayed.

Outpatient Pharmacy Prescriptions

Navitus Health Solutions (Navitus) is the Pharmacy Benefit Manager (PBM) contracted by El Paso Health to manage the outpatient pharmacy benefit for Members. Navitus operates on a payment cycle which allows all payments for clean electronic claims to be made within 18-Days. Claims received non-electronically are adjudicated no later than 21 Days after receipt. Pharmacy payment cycles occur twice per month.

Compounded Prescriptions

A compound consists of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order. For Navitus to cover a compound medication, one active ingredient must be covered on the patient's formulary. In general, drugs used in a compound follow the Member's formulary as if each drug components were being dispensed individually. Compound drugs must be included as a covered benefit for the Member for Navitus to allow reimbursement. The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices. Any compounded prescription ingredient that is not approved by the FDA (e.g. Estriol) is considered a non-covered product and will not be eligible for reimbursement.

Processing Compound Prescriptions

Navitus uses a combination of the claims, compound, and DUR segment to fully adjudicate a compound prescription.

- Use the Compound Code of 02 (NCPDP field 406-D6 located in Claim Segment on payer sheet) when submitting compound claims.
- The claim must include an NDC for each ingredient within the compound prescription with a minimum of 2 NDCs and a maximum of 25 NDCs (NCDPD field 447-EC located in Compound Segment).
- The claim must include a qualifier of "03" (NDC) to be populate in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC's).

If an NDC for a non-covered drug is submitted, the claim will be denied.

If the pharmacy will accept non-payment for the ingredient, submit an "8" in the Clarification Code Field (420-DK located on the D.0 Claim Segment Field).

If a compound includes a drug that requires prior authorization, the prior authorization must be approved before the compound is submitted. Prior authorization forms are available at https://www.navitus.com/texas-medicaid-star-chip/prior-authorization-forms.aspx The minutes spent compounding the prescription must be submitted for reimbursement.

The minutes listed are to be populated within NCPDP D.0 Field 474-8E (level of effort- DUR segment).

How to find a list of covered drugs

The HHSC formulary is available for our Providers to view on-line at www.elpasohealth.com or through the Vendor Drug Program at http://www.txvendordrug.com/formulary/formulary The HHSC formulary is available for our Providers to view on-line at www.elpasohealth.com or through the Vendor Drug Program at http://www.txvendordrug.com/formulary/formularysearch.asp.

How to find a list of preferred drugs

The HHSC Preferred Drug List is available for our Providers to view on-line through the Vendor Drug Program at https://www.txvendordrug.com/formulary/formulary-search

Process for requesting a prior authorization (PA) for Pharmacy

Navitus processes pharmacy prior authorization requests. The formulary, the Preferred Drug List and the prior authorization criteria are determined by HHSC. Information regarding the formulary and the specific prior authorization criteria can be found on the Vendor Drug Program's website www.txvendordrug.com

Prescribers can access prior authorization forms online via www.navitus.com under the "Prescribers – Texas Medicaid STAR/CHIP" section or have them faxed by Navitus Customer Care to their office.

Completed prior authorization forms can be faxed 24/7 to Navitus at 920-735-5312 or toll-free at 855-668-8553.

Prescribers can also call Navitus Customer Care toll-free at 877-908-6023. Providers can select the prescriber option and speak with the Prior Authorization department between 8 am-5 pm Monday-Friday to submit a PA request over the phone. Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The Provider will be notified by fax regarding the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will undergo an automated review to determine if the necessary criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the process identified previously should be followed.

72 Hour Override Emergency Prescription Supply

A 72 hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and the prior authorization (PA) is not available. The 72 hour emergency supply applies to all drugs requiring PA either because they are non-preferred on the Preferred Drug List or are subject to clinical edits. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. The 72 hour emergency supply is also applicable any time a PA cannot be resolved within 24 hours for a medication on the HHSC formulary that is appropriate for the Member's condition. This procedure should not be used for routine and continuous overrides, but can be used more than once if the Provider remains unavailable. If a pharmacy is not

complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of Inspector General and the Navitus Network department at 608-729-1577 for review.

Submitting Corrected Claims

Providers that receive an EDI rejection may resubmit an electronic claim within 95 Days of the DOS. 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 Health -assigned batch ID number

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

Only zero Paid Denied claims may be sent electronically within a 95 Day timely filing. Claims with partial payments should be submitted on paper.

All corrected paper claims must be submitted within 120 Days of the EOB to meet the filing deadline of a corrected claim timeline. Each corrected claim must include: a corrected CMS 1500.

Nursing Facility Unit Rate

Nursing Facility Unit Rates will continue to be authorized by HHSC. El Paso Health will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. 10-day Clean Claim payment for NF.

Nursing Facility Providers must file claims:

- 365 Days after the date of service
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor.

Adjusted Claims

El Paso Health will implement an automated process for the NF Unit Rate. EPH will monitor and auto-adjudicate previously adjudicated claims within 30 days from the date of receipt of an adjustment from HHSC to reflect changes to such things as:

- Nursing Facility Daily Rate
- Provider Contracts
- Service Authorizations
- Applied Income
- Level of Service (RUG)

Level of Service (RUG)

Claims submitted by a NF must meet DADS' criteria for clean claims submission as described in UMCM Chapter 2.3, "Nursing Facility Claims Manual".

Please contact the Provider Relations Department for additional assistance at 1-833-742-3127.

Nursing Facility Add-on Services Claims

Add-on services are provided in the Facility setting by the Provider or another network provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices. Add-on Services Claims must be billed separate from Nursing Facility Unit Rate claims. Claims filed for add-on services must conform to national billing standards and Medicaid billing guidelines. A clean claim must include El Paso Health published requirements for adjudication such as the appropriate Medicaid number, TIN number, NPI and taxonomy or medical records. For additional information on billing guidelines including taxonomy placement, please reference Section 12 - Claims Processing Guidelines of the El Paso Health Provider Manual.

Nursing Facility Providers must file Nursing Facility Add-on Services claims by the later of:

- 95 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

All clean claims (including professional and institutional claims submissions) will be processed within 30 Days of receipt.

Nursing Facility Add-on Service providers have 120 days from the date of the initial denial notification to submit an appeal.

Medicare Coinsurance

NF files claim for Medicare coinsurance. NFs must file a claim with the MCO by the later of:

1. 365 days after the date of service, or
2. 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor
    - NF must submit an electronic version of the Medicare Remittances and Advice form

- Acute Care Service (See STAR+PLUS Provider Manual)

Applied Income

Applied Income is the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and the Member's spouse, that is paid under the Medicaid program to an institution or long-term care facility in which the member resides. HHSC will determine the amount of the applied income.

The Nursing Facility is responsible for the collection of monthly Applied Income. Applied Income is to be prorated as based on the number of days in the month. The Provider must make reasonable efforts to collect Applied Income, document those efforts and notify the Service Coordinator when it has made two unsuccessful attempts to collect applied income in a month.

This provision in no way subrogates the Provider's existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40. TAC 19.2316.

Appeal Of Denial Decision

Providers may request a reconsideration of a claim denial by resubmitting the claim with the appropriate documentation and /or necessary corrections or by calling El Paso Health. If you have attempted to resolve your claim issues with El Paso Health but are still dissatisfied with the outcome, you may file a formal complaint with El Paso Health Complaints and Appeals Department.

The complaint must be a formal written letter addressed to the attention of the Complaints and Appeals Department. The Provider must provide the certified mail receipt and a log that includes the Medicaid ID number, billed amount, and a signed claim copy:

El Paso Health Attn:

Complaints and Appeals Department P.O. BOX 971100,

El Paso, Texas 79997-1370

Note: All appeals of denied claims and requests for adjustments on paid / denied claims must be received by El Paso Health within 120 Days from the date of the Remittance Advice on which the claim appears.

Coordination Of Benefits (COB)

El Paso Health does not process as a primary carrier if the services qualify for COB benefits unless the services have not been allowed or were denied by the primary carrier. The remittance advice on the primary carrier should reflect the denial.

Claims submitted to El Paso Health should include a copy of the Explanation of Benefits (EOB), an Explanation of Payment (EOP) or a rejection letter from the other insurance carrier.

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

Medicare/Medicaid Eligible Status: The payable period for Medicare /Medicaid eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice. El Paso Health is only required to pay for coinsurance and/or deductibles for QMBs.

Providers must submit Medicare-paid claims to El Paso Health for payment for the coinsurance and/or 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 Health. An assigned claim that was denied by Medicare because the client does not have Part B benefits or because the transport destination is not allowed can be submitted to El Paso Health for consideration.

For Out-of-Network providers without a written reimbursement arrangement, El Paso Health will pay the unpaid balance for Covered Services in accordance with TDI's rules regarding usual and customary payment. The COB process will mirror the Medicaid COB claims process.

El Paso Health will be responsible for the remainder of the claim if a third party does not cover the full 100% of the Medicaid allowable amount billed.

STAR+PLUS Emergency Service Claims

El Paso Health will pay both In-Network and Out-of-Network (OON) providers for emergency, stabilization and post-stabilization services. This includes professional, facility, and ancillary services provided in a Hospital emergency department. Emergency services are available to enrolled members at all times without regard to prior authorization or a provider's contractual relationship.

Billing Members

Co-payment

Provider understands and agrees that Provider is responsible for collecting at the time of the service any applicable co-payments, given the limitations on those co-payments. Copayments are the only amounts that a Provider may collect from Members.

Non-Covered Services

Providers must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed acknowledgement statement from the Member.

Balance Billing

Providers agree to accept payment made by El Paso Health as payment in full. The Member cannot be held liable for any balance related to covered services.

Member Acknowledgement Statement

A Provider may only bill a Member when the Member has signed the Member Acknowledgement Statement and the following conditions are met:

- A claim is denied as not being medically necessary
- A claim is denied as part of a non-covered service,
- The service is provided at the request of the client

Private Pay

If the Provider accepts the Member as a private pay patient and informs the Member at the time of service that the Member will be responsible for paying for all services, the Provider may bill the Member. In this situation, it is recommended that the Provider use a Private Pay Form. Without written, signed documentation that the Member has been properly notified of their private pay status, the Provider cannot ask for payment from a Member. The Private Pay Form can be found as ATTACHMENT of this manual.

Resources For Claims Status

Member Services Department Member Services Department can assist providers with claims inquiries. Member Services Department can be reached at 1-877-742-3124. When calling, you will reach a Call Center Representative (CCR) who can assist you with:

- Claim status
- Answers to claim questions
- Answers to electronic claims submission rejections or questions
- Resolving claims
- Special billing for newborn claims, value added services (for compounded medications please contact NAVITUS)

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

El Paso Health

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**

Provider Relations Specialist Role

Provider Relations Specialist Role is a designated MCO representative who is proficient in Nursing Facility billing matters and able to resolve billing and payment inquiries. Regulatory Requirements means all state and federal laws, rules, regulations, waivers, policies and guidelines, and court ordered consent decrees, settlement agreements, or other court orders that apply to: this Agreement, MCO's managed care contract with HHSC, the STAR+PLUS Program, nursing facility services, and all persons or entities receiving state and federal funds. SAO means the Texas State Auditor's Office. 1-833-742-3127or email us at: NF_EPH@elpasohealth.com

Web Portal Access (Provider Portal)

El Paso Health offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Online Batch Claims Processing
- Request Prior Authorizations

You can register online at www.elpasohealth.com. By taking advantage of El Paso Health services, you can easily reduce your administrative costs and improve the accuracy of claim submissions.

HEALTHX

The Health X Fax System is an automated fax system created to provide status inquiries pertaining to Member eligibility, claims and pre-authorizations status. Providers can dial 915-225-5463 or 866-283-2792 and follow the automated instructions. Confirmation can be provided by fax or voice play back. A flow chart has been included as ATTACHMENT 24 of this manual.

Value-Added Services (VAS) – STAR+PLUS Nursing Facility

STAR+PLUS members who reside in a Nursing Facility may qualify to receive gift cards or health related items for completing health screenings and testing.

Please visit our website at elpasohealth.com for the most current Value-Added services list or contact our Member Services line at 1-833-742-3127 for additional information.

- ✓ Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical Director on call.
- ✓ Dental Services
  - Dual eligible members receive up to $2,000 each year for dental check-ups, x-rays, cleanings, filling and simple tooth extractions for members 21 and older for STAR+PLUS non-HCBS waiver members.
  - Medicaid only members receive up to $600 each year for dental check-ups, x-rays, and cleanings (no extractions) for members 21 and older.
- ✓ Allowance every year, includes one pair of eyeglasses (lenses and frames) or contact lenses. One routine eye exam per year.
  - Medicaid only members get $150 allowance every two years to be used on one pair of eyeglasses (lenses and frames) or contact lenses and get one routine eye exam every two years.
  - Dual eligible members receive a $300 yearly allowance and get one routine eye exam per year.
- ✓ Extra Foot Doctor (Podiatry Services)
  - Medicaid only members receive 4 additional visits each year.
  - Dual eligible members receive 12 additional visits each year
- ✓ El Paso Health Members ages 18 years and older eligible for the Federal Lifeline Program and Affordable Connectivity Program are offered at no cost to the member the exclusive El Paso Health Unlimited Plan that includes: An Android Smartphone, Unlimited Calling, Unlimited Text, Unlimited Data.
- ✓ Dual coverage members can receive a hearing aid allowance limited to $2,000 every year.
- ✓ Diabetic STAR+PLUS Non-HCBS waiver members can participate in the Healthy Eats Program and receive a $50 gift card each quarter to obtain nutritious food. (Medicaid only)
- ✓ El Paso Health Get Fit Program
  - Dual Members in a Nursing Facility are eligible to receive a home fitness kit.
- ✓ Receive a free personal blanket,skid proof socks, and accessory tote bag, and a large print digital clock. Medicaid only and Dual eligible members qualify.

✓ Gift Programs

Members are eligible to receive a $25 gift card as a Thank You for completing the following Preventative Screenings.

- $25 gift card for members after completing an annual wellness exam each year.
- $25 gift card for members that get an annual flu shot and COVID-19 vaccine.
- $25 gift card for members who have a follow-up doctor visit within 30 days of getting out of the hospital once a year.
- $25 gift card for members after completing an HbA1c blood test each year.
- $25 gift card for members after completing a diabetic eye exam each year.
- $25 gift card for female members ages 21-64 who get a recommended cervical cancer screening once every three years.
- $25 gift card for members that complete a doctor follow-up visit within 30 days of hospital discharge for a mental illness condition. Limit one gift card every 30 days.

Restrictions and limitations apply

Coordination with Providers of Non-Capitated Services

El Paso Health is required, through its contractual relationship with HHSC, to coordinate with public health entities regarding the provision of services for essential public health services or for services not directly provided by El Paso Health. Providers must assist in these efforts. These non-capitated services are not included in the NF Unit Rate nor are they part of the Nursing Facility Add-On services. The Texas Medicaid Provider Procedures Manual (TMPPM) includes the following services. The Service Coordinator will work with NF staff to refer members to obtain services as described in the TMPPM:

Behavioral Health Services in the Dallas SDA (will be delivered through fee-for-service) – STAR+PLUS only.

Tuberculosis (TB) services provided by DSHS-approved providers (directly observed therapy and contact investigation). Providers must coordinate with the local tuberculosis control program to ensure that all Members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy by a DSHS-approved provider. The Provider must report to DSHS or the local Tuberculosis control program any Member who is non-compliant, drug resistant, or who is or may be posing a public threat.

Hospice services provided by Home and Community Support Service Agencies contracted with Department of Aging and disability Services (DADS).

Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local mental health authority (LMHA).

Specialized services provided by the LA include:

- Service coordination, alternate placement, and vocational
- Mental health rehabilitative serviced and targeted case management
- Specialized serviced provided by a NF for individuals identified as IDD include physical therapy, occupational therapy, speech therapy and customized adaptive aids
- All PASRR specialized services are non-capitated, fee-for-service
- Long Term Care services and supports (LTSS) for individuals who have IDD provided by DADS-contracted providers

PCPs are responsible for the appropriate coordination and referral of El Paso Health Members for the following non-Medicaid Managed Care Covered Services (Non-Capitated Services), as identified in the Texas Medicaid Provider Procedures Manual:

- Texas Health Steps Dental (including orthodontia)
- Texas Health Steps Environmental Lead Investigation (ELI)
- Early Childhood Intervention (ECI) Case Management/Service Coordination
- Early Childhood Intervention Specialized Skills Training
- Department of State Health Services (DSHS) Targeted Case Management (w/Modifier HZ)
- DSHS Mental health rehabilitation (w/Modifier HZ)
- Mental Health Targeted Case Management
- Texas Health Steps Medical Case Management (STAR)
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Texas Commission for the Blind (TCB) Case Management
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Women, Infants and Children nutrition program (WIC)
- Case Management for Children and Pregnant Women: Members will still have access to an El Paso Health STAR+PLUS case manager for all other case management services. For additional benefit details and requirements, refer to the Texas Medicaid Provider Procedures Manual Behavioral Health and Case Management Services Handbook at https://www.tmhp.com/resources/provider-manuals/tmppm
- Health and Human Services (HHS) hospice services
- Admissions to inpatient mental health facilities as a condition of probation
- For STAR+PLUS, Texas Health Steps Personal Care Services for Members birth through age 20
- HHS contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities.
- HHS contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities.

- Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by DADS-contracted local authority (LA) and DSHS-contracted Local Mental Health Authority (LMHA). Specialized services provided by the LA include: Service Coordination, alternate placement, and vocational training. Specialized services provided by the LMHA include mental health rehabilitative services and targeted case management. Specialized services provided by a NF for individuals identified as IDD include physical therapy, occupational therapy, speech therapy, and customized adaptive aids. All PASRR specialized services are non-capitated, fee-for-service.
- Long-Term Services and Supports for individuals who have intellectual or developmental disabilities provided by DADS contracted providers.

Behavioral Health Services

Definition Of Behavioral Health

Behavioral Health Services – Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Coordination between behavioral health and physical health services

El Paso Health (EPH) is committed to promote integrated medical and behavioral health care. Currently,

PCPs are responsible for coordinating the Member's physical and behavioral health which includes making referrals to behavioral health providers when necessary, however, a referral is not required to access services.

The PCP is required to obtain consent for disclosure of information from the Member to permit the exchange of clinical information between the behavioral health Provider and the Member's PCP. If the Member refuses to release the information, they will sign the consent for disclosure of information that indicates their refusal to release the information. The Provider will document the reason(s) for declination in the medical record. El Paso Health monitors the Provider's compliance with the completion of a release of information to promote the integrated communication between the behavioral health Provider and the PCP via summary reports of the Member's behavioral health status.

Screening tools available to PCPs are the Health and Behavior Assessment (HBAI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT). PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

EPH notifies in-network PCPs on available resources to screen for and identify behavioral health disorders, EPH's referral process for Behavioral Health Services, and clinical coordination requirements for such services. EPH must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

Behavioral Health Service Providers are aware that they must refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical Health Care Services if they are licensed to do so. EPH behavioral health Providers are encouraged to send initial and quarterly, or more frequently if clinically indicated, summary reports of a Members' behavioral health status to the PCP and other subspecialty Providers with the Member's or the Member's legal guardian's consent.

Member Access To Behavioral Health Care

Members may access services through:

- A self-referral to any Network behavioral health Provider
- A referral from the PCP
- El Paso Health Case Management 1-833-742-3127

Members may receive behavioral health services from licensed professionals including:

- Child and Adult Psychiatrists (MD)
- Psychologists (PhD)
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Masters Social Worker – Advanced Clinical Practitioner (LMSW-ACP)

El Paso Health provides a Behavioral Health Crisis Hotline staffed by trained personnel 24 hours a day, seven (7) days a week at 1-877-377-2950 for members.

NOTE: A referral from a PCP is NOT required to access behavioral health services.

Primary Care Providers (Pcp) And Behavioral Health PCPs are responsible for coordinating the Member's physical and behavioral healthcare, including making referrals to behavioral health providers when necessary. The PCP is required to obtain consent for disclosure of information from the Member to permit the exchange of clinical information between the behavioral health Provider and the Member's PCP. If the Member refuses to release the information, they will sign the consent for disclosure of information that indicates their refusal to release the information. The Provider will document the reason(s) for declination in the medical record. El Paso Health monitors the Provider's compliance with the completion of a release of information to promote the integrated communication between the

behavioral health Provider and the PCP via summary reports of the Member's behavioral health status.

PCP's may provide behavioral health related services within the scope of their practice. PCP's must adhere to screening and evaluation procedures for the detection and treatment of, or referral for any known or suspected behavioral health problems or disorders. Providers should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health or the Texas Medicaid Manual. El Paso Health requires, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders

Behavioral Health Covered Services

El Paso Health covers behavioral health and chemical dependency services. Benefits and limitations vary according to coverage group and member age (STAR+PLUS).

The following services may be available:

- Inpatient and Outpatient behavioral health services
- Outpatient chemical dependency services
- Detoxification services
- Psychiatry services

Please contact our Member Services team for additional information at 1-833-742-3127.

DSM Diagnostic Codes and Behavioral Health Claims

El Paso Health addresses utilization management requirements through the use of an annual chart audit review to insure provision of services by behavioral health providers is in accordance with both state and federal regulations. The chart audits may include but are not limited to treatment plan reviews, assessment of services delivered by licensed clinical staff, a listed complete DSM diagnosis and adherence to PHI standards.

Medical records and referrals documentation are required to use the most current DSM classification to define the patient's condition.

Behavioral Health Services

Members may receive services through the local mental health authority (LMHA). The LMHA accepts patients with chronic mental health disorders (i.e. schizophrenia, bi-polar disorder, severe major depression). In the event that an El Paso Health Member will need to access services through the LMHA, the El Paso Health case management staff will assist the Member through the LMHA system of care.

Court Ordered Commitments

El Paso Health provides inpatient psychiatric services to Members birth through age 20, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under Texas Health and Safety Code Chapters 573 and 574, relating to Court-Ordered Commitments to inpatient mental health facilities. El Paso Health is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code. These placements are Non-capitated services.

El Paso Health cannot deny, reduce, or controvert the Medical Necessity of inpatient mental health services provided pursuant to a Court-ordered Commitment for Members birth through age 20. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

A Member who has been ordered to receive treatment under Texas Health and Safety Code Chapter 573 or 574 can only Appeal the commitment through the court system.

El Paso Health coordinates with the Local Mental Health Authority (LMHA) and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility.

QUALITY MANAGEMENT

Clinical Practice Guidelines

El Paso Health defines clinical practice guidelines as practice parameters, recommendations, or an agreed upon set of principles for the delivery of a certain type or aspect of health care. El Paso Health's Quality Improvement Committee (QIC) has adopted guidelines that are developed primarily to address Members' physical, behavioral health, social needs and specific identified opportunities for improvement, such as high risk or problem/prone diagnoses and conditions. Our Practice Guidelines are designed to address the needs of our Members.

You can obtain a copy of our Practice Guidelines in one of the following methods:

- Contacting the Quality Improvement Department toll free at 1-833-742-3127.
- El Paso Health website at http://www.elpasohealth.com/ under the Providers section link

Focus Studies and UM Reporting

El Paso Health recognizes the importance of conducting focus studies around health problems or services that are particularly important or prevalent to our Member population. Our focus studies are objective retrospective medical reviews designed to evaluate a specific topic. The aim of a focused study is to provide objective data necessary for problem identification; implementation of corrective action, assessment of corrective action, and problem resolution. El Paso Health's QI Department may require the assistance of our Provider network when collecting precise data for a focus study. For that reason, your collaboration and consideration is imperative to our QI endeavors that assist in delivery of quality of care and service.

Additionally, El Paso Health monitors inpatient admissions, emergency room utilization, NF add-on services, and acute care services. All utilization patterns and trends are reviewed quarterly at the Utilization Management Committee (UMC) and subsequently reviewed by the Quality Improvement Committee (QIC). Ultimately all utilization trends and patterns are reported to the BOD on a monthly and quarterly basis.

Provider Responsibilities

The Nursing Facility is responsible to coordinate all care and services with the Primary Care Provider (Nursing Facility Attending physician) to assure member needs are addressed.

The Nursing Facility must provide 24-hour, 7 day a week nursing facility covered services included in the Nursing Facility Unit Rate such as semi-private room and board, regular nursing services, medical supplies and equipment, personal need items, social services and over the counter drugs.

Additionally, the Nursing Facility will coordinate for the member access to Nursing Facility Add-On Services including but not limited to emergency dental services, physician ordered rehabilitation services; customized power wheelchairs; and augmentative communication devices. Provider understands and agrees that:

1. It will comply with all state and federal Regulatory Requirements governing nursing facilities, including as applicable:
   a. Title 42 C.F.R., Chapter IV;
   b. Texas Human Resources Code Chapter 32;
   c. Texas Human Resources Code Chapter 102;
   d. Texas Health and Safety Code Chapters 242, 250, 253, and 260; and
   e. Title 40, TAC Chapter 19.

2. It is currently, and for the term of the Agreement will remain, a Texas Medicaid participating provider under applicable state and federal Regulatory Requirements.
3. All employees, agents, and subcontractors will perform their duties in accordance with the above-referenced licensure and Regulatory Requirements, as well as all applicable national, state and local standards of professional ethics and practice.

Updates to Contact Information

The Provider must notify El Paso Health and HHSC and DADS of any changes to information including:

- Name
- Address
- Telephone number
- Billing/Payment remittance address
- Tax Identification Number (TIN)
- Change of Ownership
- National Provider Identifier (NPI)
- HHSC License Number
- Direct Care Staff Rate Enhancement Level
- General Liability Insurance status
- Professional Liability Insurance status

El Paso Health : Provider Relations Nursing Facility Representative

NF_EPH@elpasohealth.com via email or in writing to:

El Paso Health STAR+PLUS

Atten: Provider Relations NF PR Representative

1145 Westmoreland Dr.

El Paso, Tx 79925

Access to Records and Information

The Provider will provide El Paso Health representatives access to the facility for the purposes of service coordination; member services activities and general provider services activities. Hours of access will be reasonable and not interfere with the provision of patient care by the Provider.

The Provider will provide reasonable notice of and opportunity to participate in care planning discussions and activities. The Provider must provide reasonable access to the Members' medical records and allow access to the Facility and other premises where records are kept. Access includes the ability to view electronic health records as well as traditional paper records.

The Provider must comply with timelines, definitions, formats and instructions specified by HHSC. Upon the receipt of record review request from HHSC, OIG or another state or federal agency authorized to conduct compliance, regulatory or program integrity functions, the Provider must provide, at no cost to the requesting agency, the records requested within three business days.

If the HHSC, OIG or another state or federal agency representatives reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than 24 hours, the Provider must provide records requested at that time of the request or in less than 24 hours. The request for record review may include:

- Members' clinical records
- Other records pertaining to the Member;
- Any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services;
- Documents related to diagnosis, treatment, service, lab results, charting
- Billing records, invoices, documentation of delivery items, equipment or supplies;

- Business and accounting records or reports with backup support documentation;
- Financial audits
- Statistical documentation;
- Computer records and data; and
- Contracts with providers and subcontractors.

Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in the HHSC, OIG imposing sanctions against the provider as described in 1 TAC, Chapter 371, Subchapter G.

Plan Termination

EPH is committed to maintaining a network of Nursing Facility providers to meet the needs of the Members. If termination is being considered the following requirements must be met:

- Mutual Agreement to Terminate - by El Paso Health and the Nursing Facility. The agreement must be in writing with agreed upon time frames to assure continuity of services for the members.
- Termination for Cause – defined as a material breach by the other party. The notice must provide 90 days' notice and will set forth the reasons for the termination.
- The MCO must follow procedures outlined in 843.306 of the Texas Insurance Code if terminating the agreement. At least 90 days before the effective date the proposed termination of the agreement, the MCO must provide a written explanation to the Provider for the reasons for termination.

The MCO may immediately terminate the agreement in a case involving:

- Imminent harm to patient health;
- An action by a state licensing board or government agency against the Nursing Facility, or an action by a State Medical Board against the Provider's Medical Director, that effectively impairs the Provider's ability to provide services; or o Fraud or malfeasance

No later than 30 days following the receipt of the termination notice, the Provider may request a review of EPH's proposed termination by an advisory review panel, except in which there is imminent harm to patient health, an action against a license, or Fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in 843.306 of the Texas Insurance Code, including at least one representative in the provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of El Paso Health. El Paso Health must consider the advisory review panel's decision but is not binding on EPH. Within 60 days following the receipt of the provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and EPH must communicate its decision to the provider. El Paso Health must provide the affected providers, on request, a copy of the recommendation of the advisory review panel and El Paso Health's determination.

If the Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVII, XIX, XX or XXI of the Social Security Act, the Agreement will automatically and immediately terminate.

Nursing Facility Services Coordination Staff are responsible:

To invite the Service Coordinator to provide input for the development of the NF care plan, subject to the member's right to refuse, by notifying the SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on the SC participation.

To provide notice to the MCO's designated Service Coordinator via phone, facsimile, email, or other electronic means no later than one business day after the following events:

- an admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long-term care facility

- Notifying within one business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization or emergency department visit
- Nursing Facility initiates an involuntary discharge of a Member from a facility for non-payment of charges, clinical needs, clinical compliance or behavioral issues
- Providing the SC access to the facility, Nursing Facility staff and the member's medical information and records

HHSC Form 3618

The Nursing Facility Provider must complete and submit Form 3618 to HHSC's administrative services. Form 3618, Resident Transaction Notice, can only be submitted electronically by completing Form 3618 on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal. 3618 Form purpose is to notify Texas Health and Human Services Commission (HHSC) staff about transactions and status changes for Medicaid applicants and recipients, provide information necessary to initiate, close or adjust vendor payments and for statistical reporting.

Electronic submission is prescribed by the Texas Administrative Code, 40 TAC §19.2615, which states:

- A nursing facility must electronically submit to HHSC's Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice.
- The nursing facility must print out and complete all items on Form 3618, including Item 13 with the nursing facility administrator's State Board license number, and have the nursing facility administrator sign and date Form 3618 for Item 14.

Form 3618 is prepared by the NF administrator for recipients who are:

- Eligible Medicaid recipients,
- Applicants for medical assistance, or
- Medicaid recipients who are being discharged from the Medicaid program

The NF administrator prepares a separate Form 3618 for each transaction. Each admission into or discharge from the facility requires a Form 3618 except approved therapeutic passes. An admission or discharge between payor sources also requires Form 3618 or Form 3619, Medicare/Skilled Nursing Facility Patient Transaction Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicare to change payor source from Medicare to Medicaid.

Form 3618 must be completed, and all copies submitted within 72 hours of the date of the transaction.

Form 3618 is not used to report transactions involving private-pay residents, except when a resident who has been private pay is applying for Medicaid or when a recipient has been receiving Medicaid and is denied.

HHSC Form 3619

Is completed by NF Provider and submitted to HHSC's administrative services contractor to inform (HHSC) staff about transactions and status changes for Medicaid applicants and recipients.

- To provide HHSC state office with information necessary to initiate, close or adjust Medicare skilled coinsurance payments. These payments are made on behalf of eligible recipients in Medicare skilled nursing facilities.
- To provide data necessary for statistical reports.

Form 3619, Medicare/Skilled Nursing Facility Patient Transaction Notice, can only be submitted electronically by completing Form 3619 on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal.

Electronic submission is prescribed by the Texas Administrative Code, 40 TAC §19.2615, which states:

- A nursing facility must electronically submit to HHSC's Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice
- The nursing facility must print out and complete all items on Form 3619 including Item 14 with the nursing facility administrator's State Board license number and have the nursing facility administrator sign and date Form 3619 for Item 15.

Form 3619 is prepared by the nursing facility administrator for recipients who are Medicaid recipients/ applicants approved by Medicare for a Medicare skilled nursing facility (SNF) stay.

The nursing facility administrator prepares a separate Form 3619 for each transaction. Each admission into or discharge from the facility requires a Form 3619 except approved therapeutic passes. An admission or discharge between payor sources also requires Form 3618, Resident Transaction Notice, and Form 3619, Patient Transaction

Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicare to change payor source from Medicare to Medicaid.

- Form 3619 must be completed, and all copies submitted within 72 hours of the date of the transaction.
- Form 3619 is not used to report transactions involving private-pay residents.
- Access HSSC Forms and Instructions for complete submission instructions regarding Forms 3618 and 3619.

Minimum Data Set (MDS)

The Centers for Medicare and Medicaid Services (CMS) requires certified nursing facilities to complete and transmit Minimum Data Set (MDS) assessments for all nursing facility residents. Reference the Code of Federal Regulations (CFR), Title 42, Chapter IV, Part 483.20. The state of Texas requires nursing facilities to complete and transmit MDS assessments to HHSC administrative services contractor for all residents, including private pay residents. Reference the Texas Administrative Code - Nursing Facility Requirements for Licensure and Medicaid Certification, Title 40, Part 1, Chapter 19, Subchapter I, Section 19.801

According to state code, all MDS assessments and tracking forms are transmitted to the MDS central repository following the schedule, format and procedures documented in the CMS Long Term Care Resident Assessment Instrument (RAI) User's Manual. Reference the MDS 2.0 RAI Manual, effective December 2002, or the MDS 3.0 RAI Manual, effective Oct. 1, 2010. Or per any update of the RAI Manual.

Long Term Care Medical Information (LTCMI)

Providers must utilize the TMHP LTC Online Portal to complete the LTCMI in order for a Minimum Data Set (MDS) assessment to be used for State Medicaid payment, it must be submitted to the HHSC Database, and successfully extracted by the Texas Medicaid & Healthcare Partnership (TMHP) onto the Long-Term Care (LTC) Online Portal. According to the Texas Administrative Rule §19.2413(b)(2), the provider must complete the LTCMI section and submit for processing. This has been the case since September 2008 and applies to MDS Modifications as well as original submissions. An MDS assessment is not considered complete and cannot be used for State Medicaid payment until the LTCMI section is successfully submitted on the LTC Online Portal.

Access TMHP Forms and Instructions for complete submission instructions regarding LTCMI forms: http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

PASRR Administration to identify:

- individuals who have a mental illness, an intellectual disability or a developmental disability (also known as related conditions),

- the appropriateness of placement in the nursing facility, and
- the eligibility for specialized services.

The PASRR Level 1 (PL1) is completed for every individual seeking admission to a Medicaid certified nursing facility regardless of their funding source or diagnosis. The form must be completed and submitted to HHSC's administrative services contractor. Directions for completion and submission of the PL1 can be found at: http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

- If the screening is positive — meaning the individual is suspected of having a mental illness, an intellectual disability or a developmental disability — the LA will complete and submit a PASRR Evaluation form PE within seven to 14 days, depending on the type of admission and length of stay.
- If the screening is negative — meaning the individual is not suspected of having a mental illness, an intellectual disability or a developmental disability — the nursing facility enters the PL1 into the Texas Medicaid Healthcare Partnership Long-term Care (LTC) Online portal, and the PASRR process ends for that individual.

Interdisciplinary Team (IDT)

Meeting and Certification Process NFs are required to take two steps to complete the PASRR Admission Process:

1. Certify to meet the individual's needs by answering two questions/fields in Section D of the PL1:
   a. Field D0100N. NF is willing and able to serve individual.
   b. Field D0100O. NF Admitted the individual (only the admitting NF should Complete this field)
2. Invite the Local Authority/Local Mental Health Authority (LA/LMHA) to participate in the IDT/Care Planning Meeting by informing the LA/LMHA of the date and time of the meeting. This meeting must occur within the first 14 days of admission.

The LA/LMHA must participate in the IDT/Care Planning Meeting for all newly admitted PASRR positive individuals regardless of service array. The LA/LMHA does not have to be physically present at the meeting; participation by telephone is permissible. The LA/LMHA specialized services should be included in the NF's Comprehensive Care Plan. Must coordinate with LAs and LMHAs to complete a PASRR Level 2 Evaluation when an individual has been identified through the PASRR level 1 screen as potentially eligible for PASRR specialized services. All finalized specialized services must be initiated for delivery within 30 days after the specialized services are identified in the Comprehensive Care Plan.

The NF is responsible for initiating and/or providing physical therapy, occupational therapy, and speech therapy.

The LA/LMHA is responsible for initiating and/or providing service coordination, alternate placement, and vocational rehabilitation (where available).

Specialty Care Provider Responsibilities

Some specialty services require a referral from the PCP. The Specialist may order diagnostic tests without PCP involvement; however, the Specialist may not refer to another specialist except in a true emergency situation.

The Specialist provider must:

- Verify eligibility,
- Obtain referral or authorization from the PCP before providing certain services,
- Refer the member to another specialist provider,
- Provide the PCP with consultation reports and other appropriate records in a timely manner,
- Participate in Peer Review Process and be available for or provide on call coverage through another source 24 hours a day.
- Maintain regular hours of operation that are clearly defined and communicated to members, and
- Provide urgent specialty care within 24 hours of request.

Continuity of Care

El Paso Health Members who are involved in an "active course of treatment" have the option to stay with the practitioner who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between EPH and a Provider will not interfere with this option. This option includes the following Members who are:

- exhibit pre-existing conditions
- In the 24th week of pregnancy (STAR only)
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition
- Receiving care for a life-threatening illness, and
- Receiving care for a disability
- Currently hospitalized
- Transferring between facilities
- If member moves out of Service Area

For each Member identified in the categories above, EPH will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

Standard Continuity of Care requirements will remain in place for Acute Care services for 90 days and Long-Term Care Services and Supports (LTSS) for up to 6 months or until a new assessment is completed and new authorizations issued.

If a member moves out of the Service Deliver Area, El Paso Health will continue to cover medically necessary care through network and non-network providers until such time as the member can be transitioned to a MCO providing services in the new SDA.

For each Member identified in the categories above, EPH will work with the treating Provider on a transition plan over a reasonable period of time.

Each case will be individualized to meet the Member's needs. For additional information regarding continuity of care and transition of Members, please contact El Paso Health at 1-833-742-3127.

What if a member moves?

If a member moves out of the EPH Service Deliver Area, EPH will continue to cover medically necessary care through network and non-network providers until such time as the member can be transitioned to a MCO providing services in the new area.

Request to Discharge a Member

It may become necessary for a PCP to discharge a member from his/her panel. Prior to discharging a member, the primary care physician must counsel the patient regarding the patient/physician relationship. Such counseling must be documented appropriately in the medical chart, an incident report or treatment plan. If the behavior does not improve, the PCP may request in writing to the Plan, the member be dismissed from his/her panel. The Member Services department will send written notification to the member advising them to select a new PCP. The PCP is required to continue treating the member for 30 days following the notification to the member to make the transition.

Appointment Availability/Waiting Times for Appointments

The following schedule should be followed by all EPH network providers regarding appointment availability:

- Routine exams should be provided within 14 days of request.
- Preventive health services for adults within 90 days

- Urgent care should be received within 24 hours of the request.
- Emergency care should be received immediately.
- Referrals to a specialist should be seen within 30 days of a request.
- Prenatal Care in 3rd Trimester to an OB/GYN should be seen within 5 days of a request.
- New Member 90 days from a request.
- Prenatal 14 days Unless high risk

Role/Responsibility of the Primary Care Provider

Primary Care Providers (PCP) participating in the Texas Medicaid program practice the "medical home concept". The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, to specialists, network facilities and contractors, health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

- Be available for or provide on call coverage through another source 24 hours a day.
- Maintain regular hours of operation that are clearly defined and communicated to members
- Refer the member to specialist provider as needed
- Maintain clinical documentation
- The PCP may provide behavioral health-related services within their scope of practice

Referral to Specialists - The PCP must assess the medical needs of Members and make medically necessary referrals to specialty care providers who are currently enrolled as participating provider with EPH Healthcare. If PCP believes that a Member needs to be referred to an Out-of Network provider, including medical partners not contracted with EPH, documentation demonstrating the need must be submitted to EPH Healthcare for review and prior authorization before referral can occur. Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

Coordination and Referral to Other Health and Community Resources

The PCP must coordinate the care of Members with other Medicaid programs, public health agencies and community resources which provide medical, nutritional, educational, and outreach services to Members, including Women, Infants and Children Program (WIC), school health clinics, and local health and mental health departments.

Out of Hospital Do-Not-Resuscitate Order

The OOH-DNR is for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provisions of other emergency care, including comfort care. Any provider delivering care to a EPH Member must ensure Members receive information on OOH-DNR and are informed of their right to execute an OOH DNR. Providers must document such information on the permanent medical record.

Medical Records

Providers must maintain confidential and complete medical records. Records must reflect all aspects of patient care, including ancillary services. Such records will enable providers to render the highest quality health care and enable EPH to review the quality and appropriateness of services.

Medical Record Keeping Practices

The following record keeping practices must be followed:

- Each patient has a separate medical record and pages are securely attached in the medical record — Medical records are organized with dividers.
- A chronic problem list is included in the record for all adults and children.
- Records are available at each encounter or are traceable.
- A complete health history is part of the record.
- Health maintenance forms include dates of preventive services.
- Medication sheets are complete and sample medications are documented.
- A system is in place to document missed appointments and phone messages.
- Advance Directives are discussed and documented for those over 18 years of age.
- Medical record retention is sufficient (at least 6 years).

Medical Record Documentation

A confidential medical record must be maintained for each Member that includes all pertinent information regarding medical services rendered. Providers must maintain established standards for accurate medical record keeping. Six categories have been designated as critical areas. These areas are:

- Problem lists
- Allergy designation
- Past medical history
- Working diagnosis consistent with findings
- Plans of action/treatment consistent with diagnosis
- Care medically appropriate

Providers must demonstrate 85% overall compliance in medical record documentation and 85% in each of the six critical categories. EPH uses the guidelines below when evaluating medical record documentation.

- A completed problem list is in a prominent space. Any absence of chronic/significant problems must be noted.
- Allergies are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.
- A complete medical history is easily identified for patients seen three or more times. A working diagnosis is recorded with the clinical findings. Subjective, Objective, Assessment and Plan charting is recommended but not mandatory when progress notes are written.
- The plan of action and treatment is documented for the diagnosis.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name and identifying number is on each page of the record.
- The registration form or computer printout contains address, home, and work phone numbers, employer, gender and marital status. An emergency contact should also be designated.
- All staff and Provider notes are signed with initials or first initial, last name and title.
- All entries are dated.

The record is legible to someone in the office other than the Provider. - Dictation is preferred.

- There is an appropriate notation concerning the use of alcohol, tobacco, and substance abuse for patients 12 years old and older. - query history of the abuse by the time the patient has been seen three or more times.
- Pertinent history for presenting problem is included.
- Record of pertinent physical exam for the presenting problem is included.
- Lab and other studies are ordered as appropriate.

- There are notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Evidence of appropriate use of consultants. This is reviewed for under and over utilization.
- Notes from consultants are in the record.
- All reports show initials of practitioner who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate health promotion and disease prevention education. Anticipatory guidance is documented at each well child check.
- An immunization record and appropriate history of immunizations have been made for adults.
- Preventive services are appropriately used/offered in accordance with accepted practice guidelines.

Medical Record Confidentiality

EPH Members have the right to full consideration of their privacy concerning their medical care. They are also entitled to confidential treatment of all Member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the Member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or required by law.

Confidential Information

Is defined as any form of data, including but not limited to, data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of Confidential Information.

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any Confidential Information to unauthorized persons. This procedure should include:

- Written authorization obtained from the Member or his/her legal representative before medical records are made available to anyone not directly connected with his/her care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requestor and should be separated from the remainder of the Member's medical records.
- Notification to EPH of change in client condition, physical or eligibility

Confidentiality and HIPAA

Confidentiality

All Member information, records and data collected, or prepared by the Provider, or provided to the Provider by HHSC or another state agency is protected from disclosure by state and federal laws. The Provider must ensure that all information relating to Members is protected from disclosure except when the information is required to verify eligibility, provide services or assist in the investigation and prosecution of civil and criminal proceedings under state or federal law.

The Provider must inform Members of their right to have their medical records and Medicaid information kept confidential. The Provider must educate employees and Members concerning the human immunodeficiency virus (HIV) and its related conditions including acquired immunodeficiency syndrome (AIDS) and must develop and implement a policy for protecting the confidentiality of AIDS

and HIVrelated medical information and an anti-discrimination policy for employees and Members with communicable diseases. See also Health and Safety Code, Chapter 85, Subchapter E, relating to Duties of State Agencies and State Contractors.

HIPAA (Health Insurance Portability and Accountability Act) Requirements

El Paso Health's Commitment to Patient Privacy Protecting the privacy of members' personal health information is a core responsibility that EPH Healthcare takes very seriously. EPH Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

El Paso Health Healthcare expects that its contracted Providers/Practitioners will respect the privacy of EPH Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/Practitioners must comply with. In general, most Texas healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
   a. HIPAA b. Medicare and Medicaid laws
2. TX Medical Privacy Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider/Practitioner's own TPO activities, but also for the TPO of another covered entity. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

2. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.)
3. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
   a. Quality improvement
   b. Disease management
   c. Case management and care coordination
   d. Training Programs
   e. Accreditation, licensing, and credentialing Importantly, this allows Providers/Practitioners

to share PHI with EPH Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. EPH Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner's practice:

Notice of Privacy Practices

Providers/Practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

Requests for Restrictions on Uses and Disclosures of PHI

Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

Requests for Confidential Communications

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

Requests for Patient Access to PHI Patients have a right to access their own PHI within a Provider/Practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider/Practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

Request to Amend PHI

Patients have a right to request that the Provider/Practitioner amend information in their designated record set.

Request Accounting of PHI Disclosures

Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information – without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to EPH Healthcare.

HIPAA Transactions and Code Sets

El Paso Health Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. EPH Healthcare Providers/Practitioners are encouraged to submit claims and other transactions to EPH Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advice EPH Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with EPH should refer to El Paso Health website at www.elpsohealth.comXXXXXX for additional information.

Advanced Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult Members 18 years of age and older about their rights under state and federal law, in advance of their receiving care (Social Security Act §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the Member's right to refuse, withhold, or withdraw medical treatment advance directives. These policies and procedures must comply with provisions contained in 42 CFR §§434.28 and 489, Subpart I, relating to the following state laws and rules:

- A Member's right to self-determination in making healthcare decisions
  The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
  - A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition
  - A Member's right to make written and non-written Out-of- Hospital Do-NotResuscitate Orders
  - A Member's right to execute a Medical Power of Attorney to appoint an agent to make healthcare decisions on the Member's behalf if the Member becomes incompetent.
- These policies can include a clear and precise statement of limitation if a participating Provider cannot or will not implement a Member's advance 24 Last Revision: 01-13-12 directive. A statement of limitation on implementing a Member's advance directive should include at least the following information:
  - A clarification of the Provider's conscience objections
  - Identification of the state legal authority permitting a Provider's conscience objections to carrying out an advance directive
  - A description of the range of medical conditions or procedures affected by the conscience objection
- A Provider cannot require a Member to execute or issue an advance directive as a condition for receiving healthcare services. A Provider cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive. A Provider's policies and

procedures must require the Provider to comply with the requirements of state and federal law relating to advance directives.

Private Pay

If the Provider accepts the Member as a private pay patient and informs the Member at the time of service that the Member will be responsible for paying for all services, the Provider may bill the Member. In this situation, it is recommended that the Provider use a Private Pay Form.

Without written, signed documentation that the Member has been properly notified of their private pay status, the Provider cannot ask for payment from a Member.

Referrals

Referrals are an integral component of El Paso Health. Referrals ensure that Members gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting. El Paso Health operates a closed specialty network which means that Primary Care Physicians (PCP) should refer Members to El Paso Health network specialists only.

The PCP functions as the medical home for assigned Members. PCPs are responsible for arranging and coordinating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the services of other providers. PCPs are required to maintain documentation of communication with the specialist in the Member's medical record and must supply the specialist with his/her El Paso Health Provider number for inclusion on the specialist's claim

Referrals to Network Facilities and Contractors

Referrals to network facilities and contractors do not require a prior authorization except as specifically noted on the current Prior Authorization Guide. See Chapter XX Authorization and Utilization

Members Right to a Second Opinion

Members or Member's PCP can request a second opinion on behalf of the Member. If you or a Member request a second opinion, EPH will give you a decision within 48 hours. If it is an imminent and serious threat, EPH will respond within one (1) day and the second opinion will be given within seventy-two (72) hours. If a qualified Participating Provider is not available to give the Member a second opinion, EPH will make arrangements for a Non-Participating Provider to give them a second opinion. If EPH denies the second opinion because it is not medically necessary, we will send the Member a letter. Members or Providers may appeal the decision. The letter from EPH will tell you how to appeal.

Out-of- Network Referrals

El Paso Health recognizes that there may be instances when an out-of-network referral is justified. The Health Services staff will work with our Medical Director and the PCP to determine the medical necessity of the out-of-network referral. Out-of-network referrals will be authorized on a limited basis. Providers are responsible for providing a justification to El Paso Health regarding Out-of-Network referrals, including partners not contracted with El Paso Health. El Paso Health may be contacted toll free at 1-833-742-3127 for questions regarding non-network providers.

Reporting Abuse, Neglect, Or Exploitation (ANE)

Report Suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult day care centers; or
- Licensed adult foster care providers
- Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
    - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to HHS;
    - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
    - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
    - A managed care organization;
    - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option.
  Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

The Provider must provide El Paso Health with a copy of the abuse, neglect, and exploitation report findings within one (1) Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Routine, Urgent, and Emergent Service

Based on the following definitions, Members of El Paso Health may seek care from any Provider in an office, clinic, or emergency room. Treatment of emergency conditions does not require pre- certification or a referral from the Member's PCP. Emergency Room (ER) staff is requested to call the PCP or El Paso Health if a Member presents with a non-emergent condition at **1-833-742-3127**.

Routine Care means health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.

An **urgent condition** means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

An **emergency medical condition** means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could:

1. Place the patient's health in serious jeopardy;
2. Result in serious impairment to bodily functions;
3. Result in serious dysfunction of a bodily organ or part;
4. Result in serious disfigurement; or
5. For a pregnant woman result in serious jeopardy to the health of the fetus.

An **emergency behavioral health condition** means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

1. Requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others or
2. Renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Appointment Accessibility

Providers must assure that Members have access to routine, urgent, and emergent services within the following time frames:

(in this section, days refers to calendar days)

Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;

Urgent care, including urgent specialty care and behavioral health services, must be provided within 24 hours of request; treatment for behavioral health services may be provided by a licensed behavioral health clinician.

Primary Routine Care must be provided within 14 Days of request;

Specialty Routine Care must be provided within 21 Days;

Initial outpatient behavioral health visits must be provided within 14 Days of request.

A Member may select any Provider or hospital for true emergency care.

El Paso Health will pay for professional, facility, and ancillary services provided in a hospital emergency department that are medically necessary to perform the medical screening examination and stabilization

of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition, whether rendered by Network Providers or Out-of- Network providers.

Emergency care obtained out-of-network and out of El Paso Health's service area will be reviewed as soon as notification is received.

El Paso Health will not require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. El Paso Health will not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. El Paso Health will not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP or El Paso Health of the Member's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services.

El Paso Health will pay for post-stabilization care services obtained within or outside the Network that are not pre-approved by a Provider or other El Paso Health representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

- El Paso Health does not respond to a request for pre-approval within one (1) hour;
- El Paso Health cannot be contacted; or
- El Paso Health representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, El Paso Health will give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the patient until a Network physician is reached. El Paso Health's financial responsibility ends as follows:
- the Network physician with privileges at the treating Hospital assumes responsibility for the Member's care;
- the Network physician assumes responsibility for the Member's care through transfer;
- El Paso Health's representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharge

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the Member's medical condition. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU).
- "8Ø1" in "Prior Authorization Number Submitted" (Field 462-EV).
- "3" in "Days' Supply" (Field 4Ø5-D5, in the Claim segment of the billing transaction)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being

dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispense.

Call Navitus, El Paso Health's Pharmacy Benefit Manager, toll-free at 1-877-908-6023 for more information about the 72-hour emergency prescription supply policy.

Emergency Transportation

Emergency transport is a service provided by an ambulance Provider for a Member whose condition meets the definition of an emergency medical condition. Conditions requiring cardio pulmonary resuscitation (CPR) in transit or the use of routine restraints for the safety of the Member or crew are also considered emergencies.

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria. Emergency transports do not require prior authorization.

Examples of conditions considered for emergency transports include, but are not limited to:

- Acute and severe illnesses
- Untreated fractures
- Loss of consciousness
- Semi-consciousness
- Seizures
- Necessity for CPR
- Injuries from auto accidents
- Extensive burns

Non-Emergency Transportation

The Nursing Facility (NF) is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the NF Unit Rate. Transports of NF Members for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians' offices for recertification examinations for NF care are not reimbursable services by El Paso Health.

El Paso Health is responsible for authorizing non-emergency ambulance transportation for a Member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

Emergency Dental Services

Medicaid Emergency Dental Services:

El Paso Health is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- open or closed reduction of fracture of the maxilla or mandible;
- repair of laceration in or around oral cavity;
- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- incision and drainage of cellulitis;
- root canal therapy. Payment is subject to dental necessity review and pre- and post- operative

x-rays are required; and
- extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Non-Emergency Dental Services

Medicaid Non-emergency Dental Services:

El Paso Health is not responsible for paying for routine dental services provided to Medicaid Members.

El Paso Health is responsible, however, for paying for treatment and devices for craniofacial anomalies.

Durable Medical Equipment And Other Products Normally Found In A Pharmacy

El Paso Health reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the NF unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as canulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

Provider Complaint / Appeal Process

STAR+PLUS Provider Complaints and Appeals Process

Provider Complaints

El Paso Health wants all Providers to be satisfied. If at any time you are not satisfied , you may call 1-833-742-3127 if outside the service area for inquiries.

Providers have the right to file a complaint with El Paso Health.

Complaints may be submitted in writing to:

El Paso Health

Attn: Complaints and Appeals Department 1145 Westmoreland Dr.

El Paso, TX 79925

Complaints may be submitted by fax at: (915) 298-7872 Complaints may be submitted electronically through our WebPortal at: http://www.elpasohealth.com

When a complaint is received, no later than the fifth (5th) Business Day, El Paso Health will send the complainant an acknowledgement letter including the complaint procedures and time frames.

El Paso Health records, tracks, maintains, and date stamps all written, faxed, and electronic complaints received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system. Complaints will be resolved no later than thirty (30) Calendar Days after the date El Paso Health receives the complaint. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

Provider Complaints to HHSC

If you are not satisfied with the El Paso Health Complaint outcome, a complaint can be submitted to the Health and Human Services Commission (HHSC).

The complaint can be submitted in writing or via email to the Health and Human Services Commission.

The letter should be sent to the following address:

Texas Health and Human Services Commission
MCCO Research and Resolution
P.O. Box 149030, MC:0210
Austin, TX 78714-9030
Attn: Resolution Services
or HPM_Complaints@hhsc.state.tx.us

Provider Appeals

El Paso Health recognizes two levels of appeals: 1st level and the 2nd level appeal. An appeal is a request for reconsideration of a previously dispositioned claim.

Appeals of denied claims and requests for adjustments on paid claims must be in writing and must be received by El Paso Health within one hundred twenty (120) Days from the date of the Remittance Advice (RA) on which that claim appears. If the one hundred twenty (120) Day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Appeals for Level of Care Determinations

TMHP is responsible to determine whether the Member meets medical necessity criteria for nursing facility admissions.

If TMHP denies a Medical Necessity Level of Care, the Member and the Nursing Facility will be notified by mail from TMHP. The letter will include information regarding rights to a Fair Hearing.

EPH's Service Coordinator will work with the Nursing Facility staff to prepare documentation for the Member's appeal. The Service Coordinator will make every effort to attend the Fair Hearing.

If the member would like to make a request they can send it to the following address:

Texas Medicaid & Healthcare Partnership (TMHP)
Attention: Medical Affairs Support, MC A13
PO Box 204270
Austin, TX 78720-4270

STAR+PLUS Provider 1st Level Claims Appeal Process

If the Provider is not satisfied with the disposition of the claim, the Provider has the right file an appeal. El Paso Health will recognize this appeal as a 1st level appeal. A Provider may appeal the claim by completing the following steps:

- Submit an appeal letter for each member specifying the reason for appealing the claim
- Letter MUST include:
    - Date
    - Contact Names (First and Last Name)
    - Mailing Address
    - Phone Number
    - Provider Name and NPI #
    - Member Name, Date of Birth, and ID number
    - Date of Service
    - Claim #
    - Reason for Appeal (be detailed)
- Support information:

- Copy of Remittance Advice
- Medical Records (if necessary)
- Proof of Timely Filing
- Any pertinent information for review

The appeal must be submitted in writing to:

El Paso Health

Attn: Complaint and Appeal Department 1145 Westmoreland Dr.

El Paso, TX 79925

Appeals may be submitted via fax at: Fax (915) 298-7872.

Appeals may be submitted electronically through our WebPortal at: www.elpasohealth.com

Upon receipt of the appeal, the appeal will be date stamped, logged and tracked by the Complaints and Appeals Department. The Appeal will be acknowledged within five (5) Business Days from receipt. El Paso Health will send the Provider a letter acknowledging the date of receipt and a description of El Paso Health appeal procedures and time frames. The Appeal will be resolved within thirty (30) Calendar Days of receipt. El Paso Health records, tracks, maintains, and date stamps all telephonic, written, faxed and electronic appeals received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

If the Provider is not satisfied with the resolution of the appeal, and the Provider has additional information and/or documentation regarding the case that has not been previously considered, the Provider has the right to file a request for a 2nd level appeal. The request for a 2nd level appeal must be filed within one hundred twenty (120) Days of the resolution of the 1st level appeal or from the last Provider Remittance Advice Notification received in regards to the claim in question.

Provider 2nd Claim Appeal Process

Upon receipt of the 2nd level appeal, the appeal will be date stamped, logged and tracked by the Complaints and Appeals Department. The Appeal will be acknowledged within five (5) Business Days from receipt. El Paso Health will send the Provider a letter acknowledging the date of receipt and a description of El Paso Health appeal procedures and time frames. The 2nd level appeal will be resolved within thirty (30) Calendar Days of receipt. El Paso Health records, tracks, maintains, and date stamps all telephonic, written, faxed and electronic appeals received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

Following the conclusion of the 2nd Level Claims Appeal Process, the Provider has exhausted the El Paso Health appeal process. If the Provider is not satisfied with the resolution of the 2nd level appeal and believes that they have not been given full due process the Provider may file a complaint to Health and Human Services Commission (HHSC) after they have exhausted El Paso Health's process.

Member Complaint Process

Member Complaint Process

What should I do if I have a complaint?

Members may file complaints to El Paso Health verbally or in writing. It is El Paso Health's goal to resolve all complaints in a timely manner. When a complaint is received, a written acknowledgment is sent within five (5) Business Day

How long will it take to investigate and resolve my complaint?

El Paso Health has thirty (30) Calendar Days to resolve any complaint received.

Can someone from El Paso Health help me file a complaint?

Yes. El Paso Health's Member Services Representative or one of our Member Advocates can assist Members with the process of filing a complaint.

Who do I call?

A Member can call the Member Services Department at TTY 711 toll free 1-833-742-3127, if outside the service area. Members can also complete a complaint form provided by a Member Services Representative or mail a complaint letter to:

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, TX 79925
Complaints may be submitted by fax at: (915) 298-7872

For STAR+PLUS Members – If I am not satisfied with the outcome, who else can I call?

Once you have gone through El Paso Health's complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services
Commission Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can send your complaint at: hhs.texas.gov/managed-care-help

Members who live in Nursing Facilities and Assisted Living Facilities can file a complaint through the Office of Long Term Care Ombudsman. They can be contacted at 1-800-252-2412. If a member can get on the Internet, they can send their complaint in an email to: ltc.ombudsman@hhsc.state.tx.us

Member Appeal Process

What can I do if the MCO denies or limits my Member's request for a Covered Service?

If the member does not agree with El Paso Health's decision to deny or limit their services, an appeal can be requested.

If El Paso Health denies the appeal, the member has the option to request an External Medical Review and State Fair Hearing no later than 120 Days after El Paso Health mails the appeal decision notice.

Member's also have the option to request only a State Fair Hearing, no later than 120 days after El Paso Health mails the appeal decision notice.

How will I find out if services are denied?

If your services are denied, El Paso Health will send the Member a letter with the outcome of the initial request determination.

The notice will also include the procedure for the complaint and appeal process, including a notice to the Member of:

- The dates, type and units requested
- The type of action El Paso Health has taken or intends to take
  1. Deny or limit authorization requested, including the type or level of service
  2. Reduction, suspension, or termination of a previously authorized service
  3. Denial in whole or in part of payment for services
  4. The failure to provide services in a timely manner
  5. The failure of El Paso Health to act within the timeframes stipulate under section titled Timeframe for Notice of Adverse Determination shown above
  6. For a resident of a rural area with only one MCO, the denial for out of network services
- The date El Paso Health intends to take the action
- An explanation of the reasons for El Paso Health's decision, the screening criteria utilized to make the decision, and the medical basis for making the determination and how medical criteria was not met for determining the medical necessity.
- the circumstances under which the Member may continue to receive benefits pending resolution of the appeal;
- how to request that benefits be continued;
- the circumstances under which the Member may be required to pay the costs of these services;
- the right to appeal for denial of payment for services in whole or in part;
- the specialty of the physician making the determination;
- the deadline for making a determination of the appeal; and
- the Member's right to a State Fair Hearing and the procedures for obtaining a State Fair Hearing.
- Timeframes for the Appeals Process

El Paso Health must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If El Paso Health needs to extend, Member must receive written notice of the reason for delay.

Member has the option to request an External Medical Review and State Fair Hearing no later than 120 Days after El Paso health mails the appeal decision notice. Member has the option to request only a State Fair Hearing, no later than 120 days after El Paso Health mails the appeal decision notice

When does Member have the right to request an appeal?

A member has a right to request an appeal for denial of payment for services in whole or in part. Appeals need to be filed within sixty (60) Days of the notice of the adverse determination.

A member or their authorized representative may appeal an Adverse Determination. A physician who has not previously reviewed the case will review the appeal. This includes an Expedited Appeal for emergency care or life-threatening situations.

Appeals can be made orally or in writing to:

El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Fax No: 915-298-7872
Phone: 1-833-742-3127
Online: www.elpasohealth.com

In order to ensure continuity of current authorized services, the Member must file the Appeal on or before the later of: 10 Days following El Paso Health's mailing of the notice of the Action, or the intended effective date of the proposed Action.

Note: The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member.

Can someone from El Paso Health help me file an Appeal? A Member Services Representative or a Member Advocate can help in filing an appeal. A member can call El Paso Health at 1-833-742-3127.

Timeframes for the Appeals Process

El Paso Health must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If El Paso Health needs to extend, Member must receive written notice of the reason for delay.

Member has the option to request an External Medical Review and State Fair Hearing no later than 120 Days after El Paso health mails the appeal decision notice. Member has the option to request only a State Fair Hearing, no later than 120 days after El Paso Health mails the appeal decision notice.

Member Expedited MCO Appeal

An Expedited (Emergency) Appeal is when the health plan has to decide quickly based on the condition of the member's health, and taking the time for a standard appeal could jeopardize their life or health.

How to request an Emergency Appeal

Emergency Appeals can be made orally or in writing to:

Expedited Appeals can be made orally or in writing to:
El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Fax No: 915-298-7872
Phone: 1-833-742-3127
Online: www.elpasohealth.com

Who can help me file an Emergency Appeal?

A Member Services Representative or a Member Advocate can help in filing an emergency appeal. A member can call El Paso Health at 1-833-742-3127.

Timeframes for an Expedited Appeal

El Paso Health must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If El Paso Health needs to extend, Member must receive written notice of the reason for delay.

Member has the option to request an External Medical Review and State Fair Hearing no later than 120 Days after El Paso health mails the appeal decision notice. Member has the option to request only a State Fair Hearing, no later than 120 days after El Paso Health mails the appeal decision notice.

- **Standard Appeal**: An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal**: An Expedited (Emergency) Appeal is when the health plan has to decide quickly based on the condition of the member's health, and taking the time for a standard appeal could jeopardize their life or health.

State Fair Hearing Information

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied. HHSC will

Timeframes for an Emergency Appeal:

El Paso Health will notify the member by telephone or fax of the emergency appeal decision within 72 hours if the emergency appeal request meets the criteria of the seriousness of the condition. They will also receive a letter within three (3) working days following the phone or fax notification of the appeal decision.

What happens if the El Paso Health denies the request for an Emergency Appeal?

If El Paso Health determines that the emergency appeal request does not meet the emergency criteria, El Paso Health will notify the member immediately and will process the appeal as Standard and provide the member a response within thirty (30) Calendar days.

If a Member, as a member of El Paso Health, disagrees with the El Paso Health's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling El Paso Health the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to El Paso Health, Attention: Complaints and Appeals Department, 1145 Westmoreland Drive, El Paso Texas 79925 or call 1-833-742-3127.

External Medical Review Information

Can a member ask for an External Medical Review?

If a Member, as a member of El Paso Health, disagrees with the internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to El Paso Health telling El Paso Health the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the

Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of El Paso Health Internal Appeal Decision letter and mail or fax it to El Paso Health by using the address or fax number at the top of the form;
- Call El Paso Health at: 1-833-742-3127
- Email El Paso Health at Complaints&AppealsTeam@elpasohealth.com

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

The Member can make both of these requests by contacting the Member's MCO at El Paso Health, Attention:

Complaints and Appeals Department,

1145 Westmoreland Drive, El Paso Texas 79925

or call 1-833-742-3127

or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

- Email the MCO at ComplaintsandAppealsDepartment@elpasohealth.com

Member Information

Can a member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling El Paso Health. To qualify for an emergency External Medical Review and emergency State Fair Hearing, the Member must first complete El Paso Health's internal appeals process.

Span Of Coverage (Hospital)

Responsibility during a Continuous Inpatient Stay [1]

Payment responsibility for Medicaid enrollment changes that occur during Continuous Inpatient Stay in a Hospital, as of the Member's Effective Date of Coverage with the receiving (New) MCO.

Scenario	Hospital Facility Charge
Client moves from FFS to STAR+PLUS Plan	FFS
Client moves from FFS to STAR+PLUS Plan but is transferred with no other break in service	FFS (original coverage at initial admit prior to transfer)
Client moves from STAR+PLUS Plan to FFS	STAR+PLUS
Client moves from STAR+PLUS Plan to FFS but is transferred with no other break in service	STAR+PLUS Plan (original coverage at initial admit prior to transfer)
Client moves from STAR+PLUS Plan to a new STAR+PLUS Plan	Former STAR+PLUS Plan
Client moves from STAR+PLUS Plan to a new STAR+PLUS Plan but is transferred with no other break in service	Former STAR+PLUS Plan (original coverage at initial admit prior to transfer)
Client moves from STAR+PLUS to a STAR HEALTH Plan	STAR+PLUS Plan
Client moves from STAR+PLUS to a STAR HEALTH Plan but is transferred with no other break in service	STAR+PLUS Plan (original coverage at initial admit prior to transfer)
Client moves from STAR HEALTH to a STAR+PLUS Plan	STAR HEALTH
Client moves from STAR HEALTH to a STAR+PLUS Plan but is transferred with no other break in service	STAR HEALTH (original coverage at initial admit prior to transfer)
Client moves from FFS to STAR HEALTH	FFS
Client moves from FFS to STAR HEALTH but is transferred with no other break in service	FFS (original coverage at initial admit prior to transfer)
Client moves from STAR HEALTH to FFS	STAR HEALTH
Client moves from STAR HEALTH to FFS but is transferred with no other break in service	STAR HEALTH (original coverage at initial admit prior to transfer)
Client is retroactively enrolled in STAR or STAR+PLUS	New MCO

[1] This document is not intended to supercede any HHSC Contract. This is a reference tool determining the span of coverage limitation. For up to date references, please see the following: Uniform Managed Care Contract for Medicaid and CHIP, STAR+PLUS Expansion Contract, STAR Health Managed Care Contract, and STAR+PLUS Medicaid Rural Services Area (MRSA) Contract.

http://www.hhsc.state.tx.us/medicaid/managed-care/forms.shtml

STAR+PLUS Member Identification

Your Texas Benefits Medicaid Card.

Medicaid recipients received a plastic credit card-type ID. This new plastic card will take the place of the paper Medicaid ID letter (Form3087). Information on the new Medicaid ID card is included as ATTACHMENT 14 of this manual. If Members lose the Your Texas Benefits Medicaid Card, they will be issued a temporary ID form 1027-A that they can present as proof of eligibility at Provider offices.

Verifying Member Medicaid Eligbility

Providers should verify Member eligibility prior to delivering services at each visit.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the Member has current Medicaid coverage. A provider should verify the Member's eligibility for the date of service before rendering services. There are multiple ways to do this:

- Call El Paso Health at 1-833-742-3127 or check the El Paso Health Provider Portal at: www.elpasohealth.com.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Log into your TMHP user account and accessing Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
- Your Texas Benefits Medicaid Card
    - — Temporary ID (Form 1027-A)
    - — El Paso Health ID Card

STAR+PLUS Dual Eligible - If the Member has Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's El Paso Health ID card. The Member receives long-term services and supports through El Paso Health.

Additional STAR+PLUS Benefits

- Unlimited Prescriptions for Adults – the three prescriptions per month limit has been eliminated. Under the STAR+PLUS program, El Paso Health Members are entitled to all medically necessary prescriptions. This benefit is only available for Members who are NOT covered by Medicare. El Paso Health is responsible for administering the prescription program. A Medicaid formulary listing is included on the Vendor Drug Programs Website, at: http://www.hhsc.state, http://www.hhsc.state. tx.us/HCF/vdp/vdpstart.html
- Unlimited Medically Necessary Inpatient Days – The 30-Day spell of illness limitation has been removed for STAR+Plus program and El Paso Health Members over age of 21 who require inpatient hospital care
- Spell-of-illness limitation does not apply for STAR Members.
- $200,000 annual limit on inpatient services does not apply for STAR and STAR+PLUS Members.

Member Rights and Responsibilities

STAR+PLUS Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health

care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

STAR+PLUS Member Responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plans and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

Fraud Reporting

Fraud Information

As government-funded programs, the Medicaid programs includes an important element of fraud and abuse prevention, which includes the cooperation and participation of El Paso Health's Provider network in fraud and abuse prevention and reporting.

El Paso Health has a fraud and abuse plan that complies with State and federal law, including Tex. Rev. Civ. Stat. Ann. Art. 4413(502) §16A, Tex. Government Code, §532.112, and 31 U.S.C. §3729-3733. El Paso Health contracts its Fraud Special Investigation Unit with Cotiviti.

El Paso Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse. It is your responsibility as a participating Provider to report any Member or Provider suspected of fraud and abuse.

Fraud Information

Reporting Waste, Abuse or Fraud by a Provider or Client

Medicaid Managed Care

Do you want to report Waste, Abuse or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.texas.gov/ and click "Report Fraud" to complete the online form; or
- You can report directly to your health plan:

El Paso Health Special Investigations

Unit 1145 Westmoreland Dr. El Paso, TX 79925

1-866-356-8395

www.elpasohealth.com

To report waste, abuse or fraud, gather as much information as possible.

When reporting a Provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of Provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and facility if you have it
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events o Summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse or fraud

All El Paso Health providers who receive five (5) million dollars or more from Medicaid in any given year must be aware of the Deficit Reduction Act of 2005. El Paso Health's Deficit Reduction Act of 2005 policy is readily available to all providers upon request.

A copy of the sample letter you would receive in the event you incur billing errors and we need to recoup money from you can be found on ATTACHMENT

Special Investigations Unit

El Paso Health's Special Investigations Unit (SIU) carries out the functions described in the Plan to Prevent and Reduce Waste, Abuse, Fraud. These functions include regular audits, verifications that Members receive services as they were billed, and OB audits (elective deliveries prior to 39 weeks). SIU staff is also available to provide education to Providers and their staff.

If you receive a records request, it is important to meet the submission dates and include all relevant documentation. You may not dispute or appeal a claims recoupment if you did not submit complete documentation for review.

For assistance, please call the SIU Program Director at 1-833-742-3127 or Catherine Gibson, CHC,El Paso Health Chief Compliance Officer at 1-833-742-3127.

Managed Care Member Enrollment and Disenrollment from MCO

Enrollment

The Texas Health and Human Services Commission (HHSC) is responsible for determining Medicaid eligibility. Contact El Paso Health Member Services if you need information about or location of HHSC eligibility offices. The State's Enrollment Broker, MAXIMUS, is responsible for enrolling individuals into the Medicaid programs.

MAXIMUS can be contacted through the Texas STAR+PLUS Program Hotline at 1-800-964-2777. El Paso Health is not financially responsible for services until the actual date of enrollment.

Automatic Re-enrollment

Members who are disenrolled because of temporary ineligibility will be automatically re- enrolled in the same health plan when they regain eligibility. Temporary loss of eligibility is defined as a period of six months or less. Members may also choose to enroll with another STAR+Plus managed care plan in their service area at that time if they so desire. Providers should use special caution to verify eligibility to determine if a plan change has occurred.

Retaliation Prohibited

Providers cannot take retaliatory action against a Member.

El Paso Health will not take any retaliatory action, including refusal to renew coverage, against a Medicaid Member because the Member or person acting on behalf of the Member has filed a complaint against El Paso Health or appealed a decision made by El Paso Health.

El Paso Health shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a physician or Perinatal Provider because the physician or Perinatal Provider has, on behalf of a Member, reasonably filed a complaint against El Paso Health or has appealed a decision made by El Paso Health.

- Member's disenrollment request from managed care will require medical documentation from Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment
- HHSC will make the final decision

Disenrollment from El Paso Health

Member's disenrollment request from managed care will require medical documentation from Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

El Paso Health can request that a Member be terminated from the Plan only under certain conditions.

HHSC will make the final decision on these requests.

El Paso Health has a limited right to request a Member be disenrolled from the plan without the Member's consent. HHSC must approve requests for disenrollment of a Member for cause.

HHSC may permit disenrollment of a Member under the following circumstances (This list is not all inclusive):

- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HMO to treat the underlying medical condition).
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's Membership seriously impairs HMO's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.

Providers cannot take retaliatory action against a Member.

Medicaid Managed Care Special Access Requirements

ADDITIONAL TRANSPORTATION BENEFITS

El Paso Health also offers additional transportation services for medical appointments, when NEMT is not an option or is unavailable. STAR+PLUS members or their advocates may call the Member Services Department at 1-833-742-3127 to request transportation services offered through El Paso Health Value Added Services. For STAR+PLUS Members and or their advocates they may call the Member Services Department at 1-833-742-3127. Transportation requests should be requested at least 48-hours before the scheduled appointment. The following Member information must be provided to the intake operator at the time of the call:

- Medicaid ID number
- Name, address, and telephone number
- Name, address, and telephone number of the healthcare Provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special needs, wheelchair lift, or attendant need
- Interpreter/translation services- Update /Review EPHPM pg 235, 240, & 241
- MCO/Provider coordination
- Cultural sensitivity
    - Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

CULTURAL SENSITIVITY

El Paso Health places great emphasis on the wellness of our Members. A large part of quality healthcare delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a Provider's relationship with patients and in the long run the health and wellness of the patients themselves. We coordinate interpreter and translation services to meet the Member's needs. El Paso Health's Cultural Competency and Linguistic Services Plan is available to its Network Providers upon request.

Member Education

Members receive various pieces of information from El Paso Health through mailings, internet resources and face-to-face contact. These materials include:

- El Paso Health Member Handbook

- Quarterly Newsletters
- Targeted Disease Management Brochures
- El Paso Health Provider Directories
- El Paso Health website
- Special mailings

All educational materials, including videos and written text, are available in both English and Spanish and in other languages if needed. These materials are also modified for 4th to 6th grade reading levels.

Member's Right To Designate An Ob/Gyn:

El Paso Health allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

Attention Female Members

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

1145 Westmoreland Dr.
El Paso, TX 79925
1-833-742-3127
www.elpasohealth.com