JANUARY 2026

Provider Manual

El Paso Health Medicare Advantage Dual (HMO D-SNP),
El Paso Health Total (HMO) and El Paso Health Giveback (HMO)

Service Area
El Paso and Hudspeth Counties

1145 Westmoreland Drive, El Paso, Texas 79925
Toll Free Dual SNP 1-833-742-3125
Medicare Advantage (MAPD) 1-833-742-2121

El Paso Health
Medicare Advantage

Table of Contents

SECTION 1: INTRODUCTION

1.1 Introduction

El Paso Health is pleased to welcome you into our Provider Network.

The Provider Manual contains information about El Paso Health policies and procedures and specific "how to" instructions for providers when working with El Paso Health Medicare Advantage Members. As changes occur, we will update the Provider Manual and forward new sections for insertion.

It is the intention of El Paso Health, in the development of this Provider Manual, to help you navigate the process of providing and billing for healthcare services to our Members. The Provider Manual describes the services covered by El Paso Health Medicare Advantage your responsibilities in providing services, and processes.

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

El Paso Health Medicare Advantage
ATTN: Provider Relations
1145 Westmoreland Dr.
El Paso, Texas 79925
D-SNP 1-833-742-3125
El Paso Health Total/El Paso Health Giveback 1-833-742-2121

The Provider Relations department is always available to answer any of your questions. Please see the Quick Reference Guide included in this Manual for additional contact providerservicesdg@elpasohealth.com.

1.2 Background

El Paso Health Medicare Advantage is a Texas-based Health Maintenance Organization (HMO) offering Prescription Drug Coverage. We have contracted with the Centers for Medicare & Medicaid Services (CMS) to deliver quality healthcare to our members. Our Medicare Advantage plans include three options: El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO). At El Paso Health, we are proud to have you as a participating provider and appreciate your shared commitment to improving healthcare in the El Paso community.

Building New Partnerships

El Paso Health believes that a successful managed care program is based on an effective partnership with Providers, Members, and The Community.

Providers

El Paso Health is sensitive to the many demands on a Provider's time and resources. Our Provider Relations department offers support and streamlines administrative procedures. El Paso Health pledges to Providers the following:

- A Provider Relations Representative is available to provide education and office staff training on an ongoing basis.
- The Board of Directors and Quality Improvement Committees (QIC), composed of physicians and other providers, plays an active role in all policy decisions.
- State-of-the-art information systems provide on-line member profiles, case management data and administrative support.

Members

El Paso Health offers a comprehensive range of health, social, and support services designed to meet the needs of our members. In addition to standard benefits, El Paso Health pledges to our members the following:

- Every Member will be treated with dignity and respect throughout the care process
- Services are available and accessible
- A local, bilingual Member Services Line is available to answer questions and ensure assistance to community services
- Providers, Case Managers, and other staff are fully responsive to the unique needs of each Member
- El Paso Health staff facilitates information and links to necessary social and support programs

Community

El Paso Health is committed to long-term participation and investment in our community. El Paso Health's network builds upon the existing structure of community providers and organizations. El Paso Health expects to draw from and add to the community strengths in program development and implementation.

1.3 Contact Information

El Paso Health has different departments to assist you with your day-to-day operations, questions or problems you may encounter. Listed below are the descriptions of El Paso

Health Departments and their functions. Departmental Directors and Managers' contact information is listed for your convenience.

Provider Relations can assist you with the following:

- Provider Inquiries
- Provider Updates/Demographic changes

Provider Relations Manager: Cynthia Moreno **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1044

Contracting & Credentialing can assist you with the following:

- Credentialing
- Network Participation
- Contract Related Inquiries that include contract reimbursement

Contracting/Credentialing Manager: Gabriel De Los Santos **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1128

Member Services consist of highly qualified individuals that are fluent in both English and Spanish. Our member services staff can assist with the following:

- Explain what services are covered
- Help Members choose a PCP
- Process PCP changes
- Sending new ID cards
- Schedule Transportation
- Send Provider Directories
- Assist with OTC Card Balances and Replacement Requests

Director of Member Services: Nellie Ontiveros, **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1112
Member Service Manager: Roberto Sepulveda, **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1055

Claims Department can assist you with the following:

- Claims inquiry/processing
- Electronic Billing
- Corrected Claims
- Appeals

Director of Claims: Diana Carreon **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1190
Claims Manager: Angie Dominguez **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1097

Health Services can assist you with the following:

- Referral to in-network and necessary out-of-network services
- Pre-Authorizations/Pre-Certifications
- Disease Management
- Utilization Management
- Case Management
- Adverse determination appeals

Medical Director: Dr. Jorge Guzman **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1221
Director of Pharmacy: Angel Palacios **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1085
Director of Health Services: Vianka Navedo-Sanchez **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1135
Service Coordination Manager: Jesus Ochoa **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1017
Utilization Review Manager: Carolina Castillo **1-833-742-3125 (D-SNP**)
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1122
HS Administrative Manager: Celina Dominguez **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1091

Compliance can assist you with the following:

- Administering health plan program compliance with Centers for Medicare and Medicaid Services (CMS)
- Education and training on rules and regulations such as False Claims Act, Deficit Reduction Act and HIPAA and Waste, Fraud and Abuse
- Provider complaints and appeals

Director of Compliance: Vanessa Berrios **1-833-742-3125 (D-SNP)** Ext.1040
Compliance Manager: Yvette Ramos **1-833-742-3125 (D-SNP**)
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1328
Special Investigation Unit Manager: Jennifer Huereca **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1228

Quality Improvement Department can assist you with the following:

- Access and Availability
- CMS and El Paso Health Quality Initiatives
- Member Events Review
- Provider Profiling

Director of Quality Improvement: Angelica Chagolla **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1165

Complaints and Appeals can assist you with the following:

- Coverage Decisions
- Grievances
- Appeals

Complaints and Appeals Manager: Corina Diaz **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1092

Business Development & Marketing can assist you with the following:

- Approved Marketing Material
- Informational Material
- Community Events

Director of Business Development and Marketing: Eric Call, **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1255
Marketing Programs Manager: Reynaldo Barrozo, **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1186

Medicare Operations Sales Team can assist you with the following:

- Educational/Marketing Events
- Plan Benefit Overview

Medicare Sales Manager: Viridiana Garcia, Licensed Agent, **1-833-742-3125 (D-SNP)**
1-833-742-2121 (EPH Total/EPH Giveback) Ext. 1079

QUICK REFERENCE PHONE LIST

Quick Reference Phone List	Telephone Number/Website
Website	ephmedicare.com/providers
Complaints and Appeals Department Fax Mailing Address	1-833-742-3125 (D-SNP)/ 1-833-742-2121 **EPH Total/EPH Giveback** 1-915-298-7872 Attn: Complaints and Appeals Department P.O. Box 971100 El Paso, TX 79997-1100
Part D Prescription Drugs Fax Mailing Address	1-833-742-3125(D-SNP)/ 1-833-742-2121 **EPH Total/EPH Giveback** 1-915-298-7872 Attn: El Paso Health Medicare Advantage Dual P.O. Box 1039 Appleton, WI 54912-1039
Appeals for Part D Prescription Drugs Fax Mailing Address	1-833-742-3125(D-SNP)/ 1-833-742-2121 **EPH Total/EPH Giveback** 1-915-298-7872 Attn: El Paso Health Medicare Advantage Dual P.O. Box 971100 El Paso, TX 79997-1100
Behavioral Crisis Line	1-877-379-7647
First Call	1-844-549-2826

SECTION 2: MEMBER INFORMATION

2.1 Member Eligibility & Benefits

Participating Providers may request a Member's eligibility statement from El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO) to determine the Member's eligibility for health services at the time of the visit.

2.2 Member Identification Cards (ID)

El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO) members receive a member identification (ID) card. Members should present these ID cards when they are seeking services from El Paso Health network providers. If the member does not have his/her ID card or enrollment for new members, the provider's office can call Member Services to verify eligibility at

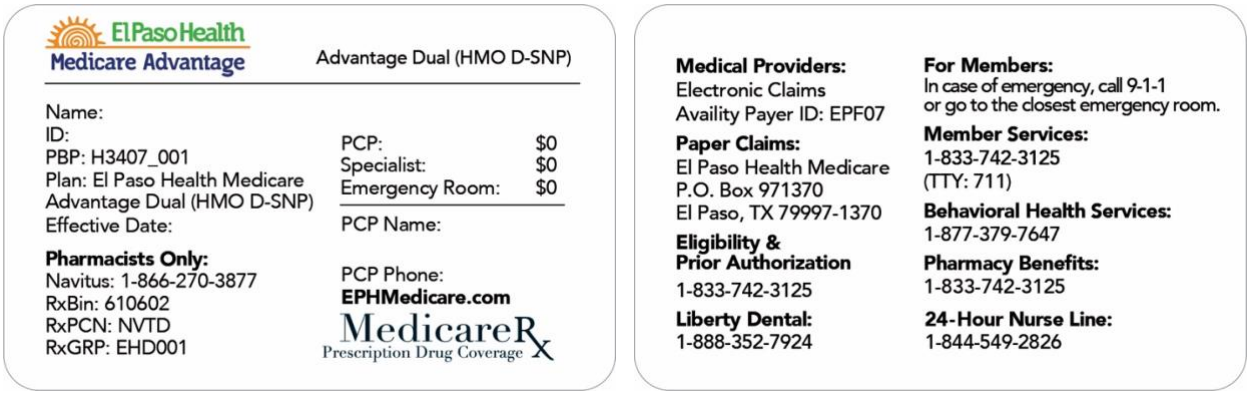
D-SNP 1-833-742-3125
EPH Total/EPH Giveback 1-833-742-2121
Monday-Friday 8am-8pm.

Please remember that possession of an ID card does not guarantee eligibility. Providers are encouraged to verify the effective date of benefit coverage as well as member identity prior to rendering services to the member.

The ID card will contain the following information:

Name of Member	Pharmacy Number
Contract/Plan Number	RxBIN Number (Prescription Benefit ID)
Member ID Number	RxPCN Number (Processor Control Number)
Effective Date	RxGRP Number (Group Number)

El Paso Health Medicare Advantage Dual (HMO D-SNP)


El Paso Health Medicare Advantage

Advantage Dual (HMO D-SNP)

Name:
ID:
PBP: H3407_001
Plan: El Paso Health Medicare Advantage Dual (HMO D-SNP)
Effective Date:

Pharmacists Only:
Navitus: 1-866-270-3877
RxBin: 610602
RxPCN: NVTD
RxGRP: EHD001

PCP:	$0
Specialist:	$0
Emergency Room:	$0

PCP Name:

PCP Phone:
EPHMedicare.com

MedicareRx Prescription Drug Coverage

Medical Providers:
Electronic Claims
Availity Payer ID: EPF07

Paper Claims:
El Paso Health Medicare
P.O. Box 971370
El Paso, TX 79997-1370

Eligibility & Prior Authorization
1-833-742-3125

Liberty Dental:
1-888-352-7924

For Members:
In case of emergency, call 9-1-1 or go to the closest emergency room.

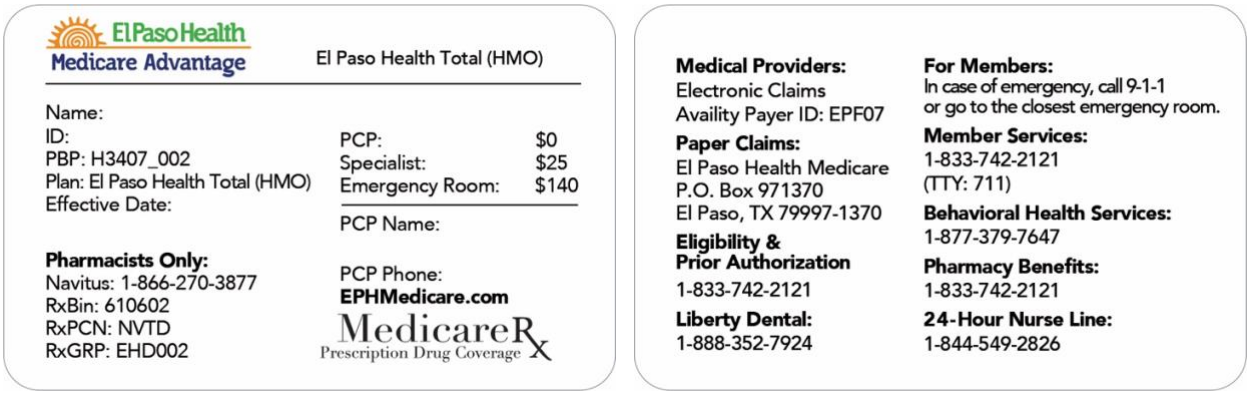
Member Services:
1-833-742-3125
(TTY: 711)

Behavioral Health Services:
1-877-379-7647

Pharmacy Benefits:
1-833-742-3125

24-Hour Nurse Line:
1-844-549-2826

El Paso Health Total (HMO)


El Paso Health Medicare Advantage

El Paso Health Total (HMO)

Name:
ID:
PBP: H3407_002
Plan: El Paso Health Total (HMO)
Effective Date:

Pharmacists Only:
Navitus: 1-866-270-3877
RxBin: 610602
RxPCN: NVTD
RxGRP: EHD002

PCP:	$0
Specialist:	$25
Emergency Room:	$140

PCP Name:

PCP Phone:
EPHMedicare.com

MedicareRx Prescription Drug Coverage

Medical Providers:
Electronic Claims
Availity Payer ID: EPF07

Paper Claims:
El Paso Health Medicare
P.O. Box 971370
El Paso, TX 79997-1370

Eligibility & Prior Authorization
1-833-742-2121

Liberty Dental:
1-888-352-7924

For Members:
In case of emergency, call 9-1-1 or go to the closest emergency room.

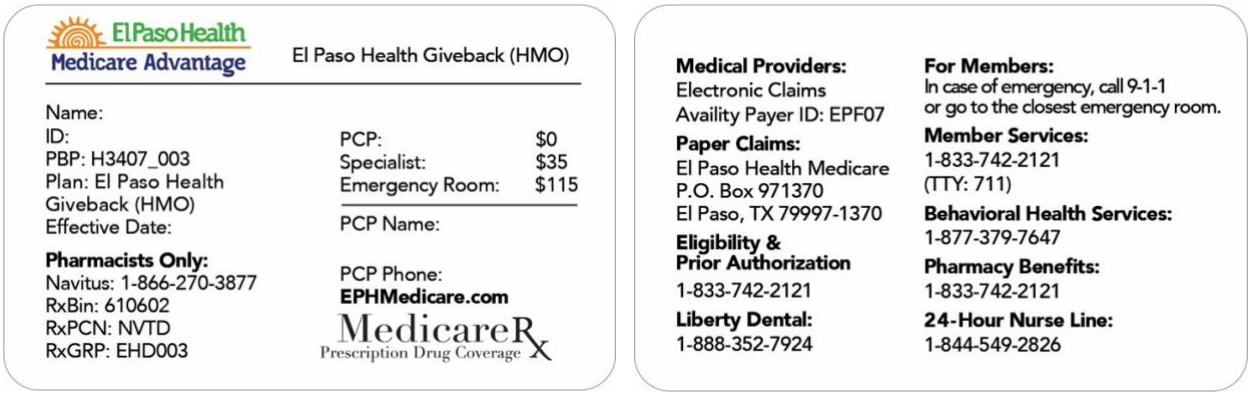
Member Services:
1-833-742-2121
(TTY: 711)

Behavioral Health Services:
1-877-379-7647

Pharmacy Benefits:
1-833-742-2121

24-Hour Nurse Line:
1-844-549-2826

El Paso Health Giveback (HMO)


El Paso Health Medicare Advantage

El Paso Health Giveback (HMO)

Name:
ID:
PBP: H3407_003
Plan: El Paso Health Giveback (HMO)
Effective Date:

Pharmacists Only:
Navitus: 1-866-270-3877
RxBin: 610602
RxPCN: NVTD
RxGRP: EHD003

PCP:	$0
Specialist:	$35
Emergency Room:	$115

PCP Name:

PCP Phone:
EPHMedicare.com

MedicareRx Prescription Drug Coverage

Medical Providers:
Electronic Claims
Availity Payer ID: EPF07

Paper Claims:
El Paso Health Medicare
P.O. Box 971370
El Paso, TX 79997-1370

Eligibility & Prior Authorization
1-833-742-2121

Liberty Dental:
1-888-352-7924

For Members:
In case of emergency, call 9-1-1 or go to the closest emergency room.

Member Services:
1-833-742-2121
(TTY: 711)

Behavioral Health Services:
1-877-379-7647

Pharmacy Benefits:
1-833-742-2121

24-Hour Nurse Line:
1-844-549-2826

SECTION 3: MEMBER SUPPORT SERVICES

3.1 Member Information

El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO)members and providers can obtain any information by calling Member Services at 1-833-742-3125 (D-SNP) and 1-833-742-2121 (Giveback/Total), TTY Users 711. Our hours of operation are from October 1 to March 31, 8:00 a.m. to 8:00 p.m. seven days a week and April 1 to September 30, 8:00 a.m. to 8:00 p.m. Monday through Friday.

3.2 Member Welcome Packet

El Paso Health members will receive a Plan Document Notice upon enrolling in El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) or El Paso Health Giveback (HMO). The notice contains information on how to request any plan material such as:

- Evidence of Coverage
- Provider Directory
- Pharmacy Directory
- Abridged Formulary
- Comprehensive Formulary
- Health Risk Assessment
- Prescription Payment Plan Application for those who qualify (through Simplicity RX)

Along with the Plan Document Notice, members will also obtain an El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) or El Paso Health Giveback (HMO) Identification Card.

3.3 Assistance with Cultural & Linguistic Services

Our plan has free interpreter services available to answer questions for non-English speaking members. Written material is available in Spanish and other languages upon request. We can also give the member information in Braille, large print or other alternate formats at no cost to them. We are required to provide information about our plan's benefits in a format that is accessible and appropriate to members. If any member has trouble obtaining information from our plan in a format that is accessible and appropriate, they can file a grievance with El Paso Health. Members can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights.

SECTION 4: MEMBER RIGHTS & RESPONSIBILITIES

4.1 Member Rights

- El Paso Health members have the right to choose a Primary Care Provider (PCP) in the plan's network to provide and arrange for their covered services. Females have the right to a women's health specialist (such as a gynecologist) without a referral. El Paso Health does not require referrals to see a network provider.
- Members have the right to schedule an appointment and receive covered services from the plans network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when the member needs care. Members also have the right to get prescriptions filled at any of our network pharmacies without long delays.
- Federal and state laws protect the privacy of a member's medical records and personal information. El Paso Health and Providers will comply with these regulations and protect our members personal health information.
- To voice complaints or appeals about the managed care organization or the care provided.
- Right to make recommendations regarding our organization's member rights and responsibilities policy.

4.2 Members Responsibilities

- Members will be required to be familiar with their covered services and follow the guidelines in order to obtain those covered services.
- If members have other health insurance coverage or prescription drug coverage in addition to El Paso Health, they are required to notify our plan and attending provider.
- Members are required to show their El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) or El Paso Health Giveback (HMO) ID card and Medicaid card whenever they attend doctor visits and/or obtain prescription drugs.
- Be considerate of other members' rights. We expect our members to act in a way that helps the smooth running of a doctor's office, hospitals, and other provider locations.
- Members are responsible for paying their Part B premiums in order to be eligible for our plan.
- For most El Paso Health Medicare Advantage Dual (HMO-D-SNP) members, Medicaid pays for their Part A and Part B premium.
- If a member moves out of the El Paso County service area, they are no longer eligible for our plan and must notify Member Services Department at 1-833-742-3125 (D-SNP) or 1-833-742-2121 (Total/Giveback) TTY 711.

4.3 HIPAA Notice of Privacy Practices

El Paso Health will obey all Federal and State Laws protecting member's personal health and medical records by assuring the following:

- No unauthorized person can see or change a member's records.
- We will need to obtain written permission in order to disclose a member's health information to anyone who is not providing or paying for his/her care.

4.4 Advance Directives

The Patient Self-Determination Act of 1990 and State Law provides every adult member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially.

These rights may be communicated by the member through an advance directive. Two kinds of advance directives are generally recognized by the law: the living will and the durable power of attorney for healthcare.

The members' primary care office is not required to have living will or durable power of attorney blank forms available. However, the primary care office must have procedures in place to help assure that the existence of completed advance directive forms are conspicuously noted in the members' medical report.

EPH Members will have the right to the following:

- The right to fill out a form to give someone the legal authority to make medical decisions for them if unable to do so and/or;
- The right to give doctors written instructions about how they want their medical care handled if unable to make decisions for themselves.

SECTION 5: COVERED SERVICES

5.1 Roles & Responsibilities of a PCP

The Primary Care Physician (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 provide better health outcomes. Primary care includes ongoing 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. Provider types who are eligible to serve as a PCP include:

- General Practitioners
- Family Practitioners
- Internal Medicine
- Obstetrician/Gynecologists (OB/GYN) for females

5.2 Member Assignment

El Paso Health will provide PCPs a monthly listing of members that have been assigned or selected to them. The purpose is to have PCPs oversee the delivery of health care services to our members.

If a member is not on their eligibility list, the PCP is required to contact El Paso Health, Member Service Department to determine eligibility when contacted by the member seeking care. Failure to verify assignment to the PCP may prevent the PCP from receiving reimbursement for services rendered.

A "member dismissal provider process" refers to the procedure where a Medicare provider formally terminates their relationship with a patient. Process shall include: a form request for submission from provider, review of request, decision and notification, effective date of reassignment and continued responsibility. Please contact Provider Relations Department via email ProviderRelationsDG@elpasohealth.com.

5.3 Designation of an OB/GYN for Female Members

Our female members, in addition to choosing a PCP, may designate an OB/GYN physician to provide for their needs relating to:

- Once a year well woman exam,
- Care related to pregnancy;
- Care for all active gynecological conditions; and

- Gender-related care within the OB/GYN scope of professional practice, including treatment of medical conditions concerning the breasts, genital tract, female endocrinology, reproductive physiology, infertility, and pregnancy.

5.4 Roles & Responsibilities of a Specialist

A Specialty Care Provider collaborates with the PCP to deliver scare 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 authorizations have been obtained prior to providing services. Specialty Care Provider responsibilities must adhere to availability and accessibility standards of El Paso Health.

5.5 Access to Care

Primary Care Providers are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

PCP's and Specialty care providers must have adequate office hours to accommodate appointments for Members and arrange for coverage with another El Paso Health Provider during scheduled and unscheduled time off.

The following are general El Paso Health guidelines.

We have appointment standards for access and after-hours care to help ensure timely access to care for members. We use these to measure performance annually.

Our standards are shown in the following:

- Type of service Standard Preventive care Within 30 calendar days
- Regular/routine care appointment Within 30 calendar days
- Urgent care appointment Same day
- Emergency care Immediate
- After-hours care 24 hours/7 days a week for PCPs

Newly enrolled members who need transitional care or continuity of care

When a new member enrolls with El Paso Health, they may qualify for coverage of transitional care services rendered by their non-participating health care providers.

Transition of care (TOC) allows newly enrolled members the option to request an extension of care from a currently treating out-of-network provider. Service Coordinators will assist with care transitions, including but not limited to medication reconciliation, follow-up visits, home health needs, and prescription management. To request TOC, please contact Health Services at

D-SNP 1-833-742-3125 or

EPH Total/EPH Giveback 1-833-742-2121

- TOC request must be received within 30 days from a member's enrollment effective date
- TOC request can be submitted by a member or provider via phone or fax
- Transition to a contracted provider will be required within 90 days if TOC request is approved

5.6 Services Covered under Specific Conditions

There are some services considered a Medical Necessity which El Paso Health must approve. The following are examples of these services:

- Private room in a hospital
- Cosmetic surgery or procedure – in cases of an accidental injury or for improvement of the functioning of a malformed body member. Also, for reconstruction of a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Non-Routine Dental Care – Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Routine chiropractic care – manual manipulation of the spine to correct a sublimation.
- Orthopedic shoes – if shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for diabetic foot disease.
- Routine eye examinations – Eye exam and one pair of eyeglasses (or contact lenses) covered for people after cataract surgery.

5.7 Out-of-Network Providers

Members in our plan must use providers within our network. El Paso Health authorizes the use of out-of-network providers in the following exceptions:

- Emergency care or urgently needed services.
- Medical care that is not available from our in-network providers that is a Medicare required benefit will need a "prior-authorization" from our Utilization Management Department.

- Kidney dialysis services from a Medicare-certified dialysis facility when they are temporarily outside the plan's service area.

5.8 Emergency Care

El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) or El Paso Health Giveback (HMO) Members are able to obtain Emergency Care rendered by a provider qualified to furnish emergency services and needed to treat, evaluate or stabilize an emergency medical condition. Referrals are not required for emergency care. In case of an emergency, our Members are able to see out-of-network Providers.

5.9 Covered Services

El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO) cover Original Medicare Part A and Part B covered services and supplemental benefits.

Part A Covered Services

- Inpatient Hospital Care
- Skilled Nursing Facility Care
- Inpatient Skilled Nursing Facility (non-custodial)
- Hospice Care
- Home Health Care

Part B Covered Services

- Medically necessary services: Services or supplies that meet accepted standards of medical practice to diagnose or treat your medical condition
- Preventative services: health care to prevent illness or detect it at an early stage when treatments are likely to work best
- Clinical Research
- Ambulance Services
- Durable Medical Equipment (DME)
- Mental Health - inpatient, outpatient, and partial hospitalization
- Limited Outpatient Prescription Drugs such as:
    - *Drugs used with an item of durable equipment (DME), Infusion pump or nebulizer Some antigens*
    - *Injectable osteoporosis drugs*
    - *HIV prevention drugs*
    - *Injectable and infused drugs*

- *Erythropoiesis- stimulating agents*
- *Blood clotting factors*
- *Oral End-Stage Renal Disease (ESRD) drugs*
- *Parental and eternal nutrition (intravenous and tube feeding)*
- *Intravenous Immune Globulin (IVIG) provided in home*
- *Shots (vaccinations): flu shots, pneumococcal shots, Hepatitis B shots*
  Transplant/immunosuppressive drugs

SECTION 6: PROVIDER CREDENTIALING

6.1 Credentialing & Re-credentialing Process

El Paso Health Credentialing Department follows the Utilization Review Accreditation Commission (URAC), National Committee for Quality Assurance (NCQA) guidelines in addition to relevant and federal regulations for initial and re-credentialing standards. El Paso Health requires Providers to be credentialed prior to joining the network with exception of Hospital Based Providers. Credentialing for Providers is required every 3-years.

1. El Paso Health obtains a Provider Demographic Form and W-9.
2. A credentialing and contract packet are prepared for the Provider.
3. Providers complete credentialing process while the contract remains pending until the (CPRC) review is complete.
4. Provider Agreement is executed and becomes effective the 1st of the following month after the CPRC approval.
5. A copy of the original executed agreement is given to the Provider.

6.2 Excluded Providers

Providers must be eligible and remain eligible to participate in Medicare and State Health Care Programs under Title XVIII of the Social Security Act Section 1128 42 U.S.C. 1320a-7 prior to being enrolled with El Paso Health.

6.3 General Provider Rights & Responsibilities

Provider obligations are described in the Provider Agreement. These obligations specify that Providers agree to:

- Maintain any and all licenses required by the State of Texas that govern a Provider's profession or business.
- Notify El Paso Health immediately of any limitation, suspension, or revocation of any license or medical staff Membership.
- Maintain a facility that promotes patient safety.
- Maintain appropriate professional liability insurance in an amount consistent with the Texas Department of Insurance.
- Maintain all medical records for a period of at least seven years from the date of service.
- Participate in El Paso Health Quality Assessment and Performance Improvement Program (QIP) Initiatives.
- Participate in applicable compliance training, education and/or communications.

- Any Provider’s subcontractors providing Contracted Services to El Paso Health Members shall be required to comply with the terms in the Provider’s Agreement to the same extent as the Provider.
- Comply with State and Federal laws and administrative regulations concerning nondiscrimination on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion.
- Comply with all El Paso Health policies, procedures, rules and regulations including those found in the Provider Manual.

El Paso Health encourages PCPs to meet the following goals:

- Coordinate care with specialists and ancillary providers as appropriate for patients needs
- Examine all patients at least once within a 6-month period
- Conduct follow-up visits within 7 days of discharge for recently hospitalized patients
- Conduct preventive screenings in accordance with CMS quality measures
- Monitor patients’ medication use and adherence
- Refer patients for El Paso Health’s Case management services as appropriate
- Participate in CMS quality improvement and El Paso Health administrative initiatives
- Periodically review utilization metrics with El Paso Health clinical staff as requested

6.4 Out-of-Network Providers

Out of Network Providers must contact the El Paso Health Contracting Department for enrollment. El Paso Health's Contracting Department will obtain a Provider Demographic Form and W-9 to ensure that the Provider is set up accordingly.

SECTION 7: REFERRALS & PRIOR AUTHORIZATION

The purpose of the El Paso Health program is to determine if medical services are:

- Covered under the member's benefit plan
- Clinically necessary and appropriate
- Performed at the most appropriate setting for the member

7.1 Referrals

El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO) Members are required to choose a PCP who provides and oversees their care. In most situations, the PCP is responsible for providing a member with a referral to use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. Referrals from a PCP are not required for emergency care or urgently needed services.

7.2 Prior Authorization Procedures

Providers will need to obtain prior authorization from El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) or El Paso Health Giveback (HMO) for required services from our Utilization Management department. Emergency or out-of-area urgently needed services do not require prior authorization. To ensure that we provide you with a response prior to providing a service please submit your request at least five (5) days in advance. Requests for prior authorization may be submitted online, fax, or telephonic.
It may take up to three (3) business days for standard requests and one (1) business day for expedited requests for an authorization determination. We may extend this time if we need additional information. Submitting requests through the Prior Authorization tool in the El Paso Health Provider Portal assists in timely decisions.
Online Provider Portal: El Paso Health offers a secure online Provider Portal accessible 24/7. This portal provides tools and services for:

- Viewing claim status
- Checking Member eligibility and benefits
- Monitoring the status of pre-authorizations

How to Access the Portal:

1. Visit https://ephmedicare.com/providers/
2. Click on the **Provider** Login tab and select **"Need a username and password? Proceed to our signup process"**
3. Complete the Secure Access prompts and submit it to EPH.

For any questions or assistance, feel free to contact us.

http://ephmedicare.com/providers/
Telephone: 1-833-742-3125 (D-SNP)
1-833-742-2121 (EPH Total/EPH Giveback)

Fax: Outpatient
915-298-7866
Toll Free: 844-298-7866

In-Patient
915-298-5278
Toll Free: 844-298-5278

7.3 Services Requiring Prior Authorization

Service	Description
Ambulance	Non-emergent (air, ground, water)
Ambulatory surgical	Any procedure performed in an outpatient hospital or free standing ambulatory surgical center.
Behavioral Health	• Inpatient Psychiatric • Partial Hospitalization
Cardiology	• Cardiac Catheterization (not required for emergent or urgent care) • Cardiac implants (not required for emergent care)
Chemotherapy	• Inpatient • Outpatient • Freestanding clinic • Doctor's Office
Chiropractic Services	After initial evaluation
Drugs and Medical Injectable	Required for prompt repair of accidental injury or to improve the function of a malformed body part. Breast prostheses for breast reconstruction if you had a mastectomy because of breast cancer.

Durable Medical Equipment (DME) – Prior Authorization is needed for any over $500	Includes, but not limited to: • BIPAP • Bone Growth Stimulator • CPAP • CPM device • Custom Wheelchair • Electric or Motorized Wheelchair • Enteral Supplies • Hospital Bed/Mattress • Infusion Pumps • Lift Devices • Oxygen • Rentals exceeding 2 months • Scooters • Speech Generating Device • TENS unit • Therapeutic Glucose Monitors • Ventilators • Wound Vacuum Devices • Vagus Nerve Stimulator
Genetic and Molecular Testing	• Genetic Analysis • Molecular Pathology Procedures • Genomic Sequencing Procedures • Multianalyte Assays with Algorithmic Analysis that include Molecular Pathology Testing
Home Health Services	• Home IV Infusion • Home Health Aide • Occupational Therapy • Physical Therapy • Speech Therapy • Skilled Nursing Services • Social Work Services

Hyperbaric Oxygen Therapy (HBO)	A medical treatment that involves breathing pure oxygen in a pressurized room or chamber. Used to treat: 1. **Decompression sickness** (common in scuba divers) **2. Carbon monoxide poisoning** 3. **Chronic non-healing wounds** (like diabetic foot ulcers) 4. I**nfections** that are resistant to standard treatments 5. **Radiation injuries** from cancer treatment 6. **Certain neurological conditions** (though this is more experimental)
Inpatient Admission: Elective or Scheduled	• Acute Inpatient Hospital • Inpatient Rehabilitation • Hospice • Long-Term Care Hospital (LTCH) • Psychiatric Inpatient Hospital • Skilled Nursing Facility (SNF) • Substance Use Disorder Treatment/ Rehabilitation
Orthotics	Exceeding $200
Out-of-Network Services (unless services are for emergency care or out-of-area urgent)	Prior Authorization is required for any Out-of- Network Services, unless emergency or urgent care is needed
Part B Drugs (Medicare)	• Clinician Administered Drugs exceeding $500 • Anti-cancer • Blood Clotting Factors • Dialysis drugs • Intravenous Immune Globulin (IVIG) (in-home) • Total Parenteral Nutrition (in-home)
Prosthetics	• Exceeding $200 • Artificial limbs • Braces

Radiology	• PET Scans
Sleep Study	• When performed as outpatient
Surgeries	• Elective • Outpatient Hospital • Pre-Scheduled • Reconstructive • Freestanding Ambulatory Surgical Facility
Outpatient Rehabilitation Services-Occupational Therapy, Physical Therapy & Speech Therapy. Initial evaluation does not require Prior Authorization	• Cardiac Rehab • Occupational Therapy • Physical Therapy • Pulmonary Therapy • Speech Therapy
Transplants	All transplant services including, but not limited to, evaluation, transplant consult visits, HLA typing
Venous Procedures	When performed in office or outpatient

7.4 Admission Notifications

Facilities are responsible for admission notification for the following inpatient admissions. We need admission notification, even if the physician provided advance notification and pre-service coverage approval is on file:

- Planned/elective admissions for acute care
- Acute inpatient rehabilitation
- Long-term acute care
- Unplanned admissions for acute care
- SNF admissions
- Admissions following outpatient surgery
- Admissions following observation

Emergency admissions (when a member is unstable and not capable of providing coverage information), you must notify us within 24-hours, or the next business day if on a weekend/holiday, from the time coverage information is known

7.5 Appeals

EPH offers a peer-to-peer discussion with the medical director that made the pre-service determination. Once a pre-service adverse determination has been made, Medicare does not allow the decision to be changed as a result of the peer-to-peer discussion. You must submit any additional information from the post decision discussion if you want to submit a Medicare appeal. To allow for a change in decision as a result of a peer-to-peer discussion, we have a pre-decision peer-to-peer window for standard clinical denials (excludes expedited and administrative denials). This is for outpatient and inpatient pre-service requests. We reach out to offer a 24-hour window, prior to finalizing a potential adverse determination, to allow for discussion between the physician and the medical director. If we receive additional information during this pre-decision peer-to-peer window, it can change the final decision of the determination. If the discussion does not happen before the end of the 24-hour window, the decision is finalized and any peer-to-peer discussion that follows is informational only.

7.6 Notice of Medicare Non-Coverage

You must deliver required notice to members at least 2 calendar days before termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the members' services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished. Delivery of notice is valid only upon signature and date of member or their authorized representative, if the member is incompetent. You must use the most current version of the standard CMS approved notice titled Notice of Medicare Non-Coverage (NOMNC).

Any appeals of such service terminations are called fast track appeals and are reviewed by the QIO (Quality Improvement Organization). You must provide requested records and documentation to us or the QIO (Quality Improvement Organization)., as requested, no later than by close of calendar day of the day you are notified by us or the QIO (Quality Improvement Organization). if the member has requested a fast-track appeal. This includes weekends and holidays.

SECTION 8: MEMBER COMPLAINTS

8.1 Coverage Decisions

Members have the right to file a grievance, request an appeal or ask for a coverage decision.

A coverage decision is a determination El Paso Health makes about benefits, coverage or amount paid for medical services or drugs.

You can request a coverage decision for instances when there is uncertainty about a medical service or drug being covered. If the Member disagrees with the decision, they have the right for an appeal.

For questions or a status update, please call our Member Service Department toll free at

D-SNP 1-833-742-3125
EPH Total/EPH Giveback 1-833-742-2121
TTY users should call 711.
October 1- March 31, from 8 a.m.-8 p.m. Mountain Time (MT) 7 days a week.
April 1- Sept. 30, from 8 a.m.-8 p.m. Mountain Time (CT) Monday through Friday.

Write

El Paso Health Medicare Advantage
Attention: Complaints and Appeals
P.O. Box 971100
El Paso, TX 79997-1100
Fax: 915-298-7872

8.2 Grievances

Members can submit a grievance if they have a complaint against El Paso Health or are dissatisfied with the care or treatment from our network providers.
Members may call our Member Services Department toll free at

D-SNP 1-833-742-3125
EPH Total/EPH Giveback 1-833-742-2121
TTY users should call 711.
October 1- March 31, from 8 a.m. to 8 p.m. Mountain Time (MT) 7 days a week.
April 1-Sept. 30, from 8 a.m. to 8 p.m. Mountain Time (MT) Monday - Friday.

A member, a representative (with appropriate authorization), or treating physician, may submit a complaint. Complaints must be submitted verbally or in writing within 60 calendar days from the date of the incident.

Write

El Paso Health Medicare Advantage
Attention: Complaints and Appeals Department
P.O. Box 971100
El Paso, TX 79997-1100
Fax: 915-298-7872

All Grievances must be responded to in writing. They will be investigated as expeditiously as the case requires, based on health status, but no later than 30 days of receipt of the request or within 24 hours for expedited grievances. We may take a 14-day extension if there is a request for an extension or if we justify a need for additional information and how the delay is in the best interest of our members.

Members may also contact Medicare

If a member wishes to place a complaint on El Paso Health, they may do so by visiting Medicare's website at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

8.3 Appeals

Members may also request "expedited" appeals if we have denied coverage that is not related to payment for services already received.

Call Member Services Department toll free at

D-SNP 1-833-742-3125
EPH Total/EPH Giveback 1-833-742-2121
TTY users should call 711.
October 1- March 31, from 8 a.m.-8 p.m. Mountain Time (MT) 7 days a week.
April 1- Sept. 30, from 8 a.m.-8 p.m. Mountain Time (MT) Monday through Friday.

A member representative (with appropriate authorization), or treating physician, may submit an appeal. Appeals must be submitted verbally or in writing within 60 calendar days from the date of the decision. If a member misses the deadline, with good reason, we may allow more time for the appeal.

Write

El Paso Health Medicare Advantage
Attention: Complaints and Appeals
PO Box 971100
El Paso, TX 79997-1100
Fax: 915-298-7872

We will authorize the service or benefit as expeditiously as the case requires, based on health no later than 30 days of the request or in the case of expedited appeals, within 72 hours. We may accept a 14-day extension request, if we determine it is in the best interest based on additional information from the Provider or in circumstances beyond our control.

How to obtain an Aggregate Number of Grievances, Appeals and Exceptions Filed with El Paso Health:

To obtain an aggregate number of El Paso Health grievances, appeals and exceptions, please call Member Services Department toll free at

D-SNP 1-833-742-3125
EPH Total/EPH Giveback 1-833-742-2121
TTY users should call 711.
October 1- March 31, from 8 a.m.-8 p.m. Mountain Time (MT) 7 days a week
April 1- Sept. 30, from 8 a.m.-8 p.m. Mountain Time (MT) Monday through Friday

8.4 Part D Grievance & Appeals

El Paso Health Medicare Advantage Dual (HMO D-SNP) processes all Part D coverage re-determinations. Providers and Members have the right to request an (appeal) up to 60 days from the date of The Notice of Denial of Medicare Prescription Drug Coverage. The appeal may be sent to us by mail or fax.

El Paso Health Medicare Advantage
Attention: Complaints and Appeals
PO Box 971100
El Paso, TX 79997-1100
Fax: 915-298-7872

You can ask us to "expedite" or provide a quick decision if coverage was denied in a situation you believe may cause serious harm to the member by using standard deadlines.

SECTION 9: PROVIDER PAYMENT DISPUTE & APPEAL PROCESS

9.1 Contracted Providers

If you disagree with our payment decision, please submit your dispute request in writing to the following:

El Paso Health Medicare Advantage
Attn: Complaints and Appeals Department
P.O. Box 971100
El Paso, TX 79997
Email: Complaints&AppealsTeam@elpasohealth.com

El Paso Health recognizes two levels of disputes: 1st level and 2nd level.

A dispute is a request for reconsideration of a previously dispositioned claim.

Disputes 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 and twenty (120) days from the date of the Remittance Advice (RA) on which that claim appears. If the one hundred twenty (120) days deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Level 1

Contracted Providers may dispute the claim by completing the following steps:

- Submit a dispute letter for each member for each date of service specifying the reason for dispute.
- Letter must include:
    - Date and Contact Names (first and last name)
    - Mailing Address
    - Phone Number
    - Provider Name and NPI Number
    - Member Name, Date of Birth and ID Number
    - Date of Service
    - Claim Number
    - Reason for Dispute (detailed explanation)
- Support information:
    - Copy of Remittance Advice
    - Medical Records (if necessary)
    - Proof of Timely Filing
    - Any pertinent information for review

The dispute will be acknowledged within 5 business days and resolved within 30 calendar days from date of receipt.

Level 2

If the contracted provider is not satisfied with the resolution of the Level 1dispute, they can submit a Level 2 by following the same steps in Level 1.

Following the conclusion of Level 2, the contracted provider has now exhausted their dispute process.

9.2 Non-Contracted Providers

Payment Dispute:

Non-contracted providers may submit a formal request disputing the amount paid by El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) and El Paso Health Giveback (HMO) for a covered service. (The form is available on our website under the provider information section) Examples of items that can be disputed include:

- Underpayment (the amount paid by El Paso Health for covered services is less than the amount that would have been paid under Original Medicare), or
- Disagreement between a non-contracting Provider and El Paso Health regarding the decision to make payment on an appropriate code (down coding).

Payment Dispute Time Frame:

Payment dispute must be submitted within 120 calendar days after the date of the initial payment determination.

Payment Appeals (Reconsiderations):

Non-contracted Providers may submit a formal payment Appeals (Reconsideration) if Providers **do not agree with our payment denial**. Examples of appealable claims include but not limited to:

- Services not approved and were determined not to be urgent/emergent; or
- Services determined not covered in the Evidence of Coverage or by Medicare.

Payment Appeals/Reconsideration Time Frame:

Payment appeals/reconsideration must be submitted within 60 calendar days of the initial determination date.

Information required for filing a Payment Dispute and Reconsideration:

1. Provider's Name
2. Provider's Identification Number (NPI/Tax ID Number)
3. Contract Information
4. Member Information
5. A clear explanation of the disputed item should include:
   - The date of service
   - A clear identification of the basis upon which the Provider believes the payment amount is incorrect
   - Copy of the Provider's submitted claim with dispute portion identified
   - Request for reimbursement for the overpayment of a claim (if item being disputed is for overpayment request).

Waiver of Liability:

Non-Contracted Providers must sign a waiver of liability form releasing our Member from any financial obligation. An appeal will not be processed without the signed Waiver of Liability Form. (The form is available on our Health Plan website under the provider information section.) The case will be dismissed if the non-contracted provider does not submit the signed Waiver of Liability within the appeal time frame.

Non-Contracted Providers Payment Dispute/Appeals can be mailed or faxed to the following:

El Paso Health Medicare Advantage
Attn: Complaints and Appeals Department
P.O. Box 971100
El Paso, TX 79997
Fax number (915) 298-7872

Contact Information:

- If you need information or help in submitting your request, call Member Services Department toll free at **D-SNP 1-833-742-3125; Total/Giveback 1-833-742-2121. TTY users should call 711.**
- October 1- March 31, from 8 a.m.-8 p.m. Mountain Time (MT) 7 days a week. April 1- Sept. 30, from 8 a.m.-8 p.m. Mountain Time (MT) Monday through Friday
- You may also check our website: ephmedicare.com/providers

Forms:

Provider Dispute Resolution Form
Waiver of Liability Form Non-Contracted Providers Only

SECTION 10: CLAIM PROCESSING GUIDELINES

This section establishes the Claims Processing requirements and time lines that must be used by Providers. These requirements are based on the following authorities noted below. El Paso Health follows Texas Department of Insurance (TDI), Health and Human Services Commission (HHSC), Health Insurance Portability and Accountability Act of 1996 (HIPAA), National Standard Correct Coding Initiative (NSCCI) and Centers for Medicare and Medicaid Services (CMS) guidelines.

10.1 Prompt Payment Requirements

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

1. Claim Type
2. Program and
3. 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 time frames set by CMS:

1. 95% of all Clean Claims within 30 days of receipt (whether paper or electronic)
2. Pay interest on clean claims that are not paid within 30 days
3. All other claims must be paid or denied within 60 calendar days from the date of the request.

Time frames are based on calendar days and are subject to change due to updates in CMS requirements, Federal and State laws, rules or regulations.

Payment of a clean claim is considered to have been made on the earliest of the following:

1. The date a check is issued along with the corresponding remittance advice.
2. The date of electronic funds transmission, if paid electronically.
3. The date payment is delivered via a commercial carrier with tracking (e.g., UPS or FedEx).
4. If none of the above apply, the date the payment is made available to the provider.

El Paso Health is not required to pay any claims to Providers who, are excluded or suspended from CMS for Fraud, Waste and Abuse.

REQUIREMENTS

Under the National Uniform Insurance Industry and CMS, El Paso Health will only accept paper claims submitted on CMS 1500 or CMS 1450 UB-04 claim forms. **It is important to note that the National Uniform Claim Committee (NUCC) has approved a revised version of the CMS 1500 claim form effective 04/01/2014.**

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 the X12.

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

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

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 on-line 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 Washington Publishing Company website at www.wpc-edi.com). Providers must verify the taxonomy code associated with their Provider type and specialty before beginning the on-line attestation process.

Diagnosis Codes (IDC-10-CM/PCS)

El Paso Health requires the International Classification of Diseases, Ninth 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)

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
- 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

10.2 In-Patient Hospital Claims

Present on Admission (POA) reporting is required for all inpatient hospital claims, except for the following types of hospitals, which are exempt:

- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals
- Cancer Hospitals, Children’s Inpatient Facilities
- Rural Health Clinics
- Federally Qualified Health Centers (FQHCs)
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities (IRFs)
- Veterans Administration/Department of Defense Hospitals

All hospital providers are required to submit a POA value for each diagnosis on the claim form. POA is defined as a condition present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are also considered POA.

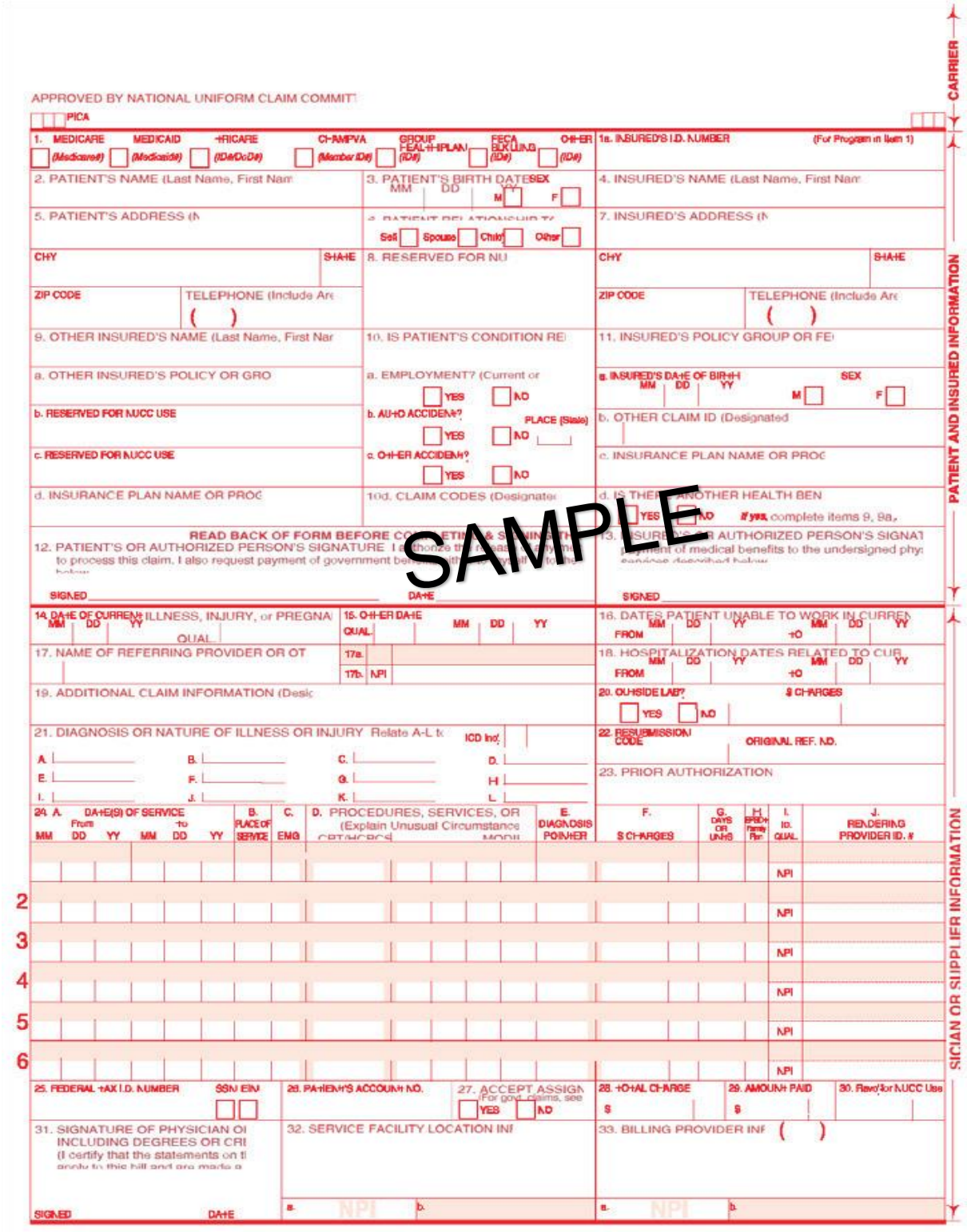
POA information helps to determine whether a claim will be considered for payment. No payment will be made for claims containing POA indicators “N” or “U” when a Hospital Acquired Condition (HAC) is present.

10.3 Claim Submission Timelines

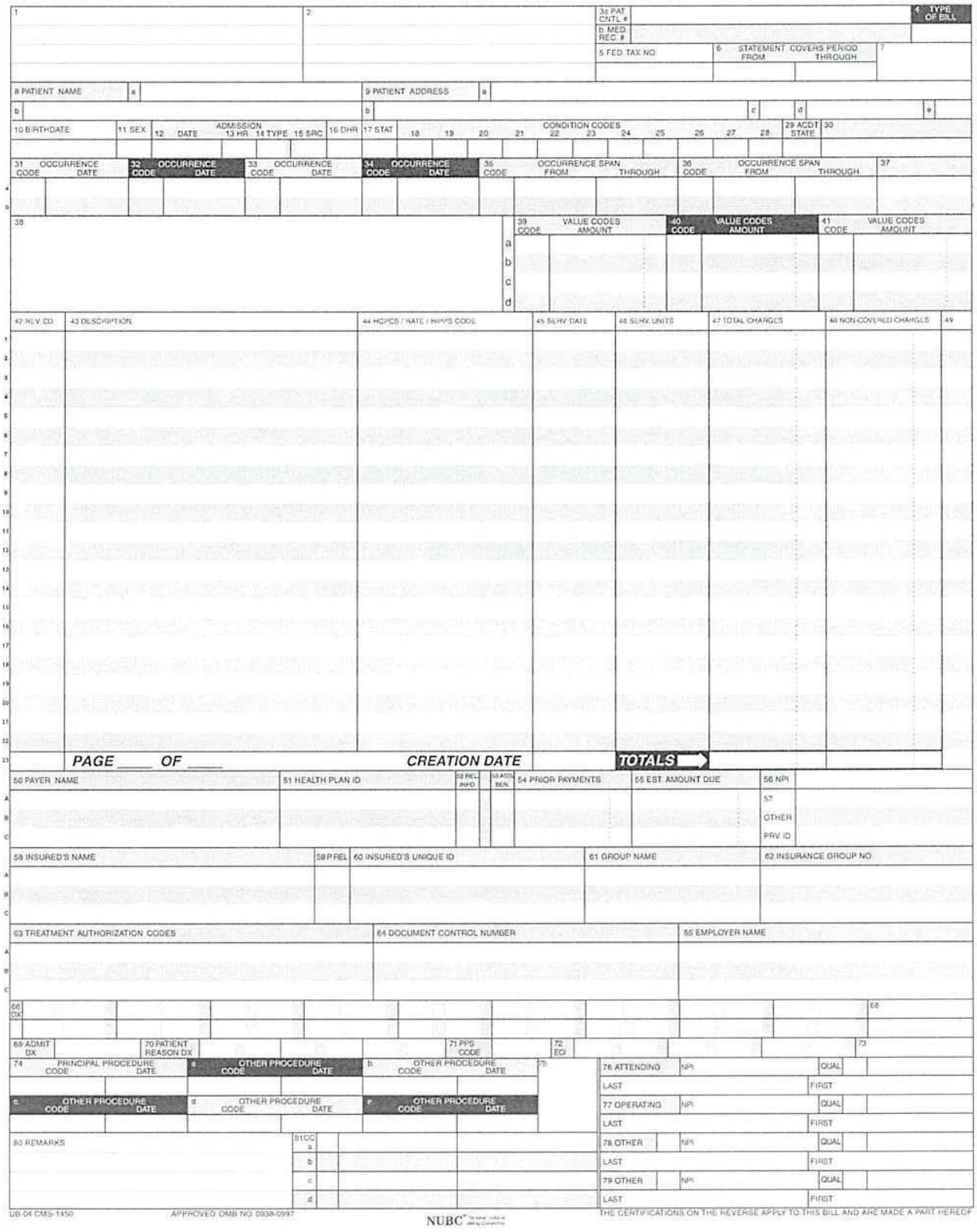
In reference to Professional Provider claims, the Date of Service (DOS) dictates submission timelines. In order to be considered timely, a claim for medical service must be presented for processing within 365 days of the DOS. In the case of Institutional claims, the through date is the driving element. In the cases of prolonged in-patient stays, Institutional Providers may submit interim billing.

At no time will El Paso Health charge a Provider or a Member a fee for claim adjudication.

Example: HCFA CMS 1500 Form



Example: UB-04 Claim Form



Revised CMS 1500 (02/12)

It is important to note that the National Uniform Claim Committee (NUCC) has approved a revised version of the CMS 1500 claim form. This version shall be CMS (02/12). CMS has announced the following tentative datelines:

- January 6, 2014: Payers will begin to receive and process paper claims submitted on the revised 1500 Claim Form.
- January 6 through March 31, 2014: Dual use period during which payers continue to receive and process paper claims on the old 1500 Claim Form (version 08/05) along with paper claims on the new form.
- April 1, 2014: Payers receive and process paper claims submitted only on the revised 1500 Claim Form (version 02/12).

10.4 Multi-page Claims 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.
The CMS-1500 Paper claim form is designed to list six-line items in Box 24. If more than six-line items are billed on a paper claim, a Provider may attach additional forms (pages). All the claims must contain all the required billing information. On subsequent pages of a multi-page claim, the Provider should indicate “continued” in Block 28 and the combined total charges for all pages should be listed on the last page in Block 28. In addition, the Provider should indicate the number of pages of the multi-page claim on the top right-hand corner of the form for example, (page 2 of 3).

The paper UB-04 CMS-1450 is designed to list 22 lines in Box 42. If services exceed the 22-line limitation, the Provider may attach additional claim forms. Each of the claim forms must contain all the required billing information. All subsequent pages of the multi-page claim should indicate the page numbers in Box 23 and “continued” in line 23 Box 47. The combined total charges for all pages should be listed on the last page in line 23 of Box 47.

Note: It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send for processing. It is also recommended that paper claims be sent by certified mail with a return receipt requested and a detailed listing of the claims enclosed. This is important to demonstrate the claims were received by El Paso Health and that the 365-day claims filing deadline has been met.

10.5 Electronic Claim Submission & Response Reports

El Paso Health has the capability to receive ANSI X12N 837I and 837P health claims. In order to enroll, please contact an El Paso Health Provider Relations Representative to obtain a companion guide:

El Paso Health Provider Relations Department
D-SNP 1-833-742-3125
EPH Total/EPH Giveback 1-833-742-2121 ext. 1504
Email: Helpdesk@elpasohealth.com

A clearinghouse is an electronic claim and information network available to all Providers and their billing agents in the El Paso Health care community that enables physician's 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's 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

X12 Publishes Implementation Guides and offers training on EDI standards, 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 877-532-3778 (D-SNP) 1-833-742-2121 Total/Giveback.

Payer Name	Payer ID #
El Paso Health Medicare Advantage	EPF07

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 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 El Paso Health claims processing system is 28. If the services provided exceed 28-line items on an approved electronic claim 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.

10.6 Claim Filing Deadlines

Claims must be received by El Paso Health within 365 days from date of service (DOS). A clean claim will be processed within 30 days. The Provider should allow 30 days before re-billing any claim to avoid duplication of claims.

Once a Clean Claim is received, El Paso Health is required, within the 30-day claim payment period and 18-day clean claim payment for electronic pharmacy claim submission, to: (1) pay the total amount of the claim, or part of the claim, in accordance with the contract, (2) deny the entire claim, or part of the claim, and notify the Provider why the claim will not be paid.

Payment is considered to have been paid on the date of: (1) the date of issue of a check for payment and its corresponding EOB to the Provider by El Paso Health, or (2) electronic transmission, if payment is made electronically.

If a claim was denied due to a billing error, the corrected claim must be resubmitted within 120 days from the disposition date on the EOB.

If the claim was denied due to a request for medical documentation, please include a copy of the claim, a copy of the EOB and the requested documentation with re-submission. Providers must adhere to the claim filing timelines and claims received after the filing deadline will be denied for failure to meet timely filing.

When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other insurance carrier. When a service is billed to a third party and no response has been received, the Provider must allow 110 days to elapse before submitting a claim to El Paso Health however, the federal 365 day filing requirement must still be met.

10.7 Outpatient Pharmacy Prescription Claims

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.

10.8 SUBMISSION OF EDI REJECTED CLAIMS

All rejected claims must be corrected and resubmitted within 365 days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.

10.8 (a) Submission Of Electronic Corrected Claims:

Corrected CMS-1500 professional claims must have the accurate claim frequency code in Loop 2300 CLM05-3:

- Value “7” for corrected/replacement claim
- Value “8” for voided claim

Corrected UB-04 institutional claims must have the accurate claim frequency code in Loop 2300 CLM05-3:

- Value “7” for corrected/replacement claim
- Value “8” for voided claim

In addition, you must reference the EPH claim number from the ERA or RA in Loop REF*8.

10.8 (b) Corrected Paper Claims:

Corrected CMS-1500 professional paper claims must have the accurate resubmission claim frequency code in Box 22:

- Value “7” for corrected/replacement claim
- Value “8” for voided claim

Corrected UB-04 institutional paper claims should be submitted with the appropriate resubmission code in the third digit of the Bill Type:

- Value “7” for corrected/replacement claim
- Value “8” for voided claim

If a claim number is not referenced on your claim your claim will deny as a duplicate claim.

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

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 or UB04 claim **ATTACHMENT 21**, a copy of the EOB and any other attachments needed.

The following are examples of forms attached to returned claims explaining the reason(s) for the return.

UB 04

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

Thank you for participating with El Paso Health. We value your partnership with our organization and would like to assist you with the adjudication of your claims. However, the attached claim you have submitted is either missing required information or contains invalid values. In accordance with CMS & Texas Insurance regulations [under 21.2807 Effect of Filing Clean Claim], your claim is being returned as incomplete. Please review the item(s) on this form and resubmit the claim with the necessary information within 120 days of the date of this notice.

Additional Information Request for UB-04

Receipt Date:	Return Date:
Member ID #	Member DOB
From Date of Service	To Date of Service

Claims Reviewer ID:	Adjudicator ID:	Approval Signature:

The claim(s) cannot be processed due to the following reason(s):

- ☐ We are unable to identify eligibility with the information submitted. Please resubmit with a copy of the Participant's Card.
- ☐ Newborn full name and plan identification number is required. Please contact our enrollment department for assistance.
- Box 1 — Facility Name and/or Address does not match our records or is incomplete on the claim form.
- Box 3 — The patient's control number is incomplete.
- Box 4 — The Bill Type is inconsistent, invalid or incomplete with procedures.
- Box 5 — Federal Tax No. does not match our records or is incomplete.
- Box 6 — Covered Dates for Inpatient does not match our records or is incomplete.
- Box 8B — Patient's last name and/or first name does not match our records or is incomplete.
- Box 9A-B — Patient's Address does not match our records or is incomplete.
- Box 10 — Patient's Date of Birth does not match our records or is incomplete.
- Box 11 — Patient's sex does not match our records or is incomplete.
- Box 12 — Admission Date does not match our records or is incomplete.
- Box 13 — Admission Hour is invalid or incomplete.
- Box 14 — Type of Admission is invalid or incomplete.
- Box 15 — Inpatient Source of Admission is invalid or incomplete.
- Box 16 — Discharge Hour is invalid or incomplete.
- Box 17 — Discharge status is invalid or incomplete.
- Box18-28 — Condition Codes is invalid or incomplete.
- Box 31- 34 — Occurrence Codes are inconsistent, invalid or incomplete.
- Box 35 - 36 — Occurrence Span codes and Dates are invalid or incomplete.

For any questions regarding this claim(s) please contact our Provider Care Unit (915) 532-3778. 1

Box 39 - 41	Value Codes and Amounts are inconsistent or incomplete.
Box 42	Revenue Code is inconsistent, invalid or incomplete.
Box 43	Revenue Description is inconsistent, invalid or incomplete
Box 44	HCPCS/RATES are inconsistent, invalid or incomplete.
Box 45	Service Date is invalid or incomplete
Box 46	Unit(s) of Service is invalid or incomplete
Box 47	Total charges per detail line are incomplete.
Box 48	Non-covered charges required for co-insurance coverage.
Box 50	Payer Name is incomplete.
Box 51	Provider Unique identification number is inconsistent or incomplete.
Box 53	Assignment of benefits status is incomplete.
Box 54	Prior Payment(s) are inconsistent or incomplete with supporting explanation of benefits (EOB).
Box 56	The NPI number of the rendering facility does not match our records or is incomplete on the claim form.
Box 58	Insured's Name does not match our records or is incomplete.
Box 59	Patient's Relation to insured is required.
Box 60	Insured's Unique ID does not match our records or is incomplete.
Box 61	Insured Group Name does not match our records or is incomplete.
Box 62	Insured Group Number does not match our records or is incomplete.
Box 63	Treatment Authorization Code does not match our records, is invalid or is incomplete.
Box 64	Insured Employment Status Code is required.
Box 65	Employer Name and Location is required.
Box 66	Principal Diagnosis Code is required, is inconsistent with procedure or is incomplete.
Box 69	Admitting Diagnosis is required, is invalid, or incomplete.
Box 74	Principal Procedure code and dates is required.
Box 74a – 74e	Other Procedure codes and dates is required.
Box 76	Attending Physician Name and NPI number are required, does not match our records or is incomplete.
Box 77	Operating Provider Name and NPI number are required, does not match our records or is incomplete.
Box 78	Other Physician's Name and NPI number are required, does not match our records or is incomplete.
Box 80	Informational Remarks Needed.

Other Information Required: _____

_____

_____

_____

_____

For any questions regarding this claim(s) please contact our Provider Care Unit (915) 532-3778. 2

10.9 Delivery of Paper Claims

Claims must be submitted on CMS approved forms such as CMS 1500 or UB04.

Please refer to the official CMS website for most current format. www.cms.hhs. gov

It is recommended that paper claims be sent by certified mail with a return receipt requested and a detailed log listing of the claims enclosed.

El Paso Health will not accept copies of claims or faxed claims for first-time submissions. Please mail all new or corrected claims to:

El Paso Health Medicare Advantage
Attention: Claims Department
P.O. Box 971370
El Paso, TX 79997-1370

10.10 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 the Member Services department. If you have attempted to resolve your claim issues with Member Services but are still dissatisfied with the outcome, you may file a formal complaint with El Paso Health Complaints and Appeals Unit.

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

El Paso Health Medicare Advantage
Attn: Complaints and Appeals Unit
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.

10.11 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.

Deductibles:

El Paso Health will consider deductibles for reimbursement when the primary carrier applied the payment amount directly to the Member's deductible. The explanation of benefits must reflect the applicable payment by the primary carrier and a completed, signed copy of the claim must be
submitted to El Paso Health Medicare Advantage Dual (HMO D-SNP), El Paso Health Total (HMO) or El Paso Health Giveback (HMO) for consideration.

El Paso Health will consider any other coverage to include any group insurance, prepaid health plans, automobile insurance and worker's compensation or program that is or may be liable to pay all or part of the health care expenses of the member.

If the amount paid by a third-party health insurer is less that the amount payable for the services by El Paso Health, providers may bill El Paso Health for the difference between the amount paid by the third-party carrier and the El Paso Health allowable amount. The claim must be filed timely and in accordance with all the filing guidelines.

Note: If it is determined that El Paso Health is the secondary (or tertiary) payer, El Paso Health will reimburse per COB Processing Guidelines. We will calculate the difference between El Paso Health's Maximum Allowed Amount and the primary carrier's payment, paying the lesser of the two minus any applicable copays, coinsurance, or deductible.

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.

Online Claims Tools

Resources for Claim Status:

To obtain claim status call Member Service at 1-833-742-3125 (D-SNP) or 1-833-742-2121 Total and Giveback. A Member Service Representative can assist you with claim status, claim questions and resolve claim inquiries.

Claims Payment Integrity Review

El Paso Health (EPH) has adopted and implemented an effective Fraud, Waste and Abuse (FWA) investigation process and is committed to comply with applicable federal and state laws, rules and regulations related to FWA through the use of data analysis. Data analysis includes both, pre-payment and post-payment claims edits/strategies.

Claims department:

One of the key components of FWA department's ongoing activities is the data mining of the claims payment system to: (i) validate if the elements of claims are billed in accordance with standardized billing practices; (ii) ensure claims are processed

accurately; and, (iii) ensure payments reflect the service performed as authorized. Some of these claim edits are listed below:

1. Duplicate Claim Submission
2. Members eligibility at time of service
3. Non-covered services
4. Services requiring prior authorizations
5. Services requiring specific modifiers
6. Invalid procedure or diagnosis codes
7. Unbundled procedures
8. Incidental procedures
9. Exclusive procedures
10. Diagnosis and/or Procedure code with gender/age mismatch
11. New patient code billed for established patient
12. Global pre/post codes billing within the global period
13. Certain cosmetic procedures
14. Place of service with procedure code mismatch
15. Multiple procedure reductions

Provider Claims Payments Reconsideration Process

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

SECTION 11: QUALITY IMPROVEMENT PROGRAM

11.1 Overview

El Paso Health Quality Assessment and Performance Improvement (QAPI) Program is designed to evaluate and measure the degree of quality healthcare our members receive and the quality of services we offer to our Members and to you, our Providers. The aim of the QAPI Program is to ensure that the healthcare Members receive is optimal and consistent with the mission of El Paso Health. Our commitment is to improve the health status of the Members we serve through an integrated Quality Improvement (QI) approach to health and social services. Your partnership is paramount in the success in any of our QI initiatives and in fulfilling the requirements mandated by Centers for Medicaid Services (CMS) and Texas Department of Insurance (TDI). All contracted Providers are required to cooperate and participate in our QAPI Program, as outlined in their Provider contract.

11.2 QI Objective

The purpose of the El Paso Health QAPI Program is to continuously improve patient safety and Member outcomes by providing well-coordinated care within a robust network of contracted Providers, invested in providing evidence-based care in a patient-centered environment. The QAPI Program is designed to assure that Members receive care that is consistent with our mission.

Our QAPI Program is designed to improve:

- Quality of care for all physical and behavioral health care and services
- Member and Provider satisfaction
- Member safety
- Access to services

As part of our commitment to quality, we review a variety of data to track Member complaints, safety concerns, quality outcomes, and Member and Provider satisfaction in order to improve our programs and services to ensure the best quality care is provided. El Paso Health strives to build relationships that strengthen the delivery of healthcare in our community so that we may be the region’s trusted community health plan.

11.3 QI Program Evaluation

It would be both a privilege and pleasure to have you join in on our Quality Improvement journey. El Paso Health’s QAPI Program has physician driven committees who are responsible for the oversight, evaluation, and approval of our QAPI Program. All physician committees are peer protected, and the various meetings are held monthly,

quarterly or as needed. El Paso Health has the following physician committees:

- Quality Improvement Committee (QIC)
- Credentialing and Peer Review Committee (CPRC)
- Utilization Management Committee (UMC)

Here at El Paso Health, we value the input of our Providers. If you are interested in joining any of our committees, please feel free to contact our Medical Director toll-free at1-877-532-3778 (D-SNP) 1-833-742-2121 Total/EPH Giveback.

11.4 HEDIS Set Measures

The annual Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). The NCQA is an independent group established to provide objective measurements of the performance of managed health care benefit plans, including access to care, use of medical services, effectiveness of care, preventive services, and immunization rates.

HEDIS rates are calculated in three ways: administrative data, hybrid data, or electronic data. Administrative data consists of claims and encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data.

Hybrid data collection requires El Paso Health to collect data medical records on randomly selected samples of members in order to extract data regarding services rendered but not reported to the plan through claims or encounter data.

The El Paso Health Quality Improvement Department and the Provider Relations Department request medical records from providers for HEDIS and coordinate submission methods at your convenience. Medical records review audits for HEDIS may occur at any time during the year but are typically conducted February through April each year. Your prompt attention and cooperation to these requests is very important and appreciated. As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member.

Medical record documentation tips for HEDIS Hybrid measures may be found here:

11.5 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 both preventive and clinical practice guidelines for adults to address various

areas such as diabetes and behavioral health. Our Practice Guidelines are designed to address the needs of our members. You can obtain a copy of our Practice Guidelines by visiting our website at https://ephmedicare.com/quality/clinical-practice-guidelines/ or contacting the Quality Improvement Department toll free at 1-877-532-3778.

11.6 Special Needs Plan (SNP) Model Of Care (MOC)

El Paso Health Model of Care (MOC) has the following components:

- Case management beginning with the primary care physician as the Member's "medical home."
- Preventive care, early intervention, health education and continuity of care in order to improve and maintain Member's health.
- A full range of resources that are available and accessible to Members.
- A comprehensive Quality Improvement/Utilization Management system, tracking key indicators for improved healthcare outcomes and rewarding providers for preventive care.

Providers are required to participate in, and comply with, the CMS Model of Care training requirements as applicable. This includes completing an initial MOC training within 30 days of joining the EPH network and are-training and submission of attestation upon completion. Re-training will only be required during MOC renewal year. Please visit our website for the MOC training and attestation information: https://ephmedicare.com/medicare-compliance-program-2/model-of-care-training/

The MOC is a framework that EPH follows to meet the needs of our DSNP members. It ensures that we identify the unique needs of each member and address those needs through care management practices. Your role as the provider in the MOC is very important. Every SNP member must have an initial (within 90 days of enrollment) and annual HRA completed and an individual care plan (ICP) which is developed in conjunction with the member/caregiver, the PCP, and other members of the health care team. The ICP must include problems, interventions, and goals, outline the specific services and benefits to be provided, and include measurable outcomes.

11.7 Alternative Payment Models (APM)

El Paso Health offers providers quality incentive programs, known as Alternative Payment Models (APM), to drive improvement in quality of care delivered to members. PCP providers with more than 100 Medicare EPH members assigned to their panel are eligible to be offered an APM contract. These APMs define a set of quality measures with goals that providers must meet in order to earn points towards an earned financial incentive.

11.8 Case Management Program

El Paso Health administrative and clinical staff roles support Care Coordination to maximize the use of effective, efficient, safe and high-quality Member services provided by network Providers as well as Community Partners. Case Managers core functions promote the highest level of physical, psychological, and social functioning possible for Members and their families. Our Member centric, evidence-based Care Coordination is provided through an integrated staff structure in which our Members' health care needs are met and health services are delivered in the preferred setting. El Paso Health case managers are registered nurses and licensed social workers who engage the appropriate internal, external or community-based resources to support the member's needs.
The Health Risk Assessment (HRA) is a series of questions designed to best identify a Member's state of health, risk for exacerbation of acute or chronic conditions, functional decline, and social issues likely to affect the Member's ability to achieve personal health and well-being goals.

Purpose:

- Assess the medical, functional, cognitive, psychosocial and mental health needs of each member.
- Contributes to development of the Individualized Care Plan (ICP)
- Supports the Interdisciplinary Care Team (ICT) composition and activities
- EPH employs a collaborative team approach to ensure completion of the HRA. Member Services and Health Services work together to perform outreach, generate mailings, and coordinate with Providers to facilitate Member engagement.
- HRA mailing
- Member Services Outreach
- Case Manager Outreach

Every Member will have an HRA and ICP completed initially within 90 days of enrollment effective date and within 365 days of the last HRA.

The ICP is based on the initial HRA results, the Case Manager assessment, the Member's medical history, health care, cultural and linguistic preferences, pharmacy utilization, and input from all active Members of the ICT.

- When the Member cannot be reached, or opts-out of service coordination,
- EPH uses available clinical data to develop an ICP
- Includes a wellness and self-management plan
- The ICP is mailed to the address of record accompanied by a letter with request for a call to Member Services to complete the HRA and participate in development of the ICP.

11.9 Disease Management Program

El Paso Health disease management program supports our members treatment plans. They also assist members in managing their conditions. By using medical, pharmacy and behavioral health claims data, we can identify members who are high-risk and a good fit for our programs. A referral from a health risk assessment, a member/caregiver, or a member of their medical team can also help identify these high-risk members. You can refer these members to the appropriate program by calling the number on the member's health plan ID card. Participation in these programs is voluntary. Upon referral, we assess members for the appropriate level of care for their individual needs.

11.10 Risk Adjustment

Risk adjustment is a federally mandated process used by CMS to adjust capitated payments to Medicare Advantage (MA) plans. These adjustments compensate plans fairly and accurately based on the expected healthcare costs of their enrolled beneficiaries. A beneficiary's risk score is calculated using demographic data and documented diagnoses to predict their future healthcare utilization and expenditures relative to the average Medicare beneficiary.
Accurate and complete clinical documentation and coding by providers is essential to ensure that each patient's Hierarchical Condition Category (HCC) risk score accurately reflects their health status and severity of illness.

Providers play a critical role in the risk adjustment process. Key responsibilities include:

- Documenting all current conditions: Document all relevant and current conditions for Medicare Advantage beneficiaries, including chronic, acute, and inactive conditions requiring monitoring or management, at least annually.
- Ensuring documentation specificity: Document the patient's condition with the highest degree of specificity possible, including the onset, progression, severity, and manifestations of illnesses (e.g., "Type 2 diabetes with chronic kidney disease, stage 3" rather than just "diabetes").
- Linking diagnoses to care: Ensure that all diagnoses are supported by clear, specific documentation in the patient's medical record, reflecting the provider's Medical Decision Making (MDM), Evaluation, Assessment, or Treatment (M.E.A.T.) plan for that condition during the face-to-face visit.
- Adhering to coding guidelines: Use appropriate International Classification of Diseases, Clinical Modification (ICD-10-CM) codes and adhere to official coding guidelines for reporting diagnoses.

Providers should ensure documentation for each condition includes evidence of at least one of the following elements:

- Monitoring signs, symptoms, or disease progression/regression.
- Evaluating test results, medication effectiveness, or response to treatment.
- Assessing/Addressing the condition through discussion, care planning, or specialist management acknowledgement.
- Treatment with medications, surgical interventions, or referrals to specialists.

Common Documentation Best Practices

- Acuity and Severity: Document the status and severity of conditions. For malignancies, specify whether they are active or a history of (e.g., "history of breast cancer, currently in remission").
- Linkage: Use linking terminology such as "due to," "secondary to," or "caused by" to establish a causal relationship between conditions (e.g., "hypertension due to chronic kidney disease").
- Problem List/Past Medical History (PMH): The problem list or PMH should be actively managed and not relied upon as the sole source of a current diagnosis for coding purposes. Only conditions addressed during the current encounter and supported in the progress note should be coded.
- Avoid Uncertainty: Do not code diagnoses as "probable," "suspected," "questionable," or "rule out" in the outpatient setting. Code only confirmed diagnoses to the highest degree of certainty for that encounter.

Auditing and Compliance

CMS conducts Risk Adjustment Data Validation (RADV) audits as well as other audits that are linked to Risk Adjustment. These audits serve to confirm that diagnoses submitted by MA organizations are fully supported by the documentation in the enrollees' medical records. Providers may be asked to furnish medical records for these audits. Adherence to these guidelines ensures compliance and integrity in the data submission process.

SECTION 12: PHARMACY SERVICES

12.1 Formulary

El Paso Health collaborates with Pharmacy Benefit Manager, Navitus, to develop and maintain the Part D Formulary. Coverage limitations, Prior Authorization, and Quantity Limits can be found in our Formulary, which can be found on our website. You may also call 1-866-270-3877 for additional assistance.

12.2 Mail Order Services

Our plan's mail-order service allows providers to order up to a 90-day supply of medication for a chronic or long-term medical condition. Drugs that are not available through our plan's mail-order service are marked as NDS (non-extended day supply) in our Formulary. For more information, please contact us or see the mail order section of the pharmacy directory on our website.

12.3 Over-The-Counter Medications

Medicare does not cover over-the-Counter medications. However, some of these drugs may be covered for our members under their Medicare drug coverage. El Paso Health Medicare Advantage also offers a supplemental benefit where members are eligible to receive covered over-the-counter purchases such as toothbrushes, bandages, vitamins, grab bars, Nicotine Replacement Therapy drugs and other eligible items.

12.4 Prescription Drug Coverage Determinations

Some medications on our formulary may require Prior Authorization and/or Step Therapy. El Paso Health works with its Pharmacy Benefits Manager, Navitus Health Solutions, to review Coverage Determinations. You may request a drug coverage determination for a member by submitting a request by phone, fax, or electronically. Your request will be reviewed and a coverage decision will be provided to you and our member. Providers or Members may ask for an expedited coverage decision if fast decision is needed. Coverage Determination forms can be obtained on our website or you may call 1-866-270-3877 for more information.

12.5 Exceptions to the Formulary

We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. We may also make changes based on new clinical guidelines. If we make these other changes, you can ask us to make an exception and continue to

cover the brand name drug. When you request a formulary or utilization restriction exception, you should submit a statement supporting your request. Generally, we must make our decision within 72 hours of getting your supporting statement. You can request an expedited (fast) exception if you believe that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give a decision no later than 24 hours.

12.6 Medication Appeals

If El Paso Health denies your determination request, you or our member, have the right to request an appeal or "redetermination". You have 65 days from the date of the original determination to request an appeal. The "Request for Redetermination of Medicare Prescription Drug Denial" form can be obtained from our website and can be sent to us by mail or fax.

12.7 Pharmacy - Long Term Care

Resident members of a long-term care facility needing a drug that that is not on our formulary or if their ability to obtain prescription drugs is limited, El Paso Health Advantage Dual SNP will cover a 31-day emergency supply of any medication that is not on our formulary while you pursue a formulary exception.

SECTION 13: COMPLIANCE

The El Paso Health's Medicare Compliance program is designed to provide general guidance on compliance and ethics to all contractors, vendors, and personnel affiliated with El Paso Health. Its purpose is to ensure adherence to the corporate commitment of abiding by all state and federal regulations governing legal and ethical business conduct.
El Paso Health's Medicare Compliance Program, may be amended from time to time, includes information regarding El Paso Health's policies and procedures related to fraud, waste, and abuse. It provides guidance and oversight on the ethical and legal performance of work by El Paso Health, its employees, contractors (including delegated entities), and business partners. All Providers, including their employees and subcontractors, are required to comply with El Paso Health's Medicare Compliance Program requirements. Training requirements related to compliance include, but are not limited to, the following initiatives:

HIPAA Privacy and Security Training: Summarizes privacy and security requirements according to federal standards established pursuant to HIPAA and subsequent amendments. Training includes discussions on proper uses and disclosures of Protected Health Information (PHI), member rights, and physical and technical safeguards.

Fraud, Waste, and Abuse (FWA) Training: Must include information on the Special Needs Plan Model of Care, laws and regulations related to fraud, waste, and abuse (e.g., False Claims Act, Anti-Kickback Statute, HIPAA), and obligations of Providers to have appropriate policies and procedures to address fraud, waste, and abuse. It also covers the process for reporting suspected incidents and protections for those who report them.

Providers, including their employees and subcontractors, are required to report any suspected fraud, waste, or abuse, misconduct, or criminal acts by El Paso Health, any Provider, or their respective employees or subcontractors. Reports may be made anonymously through the Fraud, Waste, and Abuse Hotline at 1-866-356-8395. Details of the Medicare Compliance Program can be found at ephmedicare.com/medicare-compliance-program-2/.

13.1 Code of Conduct

El Paso Health compliance efforts are designed to establish a corporate culture promoting prevention, detection, and resolution of questionable conduct in order to conform to all Federal and State laws and regulations, private payer health plan requirements, and EPH's ethics and business policies.

EPH expects all employees ("Associates"), First Tier, Downstream, and Related Entities (FDR's) and contracted Providers to comply, identify, report, and assist in the resolution

of all concerns relating to applicable laws, regulations, and policies affecting the operations of EPH.

EPH has a compliance hot line for reporting any potential compliance violation. Reports of potential violations made by or about employees, agents, contractors, providers, FDR's, and members are maintained in a confidential manner. The hot line is available 24-hours a day, 7 days a week. Reports may also be made anonymously. These reports are never traced. Anyone can make a report without fear of intimidation or retaliation.

El Paso Health Compliance Hot line: 1-888-310-3434

You may also report any issues/concerns to the following:

- Medicare at 1-800-MEDICARE (1-800-633-4227)
- Federal OIG Fraud Hot line at 1-800-HHS-TIPS (1-800-447-8477)
- Texas OIG Fraud Hot line at 1-800-436-6184

Electronic copies of El Paso Health's Code of Conduct can be found on the website at ephmedicare.com.

13.2 Reporting Fraud Waste and Abuse

El Paso Health maintains several ways to report suspected fraud, waste and abuse. As a Medicare Advantage provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse at EPH Fraud, Waste, and Abuse Hot- line: 1-866-356-8395 Anonymous reporting, suspected fraud, waste and abuse may also be reported by reaching out directly to the EPH Director of Compliance at vberrios@elpasohealth.com.

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, and investigation and reporting.
Many types of fraud, waste and abuse have been identified, including the following:

Provider fraud, waste and abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Bundling
- Up-coding

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Member fraud, waste and abuse can consist of the following:

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent fraud, waste and abuse, Providers can educate Members about these types of fraud and penalties. One of the most important steps to help prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. EPH may not accept responsibility for the costs incurred by providers rendering services to a patient who is not an EPH member, even if that patient presents a Medicare member ID card. Providers should take measures to ensure the card holder is the person named on the card. Educate patients to carry their ID card at all times and report any lost or stolen cards to EPH as soon as possible.

13.3 Part C Reporting Requirements

Part C Medicare reporting requirements MA organizations are subject to additional reporting requirements. We may request data from you. Some measures are reported annually while others are reported quarterly or semi-annually. This includes, but is not limited to:

- Grievances
- Organization determinations/reconsiderations, including source data for all determinations and reopening’s
- Special needs plans care management
- Rewards and incentive programs
- Payments to health care providers
- Telehealth benefit

13.4 Compliance Investigation/Retaliation

EPH strictly prohibits retaliation against anyone for reporting or inquiring in good faith any belief of wrongful or unlawful activity or for participating in an investigation or proceeding related to such activity.

We feel very strongly about protecting your rights as a Provider to report a potential violation of the Code of Conduct. If we discover that you are being retaliated against for bringing a suspected violation to our attention or for participating in an investigation, we will act as per EPH policy. Any Provider who commits or allows any form of retaliation may be subject to disciplinary action, up to, and including contract termination. If you suspect healthcare fraud is occurring and feel that the Compliance Hot-line investigation is not satisfactory, or you do not feel comfortable with reporting the allegation through any internal method; you have the right to contact the Office of the Inspector General (OIG).

SECTION 14: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

14.1 HIPAA

The Health Insurance Portability and Accountability Act was signed into law in August 1996.

This act was put in place to improve the portability and continuity of health benefits, ensure accountability in the area of health care fraud and simplify the administration of health insurance. EPH strives to ensure both EPH and its contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Effective April 14, 2003 Providers must follow HIPAA privacy regulations.

EPH and its Providers under the HIPAA privacy regulations should only request the minimum necessary member information to accomplish the intended purpose. Privacy regulations allow the transfer or sharing of member information, which may be requested by EPH to conduct business and make decisions about care such as a member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs.

When faxing information to EPH, verify the receiving fax number is correct, notify the appropriate staff at EPH and verify the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to EPH (e.g., Excel spreadsheets with claim information).

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific EPH individual or department.

EPH's voice mail system is secure and password-protected. When leaving messages for EPH associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting EPH, providers or their staff should be prepared to verify identifier information.

For more information about the privacy and reporting a breach of health information, please review the Notice of Privacy Practices found at our website ephmedicare.com or call Member Services at 1-833-742-3125(D-SNP)/ 1-833-742-2121 (MAPD), (TTY 711).

SECTION 15: MARKETING GUIDELINE AND REQUIREMENTS

15.1 Provider Marketing Guidelines

Providers must conduct all marketing activities in accordance with El Paso Health, Federal and State marketing statutes and regulations.

Marketing means any communication to beneficiaries not enrolled with El Paso Health that can be intended to influence the beneficiary to enroll with El Paso Health Medicare products. This includes any communication that can influence a beneficiary to enroll or disenroll from another Health Plan.

15.2 Member Information & Marketing

All written informational or marketing materials for El Paso Health Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by El Paso Health prior to use. Please contact your Provider Services representative for information and review of proposed materials.

Member marketing material requires CMS approval. This includes: anything with the Medicare Advantage name or logo.

Center for Medicare & Medicaid Services (CMS) marketing guidance also requires that Providers must not make phone calls or direct, urge or attempt to persuade Medicare beneficiaries to enroll or disenroll in a specific plan based on the health care provider's financial or any other interest. Providers may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.

15.3 Member Communication

In regards to member correspondence that describes benefits, approval is not necessary for communications between health care providers and patients that discuss:

- Medical condition
- Treatment plan and/or options
- Information about managing their medical care

15.4 Anti-Kickback Statue

El Paso Health complies with Federal and State Anti-Kickback Statues (AKS) statutes and regulations. Providers are prohibited from engaging in any activities covered under this statute. Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business.

Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

15.5 Stark Statue

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. “Designated health services” are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

El Paso Health
Medicare Advantage

For more information:

Call 1-833-742-3125
El Paso Health Medicare Advantage Dual (HMO-D-SNP)

1-833-742-2121
El Paso Health Total (HMO) or El Paso Health Giveback (HMO)

TTY users call 711

or visit us at
ephmedicare.com