Introduction

Using Your 2019 Centennial Care Practitioner and Provider Manual

This 2019 Centennial Care Practitioner and Provider Manual is both a resource for essential information about Centennial Care Presbyterian policies and procedures and an extension of your service agreement.

For your reference, this manual and many other communications from Presbyterian Health Plan, Inc., and Presbyterian Insurance Company, Inc., will refer to both entities as “Presbyterian” on second reference.

The manual is available online at https://www.phs.org/ProviderManual and is updated quarterly or as needed. Providers can also request a paper copy of the manual be mailed to them at no charge.

Updates will also be communicated periodically through the Network Connection newsletter and on the provider communications page located at https://www.phs.org/providers/contact-us/news-and-communications/Pages/default.aspx.

You can also receive newsletters and updates from Presbyterian electronically by signing up to receive emails from Provider Network Operations at https://www.phs.org/providers/contact-us/news-and-communications/Pages/enews-registration.aspx.

How the Term “Provider” Is Used in this Manual

We acknowledge that the National Committee for Quality Assurance (NCQA) distinguishes between a practitioner (person) and a provider (facility). We make this distinction on this manual’s cover but to simplify the text within the manual, we have chosen to use the term “provider” as an umbrella term that includes facilities as well as providers, practitioners and any other staff who are directly or indirectly contracted to provide service to Presbyterian Centennial Care members.

We Want To Hear from You

We encourage you to provide us with feedback on this manual. Please forward any corrections, questions and comments to us at providercomm@phs.org.
## Revision History

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1. Presbyterian Healthcare Services

**Purpose Statement**

Presbyterian exists to improve the health of the patients, members and communities we serve.

Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. (Presbyterian) are part of Presbyterian Healthcare Services, New Mexico’s largest locally owned integrated healthcare system. Established on Oct. 24, 1908, as the Southwest Presbyterian Sanatorium, Presbyterian began as a treatment center and refuge for tuberculosis patients. Through the years, Presbyterian grew and expanded into the statewide integrated healthcare system it is today. A few key services include the following:

- Nine not-for-profit Presbyterian-operated hospitals located in Albuquerque, Clovis, Espanola, Rio Rancho, Ruidoso, Santa Fe, Socorro and Tucumcari
- The Presbyterian Medical Group (PMG), consisting of more than 500 physicians and practitioners providing medical care throughout New Mexico
- Presbyterian Health Plan, New Mexico’s largest managed care organization, providing commercial health insurance, Centennial Care and Medicare Advantage products

**Presbyterian Healthcare Services**

Presbyterian offers a statewide healthcare delivery system that provides your patients and our members with a comprehensive provider network, a quality medical management program and cost-effective, consumer-driven managed healthcare services. We are committed to providing exceptional customer service to our providers and members. Presbyterian strives to ensure members can access primary and specialty care services as needed and receive quality healthcare services in the most cost-effective setting. Unlike most managed care organizations, which are accountable to shareholders, Presbyterian is ultimately accountable to a board of directors comprised of volunteers from our communities. Presbyterian’s enduring purpose is to improve the health of the patients, members and communities we serve.

Our statewide network exists because of the partnerships and relationships we build with you, our physical health, behavioral health and long-term care providers. Presbyterian’s statewide network comprises:

- Thirty-six general acute-care hospitals (eight of these are currently owned, leased or managed by Presbyterian Healthcare Services)
- More than 10,000 practitioners
- More than 300 retail pharmacies composed of locally owned stores and most major chains
Members can use doctors, hospitals and providers outside the Presbyterian network for an additional cost.

Presbyterian offers a range of healthcare insurance products and programs to members, including commercial products, Presbyterian Centennial Care, Presbyterian Senior Care (HMO), Presbyterian Senior Care (HMO-POS) and Presbyterian MediCare PPO Plan. This manual addresses only those programs that are relevant to Centennial Care.

**Presbyterian Centennial Care**

Presbyterian Centennial Care is New Mexico’s Medicaid program that replaced the former Salud! program, State Coverage Insurance (SCI) and coordination of long-term care services in 2014. Presbyterian Centennial Care is a single, comprehensive delivery system through three managed care plans, allowing for greater administrative simplicity. It emphasizes care coordination so that recipients receive the right care, in the right place, at the right time, leading to better health outcomes.

**Medicare Advantage: Presbyterian Senior Care (HMO) and Presbyterian MediCare PPO**

Presbyterian Centennial Care members receive their care and services from the Presbyterian network of providers. Presbyterian offers a network of providers with a wide range of specialties to fit the unique needs of its beneficiaries. Presbyterian Dual Plus (HMO SNP) is a Medicare Advantage plan that includes special benefits and services for individuals with Medicare and Medicaid coverage and distinct healthcare needs. This plan includes Medicare Part D prescription drug coverage and is designed to improve care and decrease costs for the frail, elderly and disabled through improved coordination of care.

To be eligible for Presbyterian Dual Plus, individuals must meet the following criteria:

- Be over 65 years old, or be under 65 years old with a certified disability
- Receive full medical benefit assistance from Medicaid
- Have Medicare Parts A and B
- Live in one of the following four counties: Bernalillo, Sandoval, Torrance or Valencia

Presbyterian Dual Plus-eligible members qualify for full Medicaid benefits and payment of Medicare premiums and cost sharing. Identified member sub-populations who are eligible for Presbyterian Dual Plus are members with:

- Advanced illnesses
- Co-morbid disabilities and behavioral health (BH) diagnoses
- Early-stage or late-stage dementia-related diagnosis

Medicaid will act as a wrap-around that pays for services that are not covered by Medicare, such as:

- Dental services and other services provided at the state’s option
- Coverage of services still follows Medicare and Medicaid coverage rules
In addition, Medicaid covers long-term care nursing facility services and home- and community-based services.

If a Presbyterian Dual Plus enrolled member loses their Medicaid eligibility, they will have a grace period where they will remain enrolled in Presbyterian Dual Plus while they attempt to recertify their Medicaid status. During this period, they will continue to receive their Medicare and other approved benefits through Presbyterian Dual Plus.

**Regulatory Agency Websites**

This Presbyterian Provider Manual incorporates information from regulatory agencies about requirements for Presbyterian’s product lines. For more information about regulatory requirements, please visit the websites listed below.

<table>
<thead>
<tr>
<th>Regulatory Agency Websites</th>
<th>Website Location</th>
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<tbody>
<tr>
<td>New Mexico Human Services Department Medical Assistance Division</td>
<td><a href="http://www.hsd.state.nm.us/mad/">http://www.hsd.state.nm.us/mad/</a></td>
</tr>
<tr>
<td>State of New Mexico Regulations &amp; Licensing Department</td>
<td><a href="http://www.rld.state.nm.us/">http://www.rld.state.nm.us/</a></td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td><a href="https://nppes.cms.hhs.gov/">https://nppes.cms.hhs.gov/</a></td>
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</table>
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2. Centennial Care Overview

What is Centennial Care?

Centennial Care is an integrated system of care that emphasizes improved outcomes for those on Medicaid. New Mexico’s primary goal is to build a service delivery system that delivers the right amount of care at the right time in the right setting.

The Centennial Care vision is to educate members to become more savvy healthcare consumers, promote more integrated care, properly case manage the most at-risk members, involve members in their own wellness and pay providers for outcomes rather than process.

The guiding principles of Centennial Care include the following:

- Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State’s Medicaid program
- Encouraging more personal responsibility so that beneficiaries become more active participants in their own health and more efficient users of the healthcare system
- Increasing the emphasis on payment reforms that pay for performance rather than for the quantity of services delivered
- Simplifying administration of the program for the state, for providers and for beneficiaries where possible

New Mexico Medicaid Expansion

New Mexico Medicaid expansion services, also known as the Alternative Benefit Package (ABP), are provided as part of an eligible member’s Centennial Care coverage through a Centennial Care managed care organization (MCO). To be eligible for Medicaid expansion, you must be an adult between the ages of 19 and 64 and who is at or below 138 percent of the federal poverty level. Qualifying adults receive their Medicaid expansion services through a Centennial Care managed care organization (MCO). Native Americans who are eligible through the Expansion may enroll in Centennial Care or receive services through fee for service.

Medically fragile means an adult member who would be covered under the Adult Benefit Plan (ABP) but who has been determined as meeting the Human Services Department’s (HSD’s) definitions and criteria for the following:

- Disabling mental disorder, including individuals up to age 21 with serious emotional disturbances and adults with serious mental illness
- A serious complex medical condition
- A physical, intellectual or developmental disability that significantly impairs the member’s ability to perform one or more activities of daily living
Centennial Care Overview

- A disability determination based on Social Security criteria

Some members, including members in a nursing facility, may be assessed copays for certain services or drugs. Native American members are not subject to any copayments. Some copays will apply to Working Disabled (WDI) members and Children’s Health Insurance Program (CHIP) members.

For information on what services require copays, please refer to the Standard Centennial Care Copays and ABP Services with Copays tables.

<table>
<thead>
<tr>
<th>Service</th>
<th>ABP Income Level A</th>
<th>ABP Income Level B</th>
<th>ABP Exempt</th>
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<tr>
<td>Brand-name drug when a generic version is available</td>
<td>$8 per drug item</td>
<td>$8 per drug item</td>
<td>$8 per drug item</td>
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<td>Non-emergent use of the ER</td>
<td>$8</td>
<td>$8</td>
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ABP Covered Services and Authorization

Refer to the ABP Details table for a list of services included under the Centennial Care Alternative Benefit Package. Please note the covered services and authorization requirements may differ from regular Centennial Care.

Please refer to Appendix G for a list of ABP-covered services.

Centennial Care Mother and Newborn

Hospitals or other providers must complete the Notification of Birth, Medical Assistance Division (MAD) Form 313 before the discharge of an enrolled Presbyterian Centennial Care mother and her newborn. Medicaid-eligible newborns are eligible for a period of 12 months, starting with the month of the birth. The newborn is enrolled retroactively to the month of birth with the mother’s MCO.

Member Health Risk Assessment

All members receive a Health Risk Assessment (HRA) within 10 days of enrollment. The HRA form is standardized and approved by HSD. The HRA is used to determine the member’s health status and emergent needs related to care coordination. Upon completion of the HRA, members are assigned to a level of care coordination and are partnered with a
dedicated care coordinator. Members are matched with an appropriate care coordinator based on their clinical needs, geography, language, cultural preferences and history of established relationships with a provider. All members assessed at Care Coordination Level 2 and Level 3, see Appendix B, receive an in-person Comprehensive Needs Assessment (CNA) to identify and prioritize their clinical, behavioral, functional and social support needs.

**Comprehensive Needs Assessment**
The CNA is a comprehensive “in-person” assessment using a tool designed to assess the physical, behavioral, functional and social needs of a member and to determine the level of care coordination. The CNA may indicate a need for further assessment, which determines if a member meets the Nursing Facility Level of Care (NFLOC). Upon completion of the CNA, the care coordinator and member can determine the care plan and the extent of incorporating the Interdisciplinary Care Plan Team (ICPT).

**Interdisciplinary Care Plan**
Based on the results of the comprehensive assessment, an individualized care plan is developed for each member and an appropriate ICPT is established. The ICPT includes the member and all providers, including primary care providers (PCPs), specialists and support providers along with any additional resources needed to fulfill the care plan’s goals. The care plan is reviewed, modified if necessary, approved and then signed by the member. The care plan serves as the basis for utilization management authorizations and care coordination.

Presbyterian Centennial Care has structured the ICPT to address the member’s specific needs and is a central component of the care model. Members are encouraged to actively participate in the care planning process and they are provided with tools and resources that allow them to take personal responsibility for their care management.

Clinical staff from nursing homes and assisted living facilities where members live are included as integral participants in the member’s ICPT. Residential care staff members are instrumental participants in the member’s care team and play a central role in alerting our care coordinators to a change in condition or status that, if acted upon, may prevent unnecessary hospitalizations.

**Appointment Standards**
Contracted providers are expected to adhere to Centennial Care appointment standards. Presbyterian publishes appointment standards in its Provider Manual, which is distributed to the entire network on an annual basis. If a provider fails to meet the appointment standards, Presbyterian develops and implements a corrective action plan.
# Services Included Under Presbyterian Centennial Care

## Presbyterian Centennial Care Services
- Accredited Residential Treatment Center Services
- Adaptive Skills Building (Autism)
- Adult Day Health
- Adult Psychological Rehabilitation Services
- Ambulatory Surgical Center Services
- Anesthesia Services
- Assertive Community Treatment Services
- Assisted Living
- Behavior Support Consultation
- Behavior Management Skills Development Services
- Behavioral Health Professional Services: outpatient behavioral health and substance abuse services
- Care Coordination
- Case Management
- Community Transition Services
- Community Health Workers
- Comprehensive Community Support Services
- Day Treatment Services
- Dental Services
- Diagnostic Imaging and Therapeutic
- Dialysis Services
- Durable Medical Equipment (DME) and Supplies
- Emergency Response
- Emergency Services (including emergency room [ER] visits and psychiatric ER)
- Employment Supports
- Environmental Modifications
- Experimental or Investigational Procedures, Technology or Non-Drug Therapies
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- EPSDT Personal Care Services
- EPSDT Private Duty Nursing
- EPSDT Rehabilitation Services
- Family Planning
- Family Support
- Federally Qualified Health Center Services
- Hearing Aids and Related Evaluations
- Home Health Aide
- Home Health Services
- Homemaker
- Hospice Services
- Hospital Inpatient (including Detoxification services)
- Hospital Outpatient
- Indian Health Services
- Inpatient Hospitalization in Freestanding Psychiatric Hospitals
- Intensive Outpatient Program Services
- ICF/MR
- IV Outpatient Services

## Presbyterian Centennial Care Services
- Medical Services Providers
- Medication Assisted Treatment for Opioid Dependence
- Midwife Services
- Multi-Systemic Therapy Services
- Non-Accredited Residential Treatment Centers and Group Homes
- Nursing Facility Services
- Nutritional Counseling
- Nutritional Services
- Occupational Services
- Outpatient Hospital based Psychiatric Services and Partial Hospitalization
- Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
- Outpatient Healthcare Professional Services
- Personal Care Services
- Pharmacy Services
- Physical Health Services
- Physical Therapy
- Physician Visits
- Podiatry Services
- Pregnancy Termination Procedures
- Preventive Services
- Private Duty Nursing for Adults
- Prosthetics and Orthotics
- Psychosocial Rehabilitation Services
- Radiology Facilities
- Radiology Services
- Recovery Services
- Rehabilitation Option Services
- Rehabilitation Services Providers
- Related Goods
- Reproductive Health Services
- Respite
- Rural Health Clinics Services
- School-Based Services
- Skilled Maintenance Therapy Services
- Smoking Cessation Services
- Specialized Therapies
- Speech and Language Therapy
- Swing Bed Hospital Services
- Telehealth Services
- Tot-to-Teen Health Checks
- Transplant Services
- Transportation Services (medical)
- Transportation Services (non-medical)
- Treatment Foster Care
- Treatment Foster Care II
- Vision Care Services
Centennial Care Overview

### Presbyterian Centennial Care Services
- Laboratory Services

### Agency-Based Community Benefit Services Included Under Presbyterian Centennial Care
- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Personal Care Services*
- Private Duty Nursing for Adults
- Respite
- Skilled Maintenance Therapy Services

* These services may be self-directed

### Self-Directed Community Benefit Services Included Under Presbyterian Centennial Care
- Behavior Support Consultation
- Customized Community Supports
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods
- Respite
- Skilled Maintenance Therapy Services

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**Telehealth**

Telehealth refers to the use of electronic information, imaging and communication technologies (including interactive audio, video and data communications, as well as store-and-forward technologies) to provide and support healthcare delivery, diagnosis, consultation, treatment, transfer of medical data and education. Presbyterian promotes the use of telehealth within its provider network by providing necessary training in appropriate telehealth practices and ensuring access to telehealth service systems that are compliant with the Health Insurance Portability and Accountability Act (HIPAA). Partnering with Verizon and the University of New Mexico’s Extension for Community Healthcare Outcomes (ECHO) program, Presbyterian is continuously identifying new ways to bring telehealth technology to our members and providers.

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**Video Visits**

Presbyterian offers Video Visits, a platform of online and on-demand healthcare delivery services, to provide doctor visits via computer, tablet or smartphone through a webcam for Presbyterian Centennial Care members.

Video Visits enables convenient and affordable access to non-emergent health concerns.

To ensure members have continuous access to care, Video Visits are available 24 hours a day, seven days a week, when a member does not have immediate access to their preferred primary care provider (PCP). This service is not intended to replace or continually substitute for a PCP visit. Video Visits providers can refer patients to specialists when necessary, as well as prescribe non-narcotic medications.

Medical records and visit transcripts can be released to the patient and shared with their provider at any time.
Referrals to Non-participating Practitioners and Providers

A Centennial Care member is not held liable for payment of services if the PCP or specialty care provider has mistakenly made a referral to a non-participating provider, unless the member was notified in writing concerning the use of non-participating providers and informed that Presbyterian is not responsible for future payments.

In the event that medically necessary covered services are not reasonably available in-network, Presbyterian will evaluate prior authorization referrals to non-participating providers. This determination is made within the time frames listed in the policy “Timelines for Making Determinations of Benefit Coverage for Centennial Care” on monitoring the timeliness of utilization management decisions.

For behavioral health, the request may come in writing directly from the behavioral health provider. A brief medical history, treatments prescribed and a detailed reason for the out-of-network referral can be faxed, mailed or entered into the online provider service called myPRES, which allows providers to check member eligibility, benefit plan details and claims status as well as to request a benefit certification or pharmacy exception.

Presbyterian must give approval for out-of-network services before the member receives the care. The determination of whether medically necessary covered services are not reasonably available in-network is based on the following:

- Availability: There is not a contracted provider within the network who is reasonably available, as determined by Presbyterian, to treat the member’s health condition.
- Competency: A Presbyterian contracted provider does not have the necessary training required to render the service or treatment.
- Geography: There is not a participating provider in Presbyterian’s network within a reasonable distance.

Treatment of Self or Family Members

Presbyterian supports the following position of the American Medical Association (AMA) on the treatment of self or family members:


Presbyterian will not reimburse for claims submitted for treatment of self or family members.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified provider available, providers should not hesitate to treat themselves or family members until another provider becomes available.

In addition, while providers should not serve as primary or regular care providers for immediate family members, there are situations in which routine care is acceptable for short-term, minor
problems. Except in emergencies, it is not appropriate for providers to write prescriptions for controlled substances for themselves or immediate family members.

**Access Standards**

Presbyterian is committed to providing an adequate provider network that ensures members have access to quality care and all covered services.

The tables on pages below summarize our 2014 performance for both primary care and pharmacy access standards. The data in these tables is derived from Geo-Access software that matches provider ZIP codes against member ZIP codes to measure member-to-provider distance and minutes. The software compares the total universe of providers statewide to geographic segments of the member populations that match HSD’s geographic standards.

Presbyterian defines PCP to include family practitioners, general practitioners, general internists, pediatricians, certified physician’s assistants, certified nurse practitioners and other specialists who have been selected to perform the role of a PCP. For urban, rural and frontier populations, our network exceeds the standard for the percentage of members who have desired access to PCPs. By ZIP code, our network also exceeds the standard for all populations.

The pharmacy network includes any contracted licensed retail pharmacy, long-term care pharmacy, home infusion pharmacy, Indian Health Service/Tribal Health Providers/urban Indian Providers pharmacy, mail order pharmacy and specialty pharmacy. Presbyterian exceeds the standard for percentage of members with desired accessibility. Through ZIP code analysis, 100 percent of urban populations have desired access, 99.9 percent of rural populations have desired access and 99.7 percent of frontier populations have desired access.

**2014 Performance Summary**

<table>
<thead>
<tr>
<th>Health Care Service</th>
<th>Appointment Characteristic</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Routine asymptomatic member-initiated outpatient primary care</td>
<td>No more than 30 calendar days, unless the member requests a later time</td>
</tr>
<tr>
<td></td>
<td>Routine symptomatic member-initiated outpatient primary care</td>
<td>No more than 14 calendar days, unless the member requests a later time</td>
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<tr>
<td></td>
<td>Outpatient appointments for urgent medical conditions</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>Outpatient appointments for non-urgent conditions</td>
<td>No more than 14 calendar days, unless the member requests a later time</td>
</tr>
<tr>
<td></td>
<td>Outpatient appointments for urgent conditions</td>
<td>Within 24 hours</td>
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<td></td>
<td>Face-to-face crisis services</td>
<td>Within 2 hours</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Outpatient referral and consultation</td>
<td>Consistent with clinical urgency, but not more than 21 calendar days, unless the member requests a later time</td>
</tr>
<tr>
<td>Diagnostic laboratory</td>
<td>Routine outpatient appointments</td>
<td>Consistent with clinical urgency, but no more than 14</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>diagnostic imaging and other testing</th>
<th>Walk-in instead of an appointment system</th>
<th>calendar days, unless the member requests a later time</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Member wait time shall be consistent with the severity of the clinical need</td>
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<tr>
<td></td>
<td>Urgent outpatient appointments</td>
<td>Consistent with clinical urgency, but no longer than 48 hours</td>
</tr>
<tr>
<td>Dental Care</td>
<td>Routine asymptomatic appointments</td>
<td>No more than 60 calendar days, unless the member requests a later time</td>
</tr>
<tr>
<td></td>
<td>Routine symptomatic member-initiated outpatient appointments for non-urgent care</td>
<td>No more than 14 calendar days, unless the member requests a later time</td>
</tr>
<tr>
<td></td>
<td>Urgent outpatient appointments</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Prescription Fill Time</td>
<td>In-person fill time</td>
<td>No longer than 40 minutes</td>
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<tr>
<td></td>
<td>Practitioner phone-in fill time</td>
<td>No longer than 90 minutes</td>
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<tr>
<td>Follow-up Visits</td>
<td>Outpatient follow-up visits</td>
<td>Consistent with clinical need</td>
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Access Standards for Primary Care Providers

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<th>Access Standards for Primary Care Providers</th>
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<td>Population</td>
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<td>Urban</td>
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Access Standards for Pharmacy Network

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<td>Population</td>
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<td>Frontier</td>
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Care Coordinators

The care coordinator works in collaboration with the member, the member’s PCP and the ICPT to implement the care plan and facilitate access to care coordination providers and the necessary physical, behavioral and long-term care services. The care coordinator is responsible for effective communication across the system, continuous and systematic monitoring and regular reassessment to evaluate adherence to the care plan and to identify gaps, barriers and changes in condition or status. Any change in status or condition automatically triggers a reassessment and potentially a revision.

Culturally Appropriate Services

Presbyterian supports culturally competent and sensitive services. Culturally appropriate services begin with an understanding and respect for language, ethnicity, race, age and gender-based differences. It is essential that these differences are recognized and shared with all employees when interacting with members verbally, nonverbally and in writing. Without effective interactions, members may not understand their healthcare benefits or be able to participate fully in the recommended course of prevention and treatment.

At all levels of operations, Presbyterian acknowledges and promotes the importance of and respect for culture and language and the traditions
associated with different people and communities in the delivery of services. Clinical and non-clinical services are accessible to all members and are provided in a culturally competent manner with sensitivity to the member’s religious beliefs, values, traditions, diverse culture and ethnic background as well as limitations with English proficiency or reading skills, physical or mental disabilities and state of homelessness.

Presbyterian’s objectives for serving a culturally and linguistically diverse membership include the following:

- An annual assessment to describe diversity among the health plan membership
- The use of customer feedback in the form of complaints and survey data to identify disparities
- Development of work plan activities to address identified opportunities for improvement. At a minimum, work plan activities include the following:
  - Maintaining a cultural competency and sensitivity policy to provide direction for Presbyterian services and operations
  - Maintaining a translation services policy to ensure that customer information and services are available in languages other than English by offering translation services to members. For more information on accessing translation services, please refer to the “Presbyterian Customer Service Center” chapter.
  - Tracking bias and discrimination issues that hinder or prevent culturally sensitive services and care in accordance with the Americans with Disabilities Act and other applicable federal and state laws
  - Conducting an annual assessment of languages and cultural background within the provider network to determine if providers meet the needs and preferences of our members
  - Developing an annual plan to adjust the provider network if it does not meet the member’s language needs and cultural preferences
  - Providing annual cultural competency training for Presbyterian employees
  - Providing cultural competency educational materials and training for providers throughout the year
  - Assisting members in locating providers who correspond with their language, cultural and gender preferences
  - Developing communication tools and strategies to address identified race, ethnicity, age, gender and language needs. These might be subscriber materials, member handbooks, newsletters, provider directory, educational materials, telephone outreach, TTY assistance and multilingual employees
Emergency Services Responsibilities

Emergency services must be available to members 24 hours a day, seven days a week (24/7). Emergency services are healthcare services provided in a hospital or comparable facility to evaluate and stabilize medical conditions indicated by acute symptoms of sufficient severity (including severe pain). These symptoms would lead a prudent layperson (one who possesses an average knowledge of medicine and health) to reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual (or with respect to a pregnant woman, the health of the woman or the unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

Emergency care services necessary to evaluate and stabilize an emergency medical condition are covered by Presbyterian Centennial Care. Members with an emergency medical condition should be instructed to go to the nearest emergency provider. Evaluation and stabilization of an emergency medical condition in a hospital or comparable facility does not require prior authorization.

Acute general hospitals are reimbursed for emergency services provided in compliance with federal mandates, such as the “anti-dumping” law in the Omnibus Reconciliation Act of 1989, Public Law (101-239) and 42 United States Code [USC] Section 1935dd 1867 of the Social Security Act).

Members may incur cost-sharing in the form of copayments, as outlined by HSD, related to non-emergency use of the emergency room.

Prior Authorization, Referral, and Utilization Management

Presbyterian Centennial Care ensures that:

- Members have direct access to medical care 24/7 through their PCP, urgent care facilities, emergency rooms, behavioral health providers and long-term care providers, including home- and community-based services.
- Members have accessibility to medically necessary specialty referrals given in a timely manner within accepted medical guidelines for treatment timeliness.
- The PCP acts as a gatekeeper to evaluate the medical necessity of specialty consultations and request authorizations.
- Emergencies are triaged through a medical screening examination and evaluation. Presbyterian does not require prior authorization for emergency services, which include post-stabilization services and urgent care services. Post-stabilization services require authorization.
- Presbyterian evaluates requested prior authorizations to out-of-network and facility providers when medically necessary covered services are not reasonably available in-plan.
• Practitioners and facility providers may speak with a Presbyterian representative (which may include a medical director) before Presbyterian makes a decision regarding referrals, benefits or an adverse determination.

• Members and providers may request an expedited decision for prior authorization determinations that meet specific regulatory criteria.

• Services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, are blind or deaf and with diverse cultural and ethnic backgrounds.

• Long-term care services and supports are recommended by the ICPT and are reviewed by the utilization management team.

• Providers and members have online access through https://www.phs.org/providers/authorizations/Pages/default.aspx or by calling the Presbyterian Customer Service Center for authorization and prior authorization requirements, which include but are not limited to the following:
  ▪ Inpatient admissions
  ▪ Select providers
  ▪ Behavioral health services
  ▪ Select outpatient procedures
  ▪ Select major diagnostic tests
  ▪ Home healthcare
  ▪ Select durable medical equipment (DME)
  ▪ New medical technology
  ▪ Medications not on the approved drug list and/or exceeding medication limits
  ▪ Admissions to long-term care facilities
  ▪ All out-of-network services.
  ▪ Transplants
  ▪ Value-added services

Benefits with limitations may require a prior authorization. For a complete list of Centennial Care services that require prior authorization, see Appendix F.

**Encounter Reporting**

Presbyterian is required by HSD to report all services rendered to Presbyterian Centennial Care members. The reporting of these services, also known as encounter data reporting, is an essential element to the success of Presbyterian Centennial Care.

To render services to Centennial Care members, providers must be registered with HSD. Providers can register or confirm registration by going to https://nmmedicaid.portal.conduent.com/static/index.htm. Failure to register with HSD may result in claim denials.

**Critical Incident Management**

The Human Services Department/Medical Assistance Division/Quality Bureau (HSD/MAD/QB) Incident Management System describes the statewide reporting requirements for all incidents involving recipients served under Centennial Care-funded Behavioral Health or Home and Community
Based Service programs. Centennial Care contracted providers/agencies must visit www.hsd.state.nm.us to maintain up-to-date information and requirements for Critical Incident Reporting.

Contracted providers are required to receive initial and ongoing training to be competent to respond to, report and document Critical Incidents for Centennial Care members in a timely and accurate manner. Training in Critical Incidence reporting for specified provider and agencies is hosted annually. Notifications of upcoming trainings are sent to providers and agencies 30 days in advance of the scheduled presentation.

In extenuating circumstances, if a provider/agency is unable to have representation in attendance during the scheduled annual Critical Incidence training events, providers and agencies must notify the Presbyterian Health Plan (PHP) critical incidence coordinator via email at criticalincident@phs.org within five business days prior to the first training date. Providers and agencies who emailed notice that they are unable to send representatives to the annual Critical Incident trainings have 90 days to attend a make-up training session, or show proof of training completion with another MCO during the calendar year. The scheduling of a make-up session for Critical Incident training is the responsibility of the provider/agency. Scheduling arrangements are to be made by contacting the PHP critical incident coordinator via email at criticalincident@phs.org.

A review process is conducted for compliance with the annual training requirement. Specified provider and agency attendance is mandatory. Member assignment to agencies is contingent upon completion of annual Critical Incident training for specified provider and agencies.

Providers/agencies that do not comply with incident reporting requirements are in violation of state statues and federal regulations. They also may be sanctioned up to and including termination of their provider agreement by the MCO or by HSD-Medical Assistance Division (HSD-MAD).

Home- and Community-based Services (HCBS) include personal care services (PCS) and Self-directed benefit services in addition to other services. All allegations of abuse, neglect and exploitation of a recipient must be reported, as well as any incidents involving emergency services, hospitalization, the death of a recipient, the involvement of law enforcement, any environmental hazards that compromise the health and safety of a recipient and any elopement or missing recipient.

Reporting of a Critical Incident does not take the place of reporting incidents of abuse, neglect and exploitation (ANE) and any death suspected to be a result of ANE to Adult Protective Services (APS) or Children, Youth & Families Department (CYFD).

According to New Mexico Statues/Regulations, all incidents of ANE should be reported to:

- APS: 1-800-654-3129 or
- CYFD: 1-800-797-3260

Community agencies providing HCBS are required to report critical incidents through the HSD Incident Reporting website at https://criticalincident.hsd.state.nm.us.
Incidents must be reported within 24-hours of knowledge of the incident. If the incident occurs on a weekend or holiday, that incident must be reported on the next business day.

Reports made through the HSD Incident Reporting System website are limited to a list of accepted COEs. Providers are required to verify COE and eligibility before reporting.

The HSD Incident Reporting website will accept Critical Incident reports for behavioral health providers through the HSD website for Centennial Care members who have any of the HCBS accepted COEs. All other Behavioral Health Critical Incident reports that do not have one of the accepted HCBS COEs must be faxed to the member’s MCO. Providers are required to verify COE and eligibility before reporting.

Contracted providers and MCO staff receive initial and ongoing training to be competent to respond to, report and document incidents in a timely and accurate manner. All staff and providers cooperate with any investigation conducted by Presbyterian and/or outside agencies such as HSD, the Behavioral Health Purchasing Collaborative, NM Department of Health (DOH), CYFD, APS and law enforcement.

**Medicaid Fraud Reporting**

All providers are responsible for preventing and reporting alleged Medicaid fraud. Report alleged fraud using the critical incident reporting process described above and selecting the “Alleged Fraud” check box within the form. Providers are also obligated to report all incidents of Centennial Care alleged fraud to the Program Integrity Department. The toll-free number is 1-800-239-3147 and the email address is PHPFrau@phs.org.

**Reporting Compliance**

Providers that do not comply with incident reporting requirements are in violation of state statutes and federal regulations and may be sanctioned up to and including termination of their provider agreement with Presbyterian.

**Provider Responsibilities**

As a provider, you have the following responsibilities:

- Take immediate action to assure the member is protected from further harm and respond to emergency needs of the member.
- Report incidents involving abuse, neglect, exploitation and extortion to adult protective services or child protective services, as appropriate. The description of the actual incident should always be provided by the person with the most immediate knowledge of the incident.
- Complete the critical incident reporting form at [https://criticalincident.hsd.state.nm.us/](https://criticalincident.hsd.state.nm.us/) following the instructions in the HSD Incident Management Guide.
- Cooperate with any investigation conducted by Presbyterian or outside agencies such as HSD, the behavioral health purchasing collaborative, NM DOH, CYFD, APS and law enforcement.
- Participate in any planning meetings convened to resolve the critical incident or to develop
strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future.

- Submit updates regarding the critical incident, as necessary, until resolved.
- As part of your internal monitoring procedures, document unexpected or unusual incidents that are not identified as reportable. An example of a non-reportable incident which requires documentation by the provider is a medication error that does not adversely affect the member and does not require emergency care of the member by a provider or transfer of the member to the hospital.

Identifying Abuse, Neglect or Exploitation

Tables later in this chapter are included to help providers identify common signs of abuse, neglect and exploitation of children and elders.

Member/PCP Lock-In Standards and Requirements

Presbyterian requires a member to visit the same PCP when it has identified continuing utilization of unnecessary services. This requirement is referred to as a member lock-in standards. Before initiating the member lock in with the PCP, Presbyterian informs the member and/or their representative of the intent to lock in.

Presbyterian’s grievance process is available to members at all times. The member lock in is reviewed and documented by Presbyterian and reported to HSD every quarter. The member is removed from lock in when Presbyterian has determined that the utilization of unnecessary services were resolved and the problem is unlikely to reoccur. HSD is notified of all lock-in initiations and removals.

Pharmacy Lock-Ins

Presbyterian requires a member to visit a certain pharmacy provider when member non-compliance or drug-seeking behavior is suspected. A care coordinator is assigned to the member. Before placing the member on pharmacy lock-in, we inform the member and/or their representative of the intent to lock in. Presbyterian’s grievance process is made available to the member being designated for pharmacy lock-in. The pharmacy lock-in is reviewed and documented by Presbyterian and reported to HSD every quarter. The member is removed from the lock-in when Presbyterian determines that the non-compliant or drug-seeking behavior was resolved and the recurrence of the problem is judged to be improbable. HSD is notified of all lock-ins and their removals.

Provider Coordination

At the direction of HSD, providers may be asked to coordinate with other providers, subcontractors or HSD contractors to ensure compliance with Presbyterian Centennial Care and continuity of covered services.

In addition, Presbyterian utilizes its care management system and ICPT approach to ensure communication between providers and coordination of integrated care services, including physical health, behavioral health and long-term care services. The care coordinator is responsible for this communication and coordination.
Member Rights and Responsibilities

We ensure that Presbyterian Centennial Care members are free to exercise their rights and that the exercise of those rights would not adversely affect the way Presbyterian or its provider network treats its members or their representatives.

Members have the right to:

- Be treated with respect and with due consideration for his or her dignity and privacy

- Receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand

- Make and have honored an advance directive consistent with state and federal laws

- Receive covered services in a nondiscriminatory fashion

- Participate in decisions regarding his or her healthcare, including the right to refuse treatment

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

- Request and receive a copy of his or her medical records and request that they be amended or corrected as specified in the HIPAA Privacy Rule, 45 Code of Federal Regulations (CFR) Part 164

- Choose a representative to be involved as appropriate in making care decisions

- Provide informed consent

- Voice grievances about the care provided by Presbyterian and to make use of the grievance, appeal and fair hearing processes without fear of retaliation

- Choose from among providers in accordance with Presbyterian’s prior authorization requirements

- Receive information about covered services, how to access covered services and contract providers

- Be free from harassment by Presbyterian or its contract providers with regard to contractual disputes between Presbyterian and providers

- Participate in understanding physical and behavioral health problems and developing mutually agreed-upon treatment goals

Members and their representatives, to the extent possible, have a responsibility to:

- Provide information that the providers need in order to care for the member

- Follow the plans and instructions for care that they have agreed upon with their providers

- Keep, reschedule or cancel a scheduled appointment rather than to simply fail to keep it

Medical Records and Confidentiality Assurance

There may be instances where records from your office or facility are requested to ensure that correct and timely coverage decisions are rendered. Records may also be reviewed for a special utilization or quality study. Presbyterian is committed to requesting the minimum amount of
information required and assisting with either on-site review or telephone discussions to minimize administrative burdens.

Common Signs of Abuse, Neglect and Exploitation

<table>
<thead>
<tr>
<th>Common Signs of Child Physical or Sexual Abuse, Neglect, or Mental Maltreatments as Identified by the U.S. Department of Health &amp; Human Services</th>
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<tbody>
<tr>
<td><strong>Child Maltreatment and Physical Abuse</strong></td>
</tr>
<tr>
<td>• Be aggressive, oppositional, or defiant</td>
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<tr>
<td>• Cower or demonstrate a fear of adults</td>
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<tr>
<td>• Act out, displaying aggressive or disruptive behavior</td>
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<tr>
<td>• Be destructive to self or others</td>
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<tr>
<td>• Come to school too early or not want to leave school, indicating a possible fear of being at home</td>
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<tr>
<td>• Show fearlessness or extreme risk-taking</td>
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<td>• Be described as “accident prone”</td>
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<tr>
<td>• Cheat, steal, or lie (may be related to too high expectations at home)</td>
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<tr>
<td>• Be a low achiever</td>
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<tr>
<td>• Be unable to form good peer relationships</td>
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<tr>
<td>• Wear clothing that covers the body and may be inappropriate in warmer months, such as wearing a turtleneck sweater in the summer (Be aware that this may possibly be a cultural issue instead.)</td>
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<tr>
<td>• Show regressive or less mature behavior</td>
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<tr>
<td>• Dislike or shrink away from physical contact (e.g., may not tolerate physical praise, such as a pat on the back)</td>
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<tr>
<td><strong>Child Neglect</strong></td>
</tr>
<tr>
<td>• Seem inadequately dressed for the weather (e.g., wearing shorts and sandals in freezing weather)</td>
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<tr>
<td>• Appear excessively listless and tired (due to no routine or structure around bedtimes)</td>
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<tr>
<td>• Report caring for younger siblings (when they themselves are underage or are developmentally not ready to do so)</td>
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<tr>
<td>• Demonstrate poor hygiene or smell of urine or feces</td>
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<tr>
<td>• Seem unusually small or thin or have a distended stomach (indicative of malnutrition)</td>
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<tr>
<td>• Have unattended medical or dental problems, such as infected sores or badly decayed or abscessed teeth</td>
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<tr>
<td>• Appear withdrawn</td>
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<tr>
<td>• Crave unusual amounts of attention, even eliciting negative responses in order to obtain it</td>
</tr>
<tr>
<td>• Be chronically truant</td>
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<tr>
<td><strong>Child Sexual Abuse</strong></td>
</tr>
<tr>
<td>• Have bruises in the inner thigh or genital area</td>
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<tr>
<td>• Have difficulty walking or sitting</td>
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<tr>
<td>• Complain of genital or anal itching, pain, or bleeding</td>
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<tr>
<td>• Frequently vomit</td>
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<tr>
<td>• Become pregnant at a young age</td>
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<tr>
<td>• Have any sexually transmitted diseases</td>
</tr>
<tr>
<td>• Exceptional secrecy</td>
</tr>
<tr>
<td>• More sexual knowledge than is age appropriate, especially in younger children</td>
</tr>
<tr>
<td>• In-depth sexual play with peers that is not developmentally appropriate</td>
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<tr>
<td>• Extreme compliance or withdrawal</td>
</tr>
<tr>
<td>• Overt aggression</td>
</tr>
<tr>
<td>• An inordinate fear of males or females</td>
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<tr>
<td>• Seductive behavior</td>
</tr>
<tr>
<td>• Sleep problems or nightmares</td>
</tr>
<tr>
<td>• Crying without provocation</td>
</tr>
<tr>
<td>• A sudden onset of wetting or soiling of pants or bed</td>
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</table>
Centennial Care Overview

- Suicide attempts or thoughts of wanting to kill themselves
- Numerous attempts at running away from home
- Cruelty to animals (especially those that would normally be pets)
- Setting fires and enjoying watching them burn
- Self-mutilation (e.g., cutting or scratching to draw blood)

Common Signs of Neglect or Physical and Emotional Abuse of Elders as Identified by the National Institute on Aging

- Have trouble sleeping
- Seem depressed or confused
- Lose weight for no reason
- Display signs of trauma like rocking back and forth
- Act agitated or violent
- Become withdrawn
- Stop taking part in activities enjoyed in the past
- Have unexplained bruises, burns, or scars on the body
- Look messy, with unwashed hair or dirty clothes
- Develop bed sores or other preventable conditions
- **Financial abuse** happens when money or belongings are stolen. This can include forging checks, taking retirement and Social Security benefits, or using another person’s credit cards and bank accounts. Financial abuse includes changing names on a will, bank accounts, life insurance policies, or the title to a house. Financial mistreatment is becoming widespread and is hard to detect
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3. Primary Care Providers

Primary care providers (PCPs) are contracted physical health providers who meet certain objective criteria established by Presbyterian. PCPs must accept the responsibility for rendering primary physical healthcare 24 hours a day, seven days a week (24/7) and coordinating referrals. Presbyterian’s network of PCPs specializes in family practice, general practice, internal medicine, pediatrics and obstetrics and gynecology. Presbyterian’s PCP network also includes certified physician assistants, certified nurse practitioners and other specialists who are credentialed and elect to perform the role of a PCP.

The Role and Responsibilities of the PCP

PCPs play an integral role in providing care to members. They focus on the total well-being of the member and provide a “medical home” where the member can readily access preventive healthcare services and treatment rather than episodic or crisis healthcare treatment. Members are encouraged to be involved in their healthcare decisions and to build a healthy lifestyle. The PCP is responsible for teaching members how to use the available health services appropriately. It is important to educate members to seek PCP services first, except in emergent or urgent healthcare situations.

The PCP is responsible for the following:

- Providing or arranging for the provision of covered services and telephone consultations during normal office hours and on an emergency basis 24/7
- Providing appropriate preventive health services in accordance with program requirements, medical policies and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program guidelines as applicable
- Vaccinating members during PCP visits instead of writing a referral for immunizations
- Scheduling routine physical exams within four months for newly established patients
- Coordinating with other in network providers to ensure continuity of care for all covered services, including behavioral health and long-term care services
- Referring a member for behavioral services, as applicable
- Participating in the Interdisciplinary Care Plan Team
- Maintaining current medical records that meet established Presbyterian standards
- Making referrals to contracted specialty care providers, when appropriate
- Monitoring the member’s progress and facilitating the member’s return to the PCP when medically appropriate
Primary Care Providers

- Documenting communication with specialty care providers in the medical record
- Educating members and their families about their health issues
- Following established utilization management and quality management guidelines
- Adhering to Presbyterian’s administrative policies and procedures
- Meeting Presbyterian’s credentialing and recredentialing requirements
- Notifying Presbyterian of changes in address, license, liability insurance, contracting status or any other issue that could affect the provider’s ability to effectively render covered services
- Advising patients of their right to know about all treatment options related to their condition or disease, regardless of whether or not it is a covered benefit under their insurance plan. The Presbyterian Customer Service Center (PCSC) is available to assist with confirming covered benefits
- Reporting any misappropriation of property, abuse or neglect of a child or vulnerable adult that is revealed or suspected to the proper regulatory authorities using the appropriate statewide central reporting intake number:
  - Adult Protective Services (APS): 1-866-654-3219
  - Children, Youth and Families Department (CYFD): 1-800-797-3260
- Department of Health/Division of Health Improvement (DOH/DHI): 1-800-445-6242

Further information regarding state reporting requirements for suspected abuse, neglect or misappropriation of property of children and vulnerable adults can be obtained from the New Mexico DOH.

The PCP is also responsible for contacting Presbyterian to verify member eligibility and prior authorizations for covered services. You can quickly and easily verify member eligibility through myPRES, the provider online service located at http://www.phs.org (locate the myPRES login box) or through our Interactive Voice Response system by calling (505) 923-5757 or (888) 923-5757. You can also request prior authorization of covered services through myPRES.

Coverage Requirements and After-Hours Care

PCPs must have or arrange for on-call and after-hours care to support members who are experiencing emergencies. Such coverage must be available 24/7. Providers must inform members about hours of operation and provide instruction for accessing care after hours. When unavailable to provide on-call support, providers must provide members with an after-hours messaging about how to access after-hours care.

If you also see commercial members, Presbyterian requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members.
**Primary Care Providers**

**Requirement to Utilize Contracted Providers**

PCPs are required to utilize Presbyterian’s contracted providers, laboratories, durable medical equipment (DME) and other services for referrals in an effort to minimize member inconvenience and billing issues. If you need to verify whether services are available in-network, you can call the Provider Claims Activity Review and Evaluation (CARE) Unit at (505) 923-5757 or 1-888-923-5757 for assistance.

**Laboratory Services**

PCPs are responsible for sending members to Presbyterian’s preferred laboratory provider, TriCore Reference Laboratories, in the following five counties:

- Bernalillo
- Sandoval
- Santa Fe
- Torrance
- Valencia

Outside the five county area, providers must refer member to a contracted lab. If you need to refer to a different laboratory, you should immediately seek a prior authorization as outlined in the “Care Coordination and Laboratory” chapter of this manual. For a list of laboratory locations, please visit [http://www.tricore.org/locations](http://www.tricore.org/locations).

**Durable Medical Equipment (DME) Services**

PCPs are responsible for referring members to contracted DME providers. Our network design is such that our Centennial Care members throughout the state have access to DME providers for their needs. For a complete listing of DME providers, please visit our website at [http://www.phs.org](http://www.phs.org) and click “Find a Doctor” at the top of the page and search by specialty.

If you do not comply with these requirements, Presbyterian reserves the right to hold you responsible for up to 150 percent of either:

- The difference between the amount that Presbyterian would have paid if a contracted provider had been utilized and the total amount actually paid by Presbyterian to the non-contracted provider, or,
- The entire cost of such services

If Presbyterian elects to utilize this right, these amounts are withheld automatically and offset against any future claims payments owed by Presbyterian to you.

**Referrals to Non-participating Practitioners/Facilities**

A member will not be held liable for payment of services if the specialist has made a one-time referral to a non-participating practitioner or facility provider, until the member is notified in writing concerning the use of non-participating practitioners and facility providers, and informed the member that Presbyterian will not be responsible for future payments. The member will not be held responsible until they are informed and educated.

Providers who continually refer out of network may be subject to penalties, including and up to termination.

In the event that medically necessary covered services are not reasonably available in plan,
Primary Care Providers

Presbyterian may approve certifications to non-participating practitioners and facility providers. This determination will be made within the time frames listed in Health Services/Behavioral Health policy on monitoring timeliness of UM decisions.

Medicare Advantage members may request approval for certification directly. All other plans require that the practitioner/facility provider submit requests to the Health Services department via fax, online, mailed, or by telephone.

For behavioral health, the request may come in writing directly from the behavioral health practitioner. A brief medical history, treatments prescribed, and a detailed reason for the out-of-network referral can be faxed, mailed, or entered into myPRES for review by the Presbyterian medical director/behavioral health medical director.

Certifications to out-of-plan practitioners/facility providers must have approval from Presbyterian before the member receives care.

The determination of whether medically necessary covered services are not reasonably available in plan will be based on the following:

- **Availability:** There is no contracted practitioner/facility provider within the network who is reasonably available, as determined by Presbyterian, to treat the member’s health condition.

- **Scope of practice:** The Presbyterian contracted practitioner/facility provider does not have the necessary training required to render the service or treatment.

- **Location:** Where there is no participating healthcare professional in Presbyterian’s network for the services requested within a reasonable distance.
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Specialists are contracted physical and behavioral health practitioners not identified as primary care providers (PCPs). Specialists agree to accept referrals from other contracted providers.

**The Role and Responsibilities of the Specialty Care Provider**

The specialist accepts referrals from other contracted providers to render more specialized services for the member. Please see the “Care Coordination” chapter of this manual for more detailed information on referrals. The specialty care provider is responsible for the following:

- Providing medically necessary services to members who were referred by one or more of the following:
  - Their PCP
  - Another contracted provider
  - Self-referral, when appropriate, for specified treatments or diagnoses
- Referring members to other providers as needed, including laboratory services and durable medical equipment (DME) providers
- Advising patients of their right to know about all treatment options related to their condition or disease, regardless of whether it is a covered benefit under their insurance plan. The Presbyterian Customer Service Center (PCSC) is available to assist with confirming covered benefits
- Communicating with the member’s PCP or other providers about services rendered, treatment results, reports and recommendations to ensure continuity of care
- Documenting communication with the PCP or other contracted providers in the medical record
- Obtaining prior authorization from Presbyterian’s Utilization Management (UM) department for non-emergency inpatient and outpatient services in accordance with the member’s benefits package and Presbyterian’s UM policies
- Following utilization and quality management guidelines
- Adhering to Presbyterian’s administrative policies and procedures
- Meeting Presbyterian’s credentialing and recredentialing requirements
- Notifying Presbyterian of changes in address, license, liability insurance, contract status or any other issue that could affect the provider’s ability to effectively render covered services
- Participating in the Interdisciplinary Care Plan Team (ICPT)
- Specialty care providers are also responsible for reporting any misappropriation of property, abuse or neglect of a child or vulnerable adult
that is revealed or suspected to proper regulatory authorities pursuant to state law using the appropriate statewide central reporting intake number:

- Adult Protective Services (APS):
  1-866-654-3219
- Children, Youth and Families Department (CYFD):
  1-800-797-3260
- Department of Health/Division of Health Improvement (DOH/DHI):
  1-800-445-6242

Further information regarding state reporting requirements for suspected abuse, neglect or misappropriation of property of children and vulnerable adults can be obtained from the New Mexico DOH/DHI.

In addition, specialty care providers are responsible for verifying member eligibility before rendering services. This can be easily and quickly done through myPRES at https://mypres.phs.org/Pages/default.aspx or through Presbyterian’s Interactive Voice Response (IVR) system by calling (505) 923-5757 or 1-888-923-5757. Specialists can also request prior authorization of covered services through myPRES at https://mypres.phs.org/Pages/default.aspx.

**Requirement to Use Contracted Providers**

Specialty care providers are required to use Presbyterian’s contracted providers, including laboratory services, durable medical equipment (DME) and other services in an effort to minimize member inconvenience and billing issues. To verify if services are available in network, you can call the Provider Claims Activity Review and Evaluation (CARE) Unit at (505) 923-5757 or 1-888-923-5757 for assistance.

**Laboratory Services**

Specialists are responsible for sending members to Presbyterian’s preferred laboratory services provider, TriCore Reference Laboratories, in the following five counties:

- Bernalillo
- Sandoval
- Santa Fe
- Torrance
- Valencia

Outside these five counties, providers must refer members to a contracted lab. If you need to refer to a different laboratory, immediately seek a prior authorization as outlined in the “Utilization Management” chapter of this manual. For a list of laboratory locations, please visit http://www.tricore.org/locations.

**Durable Medical Equipment Services**

Specialists are responsible for referring members to contracted durable medical equipment (DME) providers. Our network design is such that our Centennial Care members throughout the state have access to DME providers for their needs. For a complete listing of DME providers, please visit our website at http://www.phs.org and click Find a
Specialists

**Doctor** at the top of the page and search by specialty.

If you do not comply with these requirements, Presbyterian reserves the right to hold you responsible for up to 150 percent of either:

- The difference between the amount that Presbyterian would have paid if a contracted provider had been utilized and the total amount actually paid by Presbyterian to the non-contracted provider
- The entire cost of such services

If Presbyterian elects to utilize this right, these amounts are withheld automatically and offset against any future claims payments owed by Presbyterian to you.

**Specialty Care Provider Termination**

Please refer to your service agreement with Presbyterian for specific time frames and obligations regarding terminations.

**Other Information for PCPs and Specialists**

Practitioners are able to freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

**Accessibility of Services Standards**

As required by our regulators and the National Committee for Quality Assurance, Presbyterian is required to provide and maintain appropriate access to primary care, specialty care and behavioral healthcare services. Presbyterian’s policy is to communicate our accessibility of services standards to our network and monitor compliance with these standards.

Presbyterian’s accessibility of services standards are consistent with regulatory requirements and exist to ensure that our members receive reasonable, appropriate and timely access to care from contracted providers. Presbyterian assists local providers with referrals and assists members with transportation needs to ensure timely access to specialty services. If a provider of the specialty type needed is not available within Presbyterian’s network, Presbyterian will assist with referrals and transportation to out-of-network providers and negotiate single case or letters of agreement as necessary.

If you also see commercial members, Presbyterian requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members.

<table>
<thead>
<tr>
<th>Healthcare Service</th>
<th>Appointment Characteristics</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Care Outpatient referral and consultation</td>
<td>Consistent with clinical urgency, but no more than 21 calendar days, unless the member requests a later time</td>
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5. Preventive Healthcare Guidelines

Presbyterian encourages members to access preventive healthcare services through the development and distribution of preventive healthcare guidelines. Health education information is distributed to our members in a variety of ways, including at health fairs and community meetings, online at phs.org and in member newsletters and handbooks. Presbyterian also offers a provider manual on the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program services. In addition, the EPSDT manual includes information about and access to recommended childhood immunization schedules. The manual can be accessed at http://docs.phs.org/idc/groups/public/documents/communication/pel_00205711.pdf

Preventive Health Care Guidelines and Screening

Preventive healthcare guidelines are systematically developed statements designed to give members and providers current information about preventive healthcare screenings, counseling and immunizations for all age groups.

Presbyterian adopts preventive healthcare guidelines that are evidence-based and relevant to the enrolled population. Adoption of these guidelines is accomplished through provider review at the Presbyterian Clinical Quality and Utilization Management Committee. The Presbyterian preventive healthcare guidelines are based on multiple resources, including but not limited to the following:

- U.S. Preventive Services Task Force (USPSTF)
- Centers for Disease Control and Prevention (CDC)
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- American Congress of Obstetricians and Gynecologists (ACOG)
- National Cancer Institute (NCI)

Presbyterian expects that providers will provide the following preventive screenings for all asymptomatic members, as appropriate, within six months of enrollment or within six months of a change in screening standards, as necessary:

- Screening for breast cancer
- Blood pressure measurement
- Screening for cervical cancer
- Screening for chlamydia
- Screening for colorectal cancer
- Screening for elevated lead levels
- Newborn screening
- Screening for obesity
- Prenatal screening
Preventative Health Care Guidelines

- Screening for rubella
- Screening for tuberculosis
- Serum cholesterol measurement
- Tot-to-Teen health checks
- Screening for Type 2 diabetes

Presbyterian adopts immunization guidelines published by the CDC and the AAP’s Bright Futures™ guidelines for members from birth through age 20. All preventive healthcare guidelines are reviewed at least every two years and are updated when clinically appropriate.

All member households receive preventive healthcare guidelines as part of their member handbooks or explanation of benefits, which are distributed at least once every two years. The guidelines are also distributed annually in the member newsletters and are available at www.phs.org.

Presbyterian also informs providers of updates to the preventive healthcare guidelines through the Network Connection provider newsletter. Written copies of the preventive healthcare guidelines are available upon request. For more information, please see: http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001475.pdf

Measurement Activities

Presbyterian conducts measurement activities at least annually based on the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS® 1) and other clinically based measurement rules. HEDIS® is widely used in the managed care industry to measure quality performance on important dimensions of care and service and is developed and maintained by NCQA. In addition, Presbyterian uses other quality metrics to assess performance. Data is collected from claims and other sources available to Presbyterian, such as lab results and medical record reviews.

This data provides feedback on the preventive health and health maintenance services members receive. Presbyterian uses these measurement results to identify members who have or are at risk for specific health problems and to notify their practitioners/providers that preventive and treatment services may be needed. For selected measures, Presbyterian provides individual scores to practitioners/providers who act as primary care providers (PCPs).

Along with the scores, Presbyterian includes lists of members who might not be receiving the care needed according to these clinical guidelines. Practitioners/providers are encouraged to use

1 HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)
Preventative Health Care Guidelines

these lists to engage members in their care and to provide Presbyterian with updated information that may correct the data reported, such as lab results or a qualifying event.

Health Risk Assessments

All members receive a telephonic Health Risk Assessment (HRA) to determine the level of care coordination the member requires. The HRA includes a series of questions designed to identify potential health risks and determine if members require focused care coordination for physical or behavioral health, or if they would benefit from one of Presbyterian’s health or disease management programs. The surveys are also used to identify special populations.

Screening for Alcohol and Drug Abuse

PCPs are requested to use a standardized alcohol and drug abuse screening tool for high-risk members. The frequency of screening is determined by the results of the first screening and other clinical indicators.

Presbyterian adopted the CAGE (Cut, Annoy, Guilty, Eye opener) standardized alcohol questionnaire and another drug abuse screening tool developed by Brown and Rounds. The CAGE questions can be used in a clinical setting in an informal manner.

It was demonstrated that the questions are most effective when used as part of a general health history and should not be preceded by questions about how frequently the patient drinks or uses illegal drugs. Responses on the CAGE screening tool are scored at either 0 or 1, with a higher score indicating possible alcohol or drug abuse problems. A total score of 2 or greater is considered clinically significant.

PCPs may use the CAGE questionnaire or any other standardized tool for an alcohol and drug abuse screening test.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

Children experience numerous health and developmental milestones that should be assessed in a timely manner. Early detection and treatment can avoid or minimize the effects of many childhood conditions.

The federally mandated EPSDT Program emphasizes early identification of illness and the need for comprehensive care. One component of the EPSDT Program is complete and timely immunizations see the Vaccines for Children information that follows. Presbyterian supports providers in coordinating these services.

EPSDT benefits include comprehensive medical and behavioral screening and treatment services available to all Presbyterian Centennial Care children from birth through age 21. The EPSDT Tot-to-Teen health checks are also referred to as Well-Child Checkups.

EPSDT training for practitioners/providers is available through the Provider Network Operations department.

Immunizations

All Presbyterian contracted PCPs are requested to provide and document all immunizations according
to the accepted immunization schedule. Schedules are available at:

- The New Mexico Done by One immunization schedule for members and providers: [https://nmhealth.org/publication/view/genera l/450/](https://nmhealth.org/publication/view/general/450/)
- The CDC Advisory Committee on Immunizations Practices (ACIP) schedules for children and adults: [http://www.cdc.gov/vaccines/schedules/hcp/index.html](http://www.cdc.gov/vaccines/schedules/hcp/index.html)
- The New Mexico Medicaid Managed Care program, in the New Mexico Administrative Code in 8.308.9.17, requires participation in the New Mexico Department of Health’s (DOH) New Mexico State Immunization Information System (NMSIIS) to ensure the secure, electronic exchange of immunization records to support the elimination of vaccine preventable diseases.

**Vaccines for Children**

Presbyterian participates in the federal Vaccines for Children (VFC) Program and supports the program goals to accomplish the following:

- Improve vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers
- Ensure that no VFC-eligible child contracts a vaccine-preventable disease because of his or her parent's inability to pay for the vaccine or its administration

VFC-eligible children are those children from birth through 18 years who meet one of these criteria:

- Are eligible for Medicaid
- Have no health insurance
- Are American Indian/Alaska Native
- Have health insurance, but it does not cover immunizations and they go to a Federally Qualified Health Center

Information regarding the VFC program may be obtained from the program manager at (505) 827-2898 or the Immunization hotline at 1-800-232-4636.


For more information about children’s vaccines, VFC and NMSIIS, visit the following sites:

- New Mexico Department of Health Immunization Program [http://nmhealth.org/about/phd/idb/imp/](http://nmhealth.org/about/phd/idb/imp/)
- New Mexico Statewide Immunization Information System (NMSIIS) [http://nmhealth.org/about/phd/idb/imp/siis/](http://nmhealth.org/about/phd/idb/imp/siis/)

Likewise, Presbyterian participates in the New Mexico Vaccine Purchase Act (VPA), which went
into effect on March 20, 2015 (NMSA 1978, § 24-5A-1 et seq). Pursuant to the VPA, the vaccine-purchasing fund was created in the state treasury. The fund consists of amounts reimbursed to the state by health insurers and group health plans for the purchase, storage and distribution of vaccines for their insured children. The Department's rules associated with the VPA went into effect on Aug. 28, 2015 (NMAC 7.5.4).

Since the inception of the VFC program in the 1990s, the department purchased vaccines universally for both privately insured and VFC-eligible children in New Mexico. The public health objective is to have a seamless vaccine distribution system in order for practitioners/providers and patients to access childhood vaccines easily.

During the 2015 New Mexico legislative session, the legislature passed the VPA, requiring all insurers and group health plans doing business in the state to pay their proportionate share for childhood vaccines. The payment amount is based on a formula found in NMSA 1978, § 24-5A-6 B.

For more information about children's vaccines, VFC, VPA and NMSIIS, visit the following sites:

- New Mexico Department of Health Immunization Program
  http://nmhealth.org/about/phd/idb/imp/
- New Mexico Statewide Immunization Information System (NMSIIS)
  http://nmhealth.org/about/phd/idb/imp/siis/
- Vaccines for Children CDC website and provider forms
  http://www.cdc.gov/vaccines/programs/vfc/index.html
- Vaccine Purchase Act (VPA)
  http://nmhealth.org/about/phd/idb/imp/vpa/

**Contact Us**

For additional information about health education and preventive healthcare services that are available to Presbyterian members or, in some cases, children who might not otherwise be vaccinated because of inability to pay, contact Performance Improvement at (505) 923-5017 or 1-866-634-2617. These are voice answering systems only.
6. Care Coordination

Presbyterian’s care coordination model facilitates the integration of physical health, behavioral health and long-term care services into a seamless and coordinated system of care. Our care coordination model provides our members with timely, appropriate services in the least restrictive and most cost-effective setting possible. This care coordination model assists and supports providers and members to improve continuity of care. It is designed to enhance access to services and achieve optimal health and quality outcomes through a variety of ways:

- Health risk assessments (HRAs) are completed telephonically, online or by mail for new members. HRAs are completed for existing members not in care coordination if it is deemed necessary. The HRA identifies health issues in need of further interventions.

- Population-based, predictive modeling that incorporates claims, lab and pharmacy data to target care opportunities and to identify members who are at risk for future adverse events and those who can benefit from care coordination interventions.

- Member-centric care coordination that encourages personal responsibility and member engagement.

- A comprehensive needs assessment (CNA), an in-home assessment designed for members with specific healthcare needs.

- Comprehensive care plans designed to identify opportunities to address physical, psychosocial, behavioral and functional needs.

- Interdisciplinary Care Planning Teams (ICPTs) collaborate to meet the diverse and holistic needs of members across domains of healthcare (physical, behavioral and long-term care).

Care coordination, disease management, transition of care and utilization management are integral components of our overall integrated care model for Centennial Care members. Activities and interventions are based on the needs of each member across this integrated care continuum. The Presbyterian Care Coordination Team includes our employed staff and those of our experienced behavioral health partner, Magellan Healthcare. Some care coordination team members have extensive behavioral health and long-term care experience. The care coordination team works with our Medicaid medical director to bring an array of clinical experience and cultural/linguistic capabilities to the care coordination process.

Our model leverages the experience and capabilities of our provider partners along with local community resources to ensure comprehensive and culturally appropriate care coordination for members. Presbyterian applies a regional care coordination approach in order to improve member engagement, particularly for high-need, difficult-to-
serve populations such as seriously mentally ill adults, severely emotionally disturbed children and their families, the elderly and the disabled. Care coordinators are a part of the community they serve. This approach is also available to Native American members who may be in remote locations or otherwise lack access to necessary healthcare support.

With approval from the New Mexico Human Services Department (HSD), Presbyterian may also contract with qualified patient-centered medical homes and future health home providers to provide care coordination services. Through these contracts, Presbyterian provides overarching care coordination services, technical assistance and systematic monitoring to assure care coordinators at these provider sites have access to Presbyterian Health Plan’s systems, resources, tools, utilization data and encounter data required for effective care coordination.

**Care Management System**

Presbyterian uses an electronic care management system to support care coordination processes and assist with the effective management of Centennial Care members’ healthcare. This system is the electronic cornerstone of the care coordination model, providing automation, standardization, risk stratification into levels 1, 2 and 3 (see Appendix B), authorizations and utilization management, population health improvement, monitoring and quality assurance. The care management system’s customized algorithms and analytics support care plan development, workflows, authorizations and help facilitate communication across the care coordination team and providers involved in the delivery of services. The care management system maintains regularly updated membership, claims, pharmacy and lab data. The member and the care coordination team can access care plans through the myPRES provider portal, where they can comment and discuss issues.

**Health Risk Assessment**

A HRA specialist conducts an HRA for all Centennial Care members. The HRA form is standardized and approved by HSD. The HRA is utilized to determine the member’s overall health status and emergent needs. The HRA is used to identify members who may require further intervention. Members who are identified for further intervention receive a comprehensive needs assessment and are assigned to a care coordination level.

**Comprehensive Needs Assessment**

Members who are identified for further intervention receive a CNA and are assigned to a care coordination level to identify and prioritize their clinical, behavioral, functional and social support needs. The CNA may indicate a need for additional assessments, such as eligibility for long-term care services and support. Upon completion of the CNA, the care coordinator, provider and member determine the member’s care plan, which includes an ICPT with the appropriate participants.

Members who require level 2 or 3 care coordination are assigned to a dedicated care coordinator. Members are matched with an appropriate care coordinator based on their clinical needs,
geographic location, language, cultural preferences and history of established provider relationships. To find your patient's assigned care coordinator, you may contact the care coordination unit at:

- Phone: 1-866-672-1242 or (505) 923-8858
- Fax: (505) 843-3150

If we are unable to reach members through telephone or mail contacts, a member of the Presbyterian care coordination team may request your help in engaging your patient in the assessment process. Similarly, you may request our assistance for care coordination for your member.

**Care Plan Development**

Based on the results of the CNA, an individualized care plan is developed for members assigned to care coordination level 2 or 3. The care plan aligns a member’s needs and preferences with appropriate services and interventions, which include the support the member needs to stabilize or improve his or her health, safety and well-being. The care plan includes all Medicaid services, value-added services and other supports or services identified for the member.

This customized care plan allows members to understand which services are available and creates a foundation for discussions about their health with them and their caregivers, care coordinator and providers. The assigned care coordinator works with the member and his or her designated family members, caregivers or authorized representatives, the member’s primary care provider (PCP), other providers and the ICPT to develop an individualized care plan that is member-driven and addresses issues and needs identified in the CNA. The member’s assigned care coordinator is accountable for the development and implementation of the member’s care plan, serves as the primary point of contact and directs all care coordination activities for the member. The member’s PCP, other providers and other ICPT members provide assistance as appropriate for their areas of expertise. The care coordinator works in collaboration with the provider and the member to identify measurable physical, behavioral, functional and social support goals and to develop interventions to address the member’s goals.

**Interdisciplinary Care Plan Team**

Based on the CNA and the individualized care plan, an appropriate ICPT is established. The ICPT addresses the member’s specific needs and is a central component of the care coordination model. Members of the ICPT are based on the member's individual needs, preferences and situation. At minimum, the ICPT consists of the member, the member’s PCP and the care coordinator. In addition, as appropriate and with the member’s input and consent, additional members of the ICPT may include the following:

- Family members or other persons with significant involvement in the member’s care
- Peer/family support specialists
- Community health workers or community health representatives
- The care coordinator manager or supervisor
Care Coordination

- The support broker (if member chooses the Self-directed Community Benefit)
- Pharmacists
- Presbyterian’s medical director
- Behavioral health providers, including mental health and substance abuse treatment providers
- Administrative support staff
- Specialty providers

Clinical staff from nursing homes and assisted living facilities where members live are also included as integral participants in the member’s ICPT. Residential care staff employees are instrumental participants in the member’s care team and play a central role in alerting care coordinators to a change in a member’s condition or status that, if acted upon in a timely and appropriate fashion, may prevent unnecessary hospitalizations.

Members are encouraged to actively participate in the care planning process and are provided with tools and resources that allow them to take personal responsibility for their care management. The care plan is reviewed, modified if necessary, approved and then signed by the member. The care plan serves as the basis for authorizations by our Utilization Management Department.

ICPT communication may occur through in-person case conferences, by telephone or electronically through the care management system. The member’s assigned care coordinator works with the provider to ensure that the provider’s input and recommendations are incorporated into the care plan where appropriate.

Care Plan Review and Authorization of Services

Our care coordination staff works in close collaboration with our utilization management staff for transitions of care, prior authorizations and approvals and discharge planning activities. Working directly with our provider community, hospitals, residential and group home programs and nursing facilities, our care coordination and utilization management team ensures members are receiving care in the most appropriate and least restrictive setting possible, as well as facilitating a smooth transition from acute care to a community or home setting. For services requiring review or prior authorization, we use Milliman Care Guidelines, behavioral healthcare and long-term care guidelines, internal policies based on industry-accepted standards and New Mexico Medicaid rules and regulations to determine the appropriateness of care and services. Services referred to non-participating and out-of-state providers, such as residential treatment centers for children, require review and/or prior authorization. The member’s PCP can directly refer the member to Centennial Care services that do not require prior authorization. Refer to the “Utilization Management” chapter of this manual for information on prior authorization requirements and guidelines. For a complete list of services that require prior authorization, please reference Appendix F.
Long-term Care

For those members requiring long-term care supports and services, the member’s care coordinator develops an individualized, member-centric care plan based on the member’s identified goals, preferences and needs identified in the CNA. See the “Long-term Care” chapter of this manual for more information about this area of support, including the community benefit.

The care plan for long-term care services is submitted to Presbyterian’s Utilization Management Department for review and authorization. A designated secondary review team reviews and approves the recommended community benefit prior to the provision of services. If the service does not appear medically necessary based on the information submitted, the service may be denied as laid out by the utilization management process.

Care Plan Distribution and Initiation of Ongoing Care Coordination Activities

Once the care plan is completed and necessary authorization of services is in place, the care coordinator ensures that the member or his or her caregiver has a copy of the signed care plan. The care coordinator also provides instruction to the member and caregiver regarding the care plan’s online availability through the member portal.

Ongoing Care Coordination and Care Plan Updates

The assigned care coordinator is responsible for managing ongoing care coordination and ensuring that documentation of care coordination activities is maintained in the member’s care management system record. These activities are conducted in accordance with the care plan and include, at a minimum, the responsibility to:

- Develop and update the care plan as needed
- Provide disease management interventions and health education related to chronic conditions
- Monitor treatment and coordinate with the provider to encourage best practice as it relates to tests, appointment frequency and adherence to clinical practice guidelines and condition specific protocols

Reassessment of Care Coordination Level

Throughout the course of participation in care coordination, a reassessment of the member’s care coordination level may be needed. A reassessment may be a scheduled event or may be prompted by a trigger event that suggests that the member’s health status or condition has changed.

Providers may request a reassessment of their patient’s care coordination level by contacting the member’s assigned care coordinator directly or through the care coordination unit at:

- Phone: 1-866-672-1242 or (505) 923-8858
- Fax: (505) 843-3150

Disease Management

Presbyterian provides comprehensive care to our members statewide through our network of services. To provide resources for providers in care coordination for Centennial Care members with chronic conditions, Presbyterian offers comprehensive disease management programs for diabetes, adolescents with depression and
coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease. These programs include distribution of blood glucose meters for all members with diabetes and educational materials for members and providers. One-on-one behavioral lifestyle coaching is conducted with the member to meet his or her self-identified goals, including condition monitoring and self-management.

Presbyterian’s innovative disease management program, Healthy Solutions, supports providers in their management of chronic illnesses. The Population Health Alliance defines population health/disease management as a program that strives to address health needs at all points along the continuum of health and well-being through participation of, engagement with and targeting interventions to address those issues. The goal is to maintain or improve the physical and psychosocial well-being of the individuals through cost-effective and tailored health solutions. More information about the Population Health Alliance is available on its website at http://populationhealthalliance.org/.

To provide resources for providers in their care coordination for Centennial Care members with chronic conditions, Presbyterian offers comprehensive disease management programs for diabetes, asthma and coronary artery disease. These programs include distribution of blood glucose meters for all members with diabetes, peak flow meters for members with asthma and educational materials for members and providers. One on one behavioral lifestyle coaching is conducted with the member to meet his/her self-identified goals including condition monitoring and self-management.

This comprehensive Healthy Solutions disease management program supports the provider/patient relationship and plan of care. It emphasizes prevention of exacerbations and complications by using evidence-based practice guidelines and patient empowerment strategies for self-management of chronic disease. In addition, it evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Through this disease management program, Presbyterian strives to achieve the following:

- Identify a member’s problems before the problems occur. Presbyterian proactively works to identify members potentially in need of these services through medical and pharmaceutical data available through the Presbyterian claims data systems.
- Stratify members by risk criteria using a predictive modeling tool to identify members’ risk level. Using these criteria for initial stratification, a member’s needs are matched to an appropriate level of intervention.
- Provide meaningful interventions through care coordination and Healthy Solutions phone-based health coaching.
- Collaborate with providers and members to support member’s goals for health improvement.
Care Coordinators

- Coach the member through preventive healthcare guidelines.

Care coordinators manage members with the highest risk score who need more intensive/multisystem medical or nursing interventions. Members with moderate risk scores are managed by our Healthy Solutions team. They provide phone-based health coaching, which is different from the traditional educational model that identifies and focuses on members who already meet the criteria of “readiness to change.” Through health coaching, we provide the member the one-on-one support he or she needs to reach the stage of “readiness to change.” This behavioral change methodology ensures we focus our efforts on developing a personalized health improvement plan for members. In turn, the staff provides support and education for the member’s health-related behavioral change.

Healthy Solutions offers a member-focused program to meet the medical, behavioral and educational healthcare needs for all of our members. Health coaches work with individuals on behavioral issues for those with a moderate risk score.

Improve Health Outcomes

Presbyterian understands the importance of improving outcomes. By tailoring the frequency and intensity of outreach to the members based on risk and severity of disease, as well as to their readiness to change, our staff is more effective with interventions. Members with chronic illness learn to manage their health to lead more productive lives. Members are also more willing to participate if their provider discusses the program with them and recommends their participation in the program. Members who are considered at risk learn to minimize problems with ongoing education. Utilization of healthcare resources becomes more appropriate and effective.

How to use the Healthy Solutions Team

You may refer your Presbyterian Centennial Care patients with diabetes, asthma or coronary artery disease to the Presbyterian Healthy Solutions disease management program at:

- Phone: 1-800-841-9705
- PHPreferral@phs.org
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7. Utilization Management

Presbyterian’s Utilization Management program ensures that Centennial Care members receive the right amount of medically necessary care at the right time, in the right setting and in the most cost-effective way. Our utilization management process includes prior authorization, monitoring for over/underutilization, concurrent inpatient and outpatient review and retrospective review.

Affirmation Regarding Decision-making for Utilization Management

The National Committee for Quality Assurance (NCQA) requires that Presbyterian distributes a statement to all members and to all practitioners, providers and employees who make utilization management decisions, affirming the following:

1. UM decision-making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Member Awareness

Members receive the Member Handbook, which describes services that are available to them. Medically necessary services or supplies may be authorized for up to one year. The Member Handbook is available online in English and Spanish on the Member Resources webpage https://www.phs.org/member.

Member Medical Summary

Members may need to access services from providers who may not be familiar with their history. Presbyterian includes a medical summary form in the Member Handbook to assist members in providing their medical histories. Members are asked to update their records by one of the following methods:

- Regularly update this medical summary and carry it with them at all times so they can present it when accessing care.
- Enter updates into MyChart (https://www.phs.org/better-health/access-your-care/Pages/access-your-health-information.aspx). Presbyterian’s MyChart gives members a secure way to access their medical records and helps them keep track of all their medical information online.
- Call the Presbyterian Customer Service Center (PCSC) at (505) 923-5200 or 1-888-977-2333.

Referral Requests/Prior Authorization

Members need to see their primary care providers (PCPs) for referrals for services and specialty care. In most cases, the PCP is required to submit a referral request for a service, such as a specialist
visit or a specific therapy. The PCP either gets an authorization number or a notice that a service requires prior authorization. PCPs or other providers submitting referral requests are encouraged to submit them online so they are immediately notified of the action, authorization number, or notice that the referral request was received and is in the prior authorization process. The referring provider should notify the treating provider of the authorization number to be submitted on a claim.

Members may self-refer and do not need prior authorization for emergency care, urgent care, behavioral health and women’s healthcare.

Presbyterian Centennial Care has additional benefits for self-referral for women’s healthcare, which are explained in the “Members’ Rights and Responsibilities” section of the Presbyterian “Customer Service Center” chapter of this manual.

Presbyterian Centennial Care ensures the following:

- Members have direct access to medical care 24 hours a day, seven days a week through their PCP, urgent care facilities, emergency rooms, behavioral health providers and long-term care providers, including a backup plan for home- and community-based services.
- Members have accessibility to medically necessary specialty referrals in a timely manner within accepted medical guidelines for treatment.
- The PCP acts as a gatekeeper to evaluate the medical necessity for specialty consultations and referral requests.
- Emergencies are triaged through a medical screening examination (Presbyterian does not require prior authorization for emergency services, which includes stabilization services and urgent care services; post-stabilization services require authorization).
- Presbyterian evaluates prior authorization requests to out-of-network providers when medically necessary covered services are not reasonably available through the plan.
- Providers may speak with a Presbyterian representative (for example, the member’s care coordinator, UM staff or a medical director) before Presbyterian makes a decision regarding referrals, benefits, or an adverse determination.
- Members and providers may only request an expedited decision for prior authorization determinations that meet specific regulatory criteria for urgently needed care or services.
- Services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds.
- Long-term services and supports are recommended by the member’s care coordinator and Interdisciplinary Care Plan Team (ICPT) based on the needs identified
in the Comprehensive Needs Assessment (CNA) and are reviewed and approved by the utilization management team before the initiation of services.

- Providers and members have access through https://www.phs.org/providers/authorizations/Pages/default.aspx or by calling PCSC for referral requests and prior authorization requirements, which include but are not limited to:
  - Inpatient admissions
  - Select providers
  - Select behavioral health services
  - Select outpatient procedures
  - Select major diagnostic tests
  - Home healthcare
  - Select durable medical equipment
  - New medical technology
  - Medications not on the approved drug list or exceeding medication limits
  - Admissions to long-term care facilities
  - All out-of-network services
  - Transplants
  - Value-added services

In addition, benefits with limitations may also require a prior authorization.

For a complete list of services that require a referral request or prior authorization, please reference Appendix F.

**Authorizations of Coverage**

Services requiring prior authorization are published in the appendix of this manual, the Centennial Care Member Handbook and Presbyterian’s website. Extensive detail is included in provider orientations and ongoing training. This ensures that the provider and member know if services are covered.

The UM team reviews cases for the following:

- Medical necessity
- Appropriate setting
- History of medical conditions and treatments
- Special circumstances
- Socioeconomic issues
- Support issues
- Complexity of health status
- Clinical quality considerations
- Availability of local health resources

Individual patient situations, risk factors, service availability and patient safety are also considered when relevant and known. Consequently, complete documentation by the referring provider is critical to demonstrate medical necessity.

Presbyterian encourages its providers to address the following issues when requesting authorization for a service:

- Recommendation of treating provider
Utilization Management

- Age
- Co-morbidities
- Complications
- Mental status
- Activities of daily living
- Instrumental activities of daily living
- Financial status
- Poly-pharmacy
- Progress of treatment
- Psychosocial and cultural situation
- Home environment
- Availability of less restrictive treatment modalities to address the member’s needs
- Availability of services including, but not limited to, skilled nursing facilities (SNF) or home care in the member’s area to support the member after discharge
- Presbyterian’s coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care
- Ability of local hospitals to provide all recommended services within the estimated length of stay

Medical Necessity Service Standards

Presbyterian uses objective, published standards to evaluate medical necessity for services and updates them through the Utilization Management Committee as explained below. The resources used by the Health Services staff most often include:

- Milliman Care Guidelines
- Apollo Criteria (rehabilitation)
- Oregon Outpatient Therapy Guidelines for Children with Special Health Needs
- National Specialty and Association Guidelines
- Hayes Medical Technology Guidelines
- NIA Medical Specialty Solutions imaging guidelines
- American Psychiatric Association criteria
- American Academy of Child and Adolescent Psychiatry criteria
- American Society of Addiction Medicine Patient Placement criteria
- Internal criteria approved by Presbyterian’s Utilization Management Committee and Clinical Quality Committee

Presbyterian reviews and updates utilization management criteria and the procedures for applying these criteria at least annually. Both proprietary and internal criteria may be modified to meet local practice standards. The process includes review by Presbyterian medical directors, local providers and the utilization management Committee. Copies of criteria are provided to providers as requested on specific cases, through direct requests, routine updates and the myPRES website.
Verifying a Member’s Eligibility and Benefits and Prior Authorization Requirements

A member must be eligible for Presbyterian Centennial Care at the time a service is delivered in order for the service provider to be reimbursed. Eligibility can be checked easily and quickly through myPRES at https://mypres.phs.org/Pages/default.aspx or by calling (505) 923-5757 or 1-888-923-5757, Option 1.

The provider can verify if prior authorization is required by referencing Appendix F.

Requesting a Prior Authorization

To serve our providers, Presbyterian has a dedicated prior authorization line that is available during normal business hours and after hours. Call Clinical Operations at (505) 923-5757 or 1-888-923-5757 (Option 4). For home healthcare requests, call (505) 559-1151 or 1-877-606-1151 (Option 4) and Option 5 for behavioral health authorizations.

When a need is identified for a service that requires a clinical review, Presbyterian offers a variety of user-friendly tools for providers to submit referral requests online through myPRES at http://www.phs.org. Using myPRES to submit referral requests or prior authorizations is the easiest, least intrusive method for the provider’s office or facility. If the provider is unable to submit the request online, it may be submitted by fax, email or telephone or through a care coordinator. If applicable, the provider should submit supporting documentation to demonstrate the medical necessity for the request. Prior authorizations, including auto-generated approvals for specific services and inpatient notifications for expectant mothers, may be obtained through myPRES at http://www.phs.org. The provider may also access the status of prior authorization requests, claims and eligibility information through myPRES 24-hours a day, seven days a week. For more information about myPRES, see the “e-Business” chapter of this manual. The provider may also contact us through either the fax number or mailing address below.

Prior Authorization Contact Information

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient prior authorization requests</td>
<td>(505) 843-3107 or (888) 923-5990</td>
</tr>
<tr>
<td>Outpatient services and DME requests</td>
<td>(505) 843-3047</td>
</tr>
<tr>
<td>Home Health Care requests</td>
<td>(505) 559-1150</td>
</tr>
<tr>
<td>Advance Imaging requests</td>
<td>(866) 236-8717 or online at <a href="http://www.radmd.com">www.radmd.com</a></td>
</tr>
<tr>
<td>Behavioral health requests</td>
<td>(505) 843-3019</td>
</tr>
<tr>
<td>Mail to Health Services:</td>
<td>Presbyterian Prior Authorization Team</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 27489, Albuquerque, NM 87125-7489</td>
</tr>
</tbody>
</table>

Inpatient Admission

For elective or emergency admissions, use myPRES for all prior authorization requests and notification of deliveries.

In compliance with the Newborns’ and Mothers’ Health Protection Act of 1996 (Newborns’ Act), Presbyterian does not require a prior authorization
to admit expectant mothers for labor and delivery services. To ensure seamless care and the best experience possible, an inpatient notification is required within 24-hours of admission. If Presbyterian isn't notified, not only is there a chance that the claim will be denied, but the member may not have the opportunity to receive coordinated postpartum care that could improve the overall quality of health for her and her child.

If necessary, the provider may also obtain prior authorization for an inpatient concurrent review or inpatient hospital admission by calling (505) 923-5757 or 1-888-923-5757 (Option 4). The provider needs to either fax the request to the number designated in the message for the type of request or leave a message.

**Urgent and Expedited Requests**

For requests of urgently needed care or services that require an expedited response, Presbyterian can provide a quick decision based on certain criteria. An urgent/expedited decision turnaround for care or treatment is appropriate in the following circumstances:

- The life, health or safety of a covered person would be seriously jeopardized because of the member's psychological state.
- In the opinion of a provider with knowledge of the member’s medical or behavioral health, the condition would subject the member to adverse health consequences without the requested care or treatment if a decision is not provided within 72-hours.
- The covered person’s ability to regain maximum function would be jeopardized if a decision is not provided within 72-hours.
- The medical exigencies of the case require an expedited decision.

All urgent and expedited prior authorization requests that the provider sends should meet one or more of these criteria. If the request does not meet the urgent and expedited criteria, it is processed as a routine prior authorization request.

When a situation meets the definition above, please call the Utilization Management department at (505) 923-5757 or 1-888-923-5757 (Option 4).

**Hours of Operation**

Presbyterian’s utilization management team of nurses, pharmacists, behavioral health specialists, therapists and medical directors are available 24 hours a day, seven days a week to assist providers with authorizations or verification of benefits.

**Appeals**

If a request is not authorized, the provider or facility may appeal this decision. The provider is not prohibited from advocating on behalf of the member, but must have the member’s written consent. The criteria used to make this determination are made available to the provider if requested. In addition, the provider may speak directly to Presbyterian’s medical director. Refer to the “Appeals and Grievances” chapter of this manual for information on filing appeals.


**Behavioral Health Services**

Members may access Centennial Care contracted behavioral health providers without a referral or prior authorization. Referrals are not needed for most outpatient services.

Presbyterian encourages PCPs and behavioral health providers to communicate with one another regarding individual cases.

A Presbyterian Centennial Care member may access behavioral health services through a referral from his or her PCP or other healthcare provider or by going directly to a behavioral health provider.

For Presbyterian Centennial Care patients, the provider can make a direct referral for behavioral services based on the following indicators:

1. Suicidal/homicidal ideation or behavior
2. At-risk of hospitalization due to a behavioral health condition
3. Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility
4. Trauma victims
5. Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation or other developmental disabilities
6. Request by member or representative for behavioral health services
7. Clinical status that suggests the need for behavioral health services
8. Identified psychosocial stressors and precipitants
9. Treatment compliance complicated by behavioral characteristics
10. Behavioral and psychiatric factors influencing medical condition
11. Victims or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect
12. Non-medical management of substance abuse
13. Follow-up to medical detoxification
14. An initial PCP contact or routine physical examination indicates a substance abuse problem
15. A prenatal visit indicates substance abuse problems
16. Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse
17. A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other behavioral health conditions
18. The persistence of serious functional impairment

For additional detail on procedures for authorization of behavioral health services, please refer to the “Behavioral Health” chapter of this manual.

**Dental Care**

Routine dental exams and prophylaxis (cleanings) do not require a referral. Members may access in-plan dental providers without obtaining a referral or
prior authorization from Presbyterian Centennial Care. Providers may contact Presbyterian’s partner, Den/Q, at (855) 343-4276. Members may call PCSC for information about in-plan dental providers.

**Family Planning**

Presbyterian Centennial Care must allow members the freedom of choice and allow access to family planning services, without requiring a referral from the PCP.

Clinics and providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by Presbyterian Centennial Care for all family planning services regardless of whether they are participating or non-participating providers. Unless otherwise negotiated, Presbyterian Centennial Care shall reimburse providers of family planning services according to the Presbyterian Centennial Care fee schedule.

Family planning services are defined as the following:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases, if medically indicated
- Screening, testing and counseling of at-risk individuals for human immunodeficiency virus and referral for treatment
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Provision of, but not payment for, contraceptive pills (refer to formulary)
- Provision of devices/supplies
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

Presbyterian Centennial Care is not required under any obligation from the Human Services Department (HSD) to reimburse non-participating family planning providers for non-emergent services outside the scope of these defined services.

For guidelines about sterilization and termination of pregnancy, please see the “Pregnancy Termination and Provider Certification of Medical Necessity for Pregnancy Termination” section of the “Claims and Payment” chapter of this manual.

**Home Health Services**

Presbyterian Centennial Care home care services are managed through the Presbyterian Utilization Management department.

The Utilization Management department provides utilization management through review of prior authorization requests for home care services. The review is to ensure that the right services are
Utilization Management

provided at the right frequency, duration and level needed. Please refer to the “Home Health” chapter of this manual for detailed authorization requirements and guidelines.

**Laboratory Services**

TriCore is our preferred laboratory in the following counties:

- Bernalillo
- Sandoval
- Santa Fe
- Torrance
- Valencia

Outside these five counties, providers must refer a member to a contracted lab.

Presbyterian utilizes the Clinical Laboratory Improvement Amendments Waive Test list. The list applies to all Presbyterian product lines and is effective for dates of service on or after Jan. 1, 2014.

Please refer to the “Laboratory Services” chapter of this manual for more information.

**Long-Term Care Services**

Long-term care is the overarching term that refers to services provided to members determined to meet Nursing Facility Level of Care (NFLOC) eligibility and includes certain community benefits, the services of a nursing facility and the services of an institutional facility.

For long-term care supports and services, the member’s care coordinator develops an individualized member-centric plan of care based on the member’s identified goals, preferences and needs from the CNA. Upon completion of the CNA and care plan, the care plan for long-term care services is submitted to Presbyterian’s Utilization Management department for review and authorization. A designated secondary review team reviews and approves recommended community benefits before the provision of services. If the service does not appear medically necessary based on information submitted, services may be denied and the provider should follow the utilization management process.

Please refer to the “Long-term Care” chapter of this manual for details on Presbyterian Centennial Care long-term care, benefits and guidelines.

**Pharmacy Benefits**

Providers are required to comply with Presbyterian’s formulary requirements for medications. Some medications on the formulary may require prior authorization. The prior authorization process is available once a member has tried and failed all formulary agents and it is deemed medically necessary to have access to a non-formulary agent. Please see the “Pharmacy” chapter for detailed information. The formularies, pharmacy prior authorization forms, specialty pharmaceuticals listing and specialty drug request form are available on the pharmacy page at [http://www.phs.org](http://www.phs.org).

**Prior Authorization for Radiology/Advanced Imaging**

Presbyterian uses the Medical Specialty Solutions (MSS) program, managed by National Imaging
Utilization Management

Associates, Inc. (NIA), for prior authorizations of both non-emergent, advanced diagnostic imaging procedures and cardiac-related imaging procedures performed in an outpatient setting. The program is designed to streamline the authorization process, reduce healthcare costs and improve patient outcomes.

The MSS program applies to all Presbyterian members who have medical benefits for in-plan radiology facilities (some employer groups may decide not to participate). The following procedures require a prior authorization through the MSS program:

- Computed tomography (CT)/Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)/Magnetic resonance angiography (MRA)
- Positron emission tomography (PET) scan
- Coronary computed tomography angiography (CCTA)
- Myocardial perfusion imaging (MPI)
- Muga scan
- Stress echocardiography
- Echocardiography

Services performed in the following settings do not require authorization through the MSS program:

- Inpatient
- Observation
- Emergency room
- Urgent care

While inpatient and observation services do not require prior authorization through the MSS program, some may require prior authorization from Presbyterian. In addition, musculoskeletal procedures and elective spine surgery performed in both inpatient and outpatient settings do require prior authorization through NIA’s Spine Management program (effective Jan. 1, 2015). Emergency room and urgent care facility procedures do not require prior authorization from the MSS program or Presbyterian. For more information, please refer to Presbyterian’s authorization guide available on Presbyterian's website at https://www.phs.org/providers/authorizations/Pages/default.aspx.

The ordering provider is responsible for obtaining prior authorization for any of the advanced imaging services listed earlier in this section. It is the responsibility of the rendering provider to ensure that an authorization was obtained, before services are provided. Providers can obtain authorizations online at www.RadMD.com or by calling 1-866-236-8717. Failure to do so may result in a claim rejection. If you have any questions regarding NIA’s MSS program, contact your Provider Network Operations (PNO) relationship executive listed in the PNO contact guide at http://www.phs.org/ContactGuide.

Transportation Services

Presbyterian covers medically necessary transportation for Presbyterian Centennial Care members; however, limitations and exclusions apply for certain services.
Utilization Management

Presbyterian or its contractor arranges transportation for appropriate services. The PCSC’s transportation coordinator assists in arrangements and appropriate authorizations. Rides for routine scheduled office visits or medical services require 48- to 72-hours of advance notice.

Presbyterian Centennial Care covers emergency transportation by ground ambulance, air ambulance or by a special equipped van, when medically appropriate. If members need emergency transportation for a life-threatening situation, call 911 or the emergency telephone number in the area. All non-emergent transfers between facilities require prior authorization.

Same-day transportation is available for urgent healthcare services or urgent referrals made by a PCP. To schedule a ride, contact Superior Medical Transport directly at 1-877-735-0111 (toll free) or (505) 341-0042 or PCSC at (505) 923-5200 or 1-888-977-2333.

Vision Services

Routine vision services do not require a referral. Members may access in-plan vision providers without obtaining a referral or prior authorization from Presbyterian Centennial Care. Providers may contact Presbyterian’s partner, VSP, at 1-800-852-7600. Members may call PCSC for information about in-plan vision providers.

Special Populations

Special populations require a broad range of primary specialized medical, behavioral health and related services. Presbyterian follows HSD guidelines for determining special populations.

Presbyterian currently defines adult special populations as the following:

- Age 18 years and older
- Having an increased risk for an ongoing physical, developmental, neurobiological, mental or behavioral/emotional health condition
- Requiring healthcare and related services that are different from the services required by most individuals
- Having functional limitations

Presbyterian currently defines child special populations as:

- Up to 18 years of age
- Having or at an increased risk for an ongoing physical, developmental, neurobiological, mental or behavioral/emotional health condition
- Requiring healthcare and related services that are different from the services required by most children
- Children who are eligible for Supplemental Security Income as disabled under Title XVI
- Children identified in the Department of Health Title V Children’s Medical Services Program
- Children receiving foster care or adoption assistance support through Title IV E
- Other children in foster care or out-of-home placement
• Children who are eligible for services through the Individuals with Disabilities Education Act
• Other children whose clinical assessment shows that they have special healthcare needs

Providers are encouraged to help educate members, their families and their caregivers regarding special considerations and needs for their care, including care coordination, special transportation needs, therapy services, durable medical equipment and coordination of emergency inpatient and outpatient ambulatory surgery services with facilities and hospitalists.

Specialists as PCPs for Members with Special Healthcare Needs

On an individual basis, specialists treating members with disabilities or chronic/complex conditions may serve in the capacity of PCP. The specialist is credentialed as a PCP/Specialist and performs all PCP duties within the scope of the participating specialist’s certification. Contact your Provider Network Operations relationship executive listed in the Provider Network Relations Contact Guide at https://www.phs.org/ContactGuide.

Continuity of Care

Clinical operations staff assists members whenever possible in making a smooth transition between providers when necessary. The following are examples of a few circumstances in which Clinical Operations staff assist members in their continuity of care if:

• A new member enrolls from a previous insurer to Presbyterian.
• A member’s healthcare provider leaves or is terminated from Presbyterian’s network.
• A member voluntarily switches or is switched to another health plan.
• A member’s coverage ends or benefits are exhausted.

The transitional period is administered in accordance with all applicable laws, rules and regulations. Currently, for members with a chronic or acute medical condition, treatment continues through the current period of active treatment or for up to 90 calendar days (whichever is less).

Continuation of care is covered for women in their second or third trimester of pregnancy through their postpartum, as well as for transplant patients.

Providers and members may call PCSC for assistance with continuity of care issues.

Medical Records and Confidentiality Assurance

There may be instances where records from your office or facility are requested to ensure that correct and timely coverage decisions are rendered. In addition, records may be requested to review for a special utilization/quality study. Presbyterian is committed to requesting the minimum amount of information required and assisting with either on-site reviews or telephone discussions to minimize administrative burdens. We currently reimburse providers $30 for the first 15 pages and $0.15 per page after the first 15 pages [based on the New
Utilization Management

Mexico Administrative Code (NMAC), Title 16, Chapter 10.17.8].

Presbyterian ensures that Health Insurance Portability and Accountability Act (HIPAA) requirements are met and maintains confidential records files. All information and medical records obtained during the course of review activities shall be treated as confidential, in compliance with all applicable state and federal regulations. Presbyterian uses reasonable diligence disclosure across the entire organization to prevent inappropriate disclosure. This obligation excludes disclosure of information that is required by state or federal law or is in the public domain.

Clinical Practice Guidelines and Tools

Clinical practice guidelines are systematically developed statements designed to give providers the most current, nationally recognized recommendations regarding the care of specific clinical circumstances. Presbyterian adopts clinical practice guidelines that are relevant to the enrolled population and are based on reasonable scientific evidence. All clinical practice guidelines are reviewed at least every two years and are updated when clinically appropriate. For access to Presbyterian’s clinical practice guidelines, go to https://www.phs.org/providers/resources/reference-guides/Pages/clinical-practice-guidelines.aspx. You may also contact the Presbyterian Quality department by phone at (505) 923-5017 or 1-866-634-2617 (these are voice answering systems only). You may also contact them by email at PerformanceImp@phs.org.

Patient Centered Medical Home

Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care services that proactively manage a population of patients with an emphasis on coordination of care. The outcome measures for each participating primary care PCMH medical group is reported with the objective of improving clinical quality outcomes and overall health status of members in the program. Tools and resources are provided to PCMHs to assist in the management of their patient population and to support member outreach activities under the following circumstances:

- Admissions
- Readmissions
- Ambulatory sensitive conditions
- High Emergency Department (ED) utilizers
- Non-emergent ED visits
- Chronic medical conditions
- Clinical quality measures

Health outcomes are measured to identify achievements in patient care and opportunities for increased efficiencies and care coordination activities. Developing a financially self-sustaining program with shared savings opportunities, aimed at decreasing inappropriate system utilization, provides a key incentive for PCMH medical groups to improve overall efficiency.

Member-centric reports are sent to supporting clinical staff at participating PCMH groups to provide a comprehensive outreach call, which
alerts members of all needed preventive screenings or gaps in care for chronic conditions.

lists are available for PCPs only.

**Under- and Overutilization Analysis**

Annually, Presbyterian chooses relevant types of utilization data to monitor for each product line to detect potential under- and overutilization of services. Examples might include the following:

- Emergency room visits
- Hospital days
- Certain procedures
- Behavioral health admissions
- Community benefits

Presbyterian monitors these data elements, compares them to national benchmarks and tracks them over time to identify trends. If under- or overutilization problems are identified, Presbyterian takes action to address causes of the trend and inform providers as appropriate.

**Technology Assessment**

The Technology Assessment Committee (TAC) provides a process for reviewing all technology recommendations and for recommending new medical, experimental, investigational or behavioral therapies or procedures.

Following a formal application process, the TAC evaluation includes a literature search, review of governmental and regulatory publications and expert opinion. The TAC also recommends clinical policies and procedures. This includes procedures, drugs and devices. The TAC is chaired by a Presbyterian Senior Medical Director.

**Medical Policy Development and Dissemination**

Coverage decisions are based on the following:

- Eligibility
- Member’s contractual benefits
- The Centennial Care Benefit Manual
- Individual, community and/or local delivery considerations
- Presbyterian utilizes nationally recognized medical review criteria to assist in certifying benefit coverage. Medical policies are reviewed by practicing New Mexico providers and must be approved by the Presbyterian Clinical Quality Committee, which consists of local providers as well as Presbyterian clinical staff. Review criteria may include the following:
  - Hayes (a nationally recognized and independent health technology assessment company)
  - Centers for Medicare & Medicaid Services (CMS)
  - United States Preventive Services Task Force
  - The CMS Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Jurisdiction C
  - Local Medical Review Board Medical Policies
**Utilization Management**

- Milliman Care Guidelines (a nationally recognized company specializing in best practice continuum of care recommendations)
- New Mexico Medical Assistance Division Program guidelines
- Oregon Outpatient Therapy Guidelines for Children with Special Health Needs
- Apollo Guidelines for Managing Physical/Occupational/Speech Therapy and Rehabilitation Care
- American Psychiatric Association Levels of Care
- American Academy of Child and Adolescent Psychiatry Levels of Care
- American Society of Addiction Medicine Levels of Care
- Health Plan’s Uniform Level of Care Guidelines
- Presbyterian Behavioral Health Level of Care Guidelines
- Presbyterian Health Plan Medical Policy Manual

Providers and members are encouraged to contact us for information about the medical policies or for copies of the medical policies used for specific coverage determinations.


**Presbyterian Centennial Care Utilization Management Summary**

A referral request may be necessary for certain benefits. When submitting a referral request, provide sufficient information to demonstrate the medical necessity for the service being requested.

**Member Eligibility Verification**

myPRES at https://mypres.phs.org/Pages/default.aspx

Interactive Voice Response numbers: (505) 923-5757 or 1-888-923-5757, Option 1

**List of Benefits Requiring Prior Authorization**


**Most Outpatient Requests**

myPRES at https://mypres.phs.org/Pages/default.aspx for the quickest response

Phone: (505) 923-5757 or 1-888-923-5757, Option 4

Fax: (505) 843-3047

**Inpatient Admissions**

myPRES at https://mypres.phs.org/Pages/default.aspx for the quickest response

Phone: (505) 923-5757 or 1-888-923-5757, Option 4

Fax: (505) 843-3107 or 1-888-923-5990
Utilization Management

Behavioral Health Requests

Phone: (505) 923-5221 or 1-866-593-7431
Fax: (505) 843-3019

Dental Requests (DentaQuest)

www.dentaquestgov.com
Phone: 1-800-233-1468
Fax: (262) 241-7150

Home Health Requests

myPRES at
https://mypres.phs.org/Pages/default.aspx for the quickest response
Phone: (505) 559-1151 or 1-877-606-1151
24/7 phone: (505) 559-1000
Local Fax: (505) 559-1150
Toll-Free Fax: 1-877-606-1155

Pharmacy Requests

Centennial Care Formulary:
https://www.phs.org/insurance-plans/our-plans/
myPRES at
https://mypres.phs.org/Pages/default.aspx for the quickest response
Phone: (505) 323-5757, Option 3 or 1-888-923-5757, Option 3

Radiology/Diagnostic Imaging Requests (NIA)

Phone: 1-866-236-8717
Utilization Management

Transportation Requests

Non-emergency medical transportation
(Superior Medical Transport) 1-877-735-0111
(toll free) or (505) 341-0042

Air Transportation: Phone: (505) 923-5757 or
1-888-923-5757, Option 4.
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8. Laboratory Services

Per your Presbyterian Services Agreement, between your practice and Presbyterian, all contracted providers are required to send lab specimens and refer Presbyterian members to TriCore Reference Laboratories (TriCore) in the following counties:

- Bernalillo
- Sandoval
- Santa Fe
- Torrance
- Valencia

Outside of these counties, providers must refer members to a contracted lab. The only exception is lab procedures covered under the In-office Laboratory List (Appendix G).

In-office Laboratory List

Presbyterian uses the In-office Laboratory List (Appendix G) for certain laboratory services. The list applies to all Presbyterian product lines and is effective for dates of service on or after Jan. 1, 2014. Reimbursement for pathology/laboratory services on the In-office Laboratory List are based on Presbyterian’s clinical lab fee schedule and a resource-based relative value scale (RBRVS), unless your contract states otherwise. Please note that certain Current Procedural Terminology (CPT) codes are restricted to specific specialties.

The list includes pathology/laboratory services that may be performed in the provider’s office. The list also includes a description identifying codes along with any limitations for each service.

Clinical Laboratory Improvement Amendments (CLIA) Waive Test List and Certification

Presbyterian generally limits testing to the In-office Laboratory List, however, some tests and/or special circumstances may be applicable under Clinical Laboratory Improvement Amendments (CLIA) waive test list.

Presbyterian must agree to the additional codes prior to the provider performing and/or being reimbursed. Services for CLIA tests will not be reimbursed unless a provider makes the request through Presbyterian for a CLIA test and provides proof of certification. The request must be approved by Presbyterian and a contractual amendment must be executed prior to the payments of labs. It is the provider’s responsibility to establish appropriate CLIA waive test certification or to apply for a CLIA waive test certificate if the choice is made to perform any of the services on the CLIA waive test list. If a provider’s CLIA classification changes, the provider would need to notify Presbyterian immediately and discontinue any CLIA tests. Reimbursement for these services remains at the current Presbyterian fee schedule and payment is subject to the member’s eligibility, benefit plan and benefit limitations.

Using Contracted Laboratory Services

Please be aware that non-contracted reference laboratories are soliciting healthcare professionals belonging to our network with the assumption that they can accept “Presbyterian insurance.” Choosing to use a non-participating reference laboratory is a breach of your Services Agreement between your practice/group and Presbyterian and could result in corrective action up to and including termination of your practice from the network.

Please be advised that Presbyterian is monitoring non-contracted laboratory use and will enforce the use of the contracted providers per the terms of your Services Agreement.

Referral of lab testing to out-of-network reference laboratories is coordinated through TriCore. If you are unable to coordinate through TriCore, separate prior authorization is required by calling (505) 923-5757 or 1-888-923-5757 (Option 4).

Beginning Jan. 30, 2015, all claims submitted from an out-of-network, non-participating laboratory will be denied by Presbyterian if not coordinated by TriCore or if a prior authorization was not approved. Providers who refer to non-contracted laboratories may have reimbursements reduced or may be subject to termination.

A complete list of TriCore locations and contact information is available online at http://www.tricore.org/locations. If you have issues or questions, please contact your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide.

<table>
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<tr>
<th>Department</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Client Services (test results, TriCore locations, specimen requirements, general information)</td>
<td>(505) 938-8922 (24 hours) 1-800-245-3296 (24 hours)</td>
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</tbody>
</table>
| Client Supplies                                                            | For phone or fax orders:  
(505) 938-8957 (phone)  
1-800-245-3296 ext. 8957 (phone)  
(505) 938-8472 (fax) |
| Logistics/Couriers                                                         | For online supply orders, call the Supply Order Desk:  
(505) 938-8957 or 1-800-245-3296, ext. 8957                                                        |
<p>| IS Help Desk (printer, TriCore Express, TriCore Direct and computer-interface assistance) | (505) 938-8974 or 1-800-245-3296, ext. 8974                                                         |
| Sales and Service                                                          | (505) 938-8917 or 1-800-245-3296, ext. 8917                                                         |</p>
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| Billing/Business Office | (505) 938-8910 or 1-800-541-9557  
                           (505) 938-8640 (fax) |
| Main Numbers         | (505) 938-8888 (24 hours)  
                           1-800-245-3296 (24 hours) |
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Provider Prescribing Guidelines

The Presbyterian pharmacy benefit is an essential element in providing Presbyterian Centennial Care patients the medication they need while appropriately managing costs. As the member’s practitioner/provider, you are the key to prescribing the appropriate medications by:

- Choosing the best, most cost-effective drug and dosage form to treat the member’s health condition or disease. This can be achieved by using Presbyterian’s Formulary or Preferred Drug List (PDL) when prescribing drugs to help our members manage their out-of-pocket costs.
- Following Presbyterian’s utilization management requirements as listed in the PDL formulary for prior authorization, quantity limits and step therapy that manage health care costs, promote safety and effective therapeutic outcomes.
- Ensuring each member clearly understands the use of a drug, the correct dose and possible side effects before prescribing the drug.
- Monitoring a member’s drug therapy to assess for therapeutic drug levels (when necessary) adverse effects and adherence to the treatment plan.
- Avoiding the use of high risk medications and prescribing formulary alternatives to prevent adverse effects and promote safety.
- Reviewing each patient’s complete medication list and dosages at every visit to educate, promote therapeutic outcomes, patient safety and avoid polypharmacy.
- Following rules and regulations of the New Mexico Medical Board and American Medical Association (AMA) code of medical ethics including but not limited to rules for prescribing for and/or treating one’s self or family member.
- Adhering to rules and regulations of the New Mexico Medical Board and the New Mexico Board of Pharmacy when prescribing any medication and using the New Mexico Prescription Monitoring Program (PMP) when prescribing controlled substances for patient safety. Please refer to the section on “Pharmacy Benefit References, Resources and Tools” in this manual to learn how to access the New Mexico PMP Program website.
- Participating in Presbyterian-patient safety audits to demonstrate that the PMP system and reports are used when prescribing controlled substances.

Pharmacy Benefit Guidelines

The following describes the general administration of the Presbyterian pharmacy benefit. All product
lines vary in structure. For example, some follow a closed, generics-based formulary while others use a multi-tier formulary structure. However, they all follow the same basic limitations.

- Under most benefits, generic substitution is mandatory for drugs that have generic Food and Drug Administration (FDA) AB-rated equivalents available. All drugs are subject to generic substitution when an approved generic becomes available.
- The formularies apply only to prescription medications obtained by patients through a participating retail pharmacy or medications administered by a health care professional that are typically administered in the patient’s home, physician’s office, freestanding (ambulatory) infusion suite, or outpatient facility and do not apply to inpatient medications.
- Not all dosage forms and strengths of a medication may be covered (e.g., sustained release, micronized, enteric coated, etc.).
- The formularies are subject to change throughout the year.

Formularies/Preferred Drug Lists (PDL)
The Formulary or Preferred Drug List (PDL) is an essential tool for providing our members with the medication they need while managing costs. The formulary covers all medically necessary treatments and includes medications in all therapeutic categories. Formularies include both brand and generic medications that are commonly prescribed. The medications listed on the formulary are subject to change. Refer to our formularies to see if the drug you are prescribing for your patient is covered by the member’s benefit plan to minimize their out-of-pocket expenses and to help manage healthcare costs. Some medications on the PDL may require prior authorization and other requirements for coverage, such as quantity limits and step therapy, to ensure that members are receiving the right medication in the right setting for the lowest cost. Please refer to the section on “Pharmacy Benefit References, Resources and Tools” in this manual to learn how to access our formularies online at PHS.org using a mobile device or request a printed copy.

Specialty Pharmaceuticals
Our formulary includes a broad list of specialty pharmaceuticals that treat complex and life-threatening conditions. Clinical Pharmacists evaluate treatment and determine the most appropriate site of care to promote therapeutic outcomes, prevent waste and manage costs. In other words, these drugs are administered by the member, a family member, or care-giver. Most specialty pharmaceuticals require prior authorization and must be obtained through our contracted specialty pharmacy network. Clinical criteria are developed with specialists and utilized to ensure the member is prescribed the right drug and the right dose for their health condition. Specialty pharmaceuticals are often expensive, typically greater than $600 for a 30-day supply. Certain specialty pharmaceuticals are limited to an initial fill (up to a 14-day supply) to ensure the member can tolerate the drug and to prevent waste. Specialty pharmaceuticals are not
available through the Mail Service Pharmacy Benefit option and are limited to a 30-day supply.
Please refer to the section on “Pharmacy Benefit References, Resources and Tools” in this manual to learn how to access our Specialty Pharmaceuticals/Medical Drug List.

Medical Drugs

Medical drugs are obtained through the Medical Benefit. A medical drug is any drug administered by a healthcare professional and is typically given in the member’s home, the provider’s office, a freestanding (ambulatory) infusion suite, or outpatient facility. Medical drugs may require a prior authorization and some must be obtained through the specialty network. Please refer to the section on “Pharmacy Benefit References, Resources and Tools” in this manual to learn how to access our Specialty Pharmaceuticals/Medical Drug List.

Experimental and Investigational Drugs

The experimental nature of drug products or the experimental use of drug products is determined by the Presbyterian Pharmacy & Therapeutics (P&T) Committee using current medical literature. Any drug product or use of an existing product that is determined to be experimental is excluded from coverage.

Pharmacy and Therapeutics (P&T) Committee

The Presbyterian P&T Committee is composed of local practicing primary care, medical specialty providers and pharmacists to adequately represent Presbyterian member population. Other committee members include Presbyterian medical directors, at least one behavioral health medical director, pharmacy department director, Presbyterian clinical pharmacists, retail pharmacy representatives and at least one physician and one pharmacist that are experts in the care of the elderly and disabled.

Committee Scope and Function

The committee serves in an advisory capacity to the Presbyterian panel of medical providers and Presbyterian management in all matters pertaining to the use of drugs.

The committee develops formularies accepted for use by Presbyterian providers and provides for constant revision of these formularies. The Presbyterian P&T Committee uses the following criteria in the evaluation of product selection:

- The drug must demonstrate unequivocal safety for medical use based on sound clinical data.
- The drug must be efficacious and be medically necessary for the treatment, maintenance, or prophylaxis of the medical condition based on sound clinical data.
- The drug must demonstrate a positive therapeutic outcome.
- The drug must be accepted for use by the medical community.
- The drug must provide a cost-effective option for the treatment of the medical condition.
- The drug must not be experimental or investigational.
• Recommendations from national organizations, committees and/or specialty societies are strongly considered
• The drug is mandated by Medicaid or CMS.
• The committee makes and reviews recommendations for changes to the formularies.

The committee may propose and approve certain utilization management mechanisms for approved formulary agents that are designed to promote appropriate usage. These mechanisms would include but not be limited to:

• Prior authorization review using medical criteria approved by the committee
• Step Therapy edits (a requirement for a trial of another appropriate formulary/drug listing agent before coverage of the targeted drug)
• Quantity limits based on manufacturer’s recommended maximum daily dosage
• The establishment of suitable educational programs for medical providers and Presbyterian enrollees on matters relating to drug therapy
• Retrospective review of prescribing practices to detect both underutilization and overutilization and providing recommendations for medically appropriate and cost-effective drug therapy
• Retrospective review of adverse drug reactions occurring in the ambulatory care setting to investigate possible causes, and providing recommendations to minimize the occurrence of adverse drug reactions and reporting serious adverse drug reactions to the FDA when appropriate
• Participation in quality assurance activities related to the distribution, administration and use of medications
• Review and approval of all Presbyterian guidelines and policies related to the use of medications
• Review and approval of all Presbyterian PDLs

P & T Committee Review and Approval of Requests for Formulary Changes

Providers may request medication additions, deletions or other changes to the Presbyterian PDL. All requests should be documented to facilitate the review and research process. Please refer to the section on “Pharmacy Benefit References, Resources and Tools” in this manual to learn how to request a Formulary addition, deletion or modification.

Once the request is received, a response is sent to the requesting provider acknowledging receipt of the request and stating when it will be reviewed. Additional information may be solicited to support the request.

Requesting providers may be invited to attend the Presbyterian P&T Committee meeting and present their case for the addition of a drug, although attendance is not mandatory.

A Presbyterian Clinical Pharmacist reviews all requests and prepares a written review of the drug for the Presbyterian P&T Committee. Formulary changes and the effective date of the changes are
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communicated to all appropriate parties through a memorandum or newsletter. Committee actions regarding deletions take effect 60 days following the decision. Additions are effective 30 days following the decision. The following steps are taken with any removal of a formulary drug:

- Identify members who are currently on the agent
- Notify the member of the change in benefit with at least a 60-day notice
- Ensure that the affected member has continued coverage of the drug during the 60-day notification period

Formulary changes are communicated to providers following each P&T Committee meeting in the Pharmacy and Therapeutics Committee Provider Update newsletter. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access the Pharmacy and Therapeutics Committee Provider Update newsletter and stay up to date with formulary changes.

Drug Utilization Review and Drug Use Evaluation Programs

Drug Utilization Review (DUR) is a review of patient data which is done to evaluate the effectiveness, safety and appropriateness of medication use. These Drug Utilization Reviews occur during claim adjudication and determines whether it is likely to cause harm based on interactions with other drugs or based on the member’s age, gender, allergies or other drugs on the member’s pharmacy profile. The DUR reviews often alert clinicians about prescribing and drug regimen problems and about patients who may be inappropriately taking medications that can produce an undesirable reaction or create other medical complications.

Utilization Management

Presbyterian uses the prior authorization process to ensure members receive the right medication, in the right setting, for the lowest cost. Spiraling prescription drug prices increase health care costs. The drugs needing prior authorization are particularly high in cost or have a potential for overutilization or abuse. Prior authorization makes sure the drugs are used responsibly as they are intended.

Pharmacy Services processes all drug prior authorizations and is under the direct supervision of at least one full-time clinical pharmacist who is accountable to a medical director to assist with decisions, as needed.

Presbyterian’s pharmacy prior authorization process includes intake, clinical review, decision-making and provider and member notification of the decision.

Pharmacy Prior Authorization Process Overview

Prior authorization (PA) is a clinical evaluation process to determine if the requested medication is a medically necessary covered benefit that is being delivered in the most appropriate healthcare setting. This does not apply to benefits mandated by law. The Presbyterian prior authorization process follows contractual requirements and state and federal laws and regulations. PA policies, clinical criteria, step therapy and quantity limits are
updated, reviewed and approved by the Presbyterian P&T Committee at least annually.

The PA process is based on various factors, including the following:

- Evidence-based practice guidelines
- National and local medical trends and practices and provider participation

Prior authorization approval is not a guarantee of payment.

Intake

Presbyterian accepts the standard Drug PA Request Form developed for all insurance companies doing business in the state of New Mexico in order to facilitate the PA process. The Drug PA Request Form may be submitted by fax. Drug PA requests may also be submitted online and by telephone. All requests are entered into the Presbyterian automated prior authorization system and are date and time stamped to ensure timeliness of decisions and notifications.

Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access and submit Drug PA requests.

Clinical Review

Presbyterian clinical pharmacists review the Drug PA request to determine if the medication meets Presbyterian requirements for benefit coverage and medical necessity by considering whether:

- Medication requires a PA
- Medication is or is not included on the PDL
- Medication meets or does not meet clinical criteria for medical necessity
- Medication quantities meet or exceed the PDL requirements and member’s benefit plan
- Medication and administration setting is appropriate for the member’s health condition or disease state
- Continuation of therapy for any drug depends on its demonstrable efficacy
- Prior use of free prescription medications (e.g., samples, free goods, etc.) will not be considered in the evaluation of a member’s eligibility for medication coverage.

The Drug PA request form is also used to request an exception once a member has tried and failed all formulary agents and it is deemed medically necessary to have access to a non-formulary agent. Members or their providers may request an exception. In order for Presbyterian to consider approving a non-formulary medication, prescribers must provide supporting information. This information may include but is not limited to the following:

- The member’s current medical condition
- The member’s medical history
- The member’s medication history, including response to medications
- Documented therapeutic failure
- Allergies
- Adverse effects
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- Diagnostic testing results and lab test results

Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to request an exception.

Pended Drug PA Request

If the clinical pharmacist or medical director needs additional information to make a medical necessity decision, the Drug PA Request is pended or placed on hold. Three attempts are made to contact the requesting provider by fax and telephone to obtain the additional information. If no additional information to support the request is received, the request may not be approved.

Revised Drug PA Request

Drug PA requests may be revised or changed to a mutually agreed upon alternative medication, following a discussion between the provider and the pharmacy benefit technician or clinical pharmacist. All changes are documented on the original Drug PA Request Form.

Decision Making

Prior authorization decisions of medical necessity are made by clinical pharmacists in most situations. In accordance with New Mexico state laws and regulations, only medical directors licensed to practice medicine in the state of New Mexico are authorized to make medical necessity decisions for Commercial and Marketplace benefit plans.

A determination of medical necessity may be approved, pended for additional information or deemed adverse when benefit coverage or clinical criteria are not met.

Decisions are made on a timely basis as required by the urgency of the situation, following sound medical principles, contractual requirements, state and federal laws and regulatory requirements. To expedite the decision making process, it is helpful to provide all of the necessary information. Most PA decisions are made within twenty-four to forty eight hours of receiving the request, unless additional information is needed.

Notifications

Approvals: When a Drug PA request is approved, the provider and pharmacy of record are notified by fax. If approved, the authorization for medication is automatically entered into the automated pharmacy claims processing system.

A letter is mailed to members listing the name and strength of the medication that was approved. The requesting provider also receives a copy of the letter that is sent to the member.

Adverse determinations: When a Drug PA decision is adverse or not approved, the provider is notified by fax of the rationale for the adverse decision. A list of alternative medications is included on the fax.

Expedited Pharmacy PA Requests: When a member of their provider believes that waiting for a decision under the standard time frame could place the member’s life, health, or ability to regain maximum function in jeopardy, an expedited Drug PA request may be made. Expedited Drug PA
requests are processed with 24 hours after the date and time Presbyterian received the request.

**Appeals Process**

An appeal may be submitted orally or in writing if a member is not satisfied with the adverse. The provider may submit an appeal on the member’s behalf when the member provides consent.

**Centennial Care Prescription Drug Benefits**

Presbyterian Centennial Care follows a closed generics-based formulary. In this formulary, the use of generic drugs is promoted as the drug of choice, except when clinically contraindicated with the exception of psychotropic medications.

Adherence to the formulary is required, but the pharmacy prior authorization process (see the “Prior Authorization Process Overview” section of this chapter) is available for members who have a documented trial and failure of formulary alternatives. The formulary covers all medically necessary treatments and includes medications in all therapeutic categories.

Presbyterian Centennial Care covers brand-name drugs and drug items not generally on the formulary when determined to be medically necessary by Presbyterian through the prior authorization process. Centennial Care limits schedule II controlled substance medications to a maximum 34-day dispensing or formulary restriction.

**Centennial Care Benefit Exclusions**

- Bulk powder compounds
- Cough and cold preparations for individuals under the age of four
- Anti-obesity items unless specifically covered under the member’s benefit
- Medications used for the treatment of sexual dysfunction
- Drug items not eligible for federal financial participation
- Personal care products (e.g., nonprescription shampoo and soaps, etc.)
- Cosmetic items (e.g., Retin-A for aging skin, Rogaine for hair loss)
- Drugs that are not assigned a national drug code and do not meet federal and state law requirements
- Herbal or alternative medicine and holistic supplements
- Immunizations for the purpose of foreign travel, flight and/or passports
- Vaccinations, drugs and immunizations for the primary intent of medical research or non-medically necessary purpose(s) including but not limited to:
  - Licensing
  - Certification
  - Employment
  - Insurance
  - Functional capacity related to employment
  - Fertility medications
  - Oral or injectable medications used to promote pregnancy
  - Infant formula
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- Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy, including “all-natural” pills, creams, lotions and gels

Local Delivery of Antimicrobial Agents (LDAA) used for Periodontal Procedures

Copayments

Presbyterian is responsible for implementation of copayments as directed by the New Mexico Human Services Department (HSD). Some members may be assessed copays for certain services or drugs.

This copayment does not apply to legend drugs that are classified as psychotropic drugs (not including Central Nervous System stimulants or minor tranquilizers) for the treatment of behavioral health conditions.

No copayments are imposed on Native American members. Presbyterian has a copayment exception process (i.e., prior authorization process) in place for other legend drugs where such drugs are not tolerated by members. At no time does Presbyterian deny services for a member’s failure to pay the copayment amounts.

Dual-eligible Members

If members are enrolled in both Medicaid and Medicare Part D, they will have more than one benefit plan for all of their healthcare benefits. Their primary prescription drug coverage is under the Medicare Part D Plan. Their Centennial Care plan may cover prescription products that are excluded from coverage under Medicare, such as select over-the-counter (OTC) products. The Centennial Care plan will not cover their copay for prescriptions under the Part D plan.

Centennial Care Pharmacy Lock-Ins

Presbyterian requires a Centennial Care member to obtain their prescription from a certain pharmacy and/or from a certain prescriber when member non-compliance or drug-seeking behavior is suspected. Before placing members on pharmacy lock-in, a Presbyterian care coordinator informs the members and/or their representative of the intent to lock in. Presbyterian’s grievance process is made available to the member who is designated for pharmacy lock-in. The pharmacy lock-in is reviewed and documented by a Presbyterian care coordinator. The member is removed from the lock-in when Presbyterian determines that the non-compliance or drug-seeking behavior is resolved and the recurrence of the problem is judged to be improbable. HSD is notified of all Centennial Care members with lock-ins and when the lock-in is removed.

Exemption for Native Americans

For Presbyterian Centennial Care, Native American members who access the pharmacy benefit at Indian Health Services/Tribal 638 Facilities/Urban Indian Clinics (I/T/Us) are exempt from Presbyterian’s formulary and prior authorization process.

Pharmacy Network

Centennial Care pharmacy network is limited to New Mexico and surrounding counties. Prescriptions filled outside of the network are
subject to approval from Presbyterian’s Pharmacy Services department.

**Centennial Care Mail Order/Home Delivery Benefit**

Under the Mail Service Pharmacy Benefit, up to a 90-day supply of medications may be obtained through the mail service pharmacy. Providers can submit prescriptions by U.S. mail, electronically, by fax or telephone. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access our Mail Order/Home Delivery Services.

**Over-the-Counter Medications**

Over-the-counter (OTC) medications and drugs are not covered for Centennial Care members. The exceptions are approved OTC medications and devices as determined by our P&T Committee. Refer to our Formulary for a list of covered OTC medications.

Please note, for Presbyterian Centennial Care Native American members accessing the pharmacy benefit at Indian Health Services/Tribal 638 Facilities/urban Indian Clinics are exempt from Presbyterian’s formulary and prior authorization process.

**Medication Therapy Management for Centennial Care Members**

The Medication Therapy Management (MTM) program is designed to optimize therapeutic outcomes by identifying potential errors and gaps in care. The program is available for all members but specifically assists people in one of the following categories:

- Those who take multiple prescription drugs.
- Those who have chronic illnesses.
- Those who expect to spend a significant amount of money on prescription drugs each year.

The member meets with a Presbyterian clinical pharmacist for a comprehensive medication review of over-the-counter medications, herbal therapies and supplements, corresponding diagnosis, appropriate dose and appropriate medication monitoring.

The pharmacist may identify drug-related allergies, potential side effects, adverse drug reactions, and omission of therapy, duplications of therapy and any barriers that prevent the member from obtaining a desired outcome.

Then the pharmacist works with the provider to develop a medication action plan, interventions and referrals. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to refer a member to our Medication Therapy Management Program.

**Commercial Prescription Drug Benefit**

Presbyterian offers numerous pharmacy benefit copay structures for our members under the Commercial and preferred provider organization (PPO) plans. Most commercial groups utilize a multi-tier (four-tier) benefit formulary that increases access and eliminates restrictions on most
medications. This multi-tier structure offers our members a greater number of options.

The member’s out-of-pocket expenses are lowest when they fill prescriptions for preferred generic medications (Tier one) and preferred brand-name drugs (Tier two). They are highest when prescriptions for non-preferred drugs (Tier three) are obtained. Specialty pharmaceuticals (Tier four) are specialized medications that may be required to be obtained through the designated specialty pharmacy network.

Prescription medications prescribed by a contracted provider and obtained at a network pharmacy will be dispensed for up to a 90-day supply up to the maximum dosing recommended by the manufacturer or the maximum dosage recommended by the U.S. Food and Drug Administration (FDA). One retail copayment will be assessed for each 30-day supply. Following prescription synchronization legislation, in some cases where less than a 30-day supply is received, the member will be charged a pro-rated copayment. The member will be charged three of the applicable copayments for a 90-day supply up to the manufacturer’s usual maximum recommended dosing for the medication or the maximum dosage recommended by the FDA. Schedule II narcotic medications are limited to a maximum 34-day supply.

Specialty pharmaceuticals obtained through our designated specialty pharmacy network require coinsurance up to a maximum dollar amount for most plans, except when administered in an inpatient hospital setting when medically necessary. These products may require a prior authorization.

Please note that specialty pharmaceuticals are not available through mail-order or retail pharmacies, are limited to a maximum of 30 days and must be obtained through our specialty pharmaceutical network.

Commercial and Healthcare Exchange Benefit Exclusions

- Items used for cosmetic purposes
- Lost, stolen or damaged
- Bulk powder compounds
- Medications unapproved by the FDA
- Medications with a DESI designation of five or six
- Items not medically necessary
- Prescription drugs requiring a pharmacy prior authorization, when prior authorization was not obtained.
- Prescriptions ordered by a non-participating provider or purchased at a non-participating pharmacy, unless required due to emergent or urgent care encounters
- Prescription drugs/medications purchased outside the United States
- OTC medications
- Compounded prescriptions drugs
- Fertility medications unless specifically covered under the member’s benefit
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- Treatments and medications for the purpose of weight reduction or control, except for medically necessary treatment for morbid obesity
- Nutritional supplements as prescribed by the attending practitioner/provider or as a sole source of nutrition
- Infant formula
- Prescription drugs/medications used for the treatment of sexual dysfunction unless specifically covered under the member’s benefit
- Herbal or alternative medicine and holistic supplements
- Oral or injectable medications used to promote pregnancy
- Immunizations for the purpose of foreign travel, flight and/or passports
- Vaccinations, drugs and immunizations for primary intent of medical research or non-medically necessary purpose(s) including but not limited to:
  - Licensing
  - Certification
  - Employment
  - Insurance
  - Functional capacity examinations related to employment
- Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy, including “all-natural” pills, creams, lotions and gels
- Drugs or drug delivery systems used during dental procedures (i.e., LDAA used for Periodontal Procedures)

Mail Order / Home Delivery Benefit for Commercial and PPO Plans

Under the Mail Order/Home Delivery pharmacy benefit, up to a 90-day supply of medications may be obtained through the mail service pharmacy. Copayments vary depending under which benefit structure a member falls. Tier-four drugs are not available through mail order; they must be provided by our specialty network and are limited to a 30-day supply. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access our Mail Order / Home Delivery Services for our members.

Medication Therapy Management for Commercial Members

The Medication Therapy Management Program is designed to optimize therapeutic outcomes by identifying potential errors and gaps in care. The program is available for all members but specifically assists people in one of the following categories:

- Those who take multiple prescription drugs.
- Those who have chronic illnesses.
- Those who expect to spend a significant amount of money on prescription drugs each year.

With the Medication Therapy Management Program, the member meets with a Presbyterian
clinical pharmacist for a comprehensive medication review of over-the-counter medications, herbal therapies and supplements, corresponding diagnosis, appropriate dose and medication monitoring. Then the pharmacist may identify drug-related allergies, potential side effects, adverse drug reactions, omission of therapy, duplications of therapy and any barriers that prevent the member from obtaining a desired outcome. Then the pharmacist works with the provider to develop a medication action plan, interventions and referrals. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to refer a member to our Medication Therapy Management Program.

Medicare Prescription Drug Benefit

The Medicare Part D Prescription Drug Benefit allows all Medicare beneficiaries to enroll in drug coverage through a prescription drug plan or Medicare Advantage Plan. Low-income beneficiaries may qualify for plan premium and cost-sharing assistance. The Medicare Part D drug benefit includes beneficiary protections intended to ensure that all beneficiaries have coverage for medically necessary drugs through nearby pharmacies. Drug plans are subject to many of the existing beneficiary protections that are available in Medicare, including requirements to meet strict pharmacy access standards to give beneficiaries access to retail pharmacies and needed drugs.

Medicare Part D prescription drug coverage is available to any individual who is Medicare-eligible. Some of the employer group plans also have prescription drug coverage. Presbyterian offers both Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans with prescription drug coverage.

Please verify the information on the member’s identification card at the time of service. If the member’s coverage and plan includes prescription drug coverage, it will be noted on the member’s ID card.

Medicare Stages of Coverage

Medicare plans consist of the following stages of coverage:

- **Annual deductible:** The amount the beneficiary will pay out of pocket for their prescriptions each year before the initial coverage begins.

- **Initial Coverage:** Initial coverage begins when the first prescription in the calendar year is filled. Presbyterian covers the cost of the medications after the member has met their copayment requirement.

- **Coverage gap (donut hole):** Depending on gap coverage rules from the Centers for Medicare & Medicaid Services (CMS), after the benefits are paid out by both Presbyterian and the member reaches a yearly specified amount, the member is responsible for a portion of the costs until their true out-of-pocket cost reaches the catastrophic stage.

- **Catastrophic coverage:** Coverage begins after the beneficiary expends the CMS set amount (specified yearly) of their own money. The beneficiary will then pay reduced copays
or coinsurance until the end of the contract year.

Additional assistance is available for qualifying beneficiaries with low incomes and limited assets. Assistance is based on income limits. Beneficiaries may contact the following agencies for information and forms:

- PCSC at (505) 923-6060 or 1-800-797-5343
- Medicare at 1-800-MEDICARE (1-800-633-4227), which is open 24 hours a day
- The Social Security Office at 1-800-772-1213, which is open from 7 a.m. to 7 p.m., Monday through Friday
- Hearing impaired members dial 711

**Presbyterian Senior Care (HMO) and Presbyterian MediCare (PPO) Copayments**

The following is Presbyterian’s Medicare prescription copay structure:

- Tier one: preferred generic drugs
- Tier two: non-preferred generic drugs
- Tier three: preferred brand-name drugs
- Tier four: non-preferred drugs
- Tier five: specialty drugs

The beneficiary's out-of-pocket expenses are lowest when filling prescriptions for preferred generic drugs (Tier one) and highest for specialty drugs (Tier five). Drugs listed on our formulary with a limited access designation are specialized medications and may be required to be obtained through our designated specialty pharmacy network. Some medications may require prior authorization.

**Mandatory Generic Substitution Requirement**

When an FDA AB-rated generic medication becomes available, the member will be given a 60-day notice that the brand-name medication will be removed from the formulary. During this 60-day period, the member may fill either the brand-name or generic medication. After the notification period, generic substitution is required.

**Specific Limitations and Exclusions**

Quantity limitations as well as specific exclusions apply. The following items are excluded:

- Items used for cosmetic and hair growth
- Items used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e. morbid obesity)
- Combination products that are not approved and regulated in their combination form by the FDA
- Items when used for the symptomatic relief of cough and cold
- Over-the-counter (OTC) or non-prescription medications
- Medications used for the treatment of sexual dysfunction or erectile dysfunction
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Pharmacy

- Drug items when the manufacturer does not participate in the Medicare Coverage Gap Discount Program
- Items when used to promote fertility

Medicare Requirements

Formularies must be developed by the P&T Committee and approved by CMS. Drugs may be added to or deleted from the formulary at any time during the plan year. Members and practitioners are notified if drugs are removed from the formulary, if tier placement changes, or if the criteria change.

Transition Supply

Beneficiaries are allowed to obtain up to a 30-day transition supply of their current non-formulary, prior authorization, step therapy and quantity limit drugs when they enroll in a Part D plan or move from one Part D plan to another. This transition fill allows new beneficiaries sufficient time to establish with a new practitioner and switch to a formulary alternative or initiate the prior authorization process.

Mail-order / Home Delivery Benefit for Medicare

Mail-order prescriptions are available to all of our Medicare Part D members. Drugs listed on our formulary with a limited access designation are not available through the Mail Service Pharmacy Benefit and must be obtained through our Specialty Pharmacy network. Specialty drugs (tier 5) may be available from a mail-order provider but will be restricted to a maximum 34 day supply.

Medication Therapy Management for Medicare Advantage Plans

The Medication Therapy Management Program is designed to optimize medication in order to improve patient outcomes. The member meets with a Presbyterian pharmacist for a comprehensive medication review and additional visits with the pharmacist throughout the year to address ongoing medication and monitor issues and event-based medication therapy problems. The program is available for all members but specifically assists people in one of the following categories:

- Those who take multiple prescription drugs.
- Those who have chronic illnesses.
- Those who expect to spend a significant amount of money on prescription drugs each year.

MTM helps to identify potential errors and gaps in care by assisting with the following:

- Reducing the risk of medication errors, especially for members who have chronic conditions, take several medications, or see multiple providers.
- Providing current information on proven medical practices to help members and their providers determine the most effective treatment.
- Helping members understand their conditions and medications, so they can take an active role in managing their health.

MTM includes the following five core components:
Pharmacy

- Medication therapy review
- A personal medication record
- A medication action plan
- Intervention and referral
- Documentation and follow up

Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to refer a member to our Medication Therapy Management Program.

Pharmacy Benefit References, Resources and Tools

Pharmacy Prior Authorization or Exception Requests:

You can find Presbyterian Drug PA Request Forms and a list of drugs that have specific edits/requirements for coverage online at phs.org under the Pharmacy section at:

https://www.phs.org/providers/authorizations/Pages/default.aspx

Drug PA Request Forms may also be used for Exception Requests.

Drug PA Request Forms may be faxed to Presbyterian Pharmacy Services at 1-800-724-6953 or 1-505-923-5540.

Instructions for “How to submit a Prior Authorization Online” is available on phs.org at:

https://www.phs.org/providers/authorizations/Pages/default.aspx

Formularies:

You can find searchable Presbyterian formularies and updates, including restrictions (e.g., quantity limits, step therapy and prior authorization criteria) and preferences, online at:

https://www.phs.org/providers/formularies/Pages/default.aspx

For a printed copy of our Formulary, please call 1-505-923-5700.

Supplement Formulary Information: (Specialty Pharmaceuticals/Medical Drugs List):

You can find Presbyterian Specialty Pharmaceuticals/Medical Drugs List online under the “Supplement Formulary Information” section at:

https://www.phs.org/providers/formularies/Pages/default.aspx

For a printed copy of our Supplement Formulary Information, please call 1-505-923-5700.

Formulary Mobile Search Application:

Formularies are accessible through the MMIT Formulary Search App, which provides quick access to formulary drugs and covered alternatives. No registration, username or password is required. Search from your desktop at www.FormularyLookup.com, or download the free app from Google Play or the App Store.

Newsletter: Pharmacy & Therapeutics (P&T) Committee Updates:

Current and past issues of the P&T Committee Provider Updates are available Online at:

https://www.phs.org/providers/formularies/Pages/default.aspx

Pharmacy Services Help Desk:
You may call Presbyterian’s Pharmacy Services Help Desk for additional assistance. The phone number is (505) 923-5500, or you can call toll-free at 1-888-923-5757. The Presbyterian Pharmacy’s Help Desk business hours are Monday through Friday, from 8 a.m. to 5 p.m. Outside of these hours, this phone line will be answered by our pharmacy benefits manager (PBM), OptumRx.

If you contact the PBM and cannot wait until the next business day, tell the OptumRx representative that your need is urgent and you wish to speak to the Presbyterian clinical pharmacist who is on call. The PBM representative will transfer you to the on-call pharmacist for Presbyterian.

**ASKRX Email:**

[ASKRX@phs.org](mailto:ASKRX@phs.org) is an email box created to better serve providers. You can email any questions or concerns directly to this email address. The email box is monitored during regular business hours (Monday through Friday, from 8 a.m. to 5 p.m.) and a clinical pharmacists will respond within one business day.

**ASK PHP P&T Email:**

Providers may request medication additions, deletions or other changes to the Presbyterian Formularies. Requests may be submitted to the email box at askphppt@phs.org.

A request form for a formulary/PDL drug list addition, deletion or modification is available under the “Supplement Formulary Information” section at:

[https://www.phs.org/providers/formularies/Pages/default.aspx](https://www.phs.org/providers/formularies/Pages/default.aspx)

Please include the following information in your request to facilitate our research and response:

- Drug name, dosage strength
- Formulary agents, if any, that are available in the same therapeutic class or for the same indication
- The advantage of the recommended agent over the current formulary options
- Supporting literature citations

**Mail Order/Home Delivery:**

Providers can send prescriptions to OptumRx electronically, by U.S. mail, facsimile or telephone:

OptumRx
P.O. Box 509075
San Diego, CA 92150
Fax: 1-800-491-4997
Telephone: 1-800-791-7658

**New Mexico Prescription Monitoring Program (PMP):**

Please use the New Mexico Prescription Monitoring Program (PMP) when prescribing controlled substances to promote safety and prevent overutilization, fraud and abuse. You can access the PMP database at [http://www.nmpmp.org/](http://www.nmpmp.org/).

**Medication Therapy Management:**

To refer a member to MTM for medication counseling, please call Presbyterian Pharmacy Medication Therapy Management Program at (505) 923-6790 or toll-free at 1-855-771-7737 to speak with a clinical pharmacist.
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10. Behavioral Health

Behavioral Health is an overarching term that refers to an array of mental health and substance abuse clinical management services that combine the best traditional approaches to healthcare delivery with innovative, emerging solutions to support members in achieving their recovery goals.

Through Presbyterian Centennial Care, the New Mexico Human Services Department (HSD) contracts with managed care organizations to deliver the full range of physical health, behavioral health and long-term care in a comprehensive and integrated manner.

As a long-time health plan and health service delivery provider across New Mexico, Presbyterian is well aware of the need to maintain a trusted network that can deliver all covered services to our members in a manner that is geographically, culturally and linguistically appropriate. We have contracted with Magellan Healthcare (Magellan) to manage behavioral health services for our Centennial Care members. Magellan specialized expertise in coordinating a full continuum of behavioral health services will support delivery in the most clinically appropriate, least-restrictive settings.

**Presbyterian Behavioral Health Provider Participation**

Contracted behavioral health providers are credentialed to provide services for eligible members enrolled in Presbyterian’s Centennial Care. Although it is the member’s responsibility to understand his or her benefit requirements, Presbyterian is available to provide assistance 24 hours a day, seven days a week to members and providers. Please call the behavioral health customer service line at 1-800-424-6035 for further information.

**Presbyterian Behavioral Health Providers**

The behavioral health component of Presbyterian Centennial Care includes a range of providers and organizations eligible to provide Medicaid services. These include the following:

- Psychiatrist
- Physician assistants
- Psychologists
- Nurse practitioners (with ANCC board certification in psychiatric or mental health specialties)
- Social workers
- Other master’s-level therapists
- Licensed alcohol and drug counselors
- Core Service Agencies (CSA)
- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Centers (CMHCs)
- Hospitals
- Tribal organizations

Presbyterian actively evaluates the cultural diversity of our behavioral health providers and makes every
Behavioral Health

effort to include professionals who are able to meet the cultural needs of our members. In addition, Presbyterian’s provider agreements, addenda and other documents are consistent with requirements from of the New Mexico Human Services Department (HSD) and Centers for Medicare & Medicaid Services (CMS) Medicaid requirements.

In order to receive referrals of Presbyterian members, a provider must accomplish the following:

- Be a registered provider with New Mexico Medicaid.
- Have an active status in Presbyterian/Magellan behavioral health credentialing system.
- Have an executed provider agreement with Presbyterian.
- Be free of any Medicare or Medicaid sanctions from the Office of the Inspector General (OIG).

Types of Behavioral Health Providers

Presbyterian Centennial Care behavioral health (BH) providers include individual, group and organization providers. Organization providers include hospitals, behavioral health clinics, agencies, CSAs and residential treatment centers.

Individual Provider

An individual provider is a clinician who renders professional behavioral healthcare services directly to a member and bills under the provider’s own taxpayer identification number (TIN) as a solo practitioner. The individual provider must be enrolled with Centennial Care and meet Presbyterian/Magellan’s credentialing criteria prior to rendering services to members, including but not limited to, a state license to practice within the scope of the individual’s discipline and class of service. In addition, the provider must hold a current, fully executed Presbyterian Provider Participation Agreement.

Group Practice

A group practice is a collection of individual providers that supply professional behavioral healthcare services and billing under a single TIN. The group practice may or may not be incorporated. The group typically provides ambulatory levels of care. Clinicians affiliated with the group are credentialed individually and must be enrolled with Centennial Care and meet Presbyterian/Magellan’s credentialing criteria prior to providing services to Centennial Care members. The group practice enters into an agreement with Presbyterian as a single entity and the group bills as a single entity for the services performed by clinicians credentialed by Presbyterian and/or Magellan.

Organization

An organization is an entity that is licensed or certified as required by the state in which it operates. The organization enters into an agreement with Presbyterian as an entity. It must be enrolled with Centennial Care and must meet Presbyterian/Magellan’s credentialing criteria for organizations. Examples of organizations providing behavioral health services for Centennial Care including:
Behavioral Health

- Inpatient facilities
- Community-based mental health centers (CMHC)
- FQHCs
- Rural health centers
- Residential Treatment Center

Behavioral Health Agencies

- Indian Health Service (IHS) or Tribal 638 facilities that offer behavioral health services

The organization enters into an agreement with Presbyterian to provide one or more levels of care, which may include outpatient care. The organization generally has Presbyterian/Magellan-credentialed physicians or other individual providers on staff, or it may contract with physicians and other individual providers to provide behavioral health services.

Core Service Agencies

Core Service Agencies (CSAs) are designated by the state to manage much of the service delivery of behavioral health services. CSAs also provide prevention, early intervention, treatment and recovery services related to behavioral health for members. CSAs are contracted as organizations and are required to provide:

- Crisis intervention 24 hours a day, seven days a week
- Behavioral health services
- Access to psychiatric evaluations
- Access to medication management
- Behavioral health out-of-home assessment and service planning
- Care coordination to members with serious mental illness or serious emotional disturbance
- Access to a range of other clinical behavioral health services
- Access to comprehensive community support services

All behavioral health providers are expected to have a current description of the behavioral health services they provide on file with Presbyterian for inclusion in our provider directory and to assist with referrals to our behavioral health providers.

Credentialing

In order to be eligible for referrals, Presbyterian behavioral health providers are required to undergo the credentialing review process before being accepted as Centennial Care providers and periodic recredentialing thereafter see the “Recredentialing” section in this chapter. Presbyterian has delegated behavioral credentialing for the Centennial Care program to Magellan. Magellan’s Credentialing Verification Organization (CVO) department is responsible for completing credentialing activities according to National Committee for Quality Assurance standards (NCQA) and the requirements of Presbyterian and the Centennial Care program.

Provider Credentialing Application Process

Provider credentialing is initiated through the provider application process. Individual providers
are asked to submit the following documents, along with a fully completed application, to facilitate the credentialing review:

- Copies of current licenses and certifications
- Education and training documentation
- Malpractice Proof of professional liability insurance information (minimum amounts of $1 million/$3 million for physicians and $1 million/$1 million for all other professional levels)
- Form W-9
- Organization providers are asked to submit the following documents, along with a fully completed application, to facilitate the credentialing review:
  - Copies of current licenses (if applicable)
  - Copy of current accreditations (if applicable)
  - Proof of professional liability insurance (minimum amounts of $1 million/$3 million)
  - Proof of general liability insurance.
  - Form W-9
  - Staff roster (to be updated as changes in clinical staffing occur)

Recredentialing

In addition to the initial review, Presbyterian behavioral health providers are required to have their credentials reviewed periodically through the recredentialing process. In New Mexico, individual, professional and organization provider recredentialing is conducted every three years.

Recredentialing includes an administrative update of the provider’s original credentialing documents as well as a review of Presbyterian’s experience with the provider.

The recredentialing evaluation includes but is not limited to the following:

- Any quality reviews
- Satisfaction survey findings
- Compliments and complaints

Appealing Credentialing Decisions

If the credentialing review is not favorable and it is determined that Presbyterian/Magellan will not continue the credentialing or recredentialing process, the provider is notified in writing. The denial notification letter includes the reason for denial and contains instructions for initiating an appeal process, if applicable.

Reporting Changes in Clinical Status

Providers are required to notify Presbyterian/Magellan in writing within 10 days of any changes, additions, or deletions that occur related to the following:

- Licensure
- Accreditation(s)
- Certification(s)
- Hospital privileges
- Insurance coverage
- Past or pending malpractice actions

New or updated credentialing information must be mailed to the following addresses:
• Presbyterian Behavioral Health
  P.O. Box 25926
  Albuquerque, NM 87125-5926

• Presbyterian Health Plan
  Attn: Behavioral Health Contracting
  3rd Floor MAG
  9521 San Mateo Blvd NE
  Albuquerque, NM 87113-2237

**Contracting with Presbyterian**

In addition to successfully completing the credentialing process, providers must have an executed Presbyterian Participating Provider Agreement (PPA) and Centennial Care product attachment under which the provider agrees to comply with Presbyterian’s and Medicaid’s policies, procedures and guidelines in order to receive referrals of and reimbursement for services rendered to Centennial Care members. For Centennial Care, all providers must have an active Medicaid ID.

**Second Opinions**

A second opinion is available to any member who requests one. Second opinions will be provided by in-network practitioners and providers. Out-of-network requests must be approved by the Behavioral Health medical director. Members pay for member-requested second opinions except for Medicare-covered members. Medicare covers second opinions, so in these cases, member cost-sharing would be limited to the applicable copayment and/or co-insurance.

**Updating Information**

Prompt notification of changes in practice information helps us maintain an efficient and effective referral process and present accurate and timely information in Presbyterian publications. Please be aware that some changes may require updates to the provider contract. The provider should notify Presbyterian Centennial Care promptly when any of the following practice changes occur:

- Medicaid enrollment
- Address
- Telephone number
- Status (including changes in the numbers of service slots available)
- Services provided (with updated program descriptions)
- Ability to accept Centennial Care referrals
- Taxpayer identification number
- Group practice membership
- Staff rosters

Providers are encouraged to submit changes electronically on www.magellanprovider.com, unless instructed to do otherwise by Presbyterian Network staff. They may also submit new or updated information by using the contact information below.

Presbyterian Health Plan
Attn: Behavioral Health Contracting Dept.
9521 San Mateo Blvd NE
3rd Floor MAG
Albuquerque, NM 87113-2237
Phone: 800-424-6035

**Expectations of the Medicaid Provider**

Centennial Care behavioral health providers agree to the following:
Behavioral Health

• Be available to accept referrals of Centennial Care members within the scope of the provider’s practice
• Deliver services in accordance with the terms of New Mexico Medicaid regulations and Presbyterian’s provider agreement, policies and procedures outlined in this manual
• Render all services in the provider’s office, or in facilities or locations that are mutually agreed upon under the terms of the Presbyterian provider agreement
• Initiate authorizations as required by Presbyterian

Expectations of Members and Their Families

As an organization, Presbyterian strongly endorses consumer empowerment and family involvement. Experience shows that when members are voluntarily engaged in the management of their behavioral health services, they are generally more compliant with treatment and medications. This compliance in turn leads to more positive outcomes.

Presbyterian not only encourages members and their families to become active participants in treatment, but we believe that members and families have a responsibility to do so. Providers are required to document member and family involvement in all treatment records and to demonstrate compliance with this requirement during site visits and audits.

Care Coordination

Presbyterian makes every attempt to perform a health risk assessment (HRA) for each Centennial Care member. Members who are identified as requiring behavioral health intervention are categorized by need using levels 1, 2 or 3, with level 3 as the highest need. Those members that are identified as having potential level 2 or 3 needs receive a Comprehensive Needs Assessment (CNA). Members with level 2 or level 3 needs are assigned a care coordinator. The care coordinator oversees the member’s treatment objectives and requires provider input to meet the member objectives. Presbyterian care coordinators who are behavioral health specialists are available to be primary care coordinators for members with extensive behavioral health needs. These care coordinators have the ability to consult with other care coordinators for members who have co-morbid behavioral health and medical conditions.

Behavioral health providers play a crucial role in the overall care coordination plan for the member. The care coordinator works with the member’s current behavioral health provider or offers referrals for services to members based on service need, geographical location and level of care, as well as the member’s preferences. Care coordination is required to ensure that service needs are met and not duplicated. The care coordinator develops a comprehensive care plan for members to meet identified objectives. This care plan is developed with input from the providers as well as any community supports. The plan is then shared with the treating providers electronically or by mail to
ensure coordination and avoid duplication of services.

Care coordination is designed to assist members who have extensive healthcare needs and who may be receiving services from other sources. The following are examples of scenarios in which coordination is required between behavioral health services provided through Centennial Care and services provided by another institution or provider:

- Need to coordinate Centennial Care behavioral health services with services provided by school-based health centers. These centers are outpatient clinics on school campuses that provide on-site primary, preventive and behavioral health services to students in order to reduce lost school time, remove barriers to care and promote family involvement. School-based providers are required to coordinate with the member’s assigned care coordinator as well as other providers.

- Need to coordinate Centennial Care behavioral health services with non-Medicaid services. Many times members benefit from community services that are not part of the benefits they receive from Centennial Care. Communication and coordination by the provider with these services increase compliance with members’ overall treatment objective.

- Need to coordinate Centennial Care behavioral health services with a provider in the planning of institutional care for members.

- Need to coordinate Centennial Care behavioral health services with member’s assigned primary care provider (PCP) and the behavioral health provider.

- Need to coordinate Centennial Care behavioral health services with CSAs when the CNA is performed.

- Need to coordinate Centennial Care behavioral health services with services provided by the Children, Youth and Families Department (CYFD).

- Need to coordinate Centennial Care behavioral health services provided to children in Tribal custody or under Tribal supervision.

Presbyterian Centennial Care PCPs are required to refer members for behavioral health services when they identify one or more of the following:

- Suicidal or homicidal ideation or behavior

- Risk of hospitalization because of a behavioral health condition

- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility

- The member is a victim of trauma

- There is serious threat of physical or sexual abuse or risk to the member’s life or health because of the member’s impaired mental
status and judgment, mental retardation, or other developmental disabilities.

- Request by a member or representative for behavioral health services
- Clinical status that suggests the need for behavioral health services
- Identified psychosocial stressors and precipitants
- Treatment compliance complicated by behavioral characteristics
- Behavioral and psychiatric factors influencing medical condition
- Victims or perpetrators of abuse or neglect and members suspected of being subject to abuse or neglect
- Non-medical management of substance abuse
- Follow-up to medical detoxification
- An initial PCP contact or routine physical examination indicating a substance abuse problem
- A prenatal visit indicating substance abuse problems
- Positive response to questions indicating substance abuse problems
- Observation of clinical indicators or laboratory values indicating substance abuse problems
- A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse problems or other behavioral health conditions
- The persistence of serious functional impairment

When members are involved or at risk of becoming involved with CYFD, it is an indicator of the possible need for more intensive care coordination activities. Providers should be prepared to participate in care coordination and CYFD protocols, staffing, discharge planning, or other requirements.

Children in Tribal Custody or under Tribal supervision pursuant to a Tribal Court order (as such term is defined in New Mexico Statutes Annotated [NMSA] 1978 § 32A-1-4) must receive a behavioral health screening within 24 hours of a referral to a behavioral health contract provider and receive a behavioral health assessment, any medically necessary covered services and care coordination as appropriate.

**Member Referrals**

Members may refer themselves to providers of covered services without contacting Presbyterian or obtaining a referral from their PCP. Regardless of whether members are self-referred, referred by Presbyterian, or referred by a PCP, providers are required to authorize services in accordance with Presbyterian’s requirements in the “Prior Authorization” section of this chapter.

**After-hours Coverage for Member Emergencies**

Behavioral health providers must have or arrange for on-call and after-hours coverage to support
members who are experiencing behavioral health crises or emergencies. Such coverage must be available 24 hours a day, seven days a week. Providers must inform members about hours of operation and provide instruction for contacting on-call staff after hours. When unavailable to provide on-call support, providers must arrange for alternative coverage with another participating clinician or provide after-hours messaging about how to access care.

**Crisis/Emergency Room Usage**

Presbyterian Centennial Care strives to provide the appropriate behavioral health services in a timely manner for all members. For members requiring intervention from a crisis or an emergency room service provider, coordination with the member’s care coordinator is required. The care coordinator can assist with identifying and referring members to the appropriate level of care.

Note that advising members to call 911 is not an acceptable form of crisis intervention for Centennial Care behavioral health providers.

**Emergency/Disaster Planning**

In the event of a federally declared disaster, Presbyterian Centennial Care coordinates with the state’s interagency Behavioral Health Purchasing Collaborative to locate providers to participate in crisis counseling implemented by the Federal Emergency Management Agency (FEMA) and supported through an interagency agreement with the Substance Abuse and Mental Health Services (SAMHSA) Administration’s Center for Mental Health Services (CMHS). Supplemental funding for crisis counseling is available to state mental health authorities through two grant mechanisms:

- The Immediate Services Program, which provides funds for up to 60 calendar days of services immediately following a disaster declaration.
- The Regular Services Program, which provides funds for up to nine months following a disaster declaration.

**Authorization of Services**

Please see Appendix F for a detailed description of the authorization requirements for all services, including behavioral health services. It is the provider’s responsibility to assure that all services are authorized in accordance with those requirements.

**Cultural Competency**

Presbyterian is committed to embracing the rich diversity of the people we serve. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who are visually and hearing impaired. We are committed to ensuring that all Centennial Care members provided with behavioral health services receive equitable and effective treatment in a respectful manner that recognizes individual spoken language, gender differences and the role culture plays in a person’s health and well-being.

In order to refer members to providers appropriate to their needs and preferences, Presbyterian’s staff is trained in cultural diversity and sensitivity. Providers with myPRES access have the opportunity to complete cultural competency
training through their portal. Magellan also provides cultural competency training, technical assistance and online resources at https://www.magellanprovider.com/MHS/MGL/education/culturalcompetency/index.asp

To help providers enhance their provision of high-quality, culturally appropriate services, Presbyterian continually monitors and assesses provider diversity and sensitivity and at the same time actively recruits, develops and works to retain a diverse array of behavioral health providers compatible with our member population.

It is the provider’s responsibility to include information on the provider’s credentialing application about language services providers offer and about any specialty services the provider’s practice offers.

**Access Standards**

Members must have timely access to appropriate mental health and substance abuse services from an in-network provider 24 hours a day, seven days a week.

Our access standards enable members to obtain behavioral health services by an in-network provider within a time frame appropriate for the clinical urgency of their situation.

Timely access to services is an essential first step in meeting the needs of our members. Member access to providers is regularly monitored against established standards as a core care coordination activity. Centennial Care behavioral health providers are responsible for providing members with immediate emergency services when necessary to evaluate or stabilize a potentially life-threatening situation.

It is the provider’s responsibility to do the following:

- Provide access to services 24 hours a day, seven days a week
- Ensure that members know what to do if they need services after business hours
- Arrange for alternative coverage with another participating clinician when the provider is not available, including, but not limited to, an answering service with emergency contact information
- Respond to telephone messages in a timely manner
- Provide immediate emergency services when necessary to evaluate or stabilize a potentially life-threatening situation
- Provide face-to-face services within two hours in a crisis evaluation
- Provide services within 24 hours in an urgent clinical situation
- Set an appointment within 14 calendar days of request for routine clinical situations, unless the member requests a later date
- Provide routine follow-up services within 30 calendar days of an initial evaluation
- Provide services within seven calendar days of a member’s discharge after an inpatient stay
- For continuing care, continually assess the urgency of member situations and provide
services within the time frame that meets the clinical urgency.

**Additional Access Requirements**

**Ambulatory Follow-up**

Members being discharged from an inpatient stay must have a follow-up appointment scheduled before they are discharged. The appointment must occur within seven calendar days of discharge.

**Timely and Confidential Exchange of Information**

With written authorization from members, providers must communicate key clinical information in a timely manner to all other healthcare providers participating in a member’s care, including member’s PCP.

**Timely Access and Follow-up for Medication Evaluation and Management**

Members must receive timely access and regular follow-ups for medication management.

**Provider Oversight**

The Quality Improvement (QI) department conducts oversight of behavioral health providers through treatment record reviews (TRR), quality of care (QOC) monitoring and critical incident (CI) management and coordination and reporting.

**Treatment Record Review**

Treatment records review (TRR) are routinely conducted on a three-year cycle with all behavioral health providers. Standardized audit tools meeting regulatory standards based on the New Mexico Administrative Code (NMAC) and other federal regulatory bodies, such as Code of Federal Regulations (CFR) are used. Clinical practice guidelines tools based on best practices and adopted from the following expert bodies are used:

- American Psychiatric Association (APA)
- National Council on Quality Assurance (NCQA)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- Society for Developmental and Behavioral Pediatrics (SDBP) are utilized based on diagnostic identification.

TRRs are completed as either a desktop audit or an on-site review. When documentation within the record indicates need for improvement, the BH Quality Improvement (QI) team assists the provider in bringing documentation into compliance through development and implementation of an improvement plan. Providers are encouraged to contact QI team members for guidance, clarification and any resource needed, including sample forms and formats. All audit tools can be found at: [https://magellanprovider.com/MHS/MGL/about/handbooks/supplements/NewMexico/index.asp](https://magellanprovider.com/MHS/MGL/about/handbooks/supplements/NewMexico/index.asp)

In addition to Routine TRRs, record reviews may be initiated in response to a QOC or an anomaly in billing or over/under utilization of services.

**Quality of Care Monitoring**

QOC reviews may utilize the standard tools as well as customized tools specific to the quality concern.

The QOC will be escalated to a site review and possible TRR should investigation of the concern be substantiated at a higher level or there have
been five or more substantiated QOCs within a 12-month rolling period.

All QOCs are reviewed by licensed behavioral health clinical reviewers. QOCs are investigated in different ways and may include the following:

- Request for an Internal Investigation
- Telephone discussion with the provider
- Site visit
- Desktop audit

During the course of investigating a QOC, the BH QI team will make every effort to assist the provider with quality improvements.

- If the QOC is substantiated it is assigned an outcome level between 1 and 4. An unsubstantiated QOC is assigned an outcome level of 0. Higher outcome levels are escalated to the appropriate Regional Network Credentialing Committee (RNCC). Five or more QOC within a 12 month rolling period substantiated at any level are taken to the RNCC as well. The Committee makes recommendations toward resolution which are then presented to the Presbyterian-Professional Practice Evaluation Committee (PPEC). PPEC has the authority to impose sanctions.

During the course of investigating a QOC, the QI team will make every effort to assist the provider with quality improvements.

**Critical Incident Management**

Critical Incident Coordination-Behavioral Health (BH) providers are required to follow NMAC regulations and report critical incidents (CIs) to Magellan. Providers can find The Critical Incident Management Guide and the Critical Incident Training Guide at [http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx](http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx). The QI team reviews all critical incident reports (CIRs) and follows up as needed. The goal of critical incident reporting is to partner with providers to ensure that providers and members have the resources needed to promote independence and safety.

**Reporting**

The QI department aims to maintain a prime status of healthcare that is safe, effective, member centered, timely, efficient and equitable. The reports sent to state and accreditation facilities allow for the identification of opportunities for improvement.

**Claims Submission Procedures**

Commercial, Medicare and Centennial Care behavioral health providers’ claims relating to mental health or substance abuse services may be submitted to Magellan directly if that is more convenient for the provider. Be assured that all behavioral health claims – even as part of a mixed service – may always be submitted directly to Presbyterian and we will reroute the behavioral claims to Magellan for adjudication and payment.

**Submitting Electronic Transactions/Claims**

Presbyterian and Magellan encourage providers to take advantage of our electronic claims.
transmission (ECT) process. ECT has become the preferred method of claims submission for the majority of our network.

**Benefits of Filing Electronically**

Presbyterian generally processes electronically submitted claims in an average of seven days, whereas hard copy claims are generally processed in an average of 14 business days. Electronic submission saves postage and paper and also gives the provider the following:

- Quicker confirmation of claims receipt and integrity of the data
- A higher percentage of claims accuracy, resulting in faster payment
- Claims data already formatted into the Health Insurance Portability and Accountability Act (HIPAA)-required ANSI-X12 837 claims format

**Claims Courier**

Accessible through the Magellan provider website at [www.magellanprovider.com](http://www.magellanprovider.com), Claims Courier is a data entry application for providers submitting professional claims on a claim-at-a-time basis. Providers can gain access to Claims Courier by signing onto the Magellan website with their username and password and following the instructions under “Submit a Claim Online.” Claims Courier streamlines the claims process by eliminating the claims middleman and there is no charge to the provider for using the service. The provider simply enters the claims information data into the online Claims Courier application. Note that Magellan must be the designated payer in order to process the submitted claims.

On the main Claims Courier (i.e., Submit a Claim) page, the provider can do the following:

- Create a new, blank claim
- Create a new claim from a copy of a previously submitted claim
- Complete a claim the provider saved previously
- View the submitted claims

**Direct Submit**

Through the Magellan application Direct Submit, HIPAA-compliant electronic data interchange (EDI) 837 files can be sent in bulk directly to Magellan, without accompanying claim data entry or the involvement of a clearinghouse. Direct Submit is available to all providers regardless of claims submission volume. There is no charge to providers for using the service. To get started on the process, providers can visit Magellan’s EDI Testing Center website at [www.edi.magellanprovider.com](http://www.edi.magellanprovider.com). The center offers an easy-to-follow, six-step process to independently validate the provider’s EDI test files (i.e., 837 Professional and Institutional) for HIPAA compliance rules and codes. Providers are assigned an information technology analyst to guide them through the process and address any questions. The process includes creating a unique user ID and password, downloading EDI guideline documentation (companion guides), uploading and testing EDI files and obtaining immediate feedback regarding the results of the validation test. Once providers have completed the six-step process,
they are able to exchange production-ready EDI files with Magellan.

Providers can register to submit EDI claims to Magellan by sending an e-mail to EDISupport@MagellanHealth.com or by contacting Magellan EDI Support at 1-800-450-7281, extension 75890.

Paper Claims

Presbyterian and Magellan encourage electronic claims submissions and offer technical assistance to providers to address any difficulties with accessing or using our electronic submission tools. Paper claims can be submitted to the address below.

Presbyterian Behavioral Health
P.O. Box 25926
Albuquerque, NM 87125-5926

Clearinghouses

External EDI clearinghouses act as a middleman between providers and Magellan and can transform non-HIPAA-compliant formats to compliant 837s. Magellan accepts 837 transactions from a number of clearinghouses. Note that there may be charges from the clearinghouses.

Note: There may be charges from the clearinghouses.

Payer ID for Clearinghouse Services

When using the services of a clearinghouse, it is critical that the proper payer ID is used so the EDI claims are sent to Magellan. The following payer IDs are required for all clearinghouses for Magellan:

- 837I Institutional: 01260
- 837P Professional: 01260

Clearinghouse Contact Information

Payerpath
9030 Stony Point Pkwy
Suite 440
Richmond, VA 23235
1-877-623-5706
www.payerpath.com

Availity®
PO Box 550857
Jacksonville, FL 32255-0857
1-800-AVAILITY (282-4548)
www.availity.com

Change Healthcare (formerly Emdeon)
3055 Lebanon Pike
Nashville, TN 37214
1-877-363-3666
http://www.changehealthcare.com

Gateway EDI
One Financial Plaza
501 North Broadway 3rd Floor
St. Louis, MO 63102
1-800-969-3666
www.gatewayedi.com

RelayHealth
700 Locust Street
Suite 500
Dubuque, IA 52001
1-800-527-8133, Option 2
www.relayhealth.com

Trizetto Provider Solutions
One Financial Plaza
501 North Broadway 3rd Floor
St. Louis, MO 63102
1-800-969-3666
www.trizetto.com/providersolutions

Office Ally
PO Box 872020
Vancouver, WA 98687
1-866-575-4120
Fax: (360) 896-2151
www.officeally.com
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Long-term care is the Medicaid benefit to provide long-term care services and supports, including home- and community-based benefits and nursing facility benefits.

The New Mexico Human Services Department (HSD) contracts with four managed care organizations (MCOs), including Presbyterian, to deliver long-term care in a comprehensive and integrated manner. The goal is to provide members with access to services and supports necessary to maintain the highest level of function and independence in their communities. For members residing in nursing facilities or other institutions, our goal is to ensure quality healthcare aimed at reducing the number of acute inpatient admissions through effective care coordination and successful care transitions.

Patient Eligibility

General Eligibility

HSD determines eligibility for enrollment in a Centennial Care program. Continued eligibility is assessed annually and includes a re-assessment by HSD or its designee. All individuals assessed as Medicaid-eligible members are required to participate in Centennial Care unless specifically excluded by a 1115(a) waiver.

Recipients with developmental disabilities in the 1915(c) waiver and recipients with developmental disabilities in the Mi Via 1915(c) waiver continue to receive home- and community-based services (HCBS) through those waivers for a limited period of time, but are required to enroll in Centennial Care for all non-HCBS. Medically fragile recipients in the 1915(c) waiver and medically fragile recipients in the Mi Via 1915(c) waiver continue to receive HCBS through those waivers unless and until such services are transitioned to Centennial Care. Medically fragile recipients in the 1915(c) waiver are required to enroll in a Centennial Care MCO for all non-HCBS.

Native American Member Eligibility

Native American members may self-refer to an Indian Health Service (IHS) or Tribal Health Center for long-term care services. Whether the provider participates in Presbyterian’s provider network or not, Presbyterian Centennial Care allows Native American members to seek care from any IHS or tribal provider, as defined in the Indian Health Care Improvement Act, 25 United States Code (USC) §§1601, et seq. To further promote access for our Native American members, Presbyterian Centennial Care does not require prior authorization for services provided within the IHS and Tribal 638 network and accepts an individual provider employed by the IHS or Tribal 638 facility that holds a current license to practice in the United States or its territories as meeting licensure requirements.

Community Benefit

Under Centennial Care, the state has created one comprehensive community benefit that includes a
multitude of HCBS, one of which is personal care services (PCS). PCS was previously provided through the coordination of long-term services in the 1915(c) waiver and the Mi Via 1915(c) waiver. Individuals who are Medicaid-eligible members and who meet Nursing Facility Level of Care (NFLOC) eligibility requirements have access to HCBS without waiting for a waiver slot to become available. Individuals who are not otherwise Medicaid-eligible and have incomes below 300 percent of supplemental security income and also meet NFLOC eligibility requirements are able to access the Community Benefit if a waiver slot is available. The state maintains a central registry for persons waiting for the Community Benefit who are not otherwise eligible for Medicaid. The central registry is managed on a statewide basis using a standardized assessment tool and in accordance with criteria established by the state registry.

**Nursing Facility Level of Care Assessment for Long-term Care Beneficiaries**

A NFLOC eligibility assessment must be performed for all applicants for whom there is a reasonable indication that long-term care services may be needed in the future. Presbyterian conducts the NFLOC eligibility assessment for individuals enrolled in Presbyterian Centennial Care who meet the criteria as identified above.

Presbyterian uses state-developed criteria and a state-approved assessment tool for determining NFLOC eligibility for all long-term care services, including facility placement and the Community Benefit. Elements of NFLOC eligibility criteria used to initially and periodically determine the individual’s medical eligibility include:

- Medical risk factors, including but not limited to medical diagnoses associated with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), range of motion limitations, need for medical treatments, need for clinical monitoring by a registered nurse and hospitalization in the last 90 days
- Availability of support and social resources, such as personal care assistance, housekeeping, home-delivered meals, living arrangements, homebound status and durable medical equipment
- Environmental conditions, including safety and accessibility issues
- Nutritional challenges, including eating issues such as swallowing problems, tube feeding, special diet, nausea and tooth or mouth problems
- Communication and cognition capability
- Behavioral/mental health status
- Health and safety risks, including susceptibility to falling
- Ability to perform ADL, including bathing and showering (e.g., washing the body), bowel and bladder management (e.g., recognizing the need to relieve oneself, etc.), dressing, eating (including chewing and swallowing), feeding (e.g., setting up food and bringing it to the mouth), functional mobility (e.g., moving from
one place to another while performing activities), personal device care, personal hygiene and grooming (including washing hair) and toilet hygiene (e.g., completing the act of relieving oneself)

- Ability to perform IADL, including doing housework and laundry, preparing meals, taking medications as prescribed, managing money, shopping for groceries or clothing, using the telephone or other form of communication, scheduling appointments, using technology (as applicable) and using transportation within the community

**Comprehensive Needs Assessment**

Following a Health Risk Assessment (HRA), Presbyterian conducts a comprehensive needs assessment (CNA) for anyone meeting level 2 or 3 of the eligibility criteria for care coordination. The CNA and NFLOC are utilized to determine the need for long-term care services. Information contained within the CNA is utilized to determine the member’s level of care coordination.

**Member Choice**

Members eligible for the Community Benefit are educated on Agency-Based Community Benefit (ABCB) and Self-Directed Community Benefit (SDCB) through the facilitation of the Community Benefit Services Questionnaire (CBSQ). Members have the option to select either, but may only select SDCB if they have received the ABCB for at least 120 days.

**Agency-Based Community Benefit**

The ABCB is a consolidation of HCBS and is available to members meeting NFLOC eligibility criteria. Members selecting the ABCB have the option to select their personal care service provider. Presbyterian Centennial Care makes the following HCBS available through the ABCB:

- Adult day healthcare
- Assisted living
- Behavior support consultation
- Community transition services
- Emergency response
- Employment support
- Environmental modifications
- Home health aide

**Nutritional Counseling**

- Personal care services (may be self-directed)
- Private duty nursing for adults
- Respite
- Skilled maintenance therapy services

Each Presbyterian Centennial Care member enrolled in the ABCB is assigned a Presbyterian care coordinator. This care coordinator helps the member understand available long-term care services and helps the member develop and implement an annual care plan that identifies the services and supports necessary to meet the member’s choices, abilities and needs. This care
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plan drives the authorization of ABCB services available to each member.

**Self-Directed Community Benefit**

Self-direction in Presbyterian Centennial Care affords members the opportunity to have choice and control over how SDCB services are provided, who provides the services and how much providers are paid for providing care in accordance with a range of rates per service established by HSD. Presbyterian supports self-directed delivery of community benefits. Member self-direction provides the opportunity for members to personally direct the purchase of long-term care supports and services and manage their long-term care budgets in a way that promotes self-advocacy and independence.

Support brokers are individuals who support the state of New Mexico’s Mi Via program (i.e., the state’s Medicaid self-directed waiver program) and self-directed members. The services of a support broker are available to assist members in understanding and using the community benefits as well as developing and managing their budgets.

The Support brokers work with Presbyterian care coordinators to provide Centennial Care members who select the SDCB with the expert help they need to develop and manage their benefit’s details. These services are provided throughout the state of New Mexico to ensure members’ needs are met.

Members who select the SDCB will receive help from their care coordinators in establishing a relationship with a support broker. We offer both an internal and external support broker options.

Under Presbyterian Centennial Care, the following community benefits are available for self-direction:

- Behavior support consultation
- Customized community support services
- Emergency response
- Employment supports
- Environmental modifications
- Home health aide
- Homemaker/personal care
- Nutritional counseling
- Private duty nursing for adults
- Related goods
- Respite
- Skilled maintenance therapy services
- Specialized therapies
- Start Up Goods and Services
- Transportation (non-medical)

Presbyterian provides members who elect the SDCB service delivery option with the information and assistance necessary to develop a budget based on member preferences, assessed need and the resources available to the member. This budget is developed in coordination with the member’s care plan and takes into account the member’s health and safety needs identified in the comprehensive needs assessment, services covered, the member’s natural or informal supports and the member’s living situation. The support broker makes the worksheets
and other tools needed available to assist the member. Presbyterian aims to ensure that members are effectively encouraged to choose the services, supports and goods they believe best meet their community living needs.

Members who participate in the SDCB choose either to serve as the employer of record (EOR) of their providers or to designate an EOR or authorized agent to serve as the EOR on his or her behalf. If an individual has a financial Power of Attorney (POA), this individual is required to serve as the EOR and cannot be a paid caregiver.

Development of the budget begins after the following:

- Completion of the comprehensive needs assessment and CBSQ by the Presbyterian care coordinator
- Member’s completion of the self-assessment required for the SDCB.
- Selection of a support broker agency
- Identification of an EOR or authorized agent if applicable

The support broker and member and EOR or authorized agent (when applicable), review the results of the CNA. Based on the results of the CNA, the support broker engages in an in-depth discussion with the member to identify each need and determine how each need can be met best. The member is also encouraged to identify his or her short-term and long-term goals, including needs related to life goals and any anticipated life changes, such as living situation, caregiver availability and/or community participation. The support broker obtains the member’s annual budget allocation amount from the care coordinator and, if appropriate, calculates the average monthly and weekly amounts for the member’s use.

The support broker then guides the member through the budget development process. The support broker helps the member address the following key decisions, which are necessary to develop the written budget plan and provide background and additional information as needed:

- What services, supports and goods are needed each month? What are the services, supports and goods needed once during the year or a few times throughout the year?
- Are there any no-cost resources available from other programs, organizations, family members, or friends that can be used instead of a covered service? Is help needed in contacting these other resources?
- Are the remaining needed services, supports and goods covered? Are any prohibited by state or federal requirements?
- What types of workers need to be hired to provide the identified services, supports and goods?
- How often are services, supports and goods (daily for how many hours, weekly, other) needed?
- What is the budget to purchase services, supports and goods? How much can providers be paid for the services, supports and goods based on the rate ranges provided by HSD?
- What is the backup or emergency plan developed with the care coordinator?
- What are the medical needs, as identified in the CNA?

The Fiscal Management Agency (FMA) is the entity contracted with HSD to provide the fiscal administration functions for members receiving the SDCB. The FMA must be an entity operating under Section 3504 of the Internal Revenue Service (IRS) code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FMA also files state income tax withholding and unemployment insurance tax forms, pays the associated taxes and processes payroll based on the eligible SDCB services authorized and provided.

A Presbyterian care coordinator ensures adequate support for participants who choose the SDCB.

**Termination from the Self-Directed Community Benefit (SDCB)**

Presbyterian Centennial Care may involuntarily terminate a member from the SDCB, with approval from HSD, whenever the following circumstances occur:

- The member refuses to follow HSD rules and regulations after receiving focused technical assistance on multiple occasions and support from the care coordinator or FMA, which is supported by documentation of the efforts to assist the member.
- There is an immediate risk to the member’s health or safety by continued self-direction of services. For example, the member is in imminent risk of death or serious bodily injury, or the member does the following:
  - Refuses to include and maintain services in his or her care plan that would address health and safety issues identified in his or her CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, care coordination, or FMA.
  - Exhibits behaviors that endanger him, her, or others.
  - The member misuses his or her SDCB budget following repeated and focused technical assistance and support from the care coordinator and/or FMA, which is supported by documentation.
  - The member expends his or her entire SDCB budget before the end of the care plan year.
  - The member commits Medicaid fraud.

Presbyterian Centennial Care will submit to HSD any requests to terminate a member from the SDCB with sufficient documentation regarding the rationale for termination. Upon HSD’s approval, Presbyterian Centennial Care will notify the member regarding termination in accordance with
HSD’s rules and regulations. The member shall have the right to appeal the determination by requesting a fair hearing.

Presbyterian Centennial Care will facilitate a seamless transition from the SDCB to ensure there are no interruptions or gaps in services. Involuntary termination of a member from the SDCB shall not affect a member’s eligibility for covered services or enrollment in Centennial Care.

Presbyterian Centennial Care will notify the FMA within one business day of processing the outbound enrollment file when a member is involuntarily terminated from SDCB and when a member is unenrolled from Centennial Care. The notification should include the effective date of termination and/or disenrollment, as applicable.

Members who are involuntarily terminated may request to be reinstated in the SDCB. Such request may not be made more than once in a 12-month period. The care coordinator will work with the FMA to ensure that issues previously identified as reasons for termination are adequately addressed before reinstatement. All members are required to participate in SDCB training programs before reinstatement in the SDCB.

**Family Members Serving As Providers**

Presbyterian complies with all appropriate contractual and regulatory requirements regarding legally responsible individuals (LRIs) serving as providers. Family members or spouses may serve as providers under extraordinary circumstances in order to assure the health and welfare of members and to avoid institutionalization. Presbyterian approves these instances on a case-by-case basis using pre-established criteria.

The following services provided by an LRI regarding the SDCB are not approved:

- The service that the LRI is proposed to perform as a provider is a service the LRI would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness.
- The LRI is the member’s EOR.
- The LRI is unable to pass a nationwide criminal history screening or is listed in the abuse registry.

When Presbyterian considers approval for an LRI, it takes into account whether attempts have been made to find other qualified, suitable providers.

*Utilization Management and Prior Authorization*

Presbyterian’s Utilization Management (UM) Program is designed to reduce overuse, underuse and misuse of healthcare resources to reduce cost and improve quality. UM components include care review (prior authorization), monitoring for over/underutilization, concurrent review and retrospective review to ensure our members receive the right amount of care at the right time, in the right setting and in the most cost-effective way.

**Care Review Process**

Presbyterian’s care review process is administered in a way that promotes timely care delivery and minimizes administrative burden by streamlining,
standardizing, and automating prior authorization. The care review process uses a team-based approach to ensure that each individual member’s needs are met in a holistic way.

The member’s care coordinator authorizes a member’s HCBS. Additional authorization is required when a member’s assessed need involves an alternative HCBS service that is a downward substitution of care; that is, the use of services that are

- Less restrictive and lower cost than otherwise might have been provided
- Considered clinically acceptable
- Required to meet specified objectives outlined in the member’s’ plan of treatment

The alternative HCBS request is reviewed by the Utilization Management Department, which determines if these services can be reasonably expected to avoid or delay institutionalization. Member consent to downward substitution of care is required.

*Review Criteria*

Presbyterian references nationally recognized, evidence-based standards to develop criteria. See the “Medical Necessity Service Standards” section of the “Care Coordination” chapter for a list of standards.

Medical policies are reviewed and approved by our Clinical Quality Committee, Pharmacy and Therapeutics Committee, and medical directors to ensure they are clinically appropriate. Both committees include local (New Mexico), community-based, actively practicing clinicians. All medical policies are available on the web at [https://www.phs.org/providers/clinicians-resources/medical-policy-manual](https://www.phs.org/providers/clinicians-resources/medical-policy-manual).

**Supporting Integration and Coordination of Physical Health, Behavioral Health, and Long-Term Care Services**

Presbyterian Centennial Care is structured to support and foster holistic care that is coordinated and integrated across providers and disciplines. This care includes the following:

- Coordination of physical health, behavioral health and long-term care services by primary care providers (PCPs), core service agencies, federally qualified health centers, patient-centered medical homes and health homes
- Participation of providers in care planning teams
- Communication and sharing information across provider systems

We collaborate with our network providers to enhance care coordination through the following:

- Comprehensive provider training and education
- Clear and simple policies and procedures for coordination and communication among physical health, behavioral health and long-term care providers. A list of policies and procedures is available at [http://www.phs.org](http://www.phs.org)
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• Data exchange and access to clinical information across systems of care through technology solutions that include Presbyterian’s web-based care management platform, where providers can access data regarding claims, authorizations, member risk stratification and care coordination.

Care Coordination

Presbyterian’s member-centric care model is designed to integrate physical health, behavioral health and long-term care services into a seamless care system that provides members with appropriate services at the right time within the least restrictive and most cost-effective setting. Our long-term care providers play a key role in this process by engaging members, participating in care planning efforts and ensuring comprehensive, coordinated and culturally appropriate care for each unique member. The care model promotes collaboration and supports providers in advancing wellness and promoting independence, resiliency, healthy living, health literacy and personal responsibility. It’s critical for providers to have a comprehensive understanding of this model.

Nursing Facility Level of Care: Care Plan Development

Once a member is determined as eligible for NFLOC, the care coordinator develops a revised care plan with the member and/or legal guardian or representative, as well as anyone else the member chooses. The care process to determine if members are eligible for long-term care services is based on the CNA. The care planning process incorporates the member’s medical, functional, behavioral, social support and community participation needs and preferences as part of a holistic plan for HCBS.

Members who elect to utilize the SDCB work with their support brokers (and their EORs or authorized agents) to identify the needed services within the scope of covered services and the HSD-provided annual allotment. A budget plan is incorporated into the member’s care plan.

The CNA and allocation tool are used as the basis for determining the types, amount and duration of HCBS the member needs. Based on established criteria for individual need level, the care coordinator develops an individual HCBS plan as follows:

• The member and/or representative identify specific HCBS the member desires/needs.
• The care coordinator educates the member on his or her option to elect the SDCB and explains the self-assessment tool that the member must complete for electing this option.
• The care coordinator ensures that the HCBS included in the care plan and budgets are sufficient to meet the member’s needs. The criteria used to make this determination include one or more of the following:
  ▪ The service is essential to enable the member to attain, maintain, or regain his or her optimal functional capacity.
  ▪ The service addresses a need related to improving the member’s health, functional outcomes, or quality-of-life outcomes.
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- The service addresses environmental safety or a safety-related long-term care need.
- The service enables the member to increase or maximize his or her independence.
- The service delays or prevents the need for more expensive institutional placement.
- The service is not available from another source.

- The care coordinator identifies one or more sources of covered services and supports available to meet identified long-term care needs, including one or more HCBS primary providers and backup providers/plans if the HCBS primary provider becomes unavailable.
- The care coordinator considers the views and choices of the member and/or the member’s representative regarding the proposed services and considers any other relevant information from qualified professionals, the member’s HCBS providers and others when authorizing services.

A comprehensive reassessment of all individuals receiving HCBS takes place at least annually, incorporating a re-evaluation of the HCBS plan. NFLOC eligibility reassessment takes place at least annually and within five business days of notification to Presbyterian that the member’s functional or medical status has changed in a way that may affect the LOC determination.

Transitions of Care

For members in out-of-home care or transitioning to a nursing facility, Presbyterian’s care coordinator participates in the facility’s care planning and discharge planning/transition processes, advocates for the member to be managed in the least restrictive setting and coordinates services to help support the member’s transition back to the community as appropriate. Care Coordinators also collaborate with facilities for discharge planning when a member is hospitalized, to ensure a smooth transition to the next level of care whether that is to another facility or community setting.

Communication

To ensure a truly integrated delivery system of care, Presbyterian requires and relies on its providers to communicate with each other and with Presbyterian’s care coordination staff. The member’s care coordinator is accountable for facilitating this communication, sharing the care plan with all providers and conducting ICPT meetings and interactions. All providers involved in a member’s care are responsible for participating in these care coordination efforts, providing updates on the member’s status and progress toward care plan goals and making referrals and recommendations as appropriate. Presbyterian Centennial Care offers web-based technologies to support our providers and community-based organizations in their work on care coordination and linking to our ICPTs.
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**Credentialing**

Physicians, other healthcare providers, facilities and hospitals that provide health services to Presbyterian members must be credentialed in accordance with Presbyterian’s policies and procedures. Under the state of New Mexico’s regulation, the credentialing process and approval must be completed before providing care to a Presbyterian member. Recredentialing occurs every three years thereafter for all credentialed entities.

**Electronic Visit Verification**

Presbyterian monitors member receipt and use of Personal Care Services (PCS) using the Electronic Visit Verification (EVV) system known as AuthentiCare®. Use of the AuthentiCare system is required for all PCS in-home caregivers and is mandated by HSD for the Centennial Care program.

To ensure accessibility and ease of use, personal care services agencies will have multiple options to access the AuthentiCare system, including by cell phone, landline, or a Wi-Fi/data-enabled mobile device. Below is a list of criteria for each option:

1. **Member’s landline or cell phone:**
   With permission from the member, caregiver will use the member’s telephone to call into AuthentiCare using an Interaction Voice Response (IVR) to clock in and out. In this instance, Presbyterian asks that agencies have the member sign an attestation form to allow the caregiver to use the member’s phone.

2. **Caregiver’s mobile device (smartphone or tablet) with stipend:**
   If caregivers are unable to use a member’s telephone, Presbyterian will provide a stipend to caregivers who use their own personal mobile devices to access the AuthentiCare application to clock in and out. Caregivers may not use their own smartphones to call into the AuthentiCare system.

3. **Presbyterian-issued tablet:**
   If caregivers do not have access to a personal mobile device or a member’s telephone, caregivers may request a pre-programmed, Wi-Fi enabled tablet from Presbyterian to access the AuthentiCare application to clock in and out.

All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT). Presbyterian will not report stipends or tablets as taxable income to providers.

The AuthentiCare system includes the following capabilities to ensure members receive appropriate services:

- AuthentiCare logs the arrival and departure of individual caregivers by using one of the options listed above.
- Verifies in accordance with business rules that PCS are delivered as authorized and in the approved location, such as the member’s home.
Long-term Care

- Verifies the identity of the individual caregiver providing the service to the member
- Matches services provided to a member with services authorized in the member’s care plan
- Ensures that the caregiver delivering the service is authorized to deliver such services
- Validates the schedule of services for each member and ensures adherence to the schedule, identifying the time at which each service is needed, as well as the amount, frequency, duration and scope of each service
- Provides real-time notification to care coordinators and/or agency staff, if a caregiver does not arrive as scheduled or otherwise deviates from the authorized schedule, which allows any service gaps to be immediately identified and addressed, including the implementation of backup plans, as appropriate

Long-term Care Claims Submission

All Centennial Care long-term care claims shall be submitted directly to Presbyterian except for claims for members enrolled in the SDCB, which are paid for by the FMA.
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Note that throughout this chapter, home healthcare (HHC) agency providers are referred to as agency or agencies.

Home care services for Presbyterian Centennial Care are managed through our prior authorization department. Our staff supports the mission of Presbyterian to improve the health of individuals, families and communities throughout New Mexico by ensuring the provision of the highest quality and most affordable home care services for patients in their home.

We provide utilization management through review of prior authorization requests for home care services. The review is to ensure that the right services are provided at the right frequency, duration and level needed.

Presbyterian utilization review nurses perform prior authorization reviews for home health services.

The Synagis Program

The Synagis (Palivizumab) program is coordinated statewide for all eligible children who are Presbyterian members and who meet qualifying criteria utilizing our network of Home Health Care agencies.

Agency Recredentialing Policy

Accredited and non-accredited HHC agency providers within the state of New Mexico, or in surrounding states who are within 100 miles of the New Mexico state boundary and carry a New Mexico home care license, may request to contract with Presbyterian.

Presbyterian confirms, among other things, that the requesting home healthcare agency adheres to the following criteria:

- Is in good standing with state and federal regulatory bodies
- Was reviewed and approved by a recognized accrediting body
- Ensures, at least every three years, that the home healthcare agency provider continues to be in good standing with state and federal regulatory bodies
- Meets Presbyterian’s credentialing standards for HHC agencies. Presbyterian’s Credentialing department does all credentialing for HHC agencies.
- Presbyterian’s credentialing department is responsible for reviewing the required credentialing documents and information as provided by the agency. The credentialing packet is presented to Presbyterian’s Peer Review Credentialing Committee for approval. Presbyterian maintains the security and confidentiality of the credentialing files. At least every three years, all contracted agencies need to comply with Presbyterian’s recredentialing
process to maintain participation with the Utilization Management department.

**Agency Contracting Policy and Process**

Presbyterian is responsible for ensuring statewide home care coverage by contracting with qualified home care providers throughout the state of New Mexico. Before any home care services may be provided to Presbyterian members, a written, fully executed contract developed by Presbyterian’s Legal department must be signed by all necessary parties. Presbyterian maintains the security and confidentiality of the contract files. Contracting is handled by Presbyterian’s Contracting department.

**New Agency Orientation**

Upon successful completion of the credentialing and contracting processes, the agency receives orientation. The orientation includes an explanation of the following topics:

- Prior authorization process
- Appeals and grievance process
- Reporting requirements
- Team conference process
- Completion of the annual self-audit and satisfaction survey
- Claims submission process

Each agency is provided access to this manual through Presbyterian’s website at www.phs.org.

**Qualifying Home care Criteria Policy**

The qualifying home care criteria policy applies to all Presbyterian plans that have a home healthcare benefit, including Commercial, Administrative Service Only (ASO), Presbyterian Senior Care (HMO and HMO-POS), Presbyterian MediCare PPO, Centennial Care and Presbyterian Insurance Company, Inc. plans.

Upon receipt of a referral or prior authorization request, our staff reviews the referral or request against qualifying criteria for home care services, which includes ensuring that a patient is homebound. At the time this manual was published, “homebound” is defined as a person meeting all of the following:

- The condition of these patients should be such that a normal inability to leave home exists and, consequently, leaving home would require a considerable and taxing effort.

- Absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive healthcare treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day care program. Attending a religious service shall be deemed to be an absence of infrequent or short duration.

- Occasional absences from the home for non-medical purposes (e.g., an occasional trip to the barber, a walk around the block, a drive, attendance at a family reunion, funeral, graduation, or another infrequent or unique event) would not require a finding that the patient is not homebound if the
Home Health

absences are on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain healthcare services outside rather than in the home.

- Patients have a condition because of an illness or injury that restricts their ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, or walkers; the use of special transportation; the assistance of another person; or if leaving home is medically contraindicated.

- When determining if a patient is homebound, their condition must be reviewed over a period of time. A patient may leave the home more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences than is normally the case.

- So long as the patient’s overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

Note: This homebound information still applies to all insurances except Centennial Care.

- The referral or request is also reviewed against the following criteria:

- Requests for services are medically necessary requiring a skilled service (e.g., nursing, physical therapy, occupational therapy and speech language pathology)

- Intermittent part-time services will meet the patient’s needs

- All care is ordered and under a provider’s direction throughout the course of care

Intermittent Skilled Services

Presbyterian Centennial Care intermittent skilled services admission criteria are modeled as follows:

- The recipient must have a documented medical need to receive care at home.

- Services are needed on an intermittent basis.

- All care must be ordered and under provider direction throughout the course of care.

- Presbyterian Centennial Care members are not required to be homebound to be eligible for home care services.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Medically Fragile Home- and Community-Based Services (HCBS)

These services are case managed through the University of New Mexico (UNM) Case Management Program for children younger than 21 years of age. Referrals to this program are directed to UNM Medically Fragile case managers at (505) 272-2910.

The UNM case manager with the interdisciplinary team evaluates the child and determines the level of care required. Services include hourly private duty nursing and/or hourly home health aide care. Presbyterian prior authorizes care as directed by

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the UNM case manager’s assessment and the budget developed in response to that assessment.

**Personal Care Services**

EPSDT Program personal care services (PCS) admission criteria are as follows:

- The recipient must be younger than 21 years of age.
- The recipient need assistance with at least two physical requirements such as eating, bathing, dressing, or toileting acts, appropriate to his or her age.
- PCS must be medically necessary, prescribed by the provider and included in the plan of treatment.
- The need for PCS is evaluated based on formal and informal support and the availability of family members, other community resources, or friends who can assist in providing such care.
- Personal care providers must have consent from recipients of PCS who are 18 years old and older. When the recipient of PCS is younger than 18 years old, the provider must have consent from the recipient’s parents or guardians.
- PCS are furnished in the recipient’s home or outside the home when medically necessary and are not available through traditional programs.
- These services cannot be provided to people who are in a hospital, nursing facility, intermediate care facility, facility for the mentally retarded, or an institution for mental disease.
- In partnership with the recipient’s school as an alternative to participation in a homebound program, PCS that are medically necessary for attending school are furnished to foster the child’s independence.
- PCS are furnished based on approval by the designated utilization review agent.
- Services must be provided by a personal care attendant (PCA), who is trained and demonstrates competency to provide assistance with personal care. The PCA must be employed by the agency and work under the supervision of a registered nurse (RN). The supervising RN must have one year direct patient care experience and must make home visits every 62 days or as often as needed to assess the recipient’s progress and the PCA’s performance. In addition, the supervising RN must update the care plan in conjunction with the recipient’s case manager.

A Presbyterian case manager performs the PCS assessment for children eligible for the EPSDT program benefit. The level of care is determined by Presbyterian’s long-term care (LTC) team and a budget is developed and submitted to a home health care nurse reviewer. The nurse reviewer collaborates with the Presbyterian case managers to identify a home healthcare provider agency.
Services are approved based on budgetary guidelines.

**Initial Prior Authorization**

Presbyterian processes all referrals for home care services through a comprehensive review process against admission criteria, in conjunction with the referral sources and/or agency. The patient’s eligibility and benefits are verified. Presbyterian may provide prior approval for home care services for admission and ongoing care for up to two weeks on all initial requests.

**Prior Authorization for Additional/Concurrent Services**

Presbyterian requires that the requesting agency submit supporting documentation including provider’s orders with a prior authorization request form for ongoing or concurrent care. Requests for re-certifications are reviewed before completion of the current certification period if requested by the agency. Concurrent authorization requests may be approved for one to two months depending on the member’s skilled care needs.

If a service under intermittent skilled services was ordered by a provider and an agency does not provide that service, the agency must let Presbyterian know of the order. A Presbyterian utilization review nurse has the option to find an alternative local agency to provide all home healthcare services or just the additional services.

**EPSDT Medically Fragile Home and Community-Based Services (HCBS)**

The number of hours identified on the EPSDT Program budget is developed by the UNM case manager. Upon receipt by Presbyterian of the recipient’s medically fragile budget, the review nurse reviews the indicated number of hours per month and designated home care providers. Presbyterian contacts the designated agencies to discuss staff availability. Presbyterian provides prior authorization to all providers rendering services. Services may be approved for up to 12-month time periods based on the medically fragile budget/ISP cycle.

Long-hour nursing care is requested in hours, not visits, as indicated on the Presbyterian hourly care prior authorization form. For billing and payment purposes, the discipline authorized must match the discipline on the claim submission (e.g., the licensed practical nurse (LPN) listed on the claim must match the LPN listed on the certification). As the LPN and RN availability change, the agency must notify Presbyterian so a revision to the authorization can be processed.

**EPSDT Personal Care Services**

Upon receipt of an EPSDT Program PCS budget from a Presbyterian case manager, Presbyterian contacts the designated home healthcare provider to initiate services as outlined on the case manager’s assessment and plan of care. Personal care is requested in hours, not visits, on the hourly care prior authorization form. Only Centennial Care members younger than 21 years of age are eligible for these services. Services may be approved for up to 12-month time periods based on the NFLOC approval cycle.
Home Health

Retroactive Authorizations
Retroactive authorizations are not provided as a general rule. For those medically necessary home care visits ordered by a provider during normal business hours for a same day visit or a new referral requiring a same day visit, a prior authorization will be approved if the request is received on the next business day.

Also, in those cases when medically necessary but unscheduled visits are ordered by the provider after business hours or on a weekend or holiday, a prior authorization will be issued when requested by the end of the next business day. Agencies should normally request prior authorization for home healthcare services before providing the services.

Transition of Care
Presbyterian allows for the transition of members who need home care services. This transition may involve members who are changing from another insurer to Presbyterian or members whose home care provider leaves the Presbyterian network of agencies.

Presbyterian facilitates continuity of home care services while members transition to or from Presbyterian Healthcare Services, or when the member changes home care providers within the plan. Members are offered the following transition of care benefits:

- When the member’s home healthcare provider leaves the Presbyterian network of home care providers, Presbyterian permits the member to continue an ongoing course of treatment with the original home care provider for a transitional period.
- The transitional period continues for a time that is sufficient to permit coordinated transition planning consistent with the member’s condition and needs relating to the continuity of the care. The transition period may be extended for a period up to 90 days.
- Presbyterian is not required to permit the member to continue treatment with a current home care provider if the provider is no longer affiliated with Presbyterian due to reasons related to professional behavior or provider competence.
- Presbyterian authorizes continued care as required by applicable law or regulation, which is currently not less than 30 days. When the transitional period exceeds 30 days, Presbyterian authorizes continued care only if the provider agrees to all of the following:
  - Accept reimbursement from Presbyterian at the rates applicable before the start of the transitional period
  - Adhere to Presbyterian’s quality assurance requirements and provide necessary medical information related to such care
  - Adhere to Presbyterian’s policies and procedures, including but not limited to procedures regarding referrals, prior
Denials

All referrals and requests for home healthcare services that do not meet treatment requirements and/or medical necessity criteria, as determined by utilization review nurses, are referred to the Presbyterian medical director to review for a decision regarding appropriateness of care through a home healthcare agency. In addition, all referrals and requests for new technologies will be directed to the Presbyterian Health Plan medical director for guidance.

In addition, all referrals and requests for services, including requests for new technologies, are reviewed by the quality review nurse.

- There are several situations in which Presbyterian would deny a member a request for authorization of care. The following are examples of these situations identified through an initial screen:
  - Some members are not eligible for care because our network is not the designated contractor for the member’s payer sources. The agency may inform the member that they may choose to go out-of-network and pay for services privately, in which no authorization would be needed.
  - The care request is for a service not provided by the network.
  - All requests that lack provider orders
  - All late requests that do not fall within the allowable retroactive authorization policy

The quality review nurse clearly documents the reason for each denial. When any of the above situations occur, the referral source is notified by the nurse, as appropriate.

When the utilization review nurse questions the medical necessity of the request for authorization, the nurse will initiate a discussion with the agency and/or referral source. When a Presbyterian care coordinator is active in the member’s case, then that care coordinator is likely to be part of the discussion. If a consensus cannot be reached, a Presbyterian medical director review is requested.

The utilization review nurse informs the agency or referral source about the pending status of the request. If the agency, member, or provider disagrees with the decision, then they may initiate the appeals process through Presbyterian.

A written notice is issued to the member and the requesting provider for any review denial or limited authorization of a requested service. The notice includes the type of level of service, or the reduction, suspension, or termination of a previously authorized service.

Home Health Utilization Management

The goal of the quality and utilization management program is to ensure that resources are appropriately allocated for the provisions of high-
quality home care. Our quality review nurses ensure that the home care services being provided are done in a cost-effective and time-efficient manner that enhances the achievement of superior clinical outcomes and improves the care recipient’s quality of life.

The quality review nurse monitors the agency’s adherence to the requirements and criteria presented in the Medicare conditions of participation and licensing regulations for home healthcare agencies, particularly interpreted by the following:

- New Mexico Human Services Department’s Medical Assistance Division’s manual sections on home care and on the EPSDT Program for long-hour care
- Any addendum related to state law
- In addition, Milliman Care Guidelines (MCG) are used as a reference to ensure appropriate utilization is occurring and that access to care for Presbyterian members is available.

All members, regardless of payer source, have access to any home care services covered under their policy benefit that are appropriate, provided by the agency and are available in their geographic area. Services are provided based on a combination of factors, including the following:

- Diagnosis and current clinical status
- Appropriateness of the services to meet the member’s needs
- Provider orders, or in some cases, specific arrangement with payer sources

**Member Care Conferences**

Monthly member care conferences are conducted by telephone as needed. The quality review nurses identify those members who will benefit from a care conference, which is based on the following criteria:

- Complexity of the case
- Need for coordination with other healthcare providers
- Members utilizing more than 20 visits within a prior authorization period
- Members with recidivism to the hospital or home care

Participants in the care conferences may be a Presbyterian quality review nurse, agency staff, provider and/or other healthcare providers. If a Presbyterian care coordinator is active in the member’s case, then that care coordinator is likely to be part of the discussion. The quality review nurse completes documentation of care conferences and results. The case-conference report is faxed to the agency with a copy maintained in the member’s record and case conference files.

**Claims Processing**

The agency should submit all home health claims on the Centers for Medicare & Medicaid Services (CMS) UB-04 claims form and complete all fields in accordance with standard home health billing requirements. Claims for EPSDT PCS services only should be submitted on a CMS-1500 claim form.
Home Health

with the CPT/HCPCS code S5125. Please refer to the “Claims and Payment” chapter of this manual for detailed information on the claims submission processes and policies. The following revenue codes should be used:

<table>
<thead>
<tr>
<th>Claims Processing Revenue Codes</th>
<th>Description</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN visit</td>
<td>0551</td>
<td></td>
</tr>
<tr>
<td>Dietitian visit</td>
<td>0581</td>
<td></td>
</tr>
<tr>
<td>Physical therapy visit</td>
<td>0421</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy visit</td>
<td>0431</td>
<td></td>
</tr>
<tr>
<td>Speech therapy visit</td>
<td>0441</td>
<td></td>
</tr>
<tr>
<td>Social worker visit</td>
<td>0561</td>
<td></td>
</tr>
<tr>
<td>Home health aide visit</td>
<td>0571</td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td>0270</td>
<td></td>
</tr>
<tr>
<td>RN per hour</td>
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<td></td>
</tr>
<tr>
<td>LPN per hour</td>
<td>0580</td>
<td></td>
</tr>
<tr>
<td>PCA per hour</td>
<td>0590</td>
<td></td>
</tr>
<tr>
<td>HHA per hour</td>
<td>0570</td>
<td></td>
</tr>
</tbody>
</table>

When submitting claims, please remember to do the following:

- Attach an itemized supply list to the UB-04 when billing under revenue code 0270.
- Record accurate federal tax identification number on the UB-04 under form Locator 5.
- Record the prior authorization number on the UB-04 under form Locator 63; it is not necessary to attach a hard copy of the approval to the claim.
- Ensure that all claims contain the agency’s National Provider Identifier number and the correct taxonomy code.
- Ensure that the correct ICD-10 code is used at the highest level of specificity.
- Ensure that an agency employee signs the UB-04 form.
- Intermittent skilled service claims are billed as one unit equal to one visit.
- When billing EPSDT Program long-hour care, the time must be billed in 15-minute increments. When services go over or under 15 minutes, the agency is responsible for rounding up or down.
- Hourly claims are processed as one unit equal to 15 minutes.

Mail paper claims to the following address:

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489

Complete billing adjustments in accordance with Presbyterian’s adjustment procedures, which are detailed in the “Claims and Payment” chapter of this manual. Direct all payment and/or adjustment questions to Presbyterian’s Provider Claims Activity Review and Evaluation (CARE) Unit at 1-888-923-5757.
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13. Quality Improvement Program

The Presbyterian Quality Improvement (QI) program provides the necessary infrastructure for continuously improving the quality of clinical care processes and services offered to all members. It is designed to support the physical health, behavioral health and long-term care services for members of Presbyterian’s various product lines.

Each year, initiatives are selected to improve the quality of the care and services Presbyterian offers. The scope of the QI program includes operational functions within Presbyterian, applicable members and contracted practitioners/providers who provide care and services. Contracted services include but are not limited to:

- Behavioral healthcare
- Care coordination
- Case management
- Diagnostic studies
- Emergency care
- Home healthcare
- Inpatient and outpatient services.
- Nurse advice and triage for medical care
- Pharmacy services
- Prevention programs
- Primary medical care
- School-based healthcare centers

- Skilled nursing care
- Specialty medical care
- Rehabilitation services
- Urgent care
- Web support resources

An evaluation is conducted annually to assess the overall effectiveness of the QI program. Instances that demonstrate the QI program has not met established targets, goals and benchmarks, result in recommendations for change in the subsequent QI program description and work plan. A report of success and progress is available to practitioners/providers upon request by contacting the Performance Improvement department at (505) 923-5017 or 1-866-634-2617.

The success of the QI program and related initiatives requires the cooperation and support of the provider network. Practitioners/providers are invited to participate in QI program activities, such as:

- Participating in clinical, service and safety improvement activities
- Cooperating with medical record data abstraction and/or production of medical records
- Participating in quality of clinical care reviews
Quality Improvement Program

- Participating in satisfaction surveys
- Providing input for disease management activities
- Serving on ad hoc quality improvement work groups
- Serving as QI committee members

Several internal QI committees meet routinely to review data and discuss and share ideas for improving the health of and service to Presbyterian members. Clinical practitioners are invited to participate as members on the following committees:

- Clinical Quality & Utilization Management Committee
- Pharmacy and Therapeutics Committee
- Technology Assessment Committee
- Credentialing Review Committee
- Professional Practice Evaluation Committee

For additional information about the QI program or opportunities to participate, please contact the Performance Improvement department at (505) 923-5017 or 1-866-634-2617 or by email at PerformanceImp@phs.org.

National Committee for Quality Assurance (NCQA)

Presbyterian Health Plan, Inc. has participated in the National Committee for Quality Assurance (NCQA) accreditation program since 2000 and Presbyterian Insurance Company, Inc. has participated since 2009. NCQA is a private not-for-profit organization dedicated to improving healthcare quality. NCQA accredits and certifies a wide range of healthcare organizations and manages the evolution of the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®), which is the performance measurement tool used by more than 90 percent of the nation’s health plans.

Presbyterian chose NCQA as its quality platform. Our goal is to maintain accreditation for our Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) products. We strive to foster service and clinical quality that meets or exceeds rigorous requirements for quality improvement. This goal can only be achieved by the combined efforts of health plan employees and network practitioners and providers.

The NCQA health plan accreditation survey includes a review of quality improvement, population health management, network management, utilization management, credentialing and recredentialing, member rights and responsibilities and member connections. It also includes delegated activity oversight, clinical care measures performance effectiveness and member and provider satisfaction improvement. As an NCQA-accredited health plan, Presbyterian is re-evaluated annually via HEDIS® and the Consumer Assessment of Healthcare Providers and Systems (CAHPS)¹ to monitor quality of care and service. NCQA also conducts a comprehensive standards compliance survey every three years.

Focus on Excellence

Presbyterian is guided by principles and practices that promote the continuous improvement of
business operations, medical care, behavioral healthcare and all services provided to members and providers. Quality improvement structures and processes are planned, systematic and clearly defined. Presbyterian employs process improvement tools such as the Presbyterian Improvement Model and the Plan-Do-Study-Act (PDSA) cycle for improvement.

The Presbyterian Improvement Model is a continuous quality improvement tool used to gain and apply knowledge. It is designed to help employees effectively think through problems and processes that will ultimately result in improved outcomes. Focusing on the Presbyterian Improvement Model’s questions increases knowledge by emphasizing a framework for learning, using data and designing effective tests or trials.

The PDSA cycle is a simple yet powerful tool for quality improvement. It is testing a change by planning, trying, observing the results and acting on what is learned. The steps in the PDSA cycle are:

- Plan- Plan the initiative or intervention, including a plan for collecting data.
- Do- Try the test on a small scale.
- Study- Set aside time to analyze the data and study the results.
- Act- Refine the change based on what was learned from the test.

**Quality Improvement Initiatives**

**Availability of Providers**

Availability of providers is measured to assess sufficient numbers of primary care and specialty care providers by geographic distribution and in ratios of members per provider.

Results are compared to established standards to identify opportunities for improvement. State regulations determine the geographic standards for Medicaid.

**Accessibility of Services (Appointment Availability)**

Access and availability of care measures look at how members access services from their healthcare system, such as:

- Adults access to preventive/ambulatory services
- Childhood and adolescent access to primary care practitioners
- Prenatal and postpartum care
- Annual dental visits

**Data Collection**

Data collection includes CAHPS survey results for questions related to accessibility of services for primary care, behavioral health and specialty care. Mystery shopping surveys are included as supplemental data to the CAHPS survey results data to the CAHPS results.

**Credentialing and Recredentialing**

Presbyterian credentials and recredentials both individual practitioners and organizational providers. The credentialing program ensures
compliance with credentialing policies and procedures, NCQA standards and state and federal requirements for verification of credentials including, but not limited to, license, board certification and education.

**Delegation**

Presbyterian may delegate to designated entities all or some credentialing responsibilities. The performance of the entity is monitored on an ongoing basis for compliance with Presbyterian requirements and all applicable regulatory and accreditation standards. Presbyterian retains the right to approve, suspend and terminate individual practitioners/providers in situations regarding quality issues. Performance by the delegate is evaluated in accordance with regulatory requirements and results are reported to the Credentialing Review Committee.

**Site Visits**

Site visits are included as part of the initial credentialing for primary care practitioners/providers (PCP), obstetrician/gynecologists and high-volume behavioral health specialists. Site visits are also performed for organizational providers who have not been approved by an accrediting body.

Initial applicants whose site visit scores are below an acceptable threshold are notified that the credentialing process is discontinued. Applicants may contact Presbyterian for information about how to improve their sites and to restart the credentialing process once the deficiencies are corrected.

If a practitioner/provider receives two or more complaints regarding their site within a 12-month period, a site visit is scheduled. If during the site visit an issue is identified, the practitioner/provider must develop a corrective action plan to address the deficiencies. A follow-up review is conducted within six months to determine compliance. If the practitioner/provider fails to submit the corrective action plan within the specified time frame, it is considered a breach of contract and may result in termination from the network.

**Ongoing Monitoring**

The Office of Inspector General (OIG) Exclusion Programs database, as well as applicable state licensing agencies, is monitored monthly for sanctions or licensure limitations. The Medicare Opt-out website is also checked monthly to ensure that practitioners/providers contracted for Medicare Advantage have not opted out of Medicare. Interventions are implemented as appropriate.

**Quality of Clinical Care**

Quality of Clinical Care investigates and resolves all clinical quality complaints and referrals. Investigations may include, but are not limited to obtaining medical records, practitioner/provider responses and subject matter expert responses.

Sources of quality of clinical care referrals are the Presbyterian Appeals and Grievances department, primarily. Where appropriate, the Quality department may also receive direct referrals from practitioners/providers, Presbyterian medical directors, Presbyterian pharmacy, or the Program Integrity Department (PID).
Clinical Quality of care monitors all practitioners/providers monthly for trends in the number and nature of complaints referred to the quality of care process. Presbyterian has two professional evaluation committees, one for behavioral health and one for physical health. When a practitioner/provider meets criteria for the number of complaints in a 12-month period, the appropriate Presbyterian Professional Practice Evaluation Committee reviews the provider’s patient care service to identify a possible pattern of contrary conduct or behavior. Additional criteria for reporting a case to the Professional Practice Evaluation Committees includes cases that meet certain outcome levels or cases identified by a Presbyterian medical director.

Any suspected inappropriate practice pattern is investigated. A medical record chart audit is performed and if it is determined to be a quality of clinical care issue it is presented to the appropriate Committee. Quality of clinical care referrals are referenced as part of the credentialing and recredentialing process.

Peer Review

The Presbyterian Board of Directors has designated the Professional Practice Evaluation Committees as part of Presbyterian’s process under the New Mexico Review Organization Immunity Act, §41.9.5.

The committee’s membership includes licensed healthcare practitioners who represent various levels of advanced practice and certification. Peer review activities include review of the quality of clinical care delivered by practitioners/providers within the same discipline and area of clinical practice that is documented in the meeting minutes. The Professional Practice Evaluation Committees have the authority to recommend disciplinary action up to and including suspensions and/or terminations from the network, at any point in the practitioner/provider’s credentialing cycle.

Continuity and Care Coordination

Continuity and care coordination that members receive is monitored to improve communication across the Presbyterian healthcare network and between medical and behavioral healthcare practitioners/providers. Information exchange between medical and behavioral practitioners/providers must be member-approved and be conducted in an effective, timely and confidential manner. Primary care providers (PCPs) are encouraged to make timely referrals for treatment of behavioral health disorders commonly seen in their practices. Drug-use evaluations of psychopharmacological medications are conducted to increase appropriate use or decrease inappropriate use and to reduce the incidence of adverse drug reactions. Data is collected and analyzed to identify opportunities for improvement. Collaborative interventions are implemented when opportunities for improvement are identified.

Standards of Care

Presbyterian has processes to ensure healthcare services provided to members are rendered according to acceptable standards of quality of care consistent with professionally recognized standards of medical practice. This is monitored through the


Quality Improvement Program

credentialing, recredentialing and quality of clinical care processes.

Service Quality Concerns

Service quality concerns from members and providers are tracked both individually and in aggregate to identify potential problems with quality of services. Provider Network Operations investigates service-related complaints that involve practitioners/providers. Interventions are identified, developed and implemented as appropriate.

Clinical Practice Guidelines

Clinical practice guidelines for both acute and chronic medical conditions including behavioral health disorders are adopted using current evidence-based, nationally recognized sources. The clinical practice guidelines are reviewed, updated as appropriate, approved by the Clinical Quality and Utilization Management Committee (CQUMC) and disseminated every two years. Through CQUMC participation, practitioners/providers are involved in the review and approval of all guidelines. The use of guidelines is measured annually using HEDIS® measures or through an internally developed methodology.

Preventive Healthcare Guidelines

Presbyterian adopts preventive healthcare guidelines from nationally recognized, evidence-based recommendations for all age groups. Approval of preventive guidelines is through CQUMC. The use of guidelines is measured annually using HEDIS® or an internally developed methodology. (For a thorough discussion of HEDIS®, see the “What is HEDIS®?” section at the end of this chapter.)

Member Medical Records

To ensure that the Presbyterian provider network meets a minimal set of standards for medical record documentation, individual practitioner/provider adherence to standards is monitored and compared to performance goals. Presbyterian regularly assesses compliance with these standards and a written report is mailed to the practice outlining the results of the evaluation. Strengths and opportunities for improvement are reported to the Clinical Quality & Utilization Management Committee and are shared with practitioners/providers along with educational information for areas needing improvement.

Integrated Care Management Program

Presbyterian provides an Integrated Care Management (ICM) program that includes care coordination, complex case management and disease management components. The program is designed to assist members with multiple and complex, physical, neurological, emotional or cognitive and behavioral healthcare needs.

The intent to identify members with moderate risk and to offer disease management services is to slow or prevent the progression and complications of chronic conditions. The provision of ICM facilitates timely access to and use of appropriate services, thereby reducing unnecessary services and the incidence and cost of inappropriate emergent and inpatient care. ICM is a member-
centered, family-focused (when appropriate), culturally sensitive and strength-based service.

The ICM program also supports practitioners/providers in their management of members with catastrophic, high-cost, high-risk or complex illnesses, injuries or conditions.

A care coordinator is assigned to provide complex case management for members who meet the criteria for care coordination. This individualized care serves to guide members through the healthcare continuum in a coordinated, caring, cost-effective and quality-oriented manner. In addition to measuring member satisfaction, two clinical measures are identified annually to monitor the effectiveness of the complex case management program.

Behavioral healthcare is included with ICM to facilitate timely and appropriate access to these services for Presbyterian Centennial Care members. The individualized care serves to guide members through the healthcare continuum in a coordinated, timely, caring, cost-effective and quality-oriented manner.

Continuum of Care

Providing members with appropriate, available service is optimal for quality, cost-effective healthcare. Presbyterian is dedicated to helping members meet their healthcare needs across the continuum of care through programs and services that address the preventive, acute and chronic care needs of members. Interventions and tools are developed from evidence-based guidelines to work with members and to create and implement care plans that provide members with the tools needed for improved self-management. Staff work collaboratively with members and healthcare practitioners/providers to promote a seamless delivery of healthcare services.

Special Populations

The identification of special populations in Presbyterian Centennial Care enables Presbyterian to facilitate timely and appropriate healthcare through effective care coordination. Presbyterian uses guidelines that promote coordination and access to care. Complaints, grievances and appeals are tracked in aggregate to identify trends and opportunities for improvement. Integrated Care Management reviews an aggregate report quarterly. Trends are tracked and addressed. Action plans are developed as needed to address opportunities for both procedural and individual case activities. For a thorough discussion of HEDIS®, see the “What is HEDIS®?” and the “QI Program: HEDIS® Medical Record Data Abstraction” sections at the end of this chapter.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Tot-to-Teen health checks (also referred to as well-child checkups) are in place for Presbyterian Centennial Care members as required by the Human Services Department (HSD). Components if the EPSDT Program are measured annually using HEDIS®.

Health Risk Assessment

All members who are new to Presbyterian Centennial Care complete an initial Health Risk
Quality Improvement Program

Assessment (HRA) of their physical and behavioral health needs. Results of these assessments enable Presbyterian to determine if members would benefit from care coordination, case management, or disease management program services.

Culturally Appropriate Services

Presbyterian supports culturally sensitive services. These services begin with an understanding of and respect for language, ethnicity, race, age and sex and gender-based differences. It is essential that these differences are recognized and shared with our staff when communicating with members verbally, non-verbally and in writing. Without effective interactions, members may not understand their healthcare benefits or be able to participate fully in the recommended course of prevention and treatment.

At all levels of operations, Presbyterian acknowledges and promotes the importance of and respect for culture and language and the traditions associated with different people and communities in the delivery of services. Clinical and non-clinical services are accessible to all members and are provided in a culturally sensitive manner with sensitivity to the member’s religious beliefs, values, traditions, diverse culture and ethnic background as well as limitations with English proficiency or reading skills, physical or mental disabilities and state of homelessness.

Presbyterian’s objectives for serving a culturally and linguistically diverse membership include the following:

- An annual assessment to describe diversity among the health plan membership.
- The use of customer feedback in the form of complaints and survey data to identify disparities.
- Development of work plan activities to address identified opportunities for improvement. At a minimum, work plan activities include the following:
  - Maintaining a cultural competency and sensitivity policy to provide direction for Presbyterian services and operations.
  - Maintaining a translation services policy to ensure that customer information and services are available in languages other than English.
  - Tracking bias and discrimination issues that hinder or prevent culturally sensitive services and care in accordance with the Americans with Disabilities Act and other applicable federal and state laws.
  - Conducting an annual assessment of languages and cultural background within the provider network to determine if providers meet the needs and preferences of members.
  - Developing an annual plan to adjust the provider network if it does not meet the members’ language needs and cultural preferences.
  - Providing annual cultural competency training for Presbyterian staff.
Quality Improvement Program

- Providing cultural competency educational materials and training for providers throughout the year.

- Assisting members in locating practitioners/providers who correspond with their languages and cultural and gender preferences.

- Developing communication tools and strategies to address identified race, ethnicity, age, gender, sex and language needs, such as subscriber materials, member handbooks, newsletters, provider directory, educational materials, telephone outreach, TTY assistance and multilingual employees.

Oversight of Delegated, Subcontracted and High-volume/Single-source Providers

Presbyterian may delegate or subcontract for specific administrative functions (e.g., credentialing, complex case management, disease management, utilization management, claims payment functions, nurse advice line services and pharmacy benefit information) to third-party entities. All delegates and subcontractors must meet Presbyterian requirements as well as applicable accreditation and regulatory standards before and during delegation. Delegates are subject to appropriate oversight activities to ensure that services are compliant with regulatory, contractual and accreditation requirements.

Delegated, subcontracted and high-volume or single-source provider functions are monitored at least semiannually to review policies, procedures, operational reports and activities to ensure that they continue to meet Presbyterian requirements as well as applicable contractual, accreditation and regulatory standards. Audit findings and applicable corrective action plans are reported to and monitored by the appropriate quality committee. Delegates who serve Centennial Care members and who are placed on corrective action are reported HSD.

Nurse Advice Line: PresRN

PresRN provides telephone triage of symptoms, medical advice, health information and medical and behavioral health referrals 24 hours a day, seven days a week. PresRN also serves as a community link between practitioners/providers and members regarding health information, flu clinics, health alerts, community resource information and links to 911 services, poison control, social services and behavioral health.

PresRN uses nationally recognized protocols for triage and health information. Documentation occurs in Epic, Presbyterian’s Electronic Health Record (EHR) and can be accessed by Presbyterian providers. The member’s provider, care coordinator and/or health coach are also notified of the call to PresRN to ensure continuity of care. PresRN employs registered nurses who are located in New Mexico and are knowledgeable about state and county resources.

Presbyterian offers our Centennial Care members direct access to our Presbyterian Customer Service Center to connect with our nurse advice line. Presbyterian Centennial Care members may
Quality Improvement Program

contact PresRN at (505) 923-5677 or 1-888-730-2300.

Utilization Management Program

The Presbyterian Utilization Management (UM) Program identifies the authority and accountability for all UM activities, including physical health, behavioral health and pharmacy. The UM program is under the direction of the Vice President of Clinical Operations and the chief medical officer. Medical directors and UM staff have substantial involvement in developing and implementing the UM program. A UM program description is reviewed annually, updated as needed and approved by the Clinical Quality & Utilization Management Committee.

Any entities delegated for utilization management functions must meet all requirements set forth by Presbyterian as outlined in delegation agreements and service level agreements. These agreements set forth accountabilities for pre- and post-auditing and oversight by Presbyterian, as well as provisions for corrective action plan requirements and delegation conditions.

The criteria resources used to determine medical necessity, including the methods by which criteria are developed or chosen and reviewed, are updated and modified as appropriate. Annual medical director and nurse inter-rater reliability agreement audits are performed to ensure consistent application of review criteria and consistent decisions.

Presbyterian continually assesses member and provider satisfaction with the utilization management processes to identify areas needing improvement. Under- and overutilization of pharmacy, physical and behavioral healthcare services is monitored quarterly to facilitate the delivery of appropriate care. Results are compared to established thresholds.

Web Resources

Presbyterian’s website, http://www.phs.org, provides member access to information that can be useful when making healthcare decisions.

Information about many services is available on Presbyterian’s website, including the following:

- Information about claims payments, medical benefits and pharmacy benefits and resource tools.
- The provider directory and hospital directories to help current and prospective members choose practitioners/providers, pharmacies and hospitals
- Web technology for members for e-appointments, e-consultations, e-referrals, online personal health information and to request lab reports.

Presbyterian evaluates website functionality to improve usability. Processes for posting and maintaining accuracy and currency of content and information are monitored.

Member and Provider Experience

Presbyterian understands the importance of obtaining feedback from our members and practitioners/providers. Presbyterian collects feedback from members and practitioners/providers
Quality Improvement Program

to improve experiences through improved processes, programs and communications. We collect feedback in a variety of ways as listed below.

Survey Data

We conduct relationship surveys such as the CAHPS survey, the annual provider satisfaction survey and a quarterly member survey. There are a number of reasons for conducting relationship surveys, including the following:

- To trend results over time.
- To compare performance against external benchmarks when available.
- To identify drivers of satisfaction and loyalty.
- To identify opportunities for improvement.

In addition, we occasionally conduct transactional surveys to evaluate the performance of specific interactions with Presbyterian such as a post-customer service call survey or a web survey.

Complaint and Inquiry Data

Whenever a member contacts the health plan, whether through calls, emails or letters, the transaction is logged in the Facets™ system. Complaints, appeals and grievances are captured in a similar manner. This data is aggregated, analyzed and reported at least annually to identify trends and opportunities for improvement. The data can be filtered to perform various analyses such as by product line, employer group, inquiry type and customer type.

Qualitative Research

Presbyterian also uses qualitative research methodologies including focus groups, formal and informal interviews, usability studies and mystery shopping, as appropriate. Consumer advisory boards are also used to evaluate the quality of our service and the customer experience.

Member Experience Steering Committee and Dedicated Teams

The Member Experience Steering Committee and dedicated teams use the aforementioned data to identify and prioritize opportunities for improvement, make recommendations to the appropriate areas and create action plans.

QI Program: HEDIS® Medical Record Data Abstraction

What is HEDIS®?

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a standardized set of performance measures developed and maintained by NCQA. HEDIS® measures are designed to focus on healthcare quality. HEDIS® data is collected annually and is intended to provide purchasers and consumers with the information they need to compare the performance of health plans. The HEDIS® report could not be prepared without the continued cooperation and support of the practitioner/provider community.

When a health plan is accredited by NCQA, it is required to prepare and submit annual audited HEDIS® results for eligible product lines as a way of continuously measuring quality care.
Both the New Mexico Human Services Department (HSD) and the Center for Medicare & Medicaid Services (CMS) require HEDIS® reporting for health plans that are contracted to provide Medicaid and Medicare benefits.

Where does HEDIS® data come from?

HEDIS® data is collected from healthcare claims and encounters, enrollment forms, surveys and medical records. Most of the data includes information from the previous calendar year. Some performance measures also require health plans to find and report on data from previous years. The HEDIS® data requirements are specific and cannot be changed by the health plan. Before submitting the report to NCQA, HSD and CMS, it is thoroughly reviewed by NCQA-certified auditors to ensure that it was prepared correctly. NCQA and regulatory agencies publish HEDIS® results in public forums so that existing and potential health plan purchasers and members can compare results.

What quality performance measures are included in the reports?

The HEDIS® measures change from year to year, and are included in the following broad categories:

- Respiratory conditions
- Musculoskeletal Conditions
- Behavioral Health
- Cardiovascular conditions and diabetes
- Satisfaction
- Utilization measures

Assessing Gaps in Care

Presbyterian generates a list of members from our claims system who may not be up to date on or who are missing recommended preventive screenings. These members may also need recommended interventions or medications for chronic conditions. A list of care gaps for your patients with these conditions and measures is available by contacting the Performance Improvement departments by phone at (505) 923-5017 or 1-866-634-2617, or by email at PerformanceImp@phs.org.

How does HEDIS® reporting impact the practice setting?

Health plans rely on the claims submitted by practice sites to prepare the HEDIS® report. When claims are not coded correctly, they cannot be used for reporting purposes. When a health plan cannot find the claims data, a medical record search begins by identifying those providers that provided a service to members selected for the HEDIS® measure.

Medical record review is also used to verify outcomes, such as lab results, or to identify compliant or exclusionary events.
Providers are given a list of their patient names and asked to make medical records available for health plan staff to review or, when this is not possible, make copies of requested medical record pages. Health plans submit the audited HEDIS® reports to NCQA in June of each year and typically begin preparing at least six months before the June deadline. Medical record data collection can begin any time during the first quarter of the calendar year. Participating providers are required to provide access to medical records during the HEDIS® data collection period.

How does Presbyterian use the HEDIS® reporting system?

For the past several years, Presbyterian has integrated the HEDIS® performance measures into its QI program to gauge the success of its clinical and service activities. For example:

- HEDIS® measures are used to determine the success of Presbyterian’s disease management programs for diabetes and coronary artery disease.
- The annual CAHPS member satisfaction survey is used to monitor improvement activities in customer service and getting care quickly.
- Selected HEDIS® and CAHPS measures are included in the Presbyterian QI program.
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This chapter provides a high-level overview of the following critical federal regulations created to address key concerns relating to electronic health information:

- The Health Insurance Portability and Accountability Act (HIPAA) of 1996
- The Health Information Technology for Economic and Clinical Health (HITECH) Act.
- The HIPAA Omnibus Rule of 2013

HIPAA regulations are detailed in the Code of Federal Regulations (CFR) Title 45, which addresses public welfare and is administered by the U.S. Department of Health and Human Services (HHS). The specific regulations that address HIPAA are 45 CFR Parts 160, 162 and 164, which can be reviewed in their entirety at: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl.

This chapter’s overview includes a brief description of the relevance of these regulations to all providers and a list of informational and training resources for providers seeking additional information.

**What Requires Your Particular Attention?**

Providers are advised to pay particular attention to the HIPAA Omnibus Rule effective March 2013.

HIPAA Omnibus Rule was published in the Federal Register on January 25, 2013; Omnibus became effective March 26, 2013. Business Associate Agreements (BAA) and the HIPAA Omnibus Rule required that certain providers met certain regulatory requirements no later than Sept. 23, 2013. (Note that a rule or regulation is promulgated; a law is enacted.) You can review the Federal Register at http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf.


Many additional resources posted online by HHS, trade associations and commercial entities are available to providers seeking to ensure that they are fully compliant.

**Who is Legally Responsible for HIPAA Compliance?**

All providers are solely responsible for their compliance with HIPAA regulations. Presbyterian does not assume any responsibility for ensuring that providers are compliant.

The information provided in this chapter should not be construed as legal advice; providers should
consult their own legal counsel for an opinion as to how these regulations apply to their office or facility.

Which Centennial Care Providers Must Be HIPAA Compliant?

All providers who transmit protected health information (PHI) in electronic form in connection with a transaction for treatment purposes are legally obliged to follow HIPAA regulations.

Those providers who perform a service or activity on behalf of Presbyterian and who are not members of Presbyterian’s workforce are also legally obliged to follow HIPAA regulations. Such a service might include, but are not limited to, any function or activity specified in the definition of business associate within the HIPAA Omnibus Rule at 45 CFR §160.103. These performed business associate activities include the following:

- Claims processing or administration
- Data analysis, processing, or administration
- Utilization review
- Quality assurance
- Patient safety activities
- Billing, benefit management, practice management and/or repricing

Additional business associate activities include legal, actuarial, accounting, consulting, data aggregation, management administration, accreditation or financial where the provision of services involves the use or disclosure of PHI.

Key HIPAA Definitions

The three definitions in this section are derived from 45 CFR 160.103. HIPAA definitions can also be found in 45 CFR 160.202, 160.401, 160.502, 162.103, 164.103, 164.304, 164.402 and 164.501. (See http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl.)

Covered entity means:

- A health plan
- A healthcare clearinghouse
- A healthcare provider who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 164

Protected Health Information (PHI) means:

Individually identifiable health information that includes demographic information collected from an individual; is created or received by a healthcare provider, health plan or healthcare clearinghouse; and relates to the past, present or future physical or mental health condition of an individual; or the past, present or future payment for the provision of healthcare to an individual; identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; is transmitted by electronic media; transmitted or maintained in any other form or medium; and excludes education records or employment records; and excludes any individually identifiable health information regarding a person who has been deceased for more than 50 years.
Health Insurance Portability and Accountability Act

**Business Associate**

A person who is not a member of the workforce that creates, receives, maintains or transmits PHI for a function or activity involving the use or disclosure of PHI on behalf of a covered entity. See “Appendix E” in this manual for a copy of the Business Associate Agreement.

**HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains several key components:

- Title I protects a workers’ health insurance coverage when they lose or change jobs.
- Title II, which is also known as the Administrative Simplification Regulation mandates that the HHS create national regulations to address several key concerns relating to the privacy and security of patient health information including the following:
  - Standardization of electronic health insurance transactions
  - Security of electronic PHI
  - Privacy of protected health information in any form or medium

**HITECH Act**

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 expands HIPAA privacy and security rules, makes the HIPAA privacy and security rules applicable to business associates and increases penalties for HIPAA violations. The HITECH Act and its implementing regulation, the HIPAA Omnibus Rule:

- Applies HIPAA privacy and security regulations directly to business associates
- Expands mandatory requirements for reporting breaches of protected health information
- Increases criminal and civil penalties for noncompliance

**HIPAA Final Omnibus Rule**

This final rule, which took effect March 26, 2013, modifies the HIPAA Privacy, Security, Enforcement and Breach Notification Rules under the HITECH Act. The HIPAA Omnibus Rule implements changes to the HIPAA Rules and include some of the following:

- Expands the obligations of providers and other healthcare professionals to protect PHI
- Requires business associates of covered entities to comply with all of the HIPAA Security Rule requirements and aspects of the HIPAA Privacy Rule requirements as they might be applicable.
- Strengthens the limitations on the use and disclosure of protected health information for marketing and fundraising purposes and prohibits the sale of PHI without individual authorization.
- Expands individuals’ rights to receive electronic copies of their health information.
- Modifies the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to
Health Insurance Portability and Accountability Act

- schools and enables access to decedent information by family members or others.
- Increases tiered civil money penalties for violations HIPAA, HITECH, HIPAA Omnibus Rule and related regulations.

HIPAA Information Resources

The resources listed here are just a few of the many online resources available to all providers seeking to ensure that they are fully compliant with all HIPAA regulations, including the HIPAA Omnibus Rule. As stated earlier in this chapter, however, Presbyterian advises providers to consult their own legal counsel for an opinion as to how these regulations apply to their office or facility.

Official HIPAA Information Sources:
- Department of Health and Human Services
- Center for Medicare & Medicaid Services

HIPAA Final Omnibus Rule

Note that in addition to the official HHS site and various medical association sites, a number of additional sources of support for providers are available, including the following:

- Department of Health and Human Services
- The American Academy of Orthopaedic Surgeons, “What You Need to Know about the HIPAA Omnibus Rule”
  - http://www.aaos.org/news/aaosnow/jul13/managing4.asp. (Requires AAOS membership or subscription to log in)

HIPAA Training

- Department of Health and Human Services:
  - http://www.hhs.gov/ocr/privacy/hipaa/understanding/training/index.html

Trade Organizations

- Providers should check with their specialty trade organization, which will have the most specific information on HIPAA compliance issues that affect their particular specialty or service.

Workgroup on Electronic Data Interchange (WEDI)

- WEDI has organized collaborative, industry-wide effort aimed at implementation of electronic health record systems, clinical initiatives and standards including those for security, privacy, electronic data interchange and transaction standards, code sets and identifiers.

Electronic Health Record Incentives

- Standards for the Electronic Health Record Incentive Program (42 CFR 495.2-370). Establishes the eligibility criteria and processes for documenting and applying for electronic health record (EHR) incentives for providers. Information regarding registration for the Medicare and
Medicaid EHR Incentive Program is available online at

Note: deadlines for participation for eligible providers have passed.

HHS Office of the National Coordinator for Health Information Technology, “EHR Incentives and Certification”

- http://www.healthit.gov/providers-professionals/faqs/ehr-incentive-payment-schedule

- “Guide to Privacy and Security of Electronic Health Information, Version 2.0:"

You may find information about New Mexico’s Medicaid Incentive program at the following link:

http://www.hsd.state.nm.us/providers/general-information.aspx
As a provider, you have signed an agreement to deliver services to Presbyterian members. By signing that agreement you have agreed to comply with all of the requirements and responsibilities under Presbyterian. However, we understand that a legal document may not always be easily accessible, so the purpose of this chapter is to try to highlight and summarize some of the key responsibilities. If there is any doubt about your responsibilities, or conflict between the agreement and this provider manual, it is always the language of the agreement that will apply.

The healthcare environment is both dynamic and heavily regulated. It is necessary for Presbyterian to make sure that our providers are in compliance with all of the requirements in this chapter. As a result, we will update this chapter as regulatory requirements are added or changed.

**Cooperation with Presbyterian’s Programs**

As a provider, you must use your best efforts to cooperate with Presbyterian’s quality improvement programs, member grievance systems, medication therapy management and utilization management programs to the extent applicable. If you have subcontractors, you also need to require them to cooperate with these programs. For example, you and your contractors have responsibilities regarding the following:

- Credentialing and recredentialing
- Quality assurance
- Utilization review and management
- Medical records maintenance
- Claims payment review
- Management peer review
- Grievance procedures

According to section 13.10.22.12 of the New Mexico Administrative Code (Managed Health Care Contracting), contracts with providers in the state of New Mexico shall contain a description of the specific hold harmless provision specifying protection of covered persons. As a result, the following language is hereby deemed incorporated and made an express part of your agreement with Presbyterian:

> “Health care professional/healthcare facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall health care professional/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, covered person, or person acting on behalf of the covered person, for healthcare services provided pursuant to this agreement. This does not prohibit healthcare professional/healthcare facility from collecting co-insurance, deductibles, or copayments as specifically
provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

Providers are also bound by the appeal procedures of Presbyterian’s utilization review and quality assurance program. [42 Code of Federal Regulations (CFR) §§ 422.152, 422.202(c)].

**Presbyterian Centennial Care Contracting Requirements**

It is important to understand the difference between Centennial Care and the former Medicaid program, Salud! Providers must review all of the requirements of this program in your contract. Because this program is jointly funded by both the federal and state governments, Presbyterian Centennial Care is required to verify your compliance.

You need to comply with all the terms of your Centennial Care agreement. For example, by participating in the Presbyterian Centennial Care network, you have agreed that you or anyone with more than 5 percent ownership is not an Excluded Person, as specified in Sections 1128 and 1128A of the Social Security Act.

You also have certain rights, such as the right to the information specified in 42 Code of Federal Regulations (CFR) § 438.10(g)(1) about the Presbyterian grievance and appeals system.

**Provider Responsibilities**

It is your responsibility to cooperate with Presbyterian to monitor your activities to ensure compliance with Presbyterian and state and federal policies. Presbyterian has established mechanisms to ensure that you comply with requirements. We monitor regularly to determine compliance and take corrective action if there is a failure to comply.

Presbyterian will help by providing education about special populations and their service needs. Work with Presbyterian to ensure that you successfully identify and refer members to specialty providers as medically necessary.

If you are a primary care provider (PCP) you need to ensure coordination and continuity of care with providers, including all behavioral health and long-term care providers.

You also need to ensure that members receive prevention services appropriate for their age group.

**Selection of or Assignment to a PCP**

Presbyterian has written policies and procedures governing the process of member selection of a PCP and requests for change. You need to cooperate with Presbyterian to help us carry out our obligations, such as the following:

*Initial Enrollment*

At the time of enrollment, Presbyterian shall ensure that each member has the freedom to choose a PCP within a reasonable distance from the member’s place of residence. The process by which Presbyterian assigns members to PCPs shall include at least the following features:

- Presbyterian shall provide the means for selecting a PCP within five business days of processing the enrollment file.
Presbyterian shall contact pregnant members within five business days of processing an enrollment file that designates the member as pregnant to assist the member in selecting a PCP.

Presbyterian shall offer freedom of choice to members in making a PCP selection.

If a member does not select a PCP within 15 calendar days of enrollment, Presbyterian shall make the assignment and notify the member in writing of his or her PCP’s name, location and office telephone number, while providing the member with an opportunity to select a different PCP if the member is dissatisfied with the assignment.

Presbyterian shall assign a PCP based on factors such as member age, residence and, if known, current provider relationships.

The member and Presbyterian agree that assignment to a different PCP in the Presbyterian provider network is in the member’s best interest, based on the member’s medical condition.

A member’s PCP ceases to be a provider.

A member’s behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made reasonable efforts to accommodate the member.

A member has initiated legal actions against the PCP.

The PCP is suspended for any reason.

If you are terminating your contract, you must provide us with sufficient notice so that we can notify a member in writing about that termination within 15 calendar days. This allows the member to select a new PCP.

Provider Disclosure of Current or Previous Affiliation with Excluded Providers

If your subcontractor is excluded or is affiliated with an excluded provider and you have had business transaction with that subcontractor totaling more than $25,000 during the previous 12 months, you have certain obligations. You are required to submit, within 35 days of the date of request, information about the ownership of that subcontractor. Reimbursement for expenditures for services furnished during the period between the due date and the date the information was actually supplied will be denied.
Legal

Hold Harmless

By contracting to provide Presbyterian Centennial Care services, you have agreed to hold harmless the state and Presbyterian’s members in the event that Presbyterian cannot or shall not pay for services performed by you. This hold harmless provision shall survive the termination of your agreement with Presbyterian for authorized services rendered before it was terminated, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the members.

Delegation (if applicable)

Your agreement specifies activities, reporting responsibilities and any delegated functions, including provisions for the revocation of delegated functions and for the imposition of other sanctions for inadequate subcontractor performance. Presbyterian has policies and procedures to ensure that:

- A delegated entity meets all standards of performance mandated by the state. These include but are not limited to:
  - Use of appropriately qualified staff
  - The application of clinical practice guidelines and utilization management
  - Reporting capability
  - Ensuring members’ access to care
- There is oversight of the delegated entity’s performance of the delegated functions, including the frequency of reporting (if applicable) and the process by which Presbyterian evaluates the delegate.

- There is consistent statewide application of all utilization management criteria when utilization management is delegated.

Cooperation with Medicaid Program Integrity

You need to comply with Presbyterian’s comprehensive internal fraud, waste and abuse program, the Medicare Fraud and Elder Abuse Division (MFEAD) of the New Mexico Attorney General’s Office and other investigatory agencies in accordance with the provisions of New Mexico Statutes Annotated (NMSA) 1978, 27-11-1 et seq. You also must comply with all federal and state requirements regarding fraud, waste and abuse, including but not limited to Sections 1128, 1156 and 1902(a)(68) of the Social Security Act, Section 6402(h) of the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid (CMS) Medicaid integrity program and the Deficit Reduction Act of 2005.

You must cooperate fully in any activity performed by the Human Services Department (HSD), MFEAD, Medicaid Recovery Audit Contractor (RAC), CMS and/or Payment Error Rate Management and CMS Audit Medicaid Integrity Contractors. You must, upon request, make available to the RAC any and all administrative, financial and medical records relating to the delivery of items or services for which state monies are expended, unless otherwise provided by law. In addition, you must provide the RAC with access during normal business hours to your place of business and records.
Employee Education

If you are paid $5 million or more in aggregated Medicaid payments annually, you must establish written policies for all employees, including management, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. These written policies must include a specific discussion of the applicable laws and detailed information regarding your policies and procedures for detecting and preventing fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers. You must also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of your policies and procedures for detecting and preventing fraud, waste and abuse.

Credentialing Requirements

You must assist Presbyterian in complying with the following requirements:

- Maintaining standards, policies and procedures for credentialing and recredentialing physicians, hospitals and other healthcare professionals and facilities that provide covered services to members under the Presbyterian Centennial Care Program. The credentialing program shall be maintained in accordance with the requirements of state and federal law and the standards of accreditation organizations.
- Enroll with New Mexico Medicaid (HSD), as required.
- Upon a change in location, licensure or certification, or status, use the New Mexico Medicaid’s provider web portal and update enrollment information/status with the Centennial Care program.

Review Requirements

Presbyterian maintains fully executed originals of all subcontracts, including your agreement with Presbyterian. These will be made accessible to the HSD Medical Assistance Division (MAD) upon request.

No Debarment

Your agreement with Presbyterian warrants that neither you nor any of your employees or subcontractors were:

- Charged with a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract or subcontract
- Listed by a federal governmental agency as debarred
- Proposed for debarment or suspension or otherwise excluded from federal program participation
- Convicted of or had a civil judgment rendered against you or them regarding dishonesty or breach of trust, including but not limited to the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction
of records, making false statements, tax evasion, or receiving stolen property

- Within a three-year period preceding the date of this agreement, had one or more public transactions (federal, state, or local) terminated for cause or default.

You must immediately notify Presbyterian if any of the above referenced representations change. Any misrepresentation of or change in your status may be grounds for immediate termination of your agreement with Presbyterian.

False Claims

You must have written policies and procedures for all employees, agents or contractors that provide detailed information regarding the New Mexico False Claims Act, NMSA 1978, 27-14-1 et seq., the New Mexico Fraud Against the Taxpayers Act, NMSA 1978, 44-9-1 et seq. and the Federal False Claims Act established under 31 United States Code (USC) §§ 3729-3733, administrative remedies for false claims established under 31 USC 3801 et seq., including but not limited to preventing and detecting fraud, waste and abuse in federal healthcare programs (as defined in Social Security Act § 1128B(f)). Such policies and procedures shall articulate Presbyterian’s commitment to compliance with federal and state standards.

You must cooperate with all appropriate state and federal agencies in investigating fraud, waste and abuse. Presbyterian has methods for identifying, investigating and referring suspected fraud cases pursuant to 42 CFR §§ 455.1, 455.13, 455.14 and 455.21. Report all confirmed, credible or suspected fraud and abuse to Presbyterian or HSD and MFEAD as follows:

- Suspected fraud, waste and abuse in the administration of Presbyterian Centennial Care shall be reported to Presbyterian, HSD and MFEAD.
- All confirmed, credible or suspected provider fraud, waste and abuse shall immediately be reported to Presbyterian, HSD and MFEAD and shall include the information provided in 42 CFR § 455.17, as applicable.

All confirmed or suspected member fraud, waste and abuse shall be reported immediately

Provider Termination

Refer to your service agreement with Presbyterian for specific time frames and obligations regarding terminations.

Presbyterian has the right to suspend, deny, refuse to renew or terminate any provider agreement in accordance with the terms of the service agreement and applicable statutes and regulations. HSD has the right to direct Presbyterian to terminate or modify this agreement when HSD determines it to be in the best interest of the state. In the event of termination of the agreement, you shall immediately make available to HSD or its designated representative in a usable form any or all records, whether medical or financial, related to your activities undertaken pursuant to the agreement. The provision of such records shall be at no expense to HSD.
**Circumstances Giving Rise to a Provider Fair Hearing**

Providers may appeal a decision to deny, suspend or terminate their participation in the Presbyterian network. If the provider disputes any such action, they must submit a written request for a hearing.

A provider has the right to a fair hearing upon receipt of a written notice from Presbyterian, or its agent, pursuant to the termination, for terminating the agreement either immediately or after notice.

Presbyterian must give reasonable advance notice if the agreement is terminated for cause, unless it is for quality of care issues. The minimum advance notice is determined by federal and state regulatory guidelines unless the provider’s contract states otherwise.

**Initiation of an Appeal Hearing**

A provider may initiate a fair hearing within 30 calendar days of receiving written notice of termination from Presbyterian, by delivering or sending by certified mail a written request for a fair hearing to Presbyterian or its agent. Failure to deliver a written request by certified mail for a fair hearing within those 30 days constitutes a waiver by the provider of any hearing regarding their termination. If a request for a hearing is not filed by that time, the provider contract ends.

**Other Important Provisions**

The following terms and conditions are deemed to be incorporated into your agreement with Presbyterian Centennial Care:

- The agreement has been and shall be considered to be executed in accordance with all applicable federal and state laws, regulations, policies, procedures and rules.
- The agreement identifies the parties of the contract and their legal basis of operation in the state of New Mexico.
- The agreement includes procedures and specific criteria for terminating the subcontract.
- The agreement identifies the services, activities and reporting responsibilities to be performed by you and those services performed under any other agreement.
- The agreement includes provisions describing how services provided under the terms of the agreement are accessed by members.
- The agreement includes the reimbursement rates and risk assumption, if applicable; you shall maintain all records relating to services provided to members for a 10-year period and shall make all enrollee medical records or other service records available for the purpose of quality review conducted by the state, or their designated agents, both during and after the contract period.
- All member information will be kept confidential, as defined by federal and state law.
- Authorized representatives of the state will have reasonable access to facilities and records for financial and medical audit purposes both during and after the contract period.
• You shall release to Presbyterian any information necessary for Presbyterian to perform any of its obligations and acknowledge that Presbyterian shall be monitoring your performance on an ongoing basis and conducting formal periodic reviews.

• You shall accept payment from Presbyterian as payment for all services included in the benefit package and you cannot request payment from the state for services performed under your agreement with Presbyterian.

• If your agreement with Presbyterian includes the provision of primary care, then the provisions for compliance with PCP requirements delineated in the Presbyterian Centennial Care Agreement shall also apply to you.

• You are required to comply with all applicable state and federal statutes, rules and regulations.

• Presbyterian may institute corrective action plans if indicated, sanctions and/or termination for any violation of applicable HSD/MAD, state, or federal statutes, rules or regulations.

• The agreement with Presbyterian does not prohibit you or your subcontractors or anyone (with the exception of third-party administrators) from entering into a contractual relationship with another managed care organization.

• The agreement with Presbyterian does not include any incentive or disincentive that encourages you or any other subcontractor not to enter into a contractual relationship with another contractor.

• The agreement with Presbyterian does not contain any gag order provisions that prohibit or otherwise restrict covered health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act or in contravention of NMSA 1978 §§ 59A-57-1 to 59A-57-11, the Patient Protection Act.

• For pharmacy providers, payments are being made consistent with 1978 NMSA § 27-2-16B, unless there is a change in law or regulation.

• You shall submit electronic claims, unless you were granted a hardship extension; the agreement with Presbyterian includes the HSD/MAD contractual provisions related to the State of New Mexico Executive Order 2007-049 concerning subcontractor health coverage requirements, as further defined in Article 37.

• You will comply with the State of New Mexico’s Statewide Immunization Information System initiative.

• You have not been restricted from participating in a federal entitlement program (i.e., Medicare or Medicaid).

**Exclusion from Federal Health Care Programs**

By contracting to provide Presbyterian Centennial Care services, you warrant that you, your employees, agents or independent contractors have, to the best of your knowledge, been excluded from participation in any federally funded...
healthcare programs, including but not limited to Medicare and Medicaid. You shall immediately notify Presbyterian if you or any of your servicing employees or subcontractors are threatened with exclusion or excluded from any such program. In the event that you or your subcontractor is excluded from participation in any such program, Presbyterian may terminate the agreement as of the effective date of the exclusion. You shall immediately remove the excluded employee or subcontractor from providing any services in connection with the agreement and shall notify Presbyterian’s compliance officer in writing. In this notification you must state the information known regarding the basis for the exclusion and the steps taken to remove the excluded persons from providing any services. If you cannot remove the excluded employee or subcontractor, Presbyterian shall have the option to terminate your agreement as of the effective date of such exclusion [42 CFR § 422.752(a)(8)].

**Provider Communications**

You shall report to Presbyterian’s compliance officer through telephone and follow-up by email with any suspected or potential fraud or other misconduct by you, your agent, your subcontractor or any other person or entity of which you become aware.

- Compliance Hotline: 1-888-435-4361

You shall also have an internal reporting process to report suspected or potential fraud to your compliance officer.

You shall report to Presbyterian any potential fraud or other misconduct by you or a subcontractor. This report shall be made as soon as you become aware of the potential fraud or other misconduct.

**Background Checks**

You will perform criminal background checks for all required individuals providing services, as specified in 7.1.9 New Mexico Administrative Code, Caregivers Criminal History Screening Requirements.

**Conflict of Interest Certification**

You and your subcontractor’s officers, directors and managers shall annually sign a statement that (1) the individual has reviewed Presbyterian’s and your conflict of interest policies; (2) the individual has disclosed any potential conflicts of interest; and (3) the individual has obtained management approval to work despite any conflicts or has eliminated the conflict. Chapter 9, Section 50.2.1.2).

**Indemnity**

You shall hold Presbyterian harmless of any loss, damage or costs (including reasonable attorneys’ fees) incurred in connection with claims resulting from your or your subcontractor’s acts or omissions.

**Section 1557 of the Affordable Care Act**

Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs and activities that receive Federal financial assistance from HHS. Provider shall be in compliance with ACA Section
1557 and its implementing regulations, which require covered entities to take reasonable steps to provide meaningful access to individuals with limited English proficiency (LEP), provide auxiliary aids and services to individuals with disabilities free of charge and provide equal access to healthcare without discrimination based on sex, including pregnancy, gender identity or sex stereotypes. (45 C.F.R. 92; 81 FR 31375).
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As a health plan, Presbyterian is required to cooperate with regulatory and law enforcement agencies in reporting any activity that appears to be suspicious in nature. According to the law, any information that we have concerning such matters must be turned over to the appropriate governmental agencies.

By identifying areas of concern relative to fraud, waste and abuse and working with physicians and other healthcare providers to make improvements, Presbyterian is able to dedicate more resources to our goal of improving the health of patients, members and communities.

This chapter of the provider manual is intended to educate providers on fraud, waste and abuse and to comply with the Centers for Medicare & Medicaid Services (CMS) mandatory requirement that providers receive the training.

**Regulatory Definitions**

**Fraud** is defined as intentional deception or misrepresentation made by an entity or person, including but not limited to a subcontractor, vendor, provider, member or other customer with the knowledge that the deception could result in some unauthorized benefit to a person or an entity. Fraud includes any attempt to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the custody or control of, any healthcare benefit program. It includes any act that constitutes fraud under applicable state and federal law. For example, fraud may exist when a provider bills for services not rendered and the service cannot be substantiated by documentation.

**Waste** is defined as an act involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent, but where the outcome of poor or inefficient methods resulted in unnecessary costs to the plan.

**Abuse** is defined as incidents or practices that are inconsistent with accepted, sound business, fiscal or medical administrative practices. Abuse may directly or indirectly result in unnecessary costs to the health plan, improper payment or payment for services that fail to meet professional standards of care or are medically unnecessary. Abuse consists of payment for items or services when there is no legal entitlement and the recipient has knowingly misrepresented the facts to receive the benefit or payment. Abuse often takes the form of claims for services not medically necessary or not medically necessary to the extent provided. Abuse also includes practices by subcontractors, providers, members or customers that result in unnecessary costs to the health plan. For example, abuse may exist when the provider fails to appropriately bill new and established patient office codes. The provider bills a “new” patient code both on the initial visit and subsequent visits.
Fraud, Waste and Abuse

Fraud, Waste and Abuse Examples

- Billing for services or procedures that have not been performed or have been performed by other
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act.
- Routinely waiving patient deductibles or copayments
- Providing or ordering medically unnecessary services and tests based on financial gain
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient)
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., a social worker billing two individual psychotherapy sessions on the same day for the same patient)
- Providing services over the telephone or Internet and billing using face-to-face codes
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Treating all patients weekly regardless of medically necessity
- Routinely maxing out of members’ benefits or authorizations regardless of whether or not the services are medically necessary
- Inserting a diagnosis code not obtained from a provider or other authorized individual
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a provider and the hospital such as a provider receiving kickbacks for referrals)
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs
- Lying about credentials, such as degree and licensure
Fraud, Waste and Abuse

How to Report Fraud, Waste, and Abuse

While true fraud involves only a small percentage of individuals, the costs associated with it are high. We realize that the majority of providers conduct their practices in accordance with proper business standards. Presbyterian’s Program Integrity Department (PID) is responsible for the detection and investigation of any suspected fraudulent activities or abuse involving any members, subcontractors, providers, brokers, agents or employer group representatives.

The PID takes a proactive approach to identify fraud and abuse by using the claims data analytic software for research to detect fraudulent activities and trends. The PID may contact the provider to assist with the investigation of any type of suspicious activity. A review of medical records for claims validation may be conducted at the provider’s office or facility.

Medical Record Documentation

Presbyterian follows policies and procedures that govern the standardization and maintenance of medical records by its contracted providers. Medical records should be complete and legible and should include the reason for the encounter and relevant history, findings and test results. There should be an assessment and impression or diagnosis. There should be a plan of care and the date and legible identity of the provider. The records should not only substantiate the service performed, but also the level of care required. The member’s progress, response to and changes in treatment and revisions of diagnosis/diagnoses should be included in the documentation.

Presbyterian may review any information, including medical records, pertaining to a claim.

The elements of a complete medical record that Presbyterian expects providers to maintain include the following:

- Date of service
- Type of service (e.g., 99212, 99213, etc.)
- Medications/interventions
- Modalities and frequencies of treatment furnished with start and stop times when performed with or without an evaluation and management service
- Clinical test results and summaries of any of the following:
  - Diagnosis
  - Functional status
  - Treatment plan
  - Treatment logs
  - Symptoms
  - Prognosis
  - Progress to date
- Name and credentials of the provider who rendered the service along with the rendering provider’s signature
- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
Documenting Timed CPT® Codes

Healthcare professionals provide a number of services that are strictly time-dependent. For accurate coding, the provider's documentation must reflect the actual face-to-face time spent with the patient. This chapter provides guidance for documenting timed Current Procedure Terminology (CPT®) codes for the following services:

- Physical therapy
- Occupational therapy
- Chiropractic services
- Acupuncture

These must have proper documentation for the time or duration of each service performed, as well as the time of the general session. Documentation of the total therapy time, including untimed codes, is required in accordance with CMS guidelines, the American Medical Association (AMA) CPT® Manual and Presbyterian's provider manual. Counseling services and behavioral health services must also provide documentation for the face-to-face time spent with the patient.

The CMS Medicare Benefit Policy Manual provides guidelines for physical therapy, occupational therapy, acupuncture services and chiropractic services. See the CMS Medicare Claims Processing Manual, Chapter 5, Section 20.3.

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intra-service care” begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time. See the American Medical Association CPT® Manual, Physical Medicine and Rehabilitation, Therapeutic Procedures: Physician or therapist [is] required to have direct [one-to-one] patient contact.

These services are generally timed. Below is an example of a CPT® code with its guidelines: 97110 Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
Documentation of Surgical Procedures:

The operative report must contain complete documentation of the procedure performed. The operative report should include the following:

1. Date and time of the procedure
2. Pre- and postoperative diagnoses
3. A list of all procedures performed
4. Type of anesthesia used
5. All surgeons who participated in the case and the role of each. This includes resident physicians, co-surgeons and assistant surgeons and/or NP’s or PA’s who assisted in the case.
6. Indications for the procedure
7. A summary of findings, including the size of tumors or lesions, complications, extra work involved in the procedure and other key information.
8. Detailed description of the procedure, including the patient’s position, the approach or approaches used and the specific organ, structure or area being treated and a detailed description of the work performed. It is not appropriate to say “arthrodesis was performed.” The work involved to complete the arthrodesis must be documented in detail. Documentation should include information about vessels or ligaments or other supporting structures that were cut or sutured, removal of organs or other structures or loose or foreign bodies, areas that were debrided, grafts or transplants, including description of material grafted or transplanted, etc.
9. Signatures of everyone who documented any part of the operative note. It should be possible to identify who documented each element of the note and, if any changes or amendments were made, who made them and when.

Providers billing Presbyterian for services must:

- Document in appropriate office and/or hospital records each time a service is provided.
- Identify the provider’s specialty if more than one provider provides services.
- Write medical information legibly and either sign each entry with a legible signature, or ensure that the identity of the provider/author/observer is present and legible. Signature stamps are allowed but should be used with caution and must be in the control of the provider at all times. The medical information should be clear, concise and reflect the patient’s condition (See instructions for signatures below).
- Sign progress notes for hospital and custodial care facility patients. All entries should be dated and signed by the provider who actually examined the patient.
- Provide sufficient detail to support diagnostic tests that were furnished and the provider’s level of care billed.
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- Provide rationale for separate procedures or services provided for purposes other than treating the chief complaint.
- Not use statements such as "same as above" or ditto marks. These are not acceptable documentation that the service was provided for that date.

Instructions for Signatures:

- Definition of a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- Definition of a signature log: Providers may include in the documentation they submit a signature log that identifies the author associated with initials or an illegible signature. The log must be part of the patient's medical record.
- Definition of an attestation statement: An attestation statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.

The burden of proof is placed on the provider to substantiate services and/or supplies billed to Presbyterian. During the audit process, if documentation is needed, the provider or supplier must send the beneficiary's medical record by the deadlines given in the written request.

Under your existing contract, Presbyterian reserves the right to audit our members' records for purposes that may include but are not limited to:

1. Accuracy of claims
2. Coverage of services
3. Appropriateness of services
4. Appropriateness of billing

Incomplete or illegible records may result in denial of payment for services billed to Presbyterian. Claim payment decisions that result from a medical review of a provider's records are not a reflection on the provider's competence as a health care professional or the quality of care provided to patients. Specifically, the results are based on review of the documentation that Presbyterian received. For a claim to be valid, there must be sufficient documentation in the provider's or hospital's records to verify the services were performed, were "reasonable and necessary," and required the level of care that was delivered.

When records are requested, it is important to send all documents that support the billed services within the time frame designated in the written request. Documentation substantiating the medical necessity for treatment must be in the medical record. Documentation of all services rendered is absolutely necessary for a claim to be properly evaluated. If there is no documentation, then there is no justification for the services or level of care billed. In addition, if there is insufficient or illegible documentation submitted to support claims that have already been adjudicated by Presbyterian,
reimbursement may be considered an overpayment and the funds may be partially or fully recovered. Presbyterian routinely conducts claims validation audits. To ensure accurate payment, please ensure that complete and accurate supporting documentation exists in the patient’s medical record that includes the following required elements:

- **Date of treatment**
- **Identification of each specific intervention/modality provided and billed for, both timed and untimed codes in language that can be compared with the billing on the claim to verify correct coding.** Providers should record each service provided that is represented by a timed code regardless of whether or not it is billed, because the unbilled timed services may impact the billing.
- **Total timed code treatment minutes and total treatment time in minutes**
- **Total treatment time including the minutes for timed code treatment and untimed code treatment.** Total treatment time does not include time for services that are not billable (e.g., rest periods). The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, Section 20.2 for a description of billing timed codes.
- **Signature and professional identification of the qualified professionals who furnished or supervised the services and a list of each person who contributed to that treatment (e.g., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT supervisor, when permitted by state and local law).**

These determine compliance with appropriate billing practices and ensure appropriate charting that must support medical necessity and covered services of specific codes billed. In addition, these audits may identify other problematic concerns where greater understanding and compliance can be achieved through education. All audits are performed in accordance with the members’ contracts and the provider existing Presbyterian provider contract.

Throughout the auditing process a number of tools are used to ensure accuracy and consistency. The tools may include but are not limited to:

- **CPT®, AMA**
- **International Classification of Diseases (ICD-9-CM and ICD-10-CM Manuals)**
- **CPT® Handbook for Psychiatrists**
- **Healthcare Common Procedure Coding System (HCPCS) Level II code book**
- **Benefit and contract language**
- **Presbyterian Health Plan Provider Manual**
- **Presbyterian Health Plan Reimbursement Guidelines**
- **Medical director review**
- **Documentation from patient charts obtained during the audit**
- **Interactions with law enforcement**
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• Claims validation audits may be conducted either onsite at the provider office or by desk audit and may be announced or unannounced.

For desk audits, the provider office is contacted in writing with a request to submit the specified medical record information to PID. The office representative is asked to sign a form that the records submitted are complete.

When an onsite audit is conducted and completed, the auditors briefly meet with the provider or a representative to discuss the general findings and impressions of the audit. The provider or representative is asked to sign a form that all of the documentation was in the patient records at the time of the audit and that the auditors returned the file to the provider in the same condition that it was provided to the auditor.

All documentation required to justify the billings must be present in each file at the time of the audit. The time period selected for medical record review may vary. Additions to the documentation or the production of missing chart notes or files at a later date cannot be accepted.

Upon completion of the data-gathering portion of the audit, all of the information obtained is organized and reviewed. Inquiries as to the results of the completed audit cannot be answered until all of the preliminary findings have been thoroughly reviewed by the Presbyterian Health Plan medical director and compiled into a finalized Audit Findings Report. The report is sent to the provider through certified return receipt delivery.

The report details the claim information such as member name, date of service, CPT® code, amount paid, amount billed and amount to be recovered, if any.

During the course of an investigation, many cases are found to be unintentional errors in which the provider was unaware of the appropriate billing criteria. In these instances, Presbyterian’s Provider Network Operations (PNO) Department is available to assist the provider in rectifying the error and facilitate education to prevent such errors in the future. To contact PNO, go to www.phs.org/ContactGuide.

Dispute Resolution and Requests for Reconsideration

The Program Integrity Department provides a process by which a provider, member, and/or other affected entity may request a reconsideration of any Program Integrity established finding. This process is limited to reconsideration requests relative to Program Integrity established findings, any other requests for reconsideration of decisions will be addressed through one of the following processes:

• For denials of other claim lines not related to Program Integrity findings will be addressed and handled within Appeals/Grievance Department policies and procedures; or

• For provider terminations, addressed and handled within the Credentialing Department policies and procedures.
If an affected provider/member/entity communicates disagreement with Program Integrity established findings, or decides to provide additional documentation related to the claims in dispute, the department will temporarily cease recoupment activities. The requester will be asked to provide their reconsideration request and any additional information in writing, sent in for review and provide to the case investigator within 30 days of the communicated education and/or retrospective review findings correspondence.

The requester is asked to explain in writing which established finding(s) reconsideration is being requested on, their perspective or response to the audit finding(s), and to provide any additional information to support their perspective or response. Requesting reconsideration of the whole audit is not adequate and will not be considered without a specific finding(s) reconsideration request and perspective or response.

**Documentation Guidelines for Amended Medical Documents**

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record bears the current date of that entry and is signed by the person making the addition or change.

A **late entry** supplies additional information that was omitted from the original entry. The late entry should bear the current date, added as soon as possible and written only if the person documenting has total recall of the omitted information.

**Example:** A **late entry** following treatment of multiple traumatic injuries might add: "The left foot was noted to be abraded laterally."

An **addendum** is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record.

**Example:** An **addendum** could note: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette."

When making a **correction** to the medical record, never write over or otherwise obliterate the passage being corrected. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin.

Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change and the identity of the person making that entry.
**Fraud, Waste and Abuse**

**Falsified Documentation**

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records could include:

- Creation of new records when records are requested
- Backdating entries
- Postdating entries
- Predating entries
- Writing over
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Presbyterian.

**Medical Identity Theft and Identity Misrepresentation Prevention**

Medical identity theft occurs when someone uses a person’s name and sometimes other parts of their identity such as insurance information without the person’s knowledge or consent to obtain medical services or goods or uses the person’s identity information to make false claims for medical services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records and can involve the creation of fictitious medical records in the victim’s name.

Identity misrepresentation is the intentional use of another’s insurance card or the intentional “loaning” of an insurance card to an individual other than the enrolled member in order to access services.

According to the National Health Care Anti-Fraud Association, approximately 250,000 to 500,000 individuals have been victims of medical identity theft in the United States. A victim of financial identity theft may also be a victim of medical identity theft.

Medical identity theft occurs when an individual uses either:

- Another person’s name, which may include the victim’s insurance information or Social Security number, without the victim’s knowledge or consent to obtain medical services or goods
- The victim’s identity to obtain money by falsifying claims for medical services and falsifying medical records to support those claims

Medical identity theft is one of the most damaging and potentially dangerous forms of identity theft and is a crime that causes harm to the victim resulting in:

- Receiving the wrong medical treatment
- Finding his or her health insurance benefits have been exhausted and potentially
becoming uninsurable for both life and health insurance coverage.

• Unexpectedly failing a physical exam for employment because a disease or condition for which the victim has never been diagnosed or received treatment that was unknowingly documented in his or her health record.

• The creation of a fictitious medical record using the victim’s name or erroneous entries in the victim’s existing medical records.

• Leaving a trail of falsified information in medical records that can plague victims’ medical and financial lives for years.

The outcomes related to medical identity theft include any of the following:

• Filing false health insurance claims, and medical and pharmaceutical bills.

• Denials of health insurance claims or coverage and life insurance claims or coverage.

• Denied employment due to a false medical history.

• Unnecessary loss of time and expense spent correcting false patient records and insurance records.

In addition, member-initiated identity theft is also increasing. In this theft type, the health plan member “lends” his or her health plan identification card to a friend or relative who does not have insurance to obtain unauthorized medical care that is ultimately billed to the health plan under the member’s name.

As a provider, you may help mitigate potential identity theft by:

• Verifying that the patient scheduled for the encounter is the correct person with the correct insurance information by asking for a photo identification card or driver’s license, in addition to the health insurance identification card.

• Verifying that the patient’s name, address, telephone and date of birth match the identification provided.

• Making copies to retain in the patient’s file including but not limited to health plan insurance ID cards, Medicaid cards and driver’s licenses.

• Asking the parent or adult accompanying a minor child to the appointment to provide his or her photo identification and making copies and retaining all the adult’s forms of identification provided in the minor child’s medical record.

Federal Register and the Code of Federal Regulations

Published by the office of the Federal Register, National Archives and Records Administration, the Federal Register (FR) is the official daily publication for rules, proposed rules and notices of federal agencies and organizations, as well as executive orders and other presidential documents. It is updated daily by 6 a.m. and is published Monday through Friday, excluding federal holidays.
The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the FR by the executive departments and agencies of the federal government. It is divided into 50 titles that represent broad areas subject to federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis.

Government Initiatives

The federal agencies responsible for oversight are the Department of Health and Human Services Office of Inspector General (DHHS OIG), Department of Justice and the CMS. Because of the identified risks, CMS is responding with intense oversight and increased funding for the DHHS OIG. Included in this oversight are additional fraud and abuse laws, audits and investigations, including more than 140 Assistant U.S. Attorneys trained on healthcare fraud.

It is important for a provider to review and monitor activities to determine that its practice is free from potential fraud, waste and abuse. If left unchecked, often waste and abuse can become fraud.

Federal and State False Claims Acts

Federal False Claims Act

The Federal False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud.

Under the Federal False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are:

- Liable for three times the damages suffered by the government
- Civil penalties of $5,500 to $11,000 per false claim
- Trial costs
- Exclusion from Medicare and Medicaid
- Potential for criminal prosecution

For example, a false $100 claim submitted for payment with government funds would result in the following penalties:

- One false claim = $11,000 penalty
- Treble damages = three × $100 or $300
- This now equals $11,300 in fines for the $100 claim. Add to that any trial costs and the potential to be excluded from participating in any government health plan.

New Mexico False Claims Act (Dual Eligible)

Effective May 2004, the act provides for

- Civil action against the filing of false claims under the New Mexico Medicaid program.
- Penalties for three times the amount of damages the state sustains as a result of the act.
- Protection rights to an employee who discloses information to the New Mexico Human Services Department (HSD).

The NM Medicaid False Claims Act (NMMFCA) signed into law in 2004 is applicable to Medicare beneficiaries who are also covered under the state’s Medicaid program (dual eligible). The
The purpose of NMMFCA is to deter persons from causing or assisting to cause the state to pay Medicaid claims that are false. It provides remedies for obtaining treble damages and civil recoveries for the state.

The NMMFCA increases the state’s ability to bring a lawsuit for Medicaid fraud and recoup funds. New Mexico’s Attorney General prosecutes Medicaid fraud.

The NMMFCA contains a whistleblower provision that provides incentives for people who come forward with knowledge and evidence of false claims submitted to Medicaid. Whistleblowers may receive up to 25 percent of the amount recovered. Employee whistleblowers are entitled to all relief necessary, including reinstatement, double the amount of back pay and compensation for any special damages sustained.

New Mexico Fraud Against Taxpayers Act

The New Mexico Fraud Against Taxpayers Act was passed by the New Mexico legislature effective July 1, 2007. It provides for private civil action on behalf of the state against a person who makes a false claim for payment and provides for civil action by a state agency and state intervention. It also provides for qui tam (whistleblower awards) and prohibits retaliation by employers.

Whistleblower Acts

In whistleblower lawsuits (qui tam)

- An employee or private citizen sues on behalf of the government.
- The plaintiff receives as much as 30% of the total award and the remainder goes to the government.

How Whistleblowers are Protected

- Employers may not retaliate against employees who report or help investigate false claims.
- No negative employment consequences are allowed such firing, demoting, suspending or harassing.
- Remedies against retaliation include job reinstatement with double back pay and other special damages.

Historically, most whistleblowers actually reported their concerns to someone in their workplace before they went to the government with the issue. Employees and private citizens can file suit on behalf of the government. It is important for a provider to be open and listen to complaints when one of your staff or patients raises a concern. If you do not take appropriate action, they will and they can receive as much as 30 percent of the total award if the government’s prosecution is successful.

New Mexico Whistleblower Protection Act

Under the New Mexico Whistleblower Protection Act, a private party brings civil action on behalf of the government and allows the government to take over litigation. If the government wins the case and damages are awarded, the private party and the government share in the recovery of damages.
Effective March 1, 2010, a public employer (any department, agency, office, institution, board commission committee, branch or district of state government) is prohibited from taking retaliatory action against a public employee who:

- Communicates to the public employer or a third party information about an action or a failure to act he or she believes in good faith constitutes an unlawful or improper act.
- Provides information or testifies before a public body as part of an investigation, hearing or inquiry into an unlawful or improper act.
- Objects or refuses to participate in an activity, policy or practice that constitutes an unlawful or improper act.

The act provides for *qui tam* (whistleblower) awards when a public employer violates the provisions of the act. The public employer is liable to the public employee for:

- Actual damages
- Reinstatement with the same seniority status that the employee would have had but for the violation
- Two times the amount of back pay with interest
- Compensation for any special damage sustained as a result of the violation
- The employer is required to pay the litigation costs and reasonable attorney fees of the employee
- The employee may bring an action pursuant to this section in any court of competent jurisdiction

**Deficit Reduction Act of 2005**

For information on the Deficit Reduction Act of 2005, see Chapter 3 “Eliminating Fraud, Waste and Abuse in Medicaid,” Section 6032, “Employee Education about False Claims Recovery.”

Effective Jan. 1, 2007, the Deficit Reduction Act amends the Social Security Act to include requiring any entity that receives or makes annual payment of at least $5,000,000 under the state Medicaid plan to:

- Educate employees, contractors and agents regarding the prevention of Medicaid fraud.
- Provide information in policies and procedures and the employee handbooks regarding:
  - The Federal False Claims Act
  - Federal administrative remedies for false claims and statements
  - State laws pertaining to civil or criminal penalties for false claims and statements
  - Detecting and preventing fraud, waste and abuse
  - Rights of employees to be protected as whistleblowers

**Anti-kickback Laws**

The anti-kickback laws prohibit anyone from knowingly and deliberately offering, giving or receiving remuneration in exchange for referrals of
healthcare goods or services that are paid for in whole or in part by Medicare or Medicaid.

Penalties include the following:

- **Criminal:** jail time, $25,000 fine, mandatory exclusion from participation in most federal healthcare programs including Medicare and Medicaid
- **Civil:** penalties and fines, permissive exclusion

**Anti-kickback Safe Harbors**

Congress added to the law provisions that designate certain provider activities as “safe harbors,” which are specified as not constituting violations of the statute.

Safe harbors allow certain activities to take place that may appear on the surface to be violations of the law, but those activities are very restricted and must take place only when all of the safe harbor conditions are met. There are many complicated safe harbor exceptions, such as:

- Personal services contracts
- Payment based on fair market value of services, not value of referral
- Sale of practice
- Proper discounts and rebates

Examples of these exceptions include the following:

- Drug “switching” programs—if structured incorrectly
- Drug rebate programs—if structured incorrectly

Pharmacy paid to “steer” patients to specific Part D plan

**Self-Referral Laws**

The provider self-referral law, commonly referred to as the “Stark Law,” prohibits a provider from referring patients for certain designated health services (DHS) to an entity in which the provider (or an immediate family member of that provider) has an ownership interest or with which the provider (or an immediate family member of that provider) has any compensation or other relationship that involves remuneration or other benefit unless certain prescriptive requirements are met.

The following items or services are DHS:

1. Clinical laboratory services
2. Physical therapy services
3. Occupational therapy services
4. Outpatient speech-language pathology services
5. Radiology and certain other imaging services
6. Radiation therapy services and supplies
7. Durable medical equipment and supplies
8. Prosthetics, orthotics and prosthetic devices and supplies
9. Parental and enteral nutrients and equipment and supplies
10. Home health services
11. Outpatient prescription drugs
12. Inpatient and outpatient hospital services
The Medicare self-referral disclosure protocol (SRDP) pursuant to Section 6409 (a) of the Patient Protection and Affordable Care Act (ACA) sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the provider self-referral statute. See the CMS FAQs for Voluntary Self-Referral Protocol at:


If those requirements are not met, the entity may not bill for any designated health service furnished pursuant to the prohibited referral. Examples of designated health services are:

- Inpatient and outpatient hospital services
- Outpatient prescription drugs
- Home health services
- Durable medical equipment and supplies.
- Clinical laboratory services

The assumption underlying the statute is that allowing such referrals would lead to unnecessary tests and increase costs. The statute is violated regardless of whether the physician or the entity providing the designated health service has any intent to violate or even knows that the referral is prohibited. Penalties include the following:

- $15,000 fine per claim and possible exclusion
- Potential anti-kickback liability (if intentional violation)

**Beneficiary Inducement Civil Monetary Penalty Law**

The beneficiary inducement law prohibits providers from incentivizing a beneficiary who is enrolled in a government healthcare program to see a particular provider because it could encourage the overutilization of healthcare supplies and services. Violations of this law can result in substantial penalties. Penalties include the following:

- Fines up to $10,000 per violation plus treble damages

Potential exclusion from participation in government programs

**Program Exclusion Lists**

The Federal Exclusion Law allows the DHHS OIG to exclude individuals and organizations from participating in Medicare, Medicaid and other government programs. Reasons for exclusion include violating fraud and abuse laws, licensing board actions (e.g., suspended license), defaulting on federal student loans and controlled substances violations, as well as other crimes.

Providers and subcontractors who participate in Medicare and Medicaid programs are required to verify that their employees are not on the federal exclusion lists (meaning the individual is prohibited from participating in Medicare and Medicaid funded services).

Physicians, non-physician practitioners and employees must not be identified on the DHHS OIG or General Services Administration (GSA) lists. Providers may log on to the following OIG/GSA websites listed to verify the eligibility of individuals.
Department of Health and Human Services/Office of Inspector General (DHHS/OIG), List of Excluded Individuals and Entities
https://oig.hhs.gov/exclusions/exclusions_list.asp

General Services Administration’s System for Award Management (GSA SAM)
https://www.sam.gov/portal/public/SAM/

Insurance companies (sponsors) do not pay for drugs prescribed or other services provided by a provider who is excluded by either the DHHS OIG or GSA. In addition, excluded providers may not contract with or perform services related to any government contract including the Federal Employee Benefit Program and Medicare or Medicaid.

According to the OIG, pharmacies cannot bill for “services performed by, prescribed by, processed by or involved in any way in filling prescriptions” by individuals who are excluded from federal and state programs to Medicare beneficiaries.

The prohibition, “also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to federal and state program beneficiaries."

You may not employ any individual who is listed as being excluded or debarred, so it is important to check the listings before hiring.

Not only will you not receive payment for services furnished by an excluded person but you will also face a fine of $10,000 for each item or service plus three times the amount of actual damages. This is another very good reason to check the listings on a regular basis.

Presbyterian requires that all providers review all of their employees and contractors or vendors against the GSA and OIG lists at least twice each year. Providers should retain written or hard copy proof that this activity has been completed and is accessible during an audit. In addition, providers should create a policy and procedure identifying the timeline for completion, the format and the handling of employees identified as excluded.

Fraud, Waste, and Abuse Prevention

The OIG has a recommended compliance plan for individual providers and small groups that can be found at their website at http://oig.hhs.gov. While this program is a voluntary program, we highly recommend providers adopt their own compliance program, which should include the following six elements identified by OIG:

- Implement written policies and procedures
- Conduct effective training and education
- Develop effective lines of communication
- Conduct internal monitoring and auditing
- Enforce standards through well-publicized disciplinary guidelines
- Implement corrective action

Additional assistance in the prevention of fraud, waste and abuse can be found at the following CMS website:
This website contains podcasts, continuing education and toolkits for both specialized practices and general topics. Regardless of which you choose, these tools will help your organization know what to look for regarding fraud, waste and abuse.

**Recoveries of Centennial Care Overpayments and Fraud**

**Identification Process for Overpayments**

Providers are required to report overpayments to Presbyterian Centennial Care by the later of:

- The date that is 60 calendar days after the date on which the overpayment was identified.
- The date any corresponding cost report is due, if applicable.
- A provider has identified an overpayment if the provider has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference of the overpayment. An overpayment shall be deemed to have been “identified” by a provider when the provider:
  - Reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursement.
  - Learns that a patient death occurred before the service date on which a claim that has been submitted for payment.
  - Learns that services were provided by an unlicensed or excluded individual on its behalf.
  - Performs an internal audit and discovers that an overpayment exists.
  - Is informed by a government agency of an audit that discovered a potential overpayment.
  - Is informed by Presbyterian Centennial Care, HSD or the Medicaid recovery audit contractor of an audit that discovered a potential overpayment.
  - Experiences a significant increase in Medicaid revenue and there is no apparent reason, such as a new partner added to a group practice or new focus on a particular area of medicine, for the increase.
  - Was notified that the contractor or a government agency has received a hotline call or email.
  - Was notified that Presbyterian Centennial Care or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the provider submitted a claim for payment.

**Self-Reporting**

Providers are required to report overpayments to Presbyterian Centennial Care by the later of:
Fraud, Waste and Abuse

- The date that is 60 calendar days after the date on which the overpayment was identified; or
- The date any corresponding cost report is due, if applicable.

The provider is required to send an overpayment report to Presbyterian Centennial Care and HSD which must include at a minimum the following information:

- Provider’s name
- Provider’s tax identification number and national provider number
- How the overpayment was discovered
- The reason for the overpayment
- The health insurance claim number, as appropriate
- Date(s) of service
- Medicaid claim control number, as appropriate
- Description of a corrective action plan to ensure the overpayment does not occur again
- Whether the provider has a corporate integrity agreement with the United States Health and Human Services Department Office of Inspector General (OIG) or is under the OIG self-disclosure protocol
- The specific dates (or time-span) within which the problem existed that caused the overpayments
- If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment
- The refund amount

Refunds

All self-reported refunds for overpayments shall be made by the provider to Presbyterian Centennial Care as an intermediary and are property of Presbyterian Centennial Care unless:

- HSD, the recovery audit contractor, or Medicaid Fraud and Elder Abuse Division (MFEAD) independently notified the provider that an overpayment existed.
- Presbyterian Centennial Care fails to initiate recovery within twelve months from the date the contractor first paid the claim.
- Presbyterian Centennial Care fails to complete the recovery within 15 months from the date Presbyterian Centennial Care first paid the claim.
- The provider may request that Presbyterian Centennial Care permit installment payments of the refund. Such request shall be agreed to by Presbyterian Centennial Care and the provider.
- In cases where HSD, the RAC or MFEAD identifies the overpayment, HSD shall seek recovery of the overpayment in accordance with NMAC §8.351.2.13.

Failure to Self-report and/or Refund Overpayments

Overpayments that have been identified by a provider and not self-reported within the 60 calendar day time frame are presumed to be false claims and are subject to referrals as credible allegations of fraud.
Fraud, Waste and Abuse

Fraud, Waste and Abuse Reporting

You can assist Presbyterian prevent fraud, waste and abuse by reporting any suspicious activity that appears to be potential fraud, waste and abuse. Report all confirmed, credible or suspected fraud, waste and abuse immediately in accordance with the following:

- For suspected fraud, waste and abuse in the administration of Centennial Care, report to Presbyterian, HSD and Medicare Fraud and Elder Abuse Division (MFEAD)
- For all confirmed, credible or suspected provider fraud, waste and abuse, report to Presbyterian, HSD and MFEAD and include the information provided in 42 CFR Section 455.17, as applicable
- For all confirmed, credible or suspected member fraud, waste and abuse, report to Presbyterian
- Please contact us to report suspicious activity using the contact numbers below.
- The PID confidential hotline phone numbers are:
  - (505) 923-5959 (local)
  - 1-800-239-3147 (toll-free)
  - Email address: PHPFrau@phs.org
- You can also mail your concerns to the address below:
  Presbyterian Health Plan
  Program Integrity Department (PID)
  P.O. Box 27489
  Albuquerque, NM 87125-7489
- Or, you may file a suspected fraud and abuse report online at: https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx

Contact information for reporting abuse, neglect and exploitation of members:
- Adult Protective Services: 1-866-654-3219
- Children, Youth and Families Department: 1-855-333-7233 or #SAFE
- Department of Health/Division of Health Improvement (DOH/DHI): 1-800-445-6242
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Presbyterian credentials both individual practitioners and organizational providers. The credentialing process focuses on verifying adequate training, experience, licensure and competence by accessing data and information collected to determine if a provider is qualified to render quality care to our members. For the credentialing and recredentialing process for behavioral health providers, please reference the “Behavioral Health” chapter of this manual.

**Program Scope**

The Presbyterian credentialing program applies to healthcare providers that are contracted with Presbyterian to provide services to its members. The following contractual relationships require providers to be credentialed before rendering services to Presbyterian members:

- Providers who have an independent relationship with Presbyterian. An independent relationship exists when Presbyterian selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as primary care providers. This is not the same as an independent contract.

- Practitioners who see members in an outpatient setting.

- Practitioners who are hospital-based but see Presbyterian members as a result of their independent relationship with Presbyterian. Examples include but are not limited to anesthesiologists with pain management practices, hospital-based cardiologists and hospital-based university faculty.

- Dentists who provide care under Presbyterian’s medical benefits. Examples of this type of provider include but are not limited to endodontists, oral surgeons and periodontists.

- Non-physician practitioners/providers who have an independent relationship with Presbyterian, as defined above and provide care under Presbyterian’s medical benefits.

As a part of their services agreement, practices must notify Presbyterian prior to allowing any new practitioner to provide services to a Presbyterian member. New practitioners need to complete the credentialing process before rendering services to Presbyterian members.

**Credentialing and Recredentialing Processes**

The following is information related to credentialing and recredentialing processes:

- Ensure that all information on the application is complete and correct. Any unexplained gaps, missing information or incomplete information delay the application processing.
Credentialing and Recredentialing

- Include the beginning and ending month and year for each work experience under work history and explain any gaps exceeding six months.

- Include a written explanation for any “yes” answer to the professional practice questions. If office staff completes the application, ensure that the answers are correct.

- Ensure that all required documents are submitted with the completed and signed application and attestation.

- Practitioners/providers can obtain an application at any time by contacting their Provider Network Operations relationship executive at http://www.phs.org/ContactGuide or credentialing examiner at the health plan. Once a request is made from Presbyterian to the Council for Affordable Quality Healthcare (CAQH), the practitioner may also go to https://proview.caqh.org/Login/Index?ReturnUrl=%2fpo and submit an application online.

It is important to notify your relationship executive if you are joining an existing group. A practitioner/provider who is not currently an in-network provider but would like to become one must submit a letter of intent. A letter of intent form can be accessed at https://www.phs.org/providers/our-networks/health-plan/Pages/contracting-form.aspx.

- Ensure timely completion of the application. After three requests for an application with no response in 45 days, Presbyterian discontinues the credentialing process. For recredentialing applications, the practitioner or provider is at risk for termination.

Organizational providers receive their application directly from Presbyterian.

Credentialing Review Committee

The Presbyterian Credentialing Review Committee is a subcommittee of the Presbyterian Quality Improvement Committee and serves as a credentialing review body. The Credentialing Review Committee was established to provide expertise about current credentialing practices in the medical and behavioral health community, provide advice on modifying criteria and maintain a review process for credentialing and recredentialing.

The committee is able to evaluate and improve the quality of healthcare services rendered by healthcare practitioners and providers and review the nature, quality and/or cost of healthcare services provided to enrollees or members of Presbyterian. The committee makes recommendations to Presbyterian regarding whether individual healthcare practitioners should be included in Presbyterian’s provider panel. The committee also provides input into the corrective action plan process and reviews and makes determinations on the appropriateness of the responses to requests for corrective action while providing oversight on whether the practitioner’s or provider’s membership on the Presbyterian
Credentialing and Recredentialing

The provider panel should be limited, suspended or revoked.

Confidentiality

Presbyterian maintains the confidentiality of all information obtained about the practitioners/providers it credentials and recredentials, as required by state law, federal law and accreditation standards.

Practitioner/Provider Rights

Under Section 13.10.28 of the New Mexico Administrative Code (NMAC), providers have rights that include but are not limited to the following:

- Timely credentialing decisions
- Reimbursement from the health carrier upon delay in the credentialing process
- Payment of overdue claims and payment of interest due to delay in credentialing decisions
- Payment dispute resolution

Credentialing Right to Review Information

Evaluation of the credentialing application includes information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), with the exception of references, recommendations or other peer-review protected information.

Right to Correct Erroneous Information

Presbyterian notifies practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Presbyterian provides the following:

- The time frame for changes
- The format for submitting corrections
- The person to whom corrections must be submitted
- Documentation of receipt of the corrections

Right to Be Informed of Application Status

All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate credentialing staff.

Right to Be Notified of These Rights Delegation

Presbyterian may delegate to designated entities all or some of the credentialing responsibilities. The performance of the entity is monitored on an ongoing basis for compliance with Presbyterian’s requirements and all applicable regulatory and accreditation standards. Presbyterian retains the right, based on quality issues, to approve, suspend or terminate individual practitioners and providers even in situations where it has delegated credentialing responsibilities.

Standard Eligibility Criteria

Practitioners

Practitioners must meet the following standard eligibility criteria, which includes but is not limited to:

- A current unrestricted license to practice within the states where services are provided; temporary licenses are not
Credentialing and Recredentialing

acceptable to fulfill this requirement for behavioral health or medical practitioners

- Appropriate training within the area of practice
- Absence of felony convictions.
- Provision of quality, appropriate and timely care
- Confirmation of the PCP’s ability to meet applicable required access and availability standards
- No sanctions, suspensions or terminations imposed by Medicare, Medicaid or other designated federal/regulatory bodies
- When contracted to see Medicare or Medicaid patients, has not opted out of the Medicare or Medicaid program
- Practitioners who serve Medicare members must be Medicare approved
- Valid Drug Enforcement Agency (DEA) certificate and applicable state pharmacy registration for controlled substances
- Current malpractice insurance coverage in the required amount (as described in greater detail later in this chapter)
- Acceptable office practices and a safe office environment that requires a score of 90 percent on the initial site visit
- Work history that reflects a consistent pattern of professional activity in good standing for the past five years
- Absence of evidence that the applicant might be unable to perform the contracted duties
- Absence of suspension, restriction or termination of hospital privileges.
- National Provider Identifier (NPI)

Organizational Providers

Organizational providers must meet the following standardized criteria, which includes but is not limited to:

- Current good standing with state and federal regulatory bodies and certified by the appropriate state certification agency, as applicable
- Was reviewed and accredited by a recognized accrediting body or, if not approved by an accrediting body, meets Presbyterian’s standards of participation
- Current applicable state license or certification
- No sanctions, suspensions or terminations imposed by Medicare, Medicaid, other designated federal/regulatory bodies or the state where services are rendered
- When contracted to see Medicare or Medicaid patients, has not opted out of the Medicare or Medicaid program
- Providers who serve Medicare members must be Medicare approved
Credentialing and Recredentialing

- Current malpractice insurance coverage in the required amount (as described in greater detail later in this chapter)
- Acceptable malpractice history within the two-year period immediately preceding the date of application
- Valid DEA certificate and applicable state pharmacy registration for controlled substances

Urgent Care Providers

Due to the ever-changing healthcare environment, emergency service-based urgent care providers are beginning to form closer relationships with patients by providing more routine and follow-up care.

Effective June 1, 2015, Presbyterian began credentialing urgent care providers. This new requirement is necessary to ensure practitioners have the legal authority and relevant training and experience to provide quality care.

The initial credentialing process focuses on verifying training, experience, licensure and competence by evaluating data and information collected to determine the qualifications of a provider to render quality care to our members. Recredentialing is required every three years in accordance with Presbyterian’s policies and procedures and the National Committee for Quality Assurance (NCQA) accreditation standards. We will send a written notification to remind you to complete your next recredentialing application.

Malpractice Insurance Requirements

Providers are required to maintain, at their sole cost and expense and at all times, both comprehensive general liability insurance and professional liability insurance. This insurance must contain provisions and be written by companies reasonably acceptable to Presbyterian. Providers must demonstrate compliance with this requirement by providing Presbyterian with certificates evidencing dates that this insurance is in effect, as well as amounts. Notwithstanding these guidelines, Presbyterian reserves the right, on a case-by-case basis, to require either higher or lower limits or other terms and conditions depending upon circumstances or other facts that Presbyterian, in its sole discretion, deems necessary to meet its legal and regulatory obligations. Currently, Presbyterian requires the following amounts of coverage:

New Mexico Practitioners and Providers

- For practitioners/ providers that are qualified under the New Mexico Medical Malpractice Act, Presbyterian requires that the practitioner and provider maintain professional liability insurance in the amounts required by the act, currently $200,000 per occurrence and $600,000 aggregate.
- For those practitioners and providers that are not qualified under the New Mexico Medical Malpractice Act, Presbyterian requires that the practitioner/provider maintain professional liability insurance in
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the following amounts: $1 million each occurrence and $3 million aggregate.

- Any obstetrician/gynecologists and other primary care practitioners/provider (PCP) who practice in New Mexico and who deliver babies as a part of their practice must also carry limits of $1 million per occurrence and $3 million aggregate, regardless of insurance coverage with the New Mexico Medical Malpractice Act.

Practitioners and Providers Outside of New Mexico

For those practitioners and providers located outside of New Mexico, we accept insurance in the amounts and types required by the law of the jurisdiction in which the practitioner or provider is located.

Site Visit

Site visits are included as part of the initial credentialing process for PCPs, obstetrics and gynecology practitioners and high-volume behavioral health specialists. In addition to the initial site visit, a site visit is conducted on any provider that receives two or more complaints within 12 months regarding their office or practice.

Initial applicants who fail a site visit are notified that the credentialing process has been discontinued. The applicant may contact Presbyterian for information about how to improve their site and to restart the credentialing process once the deficiencies have been corrected.

Any provider that receives two or more complaints regarding their office or practice within 12 months has a site visit scheduled immediately. Should the provider’s office fail the site visit, they are notified and the practitioner or provider must develop a corrective action plan within 30 days to address the deficiencies. A follow-up review is conducted within six months to determine compliance. If the practitioner or provider fails to submit the corrective action plan within the specified time frame, it is considered a breach of contract and may result in termination from the network.

Ongoing Monitoring

The Office of Inspector General’s List of Excluded Individuals and Entities Exclusion Program and the General Services Administration’s System for Award Management (previously Excluded Parties Lists System) and applicable state licensing agencies are monitored monthly for sanctions or licensure limitations.

Investigations are conducted on all quality of care and service complaints. For quality of clinical care complaints, appropriate clinical staff, including Presbyterian Health Plan medical directors, are consulted in conjunction with the review of the complaint and may include a review of relevant medical records. Upon completion of the initial investigation, the findings may be reported to the appropriate medical director, the credentialing review committee and the Provider Network Operations director.

Corrective action plans are developed in situations where there is an identified need for improvement in quality of care or service. Presbyterian offers a formal appeal process and reports the action as appropriate whenever a practitioner or provider is
Credentialing and Recredentialing

terminated or suspended for quality of care concerns.

Fair Hearing

In the course of the credentialing decision making process, applicants are given the opportunity to provide additional information that may address concerns raised by the committee that may have led to the denial of their application.

Practitioners and providers that are denied membership at credentialing or recredentialing, or are terminated for cause, have the right to appeal the decision through either the initial denial review process or fair hearing process.
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Current e-Business Resources

Presbyterian defines e-business as any tool or resource that allows information to be stored, displayed or transmitted electronically. We strive to offer online resources that save time and energy and that provide our network with improved efficiency resulting from immediate access to current and accurate information. The following is a list of current and planned e-business tools available to the network.

- **myPRES:** A password-protected portal (website) that allows your office to access a variety of Presbyterian resources, as well as member, benefit, authorization and claim information.

- **Interactive Voice Response (IVR) System:** This system complements myPRES by providing you access to member eligibility, copayment and primary care practitioner information over the phone.

- **Electronic Claims Transmission (ECT):** You can save time and money by sending your claims electronically to Presbyterian through one of our five contracted clearinghouses. A list of these clearinghouses can be found later in this chapter.

- **Electronic Data Interchange Remittance Advice (EDI-RA):** EDI-RA enables you to receive electronic explanation of payments (EOPs) and fully reconciled remittances electronically and access a secure portal to view and print remittances at no cost.

- **Electronic Funds Transfer (EFT):** This enables you to receive direct deposit of payments into a specified banking account at no cost to the provider.

- **Presbyterian ePayment Center:** This provides ERA/EFT services at no cost to contracted providers.

- **HealthXnet®:** A third-party vendor of Presbyterian that provides access to a variety of information and functions over the internet related to eligibility verification.

- **Online Provider Directory:** For the convenience of the provider and your patients, Presbyterian has improved its online provider directory by including information about our network of primary care providers, specialists and other providers.

- **The Provider Webpage:** The Presbyterian provider web page includes recent communications, benefit and criteria information, appeals and grievances, online submissions and the online provider directory.
Health Insurance Portability and Accountability Act (HIPAA) Regulations and e-Business

Claims status, member eligibility and benefit and pharmacy certification requests are some of the transactions covered under the HIPAA of 1996 regulations. Conducting these transactions through the internet qualifies as conducting these transactions “electronically” according to HIPAA and may therefore cause you to qualify as a covered entity subject to the HIPAA regulations.

If you are not already considered a covered entity under the HIPAA regulations, you may want to consider carefully before initiating these transactions over the web. Any provider that wants to determine whether they are a covered entity under HIPAA can use the Center for Medicare & Medicaid Service (CMS) tool at the following link: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/HIPAAGenInfo/.

myPRES

myPRES permits Centennial Care providers to check member eligibility, benefit plan details and claims status as well as to request a Benefit Certification or Pharmacy Exception.

It is our goal to make myPRES your first choice when accessing information from Presbyterian. This web platform provides free online access to current claims status, member eligibility and prior authorization information and much more. myPRES also enables you to submit online authorization requests and to email the Provider Claims Activity Review and Evaluation (CARE) Unit for more complex issues that require research.

In direct response to network feedback, myPRES now has the capability to auto review the following prior authorizations requests for participating providers:

- Specialized blood glucose monitors
- Durable medical equipment, with the exception of specialized equipment including wheelchairs and rehabilitation devices
- Specialty wheelchair evaluation
- Gynecomastia surgery – male.
- Breast repair and reconstruction for breast cancer
- Surgery for breast hypertrophy
- Arthroereisis subtalar – pediatric
- Epidurals
- Diapers

Keep Your Provider Directory Information Up to Date

The Centers for Medicare & Medicaid Services (CMS) have implemented new requirements to verify that networks are adequate and provider directories are current. Presbyterian has taken steps to ensure compliance with the CMS provider directory accuracy requirements.

Presbyterian requires providers to communicate demographic changes that may affect the provider record and directory profile. Changes must be
communicated as soon as possible, but no later than 14 days from the date a change is known. This includes any changes related to your practice, such as the following:

- Address
- Taxpayer identification number
- Panel status
- Contract status
- Adding or terming a provider from a group

Failure to notify Presbyterian and/or update demographic information may result in temporary suspension or removal from the online provider directory. Presbyterian will also reach out to provider offices quarterly to verify their directory information.

To reduce the administrative burden of these requirements, Presbyterian offers a solution for updating demographic changes easily and in real-time. Providers can update their information through the myPRES provider portal at www.phs.org/myPRES.

With the help of our providers, we will improve the patient and member experience by making it easier for members/patients to find their providers.

When updating information, please be sure that the practice name used for the directory listing is consistent with the signs used outside of the building and the scripting used to answer telephone calls. Members tend to search the provider directory using the practice name they most commonly see or hear.

Together we can reduce frustration, confusion and uncertainty experienced by patients and members because of incorrect provider directory information.

**Prior Authorization**

Presbyterian’s Prior Authorization Guide provides prior authorization, referral and other utilization management requirements and procedures. The most updated version of this guide is available on our website at: https://www.phs.org/providers/authorizations/Pages/default.aspx. You can also access our prior authorization request forms from the same link.

**How to Register for myPRES**

Obtain a User ID and password by entering the following link into the internet address bar: https://mypres.phs.org/Pages/provider-registration.aspx

You can also follow the steps below:

- Go to http://www.phs.org.
- Click “myPRES” on the top of the webpage.
- Click “Why register?” located on the middle of the webpage.
- Click the Providers registration link in the middle of the page.
- Fill out the form on the page to request access.

This allows you to request User IDs and passwords for multiple users. Fill out the application and click the submit button at the end of the application. Remember that your user ID and password are case-sensitive.
Each employee in your office that utilizes myPRES must have their own individual user ID and password. Under no circumstances should your myPRES user ID and password be shared. It is your responsibility to contact the Presbyterian Customer Service Center or your relationship executive to terminate access of employees who are no longer employed or who no longer require access to myPRES.

**Accessing myPRES**

Go to [http://www.phs.org](http://www.phs.org) and locate the myPRES log-in box on the right side of our website, click on log-in box and enter your user ID and password to log on to myPRES.

If you have problems locating or completing the enrollment form, you may contact the Presbyterian Provider E-Help Desk by:

- Phone at (505) 923-5590 or toll-free at 1-866-861-7444, Monday Friday from 8 a.m. to 5 p.m. (MST)
- Email: [ehelpdesk@phs.org](mailto:ehelpdesk@phs.org)

**Resetting Your myPRES Password**

User IDs and passwords are easily reset online. At the log in screen, simply click on “Forgot/Reset Password” or “Forgot User ID.” Then follow the easy steps to get your User ID or password reset. Should this fail to work, please email the E-Help desk at [ehelpdesk@phs.org](mailto:ehelpdesk@phs.org) or call (505) 923-5590 or toll free at 1-866-861-7444 for further assistance.

**Computer and Software Requirements for myPRES**

In order to take full advantage of myPRES’s capabilities, you need:

- An internet service provider connection
- Adobe Flash Player (current version suggested)
- The following browsers are compatible with myPRES:
  - Safari (current and last versions)
  - Firefox (current and last versions)
  - Chrome (current and last versions)
  - Internet Explorer 9 or above

**myPRES Hours of Availability**

myPRES offers continuous availability 24 hours a day, seven days a week, including holidays. As with any internet platform, problems with availability may arise because of heavy internet traffic.

**Information Updates**

The information available through myPRES is updated in real time and is connected to our claims processing system.

**myPRES Training and Support**

Online help is available at the touch of a button once you are in the application. The Presbyterian E-Help Desk also provides phone support Monday through Friday, 8 a.m. to 5 p.m. The Provider Network Operations department is also available to assist you.

**Interactive Voice Response**

Our IVR System complements myPRES and allows you to check member eligibility as well as obtain copayment and primary care practitioner information over the telephone. Access the IVR
system by calling (505) 923-5757 and choosing Option 1. Transactions done through the IVR system are not covered under HIPAA regulations. Use of the IVR system does not qualify providers as conducting HIPAA electronic transactions and use of the IVR system does not qualify providers as covered providers subject to HIPAA regulations.

**Electronic Claims Transmission**

We encourage you to take advantage of Presbyterian’s ECT system and capitalize on the time and savings realized from a paperless system. To submit electronic claims directly to Presbyterian, we now offer our FastClaim direct entry portal. FastClaim is designed to accommodate lower-volume claim submitting practices that would like to submit claims electronically directly to Presbyterian at no cost. If you are interested in learning more about ECT or Fast Claim, please contact the Provider Network Operations e-business analyst at (505) 923-6154. A list of clearinghouses is also available at the end of this chapter.

Providers may electronically submit corrections to previously submitted CMS-1500 claims. A corrected claim must include all previously submitted information as well as the corrected information. For example: If a claim was submitted with six lines and a correction is needed for one of the six lines, then the corrected claim must still contain the other five correct lines in addition to the corrected line. Please note that a corrected electronic claim is identified only when Field 22 on the claim has a “Resubmission Code” of seven or eight and the “Original Ref. NO.” field contains the claim number of the original claim submission.

**Electronic Data Interchange Remittance Advice**

Providers using the ECT system may be eligible to take advantage of EDI-RA. By using EDI-RA, you receive EOP data and payment funds faster because EOP data is sent electronically to your office and payment funds are directly deposited to your bank account. If you are currently submitting claims electronically and are interested in using EDI-RA, please contact your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide to check availability.

**Electronic Coordination of Benefits (eCOB)**

eCOB enables your patients to receive benefits from all health insurance plans they are covered under, while ensuring that the total combined payment from all sources is not more than the total charge for the services provided.

If you are interested in submitting eCOB, please verify with your practice management software vendor that your billing program has the capacity to do so.

**HealthXnet**

HealthXnet allows you to check member eligibility, claims and benefit certification status and to submit claims online. For more information, visit HealthXnet at http://info.healthxnet.com/index.html or contact them by phone, fax or email as follows for User Administration and Help Desk (Login ID, Password and Technical assistance):
Presbyterian ePayment Center

The Presbyterian ePayment Center offers a payments management solution to eliminate paper checks and EOPs, accelerate payments with EFT that is directly deposited in your existing bank account and receive fully reconciled remittances electronically. In addition, contracted providers will be able to receive automated clearinghouse (ACH) claim payments at no cost and coordinate the delivery of 835 files from a selection of clearinghouses. To get started and access the features available through our provider payments management solution, please visit the following link: Presbyterian.epayment.center/registration. If you have any questions about this service, please contact the Presbyterian ePayment Center at 1-855-774-4392 or email Help@ePayment.Center.

Medical Policy Information

Presbyterian’s Medical Policy Committee (MPC) has the responsibility for creating, revising, interpreting and disseminating benefit information in a uniform and organized manner for use by Presbyterian employees and service partners. As part of this process, the MPC has created the Medical Policy Manual to assist in administering plan benefits. The Medical Policy Manual is available on the Presbyterian website and is updated when new or revised pages are approved by the MPC or the Clinical Quality Committee. Not every Presbyterian plan contains the same benefits; therefore, the member’s contract must be reviewed before using the Medical Policy Manual to determine if a specific benefit is available to a member.

Information contained in the Medical Policy Manual does not replace the member’s Group Subscriber Agreement, Summary Plan Description or Evidence of Coverage.


Appeals and Grievances

Presbyterian has implemented a very comprehensive process, in conjunction with our regulatory agencies, to ensure that our members and providers have a simple method to exercise their appeal and grievance rights. In order to make this process as simple and effective as possible, you are able to file an appeal or report a grievance by using our website. Should you wish to file an appeal or report a grievance, you may do so online at https://www.phs.org/providers/resources/appeals-grievances/Pages/default.aspx.
Click on “File an Appeal or Grievance online” link. If you are interested in learning more about appeals and grievances, please refer to the “Appeals and Grievances” chapter of this manual.

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<thead>
<tr>
<th>Clearinghouse Contact Information</th>
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<tr>
<td><strong>Company</strong></td>
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<tr>
<td>Availity®</td>
</tr>
<tr>
<td>P.O. Box 550857</td>
</tr>
<tr>
<td>Jacksonville, Florida 32255-0857</td>
</tr>
<tr>
<td>HealthXnet</td>
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<td>7471 Pan American Freeway NE</td>
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<tr>
<td>Change Healthcare</td>
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<tr>
<td>Corporate Office</td>
</tr>
<tr>
<td>3055 Lebanon Pike Nashville, TN 37214</td>
</tr>
<tr>
<td>ClaimMD</td>
</tr>
<tr>
<td>P.O. Box 1177</td>
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<tr>
<td>Pecos, NM 87552</td>
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Presbyterian’s Claims Department ensures that claims submitted by our providers are processed accurately and in a timely manner. The primary reimbursement tools used in this process are:

- The application of correct coding guidelines in accordance with the standards set by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA).
- Individual provider contractual arrangements.
- The application of specific member benefits.
- The requirements in this chapter of the Provider Manual can help you ensure that your claims are submitted correctly.
- Requirements for the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as we understand them today, are included. Periodic updates are sent to your office as necessary throughout the year.
- You are required to submit claims for all services rendered, whether they are capitated or fee-for-service. For assistance with claim submissions, please contact your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide who can arrange for helpful technical assistance and training sessions.

Electronic Claims Transmission

Electronic claims are claims that are transmitted electronically to Presbyterian using a clearinghouse or a web application such as Presbyterian’s electronic claims transmission (ECT) system. Using ECT can capitalize on the time and savings realized from a paperless system. To submit electronic claims directly to Presbyterian, providers can use the Fast Claim direct entry portal at https://www.claim.md/phs.plx.

FastClaim is designed to accommodate lower-volume claim submitting practices that would like to submit claims electronically directly to Presbyterian at no cost. To learn more about ECT or FastClaim, please contact the Provider Network Operations e-business analyst at (505) 923-6154. A list of clearinghouses is also available at the end of the “e-Business” chapter. Since Oct. 16, 2003, electronically transmitted claims must meet the HIPAA transaction standards with regard to format and content.

Providers may electronically submit corrections to previously submitted CMS-1500 claims. A corrected claim must include all previously submitted information as well as the corrected information. For example: If a claim was submitted with six lines and a correction is needed for one of the six lines, then the corrected claim must still contain the other five correct lines in addition to the corrected line. Please note that a corrected electronic claim is identified only when Field 22 on
the claim has a “Resubmission Code” of seven or eight and the “Original Ref. NO.” field contains the claim number of the original claim submission. Claims that are not clearly indicated as corrected may be rejected.

Benefits of Filing Electronically

In addition to saving you postage and paper, Presbyterian processes electronically submitted claims faster than paper claims. Providers who electronically submit clean claims will be reimbursed within 30 days of receipt, while providers who submit clean paper claims will be reimbursed within 45 days. Furthermore, electronically submitted claims provide quicker confirmation of claims receipt and integrity of the data, which may result in the following:

- Higher percentage of claims accuracy, resulting in faster payment
- Required HIPAA formatting of claims data
- ANSI-X12 837 claims format
- The service is typically free for claims submitted to Presbyterian

Requirements for Filing Electronically

You need the following to file electronically:

- A compatible computer system; check with the clearinghouse technical representative for PC/Macintosh compatibility information.
- A billing system that can produce the data required by the HIPAA compliant claim format (ANSI X12 837 version 5010); check with your clearinghouse technical representative to determine this.
- A modem or internet connection.

Two important aspects of Presbyterian’s relationship with the clearinghouses are compliance and data protection. New Mexico legislation enacted during 2001 requires stringent approaches to protecting both personal health information and personal financial information. HIPAA legislation requires even more exacting procedures and processes to ensure data is protected. Presbyterian and its contracted clearinghouses work to ensure that all data is appropriately protected as it moves through the electronic environment needed to foster rapid and accurate payment.

How to Begin Filing Electronically

You may begin filing electronically by calling one or several of the clearinghouses listed at the end of the “e-Business” chapter. Presbyterian has contracted with these companies to provide you with the software that enables you to transmit claims electronically. All of these companies are endorsed by Presbyterian and they help you get started and provide timely and accurate processing of your claims.
The clearinghouse asks you some questions, more than likely sends you an informational packet and may ask you to fill out and send in a questionnaire to help determine your needs. You may compare the services available through each clearinghouse. The service is free for claims submitted to Presbyterian. There may be additional services the clearinghouse can provide at an additional cost to your office, including the submittal of claims to other payors. The clearinghouse evaluates your system, sets up a test and instructs you in the use of their system. You are up and running quickly, barring any major problems.

You do not need to notify Presbyterian to start billing electronically. However, you do need your Presbyterian assigned provider number and you must have a National Provider Identifier (NPI). You must also provide your tax identification number to submit an electronic claim. For special concerns or billing issues, first contact your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide for advice. Presbyterian does not pay claims if an NPI is not submitted. More information regarding NPI is discussed later in this chapter.

You receive either an acceptance or rejection report from the clearinghouse within one day of submission. Claims listed on the acceptance report are transmitted to Presbyterian. You then receive either an acceptance or rejection report from Presbyterian through the clearinghouse.

If You Encounter Problems

When filing electronically, you may encounter problems. Examples of common issues and solutions are listed below:

- **Issue:** An electronic claim is rejected by the clearinghouse as “unclean.”
  - **Solution:** Call the clearinghouse within 48-hours of receipt of the rejection report.

- **Issue:** An electronic claim is accepted by Presbyterian but does not show as paid in your system.
  - **Solution:** Check the claim status online or contact the Provider Claims Activity Review and Evaluation (CARE) Unit through their online web form within 30 days from the date of service.

- **Issue:** A claim is rejected by Presbyterian with an error message that you do not understand.
  - **Solution:** Contact your clearinghouse or your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide within 48 hours of receipt of the rejection report for the needed information so that you can submit your claim.

- **Issue:** You consistently submit claims that are not showing in Presbyterian’s claims system and that are not recorded on your error reports that you received from your clearinghouse and Presbyterian.
Solution: Contact your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide and discuss the issue. If the issue is determined to be a technical problem, your Provider Network Operations relationship executive at coordinates contact with Presbyterian's Information Services Department. It is important to check on a regular basis to ensure that the claims are not denied for lack of timely filing. Also, please be sure to keep detailed records regarding this activity.

Paper Claims Submission Process

Paper claims are printed on a form and mailed to Presbyterian. Presbyterian requires all providers to use one of two forms when billing hard copy paper claims, the CMS-1500 (02-12) or the UB-04.

A full itemization and medical record is required for all claims with billed amounts of $100,000.00 or greater. Payment may be delayed if the documents are not submitted.

CMS-1500

The CMS-1500 (02-12) billing form is used when submitting claims for all professional services, including ancillary services and professional services billed by a hospital. The CMS-1500 (02-12) is the only acceptable version of this form. This form accommodates new ICD-10 diagnosis codes. Box 21 of these forms requires the use of ICD-9 or ICD-10 codes and they should be billed in sequential alphabetical order at the highest level of specificity. Diagnosis pointer in box 24E should be billed alpha as well.

UB-04

The UB-04 billing form is used when submitting claims for hospital inpatient and outpatient services, dialysis services, nursing home room and board and hospice services.

National Provider Identifier

HIPAA requires that all healthcare providers acquire an NPI. In order to properly adjudicate and correctly direct reimbursement, all fields containing provider information require an NPI. All providers, with the exception of sole practitioners, must acquire and submit the appropriate Type 2, organization NPI in the appropriate field. Examples are provider group practices, hospitals or durable medical equipment suppliers. Additional information on Type 1 and Type 2 NPI is available at https://nppes.cms.hhs.gov/.

A provider that does not have an NPI is not able to:

- Submit claims for payment
- Receive payments from a health plan
- Access information from a health plan

You can apply for an NPI online at https://nppes.cms.hhs.gov.

Interim Billing Process

Interim billing is to be used when a patient is confined in a facility for an extended period of time. Interim billings should be submitted on a monthly basis.
Claims and Payments

Presbyterian encourages the submission of these monthly billings within 45 days of the beginning of the period for which you are billing.

**Submitting Late Charges (only acceptable as paper claims)**

Late charges can be billed on UB-04 billing forms only and must be submitted as a paper claim. CMS-1500 forms can only be used for the submission of late charges for facility services from ambulatory surgical centers.

On UB-04 billing forms, the bill type (Field 4) must end with a “5” except for late charges for inpatient services. Late charges for inpatient services must be submitted as a replacement claim with a bill type ending with “7.”

- Do not include the original charges when billing late charges. If the original charges must accompany late charges.
- Clearly indicate that the claim contains late billing charges.
- Do not combine late charges together with the original charges; ensure that the late charges are easily identifiable or easy to identify to avoid a duplicate payment.
- Specify the original date of service.
- Late charges must be submitted within 12 months of the date of service.

**Submitting Unlisted/Unclassified Codes**

An unlisted/unclassified Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) code may be billed if no other appropriate code exists or a code has not been assigned. If a code exists for a service or procedure you are performing, you must use the correct code and not the unlisted/unclassified procedure code. This includes both CPT and HCPCS Level II (alpha numeric) codes.

Unlisted/unclassified CPT/HCPCS codes can be accepted in the electronic 837 claim format. Information may be entered as a service line or claim level note. However, Presbyterian may require written documentation with the report and the invoice that is routed for manual review and pricing of covered services.

**Guidelines for Submitting Hemoglobin A1c Claims and Test Results**

Presbyterian requires the reporting of the actual result of hemoglobin A1c tests (CPT code 83036) so that there is an accurate assessment of the degree of control of the Presbyterian diabetic member’s blood glucose. This helps Presbyterian develop or maintain diabetes-related quality improvement programs.

When submitting charges for the A1c test, please follow these guidelines:

- Report the test result as a three-digit number with no decimal point and a leading zero. For example, a test result of 5.8 is entered as 058.
- Presbyterian edits for valid values between 3.0 and 20.0 (030 and 200). If the result is not within this range, the test is invalid.
• For UB-04 claims, the test date is the service date (field location 45, Service Date). If a service date is not entered, the test date is the From Date (field location 6, Statement Covers Period).

The following information outlines where the A1c test results need to be reported in the 837 professional and institutional electronic claim transactions. Provide this information to your software vendors in order to properly configure your electronic claims submission software.

This information pertains to claims submitted by providers to the clearinghouse in the 837 professional formats.

Place the A1c data in the NTE02 segment of the 2400 loop with the code qualifier of ADD. The data format is “A1C nnn ccymmd.” The “nnn” is the test result and “ccymmd” is the date of the test.

- Example: A1c 055 20041028

Requirement for 837 Institutional, Excluding Availity®

This information pertains to claims submitted by providers to Availity® in the 837 Institutional formats.

Place the A1C data in the PWK07 segment of the 2300 loop with the code qualifier of OZ and PWK02 of AA. Up to four test results per PWK segment, which can occur once.

The data format is “A1C nnn ccymmd.” The “nnn” is the test result and “ccymmd” is the date of the test.

- Examples:
  - A1C 055
  - 20041028 A1C 042
  - 20041029

Understanding the National Drug Code

The NDC is found on the label of a prescription drug item and certain supplies. It must be included on paper and electronic claim transactions. The NDC is a universal number that identifies a drug or related item. A complete NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format such as “12345-1234-12.”

However, sometimes the NDC as printed on a drug item omits a leading zero in one of the segments,
requiring a leading zero to be entered on the claim form and the hyphens to not be used. Instead of the digits and hyphens being in a 5-4-2 format, the NDC may be indicated in a 4-4-1 as in “1234-1234-1,” or in a 5-3-2 format as in “12345-123-12,” or less commonly in a 5-4-1 format as in “12345-1234-1.” A leading zero must be added to make the 5-4-2 format.

See the following examples:

- NDC 12345-1234-12 is complete; it is reported as 12345123412.
- NDC 1234-1234-12 needs a leading zero in the first segment to be in the 5-4-2 digit format; to become 01234-1234-12 it is reported as 01234123412.
- NDC 12345-234-12 needs a leading zero in the second segment to be in the 5-4-2 digit format; to become 12345-0234-12 it is reported as 12345023412.
- NDC 12345-1234-1 needs a leading zero in the third segment to be in the 5-4-2 digit format; to become 12345-1234-01 it is reported as 12344512301.

Presbyterian rejects claims with a date of service on or after January 1, 2011, that do not indicate a valid NDC for the following HCPCS or CPT codes:

- Codes in the range J0120–J9999 (various injections and chemotherapy).
- Codes in the range S0012-S0197 and S4990–S5014 (various items).
- Codes in the range S5550–S5571 (insulin injections).
- Codes in the range 90281–90399 (immune globulins).

The same requirement applies to providers’ billing revenue codes for facility claims. HCPCS or CPT codes are required whenever the provider bills one of the following revenue codes and the claim is an outpatient hospital, emergency room facility, dialysis facility or other outpatient facility that submits a facility claim. When the reported HCPCS or CPT code is one of the above, the NDC code must also be reported for:

- Pharmacy revenue codes 0250, 0251, 0252 and 0254
- Pharmacy revenue codes 0631, 0632, 0633, 0634, 0635 and 0636

For complete instructions on where the NDC information is to be supplied for a CMS-1500, a UB-04, or 837 transactions, please use the following link: [http://www.hsd.state.nm.us/mad/registers/2010.htm](http://www.hsd.state.nm.us/mad/registers/2010.htm). This information is found under the header “Supplements” and it is Supplement Number 10-03.

Additionally, you may view the NDC Procedure Manual by accessing the following link: [http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00079542.pdf](http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00079542.pdf).

**Obstetrical Services**

Global maternity billing (by covered providers; for example, primary care obstetricians and specialists):
Claims and Payments

- If the delivery of the newborn is greater than three months past the mother’s eligibility date, Presbyterian Centennial Care pays the global fee.
- If the delivery is within three months of the mother’s eligibility, a breakdown of services (prenatal visits, delivery and postpartum visits) from the first day of eligibility is needed from the provider.

The following procedure must be followed when submitting fragmented, non-global obstetrics (OB) delivery claims to Presbyterian Centennial Care:

- Use generic Evaluation and Management or OB visit codes to report prenatal visits
- The beginning date of service is equal to the initial prenatal visit
- The number of units equals the total number of prenatal visits
- The appropriate charge should be entered into the charge column

Pregnancy Termination

Elective pregnancy terminations are not covered by Centennial Care and will only be reimbursed when certain criteria is met as listed below, or on the Provider Certification of Medical Necessity for Pregnancy Termination form. The provider does not need to submit the certification form to Presbyterian, however, they must keep a copy in their records.

- Voluntary, informed consent by an adult, or emancipated minor, must be given to the provider before the procedure to terminate pregnancy, except: In a medical emergency.
- Recipient is unconscious, incapacitated or otherwise incapable of giving consent.
- If pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the recipient.

Coverage for pregnancy termination also includes psychological counseling.

Informed written consent for a minor who is not emancipated to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian or other acting “in loco parentis” to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting “in loco parentis” is not available. The treating provider shall note the minor’s objections or the unavailability of the parent in the minor’s chart and meet other regulatory requirements as specified at New Mexico Medicaid Assistance Division (MAD) 8.310.2.

Federally Funded Terminations

Federally funded terminations of pregnancy (those that are represented by CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856 and 59857 and on state-funded “S” HCPCS codes) are limited to those situations where:

- The procedure is necessary to terminate an ectopic pregnancy.
- The procedure is necessary because the pregnancy aggravates a pre-existing
Claims and Payments

condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis or has a profound negative impact upon the physical or mental health of an individual.

- The procedure is necessary due to rape, incest or threat to the life of the mother (modifier G7 is required).

State-Funded Terminations

All pregnancy terminations for Presbyterian Centennial Care members that do not meet the criteria for federal funding in accordance with HCPCS codes S2260, S2262, S2265, S2266, S0190, S0191, or S2267, but are covered under Presbyterian Centennial Care, require that the provider retain the certification form in the member’s medical record. However, it is not necessary to submit the certification form with the claim.

Sterilization Consent Forms

If the provider is performing a sterilization procedure, for payment of Medicaid claims a Sterilization Consent Form must be completed in accordance with 42 Code of Federal Regulations (CFR) 441.251. The consent is valid for 30 days from the date of signature, unless withdrawn by the recipient before the procedure. Federal government regulators monitor the proper and timely completion of the consent form. Presbyterian Centennial Care is required to ensure proper adherence to the requirements.
Physician Certification of Medical Necessity for Pregnancy Termination

Patient Name: ________________________________

Medicaid or Presbyterian Centennial Care Identification Number: ________________________________

After reviewing the patient chart and consulting with the patient, as the treating physician, I certify that, in my best medical judgment, pregnancy termination is medically necessary for this patient for the following reason(s):

☐ To save the life of the mother
☐ The pregnancy is a result of rape or incest
☐ To terminate an ectopic pregnancy
☐ The pregnancy aggravates a pre-existing condition
☐ The pregnancy makes treatment of a condition impossible
☐ The pregnancy interferes with or hampers a diagnosis
☐ The pregnancy has a profound negative impact upon the physical or mental health of an individual

Provider's Name: ________________________________

Provider's Signature: ________________________________

Date: __________

Filing Claims with Coordination of Benefits

Presbyterian requires that all coordination of benefits claims be submitted within 90 days from the date on the primary carrier’s Explanation of Benefit (EOB) or Explanation of Payment (EOP). Once you have billed the other carrier and received an EOB/EOP, you may then submit the completed claim to Presbyterian. Please attach a copy of the EOB/EOP to the submitted claim or submit it electronically in an 837 compliant transaction.

The EOB/EOP must be complete in order to understand the paid amount or the denial reason. Claims submitted without an EOB/EOP are denied for lack of the EOB/EOP. Claims may also be denied if other insurance carriers’ requirements are not met.

Presbyterian coordinates benefits in accordance with CMS regulations and National Association of Insurance Commissioners guidelines.

Presbyterian providers may bill the member for applicable copays, coinsurance and/or deductibles.

Presbyterian Centennial Care is, by law, the payor of last resort for Presbyterian Centennial Care members. Therefore, if a Presbyterian Centennial Care member is eligible for benefits under another insurance plan, you must file a claim and obtain an EOB/EOP from the other insurance plan, as
Claims and Payment

required by your contract. Coverage requirements of the other insurance plan must be satisfied.

In coordinating benefits between the primary insurance carrier and Presbyterian Centennial Care, Presbyterian Centennial Care still acts in the same capacity that the Human Services Department (HSD) Medical Assistance Division has in the past as the payor of last resort.

Provider’s Responsibilities and Prohibited Activities regarding Copayment

- Presbyterian prohibits any provider from denying services to a member due to inability to pay the copayment when the household has an income at or below 100 percent federal poverty level (FPL).

- A provider may require members to pay copayments as a condition for receiving items or services when:
  - The member has a household income above 100 percent FPL.
  - The member is not part of an exempted group
  - For copays imposed for non-emergency services furnished in a hospital emergency department, the requirements to charge the copay have been satisfied.
  - Before charging a copayment, the provider must confirm the member’s eligibility information by checking the member’s Presbyterian ID card or by logging on the Presbyterian’s myPRES Provider Portal to verify if a copayment applies.

- Before providing non-emergency services and imposing co-payments, the hospital providing care must:
  - Conduct an appropriate medical screening to determine that the member does not need emergency services
  - Inform the member of the amount of his or her copayment obligation for non-emergency services provided in the hospital ED
  - Provide the member with the name and location of an available and accessible alternative non-emergency services provider
  - Determine that the alternative provider can provide services to the member in a timely manner with the imposition of a lesser or no copayment
  - Provide a referral to coordinate scheduling for treatment by the alternative provider.

- If a service/item subject to copayment is provided, the member remains liable for payment of the copayment amount. The provider must apply the copayment and may attempt to collect any unpaid charges at the time of service, at a later
appointment, or by billing the member. The provider may not waive the copayment.

- A provider is required to report the applicable copayment amount on the claim form or on the provider’s corresponding billing transactions. Providers must report the copayment on the claim, regardless of whether the copayment was collected.

- When a copayment is applied to a service, the provider shall accept the amount negotiated with Presbyterian, including the deducted copayment amount, as payment in full. Please note that Presbyterian may not compensate providers for copayments that are not collected.

- If a provider has incorrectly overcharged copayments to a member, then the provider must refund any amount incorrectly collected to the member. The provider has 10 working days after receiving a notice of overcharged payments from Presbyterian to refund the copayments to the member. Failure to refund an overcharged collected copayment may result in a credible allegation of fraud.

- The member handbook describes copayments and outlines the member’s rights and responsibilities. To view the Member Handbook, please visit the following link: www.phs.org/member.

- When a copayment is assessed and charged, the member must make payment at the time of service or make arrangements with the provider to make payments at a later date. The provider or Presbyterian may utilize whatever legal actions are available to collect these amounts.

- If a member was incorrectly overcharged copayments, then the member has a right to be repaid by the provider.

Presbyterian utilizes the following methods to notify the provider network of member responsibilities:

- Explanation of payment (EOP), which includes a detailed account of the member’s responsibility
- The myPRES Provider Portal
- Electronic remittance advice (ERA)

Presbyterian Centennial Care’s normal prior authorization guidelines and plan requirements apply when Presbyterian is acting as the primary carrier if the other carrier denied the services. Presbyterian Centennial Care does not make payment for services denied by another carrier when the provider or member did not follow the requirements of the primary plan.

Presbyterian Centennial Care does not require a prior authorization or referral in the following circumstances:

- When the member’s primary insurance does not include a benefit that is covered by Presbyterian Centennial Care
- When the member’s primary insurance has reached annual plan maximums, or maximums on specific benefits that are covered by Presbyterian Centennial Care
Third-Party Liability

Presbyterian Centennial Care is responsible for identification of third-party coverage of members and coordination of benefits with applicable third-parties.

- It is also required to inform HSD within 20 calendar days of receiving information regarding any member who has other health coverage and must provide documentation within 20 calendar days to the HSD Third-Party Liability Unit, enabling HSD to pursue its right under federal and state law, regulations and rules. Documentation shall include payment information and collection and/or recoveries for services provided to enrolled members as required by HSD.

- Presbyterian Centennial Care has the sole right of collection to recover from a third-party resource or from a provider who has been overpaid due to a third-party resource for 12 months from the date Presbyterian Centennial Care first pays the claim to initiate recovery and attempt to recover any third-party resources available to Medicaid members, for all services provided by Presbyterian Centennial Care.

Without mitigating any rights a Presbyterian Centennial Care provider has pursuant to federal and state law and regulations, HSD has the sole right of:

- Collection from a third-party resource which Presbyterian Centennial Care has failed to identify within 12 months from the date Presbyterian Centennial Care first pays the claim

- Recovery from Presbyterian Centennial Care or a Presbyterian Centennial Care provider who has been overpaid due to the combined payments of Presbyterian Centennial Care and a third-party resource when Presbyterian Centennial Care has not made a recovery within 12 months from the date Presbyterian Centennial Care first pays the claim

- Recovery from a third-party resource, Presbyterian Centennial Care or a Presbyterian Centennial Care provider if Presbyterian Centennial Care has identified a third-party resource but failed to initiate recovery within the 12-month period

- Recovery from a third-party resource, Presbyterian Centennial Care or a Presbyterian Centennial Care provider if Presbyterian Centennial Care has accepted the denial of payment or recovery from a third-party resource or when the contractor fails to complete the recovery within 15 months from the date Presbyterian Centennial Care first pays the claim. HSD may permit payments to be made in accordance with state regulations.

The exception to this 12-month period is for cases in which a capitation has been recouped from Presbyterian Centennial Care pursuant to Article 6.2.4, whereupon Presbyterian Centennial Care shall retain the sole right of recovery for all paid claims related to members and months that were recouped.
Claims and Payment

Review all explanation codes on your EOP to determine if the denial was because of insufficient information or if the claim was submitted incorrectly.

Requesting an Adjustment

If you feel the claim was processed incorrectly, contact our Provider CARE Unit for an explanation. They will advise if an adjustment is necessary and request an adjustment on the claim. You may be advised to resubmit the claim with additional information. Adjustment requests must be made in a timely manner as defined in the “Timely Filing Submission Guidelines” section within this document.

Recovery of Claim Overpayments

Presbyterian will pursue the recovery of claim overpayments when identified by the provider. Claim overpayments are recovered through the EOP process whenever possible. The adjustment will appear as a negative amount on an EOP and deducted from current or future claim payments. The time frame for recovery is based on the notification to the provider or their representative by EOP or other communication type (e.g., letter, fax or phone call).

When an overpayment is initiated by the provider, Presbyterian requires the following information to process the overpayment adjustment:

- The member name
- The member ID number
- Date of service
- Presbyterian claim number
- The overpayment reason

NOTE: If there are 20 claims or more associated with one request, a spreadsheet is required with the information above.

If the provider voluntarily sends a refund check to Presbyterian and later determines that the check was sent in error, the request to correct the error must be submitted within 12 months from the date of the check.

When Presbyterian or another entity identifies an overpayment, the time frames below are followed.

Claims Overpayments

Product Line: Presbyterian Centennial Care

Time Frame: One year from the date of payment

Exception: When coordination of benefits is involved, there is no time frame for recovery of any overpayments.

Member Retro-Termination Activity

Product Line: Presbyterian Centennial Care

Time Frame: Recovery period is based on the effective date of the current contract between Presbyterian Centennial Care and the HSD.

Confirmed Fraud or Abuse Activity as Authorized by the Special Investigative Unit or Legal Department

Product Line: Presbyterian Centennial Care

Time Frame: Four years from the date of payment

The time frame for recovery is based on the notification to the provider or their representative by
Claims and Payment

EOP or other communication type (i.e., letter, fax, or phone call).

Exceptions to these guidelines may occur due to government regulations or cases of suspected fraud and abuse activities. Claim overpayments are recovered through the EOP process whenever possible. This appears as a payment reduction or negative claim payment on your EOP.

Timely Submission Guidelines

Guidelines for Original Claim Submissions

Presbyterian requires that all claims be received within three months of the date of service. Failure to adhere to the timely submission guidelines results in the denial of your claims.

If a claim has been submitted to the wrong carrier, submit the claim and denial letter or EOP from the other carrier to Presbyterian within three months of the date of the denial letter or EOB/EOP from the other insurance carrier.

When billing claims for inpatient facility charges, the three-month filing limit begins from the date of discharge.

The provider is responsible for submitting the claim timely, for tracking the status of the claim and for determining the need to resubmit the claim.

Guidelines for Claim Resubmissions, Corrected Claims, and Adjustment Requests for Additional Payment (only acceptable as paper claims)

Presbyterian requires that all claim resubmissions, corrections and adjustment requests for additional payment must be submitted within 12 months of the date of service. If a resubmission, corrected claim or adjustment request for additional payment is not received within this time frame, the original decision is upheld.

If your claim is not in the system, please resubmit it. Maintain a record of your resubmission and any contacts with Presbyterian.

If the resubmission is past the three-month filing limit, include the original filing documentation with your resubmission. Acceptable documentation includes the following:

- Computer ledgers
- Written logs
- Records of calls to Presbyterian (include date and contact name)

The exception report from Presbyterian or the ECT clearinghouse is required for ECT claims.

Documentation that is not acceptable includes a regenerated claim. Submitted documentation must:

- Be legible and clearly identify the member
- Identify the charges in question
- Include the date of service
- Include the original billed date.

Proof of timely filing may be rejected if the submitted documentation cannot be clearly linked to the claim in question. Any proof of timely filing must be submitted within 12 months of the date of service. We encourage you to follow up, on the status of your requests every 30 to 45 days. If you continue to receive no payment or documentation on your claim, contact the Provider CARE Unit.
Claims and Payment

If a member fails to notify the provider that he or she is covered through Presbyterian at the time of service, documentation that attempts were made to determine the member’s coverage is required.

Acceptable documentation includes the following:

- A copy of the patient information sheet that indicates that insurance information was not provided
- Written communication from the member verifying that he or she failed to notify the provider of coverage at the time of service

A change in the provider’s office billing personnel is not a valid reason to resubmit claims. You are encouraged to contact members regarding past due payments if the members do not respond to billing statements. This helps determine if the member is covered by Presbyterian.

“Clean” Claims

Presbyterian has adopted CMS claims processing guidelines to ensure timely and accurate claims payment by Presbyterian on behalf of members. The timeliness for processing a claim can be driven by whether or not the claim is “clean.” Accuracy and completeness of the information provided determine if the claim is considered “clean” or “unclean.”

A claim is defined as “clean” if it contains all of the required data elements necessary for accurate adjudication without the need for additional information from a source outside of Presbyterian and if it has no defect or impropriety, including but not limited to:

- The failure of an electronically transmitted claim to meet HIPAA transaction standards with regard to format or content
- The lack of required substantiation or particular circumstances requiring special treatment that prevents timely payment being made on the claim
- A claim may be “clean” even though Presbyterian refers it to a specialist within Presbyterian for examination

“Unclean” Claims

A claim is defined as “unclean” if additional substantiating documentation (such as medical records, encounter data, emergency room reports, primary insurance explanation of payments and full itemization where necessary) is required from a source external to Presbyterian Centennial Care.

Encounter Reporting

Presbyterian is required by HSD to report all services rendered to Presbyterian Centennial Care members. The reporting of these services, also known as encounter data reporting, is an essential element to the success of Presbyterian Centennial Care.

HSD uses encounter data reporting to evaluate health plan compliance on many vital issues. Regardless of whether the service you provide is capitated or fee-for-service, claims should be submitted to Presbyterian within 90 days of the date of service to accommodate the State of New Mexico’s request for timely encounter data.
Presbyterian is required to submit encounter data to the State of New Mexico within 120 days.

Providers are required to submit to Presbyterian complete encounter data in a form acceptable to and meeting Presbyterian’s standards. Encounters must be submitted within 90 calendar days of the date of service for outpatient services or the date of discharge for inpatient services in an approved format. Presbyterian accepts encounters submitted on CMS-1500 (08-05) and UB claim forms or an equivalent or substitute approved by Presbyterian.

Providers identify services rendered to members by using appropriate diagnosis and procedure codes as defined by the CPT and/or ICD-10-CM or subsequent editions. In accordance with Section 2702 of the Patient Protection and Affordable Care Act (PPACA), Presbyterian has mechanisms in place to preclude payment to providers for provider-preventable conditions. Providers report provider-preventable conditions through the claims submission process. Presbyterian tracks provider-preventable conditions data and reports data to HSD through encounter data.

**Correct Coding Standards**

Presbyterian uses a Correct Coding Standards (CCS) claim editing system to ensure consistent processing of professional and facility claims and to decrease manual intervention. This interface applies pattern recognition and intelligent reasoning to identify potential incorrect payments before claims are paid.

Presbyterian applies the National Correct Coding Initiative (NCCI) policy manual, Change Healthcare edits and other edits based on coding industry standards for consistency in the processing of certain code pairs. CMS standards require that providers must code correctly even if CCS edits do not exist. This promotes consistency of claims submission and reimbursement and prevents the use of inappropriate code combinations.

There are times when Presbyterian reviews certain edits and determines that they may not be appropriate to our current purpose – to improve the health of the patients, members and communities we serve. Most of these reviews are the result of appeals that are received by the Appeals and Grievance Department at Presbyterian. Presbyterian reviews these edits to determine if they are clinically appropriate for situations that may arise when providing care to our members.

If it is determined that a certain edit does not support our purpose, Presbyterian either removes the edit or revises it. Presbyterian is supportive of allowing providers to provide services that are clinically sound and defensible.

**National Correct Coding Initiative**

CMS developed the NCCI to promote national correct coding methodologies and to eliminate improper coding. NCCI edits are developed by the National Correct Coding Council and are based on coding conventions defined in the AMA CPT Manual’s national and local policies and edits, coding guidelines developed by national societies, analyses of standard medical and surgical practice and reviews of current coding practice.
Claims and Payment

The NCCI is administered through CMS. CMS annually updates its coding policy manual, the National Correct Coding Initiative Policy Manual for Medicare Services. Presbyterian encourages you to obtain further information regarding this manual and subsequent updates and to check the CMS website for recent NCCI edits at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd.

The NCCI edits and policies do not include all possible combinations of correct coding edits or all types of unbundling that exist.

Interest Payment

Interest payments are paid as directed in the Centennial Care Managed Care contract on clean claims. Interest shall accrue from the 31st calendar day from the clean claim received date for electronically submitted claims and on the 46th day from the clean claim received date for manual claims. Interest is paid in accordance with Centennial Care guidelines as outlined in the managed care contract Section 4.19.1.7 and will reflect updates in subsequent amendments for each month or portion of any month on a prorated basis. Amendment five of the HSD State of NM Amendment Five to Medicaid Managed Care Agreement currently directs payment of interest as required in Section 8.308.20.9 (E) of NMAC, which further outlines the provision of payment of interest as follows:

(1) *The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on a clean claim (based upon the Medicaid fee schedule).*

Note: Interest will only apply to any unpaid amounts resulting in adjustment as outlined above. Interest is not paid on adjustments related to gross receipts tax (GRT) in accordance with NMAC previsions for interest.

Claims and Payment Resources

myPRES

myPRES is available 24 hours a day, seven days a week and enables you and your office staff to obtain the following information electronically:

- If applicable, at-a-glance coinsurance, deductible and out-of-pocket amounts (the member’s responsibility and the amounts that have been met to date that are in our system at the time of inquiry)
- Other insurance information regarding the member
- Detailed demographic information on the member’s primary care provider
- Information for finding a doctor, provider, or facility
- Check summaries (listing of EOPs that were mailed, with access to all claims associated with that remittance including the address of where the check was mailed)

Provider CARE Unit

The Provider CARE Unit was established to handle complex inquiries from providers, including web-based inquiries, written inquiries, adjustment
requests and telephone calls that were not resolved through myPRES, Interactive Voice Response, http://www.phs.org, or one of our electronic submission vendors. The Provider CARE Unit accesses myPRES when assisting you with your inquiries. Please contact (505) 923-5757 or 1-888 923-5757 for assistance.

Mailing Address for Claims, Corrected Claims and Claims Resubmissions

In an ongoing effort to increase the timeliness of provider payment and maximum efficiency and resources in provider offices, Presbyterian strongly encourages the use of electronic claims submissions. In the event that it becomes necessary to submit a paper claim (new, re-submission or corrected), please direct it to one of the following mailing addresses:

Medial/Physical Health Claims

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489

Behavioral Health Claims

Presbyterian Health Plan
P.O. Box 25926
Albuquerque, NM 87125-2592

Other Contact Information

Coding Information and Resources

American Medical Association (AMA) CPT Products
515 North State Street
Chicago, IL 60654
1-800-621-8335


Center for Medicare & Medicaid Services (CMS)

http://www.cms.gov/


Provider Updates

http://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html?redirect=/center/provider.asp


National Correct Coding Initiative (NCCI) Edits

http://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd/index.html

CMS Carriers Manual and Hospital Manual

Claims and Payment

Novitas Solutions, Inc.
https://www.novitas-solutions.com/

Palmetto GBA for HCPCS information and the
DMERC Manual

http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/97NK5W3580?open

Provider Compliance Group Interactive Map

http://www.cms.gov/Research-Statistics-Data-and-
Systems/Monitoring-Programs/provider-
compliance-interactive-map/index.html

(Click the state of New Mexico on the map.)

National Center for Health Statistics

http://www.cdc.gov/

Classifications of Diseases

http://www.cdc.gov/nchs/icd.htm

Change Healthcare (Formerly McKesson)

https://www.changehealthcare.com
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It is the Presbyterian Customer Service Center’s (PCSC) objective to deliver a consistent customer experience and to provide outstanding service to every customer, every contact, every time.

**Member Contacts for Customer Service**

Members can contact the Presbyterian Customer Service Center by:

- Visiting the “Contact Us” page at [https://www.phs.org/about-us/contact-us/Pages/default.aspx](https://www.phs.org/about-us/contact-us/Pages/default.aspx).
- Emailing [info@phs.org](mailto:info@phs.org).
- Calling the number listed on the back of their ID cards.

Providers should call (505) 923-5757 or 1-888-923-5757 for assistance.

<table>
<thead>
<tr>
<th>Presbyterian Customer Service Center</th>
<th>Hours of Operation for Members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centennial Care</strong></td>
<td>8 a.m. to 6 p.m.</td>
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<td></td>
<td>Monday through Friday</td>
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<td>(except holidays)</td>
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**Member Communication and Welcome Packets**

Upon enrollment, new enrollees receive a welcome packet and a member handbook. New and existing members may access and print this information from our website at [http://www.phs.org](http://www.phs.org) or they may contact the PCSC to request a printed copy.

Providers may obtain a copy of a member handbook, group subscriber agreement, summary of benefits or evidence of coverage by contacting your Provider Network Operations relationship executive at [https://www.phs.org/ContactGuide](https://www.phs.org/ContactGuide).

**Identification Cards**

After enrollment with Presbyterian, each member is issued an identification card (ID) showing the member’s name, ID number and basic plan information.

The member’s ID card should be presented to the provider’s office each time the member presents for service; however, services should not be denied if no card is presented. The ID card does not guarantee that the member is still eligible. To verify eligibility, providers should use myPRES or Presbyterian’s Interactive Voice Response (IVR) system. The IVR can be accessed by calling (505) 923-5757 or 1-888-923-5757. However, use of these services does not guarantee payment. Members can also show their digital ID cards through the MyChart app accessed from a smartphone or mobile device.

Providers are also encouraged to take the precaution of verifying the identity of the person presenting the ID card against another form of identification, such as a driver’s license or other photo identification. This type of verification not only deters fraudulent use, but also protects the provider from performing a service for which payment may
be denied. The Federal Trade Commission recently issued its final ruling regarding identity theft red flags and address discrepancies under the Fair and Accurate Credit Transactions Act of 2003. These regulations require applicable businesses to incorporate processes and procedures in compliance with the final ruling. You are encouraged to determine if your business is subject to these regulations and implement processes to protect patient identity theft as applicable.

To report suspicion of fraud and abuse, please refer to the “Fraud, Waste and Abuse” chapter.

**Choosing a Primary Care Provider**

On an individual basis, Presbyterian may allow a specialist currently treating a member with disabilities or chronic or complex conditions to serve in the capacity of a PCP. The network specialist must agree to perform all PCP duties and such duties must be within the scope of the participating specialist's certification and in accordance with the program requirements and related medical policies.

When a member requests that a specialist serve as the member’s PCP, the PCSC assists the member by providing them with the *Specialist as a PCP* form. This form is completed by the member, who returns the form to Presbyterian. Upon receipt of the completed form, it is reviewed by the Health Services Department for approval.

*Primary Care Provider Changes*

Presbyterian Centennial Care members may request a PCP change at any time, for any reason; however, the effective date varies depending on when the request was made.

If the request was made by the 20th of the month, it becomes effective on the 1st of the following month. If the request was made after the 20th of the month, the change becomes effective the 1st of the month after the following month.

*Removing Members from Your Panel*

If a PCP determines it is in the best interest of the patient and the provider for the member to be removed from his/her panel due to the member’s non-compliant or disruptive behavior in the office, the PCP can request the member’s removal in accordance with our policies and procedures. The PCP must send the member a letter advising them of the decision to end the patient/provider relationship.

Upon contact by the provider or the member, the PCSC can help reassign the member to a new PCP. The current PCP is responsible for providing care according to the transition of care policy until the member can be reassigned.

*Member Eligibility and Enrollment*

Eligibility for Presbyterian Centennial Care is determined by the New Mexico Human Services Department (HSD), Income Support Division.

Presbyterian Centennial Care is assigned eligible participants once a month. Presbyterian Centennial Care is notified before the 1st of the month that a member is enrolled. Presbyterian Centennial Care is responsible for managing the member’s care on the first effective day of the member’s enrollment until the member is not enrolled in Presbyterian...
Presbyterian Customer Service Center

Centennial Care or, if hospitalized in an acute care setting while not enrolled, until discharge to a lower level of care.

If the member not yet enrolled with Presbyterian Centennial Care requires healthcare in the days before the effective date of enrollment, the State of New Mexico or the member’s existing managed care organization is the financially responsible party.

Transportation Services

Presbyterian covers medically necessary transportation for Presbyterian Centennial Care members; however, limitations and exclusions apply for certain services.

Presbyterian Centennial Care or its contractor arranges transportation for appropriate services. The Presbyterian Customer Service Center’s transportation coordinator assists in arrangements and appropriate authorizations. Rides for routine scheduled office visits or medical services require 48 to 72 hours advance notice.

Presbyterian Centennial Care covers emergency transportation by ground ambulance, air ambulance or by a special equipped van when medically appropriate. If members need emergency transportation for a life-threatening situation, they should call 911 or the emergency telephone number in the area.

Same day transportation is available for urgent healthcare services or urgent referrals made by a PCP. To schedule a ride contact Superior Medical Transport at:

- Toll-free: 1-877-774-PRES (7737)
- Directly: (505) 923-6300
- PCSC: (505) 923-5200 or 1-888-977-2333

Members’ Rights and Responsibilities

Presbyterian has written policies and procedures regarding members’ rights and responsibilities and implementation of such rights. As a member of Presbyterian’s network we expect you to respect, support and recognize these rights and responsibilities.

Members have the right to the following:

- Exercise their patient rights. Understand that doing this does not cause Presbyterian and its contracted providers or HSD to treat them in a negative way.
- Be treated with respect and recognition of their dignity and right to privacy
- Be told about the options open to them for their treatment. Be told about any other choices they can make about their treatment. They should get this information in a way that is right for their condition. They should be told in a way that they can understand.
- Decide on advance directives for their healthcare as allowed by law
- Receive care that is free from discrimination
- Participate with their provider in all decisions about their healthcare, including their treatment plan and the right to refuse treatment; family members and/or legal
guardians or decision-makers also have this right, as appropriate.

- Receive healthcare that is free from any form of restraint or seclusion that is used to pressure or punish them.

- Ask for and get a copy of their medical records

- Choose a stand-in decision maker to be involved as appropriate. This person is able to help with care decisions.

- Give informed consent for healthcare services

- File a grievance or appeal about Presbyterian Centennial Care or the care that they were given. They have the right to file a grievance with Presbyterian Centennial Care and New Mexico HSD without fear of retaliation (punishment).

- Choose a provider from the Presbyterian Centennial Care network. A referral or authorization may be needed to see some providers.

- Get information about Presbyterian Centennial Care. This includes the services, how to access them, their rights and responsibilities and the providers available for their care.

- Be free from harassment by Presbyterian Centennial Care or its network providers about contractual disputes between Presbyterian and its providers

- Seek family planning services from any provider, including providers outside of the Presbyterian network. Presbyterian Centennial Care members can learn about their family planning rights through the Member Handbook, the website and the online member portal. They also can learn through education and outreach programs. At the least, this includes counseling on human immunodeficiency virus (HIV) and other sexually transmitted diseases. It covers things they can do to lower their risk for sexually transmitted diseases. It also covers birth control pills and devices (including Medicaid Cover Plan B). It includes information on how to get family planning services. They can seek these services no matter their age or sex.

- Female members can self-refer to a women’s health specialist in the Presbyterian Centennial Care network. This applies to covered care needed for women’s routine and preventive healthcare services. This is in addition to the care their PCP provides if he or she is not a women’s health specialist.

- Have private medical and financial records. This is in agreement with current law. These are the records kept by Presbyterian and Presbyterian’s provider network. Members have the right to confidential records. Their records are released only with their written consent. Their legal guardian also may give
consent. Their records may be released as otherwise allowed by law.

• See their medical and financial records. This is in agreement with any laws and regulations that apply.

• Ask that the use or disclosure of their protected health information be restricted.

• Get confidential communications of their protected health information from Presbyterian Centennial Care.

• Get and inspect a copy of their protected health information (PHI) as allowed by law.

• Ask for an amendment (addition to) their PHI if, for example, they feel the information is incomplete or wrong.

• Get an accounting of PHI disclosures

• Ask for a paper copy of the official privacy notice from Presbyterian Centennial Care. This is their right even if they have already agreed to receive electronic privacy notices.

• File a complaint if they believe Presbyterian is not following the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

• Make recommendations about the Presbyterian Centennial Care member rights and responsibility policy.

• Get any information in a different format in compliance with the Americans with Disabilities Act.

Members have the responsibility to the following

• Freely exercise their rights. Understand that doing this does not cause Presbyterian and its contracted providers or HSD to treat them in a negative way.

• Give their complete health information. This helps their provider give them the care they need. This includes providing childhood immunization (shot) records for members up to age 21.

• Follow their treatment plans and instructions for medications, diet and exercise as agreed upon by the member and their provider

• Keep their appointment. If they cannot keep it, they should call their provider to reschedule or cancel no later than 24 hours before the appointment.

• Tell the provider if they do not understand his or her explanation about their care. Ask the provider questions. Talk to the PCSC about any suggestions or problems they may have.

• Respect providers and other healthcare employees. Treat them with courtesy.

• Act in a way that supports the care other patients get. Act in a way that supports the general functioning of the facility.

• Refuse to let any other person use their Presbyterian member ID card

• Tell Presbyterian right away if they lose their member ID card, or if it is stolen.
Know what could happen if they give Presbyterian information that is wrong or incomplete

Tell the New Mexico HSD and Presbyterian Centennial Care when their phone number, address or family status changes.

Tell their providers that they have Presbyterian Centennial Care at the time of service. They may have to pay for services if they do not tell their provider that they have Presbyterian coverage.

Protect the privacy of their care and of other patients’ care

Ask about any arrangements Presbyterian has with its providers. This applies to monetary policies that might limit referrals or treatment. It also applies to policies that might limit member services.

Change their PCP according to the rules described in this Member Handbook.

**Note:** Members’ rights and responsibilities are also available on our website at [http://www.phs.org](http://www.phs.org), or a member may call the PCSC to request a printed copy.

**Confidentiality**

Presbyterian is committed to protecting members’ PHI and safeguarding confidential medical information through the implementation of the Presbyterian confidentiality policy. For a printed copy of the policy, please contact your Provider Network Operations relationship executive at [https://www.phs.org/ContactGuide](https://www.phs.org/ContactGuide).

Upon enrollment and annually thereafter, Presbyterian provides each member with a Joint Notice of Privacy Practices. This notice describes the privacy practices of Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. This notice helps members understand how Presbyterian protects the privacy of their health information and also informs members of their health information rights.

**Member Health Information Rights**

The rights described below are subject to limitations and conditions.

**Legal Authority to Make Health Care Decisions for Minors or Others**

Usually, health information rights may be given to a person with legal authority to make healthcare decisions for a child or other person (for example, a parent or legal guardian). There are exceptions. For example, under New Mexico law, there are a number of circumstances in which minors (people under the age of 18) may consent to receive healthcare services without parental consent, including the following:

- Examination and treatment for sexually transmitted diseases
- Pregnancy, prenatal, delivery and postnatal care
- Family planning services
- Behavioral health services

Confidentiality
Presbyterian Customer Service Center

- Treatment in a licensed facility for substance abuse
- Life sustaining treatment
- Anatomical gifts (must be 16)

Right to See and Get a Copy of Health Information

Members have the right to see and get a copy of most of their health information. Their request to see or get a copy of health records must be made in writing.

Right to Amend Incorrect or Incomplete Health Information

Members have the right to request that we change incorrect or incomplete health information kept in our records. The member may be required to make the request in writing. Presbyterian may deny the request if we believe that the information in our records is correct and complete. If the request is denied, the member receives written notice including the reason for the denial and how the member may appeal our decision.

Right to Request Restrictions of Health Information

Members have the right to request that health information is not used or shared for certain purposes. We are not required by law to agree to the request. For example, we do not agree to limit the use or sharing of health information during a health emergency.

Right to Request Confidential Communications of Health Information

Members have the right to request that health information is delivered in a certain way or at a certain location. We must agree to a reasonable request. We may deny the request if it is against the law or our policies.

Right to Request an Accounting of Disclosures

Members have the right to request an Accounting of Disclosures Report. This report shows when health information was shared by us and others without written authorization.

Right to Receive a Paper Copy of Privacy Notice

Members have a right to receive a printed copy of the Joint Notice of Privacy Practices upon request.

Use of Consents/Authorizations to Obtain Protected Health Information

We do not re-disclose this health information without valid authorization from the member (or their legally authorized personal representative) unless required by law or as otherwise described in the plan’s Joint Notice of Privacy Practices.

Presbyterian expects that a provider will make member records available to the plan in accordance with federal and state regulations and the provider contract that exists between Presbyterian and the provider.

There may be situations in which Presbyterian requests PHI from the provider for Presbyterian’s healthcare operations. In these situations, the provider agrees to provide the requested PHI or make a good faith attempt, within a reasonable time period, to obtain a valid authorization from the member and to provide Presbyterian, upon request, with written documentation of such attempts.

Privacy regulations also permit healthcare providers to obtain consent from individuals to use...
or disclose their PHI for purposes of treatment, payment or healthcare operations. Please note that the regulations do not require that providers obtain consent to use or disclose PHI for these purposes.

If a provider opts to obtain consent as described above from the member, the provider agrees to provide a copy of that consent to Presbyterian as part of a response to a request for PHI from Presbyterian.

A member may access and print an authorization form from the website at http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001068.pdf or contact the PCSC to request a printed copy.

**Authorization forms are kept in the member’s medical record or enrollment file.**

**Members Who are Unable to Give Consent or Authorization**

For children and people who are incapacitated and unable to make health decisions for themselves, health information rights are usually given to a person with legal authority to make healthcare decisions on their behalf (such as a custodial parent, legal guardian, or person holding healthcare power of attorney). In these situations, when authorization is needed to use or disclose protected health information, the authorization form is signed by a person with legal authority to make healthcare decisions for the individual.

Presbyterian Case Management staff coordinate case(s) with appropriate agencies, such as Children, Youth and Families Department (CYFD) for those children who are under CYFD jurisdiction, Adult Protective Services with an open case on a member, Juvenile Justice and any other applicable agency or case manager for any individual who is unable to make decisions due to being incapacitated or is unable to give informed consent, consistent with federal and state laws.

**Member Access to Protected Health Information Contained in Plan Records**

PHI is kept in a physically secure location with access limited to authorized personnel only. Members have the right, with certain exceptions, to see and obtain a copy of most PHI about them that is contained in our records. To request access to inspect or obtain a copy of PHI, the member must submit the request in writing to:

Presbyterian Customer Service Center  
P.O. Box 27489  
Albuquerque, NM 87125-7489

Requests for medical records must be made by the member directly to the treating provider.

**Safeguarding Oral, Written, and Electronic Protected Health Information Across Presbyterian**

To ensure internal protection of oral, written and electronic PHI across Presbyterian, the following rules are strictly adhered to:

- PHI is accessed only if such information is necessary to the performance of job-related tasks.
- All employees, volunteers and all external entities with a business relationship with Presbyterian that involves health
Presbyterian Customer Service Center

information are held responsible for the proper handling of Presbyterian’s confidential business information and PHI and are required to sign a confidentiality statement or business associate agreement.

Violation of the above rules by an employee may be grounds for immediate dismissal.

myPRES/Website Internet Information

Presbyterian enforces security measures to protect PHI that is maintained on our website, network, software and applications. We collect information from visitors to our website, including:

- Website traffic statistics
- Where visitor traffic comes from
- How traffic flows within the website
- Browser type

These statistics help us improve the website and find out what visitors find interesting and useful.

Presbyterian uses personal information to reply to concerns. We save this information as needed to keep responsible records and handle inquiries. We do not sell, trade or rent our visitors’ personal information to anyone.

Regarding myPRES, the security features of the program allow only information pertaining to that particular member or provider to be accessed.

Website (http://www.phs.org)

The Presbyterian website does not contain any PHI, but rather is a source for general policy statements such as member rights and responsibilities, forms, listings of participating providers, and Presbyterian’s notices of privacy practices.

Protection of Information Disclosed to Plan Sponsors, Employers, or Government Agencies

Federal law limits the information that Presbyterian may disclose to employers regarding their employees to “summary information” and “information regarding enrollment and disenrollment.” Presbyterian may provide more detailed PHI regarding employees to plan sponsors (self-insured employer groups) only when the employer has certified to Presbyterian that they have informed employees about this use of their information by making certain amendments to the plan documents or the employee (or their legally authorized representative) consents to the release of information.

Cultural Competency

The ability to communicate effectively with patients and members affects their ability to understand information about their healthcare, complete a prescribed course of treatment and be involved in healthcare decisions that affect them. Being culturally competent, sensitive and aware is the key to Presbyterian’s mission to improve the health of the patients, members and communities Presbyterian serves.

Cultural competency enhances communication and treatment effectiveness. For healthcare providers, being culturally competent includes awareness of the existence of culturally diverse populations and the potential for racial and ethnic healthcare disparities. All cultures have unique views and
practices in regard to illness and well-being that affect the healthcare decisions they make.

Presbyterian requires all staff to complete annual cultural competency training to educate staff on the importance of respecting diversity, including culture and language preferences.

Presbyterian provides information to members in a culturally sensitive manner, including to those limited in English language proficiency or reading skills, those with diverse cultural and ethnic backgrounds and those with physical or mental disabilities. Presbyterian recommends registering for online Cultural Sensitivity competencies at https://www.thinkculturalhealth.hhs.gov/ or by using the Cultural Sensitivity Competencies link when logging in to myPRES. Supported by the Office of Minority Health at the United States Department of Health and Human Services and accredited by Ciné-Med, the online competencies offered are designed to assist healthcare professionals deliver culturally competent care to an ever-increasingly diverse population of members.

Translation Services

Participating network practitioners and providers are required by contract to provide or coordinate translation services for their patients. Our Customer Service Center is also available to assist providers with translation services for Presbyterian Centennial Care members through Certified Language International (CLI). CLI, a third party contractor, provides translation services in more than 170 languages including Spanish, Navajo, Vietnamese, Portuguese and Russian.

Practitioners and providers can contact CLI directly to coordinate translation services for their Centennial Care members. Direct billing arrangements are available with CLI. CLI is accessible 24 hours a day, seven days a week by calling 1-800 225-5254. For more information on translation services and culturally competent care, please see the “Centennial Care Overview” section.

Advance Directive

Members have the right to make healthcare decisions and to execute advance directives. They also have the right to accept or refuse treatment. An advance directive is a formal document, completed by a member in advance of an incapacitating illness or injury, which indicates the member’s preferences regarding healthcare treatment. Once an advance directive is created, both the member and the provider should have a copy. If a member is admitted to a hospital, the hospital should also have a copy.

As long as a member can speak for themselves, providers must honor their wishes, except as a matter of conscience. Providers must document in a prominent part of the member’s current medical record whether or not an individual has executed an advance directive.

Under the New Mexico Uniform Healthcare Decisions Act, if a healthcare practitioner or provider declines to comply with a member’s instruction or healthcare decision as a matter of conscience, the practitioner or provider must continue to provide care to the member until a transfer can be executed. The practitioner or provider must promptly inform the member, if
possible, or an agent authorized to make healthcare decisions for the member. Unless the member or the agent refuse assistance, the practitioner or provider must immediately make all reasonable efforts to assist in the transfer of the patient to another healthcare practitioner or provider that is willing to comply with the instruction. Presbyterian does not impose conditions that bar the provider from implementing advance directives as a matter of conscience if they have not filed a conscience protection waiver with Centers for Medicare & Medicaid Services (CMS). Presbyterian is not required to provide care that conflicts with an advance directive. Presbyterian is not required to provide care that conflicts with an advance directive.

A member can obtain the brochure Making Healthcare Decisions from the PCSC, which provides information and forms for completing an advance directive. These are important legal documents, however and members should consider consulting an attorney to assist them in preparing an advance directive.

Types of directives include:

- Living will – This lets members detail which treatments they want and do not want if they cannot speak for themselves.

- Durable power of attorney for healthcare – This lets members appoint a friend or relative to make medical decisions for them if they cannot do it themselves.

- Do-not-resuscitate (DNR) order – This lets members inform caregivers they do not want to receive cardiopulmonary resuscitation (CPR) if their heart stops beating.

Provider CARE Unit

The Provider Claims Activity Review and Evaluation (CARE) Unit of the PCSC is designed to handle “complex” inquiries from the provider community that cannot be resolved through self-help options.

Self-Help Options

myPRES is the quick and easy way of accessing real-time information. This service is available 24 hours a day, seven days a week to ensure the information you and your office staff needs is at your fingertips. This tool is the most efficient way of getting the information you need, when you need it.

Each employee in your office that uses myPRES must have their own individual user name and password. Under no circumstances should the myPRES user name and password be shared. It is your responsibility to contact the PCSC to terminate access of employees who are no longer employed. If you have an employee who no longer requires access to myPRES, please contact the PCSC to terminate their access. Violation of the terms and conditions for use of myPRES may result in revocation of myPRES access.

Information available through myPRES includes:

- Member eligibility
- Member benefits
- Copayment, co-insurance, deductible and out-of-pocket amounts (the member’s
responsibility and the amounts that have been met to date that are in Presbyterian’s system at the time of inquiry)

- Information regarding a member’s other insurance (if applicable)
- PCP verification (including demographic information)
- Member rosters (for PCPs)
- Information regarding finding a doctor, provider, or facility
- Claims status, inquiry, or verification
- Check summaries (listing of Explanation of Payments that were mailed, with access to all claims associated with that remittance including the address of where the check was mailed)
- Benefit certification submission and status
- Pharmacy exception submission and status
- Access to the Provider CARE Unit (electronically)

**Interactive Voice Response System**

Presbyterian’s Interactive Voice Response (IVR) system is available to assist you with member eligibility verification, benefits, claim status, benefit certifications, pharmacy exceptions and behavioral health services. The IVR can be accessed by calling (505) 923-5757 or 1-888-923-5757.

**Web-based Inquiries**

Presbyterian may contact the Provider CARE Unit electronically by going to [http://www.phs.org](http://www.phs.org) and selecting “Contact Us” from the menu at the bottom of the page, or by going to [https://www.phs.org/about-us/contact-us/Pages/default.aspx](https://www.phs.org/about-us/contact-us/Pages/default.aspx).

**Helpful Tips**

In the event that it is necessary to submit a paper claim (new, resubmission or corrected) or when submitting claims and encounter information, please direct it to the following mailing address:

Presbyterian Health Plan  
P.O. Box 27489  
Albuquerque, NM 87125-7489

The Provider CARE unit will assist you with your complex inquiries Monday through Friday between 8 a.m. and 5 p.m. The Provider CARE Unit can be contacted by providers at (505) 923-5757 or toll-free at 1-888-923-5757.

When calling the Provider CARE Unit, please have available the following information:

- Your National Provider Identifier (NPI); a requirement for you to provide as of January 1, 2008; the Provider CARE unit will be unable to assist you without this number.
- The member’s Presbyterian ID number, date of service, procedure code, billed amounts and claim number (if known).

Refer to the “Claims” chapter of this manual for:

- Questionable claims payment or denial
- Reimbursement and coding questions
- Timely submission guidelines
For benefit certification information, refer to the “Care Coordination” chapter of this manual.

For appeals and grievance information, refer to the “Appeals and Grievances” chapter.

**Contacting the Provider CARE Unit**

Please contact your Provider Network Operations relationship executive at https://www.phs.org/ContactGuide if the issue affects more than 10 claims (for example, incorrect contract payment or charge for a specific code is denying when it should be paying).

**Telephone Inquiries**

If a member needs to request PCP change or wishes to speak with a customer service representative, please have them call the customer service phone number on the back of their Presbyterian member ID card.
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21. Appeals and Grievances

A provider has the right to file an appeal if dissatisfied with a decision made by Presbyterian to terminate, suspend, reduce or not provide approved services to a member, or to deny payment for services. The provider also has the right to file an appeal if the provider disagrees with any policy or adverse action made by Presbyterian. Additionally, if a provider is dissatisfied with any of Presbyterian’s general operations, he or she may file a grievance. In order to file an appeal or grievance on behalf of a member, a provider must have the member’s written consent.

If the issue involves a utilization management decision, a provider must obtain the written consent of the member to act on his or her behalf during the appeal process, unless the matter is determined to be an expedited appeal.

Provider Appeals and Grievance Process

Any provider has the right to file a formal grievance or appeal with Presbyterian. The provider should submit the grievance or appeal to the Presbyterian grievance and appeals coordinator within the following time frame:

- **Grievances or appeals challenging a claim denial, claim adjudication, claim submission, claim resubmission or claim resubmission not acted upon by Presbyterian** must be filed within 12 months of the date of service or 60 days from the notification, whichever is the later date.

**Standard Appeal**

Presbyterian encourages providers to file claims correctly the first time or, if time allows, resubmit the claim through the Claims Activity Review and Evaluation (CARE) Unit to resolve an issue. A provider is encouraged to contact his or her Provider Network Operations relationship executive at [https://www.phs.org/ContactGuide](https://www.phs.org/ContactGuide) to help clarify any denials or other actions relevant to the claim and to help with a possible resubmission of a claim with modifications.

Remember, once a claim is initially submitted in a timely manner, a provider has one year (12 months) from the date of service to correct any defects in the initial claim submission and to resubmit the claim for reprocessing. A provider has one year (12 months) from the date of service to file an appeal regarding a claim denial.

Appeals will be resolved within 30 calendar days. If the provider appeal is not resolved within 30 calendar days, Presbyterian requests a 14 calendar day extension from the provider. If the provider requests the extension, the extension is approved by Presbyterian.

When filing an appeal, please remember to document the reasons for the reconsideration request and attach all supporting documentation for
Appeals and Grievances

review of the issue. If the issue involves a claims denial appeal and the claim was previously submitted electronically, please include a hard copy of the claim in question for review of the appeal. If the appeal is related to a claim coding matter, it is helpful to include supporting medical records such as office notes and operative reports, if applicable.

Formal Grievances

A grievance may be filed orally or in writing and must state with particularity the factual and legal basis and the relief requested, along with any supporting documents (such as claim, remittance, medical review sheet, medical records or correspondence). This means a chronology of pertinent events and a statement as to why the provider believes the action(s) by Presbyterian was incorrect. Grievances shall be resolved within 30 calendar days. If the provider grievance is not resolved within 30 calendar days, Presbyterian requests a 14-calendar-day extension from the provider. If the provider requests the extension, the extension is approved by Presbyterian. Presbyterian reviews grievances in accordance with all federal and state regulatory guidelines and Presbyterian’s policies and procedures. For a list of the applicable regulations, please access the Appeals & Grievances page at https://www.phs.org/providers/resources/appeals-grievances/Pages/default.aspx.

Member Appeals and Grievances

With written consent from the member to act as their representative during the appeal process, providers may appeal a denied benefit certification or a concurrent review decision to deny authorization that was made by the medical director. At the time of the decision, a provider or member may request that Presbyterian reconsider the denial by submitting further documentation to support medical necessity. Such requests are referred immediately to a medical director not previously involved in the case for resolution and are handled according to the member appeal guidelines.

If benefit certification or prior authorization for services for any Presbyterian member is requested by a provider and denied by Presbyterian, a provider may act on the member’s behalf and may file a request for an expedited appeal if the provider feels that the member’s health or welfare are in immediate jeopardy. Presbyterian then determines if it meets expedited criteria. If the case is deemed expedited, Presbyterian processes the expedited appeal within three business days of receipt. (Time extensions may apply with written consent from the member.)

For Presbyterian Centennial Care, unless the member or the provider requests an expedited resolution, an oral appeal must be followed by a written appeal that is signed by the member within 13 calendar days; failure to file the written appeal within 13 calendar days constitutes withdrawal of the appeal.

The Presbyterian member appeals and grievance process is published in the Presbyterian Centennial Care Member Handbook. Presbyterian provides a process that ensures all members have the right to exercise their right to an appeal and that they
Appeals and Grievances

receive the decision within the appropriate and proper time frames for resolution of their appeals.

Any member also has the right to file a grievance if he or she is dissatisfied with the services rendered through Presbyterian. In respect to grievances, the member is defined as any individual enrolled in Presbyterian or their designated representative. A provider may represent a member in a grievance or appeal with written consent from the member.

Member grievances may include but are not limited to the following:

- Dissatisfaction with providers
- Appropriateness of services rendered
- Timeliness of services rendered
- Availability of services
- Delivery of services
- Reduction or termination of services
- Disenrollment
- Any other performance that is considered unsatisfactory.

The member can submit a grievance to the Presbyterian grievance and appeals coordinator at any time. The member should submit an appeal to the grievance and appeals coordinator within 60 days from the date of denial.

Member Fair Hearing

A member may request a state fair hearing within 90 calendar days for standard appeals and within 30 calendar days for expedited appeals of Presbyterian’s final decision if he or she is dissatisfied with an action that was taken by Presbyterian and the member has exhausted Presbyterian’s internal process. A representative of the member or the member’s estate, or a provider acting on behalf of the member, with the member’s consent, may request a state fair hearing on behalf of the member.

A state fair hearing may be requested by calling or writing to:

New Mexico Human Services Department
Fair Hearings Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348

- Phone: (505) 476-6213
- Toll-free: 1-800-432-6217, Option 6
- Fax: (505) 476-6215

If a request for a Fair Hearing is received by HSD within 10 calendar days, Presbyterian’s final decision will be upheld until the outcome of the hearing is decided. However, if the Hearing Officer agrees with Presbyterian’s final decision, the member may have to pay for the continued services if those services were the reason for the hearing. The administrative law judge’s recommendation may be adopted or rejected in a final written decision by the medical assistance division director on issues that were the subject of the hearing.
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# Appendix A: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<tr>
<td>ADHD</td>
<td>Attention Deficit and Hyperactivity Disorder</td>
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<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>BADL</td>
<td>Basic Activities of Daily Living</td>
</tr>
<tr>
<td>CAGE</td>
<td>Cut, Annoy, Guilty, Eye Opener</td>
</tr>
<tr>
<td>CAHPS®</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
</tr>
<tr>
<td>CARE</td>
<td>Claims Activity Review and Evaluation</td>
</tr>
<tr>
<td>CCS</td>
<td>Correct Coding Standards</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CHR</td>
<td>Community Health Representative</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CLIA</td>
<td>Clinical Laboratory Improvement Amendments</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CNA</td>
<td>Comprehensive Needs Assessment</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>CSA</td>
<td>Core Service Agency</td>
</tr>
<tr>
<td>CT</td>
<td>Computed Tomography</td>
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<tr>
<td>CYFD</td>
<td>Children, Youth and Families Department</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
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</table>
### Appendix A: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>DHI</td>
<td>Division of Health Improvement</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>eCOB</td>
<td>Electronic Coordination of Benefits</td>
</tr>
<tr>
<td>ECHO</td>
<td>Extension for Community Healthcare Outcomes</td>
</tr>
<tr>
<td>ECT</td>
<td>Electronic Claims Transmission</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
</tr>
<tr>
<td>EOP</td>
<td>Explanation of Payment</td>
</tr>
<tr>
<td>EOR</td>
<td>Employer of Record</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis and Treatment</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>FAQ</td>
<td>Frequently Asked Question</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FICA</td>
<td>Federal Insurance Contributions Act</td>
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<tr>
<td>FMA</td>
<td>Fiscal Management Agency</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>FR</td>
<td>Federal Register</td>
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<tr>
<td>FUTA</td>
<td>Federal Unemployment Tax Act</td>
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<tr>
<td>GSA</td>
<td>Group Subscriber Agreement; Government Services Administration</td>
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<tr>
<td>HCBS</td>
<td>Home and Community-Based Services</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedural Coding System</td>
</tr>
<tr>
<td>HEDIS®</td>
<td>Healthcare Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Aide</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>HIT</td>
<td>Health Information Technology</td>
</tr>
<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>HRA</td>
<td>Health Risk Assessment</td>
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<tr>
<td>HSC</td>
<td>Hospital Services Corporation</td>
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<tr>
<td>HSD</td>
<td>Human Services Department</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
</tr>
<tr>
<td>ICM</td>
<td>Integrated Care Management</td>
</tr>
<tr>
<td>ICPT</td>
<td>Interdisciplinary Care Plan Team</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>I/T/U</td>
<td>Indian Health Service/Tribal Health Providers/urban Indian Providers</td>
</tr>
<tr>
<td>IVR</td>
<td>Interactive Voice Response</td>
</tr>
<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
</tr>
<tr>
<td>LRI</td>
<td>Legally Responsible Individual</td>
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<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
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<tr>
<td>MAD</td>
<td>Medical Assistance Division</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MFEAD</td>
<td>Medicare Fraud and Elder Abuse Division</td>
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<tr>
<td>MPC</td>
<td>Medical Policy Committee</td>
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<tr>
<td>MR</td>
<td>Magnetic Resonance</td>
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<td>MTM</td>
<td>Medication Therapy Management</td>
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<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
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<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>NDC</td>
<td>National Drug Code</td>
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<tr>
<td>NFLOC</td>
<td>Nursing Facility Level of Care</td>
</tr>
<tr>
<td>NMAC</td>
<td>New Mexico Administrative Code</td>
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<td>NMMFCA</td>
<td>New Mexico Medicare False Claims Act</td>
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<td>NMSA</td>
<td>New Mexico Statutes Annotated</td>
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<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
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<tr>
<td>P&amp;T</td>
<td>Pharmacy and Therapeutics</td>
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<tr>
<td>PCA</td>
<td>Personal Care Attendant</td>
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<tr>
<td>PCMH</td>
<td>Patient-Centered Medical Home</td>
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<tr>
<td>PCP</td>
<td>Primary Care Provider/Practitioner</td>
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<td>PCSC</td>
<td>Presbyterian Customer Service Center</td>
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<tr>
<td>PET</td>
<td>Positron Emissions Tomography</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information</td>
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</tbody>
</table>
### Appendix A: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>PHP</td>
<td>Presbyterian Health Plan</td>
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<tr>
<td>PHS</td>
<td>Presbyterian Healthcare Services</td>
</tr>
<tr>
<td>PID</td>
<td>Program Integrity Unity</td>
</tr>
<tr>
<td>PPA</td>
<td>Physician Performance Assessment</td>
</tr>
<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
</tr>
</tbody>
</table>

**Q**
- QI: Quality Improvement
- QM: Quality Management

**R**
- RAC: Recovery Audit Contractor
- RN: Registered Nurse

**S**
- SAM: System for Award Management

**T**
- TAC: Technology Assessment Committee

**U**
- UM: Utilization Management
- UNM: University of New Mexico
- USC: United States Code

**V**
- VFC: Vaccines for Children

**W**
- WEDI: Workgroup on Electronic Data Interchange
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Appendix B: Definitions

Note that the definitions provide in this list come from a number of sources. The primary sources are listed below. If the definition comes from another source, a link to that source is provided.

### HSD:
New Mexico Human Services Department (HSD) in the August 31, 2012, Request for Proposals (RFP# 13-360-8000-001) for Centennial Care.

### CMS:
http://www.medicaid.gov

### NM:
State of New Mexico website

### PM:
Within this Provider Manual

### Wiki:
Wikipedia

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<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Source</th>
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<tr>
<td>Abuse</td>
<td>Means: (i) Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with the Resident Abuse and Neglect Act, NMSA 1978, 30-47-1, et seq.; or (ii) provider practices that are inconsistent with sound fiscal, business, medical or service-related practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary services or that fail to meet professionally recognized standards for healthcare. Abuse also includes member practices that result in unnecessary cost to the Medicaid program pursuant to 42 CFR § 455.2.</td>
<td>HSD</td>
</tr>
<tr>
<td>Action</td>
<td>Means, for purposes of an appeal: (i) the denial or limited authorization of a requested service, including the type or level of service; (ii) the reduction, suspension or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure of the MCO to provide services in a timely manner, as defined by HSD or its designee; or (v) the failure of the MCO to complete the authorization request within specific time frames set forth in 42 CFR § 438.408.</td>
<td>HSD</td>
</tr>
<tr>
<td>Activities of daily living (ADL)</td>
<td>Means eating, dressing, maintaining oral hygiene, bathing, ensuring mobility, toileting, grooming, taking medications, transferring from a bed to a chair and walking, consistent with HSD regulations. See also basic activities of daily living (BADL) and instrumental activities of daily living (IADL).</td>
<td>HSD</td>
</tr>
<tr>
<td>Adult</td>
<td>Means an individual age 18 or older unless otherwise specified.</td>
<td>HSD</td>
</tr>
<tr>
<td>Advance directive</td>
<td>Means written instructions (such as an advance health directive, a mental health advance directive, a psychiatric advance directive, a living will, a durable healthcare power of attorney or a durable mental healthcare power of attorney) recognized under state law (whether statutory or as recognized by the courts of the state) relating to the provision of healthcare when an individual is incapacitated. Such written instructions must comply with NMSA 1978, §§ 24-7A-1 through 24-7A-18 and 24-7B-1 through 24-7B-16.</td>
<td>HSD</td>
</tr>
<tr>
<td>Adverse determination</td>
<td>Means a determination consistent with 42 CFR § 438.408 by the MCO or the MCO’s utilization review agent that the healthcare services furnished, or proposed to be furnished, to a member are not medically necessary or not appropriate.</td>
<td>HSD</td>
</tr>
<tr>
<td>Agency-based community benefit</td>
<td>Means the consolidated benefit of home- and community-based services (HCBS) and personal care services that are available to members meeting the nursing facility level of care.</td>
<td>HSD</td>
</tr>
<tr>
<td>Appeal</td>
<td>Means a request by a member for review by the MCO of a MCO Action.</td>
<td>HSD</td>
</tr>
<tr>
<td>Basic activities of daily living (BADL)</td>
<td>Bathing and showering (washing the body); bowel and bladder management (recognizing the need to relieve oneself); dressing; eating (including chewing and swallowing); feeding (setting up food and bringing it to the mouth); functional mobility (moving from one place to another while performing activities); personal device care; personal hygiene and grooming (including washing hair); sexual activity; toilet hygiene (completing the act of relieving oneself)</td>
<td>see link</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Behavioral health</td>
<td>Umbrella term for mental health (including psychiatric illnesses and emotional disorders) and substance abuse (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health and substance abuse disorders.</td>
<td><a href="http://en.wikipedia.org/wiki/Activities_of_daily_living">http://en.wikipedia.org/wiki/Activities_of_daily_living</a></td>
</tr>
<tr>
<td>Business days</td>
<td>Means Monday through Friday, except for State of New Mexico holidays.</td>
<td>HSD</td>
</tr>
<tr>
<td>Calendar days</td>
<td>Means all seven days of the week, including State of New Mexico holidays.</td>
<td>HSD</td>
</tr>
<tr>
<td>Care coordination</td>
<td>The management of a member’s services to ensure that needs are met and services are not duplicated by the organizations involved in providing care. See link <a href="http://medical-dictionary.thefreedictionary.com/care+coordination">http://medical-dictionary.thefreedictionary.com/care+coordination</a></td>
<td></td>
</tr>
<tr>
<td>Care level</td>
<td>See levels of care.</td>
<td>HSD</td>
</tr>
<tr>
<td>Centennial Care</td>
<td>Means the State of New Mexico’s Medicaid program operated under Section 1115(a) of the Social Security Act waiver authority.</td>
<td>HSD</td>
</tr>
<tr>
<td>Claim</td>
<td>Means a bill for services submitted to the MCO manually or electronically, a line item of service on a bill, or all services for one member within a bill.</td>
<td>HSD</td>
</tr>
<tr>
<td>(the) Collaborative</td>
<td>Means the Interagency Behavioral Health Purchasing Collaborative, established under NMSA 1978, § 9-7-6.4, responsible for planning, designing and directing a statewide behavioral health system.</td>
<td>HSD</td>
</tr>
<tr>
<td>Community benefit</td>
<td>Means both the agency-based community benefit and the self-directed community benefit subject to an individual’s annual allotment as determined by HSD.</td>
<td>HSD</td>
</tr>
<tr>
<td>Community health representative (CHR)</td>
<td>Equivalent to community health worker or promotora but in the tribal communities.</td>
<td>PM</td>
</tr>
<tr>
<td>community health workers (CHW)</td>
<td>Also known as promotoras; means lay members of communities who work either for pay or as volunteers in association with the local healthcare system in tribal, urban and rural areas and usually share ethnicity, language, socioeconomic status and life experiences with the members they serve. Community health workers include, among others, community health advisors, lay health advocates, promotoras, Outreach educators, community health representatives, peer health promoters and peer health educators.</td>
<td>HSD</td>
</tr>
<tr>
<td>Confidential Information</td>
<td>Means any communication or record – whether oral, written, electronically stored or transmitted, or in any other form – consisting of: (i) confidential member information, including HIPAA-defined protected health information; (ii) all non-public budget, expense, payment and other financial information; (iii) all privileged work product; (iv) all information designated by HSD or any other state agency as confidential and all information designated as confidential under the laws of the State of New Mexico; and (v) information utilized, developed, received, or maintained by HSD, the Collaborative, the MCO, or participating state agencies for the purpose of fulfilling a duty or obligation under this agreement and that has not been disclosed publicly.</td>
<td>HSD</td>
</tr>
<tr>
<td>Core service agencies (CSAs)</td>
<td>Means multi-service agencies that help to bridge treatment gaps in the child and Adult treatment systems, promote the appropriate level of service intensity for members with complex behavioral health service needs, ensure that community support services are integrated into treatment and develop the capacity for members to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.</td>
<td>HSD</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Means those physical, behavioral health and long-term care services provided under Centennial Care.</td>
<td>HSD</td>
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<tr>
<td>Term</td>
<td>Definition</td>
<td>Source</td>
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<tr>
<td>Critical incident</td>
<td>Means a reportable incident that may include, but is not limited to:  ▪ Abuse, neglect and exploitation  ▪ Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment  ▪ with resulting physical harm, pain, or mental anguish to a consumer. ▪ Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer. ▪ Exploitation is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a consumer's belongings or money without the consumer's consent. ▪ Death  ▪ Unexpected death is a death caused by an accident or an unknown or unanticipated cause. ▪ Natural/expected death is a death caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death ▪ Other reportable incidents  ▪ Environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer  ▪ Law enforcement intervention is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility. ▪ Emergency services refers to the provision of emergency services to a consumer that result in medical care that is not anticipated for this consumer and that would not routinely be provided by a primary care provider.</td>
<td>HSD</td>
</tr>
<tr>
<td>Cultural competence</td>
<td>Means a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency involves integrating and transforming knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual’s culture to increase the quality and appropriateness of healthcare and outcomes.</td>
<td>HSD</td>
</tr>
<tr>
<td>Desirable</td>
<td>Means “preferred.” The terms “may,” “can,” “should,” &quot;preferably,&quot; or “prefers” identify a desirable or discretionary item or factor (as opposed to “mandatory”).</td>
<td>HSD</td>
</tr>
<tr>
<td>Determination</td>
<td>Means the written documentation of a decision by the Procurement Manager, including findings of fact supporting a decision. A determination becomes part of the procurement file.</td>
<td>HSD</td>
</tr>
<tr>
<td>Dual-eligible(s)</td>
<td>Means individuals who – by reason of age, income and/or disability – qualify for Medicare and full Medicaid benefits under Section 1902(a)(10)(A) or 1902(a)(10)(C) of the Social Security Act, under Section 1902(f) of the Social Security Act, or under any other category of eligibility for medical assistance for full benefits.</td>
<td>HSD</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program</td>
<td>Means the federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. as defined in Section 1902(r) of the Social Security Act and 42 CFR Part 441, Subpart B for members under the age of twenty-one (21). It includes periodic comprehensive screening and diagnostic services to determine physical and Behavioral Health needs as well as the provision of all medically necessary services listed in Section 1905(a) of the Social Security Act even if the service is not available under the state’s Medicaid plan.</td>
<td>HSD</td>
</tr>
<tr>
<td>Electronic health record (EHR)</td>
<td>Means a record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight and billing information.</td>
<td>HSD</td>
</tr>
<tr>
<td>Emergency medical condition</td>
<td>Means a medical or behavioral health condition manifesting itself through acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the members’ health (or, with respect to a pregnant woman,</td>
<td>HSD</td>
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<td>Term</td>
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<tr>
<td>Emergency services</td>
<td>Means covered services that are inpatient or outpatient and are (i) furnished by a provider that is qualified to furnish these services and (ii) needed to evaluate or stabilize an emergency medical condition.</td>
<td>HSD</td>
</tr>
<tr>
<td>Encounter</td>
<td>Means a record of any claim adjudicated by the MCO or any of its subcontractors for a member, including Medicare claims for which there is no Medicaid reimbursement amount and/or a record of any service or administrative activity provided by the MCO or any of its subcontractors for a member that represents a member-specific service or administrative activity, regardless of whether that service was adjudicated as a claim or whether payment for the service was made.</td>
<td>HSD</td>
</tr>
<tr>
<td>Encounter data</td>
<td>Information about claims adjudicated by the MCO for services rendered to its members. Such information includes whether claims were paid or denied and any capitated and subcapitated arrangements.</td>
<td>HSD</td>
</tr>
<tr>
<td>Fair hearing</td>
<td>Means the administrative decision-making process that requires aggrieved individuals be given the opportunity to confront the evidence against them and have their evidence considered by an impartial finder of fact in a meaningful time and manner.</td>
<td>HSD</td>
</tr>
<tr>
<td>Federally qualified health center (FQHC)</td>
<td>Means an entity that meets the requirements of and receives a grant and funding pursuant to, the Public Health Service Act. An FQHC also includes an outpatient health program, a facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) and an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act, codified at 25 USC 1601 et seq.</td>
<td>HSD</td>
</tr>
<tr>
<td>Fiscal management agency (FMA)</td>
<td>Means an entity contracting with the state that provides the fiscal administration functions for members receiving the self-directed community benefit. The FMA must be an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FMA also files state income tax withholding and unemployment insurance tax forms, pays the associated taxes, 12 and processes payroll based on the eligible self-directed community benefit services authorized and provided.</td>
<td>HSD</td>
</tr>
<tr>
<td>Fraud</td>
<td>Means an intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.</td>
<td>HSD</td>
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<tr>
<td>Frontier</td>
<td>Means the following counties in New Mexico: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola.</td>
<td>HSD</td>
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<tr>
<td>Grievance</td>
<td>Means an expression of dissatisfaction about any matter or aspect of the MCO or its operation.</td>
<td>HSD</td>
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<tr>
<td>Home- and community-based services (HCBS)</td>
<td>Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual disabilities and/or physical disabilities.</td>
<td>CMS</td>
</tr>
<tr>
<td>Health education</td>
<td>Means programs, services or promotions that are designed or intended to inform the MCO’s actual or potential members about issues related to healthy lifestyles, situations that affect or influence health status, or methods or modes of medical treatment.</td>
<td>HSD</td>
</tr>
<tr>
<td>Health home</td>
<td>Means, as defined in Section 2703 of PPACA, an individual provider, team of healthcare professionals, or health team that meets all federal requirements and provides the following six services to persons with one or more specified chronic conditions: (i) comprehensive care management; (ii) care coordination and health promotion; (iii) comprehensive transitional care/follow-up; (iv) patient and family support; (v) referral to community and social support services; and (vi) use of health information technology (HIT) to link services, if applicable.</td>
<td>HSD</td>
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<tr>
<td>Term</td>
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<tr>
<td>Health information technology (HIT)</td>
<td>Means the area of information technology involving the design, development, creation, use and maintenance of information systems for the healthcare industry.</td>
<td>HSD</td>
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<tr>
<td>Health Literacy</td>
<td>Means the degree to which members are able to obtain, process and understand basic health information and services needed to make appropriate health decisions.</td>
<td>HSD</td>
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<tr>
<td>Healthcare Effectiveness Data and Information Set (HEDIS)</td>
<td>Means the tool used by health plans to measure performance of certain healthcare criteria developed by the National Community for Quality Assurance (NCQA).</td>
<td>HSD</td>
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<tr>
<td>high-volume specialty care providers</td>
<td>Anesthesia, cardiology, gastroenterology, general surgery, obstetrics and gynecology, oncology, ophthalmology, orthopedics and radiation oncology. High-volume specialists are identified as in-plan providers not identified as primary care providers who are paid the highest amount per year based on claims submitted, encounter data and the inclusion of healthcare costs across all product lines.</td>
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<tr>
<td>HIPAA</td>
<td>Means the Health Insurance Portability and Accountability Act of 1996, 42 USC 160, et seq.</td>
<td>HSD</td>
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<tr>
<td>HITECH Act</td>
<td>Means the Health Information Technology for Economic and Clinical Health Act of 2009; 42 USC 17931, et seq.</td>
<td>HSD</td>
</tr>
<tr>
<td>Health Risk Assessment (HRA)</td>
<td>An assessment performed per HSD guidelines and processes, for the purpose of (i) introducing the MCO to the member, (ii) obtaining basic health and demographic information about the member, (iii) assisting the MCO in determining the level of care coordination needed by the member and (iv) determining the need for a nursing facility level of care (NFLOC) assessment.</td>
<td>HSD</td>
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<tr>
<td>Indian Health Service (IHS)</td>
<td>Means the division of the United States Department of Health and Human Services responsible for providing health services to Native Americans.</td>
<td>HSD</td>
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<tr>
<td>Indian Health Service/tribal health providers/urban Indian providers (I/T/U) instrumental activities of daily living (IADL)</td>
<td>A collective term that references any or all of the three types of providers. Housework; taking medications as prescribed; managing money; shopping for groceries or clothing; use of telephone or other form of communication; using technology (as applicable); transportation within the community see link</td>
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</tr>
<tr>
<td>Interagency Behavioral Health Purchasing Collaborative (aka The Collaborative)</td>
<td>Collaborative created by Governor Bill Richardson and the New Mexico State Legislature during the 2004 Legislative Session (State Statute). The Legislation allows several state agencies and resources involved in behavioral health prevention, treatment and recovery to work as one in an effort to improve mental health and substance abuse services in New Mexico. This cabinet-level group represents 15 state agencies and the Governor’s office. The Collaborative consists of: the secretaries of aging and long-term services; Indian affairs; human services; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the instructional support and vocational rehabilitation division of the public education department; and the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. The collaborative is chaired by the Secretary of Human Services with the respective secretaries of Health (Services) and Children, Youth and Families (CYFD) alternating annually as co-chairs. see link</td>
<td>see link</td>
</tr>
<tr>
<td>Lean Six Sigma</td>
<td>Six Sigma is a set of tools and techniques/strategies for process improvement. Lean Six Sigma focuses on eliminating waste from processes and increasing process speed by focusing on what customers actually consider quality and working back from that. see link</td>
<td>see link</td>
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## Appendix B: Definitions

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<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Levels of care</td>
<td>The care coordination process addresses three levels of care, Level 1, 2 and 3.</td>
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<tr>
<td>• Level 1</td>
<td>Members assigned to Level 1 care coordination are those members who do not currently require a comprehensive needs assessment and who are not assigned an individual care coordinator.</td>
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<tr>
<td>• Level 2 and Level 3</td>
<td>Members assigned to Level 2 or Level 3 care coordination meet one of the indicators listed below. These members do require a comprehensive needs assessment to determine they should be in level 2 or level 3 care coordination.</td>
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<tr>
<td>• Is a high-cost user as defined by the MCO</td>
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<td>• Is in out-of-State medical placements</td>
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<tr>
<td>• Is a dependent child in out-of-home placements</td>
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<td>• Is a transplant patient</td>
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<td>• Is identified as having a high risk pregnancy</td>
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<td>• Has a behavioral health diagnosis including substance abuse that adversely affects the member’s life</td>
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<td>• Is medically fragile</td>
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<td>• Is designated as ICF/MR/DD</td>
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<td>• Has high emergency room use as defined by the MCO</td>
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<td>• Has an acute or terminal disease</td>
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<td>• Is readmitted to the hospital within thirty (30) Calendar Days of discharge</td>
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<tr>
<td>• Has other indicators as prior approved by HSD</td>
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<tr>
<td>limited English proficiency</td>
<td>Means the restricted ability to read, speak, write or understand English by individuals who do not speak English as their primary language.</td>
<td>HSD</td>
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<tr>
<td>Long-term care</td>
<td>Refers to the community benefit, the services of a nursing facility and the services of an institutional facility.</td>
<td>HSD</td>
</tr>
<tr>
<td>Managed care organization (MCO)</td>
<td>Means an entity that participates in Centennial Care under contract with HSD to assist the State in meeting the requirements established under NMSA 1978, § 27-2-12. As referenced in this Provider Manual, the MCO is Presbyterian Health Plan.</td>
<td>HSD</td>
</tr>
<tr>
<td>Medically necessary services</td>
<td>Means clinical and rehabilitative physical, mental or behavioral health services that: (i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the member to attain, maintain or regain the member’s optimal functional capacity; (ii) are delivered in the amount, duration, scope and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical and behavioral health needs of the member; (iii) are provided within professionally accepted standards of practice and national guidelines; and (iv) are required to meet the physical and behavioral health needs of the member and are not primarily for the convenience of the member, the provider or the MCO.</td>
<td>HSD</td>
</tr>
<tr>
<td>Member</td>
<td>Means a person who has been determined eligible for Centennial Care and who has enrolled in the MCO’s health plan.</td>
<td>HSD</td>
</tr>
<tr>
<td>Member materials</td>
<td>All materials distributed to members, including but is not limited to member handbooks, provider directories, member newsletters, member identification (ID) cards and, upon request, any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.</td>
<td>HSD</td>
</tr>
<tr>
<td>Member satisfaction survey</td>
<td>Annual survey that shall assess member satisfaction with the quality, availability and accessibility of care.</td>
<td>HSD</td>
</tr>
<tr>
<td>Non-contract provider</td>
<td>Means an individual provider, clinic, group, association or facility that provides covered services and that does not have a contract with the MCO.</td>
<td>HSD</td>
</tr>
<tr>
<td>Non-Medicaid contractor</td>
<td>Means the entity contracting with the Collaborative to provide behavioral health services with the use of non-Medicaid funds.</td>
<td>HSD</td>
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<tr>
<td>Not otherwise Medicaid eligible</td>
<td>Refers to individuals not eligible for Medicaid services under New Mexico’s Medicaid State Plan.</td>
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### Appendix B: Definitions

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<tr>
<td><strong>Nursing facility (NF)</strong></td>
<td>Means a licensed Medicare/Medicaid facility certified in accordance with 42 CFR § 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a provider.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Otherwise Medicaid eligible</strong></td>
<td>Refers to individuals who are eligible for Medicaid services under New Mexico’s Medicaid State Plan.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Outreach</strong></td>
<td>Means, among other things, educating or informing the MCO’s members about Centennial Care, managed care and health issues.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Patient Protection and Affordable Care Act (PPACA)</strong></td>
<td>Means Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010)).</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Patient-centered medical home (PCMH)</strong></td>
<td>Means a team-based model of care led by a personal provider who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Post-stabilization services</strong></td>
<td>Means covered services relating to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR § 438.114(e), to improve or resolve the member's condition.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Pharmacy network</strong></td>
<td>Includes licensed retail pharmacies, long-term care pharmacies, home infusion, I/T/U provider, school-based centers, mail order pharmacy and specialty pharmacies. The ratio of providers in this network to members is determined by state and federal regulations.</td>
<td>HSD</td>
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<tr>
<td><strong>Presbyterian improvement model</strong></td>
<td>Provides the foundation for process driven execution and excellence across our organization. This model guides our ongoing improvement of operational processes and provides a common quality framework for measuring, monitoring and communicating the results of improvement initiatives.</td>
<td>PM</td>
</tr>
<tr>
<td><strong>Primary care provider (PCP)</strong></td>
<td>Means an individual who is a contract provider and has the responsibility for supervising, coordinating and providing primary healthcare to members, initiating referrals for specialist care and maintaining the continuity of the member's care. Can include family practitioners, general practitioners, general internists, pediatricians, certified physician assistants and certified nurse practitioners, as well as other specialists that elect to perform in the role of primary care.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Project ECHO</strong></td>
<td>Means the Extension for Community Healthcare Outcomes program, conducted by the University of New Mexico School of Medicine. The program works to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor the outcomes of this treatment.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Promotoras</strong></td>
<td>Also known as a community health worker (CHW), lay health workers and advocates for members who assist individuals and families in obtaining the knowledge and skills necessary to achieve optimal health and well-being.</td>
<td>PM</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Means an institution, facility, agency, physician, healthcare practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Providers include individuals and vendors providing services to members through the Self-Directed Community Benefit.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Provider satisfaction survey</strong></td>
<td>Annual Provider Satisfaction Survey that covers contract providers and follows NCQA guidelines to the extent applicable.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Provider workgroup</strong></td>
<td>Means the workgroup consisting of representatives from all of the Centennial Care MCOs, HSD, the Collaborative and providers to work collaboratively to reduce administrative burdens on providers by, among other things, standardizing forms and processes.</td>
<td>HSD</td>
</tr>
<tr>
<td><strong>Qui tam</strong></td>
<td>Latin for &quot;who as well.&quot; A lawsuit brought by a private citizen (popularly called a &quot;whistle blower&quot;) against a person or company who is believed to have violated the law in the performance of a contract with the government or in violation of a government regulation, when there is a statute which provides for a penalty for such violations.</td>
<td>see link</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient</td>
<td>Means an individual who is eligible for Centennial Care but has not yet enrolled in a Centennial Care MCO.</td>
<td>HSD</td>
</tr>
<tr>
<td>Reportable incident</td>
<td>See critical incident.</td>
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</tr>
<tr>
<td>Representative</td>
<td>Means a person who has the legal right to make decisions regarding a member’s protected health information and includes surrogate decision makers, parents of un-emancipated minors, guardians and treatment guardians and agents designated pursuant to a power of attorney for healthcare.</td>
<td>HSD</td>
</tr>
<tr>
<td>Rural</td>
<td>Refers to the counties in the State of New Mexico that are not frontier or urban.</td>
<td>HSD</td>
</tr>
<tr>
<td>Rural health clinic (RHC)</td>
<td>Means a public or private hospital, clinic or provider practice designated by the federal government as complying with the Rural Health Clinics Act, Public Law 95-210.</td>
<td>HSD</td>
</tr>
<tr>
<td>School-based health centers</td>
<td>Means outpatient clinics on school campuses that provide on-site primary, preventive and behavioral health services to students while reducing lost school time, removing barriers to care, promoting family involvement and advancing the health and educational success of school-age children and adolescents.</td>
<td>HSD</td>
</tr>
<tr>
<td>Self-directed community benefit</td>
<td>Means certain Home and community-based services that are available to members meeting nursing facility level of care.</td>
<td>HSD</td>
</tr>
<tr>
<td>Telehealth</td>
<td>Means the use of electronic information, imaging and communication technologies (including interactive audio, video and data communications as well as store-and-forward technologies) to provide and support healthcare delivery, diagnosis, consultation, treatment, transfer of medical data and education.</td>
<td>HSD</td>
</tr>
<tr>
<td>Tribal</td>
<td>Means of denoting an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC § 479a located wholly or partially in the State of New Mexico.</td>
<td>HSD</td>
</tr>
<tr>
<td>Tribal 638 facility</td>
<td>Means a facility operated by a Native American/Indian Tribe authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act, 25 USC 450 et seq.</td>
<td>HSD</td>
</tr>
<tr>
<td>Urban</td>
<td>Means the following counties in New Mexico: Bernalillo, Los Alamos, Santa Fe and Doña Ana.</td>
<td>HSD</td>
</tr>
<tr>
<td>Urban Indian</td>
<td>Shall have the meaning ascribed to such term in 25 USC § 1603.</td>
<td>HSD</td>
</tr>
<tr>
<td>Utilization management (UM)</td>
<td>Means a system for reviewing the appropriate and efficient allocation of healthcare services that are provided, or proposed to be provided, to a member.</td>
<td>HSD</td>
</tr>
<tr>
<td>Value added service</td>
<td>Means any service or benefit offered by the MCO that is not a covered service.</td>
<td>HSD</td>
</tr>
<tr>
<td>Waiver</td>
<td>Waivers are vehicles states can use to test new or existing ways to deliver and pay for healthcare services in Medicaid and the Children’s Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:</td>
<td>CMS</td>
</tr>
<tr>
<td></td>
<td>• Section 1115 Research &amp; Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.</td>
<td></td>
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<tr>
<td></td>
<td>• Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people’s choice of providers.</td>
<td></td>
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<tr>
<td></td>
<td>• Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.</td>
<td></td>
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<tr>
<td></td>
<td>• Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B: Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td><strong>Waiver 1115</strong>&lt;br&gt;New Mexico State Insurance Coverage-Title XIX Component</td>
<td>According to information provided by the state, this demonstration provides coverage to uninsured childless adults with income from 0 up to 200 percent of the FPL who are unemployed, self-employed, or employed by a small employer with fewer than 50 employees. Employers and employees are required to contribute to the cost of coverage. For the title XXI component of the State Coverage Insurance section 1115 demonstration that provides coverage to parents up to 200 percent of the FPL, please see the separate listing for the <a href="#">Title XXI New Mexico State Coverage Insurance Demonstration</a>.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1115</strong>&lt;br&gt;New Mexico Coverage Insurance Title XXI Component</td>
<td>According to information provided by the state, this demonstration permits the state to impose a six month waiting period for the demonstration population, which is composed of uninsured children from birth through age 18, from 185% FPL up to, but not including, 235% FPL.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1115</strong>&lt;br&gt;Centennial Care</td>
<td>According to information provided by the state, Centennial Care proposes to create a comprehensive managed care delivery system in New Mexico under which contracted health plans will offer the full array of current Medicaid services, including acute, behavioral health, home and community based and long term institutional care. This proposal would combine existing section 1915(b), 1915(c) and 1115 waivers under a comprehensive demonstration project. Additional waivers and expenditure authorities are requested for various programmatic and financing changes, including increased cost sharing for non-emergent use of the ER and credits for healthy behaviors. The state also seeks to continue its financial support for sole community providers and to use some of the funds to support projects proposed by hospitals that will support the growth of the healthcare infrastructure of the state.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1915(b)</strong>&lt;br&gt;NM Behavioral Health Waiver</td>
<td>Managed care program which provides comprehensive mental health and substance abuse services through collaboration and partnership with a single statewide contractor.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1915(b)</strong>&lt;br&gt;New Mexico Salud</td>
<td>Salud! was the umbrella name for New Mexico's Medicaid managed care program. Salud! Services were provided by contracted managed care organizations (MCOs) to provide Medicaid services to eligible and enrolled citizens. Under waiver 1915(b), clients enrolled into had until the 25th day of their third month in a Salud! MCO to change to another MCO. After the third month with the same MCO, clients are unable to change for the next nine months. Two months before the end of their nine month enrollment period, clients received a letter that let them change their MCO.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1915(c)</strong>&lt;br&gt;NM Mi Via-ICF/MR (0448.R01.00)</td>
<td>Provides consultant/support guide, customized community supports, employment supports, homemaker/direct support services, respite, home health aide services, skilled therapy for adults, personal plan facilitation, assisted living, behavior support consultation, community direct support, customized in-home living supports, emergency response services, environmental mods, nutritional counseling, private duty nursing for adults, related goods, specialized therapies, transportation for individuals w/autism, DD, MR ages 0 – no max age.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1915(c)</strong>&lt;br&gt;NM Mi Via NF (0449.R01.00)</td>
<td>Provides consultant/support guide, customized community supports, employment supports, homemaker/direct support services, respite, home health aide services, skilled therapy for adults, personal plan facilitation, assisted living, behavior support consultation, community direct support, customized in-home living supports, emergency response services, environmental mods, nutritional counseling, private duty nursing for adults, related goods, specialized therapies, transportation for aged individuals ages 65 – no max age and disabled individuals ages 0-64.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1915(c)</strong>&lt;br&gt;NM Medically Fragile (0223.R04.00)</td>
<td>Provides case management, home health aide, respite, nutritional counseling, skilled therapy for adults, behavior support consultation, private duty nursing, specialized medical equipment and supplies for medically fragile individuals ages 0 – no max age.</td>
<td>CMS</td>
</tr>
</tbody>
</table>
### Appendix B: Definitions

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<tr>
<td><strong>Waiver 1915(c) NM DD (0173.R05.00)</strong></td>
<td>Provides case management, community integrated employment, customized community supports, living supports, personal support, respite, nutritional counseling, OT for adults, PT for adults, speech and language therapy for adults, supplemental dental care, assistive technology, behavior support consultation, crisis support, customized in-home supports, environmental mods, independent living transition, intensive medical living supports, non-medical transportation, personal support technology/on-site response, preliminary risk screening and consultation related to inappropriate sexual behavior, private duty nursing for adults, socialization and sexuality education for individuals with autism, ID, DD ages 0 – no maximum age.</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Waiver 1915(c) NM AIDS (0161.R04.00) waste</strong></td>
<td>Provides case management, homemaker/personal care, private duty nursing for individuals w/HIV/AIDS ages 0 – no max age.</td>
<td>CMS</td>
</tr>
<tr>
<td>Waste</td>
<td>Means an act involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent, but where the outcome of poor or inefficient methods resulted in unnecessary costs to the plan.</td>
<td>PM-16</td>
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</tbody>
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# Appendix C: Websites

<table>
<thead>
<tr>
<th>Name</th>
<th>Website Location</th>
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<tbody>
<tr>
<td>Access of Service Standards</td>
<td><a href="http://docs.phs.org/resources/documents/accessibility.pdf">http://docs.phs.org/resources/documents/accessibility.pdf</a></td>
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<tr>
<td>American Psychiatric Association (APA) and the American Academy of</td>
<td>APA Bipolar Disorder <a href="http://psychiatryonline.org/guidelines.aspx">http://psychiatryonline.org/guidelines.aspx</a></td>
</tr>
<tr>
<td></td>
<td>AAP Attention Deficit Hyperactivity Disorder (ADHD)</td>
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<tr>
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<td><a href="http://pediatrics.aappublications.org/content/105/5/1158.full.pdf+html?sid=f4a99748-">http://pediatrics.aappublications.org/content/105/5/1158.full.pdf+html?sid=f4a99748-</a></td>
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<td><a href="https://www.phs.org/providers/resources/appeals-grievances/Pages/default.aspx">https://www.phs.org/providers/resources/appeals-grievances/Pages/default.aspx</a></td>
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<tr>
<td>Asthma Resources and Guidance</td>
<td>Guidelines for the Diagnosis and Management of Asthma Full Report (National</td>
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<td></td>
<td>Asthma Education and Prevention Program, National Heart, Lung and Blood Institute)</td>
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<td><a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1029">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1029</a></td>
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<td>Guidelines for the Diagnosis and Management of Asthma Summary Report (National</td>
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<td><a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev10009">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev10009</a></td>
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<td>16.pdf</td>
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<td></td>
<td>Guidelines for the Diagnosis and Management of Asthma – Full Report Change Page</td>
</tr>
<tr>
<td></td>
<td>(National Heart, Lung and Blood Institute)</td>
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<td><a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031</a></td>
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<tr>
<td>Attention Deficit/Hyperactivity Disorder (ADHD) Resources</td>
<td>ADHD Diagnosis and Evaluation Guidelines</td>
</tr>
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<td><a href="http://pediatrics.aappublications.org/content/105/5/1158.full.pdf+html?sid=f4a99748-">http://pediatrics.aappublications.org/content/105/5/1158.full.pdf+html?sid=f4a99748-</a></td>
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<td>Treatment of School-Aged Children with ADHD</td>
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<td><a href="http://pediatrics.aappublications.org/content/108/4/1033.full.pdf+html">http://pediatrics.aappublications.org/content/108/4/1033.full.pdf+html</a></td>
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<tr>
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<td>ADHD Quick Reference Guide</td>
</tr>
<tr>
<td>Availity®</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
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### Websites

<table>
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<tr>
<th>Name</th>
<th>Website Location</th>
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<tbody>
<tr>
<td>Become a Contracted Provider Sign-up Page</td>
<td><a href="https://www.phs.org/providers/our-networks/Pages/default.aspx">https://www.phs.org/providers/our-networks/Pages/default.aspx</a></td>
</tr>
<tr>
<td>Behavioral Health Resources</td>
<td><a href="https://www.phs.org/providers/resources/reference-guides/Pages/medical-pharmacy-behavioral.aspx">https://www.phs.org/providers/resources/reference-guides/Pages/medical-pharmacy-behavioral.aspx</a></td>
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<tr>
<td>Claim.MD</td>
<td><a href="http://www.claim.md/">http://www.claim.md/</a></td>
</tr>
<tr>
<td>Claim MD Fast Claim Enrollment</td>
<td><a href="https://www.claim.md/phs.plx">https://www.claim.md/phs.plx</a></td>
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<td>Claims Processing Page</td>
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<td>Classification of Diseases, Functioning and Disability</td>
<td><a href="http://www.cdc.gov/nchs/icd.htm">http://www.cdc.gov/nchs/icd.htm</a></td>
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<td>CMS Provider Updates</td>
<td>Fee-for-Service Provider Updates <a href="http://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html?redirect=/center/provider.asp">http://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html?redirect=/center/provider.asp</a></td>
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<td>Contact Presbyterian – Provider Page</td>
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<td>Contact Presbyterian – Member Page</td>
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<tr>
<td><strong>Coronary Artery Disease Resources and Guidance</strong></td>
<td>AHA/ACC Secondary Prevention for Patients with Coronary and Other Vascular Disease: 2006 Update (American College of Cardiology and the American Heart Association) <a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052254.pdf">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052254.pdf</a></td>
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<td>Coronary Artery Disease Clinical Practice Guidelines (American College of Cardiology and the American Heart Association) <a href="http://docs.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev100934.pdf">http://docs.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev100934.pdf</a></td>
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<td>Coronary Artery Disease Clinical Recommendations for Prevention of Heart Disease in Women (American Heart Association) <a href="http://docs.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev100935.pdf">http://docs.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev100935.pdf</a></td>
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<tr>
<td><strong>Dentaquest Website</strong></td>
<td><a href="http://www.dentaquestgov.com">www.dentaquestgov.com</a></td>
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<tr>
<td><strong>Depression Guidelines for Primary Care Practitioners Treating Adult Patients with Depression</strong></td>
<td><a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001004.pdf">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001004.pdf</a></td>
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<td>Registration and Attestation Website <a href="https://ehrincentives.cms.gov">https://ehrincentives.cms.gov</a></td>
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<td>DHHS Office of the National Coordinator for Health Information Technology, “EHR Incentives and Certification” <a href="http://www.healthit.gov/providers-professionals/ehr-incentives-certification">http://www.healthit.gov/providers-professionals/ehr-incentives-certification</a></td>
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<td><strong>eNews Registration for Providers</strong></td>
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<td><a href="https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx">https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx</a></td>
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<td>Gateway EDI</td>
<td><a href="http://www.gatewayedi.com">www.gatewayedi.com</a></td>
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<td>General Services Administration’s System for Award Management (GSA SAM)</td>
<td><a href="https://www.sam.gov/portal/public/SAM/">https://www.sam.gov/portal/public/SAM/</a></td>
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<td>HealthXnet®</td>
<td><a href="http://www.healthxnet.com">http://www.healthxnet.com</a></td>
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<td>List of Excluded Individuals and Entities, Department of Health and Human Services/Office of Inspector General (DHHS/OIG)</td>
<td><a href="https://oig.hhs.gov/exclusions/exclusions_list.asp">https://oig.hhs.gov/exclusions/exclusions_list.asp</a></td>
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<tr>
<td>Magellan EDI Testing Center</td>
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<td><a href="http://www.mckesson.com">http://www.mckesson.com</a></td>
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<td>MedAssets</td>
<td><a href="http://www.medassets.com">http://www.medassets.com</a></td>
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<td><a href="https://www.phs.org/tools-resources/access-your-care/Pages/access-your-health-information.aspx">https://www.phs.org/tools-resources/access-your-care/Pages/access-your-health-information.aspx</a></td>
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<td>National Center for Health Statistics</td>
<td><a href="http://www.cdc.gov/nchs/">http://www.cdc.gov/nchs/</a></td>
</tr>
<tr>
<td>National Committee for Quality Assurance (NCQA) Website</td>
<td><a href="http://www.ncqa.org">http://www.ncqa.org</a></td>
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<tr>
<td>National Provider Identifier (NPI)</td>
<td><a href="https://nppes.cms.hhs.gov/">https://nppes.cms.hhs.gov/</a></td>
</tr>
<tr>
<td>New Mexico Human Services Department Medical Assistance Division</td>
<td><a href="http://www.hsd.state.nm.us/mad/">http://www.hsd.state.nm.us/mad/</a></td>
</tr>
<tr>
<td>New Mexico Immunization Program Website</td>
<td><a href="http://www.immunizenm.org/Provider/vacchild.shtml">http://www.immunizenm.org/Provider/vacchild.shtml</a></td>
</tr>
<tr>
<td>Novitas Solutions, Inc.</td>
<td><a href="https://www.novitas-solutions.com/">https://www.novitas-solutions.com/</a></td>
</tr>
<tr>
<td></td>
<td>Overweight &amp; Obesity in Primary Care (Clinical Prevention Initiative) <a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1030683.pdf">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1030683.pdf</a></td>
</tr>
<tr>
<td></td>
<td>Quick Discussion Guide for Adult Weight Counseling in Primary Care (Clinical Prevention Initiative) <a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031068.pdf">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031068.pdf</a></td>
</tr>
</tbody>
</table>
Appendix C: Websites

<table>
<thead>
<tr>
<th>Name</th>
<th>Website Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Ally</td>
<td><a href="http://www.officeally.com">www.officeally.com</a></td>
</tr>
<tr>
<td>Payerpath</td>
<td><a href="http://www.payerpath.com">www.payerpath.com</a></td>
</tr>
<tr>
<td>Pharmacy Resources and Forms</td>
<td><a href="https://www.phs.org/providers/authorizations/Pages/default.aspx">https://www.phs.org/providers/authorizations/Pages/default.aspx</a></td>
</tr>
<tr>
<td>Populations Health Alliance</td>
<td><a href="http://populationhealthalliance.org/">http://populationhealthalliance.org/</a></td>
</tr>
<tr>
<td>Presbyterian ePayment Center</td>
<td>Presbyterian.epayment.center</td>
</tr>
<tr>
<td>Presbyterian Healthcare Services website</td>
<td><a href="http://www.phs.org">http://www.phs.org</a></td>
</tr>
<tr>
<td>Provider homepage</td>
<td><a href="https://www.phs.org/providers/">https://www.phs.org/providers/</a></td>
</tr>
<tr>
<td>Provider News and Communications</td>
<td><a href="https://www.phs.org/providers/contact-us/news-and-communications/Pages/default.aspx">https://www.phs.org/providers/contact-us/news-and-communications/Pages/default.aspx</a></td>
</tr>
<tr>
<td>RelayHealth</td>
<td><a href="http://www.relayhealth.com">www.relayhealth.com</a></td>
</tr>
<tr>
<td>State of New Mexico Regulations &amp; Licensing Department</td>
<td><a href="http://www.rld.state.nm.us/">http://www.rld.state.nm.us/</a></td>
</tr>
<tr>
<td>Think Cultural Health</td>
<td><a href="https://www.thinkculturalhealth.hhs.gov/">https://www.thinkculturalhealth.hhs.gov/</a></td>
</tr>
<tr>
<td>Tricore Laboratory Locations</td>
<td><a href="http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00078812.pdf">http://docs.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00078812.pdf</a></td>
</tr>
<tr>
<td>Update Provider Directory Information</td>
<td><a href="https://www.phs.org/updatedirectory">https://www.phs.org/updatedirectory</a></td>
</tr>
<tr>
<td>Vaccines for Children Program Information (CDC)</td>
<td><a href="http://www.cdc.gov/vaccines/programs/vfc/index.html">http://www.cdc.gov/vaccines/programs/vfc/index.html</a></td>
</tr>
<tr>
<td>Workgroup on Electronic Data Interchange (WEDI)</td>
<td><a href="http://www.wedi.org/">http://www.wedi.org/</a></td>
</tr>
<tr>
<td>Name</td>
<td>Website Location</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>WEDI Health Record Systems</td>
<td><a href="http://www.wedi.org/topics/health-records-management-systems/">http://www.wedi.org/topics/health-records-management-systems/</a></td>
</tr>
</tbody>
</table>
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## Appendix D: Phone Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Protective Services</td>
<td>1-866-654-3219</td>
</tr>
<tr>
<td>Air Transportation Request</td>
<td>505-923-5757 or 1-888-923-5757 (Option 4)</td>
</tr>
<tr>
<td>American Medical Association (AMA) CPT Products</td>
<td>1-800-621-8335</td>
</tr>
<tr>
<td>Availity®</td>
<td>1-800-AVAILTY (282-4548)</td>
</tr>
<tr>
<td>Behavioral Health Care Coordination</td>
<td>Commercial/ Presbyterian Senior Care (HMO) members: 505-923-5221  or 1-866-593-7431</td>
</tr>
<tr>
<td></td>
<td>Centennial Care members: 505-923-8858 or 1-866-672-1242</td>
</tr>
<tr>
<td>Behavioral Health Customer Service</td>
<td>505-923-5678</td>
</tr>
<tr>
<td>Behavioral Health Requests</td>
<td>505-923-5221 or 1-866-593-7431 (phone) 505-843-3091 (fax)</td>
</tr>
<tr>
<td>Capario</td>
<td>1-800-586-6938</td>
</tr>
<tr>
<td>Care Coordination Unit</td>
<td>1-866-672-1242 or 505-923-8858 (phone) 505-843-3150 (fax)</td>
</tr>
<tr>
<td>Children, Youth and Families Department (CYFD)</td>
<td>1-800-797-3260</td>
</tr>
<tr>
<td>Claim.MD</td>
<td>505-757-6060</td>
</tr>
<tr>
<td>Department of Health/Division of Health Improvement (DOH/DHI)</td>
<td>1-800-445-6242</td>
</tr>
<tr>
<td>DentaQuest (Dental Care)</td>
<td>1-855-343-4276 (phone) 1-262-241-7150 (fax)</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) Requests</td>
<td>505-843-3047 (fax)</td>
</tr>
<tr>
<td>E-Help Desk</td>
<td>505-923-5590 or 1-866-861-7444</td>
</tr>
<tr>
<td>Federal Funded Pregnancy Termination Request (fax)</td>
<td>505-923-5489</td>
</tr>
<tr>
<td>Gateway EDI, Inc.</td>
<td>1-800-969-3666</td>
</tr>
<tr>
<td>Health Services</td>
<td>505-923-5757 or 1-888-923-5757 (option 4)</td>
</tr>
</tbody>
</table>
### Phone Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Solutions Disease Management Program</td>
<td>1-800-841-9705</td>
</tr>
<tr>
<td>HealthEC</td>
<td>1-877-444-7194</td>
</tr>
<tr>
<td>HealthXnet® User Administration and Help Desk</td>
<td>505-346-0290 or 1-866-676-0290 (phone) 505-346-0278 (fax)</td>
</tr>
<tr>
<td>Home Healthcare Requests</td>
<td>505-559-1151 or 1-877-606-1151 (Option 4) (phone) 505-559-1000 (24/7 phone) 505-559-1150 (local fax) 1-877-606-1155 (toll-free fax)</td>
</tr>
<tr>
<td>Immunization Hotline</td>
<td>1-800-232-4636</td>
</tr>
<tr>
<td>Inpatient Concurrent Review or Inpatient Hospital Admission</td>
<td>505-923-5757 or 1-888-923-5757 (option 4) 505-843-3107 or 1-888-923-5990 (fax)</td>
</tr>
<tr>
<td>Inpatient Prior Authorization Requests</td>
<td>505-843-3107 or 1-888-923-5990 (fax)</td>
</tr>
<tr>
<td>Interactive Voice Response (IVR)</td>
<td>505-923-5757 or 1-888-923-5757 (Option 1)</td>
</tr>
<tr>
<td>Magellan EDI Support</td>
<td>1-800-450-7281</td>
</tr>
<tr>
<td>Long-Term Care Prior Authorization Request</td>
<td>505-843-3107 or 1-888-923-5990 (fax)</td>
</tr>
<tr>
<td>MedAssets</td>
<td>Main Office: 1-678-323-2500</td>
</tr>
<tr>
<td></td>
<td>Product Information: 1-888-883-6332</td>
</tr>
<tr>
<td></td>
<td>Tech Support: 1-866-658-1629</td>
</tr>
<tr>
<td>New Mexico Human Services Department Fair Hearing Bureau</td>
<td>505-476-6213 or 1-800-432-6217 (option 6) 505-476-6215 (fax)</td>
</tr>
<tr>
<td>NurseAdvice® New Mexico</td>
<td>Centennial Care members 505-923-5677 or 1-888-730-2300 Presbyterian Senior Care (HMO) and MediCare PPO members 1-800-887-9917 Presbyterian Commercial Members 1-866-221-9679 Presbyterian Employees and Dependents 1-800-905-3282</td>
</tr>
<tr>
<td>Office Ally</td>
<td>1-866-575-4120 (phone)</td>
</tr>
<tr>
<td></td>
<td>1-360-896-2151 (fax)</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>505-923-5757 or 1-888-923-5757 (option 4) 505-843-3047 (fax)</td>
</tr>
<tr>
<td>Payerpath</td>
<td>1-877-623-5706</td>
</tr>
<tr>
<td>Pharmacy Requests</td>
<td>505-323-5757 (option 3) or 1-888-923-5757 (option 3)</td>
</tr>
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### Appendix D: Phone Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Services Helpdesk</td>
<td>505-923-5500 or 1-888-923-5757 (phone)</td>
</tr>
<tr>
<td></td>
<td>1-877-640-5814 (toll free fax)</td>
</tr>
<tr>
<td>Provider CARE Unit</td>
<td>505-923-5757 or 1-888-923-5757</td>
</tr>
<tr>
<td>Provider Network Operations e-Business Analyst</td>
<td>505-923-8726</td>
</tr>
<tr>
<td>Presbyterian Customer Service Center (PCSC)</td>
<td>505-923-5200 or 1-888-977-2333</td>
</tr>
<tr>
<td>Presbyterian ePayment Center</td>
<td>1-855-774-4392</td>
</tr>
<tr>
<td>Prior Authorization Line</td>
<td>505-923-5757 or 1-888-923-5757 (Option 4)</td>
</tr>
<tr>
<td>Quality and Population Health Management Resource Line</td>
<td>505-923-5017 or 1-866-634-2617 (message only)</td>
</tr>
<tr>
<td>Quality Management Department</td>
<td>505-923-5516</td>
</tr>
<tr>
<td>Radiology/Diagnostic Imaging Requests (NIA's Medical Specialty Solutions Program)</td>
<td>1-866-236-8717 (fax)</td>
</tr>
<tr>
<td>RelayHealth</td>
<td>1-800-527-8133 (Option 2)</td>
</tr>
<tr>
<td>SilverSneakers® Fitness Program</td>
<td>1-888-423-4632</td>
</tr>
<tr>
<td>Program Integrity Department (PID) Confidential Hotline</td>
<td>505-923-5959 or 1-800-239-3147</td>
</tr>
<tr>
<td>Superior Medical Transport</td>
<td>1-877-735-0111 (toll free) or 505-341-0042</td>
</tr>
<tr>
<td>University of New Mexico Case Managers</td>
<td>505-272-2910</td>
</tr>
<tr>
<td>University of New Mexico Prior Authorization Requests</td>
<td>505-843-3108 (fax)</td>
</tr>
<tr>
<td>Vaccines for Children (VFC) Program Director (PHS)</td>
<td>505-827-2898</td>
</tr>
</tbody>
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## Appendix D: Phone Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td><strong>TriCore Telephone Numbers</strong></td>
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<tr>
<td>Main Numbers</td>
<td>505-938-8888 (24 hours)</td>
</tr>
<tr>
<td></td>
<td>1-800-245-3296 (24 hours)</td>
</tr>
<tr>
<td>Client Services</td>
<td>505-938-8922 or 1-800-245-3296 (24 Hours)</td>
</tr>
<tr>
<td>Client Supplies</td>
<td></td>
</tr>
<tr>
<td>For phone or fax orders:</td>
<td>505-938-8957 (phone)</td>
</tr>
<tr>
<td></td>
<td>1-800-245-3296 ext. 8957 (phone)</td>
</tr>
<tr>
<td></td>
<td>505-938-8472 (fax)</td>
</tr>
<tr>
<td>For online supply orders, call the Supply Order Desk</td>
<td>505-938-8957 or 1-800-245-3296, ext. 8957</td>
</tr>
<tr>
<td>Logistics/Couriers</td>
<td>505-938-8958</td>
</tr>
<tr>
<td></td>
<td>1-800-532-2649</td>
</tr>
<tr>
<td></td>
<td>505-954-3780 (Santa Fe)</td>
</tr>
<tr>
<td>IS Help Desk (printer, TriCore Express TriCore Direct and computer-interface assistance)</td>
<td>505-938-8974 or 1-800-245-3296, ext. 8974</td>
</tr>
<tr>
<td>Sales and Service</td>
<td>505-938-8917 or 1-800-245-3296, ext. 8917</td>
</tr>
<tr>
<td>Billing/Business Office</td>
<td>505-938-8910 or 1-800-541-9557</td>
</tr>
<tr>
<td></td>
<td>505-938-8640 (fax)</td>
</tr>
<tr>
<td><strong>University of New Mexico (UNM) Case Management Program</strong></td>
<td>505-272-2910</td>
</tr>
<tr>
<td><strong>Vaccines for Children (VFC) Program Director (PHS)</strong></td>
<td>505-827-2898</td>
</tr>
<tr>
<td><strong>VSP Vision Services</strong></td>
<td>1-800-852-7600</td>
</tr>
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</table>
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## Appendix E: Prior Authorization Guide

<table>
<thead>
<tr>
<th>Centennial Care Covered Services</th>
<th>Is Prior Authorization Required?</th>
<th>Exclusions and Limitations*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>accredited residential treatment center services</strong></td>
<td>Yes</td>
<td>Member must be &lt; 21 years of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NONCOVERED SERVICES: Services furnished in residential treatment centers are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.301.3 NMAC, General Noncovered Services. Medicaid does not cover the following specific services for recipients in residential treatment centers:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A. Services not considered medically necessary for the condition of the recipient, as determined by PHP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B. Services for which prior approval was not requested</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C. Services furnished to ineligible individuals; residential treatment center services are covered only for recipients under twenty-one (21) years of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• D. Services furnished after MAD or its designee determines that the recipient no longer needs JCAHO accredited residential treatment center care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• E. Formal educational and services which relate to traditional academic subjects or vocational training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F. Experimental or investigational procedures, technologies, or non-drug therapies and related services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• G. Drugs classified as &quot;ineffective&quot; by the FDA drug evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• H. Activity therapy, group activities, and other services primarily recreational or diversional in nature</td>
</tr>
<tr>
<td><strong>adaptive skills building (Autism)</strong></td>
<td>Yes</td>
<td>Member must be &lt; 19, unless in high school in which case benefits can be continued up to age 22. Services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years of age who have autism spectrum disorder are not covered under this plan.</td>
</tr>
<tr>
<td><strong>adult day health (ABCB service</strong>)**</td>
<td>Yes</td>
<td>Only for those who qualify for Nursing Facility Level of Care and select Agency Based Community Benefits (ABCB). Services must be at least 2 hours per day for one or more days per week.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A. Adult day health services can be provided only by eligible adult day health agencies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B. Adult day health facilities must be licensed by DOH as an adult day care facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C. Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• D. An adult day health care provider agency must comply with the provisions of Title II and III of the Americans with Disabilities Act of 1990, (42 U.S.C. Section 12101 et seq.).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• E. An adult day health care provider agency must comply with all applicable city, county or state regulations governing transportation services. This service is not provided to ABCB recipients in Assisted Living facilities.</td>
</tr>
<tr>
<td><strong>adult psychological rehabilitation services</strong></td>
<td>Yes</td>
<td>Pending final determination of behavioral health UM Criteria</td>
</tr>
<tr>
<td><strong>ambulatory surgical center services</strong></td>
<td>Yes</td>
<td><strong>NONCOVERED SERVICES</strong>: If the surgery is non-covered, the anesthesia is non-covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A. Direct payment to physician. Ambulatory surgical centers are not reimbursed by PHP for physician fees. Reimbursement for physician fees is made directly to the provider of the service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B. Services furnished to dual eligible recipients. By federal regulation, the Medicare</td>
</tr>
<tr>
<td>Centennial Care Covered Services</td>
<td>Is Prior Authorization Required?</td>
<td>Exclusions and Limitations*</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| program pays ambulatory surgical centers only for an approved list of specific surgical procedures. Medicare is the primary payment source for individuals who are eligible for both Medicare and Medicaid. For these recipients, Medicaid does not pay an ambulatory surgical center for a surgical procedure denied by Medicare. Ambulatory surgical centers must refer these recipients to facilities which Medicare pays for the surgical procedure, such as an outpatient hospital. | Yes for select services | Anesthesia for Pain Management and Dental Procedures require prior authorization. ECT does not require a separate authorization for anesthesia.  
- A. When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and is not covered in addition to the procedure.  
- B. An anesthesia service is not payable if the medical or surgical procedure is not a Medicaid or other health care benefit.  
- C. Separate payment is not allowed for qualifying circumstances; payment is considered bundled into the anesthesia allowance.  
- D. Separate payment is not allowed for modifiers (modifiers that begin with the letter “P”) that are used to indicate that the anesthesia was complicated by the physical status of the patient. |
| assertive community treatment services                     | Yes                             | Pending final determination of behavioral health UM Criteria |
| assisted living (ABCB service**)                          | Yes                             | This benefit is only for those who qualify for Nursing Facility Level of Care and select Agency Based Community Benefits. The following services are not provided to recipients in Assisted Living facilities: Personal Care, Respite, Environmental Modifications, Emergency Response or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility and are included in the cost of room and board. |
| behavior management skills development services           | Yes                             | PHP does not cover the following specific services in conjunction with behavior management services:  
- A. Formal educational or vocational services related to traditional academic subjects or vocational training  
- B. Activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the behavioral management treatment plan  
- C. Residential treatment care |
| ELIGIBLE RECIPIENTS:  
- A. Behavior management services can be furnished only to Medicaid recipients under twenty-one (21) years of age who:  
  ▪ (1) Are at risk for out-of-home placement due to unmanageable behavior at home or within the community  
  ▪ (2) Need behavior management intervention to avoid inpatient hospitalizations or residential treatment  
  ▪ (3) Require behavior management support following institutional or other out-of-home placement as a transition to maintain the recipient in the home and community  
- B. To receive services, recipients must meet the level of care for this service established by PHP. |
| behavior support consultation (ABCB service**)            | Yes                             | This is only available to members who meet the Nursing Facility Level of Care criteria and must be included in the member’s care plan and approved by the UM review team. |
## Appendix E: Prior Authorization Guide

<table>
<thead>
<tr>
<th>Centennial Care Covered Services</th>
<th>Is Prior Authorization Required?</th>
<th>Exclusions and Limitations*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(SDCB service***) behavioral health professional services: outpatient behavioral health and substance abuse services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>care coordination</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>case management</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
| community transition services (ABCB service***) | LTSS | • A. Limited to $3,500 per person every five years. To be eligible, a person must have a nursing facility stay of at least 90 days prior to transition to the community.  
• B. Only for those who qualify for Nursing Facility Level of Care and select Agency Based Community Benefits |
| community health workers | No |  |
| comprehensive community support services | Yes | CCSS may not be filled in conjunction with the following PHP services:  
• A. Multi-systemic therapy;  
• B. Assertive community treatment;  
• C. Accredited residential treatment;  
• D. Residential treatment  
• E. Group home services  
• F. Inpatient hospitalization  
• G. Partial hospitalization  
• H. Treatment foster care |
| customized community supports (SDCB) | Yes | • A. Provided at least four (4) or more hours per day, one or more days per week and cannot duplicate community direct support services, employment support services or any other long-term Care Service.  
• B. Only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits. |
| day treatment services | Yes | Member must be < 21 years of age. PHP does not cover the following specific day treatment activities:  
• A. Educational programs  
• B. Vocational training which is related to specific employment opportunities, work skills, or work settings  
• C. Pre-vocational training  
• D. Any service not identified in the treatment plan  
• E. Recreation activities not related to the treatment issues  
• F. Leisure time activities such as watching television, movies or playing computer games  
• G. Transportation reimbursement for the therapist who delivers services in the family’s home  
• H. Services for which prior authorization was not obtained  
• I. Day treatment services cannot be offered at the same time as partial hospital program or any residential program |
| dental services | Yes | Benefit managed by DentlaQuest, which has published criteria. |
| diagnostic imaging and therapeutic radiology services (for imaging) | Yes for high cost services | Benefit managed by PHP Care Review team using HealthHelp, which has published criteria listing exclusions and limitations. |
| dialysis services | No |  |
| durable medical equipment (DME) and supplies | Yes for select items | Benefit managed by PHP Care Review team using HealthHelp, which has published criteria.  
• A. Special requirements for purchase of wheelchairs: Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to an |
Appendix E: Prior Authorization Guide

<table>
<thead>
<tr>
<th>Centennial Care Covered Services</th>
<th>Is Prior Authorization Required?</th>
<th>Exclusions and Limitations*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>eligible recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social, and environmental needs of the eligible recipient for whom it was authorized.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ (1) The provider assumes responsibility for correcting defects or deficiencies in wheelchair and seating systems that make them unsatisfactory for use by the eligible recipient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ (2) The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians, as necessary, to ensure that the wheelchair meets the eligible recipient’s needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ (3) Evaluations by a physical therapist or occupational therapist are required when ordering customized wheelchairs and seating systems. These therapists should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the eligible recipient and those consultants listed in Paragraph (2) of Subsection B of 8.324.5.14 NMAC to assure that the selected system matches physical seating needs. The physical or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ (4) PHP does not pay for special modifications or replacement of customized wheelchairs after the wheelchairs are furnished to the eligible recipient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ (5) When the equipment is delivered to the eligible recipient and the eligible recipient accepts the order, the provider submits the claim for reimbursement.</td>
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<td></td>
<td>▪ B. Special requirements for purchase of augmentative and alternative communication devices (AACDs):</td>
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<tr>
<td></td>
<td></td>
<td>▪ (1) The purchase of AACDs requires prior authorization. In addition to being prescribed by a physician, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.</td>
</tr>
<tr>
<td></td>
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<td>▪ (2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the eligible recipient’s medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the eligible recipient’s ability to use the communication device must be provided showing that the eligible recipient’s ability to use the device is improving and that the eligible recipient is motivated to continue to use this device.</td>
</tr>
<tr>
<td></td>
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<td>▪ (3) PHP does not pay for supplies for AACDs, such as, but not limited to, paper, printer ribbons, and computer discs.</td>
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<td></td>
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<td>▪ (4) Prior authorization is required for equipment repairs.</td>
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<td>▪ (5) A provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have in excess of a 15-calendar-day supply of the item before releasing the next supply order to the eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement.</td>
</tr>
</tbody>
</table>

<p>| emergency response (ABCB service**) (SDCB service***) | Yes |▪ A. member must have a land line phone. |
|-------------------------------------------------------|-----|▪ B. Only for those who qualify for Nursing Facility Level of Care. |
|-------------------------------------------------------|-----|▪ C. This benefit is not provided to members living in Assisted Living Facilities. The service is not provided to recipients in Assisted Living facilities. |
| emergency services (including ER visits and Psychiatric ER) | No | |
| employment supports | Yes |▪ A. Payment shall not be made for incentive payments, subsidies, or unrelated |</p>
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<thead>
<tr>
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</thead>
</table>
| (ABCB service**) (SDCB service***) | Yes | vocational training expenses.  
• B. Only for those who qualify for Nursing Facility Level of Care. |
| environmental modifications (ABCB service**) (SDCB service***) | Yes | • A. Environmental Modification services are limited to five thousand dollars ($5,000) every five (5) years. Additional services may be requested if an eligible recipient’s health and safety needs exceed the specified limit. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.  
• B. Only for those who qualify for Nursing Facility Level of Care.  
• C. This benefit is not provided to members living in Assisted Living Facilities. |
| experimental/investigational procedures, technology, or non-drug therapies | Yes | PHP does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, other products or devices, except for the following: PHP provides coverage for routine patient care costs incurred as a result of the patient’s participation in a Phase I, II, III, or IV cancer trial that meets the following criteria. The clinical trials can only be performed in New Mexico.  
• A. The cancer clinical trial is being conducted with approval of at least one of the following:  
  (1) One of the federal National Institutes of Health  
  (2) A federal National Institutes of Health cooperative group or center; 8.325.6 NMAC 1  
  (3) The federal Department of Defense  
  (4) The federal Food and Drug Administration in the form of an investigational new drug application  
  (5) the federal Department of Veteran Affairs  
  (6) S qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility  
• B. The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research risks of the federal National Institutes of Health. |
| early and periodic screening, diagnosis, and treatment (EPSDT) | No | These services are limited to members under the age of 21. |
| EPSDT personal care services (ABCB service**) (SDCB service***) | Yes | These services are limited to members under the age of 21.  
NONCOVERED SERVICES:  
Services that are not covered under the New Mexico Medicaid EPSDT Personal Care program are as follows:  
• A. Any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings, and administration of medications;  
• B. Services that are not in the recipient’s approved treatment plan and for which prior approval has not been received;  
• C. Services not considered medically necessary by PHP or its designee for the condition of the recipient. |
| EPSDT private duty nursing (ABCB service**) (SDCB service***) | Yes | These services are limited to members under the age of 21. Also, Private duty nursing services must be furnished by a registered nurse or a licensed practical nurse in a recipient’s home or in a school setting, if it is medically necessary for school attendance. The goal of the provision of care is to avoid institutionalization and maintain the |
### Appendix E: Prior Authorization Guide

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<td><strong>Centennial Care</strong></td>
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<tr>
<td><strong>Is Prior Authorization Required?</strong></td>
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<tr>
<td>recipient’s function level in a home setting.</td>
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<tr>
<td>• A. EPSDT private duty nursing services* means nursing services for recipients under twenty-one (21) years of age who require more individual and continuous care than can be received through the home health program.</td>
<td></td>
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</tr>
<tr>
<td>• B. EPSDT private duty nursing services must be ordered by the recipient’s physician and must be included in the recipient’s approved treatment plan. Services furnished must be medically necessary and be within the scope of the nursing profession.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NONCOVERED SERVICES:</strong> Private duty nursing services are subject to the limitations and coverage restrictions which exist for other Medicaid services.</td>
<td></td>
<td></td>
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<tr>
<td>Medicaid does not cover the following specific services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A. Services for which prior approval has not been received or which are not included in the recipient’s approved treatment plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• B. Services not considered medically necessary by PHP or its designees for the condition of the recipient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• C. Services which are not within the scope of practice of the nursing profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>These services are limited to members under the age of 21. NONCOVERED SERVICES:</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>A. Services furnished by speech and language pathologists, physical therapists and occupational therapists are subject to the limitations and coverage restrictions that exist for other Medicaid services.</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>B. Medicaid does not cover these specific services:</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>(1) Services furnished to individuals who are not eligible for EPSDT services</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>(2) Services for which prior approval has not been received</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>(3) Services that are not within the scope of practice of the speech and language pathologist physical therapist or occupational therapist</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>(4) Services furnished without the order or prescription of a physician or PCP</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>(5) Services that are primarily educational or vocational in nature</td>
</tr>
<tr>
<td><strong>EPSDT rehabilitation services</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>(6) Services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for Medicaid reimbursement purposes</td>
</tr>
<tr>
<td><strong>family planning</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>family support</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>federally qualified health center services</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>hearing aids and related evaluations</strong></td>
<td>Yes for hearing aid only not for evaluation</td>
<td>Hearing aid and related evaluation services are subject to the limitations and coverage restrictions that exist for other Medicaid services. Medicaid does not pay for “hearing aid checks” (assessing a hearing aid for functionality). Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and is not reimbursed separately.</td>
</tr>
<tr>
<td><strong>home health aide</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>Only for those who qualify for Nursing Facility Level of Care.</td>
</tr>
<tr>
<td><strong>home health aide</strong> (ABCB service**) (SDCB service***)</td>
<td>Yes</td>
<td>Home health services are subject to the limitations and coverage restrictions of other Medicaid services. See Section MAD-602, General Noncovered Services [now 8.301.3 NMAC, General Noncovered Services], PHP does not cover the following home health agency services:</td>
</tr>
<tr>
<td><strong>home health services</strong></td>
<td>Yes</td>
<td>• A. Services beyond the initial evaluation which are furnished without prior approval.</td>
</tr>
<tr>
<td><strong>home health services</strong></td>
<td>Yes</td>
<td>• B. Home health services which are not skilled, intermittent, and medically necessary.</td>
</tr>
</tbody>
</table>
### Centennial Care Covered Services | Is Prior Authorization Required? | Exclusions and Limitations*
---|---|---
| **homemaker (SDCB service)** | Yes | • C. Services furnished to recipients who do not meet the eligibility criteria for home health services. • D. Services furnished to recipients in places other than their place of residence. • E. Services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service. Physical, occupational, and speech therapy can be furnished to residents of nursing facilities who require a low level of service. • F. Skilled nursing services which are not supervised by registered nurses. • G. Services not included in written plans of care established by physicians in consultation with the home health agency staff.  

| hospice services | Yes | To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Recipients must elect to receive hospice care for the duration of the election period. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is six (6) months or less if the terminal illness runs its typical course. If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the 210-day period expires.  

| hospital IP (including detoxification services) | Yes |  

| hospital OP | No, but PHP reserves the rights to implement process for overutilizers |

| Indian Health services | No |  

| IP hospitalization in freestanding psychiatric hospitals | Yes | This does not cover inpatient detoxification, which is a medical benefit managed by PHP Utilization Management.  

<p>| IOP program services | Yes | The duration of IOP intervention is typically three to six months. The number of weekly services per member is directly related to the goals and objectives specified in the member’s treatment or service plan. PHP does not cover the following specific services for an eligible recipient in freestanding psychiatric hospitals: • A. Services not considered medically necessary for the condition of the eligible recipient, as determined by PHP • B. Conditions defined only by V codes in the current version of the international classification of diseases (ICD) or the current version of diagnostic statistical manual (DSM) • C. Services for which prior authorization was not obtained • D. Services in freestanding psychiatric hospital for eligible recipient 21 years of age or older • E. Services furnished after the determination by PHP or its designee has been made that the eligible recipient no longer needs hospital care • F. Formal educational or vocational services related to traditional academic subjects or vocational training; PHP only covers non-formal education services if they are part of an active treatment plan for an eligible recipient under the age of 21 |</p>
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<tr>
<th>Centennial Care Covered Services</th>
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<th>Exclusions and Limitations*</th>
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</thead>
<tbody>
<tr>
<td>ICF/MR</td>
<td>Yes</td>
<td>Must meet NFLOC criteria. Member must be 18 years or older.</td>
</tr>
<tr>
<td>IV OP services</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>lab services</td>
<td>No except for select high cost tests</td>
<td></td>
</tr>
<tr>
<td>medical services providers</td>
<td>No, but reserve rights to implement process for overutilizers</td>
<td></td>
</tr>
</tbody>
</table>
| medication assisted Tx for opioid dependence | Yes for medications only, not for office visit | Medicaid does not cover the following specific services furnished by midwives:  
  • A. Oral medications or medications, such as ointments, creams, suppositories, ophthalmic, and otic preparations which can be appropriately self-administered by the recipient  
  • B. Services furnished by an apprentice |
| midwife services                | Yes                             | MST intervention is typically three to six months. Weekly interventions may range from three to 20 hours a week. The number might be less as a case nears closure. |
| multi-systemic therapy services | Yes                             |                             |
| non-accredited residential Tx centers and group homes | No except for specific defined criteria | Member must be under 21 years of age. PHP does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:  
  • A. Services not considered medically necessary for the condition of the recipients, as determined by PHP  
  • B. Room and board  
  • C. Services for which prior approval was not obtained  
  • D. Services furnished after the determination is made by PHP or its designee that the recipient no longer needs care  
  • E. Formal educational or vocational services related to traditional academic subjects or vocational training  
  • F. Experimental or investigations procedures, technologies, or non-drug therapies and related services  
  • G. Drugs classified as “ineffective” by FDA drug evaluations  
  • H. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature |
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<tbody>
<tr>
<td>nursing facility services</td>
<td>Yes</td>
<td>For Custodial Care in SNF, member must meet the NFLOC criteria.</td>
</tr>
<tr>
<td>nutritional counseling</td>
<td>Yes</td>
<td>This benefit is only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits.</td>
</tr>
<tr>
<td>(SDCB service**)</td>
<td></td>
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<tr>
<td>nutritional services</td>
<td>No</td>
<td>PHP does not cover the following specific services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. Services not considered medically necessary for the condition of the recipient as determined by PHP</td>
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<tr>
<td></td>
<td></td>
<td>B. Dietary counseling for the sole purpose of weight loss</td>
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<tr>
<td></td>
<td></td>
<td>C. Weight control and weight management programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D. Commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management.</td>
</tr>
<tr>
<td>observation in hospital greater</td>
<td>Yes</td>
<td>Authorization does not exceed 48 total hours.</td>
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<tr>
<td>than 24 hours</td>
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<tr>
<td>occupational services (therapy)</td>
<td>Yes</td>
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<tr>
<td>outpatient hospital based</td>
<td>Yes for Partial Hospitalization, No for outpatient</td>
<td></td>
</tr>
<tr>
<td>psychiatric services and partial hospitalization</td>
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<tr>
<td>outpatient and partial</td>
<td>Yes for Partial Hospitalization, No for outpatient</td>
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<tr>
<td>hospitalization in freestanding</td>
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<tr>
<td>psychiatric hospital</td>
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<tr>
<td>OP health care professional</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
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<tr>
<td>personal care services (ABCB</td>
<td>Yes</td>
<td>• A. These services are not provided 24 hours per day.</td>
</tr>
<tr>
<td>service**)</td>
<td></td>
<td>B. Only for those who qualify for Nursing Facility Level of Care and select Agency-Based Community Benefits (ABCB).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. Personal Care services do not include those services for tasks the individual is already receiving from other sources including tasks provided by natural supports. Natural supports are friends, family, and the community (through individuals, clubs, and organizations) that are able and consistently available to provide supports and services to the consumer. This service is not provided to ABCB recipients in Assisted Living facilities.</td>
</tr>
<tr>
<td>pharmacy services</td>
<td>Yes for select medications.</td>
<td>• A. These services are not provided 24 hours per day.</td>
</tr>
<tr>
<td></td>
<td>Authorization requirements</td>
<td>B. Only for those who qualify for Nursing Facility Level of Care and select Agency-Based Community Benefits (ABCB).</td>
</tr>
<tr>
<td></td>
<td>determined by P&amp;T committee and</td>
<td>C. Personal Care services do not include those services for tasks the individual is already receiving from other sources including tasks provided by natural supports. Natural supports are friends, family, and the community (through individuals, clubs, and organizations) that are able and consistently available to provide supports and services to the consumer. This service is not provided to ABCB recipients in Assisted Living facilities.</td>
</tr>
<tr>
<td></td>
<td>managed by PBM</td>
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<tr>
<td>physical health services</td>
<td>No, but reserve rights to</td>
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<tr>
<td></td>
<td>implement process for overutilizers</td>
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</tr>
<tr>
<td>physical therapy</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>physician visits</td>
<td>Not for PCP visits, but specialty referrals may require a referral to obtain an authorization #</td>
<td></td>
</tr>
<tr>
<td>podiatry services</td>
<td>Certain services require</td>
<td>• A. Routine foot care is not covered except as indicated under “covered services” for an eligible recipient with systemic conditions meeting specified class findings.</td>
</tr>
</tbody>
</table>
## Appendix E: Prior Authorization Guide

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</thead>
</table>
| Pregnancy termination procedures                         | No                               | This benefit is only for those who qualify for Nursing Facility Level of Care. The member must be 21 years of age or older. All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician’s order in accordance with the New Mexico Nurse Practice Act, Code of Federal Regulation for Skilled Nursing. Private duty nursing services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.301.3 NMAC, General Noncovered Services. PHP does not cover the following specific services:  
  • A. Services for which prior approval has not been received or which are not included in the recipient’s approved treatment plan  
  • B. Services not considered medically necessary by PHP for the condition of the recipient  
  • C. Services which are not within the scope of practice of the nursing profession |
| Preventative services                                     | No                               |                             |
| Private duty nursing for adults (ABCB service**) (SDCB service***) | Yes                             |                             |
| Prosthetics and orthotics                                 | Yes                             | Noncovered Services:  
  Prosthetic and orthotic services are subject to the limitations and coverage restrictions that exist for other Medicaid services. See 8.301.3 NMAC, General Noncovered Services [MAD-602]. In addition to the services identified in 8.301.3 NMAC [MAD-602], General Noncovered Services, the following services are not covered:  
  • A. Orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics  
  • B. Prosthetic devices or implants that are used primarily for cosmetic purposes |
| Psychosocial rehabilitation services                      | Yes                             | PHP covers only those psychosocial rehabilitation services which comply with DOH mental health standards as detailed in the psychiatric rehabilitation user’s manual and are medically necessary to meet the individual needs of the recipient, as delineated in the treatment plan. Medical necessity is based upon the recipient’s level of functioning as affected by the mental disability. The services are limited to goal oriented psychosocial rehabilitative services which are individually designed to accommodate the level of the recipient’s functioning and which reduce the disability and restore the recipient to his/her best possible level of functioning. |
| Radiology facilities (for imaging)                        | No prior authorization for      |                             |

Exclusions and Limitations:

- Routine foot care is defined as:
  - (1) trimming, cutting, clipping and debriding toenails
  - (2) cutting or removal of corns, calluses, or hyperkeratosis
  - (3) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast patients
  - (4) any other service performed in the absence of localized illness, injury or symptoms involving the foot.
- B. Services directed toward the care or correction of a flat foot condition. “Flat foot” is defined as a condition in which one or more arches of the foot have flattened out.
- C. Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics.
- D. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.
- E. Orthotripsy is not a covered service.
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<tbody>
<tr>
<td>rehabilitation option services</td>
<td>Yes</td>
<td>Criteria in process of development</td>
</tr>
<tr>
<td>related goods (SDCB service***)</td>
<td>Yes</td>
<td>PHP does not cover the following rehabilitation services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A. Services furnished by providers who are not licensed and/or certified to furnish services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B. Educational programs or vocational training not part of an active treatment plan for residents in an intermediate care facility for the mentally retarded or for recipients under the age of twenty-one (21) receiving inpatient psychiatric services [42 CFR Section 441.13 (b)]</td>
</tr>
<tr>
<td></td>
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<td>• C. Services billed separately by home health agencies, independent physical therapists, independent occupational therapists, or outpatient rehabilitation centers to recipients in high-level nursing facilities or inpatient hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• D. Transportation, for recipients in low-level nursing facilities or other Medicaid recipients, to travel to outpatient hospital facilities unless there are no home health agencies, independent physical therapists or independent occupational therapists available in the area to provide the therapy at the recipient’s residence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• E. Services solely for maintenance of the recipient’s general condition; these services include repetitive services needed to maintain a recipient’s functional level that do not involve complex and sophisticated therapy procedures requiring the judgment and skill of a therapist; services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for Medicaid reimbursement purposes.</td>
</tr>
<tr>
<td>reproductive health services</td>
<td>No</td>
<td>A. Sterilization services: PHP covers medically necessary sterilizations only under the following conditions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• (1) Recipients are at least twenty-one (21) years old at the time consent is obtained;</td>
</tr>
<tr>
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<td>• (2) Recipients are not mentally incompetent. “Mentally incompetent” is a declaration of incompetency as made by a federal, state, or local court. A recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;</td>
</tr>
<tr>
<td></td>
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<td>• (3) Recipients are not institutionalized. For this section, “institutionalized” is defined as:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– (a) An individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or an intermediate care facility for the care and treatment of mental illness</td>
</tr>
<tr>
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<td>– (b) Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness;</td>
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<tr>
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<td>• (4) Recipients seeking sterilization must be given information regarding the procedure and the results before signing a consent form. This explanation must include the fact that sterilization is a final, irreversible procedure. Recipients must be informed of the risks and benefits associated with the procedure;</td>
</tr>
</tbody>
</table>
|                                 |                                 | • (5) Recipients seeking sterilization must also be instructed that their consent can
Appendix E: Prior Authorization Guide

<table>
<thead>
<tr>
<th>Centennial Care Covered Services</th>
<th>Is Prior Authorization Required?</th>
<th>Exclusions and Limitations*</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>be withdrawn at any time prior to the performance of the procedure and that they do not lose any other Medicaid benefits as a result of the decision to have or not have the procedure; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ (6) Recipients voluntarily give informed consent to the sterilization procedure. See 42 CFR Section 441.257(a):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ (a) The consent to sterilization form is signed by the recipient at least thirty (30) days before performance of the operation, except in the case of premature deliveries or emergency abdominal surgery when the consent form must be signed not less than seventy-two (72) hours before the time of the premature delivery.</td>
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<tr>
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<td></td>
<td>‑ (b) A consent form is valid for 180 days from the date of signature.</td>
</tr>
<tr>
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<td></td>
<td>‑ (c) Consent is not valid if obtained during labor or childbirth, while the recipient is under the influence of alcohol or other drugs, or is seeking or obtaining a procedure to terminate pregnancy.</td>
</tr>
<tr>
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<td></td>
<td>‑ (d) Providers obtaining the consent for sterilization must certify that to the best of their knowledge that the recipient is eligible, competent, and voluntarily signed the informed consent.</td>
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<tr>
<td></td>
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<td>‑ (e) Providers must provide an interpreter if needed to ensure that the recipient understands the information furnished.</td>
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<td>‑ (f) The recipient is given a copy of the completed, signed consent form and the original is placed in the recipient’s medical record.</td>
</tr>
<tr>
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<td></td>
<td>▪ B. Hysterectomies: Medicaid covers only medically necessary hysterectomies. PHP does not cover hysterectomies performed for the sole purpose of sterilization. See 42 CFR Section 441.253.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ (1) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by recipients prior to the operation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ (2) Acknowledgement of the sterilizing results of the hysterectomy is not required from recipients who have been previously sterilized or who are past child-bearing age as defined by the medical community.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ (3) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.</td>
</tr>
<tr>
<td></td>
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<td>▪ C. Other covered services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ Medicaid covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy, or contraception including oral contraceptives, condoms, intrauterine devices (IUD), depoprovera injections, diaphragms, and foams.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NONCOVERED SERVICES: Reproductive health care services are subject to the same limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, General Noncovered Services [now 8.301.3 NMAC, General Noncovered Services].</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In addition, Medicaid does not cover the following specific services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ A. Sterilization reversals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ B. Fertility drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ C. In vitro fertilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ D. Artificial insemination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‑ E. Elective procedures to terminate pregnancy</td>
</tr>
<tr>
<td></td>
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<td>‑ F. Hysterectomies performed for the sole purpose of family planning</td>
</tr>
<tr>
<td>respite</td>
<td>Yes</td>
<td>▪ A. Respite services are limited to a maximum of 100 hours annually per care plan</td>
</tr>
</tbody>
</table>
## Centennial Care Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Is Prior Authorization Required?</th>
<th>Exclusions and Limitations*</th>
</tr>
</thead>
</table>
| (ABCB service**) (SDCB service*** *)     |                                 | year, provided there is a primary caretaker. Additional hours may be requested if a member’s health and safety needs exceed the specified limit. For members up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 days.  
  - B. Respite services are only for those who qualify for Nursing Facility Level of Care or for select behavioral health patients. |
| rural health clinic services             | Services provided by RHC have same requirements as other providers | |
| school based services                    | No                              | Services furnished in school settings are subject to the limitations and coverage restrictions that exist for other Medicaid services. See 8.301.3 NMAC [MAD-602], General Noncovered Services. PHP does not cover the following specific services:  
  - A. Services classified as educational  
  - B. Services to non-Medicaid eligible individuals  
  - C. Services furnished by providers outside their area of expertise  
  - D. Vocational training that is related solely to specific employment opportunities, work skills, or work settings  
  - E. Services that duplicate services furnished outside the school setting, unless determined to be medically necessary, and given prior authorization by the medical assistance division or its designee  
  - F. Services not identified in the recipient’s IEP or IFSP, and not authorized by the recipient’s PCP  
  - G. Transportation that a recipient would otherwise receive in the course of attending school  
  - H. Transportation for a recipient with special education needs under the Individuals with Disabilities Education Act (IDEA), who rides the regular school bus to and from school with other non-disabled children |
| skilled maintenance therapy services     | Yes                             |  
  (ABCB service**) (SDCB Service*** *)  
  - A. A signed therapy referral for treatment must be obtained from the recipient’s primary care physician. The referral includes frequency, estimated duration of therapy, and treatment/procedures to be rendered.  
  - B. Only for those who qualify for Nursing Facility Level of Care.  
  - C. Member must be at least 21 years of age. |
| smoking cessation services               | No                              | Member must be over the age of 18. Coverage is limited to two 90-day courses of treatment per calendar year. |
| specialized therapies (SDCB service*** *)| Yes                             |  
  - A. Experimental or prohibited treatments and goods are excluded. Related goods are limited to $500 per person per care plan year.  
  - B. Only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits. |
| speech and language therapy              | Yes                             | This benefit is only provided to adults with short-term needs due to an acute event. |
| swing bed hospital services              | Yes                             | |
| telehealth services (provider telehealth not home-based telehealth) | No | |
| Tot-to-Teen health checks                | No                              | |
| transplant services                      | Yes                             | PHP does not cover any transplant procedures, treatments, use of drug(s), biological product(s), product(s), or device(s) which are considered unproven, experimental, investigational, or not effective for the condition for which they are intended or used. |
| transportation services (medical)        | No, except for air transport. Benefit | |
### Centennial Care Covered Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Is Prior Authorization Required?</th>
<th>Exclusions and Limitations*</th>
</tr>
</thead>
</table>
| treatment foster care | Yes | *A.** Not to be used for transportation to medical appointments, etc., and not to be used for purposes of vacation  
**B.** Only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits
| treatment foster care II | Yes | Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.301.3 NMAC, General Noncovered Services. PHP does not cover the following services:  
*A. Room and board  
*B. Formal educational or vocational services related to traditional academic subjects or vocational training  
*C. Respite care
| value added services | Yes | Varies by benefit

### General Exclusions and Limitations

- PHP does not cover the following specific vision services:  
  - A. Orthoptic assessment and treatment  
  - B. Photographic procedures, such as fundus or retinal photography and external ocular photography  
  - C. Polycarbonate lenses other than for prescriptions for high acuity  
  - D. Ultraviolet (UV) lenses  
  - E. Trifocals  
  - F. Progressive lenses  
  - G. Tinted or photochromic lenses, except in cases of documented medical necessity. See Subsection D of 8.310.6.12 NMAC above  
  - H. Oversize frames and oversize lenses  
  - I. Low vision aids  
  - J. Eyeglass cases  
  - K. Eyeglass or contact lens insurance  
  - L. Anti-scratch, anti-reflective, or mirror coating

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*To be eligible for community benefits (self-directed community benefits and agency-based community benefits), members must meet medical eligibility (nursing facility level of care) and financial eligibility. The member’s care coordinator completes a comprehensive needs assessment which forms the basis for the development of an individual plan of care that includes recommended community benefit services based on the needs of the individual. All recommended community benefits must be reviewed and approved by a PHP secondary review team prior to the provision of services.

* Presbyterian edits the prior authorization list as updates are needed. Please visit [http://www.phs.org/PHS/healthplans/providers/healthservices/] to check for the most recent version of this list.

** ABCB is an agency-based community benefit service.

*** SDCB is a self-directed community benefit service.
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### Appendix F. Alternative Benefits Package Covered Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Description</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism spectrum disorder</td>
<td><strong>Limitation:</strong> Services are only available to members through age 22.</td>
<td>No</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td><strong>Limitation:</strong> One surgery covered per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral health professional services</td>
<td>These include evaluations, therapy, and tests by licensed practitioners.</td>
<td>No</td>
</tr>
<tr>
<td>Cancer Clinical Trials</td>
<td>This is a course of treatment provided to a patient for the purpose of prevention of recurrence, early detection or treatment of cancer that is being provided in New Mexico.</td>
<td>No</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td><strong>Limitation:</strong> 36 hours per cardiac event</td>
<td>No</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Chemotherapy is the use of chemical agents in the treatment or control of disease.</td>
<td>No</td>
</tr>
<tr>
<td>Dental services</td>
<td>See Page 7-7.</td>
<td>Yes, for select services and dental procedures</td>
</tr>
<tr>
<td>Diabetes treatment, including diabetic shoes and supplies</td>
<td>This covers office visits, diabetes education and diabetic supplies including diabetic shoes, Insulin and diabetic oral agents for controlling blood sugar. Diabetic supplies used on an inpatient basis, applied as part of treatment in a practitioner's office, outpatient hospital, residential facility, or a home health service, are covered when separate payment is allowed in these settings.</td>
<td>Yes, for select services</td>
</tr>
<tr>
<td>Diagnostic imaging and therapeutic radiology services</td>
<td>Covered services include medically necessary imaging exams and radiology services ordered by doctors or other licensed providers. Some examples of these services are X-ray, ultrasound, magnetic resonance imaging (MRI), and computerized tomography (CT) scans.</td>
<td>Yes, for select services</td>
</tr>
<tr>
<td>Dialysis services</td>
<td>Medicaid covers medically necessary dialysis services and supplies furnished to members receiving dialysis at home as well as services received from a contracted provider.</td>
<td>No</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) and supplies</td>
<td>This is equipment that is medically necessary for treatment of an illness or accidental injury. It might also be needed to prevent further deterioration. DME is designed for repeated use. It includes items like oxygen equipment and supplies necessary to use equipment wheelchairs, crutches and items to assist with treatment such as casts and splints that are applied by the healthcare practitioner.</td>
<td>Some services may require prior authorization</td>
</tr>
<tr>
<td>Electroconvulsive therapy</td>
<td>ECT is a medical treatment for severe mental illness in which a small, carefully controlled amount of electricity is introduced into the brain, and is used to treat a variety of psychiatric disorders, including severe depression.</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency services</td>
<td>See Page 2-8.</td>
<td>No</td>
</tr>
</tbody>
</table>
## Appendix F: Alternative Benefits Package Covered Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Description</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Available to members under 21 years old only. See Preventive Healthcare chapter.</td>
<td>No</td>
</tr>
</tbody>
</table>
| Extended care hospitals (long term care hospitals)  | Extended care hospitals are not covered. Sometimes these are referred to as long term care hospitals (certified as acute care hospitals but focus on care for more than 25 days)  
Nursing Facility long term care stays are not covered by ABP except as a temporary step down level of care following discharge from a hospital prior to being discharged to home.                                                                                                                                 | Yes                 |
| Family planning                                      | See Page 7-7.                                                                                                                                                                                                                                                                                                                               | No                  |
| Hearing aids and related evaluations                 | Routine hearing screenings and evaluations are covered without authorization. Hearing aids and their accessories and supplies are not covered. Hearing testing by an audiologist or a hearing aid dealer is not covered.                                                                                       | No                  |
| Home health services                                 | These cover services that are skilled and medically necessary. Services must be ordered by the member’s attending doctor and included in the care plan established by the member’s attending doctor. The plan of care must be reviewed, signed, and dated by the attending doctor.  
**Limitation:** 100 visits per year. A visit cannot exceed four hours.                                                                                       | Yes                 |
| Hospice services                                     | These inpatient and in-home hospice services are designed to keep you comfortable if you are terminally ill. An approved hospice program must provide these services during a hospice benefit period. Hospice services require prior authorization. You must be a covered member throughout your hospice benefit period.  
The hospice benefit period is defined as follows:  
- Beginning on the date your provider certifies that you are terminally ill with a life expectancy of six months or less.  
- Ending six months after it began, unless you require an extension of the hospice benefit period below, or upon your death.  
If you need an extension of the hospice benefit period, the hospice must provide a new treatment plan. Your provider also must reauthorize your medical condition to us. We will not authorize more than one additional hospice benefit period.  
If the hospice recipient requires Nursing Facility level of care, the recipient will have to meet the requirements for receiving Nursing Facility care. | Yes, inpatient only |
<p>| Hospital inpatient (including detoxification services) | Hospital stays must be provided under the direction of the member’s PCP or a consulting provider referred to the member by his PCP. All cases and treatment must be medically necessary. Acute medical detoxification benefits are covered under inpatient services.                                                                 | Yes                 |
| Indian Health Services                               | Indian Health Services (IHS) is the primary provider of healthcare services for the tribal nations and pueblos. Members may self-refer to IHS facilities.                                                                                                                                                                                                 | No                  |</p>
<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Inpatient hospitalization in freestanding psychiatric hospitals</td>
<td>These services include necessary evaluations and psychological testing for treating severe emotional or substance abuse problems. They also include regularly scheduled structured counseling and therapy sessions. These services are only for individuals under 21 years of age. Inpatient drug rehabilitation services are not covered. Acute inpatient services for &quot;detox&quot; are covered.</td>
<td>Yes</td>
</tr>
<tr>
<td>Intravenous (IV) outpatient services</td>
<td>Hospital outpatient care includes the use of intravenous (IV) infusions, catheter changes, first aid for IV associated injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. A partial hospitalization in a general hospital psychiatric unit is considered an outpatient service.</td>
<td>No, Some medications may require prior authorization</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>These are medically necessary lab services ordered by doctors or other licensed providers. They are performed by ordering providers or are done under their supervision in an office lab. They also can be performed by a clinical lab. This includes laboratory genetic testing to specific molecular lab tests such as BRCA1 and BRCA2 and similar tests used to determine appropriate treatment. Does not include random genetic screening.</td>
<td>No</td>
</tr>
<tr>
<td>Medication Assisted Treatment (MAT) for opioid dependence</td>
<td>This service is treatment for addiction that includes the use of medication along with counseling and other support.</td>
<td>Yes, for medications only. Not for office visits</td>
</tr>
<tr>
<td>Midwife services</td>
<td>See Appendix E.</td>
<td>No</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>Dietary evaluation of counseling as medical management of a documented disease, including obesity.</td>
<td>Yes</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>These promote fine motor skills, coordination, and integration of the senses. They help the member use adaptive equipment or other technology.</td>
<td>No</td>
</tr>
<tr>
<td>Limitation: Short-term therapy only for a two-month period from the initial date of treatment.</td>
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<td></td>
</tr>
<tr>
<td>Outpatient hospital-based psychiatric services and partial hospitalization</td>
<td>These services are medically necessary for the diagnosis and/or treatment of a mental illness, as indicated by the member's condition. Services and stabilization must be for the purpose of diagnostic study or be expected to improve the member’s condition.</td>
<td>No, outpatient services provided in hospital setting</td>
</tr>
<tr>
<td></td>
<td>Yes, for partial hospitalization and psychological testing.</td>
<td></td>
</tr>
<tr>
<td>Outpatient health care professional services</td>
<td>These cover outpatient assessments, evaluations, testing, and therapy.</td>
<td>No, for evaluations and testing. Some therapies may require prior authorization.</td>
</tr>
<tr>
<td>Pharmacy services</td>
<td>Certain over-the-counter drugs are covered, such as prenatal drug items (examples—vitamins, folic acid; iron), low dose aspirin as preventative for cardiac conditions; contraception drugs and devices, and items for treating diabetes.</td>
<td>Yes, for select medications</td>
</tr>
<tr>
<td>Physical therapy services</td>
<td>These services promote gross and fine motor skills, help with independent activities.</td>
<td>No</td>
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</tbody>
</table>
### Appendix F: Alternative Benefits Package Covered Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Physician visits</td>
<td>These are provider services required by members to maintain good health. They include but are not limited to periodic exams and office visits provided by licensed providers. Limitation: Short-term therapy only for a two-month period from the initial date of treatment.</td>
<td>No</td>
</tr>
</tbody>
</table>
| Podiatry services                   | These are only medically necessary podiatric services given by providers, as required by the member’s condition. Specified services include:  
- Routine foot care when there is evidence of a systemic condition, circulatory distress, or areas of diminished sensation in the feet demonstrated through physical or clinical exam  
- Routine foot care, non-surgical and surgical correction of a subluxated foot structure  
- Treatment of warts on the feet  
- Treatment of asymptomatic nails with a fungal infection may be covered  
Orthopedic shoes and other supportive devices only when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics. | No                  |
| Pregnancy termination procedures    | See Page 19-7.                                                                                                                                                                                                                                                               | No                  |
| Preventive services                 | See Page 5-1.                                                                                                                                                                                                                                                                | No                  |
| Prosthetics and orthotics           | Prosthetics and orthotics supplied by providers are covered only when certain requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye. Orthotic devices support or brace the body, such as trusses, compression custom-made stockings, and braces. Limitation: Foot orthotic, including shoe and arch supports, are only covered when an integral part of a leg brace or diabetic shoes. | Yes                 |
| Pulmonary rehabilitation            | Limitation: 36 hours per year.                                                                                                                                                                                                                                               | No                  |
| Reproductive health services        | See the Care Coordination chapter and Appendix E.                                                                                                                                                                                                                           | No                  |
| Skilled nursing                     | Skilled nursing is generally provided only through a home health agency. However, it can also be provided through private duty nursing.                                                                                                                                              | Yes                 |
| Smoking cessation/ tobacco services | These include diagnostic services, tobacco/smoking cessation counseling and pharmacotherapy. Group counseling, including classes or a telephone Quit Line, are covered when offered by an in-network provider. Some organizations, such as the American Cancer Society and the Tobacco Use Prevention and Control (TUPAC), offer group counseling services at no charge. | No                  |
### Covered Service
<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Description</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco/smoking cessation pharmacotherapy</td>
<td>Prescription drugs/medications prescribed by your provider for a 30-day supply up to the maximum dose recommended by the manufacturer. These medications can be purchased at a pharmacy. Coverage is limited to two 90-day courses of treatment per calendar year.</td>
<td>No</td>
</tr>
<tr>
<td>Specialized behavioral health services for adults</td>
<td>These include Intensive Outpatient (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR).</td>
<td>No</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>This is a covered benefit for members under the age of 21. The services must be provided by speech and language pathologists, physical therapists, and occupational therapists. Services must be prescribed or ordered by the member's PCP or other doctor. Limitation: Short-term therapy only for a two-month period from the initial date of treatment.</td>
<td>No</td>
</tr>
<tr>
<td>Telehealth services</td>
<td>An interactive telehealth communication system that must include both interactive audio and video. It must be delivered on a real-time basis at the original site and distant sites. Providers may use telehealth when it is available for the following services: Consultations Evaluation and management services Individual psychotherapy Pharmacologic management Psychiatric diagnostic interview exams End-stage renal disease-related services Individual medical nutrition services</td>
<td>No</td>
</tr>
<tr>
<td>Transplant services</td>
<td>These include hospital, doctor, laboratory, outpatient surgical, and other covered services needed to perform a transplant. Limitation: Two per lifetime.</td>
<td>Yes</td>
</tr>
<tr>
<td>Transportation services (medical)</td>
<td>Presbyterian covers expenses for transportation and other related expenses which are determined as necessary to secure Medicaid-covered medical examinations and treatment for eligible recipients in or out of their home community. Travel expenses include the cost of transportation by public transportation, taxicab, handivan, and ground or air ambulance. Related travel expenses include the cost of meals and lodging made necessary by receipt of medical care away from the recipient's home community. When medically necessary, Medicaid covers similar expenses for an attendant who accompanies the recipient to the medical examination or treatment.</td>
<td>No</td>
</tr>
<tr>
<td>Vision services</td>
<td>The diagnoses and treatment of eye diseases and the correction of vision problems. Certain types of glasses are not covered. See the Non-covered Benefits list. Exclusion: Refractions are not covered. Limitation: Eyeglasses and contact lenses are only covered for aphakia following the removal of the lens.</td>
<td>Some services require prior authorization</td>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limitation</th>
</tr>
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<tbody>
<tr>
<td>36415</td>
<td>Collection Of Venous Blood By Venipuncture</td>
<td></td>
</tr>
<tr>
<td>80305</td>
<td>Drug Test Prsmv Dir Opt Obs</td>
<td></td>
</tr>
<tr>
<td>80306</td>
<td>Drug Test Prsmv Instrmnt</td>
<td></td>
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<tr>
<td>80307</td>
<td>Drug Test Prsmv Chem Anlyzr</td>
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<td>80320</td>
<td>Drug Screen Quantalcohols</td>
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<tr>
<td>80321</td>
<td>Alcohols Biomarkers 1 or 2</td>
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<tr>
<td>80322</td>
<td>Alcohols Biomarkers 3/More</td>
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</tr>
<tr>
<td>80323</td>
<td>Alkaloids Nos</td>
<td></td>
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<td>80324</td>
<td>Drug Screen Amphetamines 1/2</td>
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<td>80325</td>
<td>Amphetamines 3 or 4</td>
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<td>80326</td>
<td>Amphetamines 5 or More</td>
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<tr>
<td>80327</td>
<td>Anabolic Steroid 1 or 2</td>
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<td>80328</td>
<td>Anabolic Steroid 3 or More</td>
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<td>80329</td>
<td>Analgesics Non-Opioid 1 or 2</td>
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<td>Analgesics Non-Opioid 3-5</td>
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<td>80331</td>
<td>Analgesics Non-Opioid 6/More</td>
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<td>80332</td>
<td>Antidepressants Class 1 or 2</td>
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<td>80333</td>
<td>Antidepressants Class 3-5</td>
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<td>80334</td>
<td>Antidepressants Class 6/More</td>
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<td>Antidepressant Tricyclic 1/2</td>
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<td>Antidepressant Tricyclic 3-5</td>
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<td>Tricyclic &amp; Cyclicals 6/More</td>
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<td>80338</td>
<td>Antidepressant Not Specified</td>
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<td>80339</td>
<td>Antiepileptics Nos 1-3</td>
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<td>Antiepileptics Nos 7/More</td>
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<td>80342</td>
<td>Antipsychotics Nos 1-3</td>
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<td>80343</td>
<td>Antipsychotics Nos 4-6</td>
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<td>80344</td>
<td>Antipsychotics Nos 7/More</td>
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<tr>
<td>80345</td>
<td>Drug Screening Barbiturates</td>
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<tr>
<td>80346</td>
<td>Benzodiazepines 1-12</td>
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</table>
### In-office Lab List

* Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Limitation</th>
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<tr>
<td>80347</td>
<td>Benzodiazepines 13 Or More</td>
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<tr>
<td>80348</td>
<td>Drug Screening Buprenorphine</td>
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<td>80349</td>
<td>Cannabinoids Natural</td>
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<td>80350</td>
<td>Cannabinoids Synthetic 1-3</td>
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<td>80351</td>
<td>Cannabinoids Synthetic 4-6</td>
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<tr>
<td>80352</td>
<td>Cannabinoid Synthetic 7/More</td>
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<td>80353</td>
<td>Drug Screening Cocaine</td>
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<td>80354</td>
<td>Drug Screening Fentanyl</td>
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<td>80355</td>
<td>Gabapentin Non-Blood</td>
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<tr>
<td>80356</td>
<td>Heroin Metabolite</td>
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<tr>
<td>80357</td>
<td>Ketamine And Norketamine</td>
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<td>80358</td>
<td>Drug Screening Methadone</td>
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<td>80359</td>
<td>Methylenedioxyamphetamine</td>
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<td>80360</td>
<td>Methylphenidate</td>
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<td>80361</td>
<td>Opiates 1 Or More</td>
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<td>80362</td>
<td>Opioids &amp; Opiate Analogs 1/2</td>
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<td>80363</td>
<td>Opioids &amp; Opiate Analogs 3/4</td>
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<td>80364</td>
<td>Opioid &amp; Opiate Analog 5/More</td>
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<td>80365</td>
<td>Drug Screening Oxycodone</td>
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<td>80366</td>
<td>Drug Screening Pregabalin</td>
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<td>80367</td>
<td>Drug Screening Propoxyphene</td>
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<td>80368</td>
<td>Sedative Hypnotics</td>
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<td>80369</td>
<td>Skeletal Muscle Relaxant 1/2</td>
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<td>80370</td>
<td>Skel Musc Relaxant 3 Or More</td>
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<td>80371</td>
<td>Stimulants Synthetic</td>
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<td>80372</td>
<td>Drug Screening Tapentadol</td>
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<td>80373</td>
<td>Drug Screening Tramadol</td>
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<td>80374</td>
<td>Stereoisomer Analysis</td>
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<tr>
<td>80375</td>
<td>Drug/Substance Nos 1-3</td>
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<tr>
<td>80376</td>
<td>Drug/Substance Nos 4-6</td>
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<tr>
<td>80377</td>
<td>Drug/Substance Nos 7/More</td>
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<tr>
<td>81000</td>
<td>Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrile, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated with microscopy</td>
<td></td>
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</tbody>
</table>
## In-office Lab List

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>81005</td>
<td>Urinalysis; qualitative or semi-quantitative, except immunoassays</td>
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<tr>
<td>81015</td>
<td>Urinalysis, microscopic only</td>
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<tr>
<td>82948</td>
<td>Glucose; blood, reagent strip</td>
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<tr>
<td>84702</td>
<td>Gonadotropin, chorionic (hCG); quantitative (second or repeats require PA)</td>
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<tr>
<td>85002</td>
<td>Bleeding time</td>
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<tr>
<td>85007</td>
<td>Blood smear, microscopic examination with manual differential WBC count</td>
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<tr>
<td>85009</td>
<td>Manual differential WBC count, buffy coat</td>
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<tr>
<td>85025</td>
<td>Hemogram and platelet count, automated and automated complete differential WBC count (CBC)</td>
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<tr>
<td>85027</td>
<td>Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)</td>
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<tr>
<td>85049</td>
<td>Platelet, automated</td>
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<tr>
<td>85660</td>
<td>Sickling of RBC, reduction</td>
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<tr>
<td>86403</td>
<td>Particle agglutination; screen, each antibody</td>
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<tr>
<td>86485</td>
<td>Candida skin test</td>
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<tr>
<td>86486</td>
<td>Skin test, unlisted antigen (used for mumps skin test)</td>
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<tr>
<td>86490</td>
<td>Coccidioidomycosis</td>
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<tr>
<td>86580</td>
<td>Tuberculosis, intradermal</td>
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<tr>
<td>86703</td>
<td>HIV-1 and HIV-2, single assay</td>
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<tr>
<td>86901</td>
<td>Blood typing, Rh (D)</td>
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<tr>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening only</td>
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<tr>
<td>87101</td>
<td>Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail</td>
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<tr>
<td>87102</td>
<td>Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail, other source (except blood)</td>
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<tr>
<td>87106</td>
<td>Culture, fungi, definitive identification, each organism; yeast</td>
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<tr>
<td>87110</td>
<td>Culture, chlamydia, any source</td>
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<tr>
<td>87205</td>
<td>Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi or cell types</td>
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</tr>
</tbody>
</table>
## Appendix G: In-office Laboratory Lists

### In-office Lab List

* Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>87206</td>
<td>Smear, primary source, with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types</td>
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<tr>
<td>87207</td>
<td>Special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)</td>
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<tr>
<td>87220</td>
<td>Tissue examination by KOH slide of samples from skin, hair, nails for fungi or ectoparasite ova or mites (e.g., scabies)</td>
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<tr>
<td>87270</td>
<td>Chlamydia trachomatis</td>
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<tr>
<td>87320</td>
<td>Chlamydia trachomatis</td>
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<tr>
<td>87400</td>
<td>Influenza, A or B, each</td>
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<tr>
<td>87430</td>
<td>Streptococcus, group A antigen, detection by enzyme immunoassay technique, qualitative or semi-qualitative, multi-step method</td>
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<tr>
<td>87490</td>
<td>Chlamydia trachomatis, direct probe technique</td>
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<tr>
<td>87491</td>
<td>Chlamydia trachomatis, amplified probe technique</td>
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<tr>
<td>87591</td>
<td>Neisseria gonorrhoeae, amplified probe technique</td>
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<td>87810</td>
<td>Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis</td>
<td>Can only be performed by Certified Dermatopathologist</td>
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<tr>
<td>88304</td>
<td>Level III surgical pathology, gross and microscopic examination</td>
<td>Can only be performed by Certified Dermatopathologist</td>
</tr>
<tr>
<td>88305</td>
<td>Level IV surgical pathology, gross and microscopic examination</td>
<td>Can only be performed by Certified Dermatopathologist</td>
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<tr>
<td>88321</td>
<td>Consultation and report on referred slides prepared elsewhere</td>
<td>Can only be performed by Certified Dermatopathologist</td>
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<tr>
<td>89060</td>
<td>Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)</td>
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<tr>
<td>89190</td>
<td>Nasal smear for eosinophils</td>
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<tr>
<td>89310</td>
<td>Semen analysis; motility and count (not including Huhner test)</td>
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<tr>
<td>89330</td>
<td>Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test</td>
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<tr>
<td>80047*</td>
<td>Metabolic panel ionized ca</td>
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<tr>
<td>80048*</td>
<td>Basic metabolic panel</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Limitation</td>
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<tr>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>80051*</td>
<td>Electrolyte panel</td>
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<tr>
<td>80053*</td>
<td>Comprehensive metabolic panel</td>
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<tr>
<td>80061*</td>
<td>Lipid panel</td>
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<td>80069*</td>
<td>Renal function panel</td>
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<tr>
<td>80178*</td>
<td>Assay of Lithium</td>
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<td>81002*</td>
<td>Urinalysis, by dipstick or tablet reagent for bilirubin, glucose,</td>
<td>Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated without microscopy</td>
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<td>81003*</td>
<td>Urinalysis, automated, without microscopy</td>
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<td>81007*</td>
<td>Urinalysis, bacteriuria screen, except by culture or dipstick</td>
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<td>81025*</td>
<td>Urine pregnancy test, by visual color comparison methods</td>
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<td>82010*</td>
<td>Acetone or other ketone bodies, serum; quantitative</td>
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<tr>
<td>82040*</td>
<td>Assay of serum albumin</td>
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<tr>
<td>82043*</td>
<td>Microalbumin quantitative</td>
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<tr>
<td>82044*</td>
<td>Albumin, urine, microalbumin, semi-quantitative (e.g., reagent strip assay)</td>
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<tr>
<td>82120*</td>
<td>Amines, vaginal fluid, qualitative</td>
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<td>82150*</td>
<td>Assay of amylase</td>
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<td>82247*</td>
<td>Bilirubin total</td>
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<td>82270*</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces,</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)</td>
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<tr>
<td>82271*</td>
<td>Occult blood other sources</td>
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<tr>
<td>82272*</td>
<td>Occult bld feces 1-3 tests</td>
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<tr>
<td>82274*</td>
<td>Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations</td>
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<tr>
<td>82310*</td>
<td>Assay of calcium</td>
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<tr>
<td>82330*</td>
<td>Assay of calcium</td>
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<tr>
<td>82374*</td>
<td>Assay blood carbon dioxide</td>
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<tr>
<td>82435*</td>
<td>Assay of blood chloride</td>
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</tr>
<tr>
<td>82465*</td>
<td>Assay bld/serum cholesterol</td>
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</tbody>
</table>
### In-office Lab List

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<table>
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<th>Description</th>
<th>Limitation</th>
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<td>82523*</td>
<td>Collagen, cross links, any method</td>
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<tr>
<td>82550*</td>
<td>Assay of ck (cpk)</td>
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<td>82565*</td>
<td>Creatinine; blood</td>
<td>Can only be performed by Nephrology</td>
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<tr>
<td>82570*</td>
<td>Creatinine, other source</td>
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<tr>
<td>82679*</td>
<td>Estrone</td>
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</tr>
<tr>
<td>82947*</td>
<td>Glucose; quantitative, blood (except reagent strip)</td>
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<td>82950*</td>
<td>Post glucose dose (includes glucose)</td>
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<tr>
<td>82951*</td>
<td>Tolerance test (GTT), three specimens (includes glucose)</td>
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<td>82952*</td>
<td>Tolerance test, each additional beyond tree specimens</td>
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<tr>
<td>82962*</td>
<td>Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use</td>
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<tr>
<td>82977*</td>
<td>Assay of GGT</td>
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<td>82985*</td>
<td>Glycated protein</td>
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<td>83001*</td>
<td>Gonadotropin; follicle stimulating hormone (FSH)</td>
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<td>83002*</td>
<td>Gonadotropin; luteinizing hormone (LH)</td>
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<td>83026*</td>
<td>Hemoglobin; by copper sulfate method, non-automated</td>
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<tr>
<td>83036*</td>
<td>Hemoglobin; glycated, A1c (Test result required on claim submission for reimbursement)</td>
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<tr>
<td>83037*</td>
<td>Glycosylated hb home device</td>
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<tr>
<td>83516*</td>
<td>Immunoassay for analyte other than infectious agent antibody or infection agent qualitative or semiquantitative multi-step method</td>
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<tr>
<td>83518*</td>
<td>Immunoassay for analyte other than infectious agent antibody or infection agent antigen, qualitative or semi-quantitative; single step method (eg, reagent strip)</td>
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<td>83605*</td>
<td>Lactate (lactic acid)</td>
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<tr>
<td>83605*</td>
<td>Lactate (lactic acid)</td>
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<tr>
<td>83655*</td>
<td>Lead</td>
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<tr>
<td>83718*</td>
<td>Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)</td>
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<tr>
<td>83721*</td>
<td>LDL Cholesterol</td>
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<tr>
<td>83861*</td>
<td>Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity</td>
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<tr>
<td>83880*</td>
<td>Natriuretic peptide</td>
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<tr>
<td>83986*</td>
<td>pH, body fluid, except blood</td>
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</tbody>
</table>
### Appendix G: In-office Laboratory Lists

#### In-office Lab List

* Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limitation</th>
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<tbody>
<tr>
<td>84075*</td>
<td>Assay alkaline phosphatase</td>
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<tr>
<td>84132*</td>
<td>Assay of serum potassium</td>
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<tr>
<td>84155*</td>
<td>Assay of protein serum</td>
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</tr>
<tr>
<td>84295*</td>
<td>Assay of serum sodium</td>
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</tr>
<tr>
<td>84443*</td>
<td>Thyroid stimulating hormone</td>
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<tr>
<td>84450*</td>
<td>Transferase (AST) (SGOT)</td>
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<tr>
<td>84460*</td>
<td>Transferase; alanine amino (ALT) (SGPT)</td>
<td></td>
</tr>
<tr>
<td>84478*</td>
<td>Triglycerides</td>
<td></td>
</tr>
<tr>
<td>84520*</td>
<td>Urea nitrogen, quantitative</td>
<td>Can only be performed by Nephrology</td>
</tr>
<tr>
<td>84703*</td>
<td>Gonadotropin; chorionic (hCG); qualitative</td>
<td></td>
</tr>
<tr>
<td>84830*</td>
<td>Ovulation tests, by visual color comparison methods for human luteinizing hormone</td>
<td></td>
</tr>
<tr>
<td>85013*</td>
<td>Spun microhematocrit</td>
<td></td>
</tr>
<tr>
<td>85014*</td>
<td>Blood count; hematocrit (Hct)</td>
<td></td>
</tr>
<tr>
<td>85018*</td>
<td>Hemoglobin</td>
<td></td>
</tr>
<tr>
<td>85576*</td>
<td>Blood platelet aggregation</td>
<td></td>
</tr>
<tr>
<td>85610*</td>
<td>Prothrombin time</td>
<td></td>
</tr>
<tr>
<td>85651*</td>
<td>Sedimentation rate, erythrocyte; non-automated</td>
<td></td>
</tr>
<tr>
<td>86294*</td>
<td>Immunoassay for tumor antigen, qualitative or semi-quantitative (eg, bladder tumor antigen)</td>
<td></td>
</tr>
<tr>
<td>86308*</td>
<td>Heterophile antibodies; screening</td>
<td></td>
</tr>
<tr>
<td>86318*</td>
<td>Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (eg, reagent strip)</td>
<td></td>
</tr>
<tr>
<td>86386*</td>
<td>Nuclear Matrix Protein 22 (NMp22) qualitative</td>
<td></td>
</tr>
<tr>
<td>86618*</td>
<td>Borrelia burgdorferi (Lyme Disease)</td>
<td></td>
</tr>
<tr>
<td>86701*</td>
<td>Rapid HIV-1 antibody test</td>
<td></td>
</tr>
<tr>
<td>86738*</td>
<td>Treponema pallidum</td>
<td></td>
</tr>
<tr>
<td>86803*</td>
<td>Hepatitis C antibody</td>
<td></td>
</tr>
<tr>
<td>87077*</td>
<td>Aerobic isolate, additional methods required for definitive identification, each isolate</td>
<td></td>
</tr>
<tr>
<td>87210*</td>
<td>Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)</td>
<td></td>
</tr>
<tr>
<td>87338*</td>
<td>Helicobacter pylori; stool</td>
<td></td>
</tr>
<tr>
<td>87389*</td>
<td>Helicobacter pylori</td>
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</tbody>
</table>
### In-office Lab List

* Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>87449*</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique qualitative or semi-quantitative; multiple step method, not otherwise specified, each organism</td>
<td></td>
</tr>
<tr>
<td>87502*</td>
<td>influenza virus for multiple or sub types including multiplex reverse transcription, when performed and multiplex amplified probe technique first 2 types or sub-types</td>
<td></td>
</tr>
<tr>
<td>87631*</td>
<td>respiratory virus</td>
<td></td>
</tr>
<tr>
<td>87633*</td>
<td>respiratory virus</td>
<td></td>
</tr>
<tr>
<td>87651*</td>
<td>streptococcus group A amplified probe technique</td>
<td></td>
</tr>
<tr>
<td>87804*</td>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>87807*</td>
<td>Rsv assay w/optic</td>
<td></td>
</tr>
<tr>
<td>87808*</td>
<td>Trichomonas assay w/optic</td>
<td></td>
</tr>
<tr>
<td>87809*</td>
<td>Adenovirus assay w/optic</td>
<td></td>
</tr>
<tr>
<td>87880*</td>
<td>Streptococcus, group A</td>
<td></td>
</tr>
<tr>
<td>87905*</td>
<td>Sialidase enzyme assay</td>
<td></td>
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<tr>
<td>89300*</td>
<td>Semen analysis; presence and/or motility of sperm including Huhner test (post coital)</td>
<td></td>
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<tr>
<td>89321*</td>
<td>Semen anal sperm detection</td>
<td></td>
</tr>
<tr>
<td>G0103</td>
<td>Prostate cancer screening; PSA Test</td>
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<tr>
<td>G0328*</td>
<td>Colorectal cancer screening fecal occult blood test</td>
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<tr>
<td>G0431</td>
<td>RX SCR MX RX CLASS HI CMPLX PT ENC</td>
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</tr>
<tr>
<td>G0432</td>
<td>INF AB EIA TECH HIV-1 &amp;/OR HIV-2</td>
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<tr>
<td>G0433*</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA)</td>
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<tr>
<td>G0434</td>
<td>DRUG SCR NOT CGC: ANY NUMBER PT ENC</td>
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<tr>
<td>G0435</td>
<td>INF AGT ANTIG DETECT RPD AB TST OMT</td>
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<tr>
<td>G0472*</td>
<td>Hepatitis C antibody screening for individual at high risk</td>
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<tr>
<td>G0477*</td>
<td>Drug Test</td>
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</tr>
<tr>
<td>Q0111</td>
<td>Wet mounts, including preparation of vaginal, cervical or skin specimens</td>
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<tr>
<td>Q0112</td>
<td>All potassium hydroxide (KOH) preparations</td>
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<tr>
<td>Q0113</td>
<td>Pinworm examination</td>
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</tr>
<tr>
<td>Q0114</td>
<td>Fern test</td>
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</tbody>
</table>
## In-office Lab List

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<thead>
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<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Q0115</td>
<td>Post-coital direct, qualitative examinations of vaginal or cervical mucous</td>
<td></td>
</tr>
</tbody>
</table>
### Presbyterian Behavioral Health Covered Lab Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415</td>
<td>Collection of venous blood by venipuncture</td>
</tr>
<tr>
<td>80047</td>
<td>Metabolic panel ionized ca</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel</td>
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<tr>
<td>80061</td>
<td>Lipid panel</td>
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<tr>
<td>80069</td>
<td>Renal function panel</td>
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<tr>
<td>81000</td>
<td>Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated with microscopy</td>
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<tr>
<td>81005</td>
<td>Urinalysis; qualitative or semi-quantitative, except immunoassays</td>
</tr>
<tr>
<td>81007</td>
<td>Dipstick, bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81015</td>
<td>Urinalysis, microscopic only</td>
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<tr>
<td>82040</td>
<td>Assay of serum albumin</td>
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<tr>
<td>82043</td>
<td>Microalbumin quantitative</td>
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<tr>
<td>82150</td>
<td>Assay of amylase</td>
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<tr>
<td>82247</td>
<td>Bilirubin total</td>
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<tr>
<td>82271</td>
<td>Occult blood other sources</td>
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<tr>
<td>82272</td>
<td>Occult bld feces 1-3 tests</td>
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<tr>
<td>82310</td>
<td>Assay of calcium</td>
</tr>
<tr>
<td>82330</td>
<td>Assay of calcium</td>
</tr>
<tr>
<td>82374</td>
<td>Assay blood carbon dioxide</td>
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<tr>
<td>82435</td>
<td>Assay of blood chloride</td>
</tr>
<tr>
<td>82465</td>
<td>Assay bld/serum cholesterol</td>
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<tr>
<td>82550</td>
<td>Assay of ck (cpk)</td>
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<tr>
<td>82948</td>
<td>Glucose; blood, reagent strip</td>
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<tr>
<td>82977</td>
<td>Assay of GGT</td>
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<tr>
<td>82985</td>
<td>Glycated protein</td>
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<tr>
<td>83037</td>
<td>Glycosylated hb home device</td>
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<tr>
<td>83880</td>
<td>Natriuretic peptide</td>
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<tr>
<td>84075</td>
<td>Assay alkaline phosphatase</td>
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<tr>
<td>84132</td>
<td>Assay of serum potassium</td>
</tr>
<tr>
<td>84155</td>
<td>Assay of protein serum</td>
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<tr>
<td>84295</td>
<td>Assay of serum sodium</td>
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</tbody>
</table>
### Presbyterian Behavioral Health Covered Lab Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>84450</td>
<td>Transferase (AST) (SGOT)</td>
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<tr>
<td>84550</td>
<td>Assay of blood/uric acid</td>
</tr>
<tr>
<td>84702</td>
<td>Gonadotropin, chorionic (hCG); quantitative (second or repeats require PA)</td>
</tr>
<tr>
<td>85002</td>
<td>Bleeding time</td>
</tr>
<tr>
<td>85007</td>
<td>Blood smear, microscopic examination with manual differential WBC count</td>
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<tr>
<td>85009</td>
<td>Manual differential WBC count, buffy coat</td>
</tr>
<tr>
<td>85025</td>
<td>Hemogram and platelet count, automated and automated complete differential WBC count (CBC)</td>
</tr>
<tr>
<td>85027</td>
<td>Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)</td>
</tr>
<tr>
<td>85049</td>
<td>Platelet, automated</td>
</tr>
<tr>
<td>85576</td>
<td>Blood platelet aggregation</td>
</tr>
<tr>
<td>85651</td>
<td>Sedimentation rate, erythocytes; non-automated</td>
</tr>
<tr>
<td>85660</td>
<td>Sickling of RBC, reduction</td>
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<tr>
<td>86403</td>
<td>Particle agglutination; screen, each antibody</td>
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<tr>
<td>86485</td>
<td>Candida skin test</td>
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<tr>
<td>86486</td>
<td>Skin test, unlisted antigen (used for mumps skin test)</td>
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<tr>
<td>86490</td>
<td>Coccidioidomycosis</td>
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<tr>
<td>86580</td>
<td>Tuberculosis, intradermal</td>
</tr>
<tr>
<td>86677</td>
<td>Helicobacter pylori, antibody</td>
</tr>
<tr>
<td>86701</td>
<td>Rapid HIV-1 antibody test</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing, Rh (D)</td>
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<tr>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening only</td>
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<tr>
<td>87101</td>
<td>Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail</td>
</tr>
<tr>
<td>87102</td>
<td>Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail, other source (except blood)</td>
</tr>
<tr>
<td>87106</td>
<td>Culture, fungi, definitive identification, each organism; yeast</td>
</tr>
<tr>
<td>87110</td>
<td>Culture, chlamydia, any source</td>
</tr>
<tr>
<td>87205</td>
<td>Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi or cell types</td>
</tr>
<tr>
<td>87206</td>
<td>Smear, primary source, with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87207</td>
<td>Special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)</td>
</tr>
<tr>
<td>87220</td>
<td>Tissue examination by KOH slide of samples from skin, hair, nails for fungi or ectoparasite ova or mites (e.g., scabies)</td>
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<tr>
<td>87270</td>
<td>Chlamydia trachomatis</td>
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<tr>
<td>87320</td>
<td>Chlamydia trachomatis</td>
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<tr>
<td>87400</td>
<td>Influenza, A or B, each</td>
</tr>
<tr>
<td>87430</td>
<td>Streptococcus, group A antigen, detection by enzyme immunoassay technique, qualitative or semi-qualitative, multi-step method</td>
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<tr>
<td>87490</td>
<td>Chlamydia trachomatis, direct probe technique</td>
</tr>
<tr>
<td>87491</td>
<td>Chlamydia trachomatis, amplified probe technique</td>
</tr>
<tr>
<td>87591</td>
<td>Neisseria gonorrhoeae, amplified probe technique</td>
</tr>
<tr>
<td>87807</td>
<td>Rsv assay w/optic</td>
</tr>
<tr>
<td>87808</td>
<td>Trichomonas assay w/optic</td>
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<tr>
<td>87809</td>
<td>Adenovirus assay w/optic</td>
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<tr>
<td>87810</td>
<td>Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis</td>
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<tr>
<td>87807</td>
<td>Rsv assay w/optic</td>
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<tr>
<td>87899</td>
<td>Agent nos assay w/optic</td>
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<tr>
<td>87905</td>
<td>Sialidase enzyme assay</td>
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<tr>
<td>89060</td>
<td>Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)</td>
</tr>
<tr>
<td>89190</td>
<td>Nasal smear for eosinophils</td>
</tr>
<tr>
<td>89310</td>
<td>Semen analysis; motility and count (not including Huhner test)</td>
</tr>
<tr>
<td>89321</td>
<td>Semen anal sperm detection</td>
</tr>
<tr>
<td>89330</td>
<td>Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test</td>
</tr>
<tr>
<td>80048*</td>
<td>Basic metabolic panel</td>
</tr>
<tr>
<td>80053*</td>
<td>Comprehensive metabolic panel</td>
</tr>
<tr>
<td>80061*</td>
<td>Lipid panel</td>
</tr>
<tr>
<td>81002*</td>
<td>Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated without microscopy</td>
</tr>
<tr>
<td>81003*</td>
<td>Urinalysis, automated, without microscopy</td>
</tr>
</tbody>
</table>
# Presbyterian Behavioral Health Covered Lab Codes

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<tr>
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<tbody>
<tr>
<td>81007*</td>
<td>Urinalysis, bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81025*</td>
<td>Urine pregnancy test, by visual color comparison methods</td>
</tr>
<tr>
<td>82010*</td>
<td>Acetone or other ketone bodies, serum; quantitative</td>
</tr>
<tr>
<td>82044*</td>
<td>Albumin, urine, microalbumin, semi-quantitative (e.g., reagent strip assay)</td>
</tr>
<tr>
<td>82120*</td>
<td>Amines, vaginal fluid, qualitative</td>
</tr>
<tr>
<td>82270*</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)</td>
</tr>
<tr>
<td>82274*</td>
<td>Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>82523*</td>
<td>Collagen, cross links, any method</td>
</tr>
<tr>
<td>82570*</td>
<td>Creatinine, other source</td>
</tr>
<tr>
<td>82679*</td>
<td>Estrone</td>
</tr>
<tr>
<td>82947*</td>
<td>Glucose; quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82950*</td>
<td>Post glucose dose (includes glucose)</td>
</tr>
<tr>
<td>82951*</td>
<td>Tolerance test (GTT), three specimens (includes glucose)</td>
</tr>
<tr>
<td>82952*</td>
<td>Tolerance test, each additional beyond tree specimens</td>
</tr>
<tr>
<td>82962*</td>
<td>Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use</td>
</tr>
<tr>
<td>83001*</td>
<td>Gonadotropin; follicle stimulating hormone (FSH)</td>
</tr>
<tr>
<td>83002*</td>
<td>Gonadotropin; luteinizing hormone (LH)</td>
</tr>
<tr>
<td>83026*</td>
<td>Hemoglobin; by copper sulfate method, non-automated</td>
</tr>
<tr>
<td>83036*</td>
<td>Hemoglobin; glycated, A1c (Test result required on claim submission for reimbursement)</td>
</tr>
<tr>
<td>83518*</td>
<td>Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semi-quantitative; single step method (e.g., reagent strip)</td>
</tr>
<tr>
<td>83605*</td>
<td>Lactate (lactic acid)</td>
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<tr>
<td>83718*</td>
<td>Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)</td>
</tr>
<tr>
<td>83986*</td>
<td>pH, body fluid, except blood</td>
</tr>
<tr>
<td>8443*</td>
<td>Thyroid stimulating hormone</td>
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<tr>
<td>84460*</td>
<td>Transferase; alanine amino (ALT) (SGPT)</td>
</tr>
<tr>
<td>84478*</td>
<td>Triglycerides</td>
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<td>Ovulation tests, by visual color comparison methods for human luteinizing hormone</td>
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<tr>
<td>85013*</td>
<td>Spun microhematocrit</td>
</tr>
<tr>
<td>85014*</td>
<td>Blood count; hematocrit (Hct)</td>
</tr>
<tr>
<td>85018*</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>85610*</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>85651*</td>
<td>Sedimentation rate, erythrocyte; non-automated</td>
</tr>
<tr>
<td>86294*</td>
<td>Immunoassay for tumor antigen, qualitative or semi-quantitative (eg, bladder tumor antigen)</td>
</tr>
<tr>
<td>86308*</td>
<td>Heterophile antibodies; screening</td>
</tr>
<tr>
<td>86318*</td>
<td>Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (eg, reagent strip)</td>
</tr>
<tr>
<td>86618*</td>
<td>Borrelia burgdorferi (Lyme Disease)</td>
</tr>
<tr>
<td>86701*</td>
<td>Rapid HIV-1 antibody test</td>
</tr>
<tr>
<td>86703*</td>
<td>HIV-1 and HIV-2, single assay</td>
</tr>
<tr>
<td>87077*</td>
<td>Aerobic isolate, additional methods required for definitive identification, each isolate</td>
</tr>
<tr>
<td>87210*</td>
<td>Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)</td>
</tr>
<tr>
<td>87449*</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique qualitative or semi-quantitative; multiple step method, not otherwise specified, each organism</td>
</tr>
<tr>
<td>87804*</td>
<td>Influenza</td>
</tr>
<tr>
<td>87880*</td>
<td>Streptococcus, group A</td>
</tr>
<tr>
<td>89300*</td>
<td>Semen analysis; presence and/or motility of sperm including Huhner test (post coital)</td>
</tr>
<tr>
<td>G0431</td>
<td>Drug Screen, Qualitative; multiple drug classes by high complexity test method</td>
</tr>
<tr>
<td>G0477</td>
<td>Drug test presump optical</td>
</tr>
<tr>
<td>G0478</td>
<td>Drug test presump opt inst</td>
</tr>
<tr>
<td>G0479</td>
<td>Drug test presump not opt</td>
</tr>
<tr>
<td>G0480</td>
<td>Drug test def 1-7 classes</td>
</tr>
<tr>
<td>G0481</td>
<td>Drug test def 8-14 classes</td>
</tr>
<tr>
<td>G0482</td>
<td>Drug test def 15-21 classes</td>
</tr>
</tbody>
</table>
### Presbyterian Behavioral Health Covered Lab Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>G0483</td>
<td>Drug test def 22+ classes</td>
</tr>
<tr>
<td>G0631</td>
<td>Assay of Benzodiazepines</td>
</tr>
<tr>
<td>G0630</td>
<td>Assay of Amitriptyline</td>
</tr>
<tr>
<td>G0632</td>
<td>Assay of Desipramine</td>
</tr>
<tr>
<td>G0636</td>
<td>Assay of Imipramine</td>
</tr>
<tr>
<td>G0637</td>
<td>Assya of Nortriptyline</td>
</tr>
<tr>
<td>G0640</td>
<td>Assay of Ethanol</td>
</tr>
<tr>
<td>G0642</td>
<td>Assay of Amphetamines</td>
</tr>
<tr>
<td>G0653</td>
<td>Assay of Methadone</td>
</tr>
<tr>
<td>G0656</td>
<td>Assay of Opiates</td>
</tr>
<tr>
<td>Q0111</td>
<td>Wet mounts, including preparation of vaginal, cervical or skin specimens</td>
</tr>
<tr>
<td>Q0112</td>
<td>All potassium hydroxide (KOH) preparations</td>
</tr>
<tr>
<td>Q0113</td>
<td>Pinworm examination</td>
</tr>
<tr>
<td>Q0114</td>
<td>Fern test</td>
</tr>
<tr>
<td>Q0115</td>
<td>Post-coital direct, qualitative examinations of vaginal or cervical mucous</td>
</tr>
</tbody>
</table>
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Appendix H: ABP-Exempt Medically Frail Conditions

Below is a list of ABP-exempt medically frail conditions:

- AIDS
- ALS (Lou Gehrig’s Disease)
- Angina Pectoris
- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Ascites
- Assistance with one or more ADL’s
- Cancer (current, within five years)
- Chronic Substance Use Disorder
- Cirrhosis of the Liver
- Compromised Immune System
- Coronary Insufficiency
- Coronary Occlusion
- Crohn’s Disease
- Cystic Fibrosis
- Dermatomiositis
- Diabetes (Insulin Dependent)
- Friedreich’s Disease
- Hemophilia
- Hepatitis C (active)
- HIV+
- Hodgkin’s Disease
- Huntington’s Chorea
- Hydrocephalus
- Intermittent Claudication
- Juvenile Diabetes
- Kidney Failure
- Lead Poisoning with Cerebral Involvement
- Leukemia
- Lupus
- Malignant Tumor
- Metastatic Cancer
- Motor or sensory Aphasia
- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myasthenia Gravis
- Myotonia
- Open Heart Surgery
- Organ Transplant
- Paraplegia or Quadriplegia
- Parkinson’s Disease
- Peripheral Arteriosclerosis
- Polyarthritis
- Polycystic Kidney
- Posterolateral Sclerosis
- Renal Failure
- Serious Mental Illness*
- Sickle Cell Anemia
- Silicosis
- Splenic Anemia
- Still’s Disease
Appendix H: ABP-exempt Medically Frail Conditions

- Stroke (CVA)
- Syringomyelia
- Tabes Dorsalis
- Thalassemia
- Topectomy and Lobotomy
- Wilson's Disease

SMI/CSD Eligibility

Serious mental illness (SMI) and chronic substance dependency (CSD) is based on the age of the individual, function impairment, duration of the disorder and the diagnosis. Adults must meet the following criteria:

- Age: Must be an adult 18 years and older.
- Diagnosis: Must have one of the following diagnoses determined within the last 12 months by qualifying clinician/psychiatrist:
  - Schizophrenia, Schizotypal, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder and Psychotic Disorder NOS.
  - Major Depressive Disorder
  - Bi-Polar Disorders (EXCEPT Bi-polar, NOS), Cyclothymic Disorder
  - CSD Diagnosis include: Alcohol Dependence, Cannabis Dependence, Cocaine Dependence, Amphetamine Dependence, Hallucinogen Dependence, Opioid Dependence, Phencyclidine Dependence, Sedative, Hypnotic, or Anxiolytic Dependence and Polysubstance Dependence.
- Functional Impairment: GAF Score of 50 or below identified on AXIS V on clinical assessment.
- Functional Domain: Functional Limitation on Axis VI such as financial problems, family stressors, etc.

Duration: Expected duration of the disorder is to be six months or longer.