PRESBYTERIAN

Network Connection

Information for Presbyterian Healthcare Professionals, Providers and Staff

SEPTEMBER 2017

NEWS FOR YOU

UP FRONT
Centennial Care Providers Must Enroll with the Appropriate Provider Type 2
Help Members Find Your Office by Making Real-time Provider Directory Updates 2

TAKE NOTE
Partnering to Improve the Member Experience 3
Assisting Providers with Their Patients' Behavioral Healthcare Needs 3
Supporting Members with Depression 4
Cyber Threat and Malware Attack Help Available 4
Healthy Solutions. 5

FEATURE
Helping Members Control Their Asthma 5

REGULATORY REMINDERS
Member Appeals and Grievances Information 6
Member Rights and Responsibilities. 6
Compliance with After-hours Messaging 6
Medical Policy Information and Updates 7
Affirmative Statement about Incentives 7
Medical Record Standards and Documentation 8
"Incident to" Services 9

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

Talking to Members about Care Teams

When a member receives care, a multitude of people with different titles, positions and roles may be involved. Each individual on the care team has a distinct and integral role in delivering care. Although the care team is not a new concept in the healthcare setting, how the concept is communicated to patients and members can be confusing.

We want to let providers know that we are working to clarify this concept for patients and members. Earlier this year, Presbyterian explained to members the role a care team has in delivering quality healthcare. We indicated that a care team may include a doctor, physician, specialist, nurse or other medical staff.

We understand how important it is for members to understand the role of their care team, especially when it comes to enhancing the provider-patient relationship, coordinating care and responding to satisfaction surveys. We will continue to work with members to assist with their care needs.

Centennial Care Providers Must Enroll with the Appropriate Provider Type

Committed to ensuring timely and accurate claims payments, Presbyterian wants to remind Centennial Care providers that the New Mexico Human Services Department (HSD) requires both group and individual providers to enroll with New Mexico Medicaid. Providers are required to enroll with the appropriate provider type to render services to eligible members and receive reimbursement. This ensures that billing and rendering providers can be identified on claims and encounter reports by a National Practitioner Identifier (NPI) number.

Presbyterian now rejects and/or denies claims when:

- The group and individual provider are not enrolled with HSD.
- Providers are not enrolled with the appropriate provider type.
- Providers bill codes outside of their enrolled provider type.

Please note that if providers have more than one provider type on file, they must submit the taxonomy on the claim. Otherwise we are unable to match the code to the correct provider type and the claim will be denied with the exception 0299. Presbyterian is recouping payments when providers have not enrolled, or if they enrolled with an inaccurate provider type and billed codes that they are not enrolled for within the past year.

Individual and group providers who still need to enroll with New Mexico Medicaid can complete the Provider Participation Agreement (PPA) MAD 312 or 335 online or by printing and mailing the application. To print out or submit a Medicaid application electronically, go online to https://nmmedicaid.acs-inc.com/webportal/enrollOnline.

It is both the individual provider's and the provider group's responsibility to submit their applications within a sufficient time frame to allow completion of the enrollment process and submission of the claim within the MAD timely filing limit. Presbyterian will use the MAD approval date on the Medicaid file to determine timely filing. For more information, view Supplement 15-01 at http://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx.

For questions, or assistance with the application process, contact your Provider Network Management relationship executive. You can find his/her contact information at www.phs.org/ContactGuide.

Help Members Find Your Office by Making Real-time Provider Directory Updates

To ensure members have access to the care they need, Presbyterian wants to remind providers to make real-time updates by using the myPRES provider portal. When providers routinely update and verify their demographic information, they ensure that members have access to accurate information, which allows them to contact providers and find their office. Also, when providers update and verify their addresses, it helps prevent any delays in processing claims.

Providers can verify and update their demographic information through the myPRES Provider Portal, which uses a web-based solution that interfaces directly with our internal database. Providers can update their:

- Hours of operation
- Panel status
- Directory address
- Phone number

To make updates to this information, you will need to log in to myPRES and choose "Update Provider Demographic Information" from the myPRES Workforce screen. For step-by-step instructions, watch our short how-to video by using the following link: https://www.phs.org/providers/contact-us/Pages/update-provider-directory.aspx.

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. For frequently asked questions about how to get started, please go to www.phs.org/DirectoryUpdate.

As indicated in the 2017 Practitioner and Provider Manual, which is an extension of provider contracts, providers are responsible for 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. The Services Agreement with Presbyterian also requires providers to notify Presbyterian electronically or in writing of any changes as soon as they are known.

To help providers keep their information up to date, we will continue to conduct provider outreach twice a year. If you have any questions, please contact your Provider Network Management relationship executive. You can find his or her contact information at www.phs.org/ContactGuide.

Partnering to Improve the Member Experience

Presbyterian is committed to improving the member experience. One of the ways we do that is by partnering with other leaders in the healthcare industry. Recently, Presbyterian partnered with Eliza Corporation, a healthcare engagement and communications solutions company, to conduct a member survey that measures the quality of care and services they receive. Please be assured the information shared about patients and members is secure and confidential.

The survey is administered throughout the year via automated telephone calls. Members may be contacted to participate in one or more of the following call initiatives:

- Preventive or condition-management screenings or tests related to quality measures
  - Reminders to schedule appointments or screenings
  - Reminders to attend appointments or health events
- Pre-survey data collection for Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] Survey
- Medication refill reminders

To help providers improve health outcomes for their patients, we will share the responses we receive from their paneled members when the survey ends. Based on the types of responses we receive from members, we will also reach out to providers to ensure appropriate follow-up care can be determined. We look forward to sharing information related to these initiatives that may be relevant to you and the quality care you deliver to our members.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Assisting Providers with Their Patients' Behavioral Healthcare Needs

Magellan Healthcare (Magellan) is Presbyterian's behavioral health team for members enrolled in Commercial and Medicare plans. Our behavioral health team offers access to a variety of resources and services to assist providers in enhancing medical and behavioral outcomes for their patients.

Website resources

Providers can access a practitioner toolkit of behavioral health resources at www.MagellanPCPtoolkit.com, which is designed to give medical practitioners the information and screening tools needed to assist in making behavioral health referrals.

Contact our behavioral health case management team

Our behavioral health team offers case management support for members with complex behavioral health needs. Case management programs assess, plan, implement, coordinate and evaluate options and services to meet a member's clinical and medical needs. Activities vary based on the specifics of the member's needs, and our case managers help create a personalized plan of care for every member. We strongly recommend referring patients who may suffer from severe and persistent mental illness to our behavioral health team's case management program.

For assistance with screening patients for co-occurring depression and substance abuse, or to refer patients who may suffer from mental illness, providers can contact our behavioral health Case Management Team at 1-800-741-5044.

Referrals

All referrals to care coordination, case management or disease management can be made by contacting the Presbyterian's Intake Team at 1-866-672-1242 or (505) 923-8858. Providers can also fax referrals to (505) 843-3150 or by secure email to PHPreferral@phs.org.

TAKE NOTE

Supporting Members with Depression

Presbyterian is dedicated to supporting the health of patients, members and communities we serve by partnering with providers to develop a care plan to properly diagnose and treat depression. When treating patients who have depression, it is critical that they are monitored closely over time to ensure an adequate medication trial and to prevent them from abandoning their treatment. Since the risk of remission or relapse is significant, key points to manage patients with depression include regular follow-ups and access to medication refills. This supports them with following their treatment plan and preventing any gaps in treatment.

Important facts

- Major depressive disorder affects nearly 20 percent of adults at least once in their lifetime.
- Almost eight percent of Americans who are 12 years old and older have experienced depressive symptoms.
- There is significant co-occurrence of depression in patients with medical conditions, including diabetes, cardiac disease and stroke.
- The U.S. Preventive Services Task Force published recommendations stating that everyone who is 12 years old and older should be screened routinely for major depressive disorder and that adequate systems should be in place to ensure accurate diagnoses, effective treatment and appropriate follow-up actions.
- PHQ-2 and PHQ-9, as well as other tools, can be administered easily in an office setting to screen for suicidality and depression. (Source: The Centers for Disease Prevention and Control)

Treatment pearls

- There are three phases of treating depression with antidepressants: acute, continuation and maintenance.
- During the acute phase, which may last several weeks, antidepressants are used to gradually induce remission of symptoms. Antidepressants usually take two weeks to decrease symptoms.
- During the continuation phase, which is 16 to 20 weeks once the patient is in remission, the antidepressant should be continued to prevent relapse.
- During the maintenance phase, consideration to continue the full dose of medication should be determined by the number of episodes the patient has experienced:
  – Six months after one episode
  – Three years after second episode
  – Possibly indefinitely for three or more episodes, or if prior episodes were particularly severe or dangerous

For additional information on how to manage depression, a helpful resource is available at the Magellan Healthcare Medical Providers' Behavioral Health Toolkit at http://magellanpcptoolkit.com/mood-disorders.aspx?ref=DEFAULT.

Cyber Threat and Malware Attack Help Available

The Department of Health and Human Services (HHS) created a new department to handle and distribute information regarding cyber threats affecting the healthcare industry. This new department is known as the Healthcare Cybersecurity and Communications Integration Center (HCCIC). The purpose of this department is to analyze threats and the impact of cyberattacks, such as ransomware, and share them in real time with the healthcare community.

According to the HHS deputy chief, this department is designed to be a resource for healthcare providers to report cyber threats and receive possible resolutions. The HCCIC has three high-level goals:

- Strengthen engagement across HHS operating divisions
- Enhance reporting and increase awareness of healthcare cyber threats across the HHS enterprise
- Promote public-private partnership through regular engagement and outreach

Small provider offices are considered the most at-risk because many do not have staff dedicated to IT security. Additionally, they may not be able to afford the latest and most secure technology that is available. To help protect your office from cyber threats, only open emails from people you know, don't click on links in emails if you weren't expecting them and keep your computer and antivirus software up to date.

If your office is the victim of a ransomware attack, report the incident(s) to:

- Your FBI Field Office Cyber Task Force (https://www.fbi.gov/contact-us/field-offices/field-offices), which will work with state and local law enforcement and other federal and international partners to pursue cyber criminals globally and to assist victims of cybercrime
- The FBI's Internet Crime Complaint Center at https://www.ic3.gov/default.aspx
- If medical devices are affected by the attack, contact the FDA's emergency line at 1-866-300-4374
- The HCCIC at HCCIC-mgmt@hhs.gov
- The US Computer Emergency Readiness Team (US-CERT) at soc@us-cert.gov

Helping Members Control Their Asthma

Asthma is a serious health issue that affects people of all ages around the world. While some countries have seen a decline in hospitalizations and deaths from asthma, the number of people with asthma continues to grow. According to the Centers for Disease Control and Prevention (CDC), one in 11 children and one in 12 adults has asthma in the United States. Managing asthma is a life-long commitment, and Presbyterian wants its members to feel empowered when it comes to controlling their asthma.

We believe that providers can help set the foundation for empowerment by sharing their knowledge, providing care and building a good rapport with patients. Providers can help their patients manage their asthma by:

- Providing basic and in-depth information about asthma, the purpose of asthma medications and how often medications should be used
- Identifying and documenting what triggers symptoms
- Encouraging patients to remove triggers from common areas and routinely clean those areas
- Working with them to create and implement an action plan to reduce and prevent flare-ups and emergency department visits through day-to-day management
  - A good example of an action plan can be found at https://www.nhlbi.nih.gov/health/resources/lung/asthma-action-plan-html

While asthma is an incurable disease, a strong patient-provider relationship is one of the most effective treatments for asthma. With help from healthcare providers, people with asthma can better manage their condition and live full, normal and unrestricted lives.

Healthy Solutions: Health Coaching for Presbyterian Members with Diabetes, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure

The Presbyterian Healthy Solutions health coaching program is available to assist Presbyterian members with chronic conditions to better understand their conditions, update them on new information about their condition and provide them with assistance to help manage their condition. The program is designed to reinforce treatment plans and is available at no additional cost to Presbyterian members who are 18 years old or older.

Healthy Solutions contacts members who have difficulty managing their blood glucose, cholesterol, or who have recently visited the emergency room or hospital, and invites them to receive coaching. Presbyterian will notify providers whose members agree to participate. To enroll Presbyterian members in the Healthy Solutions program, please contact us at 1-800-841-9705 or by email at healthysolutions@phs.org.

Participation in Presbyterian's Healthy Solutions coaching program is voluntary. If at any time a participant wishes to discontinue the program, they simply need to contact us and let us know.

Member Appeals and Grievances Information

Providers have the right to file a formal appeal and grievance with Presbyterian. An appeal may be filed when an authorization or concurrent review results in a decision to deny, reduce or terminate a service or item. At the time of the decision, a provider or member may request that Presbyterian reconsider the denial by submitting additional documentation to support medical necessity. Such requests will be immediately referred to a medical director who was not previously involved in the case for resolution and will be handled according to the member appeal guidelines.

If 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 and/or welfare is in immediate jeopardy. Presbyterian will then determine if it meets expedited criteria. If the case is deemed expedited, then Presbyterian will process the expedited appeal within 72 hours of receipt. Time extensions may apply with written consent from the member.

Any member also has the right to file a grievance if he or she is dissatisfied with the services rendered through Presbyterian. Member grievances may include but are not limited to the following:

- Dissatisfaction with services rendered
- Availability of services
- Delivery of services
- Reduction and/or termination of services
- Disenrollment
- Any other performance that is considered unsatisfactory

The member should submit his or her appeal or grievance to Presbyterian's appeals and grievance coordinator within the following time frames:

Lines of Business	Time Frame
Presbyterian Centennial Care (New Mexico Medicaid Managed Care)	Within 90 days from the date of denial
Presbyterian Senior Care (HMO) (Medicare Advantage) and Presbyterian Medicare PPO (Medicare Advantage)	Within 60 days from the date of denial
All Other Plans	Within 180 days from the date of denial

Member Rights and Responsibilities

Presbyterian has written policies and procedures regarding members' rights and responsibilities as well as the implementation of such rights. All Presbyterian members or their legal guardians have rights and responsibilities, and Presbyterian requires its network of practitioners and providers to uphold and support these rights and responsibilities.

To view a list of these rights and responsibilities, go to https://www.phs.org/Pages/member-rights.aspx. Please note that this list comprises the rights and responsibilities as dictated by the New Mexico Human Services Department (HSD) and the National Committee for Quality Assurance (NCQA). In addition, the list includes information specific to different lines of business.

Compliance with After-hours Messaging

Presbyterian requires primary care providers to have or arrange on-call and after-hours care to support members who experience emergencies. Such coverage must be available 24 hours a day, seven days a week.

Providers must inform members about their hours of operation and give instructions for accessing care after hours. Presbyterian requires that the hours of operation that practitioners and providers offer to Medicaid are no less than those offered to Commercial members.

Presbyterian requests that all primary care providers ensure that their contact information and after-hours messaging is up to date and provides members with the information they need to seek appropriate care outside of regular office hours.

Medical Policy Information and Updates

Presbyterian maintains medical policies that assist in administering plan benefits. All medical polices are regularly reviewed and approved through appropriate quality committees. Medical policies include the following information:

- Services covered including clinical indications for the service
- Prior authorization requirements
  Note: Even when prior authorization is not required, the clinical indications for the service still apply. All claims are subject to retrospective review.
- Exclusions to coverage
- Covered and non-covered codes included in the coding list

General information about medical policy coverage determinations

Presbyterian uses recommendations from Hayes Inc., an independent technology assessment firm, and current medical literature including clinical trials to support decisions. Presbyterian also considers the decisions of the Centers for Medicare & Medicaid Services (CMS) to provide guidance related to medical policies and procedures. Other resources Presbyterian may use to determine if an item is investigational or experimental are:

- U.S. Food and Drug Administration reviews
- Evidence obtained from reports and articles in peer-reviewed medical and scientific literature
- Formalized position statements of professional organizations

Criteria used for authorization determination include but are not limited to Milliman Care Guidelines (MCG), Apollo Guidelines and NIA Magellan.

New, reviewed or updated medical policies

The following is a list of medical policies that are new or that have been recently reviewed or updated:

- "Durable Medical Equipment: Rehabilitation and Mobility Devices" – Retired the language to Gait Trainers and LCD 11450, following Article A52503.
- "Gastric Electric Stimulation for the Treatment of Chronic Gastroparesis" – No longer using Milliman. All requests are reviewed by a medical director on case-by-case basis.
- "Genetic and Genomic Testing" – Removed repetitive language about chromosomal microarray analysis.
- "LINX Reflux Management System for the Treatment of GERD" – Removed language for use of the CMS national coverage determination (NCD) of anti-gastroesophageal reflux device (100.9) because it does not mention the LINX system.

Accessing the Medical Policy Manual

The Medical Policy Manual is available on phs.org.

- Log on to www.phs.org
- Select "For Providers" from the upper menu
- Select "Tools and Resources"
- Select "Medical Policy Manual" from menu on the left

Medical policy reviews

Medical policies receive an annual review. The following is a list of medical policies that did not change:

- Artificial disk replacement
- Autism spectrum disorder
- Autologous chondrocyte implantation
- Blepharoplasty
- Breast reconstruction following mastectomy
- Breast reduction mammoplasty
- Bronchial thermoplasty
- Cancer clinical trials
- Cholecystectomy by laparoscopy
- Coronary computed tomography
- Cryoablation for prostate cancer
- Genetic Testing Cologard
- Gynecomastia
- Hyperbaric Oxygen Therapy (HBOT)
- Magnetoencephalography
- PET scan
- Rad Oncology Brachytherapy
- Tonsillectomy
- XStop

Affirmative Statement about Incentives

Presbyterian wants members to get the right care, in the right place, at the right time. One of the processes we use to ensure our members receive appropriate care is through prior authorization, also known as a benefit certification. Presbyterian's accreditation body, the National Committee for Quality Assurance (NCQA), considers prior authorization to be part of our utilization management (UM) program.

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

For more information about Presbyterian's prior authorization or benefit certification processes, refer to the Care Coordination chapter of the 2017 Presbyterian Practitioner and Provider Manual at www.phs.org/ProviderManual.

Medical Record Standards and Documentation

As part of our regulatory requirements, Presbyterian must ensure that our members' medical records are complete and consistent with standard documentation practices. Presbyterian reports information to several agencies, including the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and the New Mexico Human Services Department (HSD). These agencies require that specific information is documented in every member's chart, including medical history and advance directive information.

We are updating our medical record review process to include a study of continuity and coordination of care between medical and behavioral healthcare. This year, we are reviewing a sample of records from 2016 to evaluate the communication between the prescribing provider and the behavioral health provider.

For child members who were diagnosed with attention-deficit/hyperactivity disorder (ADHD) and adult members who were diagnosed with depression and prescribed antidepressants in 2016, the medical record should include the tool used to diagnose our members. The record will be scored based on the accuracy, sufficiency, timeliness, frequency and clarity of information shared between the behavioral health provider and the primary care provider (PCP).

All providers are held to the minimum standards provided in the Presbyterian annual provider training and in the provider manual. Presbyterian standards include requirements for confidentiality of medical records, documentation specifications, record-keeping practices and the availability of records. Presbyterian monitors and assesses compliance with these standards annually.

Advance directive documentation

Presbyterian requires providers to indicate whether a member has executed an advance directive. This can be accomplished by noting "Yes" or "No" in a prominent location within the member's hard copy or electronic medical record. In addition, if a member presents his or her provider with an advance directive, a copy should be added to the member's medical record.

Presbyterian will evaluate mandatory provider compliance with this standard when we perform our medical record standards audits. Advance directive forms are available at http://docs.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/pel_00133737.pdf.

We appreciate your continued commitment to comply with these standards and the actions taken to improve medical record keeping for our members. For questions about medical record documentation standards, please contact Susan Taylor at (505) 923-8040 or staylor7@phs.org.

"Incident to" Services

The Centers for Medicare & Medicaid Services (CMS) defines "incident to" services as those services that are furnished incident to physician professional services in the physician's office, whether located in a separate office suite, within an institution or in a patient's home.

To qualify as "incident to," services must be part of a patient's normal course of treatment during which a physician personally performed an initial service and remains actively involved in the course of treatment. Providers do not have to be physically present in the patient's treatment room while these services are provided, but they must provide direct supervision. This can also mean that, if necessary, providers may be present in the office suite to render assistance.

The patient record should also document the essential requirements for "incident to" service. More specifically, these services must be all of the following:

- An integral part of the patient's treatment course
- Commonly rendered without charge (included in the physician's bill)
- Of a type commonly furnished in a physician's office or clinic (i.e., not in an institutional setting)
- An expense to the physician or physician's office

Services provided by a non-physician (but supervised by a physician) must follow the CMS guidelines to qualify for "incident to" care. The physician must perform the initial visit and be in the office or facility when services are rendered to provide supervision and assistance.

As outlined in the provider's Services Agreement with Presbyterian, all providers must be credentialed with Presbyterian prior to seeing our members. All services should be billed under the rendering provider.

The Presbyterian Program Integrity Department (PID) performs random claims validation audits on claims submissions to verify that services billed were rendered and accurately billed. More information on these requirements can be found on the CMS website at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0441.pdf.

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TAKE NOTE

TALK TO US

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READERSHIP SURVEY

We appreciate receiving your feedback. Please use the link below to let us know how you think we can improve our newsletter and what you would like to read about in future issues. Each person who fills out our short survey at the link below will be entered into a quarterly drawing to win a prize.

https://www.surveymonkey.com/r/PHPnewsletter