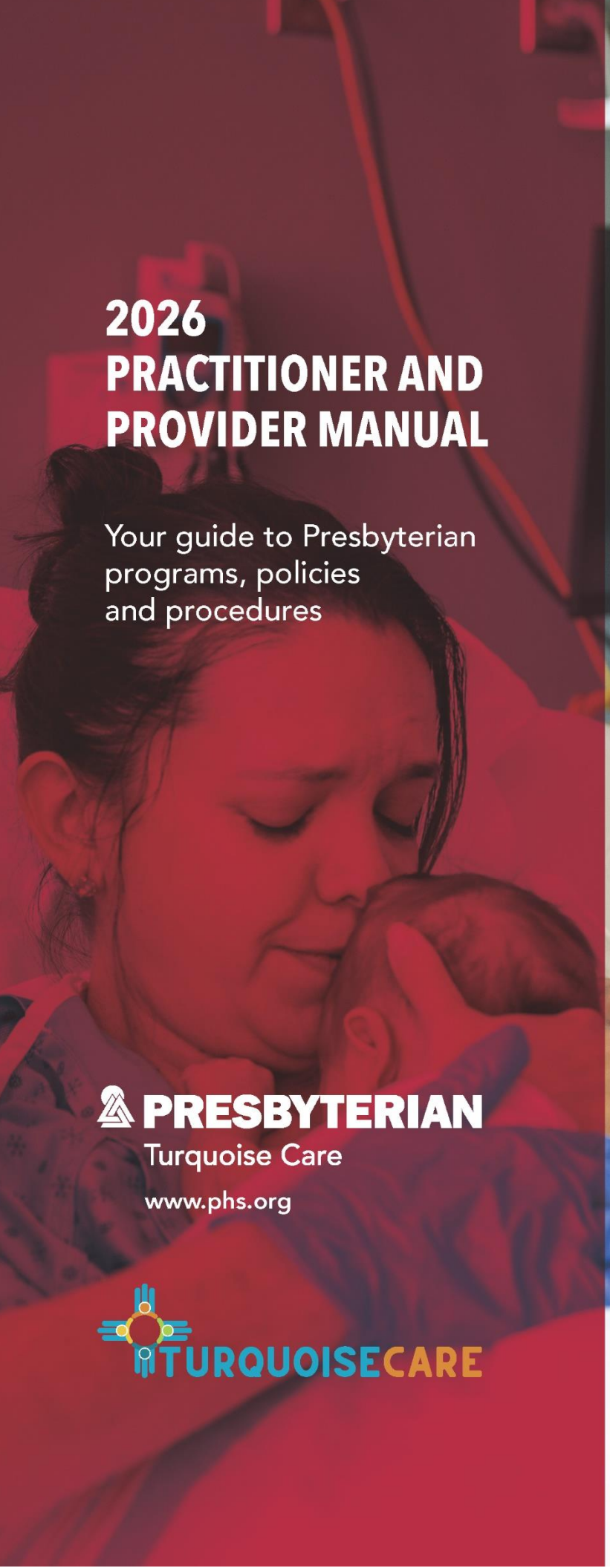
2026 PRACTITIONER AND PROVIDER MANUAL

Your guide to Presbyterian programs, policies and procedures



PRESBYTERIAN
Turquoise Care

www.phs.org

TURQUOISECARE

Introduction

Using the 2026 Turquoise Care Practitioner and Provider Manual

This 2026 Turquoise Care Practitioner and Provider Manual is both a resource for essential information about Turquoise Care Presbyterian policies and procedures and an extension of your Provider 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 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 www.phs.org/providercommunications.

Providers can also receive newsletters and updates from Presbyterian electronically by signing up to receive emails from Presbyterian at www.phs.org/enews.

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 Turquoise Care members.

We Want to Hear From You

Presbyterian’s Provider Network Operations department is committed to supporting providers and office staff. If you have any questions, please contact your dedicated relationship team. You can find their contact information, along with other useful Presbyterian contact information, in the Provider Services Contact Guide, which is available at www.phs.org/ContactGuide.

Revision History

Version	Date	Change Description

Table of Contents

Ch. 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 providers and practitioners providing medical care throughout New Mexico
- Presbyterian, New Mexico's largest managed care organization, providing Commercial health insurance, Turquoise Care and Medicare Advantage products

Presbyterian Healthcare Services

Presbyterian offers a statewide healthcare delivery system that provides members 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 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 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 Turquoise Care and Presbyterian Senior Care (HMO/HMO-POS). This manual addresses only those programs that are relevant to Turquoise Care.

Presbyterian Turquoise Care

Turquoise Care is New Mexico's Medicaid program. Turquoise Care is a single, comprehensive delivery system directed through four managed care plans to allow for greater administrative simplicity. It includes a wide range of services, such as physical and behavioral health, dental and vision care, prescription drugs, transportation, and long-term care options. Turquoise Care emphasizes care coordination so that recipients receive the right care, in the right place, at the right time, leading to better health outcomes. For detailed information on Presbyterian's Turquoise Care program, please view the Presbyterian Turquoise Care Practitioner and Provider Manual at www.phs.org/providermanual.

Turquoise Care Children in State Custody Program

The Children in State Custody (CISC) program is New Mexico's Medicaid program dedicated to supporting all children in state custody. At any given time, **Presbyterian** serve**s** the needs of approximately 2,220 children in foster care across New Mexico, ensuring they receive comprehensive **and** coordinated care.
Presbyterian Health Plan, as part of Presbyterian Healthcare Services, was selected as the single entity to manage CISC. For decades, Presbyterian has addressed the complex and multifaceted needs of this population, recognizing the profound impact of trauma experienced both prior to and following removal from biological homes. These adverse experiences often result in long-term physical, behavioral and social challenges that can persist throughout life.

Our approach is grounded in integrated care delivery, combining physical and behavioral health services with a strong focus on social determinants of health (SDOH) and equitable outcomes. We understand that many children in state custody face complex and chronic health conditions, requiring a highly coordinated system of

care that spans multiple providers and agencies. This complexity demands a health plan and delivery system capable of addressing layered needs with precision and compassion.
Presbyterian partners closely with the New Mexico Health Care Authority (HCA) and the Children, Youth, and Families Department (CYFD), and other agencies to ensure seamless coordination for this vulnerable population.

Essential Elements of the CISC Program:

- Developing population health insights to inform proactive care strategies
- Creating actionable data to drive continuous quality improvement
- Supporting systemic health improvements and closing gaps in care delivery
- Ensuring children receive the right service at the right time
- Making Well Child Visits a cornerstone of health improvement
- Targeting outcomes that align with child welfare system goals

Medicare Advantage Presbyterian Dual Plus

Presbyterian Dual Plus (HMO D-SNP) is a Medicare Advantage plan that focuses on care coordination to combine Medicare and Medicaid for members 65 years old or older, or for people under the age of 65 with certain disabilities who are enrolled in Medicare Part A and Medicare Part B and live in New Mexico.

Presbyterian Dual Plus includes both full and partial benefits for individuals who are eligible for both Medicare and Medicaid benefits. Identified member sub-populations who are eligible for Presbyterian Dual Plus are members with one of the following conditions:

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

Medicaid covers the gaps in Medicare benefits for low-income Medicare members. Medicaid acts as a wrap-around that pays for services that are not covered by Medicare, such as:

- Dental services
- Vision services
- Long Term Support and Services (LTSS)
    - Long-term acute care (LTAC) nursing facility services
    - Home and Community-Based Services (HCBS)

- 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 HCBS.

Partial dual eligibility refers to dual-eligible members who qualify to have Medicaid pay some of the expenses they incur under Medicare. Partial dual-eligible members are enrolled in Medicaid fee-for-service, not the New Mexico Medicaid plan. The following partial benefit member types receive assistance from Medicaid to pay Medicare premiums only:

- Specified low-income Medicare beneficiaries
- Qualified individuals
- Qualified disabled and working individuals

Partial benefit members who are qualified Medicare beneficiaries receive assistance from Medicaid to pay their Medicare premiums and cost-sharing obligations.

If a Presbyterian Dual Plus enrolled member loses their Medicaid eligibility, they will have a four-month 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.

Presbyterian Dual Plus has as number of specialized services and processes in place to meet the unique needs of Dual Plus members. Annual training regarding the Dual Plus model of care is required for providers engaged in Dual Plus member's Interdisciplinary Care Team (ICT). The ICT consists of participants involved in the member's care, including the member and the member's power of attorney or legal guardian, care coordinator, primary care provider (PCP) and any additional participants who are working to support the member's needs. As part of the ICT, providers receive communication from other members of the ICT. Providers also communicate with the ICT and a care coordinator when a change in condition has been identified, to ensure compliance with the treatment plan, or to discuss member engagement opportunities.

Presbyterian's individual and employer group benefit plans offer more benefits than original Medicare and include prevention and wellness benefits.

Regulatory Agency Websites

This 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 in the Regulatory Agencies Website table below.

Regulatory Agency Websites	
Agency	**Website Location**
New Mexico Health Care Authority Medical Assistance Division	www.hca.nm.gov/about_the_department/medical_assistance_division/
Centers for Medicare & Medicaid Services	www.cms.gov/
State of New Mexico Regulations & Licensing Department	www.rld.state.nm.us/
Office of the Superintendent of Insurance	www.osi.state.nm.us/
National Provider Identifier (NPI)	https://nppes.cms.hhs.gov/
Children Youth and Families Department	www.cyfd.nm.gov/

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Ch. 2: Turquoise Care Overview

What Is Turquoise Care?

Turquoise Care is the New Mexico Medicaid managed care program that provides health services through contracted health plans. Presbyterian Turquoise Care offers standard Medicaid benefits in addition to value-added services and programs like dental, vision, transportation, and a rewards program for completing heathy activities. We are an integrated, comprehensive delivery system responsible for coordinating the member's full array of services, including physical health services, acute care (including pharmacy), behavioral health services, institutional services, and home and community-based services. The initiative is to address specific gaps in care and improve healthcare outcomes for members enrolled in Medicaid. Presbyterian's primary goal is to assure that Medicaid members receive the right amount of care delivered at the right time and in the right setting.

The Turquoise Care vision is to educate members to become savvy healthcare consumers, promote better integrated care, properly case manage the most at-risk members, involve members in their own wellness and reimburse providers for quality outcomes rather than quantity of services rendered.

The Turquoise Care key initiatives include the following:

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible and increasing utilization of preventive services
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care

- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care
- Further simplify administrative complexities and implement refinements in program and benefit design

Eligibility for Turquoise Care requires that individuals meet certain federal guidelines. These include citizenship, residency and income requirements.

Presbyterian Turquoise Care supports most of New Mexico's CISC population. We aim to make a significant, positive impact offering hope and opportunities for a brighter future. Together with community-based organizations who serve youth, we can make a difference in the lives of all children across New Mexico.

Alternative Benefit Plan or "Other Adult Group"

Most adults who qualify for the Medicaid category known as the "Other Adult Group" receive services under the Alternative Benefit Plan (ABP). ABP coverage is only available to individuals aged 19-65, with or without dependents with no Medicare entitlement who meet non-financial and financial criteria.

ABP provides coverage for basic medical and behavioral health services to members in the Other Adult Group. Please refer to Appendix F for a list of ABP-covered services.

Another category of ABP is ABP Exempt. ABP Exempt means members subject to coverage under the ABP and who have been determined as meeting the definition and criteria of Medically Frail or otherwise exempt from mandatory enrollment in the ABP. Members may self-identify by telephone that they may be medically frail and may do so at any time during their ABP eligibility. Members may also be identified as potentially medically frail through the care coordination process. To determine whether a member qualifies as medically frail, reference HCA's definitions and criteria for Medically Frail Conditions List in the Managed Care Policy Manual including the following conditions:

- Disabling mental disorder, including individuals up to age 21 with serious emotional disturbances (SEDs) and adults with serious mental illness (SMI)
- Chronic substance use disorder
- Serious and complex medical condition

- Physical, intellectual or developmental disability that significantly impairs the member's ability to perform one or more Activities of Daily Living (ADL)
- Disability determination based on Social Security criteria

When an ABP member's condition is determined to meet qualifying criteria, the member may choose to become an ABP Exempt member. The benefit package of an ABP Exempt member is the standard full Medicaid benefit package.

Children in State Custody

CISC members will be served by the same established provider network as Turquoise Care. Providers interested in becoming a CISC-enhanced network provider will be required to take additional trainings to better serve CISC members whose treatment requires a specialized approach. These training courses include, but are not limited to:

- CISC orientation
- New Mexico Children's Code and the New Mexico Administrative Code (NMAC)
- Trauma-informed care
- Evidence-based practices
- No reject/no eject
- Polypharmacy in CISC
- Crisis Now and 988
- High Fidelity Wrap Around Services

Turquoise Care Enrollment and Eligibility

HCA enrolls individuals determined eligible for Presbyterian Turquoise Care. Enrollment in Presbyterian's Turquoise Care program may be the result of member selection or assignment by HCA.

Children in State Custody Enrollment and Eligibility

HCA enrolls individuals within the CISC program based on CYFD Categories of Eligibility. Native American CISC will have the choice to enroll with Presbyterian or receive services through New Mexico's fee-for-service program.

Turquoise Care Mother and Newborn

Hospitals or other facility providers must complete the Notification of Birth, Medical Assistance Division (MAD) Form 313 before the discharge of an enrolled Presbyterian Turquoise 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 30 days of enrollment. The HRA form is standardized and approved by HCA. The HRA is used to determine the member's health status and emergent needs related to care coordination. Upon completion of the HRA, members who meet criteria are assigned to a dedicated care coordinator for further evaluation. 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. Upon assignment to a care coordinator, members receive an in-person Comprehensive Needs Assessment (CNA) to identify and prioritize their clinical, behavioral, functional and social support needs. The CNA is further utilized to determine the appropriate care coordination level: 1 or 2.

Comprehensive Needs Assessment

The CNA is a standardized assessment tool used to facilitate a comprehensive "in-person" evaluation. The tool is designed to assess the physical, behavioral, functional and social needs of a member and to determine the appropriate level of care coordination. The CNA may indicate a need for further assessment and evaluation of Nursing Facility Level of Care (NFLOC). Upon completion of the CNA, the care coordinator and member will develop the care plan and establish the member's ICT.

Comprehensive Care Plan

Based on the results of the comprehensive assessment, an individualized care plan is developed for each member, and an appropriate ICT is established. The ICT includes the member and all providers, including 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 encompasses the member's goals, strengths, opportunities, authorized services, back up and disaster plan, and ongoing care coordination activities. Members are encouraged to actively participate in the care planning process, and they are provided with tools and resources that allow them to be actively engaged in their health journey.

Appointment Standards

Contracted in-network providers are expected to adhere to Turquoise 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 Turquoise Care

Presbyterian Turquoise Care includes but is not limited to the services identified in the following table.

Presbyterian Turquoise Care Services	Presbyterian Turquoise Care Services
• Accredited Residential SUD Treatment Centers (Adult) • Accredited Residential Treatment Center Services • Applied Behavior Analysis (ABA) • Adult Psychological Rehabilitation Services • Allergy Testing and Injection • Ambulatory Surgical Center Services (outpatient surgery) • Anesthesia Services • Annual Physical Exam and Consultation • Assertive Community Treatment (ACT) Services • Bariatric Surgery • Behavior Management Skills Development Services • Behavioral Health Professional Services: outpatient • Behavioral Health and SUD Services • Biomarker Testing • Cancer Clinical Trials • Cardiovascular Rehabilitation • Case Management • Chemotherapy • Chiropractic Services • Chronic Care Management Services • Community Health Workers • Community Interveners for the Deaf and Blind • Comprehensive Community Support Services (CCSS) • Crisis Services, Including Telephone, Clinic, Mobile and Stabilization Centers • Crisis Triage Centers, Including Residential • Day Treatment Services • Dental Services, Including Fluoride Varnish • Diabetes Treatment, Including Diabetic Shoes, Medical Supplies, Equipment and Education • Diagnostic Imaging and Therapeutic Radiology Services • Dialysis Services • Disease Management • Doula Services • Durable Medical Equipment (DME) and Supplies • Early and Periodic Screening Diagnostic and Treatment (EPSDT) • Electroconvulsive Therapy • Emergency Services (including emergency room [ER] visits and psychiatric ER) • Experimental or Investigational Procedures, Technology or Non-Drug Therapies • EPSDT Personal Care Services • EPSDT Private Duty Nursing • EPSDT Rehabilitation Services	• Lactation Care Provider Services • Maternity Care, Including Delivery and Inpatient Maternity Services Non-Hospital Births and Pre- and Post-Natal Care • Medically Tailored Meals or Groceries for Pregnant Members With Diabetes • Medication Assisted Treatment (MAT) for Opioid Dependence • Midwife Services • Multi-Systemic Therapy (MST) Services • Non-Accredited Residential Treatment Centers and Group Homes • Nursing Facility Services • Nutritional Services • Occupational Therapy/Services • Outpatient Hospital based Psychiatric Services and Partial Hospitalization • Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital • Outpatient Healthcare Professional Services • Peer Support Services • Pharmacy Services • Physical Health Services • Physical Therapy • Physician Visits • Podiatry Services • Pregnancy Termination Procedures • Prenatal Genetic Screening • Preventive Services • Prosthetics and Orthotics • Psychosocial Rehabilitation Services • Radiology Facilities • Recovery Services (Behavioral Health) • Rehabilitation Option Services • Rehabilitation Services Providers • Reproductive Health Services • Respite (Behavioral Health) • Rural Health Clinics (RHS) Services • School-Based Services • Screening, Brief Intervention, Referral to Treatment (SBIRT) Services • Smoking and Tobacco Cessation Services (may include counseling, prescription medications and products) • Speech and Language Therapy • Supportive Housing • Swing Bed Hospital Services • Telemedicine Services

Presbyterian Turquoise Care Services
• Experimental or Investigational Procedures, Technology or Non-Drug Therapies • Family Planning • Family Support (Behavioral Health) • Federally Qualified Health Center (FQHC) Services • Gender Affirming Care • Genetic Evaluation and Testing • Group Home • Habilitative and Rehabilitative Services • Hearing Aids and Related Evaluations • Home Health Services • Hospice Services • Hospital Inpatient (including detoxification services) • Hospital Outpatient • Human Donor Milk • Immunizations • Inpatient Hospitalization in Freestanding Psychiatric Hospitals • Institutions for Mental Disease (IMD) for SUD only • Intensive Outpatient Program (OIP) Services • Intravenous (IV) Outpatient Services • Laboratory Services

Presbyterian Turquoise Care Services
• Tot-to-Teen Health Checks (preventive healthcare guidelines) • Transplant Services • Transportation Services (medical) • Transitional Care Management services • Treatment Foster Care I and II • Vision Care Services

Agency-Based Community Benefit Services Included Under Presbyterian Turquoise Care
• Adult Day Health • Assisted Living • Behavior Support Consultation • Community Transition Services • Emergency Response • Employment Supports • Environmental Modifications • Home Health Aide • Nutritional Counseling • 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 Turquoise Care
• Behavior Support Consultation • Customized Community Supports • Emergency Response • Employment Supports • Environmental Modifications • Home Health Aide • Self-Directed Personal Care • Start-Up Goods • Nutritional Counseling • Private Duty Nursing for Adults • Related Goods • Respite • Skilled Maintenance Therapy Services • Specialized Therapies • Transportation (non-medical)

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.

Video Visits

Presbyterian offers "Video Visits," a name for a platform of online and on-demand healthcare delivery services, used to provide doctor visits via a member's computer, tablet or smartphone through a webcam for Presbyterian Turquoise Care members. Video Visits enables convenient and affordable access to care for non-emergent health concerns.

To ensure members have continuous access to care, Video Visits are available 24 hours a day, seven days a week (24/7), when a member does not have immediate access to their preferred PCP. This service is not intended to replace or continually substitute for a PCP visit. Video Visits providers can refer members to specialists when necessary, as well as prescribe non-narcotic medications.

Medical records and visit transcripts can be released to the member and shared with their provider at any time.

Referrals to Non-Participating Practitioners and Providers

A Turquoise Care member is not held liable for payment of services if their PCP or specialty care provider has mistakenly referred them to a non-contracted or out-of-network provider, unless the member was previously notified in writing about the use of non-participating providers and informed that Presbyterian is not responsible for future payments.

In the rare 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 Turquoise 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 to the member

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: www.ama-assn.org/delivering-care/ethics/treating-self-or-family.

Presbyterian will not reimburse for claims submitted for treatment of self or family members. In emergency settings or isolated settings where there is no other qualified provider available, then 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 network that ensures members have access to quality care and all covered services.

The tables on the pages below summarize our 2026 performance for both primary care and pharmacy access standards. The data in these tables is derived from Geo-Access software that measures provider ZIP code locations against member ZIP code locations to calculate member-to-provider distance and minutes from each other. For examples, the software can calculate how far away the provider is from a member and how long it would take for a member to drive the distance. The software compares the total universe of providers statewide to geographic segments of the member populations that match HCA's geographic access standards.

Presbyterian defines a PCP as inclusive of family practitioners, general practitioners, general internists, pediatricians, obstetricians and gynecologists, geriatricians, certified physician's assistants, certified nurse practitioners, and other specialists like OB/GYNs, who have been approved 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 urban, rural and frontier 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 Geo-Access analysis, 100% of urban populations have desired access, 99.9% of rural populations have desired access and 99.9% of frontier populations have desired access.

Performance Summary

Presbyterian Performance Summary		
Health Care Service	**Appointment Characteristic**	**Appointment Standard**
Primary Care	Asymptomatic/Routine member-initiated outpatient primary care	No more than 30 calendar days, unless the member requests a later time
	Symptomatic member-initiated outpatient primary care	No more than 14 calendar days, unless the member requests a later time
	Outpatient appointments for urgent medical conditions	Within 24 hours
Behavioral Health Care	Initial assessment non-urgent appointments	No more than 7 calendar days, unless the member requests a later time
	Appointment following an initial assessment	No more than 7 calendar days, unless the member requests a later time
	Non-urgent follow-up appointment	No more than 30 calendar days of request
Specialty Care	Symptomatic outpatient referral and consultation	No more than 14 calendar days, unless the member requests a later time
	Asymptomatic outpatient referral and consultation	No more than 45 calendar days, unless the member requests a later time
	Outpatient appointments for urgent medical conditions	Within 24 hours
Maternity Care	Outpatient appointments for urgent medical conditions	Within 24 hours
Prenatal Care	Routine outpatient appointment during the first trimester	No more than 14 calendar days
	Routine outpatient appointment during the second trimester	No more than 7 calendar days
	Routine outpatient appointment during the third trimester	No more than 3 business days
Diagnostic Laboratory, Diagnostic Imaging and Other Testing	Routine outpatient appointments	Consistent with clinical urgency, but no more than 14 calendar days, unless the member requests a later time
	Walk-in instead of an appointment system	Member wait time will be consistent with the severity of the clinical need
	Urgent outpatient appointments	Consistent with clinical urgency, but no longer than 48 hours
Dental Care	Asymptomatic member-initiated appointments	No more than 60 calendar days, unless the member requests a later time
	Symptomatic member-initiated outpatient appointments for non-urgent care	No more than 14 calendar days, unless the member requests a later time
	Urgent outpatient appointments	Within 24 hours

Prescription Fill Time	In-person fill time	No longer than 40 minutes
	Practitioner phone-in or electronically submitted fill time	No longer than 90 minutes
Follow-Up Visits (Excluding Behavioral Health)	Outpatient follow-up visits	Consistent with clinical need

Access Standards for Primary Care and Pharmacy Providers

Access Standards for Primary Care Providers					Access Standards for Pharmacy Providers			
Population	**Goals**	**Target**	**2025 Results**	**Outcome**	**Goals**	**Target**	**2025 Results**	**Outcome**
Urban	1 PCP within 30 miles	90%	100%	Goal Met	1 Pharmacy within 30 miles	90%	100%	Goal Met
Rural	1 PCP within 45 miles	90%	99.9%	Goal Met	1 Pharmacy within 45 miles	90%	99.9%	Goal Met
Frontier	1 PCP within 60 miles	90%	99.8%	Goal Met	1 Pharmacy within 60 miles	90%	99.9%	Goal Met

Care Coordinators

Care coordinators work in collaboration with the member, the member's PCP, and the ICT to implement the care plan and facilitate access to services, specialty providers, community resources and long-term care services as appropriate. The care coordinator is responsible for effective communication across the healthcare system, continuous and systematic monitoring, and regular reassessment to evaluate adherence to the care plan and to identify gaps, barriers and/or changes in a member's condition or status. Care coordinators for CISC members are knowledgeable of the resources available to CISC members within communities and within the state and local-level systems. Any change in a member's status or condition automatically triggers a reassessment.

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 who interact 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 grievances 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, multilingual employees, and TTY assistance, which allows people who are deaf, hard of hearing, or speech-impaired to use the telephone to communicate

Emergency Services Responsibilities

Emergency services must be available to members 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 Turquoise 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).

Prior Authorization, Referral and Utilization Management

Presbyterian Turquoise Care ensures the following:

- Members have direct access to medical care 24/7 through their PCP, urgent care facilities, ERs, 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 network
- 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 ICT and are reviewed by the utilization management team
- Providers and members can view authorization requirements and submit prior authorizations by visiting www.phs.org/providers/authorizations or calling the Presbyterian Customer Service Center (PCSC) for authorization and prior authorization requirements, which include but are not limited to the following:
    - Inpatient admissions
    - Select providers
    - Behavioral health service
    - Select outpatient procedures
    - Select major diagnostic tests
    - Home healthcare
    - Select 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 Turquoise Care services that require prior authorization, see Appendix E.

Encounter Reporting

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

HCA uses encounter data reporting to evaluate health plan compliance on many vital issues. Regardless of whether the service providers furnish 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.

All billing, attending, ordering, referring, rendering and prescribing providers must be enrolled with New Mexico's Medicaid program. For Presbyterian to meet the encounter submission requirements for New Mexico Medicaid, providers are required to report the appropriate NPI and taxonomy code on claims when the provider has more than one Turquoise Care provider type associated with the submitted NPI. The NPI and taxonomy code submitted on claims should match the provider's New Mexico Medicaid provider type registration.

Presbyterian can deny claims when a provider with multiple provider types registered with New Mexico Medicaid uses an incorrect taxonomy code on a claim.

Billing and Coding Tips

- Hospitals can prevent billing errors by billing for physician services when appropriate
    - For example, hospitals should only bill with a taxonomy code associated with provider type 201 (Hospital, General Acute) when they are billing for a hospital service. Hospitals should not bill provider type 201 when they are billing for physician services
        - When hospitals bill for a physician service, they should bill for the taxonomy code associated with the provider type that the individual provider registered with New Mexico Medicaid that is most appropriate for the services that were provided
- Some taxonomy codes are associated with multiple provider types. Individual providers with multiple registered provider types should bill using the most appropriate taxonomy code and provider type combination for the service provided that does not overlap with another registered provider type

The New Mexico Medicaid Provider Types and Taxonomy Codes Reference Guide gives providers an overview of the taxonomy codes that HCA assigned. To view the guide, visit https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000015498.

To register with HCA, providers can go to https://Yes.NM.GOV.

Providers can also view active and inactive registrations by going to https://nmmedicaid.portal.conduent.com/static/index.htm. Failure to register with HCA may result in claim denials.

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 HCA every quarter. The member is removed from lock in when Presbyterian has determined that the utilization of unnecessary services was resolved and the problem is unlikely to reoccur. HCA 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 HCA every quarter. The member is removed from the lock-in when Presbyterian determines that the non-compliant or drug-seeking behavior is resolved and the recurrence of the problem is judged to be improbable. HCA is notified of all lock-ins and their removals.

Provider Coordination

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

In addition, Presbyterian utilizes its care management system and ICT 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.

Medical Records and Confidentiality Assurance

There may be instances where records from a provider 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

Common Signs of Child Physical or Sexual Abuse, Neglect or Mental Maltreatments as Identified by the U.S. Department of Health & Human Services

Child maltreatment and physical abuse may cause a child to:

- Be aggressive, oppositional or defiant
- Cower or demonstrate a fear of adults
- Act out, displaying aggressive or disruptive behavior
- Be destructive to self or others
- Come to school too early or not want to leave school, indicating a possible fear of being at home
- Show fearlessness or demonstrate extreme risk-taking
- Be described as "accident prone"
- Cheat, steal, or lie (may be related to too high expectations at home)
- Be a low achiever
- Be unable to form good peer relationships
- 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.)
- Show regressive or less mature behavior
- Dislike or shrink away from physical contact (e.g., may not tolerate physical praise, such as a pat on the back)

Child Neglect

- Seem inadequately dressed for the weather (e.g., wearing shorts and sandals in freezing weather)
- Appear excessively listless and tired (due to no routine or structure around bedtimes)
- Report caring for younger siblings (when they themselves are underage or are developmentally not ready to do so)
- Demonstrate poor hygiene or smell of urine or feces
- Seem unusually small or thin or have a distended stomach (indicative of malnutrition)
- Have unattended medical or dental problems, such as infected sores or badly decayed or abscessed teeth
- Appear withdrawn
- Crave unusual amounts of attention, even eliciting negative responses in order to obtain it
- Be chronically truant

Child Sexual Abuse

- Have bruises in the inner thigh or genital area
- Have difficulty walking or sitting
- Complain of genital or anal itching, pain, or bleeding
- Frequently vomit
- Become pregnant at a young age
- Have any sexually transmitted diseases
- Exceptional secrecy
- More sexual knowledge than is age appropriate, especially in younger children

Common Signs of Child Physical or Sexual Abuse, Neglect or Mental Maltreatments as Identified by the U.S. Department of Health & Human Services

- In-depth sexual play with peers that is not developmentally appropriate
- Extreme compliance or withdrawal
- Overt aggression
- An inordinate fear of males or females
- Seductive behavior
- Sleep problems or nightmares
- Crying without provocation
- A sudden onset of wetting or soiling of pants or bed
- 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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Ch. 3: Primary Care Providers

PCPs are contracted physical health providers who meet certain objective criteria established by Presbyterian. PCPs must accept the responsibility for ensuring the provision of healthcare 24/7. Presbyterian's network of PCPs specializes in family practice, general practice, geriatrics, internal medicine, pediatrics and OB/GYNs. Presbyterian's PCP network also includes certified physician assistants, certified nurse practitioners and other specialists who are credentialed and elect to perform in the role of a PCP.

The Description, Role and Responsibilities of PCPs

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 to reduce the need for 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.

Presbyterian PCPs are 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 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 contracted 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 (see the Behavioral Health chapter)
- Participating in the ICT for Turquoise Care members
- Maintaining current medical records that meet established Presbyterian standards
- Making referrals to contracted (in-network) specialty care providers when appropriate
- Monitoring the member's progress and facilitating the member's return to the PCP when medically appropriate
- Documenting communication with specialty care providers in the medical record
- Educating members and their families about their health issues
- Following established 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, tax identification number (TIN), 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 it is a covered benefit under their insurance plan. PCSC is available to assist with confirming a member's 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: 1-866-654-3219

Children, Youth and Families Department (CYFD): 1-800-797-3260

Department of Health/Division of Health Improvement (DOH/DHI): 1-833-796-8773 (toll-free)

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.

PCPs are also responsible for contacting Presbyterian to verify member eligibility and prior authorizations for covered services. Providers can verify member eligibility and request prior authorization through the provider portal at www.phs.org/mypres or by calling (505) 923-5757 or 1-888-923-5757.

PCP Selections and Assignments

Presbyterian has written policies and procedures governing the process of member selection of a PCP and requests to change PCPs. Please cooperate with Presbyterian to help us carry out our assignment obligations, with the following:

Initial Enrollment

At the time of enrollment, Presbyterian will 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 will include at least the following features:

- Presbyterian will provide the means for selecting a PCP within five business days of processing the enrollment file
- Presbyterian will 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 will 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 will make the assignment and notify the member in writing of their 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 will assign a PCP based on factors such as member age, residence and, if known, current provider relationships

Subsequent Change in PCP Initiated by Member

Members may request to change their PCP at any time for any reason. The request can be made in writing or by telephone. If a request is made on or before the 20th calendar day of a month, the change will be effective as of the first following business day of the receipt of the request or at the date requested by the member, provided the date is not retroactive.

Presbyterian Turquoise 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 first day of the following month. If the request is made after the 20th

calendar day of the month, the change will be effective on the first calendar day of the second month following the request.

Subsequent Change in PCP Initiated by Presbyterian

Presbyterian may initiate a PCP change for a member under the following circumstances:

- 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 for the PCP to safely or prudently provide medical care, and the PCP made reasonable efforts to accommodate the member
- A member has initiated legal actions against the PCP
- The PCP is suspended for any reason

If providers are terminating their contract, then they must provide Presbyterian with sufficient notice so that we can notify our members in writing about that termination within 15 calendar days. This allows for continuity of care and adequate time for the member to select a new PCP.

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 after-hours messaging about how to access after-hours care.

Presbyterian requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to Commercial members.

Use Contracted Providers

PCPs are required to utilize Presbyterian's contracted in-network providers, laboratories, DME and other services for referrals in an effort to minimize member inconvenience and balance billing issues. If providers need to verify whether services are available in network, then they can call (505) 923-5757 or 1-888-923-5757 for assistance or visit our website at www.phs.org/directory.

Laboratory Services

All contracted, in-network PCPs are required to send lab specimens and refer members to TriCore Reference Laboratories, Quest Diagnostic Laboratories (Quest) or Laboratory Corporation of America (LabCorp).

Providers may reference the Presbyterian Provider Directory for other lab providers contracted with Presbyterian. The Presbyterian Provider Directory is available at www.phs.org/directory.

For a list of TriCore, Quest or LabCorp laboratory or draw stations locations, please visit the following links:

- www.tricore.org/locations/
- www.questdiagnostics.com/locations/search
- www.labcorp.com

Durable Medical Equipment Services

PCPs are responsible for referring members to contracted DME providers. Our network design is such that our members throughout the state have access to DME providers. For a complete listing of DME providers, please visit our website at www.phs.org, then click "**Find a Doctor**" at the top of the page and search by specialty.

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 their 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. For those who do not comply with the requirement to utilize in-network contracted providers, Presbyterian reserves the right to hold them responsible for up to 150% of either:

- The difference between the amount that Presbyterian would have paid if a contracted provider was 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.

In the rare event that medically necessary covered services are not reasonably available in plan, Presbyterian may approve certifications to non-participating practitioners or facility providers. This determination will be made within the time frames listed in Health Services/Behavioral Health policy on monitoring timeliness of utilization management decisions.

Presbyterian Medicaid plans require that the practitioner or 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.

Out-of-network practitioners and facility providers must have approval via certification 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 or 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 or facility provider does not have the necessary training required to render the service or treatment
- **Location:** Where there are no participating healthcare professionals in Presbyterian's network for the services requested within a reasonable distance to the member

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Ch. 4: Specialists

The Description, Role and Responsibilities of the Specialty Care Provider

Specialists are contracted physical and behavioral health providers not identified as a PCPs. Specialists agree to accept referrals from other contracted in-network providers.

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
    - Indian Health Service/Tribal 638 Facilities/Urban Indian Clinics (I/T/U) providers
    - Another contracted provider
    - Self-referral, when appropriate, for specified treatments or diagnoses
- Referring members to other providers as needed, including laboratory services, radiology and DME providers

Specialists

- 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. PCSC is available to assist with confirming covered benefits
- Communicating with the member's PCP or other providers about services rendered, treatment results, and 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 Health Services department for non-emergency inpatient and outpatient services in accordance with the member's benefits package and Presbyterian's utilization management 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, TIN, license, liability insurance, contract status or any other issue that could affect the provider's ability to effectively render covered services
- Participating in the ICT
- 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: 1-866-654-3219
  - CYFD: 1-800-797-3260
  - DOH/DHI: 1-833-796-8773

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 the provider portal at www.phs.org/myPRES 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 the provider portal.

Use Contracted Providers

Specialty care providers are required to use Presbyterian's contracted in-network providers, including for services such as laboratory, radiology, DME and other services, to minimize member inconvenience and

balance billing issues. To verify if services are available in network, providers can call (505) 923-5757 or 1-888-923-5757 (toll-free) for assistance or visit our website at www.phs.org/directory.

Laboratory Services

All contracted, in-network specialists are required to send lab specimens and refer members to TriCore Reference Laboratories, Quest Diagnostic Laboratories (Quest), or Laboratory Corporation of America (LabCorp). Providers may reference the Presbyterian Provider Directory for other lab providers contracted with Presbyterian. The Presbyterian Provider Directory is available at www.phs.org/directory.

For a list of TriCore, Quest or LabCorp laboratory or draw stations locations, please visit the following links:

- www.tricore.org/locations/
- www.questdiagnostics.com/locations/search
- www.labcorp.com

Durable Medical Equipment Services

Specialists are responsible for referring members to contracted DME providers. Our network is designed to ensure that our members throughout the state have access to DME providers. For a complete listing of DME providers, please visit our website at www.phs.org, then click “Find a Doctor” at the top of the page and search by specialty.

Referrals to Non-Participating Practitioners and 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/facility provider, until the member is notified in writing concerning the use of non-participating practitioners/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. For those who do not comply with the requirement to utilize in-network contracted providers, Presbyterian reserves the right to hold them responsible for up to 150% of either:

- The difference between the amount that Presbyterian would have paid if a contracted provider had been used 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.

Specialists

In the rare event that medically necessary covered services are not reasonably available in plan, Presbyterian may approve certifications to non-participating practitioners or facility providers. This determination will be made within the time frames listed in Health Services/Behavioral Health policy on monitoring timeliness of utilization management decisions.

Medicaid plans require that the practitioner or facility providers submit requests to the Health Services department via fax, online, mail or by telephone.

For behavioral health, the request may come in writing directly from the behavioral health practitioner or provider facility. 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-network practitioners or 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 or 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 or 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 of the member

Accessibility of Services Standards

As required by our regulators and NCQA, 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.

Appointment Standards for Specialists (All Product Lines)		
Healthcare Service	**Appointment Characteristics**	**Standard**
Specialty Care	Symptomatic outpatient referral and consultation	No more than 14 calendar days, unless the member requests a later time
	Asymptomatic outpatient referral and consultation	No more than 45 calendar days, unless the member requests a later time

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.

Specialists

Presbyterian requires the hours of operations that providers offer to Medicaid members to be no less than those offered to Commercial members.

Specialty Care Provider Termination

Providers should refer to their provider 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 members about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

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Ch. 5: Healthcare Guidelines

Preventive Healthcare Services and Guidelines

Presbyterian Healthcare Guidelines are evidence-based, systematically-developed statements designed to provide members and providers with age- and gender-based recommendations about services that should be routinely incorporated into primary medical care. Presbyterian's Preventive Healthcare Guidelines are available to members and providers at the following links:

- **Providers**

  www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral

- **Members**

  www.phs.org/preventive

Adoption of preventive guidelines is accomplished through provider review at the Population Health and Clinical Quality 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) A and B recommendations
- Centers for Disease Control and Prevention / Advisory Committee on Immunization Practices (CDC/ACIP)

- American Academy of Pediatrics (AAP) / Bright Futures
- Health Resources and Services Administration (HRSA)

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

Presbyterian adopts immunization guidelines published by CDC/ACIP for all ages, 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 guideline information as part of their member handbooks or summary of benefits and coverage, which are available to members and providers online at www.phs.org. The guidelines are also available to all members at the following link: www.phs.org/tools-resources/member/health-wellness-information.

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 visit www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral

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 evidence-based. Clinical practice guidelines are approved by providers at the Presbyterian Population Health and Clinical Quality Committee. Previously approved clinical practice guidelines are reviewed annually and updated when clinically appropriate.

Clinical Practice Guidelines and Tools	
Guidelines and Tools	**Website Location**
Behavioral Health	www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral
Physical Health	www.phs.org/providers/resources/reference-guides/clinical-practice-guidelines

As guidelines are updated, Presbyterian notifies providers in a subsequent issue of the Network Connection provider newsletter. In addition, updates are posted on the Presbyterian website listed in the table above.

Measurement Activities

Presbyterian conducts measurement activities throughout each year based on the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[1].

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. Data is collected from claims and other sources available to Presbyterian, such as lab results, direct access to electronic medical records (EMR) and data feeds from various network providers, and on-site or EMR 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, notifying and assisting these members in addressing these risks through preventive annual screens/tests and notifying providers when preventive and/or treatment services may be needed for their patients. For selected measures, Presbyterian provides individual scores to providers who deliver primary care.

Along with the scores, Presbyterian includes lists of members who might not be receiving the care needed according to these clinical guidelines. Providers are encouraged to use these lists to engage members in their

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

In addition, Presbyterian provides a Quality Measures Toolkit for providers. This toolkit outlines the HEDIS preventive and health maintenance measures in focus for our member outreach, as well as member and provider incentive programs. It includes the HEDIS specifications for each measure, the appropriate billing codes to accurately capture for reportability, and descriptions and enrollment information for incentive programs.

Health Risk Assessments

Presbyterian encourages members to participate in HRAs, also known as Personal HRAs. The HRAs include a series of questions designed to identify potential health risks. The results are used to determine if new members require focused care coordination for physical or behavioral health issues, or if they might benefit from one of Presbyterian's health or disease management programs.

Turquoise Care HRAs

All Turquoise Care members are offered a telephonic HRA to determine the level of care coordination the member requires. The HRA includes a series of questions designed to identify potential health risks. The results are used to determine if members require focused care coordination for physical or behavioral health, or if they might benefit from one of Presbyterian's health or disease management programs.

Presbyterian Dual Plus: Special Needs Plan HRAs

All Presbyterian Dual Plus members receive a HRA upon enrollment and annually. The results of these assessments enable Presbyterian to determine the appropriate level of care coordination. The HRA completed by the Dual Plus member is used to develop an individualized care plan. Presbyterian Care Coordination conducts a CNA on Dual Plus members who meet higher level Care Coordination criteria to complete a comprehensive care plan.

Early and Periodic Screening, Diagnostic and Treatment Program

Children experience numerous health and developmental milestones that should be assessed in a timely manner. Early detection and treatment can help prevent 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" section). Presbyterian commits to member reminders for these immunizations and supports providers in coordinating these services.

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

EPSDT Program training for providers is available through the Provider Network Operations (PNO) department.

Immunizations

Presbyterian recommends immunization guidelines from the CDC, ACIP and HCA. Please review the following information:

- The CDC/ACIP schedules for children and adults are available at www.cdc.gov/vaccines/schedules/hcp/index.html
- The NM HCA immunization schedule for members and providers is available at www.nmhealth.org/about/phd/idb/imp/imsc
- The New Mexico Medicaid Managed Care program, in the NMAC in 8.308.9.17, expects participation in the 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 their 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 the following criteria:

- Eligibility for Medicaid
- Do not have any health insurance
- American Indian or Alaska Native
- Underinsured (i.e., they 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 NM HCA program manager at (505) 827-2898 or the CDC Immunization hotline at 1-800-232-4636.

Presbyterian also participates in the New Mexico Vaccine Purchase Act (VPA), which went into effect on March 20, 2015 (New Mexico Statutes Annotated [NMSA] 1978, § 24-5A-1 et seq). Pursuant to the VPA, the vaccine-purchasing fund was created in the state treasury.

Since the inception of the VFC program in the 1990s, the DOH 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 for providers and patients to easily access childhood vaccines.

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

- New Mexico DOH Immunization Program: http://nmhealth.org/about/phd/idb/imp/
- NMSIIS: http://nmhealth.org/about/phd/idb/imp/siis/
- VFC CDC site and provider forms: www.cdc.gov/vaccines/programs/vfc/index.html
- VPA: http://nmhealth.org/about/phd/idb/imp/vpa/

Contact Us

For additional information about health education and preventive healthcare services available to Presbyterian members or, in some cases, children who might not otherwise be vaccinated because of their inability to pay, contact Presbyterian's Quality Performance Improvement department at (505) 923-2074 or 1-866-634-2617. These are voice-answering systems only.

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Ch. 6: Care Coordination

Care Coordination and Utilization Management

Presbyterian's Care Coordination program exists to support providers and their Presbyterian patients. The Care Coordination department assists providers with coordination of care and services for their Presbyterian patients with chronic or catastrophic illnesses and injuries and in promoting healthy lifestyles. Care coordination facilitates communication and collaboration along the continuum of care to ensure patients receive the care and services they need to reduce risk and improve health outcomes.

Presbyterian's Utilization Management program evaluates the appropriateness, medical necessity, and the efficiency of healthcare services, procedures and facilities, according to established criteria and guidelines. Utilization management processes are comprised of a comprehensive set of integrated components, including prior authorization, concurrent review, continued stay review, retrospective review, discharge planning and transition of care. Presbyterian's Utilization Management team of nurses, pharmacists, behavioral health specialists, therapists and medical directors are available 24/7 to assist providers with authorizations or verification of benefits. For a list of services that require prior authorization, visit www.phs.org/providers/authorizations or call PCSC at (505) 923-5757 or 1-888-923-5757 during and after normal business hours.

The NCQA affirmative statement about incentives for utilization management decision-making requires the organization to distribute a statement to all members and to all practitioners, providers and employees who make utilization management decisions, affirming the following:

1. Utilization management 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 utilization management decision-makers do not encourage decisions that result in underutilization."

Our Care Coordination Model

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 the following:

- Member-centric care coordination that encourages personal responsibility and member engagement
- 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
- HRAs that are completed telephonically for new members and also for existing members who are not in care coordination if it is deemed necessary. The HRA identifies health issues in need of further evaluation and potential care coordination services
- A CNA that is designed for members with specific healthcare needs
- A comprehensive care plan that addresses physical, psychosocial, behavioral and functional needs
- ICTs that work together to meet the diverse and holistic needs of members across domains of healthcare
- Evidence-based practice guidelines and clinical pathways
- Technology solutions and clinical decision support tools

Care coordination, disease management, utilization management and transition of care are integral components of our overall integrated care model for Turquoise 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. 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 HCA, Presbyterian may also contract with qualified Patient-Centered Medical Homes (PCMHs), community providers and/or 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'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 Turquoise 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), utilization management, authorizations, population health improvement, monitoring and quality assurance.

CISC members, as determined by CYFD Category of Eligibility, are automatically enrolled with a level of 1 or 2. In the event a CISC guardian/representative refuses Care Coordination, Presbyterian will have the CISC guardian/representative sign an HCA-approved Care Coordination Declination Form. If the CISC guardian/representative refuses to sign the Care Coordination Declination Form, Presbyterian shall document such refusal in the member's file. Children 14 years or older can sign the Care Coordination Declination Form. Presbyterian will contact the CISC's CYFD Permanency Planning Worker within three business days of the member's refusal of care coordination to inform them of the refusal. Presbyterian will include documentation in

the member file of the CYFD contact. The CISC member shall be monitored by Presbyterian on an on-going basis.

The care management system's customized algorithms and analytics support member assessment, care plan development, automated 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 provider portal, where they can comment and discuss issues.

Health Risk Assessment

A HRA specialist conducts a HRA for all Turquoise Care members. The HRA form is standardized and approved by HCA. 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 evaluation receive a CNA and are assigned to a care coordination level.

Comprehensive Needs Assessment

Members who are identified for further evaluation 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, appropriate providers and member determine the member's care plan, which includes an ICT with the appropriate participants.

Members who require Level 1 or 2 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. Providers can find their patient's assigned care coordinator by using the information below to contact the Presbyterian Care Coordination Unit:

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

If Presbyterian is unable to reach members through telephone or mail contacts, a member of the Presbyterian care coordination team may request the providers help in engaging their patient in the assessment process. Similarly, providers may request assistance for care coordination for their Presbyterian patient.

Care Plan Development

Based on the results of the CNA, an individualized care plan is developed for members assigned to care coordination Level 1 or 2. 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 their 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 their designated family members, caregivers or authorized representatives, the member's PCP, other providers and the ICT 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 ICT 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. Medication reconciliation is performed and utilized to evaluate medication adherence.

Interdisciplinary Care Team

Based on the CNA and the individualized care plan, an appropriate ICT is established. The ICT addresses the member's specific needs and is a central component of the care coordination model for members with extensive medical history and complex needs. Members of the ICT are based on the member's individual needs, preferences and situation. At minimum, the ICT 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 ICT 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
- 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 ICT. 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 Presbyterian's Utilization Management department.

ICT 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, 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 teams 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 (MCG), 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 Turquoise 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 E.

Long-Term Services and Supports

Under Turquoise 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 meet NFLOC eligibility requirements have access to HCBS without waiting for a waiver slot to become available. Individuals who are not otherwise Medicaid-eligible, have incomes below 300% of supplemental security income, and 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.

Please refer to the Long-Term Care chapter of this manual for more information about this area of support, including the community benefit.

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 their 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 do the following:

- 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. Presbyterian's disease management program offers a member-centric program to meet the medical, behavioral and educational needs of members. To provide resources for providers in care coordination for Turquoise Care members with chronic conditions, Presbyterian offers comprehensive disease management programs for asthma, coronary artery disease, diabetes, hypertension, chronic obstructive pulmonary disease, and adolescents with depression. These programs distribute educational materials to members and providers. They also provide Turquoise Care members blood glucose meters to those diagnosed with diabetes and peak flow meters for those diagnosed with asthma. One-on-one behavioral lifestyle coaching is conducted with the member to meet their self-identified goals, including condition-monitoring and self-management.

Presbyterian's comprehensive disease management program aligns with evidence-based guidelines and supports providers in managing chronic illnesses. The Population Health Alliance defines population health/disease management as a system of coordinated healthcare interventions for populations with conditions that can be significantly managed by an individual member's self-care efforts. It 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 at http://populationhealthalliance.org/.

This comprehensive disease management program supports the provider/patient relationship and care plan. It emphasizes prevention of exacerbations and complications by using evidence-based practice guidelines and patient empowerment strategies for self-management of chronic diseases. 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 members potentially in need of disease management services through medical and pharmaceutical data available through the Presbyterian claims data systems
- Stratify members by risk criteria using a predictive modeling match members to an appropriate level of intervention
- Provide disease management education and health coaching for lifestyle modifications
- Collaborate with providers and members to support member's goals for health improvement
- Provide education for preventive healthcare guidelines

Care coordinators manage members with the highest risk score who need more intensive/multisystem medical interventions. Members with moderate risk scores are managed by our Disease Management 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 they need to reach the stage of “readiness to change.” This motivational behavioral interviewing methodology ensures we focus our efforts on developing a personalized health improvement plan for members.

Disease Management 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 health outcomes. By tailoring the frequency and intensity of outreach to members based on risk, severity of disease and their readiness to change, our staff are 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 in the disease management program if their provider discusses it with them and recommends that they participate in it. Members who are considered at risk learn to minimize problems with ongoing education and utilization of healthcare resources becomes more appropriate and effective.

Healthy Solutions Coaching Program

One of the many components of Presbyterian’s Disease Management Program is the Healthy Solutions Coaching program. This behavioral lifestyle coaching program is offered to adult members with a diagnosis of asthma, coronary artery disease, diabetes, and hypertension. Coaching provides lifestyle coaching aligned with evidence-based care, including healthy eating, being active, medication adherence, condition-monitoring, problem-solving, reducing risks, and healthy coping. The health coach emphasizes the importance of establishing self-management goals and utilizes motivational interviewing to help members identify barriers to self-management and address lifestyle challenges.

The interventions and strategies include:

- Providing education to increase the member’s understanding of their chronic condition
- Emphasizing the prevention of exacerbations and complications by applying cost-effective, evidence-based practice guidelines
- Encouraging members to adopt a healthy lifestyle and providing them a variety of self-management tools to support their success

Care Coordination

- Utilizing targeted shared decision-making assist the member in establishing one or two self-management goals related to their chronic condition
- Provide behavioral coaching for life-style modifications, using motivational interviewing techniques
- Promoting the patient/provider relationship to achieve optimal health by closing gaps between recommended and actual care
- Reinforcing the established plan of care
- Monitoring performance measurements and health outcomes to evaluate the efficacy of the program

How to Refer the Healthy Solutions Team

Providers may use the following contact information to refer their Presbyterian Turquoise Care patients with diabetes, asthma, hypertension or coronary artery disease to the Presbyterian Disease Management Healthy Solutions Coaching Program.

Phone: (505) 923-5487

Toll-Free Phone: 1-800-841-9705

Fax: (505) 355-7594

HealthySolutions@phs.org

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Ch. 7: Utilization Management

Presbyterian's Utilization Management program ensures that Turquoise 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

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. Utilization management 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 utilization management 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 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 (www.phs.org/tools-resources/patient/access-your-health-information). 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 PCSC at (505) 923-5256 or 1-888-977-2333

Referral Requests and Prior Authorization

Turquoise Care members need to see their PCPs for specialist referrals and prior authorization for services and specialty care. In most cases, the PCP is not required to submit a referral request to Presbyterian for a service, such as a specialist visit or a specific therapy. The specialist that the PCP is sending the member to may require a referral from the PCP only. PCPs or other providers submitting prior authorization requests are encouraged to submit them online so they are immediately notified of the action, receive a reference number, or notice that the 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 the following:

- Emergency care
- Urgent care
- Women’s healthcare

Note: Presbyterian Turquoise Care has additional benefits for self-referral for women’s healthcare.

Presbyterian Turquoise 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.

Utilization Management

Presbyterian Turquoise Care ensures the following:

- Members have direct access to medical care 24/7 through their PCP, urgent care facilities, ERs, 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 (e.g., the member's care coordinator, Utilization Management 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 ICT based on the needs identified in the CNA and are reviewed and approved by the utilization management team before the initiation of services
- Information about prior authorization requests and requirements, which include but are not limited to the following, is available at www.phs.org/providers/authorizations or by calling (505) 923-5757 or 1-888-923-5757:
- Inpatient admissions
- Select providers
- Select behavioral health services
- Select outpatient procedures

- Select diagnostic tests
- Home healthcare
- Select DME
- 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 E.

Authorizations of Coverage

Services requiring prior authorization are published in appendix E of this manual, the Turquoise Care Member Handbook and Presbyterian's website. Extensive details are also included in provider orientations and ongoing training. These collective efforts ensure that the provider and member know if services are covered.

The Health Services team reviews cases for the following:

- Medical necessity
- Appropriate setting
- History of medical conditions and treatment
- 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 and current documentation by the referring provider is critical to demonstrate medical necessity.

Utilization Management

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

- Recommendation of treating provider
- Age
- Co-morbidities
- Complications
- Mental status
- Activities of daily living
- Instrumental activities of daily living
- Financial status
- Polypharmacy
- 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 SNF, 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 the following:

- MCG
- Oregon Outpatient Therapy Guidelines for Children with Special Health Needs
- National Specialty and Association Guidelines
- Hayes Medical Technology Guidelines
- Evolent Medical Specialty Solutions spine surgery guidelines

- Stanson Health 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
- Centers for Medicare & Medicaid Services (CMS)
- NMAC

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 Turquoise Care at the time a service is delivered for the service provider to be reimbursed. Eligibility can be checked easily and quickly through provider portal at www.phs.org/myPRES or by calling (505) 923-5757 or 1-888-923-5757, Option 1. Providers can verify if prior authorization is required by referencing Appendix E or going to www.phs.org/providers/authorizations.

Requesting Prior Authorization

Providers may use the information in the following table to contact Presbyterian's coverage review team. For after-hours review, please contact (505) 923-5757, option 9 followed by option 3 for pharmacy, option 4 for medical prior authorization, and option 5 for behavioral health. Providers may also all (505) 923-5757 for a peer-to-peer discussion about a prior authorization request or decision.

Department	Online	Phone Number	Fax Number
Physical Health Services	• Presbyterian Log In: https://ds.phs.org/preslogin/index.jsp	• (505) 923-5757 or 1-888-923-5757, option 4 followed by option 1	• Inpatient Services: (505) 843-3107 • Outpatient Services: (505) 843-3047 • Long-Term Care: (505) 843-3195 • University of New Mexico: (505) 843-3108 • Home Health Care: (505) 559-1150 • Transplant Requests: (505) 843-3110

Pharmacy Services	• Presbyterian Log In: https://ds.phs.org/preslogin/index.jsp • Formularies for Providers www.phs.org/providers/formularies • Clinical Criteria Document for Commercial Large Group Non-Metal Level Health Insurance Plans https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_0000000024715 • Clinical Criteria Document for Individual and Family/Employer Metal Level Health Insurance Plans https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_0000000024716 • Specialty Pharmaceuticals and Medical Drugs List https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00052739	• (505) 923-5757, option 3 • 1-888-923-5757, option 3	• (505) 923-5540 • 1-800-724-6953
Behavioral Health Services	• Commercial/Medicare: www.magellanprovider.com/MagellanProvider/do/LoadHome • Turquoise Care: https://ds.phs.org/preslogin/index.jsp	• 1-800-424-4661 • 1-888-923-5757, option 4 followed by option 2	• 1-888-656-4967 • (505) 843-3019
Spine Surgery Services	• Evolent RadMD Authorization Tracking: www1.radmd.com	• 1-866-236-8717	• 1-800-784-6864
Advanced Imaging	• Stanson Health https://php.careportal.com	• 1-888-487-0733	• 1-646-502-5041

Providers should submit supporting documentation along with their request to demonstrate medical necessity. 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 authorization requests online through myPRES at www.phs.org/mypres. Using myPRES to submit 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, 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. The provider may also access the status of prior authorization requests, claims and eligibility information through myPRES 24/7. For more information about myPRES, see the e-Business chapter of this manual.

Providers may submit prior authorization requests in the following ways:

- Medical and behavioral authorization requests may be submitted online through Presbyterian's Prior Authorization Portal, which providers can access by visiting https://sso.phs.org/ssocontroller/mpa and signing in with your provider portal credentials
- Inpatient prior authorization requests may be faxed to (505) 843-3107 or 1-888-923-5990
- Prior authorizations requests for specialized behavioral health services may be faxed to (505) 843-3019
- Outpatient services and DME requests may be faxed to (505) 843-3047
- University of New Mexico prior authorizations may be faxed to (505) 843-3108
- Long-term care prior authorizations may be faxed to (505) 843-3195
- Transplant Requests may be faxed to (505) 843-3110
- Mail to Presbyterian's Health Services department at:

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

Standard Requests

Standard requests are processed according to the following regulatory timeliness requirements when all necessary and relevant documentation supporting the prior authorization request is submitted within seven calendar days. If we do not have all the documentation needed to make a decision, then we will attempt to obtain the necessary information. We will deny the prior authorization request if we do not receive all of the documentation needed to make a decision within 7 calendar days of the day the request was received.

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. The following criteria are for requests that require a quick decision (urgent and expedited) from Presbyterian:

- 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 24 hours
- The covered person's ability to regain maximum function would be jeopardized if a decision is not provided within 24 hours
- The medical exigencies of the case require an expedited decision

By selecting "Expedited/Urgent," the provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee. Expedited requests for Turquoise Care members are processed within 24 hours when all necessary and relevant documentation supporting an expedited authorization is submitted with the request.

When providers have a situation that meets the definition of an urgent or expedited determination, then they should call (505) 923-5757 or 1-888-923-5757 (option 4). All urgent and expedited prior authorization requests that the provider submits should meet one or more of the above criteria. If the request does not meet the urgent and expedited criteria, then it is processed as a routine prior authorization request.

Authorization for Inpatient Admission

For elective or emergency admissions, use myPRES for all prior authorization requests and notification of deliveries. If necessary, the provider may also obtain authorization for an inpatient concurrent review or inpatient hospital admission by calling (505) 923-5757 or 1-888-923-5757 (Option 4). For Turquoise Care behavioral health prior authorizations requests, fax (505) 843-3019 or email nmturquoisecare@magellanhealth.com.

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.

Prior Authorization for Radiology/Advanced Imaging

Presbyterian uses Stanson Health 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.

Advanced Imaging authorization through Stanson Health applies to all Presbyterian members who have medical benefits for in-network radiology facilities. The following procedures require a prior authorization through Stanson Health:

- 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 Stanson Health:

- Inpatient
- Observation
- ER
- Urgent care
- While inpatient and observation services do not require prior authorization through Stanson Health, some may require prior authorization from Presbyterian
- ER and urgent care facility procedures do not require prior authorization from Stanson Health, the MSS program or Presbyterian. For more information, please refer to Presbyterian's authorization guide available on Presbyterian's website at www.phs.org/providers/authorizations
- 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 for Stanson Health at https://php.careportal.com/ or by calling 1-888-487-0733
- Musculoskeletal procedures and elective spine surgery performed in both inpatient and outpatient settings do require prior authorization through Evolent's Spine Management program (effective Jan. 1, 2015). Please contact Evolent at www.RadMD.com or by calling 1-866-236-8717. Failure to do so may result in a claim rejection
- If providers have any questions regarding Stanson Health and Evolent, they should contact their PNO relationship team. Contact information for PNO relationship teams can be found in the PNO Contact Guide at www.phs.org/ContactGuide

Retroactive Denial of Prior Authorization Requests

For all benefit types, retroactive denial of previously approved prior authorization is not permitted.

Assurance of Medical Necessary Services

Presbyterian does not engage in any practices that would deny medically necessary services to a covered person, including:

- Offering an inducement, financial or otherwise, to provide less than medically necessary services to the covered person
- Penalizing a provider that assists a covered person in appealing a carrier's decision to deny or limit benefits to the covered person pursuant to 13.10.17.9 NMAC
- Prohibiting providers from discussing treatment options with covered persons irrespective of the carrier's position regarding treatment options pursuant to 13.10.17.11(D) NMAC

Hours of Operation

Presbyterian's utilization management team of nurses, pharmacists, behavioral health specialists, therapists and medical directors are available 24/7 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.

Medical Records and Confidentiality Assurance

There may be instances where records from a provider's office or facility are requested to ensure that correct and timely coverage decisions are rendered. In addition, records may be requested for a special utilization/quality study, or as required by regulatory agencies such as HCA or CMS. 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. We currently reimburse providers $30 for the first 15 pages and $0.25 per page after the first 15 pages (based on NMAC, Title 16, Chapter 10.17.8).

Presbyterian ensures that 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 to prevent inappropriate disclosure. This obligation excludes disclosure of information that is required by state or federal law or is in the public domain.

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 utilizers
- Non-emergent emergency department 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.

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:

- ER 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 Turquoise Care Benefit Manual
- Individual, community and/or local delivery considerations

If there is a conflict between the member's contract and the Medical Policy Manual, then the contract will govern.

Presbyterian utilizes nationally recognized medical review criteria to assist in certifying benefit coverage. Medical policies are reviewed by practicing New Mexico providers and 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)
- CMS Medical Policy Guidelines
- The CMS DME Medicare Administrative Contractor, Jurisdiction C
- Local Medical Review Board Medical Policies
- MCG (a nationally recognized company specializing in best practice continuum of care recommendations)

Utilization Management

- MAD Program regulations and policy manual
- Oregon Outpatient Therapy Guidelines for Children with Special Health Needs
- Apollo Guidelines for Managing Physical/Occupational/Speech Therapy and Rehabilitation Care
- American Psychiatric Association (APA) Levels of Care
- American Academy of Child and Adolescent Psychiatry (AACAP) Levels of Care
- American Society of Addiction Medicine Levels of Care
- Health Plan's Uniform Level of Care Guidelines
- Presbyterian's Uniform Level of Care Guidelines
- Presbyterian's 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. The Medical Policy Manual is available at www.phs.org/medicalpolicymanual.

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
- A member transitions from a pediatric provider to an adult PCP

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.

Family Planning

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

Utilization Management

Clinics and providers, including those funded by Title X of the Public Health Service Act, will be reimbursed by Presbyterian Turquoise Care for all family planning services regardless of whether they are participating or non-participating providers. Unless otherwise negotiated, Presbyterian Turquoise Care will reimburse providers of family planning services according to the Presbyterian Turquoise 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 Turquoise Care is not required under any obligation from HCA 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.

Dental Services

Routine dental exams and prophylaxis (cleanings) do not require a referral. Members may access in-network dental providers without obtaining a referral or prior authorization from Presbyterian Turquoise Care. Providers may contact Presbyterian’s partner, DentaQuest, at 1-855-343-4276. Members may call PCSC for information about in-network dental providers.

Vision Services

Routine vision services do not require a referral. Members may access in-network vision providers without obtaining a referral or prior authorization from Presbyterian Turquoise Care. Providers may contact Presbyterian's partner, Superior Vision Services, at 1-800-507-3800. Members may call PCSC for information about in-network vision providers.

Special Populations

Special populations require a broad range of primary specialized medical, behavioral health and related services. Presbyterian follows HCA 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 (SSI) as disabled under Title XVI
- Children identified in the DOH 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, DME 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.

Behavioral Health Practitioners

For patients who receive three or more services within a 12-month period, the following must be documented in the behavioral health record:

- A mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control
- Diagnostic Statistical Manual (DSM)-IV diagnosis consistent with the history, mental status examination or other assessment data
- A treatment plan consistent with diagnosis, which has objective, measurable goals and time frames for goal attainment or problem resolution
- Documentation of progress toward attainment of the goal
- Preventive services, such as relapse prevention and stress management

Behavioral Health Referrals

Members may access Turquoise Care contracted behavioral health providers without a referral. Referrals are not needed for most outpatient services. A Presbyterian Turquoise Care member may access behavioral health services through a referral from their PCP or other healthcare provider. For Presbyterian Turquoise Care members, the provider can make a direct referral for behavioral services based on the following indicators:

- Suicidal/homicidal ideation or behavior
- At-risk of hospitalization due to 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
- Trauma victims
- 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

Utilization Management

- Request by 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 and/or neglect and members suspected of being subject to abuse and/or neglect
- Non-medical management of substance abuse
- Follow-up to medical detoxification
- An initial PCP contact or routine physical examination indicates a substance abuse problem
- A prenatal visit indicates substance abuse problems
- Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse
- A pattern of inappropriate use of medical, surgical, trauma or ER services that could be related to substance abuse or other behavioral health conditions
- The persistence of serious functional impairment

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

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

Home Health Services

Presbyterian Turquoise Care home care services are managed through the Presbyterian Utilization Management department, which provides 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. Please refer to the Home Health chapter of this manual for detailed authorization requirements and guidelines.

Long-Term Care Services

Long-term care is the overarching term that refers to services provided to members determined to meet 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. The provider should follow the Appeals and Grievance process.

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

Laboratory Services

All contracted, in-network providers are required to send lab specimens and refer members to TriCore Reference Laboratories, Quest Diagnostic Laboratories (Quest), or Laboratory Corporation of America (LabCorp). Providers may reference the Presbyterian Provider Directory for other lab providers contracted with Presbyterian. The Presbyterian Provider Directory is available at www.phs.org/directory.

For a list of TriCore, Quest or LabCorp laboratory or draw stations locations, please visit the following links:

- www.tricore.org/locations/
- www.questdiagnostics.com/locations/search
- www.labcorp.com

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 www.phs.org.

Transportation Services

Presbyterian Turquoise Care provides non-emergent transportation to covered medical and behavioral health services. Presbyterian's transportation coordinator or its transportation partner assists with arranging transportation for appropriate services based on medical need and obtaining the appropriate authorizations. At least a 48-hour advance notice is required to schedule a ride. Same-day transportation is available for urgent healthcare services or urgent referrals made by a PCP.

Presbyterian Turquoise Care covers emergency transportation by ground ambulance, air ambulance or by a special needs-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.

To schedule a ride, call one of the following phone numbers:

- Modivcare Solutions, LLC: (505) 923-6300 or 1-855-774-7737 (toll-free)
- PCSC: (505) 923-5200 or 1-888-977-2333 (toll-free)

Contacts for Other Information

The following table includes additional contact information that providers may need. A prior authorization request may be necessary for certain benefits. When submitting a prior authorization request, provide sufficient information to demonstrate the medical necessity for the service being requested.

Contacts for Other Information Providers May Need	
Request or Resource	**Contact Information**
Behavioral Health Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4, followed by 2) Fax: (505) 843-3019 Email: nmturquoisecare@magellanhealth.com
Dental Requests (DentaQuest)	Phone: 1-800-233-1468 (toll-free) Fax: 1-262-241-7150 Website: www.dentaquestgov.com myPRES: www.phs.org/mypres
Spine Surgery via Evolent Magellan	Phone: 1-866 236-8717 Fax: 1-800-784-6864 Website: www.radmd.com
Diagnostic Imaging / Radiology Requests via Stanson Health	Phone: 1-888-487-0733 Fax: 1-646-502-5041 Website: https://php.careportal.com
Home Health Care Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4, followed by 1) Fax: (505) 559-1150 Website: www.phs.org/providers/authorizations

Contacts for Other Information Providers May Need	
Request or Resource	**Contact Information**
	myPRES: www.phs.org/mypres
Inpatient Admissions Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4, followed by 1) Fax: (505) 843-3107 or 1-888-923-5990 Website: www.phs.org/providers/authorizations myPRES: www.phs.org/mypres
Member Eligibility Verification Resource	Phone: (505) 923-5757 or 1-888-923-5757 (option 1) myPRES: www.phs.org/mypres
Most Outpatient Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4, followed by 1) Fax: (505) 843-3047 Website: www.phs.org/providers/authorizations myPRES: www.phs.org/mypres
Non-Emergency Medical Transportation Requests via Modivcare Solutions, LLC	Phone: (505) 923-6300 or 1-855-774-7737 (toll-free)
Pharmacy Requests	Phone: (505) 923-5500, (505) 923-5757 or 1-888-923-5757 (option 3)
Transplant Requests	Fax: (505) 843-3110

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Ch. 8: Laboratory Services

Requirement to Utilize Contracted Laboratory Providers

All contracted, in-network providers are required to send lab specimens and refer members to TriCore Reference Laboratories, Quest Diagnostic Laboratories (Quest), or Laboratory Corporation of America (LabCorp). Providers may reference the Presbyterian Provider Directory for other lab providers contracted with Presbyterian. The Presbyterian Provider Directory is available at www.phs.org/directory.

For a list of TriCore, Quest or LabCorp laboratory or draw stations locations, please visit the following links:

- www.tricore.org/locations/
- www.questdiagnostics.com/locations/search
- www.labcorp.com

Providers may reference our provider directory for other lab providers contracted with Presbyterian. Only providers who perform in-office lab procedures covered under the “In-office Laboratory List” are excluded from the requirement to use TriCore, Quest and LabCorp. Please note that this is the only exception to the requirement to use Presbyterian-contracted laboratories.

In-Office Laboratory List

Presbyterian uses the In-Office Laboratory List (Appendix G) for certain laboratory services, which applies to all Presbyterian product lines and is effective for dates of service on or after Jan. 1, 2014. Reimbursement for

pathology/laboratory services included on the In-office Laboratory List are based on Presbyterian's clinical lab fee schedule and the Medicare Resource-Based Relative Value Scale (RBRVS) fee schedule, unless the provider's contract states otherwise. Please note that certain Current Procedural Terminology (CPT) codes are restricted to specific specialties.

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

Clinical Laboratory Improvement Amendments Waived 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 the Clinical Laboratory Improvement Amendments (CLIA) waived test list. Providers must provide Presbyterian with a copy of their CLIA certification in order to bill for lab services under the various levels of CLIA.

Presbyterian must agree to the additional codes prior to the provider performing the service and/or being reimbursed. Lab or pathology services for CLIA waived 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 testing on the CLIA waived 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.

The CLIA waived test list can be located at www.cms.gov/files/document/r11547CP.pdf#page=5.

Use Contracted Laboratories

Please be aware that non-contracted, out-of-network reference laboratories are soliciting healthcare professionals belonging to our network with the false claim that they can "accept Presbyterian insurance." Utilizing non-contracted laboratories often results in large balance bills for members, and there is a risk that non-contracted laboratories may not be certified or accredited. Choosing to use a non-participating reference laboratory is a breach of a provider's Services Agreement between the practice/group and Presbyterian. Please be advised that Presbyterian is monitoring non-contracted laboratory use and will enforce the use of the contracted providers per the terms of the Services Agreement.

Laboratory Services

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 reimbursement reduced or may be subject to termination.

Referral of lab testing to out-of-network reference laboratories is coordinated through TriCore. If providers are unable to coordinate through TriCore, then a separate prior authorization is required. For more information, call (505) 923-5757 or 1-888-923-5757 (option 4).

TriCore, Quest and LabCorp all offer lab specimen pick-up and transportation services and providers should contact these laboratories directly to utilize their services. PNO relationship teams can answer any questions that providers may have and assist providers with everything they need to get started, including initial account setup and courier services. Providers can find their relationship team's contact information online in the Presbyterian Provider Network Contact Guide at www.phs.org/ContactGuide.

TriCore Contact Information	
Department	**Contact Information**
Client Services (test results, TriCore locations, specimen requirements, general information)	(505) 938-8922 (24 hours) 1-800-245-3296 (24 hours)
Client Supplies	Phone or fax orders: (505) 938-8957 (phone) 1-800-245-3296 ext. 8957 (phone) (505) 938-8472 (fax) Online supply orders, call the Supply Order Desk: (505) 938-8957 or 1-800-245-3296, ext. 8957
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
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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Ch. 9: Pharmacy

Provider Prescribing Guidelines

The Presbyterian pharmacy benefit is an essential element in providing Presbyterian members the medication they need while appropriately managing costs. As the member's provider, it is essential that providers prescribe 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 the following:

- Using Presbyterian's Formulary or Preferred Drug Listing (PDL) when prescribing drugs to help our member manage their out-of-pocket costs
- Following Presbyterian's utilization management requirements as listed in the PDL for prior authorization, quantity limits and step therapy to manage healthcare costs and promote safe and effective therapeutic outcomes
- Ensuring each member clearly understands the use of the drug, the correct dose and possible side effects before prescribing the drug
- Monitoring a member's drug therapy to assess 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 member's medication list and dosages at every visit to educate, promote therapeutic outcomes and patient safety and avoid polypharmacy

- Following rules and regulations of the New Mexico Medical Board and AMA code of medical ethics including but not limited to rules for prescribing and/or treating oneself 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 "Pharmacy Benefit References, Resources and Tools" section within this chapter to learn how to access the New Mexico PMP 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 first-based formulary while others use a multi-tier formulary structure. They all, however, adhere to following 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 healthcare professional in the patient's home, provider'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 released, micronized, enteric coated, etc.)
- The formularies are subject to change throughout the year

Formularies / Preferred Drug Lists

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 name and generic medications that are commonly prescribed. Please refer to our formularies to see if the drug being prescribed 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 “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access our formularies online, by using a mobile device or to 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. 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 $950 for a 30-day supply. Certain specialty pharmaceuticals may have additional day supply limitations to ensure the member can tolerate the drug and to prevent waste. Specialty pharmaceuticals are generally not available through the Mail Service Pharmacy Benefit option and are usually 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 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 and a freestanding (ambulatory) infusion suite or outpatient facility. Medical drugs may require a prior authorization, and some must be obtained through the Specialty Pharmacy network. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access our Specialty Pharmaceuticals/Medical Drug List.

Advising Patients on Risks of Opioid Overdose

Presbyterian ensures the appropriate use of prescription medications by monitoring potential abuse or inappropriate utilization of medications and implementing interventions that ensure safer prescribing practices for chronic pain management, early screening and detection of opioid misuse, and early intervention and treatment of substance use disorders.

In addition, in accordance with New Mexico State Senate Bill 221, Presbyterian requires providers to do the following:

Pharmacy

- Advise patients on the risks of opioid overdose and availability of an opioid antagonist when they first prescribe, distribute or dispense an opioid analgesic and on the first occasion each calendar year thereafter
- Co-prescribe an opioid antagonist when the amount of the opioid analgesic prescribed is at least a five-day supply
- Include the following information in the prescription for the opioid antagonist:
    - Written information about the temporary effects of the opioid antagonist
    - Techniques for administering the opioid antagonist
    - A warning that instructs the person who administers the opioid antagonist to call 911 immediately after administering the opioid antagonist

Providers can review Senate Bill 221 in its entirety at https://legiscan.com/NM/bill/SB221/2019.

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 and/or investigational is excluded from coverage.

Pharmacy and Therapeutics Committee

The Presbyterian P&T Committee is composed of local practicing primary care and 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 of national organizations, committees and/or specialty societies are strongly considered
- The drug is mandated by HCA or CMS
- The committee suggests 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 patient safety and medically appropriate and cost-effective drug therapy. These mechanisms would include but are not limited to the following:

- 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
- Appropriate diagnosis code (ICD-10) code at the point of sale
- 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 under- and overutilization and provide 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, providing recommendations to minimize the occurrence of adverse drug reactions and report 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 PDL

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 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 P&T Committee Provider Update newsletter. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access the P&T 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 DURs occur during claim adjudication at the retail pharmacy 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 alert pharmacists and practitioners of the need to consider prescribing and drug regimen problems and 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 healthcare 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 has processes in place to review all drug prior authorization requests in a timely manner based on the clinical urgency, appropriateness of drug therapy and the member's covered benefit. The Pharmacy Services department 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. Processes are routinely monitored to ensure timely and appropriate clinical decisions.

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
- Provider participation

Prior authorization approval is not a guarantee of payment.

Intake

Presbyterian accepts the Uniform Prior Authorization Form developed for all insurance companies doing business in the state of New Mexico to facilitate the PA process. When used for requesting prior authorization for a drug, the uniform PA Form may be submitted to Presbyterian Pharmacy Services online, by telephone or fax. All requests are accepted into the Presbyterian automated prior authorization system and are date and time stamped to ensure timeliness of decisions and notifications.

Alternatively, electronic Prior Authorizations (ePA) can be submitted through either an ePA tool embedded in your EMR or through the Surescripts Provider Portal at https://providerportal.surescripts.net/ProviderPortal/login. When submitting an ePA request, please ensure that all questions are answered as completely and accurately as possible.

Please refer to the "Pharmacy Benefit References, Resources and Tools" section within this chapter to learn how to request a drug PA.

Incomplete or Invalid Prior Authorization Requests

Incomplete or invalid prior authorization requests will not be processed. Presbyterian Pharmacy Services will notify the requesting provider if the prior authorization request cannot be processed. This includes, but is not limited to:

- The PA request does not have member information included
- The member does not have active coverage with Presbyterian
- The member does not have primary coverage with Presbyterian
- The member does not have prescription coverage with Presbyterian

Clinical Review of Drug Prior Authorization Requests

Presbyterian Clinical Pharmacy Review Team reviews 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 Uniform PA Form is also used to request an exception to the formulary 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 effect
- 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 to the formulary.

Pended Drug PA Request

If the clinical pharmacist or medical director needs additional information to make a medical necessity decision, then 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 in the prior authorization processing system.

Prior Authorization Decision-Making Process

Prior authorization decisions of medical necessity are made by clinical pharmacists in most situations. 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 the necessary information. Pharmacy Services can make most PA decisions within 24 to 48 hours within receiving the request, unless additional information is needed.

Prior Authorization 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 so the pharmacy can fill the prescription. A letter is mailed to members listing the name and strength of the medication that was approved.

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. A letter is mailed to the member to explain the adverse decision and how to appeal the decision.

Expedited Pharmacy Prior Authorization Requests

When a member or 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 within 24 hours after the date and time Presbyterian received the request.

Appeals Process

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

Turquoise Care Prescription Drug Benefits

Presbyterian Turquoise 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 (excluding psychotropic medications).

Adherence to the formulary is required, but the pharmacy prior authorization process (see the "Pharmacy 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 Turquoise 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. Turquoise Care limits schedule II-controlled substance medications to a maximum 34-day dispensing or formulary restriction.

Turquoise Care Benefit Exclusions

- Bulk powder compounds
- Cough and cold preparations for individuals under the age of 4
- 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 the following:
    - Licensing
    - Certification
    - Employment
    - Insurance
    - Functional capacity related to employment
- Oral or injectable medications used to promote pregnancy
- Infant formula
- 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

Dual-Eligible Members

If members are enrolled in both Medicaid and Medicare Part D, they will have more than one benefit plan for all their healthcare benefits. Their primary prescription drug coverage is under the Medicare Part D Plan. Their Turquoise Care plan may cover prescription products that are excluded from coverage under Medicare, such

as select over-the-counter (OTC) products. The Turquoise Care plan will not cover their copay for prescriptions under the Part D plan.

Turquoise Care Pharmacy Lock-Ins

Presbyterian requires a Turquoise 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. Presbyterian will try to lock in the member to their preferred pharmacy. 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 member of the Provider Profile Lock-In Member Safety Workgroup. 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. HCA is notified of all Turquoise Care members with lock-ins and when the lock-in is removed.

Exemption for Native Americans

For Presbyterian Turquoise 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

Turquoise 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.

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. Specialty pharmaceuticals are generally not available through mail service pharmacy. They must be provided by our specialty network and are limited to a 30-day supply. Controlled substance medications are generally not available through mail order. They must be filled at an in-network retail pharmacy.

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 Turquoise 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 Turquoise 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.

Poly-Pharmacy Program

The Poly-Pharmacy Program is designed to reduce medication-related harm. The goal is to reduce inappropriate medications and ensure appropriate medications are being prescribed based on best available evidence and consideration of individual patient factors. The program primarily focuses on members with:

- Simultaneous use of six or more medications from different drug classes
- Simultaneous use of three or more medications from the same drug class

With the Poly-Pharmacy Program, a clinical pharmacist will utilize claims data to identify a member's eligibility for the program. The pharmacist will then validate current medications and medical conditions by making outreach to either the provider and/or member. The pharmacist will 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 will work with the provider to develop a medication action plan, interventions and referrals to Case Management or Disease Management for additional services if needed.

Medication Therapy Management for Turquoise 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 at no cost but is specifically designed to assist members 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 MTM program, the member meets with a Presbyterian clinical pharmacist for a comprehensive medication review of OTC medications, herbal therapies and supplements, corresponding diagnosis, appropriate dose and appropriate 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.

Pharmacy Benefit References, Resources and Tools

Pharmacy Prior Authorization or Exception Requests

The New Mexico Uniform Prior Authorization Form may be used to submit pharmacy prior authorization and exception requests. Providers can find the uniform PA form and a list of drugs that have specific edits/requirements for coverage online under the "Pharmacy" section at www.phs.org/providers/authorizations.

Pharmacy prior authorization requests may be faxed to Presbyterian Pharmacy Services at (505) 923-5540 or toll-free at 1-800-724-6953. Instructions for "How to submit a Prior Authorization Online" is available at the phs.org at the same location.

Formularies

Provider can view searchable Presbyterian formularies, supplemental information (i.e., specialty pharmaceuticals/medical drug lists), preferences and updates, including restrictions (e.g., quantity limits, step therapy and prior authorization criteria), online at: www.phs.org/providers/formularies. Provider can also request a printed copy of a formulary by calling (505) 923-5700.

P&T Committee Provider Update Newsletter

Providers can find current and past issues of the P&T Committee Provider Update newsletter online at www.phs.org/providers/formularies.

Pharmacy Services Team

Should providers need any assistance regarding pharmacy benefits, then they can contact Presbyterian's Pharmacy Services Help Desk at (505) 923-5500 or toll-free at 1-888-923-5757. The Presbyterian's Pharmacy 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, CapitalRx.

If providers contact CapitalRX and cannot wait until the next business day, then they should tell the CapitalRx representative that their need is urgent and they wish to speak to the Presbyterian clinical pharmacist who is on call. Then the CapitalRX representative will transfer the provider to the on-call pharmacist for Presbyterian.

ASKRX Email

Providers can email any clinical questions or concerns directly to ASKRX@phs.org. The email box is monitored during regular business hours, Monday through Friday, from 8 a.m. to 5 p.m., and a clinical pharmacist will respond within one business day.

ASK PHARMACY Email

Providers can email any general claims and benefit questions directly to ASKPHARMACY@phs.org. The email box is monitored during regular business hours, Monday through Friday, from 8 a.m. to 5 p.m., and a Pharmacy Service Team Specialist 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 "Formulary Addition Request Form" is available under the "Supplement Formulary Information" section at the following link:

www.phs.org/providers/formularies. Providers should include the following information in their 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 Costco Pharmacy electronically or via fax:

Costco Pharmacy Mail Order #1348
ZIP Code: 47130

1-877-258-9584

New Mexico Prescription Monitoring Program

PER NMAC 16.10.14.8, prescribers must use the PMP when prescribing controlled substances to promote safety and prevent overutilization, fraud and abuse. Providers can access the PMP database at https://newmexico.pmpaware.net.

Medication Therapy Management

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

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Ch. 10: Behavioral Health

Behavioral health is an overarching term that refers to an array of mental health and substance use 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 Turquoise Care, HCA 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 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 to manage behavioral health services for our Turquoise Care members. Magellan's 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 Turquoise Care. Although it is the member's responsibility to understand their benefit requirements, Presbyterian is available to provide assistance 24/7 to members and providers. Please call (505) 923-5757 for additional information.

Presbyterian Behavioral Health Providers

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

- Psychiatrists
- Psychologists
- Nurse practitioners (with American Nurses Credentialing Center board certification in psychiatric or mental health specialties)
- Social workers
- Other master's-level therapists
- Core Service Agencies (CSAs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Community Mental Health Centers (CMHCs)
- Hospitals
- Residential services for mental health and SUD
- Tribal organizations

Presbyterian actively evaluates the cultural diversity of our behavioral health providers and makes every 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 of HCA and 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 for Turquoise Care
- Be a Medicaid participating provider
- Have an active status in the Presbyterian/Magellan credentialing system
- Have an executed Participating 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 Turquoise Care behavioral health providers include individual, group and organizational providers. Behavioral health organizational providers include but are not limited to hospitals, clinics, behavioral health agencies, CCBHC's, 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 TIN as an individual provider. The individual provider must complete Presbyterian/Magellan's credentialing criteria before 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 (PPA).

Group Practice

A group practice is a collection of individual providers who 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 complete Presbyterian/Magellan's credentialing criteria before they provide services to 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/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 meet Presbyterian/Magellan's credentialing criteria for organizations. Examples of organizations providing behavioral health services include the following:

- Inpatient facilities
- CMHCs
- CSAs
- FQHCs
- CCBHCs
- RHCs
- Residential treatment centers
- Behavioral health agencies

- Indian Health Service or Tribal 638 facilities that offer behavioral health services
- Intensive outpatient program agencies

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 providers or other individual providers on staff, or it may contract with groups or other individual providers to provide behavioral health services. In addition, the organization must hold a current, fully executed Presbyterian Provider Participation Agreement (PPA).

Certified Community Behavioral Health Clinics

CCBHCs are specially designated clinics that provide a comprehensive range of outpatient mental health, substance use disorder and primary care screening services serving youth and adults of all ages. CCBHCs serve anyone who walks through the door, regardless of their diagnosis and insurance status; meet stringent criteria regarding timeliness of access, quality reporting, staffing and coordination with social services, judicial and education systems; and are funded through a flexible prospective payment system to support the costs of expanding services to fully meet the need for care in their communities.

CCBHCs provide access to integrated, evidence-based substance use disorder and mental health services, including 24/7 mobile crisis response, medication-assisted treatment and the following:

- Community-Based Mental Health Care for Veterans
- Person- and family-centered treatment planning
- Primary care screening and monitoring
- Targeted case management
- Peer, family support and counseling services
- Outpatient mental health and SUD services
- Crisis services
- Psychiatric rehabilitation services
- Screening, diagnosis, and risk assessment

Core Service Agencies

CSAs are designated by the state to manage much of the delivery service 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 the following:

- Crisis intervention 24/7, 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.

Community Mental Health Center

CMHC is an agency licensed to provide a range of mental health services and comprehensive community-based care. CMHCs are contracted as organizations and are required to provide the following:

- Behavioral health services
- Access to psychiatric evaluations
- Access to medication management
- Behavioral health out-of-home assessment and service planning
- Treatment 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

Credentialing

To be eligible for referrals, Presbyterian behavioral health providers are required to undergo the credentialing review process before being accepted as Turquoise Care providers, and then they must undergo periodic recredentialing thereafter (see the “Recredentialing” section in this chapter). Presbyterian has delegated behavioral credentialing for the Turquoise Care program to Magellan. Magellan’s Credentialing Verification Organization department is responsible for completing credentialing activities according to NCQA, HCA standards and the requirements of Presbyterian and the Turquoise 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
- 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)
- Copies of current accreditations (if applicable)
- Proof of professional liability insurance (minimum amounts of $1 million/$3 million)
- Proof of general liability insurance (minimum amounts of $1 million/$3 million)
- Form W-9
- Staff roster (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 grievances

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 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
- Accreditations
- Certifications
- 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
9521 San Mateo Blvd NE
Albuquerque, NM 87113-2237

It can also be emailed to phpccbh@magellanhealth.com.

Providers may also contact their Presbyterian provider liaison or contract specialist. Their contact information can be viewed at www.phs.org/ContactGuide.

Contracting with Presbyterian

In addition to successfully completing the credentialing process, providers must have an executed Presbyterian Participating Provider Agreement and Turquoise 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 and reimbursement for services rendered to Turquoise Care members. For Turquoise Care, all providers must have an active Medicaid ID. This can be obtained through New Mexico HCA third party administrator: https://nmmedicaid.portal.conduent.com/static/index.htm.

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 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 Turquoise Care referrals
- TIN
- 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
Albuquerque, NM 87113-2237

Email: phpccbh@magellanhealth.com

Providers are required to review all demographic information every 90 days per CMS guidelines. All demographic information needs to be updated on www.magellanprovider.com. Providers may contact their Provider Services liaison for sign on and password issues.

Expectations of the Medicaid Provider

Turquoise Care behavioral health providers agree to the following:

- Be available to accept referrals of Turquoise Care members within the scope of the provider's practice
- Appointment standards below:
    - Initial assessment non-urgent appointments No more than 7 calendar days, unless the member requests a later time
    - Appointment following an initial assessment no more than 7 calendar days, unless the member requests a later time
    - Non-urgent follow-up appointment no more than 30 calendar days of request
- 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 an HRA for each Turquoise 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

CNA. Members with Level 2 or 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 can consult with other specialty 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 Turquoise Care and services provided by another institution or provider:

- Need to coordinate Turquoise 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 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 Turquoise 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 Turquoise Care. Communication and coordination by the provider with these services increase compliance with members' overall treatment objective
- Need to coordinate Turquoise Care behavioral health services with a provider in the planning of institutional care for members
- Need to coordinate Turquoise Care behavioral health services with member's assigned PCP and the behavioral health provider
- Need to coordinate Turquoise Care behavioral health services with CSAs, when the CNA is performed
- Need to coordinate Turquoise Care behavioral health services with services provided by CYFD

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

Presbyterian Turquoise 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 has experienced a significant traumatic event. 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, cognitive impairment 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 use
- Follow-up to medical detoxification
- An initial PCP contact or routine physical examination indicating a substance use problem
- A prenatal visit indicating substance use problems
- Positive response to questions indicating substance use problems
- Observation of clinical indicators or laboratory values indicating substance use problems
- A pattern of inappropriate use of medical, surgical, trauma or ER services that could be related to substance use 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 NMSA 1978 § 32A-1-4] must receive a behavioral health screening within 24 hours of a referral to a behavioral health contract provider. They must also receive a behavioral HRA and 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 24/7.

Providers must inform members about hours of operation and provide instructions 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 Turquoise 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 ER 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: Advising members to call 911 is not an acceptable form of crisis intervention for Turquoise Care behavioral health providers.

Emergency/Disaster Planning

In the event of a federally declared disaster, Presbyterian Turquoise 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 Administration's (SAMHSA) Center for

Mental Health Services (CMHS). Supplemental funding for crisis counseling is available to state mental health authorities through the following two grant mechanisms:

- The Immediate Services Program (ISP), that provides funds for up to 60 calendar days of services immediately following a disaster declaration
- The Regular Services Program (RSP) that provides funds for up to nine months following a disaster declaration

Authorization of Services

Please see Appendix E 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 Sensitivity

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 Turquoise 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 the following link: 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 use services from an in-network provider 24/7.

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. Turquoise 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 24/7
- Ensure members know what to do if they need services after business hours
- Arrange 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 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, as clinically appropriate.

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 NMAC and other federal regulatory bodies, such as CFR, are used. Clinical practice guidelines tools based on best practices and adopted from the following expert bodies are used:

- APA
- NCQA
- AACAP
- Society for Developmental and Behavioral Pediatrics (SDBP)

TRRs are completed as either a desktop audit or an on-site review. When documentation within the record indicates need for improvement, the behavioral health QI team assists the provider in bringing documentation into compliance through development and implementation of an improvement plan. Providers are encouraged to contact behavioral health QI team members for guidance, clarification and any resource needed, including sample forms and formats. All audit tools can be found at www.magellanprovider.com.

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 Practice Pattern Review (PPR) 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 approaches:

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

During the course of investigating a QOC, the behavioral health 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 Presbyterian's Professional Practice Evaluation Committee (PPEC). The PPEC has the authority to impose sanctions and makes recommendations toward resolution. PPEC outcomes are reported to the appropriate Regional Network Credentialing Committee. 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 providers are required to follow NMAC regulations and report critical incidents (CIRs) to Magellan. Providers can find The Critical Incident Management Guide and the Critical Incident Training Guide at www.hsd.state.nm.us/providers/critical-incident-reporting. The Quality of Care team reviews all 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 Quality department aims to maintain a prime status of healthcare that is safe, effective, member-centered, timely, efficient and equitable. The reports are sent to state and accreditation facilities to help identify improvement opportunities.

Claims Submission Procedures

Commercial, Medicare and Turquoise Care behavioral health providers' claims relating to mental health or substance use services may be submitted to Magellan directly if that is more convenient for the provider. All behavioral health claims – even those a part of a mixed service – may be submitted directly to Presbyterian, however, behavioral health claims will be routed 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 most 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 HIPAA-required ANSI-X12 837 claims format

Claims Courier

Accessible through the Magellan provider website at www.magellanprovider.com, Claims Courier is a data entry application for Turquoise Care 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 then following the instructions under “Submit a Claim.” Claims Courier streamlines the claims process by eliminating the third-party claims vendor, 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: Magellan must be the designated payor 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 Presbyterian Turquoise Care 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.

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 emailing EDISupport@MagellanHealth.com or calling 1-800-450-7281, ext. 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 third party between providers and Presbyterian and/or Magellan and can transform formats that are not compliant with HIPAA to compliant 837s. Both Presbyterian and Magellan accept 837 transactions from a number of clearinghouses.

Note: There may be charges from the clearinghouses.

Payer ID for Clearinghouse Services

When using clearinghouse services, 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

Clearinghouse	Address	Contact Information	Website
Availity®	P.O. Box 550857 Jacksonville, FL 32255-0857	1-800-AVAILITY (282-4548)	www.availity.com

Clearinghouse	Address	Contact Information	Website
Change Healthcare	One Century Place 26 Century Blvd, Suite 601 Nashville, TN 37214	1-866-817-3813	www.changehealthcare.com
Office Ally	P.O. Box 872020 Vancouver, WA 98687	1-866-575-4120 Fax: 360-896-2151	www.officeally.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 Third Floor St. Louis, MO 63102	1-800-969-3666	www.trizetto.com/providersolutions
Veradigm/ AllScripts	304 Church at North Hills Street Suite 100 Raleigh, NC 27609	1-800-877-5678	www.veradigm.com

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Ch. 11: Long-Term Care

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.

HCA contracts with three 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.

Member Eligibility

General Eligibility

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

Members on one of the following waivers will receive HCBS through their waiver benefit:

- Medically fragile
- Developmental disabilities
- Mi Via
- Supports Waiver

Individuals on these waivers will access all non-HCBS services through their Turquoise Care MCO.

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 Turquoise 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 Turquoise 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 Turquoise Care, the state has created one comprehensive Community Benefit that includes a multitude of HCBS, one of which is personal care services. Personal care services were 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 meet NFLOC eligibility requirements have access to HCBS without waiting for a waiver slot to become available. Individuals who are not otherwise Medicaid-eligible, have incomes below 300% of supplemental security income and 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 Turquoise 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 nursing facility placement and the Community Benefit. Elements of NFLOC eligibility criteria is used determine the individual's medical eligibility or need for HCBS include the following:

- Medical risk factors including but not limited to medical diagnoses associated with 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 DME
- Communication and cognition capability, including prompting and cueing
- 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
- Behavioral/mental health status
- Health and safety risks, including susceptibility to falling
- Ability to perform ADL, including bathing and showering (i.e., washing the body), bowel and bladder management (i.e., recognizing the need to relieve oneself), dressing, eating (including chewing and swallowing), feeding (i.e., setting up food and bringing it to the mouth), functional mobility (i.e., moving from one place to another while performing activities), personal device care, personal hygiene and grooming (including washing hair) and toilet hygiene (i.e., 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 an HRA (an HRA is used to determine the member's health status and emergent needs related to care coordination), Presbyterian conducts a 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 who meet NFLOC eligibility criteria. Members who select the ABCB have the option to select their personal care service provider. Presbyterian Turquoise 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
- PCS (Delegated and Directed)
- Private duty nursing for adults
- Respite
- Skilled maintenance therapy services

Each Presbyterian Turquoise 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 plan drives the authorization of ABCB services available to each member.

Self-Directed Community Benefit

Self-direction in Presbyterian Turquoise 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 HCA. Presbyterian supports self-directed delivery of community benefits. Member self-direction provides the opportunity for members to personally direct and manage their 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 self-directed members in arranging for, directing, and managing services and supports as well as developing, implementing, and monitoring the SDCB care plan and budget.

The support brokers work with Presbyterian care coordinators to provide Turquoise 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 internal and external support broker options.

Under Presbyterian Turquoise 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
- Nutritional counseling
- Private duty nursing for adults
- Related goods
- Respite
- Self-directed personal care services
- 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 considers the member's health and safety needs identified in the CNA, services covered, the member's natural or informal supports, and the member's living situation. The support broker provides the worksheets and other tools needed 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 their 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 CNA 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 their 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 HCA?
- 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 HCA 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

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

- The member refuses to follow HCA 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 their care plan that would address health and safety issues identified in their CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, care coordination or FMA
    - Experiences significant health or safety needs and refuses to incorporate the care coordinator's recommendations into their care plan
    - Exhibits behaviors that endangers themselves or others
- The member misuses their 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 their entire SDCB budget before the end of the care plan year
- The member commits Medicaid fraud

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

Presbyterian Turquoise 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 will not affect a member's eligibility for covered services or enrollment in Turquoise Care.

Presbyterian Turquoise 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 Turquoise 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 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 criteria will result in a denial of an LRI request:

- 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 (for SDCB)
- 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 were made to find other qualified, suitable providers.

Utilization Management and Prior Authorization

Presbyterian's Utilization Management program is designed to reduce overuse, underuse and misuse of healthcare resources to reduce cost and improve quality. Utilization management components include care

review (prior authorization), monitoring for over/underutilization, duplication of services, benefit limitations, 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 Plan Review Process

Presbyterian's care plan 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 requests services as identified in the CNA, CBSQ and care plan for review by the long-term care Utilization Management team. Utilization Management reviews and authorizes a member's community benefit based on the needs identified. Additional authorization is required when a member's assessed needs involve an alternative community benefit service that is a downward substitution of care. This includes the use of services that meet the following criteria:

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

The alternative community benefit 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 Care Coordination chapter for a list of standards.

Medical policies are reviewed and approved by Presbyterian's Clinical Quality Utilization Management Committee, P&T 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 at www.phs.org/medicalpolicymanual.

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

Presbyterian Turquoise 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 PCPs, CSAs, FQHCs, PCMHs 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 www.phs.org
- 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 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 HCA-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 or needs
- The care coordinator educates the member on their 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 budget 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 their optimal functional capacity
    - The service addresses a need related to improving the member's health, functional outcomes or quality-of-life outcomes
    - The service addresses environmental safety or a safety-related long-term care need
    - The service enables the member to increase or maximize their 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 transitioning out of 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.

Required Discharge Plan

The responsibility for a member's care does not end for hospitals and other facilities upon discharge. Facilities maintain and should embrace their responsibility for ensuring our members receive necessary supports and services as identified in their discharge planning and treatment plans.

Sharing your discharge plan with Presbyterian is critical to maintaining continuity of care. Discharge is a critical juncture for transitioning to post-facility care, and incomplete discharge processes may cause avoidable harm to our members. The discharge process is intended to provide the Presbyterian and our members with adequate information and necessary resources to improve or maintain their health during the post-facility period and prevent adverse events and unnecessary rehospitalization.

All facilities must have a safe and appropriate discharge plan in place prior to discharging Presbyterian members from their care. The discharge plan, including a copy of the discharge instructions, should be communicated to Presbyterian within one business day of the member's discharge. This vital information helps ensure we can support the member through transition of care as needed. It is also important that the discharge plan is fully communicated to our member's care coordinator or utilization reviewer.

At a minimum, the discharge plan must include:

- Member's discharge date
- Copy of discharge instructions
- Member's plan of care, which must include the following:
    1. The care and services our member may need after discharge, such as long-term care, nursing services, and physical, occupational and/or speech therapy.
    2. The scheduled date and time of necessary medical and/or behavioral health provider appointments, Including the agency or provider assigned to perform follow-up care for our member.
    3. Any equipment needed by our member such as: DME, oxygen and incontinence supplies.
    4. Information necessary to transfer the member to another healthcare setting, such as a SNF, rehabilitation hospital, assisted living facility care or to the member's home.
    5. Transportation plan for transferring the member to their home or another healthcare setting

6. Any other necessary services and supports.

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 ICT 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 Turquoise Care offers web-based technologies to support our providers and community-based organizations in their work on care coordination and linking to our ICTs.

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 PCS (both agency-based and self-directed) and EPSDT using the Electronic Visit Verification (EVV) system known as AuthentiCare®. Use of the AuthentiCare system is required for all PCS and EPSDT in-home caregivers and is mandated by HCA for the Turquoise Care program.

To ensure accessibility and ease of use, provider 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 uses the member's telephone to call into AuthentiCare using an IVR to clock in and out. In this instance, Presbyterian requests 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, provider agencies may request a pre-programmed, Wi-Fi enabled tablet from Presbyterian to access the AuthentiCare application for caregivers 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:

- Logs the arrival and departure of individual caregivers by using one of the options listed above
- Verifies in accordance with business rules that EVV services are delivered as authorized and in the approved location, such as the member's home
- 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, as applicable
- 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

Personal Care Services Critical Incident Management

PCS providers are required to follow NMAC regulations, report critical incidents to Presbyterian's Long-Term Care team and attend Critical Incident Report training on an annual basis. Providers can find the Critical Incident Management Guide and the Critical Incident Training Guide at www.hsd.state.nm.us/providers/critical-incident-reporting. 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.

Below are the following types of incidents that are required to be reported:

- Abuse
- Death
- Emergency services
- Environmental hazards
- Exploitation
- Law enforcement
- Missing person / elopement
- Neglect

Critical incident reports are required for all Turquoise Care members within the Categories of Eligibility identified in the following table.

Category	Description
001	SSI or Medicaid Extension (aged)
003	SSI or Medicaid Extension (blind)
004	SSI or Medicaid Extension (disabled)
081	Institutional Care (aged)
083	Institutional Care (blind)
084	Institutional Care (disabled)
090	HIV/AIDS
091	Disabled and Elderly (aged) - Home and Community Based Services (HCBS) Waiver
092	Brain Injury HCBS Waiver
093	Disabled and Elderly (blind)
094	Disabled and Elderly (disabled)
100	With NFLOC
200	With NFLOC

PCS providers are responsible for advocating and submitting critical incident members who choose the consumer-delegated and consumer-directed models of care.

- NMAC (8.308.21.15 NMAC): www.srca.nm.gov/parts/title08/08.308.0021.html
- The New Mexico Managed Care Policy Manual (Section 18.3): www.hsd.state.nm.us/wp-content/uploads/2020/12/Centennial-Care-Managed-Care-Policy-M.pdf
- Providers' Service Agreement with Presbyterian
- Presbyterian’s Practitioner and Provider Manual, which is an extension of the provider's Service Agreement with Presbyterian

For questions about reporting critical incidents, contact criticalincident@phs.org.

Long-Term Care Claims Submission

All Turquoise Care long-term care claims will 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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Ch. 12: Home Health

Please note that throughout this chapter, home healthcare (HHC) agency providers are referred to as “agency” or “agencies.”

Home care services for Presbyterian Turquoise 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 HHC agencies.

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/HMO-POS), Presbyterian Dual Plus (HMO D-SNP) Turquoise 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 will 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 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
- Members 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 member's overall condition and experience is such that they meet these qualifications, then they should be considered confined to the home

Note: This homebound information still applies to all product lines.

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 Turquoise 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

Early and Periodic Screening, Diagnosis and Treatment Services

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 needs assistance with at least two physical requirements such as eating, bathing, dressing or toileting acts, appropriate to their 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 care coordinator performs the PCS assessment for children eligible for the EPSDT benefit. The level of care and service request(s) are reviewed and determined by Presbyterian's long-term care Utilization Management team.

Upon receipt of an EPSDT approval, the Presbyterian care coordinator contacts the authorized provider to initiate services as outlined in the authorization and in alignment with the assessment and plan of care. Personal care services are requested and authorized in hours for up to a 12-month time period. Only Turquoise Care members younger than 21 years of age are eligible to access these services.

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 during a 60-day certification period.

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.

EPSDT Medically Fragile Home and Community-Based Services

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 evaluates the child and determines the level of care required. Services may include hourly private duty nursing and/or hourly home health aide care. Presbyterian prior authorizes care as directed by the UNM case manager's assessment and the budget developed in response to that assessment.

The number of hours identified on the EPSDT Program budget is developed by the UNM case manager. When Presbyterian receives the recipient's medically fragile budget, the Utilization Management team 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.

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 the Presbyterian Utilization Management department so a revision to the authorization can be processed.

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 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 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 authorization, treatments approved by Presbyterian' Prior Authorization department, cultural sensitivity and confidentiality

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's medical director for guidance. Situations in which utilization review nurses may perform administrative denials include the following:

- Failure of a provider to provide medical or other individualized information needed to establish medical necessity
- All requests that lack provider orders
- All late requests that do not fall within the allowable retroactive authorization policy

The utilization 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 a member refuses services, the agency is responsible for contacting the provider, who may discuss with the member the rationale for home care services.

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. When a consensus cannot be reached, a Presbyterian medical director review is requested. If the agency, member, or provider disagrees with the denial, 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.

Appeals

For information on filing an appeal or grievance, please refer to the Appeals and Grievances chapter of this manual.

Home Health Utilization Management

The goal of the utilization management program is to ensure that resources are appropriately allocated for the provisions of high-quality home care. Our utilization 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 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 HHC agencies, particularly interpreted by the following:

- Medicare Home Health Agency Manual (HIM-11), a guide that defines regulatory standards
- Medicare home care interpretive guide

- Presbyterian Senior criteria manuals
- The HCA/MAD manual sections on home care and on the EPSDT Program for long-hour care
- Presbyterian Commercial plans benefit descriptions
- Any addendum related to state law
- In addition, MCG criteria is 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

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Ch. 13: Quality Improvement Program

Improving Care for Presbyterian Members

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 providers who render care and services.

An evaluation is conducted annually to assess the overall effectiveness of the QI program. Instances where established targets, goals and benchmarks have not been met result in recommendations for change to the subsequent QI program description and work plan. A report of success and progress is available to providers upon request by contacting the Quality Management department at PHPQuality@phs.org.

The success of the QI program and related initiatives requires the cooperation and support of the provider network. This cooperation includes collection of performance measurement data and participation in the organization's clinical and service measure QI programs. Presbyterian may use provider performance data for

quality improvement activities. Providers are invited to participate in QI program activities. Examples of participation include the following:

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

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:

- Population Health and Clinical Quality Committee
- P&T Committee
- TAC
- Credentialing Review Committee
- Professional Practice Evaluation Committees

For additional information about the QI program or opportunities for participation, please contact the Quality Management department PHPQuality@phs.org.

Critical Incident Management

The HCA/MAD/QB Incident Management System describes the statewide reporting requirements for all incidents involving recipients served under Turquoise Care-funded HCBS programs or behavioral health services, including but not limited to treatment foster care agencies, residential treatment centers, individual providers and group homes. Turquoise Care contracted providers/agencies must visit www.hca.nm.gov/ to maintain up-to-date information and requirements for Critical Incident Reporting.

Contracted providers are required to receive initial, annual, and ongoing training to be competent to respond to, report and document Critical Incidents for Turquoise Care members in a timely and accurate manner. Training in Critical Incident Reporting for specified providers and agencies is hosted quarterly. Notifications of

upcoming training webinars are sent to providers and agencies at least 30 days in advance of the scheduled presentation.

The scheduling of a make-up session for Critical Incident training is the responsibility of the provider/agency. Contact the Presbyterian critical incident coordinator at criticalincident@phs.org to make scheduling arrangements.

A review process is conducted for compliance with the annual training requirement. Specified provider and agency attendance is mandatory. Providers/agencies that do not comply with incident reporting requirements may be sanctioned up to and including termination of their provider agreement by the MCO or by HCA/MAD.

HCBS includes PCS and SDCB 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 medication errors, misuse of restraints both physical and chemical, the death 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 or CYFD.

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

- Adult Protective Services: 1-866-654-3219
- CYFD: 1-855-333-7233

Community agencies providing HCBS are required to report critical incidents through the HCA 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 HCA Incident Reporting System website are limited to a list of accepted COEs. Providers are required to verify COE and eligibility before reporting.

The HCA Incident Reporting website will accept Critical Incident reports for behavioral health providers for Turquoise 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 at (505) 843-3011. Providers are **required** to verify COE and eligibility before reporting.

All staff and providers cooperate with any investigation conducted by Presbyterian and/or outside agencies such as HCA, the Behavioral Health Purchasing Collaborative, New Mexico DOH, CYFD, Adult Protective Services 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 Turquoise Care alleged fraud to the Presbyterian Program Integrity Department (PID) by calling 1-800-239-3147 or emailing PHPFraud@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

Providers 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/ following the instructions in the HCA Incident Management Guide
- Cooperate with any investigation conducted by Presbyterian or outside agencies such as HCA, the Behavioral Health Purchasing Collaborative, New Mexico DOH, CYFD, Adult Protective Services 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 providers’ internal monitoring procedures, providers should 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

National Committee for Quality Assurance

Presbyterian Health Plan, Inc. has participated in the 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 NCQA HEDIS, which is the performance measurement tool used by more than 90% of the nation's health plans.

Presbyterian chose NCQA as its quality platform because NCQA is member-focused, and quality supports that improve member health outcomes. 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 as demonstrated by members who effectively engaged in patient-center relationships with their care provider. Better member care is only 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 experience, and long-term services and supports. 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®)[2] 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 medical care, behavioral healthcare, services provided to members and providers, and business operations. 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 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.

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

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 following are steps in the PDSA cycle:

- **Plan:** Plan the initiative or intervention, including a plan for collecting data
- **Do:** Try out the test on a small scale
- **Study:** Analyze the data and study the results
- **Act:** Refine the change based on what was learned from the test

What Is HEDIS?

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. Improved member health outcomes, as measured by HEDIS, could not be accomplished without the continued cooperation and support of the 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 HCA and CMS require HEDIS reporting for health plans that are contracted to provide Medicaid and Medicare benefits. The New Mexico Office of the Superintendent of Insurance (OSI) requires HEDIS reporting for Qualified Health Plans with membership over 15,000 on the Exchange.

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 standardized and cannot be changed by the health plan. Before submitting the report to NCQA, HCA and CMS, it is thoroughly reviewed by NCQA-certified auditors to ensure data integrity and reliability. NCQA and regulatory agencies publish HEDIS results in public forums so that existing and potential health plan purchasers and members can compare results.

HEDIS Quality Performance Measures

The HEDIS measures change from year to year, and are included in the following broad categories:

- Prevention and screening
- Health maintenance and improvement outcomes
- Respiratory conditions

- Musculoskeletal conditions
- Behavioral health
- Cardiovascular conditions and diabetes
- Access and availability of care
- Experience of care
- Utilization and risk adjusted measures

How HEDIS Reporting Impacts 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 who 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 member names and asked that medical records be made available for both the health plan and HEDIS contractor to review through sharing of those physical records or through granting access to EMRs or Clinical Data Integration shared files. Providers are required to provide access to medical records during the HEDIS data collection period. Generally, HEDIS medical record data collection or medical record review (MRR) begins during the first quarter of the calendar year. MRR will occur at a variety of cadences for differing HEDIS measures, some of which receive MRR year-round. Health plans submit the audited HEDIS reports to NCQA in June of each year. Presbyterian conducts year around medical data collection to minimize interrupting provider practices during these few months of the year, which is made easier through electronic data access and sharing.

Additionally, providers and clinics can establish Clinical Data Integration feeds between the clinic's medical record documentation system and Presbyterian for a more automated MRR experience.

Assessing Gaps in Care

Presbyterian generates a gap in care list of members from our claims system who may not be up to date on, or who are missing, recommended preventive screenings or visits, and/or medications for chronic conditions. A list of all Presbyterian members identified as having care gaps is available to providers on the provider portal. Providers can also obtain a list of members with gaps in care by contacting the Presbyterian Value Based Program team at valuebasedprogram@phs.org. .

How Presbyterian Uses HEDIS Reports

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. See the following for examples:

- HEDIS measures are used to determine the effectiveness and success of Presbyterian's programs, interventions, and all associated QI initiatives and incentive programs
- The annual CAHPS member satisfaction survey is used to monitor improvement activities in customer service and getting care quickly as well as targeting improvement opportunities

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 the following:

- Adults' access to preventive/ambulatory services
- Initiation and engagement of alcohol and other drug abuse or dependence treatment
- Children's and adolescents' access to PCPs
- 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. Grievances, appeals and mystery shopping surveys are included as supplemental member satisfaction data to the CAHPS survey 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 or prohibit individual 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.

Standards of Care

Presbyterian has processes to ensure healthcare services provided to members are rendered according to acceptable standards of care consistent with professionally recognized standards of medical practice. This is monitored through the credentialing, recredentialing, quality of clinical care and peer review processes.

Quality of Clinical Care

Quality of Clinical Care investigates all clinical quality grievances and referrals. Investigations may include but are not limited to, obtaining medical records, provider responses and subject matter expert input.

The primary source of clinical care referrals is the Presbyterian Appeals and Grievances department. The Quality department also receives direct referrals from providers, Presbyterian medical directors, Presbyterian Pharmacy Services, Presbyterian Clinical Operations and PID.

Clinical Quality of Clinical Care monitors all providers monthly for trends in the number and nature of grievances referred to the quality of care process. A medical record chart audit is performed and if it is determined to be a significant quality of clinical care issue, then it is presented to the appropriate Professional Practice Evaluation Committee. Presbyterian has two professional practice evaluation committees, one for behavioral health and one for physical health. When a provider meets criteria for the number of grievances 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 treatment. Quality of clinical care referrals are referenced as part of the credentialing and recredentialing process.

Peer Review

Presbyterian’s board of directors 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 providers that represent various levels of advanced practice and certification. Peer review activities are confidential and include review of the quality of clinical care delivered by providers within the same discipline and area of clinical practice.

The Professional Practice Evaluation Committees have the authority to recommend disciplinary action ranging from improvement plans up to and including suspensions, terminations and/or prohibitions from the network at any point in the provider's credentialing cycle. If a claim is billed for a prohibited provider, then it may result in a claim rejection.

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 providers. Information exchange between medical and behavioral providers must be member-approved and conducted in an effective, timely and confidential manner. PCPs are encouraged to make timely referrals for treatment of behavioral health disorders commonly seen in their practices.

A drug-use evaluation of psychopharmacological medications is 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.

Open Communication with Patients

To ensure standards of quality of care are met, Presbyterian issues the following affirmative statement: Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

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. The Appeals and Grievance Department works closely with other internal departments including Provider Network Operations to investigate service-related grievances that involve providers. Interventions are identified, developed and implemented as appropriate.

Continuum of Care

Providing members with timely, medically necessary clinical services is optimal for quality, cost-effective healthcare. Presbyterian is dedicated to helping members meet their healthcare needs across the continuum of care through programs, services and activities that address wellness and prevention, chronic condition care, acute/long-term care, catastrophic care, and end-of-life needs. Interventions and tools are developed from evidence-based guidelines to work with members and create and implement plans of care that provide members with the tools needed to move toward self-management. The associated Preventive Healthcare Guidelines and Clinical Practice and Preventive Healthcare Guidelines are detailed in Chapter 5.

Our staff works collaboratively with members and providers to promote a seamless delivery of healthcare services.

Culturally Appropriate Services

Presbyterian's approach to serving a diverse membership begins with the underlying philosophy that all members must receive the highest quality services provided in a respectful manner, recognizing an individual's language(s), gender, sexual orientation, physical/cognitive/behavioral abilities or disabilities, and the role that culture and language play in a person's health and well-being. It is essential that these differences are recognized and shared with our staff, providers and contractors when communicating and interfacing with members verbally, non-verbally and in writing. Without meaningful and effective interactions, members may not understand their healthcare benefits or be able to participate fully in the recommended course of prevention and treatment.

Our objectives for serving our culturally and linguistically diverse membership include the following:

- An annual assessment to understand and describe diversity among our membership
- A Cultural Competence/Sensitivity Committee that meets throughout the year
- Development of culturally sensitive activities documented in a work plan

At a minimum, work plan activities include the following:

- Maintaining a Cultural Competence/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
- Recruiting and training diverse staff and leadership who are representative of the unique demographic characteristics of New Mexico
- Utilizing data along with provider-patient policies and procedures to ensure network service adequacy
- Providing annual cultural competency training for Presbyterian staff, providers and contractors
- Targeting cultural competency training for member service staff and contracted providers
- Utilizing PCSC to assist members in locating providers who meet their language and gender preferences
- Employing communication tools and strategies to ensure cultural sensitivity

  - Tools and strategies include subscriber materials, member handbooks, newsletters, provider directory, educational materials, telephone outreach, electronic learning (eLearning), TTY hearing loss assistance and multilingual employees

- 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

We collect, monitor and address member preferences to ensure we provide healthcare services that are respectful and responsive to the Presbyterian membership.

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 is to identify members with moderate risk and to offer disease management services to slow or prevent the progression 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 avoidable emergent and inpatient care.

ICM is a member-centered, family-focused (when appropriate), culturally sensitive and strength-based service.

The ICM program also supports 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 or care coordination for members who meet criteria. 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, clinical measures are identified annually to monitor the effectiveness of the complex case management program.

Behavioral healthcare is included in the ICM to facilitate timely and appropriate access to services for Presbyterian Turquoise Care members. The individualized care serves to guide members through the healthcare continuum in a coordinated, timely, caring, cost-effective and quality-oriented manner.

PCPs are considered part of the member's ICT. PCPs are encouraged to participate in the member's care planning process.

Special Populations

The identification of special populations in Presbyterian Turquoise Care enables Presbyterian to facilitate timely and appropriate healthcare through effective care coordination. Presbyterian offers specialty care coordination for high needs populations to ensure the utmost support is provided.

Specialty Care Coordinators and Consultants receive specialized training for the respective population supported to ensure thorough knowledge of associated needs and available resources to best assist members.

Specialty populations include the following:

- Justice involved
- Traumatic brain injury
- Members currently receiving services through the Brain Injury Waiver
- Medically fragile members receiving case management services through UNM
- Individuals with intellectual disabilities
- Children and adults with special health care needs
- Members with housing insecurity needs
- High-risk maternity
- Individuals with complex behavioral health needs
- CISC
- Members participating in a Comprehensive Addiction and Recovery Act (CARA) Program

Early and Periodic Screening, Diagnostic and Treatment Program

Well Child Visits are in place for Presbyterian Turquoise Care members ages 0-30 months and age 3-21, as required by HCA. Components of the EPSDT Program are measured annually using HEDIS and the Medical Record Review process.

Oversight of Delegated, Subcontracted and High-Volume/Single-Source Providers

Presbyterian may delegate or subcontract specific administrative functions (e.g., credentialing, complex case management, disease management, utilization management, claims payment functions, nurse advice line services, or 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 annually to review policies, procedures, information integrity (if applicable) and activities to ensure that they continue to meet Presbyterian requirements as well as applicable contractual, accreditation and regulatory standards. Operational reports are reviewed at least semiannually. Audit findings and applicable corrective action plans are reported to and monitored by the appropriate quality committee. Delegates who serve Turquoise Care members and who are placed on corrective action are reported to HCA.

Web Resources

Presbyterian's website, www.phs.org, was enhanced to improve 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 and pharmacy benefits, and resource tools
- Provider and hospital directories to help current and prospective members choose providers, pharmacies, and hospitals
- Web technology for members to have 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 providers. Presbyterian collects feedback from members and providers to improve experiences through improved processes, programs and communications. We collect feedback in a variety of ways:.

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:

- Trend results over time
- Compare performance against external benchmarks when available
- Identify drivers of satisfaction and loyalty
- Identify opportunities for improvement

In addition, transactional surveys are conducted to evaluate the performance of specific interactions with Presbyterian, such as a post-customer service call survey or a web survey.

Grievance and Inquiry Data

When a member contacts the health plan, whether through calls, emails, or letters, the transaction is logged and stored. 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, 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.

Service Quality Committee and Dedicated Teams

The Service Quality Committee and delegated teams use the aforementioned data to identify and prioritize opportunities for improvement, make recommendations to the appropriate areas and create action plans.

Presbyterian Access to Medical Records and Confidentiality Assurance

Presbyterian has adopted the following medical record access standards from Title 8 and Title 13 of NMAC, the Medicare Managed Care Manual, and the HIPAA Standards for Privacy of Individually Identifiable Health Information. Providers agree to comply with the following:

- Providers shall request information from other treating providers, with a signed consent from the member, as necessary to ensure continuity of care
- The PCP must maintain a primary medical record for each member that contains sufficient medical information from all providers involved in the member's care to ensure continuity of care
- All providers involved in the member's care shall have access to the member's primary medical record
- Medical records shall be available to providers for each clinical encounter. Each specialty care practitioner shall forward a record to the member's PCP of the services provided

Providers shall ensure the confidential transfer of medical, dental or behavioral health information to another primary medical, dental or behavioral health provider when a PCP, dental or behavioral provider leaves Presbyterian or when the member changes PCPs. The information forwarded shall include but is not limited to the following:

- A list of the member's principal physical and behavioral health problems, as applicable
- A list of the member's current medications, dosage amounts and frequency
- The member's preventive health services history
- EPSDT Program screening results (for Presbyterian Turquoise Care members under age 21)
- Other information necessary to ensure continuity of care

Practitioners shall ensure that they have policies or plans in place for medical record authorized access and coordination in the event that they are incapacitated in some way.

Practitioners and providers shall make any and all member medical records available to Presbyterian, OSI, CMS, HCA and other state and federal regulatory agencies or their agents for the purpose of quality review, annual HEDIS audits by NCQA, and for the investigation of member grievances.

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. We currently reimburse providers $30 for the first 15 pages and $0.25 per page after the first 15 pages (based on NMAC, Title 16, Chapter 10.17.8).

Presbyterian ensures that 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 to prevent inappropriate disclosure. This obligation excludes disclosure of information that is required by state or federal law or is in the public domain.

Medical Record Documentation Standards

Medical record reviews are conducted throughout the year based on requirements from CMS, HCA, NCQA, and other regulators.

Presbyterian has adopted medical records standards from NCQA, NMAC Title 8 Section 308.21.16, and the Medicare Managed Care Manual. The following standards apply to both physical and behavioral health unless otherwise noted:

- **Confidentiality:** Patient records must be maintained and managed in a confidential manner in accordance with all applicable state and federal laws, including but not limited to the privacy and security rules as provided for under HIPAA
- **Legibility:** Patient records must be maintained in a timely, legible, current, detailed, and organized manner to permit effective and confidential patient care and quality review. The patient record must

be legible to persons other than the writer

- **Entries and Provider Identification:** All entries must be dated and include date of entry and date of encounter. The entries, including dictation, must be identified by the author and authenticated by their entry. Authentication may include signature or initials that verify the report is complete and accurate. Patient record notes generated or stored electronically by computers are considered authenticated if there is a demonstrated password-protected entry with a time-limited edit capability

Organization/Patient Identification

Medical records must be organized systematically and uniformly. Paper documentation must be firmly secured or attached in the patient record/medical record. Patient identification information must be present on each page or electronic file.

Individual patient records are recommended as opposed to family records. If family records are used, each patient's component of the record must be clearly distinguishable and organized. Each page in the patient's record must contain patient name or patient identification number.

Personal Biographical Data

Personal biographical data in medical records may include the following:

- Age
- Sex
- Date of birth
- Address
- Employer
- School
- Home and work telephone numbers
- Names of emergency contact and their telephone numbers
- Marital status
- Consent forms
- Guardianship information

Allergies

Allergies must be documented in a uniform location on the medical record. Adverse reactions must be listed if present. If applicable, document no known allergies.

Documentation of Tobacco, Alcohol and Substance Abuse

In the medical record for members 12 years and older, there must be notations concerning tobacco, alcohol or recreational/illicit substance use.

Problem List (as appropriate for practitioner/practice type)

Identification of current problems, significant illness and medical conditions must be documented in the medical record on the problem list. If the member does not have any known medical illness or condition, then the medical record must include a flow sheet for health maintenance.

Medication List and History (as appropriate for practitioner/practice type)

The medical record must include a medication list and history that reflects current medications and medication history, including what has and has not been effective.

Periodic Health Examinations (Physical Health Only)

Periodic health examinations must be documented in the medical record. Required examination elements are included in Presbyterian's Preventive Healthcare Guidelines at www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral.

Examinations for Presbyterian Turquoise Care members up to the age of 21 must meet the guidelines for the EPSDT Program services for New Mexico Medicaid.

Prevention Screening, Patient Education and Counseling (Physical Health Only)

Documentation is present in the medical record for problems and current diagnosis as applicable.

For Turquoise Care members, the status of preventive services, or at least those specified by HCA, must be summarized on a single sheet in the medical record within six months of enrollment. Lifestyle management and preventive healthcare information must also be documented. Information may include but is not limited to the following:

- Family planning
- Cancer prevention and detection (such as sun exposure and breast, cervical, testicular and colon cancer screenings, as appropriate)
- Injury prevention – at least one of the following:
    - Vehicle safety belts
    - Occupational hazards
    - Home safety
- Smoke alarms
- Promotion of preventive healthcare screening and counseling
- HIV infection and other sexually transmitted diseases
- Tobacco use
- Alcohol and substance use/abuse
- Osteoporosis and heart disease in menopausal women
- Motor vehicle injuries
- Household and recreational injuries
- Dental and periodontal disease

- Unintended or mistimed pregnancies
- Obesity
- Physical activity
- Healthy diet

A comprehensive list of screening and counseling topics is available in the Presbyterian Preventive Healthcare Guidelines for practitioners at www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral.

Durable Power of Attorney/Advance Directives (Physical Health Only)

Documentation must be present in the medical record that each adult patient 18 years of age and older was offered information on durable power of attorney/advance directives. The documentation should be signed and dated by the member and the practitioner, and it should be maintained in the member's medical record. An advance directive form is available on Presbyterian's website at www.phs.org/member-rights.

Patient Notification of Abnormal Diagnostic Test Results (Physical Health Only)

Members must be notified of abnormal diagnostic test results and the scheduled follow-up visit, plans and/or directions and this information must also be documented in their medical record.

Consultations/Referrals

Documentation must be present in the medical record regarding medical care, services and results for consultations. The following information must be recorded in the member's medical record for referrals:

- Member's medical history
- Member's surgical history
- Results of previous diagnostic tests

Documentation must be present in the member's medical record that indicates pertinent medical or behavioral information was communicated from the specialist to the PCP.

X-Ray, Lab and Imaging Reports, Referrals and Diagnostic Information (Physical Health Only)

- Reports must be filed in the medical record and initialed by the PCP to signify the review
- Consultation and abnormal lab imaging study results must have an explicit notation in the medical record for follow-up plans
- Referrals, past medical records, hospital records (e.g., operative and pathology reports, admission and discharge summaries, consultations, and ER reports) should be filed in the medical record

Past Medical History (as appropriate for practitioner/practice type)

- Past medical history must be obtained on first visit for members under the age of 21 and for members age 21 years old or older when they are seen at least twice
- Past medical history must be documented in the member's medical record as well as be easily identifiable and include serious accidents, operations, illnesses, and familial or hereditary disease or mental illness. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses

Medically Appropriate Care (as appropriate for practitioner/practice type)

Diagnosis and treatment plans must be medically appropriate and documented in the member's medical record.

Hospital and Outside Clinical Records (as appropriate for practitioner/practice type)

Pertinent documents must be present in the member's medical record to facilitate continuity of care for hospital, ambulatory surgical facility, behavioral health facility, ER visits, etc.

Immunization Status (Physical Health Only)

Appropriate immunizations for children, adolescents and adults must be documented in the member's medical record.

Individual Clinical Encounters

At a minimum, the member's medical record must include the following details, as appropriate, for the practitioner/practice type:

- History and physical examination for the presenting complaint, including relevant psychological and social conditions that affect the patient's medical and psychiatric status
- Subjective patient information and objective physical findings
- Working diagnosis consistent with findings (i.e., practitioner's medical impression)
- Documentation of plan of action and treatment consistent with diagnoses
- Diagnostic tests and/or results
- Drugs prescribed including the strength, amount and directions for use and refills
- Therapies and other prescribed regimes or results
- Follow-up plans or directions such as time for return visit or symptoms that should prompt a return visit
- Consultations, referrals and results

- Patient compliance/non-compliance, such as canceled, missed or no-show appointments, or other indications of patient non-compliance
- Documented patient follow-up appointment
- Counseling session start and stop time (behavioral health only)
- Any other significant aspects of patient care

Medical Record Review

Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The following 21 elements are accepted standards for medical record documentation. Please note that six of the 21 elements are core components to medical record documentation and are indicated by an asterisk (*).

1. Each page in the record contains the patient's name or ID number
2. Personal biographical data include the address, employer, home and work telephone numbers, and marital status
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials
4. All entries are dated
5. The record is legible to someone other than the writer
6. *Significant illnesses and medical conditions are indicated on the problem list
7. *Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record
8. *Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses
9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history)
10. The history and physical examination identify appropriate subjective and objective information pertinent to the patient's presenting complaints
11. Laboratory and other studies are ordered, as appropriate
12. *Working diagnoses are consistent with findings

13. *Treatment plans are consistent with diagnoses
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed
15. Unresolved problems from previous office visits are addressed in subsequent visits
16. There is review for under and overutilization of consultants
17. If a consultation is requested, there is a note from the consultant in the record
18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans
19. *There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record (for children) is up to date, or an appropriate history has been made in the medical record (for adults)
21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines

Based on the previous 21 elements, an annual medical record review ensures medical record performance standards are met for primary care practitioners, OB/GYN practitioners, pediatricians and high-volume behavioral health specialists. The following criteria apply:

- A passing score of 85%, or the score established by the auditor, is required
- If the medical record review score is less than 85% or less than the score established by the auditor, Presbyterian may choose to do any or all of the following:
    - Identify opportunities and mail/fax a letter to the provider that identifies compliance issues
    - Suggest an action plan for improvement and send an example education form
    - Publish best practices for medical record documentation in the provider newsletter
    - Coordinate with Provider Services for a medical record review follow-up

Behavioral Health Practitioners

For patients who receive behavioral health services, the following must be documented in the member's behavioral health medical record:

- A mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control
- Diagnostic statistical manual-5 diagnosis consistent with the history, mental status examination or other assessment data
- A treatment plan consistent with diagnosis, which has objective, measurable goals and time frames for goal attainment or problem resolution
- Documentation of progress toward attainment of the goal
- Preventive services, such as relapse prevention and stress management

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Ch. 14: Health Insurance Portability and Accountability Act

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 of 1996 (HIPAA)
- The Health Information Technology for Economic and Clinical Health (HITECH) Act
- The HIPAA Omnibus Rule of 2013

HIPAA regulations are detailed in the United States Code of Federal Regulations (CFR) Title 45, which addresses public welfare and is implemented 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: www.hhs.gov/hipaa/for-professionals/privacy/index.html.

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 Particular Attention?

Providers are advised to pay particular attention to the HIPAA Omnibus Rule that took effect in March 2013.

The HIPAA Omnibus Rule was published in the Federal Register on Jan. 25, 2013; Omnibus became

effective March 26, 2013. Business Associate Agreements (BAA) and the HIPAA Omnibus Rule required certain providers to meet those regulations no later than Sept. 23, 2013.

Note: A rule or regulation is promulgated, while a law is enacted.

Providers can review the Federal Register release of this rule by visiting the following link: www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf.

The AMA provides a number of HIPAA resources for providers at www.ama-assn.org/practice-management/hipaa. 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 Turquoise Care Providers Must Be HIPAA Compliant?

All providers and their workforce members 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 is 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, but are not limited to, 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 definition of “covered entity,” “protected health information” and “business associate” are derived from 45 CFR 160.103. HIPAA applies to a covered entity, a business associate, and their respective workforce members. Some HIPAA definitions can also be found in 45 CFR §§160.103; 160.202; 162.103; 164.103; 164.402; 164.501; and 164.304.

For more information, see www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl.

Covered Entity

- 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:

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.

Business Associate

A person who is not a member of the workforce that creates, receives, maintains, or transmits protected PHI on behalf of a covered entity for a function or activity regulated by HIPAA.

HIPAA

HIPAA contains several key components:

- Title I protects a worker’s 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 to business associates for reporting breaches of protected health information
- Increases criminal and civil penalties for noncompliance that also apply to business associates

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 and the Genetic Nondiscrimination Act. The HIPAA Omnibus Rule implements changes to the HIPAA Rules and includes some of the following:

- Expands the obligations of physicians and other healthcare providers to protect PHI
- Requires business associates of covered entities to comply with all requirements of the HIPAA Security Rule and the HIPAA Privacy Rule, as privacy 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 and certain marketing without individual prior authorization
- Expands an individual's right to receive electronic copies of the health information, if readily producible in such form
- Modifies the individual authorization and other requirements related to research and disclosure of child immunization records to schools
- Increases tiered civil money penalties for violations of HIPAA, HITECH, the 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:

- HHS: www.hhs.gov/hipaa/for-professionals/privacy/index.html
- CMS: www.cms.gov/about-cms/information-systems/privacy/health-insurance-portability-and-accountability-act-1996

HIPAA Omnibus Rule Resources

Please 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:

- HHS: www.hhs.gov/hipaa/for-professionals/privacy/guidance/index.html; www.hhs.gov/hipaa/for-professionals/privacy/guidance/resource-health-care-providers-educating-patients/index.html
- The American Academy of Orthopaedic Surgeons (AAOS), "What You Need to Know about the HIPAA Omnibus Rule:" www.aaos.org/aaosnow/2013/jul/managing/managing4/

  Note: Requires AAOS membership or subscription to log in.

HIPAA Training

- HHS: 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.

Electronic Health Record Incentives

- Standards for the Electronic Health Record (EHR) Incentive Program (42 CFR 495.2-370). Establishes the eligibility criteria and processes for documenting and applying for EHR incentives for providers. Information regarding registration for the Medicare and Medicaid EHR Incentive Program is available online at www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs?redirect=/EHRIncentivePrograms

  Note: Deadlines for participation for eligible providers have passed.
- HHS Office of the National Coordinator for Health Information Technology, "EHR Incentives and Certification:" www.healthit.gov/data/datasets/centers-medicare-medicaid-services-cms-ehr-incentive-program-measures

Health Insurance Portability and Accountability Act

- "Guide to Privacy and Security of Electronic Health Information, Version 2.0:"

  www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide.pdf

- For information about New Mexico's Medicaid Incentive program, visit the following link:

  https://nmmedicaid.portal.conduent.com/static/PDFs/EHR%20Program%20Basics%20for%20Eligible%20Professionals.pdf

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Ch. 15: Regulatory and Contracting

Participating providers have signed an agreement to deliver services to Presbyterian members. By signing that agreement, providers 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 provider 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

Providers must use their best efforts to cooperate with Presbyterian's QI programs, member grievance systems, medication therapy management and utilization management programs to the extent applicable. If providers have subcontractors, then the provider must also require them to cooperate with these programs. For example, providers and their 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 NMAC (Managed Health Care Contracting), contracts with providers in New Mexico will 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 the provider's agreement with Presbyterian:

> "Health care professionals/health care 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, will 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 health care services provided pursuant to this agreement. This does not prohibit health care professional/health care facility from collecting coinsurance, 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 CFR §§ 422.152, 422.202(c)].

Presbyterian Turquoise Care Contracting Requirements

It is important to understand the difference between Turquoise Care and the former Medicaid program, Salud! Providers must review all of the requirements of this program in the provider's contract. Because this program is jointly funded by both the federal and state governments, Presbyterian Turquoise Care is required to verify provider compliance.

Providers need to comply with all the terms of their Turquoise Care agreement. For example, by participating in the Presbyterian Medicaid Managed Care network, providers have agreed that they or anyone with more than 5% ownership is not an excluded person, as specified in Sections 1128 and 1128A of the Social Security Act.

Providers also have certain rights, such as the right to the information specified in 42 CFR § 438.10(g)(1) about the Presbyterian grievance and appeals system.

Home Health Agency Contracting Requirement

Presbyterian is responsible for ensuring statewide home care coverage by contracting with qualified home care providers throughout 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.

Provider Responsibilities

It is the provider's responsibility to cooperate with Presbyterian to monitor their activities to ensure compliance with Presbyterian and state and federal policies. Presbyterian has established mechanisms to ensure that providers 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. Providers should work with Presbyterian to ensure that they successfully identify and refer members to specialty providers as medically necessary.

PCP and advanced medical homes (AMH) need to ensure coordination and continuity of care with providers, including all behavioral health and long-term care providers.

Providers also need to ensure that members receive prevention services appropriate for their age group.

Presbyterian may designate primary care teams consisting of residents and a supervising faculty provider for contracts with teaching facilities or teams that include certified advanced practice clinicians who, at the member's request, may serve as the point of first contact. In both instances, the Presbyterian organizes its team to ensure continuity of care to its members and identifies a "lead provider" to be the attending provider as appropriate. Please note that medical students, interns and residents may not serve at the "lead provider."

Section 508 Compliance

As part of our commitment to work with providers to improve the health of the individuals, families and communities we serve, we are committed to making information communication technologies (ICT) accessible to people with disabilities. As a contractor with state and federal agencies, Presbyterian is also required to comply with Section 508 (Federal Electronic and Information Technology) of the Rehabilitation Act. By extension, all Presbyterian contractors and providers are required to comply with accessibility standards established by Section 508.

Regulatory and Contracting

Presbyterian or regulatory agencies may require provider offices and organizations to submit documentation to certify that the provider's ICT meets the standards. This certification can be achieved by obtaining an Accessibility Compliance Report (ACR) from the Information Technology Industry Council.

The certification process begins by completing a Voluntary Product Accessibility Template (VPAT) available at this link: www.section508.gov/sell/acr/. The VPAT and the ACR are documents that explain how to validate your ICT products and ensure they comply with the Revised 508 Standards for IT accessibility. Examples of ICT products include software, hardware, electronic content and support documentation.

To learn more, please review the following resources:

- Section 508 requirements: www.access-board.gov/law/ra.html#section-508-federal-electronic-and-information-technology
- Information Technology Industry Council and VPAT information: www.itic.org/policy/accessibility/vpat
- ACR information: www.fdic.gov/formsdocuments/acr.pdf

No Debarment

In providers' agreements with Presbyterian, providers have represented that neither they nor any of their 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 the provider of their employees/subcontractors 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

Provider should take the following steps to ensure that Medicaid funds are not being used to reimburse excluded individuals or entities:

1. Screen all new and existing employees and contractors to determine ensure that none of them have been excluded.

2. Routinely search the HHS OIG exclusions database (https://exclusions.oig.hhs.gov/) to identify exclusions and reinstatements that have occurred since the last search. In addition to housing the online database, this website has Quick Tips and Frequently Asked Questions regarding OIG's Exclusions Program.

Providers must immediately notify Presbyterian in writing if any of the above referenced representations change. Any misrepresentation of or change in a provider's status may be grounds for immediate termination of their agreement with Presbyterian.

Providers will immediately notify Presbyterian if they or any of their servicing employees or subcontractors are threatened with exclusion or excluded from any federally funded healthcare program, including but not limited to, Medicare and Medicaid. In the event that the provider or their subcontractor is excluded from participation in any such program, Presbyterian may terminate the agreement as of the effective date of the exclusion. Providers will immediately remove the excluded employee or subcontractor from providing any services in connection with the agreement and will notify Presbyterian's compliance officer in writing. In this notification, providers 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 providers cannot remove the excluded employee or subcontractor, then Presbyterian will have the option to terminate their agreement as of the effective date of such exclusion.

Provider Disclosure of Current or Previous Affiliation with Excluded Providers

If a provider's subcontractor was excluded or is affiliated with an excluded provider, and the provider has had a business transaction with that subcontractor totaling more than $25,000 during the previous 12 months, then the provider has certain obligations. Providers are required to submit information about the ownership of that subcontractor within 35 days of the date of the request. Reimbursement for expenditures for services furnished during the period between the due date and the date the information was actually supplied will be denied.

Hold Harmless

By contracting to provide Presbyterian Medicaid Managed Care services, providers have agreed to hold harmless the state and Presbyterian's members in the event that Presbyterian cannot or will not pay for services the provider performed. This hold harmless provision will survive the termination of the provider's agreement with Presbyterian for authorized services rendered before it was terminated, regardless of the cause giving rise to termination and will be construed to be for the benefit of the members.

Delegation

If applicable, the provider's agreement with Presbyterian 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 the following:

- A delegated entity meets all standards of performance mandated by the state. These include but are not limited to the following:
    - 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

Provider Communications

Providers will report to Presbyterian's compliance officer through telephone and follow-up email communication any suspected or potential fraud or other misconduct by the provider, their agent, their subcontractor, or any other person or entity of which they become aware. Providers will also have an internal reporting process to report suspected or potential fraud to their compliance officer.

Providers will report to Presbyterian any potential fraud or other misconduct by the provider or a subcontractor. This report will be made as soon as the provider becomes aware of the potential fraud or other misconduct.

Review Requirements

Presbyterian maintains fully executed originals of all subcontracts, including agreements providers have with Presbyterian. Turquoise Care agreements will be made accessible to HCA/MAD upon request. Medicare agreements will be accessible to CMS.

Background Checks

Providers will perform criminal background checks for all required individuals providing services, as specified in 7.1.9 NMAC, Caregivers Criminal History Screening Requirements.

Conflict of Interest Certification

Providers and their subcontractor's officers, directors and managers will sign a statement annually that (1) the individual has reviewed Presbyterian's and the provider's 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.

Indemnity

Providers indemnify, defend and will hold Presbyterian harmless of any loss, damage, or costs (including reasonable attorneys' fees) incurred in connection with claims resulting from their or their subcontractor's acts, omissions, or failure to comply with all applicable product lines and product or program requirements.

Section 1557 of the Patient Protection and 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 will 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 pursuant to 45 C.F.R. 92; 81 FR 31375.

Other Important Provisions

The following terms and conditions are deemed to be incorporated into a provider's agreement with Presbyterian Turquoise Care:

- The agreement has been and will 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 the provider 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; providers will maintain all records relating to services provided to members for a 10-year period and will 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

Regulatory and Contracting

- Providers shall release to Presbyterian any information necessary for Presbyterian to perform any of its obligations and acknowledge that Presbyterian shall be monitoring their performance on an ongoing basis and conducting formal periodic reviews
- Providers will accept payment from Presbyterian as payment for all services included in the benefit package and may not request payment from the state for services performed under their agreement with Presbyterian
- If a provider's agreement with Presbyterian includes the provision of primary care, then the provisions for compliance with PCP requirements delineated in the Presbyterian Turquoise Care Agreement will also apply to the provider
- Providers 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 HCA/MAD, state, or federal statutes, rules or regulations
- The agreement with Presbyterian does not prohibit providers, their subcontractors or anyone (except for third-party administrators) from entering into a contractual relationship with another MCO
- The agreement with Presbyterian does not include any incentive or disincentive that encourages providers 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 ACA
- For pharmacy providers, payments are made consistent with 1978 NMSA § 27-2-16B
- Providers will submit electronic claims, unless they were granted a hardship extension; the agreement with Presbyterian includes the HCA/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 of the order
- Providers will comply with the State of New Mexico's Statewide Immunization Information System initiative
- Provider and its subcontractors must provide the access to records, books and documents described herein upon HCA's request through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, in accordance with 42 C.F.R. § 438.3(h); 42 C.F.R. § 438.230(c)(3)(iii); and 42 C.F.R. § 438.3(k). This request may be for, but is not limited to, the

following purposes: examination; audit; investigation; agreement administration; or the making of copies, excerpts, or transcripts

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Ch. 16: Fraud, Waste and Abuse

Presbyterian's Special Investigative Unit (SIU) is part of the Program Integrity Department (PID). The SIU is responsible for the detection, investigation, prevention, and reporting of suspect healthcare fraud, waste, and abuse (FWA). We are required to cooperate with regulatory and law enforcement agencies in reporting activity that appears to be suspicious in nature. Per state and federal laws, any information Presbyterian has concerning such matters must be turned over to the appropriate governmental agencies and/or law enforcement.

As such, this chapter of the provider manual is intended to educate providers on how the PID SIU addresses issues like FWA, as well as provide information on the following:

- How we conduct reviews and investigations into suspect activity
- Industry standard expectations related to medical record documentation
- State and federal laws related to FWA
- How to report FWA

The information provided on FWA complies with the CMS mandatory FWA provider training requirement.

By identifying areas of concern relative to FWA 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 while also ensuring that valuable and limited resources are managed in a financially prudent manner.

Fraud, Waste and Abuse Definitions

Fraud: 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: 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: Incidents or practices that are inconsistent with accepted and 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 Examples

Improper Billing Practices

Billing for services or procedures that have not been performed or for a member visit that was never received

- Misrepresenting the services performed (e.g., up-coding or adding a modifier or add-on procedure code to increase reimbursement); inappropriate use of procedure code modifiers to circumvent claims edits or increase reimbursement
- Unbundling inclusive higher level of care services (e.g., Intensive Outpatient Program [IOP]/ Presbyterian services billed as individual and group therapy codes with modifiers, when the facility has a contracted/inclusive per diem rate)
- Inappropriate use of modifiers when coding medical claims
- Billing multiple members for the same family therapy session on the same day instead of the primary patient seeking treatment.

- Providing services over the telephone or internet and billing face-to-face codes
- Resubmitting a denied claim with false or misleading information in order to obtain reimbursement
- Routinely waiving patient deductibles or copayments
- 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)
- Billing the originating site facility fee Q3014 for a telehealth encounter when the rendering provider is billing the CPT/Healthcare Common Procedure Coding System (HCPCS) code with the appropriate telehealth place of service / modifier

Documentation Deficiencies

- Submitting false or misleading information about services performed, level of care or diagnosis to obtain authorization
- Not complying with regulatory documentation and billing requirements
- Lack of documentation to support services performed
- Medical record amendments and late entries not signed by the provider or not signed in a timely manner prior to billing claims
- Creation of new records, backdating, post-dating entries, writing over or adding to existing documentation without a valid amendment
- Progress notes that appear cloned and not specific to the service rendered
- Documentation that does not clearly reflect the start and stop times to support the duration and billing of the service
- Improper use of EHRs (refer to the CMS Toolkit on EHRs at www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html for additional information)

Clinical/Medical Necessity Issues

- Providing or ordering medically unnecessary services and tests
- Treating all patients weekly or multiple times per week regardless of medical necessity

- Routinely exhausting members' benefits or authorizations regardless of whether services are medically necessary
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Billing for services outside of scope of practice

Legal/Compliance Violations

- Retaining and failing to refund and report overpayments (e.g., if the claim was overpaid, providers are required to report and refund the overpayment within 60 days per ACA; unpaid overpayments are grounds for program exclusion)
- Submitting a claim that includes items or services resulting from a violation of the Anti-Kickback Statute, which constitutes a false or fraudulent claim under the False Claims Act
- Drug Diversion
- Kickbacks and bribery – such as paying a member for personal information to bill Presbyterian for services that were not performed
- Collusion
- Stark Law Violations
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs

Credentialing/Staffing Issues

- Misrepresenting credentials, such as degree, licensure or certification information
- Use of unlicensed or non-contracted staff and billing under the name of a licensed/credentialed provider
- Failure to include the U7 modifier when services are rendered by an individual in training pending Medicaid enrollment
- Continuing to bill under the supervisor's name with the U7 modifier after the rendering provider has obtained Medicaid enrollment

Special Investigative Unit

While we realize that most providers conduct their practices in accordance with proper business standards, the PID SIU is responsible for the detection, prevention, investigation, and reporting of suspect FWA involving health plan members, subcontractors, providers, brokers, agents or employer group representatives.

The SIU, in keeping with state and federal regulatory requirements, conducts audits and investigations to verify and validate services billed were provided. While the SIU accepts and reviews referrals made to the unit for investigation, the SIU also takes a proactive approach in data mining for suspect activity using fraud analytics software.

SIU Audits

The SIU may contact a provider to request medical record documentation to validate services billed. It is Presbyterian's expectation that providers **will** cooperate with SIU audits and investigations, in keeping with the provider's contract with Presbyterian and in compliance with state and federal anti-fraud laws. 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, Presbyterian's SIU will contact the provider office in writing to request that the provider submit the specified medical record documentation to the SIU in the time specified in the request. We will ask the provider office representative to sign a form to indicate that the records they are submitting are complete.

When an onsite audit is conducted and completed, the provider or representative is asked to sign a form to indicate that all the documentation was in the member's record at the time of the audit, and that the medical record was returned to the provider in the same condition.

Throughout the auditing process, several references are used to ensure accuracy and consistency. These may include but are not limited to the following:

- AMA CPT
- International Classification of Diseases (ICD-9-CM and ICD-10-CM Manuals)
- CPT Handbook for Psychiatrists
- HCPCS Level II code book
- Benefit and contract language
- Presbyterian Reimbursement Guidelines
- Presbyterian Practitioner and Provider Manual
- Medical director review
- Documentation from patient charts obtained during the audit
- Interactions and/or directive from regulatory and/or law enforcement agency

All documentation required to justify the dates of service under review must be present in each file at the time of the SIU 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 **that do not meet addendum guidelines** will not be accepted by the SIU for review, including during the SIU claim reconsideration process related to a SIU audit and/or investigation.

The burden of proof is on the provider to substantiate services and/or supplies billed to Presbyterian. During the audit process, if documentation is needed by the SIU, the provider or supplier must send requested medical record by the deadline(s) given in the written request. **Failure to supply medical record documentation in a timely manner may result in the retrospective denial of claims and/or the matter being reported to regulatory and/or law enforcement agencies, as claims not supported by documentation are not eligible for reimbursement.**

Under a provider's existing contract, Presbyterian reserves the right to audit our members' records for purposes that may include but are not limited to the following:

- Accuracy of claims
- Coverage of services
- Appropriateness of services
- Appropriateness of billing

To ensure accurate payment, please ensure complete and accurate supporting documentation exists in the member's medical record. Below are the **required** elements for member medical records and supporting documentation:

- Date of treatment
- Identification of each specific intervention/modality that was provided and billed
    - Includes 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 billing
- The 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

- Signatures and professional identification for 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 John Doe, physical therapy assistant, with notation of phone consultation with Jane Doe, physical therapy supervisor, when permitted by state and local law)

These elements determine compliance with appropriate billing practices and ensure appropriate charting, which must support medical necessity and covered services for 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 state and federal laws and regulations and the existing Presbyterian provider contract.

Results are based on the review of the documentation that Presbyterian received. For a claim to be valid, there must be sufficient documentation in the provider's or facility's records to verify the services performed were "reasonable and necessary" and required the level of care 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 imperative for a claim to be properly evaluated.

If there is no documentation, then the service is not eligible for reimbursement. In addition, if there is insufficient or illegible documentation submitted to support claims that have already been adjudicated by Presbyterian, **then reimbursement may be considered an overpayment and the funds may be partially or fully recovered**.

Upon completion of the data-gathering component of the audit, all the information obtained is organized and reviewed. Inquiries as to the results of the audit cannot be answered until all findings are finalized by Presbyterian's SIU. The audit report is sent to the provider by 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. Members may not be balance billed for claims resulting in denial based on a SIU audit or investigation.

During an investigation, unintentional errors in which the provider was unaware of the appropriate billing criteria may be found. In these instances, Presbyterian's PNO department is available to assist the provider in rectifying the error and to facilitate education to prevent such errors in the future. To contact your PNO relationship team or reach other contacts, visit www.phs.org/ContactGuide.

Extrapolation of SIU Findings

The Presbyterian SIU will select a statistically valid sample of medical records from providers and facilities, which aids the SIU in determining the final error rate and the final overpayment amount due to Presbyterian. This practice is used for both contracted and non-contracted providers and facilities.

Error rate is based upon an appropriate sampling and a representative sample of claims computed by valid statistical methods in accordance with the most recently published Medicare program integrity manual and using statistical software methodology that is HHS compliant.

Dispute Resolution and Requests for Reconsideration

The PID provides a process by which a provider, member and/or other affected entity may request a reconsideration of any of the SIU's findings. Reconsideration occurs directly with the SIU in writing following the directive provided in the retrospective review findings letter given to the provider and/or facility.

If an affected provider/member/entity communicates disagreement with the SIU's established findings or decides to provide additional documentation related to the claims in dispute, then the department will temporarily cease recoupment activities.

The requester is asked to explain in writing which established finding(s) reconsideration is being requested for, their perspective or response to the audit finding(s), and to provide any additional information not already provided to the SIU in the original audit 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.

The requester must provide the reconsideration request and any additional information to the SIU within **30 days** of the date of the communicated education and/or retrospective review findings correspondence.

Any other requests for reconsideration of decisions will be addressed through one of the following processes:

- Denials of other claim lines **not related** to SIU findings will be addressed and handled by the Appeals and Grievances department in accordance with Appeals and Grievances policies and procedures
- Provider terminations will be addressed and handled by the Credentialing department in accordance with Credentialing policies and procedures

The requestor is afforded by the SIU two levels of reconsideration. If the requestor is in disagreement with the results of the Level 1 Reconsideration, the requestor may submit a request for Level 2 Reconsideration within 30 days of the date of the Level 1 Reconsideration notice. Should the requestor (e.g., provider) disagree with the results of the Level 2 Reconsideration, the requestor, per the provider contract, may elect to enter into arbitration.

Accurate Provider Payment Unit

Presbyterian's Accurate Provider Payment Unit (APPU) conducts prospective and retrospective high dollar inpatient claims reviews.

- Prospective claims reviews pertain to paid claims that equal or exceed $100,000
- Retrospective claims reviews focus on paid claims that are equal to or exceed $25,000 but less than $99,999, depending on individual facility contracts

To help ensure claims are paid correctly and timely, providers should submit **complete** information with these claims, which includes the UB-04, the itemization and the associated medical records. Failure to do so will result in delayed payment and/or denial of payment.

The APPU applies local and nationally recognized standards of care, along with billing and coding guidelines, when making a final determination.

For facilities where Presbyterian has established a Secure File Transfer Protocol (SFTP) site for submission of medical records and itemizations, please follow the directive established between the APPU and your facility, which is also provided by the APPU in its medical records request letter.

Facilities with questions regarding APPU reviews may contact the APPU toll-free at (866) 902-8011 or local in Albuquerque at (505) 923-5238.

Medical Record Documentation

Presbyterian follows policies and procedures that govern the standardization and maintenance of medical records by its contracted providers. Presbyterian may review any information, including medical records that pertain to a claim.

Medical records **must be** complete and legible, and must include:

- Reason for the encounter and relevant history, findings and test results
- Assessment and impression or diagnosis.
- Plan of care
- 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 changes in treatment, and revisions of diagnosis/diagnoses should be included in the documentation.

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
- Progress notes of another provider that are referenced in the physician's note
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports

Documenting Timed Current Procedural Terminology Codes

Healthcare professionals provide several services that are strictly dependent on time. 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 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 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 service 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 provider (or an assistant under the supervision of a provider 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 AMA 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.
    - Includes resident physicians, co-surgeons and assistant surgeons and/or nurse practitioners or physician assistants 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. A 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 and 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 identifies who made any changes or amendments

Providers billing Presbyterian for services must perform the following:

- Document in the 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
- 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 because they 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

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.

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 include the following:

- Creation of new records when records are requested
- Backdating entries
- Postdating entries
- Predating entries
- Writing over and/or striking out previous entries made in the medical record documentation
- 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.

Preventing Medical Identity Theft

Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity, such as health insurance information, without the person's knowledge or consent to obtain 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 may 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 are 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 identify 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 the following:

- Receiving the wrong medical treatment
- Finding their health insurance benefits were exhausted and potentially becoming uninsurable for both life and health insurance coverage
- Unexpectedly failing a physical exam for employment because of a disease or condition for which the victim was never diagnosed, or received treatment that was unknowingly documented in their 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 the victim's medical and financial life 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 type of theft, the health plan member "lends" their health plan identification card ID) 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.

Providers 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 photo ID (e.g., driver's license or other governmental issued ID) 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 license or other government issued ID

- Asking the parent or adult accompanying a minor child to the appointment to provide their photo ID and making copies and retaining all the adult's forms of identification provided in the minor child's medical record

Federal and State False Claims Acts

Federal False Claims Act

The Federal False Claims Act covers fraud involving any federally funded contract or program, except for 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 $14,308 to $28,619 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 = $14,308penalty
- Treble damages = three × $100 or $300
- This now equals $14,608 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 HCA

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 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% 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 may receive 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 as firing, demoting, suspending or harassing
- Remedies against retaliation include job reinstatement with double-back pay and other special damages

Historically, most whistleblowers 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 grievances when staff or patients raise a concern.

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 that they believe 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 the following:

- 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

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 do the following:

- Educate employees, contractors and agents regarding the prevention of Medicaid fraud
- Provide information in policies and procedures and the employee handbooks regarding the following:
    - 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

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.”

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: $ 100,000 per violation and imprisonment for up to 10 years,
- Civil: penalties and fines up to $50,000 fine per violation plus treble damages, permissive exclusion
- Mandatory exclusion from participation in most federal healthcare programs including Medicare and Medicaid

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 may take place only when all 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. DME and supplies
8. Prosthetics, orthotics and prosthetic devices and supplies
9. Parental and enteral nutrients equipment and supplies
10. Home health services
11. Outpatient prescription drugs
12. Inpatient and outpatient hospital services

The Medicare self-referral disclosure protocol pursuant to Section 6409 (a) of the 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 frequently asked questions (FAQs) for Voluntary Self-referral Protocol at www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/FAQs.html. 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 include the following:

- Inpatient and outpatient hospital services
- Outpatient prescription drugs
- Home health services
- DME 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 provider 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 or up to $100,000 per violation

- Possible exclusion from federal programs (i.e., Medicare, Medicaid)
- 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 item or service
- Potential exclusion from participation from federal healthcare programs

Program Exclusion Lists

The Federal Exclusion Law allows HHS OIG to exclude individuals and organizations from participating in Medicare, Medicaid and other government programs. Reasons for exclusion include violating fraud, waste, 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).

Providers, non-physician practitioners and employees must not be identified on the HHS OIG or General Services Administration (GSA) lists. Providers may log on to the following HHS OIG/GSA websites listed to verify the eligibility of individuals:

- HHS OIG List of Excluded Individuals and Entities https://oig.hhs.gov/exclusions/exclusions_list.asp
- GSA's System for Award Management (GSA SAM) https://sam.gov/

Insurance companies (sponsors) **do not** pay for drugs prescribed or other services provided by a provider who is excluded by either the HHS OIG or GSA. In addition, excluded providers may not contract with or perform services related to any government contract including the Federal Employee Health Benefits Program, Medicare or Medicaid.

According to the HHS 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."

Providers 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 providers not receive payment for services furnished by an excluded person, but they will also face a fine of $10,000 for each item or service, plus three times the amount of actual damages.

Presbyterian requires all providers to review employee, contractor, or vendor against the HHS OIG and GSA exclusion lists at least twice each year. Providers should retain written or hard-copy proof that this activity was completed and make it 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.

Preclusion List

The Preclusion List is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (Presbyterian Senior Care [HMO/HMO-POS] and Presbyterian Dual Plus [HMO D-SNP]) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. CMS updates the Preclusion List each month and makes the list available Medicare Advantage plans. Individuals or entities who meet either of the following criteria are included on the list:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program

Medicare Advantage plans are required to deny payment/reject claims associated with a precluded provider. Presbyterian will provide impacted members with at least 60 days advance notice from the provider's inclusion on the Preclusion List before denying payment/rejecting claims. This period will allow members at least 60 days to find a new provider and obtain new prescriptions. Provider claim payment denial/rejection will correspond with the provider's 91st day in precluded status.

Fraud, Waste and Abuse Prevention

The HHS OIG has a recommended compliance plan template and instructions for individual providers and small groups that can be found at their website at https://oig.hhs.gov/. While this is a voluntary program, we

highly recommend providers adopt their own compliance program, which should include the following six elements identified by HHS 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 on the prevention of fraud, waste, and abuse can be found at the following CMS website: www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.

This website contains podcasts, continuing education and toolkits for both specialized practices and general topics. Regardless of what providers choose, these tools will help their organization know what to look for regarding fraud, waste and abuse.

Recoveries of Turquoise Care Overpayments and Fraud

While it is the provider's responsibility to report and refund any overpayment they identify, Turquoise Care has specific requirements regarding the identification process for overpayments, self-reporting, refunds, and failure to self-report and/or refund, as outlined below. This also applies to Medicare overpayments.

Identification Process for Overpayments

Providers are required to report and refund overpayments to Presbyterian Turquoise Care by the later of:

- 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 was 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 Turquoise Care, HCA 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 in 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 Turquoise 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 and refund overpayments to Presbyterian Turquoise Care by the later of:

- 60 calendar days after the date on which the overpayment was identified
- The date any corresponding cost report is due, if applicable

The provider is required to send an overpayment report to Presbyterian Turquoise Care and HCA, which must include at a minimum the following information:

- Provider's name
- Provider's TIN and NPI
- 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 HHS 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 Turquoise Care as an intermediary and are property of Presbyterian Turquoise Care unless:

- HCA, the recovery audit contractor, or Medicaid Fraud and Elder Abuse Division (MFEAD), independently notified the provider that an overpayment existed
- Presbyterian Turquoise Care fails to initiate recovery within 12 months from the date the contractor first paid the claim
- Presbyterian Turquoise Care fails to complete the recovery within 15 months from the date Presbyterian Turquoise Care first paid the claim
- The provider may request that Presbyterian Turquoise Care permit installment payments of the refund. Such request shall be agreed to by Presbyterian Turquoise Care and the provider
- In cases where HCA, the Recovery Audit Contractor (RAC), or the MFEAD identifies the overpayment, HCA shall seek recovery of the overpayment in accordance with NMAC §8.351.2.13

Failure to Self-Report and/or Refund Overpayments

Overpayments that were 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.

Reporting Fraud, Waste and Abuse

Providers are obligated to immediately report all confirmed, credible or suspected fraud, waste and abuse in accordance with the following:

- For suspected fraud, waste and abuse in the administration of Turquoise Care, report to Presbyterian, HCA and MFEAD
- For all confirmed, credible, or suspected provider fraud, waste and abuse, report to Presbyterian, HCA 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 information below. Please use the following contact information for the PID confidential hotline. Those reporting information to PID may

remain anonymous. Please be certain to provide as much information as possible. The more information provided, the more successful the PID's SIU will be in investigating the concern:

Toll-free Compliance and Fraud, Waste, and Abuse Hotline 1-888-435-4361

Email: PHPFraud@phs.org

- Providers may also mail their concerns to the address listed below:

Presbyterian Health Plan
Program Integrity Department
Special Investigative Unit (SIU)
P.O. Box 27489
Albuquerque, NM 87125-7489

- Providers may also file a suspected fraud, waste and abuse report online at the following link: www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx

The following is contact information for reporting abuse, neglect and exploitation of members:

Adult Protective Services: 1 (866) 654-3219

CYFD: 1 (855) 333-7233 or #SAFE

DOH/DHI: 1-833-796-8773 (toll-free)

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Ch. 17: Credentialing and Recredentialing

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 who 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 PCPs. This is not the same as an independent contract
- Practitioners who see members in an outpatient setting including but not limited to urgent care providers

- 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 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
- 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 team (www.phs.org/ContactGuide) or credentialing examiner at the health plan or complete a Credentialing Request form at https://www.phs.org/providers/our-networks/health-plan
    - Once a request is made from Presbyterian to the Council for Affordable Quality Healthcare (CAQH), the practitioner may also go to the following link to submit an application online: https://proview.caqh.org/Login?Type=PR
- It is important for providers to notify their PNO relationship team if they 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 Interest form can be accessed at www.phs.org/providers/our-networks/health-plan

- Ensure timely completion of the application
    - After three requests for an application with no response in 30 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 QI 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 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, conducts 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 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 accreditation standards and state and federal laws.

Practitioner/Provider Rights

Under Section 13.10.28 of 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. In addition, applications are approved or denied within 30 days after receiving all required information pursuant to NMAC 13.10.28.11. Providers have the right to review information submitted to support their credentialing application.

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, upon request. 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 the following:

- A current unrestricted license to practice within the states where services are provided; temporary licenses are not 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 PCPs 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 Administration (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% 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
- NPI
- Ownership and control disclosure

Organizational Providers

Organizational providers must meet the following standardized criteria, which includes but is not limited to the following:

- 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
- Current malpractice or general liability 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

Credentialing: 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: Recredentialing is required every three years in accordance with Presbyterian's policies and procedures and NCQA accreditation standards. We will send a written notification to remind providers to complete their next recredentialing application.

Home Health 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 HHC 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 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 their network participation.

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 who 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 $250,000 per occurrence and $750,000 aggregate
- For those practitioners and providers who are **not** qualified under the New Mexico Medical Malpractice Act, Presbyterian requires that the practitioner/provider maintain professional liability insurance in the following amounts: $1 million each occurrence and $3 million aggregate
- Any obstetrician/gynecologists and other 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, OB/GYNs and high-volume behavioral health specialists.

Initial applicants who fail a site visit are notified of the discontinuation of the credentialing process. The applicant may contact Presbyterian for information about how to improve their site and to restart the credentialing process once the deficiencies are corrected.

In addition to the initial site visit, a site visit is conducted on any provider that receives two or more grievances within 12 months regarding their office or practice. 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 OIG List of Excluded Individuals and Entities Exclusion Program and the General Services Administration's System for Award Management (previously Excluded Parties Lists System), the Medicare Preclusion List, and applicable state licensing agencies are monitored monthly for sanctions or licensure limitations.

Investigations are conducted on all quality of care and service grievances. For quality of clinical care grievances, appropriate clinical staff, including Presbyterian medical directors, are consulted in conjunction with the review of the grievance, which 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 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 who 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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Ch. 18: e-Business

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 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.

- PROVIDERConnect is a password-protected portal (website) that allows providers to access a variety of Presbyterian resources, as well as member, benefit, authorization and claim information
- IVR system is a tool that complements PROVIDERConnect by giving providers access to member eligibility, copayment and PCP information over the phone
- Electronic Claims Transmission (ECT) is a tool that saves time and money by sending claims electronically to Presbyterian through one of our four contracted clearinghouses. A list of these clearinghouses can be found later in this chapter
- Electronic Data Interchange Remittance Advice (EDI-RA) enables providers 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) enables providers to receive direct deposit of payments into a specified banking account at no cost to the provider

e-Business

- The Presbyterian ePayment Center provides Electronic Remittance Advice (ERA)/EFT services at no cost to contracted providers
- HealthXnet® is a third-party vendor of Presbyterian that provides access to a variety of information and functions over the internet related to eligibility verification
- Presbyterian's online provider directory is a convenient tool for members and providers and includes information about our network of PCPs, specialists and other providers
- Presbyterian's provider webpage includes recent communications, benefit and criteria information, appeals and grievances information, online submissions and the online provider directory

HIPAA Regulations and e-Business

Claims status, member eligibility and benefit and pharmacy certification requests are some of the transactions covered under HIPAA regulations. According to HIPAA, conducting these transactions through the internet qualifies as conducting these transactions "electronically" and may therefore cause providers to qualify as a covered entity subject to the HIPAA regulations.

If providers are not already considered a covered entity under the HIPAA regulations, then they 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 CMS tool at the following link: www.cms.gov/regulations-and-guidance/administrative-simplification/hipaa-aca.

myPRES and the PROVIDERConnect Provider Portal

myPRES permits providers to check member eligibility, benefit plan details and claims status, request a Benefit Certification or Pharmacy Exception, and access the PROVIDERConnect portal.

It is our goal to make myPRES and the PROVIDERConnect portal the first choice of providers 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 providers to submit online authorization requests and to email the Provider Care Unit for more complex issues that require research.

How to Register for the PROVIDERConnect Portal through myPRES:

Obtain a user ID and password by entering this link into the internet address bar:

https://mypres.phs.org/Pages/provider-registration.aspx

Providers can also follow the steps below:

- Go to www.phs.org
- Click "myPRES" on the top of the webpage

e-Business

- Click “Why register?” located on the middle of the webpage
- Click the provider’s registration link in the middle of the page
- Fill out the form on the page to request access

This allows providers 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 the user ID and password are case-sensitive.

Each employee in a provider’s office that utilizes myPRES must have their own individual user ID and password. Under no circumstances should a myPRES user ID and password be shared. It is the provider’s responsibility to contact PCSC or their relationship team to terminate access of employees who are no longer employed or who no longer require access to myPRES.

Accessing myPRES

To access myPRES, providers should go to www.phs.org and locate the myPRES log-in box on the right side of our website, click on the log-in box and enter their user ID and password to log into myPRES.

If providers have problems locating or completing the enrollment form, then they should contact the Presbyterian Provider E-Help Desk using the following contact information:

Phone at (505) 923-5590 or toll-free at (866) 861-7444, Monday through Friday, 8 a.m. to 5 p.m. (MST)

Email: 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 reset the user ID or password. Should this fail to work, please email ehelpdesk@phs.org or call (505) 923-5590 or (866) 861-7444 (toll-free) for further assistance.

Computer and Software Requirements for myPRES

In order to take full advantage of myPRES’s capabilities, providers need the following:

- 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)
    - Microsoft Edge

myPRES Hours of Availability

myPRES offers continuous availability 24/7, 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. For questions concerning prior authorization information, please call (505) 923-5757, or 1-888-923-5757 and select the “Health Services” option from the menu.

myPRES and PROVIDERConnect Portal Training and Support

Presbyterian is committed to ensuring providers have the training and support they need to use the myPRES application. Once signed into the application, online help is available at the touch of a button. For additional assistance, providers may also contact the Presbyterian E-Help Desk or Provider Network Operations Department Monday through Friday, 8 a.m. to 5 p.m.

Keeping Provider Directory Information Up to Date

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.

Providers are required to verify their data every 90 days pursuant to the federal Consolidated Appropriations Act (CAA). 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 the provider’s practice, such as the following:

- Address
- TIN
- 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.

e-Business

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 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.

For more information, view Chapter 22.

Credentialing Requirements

Providers 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 Presbyterian members
- Maintaining credentialing for Turquoise Care program and Medicare Advantage plans in accordance with the requirements of state and federal law and the standards of accreditation organizations
- Enrolling with New Mexico Medicaid, as required
- Participating with Medicare, as required
- Using the New Mexico Medicaid Provider Web Portal to update enrollment information/status with HCA when there is a change in location, licensure or certification, or status for Turquoise Care providers

Interactive Voice Response System

Our IVR system complements myPRES and allows providers 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 or 1-888-923-5757 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 providers 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 offer FastClaim direct entry portal. FastClaim is designed to accommodate lower-volume practices that would like to submit electronic claims directly to Presbyterian at no cost. If providers are interested in learning more about ECT or FastClaim, please contact the Provider Network Operations e-business analyst at (505) 923-6154. Below is also a list of available clearinghouses.

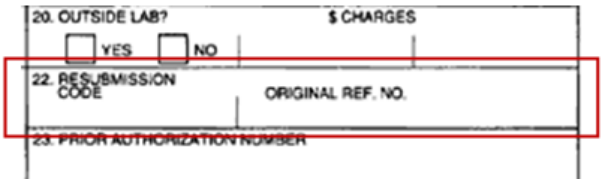
Clearinghouse Contact Information

Company	Contact Information	Payor Identification Number
Availity® P.O. Box 550857 Jacksonville, Florida 32255-0857	1-800-AVAILITY (282-4548) Website: www.availity.com/	PREHP (Commercial) PRESA (Turquoise Care) PRESA (Medicare)
Nthrive 5543 Legacy Dr. Plano TX 75024-3502	(678) 323-2500 Website: www.nthrive.com	Z0003 (Commercial) Z0077 (Turquoise Care)
Change Healthcare Corporate Office 3055 Lebanon Pike Nashville, TN 37214	1-866-817-3813 Website: www.changehealthcare.com/	05003 (all product lines)
Claim.MD P.O. Box 1177 Pecos, NM 87552	1-877-757-6060 Website: www.claim.md/	PRESB (all product lines)

Providers may electronically submit corrections to previously submitted 837 professional/institutional claims, CMS-1500 claims or UB-04 institutional 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 in Loop 2300 (837) or when Field 22 on the claim (CMS-1500 claims) has a "Resubmission Code" of seven or eight and the "Original Ref. NO" field contains the claim number of the original claim submission. UB-04 institutional claims utilize the facility bill type for a corrected claim.

Note: When an original claim is rejected or denied due to "member not found," verify the member ID and date of birth, and refile the claim as an original claim, **not** a corrected claim.



Electronic Data Interchange Remittance Advice

Providers using the ECT system may be eligible to take advantage of electronic data interchange remittance advice (EDI-RA). By using EDI-RA, providers receive EOP data and payment funds faster because EOP data is sent electronically to their office and payment funds are directly deposited to their bank account. If providers are currently submitting claims electronically and are interested in using EDI-RA, then they should contact their PNO relationship team to check availability. To view the Provider Services Contact Guide, visit www.phs.org/ContactGuide.

Electronic Coordination of Benefits

Electronic coordination of benefits (eCOBs) enables members 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 providers are interested in submitting an eCOB, then they should verify with their practice management software vendor that their billing program has the capacity to do so.

HealthXnet

HealthXnet allows providers to check member eligibility, claims and benefit certification status. It also allows providers to submit claims online. For more information, visit HealthXnet at www.healthxnet.com. Providers may also use the following information to contact HealthXnet:

Local: (505) 346-0290
Toll Free: 1-866-676-0290

Fax: (505) 346-0278

Email: healthxnet@nmhsc.com

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 providers' 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: https://presbyterian.epayment.center/registration. If providers have any

questions about this service, then they should contact the Presbyterian ePayment Center at 1-855-774-4392 or Help@ePayment.Center.

Presbyterian's Provider Website

Visit the provider page at www.phs.org/providers to access useful information, documents and forms, as well as to send online requests to Presbyterian.

To access the provider page

- Go to www.phs.org
- Select "For Providers" at the top of the screen

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 www.phs.org/providers/authorizations. Providers can also access our prior authorization request forms from the same link.

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. To access the Medical Policy Manual, visit www.phs.org/medicalpolicymanual.

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, providers are able to file an appeal or report a grievance by using our website. Should providers wish to file an appeal or report a grievance, they may do so online at www.phs.org/providers/resources/appeals-grievances. Click on the "File an Appeal or Grievance

online" link. Providers can check the status of submitted appeals anytime in the PROVIDERConnect Provider Portal.

To learn more about appeals and grievances, please refer to the Appeals and Grievances chapter of this manual.

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Ch. 19: Claims and Payment

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 include the following:

- The application of correct coding guidelines in accordance with the standards set by CMS and the AMA. Clinical Editing (CES) is configured. CES edits include but are not limited to: National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits, Avalon edits, Cotiviti edits, medically unlikely edits (MUEs) and add-on code edits
- Individual provider contractual arrangements
- The application of specific member benefits
- The requirements in this chapter of the provider manual can help providers ensure that their claims are submitted correctly
- Requirements for HIPAA, as we understand them today, are included. Periodic updates are sent to the provider's office, as necessary, throughout the year
- Providers are required to submit claims for all services rendered, whether they are capitated or fee-for-service. For technical assistance, assistance with claim submissions or to receive training, providers should contact their (PNO relationship team. Providers may find their contact information at www.phs.org/ContactGuide

Electronic Claims Transmission

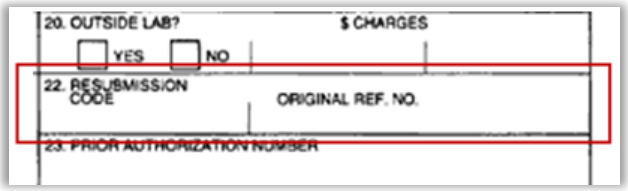
Electronic claims are claims that are transmitted electronically to Presbyterian using a clearinghouse or a web application such as Presbyterian's electronic claims transmission (ECT) system. Using ECT can capitalize on the time and savings realized from a paperless system. To submit electronic claims directly to Presbyterian, providers can use the Fast Claim direct entry portal at (www.claim.md/phs.plx).

Fast Claim 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 Fast Claim, please contact the Provider Care Unit at (505) 923-5757. A list of clearinghouses is also available at the end of the e-Business chapter. Electronically transmitted claims must meet the HIPAA transaction standards with regard to format and content.

Providers may electronically submit corrections to previously submitted 837 professional/institutional claims, CMS-1500 claims or UB-04 institutional 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 in Loop 2300 (837) or when Field 22 on the claim (CMS-1500 claims) has a "Resubmission Code" of seven or eight and the "Original Ref. NO" field contains the claim number of the original claim submission. UB-04 institutional claims utilize the facility bill type for a corrected claim.

Note: When an original claim is rejected or denied due to "member not found," verify the member ID and date of birth, and refile the claim as an original claim, **not** a corrected claim.



Benefits of Filing Electronically

In addition to saving providers 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 provides 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

Providers 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 the 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. 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

Providers 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 software that enables providers to transmit claims electronically. All of these companies are endorsed by Presbyterian, and they help providers get started and provide timely and accurate processing of their claims.

The clearinghouse will ask providers questions, more than likely sends providers an informational packet and may ask providers to fill out and send in a questionnaire to help identify their needs. Providers 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 the provider's office, including the submittal of claims to other payors. The clearinghouse evaluates the provider's system, sets up a test, and instructs the provider in the use of their system. The setup is usually quick, barring any major problems.

Providers do not need to notify Presbyterian to start billing electronically. However, providers must have an NPI and a Presbyterian-assigned provider number. Providers must also provide their tax identification number to submit an electronic claim. For special concerns or billing issues, providers should contact their PNO relationship team for advice. Presbyterian does not pay claims if an NPI is not submitted. More information regarding NPI is discussed later in this chapter.

Providers will 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. Providers then receive either an acceptance or rejection report from Presbyterian through the clearinghouse.

If Providers Encounter Problems

When filing electronically, providers 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 the provider's system.

- **Solution:** Check the claim status online or contact the Provider Care Unit through their online web form within 30 days from the date of service.

Issue: Presbyterian rejects a claim with an error message that the provider does not understand.

- **Solution:** Providers should contact their clearinghouse or their PNO relationship team within 48 hours of receipt of the rejection report for the needed information.

Issue: You submit claims that are not showing in Presbyterian's claims system and are not recorded on the provider's error reports that they received from their clearinghouse and Presbyterian.

- **Solution:** Providers should contact their PNO relationship team and discuss the issue. If the issue is determined to be a technical problem, then their PNO relationship team coordinates contact with Presbyterian's Information Services Department. It is important for providers to check on a regular basis to ensure that the claims are not denied for lack of timely filing. Providers should also keep detailed records regarding this activity.

Paper Claims Submission Process

Paper claims are printed on a form and mailed to Presbyterian. 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

Presbyterian requires all providers to use either the CMS-1500 (02-12) or the UB-04 when billing hard copy paper claims. 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. Box 21 of these forms requires the 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.

Presbyterian Health Plan Member ID

Presbyterian can match to Presbyterian member ID, Medicare Beneficiary Identifier (MBI), Medicaid ID and/or Social Security Number. Date of birth must match to the submitted ID. If there is not a match, the claim will be rejected/denied. If an original claim is denied for “member not found/not matched,” then the claim should be resubmitted with the corrected information as an original claim, not a frequency 7 corrected claim.

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 and atypical providers, must acquire and submit the appropriate Type 2, organization NPI in the appropriate field. Examples are provider group practices, hospitals, or DME 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 do the following:

- Submit claims for payment
- Receive payments from a health plan
- Access information from a health plan

Providers can apply for an NPI number online at the following web address: https://nppes.cms.hhs.gov.

Federally Qualified Health Centers

Claims must be submitted on the appropriate claim form per NMAC supplement 16-13 and NMAC 8.310.4.15.

A UB-04 claim form must be submitted for members that have Medicaid or Medicare Advantage coverage with Presbyterian.

When the member's primary coverage is a Presbyterian ASO or Commercial plan and the member's secondary coverage is Presbyterian Medicaid or a Medicare Advantage plan, submit a CMS-1500 claim form to the member's primary Presbyterian ASO or Commercial plan first. After the primary EOP is received, submit the secondary claim EOP with the appropriate claim form and the primary carrier's EOP to the member's secondary Presbyterian Medicaid or Medicare Advantage plan for consideration.

- If Medicaid is secondary, submit a UB-04
- If Medicare Advantage or D-SNP is secondary, submit the appropriate form (UB-04 or CMS 1500)

Failure to submit the appropriate claim form based on the member's coverage may result in incorrect reimbursement based on the fee schedule or encounter rate or result in a denial.

High Dollar Institutional Services

When total billed charges equal or exceed $100,000 for a single confinement, Presbyterian requires the corresponding medical record and itemization. If the itemization is not submitted, then the claim will be denied.

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. Interim UB (facility) claims are identified by the Bill Type Frequency and the Patient Status code (30).

The appropriate bill type frequencies are as follows:

- XX2: Indicates the beginning of the stay
- XX3: Indicates the middle of the stay
- XX4: Indicates the final bill

Presbyterian encourages the submission of these monthly billings within 45 days of the beginning of the period for which providers are billing.

Submitting Late Charges

In accordance with CMS guidelines, facilities must bill late charges, corrections, or for facility services from ambulatory surgical centers. Submitting late charges are only acceptable when submitted as paper claims.

On UB-04 billing forms, the bill type (Field 4) must end with a “5” with the exception for late charges for inpatient services, which must be submitted as a replacement claim with a bill type ending with “7.”

The appropriate Bill Type Frequencies are as follows:

- XX5: Outpatient hospital late charges
- XX7: Outpatient hospital replacement charges
- XX7: Inpatient hospital late or replacement charges. Please note that any corrections must be submitted with an XX7. If a corrected UB-04 is not submitted with an XX7, then the claim will be denied

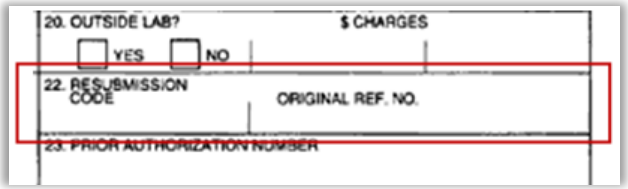
Ambulatory Surgical Centers must submit late charges or replacement charges on a CMS-1500 (02-12) form.

For outpatient hospital late charges (XX5), submit the late charges only. 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 easy to identify to avoid a duplicate payment
- Specify the original date of service

Late charges must be submitted within 12 months from the date of service.

Submitting Corrections on a CMS-1500 Form



A corrected 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.
Corrected claims submitted on paper must be clearly marked as corrected or resubmitted. Claims that are not clearly indicated as corrected will be denied.

Submitting Unlisted/Unclassified Codes

An unlisted/unclassified CPT or 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 the provider is performing, then the provider 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. When submitting an unlisted/unclassified code electronically, information may be entered as a service line or claim level note. The description of the unlisted procedure must be submitted. If the description is not submitted, then the entire claim will be denied.

EPSDT PCS / Home Health Claims Submission Guidelines

The agency should submit all home health claims on the CMS UB-04 claims form and complete all fields in accordance with standard home health billing requirements. Claims for EPSDT Program PCS services only should be submitted on a CMS-1500 claim form with CPT/HCPCS codes G0151, G0152, G0153, S5125, T1001 and T2023. 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:

Claims Processing Revenue Codes	
Description	**Revenue Code**
RN visit	0551
Dietitian visit	0581
Physical therapy visit	0421
Occupational therapy visit	0431
Speech therapy visit	0441
Social worker visit	0561
Home health aide visit	0571
Supplies	0270
RN per hour	0550
LPN per hour	0580
PCA per hour	S5125
HHA per hour	0570

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 NPI 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 Care Unit at 1-888-923-5757.

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 QI 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)

Requirement for 837 Professional

The following information outlines where the A1c test results need to be reported in the 837 professional and institutional electronic claim transactions. Providers should share this information with their software vendors in order to properly configure their 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 the following:

- A1c nnn ccyymmdd – nnn is the test result and ccyymmdd 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 the clearinghouse in the 837 institutional format, excluding Availity.

Place the A1c data in the PWK07 segment of the 2300 loop with the code qualifier of OZ and PWK02 of AA. One test result per PWK segment, which can occur up to 10 times. The data format is the following:

- A1C nnn ccyymmdd – nnn is the test result and ccyymmdd is the date of the test.
- **Example**: A1C 055 20041028

Requirement for 837 Institutional for Availity

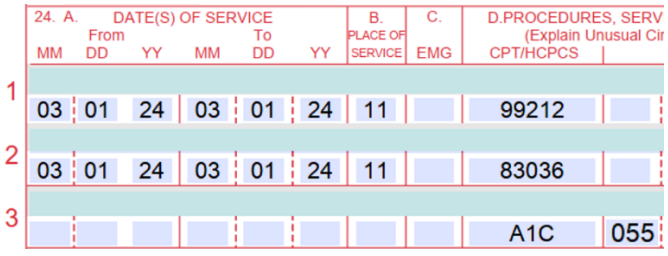
This information pertains to claims submitted by providers to Availity in the 837 Institutional formats. Place the A1c data in the PWK07 segment of the 2300 loop with the code qualifier of OZ and PWK02 of AA. Up to four test results per PWK segment, which can occur once. The data format is:

- A1c nnn ccyymmdd – nnn is the test result and ccyymmdd is the date of the test.

Examples:

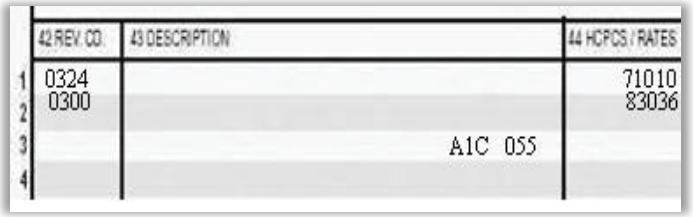
- A1c 055
- 20041028 A1c 042
- 20041029

A1c CMS-1500 (02-12) Paper Claims:



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D.PROCEDURES, SERV (Explain Unusual Cir CPT/HCPCS	
1	03	01	24	03	01	24	11		99212	
2	03	01	24	03	01	24	11		83036	
3									A1C	055

A1c UB-04 Paper Claims:



	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES
1	0324		71010
2	0300		83036
3		A1C 055	
4			

Understanding the National Drug Code

The National Drug Code (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 denies claims 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,

ER 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 the following:

- 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 UB04 or 837 transactions, please use the following link: www.hsd.state.nm.us/wp-content/uploads/FileLinks/c78b68d063e04ce5adffe29376ff402e/MAD_SUPP_10_03_New_Requirements_for_Billing_for_Drug_Items.pdf. This information is found under the header "Supplements" and it is Supplement Number 10-03.

In addition, providers may view the NDC Procedure Manual at: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00079542.

Obstetrical Services

Global maternity billing (by covered providers; for example, primary care obstetricians and specialists):

- If the delivery of the newborn is greater than three months past the mother's eligibility date, Presbyterian Turquoise 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 delivery claims to Presbyterian Turquoise Care:

- Use generic Evaluation and Management or obstetrics 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 Turquoise Care and will only be reimbursed when certain criteria are met as listed below or on the "Provider Certification of Medical Necessity for Pregnancy Termination" form.

1. 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.

2. Recipient is unconscious, incapacitated, or otherwise incapable of giving consent.
3. If pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the recipient.

Providers do not need to submit certification, however; they must keep a copy in their records.

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 providers will note the minor’s objections or the unavailability of the parent in the minor’s chart and meet other regulatory requirements as specified at NMAC 8.310.2. Coverage for pregnancy termination includes psychological counseling.

Federally and State-Funded Terminations

Federally funded terminations of pregnancy (those that are represented by CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, and 59857 and 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 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

Provider Certification of Medical Necessity for Pregnancy Termination

The HCA and Healthcare Services Directory currently requires that the provider retain a copy of the provider certification form in the patient’s medical record. A copy of the form is not required to be submitted with the claim.

State-Funded Terminations

All pregnancy terminations for Presbyterian Turquoise 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 Turquoise 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 for Turquoise Care Members

If the provider is performing a sterilization procedure, for payment of Medicaid claims a Sterilization Consent Form must be completed and submitted with the claim in accordance with 42 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 Turquoise Care is required to ensure proper adherence to the requirements, as outlined in NMAC 8.310.2.12.

Physician Certification of Medical Necessity for Pregnancy Termination

Provider Certification of Medical Necessity for Pregnancy Termination

Patient Name:

Medicaid or Presbyterian Turquoise Care Identification Number:

After reviewing the patient chart and consulting with the patient, as the treating provider, 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

Practitioner's Name: _____

Practitioner's Signature: _____

Date: _____

Filing Claims with Coordination of Benefits

When the member has coverage under two Presbyterian benefit plans, the claim must be submitted to the primary member ID first. If the claim is submitted to the member's secondary ID first, the claim will be denied. When the member's primary health insurance carrier is not Presbyterian, then the primary carrier's EOP must be provided when submitting claims to Presbyterian for consideration. Presbyterian requires that all

coordination of benefits claims be submitted within 90 days from the date on the primary carrier's EOP, including adjustment requests.

Once providers have billed the other carrier and received an EOP, then they may submit the completed claim to Presbyterian. Claims with coordination of benefits must be received within 90 calendar days of the date the other payor paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payor, not to exceed 210 calendar days from the date of service.

The primary carrier's itemized EOP is required to be submitted with the claim or submitted electronically in an 837 compliant transaction. The EOP must be complete in order to understand the paid amount or the denial reason and must match the billed services for the member. Claims submitted without an EOP are denied. Claims may also be denied if other insurance carriers' requirements are not met.

Presbyterian Turquoise Care is, by law, the payor of last resort for Presbyterian Turquoise Care members. Therefore, if a Presbyterian Turquoise Care member is eligible for benefits under another insurance plan, providers must file a claim and obtain an itemized EOP from the other insurance plan, as required by the provider's contract. Coverage requirements of the other insurance plan must be satisfied. In coordinating benefits between the primary insurance carrier and Presbyterian Turquoise Care, Presbyterian Turquoise Care still acts in the same capacity that HCA/MAD has in the past as the payor of last resort.

Presbyterian Turquoise 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 Turquoise Care does not make payments for services denied by another carrier when the provider or member did not follow the requirements of the primary plan. When a Turquoise Care member's primary carrier is Medicare, then claims are processed in accordance with NMAC 8.302.3.10.

Presbyterian coordinates benefits in accordance with CMS and NMAC regulations, the National Association of Insurance Commissioners' guidelines and the member's benefit plan.

Medicare Part B Coverage Only

When a member only has Medicare Part B and has an inpatient hospital stay, Medicare Part B will pay applicable Part B Services. The inpatient hospital claim must be submitted to Medicare Part B first with bill type 012X and to Presbyterian with the bill type 011X and Medicare Part B Explanation of Medical Benefits (EOMB).

For Medicaid-eligible members, when Presbyterian receives the cross-over claim with bill type 012X for the Medicare Part B services, the claim will be denied. Providers must submit the inpatient facility claim with bill type 011X to Presbyterian. Presbyterian will reimburse providers at the inpatient rate minus the Medicare Part B payment.

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% Federal Poverty Level (FPL). Presbyterian providers may bill the member for applicable copays, coinsurance and/or deductibles. 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% 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 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 their copayment obligation for non-emergency services provided in the hospital emergency department
  - 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

Claims and Payment

- When a copayment is applied to a service, the provider will 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 co-payments 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 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:

- EOP, which includes a detailed account of the member's responsibility
- The provider portal
- ERA

Presbyterian Turquoise 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 Turquoise 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 Turquoise 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 Turquoise Care
- When the member's primary insurance has reached annual plan maximums, or maximums on specific benefits that are covered by Presbyterian Turquoise Care

Third-Party Liability

Presbyterian Turquoise Care is responsible for identification of third-party coverage of members and coordination of benefits with applicable third parties. It is important for providers to obtain all possible health

insurance information for members for Medicaid eligibility before rendering services. Providers should use patient information resources to collect from HCA, CMS and Presbyterian to collect member coverage information.

If a member is eligible for Medicaid, Presbyterian will identify the member's third-party coverage and coordinate benefits with third parties as required by federal law. Presbyterian will also inform HCA when a member has other health care insurance coverage. Presbyterian complies with 42 CFR 433.138, NMAC 8.302 part 3 and HCA LOD 19 for our right of third-party liability (TPL) recovery.

Effective Jan. 1, 2021, HCA's TPL contractor, Health Management Services, Inc. (HMS), will be responsible for all managed care Subrogation Recoveries with dates of incident or accident of Jan. 1, 2021, and after, and recovered funds will revert to the State. Any cases with dates of incident or accident prior to Jan. 1, 2021, will remain with the MCOs.

For dates of accident/incident prior to Jan. 1, 2021, Presbyterian Turquoise 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 Turquoise 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 Turquoise Care.

Without mitigating any rights, a Presbyterian Turquoise Care provider has pursuant to federal and state law and regulations, HCA has the sole right of:

- Collection from a third-party resource which Presbyterian Turquoise Care has failed to identify within 12 months from the date Presbyterian Turquoise Care first pays the claim
- Recovery from Presbyterian Turquoise Care or a Presbyterian Turquoise Care provider who has been overpaid due to the combined payments of Presbyterian Turquoise Care and a third-party resource when Presbyterian Turquoise Care has not made a recovery within 12 months from the date Presbyterian Turquoise Care first pays the claim
- Recovery from a third-party resource, Presbyterian Turquoise Care or a Presbyterian Turquoise Care provider if Presbyterian Turquoise Care has identified a third-party resource but failed to initiate recovery within the 12-month period
- Recovery from a third-party resource, Presbyterian Turquoise Care or a Presbyterian Turquoise Care provider if Presbyterian Turquoise 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 Turquoise Care first pays the claim. HCA 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 Turquoise Care pursuant to Article 6.2.4, whereupon Presbyterian Turquoise Care will retain the sole right of recovery for all paid claims related to members and months that were recouped.

Providers should review all explanation codes on their EOP to determine if the denial was because of insufficient information or if the claim was submitted incorrectly.

Requesting an Adjustment

If providers feel a claim was processed incorrectly or would like to check the status of payment, then they should logon to the provider portal or contact the Provider Care Unit at (505) 923-5757. They will advise if an adjustment is necessary and request an adjustment on the claim. Providers 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. Providers should only resubmit claims if there is corrected information. Claims without any changes should not be resubmitted.

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 payment reduction or negative claim payment on the provider's EOP. 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, then 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, then the request to correct the error must be submitted within 12 months from the date of the check.

Acceptable Time Frames for Recovery of Overpayments

When Presbyterian or another entity identifies an overpayment, the time frames below are followed.

Product Line: Presbyterian Turquoise Care

Time Frame: One year from the date of payment

Exception: When coordination of benefits is involved, then there is no time frame for recovery of any overpayments if Presbyterian has documented verification that the provider has received payment from the other insurance carrier.

Exception: For in-network and out-of-network Indian Health Services (IHS) providers, a two-year filing limit applies.

Acceptable Time Frames for Recovery of Member Retro-Terminations

Product Line: Presbyterian Turquoise Care

Time Frame: Recovery period is two years from the date of payment

Acceptable Time Frames for Confirmed Fraud or Abuse Activity as Authorized by the Special Investigative Unit or Legal Department

Product Line: Presbyterian Turquoise Care

Time Frame: Four years from the date of payment

Exceptions to these guidelines above 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 the provider's EOP.

Timely Submission Guidelines

Guidelines for Original Claim Submissions

Presbyterian requires that all claims from in-network providers are received within 90 days of the date of service. When billing claims for inpatient facility charges, 90-day filing limit begins from the date of discharge. Failure to adhere to the timely submission guidelines results in the denial of claims.

If a claim was submitted to the wrong carrier, submit the claim and denial letter or EOP from the other carrier to Presbyterian within 90 days of the date of the denial letter or EOP from the other insurance carrier.

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.

For a provider of services not enrolled with New Mexico's Medicaid program at the time services are rendered, including a provider that is in the process of purchasing an enrolled New Mexico Medicaid provider entity such as a practice or facility, claims must be received within **90 calendar days of the date the provider is notified of the New Mexico Medicaid program approval of the PPA, not to exceed 210 calendar days from the date of service**. It is the provider's responsibility to submit a PPA within a sufficient timeframe to allow completion of the provider enrollment process and submission of the claim within the MAD timely filing limit.

Guidelines for Claim Resubmissions, Corrected Claims and Adjustment Requests for Additional Payment

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 a provider's claim is not in the system, then they should resubmit it. Providers should maintain a record of their resubmission and any contacts with Presbyterian. If the resubmission is past the 90-day filing limit, then providers should include the original filing documentation with their 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 include the following:

- Be legible and clearly identify the member
- Must 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 providers to follow up on the status of their requests every 30 to 45 days. If providers continue to not to receive any payment or documentation on their claim, then they contact the Provider Care Unit.

If a member fails to notify the provider that they are 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 they 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. Providers 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.

"Unclean" and "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 "unclean" or "clean."

A claim is defined as "unclean" if additional substantiating documentation (such as medical records, encounter data, ER reports, primary insurance explanation of payments and full itemization where necessary) is required from a source external to Presbyterian.

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 following:

- 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

Interest Payment

Interest payments are paid as directed in the Turquoise Care Managed Care contract on clean claims. Interest will 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 Turquoise 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 HCA 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 will 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 provisions for interest.

Encounter Reporting

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

HCA uses encounter data reporting to evaluate health plan compliance on many vital issues. Regardless of whether the service the provider rendered 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 (02-12) 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 ACA, 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 HCA through encounter data.

All billing, attending, ordering, referring, rendering and prescribing providers must be enrolled with New Mexico's Medicaid program. For Presbyterian to meet the encounter submission requirements for New Mexico Medicaid, providers are required to report the appropriate NPI and taxonomy code on claims when the provider

has more than one Turquoise Care provider type associated with the submitted NPI. The NPI and taxonomy code submitted on claims should match the provider's New Mexico Medicaid provider type registration.

Presbyterian can deny claims when a provider with multiple provider types registered with New Mexico Medicaid uses an incorrect taxonomy code on a claim.

Billing and Coding Tips

- Hospitals can prevent billing errors by billing for physician services when appropriate
    - For example, hospitals should only bill with a taxonomy code associated with provider type 201 (Hospital, General Acute) when they are billing for a hospital service. Hospitals should not bill provider type 201 when they are billing for physician services
        - When hospitals bill for a physician service, they should bill for the taxonomy code associated with the provider type that the individual provider supplied when registering with New Mexico Medicaid and that is most appropriate for the services that were provided
        - Some taxonomy codes are associated with multiple provider types. Individual providers with multiple registered provider types should bill using the most appropriate taxonomy code and provider type combination for the service provided that does not overlap with another registered provider type

The New Mexico Medicaid Provider Types and Taxonomy Codes Reference Guide gives providers an overview of the taxonomy codes that HCA assigned. To view the guide, visit https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000015498.

To render services to Turquoise Care members, providers must be registered with HCA.

To register with HCA, providers can go to https://Yes.NM.GOV.

Providers can also view active and termed registration by going to https://nmmedicaid.portal.conduent.com/static/index.htm. Failure to register with HCA may result in claim denials.

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, intelligent reasoning and claims history review to identify potential incorrect payments before claims are paid.

Presbyterian applies the National Correct Coding Initiative (NCCI) policy manual, clinical editing system (CES) edits, Avalon edits, Cotiviti edits and other edits based on coding industry standards for consistency in the

processing of certain code pairs, modifiers and diagnosis specification. 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. When a service is denied by CES, Avalon or Cotiviti, the member is not financially responsible for the service.

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.

Retroactive Claim Review

Retroactive claim reviews may include requests for medical records. These reviews ensure that billing practices are accurate, compliant and reflective of the services provided.

In accordance with CMS standards, providers are required to submit claims using the most accurate Diagnosis Related Group (DRG). Medical records may be requested to validate DRG submissions and support claim accuracy.

Other types of reviews may include but are not limited to:

- Inpatient/outpatient overlap claims
- Inpatient/physician overlap claims
- Hospice overlap claims

These reviews are conducted to confirm appropriate billing, prevent duplication and maintain compliance with regulatory requirements.

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. The most specific diagnosis from the ICD-10-CM should be reported for all services.

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 providers to obtain further information regarding this manual and subsequent updates. Providers are also encouraged to check the following CMS website for recent NCCI edits: 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.

Claims and Payment Resources

myPRES and PROVIDERConnect

myPRES and the PROVIDERConnect Provider Portal are available 24/7 and enables providers and 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 PCP
- Information for finding a doctor, provider or facilit
- 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, IVR, www.phs.org, or one of our electronic submission vendors. The Provider Care Unit accesses myPRES when assisting provider with inquiries. To contact the Provider Care Unit for assistance, call (505) 923-5757 or 1-888-923-5757.

Mailing Address for Paper 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:

Claims and Payment

- Medical/Physical Health claims:

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

- Behavioral Health Commercial and Medicare claims:

  Presbyterian Health Plan
  P.O. Box 2216
  Maryland Heights, MO 66043

- Behavioral Health Turquoise Care claims:

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

Coding Information and Resources

AMA CPT Products

Address: 515 North State Street
Chicago, IL 60654

Phone: 1-800-621-8335

Website: https://commerce.ama-assn.org/store/ui/catalog/subCategoryDetail?category_id=cat1150004&navAction=jump

CMS

- www.cms.gov

Provider Updates

- www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html?redirect=/center/provider.asp
- www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html

National Correct Coding Initiative (NCCI) Edits

- www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS Carriers Manual and Hospital Manual

- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html

Claims and Payment

Novitas Solutions Inc

- www.novitas-solutions.com/

Palmetto GBA for HCPCS information and the DMERC Manual

- www.palmettogba.com/palmetto/providers.nsf/vMasterDID/97NK5W3580?open

Provider Compliance Group Interactive Map

- www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html

Note: Click the state of New Mexico on the map.

National Center for Health Statistics

- www.cdc.gov

Classifications of Diseases

- www.cdc.gov/nchs/icd.htm

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Ch. 20: Presbyterian Customer Service Center

Presbyterian Customer Service Center's (PCSC's) objective is to deliver a consistent customer experience and to provide outstanding service to every customer, every contact, every time.

Presbyterian Customer Service Center Contact Information for Members

Presbyterian's Turquoise Care PCSC is available 8 a.m. to 6 p.m., Monday through Friday (except on holidays). Members can contact PCSC by calling the local or toll-free number on the back of their member ID cards, emailing info@phs.org, or visiting Presbyterian's "Contact Us" page at www.phs.org/about-us/contact-us/. For assistance with complex inquiries, providers can call (505) 923-5757 or 1-888-923-5757.

Member Communication and Welcome Packets

Upon enrollment, new enrollees receive a welcome packet, including group subscriber agreements, member handbooks, summary of benefits, or evidence of coverage as appropriate. New and existing members may access and print this information from our website at 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 their PNO relationship team. Providers can find their contact information at www.phs.org/ContactGuide.

Presbyterian Member ID Cards

After enrollment with Presbyterian, each member is issued a Presbyterian member ID card that includes the member's name, member ID number and basic plan information. Members should present their Presbyterian member ID card to the provider's office each time they arrive for a service; however, services should not be denied if no card is presented. Members can also show their digital Presbyterian member ID cards through the myPRES app accessed from a smartphone or mobile device.

The Presbyterian member ID card does not guarantee that the member is still eligible. To verify eligibility, providers should use the PROVIDERConnect portal on myPRES or Presbyterian's IVR system. The IVR can be accessed by calling (505) 923-5757 or 1-888-923-5757. The use of these services does not guarantee payment.

Providers are also encouraged to take the precaution of verifying the identity of the person presenting the Presbyterian member ID card against another form of identification, such as a driver's license or other photo ID. 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 issued its final ruling regarding identity theft red flags and addressing 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. Providers are encouraged to determine if their 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

A member of the Presbyterian HMO plan or a member of Presbyterian is highly encouraged to select a PCP to manage their healthcare needs. The PCP will be able to meet most of these needs. A member of the Presbyterian HMO plan may choose any participating PCP with an open panel.

If a member does not designate a PCP on their enrollment form, then Presbyterian may attempt to call the member to assist with the selection. If a member does not select a PCP within 15 calendar days of enrollment, Presbyterian automatically selects a PCP for the member. The PCP selection is based on factors such as the member's residence and physical ZIP code, the member's age and, if known, current provider relationships. The selection may include those practicing in a variety of areas, such as family practice, general practice, internal medicine and pediatrics.

Specialist Assigned as 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 follow the program requirements and related medical policies.

When a member requests that a specialist serve as the member's PCP, PCSC assists the member by providing them with the specialist-as-a-PCP form. This form is completed by the provider, who returns the form to Presbyterian by emailing pcscmemberadvocate@phs.org with the member's name in the subject line. Upon receipt of the completed form, the Health Services Department will review it for approval.

Primary Care Provider Changes

Members may request to change their PCP at any time, for any reason, throughout the month. PCP changes become effective the following business day of the receipt of the request or at the date requested by the member, provided the date is not retroactive.

Presbyterian Turquoise 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 first of the following month. If the request was made after the 20th of the month, the change becomes effective the first of the month after the following month.

Removing Members from Your Provider Panel

A PCP may determine it is in the member's best interest to remove the member from the PCP's panel because of the member's non-compliant or disruptive behavior in the office. In that case, the PCP can request the member's removal following Presbyterian's 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, 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 Turquoise Care is determined by the HCA Income Support Division.

Presbyterian Turquoise Care is assigned eligible participants once a month. Presbyterian Turquoise Care is notified before the first of the month that a member is enrolled. Presbyterian Turquoise 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 Turquoise Care or, if hospitalized in an acute care setting while not enrolled, until discharge to a lower level of care.

Presbyterian Customer Service Center

If the member not yet enrolled with Presbyterian Turquoise 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 Turquoise Care provides non-emergent transportation to covered medical and behavioral health services. Presbyterian's transportation coordinator or its transportation partner assists with arranging transportation for appropriate services based on medical need and obtaining the appropriate authorizations. At least a 48-hour advance notice is required to schedule a ride. Same-day transportation is available for urgent healthcare services or urgent referrals made by a PCP.

Presbyterian Turquoise Care covers emergency transportation by ground ambulance, air ambulance or by a special needs-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.

To schedule a ride, call one of the following phone numbers:

- Modivcare Solutions, LLC: (505) 923-6300 or 1-855-774-7737 (toll-free)
- PCSC: (505) 923-5200 or 1-888- 977-2333 (toll-free)

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 providers to respect, support and recognize these rights and responsibilities.

Members have the right to the following:

- Receive information about Presbyterian, , its services, and providers and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Participate with providers in making decisions about their healthcare. This includes their treatment plan and the right to refuse treatment; family members and/or legal guardians or decision-makers also have this right, as appropriate
- Candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Be informed about the options open to them for their treatment. Be informed 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

- Voice grievances or appeals about the organization or the care it provides
- Make recommendations regarding the organization's member rights and responsibilities policy
- Exercise their member rights. Understand that doing this does not cause Presbyterian and its contracted providers or HCA to treat them in a negative way
- Be informed about the options open to them for their treatment. Be informed 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
- Receive healthcare that is free from any form of restraint or seclusion that is used to pressure or punish them
- Request and receive 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 or the care that they were given without fear of retaliation (punishment)
- Choose a provider from the Presbyterian network. A referral or authorization may be needed to see some providers
- Be free from harassment by Presbyterian 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
- Self-refer to a women's health specialist in the Presbyterian network if a female member. 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 they are not a women's health specialist
- Obtaining a second opinion for surgery or clarification of the treatment plan, utilizing providers within the HMO network or arranging for the member to obtain one outside the network if there is not another

qualified provider in the network, at no cost to the member. Presbyterian Insurance Company, Inc. (PIC) PPO members who request a second opinion are subject to the office visit deductible, copayment and coinsurance according to their plan. PIC PPO members may see any provider for higher cost-sharing

- 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 PHI be restricted
- Receive confidential communications of their PHI from Presbyterian
- Receive and inspect a copy of their PHI as allowed by law
- Ask for an amendment (addition to) their PHI if, for example, they feel the information is incomplete or wrong
- Receive an accounting of PHI disclosures
- Ask for a paper copy of the official privacy notice from Presbyterian. This is their right even if they have already agreed to receive electronic privacy notices
- File a grievance if they believe Presbyterian is not following the HIPAA Standards for Privacy of Individually Identifiable Health Information
- Receive any information in a different format in compliance with the Americans with Disabilities Act

Members have the responsibility to the following:

- Supply information (to the extent possible) that the organization and its providers need in order to provide care. This helps their provider give them the care they need. This includes providing childhood immunization (shot) records for members up to age 21
- Follow plans and instructions for care that they have agreed to with their providers. This includes following their treatment plans and instructions for medications, diet and exercise, as agreed upon by the member and their provider
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Presbyterian Customer Service Center

- 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 their explanation about their care. Ask the provider questions. Talk to 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 members 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 inaccurate or incomplete
- Notify HCA for Turquoise Care and Presbyterian when their phone number, address or family status changes
- Notify their providers that they have Presbyterian insurance coverage 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 members' 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 the Member Handbook

Note: Members' rights and responsibilities are also available on our website at www.phs.org, or a member may call PCSC to request a printed copy.

Member's Right to Confidentiality

Presbyterian is committed to protecting members' PHI and safeguarding confidential medical information through the publication of the Presbyterian Joint Notice of Privacy Practices. For a printed copy of the policy, provider should contact their PNO relationship team (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.

Presbyterian Customer Service Center

Legal Authority to Make Healthcare 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
- 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.

Presbyterian Customer Service Center

Right to Request an Accounting of Disclosures Report

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 HIPAA Authorizations to Obtain Protected Health Information

When the member signs a plan enrollment form, they are authorizing Presbyterian (including its authorized agents, regulatory agencies and affiliates) to obtain limited information about the member for enrollment purposes. 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 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.

A provider or member may access and print a Presbyterian authorization form for release of PHI at https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00943110.

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 PHI, the authorization form is signed by a person with legal authority to make healthcare decisions for the individual.

Presbyterian Case Management staff coordinate cases with appropriate agencies, such as 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 because of incapacitation or the inability 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.

Presbyterian Customer Service Center

To request access to inspect or obtain a copy of PHI, the member must submit the request in writing to the following address:

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 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.

Presbyterian Website and myPRES Platform Information

Presbyterian enforces security measures to protect PHI that is maintained on our website, network, software and applications. We collect the following information from our website visitors to help us improve the website and understand what visitors find interesting and useful:

- Website traffic statistics.
- Where visitor traffic comes from.
- How traffic flows within the website.
- Browser type.

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.

The Presbyterian website (www.phs.org) 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.

Presbyterian Customer Service Center

As for myPRES and the PROVIDERConnect portal, the platform's security features only allow information pertaining to that particular member or provider to be accessed.

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 dis-enrollment." 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 participate in healthcare decisions that affect them. Being culturally sensitive and aware is the key to Presbyterian's mission to improve the health of the patients, members and communities Presbyterian serves.

Cultural sensitivity enhances communication and treatment effectiveness. For healthcare providers, being culturally sensitive 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://thinkculturalhealth.hhs.gov or using the Cultural Sensitivity Competencies link when logging into myPRES. Supported by the Office of Minority Health at HHS, and accredited by Ciné-Med, the online competencies offered are designed to assist healthcare professionals deliver culturally sensitive care to an increasingly diverse population of members.

Interpreter Services

Participating network providers are required by contract to provide or coordinate interpreter services for their patients. Our Customer Service Center is also available to assist providers with interpreter services for Presbyterian members through Certified Language International (CLI). CLI, a third-party contractor, provides

interpreter services in more than 170 languages including Spanish, Navajo, Vietnamese, Portuguese and Russian.

Providers can contact CLI directly to coordinate translation services for their members. Interpreters needed for LEP individuals or patients who qualify under the Americans with Disabilities Act are made available to provider offices at no additional cost to providers. Direct billing arrangements are available with CLI.

CLI is accessible 24/7 by calling 1-800-225-5254 (toll-free). The operator will ask for the provider's name, NPI, the patient's member number and the Presbyterian customer code. The Presbyterian customer code is 72PHP.

For more information on translation services and culturally competent care, please see the "Turquoise 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 provider declines to comply with a member's instruction or healthcare decision as a matter of conscience, the provider must continue to provide care to the member until a transfer can be executed. The 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 provider must immediately make all reasonable efforts to assist in the transfer of the patient to another healthcare 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 CMS. Presbyterian is not required to provide care that conflicts with an advance directive.

A member can obtain the brochure Making Healthcare Decisions from 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 the following:

- Living will, which lets members detail the treatments they want and do not want if they cannot speak for themselves
- Durable power of attorney for healthcare, which lets members appoint a friend or relative to make medical decisions for them if they cannot do it themselves
- Do-not-resuscitate order, which lets members inform caregivers they do not want to receive cardiopulmonary resuscitation (CPR) if their heart stops beating

Self-Help Options

Self-service options are highly encouraged for 3rd party billers regarding claim status, benefits or eligibility. These self-service options allow 3rd party billers to view claims filed under the NPI or Tax ID for which they are registered through the portal. Another option for third party billers that have the NPI and Tax ID associated with the claim in question is using the IVR for claims status, benefits, or eligibility. Third party billers do not need to speak to an agent to get this information.

myPRES and the PROVIDERConnect Portal

Using myPRES and the PROVIDERConnect Portal is the quickest and easiest way to access real-time information. These services are available 24/7 to ensure that the information providers and office staff need is at their fingertips. These tools provide the most efficient means for providers to get the information they need when they need it. Information available through myPRES and PROVIDERConnect includes the following:

- Member eligibility
- Member benefits
- Copayment, coinsurance, 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 (A mailed listing of EOP) with access to all claims associated with that remittance, including the address of where the check was mailed)
- Benefit certification submission and status

Presbyterian Customer Service Center

- Pharmacy exception submission and status
- Electronic access to the Provider Care Unit

Each employee in a provider's office that uses myPRES must have their own individual username and password. Under no circumstances should myPRES usernames and passwords be shared. It is the provider's responsibility to contact PCSC to terminate access of employees who are no longer employed. If providers have an employee who no longer requires access to myPRES, then providers should contact PCSC to terminate their access.

Violation of the terms and conditions for use of myPRES may result in revocation of myPRES access.

Interactive Voice Response System

Presbyterian's IVR system is available to assist providers 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.

Telephone Inquiries

If a member needs to request a PCP change or wishes to speak with a customer service representative, please have them call the phone number on the back of their Presbyterian member ID card.

Web-Based Inquiries

Presbyterian may contact Provider Network Operations electronically by going to www.phs.org and selecting "Contact Us" from the menu at the bottom of the page, or by going to www.phs.org/ContactGuide.

The Provider Care Unit

The Provider Care Unit is part of PCSC and is designed to handle complex inquiries from the provider community that cannot be resolved through self-help options like myPRES or IVR.The Provider Care Unit is available Monday through Friday, between 8 a.m. and 5 p.m. Providers can contact the Provider Care Unit at (505) 923-5757 or toll-free at 1-888-923-5757. Provider should have the following information ready when they call:

- Their TIN or NPI. The Provider Care Unit will be unable to assist without one of these numbers
- The member's date of birth, Presbyterian ID number, date of service, procedure code, billed amounts and claim number (if known)

Refer to the Claims chapter of this manual for the following:

- Questionable claim payment or denial

Presbyterian Customer Service Center

- 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 Provider Network Operations

Providers should contact their PNO relationship team if the issue affects more than five claims (e.g., incorrect contract payment or a charge for a specific code is denied when it should have been paid). Providers can find their relationship team's contact information at www.phs.org/ContactGuide.

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Ch. 21: Appeals and Grievances

A provider has the right to file an appeal if they are 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. In addition, if a provider is dissatisfied with any of Presbyterian's general operations, then they 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 their 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. Provider appeals and grievances may be submitted to the grievance and appeals coordinator by mail, phone, fax and online:

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

Phone: 1-888-923-5757
(toll-free)

Fax: (505) 923-6111

Online: www.phs.org/providers/resources/appeals-grievances

The provider should submit the grievance or appeal 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
- Appeals and grievances related to overpayments identified 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 Provider Care Unit to resolve an issue. A provider is encouraged to contact their PNO relationship team (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 12 months from the date of service to file an appeal regarding a claim. 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 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 will be resolved within 30 calendar days.

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 www.phs.org/providers/resources/appeals-grievances.

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, then 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, then Presbyterian processes the expedited appeal within 72 hours of receipt (time extensions may apply with written consent from the member). Members, or the provider acting on the member's behalf, may request an appeal for a denied service either orally or in writing.

The Presbyterian member appeals and grievance process is published in the Presbyterian Turquoise Care Member Handbook. Presbyterian provides a process that ensures all members have the right to exercise their right to an appeal and that they 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 they are 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.

Continuation of Benefits

You may have the right to request that you continue getting the services in question while your appeal with Presbyterian or your fair hearing with the HCA is in process. You have the right to receive continued benefits only under certain conditions:

- **At the first review,** you may request your benefits to continue any time prior to Presbyterian's initial decision to deny the services, or within ten calendar days from the date on your first denial letter, whichever is the later date. Services must be ordered by an authorized provider
- If you have requested a Presbyterian appeal and asked for benefits to continue and Presbyterian denies your appeal after 30 days, you can file for a fair hearing at that time, but it will be too late to ask for your benefits to continue pending the outcome of the fair hearing
- If the result of the appeal or the fair hearing is the same as Presbyterian's first decision to **terminate, modify, suspend, reduce or deny a service**, you will have to pay for the services you received during this time. If the result of the **Presbyterian** appeal or the fair hearing is in your favor, Presbyterian will pay for the services you received during this time
- You may also request to end your continued benefit at any time during the appeals process

For continuation of benefits, please contact us at:

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

Phone: 1-800-356-2219
(toll-free)

Fax: (505) 923-6111

Online: www.phs.org/providers/resources/appeals-grievances

Member Fair Hearing

A member may request a state fair hearing within 90 calendar days for standard appeals and expedited appeals of Presbyterian's final decision if they are 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.

The following contact information may used to request a state fair hearing:

New Mexico Health Care Authority
Office of Fair Hearings
P.O. Box 2348
Santa Fe, NM 87504-2348

Phone: (505) 476-6213 or 1-800-432-6217 (option 6) Fax: (505) 476-6215

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Ch. 22: Provider Directory

Presbyterian maintains an accurate, up-to-date online provider directory to help members locate participating practitioners and providers across all lines of business. The directory plays an essential role in:

- Ensuring members have accurate information when selecting providers
- Supporting compliance with federal and state regulations
- Meeting access-to-care and network adequacy standards
- Reducing member confusion and administrative burden
- Promoting transparency regarding provider participation status, locations and availability

Because the directory is used by members, regulators and internal Presbyterian departments (Care Coordination, Claims, Customer Service and PNO), all providers must meet directory maintenance requirements as a condition of network participation.

Regulatory Requirements

Multiple regulatory entities govern provider directory accuracy and timeliness. Providers participating in any Presbyterian network must comply with the following federal, state and accreditation rules.

Unified provider directory requirements

1. Attest to directory accuracy at least every 90 days.

2. Report demographic or practice changes within 14 days of the change.
3. Maintain accurate, working practice addresses, phone numbers and office hours.
4. Ensure correct participation status, accepting-new-patients status and panel availability.
5. Respond to directory verification outreach in a timely manner.
6. Ensure specialties, licensures, taxonomy codes and services reflect actual practice.
7. Provide accurate information that supports access, equity and cultural responsiveness.
8. Ensure accurate display of languages, accessibility features, and telehealth services.
9. Meet appointment availability, access-to-care and network adequacy requirements.
10. Understand that unverified information must be suppressed, even if the provider remains contracted.

Directory Health Equity Requirements

Presbyterian's provider directory supports organizational and regulatory efforts to advance health equity by helping members identify providers who meet their cultural, linguistic and accessibility needs. These elements also support culturally responsive care and help reduce disparities across diverse member populations. NCQA Health Equity Accreditation requires health plans to collect and maintain provider information that promotes equitable access to care, including:

- Languages spoken by the provider and staff
- Interpreter services and communication accommodations
- Accessibility features
- Populations served
- Behavioral health specializations and levels of care
- Telehealth availability

Directory Eligibility and Display Requirements

Presbyterian maintains its provider directory to ensure members can locate accurate, up-to-date information about practitioners and facilities available to deliver care. This section explains which providers are included or excluded from the directory, the difference between network and directory providers, and why directory status does not affect claims payment.

Providers Included in the Directory

A provider is eligible to appear in the Presbyterian directory when all of the following criteria are met:

The provider is contracted with Presbyterian.

The provider has an active contract or is included under a contracted group or delegated arrangement.

Credentialing is complete (if required).

Credentialed provider types (e.g., physicians, nurse practitioners, physician assistants, licensed behavioral health clinicians) must:

- Complete initial credentialing
- Maintain active and unrestricted licensure
- Have no sanctions or pending disciplinary issues
- Pass recredentialing processes when due

The provider is actively practicing and available to members.

Directory inclusion requires active availability to treat Presbyterian members, whether through:

- In-person care
- Telehealth services
- Behavioral health therapy or medication management
- Specialty or subspecialty services

The provider has at least one valid service location.

To be displayed, providers must have:

- A verified practice or telehealth location
- A working phone number
- Updated hours of operation
- A functional scheduling process

The provider offers direct member-facing care.

Only providers who directly interact and treat members are included (primary care, specialists, behavioral health clinicians, ancillary providers, etc.).

Providers Not Displayed

Certain providers must be excluded or suppressed due to regulatory, operational or data-accuracy requirements. Providers will not be displayed if they are locum tenens, traveling or temporary coverage providers who do not maintain a consistent schedule or practice location under their own name.

A provider will not be displayed in the directory if they meet any of the following criteria:

Credentialing is not complete.

Providers undergoing credentialing, recredentialing or review are not displayed until approved.

Provider does not offer direct member-facing care.

Examples include:

- Administrative-only or corporate roles
- Supervising physicians who do not see patients
- Billing-only NPI entities

Provider is not practicing at the listed location.

This includes “ghost providers” who:

- Are no longer associated with the group
- Have no meaningful claims history
- Cannot be confirmed during directory audits

Provider has unresolved data or compliance issues.

Providers may be temporarily suppressed if:

- Phone numbers or hours cannot be validated
- Locations cannot be verified
- 90-day directory attestations are not completed
- Required demographic elements are missing
- Outreach attempts go unanswered

All of the provider’s locations are invalid.

If a provider has no active validated service location, they cannot be displayed publicly.

Provider is roster-only, administrative or back-office.

Individuals who do not provide direct clinical services to members are excluded.

Network vs. Directory Providers

Understanding the distinction between a network provider and a directory provider is essential for interpreting directory display rules and complying with federal and state requirements. Under CMS definitions, a **network provider** is any contracted provider eligible to render covered services and receive Medicaid or CHIP payment, while a **directory provider** is a subset of network providers who meet all criteria for inclusion in a public, searchable provider directory. Presbyterian uses these definitions to determine which providers must

appear in the directory and when a provider may be temporarily suppressed or excluded based on regulatory standards.

Network Providers

A network provider is any provider or practitioner who is contracted with Presbyterian and eligible to render covered services and receive payment under Medicaid, Medicare or commercial health plan products. Network providers may include individual practitioners, groups, facilities, ancillary providers and behavioral health providers contracted through Magellan.

A provider may be a fully valid network provider even if they do not appear in the online directory. Directory display is separate from contracting and billing eligibility. A provider may remain in-network and reimbursable even when temporarily suppressed from the directory for reasons such as incomplete demographic information or missing verification requirements.

Examples of network providers who may not appear in the directory:

- Supervising or administrative-only providers
- Providers temporarily covering for another practitioner
- Providers with incomplete directory-required elements
- Providers between practice locations
- Providers with unverified demographic data
- Providers temporarily suppressed during directory audits

Directory Providers

A directory provider is a network provider who meets all federal, state and Presbyterian requirements for inclusion in the public, searchable provider directory. Directory providers must have verified practice locations, complete demographic information, and meet ongoing attestation, accessibility and participation standards.

To appear in the directory, a provider must:

- Have at least one verified practice location where appointments are offered
- Maintain accurate and current demographic information
- Completed required 90-day attestations
- Maintain active credentialing and licensure (when applicable)
- Be available for direct scheduling or member access (as appropriate to their role)
- Meet CMS, NSA/CAA, OSI, Turquoise Care and NCQA directory data requirements

Providers who do not meet these requirements may be temporarily suppressed until discrepancies are resolved. Directory display is intended to help members identify accessible and available providers – **not** to determine network or billing status.

Directory Visibility and Claims Payment

A provider's inclusion or exclusion from the directory does not determine whether claims will be paid. Claims payment is based on contract status, credentialing, licensure, and applicable plan benefits, and covered services continue to pay according to the contract even when a provider is temporarily suppressed from the directory. Directory suppression is required by regulatory agencies to protect members from inaccurate information.

Required Provider Responsibilities

Contracted providers must maintain the accuracy of your demographic and practice information in the Presbyterian provider directory. Providers must:

Verify Information Every 90 Days

Providers must complete verification/attestation every 90 days as required by federal law.

Report Changes Within 14 Days

Providers must notify Presbyterian of any demographic or practice changes as soon as possible, but no later than 14 days from the date the change is known. This includes changes to:

- Practice name, physical address, phone number, website
- TIN
- Panel status (accepting new patients)
- Contract participation status
- Hours of operation
- Appointment availability
- Provider joining or leaving a group practice
- Temporary or permanent leaves of absence
- Any material change affecting access or availability
- Specialty

Maintain Consistency Across Public Materials

To support accurate searches and reduce confusion, providers must ensure all public-facing information matches their directory listings, including:

- Practice names match outdoor signage
- Telephone greetings align with the directory listing

- Information is consistent across websites, business cards and marketing materials

Maintain Credentialing and Contract Compliance

- Providers must remain fully credentialed and maintain all licensure requirements
- Providers must comply with network development requirements for additional locations, specialties or services

Keep NPPES Information Accurate and Current

Providers must keep their information in the CMS National Plan and Provider Enumeration System (NPPES) NPI registry accurate and up to date. NPPES is used by CMS and other regulators to confirm provider identity, demographic information and practice locations. Discrepancies between NPPES and directory data may cause delays in processing updates or may require additional verification.

Maintain Accurate Information in the New Mexico Medicaid Provider Portal

Providers participating in Presbyterian's Medicaid products must keep their information accurate and current in the New Mexico Medicaid provider portal managed by Conduent. Updates to practice locations, licensure, billing, and pay-to information, taxonomies, or other enrollment elements must be submitted directly to the Medicaid portal in addition to notifying Presbyterian. Inaccurate or outdated information in the Medicaid system may delay enrollment-related actions or require additional verification. Updates submitted to Presbyterian do not automatically update the State's Medicaid system.

Maintaining Accurate Provider Data (Beyond Directory Requirements)

Providers must maintain accurate and current information across all provider data elements on file with Presbyterian, even if the information does not appear in the online directory. These data elements support contracting, credentialing, claims processing, member access, network adequacy reporting and regulatory compliance.

Provider data elements that must be kept current include, but are not limited to:

- Legal name, organization name and tax identification number
- Contracted specialties, subspecialties and taxonomy codes
- Billing and pay-to addresses
- Practice and service locations, including coverage arrangements and supervising relationships
- Hours of operation and after-hours contact requirements
- Hospital affiliations, group affiliations and facility relationships
- Panel status and accepting-new-patients information

- Telehealth availability and modalities
- Cultural, linguistic, accessibility/ADA compliance and population-served information
- Credentialing details, licensure status, DEA/CSR, malpractice coverage and sanctions
- Delegated or roster-based information submitted through authorized channels

Providers must notify Presbyterian within 14 days of any changes to these elements. Inaccurate or outdated provider data may delay credentialing, contracting or claims processing and may require additional verification.

Accessibility, ADA Compliance and Accessible Care Requirements

Providers and facilities must ensure that physical accessibility information is accurate and current for each practice location. This information must reflect ADA compliance requirements and is used to help members with disabilities identify accessible care settings. Providers must disclose whether each location includes:

- Accessible parking, passenger loading zones and path of travel
- Step-free or ramp entry and doorway clearance
- Elevators, lifts and accessible interior pathways
- Wheelchair-accessible restrooms
- Accessible exam rooms and medical diagnostic equipment
- Height-adjustable exam tables
- Accessible weight scales
- Assistive devices or staff accommodations for transfers
- Communication accessibility accommodations, including auxiliary aids

This information may be validated through directory audits or external accessibility reviews. Providers must update Presbyterian within 14 days when accessibility features change, are added, or are temporarily unavailable due to construction, equipment failure, or other barriers affecting ADA compliance. Locations that cannot confirm accessibility may be suppressed from directory display until verification is received.

Rostered Groups and Delegated Entity Responsibilities

Presbyterian may designate certain provider groups, health systems or behavioral health agencies as rostered or delegated entities for purposes of submitting demographic updates in bulk. Delegated and rostered groups must meet all federal, state and accreditation requirements for maintaining accurate provider data, including:

- Submitting complete and accurate roster files at the frequency required by Presbyterian

- Reporting additions, terminations and location changes within 14 days or sooner if required under contract
- Ensuring roster data matches NPPES, Conduent/Medicaid enrollment and credentialing records
- Maintaining accurate taxonomies, specialties, coverage arrangements and accepting-new-patients status
- Including all practice locations where services are delivered or where appointments are available
- Responding promptly to Presbyterian's requests to resolve discrepancies or verify information
- Ensuring all individual practitioners complete required 90-day attestation
- Coordinating with Magellan for roster-based updates to behavioral health provider data

Presbyterian will validate roster accuracy through audits, outreach and external verification sources. Discrepancies may result in correction requests, delays in processing or temporary suppression from the directory until information is verified.

Updating and Verifying Provider Information

Providers are responsible for keeping their demographic and directory information accurate and current. Updates may be submitted using any of the following methods:

- **Using the "Update Provider Demographics" application in the PROVIDERConnect Provider Portal** (preferred for physical health providers)
- Contacting your assigned PNO relationship team
- Submitting the required change forms, updated rosters or other documentation requested by PNO

Completing Directory Attestations

Attestation and demographic updates can be completed through the Update Provider Demographics application by users who have approved delegated access. Only designated users are permitted to use this real-time update tool. Providers needing access must submit the Delegate Access Request form at: https://phs.swoogo.com/delegate-access

Behavioral Health Provider Updates Through Magellan

Behavioral health providers may update their demographic and directory information – and complete required 90-day attestations – directly through Magellan by contacting Magellan Provider Services or using Magellan's provider portal. This is the preferred method for updating behavioral health provider records. Providers may also contact PNO if needed, and PNO will forward update requests to Magellan; however, this may result in processing delays. To find your assigned representative(s), visit www.phs.org/contactguide.

Presbyterian will send reminder notices to provider offices quarterly to verify and attest to the accuracy of their directory information.

Outreach, Audits and Validation

Presbyterian conducts routine outreach to ensure the accuracy, completeness and regulatory compliance of the provider directory. Outreach supports regulatory requirements and ensures that provider information remains correct, accessible and useful to members. These efforts include internal audits, third-party validation, and continuous communication through email and provider communications channels.

Internal Directory Validation Activities

Presbyterian performs ongoing directory validation and compliance activities to ensure provider information is accurate and compliant with CMS, NSA/CAA, NCQA, OSI, and Turquoise Care requirements. Providers are expected to respond promptly and supply updated information when discrepancies are identified. Failure to respond may result in temporary directory suppression.

These activities include monthly outreach, internal reviews and data checks conducted throughout the year.

- Verifying practice locations, location names and address accuracy
- Confirming phone numbers, hours of operation and appointment line functionality
- Confirming provider participation at each location
- Verifying accepting-new-patients status
- Validating medical group and hospital affiliations
- Confirming licensure, specialty and discipline
- Verifying staff awareness of the provider's participation in Presbyterian's networks
- Identifying potential "ghost providers"
- Reviewing changes that may affect member access
- Confirming that listed specialties and services match actual practice
- Conducting claims-based reviews to identify inactive providers
- Completing regulatory readiness checks to support federal and state requirements

External Independent Validation

Independent directory audits and secret shopper-style reviews are also conducted by contracted research or polling agencies, and they help validate member experience while supplementing Presbyterian's internal processes.

External validation activities may include:

- Validating directory information
- Verifying phone line accuracy
- Confirming scheduling accuracy
- Testing appointment and wait-time availability
- Confirming whether providers are accepting new patients

Email Outreach Requirements

Presbyterian uses email as a primary method of directory compliance communication, and providers must keep administrative and billing contact information up to date to ensure they continue receiving required notices. Emails may include:

- Requests to verify or correct demographic information
- Notices of overdue 90-day attestations
- Alerts about missing, outdated or conflicting directory data
- Follow-up requests to resolve audit findings
- Updates to regulatory requirements that affect provider responsibilities

Provider Newsletter (Network Connection)

Presbyterian distributes a bimonthly provider newsletter, Network Connection. The newsletter is posted on the Presbyterian Provider News & Communications page (www.phs.org/ProviderCommunications) and emailed to provider contacts on file. Providers should register for Presbyterian eNews at www.phs.org/enews and ensure their contact information is current with their PNO relationship team to continue receiving it. The newsletter includes:

- Updates on regulatory requirements related to directory accuracy
- Process changes affecting provider data or member access
- Reminders for attestation timeframes and reporting deadlines
- Clarifications on billing, coding and operational procedures
- Policy updates and system enhancements

Consequences of Non-Compliance

Presbyterian is required by law and accreditation standards to suppress or remove providers whose directory information is inaccurate, unverifiable or out of compliance. Presbyterian will make reasonable efforts to contact providers before suppression when required information is missing or cannot be verified.

Directory Suppression and Removal

A provider may be suppressed or removed from the directory if:

- 90-Day Attestation is not completed. Failure to attest will result in temporary suppression until the attestation is completed
- Presbyterian cannot verify provider information
- If a provider or group refuses to participate in or does not respond to verification outreach attempts
- If listed addresses or phone numbers cannot be confirmed
- Provider is no longer practicing at the listed location
- Providers discovered to be no longer at a location (“ghost providers”) will be suppressed
- Credentialing or contract status change
- Providers who are no longer credentialed or whose contracts have terminated will be removed.
- Quality, safety or compliance concerns
- Providers under investigation or subject to disciplinary action may be suppressed pending review

Directory Reinstatement

Providers suppressed or removed from the directory may be reinstated once:

- Required corrections are submitted
- Attestation is completed
- Credentialing or contract issues, if applicable, are resolved
- Presbyterian can confirm all required demographic and directory elements

Reinstatement timelines vary based on regulatory requirements and processing time.

How Presbyterian Uses Directory Information

The online directory supports key operational functions across Presbyterian, helping ensure accurate provider data is available for members, providers and internal teams. Directory information is used for:

- Member provider search and plan selection
- Network adequacy reporting
- Regulatory reporting (CMS, OSI, Turquoise Care)
- Call center scripting and navigation
- Prior authorization, referrals and care coordination
- Provider onboarding and servicing

Support and Resources

Presbyterian offers several resources to help providers maintain accurate directory information and stay informed about regulatory updates:

- **PNO Relationship Team:** Your primary contact for directory questions and support
- **Provider Communications:** Newsletter and updates with regulatory and process changes
- **PROVIDERConnect Provider Portal:** “Update Provider Demographics” and related tools

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Appendix A: Acronyms

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

A

Back to top

AACAP	American Academy of Child and Adolescent Psychiatry
AAP	American Academy of Pediatrics
ADHD	Attention Deficit and Hyperactivity Disorder
ACA	Patient Protection and Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADL	Activities of Daily Living
AMA	American Medical Association
APA	American Psychiatric Association
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Only

B

Back to top

BADL	Basic Activities of Daily Living

C

Back to top

CAGE	Cut, Annoy, Guilty, Eye Opener
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCS	Correct Coding Standards
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHR	Community Health Representative
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CNA	Comprehensive Needs Assessment
CPT	Current Procedural Terminology
CSA	Core Service Agency
CT	Computed Tomography

CYFD	Children, Youth, and Families Department

D Back to top

DEA	Drug Enforcement Agency
DHI	Division of Health Improvement
DME	Durable Medical Equipment
DOH	Department of Health
DSM	Diagnostic Statistical Manual
DUR	Drug Utilization Review

E Back to top

eCOB	Electronic Coordination of Benefits
ECHO	Extension for Community Healthcare Outcomes
ECT	Electronic Claims Transmission
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EOP	Explanation of Payment
EOR	Employer of Record
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ER	Emergency Room

F Back to top

FAQ	Frequently Asked Question
FDA	Food and Drug Administration
FICA	Federal Insurance Contributions Act
FMA	Fiscal Management Agency
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FR	Federal Register
FUTA	Federal Unemployment Tax Act

G Back to top

GSA	Group Subscriber Agreement; Government Services Administration

H Back to top

HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HHA	Home Health Aide

HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HRA	Health Risk Assessment
HRSA	Health Resources and Services Administration
HSC	Hospital Services Corporation
HCA	Health Care Authority

I Back to top

IADL	Instrumental Activities of Daily Living
ICM	Integrated Care Management
ICT	Interdisciplinary Care Team
IHS	Indian Health Service
I/T/U	Indian Health Service/Tribal Health Providers/urban Indian Providers
IVR	Interactive Voice Response

L Back to top

LEP	Limited English Proficient
LPN	Licensed Practical Nurse
LRI	Legally Responsible Individual

M Back to top

MAD	Medical Assistance Division
MCO	Managed Care Organization
MFEAD	Medicare Fraud and Elder Abuse Division
MPC	Medical Policy Committee
MRI/MRA	Magnetic Resonance Imaging/Angiography
MRR	Medical Record Review
MTM	Medication Therapy Management

N Back to top

NCCI	National Correct Coding Initiative
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NFLOC	Nursing Facility Level of Care
NMAC	New Mexico Administrative Code
NMMFCA	New Mexico Medicare False Claims Act
NMSA	New Mexico Statutes Annotated

NMSIIS	New Mexico State Immunization Information System
NPI	National Provider Identifier

O Back to top

OIG	Office of the Inspector General
OSI	New Mexico Office of the Superintendent of Insurance

P Back to top

P&T	Pharmacy & Therapeutics
PCA	Personal Care Attendant
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider/Practitioner
PCSC	Presbyterian Customer Service Center
PDL	Preferred Drug List
PET	Positron Emissions Tomography
PHI	Protected Health Information
PHP	Presbyterian Health Plan
PHS	Presbyterian Healthcare Services
PIC	Presbyterian Insurance Company
PID	Presbyterian Program Integrity Department
PMP	Prescription Monitoring Program
PPA	Provider Participation Agreement
PPO	Preferred Provider Organization

Q Back to top

QI	Quality Improvement
QM	Quality Management

R Back to top

RAC	Recovery Audit Contractor
RBRVS	Resource-Based Relative Value Scale
RN	Registered Nurse

S Back to top

SAM	System for Award Management
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income

T Back to top

TAC	Technology Assessment Committee

U		Back to top
UNM	University of New Mexico	
USC	United States Code	
USPSTF	United States Preventive Services Task Force	

V		Back to top
VFC	Vaccines for Children	
VPA	Vaccine Purchase Act	

W		Back to top
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.

HCA: In the Aug. 31, 2012, Request for Proposals (RFP# 13-360-8000-001) for Turquoise Care.
CMS: www.medicaid.gov
NM: State of New Mexico website
PM: Within this Provider Manual
Wiki: Wikipedia

Term	Definition	Source
Abuse	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.	HCA
Action	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 HCA 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.	HCA
Activities of daily living (ADL)	Means eating, dressing, maintaining oral hygiene, bathing, ensuring mobility, toileting, grooming, taking medications, transferring from a bed to a chair and walking, consistent with HCA regulations. See also basic activities of daily living (BADL) and instrumental activities of daily living (IADL).	HCA
Adult	Means an individual age 18 or older unless otherwise specified.	HCA
Advance directive	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.	HCA
Adverse determination	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.	HCA
Agency-based community benefit	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.	HCA
Appeal	Means a request by a member for review by the MCO of a MCO Action.	HCA
Basic activities of daily living (BADL)	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) http://en.wikipedia.org/wiki/Activities_of_daily_living	see link

Term	Definition	Source
Behavioral health	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.	HCA
Business days	Means Monday through Friday, except for State of New Mexico holidays.	HCA
Calendar days	Means all seven days of the week, including State of New Mexico holidays.	HCA
Care coordination	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 http://medical-dictionary.thefreedictionary.com/care+coordination	see link
Care level	See levels of care.	HCA
Turquoise Care	Means the State of New Mexico's Medicaid program operated under Section 1115(a) of the Social Security Act waiver authority.	HCA
Claim	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.	HCA
(the) Collaborative	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.	HCA
Community benefit	Means both the agency-based community benefit and the self-directed community benefit subject to an individual's annual allotment as determined by HCA.	HCA
Community health representative (CHR)	Equivalent to community health worker or *promotora* but in the tribal communities.	PM
community health workers (CHW)	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, frontier 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.	HCA
Confidential Information	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 HCA 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 HCA, 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.	HCA
Core service agencies (CSAs)	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.	HCA
Covered Services	Means those physical, behavioral health and long-term care services provided under Turquoise Care.	HCA

Term	Definition	Source
Critical incident	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 PCP.	HCA
Cultural competence	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.	HCA
Desirable	Means "preferred." The terms "may," "can," "should," "preferably," or "prefers" identify a desirable or discretionary item or factor (as opposed to "mandatory").	HCA
Determination	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.	HCA
Dual-eligible(s)	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.	HCA
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program	Means the federally required 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 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.	HCA
Electronic health record (EHR)	Means a record in digital format that is a systematic collection of electronic health information. EHRs 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.	HCA
Emergency medical condition	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, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to	HCA

Term	Definition	Source
	bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the member.	
Emergency services	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.	HCA
Encounter	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.	HCA
Encounter data	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.	HCA
Fair hearing	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.	HCA
Federally qualified health center (FQHC)	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.	HCA
Fiscal management agency (FMA)	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.	HCA
Fraud	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 themself or some other person. It includes any act that constitutes fraud under applicable federal or state law.	HCA
Frontier	Means the following counties in New Mexico: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola.	HCA
Grievance	Means an expression of dissatisfaction about any matter or aspect of the MCO or its operation.	HCA
Home- and community-based services (HCBS)	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.	CMS
Health education	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.	HCA
Health home	Means, as defined in Section 2703 of ACA, 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.	HCA

Term	Definition	Source
Health information technology (HIT)	Means the area of information technology involving the design, development, creation, use and maintenance of information systems for the healthcare industry.	HCA
Health Literacy	Means the degree to which members are able to obtain, process and understand basic health information and services needed to make appropriate health decisions.	HCA
Healthcare Effectiveness Data and Information Set (HEDIS)	Means the tool used by health plans to measure performance of certain healthcare criteria developed by the National Community for Quality Assurance (NCQA).	HCA
high-volume specialty care providers	Anesthesia, cardiology, gastroenterology, general surgery, OB/GYN, oncology, ophthalmology, orthopedics and radiation oncology. High-volume specialists are identified as in-network providers not identified as PCPs who are paid the highest amount per year based on claims submitted, encounter data and the inclusion of healthcare costs across all product lines.	
HIPAA	Means the Health Insurance Portability and Accountability Act of 1996, 42 USC 160, et seq.	HCA
HITECH Act	Means the Health Information Technology for Economic and Clinical Health Act of 2009; 42 USC 17931, et seq.	HCA
Health Risk Assessment (HRA)	An assessment performed per HCA 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.	HCA
Indian Health Service (IHS)	Means the division of the HHS responsible for providing health services to Native Americans.	HCA
Indian Health Service/tribal health providers/urban Indian providers (I/T/U)	A collective term that references any or all of the three types of providers.	
instrumental activities of daily living (IADL)	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 http://en.wikipedia.org/wiki/Activities_of_daily_living	see link
Interagency Behavioral Health Purchasing Collaborative (aka The Collaborative)	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 CYFD alternating annually as co-chairs. www.bhc.state.nm.us/	see link
Lean Six Sigma	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. www.ehow.com/facts_5007027_definition-lean-six-sigma.html	see link

Term	Definition	Source
Levels of care	The care coordination process addresses three levels of care, Level 1, 2 and 3. • **Level 1.** Members assigned to Level 1 care coordination are those members who do not currently require a CNA and who are not assigned an individual care coordinator. • **Level 2 and Level 3**. Members assigned to Level 2 or 3 care coordination meet one of the indicators listed below. These members do require a CNA to determine they should be in Level 2 or 3 care coordination. ▪ Is a high-cost user as defined by the MCO ▪ Is in out-of-State medical placements ▪ Is a dependent child in out-of-home placements ▪ Is a transplant patient ▪ Is identified as having a high risk pregnancy ▪ Has a behavioral health diagnosis including substance abuse that adversely affects the member's life ▪ Is medically fragile ▪ Is designated as ICF/MR/DD ▪ Has high ER use as defined by the MCO ▪ Has an acute or terminal disease ▪ Is readmitted to the hospital within 30 calendar days of discharge ▪ Has other indicators as prior approved by HCA	
limited English proficiency	Means the restricted ability to read, speak, write or understand English by individuals who do not speak English as their primary language.	HCA
Long-term care	Refers to the community benefit, the services of a nursing facility and the services of an institutional facility.	HCA
Managed care organization (MCO)	Means an entity that participates in Turquoise Care under contract with HCA 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.	HCA
Medically necessary services	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.	HCA
Member	Means a person who has been determined eligible for Turquoise Care and who has enrolled in the MCO's health plan.	HCA
Member materials	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.	HCA
Member satisfaction survey	Annual survey that will assess member satisfaction with the quality, availability and accessibility of care.	HCA
Non-contract provider	Means an individual provider, clinic, group, association or facility that provides covered services and that does not have a contract with the MCO.	HCA
Non-Medicaid nontractor	Means the entity contracting with the Collaborative to provide behavioral health services with the use of non-Medicaid funds.	HCA
Not otherwise Medicaid eligible	Refers to individuals not eligible for Medicaid services under New Mexico's Medicaid State Plan.	HCA

Term	Definition	Source
Nursing facility (NF)	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.	HCA
Otherwise Medicaid eligible	Refers to individuals who are eligible for Medicaid services under New Mexico's Medicaid State Plan.	HCA
Outreach	Means, among other things, educating or informing the MCO's members about Turquoise Care, managed care and health issues.	HCA
Patient Protection and Affordable Care Act (ACA)	Means Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010).	HCA
Patient-centered medical home (PCMH)	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.	HCA
Post-stabilization services	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.	HCA
Pharmacy network	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	
Presbyterian improvement model	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 of results of improvement initiatives.	PM
Primary care provider (PCP)	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.	HCA
Project ECHO	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.	HCA
Promotoras	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.	PM
Provider	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.	HCA
Provider satisfaction survey	Annual Provider Satisfaction Survey that covers contract providers and follows NCQA guidelines to the extent applicable.	HCA
Provider workgroup	Means the workgroup consisting of representatives from all of the Turquoise Care MCOs, HCA, the Collaborative and providers to work collaboratively to reduce administrative burdens on providers by, among other things, standardizing forms and processes.	HCA
Qui tam	Latin for "who as well." A lawsuit brought by a private citizen (popularly called a "whistle blower") 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. http://dictionary.law.com/Default.aspx?selected=1709	see link

Term	Definition	Source
Recipient	Means an individual who is eligible for Turquoise Care but has not yet enrolled in a Turquoise Care MCO.	HCA
Reportable incident	See critical incident.	--
Representative	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.	HCA
Rural	Refers to the counties in the State of New Mexico that are not frontier or urban.	HCA
Rural health clinic (RHC)	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.	HCA
School-based health centers	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.	HCA
Self-directed community benefit	Means certain Home and community-based services that are available to members meeting nursing facility level of care.	HCA
Telehealth	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.	HCA
Tribal	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.	HCA
Tribal 638 facility	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.	HCA
Urban	Means the following counties in New Mexico: Bernalillo, Los Alamos, Santa Fe and Doña Ana.	HCA
Urban Indian	Will have the meaning ascribed to such term in 25 USC § 1603.	HCA
Utilization management	Means a system for reviewing the appropriate and efficient allocation of healthcare services that are provided, or proposed to be provided, to a member.	HCA
Value added service	Means any service or benefit offered by the MCO that is not a covered service.	HCA
Waiver	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: • Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. • 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. • 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. • 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.	CMS

Term	Definition	Source
Waiver 1115 New Mexico State Insurance Coverage-Title XIX Component	According to information provided by the state, this demonstration provides coverage to uninsured childless adults with income from 0 up to 200% 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% of the FPL, please see the separate listing for the Title XXI New Mexico State Coverage Insurance Demonstration.	CMS
Waiver 1115 New Mexico Coverage Insurance Title XXI Component	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.	CMS
Waiver 1115 Turquoise Care	According to information provided by the state, Turquoise 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.	CMS
Waiver 1915(b) NM Behavioral Health Waiver	Managed care program which provides comprehensive mental health and substance abuse services through collaboration and partnership with a single statewide contractor.	CMS
Waiver 1915(b) New Mexico Salud	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.	CMS
Waiver 1915(c) NM Mi Via-ICF/MR (0448.R01.00)	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.	CMS
Waiver 1915(c) NM Mi Via NF (0449.R01.00)	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.	CMS
Waiver 1915(c) NM Medically Fragile (0223.R04.00)	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.	CMS

Term	Definition	Source
Waiver 1915(c) NM DD (0173.R05.00)	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.	CMS
Waiver 1915(c) NM AIDS (0161.R04.00)	Provides case management, homemaker/personal care, private duty nursing for individuals w/HIV/AIDS ages 0 – no max age.	CMS
Waste	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.	PM-16

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Appendix C: Websites

Name	Website Location
Access of Service Standards	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00950866
American Psychiatric Association (APA) and the American Academy of Pediatrics (AAP) Resources and Guidance	http://psychiatryonline.org/guidelines
Appeals and Grievances webpage	www.phs.org/providers/resources/appeals-grievances
Asthma Resources and Guidance	**Guidelines for the Diagnosis and Management of Asthma Full Report (National Asthma Education and Prevention Program, National Heart, Lung and Blood Institute)** www.nhlbi.nih.gov/sites/default/files/media/docs/EPR-3_Asthma_Full_Report_2007.pdf **Guidelines for the Diagnosis and Management of Asthma Summary Report (National Asthma Education and Prevention Program, National Heart, Lung and Blood Institute)** www.nhlbi.nih.gov/sites/default/files/media/docs/asthsumm.pdf **Guidelines for the Diagnosis and Management of Asthma – 2020 Focused Updates (National Heart, Lung and Blood Institute)** www.nhlbi.nih.gov/resources/2020-focused-updates-asthma-management-guidelines
Attention Deficit/Hyperactivity Disorder (ADHD) Resources	**ADHD Diagnosis and Evaluation Guidelines** http://pediatrics.aappublications.org/content/105/5/1158.full.pdf+html?sid=f4a99748-b682-4ec4-a4f3-8d545eb204a6 **Treatment of School-Aged Children with ADHD** http://pediatrics.aappublications.org/content/108/4/1033.full.pdf+html **ADHD Quick Reference Guide** https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=wcmdev1000899
Availity®	www.availity.com
Become a Contracted Provider	http://www.phs.org/providers/our-networks
Behavioral Health Resources	www.phs.org/providers/resources/reference-guides/Pages/medical-pharmacy-behavioral.aspx
CAQH Website	www.caqh.org/
Claim.MD	www.claim.md/

Appendix C: Websites

Name	Website Location
Claim.MD Fast Claim Enrollment	www.claim.md/phs.plx
Claims Processing Page	www.phs.org/providers/claims
Classification of Diseases, Functioning and Disability	www.cdc.gov/nchs/icd.htm
CLIA Waived Test List	http://www.cms.gov/files/document/r11547CP.pdf#page=5
CMS Carriers Manual and Hospital Manual	www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html
CMS Provider Updates	**Fee-for-Service Provider Updates** www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html?redirect=/center/provider.asp **Quarterly Provider Updates** www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html
Coding and Reimbursement Store (AMA)	https://commerce.ama-assn.org/store/catalog/categoryDetail.jsp?category_id=cat1150004&navAction=jump
Contact Presbyterian – Provider Page	www.phs.org/ContactGuide
Contact Presbyterian – Member Page	http://www.phs.org/providers/contact-us/
Coronary Artery Disease Resources and Guidance	**AHA/ACC Secondary Prevention for Patients with Coronary and Other Vascular Disease: 2006 Update (American College of Cardiology and the American Heart Association)** https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052254 **Coronary Artery Disease Clinical Practice Guidelines (American College of Cardiology and the American Heart Association)** https://www.ahajournals.org/doi/10.1161/CIR.0000000000001309 **Coronary Artery Disease Clinical Recommendations for Prevention of Heart Disease in Women (American Heart Association)** https://www.ahajournals.org/doi/full/10.1161/01.ATV.0000114834.85476.81?doi=10.1161/01.ATV.0000114834.85476.81
Cultural Competency Resource Kit	www.magellanprovider.com/MHS/MGL/education/culturalcompetency/index.asp
Dentaquest Website	www.dentaquestgov.com
Depression Guidelines for Primary Care Practitioners Treating Adult Patients with Depression	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=wcmdev1001004

Name	Website Location
Depression Recognition Tools: PHQ-9 and Other Information	www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001006.pdf
Diabetes Clinical Practice Guidelines for Providers–Non-Pregnant Adult	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=wcmdev1001010
Drug Prior Authorization Request Form	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000029118
Electronic Code of Federal Regulations	www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl
eNews Registration for Providers	www.phs.org/providers/contact-us/news-and-communications/Pages/enews-registration.aspx
Fraud and Abuse Information and Reporting Page	www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx
Gateway EDI	https://payers.gatewayedi.com/payerlist/
General Services Administration's System for Award Management (GSA SAM)	https://sam.gov/
HealthEC	www.healthec.com/
HealthXnet®	www.healthxnet.com
HIPAA Final Omnibus Rule Resources	**Federal Register Release** www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf **Department of Health and Human Services** www.hhs.gov/ocr/privacy/hipaa/administrative/omnibus/index.html
HIPAA Resources	**American Medical Association** www.ama-assn.org/practice-management/hipaa **Department of Health and Human Services** www.hhs.gov/ocr/privacy/index.html **Centers for Medicare and Medicaid Services** www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA
HIPAA Training Materials	www.hhs.gov/ocr/privacy/hipaa/understanding/training/index.html
Laboratory Benefit Management (LBM) Policies	**Policies** www.phs.org/providers/resources/medical-policy-manual/lbm **Administrative Claims Edits Guide Summary of Updates** https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_000000018213

Name	Website Location
List of Excluded Individuals and Entities, Department of Health and Human Services/Office of Inspector General (HHS OIG)	https://oig.hhs.gov/exclusions/exclusions_list.asp
Magellan EDI Testing Center	www.edi.magellanprovider.com/index.jsp
Magellan Provider Website	www.magellanprovider.com
McKesson	www.mckesson.com
MedAssets	www.medassets.com
Medical Policy Manual	www.phs.org/medicalpolicymanual
MLN Store (CMS)	www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training
MyChart Information Page	www.phs.org/tools-resources/access-your-care/Pages/access-your-health-information.aspx
myPRES Sign-in Page	www.phs.org/myPRES
National Center for Health Statistics	www.cdc.gov/nchs/
National Committee for Quality Assurance (NCQA) Website	www.ncqa.org
National Correct Coding Initiative Edits	www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd
National Drug Code Billing Procedure Manual for Providers	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00079542
National Provider Identifier (NPI)	https://nppes.cms.hhs.gov/
New Mexico Health Care Authority Medical Assistance Division	www.hca.nm.gov/about_the_department/medical_assistance_division/
New Mexico Immunization Program Website	www.nmhealth.org/about/phd/idb/imp/
Novitas Solutions, Inc.	www.novitas-solutions.com/

Name	Website Location
Obesity Resources	**Getting in Balance Worksheet to Identify Overall Weight-Related Health Risk (Clinical prevention Initiative)** www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031069.pdf **Overweight & Obesity in Primary Care (Clinical Prevention Initiative)** https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=wcmprod1030683 **Quick Discussion Guide for Adult Weight Counseling in Primary Care (Clinical Prevention Initiative)** https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=wcmprod1031068
Office Ally	www.officeally.com
Office of Inspector General: US Department of Health and Human Services website	http://oig.hhs.gov/
Palmetto GBA for Healthcare Common Procedure Coding System (HCPCS) information and the DMERC Manual	www.palmettogba.com/
Payerpath	www.payerpath.com
Pharmacy Resources and Forms	www.phs.org/providers/authorizations
Populations Health Alliance	http://populationhealthalliance.org/
Presbyterian ePayment Center	https://presbyterian.epayment.center/
Presbyterian Healthcare Services website	www.phs.org
Preventative Healthcare Guidelines for Practitioners	www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral
Preventative Healthcare Guidelines Website	www.phs.org/tools-resources/access-your-care/Pages/preventive-care-guidelines.aspx
Prior Authorization Guide	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00179220
Promoting Interoperability Programs	**Official Web Site for the Medicare Promoting Interoperability Programs** www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs?redirect=/ehrincentiveprograms/ **HHS Office of the National Coordinator for Health Information Technology, "Certification Program Requirements"** www.healthit.gov/providers-professionals/ehr-incentives-certification
Provider Compliance Group Interactive Map	www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html

Name	Website Location
Presbyterian Health Plan Provider Homepage	www.phs.org/providers
Provider Services Contact Guide	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00140718
Provider News and Communications	www.phs.org/providercommunications
Radiology/Diagnostic Imaging Requests through Stanson Health	https://php.careportal.com
RelayHealth	www.relayhealth.com
State of New Mexico Regulations & Licensing Department	www.rld.state.nm.us/
Think Cultural Health	https://thinkculturalhealth.hhs.gov/
Tricore Laboratory Locations	www.tricore.org/locations/
Vaccines for Children (VFC) Program Information (CDC)	www.cdc.gov/vaccines/programs/vfc/index.html
Workgroup on Electronic Data Interchange (WEDI)	www.wedi.org/

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Appendix D: Phone Numbers

Name	Phone Number
Adult Protective Services	1-866-654-3219
Air Transportation Request	505-923-5757 or 1-888-923-5757 (option 4)
American Medical Association (AMA) CPT Products	1-800-621-8335
Availity®	1-800-AVAILTY (282-4548)
Behavioral Health Care Coordination	Commercial/ Presbyterian Senior Care (HMO) members: 505-923-5221 or 1-866-593-7431 Turquoise Care members: 505-923-8858 or 1-866-672-1242
Behavioral Health Customer Service	505-923-5678
Behavioral Health Requests	(505) 923-5757 or 1-888-923-5757 (option 5) (phone) 505-843-3091 (fax)
Capario	1-800-586-6938
Care Coordination Unit	1-866-672-1242 or 505-923-8858 (phone) 505-843-3150 (fax)
Children, Youth and Families Department (CYFD)	1-800-797-3260
Claim.MD	1-855-757-6060
Department of Health/Division of Health Improvement (DOH/DHI)	1-800-445-6242
DentaQuest (Dental Care)	1-855-343-4276 (phone) 1-262-241-7150 (fax)
Durable Medical Equipment (DME) Requests	505-843-3047 (fax)
E-Help Desk	505-923-5590 or 1-866-861-7444
Emdeon Business Services	Customer Support: 1-877-469-3263 Corporate Office: 1-615-932-3000
Federal Funded Pregnancy Termination Request (fax)	505-923-5489
Gateway EDI, Inc.	1-800-969-3666
Health Services	505-923-5757 or 1-888-923-5757 (option 4)

Name	Phone Number
Healthy Solutions Disease Management Program	1-800-841-9705
HealthEC	1-877-444-7194
HealthXnet® User Administration and Help Desk	505-346-0290 or 1-866-676-0290 (phone) 505-346-0278 (fax)
Home Healthcare Requests	505-559-1151 or 1-877-606-1151 (option 4) (phone) 505-559-1150 (fax)
Immunization Hotline	1-800-232-4636
Inpatient Concurrent Review or Inpatient Hospital Admission	505-923-5757 or 1-888-923-5757 (option 4) 505-843-3107 or 1-888-923-5990 (fax)
Inpatient Prior Authorization Requests	505-923-5757 or 1-888-923-5757 (option 4) 505-843-3107 or 1-888-923-5990 (fax)
Interactive Voice Response (IVR)	505-923-5757 or 1-888-923-5757 (Option 1)
Magellan EDI Support	1-800-450-7281
Long-Term Care Prior Authorization Request	505-843-3107 1-888-923-5990 (fax)
MedAssets	Main Office: 1-678-323-2500 Product Information: 1-888-883-6332 Tech Support: 1-866-658-1629
New Mexico Health Care Authority Office of Fair Hearing	505-476-6213 or 1-800-432-6217 (option 6) 505-476-6215 (fax)
NurseAdvice® New Mexico	Turquoise Care members: 505-923-5677 or 1-888-730-2300 Presbyterian Senior Care (HMO/HMO-POS) members: 1-800-887-9917 Presbyterian Commercial members: 1-866-221-9679 Presbyterian employees and dependents: 1-800-905-3282
Office Ally	1-866-575-4120 (phone) 1-360-896-2151 (fax)
Outpatient Services	505-923-5757 or 1-888-923-5757 (option 4) 505-843-3047 (fax)
Payerpath	1-877-623-5706
Pharmacy Requests	505-923-5757 (option 3) or 1-888-923-5757 (option 3)

Name	Phone Number
Pharmacy Services Helpdesk	505-923-5500 or 1-888-923-5757 (phone) 1-877-640-5814 (toll free fax)
Provider Care Unit	505-923-5757 or 1-888-923-5757
Provider Network Operations e-Business Analyst	505-923-8726
Presbyterian Customer Service Center (PCSC)	505-923-5200 or 1-888-977-2333
Presbyterian ePayment Center	1-855-774-4392
Prior Authorization Line	505-923-5757 or 1-888-923-5757 (option 4)
Quality and Population Health Management Resource Line	505-923-5017 or 1-866-634-2617 (message only)
Quality Management Department	505-923-5516
Radiology/Diagnostic Imaging Requests through Stanson Health	Phone: 1-888-487-0733 Fax: 1-646-502-5041
RelayHealth	1-800-527-8133 (Option 2)
SilverSneakers® Fitness Program	1-888-423-4632
Spine Surgery Imaging Requests (Evolent's Medical Specialty Solutions Program)	Phone: 1-866-236-8717 Fax: 1-800-784-6864
Program Integrity Department (PID) Confidential Hotline	505-923-5959 or 1-800-239-3147
Superior Medical Transport	1-877-735-0111 (toll free) or 505-341-0042
Superior Vision Services	1-800-507-3800
University of New Mexico Case Managers	505-272-2910
University of New Mexico Prior Authorization Requests	(505) 923-5757 or 1-888-923-5757 (option 4) 505-843-3108 (fax)
Vaccines for Children (VFC) Program Director (PHS)	505-827-2898

Name	Phone Number
TriCore Telephone Numbers	Main Numbers 505-938-8888 (24 hours) 1-800-245-3296 (24 hours) Client Services 505-938-8922 or 1-800-245-3296 (24 Hours) Client Supplies For phone or fax orders: 505-938-8957 (phone) 1-800-245-3296 ext. 8957 (phone) 505-938-8472 (fax) For online supply orders, call the Supply Order Desk 505-938-8957 or 1-800-245-3296, ext. 8957 Logistics/Couriers 505-938-8958 1-800-532-2649 505-954-3780 (Santa Fe) 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 Billing/Business Office 505-938-8910 or 1-800-541-9557 505-938-8640 (fax)
University of New Mexico (UNM) Case Management Program	505-272-2910
Vaccines for Children (VFC) Program Director (PHS)	505-827-2898

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Appendix E: Prior Authorization Guide

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Accredited residential treatment center services	Yes	Member must be less than 21 years of age. NON-COVERED SERVICES: Services furnished in residential treatment centers are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.310.2.13NMAC, General Non-covered Services. Medicaid does not cover the following specific services for recipients in residential treatment centers: • Services not considered medically necessary for the condition of the recipient, as determined by Presbyterian. • Services for which prior approval was not requested. • Services furnished to ineligible individuals; residential treatment center services are covered only for recipients under 21 years of age. • Services furnished after Medical Assistance Division (MAD) or its designee determines that the recipient no longer needs Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited residential treatment center care. • Formal educational and services which relate to traditional academic subjects or vocational training. • Experimental or investigational procedures, technologies, or non-drug therapies and related services. • Drugs classified as “ineffective” by the FDA drug evaluation. • Activity therapy, group activities and other services primarily recreational or diversional in nature.
Adult day health (ABCB service)**	Yes	Only for those who qualify for Nursing Facility Level of Care and select Agency Based Community Benefits (ABCB). Services must be at least two hours per day for one or more days per week. • Adult day health services can be provided only by eligible adult day health agencies. • Adult day health facilities must be licensed by DOH as an adult day care facility. • Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility. • An adult day healthcare 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.). • An adult day healthcare provider agency must comply with all applicable city, county, or state regulations governing transportation services. This service is

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		not provided to ABCB recipients in Assisted Living facilities.
Advanced Imaging Ordering Program	Yes for high-cost services	Presbyterian uses the Advanced Imaging Program, managed by Stanson Health, 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.
Ambulatory surgical center services	Yes for selected services	NON-COVERED SERVICES: If the surgery is non-covered, the anesthesia is non-covered. • Direct payment to provider. Ambulatory surgical centers are not reimbursed by Presbyterian for provider fees. Reimbursement for provider fees is made directly to the provider of the service. • Services furnished to dual-eligible recipients. By federal regulation, the Medicare 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 where Medicare pays for the surgical procedure, such as an outpatient hospital.
Anesthesia services	Yes for select services	Anesthesia for pain management and dental procedures require prior authorization. Electronic Claims Transmission (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 healthcare 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	No	Services are limited to recipients ages 18 years and older who have a diagnosis of a serious mental illness or a serious emotional disturbance.
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.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Behavior management skills development services	No	Presbyterian 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 21 years of age who: a. Are at risk for out-of-home placement because of unmanageable behavior at home or within the community. b. Need behavior management intervention to avoid inpatient hospitalizations or residential treatment. c. 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 Presbyterian.
Behavior support consultation (ABCB service) (SDCB 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 Utiliation Management review team.
Behavioral health professional services: outpatient behavioral health and substance abuse services	No	
Care coordination	No	
Case management	No	
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 before 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	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Comprehensive community support services (CCSS)	No	CCSS may not be filled in conjunction with the following Presbyterian 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 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	No	Member must be under 21 years of age. Presbyterian 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. Day treatment services cannot be offered at the same time as partial hospital program or any residential program.
Dental services	Yes	Benefit managed by DentaQuest, which has published criteria.
Dialysis services	No	Dialysis at non-contracted facilities within New Mexico will require a prior authorization. Dialysis outside of New Mexico, for travel, will not require prior authorization. (This does not apply to Medicare members.)
Durable medical equipment (DME) and supplies	Yes for select items	A. Special requirements for purchase of wheelchairs: Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to an 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.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		A. The provider assumes responsibility for correcting defects or deficiencies in wheelchair and seating systems that make them unsatisfactory for use by the eligible recipient. B. 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. C. 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. D. Presbyterian does not pay for special modifications or replacement of customized wheelchairs after the wheelchairs are furnished to the eligible recipient. E. When the equipment is delivered to the eligible recipient and the eligible recipient accepts the order, the provider submits the claim for reimbursement. B. Special requirements for purchase of augmentative and alternative communication devices (AACDs): A. The purchase of AACDs requires prior authorization. In addition to being prescribed by a provider, 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. B. 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. C. Presbyterian does not pay for supplies for AACDs, such as but not limited to paper, printer ribbons and computer discs. D. Prior authorization is required for equipment repairs. E. 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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.
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 (ABCB service) (SDCB service***)**	Yes	1. Payment will not be made for incentive payments, subsidies, or unrelated vocational training expenses. 2. Only for those who qualify for Nursing Facility Level of Care.
Environmental modifications (ABCB service) (SDCB service***)**	Yes	1. Environmental Modification services are limited to $5,000 every five 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. 2. Only for those who qualify for Nursing Facility Level of Care. 3. This benefit is not provided to members living in assisted living facilities.
Experimental/investigational procedures, technology, or non-drug therapies	Yes	Presbyterian does not cover experimental or investigational medical, surgical, or other healthcare procedures or treatments, including the use of drugs, biological products, other products or devices, except for the following: Presbyterian 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: A. One of the federal National Institutes of Health. B. A federal National Institutes of Health cooperative group or center; 8.325.6 NMAC 1. C. The federal Department of Defense. D. The federal FDA in the form of an investigational new drug application. E. the federal Department of Veteran Affairs.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		F. S qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility. B. The clinical trial is 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) Program	No	These services are limited to members under the age of 21.
EPSDT Program personal care services (ABCB service) (SDCB service***)**	Yes	These services are limited to members under the age of 21. NON-COVERED SERVICES: Services that are not covered under the New Mexico Medicaid EPSDT Program 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 Presbyterian or its designee for the condition of the recipient.
EPSDT Program 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 recipient's function level in a home setting. 1. EPSDT Program private duty nursing services" means nursing services for recipients under 21 years of age who require more individual and continuous care than can be received through the home health program. 2. EPSDT Program private duty nursing services must be ordered by the recipient's provider 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. NON-COVERED SERVICES: Private duty nursing services are subject to the limitations and coverage restrictions which exist for other Medicaid services. Medicaid 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 Presbyterian or its designees for the condition of the recipient. C. Services which are not within the scope of practice of the nursing profession.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
EPSDT Program rehabilitation services (ABCB service) (SDCB service***)**	Yes	These services are limited to members under the age of 21. NON-COVERED SERVICES: A. 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. B. B. Medicaid does not cover these specific services: • Services furnished to individuals who are not eligible for EPSDT Program services. • Services for which prior approval has not been received. • Services that are not within the scope of practice of the speech and language pathologist physical therapist or occupational therapist. • Services furnished without the order or prescription of a provider or PCP. • Services that are primarily educational or vocational in nature • 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.
Family planning	No	
Family support	No	
Federally qualified health center services	No	
Hearing aids and related evaluations	No	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.
Home health aide (ABCB service) (SDCB service***)**	Yes	Only for those who qualify for Nursing Facility Level of Care.
Home health services	Yes	Home health services are subject to the limitations and coverage restrictions of other Medicaid services. See Section MAD-602, General Non-covered Services [now 8.301.3 NMAC, General Non-covered Services]. Presbyterian does not cover the following home health agency services: A. Services beyond the initial evaluation which are furnished without prior approval. B. Home health services which are not skilled, intermittent and medically necessary. 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 providers in consultation with the home health agency staff.
Homemaker (SDCB service*)**	Yes	A. An individual may not access assisted living services and homemaker services at the same time and this benefit may not be accessed by members under 21 years of age. Homemaker services should not take the place of home health aide services. B. Only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits.
Hospice services	Yes	For a recipient to be eligible for hospice care, a provider 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 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 providers at the hospice interdisciplinary group before the 210-day period expires.
Hospital inpatient (including detoxification services)	Yes	
Hospital outpatient	No, but Presbyterian reserves the rights to implement process for overutilizers	
Indian Health services	No	
IP hospitalization in freestanding psychiatric hospitals	Yes	Standard Medicaid does not cover inpatient detoxification, which is a medical benefit managed by Presbyterian Utilization Management. Presbyterian 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 Presbyterian. 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 furnished after the determination by Presbyterian or its designee was made so that the eligible recipient no longer needs hospital care. E. Formal educational or vocational services related to traditional academic

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		subjects or vocational training; Presbyterian only covers non-formal education services if they are part of an active treatment plan for an eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b). F. Experimental or investigational procedures, technologies, or non-drug therapies and related services or treatment. G. Drugs classified as "ineffective" by the FDA drug evaluation. H. Activity therapy, group activities and other services primarily recreational or diversional in nature. I. Presbyterian covers “awaiting placement days” in freestanding psychiatric hospitals when the Presbyterian utilization review contractor determines that an eligible recipient under 21 years of age no longer meets acute care criteria and the children’s mental health services review panel determines that the eligible recipient requires a psychosocial residential level of care which cannot be immediately located. J. Those days during which the eligible recipient is awaiting placement to the lower level of care are termed awaiting placement days. K. Payment to the hospital for awaiting placement days is made at the weighted average rate paid by Presbyterian for psychosocial accredited residential services for eligible recipients classified as Level III, IV, or IV+ plus 5%; a separate claim form must be submitted for awaiting placement days.
Intensive Outpatient Program (IOP) services	No	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.
ICF/MR	Yes	Must meet Nursing Facility Level of Care criteria. member must be 18 years or older.
IV OP services	Yes	
Lab services	No except for select high-cost tests	
Medical services providers	No, but reserve rights to implement process for over utilizers	
Medication assisted medical treatment (Tx) for opioid dependence	Yes for medications only, not for office visit	
Midwife services	Yes	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.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Multi-systemic therapy (MST) services	No	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.
Musculoskeletal Surgery (Spine) Ordering Program	Yes for high-cost services	Presbyterian uses the Medical Specialty Solutions program, managed by Evolent Specialty Services, for prior authorizations. The program is designed to streamline the authorization process, reduce healthcare costs, and improve patient outcomes.
Non-accredited residential Tx centers and group homes	Yes	Member must be under 21 years of age. Presbyterian 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 Presbyterian. B. Room and board. C. Services for which prior approval was not obtained. D. Services furnished after the determination is made by Presbyterian 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.
Nursing facility services	Yes	For custodial care in a SNF, member must meet the Nursing Facility Level of Care criteria.
Nutritional counseling (SDCB service*)**	Yes	This benefit is only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits.
Nutritional services	No	Presbyterian does not cover the following specific services: A. Services not considered medically necessary for the condition of the recipient as determined by Presbyterian. B. Dietary counseling for the sole purpose of weight loss. C. Weight control and weight management programs. D. Commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management.
Observation in hospital greater than 24 hours	Yes	Authorization does not exceed 48 total hours.
Occupational services (therapy)	No	
Outpatient hospital based psychiatric services and partial hospitalization	Yes for partial hospitalization, No for outpatient	
Outpatient and partial hospitalization in	Yes for partial hospitalization, No for outpatient	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
freestanding psychiatric hospital		
Outpatient healthcare professional services	No	
Personal care services (ABCB service)**	Yes	A. These services are not provided 24 hours per day. B. Only for those who qualify for Nursing Facility Level of Care and select agency-based community benefits (ABCB). 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.
Pharmacy services	Yes	
Physical health services	No, but reserve rights to implement process for overutilizers	
Physical therapy	No	
Provider visits	Not for PCP visits, but specialty referrals may require a referral to obtain an authorization number	
Podiatry services	Certain services require authorization	A. Routine foot care is not covered except as indicated under "covered services" for an eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as: • Trimming, cutting, clipping and debriding toenails. • Cutting or removal of corns, calluses, or hyperkeratosis. • 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. • 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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.
Pregnancy termination procedures	No	
Preventative services	No	
Private duty nursing for adults **(ABCB service**)** **(SDCB service***)**	Yes	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 provider'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 Non-covered Services. Presbyterian 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 Presbyterian for the condition of the recipient. C. Services which are not within the scope of practice of the nursing profession.
Prosthetics and orthotics	Yes, for selected items	NON-COVERED 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 Non-covered Services [MAD-602]. In addition to the services identified in 8.301.3 NMAC [MAD-602], General Non-covered 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	No	Presbyterian 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 their best possible level of functioning. Services are for adults 21 years and older who are not a resident in an institution for mental illness who have a diagnosis that meets the criteria for serious mental illness or individuals ages 18 through 20 who meet criteria for SED.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Radiology facilities (for imaging)	No prior authorization for the facility is needed. The specific service to be provided may require prior authorization.	
Rehabilitation option services	Yes	Criteria in process of development.
Rehabilitation services Providers	Yes	Presbyterian does not cover the following rehabilitation services: A. Services furnished by providers who are not licensed and/or certified to furnish services. 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 21 receiving inpatient psychiatric services [42 CFR Section 441.13 (b)]. 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. 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. 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.
Related goods (SDCB service*)**	Yes	A. Related goods are limited to $500 per person per year. Related goods do not include services, service agreements or insurance. B. Only for those who qualify for Nursing Facility Level of Care and select Self-Directed Community Benefits.
Reproductive health services	No	A. Sterilization services: Presbyterian covers medically necessary sterilizations only under the following conditions. • Recipients are at least 21 years old at the time consent is obtained. • Recipients are not mentally incompetent. "Mentally incompetent" is a declaration of incompetency as made by a federal, state, or local

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		court. A recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization. • Recipients are not institutionalized. For this section, "institutionalized" is defined as: ▪ 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 ▪ Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness • 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;. • Recipients seeking sterilization must also be instructed that their consent can be withdrawn at any time before 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. • Recipients voluntarily give informed consent to the sterilization procedure. See 42 CFR Section 441.257(a): ▪ The consent to sterilization form is signed by the recipient at least 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 72 hours before the time of the premature delivery. ▪ A consent form is valid for 180 days from the date of signature. ▪ 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. ▪ 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. ▪ Providers must provide an interpreter if needed to ensure that the recipient understands the information furnished. ▪ The recipient is given a copy of the completed, signed consent form and the original is placed in the recipient's medical record. B. Hysterectomies: Medicaid covers only medically necessary hysterectomies. Presbyterian does not cover hysterectomies performed for the sole purpose of

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		sterilization. See 42 CFR Section 441.253. • Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by recipients before the operation. • Acknowledgement of the sterilizing results of the hysterectomy is not required from recipients who were previously sterilized or who are past child-bearing age as defined by the medical community. • An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency. C. Other covered services: • 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. NON-COVERED SERVICES: Reproductive healthcare services are subject to the same limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, General Non-covered Services [now 8.301.3 NMAC, General Non-covered Services]. In addition, Medicaid does not cover the following specific services: • Sterilization reversals • Fertility drugs • In vitro fertilization • Artificial insemination • Elective procedures to terminate pregnancy • Hysterectomies performed for the sole purpose of family planning
Respite **(ABCB service**)** **(SDCB service***)**	Yes	A. Respite services are limited to a maximum of 100 hours annually per care plan 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 (RHC) services	Services provided by RHC have same requirements as other providers	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
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 Non-covered Services. Presbyterian 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 Individual Education Program or Individualized Family Service Plan 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 **(ABCB service**)** **(SDCB Service***)**	Yes	A. A signed therapy referral for treatment must be obtained from the recipient's PCP. 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	No	This benefit is only provided to adults with short-term needs because of an acute event.
Spine surgeries non-emergent and outpatient	Yes	Prior authorization required for the following: A. Lumbar Microdiscectomy. B. Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy and Foraminotomy). C. Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single and Multiple Levels. D. Cervical Anterior Decompression with Fusion –Single and Multiple Levels . E. Cervical Posterior Decompression with Fusion –Single and Multiple Levels.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		F. Cervical Posterior Decompression (without fusion). G. Cervical Artificial Disc Replacement. H. Cervical Anterior Decompression (without fusion).
Swing bed hospital services	Yes	
Telehealth services (provider telehealth, not home-based telehealth)	No	
Tot-to-Teen health checks	No	
Transplant services	Yes	Presbyterian 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 managed by a vendor.	
Transportation services (non-medical) (SDCB service*)**	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	Yes	Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.310.2.13NMAC, General Non-covered Services. Presbyterian 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.
Treatment foster care II	Yes	Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.310.2.13 NMAC, General Non-covered Services. Presbyterian 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.
Vision care services	Yes	Presbyterian does not cover the following specific vision services: A. Orthoptic assessment and treatment.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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.

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 CNA, 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 Presbyterian secondary review team before the provision of services.

* Presbyterian edits the prior authorization list as updates are needed. To view the most recent version of this list, please visit the following web address: www.phs.org/providers/authorizations.

** ABCB is an agency-based community benefit service.

*** SDCB is a self-directed community benefit service.

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Appendix F. Alternative Benefits Plan (ABP) Covered Services

Covered Service	Description
Allergy testing and injections	A skin or blood test done in a provider's office to help find what things you eat, touch or breathe that may trigger an allergic reaction. Treatment options may include injections.
Anesthesia services	Includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures.
Annual physical exam and consultation	Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.
Applied Behavioral Analysis (ABA)	Medically necessary and empirically supported ABA services for members who have a well-documented diagnosis of autism spectrum disorder (ASD) and for members who have well-documented risk for the development of ASD.
Bariatric surgery	**Limitation**: One surgery covered per lifetime. Meeting additional criteria to assure medical necessity may be required prior to accessing services.
Behavioral health professional and substance abuse services	Includes evaluations, therapy and testing, assessments, therapies and medication management by licensed practitioners.
Cancer clinical trials	A course of treatment provided to a patient for the purpose of prevention of reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.
Cardiovascular rehabilitation	**Limitation**: 36 visits per cardiac event. Short-term therapy (two consecutive months) per cardiac event.
Chemotherapy	The use of chemical agents in the treatment or control of disease.
Chronic Care Management services	Helps members with chronic long-term, complex or behavioral health needs.
Dental services	Covers dental services for adults. Members aged 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education	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 provider's office, outpatient hospital, residential facility or a home health service are covered when separate payment is allowed in these settings.
Diagnostic imaging	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.
Dialysis services	Medicaid covers medically necessary dialysis services and supplies furnished to members receiving dialysis at home as well as services received from a contracted provider. Dialysis at non-contracted facilities within New Mexico will require a prior authorization. Dialysis outside of New Mexico will not require prior authorization (this does not apply to Medicare members).
Disease management	For members with identified chronic conditions.

Covered Service	Description
Drug/alcohol dependency treatment services	Coverage includes outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services.
Durable Medical Equipment (DME)	Coverage includes medical supplies, orthotic appliances and prosthetic devices, including repair or replacement. Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace or are diabetic shoes.
Electroconvulsive therapy (ECT)	A medical treatment for severe mental illness in which a small and carefully controlled amount of electricity is introduced into the brain and is used to treat a variety of psychiatric disorders, including severe depression.
Emergency services	Includes ER visits, emergency transportation, psychiatric emergencies and emergency dental care. See Page 10-12.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program	Includes routine oral and vision care for individuals aged 19-20. See Pages 12-4.
Family planning and reproductive health services	Includes devices, sterilization, pregnancy termination, contraceptives, and insertion and/or removal of contraceptive devices. Sterilization reversal is not covered. Infertility treatment is not covered. See Pages 7-10.
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services	FQHC includes an outpatient health program, a facility operated by a tribe or tribal organization under the Indian Self-Determination Act. RHC means a public or private hospital, clinic or physician practice designated by the federal government.
Genetic evaluation and testing	**Limitation:** Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.
Habilitative and rehabilitative services	Includes physical, speech and occupational therapy. **Limitation:** Short-term therapy (two consecutive months) per condition.
Hearing screening as part of a routine health exam	Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients aged 19-20. The ABP does not cover audiology services.
Holter monitors and cardiac event monitors	A holter monitor is a small, wearable device that records the heart's rhythm. An event monitor is a portable device used to record your heart's electrical activity when you have symptoms. It records the same information as an electrocardiogram (ECG) but for longer durations of time.
Home health care	Covers skilled nursing and intravenous services. 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.

Covered Service	Description
Hospice care services	Inpatient and in-home hospice services designed to keep members comfortable if they are terminally ill. An approved hospice program must provide these services during a hospice benefit period. Hospice services require prior authorization. To receive these services, members must be covered throughout their hospice benefit period. The hospice benefit period is defined as follows: • Beginning on the date, the member's provider certifies that the member is terminally ill with a life expectancy of six months or less • Ending six months after it began, unless the member requires an extension of the hospice benefit period below or upon the member's death If a member needs an extension of the hospice benefit period, then the hospice must provide a new treatment plan. The member's provider also must reauthorize their medical condition to Presbyterian. Presbyterian will not authorize more than one additional hospice benefit period. If the hospice recipient requires nursing facility level of care, then the recipient will have to meet the requirements for receiving nursing facility care.
Hospital outpatient services	Includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services.
Immunizations	Includes ACIP recommended vaccines.
Indian Health Services (HIS)	The primary provider of healthcare services for the tribal nations and pueblos. Members may self-refer to IHS facilities.
Inpatient physical and behavioral health hospital/medical services and surgical care	Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.
Inpatient rehabilitative services/facilities	Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is **limited** to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.
Internal prosthetics	Replacements or substitutes for a body part or organ.
Intravenous (IV) infusions	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.
Lab tests, x-ray services and pathology	Medically necessary lab services ordered by doctors or other licensed providers. These services are performed by ordering providers or are done under their supervision in an office lab. These services can also be performed by a clinical lab.
Maternity care	Includes delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care
Medication Assisted Treatment (MAT) for opioid additction	Treatment for addiction that includes the use of medication along with counseling and other support.
Non-emergency transportation	Covers expenses for transportation, meals and lodging it determines are necessary to secure covered medical or behavioral health services for an ABP-eligible member in or out of their home community.

Covered Service	Description
Nutritional evaluations and counseling	Dietary evaluation of counseling as medical management of a documented disease, including obesity.
Organ and tissue transplants	**Limitation:** Transplants are limited to two per lifetime.
Osteoporosis diagnosis, treatment and management	The condition in which bones become weak and brittle. Treatment includes medications, healthy diet and weight-bearing exercise to help prevent bone loss or strengthen already weak bones.
Outpatient surgery	Surgical procedures not requiring an overnight hospital stay.
Over-the-counter medicines	Prenatal drug items and low-dose aspirin as preventive for cardiac conditions. Other over-the-counter items may be considered for coverage only when the items are considered more medically or economically appropriate than a prescription drug, contraceptive drug, or device, or for treating diabetes.
Periodic age-appropriate testing and examinations	Includes glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol, and other preventive/diagnostic care and screenings. Includes USPSTF "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program and additional preventive services for women recommended by the Institute of Medicine.
Physician visits	Services required by members to maintain good health. Included but not limited to periodic exams and office visits provided by licensed providers
Podiatry and routine foot care	Covered when medically necessary due to malformations, injury, acute trauma or diabetes.
Prescription medicines	See Pharmacy Chapter (Page 9-1).
Primary Care to treat illness/injury and chronic disease management	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.
Pulmonary rehabilitation	**Limitation:** Short-term therapy (two consecutive months) per condition.
Radiation therapy	Therapy using ionizing radiation, generally provided as part of cancer treatment to control or kill malignant cells and normally delivered by a linear accelerator
Reconstructive surgery	For the correction of disorders that result from accidental injury, congenital defects or disease.
Skilled Nursing	Skilled nursing is generally provided only through a home health agency. However, it can also be provided through private-duty nursing. **Limitation:** Subject to the 100-visit home health limit when provided through a home health agency.
Sleep studies	**Limitation**: Limited to diagnostic sleep studies performed by certified providers/facilities.
Specialist visits	A doctor or other healthcare provider who has had extra training to treat certain health problems.
Specialized behavioral health services for adults	Includes Intensive Outpatient (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR).
Telemedicine Services	Electronic information, imaging and communication technologies (including interactive audio, video and data communications as well as store-and-forward technologies) to provide and support health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education.
Tobacco Cessation treatment and services	Including individual and group counseling, prescription medications, a dedicated Quit Line and products.
Transitional Care Management services	Intended to reduce potentially preventable readmissions and medical errors during the 30 days following discharge from the acute care setting.

Covered Service	Description
Urgent care services/facilities	Focused on the delivery of ambulatory care based on the scope of conditions treated in a medical facility outside of a traditional ER. Urgent care treats conditions serious enough to warrant same-day care but not severe enough to require ER care.
Vision care for eye injury or disease	Refraction for visual acuity and routine vision care are not covered except for members aged 19-20.
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery within 90 days following surgery. Vision hardware and routine vision care are covered for recipients aged 19-20 following a periodicity schedule

Note: Please visit Appendix E for information on prior authorization.

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Appendix G: In-Office Laboratory Lists

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
36415	Collection of Venous Blood by Venipuncture	
36416	Capillary Blood Draw	
80050	General health panel	
80055	Obstetric panel	
80074	Acute hepatitis panel	
80076	Hepatic function panel	
80305	Drug Test Prsmv Dir Opt Obs	
80306	Drug Test Prsmv Instrmnt	
80307	Drug Test Prsmv Chem Anlyzr	
80320	Drug Screen Quantalcohols	
80321	Alcohols Biomarkers 1 or 2	
80322	Alcohols Biomarkers 3/More	
80323	Alkaloids Nos	
80324	Drug Screen Amphetamines 1/2	
80325	Amphetamines 3 or 4	
80326	Amphetamines 5 or more	
80327	Anabolic Steroid 1 or 2	
80328	Anabolic Steroid 3 or more	
80329	Analgesics Non-Opioid 1 or 2	
80330	Analgesics Non-Opioid 3-5	
80331	Analgesics Non-Opioid 6/More	
80332	Antidepressants Class 1 or 2	
80333	Antidepressants Class 3-5	
80334	Antidepressants Class 6/More	
80335	Antidepressant Tricyclic 1/2	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
80336	Antidepressant Tricyclic 3-5	
80337	Tricyclic & Cyclicals 6/More	
80338	Antidepressant Not Specified	
80339	Antiepileptics Nos 1-3	
80340	Antiepileptics Nos 4-6	
80341	Antiepileptics Nos 7/More	
80342	Antipsychotics Nos 1-3	
80343	Antipsychotics Nos 4-6	
80344	Antipsychotics Nos 7/More	
80345	Drug Screening Barbiturates	
80346	Benzodiazepines 1-12	
80347	Benzodiazepines 13 or more	
80348	Drug Screening Buprenorphine	
80349	Cannabinoids Natural	
80350	Cannabinoids Synthetic 1-3	
80351	Cannabinoids Synthetic 4-6	
80352	Cannabinoid Synthetic 7/More	
80353	Drug Screening Cocaine	
80354	Drug Screening Fentanyl	
80355	Gabapentin Non-Blood	
80356	Heroin Metabolite	
80357	Ketamine And Norketamine	
80358	Drug Screening Methadone	
80359	Methylenedioxyamphetamines	
80360	Methylphenidate	
80361	Opiates 1 or more	
80362	Opioids & Opiate Analogs 1/2	
80363	Opioids & Opiate Analogs 3/4	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
80364	Opioid &Opiate Analog 5/More	
80365	Drug Screening Oxycodone	
80366	Drug Screening Pregabalin	
80367	Drug Screening Propoxyphene	
80368	Sedative Hypnotics	
80369	Skeletal Muscle Relaxant 1/2	
80370	Skel Musc Relaxant 3 or more	
80371	Stimulants Synthetic	
80372	Drug Screening Tapentadol	
80373	Drug Screening Tramadol	
80374	Stereoisomer Analysis	
80375	Drug/Substance Nos 1-3	
80376	Drug/Substance Nos 4-6	
80377	Drug/Substance Nos 7/More	
81000	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	
81001	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	
81005	Urinalysis; qualitative or semi-quantitative, except immunoassays	
81015	Urinalysis, microscopic only	
82248	Bilirubin direct	
82306	Vitamin d 25 hydroxy	
82607	Vitamin b-12	
82670	Assay of estradiol	
82728	Assay of ferritin	
82948	Glucose; blood, reagent strip	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
83013	H pylori (c-13) breath	
83014	H pylori drug admin	
83540	Assay of iron	
83615	Lactate (ld) (ldh) enzyme	
83690	Assay of lipase	
83735	Assay of magnesium	
83970	Assay of parathormone	
84100	Assay of phosphorus	
84144	Assay of progesterone	
84153	Assay of psa total	
84403	Assay of total testosterone	
84436	Assay of total thyroxine	
84439	Assay of free thyroxine	
84445	Assay of tsi globulin	
84481	Free assay (ft-3)	
84490	Assay of feces for trypsin	
84550	Assay of blood/uric acid	
84702	Gonadotropin, chorionic (hCG); quantitative (second or repeats require PA)	
85002	Bleeding time	
85007	Blood smear, microscopic examination with manual differential WBC count	
85009	Manual differential WBC count, buffy coat	
85025	Hemogram and platelet count, automated and automated complete differential WBC count (CBC)	
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	
85049	Platelet, automated	
85652	Rbc sed rate automated	
85660	Sickling of RBC, reduction	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
86140	C-reactive protein	
86147	Cardiolipin antibody ea ig	
86160	Complement antigen	
86200	Ccp antibody	
86225	Dna antibody native	
86226	Dna antibody single strand	
86235	Nuclear antigen antibody	
86403	Particle agglutination; screen, each antibody	
86431	Rheumatoid factor quant	
86480	Tb test cell immun measure	
86485	Candida skin test	
86486	Skin test, unlisted antigen (used for mumps skin test)	
86490	Coccidioidomycosis	
86580	Tuberculosis, intradermal	
86677	Helicobacter pylori, antibody	
86689	HTLV/HIV CONFIRMJ ANTIBODY	
86702	HIV-2 ANTIBODY	
86703	HIV-1 and HIV-2, single assay	
86901	Blood typing, Rh (D)	
87081	Culture, presumptive, pathogenic organisms, screening only	
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail	
87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail, other source (except blood)	
87106	Culture, fungi, definitive identification, each organism; yeast	
87110	Culture, chlamydia, any source	
87205	Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi or cell types	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
87206	Smear, primary source, with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	
87207	Special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)	
87220	Tissue examination by KOH slide of samples from skin, hair, nails for fungi or ectoparasite ova or mites (e.g., scabies)	
87270	Chlamydia trachomatis	
87320	Chlamydia trachomatis	
87390	HIV-1 AG IA	
87400	Influenza, A or B, each	
87430	Streptococcus, group A antigen, detection by enzyme immunoassay technique, qualitative or semi-qualitative, multi-step method	
87490	Chlamydia trachomatis, direct probe technique	
87491	Chlamydia trachomatis, amplified probe technique	
87534	HIV-1 DNA DIR PROBE	
87535	HIV-1 PROBE&REVERSE TRNSCRPJ	
87536	HIV-1 QUANT&REVRSE TRNSCRPJ	
87591	Neisseria gonorrhoeae, amplified probe technique	
87801	Detect agnt mult dna ampli	
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis	
88142	Cytopath c/v thin layer	
88304	Level III surgical pathology, gross and microscopic examination	Can only be performed by Certified Dermatopathologist
88305	Level IV surgical pathology, gross and microscopic examination	Can only be performed by Certified Dermatopathologist

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
88321	Consultation and report on referred slides prepared elsewhere	Can only be performed by Certified Dermatopathologist
88720	BILIRUBIN TOTAL TRANSCUT	
88740	TRANSCUTANEOUS CARBOXYHB	
88741	TRANSCUTANEOUS METHB	
89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)	
89190	Nasal smear for eosinophils	
89310	Semen analysis; motility and count (not including Huhner test)	
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	
80047*	Metabolic panel ionized ca	
80048*	Basic metabolic panel	
80051*	Electrolyte panel	
80053*	Comprehensive metabolic panel	
80061*	Lipid panel	
80069*	Renal function panel	
80178*	Assay of Lithium	
81002*	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	
81003*	Urinalysis, automated, without microscopy	
81007*	Urinalysis, bacteriuria screen, except by culture or dipstick	
81025*	Urine pregnancy test, by visual color comparison methods	
82010*	Acetone or other ketone bodies, serum; quantitative	
82040*	Assay of serum albumin	
82043*	Microalbumin quantitative	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
82044*	Albumin, urine, microalbumin, semi-quantitative (e.g., reagent strip assay)	
82120*	Amines, vaginal fluid, qualitative	
82150*	Assay of amylase	
82247*	Bilirubin total	
82270*	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)	
82271*	Occult blood other sources	
82272*	Occult bld feces 1-3 tests	
82274*	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	
82310*	Assay of calcium	
82330*	Assay of calcium	
82374*	Assay blood carbon dioxide	
82435*	Assay of blood chloride	
82465*	Assay bld/serum cholesterol	
82523*	Collagen, cross links, any method	
82550*	Assay of ck (cpk)	
82565*	Creatinine; blood	Can only be performed by Nephrology
82570*	Creatinine, other source	
82679*	Estrone	
82947*	Glucose; quantitative, blood (except reagent strip)	
82950*	Post glucose dose (includes glucose)	
82951*	Tolerance test (GTT), three specimens (includes glucose)	
82952*	Tolerance test, each additional beyond tree specimens	
82962*	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
82977*	Assay of GGT	
82985*	Glycated protein	
83001*	Gonadotropin; follicle stimulating hormone (FSH)	
83002*	Gonadotropin; luteinizing hormone (LH)	
83026*	Hemoglobin; by copper sulfate method, non-automated	
83036*	Hemoglobin; glycated, A1c (Test result required on claim submission for reimbursement)	
83037*	Glycosylated hb home device	
83516*	Immunoassy for analyte other than infectious agent antibody or infection agent qualitative or semiquantitative multipe step method	
83518*	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semi-quantitative; single step method (eg, reagent strip)	
83605*	Lactate (lactic acid)	
83655*	Lead	
83718*	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	
83721*	LDL Cholesterol	
83861*	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	
83880*	Natriuretic peptide	
83986*	pH, body fluid, except blood	
84075*	Assay alkaline phosphatase	
84132*	Assay of serum potassium	
84155*	Assay of protein serum	
84295*	Assay of serum sodium	
84443*	Thyroid stimulating hormone	
84450*	Transferase (AST) (SGOT)	
84460*	Transferase; alanine amino (ALT) (SGPT)	
84478*	Triglycerides	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
84520*	Urea nitrogen, quantitative	Can only be performed by Nephrology
84703*	Gonadotropin; chorionic (hCG); qualitative	
84830*	Ovulation tests, by visual color comparison methods for human luteinizing hormone	
85013*	Spun microhematocrit	
85014*	Blood count; hematocrit (Hct)	
85018*	Hemoglobin	
85576*	Blood platelet aggregation	
85610*	Prothrombin time	
85651*	Sedimentation rate, erythrocyte; non-automated	
86294*	Immunoassay for tumor antigen, qualitative or semi-quantitative (eg, bladder tumor antigen)	
86308*	Heterophile antibodies; screening	
86318*	Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (eg, reagent strip)	
86386*	Nuclear Matrix Protein 22 (NMp22) qualitative	
86618*	Borrelia burgdorferi (Lyme Disease)	
86701*	Rapid HIV-1 antibody test	
86780*	Treponema pallidum	
86803*	Hepatitis C antibody	
87077*	Aerobic isolate, additional methods required for definitive identification, each isolate	
87210*	Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)	
87338*	Helicobacter pylori; stool	
87389*	Helicobacter pylori	
87449*	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semi-quantitative; multiple step method, not otherwise specified, each organism	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)		
Code	**Description**	**Limitation**
87502*	influenza virus for multiple or sub types including multiplex reverse transcription, when performed and multiplex amplified probe technique first 2 types or sub-types	
87631*	respiratory virus	
87633*	respiratory virus	
87651*	streptococcus group A amplified probe technique	
87804*	Influenza	
87807*	Rsv assay w/optic	
87808*	Trichomonas assay w/optic	
87809*	Adenovirus assay w/optic	
87880*	Streptococcus, group A	
87899*	Agent nos assay w/optic	
87905*	Sialidase enzyme assay	
89300*	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	
89321*	Semen anal sperm detection	
G0103	Prostate cancer screening; PSA Test	
G0328*	Colorectal cancer screening fecal occult blood test	
G0432	INF AB EIA TECH HIV-1 &/OR HIV-2	
G0433*	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA)	
G0435	INF AGT ANTIG DETECT RPD AB TST OMT	
G0472*	Hepatitis C antibody screening for individual at high risk	
Q0111	Wet mounts, including preparation of vaginal, cervical or skin specimens	
Q0112	All potassium hydroxide (KOH) preparations	
Q0113	Pinworm examination	
Q0114	Fern test	
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous	

Behavioral Health Lab List

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
36415	Collection of venous blood by venipuncture
80047	Metabolic panel ionized ca
80051	Electrolyte panel
80061	Lipid panel
80069	Renal function panel
81000	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
81005	Urinalysis; qualitative or semi-quantitative, except immunoassays
81007	Dipstick, bacteriuria screen, except by culture or dipstick
81015	Urinalysis, microscopic only
82040	Assay of serum albumin
82043	Microalbumin quantitative
82150	Assay of amylase
82247	Bilirubin total
82271	Occult blood other sources
82272	Occult bld feces 1-3 tests
82310	Assay of calcium
82330	Assay of calcium
82374	Assay blood carbon dioxide
82435	Assay of blood chloride
82465	Assay bld/serum cholesterol
82550	Assay of ck (cpk)
82948	Glucose; blood, reagent strip
82977	Assay of GGT
82985	Glycated protein
83037	Glycosylated hb home device

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
83880	Natriuretic peptide
84075	Assay alkaline phosphatase
84132	Assay of serum potassium
84155	Assay of protein serum
84295	Assay of serum sodium
84450	Transferase (AST) (SGOT)
84550	Assay of blood/uric acid
84702	Gonadotropin, chorionic (hCG); quantitative (second or repeats require PA)
85002	Bleeding time
85007	Blood smear, microscopic examination with manual differential WBC count
85009	Manual differential WBC count, buffy coat
85025	Hemogram and platelet count, automated and automated complete differential WBC count (CBC)
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85049	Platelet, automated
85576	Blood platelet aggregation
85651	Sedimentation rate, erythocytes; non-automated
85660	Sickling of RBC, reduction
86403	Particle agglutination; screen, each antibody
86485	Candida skin test
86486	Skin test, unlisted antigen (used for mumps skin test)
86490	Coccidioidomycosis
86580	Tuberculosis, intradermal
86677	Helicobacter pylori, antibody
86701	Rapid HIV-1 antibody test
86901	Blood typing, Rh (D)
87081	Culture, presumptive, pathogenic organisms, screening only
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail, other source (except blood)
87106	Culture, fungi, definitive identification, each organism; yeast
87110	Culture, chlamydia, any source
87205	Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi or cell types
87206	Smear, primary source, with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types
87207	Special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87220	Tissue examination by KOH slide of samples from skin, hair, nails for fungi or ectoparasite ova or mites (e.g., scabies)
87270	Chlamydia trachomatis
87320	Chlamydia trachomatis
87400	Influenza, A or B, each
87430	Streptococcus, group A antigen, detection by enzyme immunoassay technique, qualitative or semi-qualitative, multi-step method
87490	Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87807	Rsv assay w/optic
87808	Trichomonas assay w/optic
87809	Adenovirus assay w/optic
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis
87880	Streptococcus, group A
87899	Agent nos assay w/optic
87905	Sialidase enzyme assay
89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
89190	Nasal smear for eosinophils

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
89310	Semen analysis; motility and count (not including Huhner test)
89321	Semen anal sperm detection
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test
80048*	Basic metabolic panel
80053*	Comprehensive metabolic panel
80061*	Lipid panel
81002*	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
81003*	Urinalysis, automated, without microscopy
81007*	Urinalysis, bacteriuria screen, except by culture or dipstick
81025*	Urine pregnancy test, by visual color comparison methods
82010*	Acetone or other ketone bodies, serum; quantitative
82044*	Albumin, urine, microalbumin, semi-quantitative (e.g., reagent strip assay)
82120*	Amines, vaginal fluid, qualitative
82270*	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)
82274*	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82523*	Collagen, cross links, any method
82570*	Creatinine, other source
82679*	Estrone
82947*	Glucose; quantitative, blood (except reagent strip)
82950*	Post glucose dose (includes glucose)
82951*	Tolerance test (GTT), three specimens (includes glucose)
82952*	Tolerance test, each additional beyond tree specimens
82962*	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use
83001*	Gonadotropin; follicle stimulating hormone (FSH)

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
83002*	Gonadotropin; luteinizing hormone (LH)
83026*	Hemoglobin; by copper sulfate method, non-automated
83036*	Hemoglobin; glycated, A1c (Test result required on claim submission for reimbursement)
83518*	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semi-quantitative; single step method (eg, reagent strip)
83605*	Lactate (lactic acid)
83718*	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83986*	pH, body fluid, except blood
84443*	Thyroid stimulating hormone
84460*	Transferase; alanine amino (ALT) (SGPT)
84478*	Triglycerides
84703*	Gonadotropin; chorionic (hCG); qualitative
84830*	Ovulation tests, by visual color comparison methods for human luteinizing hormone
85013*	Spun microhematocrit
85014*	Blood count; hematocrit (Hct)
85018*	Hemoglobin
85610*	Prothrombin time
85651*	Sedimentation rate, erythrocyte; non-automated
86294*	Immunoassay for tumor antigen, qualitative or semi-quantitative (eg, bladder tumor antigen)
86308*	Heterophile antibodies; screening
86318*	Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (eg, reagent strip)
86618*	Borrelia burgdorferi (Lyme Disease)
86701*	Rapid HIV-1 antibody test
86703*	HIV-1 and HIV-2, single assay
87077*	Aerobic isolate, additional methods required for definitive identification, each isolate

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
87210*	Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87449*	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semi-quantitative; multiple step method, not otherwise specified, each organism
87804*	Influenza
87880*	Streptococcus, group A
89300*	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
G0431	Drug Screen, Qualitative; multiple drug classes by high complexity test method
G0477	Drug test presump optical
G0478	Drug test presump opt inst
G0479	Drug test presump not opt
G0480	Drug test def 1-7 classes
G0481	Drug test def 8-14 classes
G0482	Drug test def 15-21 classes
G0483	Drug test def 22+ classes
G6031	Assay of Benzodiazepines
G6030	Assy of Amitriptyline
G6032	Assay of Desipramine
G6036	Assay of Imipramine
G6037	Assya of Nortriptyline
G6040	Assay of Ethanol
G6042	Assay of Amphetamines
G6053	Assay of Methadone
G6056	Assay of Opiates
Q0111	Wet mounts, including preparation of vaginal, cervical or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examination
Q0114	Fern test

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous

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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 ADLs
- 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
- Dermatomayositis
- Diabetes (insulin dependent)
- Friedreich's disease
- Hemophilia.
- Hepatitis C (active)
- HIV positive
- 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
- Stills disease
- Stroke (CVA)

- Syringomyelia
- Tabes dorsalis
- Thalassemia
- Topectomy and lobotomy
- Wilson's disease

SMI/CSD Eligibility

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:

- Be 18 years old and older
- Must have one of the following diagnoses determined within the last 12 months by qualifying clinician/psychiatrist:
    - Schizophrenia, schizophreniform, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared Pspchotic disorder and psychotic disorder NOS
    - Major depressive disorder
    - Bipolar disorders (except bipolar, NOS), cyclothymic disorder
    - CSD diagnosis, such as dependenceon alcohol, cannabis, cocaine, amphetamine, hallucinogens, opioids, phencyclidines, sedatives, hypnotisc, anxiolytics and polysubstances
- Functional impairment with a GAF score of 50 or below identified on AXIS V on clinical assessment
- Functional Limitation on Axis VI such as financial problems, family stressors, etc.
- Expected duration of the disorder is to be six months or longer

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