MAY 2023

NETWORK Connection

PRESBYTERIAN

Baby Benefits Incentive Program

Presbyterian would like to remind providers of its Baby Benefits incentive program that is available to eligible Centennial Care members at no extra cost. This program rewards members for attending prenatal and postpartum appointments when they complete the following steps:

STEP 1 Members who complete a prenatal (pre-birth) visit before week 14 of their pregnancy are rewarded with a $150 gift card to buy healthy items for themselves during their pregnancy.

STEP 2 Members who complete at least 10 prenatal care visits, or who complete 80% of the number of visits as determined by their provider, are rewarded with a $75 gift card for supplies for themselves and their baby.

STEP 3 Members who complete a postpartum visit within seven to 84 days after the baby is born are rewarded with a $100 gift card for newborn items.

For more information or to help members enroll in the Baby Benefits program, please visit www.phs.org/babybenefits.

INSIDE

Presbyterian exists to ensure all of the patients, members and communities we serve can achieve their best health.

TAKE NOTE

Provider Education 2023

Upcoming Trainings

Providers and office staff are invited to attend a variety of trainings throughout the year, including but not limited to:

- Provider Education Conference and Webinar Series
- Indian Health Services and Tribal Conversations
- Critical Incident Reporting
- Behavioral Health Town Halls
- Presbyterian Dual Plus (HMO D-SNP)
- Cultural Sensitivity
- Health Equity

For more information about the dates and times of these training opportunities, please visit Presbyterian's provider training page at www.phs.org/providertraining.

Medical Record Review Audit Q&A

Medical record reviews (MRR) are essential to identifying errors through claims analysis and/or medical record review activities. To ensure that providers have an in-depth understanding of the MRR audit process, Presbyterian is sharing the following Q&A guide:

Q: What provider specialties will be audited this year?

A: This year we are auditing different provider types each quarter, specifically including OB/GYNs, pediatricians and primary care providers.

Q: What is the most frequently missed question in the MRR audit?

A: The most frequently missed question in the MRR is, "Were advanced directives discussed with patients 18 years old and older?" To receive credit for this question, a discussion about advance directives must be documented in the member's medical record within the rolling calendar year. This can include receipt of an advance directive, patient declination or education.

Q: How can I ensure I meet all criteria for the clinical practice guideline (CPG) questions?

A: If a patient has diabetes, asthma, coronary artery disease and/or hypertension (CAD/HTN), then it is important to document it thoroughly in their medical record to receive full credit for the visit on the audit. Presbyterian's CPGs are available at www.phs.org/clinicalpracticeguidelines. Please see the key points of each CPG below, which should be documented in the member's medical record:

- **Diabetes:** completion of/referral for a diabetic eye exam, neuropathy screening, A1c results or orders, review of blood pressure and addressed if abnormal, review of lipids, diabetic medication, and blood glucose monitoring reviewed with the patient
- **Asthma:** assessment/monitoring of the condition, severity, triggers, any education provided to the patient, and asthma medication review completed
- **CAD/HTN:** completion of risk assessment, discussion of weight and diet, review of lipids results, diabetic status reviewed if applicable, patient's smoking status reviewed, vitals, current blood pressure and medication reviewed

For questions about the MRR audit process, please contact the Quality Management department at PHPQuality@phs.org.

Medicaid Benefits Renewal

During the COVID-19 public health emergency, certain Medicaid and Children's Health Insurance Program (CHIP) requirements and conditions were temporarily waived. In addition, Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits were automatically renewed. These combined measures helped prevent people with these benefits from losing their health coverage during the pandemic. Due to the end of the public health emergency, this is changing.

The New Mexico Human Services Department (HSD) is issuing a renewal letter to Centennial Care members to inform them that they will need to actively renew their Medicaid and/or SNAP benefits. If they do not renew their Medicaid and/or SNAP benefits, then their coverage will be discontinued and they will lose their benefits.

HSD is also issuing a Medicaid CHIP renewal letter that will tell members one of three things:

- Their Medicaid CHIP coverage will be renewed
- Their Medicaid CHIP coverage will end
- Additional information is required to determine if they still qualify for Medicaid CHIP coverage
  - If additional information is needed, HSD will include a renewal form for members to complete

What can providers do?

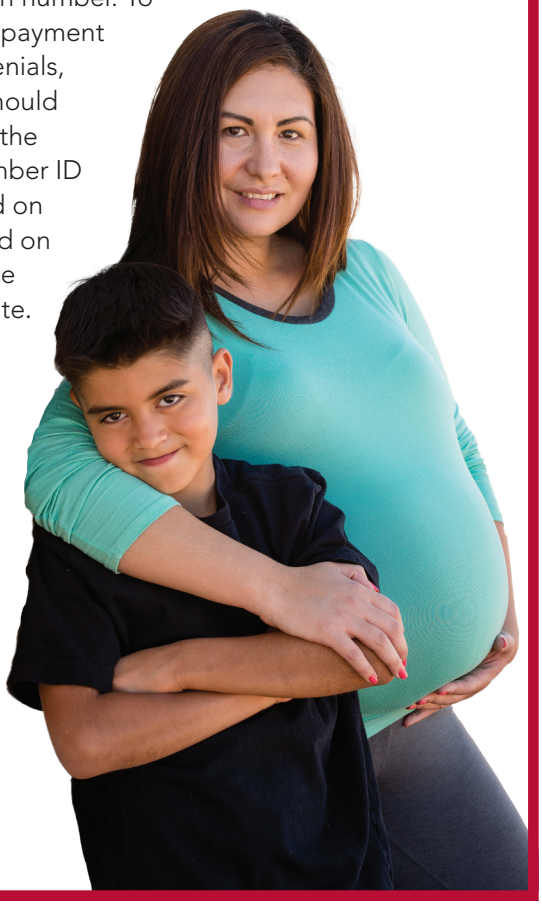
The U.S. Office of Personnel Management (OPM) and HSD are asking health insurers, providers and communities to remind their members, patients, friends and family enrolled in Medicaid to be on the lookout for the Medicaid renewal letter in the turquoise envelope and complete the renewal application from HSD. To ensure they receive this critical piece of mail, members should visit www.Medicaid.gov/renewals to ensure their contact information is up to date with HSD.

If members did not receive the renewal letter or misplaced their renewal application packet for Medicaid and/or SNAP benefits, they can go to yes.state.nm.us and click Renew My Benefits. Please note that patients who are no longer eligible for Medicaid benefits may still have low- or no-cost health coverage options. Learn more at www.bewellnm.com.

For additional information and educational materials that can be distributed to your Centennial Care patients, please visit https://renew.hsd.nm.gov/partners-toolkit or www.Medicaid.gov/unwinding.

How can this change affect claims?

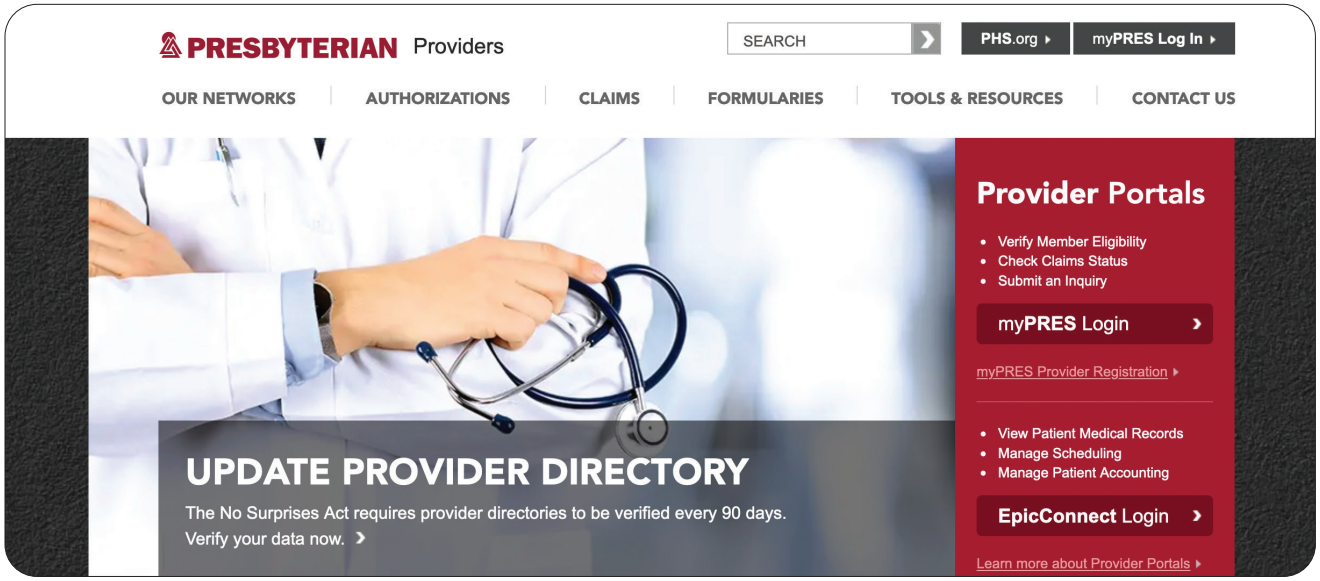
Centennial Care members transitioning off Medicaid due to re-certification to an Exchange plan will be issued a new health plan member identification number. To avoid claim payment delays or denials, providers should ensure that the proper member ID is submitted on claims based on the coverage effective date.



PROVIDER SATISFACTION CORNER

Provider Website Updated

Presbyterian recently updated the provider website homepage (www.phs.org/providers) to provide more direct and immediate access to information about updating the provider directory.



When providers click the "Verify your data now" link in the gray "Update Provider Directory" box on the homepage, they are directed to Presbyterian's "Update Provider Directory Profile" page, which is also available directly at www.phs.org/directoryupdate.

In addition, the "Update Provider Directory Profile" page was previously located under the "Contact Us" tab and is now located under the "Provider Portals" page listed under the "Tools & References" tab.

Please note that moving the "Update Provider Directory Profile" page to another location on Presbyterian's provider website does not affect the provider directory verification and update process. In addition, providers can continue to access all the provider directory information and resources that they previously had access to on Presbyterian's provider website, including:

- The Individual Provider User Guide
- The Provider Group User Guide
- The Facility User Guide
- The Delegate Access Request Form

For questions about this update, please contact your Provider Network Operations relationship executive.

Verify Provider Directory Information Every 90 Days

In accordance with the No Surprises Act, which is part of the Consolidated Appropriations Act (CAA) of 2021, as of Jan. 1, 2022, all providers are required to verify their directory information with Presbyterian every 90 days. There are no exemptions to this federal requirement. To ensure compliance with the CAA, providers must verify their directory information with Presbyterian by June 30.

Physical health providers must log in to the myPRES platform to make updates. Physical health providers can also request delegate access and find instructional guides, a how-to video and FAQs at www.phs.org/directoryupdate.

Behavioral health providers must log in to the behavioral health portal at www.magellanprovider.com. For questions or assistance, contact Gerald Schiebe at gscheibe@magellanhealth.com.

All currently rostered physical health medical groups and behavioral health organizations should continue to follow the current roster process.

Prior Authorization Tools and Resources

The following resources are available to providers to verify whether a prior authorization is required:

- Medical Policy Manual: **www.phs.org/providers/resources/medical-policy-manual**
- myPRES Provider Portal Prior Authorization Tool: **www.phs.org/mypres**
- Prior Authorization Check Tool: **prescoverage.phs.org/ac**
- Prior Authorization Guide: **www.phs.org/providers/authorizations**

Tobacco Cessation Resources

Need information about tobacco cessation resources available to your patients? Call the Presbyterian Customer Service Center at (505) 923-5757 or toll-free at 1-888-923-5757 Monday through Friday, 8 a.m. to 5 p.m.

Clinical Operations Overview

The Presbyterian Clinical Operations department is available to help members improve their health and make it easier for providers to connect with a member's care team. Our Clinical Operations staff includes providers, nurses, social workers and other healthcare professionals. These professionals are trained to support the member, the member's primary care provider and other providers to make sure members stay as healthy and functional as possible in the community.

The Clinical Operations department includes two key functional areas: care coordination and utilization management.

Care Coordination

Care coordination refers to how Clinical Operations manages the member's medical, behavioral and long-term care needs, whether in a hospital, facility or at home. Our Care Coordination team is comprised of nurses, licensed social workers and other health experts.

Care coordinators conduct home and telephonic visits with members to complete a comprehensive assessment. Then, a care plan is developed collaboratively with the member, caregiver and providers to ensure the identified needs are addressed.

Members who are appropriate for care coordination have complex needs, functional concerns, transition of care needs, and physical or behavioral needs. To refer a member to our Care Coordination team, please call (505) 923-8858 or toll-free 1-866-672-1242, or visit www.phs.org/tools-resources.

Utilization Management

Presbyterian follows utilization management guidelines to ensure members receive the right care, in the right place, at the right time. Utilization management decision-making is based on the appropriateness of care and services and the benefits covered under the member's plan. This includes the prior authorization, concurrent review and retrospective review processes as described below.

Prior Authorization	Concurrent Review	Retrospective Review
Some healthcare services require prior authorization. This means that Presbyterian Clinical Operations nurses and physicians must verify that the service is a benefit and medically necessary.	Through concurrent review, nurses work with discharge planners at hospitals or other facilities to ensure the member is at the appropriate level of care for their needs.	During retrospective review, nurses review insurance claims to make sure the member received the most appropriate care. Presbyterian does not reward practitioners for issuing denials of coverage. Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

REGULATORY **REMINDERS**

Improving **Medicare Star Rating**

CMS measures the quality of health and drug services received by individuals enrolled in Medicare Advantage (MA) and prescription drug plans. Star ratings are intended to assist Medicare members in comparing the quality of available Medicare health and drug plans to empower them to be more active participants in their healthcare and make decisions in their best health and care interests.

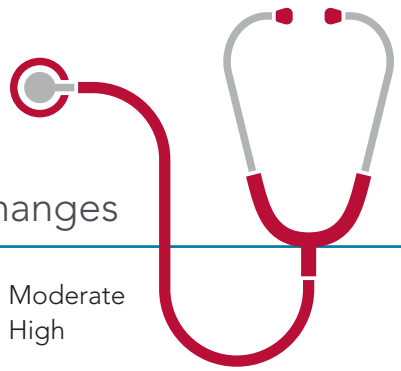
Presbyterian Pharmacy Services is working closely with our members and providers to improve our overall Medicare Star ratings related to medication adherence to ensure our members receive the best possible care. Medication adherence is generally measured by the percentage of health plan members with a medication prescription who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

The four Medicare Stars adherence measures are:

- **Medication adherence for cholesterol (statins):** Presbyterian recently tiered down Atorvastatin to Tier 1 (T1), which is a $0 copay, effective April 1, 2023.
- **Medication adherence for diabetes medications:** Presbyterian offers many diabetes medications at T1 with a $0 copay.
- **Medication adherence for hypertension [renin angiotensin system (RAS) antagonists]:** Presbyterian offers many angiotensin-converting-enzyme inhibitors and angiotensin II receptor blockers at T1 with a $0 copay.
- **Statin Use in Persons with Diabetes (SUPD):** the percentage of Medicare members with diabetes ages 40-75 who receive at least one fill of a statin medication during the measurement year.

Our clinical pharmacists call members on chronic (daily) medications every month to provide education and help with barriers that may cause them not to take their medication. After speaking with the member, we call their pharmacy of choice to request a refill for them.

We also work with providers to close these gaps in care and look forward to collaborating with the Presbyterian provider network in 2023 to help improve the quality of care received by Presbyterian Medicare members.



2023 Emergency Department Services Guideline Changes

The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) Evaluation and Management (E/M) guideline changes effective Jan. 1, 2023, include changes to emergency department (ED) services. According to the AMA, ED services codes 99281-99285 have been revised to align with the 2021 changes.

The components used to determine level of service have changed, with history, exam, counseling, coordination of care and nature of presenting problem no longer used in the determination. In addition, a medically appropriate history and/or examination should be performed; however, the history and exam are not used in selection of the E/M service.

The code structure of the ED codes and the criteria of code selection have been changed to match the overall 2023 changes, with the appropriate level of Medical Decision Making (MDM) as defined for each service being used to select the appropriate ED service level code:

- Straightforward
- Low
- Moderate
- High

Furthermore, the AMA has reported that time may not be used to select levels of E/M services for the ED. This is because ED services typically involve encounters with several patients on a variable intensity basis over an extended period. As a result, only MDM is used to select ED service levels.

For a complete list of reporting considerations and guideline changes for ED services for 2023, please refer to the AMA.

Unique DEA Number No Longer Needed to Prescribe Buprenorphine for Treating Opioid Use Disorder

Buprenorphine, a medicine usually combined with naloxone, has been available for 20 years as an office-based alternative to methadone for the treatment of opioid use disorder (OUD). As this involved using an opioid to treat opioid misuse, the DEA initially required specific training and licensing to prescribe this drug. Known as the X-waiver, the DEA number began with the letter X. Initially these licenses were limited to physicians, and a certain number of patients per license, with the provider type and number of patients eventually increased.

The Consolidated Appropriations Act of 2023 removed the requirement for the X-waiver and specific training. Now, any provider with a DEA license that includes Schedule III drugs can prescribe buprenorphine without restriction.

The bill does require all holders of DEA controlled-substance licenses to meet a one-time, eight-hour training requirement on identifying, treating and managing patients with opioid or other substance use disorders. The DEA is currently reviewing how to accommodate that requirement, due in June of 2023.

Presbyterian strongly encourages providers, especially those who provide chronic care, to consider including buprenorphine/naloxone in their clinical toolbox to help in the treatment of widespread OUD.

It is important to know how to properly use this medication in the context of OUD as it requires careful initiation and management. Options for learning how to use this drug include documents from the Substance Abuse and Mental Health Services Administration, such as "Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings," found at www.samhsa.gov/resource/ebp/practical-tools-prescribing-buprenorphine-primary-care. Also, the University of New Mexico Project ECHO program offers resources for training and complex case consultation: https://hsc.unm.edu/echo/partner-portal/programs/new-mexico/med-for-oud/.

The New Mexico Poison Center is taking addiction calls for the state and has three board-certified addiction physicians on call 24/7. Call 1-800-222-1222 to utilize this free service for healthcare providers and those in the community.

Finally, under Presbyterian pharmacy benefits, buprenorphine/naloxone is available without the need for prior authorization.

Presbyterian's hope is to see increased proper and successful utilization of this tool in the treatment of OUD.

Use the Correct Taxonomy Code and Provider Type to Prevent Claim Denials

Presbyterian is reminding Centennial Care providers that 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 National Provider Identifier (NPI) and taxonomy code on claims when the provider has more than one Centennial 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.

Important: Providers who have multiple provider types registered with the same NPI must submit claims with the appropriate taxonomy code that corresponds with the provider type for the services billed.

Effective April 1, 2023, Presbyterian will deny claims when a provider with multiple provider types registered with New Mexico Medicaid uses an incorrect taxonomy code on a claim.

Note: Presbyterian will not deny payment to a provider who does not submit a taxonomy code or submits an inaccurate taxonomy code when the provider has only one provider type registered with New Mexico Medicaid. This may change in the future if New Mexico Medicaid guidelines result in encounter denials.

For more information and for billing and coding tips, view this recent communication from Presbyterian: https://mailchi.mp/phs.org/prevent-claim-denials-use-the-correct-taxonomy-code-and-provider-type?e=ad35c6f684. For additional claims guidance and resources, visit Presbyterian's Claims page at www.phs.org/providers/claims.

PRESBYTERIAN

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Let's **Connect**

CONTACT GUIDE:
www.phs.org/ContactGuide

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https://phs.qualtrics.com/jfe/form/SV_3Jl9H4yZ81DZtA2

PHONE:
(505) 923-5757

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