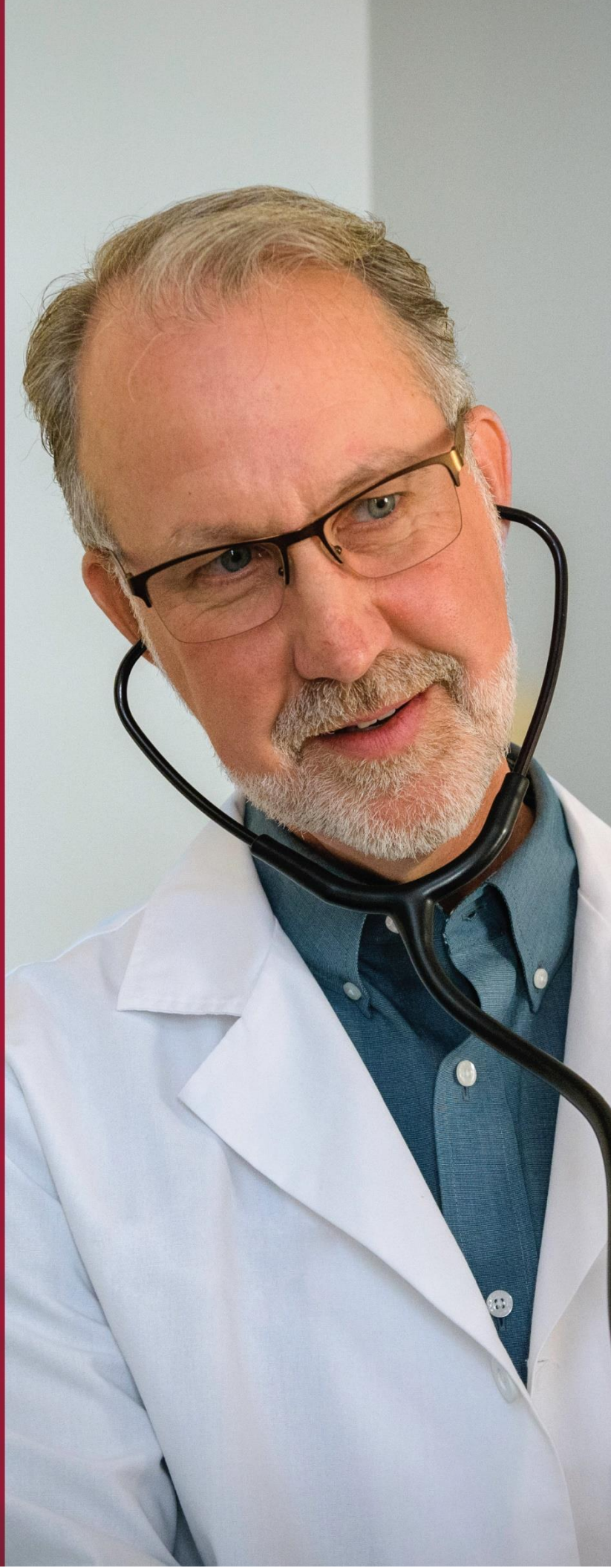
2026 PRACTITIONER AND PROVIDER MANUAL

Your guide to Presbyterian programs, policies and procedures



PRESBYTERIAN

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Introduction

Using the 2026 Provider Manual

This 2026 Practitioner and Provider Manual is both a resource for essential information about Presbyterian policies and procedures and an extension of a provider's service agreement.

For provider's 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.

This provider manual and the Turquoise Care provider manual are available online at www.phs.org/providermanual. The manuals are updated quarterly or as needed. Providers can also request a printed copy of the manual to be mailed to them at no charge.

Presbyterian updates and news will also be communicated periodically through the Network Connection newsletter and on the provider communications page, located at www.phs.org/providercommunications. Providers can receive newsletters and updates from Presbyterian by signing up to receive emails from Provider Network Operations 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 (i.e., a person) and a provider (i.e., a 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 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

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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 our members with a comprehensive provider network, a quality medical management program and cost-effective, consumer-driven managed healthcare services. We are committed to providing exceptional customer service to our providers and members. Presbyterian strives to ensure members can access primary and specialty care services as needed and receive quality healthcare services in the most cost-effective setting. Unlike most managed care organizations, which are accountable to shareholders, Presbyterian is ultimately accountable to a board of

directors comprised of volunteers from our communities. Presbyterian's enduring purpose is to improve the health of the patients, members and communities we serve.

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

- Thirty-six general, acute-care hospitals (eight of these are currently owned, leased or managed by Presbyterian Healthcare Services)
- More than 10,000 practitioners
- More than 300 retail pharmacies composed of locally owned stores and most major chains

Commercial Products

Presbyterian offers a portfolio of products for employers, including health maintenance organization (HMO), point-of-service (POS) and administrative service only (ASO) products. Presbyterian Insurance Company, Inc. (PIC) offers a preferred provider organization (PPO) product for groups.

Medicare Advantage

Presbyterian Senior Care (HMO/HMO-POS) Medicare Advantage plans are for people who are 65 years old or older, or for people under the age of 65 with certain disabilities who are entitled to Medicare Part A, and are enrolled in Medicare Part B. The Medicare Advantage plans are designed to meet the special healthcare and financial needs of Medicare beneficiaries. Presbyterian Senior Care (HMO/HMO-POS) is available to Medicare recipients living in the following counties in New Mexico:

- Bernalillo
- Cibola
- Rio Arriba
- Sandoval
- Santa Fe
- Socorro
- Torrance
- Valencia

Presbyterian Senior Care (HMO/HMO-POS) is only offered to employer groups.

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 (HMO D-SNP) includes both full and partial benefits to individuals who are eligible for both Medicare and Medicaid benefits.

Identified member sub-populations who are eligible for Presbyterian Dual Plus (HMO D-SNP) 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 cost-shares for Medicare benefits for members that qualify for a Dual Special Needs Plan. Medicaid can also act as a wrap-around program to pay for services that not covered by Medicare, such as, but not limited to, the following:

- 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

Partial dual eligibility refers to members who qualify to have Medicaid pay some of the expenses they incur under Medicare. 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 (QMBs) receive assistance from Medicaid to pay their Medicare premiums and cost-sharing obligations. If a Presbyterian Dual Plus (HMO D-SNP) enrolled member loses their Medicaid eligibility, they will have a 120-day grace period where they will remain enrolled in Presbyterian Dual Plus (HMO D-SNP) while they attempt to recertify their Medicaid status. During this grace period, members will continue to receive their Medicare benefits through Presbyterian Dual Plus (HMO D-SNP).

Presbyterian Dual Plus Plus (HMO D-SNP) has a 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, power of attorney or legal guardian, care coordinator, primary care provider (PCP) and additional participants who are working to support the member's needs. As a part of the ICT, providers receive communication from other members of the ICT. Providers also communicate with the ICT and 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, known as supplemental benefits, and also includes prevention and wellness benefits.

Presbyterian offers a network of providers with a wide range of specialties to fit the unique needs of Medicare Advantage members. Most Presbyterian Senior Care (HMO/HMO-POS) and Presbyterian Dual Plus (HMO D-SNP)include Medicare Part D prescription drug coverage.

POS members can use practitioners, hospitals and providers outside the Presbyterian network for an additional cost.

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** serves 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

Alternative Benefit Plan

Medicaid expansion services, also known as the Alternative Benefit Package (ABP), are provided to qualified enrollees through the Presbyterian Turquoise Care program. Before Turquoise Care, Medicaid was primarily available to children, pregnant women, very low-income mothers, and people with disabilities.

As New Mexico opted to expand Medicaid under the Patient Protection and Affordable Care Act (ACA), many adults who had never qualified for Medicaid before became eligible in 2014. Network providers are required to provide ABP-covered services under the terms of the Presbyterian Turquoise Care Service Agreement.

The ABP offers low-cost healthcare coverage to low-income adults who meet ABP eligibility standards under the New Mexico HCA Category of Eligibility 100. Eligibility is based on income, rather than the multiple eligibility categories that were used before. To be eligible for ABP, enrollees must be adults between the ages of 19 and 64, and at or below 138% of the Federal Poverty Level (FPL).

Qualifying adults will receive ABP services through Presbyterian Turquoise Care. Native Americans who are eligible through the Medicaid expansion may enroll in Turquoise Care or receive services through fee for service.

Alternative Benefit Plan Covered Services and Authorization

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

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

Alternative Benefit Plan-Exempt Benefit Package

An ABP-exempt member has full Medicaid benefit coverage rather than narrower ABP coverage.

The ABP exempt is for an individual who has a physical health or behavioral health condition that qualifies the member as “medically frail.” When an AMP member’s condition is confirmed as meeting criteria, the member is moved to the ABP-exempt category. A member may self-identify with a qualifying condition by contacting the

Presbyterian Customer Service Center (PCSC) or is identified and confirmed through the care coordination process.

Please refer to Appendix I for a list of medically frail conditions that qualify a member for the ABP-exempt Benefit Package

Video Visits

Presbyterian introduced Video Visits, a platform of online and on-demand healthcare delivery services, to provide doctor visits via computer, tablet or smartphone through a webcam for members. Video Visits enable convenient and affordable access to members 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. Video Visits are not intended to replace or continually substitute for a PCP visit.

Video Visits providers can refer patients to specialists when necessary, as well as prescribe non-narcotic medications.

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

Regulatory Agency Websites

This 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/
New Mexico Office of the Superintendent of Insurance	www.osi.state.nm.us/
National Provider Identifier	https://nppes.cms.hhs.gov/

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Ch. 2: Provider Network Operations

About Provider Network Operations

Presbyterian has an internal Provider Network Operations (PNO) team that is dedicated to working with our network of practitioners and providers. PNO is committed to delivering an exceptional provider experience through relationship management and engagement, timely and informative communications, modern resources and services and good customer service. We develop and share programs, tools and communications that provide our network with critical information, managed care-related training and education, facilitation and support. As an integral part of Presbyterian, we are continually evaluating new services and methods that increase efficiency, add value and lower costs for our network and other stakeholders.

What We Do

PNO team members provide their expertise and service to the following areas:

- Practitioner and provider relationship management
- Provider and practitioner training/education
- Credentials verification
- Practitioner and provider e-business resources
- Network communications
- Business analysis
- Provider data integrity

Each provider within the Presbyterian network has a designated PNO relationship team that serves as the provider's advocate within the health plan. Our relationship team reaches out to their assigned practitioners and providers through in-person or video visits, phone calls and emails. They serve as a provider's first and dedicated resource for questions and support relative to Presbyterian products, services and initiatives. Providers can find their relationship team in the Presbyterian Provider Network Contact Guide at www.phs.org/ContactGuide.

Keeping Provider Directory Information Up to Date

Presbyterian is required by federal and state regulations to maintain an accurate and up-to-date provider directory. Providers must verify their information every 90 days and report any demographic or practice changes within 14 days. These requirements help ensure members can reliably identify providers and access timely care.

Providers may update their information using the tools and processes described in Chapter 22: Provider Directory, including the "Update Provider Demographics" tool in the PROVIDERConnect Provider Portal, Magellan's provider portal for behavioral health providers, roster submissions for approved groups or by contacting their assigned PNO relationship team for assistance.

To reduce administrative burden, Presbyterian offers real-time and self-service options for updating demographic changes through the provider portal. Providers should ensure that directory information is consistent with signage, phone greetings, websites and other public-facing listings, as discrepancies may cause member confusion or access delays.

For detailed responsibilities, definitions, update pathways and compliance requirements, refer to Chapter 22**.**

Expanding Contracted Services

All providers interested in contracting for an additional practice location, additional services or specialty must comply with the applicable Presbyterian policies and procedures for network development. Providers must contact their PNO relationship team before adding any new locations, services or specialties.

The addition of providers of the same specialty does not require formal compliance with the Presbyterian network development process. However, providers must notify Presbyterian before allowing any new provider to provide services to a member until the credentialing process is completed, if applicable.

Network Training and Education

If providers are new to Presbyterian's network, or would like a refresher course regarding our resources, programs or initiatives, they can contact their PNO relationship team. Relationship teams can provide training and information about billing, coding, appeals and grievances, myPRES and many other informative topics.

They will serve as a guide and advocate in connecting providers with other health plan personnel, as necessary.

Presbyterian's Annual Training Conferences for Healthcare Professionals, Providers and Staff

In addition to the ongoing training provided by assigned PNO relationship team, Presbyterian hosts in-person conferences and webinars for all healthcare professionals and providers, to include physical health, behavioral health and long-term care services for all plan products. The purpose of the conference is to give our network the most current regulatory information, as it relates to Presbyterian and other key information to ensure a successful partnership for provider's patients and our members.

During the conference and webinar, we distribute new, updated and important regulatory information to our contracted healthcare providers. Providers are reminded that attendance at one Provider Education Conference annually is a requirement of your contract with Presbyterian.

Network Communications

Presbyterian uses a variety of publications and communication methods to provide the network with accurate, timely, relevant and engaging information about changes and initiatives at the health plan and other important news affecting the network. To ensure that they always remain to up to date, providers and their staff are encouraged to register for Presbyterian Provider eNews at www.phs.org/enews.

Communication topics may include the following:

- Notification of internal process changes
- Notification of regulatory requirements and changes
- Announcements of value-added benefits for both providers and members
- Clarification of coding issues
- Education regarding utilization of the health management programs available to our members
- Information about product-line specific policies and procedures as required by the specific regulatory agencies, such as HCA, the Centers for Medicare & Medicaid Services (CMS) and the New Mexico Office of the Superintendent of Insurance (OSI)

Presbyterian publishes a bimonthly practitioner and provider communications program newsletter titled "Network Connection." The provider newsletter contains articles about new resources and programs at Presbyterian, important business updates and changes, and regulatory updates and requirements. The newsletter is also posted on the News & Communications page at www.phs.org/providercommunications, along an archive of other recently distributed provider communications.

Provider Satisfaction Survey

PNO contracts with a third-party independent healthcare survey group to administer an annual satisfaction survey. Providers are highly encouraged to participate in the survey. This is an opportunity for providers to help Presbyterian effect positive changes to its organizational policies and procedures as they relate to member care processes. All provider's responses are anonymous unless the providers record their information and request to be contacted. We collect all responses to determine and address areas of need to improve the provider experience.

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Ch. 3: Primary Care Providers

The Description, Role and Responsibilities of Primary Care Providers

Primary care providers (PCPs) are contracted physical health providers who meet certain objective criteria established by Presbyterian. PCPs must accept the responsibility for ensuring the provision of healthcare year-round, 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. PCPs are not required to see more than four patients in an hour.

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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program guidelines, as applicable
- Vaccinating members during PCP visits instead of writing a referral for immunizations
- Scheduling routine physical exams within four months for newly established patients
- Coordinating with other 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 and Dual Plus 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 management and quality management guidelines
- Adhering to Presbyterian's administrative policies and procedures
- Meeting Presbyterian's credentialing and recredentialing requirements
- Notifying Presbyterian of changes in address, tax identification, 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
    - **Note:** 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
- CYFD: 1-800-797-3260 (toll-free)
- Department of Health/Division of Health Improvement (DOH/DHI): 1-833-796-8773 (toll-free)

Providers can obtain additional information regarding state reporting requirements for suspected abuse, neglect, or misappropriation of property of children and vulnerable adults 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.

Selection of, or Assignment to, a PCP

Presbyterian has written policies and procedures governing the process of member selection of a PCP and requests for a change of PCP. 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 action against the PCP
- The PCP is suspended for any reason

If providers are terminating their contract, they must provide Presbyterian with sufficient notice of termination so that we can notify our members in writing 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.

Requirement to Utilize Contracted Providers

PCPs are required to utilize Presbyterian's contracted in-network providers, laboratories, durable medical equipment (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, they can call

(505) 923-5757 or 1-888-923-5757 for assistance.

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 at www.phs.org/directory for other lab providers contracted with Presbyterian.

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 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 or facility provider until the member is notified in writing about their use of non-participating practitioners and facility providers and informed 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.

If providers do not comply with the requirements to utilize contracted providers, Presbyterian reserves the right to hold the provider 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 the referring provider.

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.

Medicare Advantage members may request approval for certification directly. All other Presbyterian 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 a behavioral health practitioner or facility provider. 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 or 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 from the member.

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Ch. 4: Specialists

The Role and Responsibilities of Specialty Care Providers

Specialists are contracted physical and behavioral health practitioners not identified as 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 by member, when appropriate, for specified treatments or diagnoses
- Referring members to other providers as needed, including laboratory services, radiology, and DME providers
- Advising patients of their right to know about all treatment options related to their condition or disease, regardless of whether it is a covered benefit under their insurance plan
    - **Note:** PCSC is available to assist with confirming covered benefits

- Communicating with the member's PCP or other providers about services rendered, treatment results, reports and recommendations to ensure continuity of care
- Documenting communication with the PCP or other contracted providers in the medical record
- Obtaining prior authorization from Presbyterian's 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, tax identification, 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 (for Turquoise Care and Dual Plus members)
- 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 (toll-free)
  - 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.

In addition, specialty care providers are responsible for verifying member eligibility before rendering services and requesting prior authorization of covered services. This can be easily and quickly done through myPRES at www.phs.org/mypres or by calling (505) 923-5757 or 1-888-923-57575757 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.

Requirement to Use Contracted Providers

Specialty care providers are required to use Presbyterian's contracted in-network providers, including laboratory services, radiology services, 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).

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 at www.phs.org/directory for other lab providers contracted with Presbyterian.

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/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.

If providers do not comply with these requirements, 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 the referring provider.

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.

Medicare Advantage members may request approval for certification directly. All other plans require that the practitioner or facility providers submit requests to Presbyterian's 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.

Appointment Standards for Specialists (All Product Lines)		
Healthcare Service	**Appointment Characteristics**	**Standard**
Specialty Care	Outpatient referral and consultation	Consistent with clinical urgency, but no more than 21 calendar days, unless the member requests a later time

Specialty Care Provider Termination

Providers must refer to their service agreement with Presbyterian for specific time frames and obligations regarding terminations.

Other Information for PCPs and Specialists

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

Accessibility of Services Standards

As required by our regulators and 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.

Presbyterian's accessibility of services standards are consistent with regulatory requirements and exist to ensure that our members receive reasonable, appropriate and timely access to care from contracted providers.

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

Issuing Notice of Medicare Non-Coverage in Skilled Nursing Facility, Home Health and Comprehensive Outpatient Rehabilitation Services Settings

As an enrollee has the right to request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC QIO) when a skilled nursing facility (SNF), home health agency or comprehensive outpatient rehabilitation services (CORF) decides to terminate previously approved coverage, which includes an MA plan or contract provider directing an enrollee to seek care from a non-contracted provider or facility. All enrollees receiving covered services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC), delivered by the facility or provider before their services end.

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare-covered services end or the second to the last day of service if care is not being provided daily. For example, if the last day of covered SNF care is a Friday, then the NOMNC should be delivered no later than the preceding Wednesday.

Please note that the two-day advance requirement is not a 48-hour requirement. For example, if a member's last covered home health service is at 10 a.m. on Wednesday and the notice is delivered at 4 p.m. on the prior Monday, then it is considered timely.

If home health services are being provided less frequently than daily, then the NOMNC notice must be delivered no later than the next to last visit before Medicare-covered services end. For example, if home health care is provided on Tuesdays and Thursdays, and Tuesday is the last day of Medicare-covered services, then the NOMNC notice must be delivered no later than the preceding Thursday.

The NOMNC may be delivered earlier than two days preceding the end of coverage, so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.

The NOMNC notice may not be routinely given at the time services begin. An exception is when the services are expected to last fewer than two days. In these instances, the NOMNC notice may be given by the provider when services begin.

There is an accepted circumstance when the NOMNC may be delivered sooner than two days or the next-to-last visit before coverage ends. This exception is limited to cases where a beneficiary receiving home health services is found to no longer be homebound, and thus ineligible for covered home health care. In this circumstance, the NOMNC should be immediately delivered to the beneficiary upon discovery of the loss of homebound status. We expect that in most cases, in all settings, the decision of a provider to end care will be based on medical necessity, and thus, foreseeable by the provider within the required time frames for notice delivery.

Detailed instructions for the NOMNC can be found in §260 of chapter 30 of the Medicare Claims Processing Manual. For additional guidance, including a copy of the NOMNC, see the Beneficiary Notices Initiative webpage at www.cms.gov/Medicare/Medicare-General-Information/BNI.

Issuing the Medicare Outpatient Observation Notice for Observation Services

Hospitals and critical access hospitals are required to provide written and verbal explanations to original Medicare and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours.

The Medicare Outpatient Observation Notice (MOON) informs all Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital.

The MOON must be delivered to beneficiaries in original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or critical access hospital must provide the MOON no later than 36 hours after observation services as an outpatient begins. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Medicare Part B coverage. As noted on the MOON, observation stays are covered under Medicare Part B
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON
- Beneficiaries for whom Medicare is either the primary or secondary payer

Note: For purposes of these instructions, the term “beneficiary” means either beneficiary or representative when a representative is acting for the beneficiary. Please see chapter 13 of the Medicare Managed Care Manual for Medicare Advantage instructions.

The statute expressly provides that the MOON be delivered to beneficiaries who receive observation services as an outpatient for more than 24 hours. In other words, the statute does not require hospitals to deliver the MOON to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services

and not inpatients and the reasons for such status. Also, it must be delivered no later than 36 hours after observation services begin.

However, hospitals and critical access hospitals may deliver the MOON to an individual receiving observation services as an outpatient before the individual has received 24 hours of observation services. Allowing delivery of the MOON before an individual has received 24 hours of observation services affords hospitals and critical access hospitals the flexibility to deliver the MOON consistent with any applicable state law that requires notice to outpatients receiving observation services within 24 hours after observation services begin. The flexibility to deliver the MOON any time up to but no later than 36 hours after observation services begin also allows hospitals and critical access hospitals to spread out the delivery of the notice and other hospital paperwork to help avoid overwhelming beneficiaries.

Please note that these instructions apply to hospitals and critical access hospitals per section 1861(e) and section 1861(mm) of the Social Security Act.

The detailed process for delivery of this standardized notice (form CMS-10611), MOON, can be found in §400 of chapter 30 of the Medicare Claims Processing Manual. For additional guidance, including a copy of the MOON, see the Beneficiary Notices Initiative webpage at www.cms.gov/Medicare/Medicare-General-Information/BNI.

Issuing the Important Message From Medicare in Hospital Settings

An enrollee has the right to request an immediate review by the BFCC QIO of a decision that inpatient hospital care is no longer necessary. For all Medicare Advantage enrollees, hospitals must deliver valid, written notice of an enrollee's rights as a hospital inpatient, including discharge appeal rights, using the standardized CMS Form R-193, an Important Message from Medicare.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare, a statutorily required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the Important Message from Medicare within two calendar days of admission, must obtain the signature of the beneficiary or their representative, and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of the discharge as possible, but not more than two calendar days before discharge.

For beneficiaries who request a QIO review, hospitals must deliver a Detailed Notice of Discharge (DND) as soon as possible, but no later than noon of the day after the QIO's notification. Both the Important Message from Medicare and the DND must be the standardized notices provided by CMS.

Detailed delivery and from instructions for the standardized notice, Important Messages from Medicare, and the DND can be found in §200 of chapter 30 of the Medicare Claims Processing Manual. For additional guidance, including a copy of the Important Message from Medicare and the DND, see the Hospital Discharge Appeal Notices webpage at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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Ch. 5: Healthcare Guidelines

Preventive Health Services and Guidelines

Preventive health guidelines are evidence-based, systematically-developed statements that are designed to give providers and members age- and gender-based recommendations about services that providers should routinely incorporate 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 Presbyterian 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)
- Centers for Disease Control and Prevention (CDC) / 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 the 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 generally available 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 see the following link: 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 are 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 electronic health record (EHR) access and data feeds from various network providers, and on-site or electronic medical record (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 act as PCPs.

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

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 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 the Quality Measures Toolkit to providers. The Quality Measures 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 Health Risk Assessments (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 Health Risk Assessments

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.

Medicare Health Risk Assessments

All Medicare members who are new to Presbyterian Medicare Advantage products are encouraged to complete an initial HRA of their physical and behavioral health needs. The results of these assessments enable Presbyterian to determine if new members may benefit from care coordination, case management, or disease management program services.

Dual Special Needs Plan Health Risk Assessments

All 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 Comprehensive Needs Assessment (CNA) on Dual Plus members who meet higher level Care Coordination criteria to complete a comprehensive care plan.

Commercial Health Risk Assessments

All Commercial members are encouraged to complete an initial HRA. The results of these assessments are used to determine if 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.

Immunizations

Presbyterian recommends immunization guidelines from the CDC, ACIP and HCA. Please see more information below.

- The CDC/ACIP schedule for children and adults is available at www.cdc.gov/vaccines/schedules/hcp/index.html
- The 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, NMAC 8.308.9.17, expects participation in the New Mexico 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 HCA program manager at (505) 827-2898 or the CDC Immunization hotline toll-free 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 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.

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Ch. 6: Care Coordination

Care Coordination

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 to support self-management and promote healthy lifestyles. Care coordination facilitates communication and collaboration along the continuum of care to ensure the patient receives the care and services needed to reduce risk and improve health outcomes.

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 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 identify care opportunities and to identify members who are at risk for future adverse events that can benefit from care coordination interventions
- HRAs that are completed during a new member's onboarding, which are designed to identify members in need of care coordination services.
- An assessment that is designed to identify the member's holistic needs
- A comprehensive care plan that address physical, psychosocial, behavioral and functional needs
- ICTs, including providers, that work together and collaborate 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 members. Activities and interventions are based on the member needs across the integrated care continuum.

The Presbyterian Care Coordination Team includes our employed staff and those of our experienced behavioral health partner, Magellan Healthcare. Some care coordination team members have extensive behavioral health and long-term care experience. The care coordination team works with our medical directors for each product line 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 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, community providers and/or future health home providers to provide care coordination services to Turquoise Care members. 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.

Members are matched with a care coordinator based on the following:

- Clinical needs
- Geographic location
- Language
- Cultural preferences
- History of established provider relationships

Providers can obtain additional information by using the following contact information:

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

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 ongoing 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 an HRA for Turquoise Care and Medicare 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 intervention receive an assessment and are assigned to a care coordination level.

Assessment

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

Turquoise Care members who require Level 2 or 3 care coordination are assigned to a dedicated care coordinator. Members are matched with an appropriate care coordinator based on their clinical needs, geographic location, language, cultural preferences and history of established provider relationships. 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 a provider's help in engaging their patient in the assessment process. Similarly, providers may request our assistance for care coordination for their Presbyterian patient.

Care Plan Development

Based on the results of the assessment, an individualized care plan is developed for members. 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.

This customized care plan allows members to understand which services are available and creates a foundation for discussions about their health with the member, their caregivers, care coordinator and providers. The care coordinator works with the member and their designated family members, caregivers, or authorized representatives, the member's PCP and other providers to develop an individualized care plan that is member-driven and addresses issues and needs identified in the assessment.

The member's 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 and other providers assist members as appropriate for their areas of expertise. The care coordinator works in collaboration with the provider(s) and the member to identify measurable physical, behavioral, functional and social support goals, and to develop targeted interventions to address the member's goals. Medication reconciliation is preformed and utilized to evaluate medication adherence.

Interdisciplinary Care Team

Based on the member's assessment and individualized care plan, an ICT is established. The ICT addresses the member's specific needs and is an important 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 tools, education and resources that assist them to take personal responsibility for their care management. The care plan is reviewed, modified if necessary and approved by the member.

ICT communication may occur through in-person case conferences, by telephone, secure video or electronically through a care management platform. 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

Presbyterian's Care Coordination staff works in close collaboration with the Utilization Management staff for transitions of care, prior authorizations, approvals, and discharge planning activities. Working directly with provider community, hospitals, residential and group home programs, and nursing facilities, our Care Coordination and Utilization Management teams ensure members are receiving care in the most appropriate and least restrictive setting possible, and they help facilitate a smooth transition from acute care to a community or home setting.

For services requiring review or prior authorization, Presbyterian uses Milliman Care Guidelines (MCG) criteria, the New Mexico Administrative Code (NMAC), national behavioral healthcare and long-term care guidelines, internal policies based on industry-accepted standards and approved regulatory standards 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. For Turquoise Care members, 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 Nursing Facility Level of Care (NFLOC) eligibility requirements have access to HCBS without waiting for a waiver slot to become available. Individuals who are not otherwise Medicaid-eligible, 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 otherwise not 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 details on Presbyterian Turquoise Care long-term care, benefits and guidelines.

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 Turquoise Care 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 Turquoise Care 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 Turquoise Care 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 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 members with chronic conditions, Presbyterian offers comprehensive disease management programs for asthma, coronary artery disease, diabetes, hypertension, chronic obstructive pulmonary disease, and adolescent Turquoise Care members 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 tool and match members to an appropriate level of intervention
- Provide disease management education and health coaching for lifestyle modifications
- Collaborate with members and providers to support self-management goals for health improvement
- Provide education for preventive healthcare guidelines

Care coordinators manage Turquoise Care members with the highest risk score who need more intensive/multisystem medical or nursing interventions. Turquoise Care 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, Presbyterian provides all members the one-on-one support they need to reach the stage of "readiness to change." The motivational behavioral interviewing methodology ensures we focus our efforts on developing a personalized health improvement plan for members.

Improving 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 targeted interventions. Members with chronic illness learn to manage their health to lead more productive lives. Members tend to be more willing to participate in the Healthy Solutions 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. Healthy Solutions 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 Healthy Solutions 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 provide them a variety of self-management tools to support their success
- Supporting shared decision-making to 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/PCP relationship to achieve optimal health by closing gaps between recommended and actual care
- Reinforcing the established plan of care
- Monitoring performance measures and health outcomes to evaluate the efficacy of the program

How to Refer to the Healthy Solutions Team

Providers may use the following contact information to refer their Presbyterian patients with asthma, coronary artery disease, diabetes, or hypertension to the Presbyterian Healthy Solutions Disease Management 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 evaluates the appropriateness, medical necessity and 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, 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 (505) 923-5757 or 1-888-923-5757 (toll-free) during and after normal business hours.

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. Member handbooks are 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 Turquoise Care 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

The PCP either gets an authorization number or a notice that a service requires prior authorization. PCPs or other providers are encouraged to submit prior authorization request online to receive immediate notification of the action, authorization 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.

In addition, benefits with limitations may also require a prior authorization. Services that require a prior authorization are published in our provider manual (see Appendix E), in the member handbooks and on Presbyterian's website. Extensive detail is included in provider orientations and ongoing training. This ensures that the provider and member know which services require prior authorization.

Presbyterian annually reviews utilization management criteria and procedures for applying them and updates criteria when appropriate. Presbyterian involves appropriate practitioners in developing, adopting and reviewing criteria. Providers may access utilization management criteria online through the Medical Policy review manual available at www.phs.org/medicalpolicymanual or by calling (505) 923-5757 or 1-888-923-5757.

For Commercial, Presbyterian Senior Care (HMO/HMO-POS) and select ASO plans, the model is "no referral required" for most care rendered by contracted specialists. This includes referrals from one contracted specialist to another. Refer to specific plans for any special requirements.

For ASO plans not participating in the open access model and for Presbyterian Turquoise Care, members need to continue to see their PCPs for a specialist referral. PCPs, however, are not required to get referral authorization numbers from Presbyterian. The form of communication between the PCP and specialist (prescription, phone call, or note in medical record) is at the discretion of the PCP and the specialist.

Authorizations of Coverage

Services requiring prior authorization are published in appendix E of this manual, the 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 documentation by the referring provider is critical to demonstrate medical necessity.

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

- Recommendation of treating provider
- Age
- Co-morbidities
- Complications
- Mental status
- Activities of daily living
- Instrumental activities of daily living
- Financial status
- Poly-pharmacy

- Progress of treatment
- Psychosocial and cultural situation
- Home environment
- Availability of less restrictive treatment modalities to address the member's needs
- Availability of services including, but not limited to, 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 (APA) criteria
- American Academy of Child and Adolescent Psychiatry (AACAP) criteria
- American Society of Addiction Medicine (ASAM) Patient Placement criteria
- Internal criteria approved by Presbyterian's Utilization Management Committee and Clinical Quality Committee
- 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

Providers can quickly and easily verify member eligibility and benefits by logging in to myPRES 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 call (505) 923-5757 for a peer-to-peer discussion about a prior authorization request or decision.

Department	Online	Phone Number	Fax Number
Utilization Management staff are available from 8 a.m. to 5 p.m., Monday-Friday. After hours, an on-call Utilization Management nurse is available evenings, weekends and holidays.			
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_00000002 4715 • Clinical Criteria Document for Individual and Family/Employer Metal Level Health Insurance Plans https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_00000002 4716 • 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

Utilization Management

Department	Online	Phone Number	Fax Number
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 Services	• Stanson Health https://php.careportal.com/	• 1-888-487-0733	• 1-646-502-5041
OptumCare (Medicare delegated members only)	• Home Optum Pro Portal www.optumproportal.com/home • Optum Pro Instructions https://cdn.linkhealth.com/site-builder/68/32cc98b3-d625-4360-a59a-c8e289c9e588/Accessing%20Optum%20Pro%20How-To.pdf	• Inpatient (505) 232-1600 • Prior Authorization 1-800-620-6768	• Inpatient: (505) 232-1387 • Prior Authorization: (505) 232-1387

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 also contact Presbyterian in the following ways:

- Health Services: (505) 923-5757 or 1-888-923-5757 (option 4)
- Home Health Care requests: (505) 923-5757 or 1-888-923-5757 (option 4)
- Commercial and Medicare behavioral health prior authorization requests: (505) 923-5757 or 1-888-923-5757 (option 5)
- Turquoise Care behavioral health prior authorization requests: fax (505) 843-3019 or email nmturquoisecare@magellanhealth.com

Provider 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.

Providers may submit prior authorization requests in the following ways:

Utilization Management

- 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
- Transplant Requests may be faxed to (505) 843-3110
- Long-term care prior authorizations may be faxed to (505) 843-3195
- 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:

- Commercial, Individual, Exchange: seven business days
- ASO, FEHB Plans: 15 calendar days
- Medicaid: seven calendar days
- Medicare: 7 calendar days for pre-service

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 7-15 calendar days of the request for additional information.

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 practitioner with knowledge of the member's medical or behavioral health condition, the member would be subjected to adverse health consequences without the care or treatment requested
- The covered person's ability to regain maximum function would be jeopardized
- 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 are processed according to the following regulatory timeliness requirements when all necessary and relevant documentation supporting the prior authorization request is submitted:

- Commercial, Individual, Exchange: 24 hours
- ASO, FEHB Plans: 72 hours
- Medicaid: 24 hours
- Medicare: 72 hours

If we do not have all the documentation needed to make a decision, then we will attempt to obtain the necessary information and will make a determination no later than three calendar days.

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

Authorization for Inpatient Admission

For elective or emergency admissions, use myPRES for all authorization requests and notification of deliveries. If necessary, the provider may also obtain prior authorization for an inpatient concurrent review or inpatient hospital admission by calling (505) 923-5757 or 1-888-923-5757 (option 4),or faxing (505) 843-3107.

For Commercial and Medicare behavioral health prior authorizations requests, fax 1-888-656-4976. For Turquoise Care behavioral health prior authorizations requests, fax (505) 843-3019 or email nmturquoisecare@magellanhealth.com. The provider needs to either fax the request to the number designated in the message for the type of request or leave a message.

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 authorizations through Stanson Health apply 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
- Emergency room (ER)
- Urgent care
- ER and urgent care facility procedures do not require prior authorization from Stanson Health 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 at for Stanson Health https://php.careportal.com or by calling 1-888-487-0733
- For specific musculoskeletal and elective spine surgery performed both in an inpatient and outpatient settings, please contact Evolent at www.RadMD.com or by calling 1-866-236-8717. Failure to do so

may result in a claim rejection. For more information, please refer to Presbyterian's authorization guide available on Presbyterian's website at www.phs.org/providers/authorizations

- If providers have any questions regarding Stanson Health or Evolent, then they should contact their PNO relationship team. Contact information for PNO relationship teams can be found in the Provider Services 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:

- Prohibiting providers from discussing cheaper treatment or drug options with covered persons
- 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 they 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 the NMAC, Title 16, Chapter 10.17.8).

Presbyterian ensures that Health Insurance Portability and Accountability Act (HIPAA) requirements are met and maintains confidential records files. All information and medical records obtained during the course of review activities shall be treated as confidential, in compliance with all applicable state and federal regulations. Presbyterian uses reasonable diligence 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

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)
- Medical Assistance Division (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
- APA Levels of Care
- AACAP Levels of Care
- ASAM 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 primary care provider

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, including postpartum care, 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. 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.

The following is information regarding global maternity billing by covered providers such as primary care obstetricians and specialists:

- If the delivery of the newborn is greater than three months past the mother's eligibility date, then Presbyterian pays the global fee
- If the delivery is within three months of the mother's eligibility, then 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:

- 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.

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.

Medicare Notices

Important Message to Medicare Beneficiaries

Upon admission to a contracted or non-contracted acute care hospital, the hospital will provide Medicare Advantage members with the CMS document entitled “An Important Message to Medicare Beneficiaries.” This document explains the Medicare Advantage member’s appeal rights when receiving care in an acute hospital setting.

Once the Medicare Advantage member has signed the document, the hospital must deliver a follow-up copy as far in advance of discharge as possible but not more than two calendar days before the planned date of discharge, except when the original important message from Medicare was delivered within two calendar days of discharge.

Detailed Notice of Discharge

Presbyterian will communicate in an expeditious manner with the QIO to facilitate appeals. When a QIO notifies Presbyterian that a member has requested an immediate review, Presbyterian will directly or by delegation deliver a “Detailed Notice of Discharge” to the member. This document provides a detailed explanation of why acute care hospital services are no longer covered.

Notice of Medicare Non-Coverage

Presbyterian Medicare Advantage beneficiaries and Medicare recipients receiving home healthcare, or those in a SNF, must be given a CMS-approved written notice informing them that their covered home healthcare or SNF services are ending. The notice must be given two days in advance of services ending. If services are expected to end in less than two days, then the notice must be given upon admission to the provider (facility).

In a non-institutional setting, if the span of time between services exceeds two days, the provider should deliver the notice no later than the second to last time that services are furnished. The notice includes the date the enrollee’s financial liability for continued services begins and a description of the member’s right to an expedited appeal to a QIO. Care Coordination will ensure that providers have the appropriate CMS-approved forms to give to members.

Home Skilled Nursing Facility Rule Under Medicare

The “Home SNF Rule” refers to provisions affecting the choices Medicare Advantage members have when needing SNF care after they are discharged from a hospital stay. The rule allows a hospitalized Medicare Advantage member who requires skilled nursing care and is ready for discharge to elect one of the following three options:

- The member can return to the SNF from which they came

- The member may go to the SNF where their spouse is
- The member may go back to their Continuing Care Retirement Community SNF, if applicable

If the “Home SNF” is a non-participating provider (facility), Presbyterian Medicare Advantage beneficiaries or the delegated entity must attempt to contract with the non-participating provider.

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 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, Presbyterian must allow qualified healthcare professionals who are specialists to act as PCPs for patients with chronic medical conditions of sufficient severity who require primary coordination of care by a specialist as determined by the member, the member's current treating provider, the member's PCP if different than the treating provider, or Presbyterian, provided that the specialist does the following:

- Offers all basic healthcare services that are required of them by the Managed HealthCare Plan
- Meets Presbyterian's eligibility criteria for healthcare professionals who provide primary care

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
- 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.

Contacts for Other Information Providers May Need	
Request or Resource	**Contact Information**
Behavioral Health	Phone: (505) 923-5757 or 1-888-923-5757 (option 5) Turquoise Care Fax: (505) 843-3019 Commercial / Medicare Fax: 1-888-656-4967 Turquoise Care Email: nmturquoisecare@magellanhealth.com Commercial / Medicare Website: www.magellanhealth.com/provider
Dental (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	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	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 559-1150 Website: www.phs.org/providers/authorizations myPRES: www.phs.org/mypres
Inpatient Admissions	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 843-3107 or 1-888-923-5990

Contacts for Other Information Providers May Need	
Request or Resource	**Contact Information**
	Website: www.phs.org/providers/authorizations myPRES: www.phs.org/mypres
Member Eligibility Verification	Phone: (505) 923-5757 or 1-888-923-5757 (option 1) myPRES: www.phs.org/mypres
Most Outpatient	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 843-3047 Website: www.phs.org/providers/authorizations myPRES: www.phs.org/mypres
Non-Emergency Medical Transportation via Modivcare Solutions, LLC (For Presbyterian Turquoise Care and Presbyterian Dual Plus Members Only)	Phone: (505) 923-6300 or 1-855-774-7737 (toll-free)
Pharmacy	Phone: (505) 923-5500, (505) 923-5757 (option 3) or 1-888-923-5757 (option 3)
Prior Authorization Guide for Commercial and Medicare Plans	Website: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00179220
Transplant Requests	Fax: (505) 843-3110

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Ch. 8: Laboratory Services

Requirements 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 station 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

The list on Appendix G applies to all Presbyterian product lines and is effective for dates of service on or after Jan. 1, 2014. Reimbursement for pathology/laboratory services depicted on the In-office Laboratory List are based on Presbyterian's clinical lab fee schedule and the Medicare Resource-Based Relative Value Scale fee

schedule, unless a 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 waive test list can be located at www.cms.gov/files/document/r11547CP.pdf#page=5.

Always Use Contracted Reference Laboratory Services

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." Using 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 the provider's services agreement between their 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 their services agreement.

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

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. Call (505) 923-5757 or 1-888-923-5757 (option 4) for prior authorization assistance.

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.

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Ch. 9: Pharmacy

Provider Prescribing Guidelines

The Presbyterian pharmacy benefit is an essential element in providing 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 members 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 American Medical Association (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 Program website
- Participating in Presbyterian patient safety audits to demonstrate that the PMP system and reports are used when prescribing controlled substances

Pharmacy Benefit Guidelines

The following describes the general administration of the Presbyterian pharmacy benefit. All product lines vary in structure. For example, some follow a closed, generics first-based formulary while others use a multi-tier formulary structure. They all, however, adhere to the 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 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:

- 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, 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 the 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 who are experts in the care of the elderly and disabled.

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

  - Be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition based on sound clinical data
  - Demonstrate a positive therapeutic outcome
  - Be accepted for use by the medical community
  - Provide a cost-effective option for the treatment of the medical condition
  - Not be experimental or investigational
  - Be mandated by HCA or CMS
- Recommendations of national organizations, committees and/or specialty societies are strongly considered
- 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 the manufacturer's recommended maximum daily dosage
- Appropriate diagnosis (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, provide 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 PDLs

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

Providers may request medication additions, deletions or other changes to the Presbyterian PDL. All requests should be documented to facilitate the review and research process. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter 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 a Presbyterian P&T Committee meeting to 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 P&T Committee.

Communicating P&T Committee Decisions (Formulary and Benefit Changes)

Following approval by the P&T Committee, all formulary changes and the effective date of the changes are communicated to affected members and all providers.

Members who are currently using the drug are sent a letter explaining the benefit change at least 60 days before the effective date. The member is encouraged to contact their provider and is assured continued coverage during the 60-day notification period.

Formulary changes are communicated to providers after each P&T Committee meeting and before the effective date of the changes by newsletter and updates to online formularies or mobile applications. The P&T Committee Provider Update newsletter is mailed and emailed following each P&T Committee meeting. At the same time, updates are made to the formulary pages at www.phs.org and searchable online formulary tools and mobile applications.

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, our searchable online formularies and mobile application to 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 that is done to evaluate the effectiveness, safety and appropriateness of medication use. DURs occur during claim adjudication at the retail pharmacy and determine 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. 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 in order to facilitate the prior authorization process. When used for requesting prior authorization for a drug, the Uniform Prior Authorization Form may be submitted to Presbyterian Pharmacy Services online, by telephone or fax. All requests are accepted into the Presbyterian

automated prior authorization system, are date and time-stamped to ensure the timeliness of decisions and notifications.

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

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

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 prior authorization 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
- The prior authorization request does not have drug information

Clinical Review of Drug Prior Authorization Requests

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

- Medication requires a PA
- Medication is **or** is not included on the PDL
- Medication meets **or** does not meet clinical criteria for medical necessity
- Medication quantities meet or exceed the PDL requirements and member’s benefit plan
- Medication and administration setting is appropriate for the member’s health condition or disease state
- Continuation of therapy for any drug depends on its demonstrable clinical 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 effects
- 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 Prior Authorization Request

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

Revised Drug Prior Authorization 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. In accordance with New Mexico state laws and regulations, only medical directors licensed to practice medicine in the state of New Mexico are authorized to make medical necessity decisions for Commercial and Health Insurance Exchange Metal Level benefit plans. NCQA (UM 4E) requires that organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity.

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 of receiving the request unless additional information is needed.

Notifications

Approvals

When a drug PA request is approved, the provider and pharmacy of record are notified by fax. Once 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. For benefit plans that require verbal notification of an approval, a call is also made to the member to notify them of the approval.

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. For benefit plans that require verbal notification of an adverse determination, a call is also made to the member to notify them of the adverse decision.

Time Frames

Standard Pharmacy Prior Authorization Requests

When all necessary information is provided with the Drug PA request, standard requests are processed as expeditiously as the member's health requires, but no later than 72 hours after the date and time Presbyterian received the request.

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 orally 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 except for 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
- Fertility medications
- 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

Turquoise Care Copayments

Presbyterian is responsible for implementation of copayments as directed by HCA. Some members may be assessed copays for certain services or drugs.

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

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

Dual-Eligible Members

If members are enrolled in both Medicaid and Medicare Part D, they will have more than one benefit plan for all 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. Before placing members on pharmacy lock-in, a Presbyterian care coordinator informs the members and/or their representative of the intent to lock in. Presbyterian’s grievance process is made available to the member who is designated for pharmacy lock-in. The pharmacy lock-in is reviewed and documented by a Presbyterian care

coordinator. The member is removed from the lock-in when Presbyterian determines that the non-compliance or drug-seeking behavior is resolved and the recurrence of the problem is judged to be improbable. 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 I/T/Us are exempt from Presbyterian's formulary and prior authorization process.

Turquoise Care 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.

Turquoise Care Transition Supply

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

Turquoise Care Mail Order/Home Delivery Benefit

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

Over-the-Counter Medications

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 I/T/U Clinics are exempt from Presbyterian's formulary and prior authorization process.

Turquoise Care Medication Therapy Management

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.

Commercial Prescription Drug Benefit

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

The member’s out-of-pocket expenses are lowest when they fill prescriptions for preferred generic medications (Tier 1) and preferred brand-name drugs (Tier 2). They are highest when prescriptions for non-preferred drugs (Tier 3) are obtained. Specialty pharmaceuticals (Tier 4) are specialized medications that may be required to be obtained through the designated specialty pharmacy network.

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

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

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

Commercial and Healthcare Exchange Benefit Exclusions

- Items used for cosmetic purposes
- Lost, stolen or damaged
- Bulk powder compounds
- Medications unapproved by the FDA
- Medications with a Drug Efficacy Study Implementation designation of five or six
- Items not medically necessary
- Prescription drugs requiring a pharmacy prior authorization, when prior authorization was not obtained
- Prescriptions ordered by a non-participating provider or purchased at a non-participating pharmacy, unless required due to emergent or urgent care encounters
- Prescription drugs/medications purchased outside the United States
- OTC medications
- Compounded prescriptions drugs
- Fertility medications unless specifically covered under the member's benefit
- Treatments and medications for the purpose of weight reduction or control, except for medically-necessary treatment for morbid obesity
- Nutritional supplements as prescribed by the attending practitioner/provider or as a sole source of nutrition
- Infant formula
- Prescription drugs/medications used for the treatment of sexual dysfunction unless specifically covered under the member's benefit.
- Herbal or alternative medicine and holistic supplements
- Oral or injectable medications used to promote pregnancy, unless specifically covered under the member's benefit
- Immunizations for the purpose of foreign travel, flight and/or passports
- Vaccinations, drugs and immunizations for primary intent of medical research or non-medically necessary purpose(s) including but not limited to the following:
    - Licensing
    - Certification
    - Employment
    - Insurance

- Functional capacity examinations related to employment
- BHRT, also known as bioidentical hormone therapy or natural hormone therapy, including “all-natural” pills, creams, lotions and gels

Drugs or drug delivery systems used during dental procedures (i.e., LDAA used for periodontal procedures)

Mail Order / Home Delivery Benefit for Commercial and PPO Plans

Under the Mail Order/Home Delivery pharmacy benefit, up to a 90-day supply of medications may be obtained through the mail service pharmacy. Copayments vary depending under which benefit structure a member falls under Tier 4 drugs are not available through mail order; they must be provided by our specialty network and are limited to a 30-day supply. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to access our Mail Order/Home Delivery Services for our members.

Medication Therapy Management for Commercial Members

The 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 medication monitoring. Then the pharmacist may identify drug-related allergies, potential side effects, adverse drug reactions, omission of therapy, duplications of therapy and any barriers that prevent the member from obtaining a desired outcome. Then the pharmacist works with the provider to develop a medication action plan, interventions and referrals. Please refer to the “Pharmacy Benefit References, Resources and Tools” section within this chapter to learn how to refer a member to our Medication Therapy Management Program.

Medicare Prescription Drug Benefit

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

Medicare, including requirements to meet strict pharmacy access standards to give beneficiaries access to retail pharmacies and needed drugs.

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

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

Medicare Stages of Coverage

Medicare plans consist of the following stages of coverage:

- **Annual deductible:** The amount the beneficiary will pay out of pocket for their prescriptions each year before the initial coverage begins.
- **Initial coverage:** Initial coverage begins when the first prescription in the calendar year is filled. Presbyterian covers the cost of the medications after the member has met their copayment requirement.
- **Catastrophic coverage:** Coverage begins after the beneficiary expends the CMS set amount (specified yearly) of their own money. The beneficiary will then pay reduced copays or coinsurance until the end of the contract year.

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

- MyAdvocate is a personal service that helps members find out if they qualify for additional assistance
    - 1-888-282-0773
- PCSC at (505) 923-6060 or toll-free at 1-800-797-5343
- Medicare toll-free at 1-800-MEDICARE (1-800-633-4227), which is open 24 hours a day
- The Social Security Office toll-free at 1-800-772-1213, which is open from 7 a.m. to 7 p.m., Monday through Friday
- Hearing-impaired members dial 711

Presbyterian Senior Care (HMO/HMO-POS) Copayments

The following is Presbyterian's Medicare prescription copay structure:

- Tier 1: preferred generic or brand-name drugs that are available at the lowest cost share for these plans
- Tier 2: generic or brand-name drugs that these plans offer at a higher cost than Tier 1 preferred generic drugs
- Tier 3: preferred brand-name or generic drugs that the plan offers at a lower cost than Tier 4 non-preferred drugs
- Tier 4: non-preferred generic or brand-name drugs that the plan offers at a higher cost than Tier 3 preferred brand drugs
- Tier 5: specialty drugs that include some injectables and other high-cost drugs

The beneficiary's out-of-pocket expenses are lowest when filling prescriptions for preferred generic drugs (Tier 1) and highest for specialty drugs (Tier 5). Drugs listed on our formulary with a limited access designation are specialized medications and may be required to be obtained through our designated specialty pharmacy network. Some medications may require prior authorization.

Mandatory Generic Substitution Requirement

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

Specific Limitations and Exclusions

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

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

- Items when used to promote fertility

Medicare Requirements

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

Medicare Part D Transition Supply

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

Mail-Order / Home Delivery Benefit for Medicare

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

Medication Therapy Management for Medicare Advantage Plans

The MTM program is designed to optimize medication in order to improve patient outcomes. The member meets with a Presbyterian pharmacist for a comprehensive medication review and additional visits with the pharmacist throughout the year to address ongoing medication and monitor issues and event-based medication therapy problems. The program is available for all members 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 are identified as being an at-risk beneficiary, as defined by having a history of filling opioids from multiple providers and/or multiple pharmacies
- Those who expect to spend a significant amount of money on prescription drugs each year

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

- Reducing the risk of medication errors, especially for members who have chronic conditions, take several medications or see multiple providers

- Providing current information on proven medical practices to help members and their providers determine the most effective treatment
- Helping members understand their conditions and medications, so they can take an active role in managing their health

MTM includes the following five core components:

- Medication therapy review
- A personal medication record
- A medication action plan
- Intervention and referral
- Documentation and follow-up
- Information about disposal of prescription drugs that are controlled substances

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.

Drug Management Program

Pursuant to the Social Security Act, Presbyterian is required to engage in a Drug Management Program (DMP). The purpose of this program is to improve member safety and increase coordination of care between prescribers by case managing identified members through a review of potential use and abuse of frequently abused drugs (FADs), particularly opioid and commonly co-prescribed potentiators such as benzodiazepines. The goal of this program is to address overutilization of FADs while maintaining member access to such drugs as medically necessary.

Pharmacy Benefit References, Resources and Tools

Reference/Resource	Descriptions, Contact Information and Links
Pharmacy Prior Authorization and Exception Requests	Providers can find the "Presbyterian 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.

Reference/Resource	Descriptions, Contact Information and Links
	The “Uniform PA Form” may also be used for Exception Requests. Drug PA requests may be faxed to Presbyterian Pharmacy Services at 1-800-724-6953 or (505) 923-5540. Providers can find a link to submit Drug PA requests and Exception Requests online at www.phs.org/providers/authorizations. Instructions for “How to submit a Prior Authorization Online” is also available under the “Pharmacy” section at www.phs.org/providers/authorizations.
Formularies	Providers can find a link to searchable Presbyterian formularies and updates, including restrictions (e.g., quantity limits, step therapy and prior authorization criteria) and preferences, at www.phs.org/providers/formularies. For a printed copy of a formulary, please call (505) 923-5500.
Supplemental Formulary Information (Specialty Pharmaceuticals/Medical Drugs List)	Providers can find Presbyterian Specialty Pharmaceuticals/Medical Drugs List online under the “Supplement Formulary Information” section at www.phs.org/providers/formularies. For a printed copy of our Supplement Formulary Information, please call (505) 923-5500.
Newsletter: P&T Committee Updates	Current and past issues of the P&T Committee Provider Updates are available online at www.phs.org/providers/formularies.
Pharmacy Services Help Desk	Providers may call Presbyterian’s Pharmacy Services Help Desk for assistance. The phone number is (505) 923-5500. Providers can also call toll-free by dialing 1-888-923-5757. The Presbyterian Pharmacy’s Help Desk business hours are Monday through Friday, from 8 a.m. to 5 p.m. Outside of these hours, this phone line will be answered by our pharmacy benefits manager (PBM), Capital Rx. If providers contact the PBM and cannot wait until the next business day, then providers should inform the Capital Rx representative that their need is urgent and that they wish to speak to the Presbyterian clinical pharmacist who is on call. The PBM representative will transfer the provider to the on-call pharmacist for Presbyterian.
ASKRX Email	ASKRX@phs.org is an email box created to better serve providers. Providers can email clinical questions or concerns directly to this email address. The email box is monitored during regular business hours, Monday through Friday, from 8 a.m. to 5 p.m., and a clinical pharmacist will respond within one business day.

Reference/Resource	Descriptions, Contact Information and Links
ASKPharmacy Email	ASKPharmacy@phs.org is an email box that assists providers with general pharmacy claim and benefit-related questions. 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 by emailing askphppt@phs.org. A "Formulary Addition Request Form" is available under the "Supplement Formulary Information" section at 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  Fax: 1-877-258-9584
New Mexico PMP	Please use the New Mexico 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 MTM for medication counseling and speak with a clinical pharmacist, please call Presbyterian Pharmacy MTM Program at (505) 923-6790 or toll-free at 1-855-771-7737.

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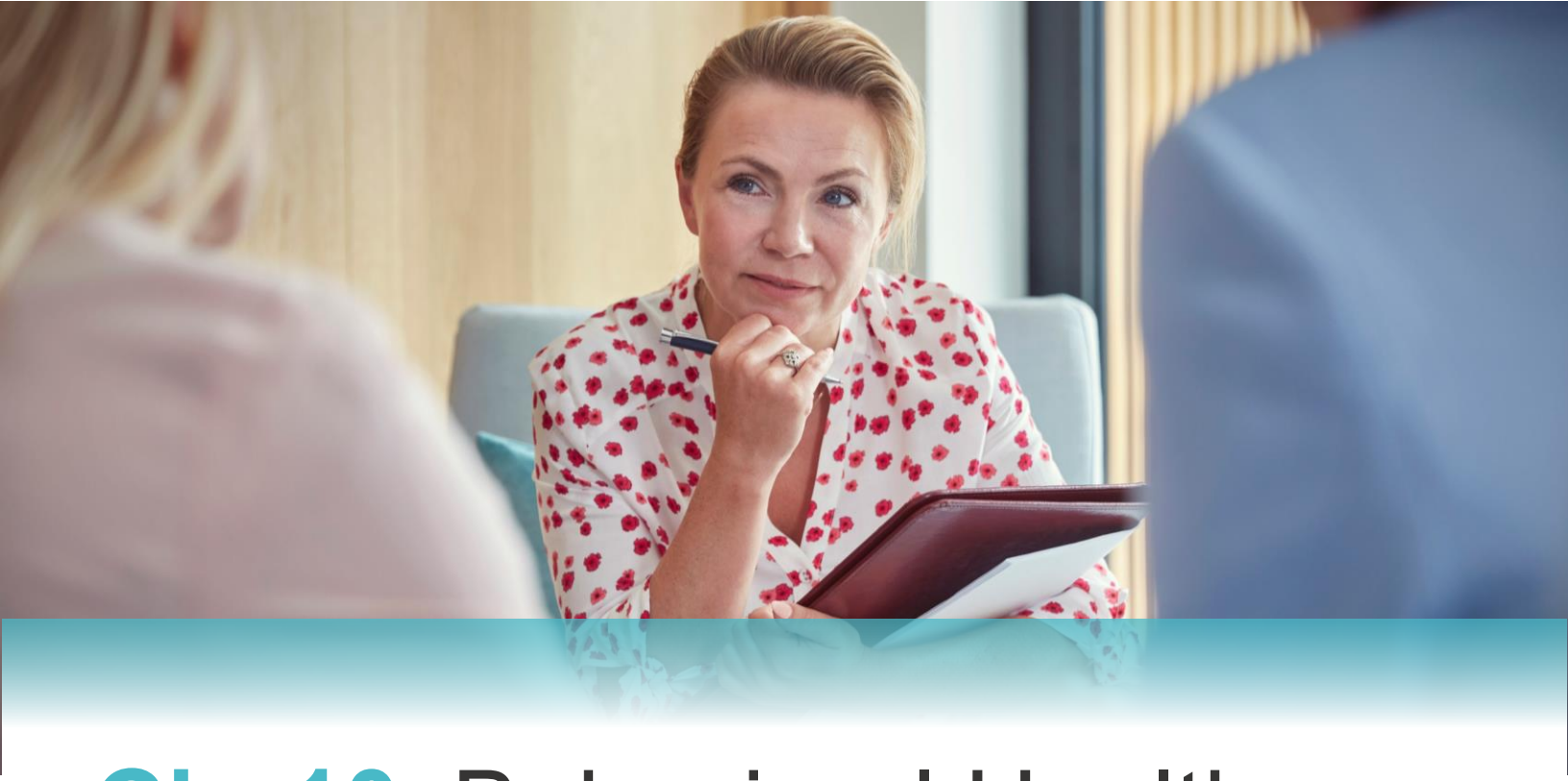

Ch. 10: Behavioral Health

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

As a long-time health plan and health service delivery provider across New Mexico, Presbyterian is well aware of the need to maintain a trusted network that can deliver all covered services to our members in a manner that is geographically, culturally and linguistically appropriate. We have contracted with Magellan Healthcare (Magellan) to manage behavioral health services for our 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 health plans. Although it is the member's responsibility to understand their benefit requirements, Presbyterian is available to provide assistance from 8 a.m. to 5 p.m. to Turquoise Care, Medicare and Commercial members and providers. Providers who have questions or need assistance can call (505) 923-5757 for additional information.

Presbyterian Behavioral Health Providers

The behavioral health component of Presbyterian includes a range of providers and organizations, including but not limited to the following who are eligible to provide services:

- 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)
- Community Mental Health Centers (CMHCs)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Hospitals
- Residential services for mental health and substance use disorders
- 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 from HCA and CMS.

In order to receive member referrals, a provider must accomplish the following:

- Turquoise Care:
    - Be a registered provider with New Mexico Medicaid for Turquoise Care
    - Be a Medicaid participating provider
- Medicare:
    - Be currently enrolled with Medicare to provide services to a member enrolled in a Medicare product
- All products:
    - Have an active status in the Presbyterian/Magellan behavioral health 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 behavioral health providers include individual, group and organizational providers. Behavioral health organizational providers include but are not limited to hospitals, clinics, behavioral health agencies, CCBHCs, CSAs and residential treatment centers.

Individual Provider

An individual provider is a clinician who renders professional behavioral healthcare services directly to a member and bills under the provider's own Taxpayer Identification Number (TIN) as 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. In addition, the group practice must hold a current, fully executed PPA.

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
- Community mental health centers (CMHC)
- CSAs
- FQHCs
- CCBHCs
- Rural health centers
- Residential treatment centers

- Behavioral health agencies
- Indian Health Services or Tribal 638 facilities that offer behavioral health services
- Treatment foster care agencies
- 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 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 cater to all regardless of diagnosis and insurance status. Clinics must meet stringent criteria regarding timeliness of access, quality reporting, staffing, and coordination with social services as well as judicial and educational systems. CCBHCs 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:

- Crisis services
- Outpatient mental health and substance use services
- Person- and family-centered treatment planning
- Community-based mental health care for veterans
- Peer, family support and counselor services
- Targeted case management
- Outpatient primary care screening and monitoring
- Psychiatric rehabilitation services
- Screening, diagnosis and risk assessment

Core Service Agencies

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

- Crisis intervention 24/7
- 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

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

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

Credentialing

In order to be eligible for referrals, Presbyterian behavioral health providers are required to undergo the credentialing review process before being accepted as Presbyterian providers, and then they must undergo periodic recredentialing thereafter. See the "Recredentialing" section in this chapter. Presbyterian has delegated behavioral credentialing to Magellan. Magellan's Credentialing Verification Organization department is responsible for completing credentialing activities according to NCQA, HCA and CMS standards, as well as Presbyterian requirements.

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
- 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 the state of 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:

- 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 Health Plan
Attn: Behavioral Health Contracting Dept.
9521 San Mateo Blvd NE
Albuquerque, NM 87113-2237

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

Providers may also contact their provider liaison or contract specialist with Presbyterian. The contact guide 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 PPA and appropriate product attachment under which the provider agrees to comply with Presbyterian's and

all state and federal policies, procedures and guidelines. This is required to receive referrals of and reimbursement for services rendered to members. For Turquoise Care, all providers must have an active Medicaid ID. For Medicare products, all providers must have a current registration with Medicare.

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. In these cases, member cost-sharing would be limited to the applicable copayment and/or coinsurance.

Updating Information

Prompt notification of changes regarding 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 (Please contact Presbyterian network staff)
- Group practice membership
- Staff rosters

Providers are encouraged to submit changes electronically on www.magellanprovider.com, unless instructed to do otherwise by Presbyterian Network Operations 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 Turquoise Care Behavioral Health Providers

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
- Adhere to 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 Turquoise Care 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 also believe that members and families have a responsibility to do so. Providers are required to document member and family involvement in all treatment records. They are also required to demonstrate compliance with this requirement during site visits and audits.

Care Coordination Communication Requirements for Commercial and Medicare

We require that communication take place between the behavioral health provider and the member's PCP within seven days of admission for behavioral health services, upon any significant change in the member's behavioral health status and/or discharge from services. Documentation of this communication must be evident in the member's medical record.

Presbyterian has policies and procedures in place to help with such communication, such as the Coordination of Care Form. If used, Presbyterian's Coordination of Care Form meets the documentation requirements and can be accessed through the provider webpage at www.phs.org/providers/authorizations.

The form is a valuable tool, not only for practitioner-to-practitioner communication, but also for practitioner-patient discussion of the benefits of care coordination. The reasons for coordinating care should be explained to members, so they can take an active role in managing their care and sharing critical information. If the member prefers not to release information, the form allows the provider to document this and remain in compliance with the standard. Presbyterian will audit compliance related to this communication periodically as well as at the time of recredentialing. The managed care member's PCP is responsible for reciprocal communication with the behavioral health professional.

Care Coordination for Turquoise Care Members

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 have the ability to 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. Care coordination needs 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 in order to reduce lost school time, remove barriers to care and promote family involvement. School-based providers are required to coordinate with the member's assigned care coordinator as well as other providers
- 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
- A provider in the planning of institutional care for members
- A member's assigned PCP and the behavioral health provider
- CSAs when the CNA is performed
- Services provided by CYFD
- 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 abuse
- Follow-up to medical detoxification
- An initial PCP contact or routine physical examination indicating a substance abuse problem
- A prenatal visit indicating substance abuse problems
- Positive response to questions indicating substance abuse problems
- Observation of clinical indicators or laboratory values indicating substance abuse problems
- A pattern of inappropriate use of medical, surgical, trauma or ER services that could be related to substance abuse problems or other behavioral health conditions
- The persistence of serious functional impairment

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

Children in Tribal Custody or under Tribal supervision pursuant to a Tribal Court order (as such term is defined in 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.

For additional information, please see Chapter 1.

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 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 instruction for contacting on-call staff after hours. When unavailable to provide on-call support, providers must arrange for alternative coverage with another participating clinician or provide after-hours messaging about how to access care.

Crisis/Emergency Room Usage

Presbyterian 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 and supported through an interagency agreement with the Substance Abuse and Mental Health Services Administration's 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)** provides funds for up to 60 calendar days of services immediately following a disaster declaration
- The **Regular Services Program (RSP)** provides funds for up to nine months following a disaster declaration

Authorization of Services

Appendix E provides 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. Presbyterian provides the following communication services regarding utilization management issues:

- Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls

- Staff can receive inbound communication after normal business hours
- Staff are identified by name, title and organization name when initiating or returning calls

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 all members provided with behavioral health services receive equitable and effective treatment in a respectful manner that recognizes an individual's spoken language, gender differences and the role culture plays in their 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 can complete cultural competency training through their portal at www.phs.org. Magellan also provides cultural competency training, technical assistance and online resources at www.magellanprovider.com/education/cultural-competency to help providers enhance their provision of high-quality, culturally appropriate services. Presbyterian continually monitors and assesses provider diversity and sensitivity, and actively recruits, develops and works to retain a diverse array of behavioral health providers compatible with our member population.

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

Access Standards

Members must have timely access to appropriate mental health and substance abuse services from an in-network provider 24/7. 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.

The following is a list of the provider's responsibilities:

- Provide access to services 24/7
- Ensure members know what to do if they need services after business hours
- Arrange for alternative coverage with another participating clinician when the provider is not available, including but not limited to an answering service with emergency contact information
- Respond to telephone messages in a timely manner

- Provide immediate emergency services when necessary to evaluate or stabilize a potentially life-threatening situation
- Provide face-to-face services within two hours in a crisis evaluation
- Provide services within 24 hours in an urgent clinical situation
- Set an appointment within 14 calendar days of request for routine clinical situations, unless the member requests a later date (See Turquoise Care appointment standards)
- Provide routine follow-up services within 30 calendar days of an initial evaluation (See Turquoise Care appointment standards)
- 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 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 the 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 Performance Improvement department conducts oversight of behavioral health providers through Treatment Record Reviews (TRR), Quality of Care (QOC) monitoring and the coordination of critical incident (CI) management and reporting.

Treatment Record Review

Routine TRRs are 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 Code of Federal Regulations (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

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 Quality Improvement (QI) team assists the provider in bringing documentation into compliance through development and implementation of an improvement plan. Providers are encouraged to contact 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 if the investigation of the concern is substantiated at a higher level or there are 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 one and four. An unsubstantiated QOC is assigned an outcome level of zero. 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 (RNCC).

Critical Incident Management

Behavioral health providers are required to follow NMAC regulations and report CIs to Presbyterian behavioral health. 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 critical incident reports (CIRs) and follow-ups, 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 provider claims relating to mental health or substance abuse services may be submitted to Magellan directly if that is more convenient for the provider. All behavioral health claims – even those that are part of a mixed service – may be submitted directly to Presbyterian; however, they 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, which has become the preferred method of claims submission for the majority of our network.

Benefits of Filing Electronically

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

- Quicker confirmation of claims receipt and integrity of the data
- A higher percentage of claims accuracy, resulting in faster payment
- Claims data already formatted into the 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 payer in order to process the submitted claims.

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

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

Direct Submit

Through the Magellan application Direct Submit, HIPAA-compliant electronic data interchange (EDI) 837 files can be sent in bulk directly to Magellan without accompanying claim data entry or the involvement of a clearinghouse. Direct Submit is available to all 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 (toll-free) 1-800-450-7281, extension 75890.

Paper Claims

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

Commercial/Medicare Plans
Presbyterian Health Plan
P.O. Box 2216
Maryland Heights, MO 63043

Turquoise Care Plan
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 HIPAA compliant 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 (Turquoise Care)

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 (Magellan)

Clearinghouse	Address	Contact Information	Website
Availity®	P.O. Box 550857 Jacksonville, FL 32255-0857	1-800-AVAILITY (282-4548)	www.availity.com
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 3rd 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

Please note that this chapter applies specifically to the Turquoise Care program.

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 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.

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 are used to 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 Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), range of motion limitations, need for medical treatments, need for clinical monitoring by a registered nurse, and hospitalization in the last 90 days
- Availability of support and social resources, such as personal care assistance, housekeeping, home-delivered meals, living arrangements, homebound status and 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 a 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 takes into account 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, then 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 Federal Unemployment Tax Act (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 shall 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 shall 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 in order to assure the health and welfare of members and to avoid institutionalization. Presbyterian approves these instances on a case-by-case basis using pre-established criteria.

The following 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 considers 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 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. The Utilization Management team 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 on the web 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, core service agencies (CSAs), federally qualified health centers (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 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 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 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 system 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.

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	Supplemental Security Income (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)

Category	Description
094	Disabled and Elderly (disabled)
100	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.

As a reminder, reporting critical incidents is required by the following:

- 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 shall be submitted directly to Presbyterian except for claims for members enrolled in the SDCB, which are paid for by the FMA.

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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 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 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 members and who meet qualifying criteria through utilizing our network of qualified home health care 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, ASO, Presbyterian Senior Care (HMO/HMO-POS), Presbyterian Dual Plus (HMO D-SNP) Turquoise Care and PIC plans.

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

- The condition of these patients should be such that a normal inability to leave home exists and, consequently, leaving home would require a considerable and taxing effort
- Absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive healthcare treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day care program. Attending a religious service shall be deemed to be an absence of infrequent or short duration
- Occasional absences from the home for non-medical purposes (e.g., an occasional trip to the barber, a walk around the block, a drive, attendance at a family reunion, funeral, graduation, or another infrequent or unique event) would not require a finding that the patient is not homebound if the 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 patient'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

Presbyterian Turquoise 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

EPSDT Program: Home and Community-Based Services for Medically Fragile Members (Turquoise Care Only)

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

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

EPSDT Program: Personal Care Services (Turquoise Care Only)

EPSDT Program PCS admission criteria are as follows:

- The recipient must be younger than 21 years of age
- The recipient need assistance with at least two physical requirements such as eating, bathing, dressing or toileting acts, appropriate to 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.

Prior Authorization Processes

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 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 the next certification period depending on the member's skilled care needs.

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.

Copayments, Coinsurance and Deductibles

The agency may call PNO for any questions regarding member's applicable copayment, coinsurance or deductible under Commercial HMO, Point-of-Service (POS), ASO, PIC, New Mexico Health Insurance Exchange plans, and under Medicaid's Children's Health Insurance Program (CHIP) or Working Disabled Insurance.

The agency is responsible for informing the member of their financial responsibility before initiation of home care services. The agency is responsible for billing the member and collecting all copayments and deductibles as they relate to home care services. Copayments are based on an agency's Presbyterian-contracted rates and not on an agency's charges.

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 home healthcare 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
- MCG Criteria is used as a reference to ensure appropriate utilization is occurring and that access to care for 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 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 members. Clinical practitioners are invited to participate as members on the following committees:

- Population Health and Clinical Quality Committee
- Pharmacy & Therapeutics Committee
- Technology Assessment Committee
- Credentialing Review Committee
- Professional Practice Evaluation Committees

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

National Committee for Quality Assurance

Presbyterian 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 improved member health outcomes. Our goal is to maintain accreditation for our HMO and PPO products. We strive to foster service and clinical quality that meets or exceeds rigorous requirements for quality improvement as evidenced through more members effectively engaged in member-centered relationships with their care

providers. 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, and all 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.

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.

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

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 the CMS require HEDIS reporting for health plans that are contracted to provide Medicaid and Medicare benefits. 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, CMS, the state Medicaid, and other regulatory agencies, 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 physical records or 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 in order 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 Value Based Programs 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, 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 (Turquoise Care)

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 health care services provided to members are rendered according to acceptable standards of quality of care consistent with professionally recognized standards of medical practice. This is monitored through the 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, or the Presbyterian Program Integrity Department (PID).

Clinical Quality of 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, 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 PNO, 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, and end of life needs. Interventions and tools are developed from evidence-based guidelines to work with members, and to 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, practitioners, and other health care 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 product line work plans (Turquoise Care, Commercial/Exchange and Medicare)

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 that 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 ADA and other applicable federal and state laws

We collect, monitor and address member preferences to ensure we are providing 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 physical, neurological, emotional or cognitive, and behavioral health 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 timely access to and use of appropriate services reduces unnecessary utilization of services and the cost of avoidable emergency department visits and hospitalizations.

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

The ICM program supports providers in their management of members with catastrophic, high-cost, high-risk, and/or complex conditions.

A care coordinator is assigned to provide complex case management or care coordination for members who meet criteria. The ICM program assists and supports providers and members to improve the continuity of care. It is designed to enhance access to services and achieve optimal health and quality outcomes. In addition to measuring member satisfaction, two clinical measures are identified annually to monitor the effectiveness of the complex case management program.

Behavioral health is a key component of ICM and provides a holistic approach to enhance the member's access to services and support the plan of care.

Special Populations (Turquoise Care)

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 the University of New Mexico
- Individuals with intellectual disabilities
- Children and adults with Special Health Care Needs
- Members with housing insecurity needs
- High-risk maternity
- Members participating in a Comprehensive Addiction and Recovery Act (CARA) Program
- Children In State Custody (CISC)
- Individuals with complex behavioral health needs

Early and Periodic Screening, Diagnostic and Treatment Program

Well Child Visits are in place for Presbyterian Turquoise Care members aged from birth to 30 months and ages 3-21, as required by HCA. Components of the EPSDT Program are measured annually using HEDIS and the MRR 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.

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 for e-appointments, e-consultations, e-referrals, online personal health information and to request lab reports

Presbyterian evaluates website functionality to improve usability. Processes for posting and maintaining accuracy and currency of content and information are monitored.

Member and Provider Experience

Presbyterian understands the importance of obtaining feedback from our members and 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 as listed below:

Survey Data

We conduct relationship surveys such as the CAHPS survey, the annual provider satisfaction survey and a quarterly member survey. There are a number of reasons for conducting relationship surveys, including:

- 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, employer group, inquiry type, and customer type.

Qualitative Research

Presbyterian also uses qualitative research methodologies including focus groups, formal and informal interviews, usability studies and mystery shopping, as appropriate. Consumer advisory boards are also used to evaluate the quality of our service and the customer experience.

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, New Mexico 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 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 the 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 emergency room 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, and it must 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, emergency room 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 elements are accepted standards for medical record documentation. Six of the 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 includes 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 old 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- or 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 preceding 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
- DSM-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 United States 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 Providers' 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 at 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 and their workforce members 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 Providers Must Be HIPAA Compliant?

All providers who transmit protected health information (PHI) in electronic form in connection with a transaction for treatment purposes are legally obliged to follow HIPAA regulations.

Those providers who perform a service or activity on behalf of Presbyterian and who are not members of Presbyterian's workforce are also legally obliged to follow HIPAA regulations. Such a service might include but 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 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. HIPAA definitions can also be found in 45 CFR §§160.103, 160.202, 162.103, 164.103, 164.402, 164.501 and 164.304. See www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl.

Covered entity means:

- A health plan
- A healthcare clearinghouse
- A healthcare provider who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 164

Protected Health Information:

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 on behalf of a covered entity creates, receives, maintains, or transmits PHI 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 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 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 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 of the 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 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 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
- "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

- Providers may find information about New Mexico's Medicaid Incentive program at 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

Providers signed an agreement to deliver services to 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 a provider's 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 providers also need to 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 NMAC section 13.10.22.12, contracts with providers in New Mexico shall contain a description of the specific hold harmless provision specifying protection of covered persons. As a result, the following language is hereby deemed incorporated and made an express part of 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, shall health care professional/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, covered person, or person acting on behalf of the covered person, for 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.

Presbyterian Medicaid Managed Care Contracting Requirements

It is important to understand the difference between New Mexico's Medicaid Managed Care model. Providers must review all of the requirements of this program in their contract. Because this program is jointly funded by both the federal and state governments, Presbyterian is required to verify provider's 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 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. Work with Presbyterian to ensure that providers successfully identify and refer members to specialty providers as medically necessary.

If providers are a PCP or advanced medical home, then they 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.

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 their agreement 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 them regarding dishonesty or breach of trust, including but not limited to the following:
    - 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, or bribery
    - Falsification or destruction of records
    - Making false statements
    - Tax evasion
    - 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

Providers should be taking the following steps to ensure that federal 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 shall 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 providers 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 shall immediately remove the excluded employee or subcontractor from providing any services in connection with the agreement and shall notify Presbyterian's compliance officer in writing. In this notification, 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, Presbyterian shall 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 had a business transaction with that subcontractor totaling more than $25,000 during the previous 12 months, then providers have certain obligations. Providers are required to submit, within 35 days of the date of request, information about the ownership of that subcontractor. Reimbursement for expenditures for services furnished during the period between the due date and the date the information was actually supplied will be denied.

Prohibition on Billing Medicare-Medicaid Enrollees for Medicare Cost-Sharing

Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the QMB program, a dual eligible program which exempts

individuals from Medicare cost-sharing liability (See Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997).

Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program (Turquoise Care) holds these individuals harmless for Part A and Part B cost sharing. Providers accept the Medicare Advantage payment in full, or bill Medicaid (Turquoise Care) as the secondary. Balance billing restrictions apply regardless of whether the State Medicaid Agency is liable to pay the full Medicare cost sharing amounts.

Medicare Advantage Plan Enrollee Hold Harmless

Provider hereby agrees and will require all subcontractors to agree to seek payment for covered prescription drug services only from Presbyterian. In no event, including, but not limited to, termination of the Agreement(s) or this Amendment, non-payment by Presbyterian, Presbyterian's insolvency or breach of the Agreement(s) or this Amendment, shall a provider or a subcontractor bill, charge, collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against enrollees, their families, or people acting on their behalf for covered prescription drug services. The foregoing sentence shall not prohibit collection by provider or a subcontractor of applicable copayments, coinsurance and cost-sharing charges for non-covered services [42 CFR § 422.504(g)(1)(i) & (i)(3)].

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 shall not pay for services performed by the provider. This hold harmless provision shall 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 shall be construed to be for the benefit of the members.

Delegation (if applicable)

A provider's agreement specifies activities, reporting responsibilities and any delegated functions, including provisions for the revocation of delegated functions and for the imposition of other sanctions for inadequate subcontractor performance. Presbyterian has policies and procedures to ensure 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

Providers Reporting Compliance

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

Providers shall report to Presbyterian any potential fraud or other misconduct by them or a subcontractor. This report shall 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 their agreement 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 NMAC 7.1.9, Caregivers Criminal History Screening Requirements.

Conflict of Interest Certification

Providers and their subcontractor's officers, directors and managers shall annually sign a statement that (1) the individual has reviewed Presbyterian's and their 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 shall 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 ACA prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs and activities that receive federal financial assistance from HHS. Provider shall be in compliance with ACA Section 1557 and its implementing regulations, which require covered entities to take reasonable steps to provide meaningful access to individuals with limited English proficiency (LEP), provide auxiliary aids and services to individuals with disabilities free of charge and provide equal access to healthcare without discrimination based on sex, including pregnancy, gender identity or sex stereotypes 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 shall be considered to be executed in accordance with all applicable federal and state laws, regulations, policies, procedures and rules
- The agreement identifies the parties of the contract and their legal basis of operation in the State of New Mexico
- The agreement includes procedures and specific criteria for terminating the subcontract
- The agreement identifies the services, activities, and reporting responsibilities to be performed by providers 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 shall maintain all records relating to services provided to members for a 10-year period and shall make all enrollee medical records or other service records available for the purpose of quality review conducted by the state, or their designated agents, both during and after the contract period
- All member information will be kept confidential, as defined by federal and state law
- Authorized representatives of the state will have reasonable access to facilities and records for financial and medical audit purposes both during and after the contract period
- 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 shall 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 shall also apply to them
- 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 or their subcontractors or anyone (with the exception of 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 shall 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 shall comply with the NMSIIS initiative
- Turquoise Care providers and their 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 Electronic Health Records 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
- Medical director review
- Presbyterian Practitioner and Provider Manual
- Presbyterian Reimbursement Guidelines
- 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.

Credentialing 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 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 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 member. New practitioners need to complete the credentialing process before rendering services to 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 PNO 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 that providers 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 NMAC Section 13.10.28 of the, 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 Agency (DEA) certificate and applicable state pharmacy registration for controlled substances
- Current malpractice insurance coverage in the required amount, as described in greater detail later in this chapter
- Acceptable office practices and a safe office environment that requires a score of 90% 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

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 OB/GYNs and other PCPs 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's 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 PNO 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 a provider's office to access a variety of Presbyterian resources, as well as member, benefit, authorization and claim information
- The 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 a provider's 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

- The Presbyterian ePayment Center provides 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 the 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, 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 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
- Click "Why register?" located on the middle of the webpage

- Click the provider's registration link in the middle of the webpage
- 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. Please keep in mind that a provider's user ID and password are case-sensitive.

Each employee in the provider's office that utilizes myPRES must have their own individual user ID and password. Under no circumstances should a provider's 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

Go to www.phs.org and locate the myPRES login box on the right side of our website, click on login box and enter a user ID and password to log on to myPRES.

If providers have problems locating or completing the enrollment form, they may contact the Presbyterian Provider E-Help Desk by:

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 a Password on myPRES

User IDs and passwords are easy to reset online. At the log in screen, simply click on "Forgot/Reset Password" or "Forgot User ID." Then follow the easy steps to get a User ID or password reset. Should this fail to work, please email ehelpdesk@phs.org or call (505) 923-5590 or toll free at 1-866-861-7444 for further assistance.

Computer and Software Requirements for myPRES

In order to take full advantage of myPRES's capabilities, 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 about prior authorizations, please call (505) 923-5757 or 1-888-923-5757 (option 4).

myPRES Training and Support

Online help is available at the touch of a button once providers are in the application. The Presbyterian E-Help Desk also provides phone support Monday through Friday, 8 a.m. to 5 p.m. The PNO Department is also available to assist providers.

Keeping Provider Directory Information Up to Date

CMS implemented new requirements to verify that networks are adequate, and provider directories are current. Presbyterian has taken steps to ensure compliance with the CMS provider directory accuracy requirements.

Presbyterian requires providers to communicate demographic changes that may affect the provider record and directory profile. Changes must be communicated as soon as possible, but no later than 14 days from the date a change is known. This includes any changes related to 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.

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 now offer our 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 PNO e-business analyst at (505) 923-6154. Below is also a list of available clearinghouses.

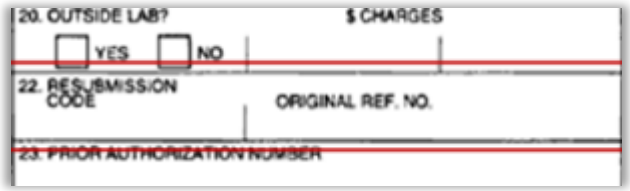
Clearinghouse Contact Information

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 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 can contact their PNO relationship team using the Provider Services Contact Guide to check availability. The contact guide can be accessed at www.phs.org/ContactGuide.

Electronic Coordination of Benefits

Electronic coordination of benefits (eCOB) enables provider's patients to receive benefits from all health insurance plans they are covered under, while ensuring that the total combined payment from all sources is not more than the total charge for the services provided.

If providers are interested in submitting eCOB, they can 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, and it allows them to submit claims online.

For more information, visit HealthXnet at www.healthxnet.com or use the following contact information for help and technical assistance:

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

Fax: (505) 346-0278

Email: healthxnet@nmhsc.com

The 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 a provider's 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, please 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 want 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, visit 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
- 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 can contact their PNO relationship team. Providers can find their relationship team's 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

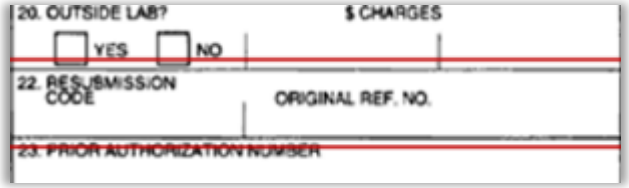
the time and savings realized from a paperless system. To submit electronic claims directly to Presbyterian, providers can use the Fast Claim direct entry portal at www.claim.md/phs.plx.

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 call (505) 923-5757. A list of clearinghouses is also available at the end of the e-Business chapter. Since Oct. 16, 2003, electronically transmitted claims must meet the HIPAA transaction standards with regard to format and content.

Providers may electronically submit corrections to previously submitted 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 on 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 their 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 give providers the software that enables them 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 asks providers some questions, more than likely sends providers an informational packet and may ask providers to fill out and send in a questionnaire to help determine 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. Providers are up and running quickly, barring any major problems.

Providers do not need to notify Presbyterian to start billing electronically. However, providers do need their Presbyterian-assigned provider number, and they must have an NPI. Providers must also provide their TIN to submit an electronic claim. For special concerns or billing issues, providers will first 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 will then receive either an acceptance or rejection report from Presbyterian through the clearinghouse.

If Providers Encounter Problems

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 providers do not understand.

- **Solution:** Providers should contact their clearinghouse or their PNO relationship team (www.phs.org/ContactGuide) within 48 hours of receipt of the rejection report for the needed information so that providers can submit their claim

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

- **Solution:** Providers should contact their PNO relationship team (www.phs.org/ContactGuide) and discuss the issue. If the issue is determined to be a technical problem, the provider's assigned PNO relationship team coordinates contact with Presbyterian's Information Services Department. It is important to check on a regular basis to ensure that the claims are not denied for lack of timely filing. Also, please be sure to keep detailed records regarding this activity

Paper Claims Submission Process

Paper claims are printed on a form and mailed to Presbyterian. 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 this form requires ICD-10 codes that 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 National Provider Identifier (NPI) number. 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 online at 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.

A CMS-1500 claim form must be submitted for members that have ASO or Commercial 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 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 Presbyterian Dual Plus 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 may result in a denial.

High Dollar Institutional Services

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

Interim Billing Process for Institutional Services

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 and Replacement Claims for Institutional Services

In accordance with CMS guidelines, facilities must bill late charges, corrections, or for facility services from ambulatory surgical centers.

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:

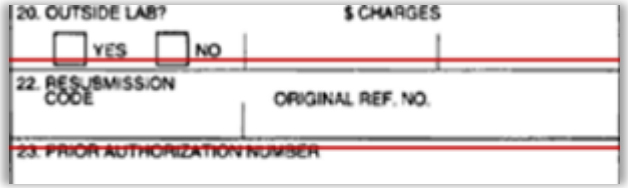
- XX5: Outpatient hospital late charges
- XX7: Outpatient hospital replacement charges
- XX7: Inpatient hospital late or replacement charges
    - Please note that any corrections must be submitted with an XX7. If a corrected UB-04 is not submitted with an XX7, then the claim will be denied

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 (02-12) 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 that providers are performing, they 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

Claims for EPSDT Program PCS services only should be submitted on a CMS-1500 claim form with the CPT)/ HCPCS code S5125.

The agency should submit all home health claims on the CMS-1450 UB-04 claim form and complete all fields in accordance with standard home health billing requirements. 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	Description	Revenue Code
RN visit	0551	Home health aide visit	0571
Dietitian visit	0581	Supplies	0270
Physical therapy visit	0421	RN per hour	0550
Occupational therapy visit	0431	LPN per hour	0580
Speech therapy visit	0441	PCA per hour	S5125
Social worker visit	0561	HHA per hour	0570

When submitting claims, include the following:

- Attach an itemized supply list to the UB-04 when billing Revenue Code 0270
- Record accurate federal TIN 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 number and the correct taxonomy code
- Ensure that the correct ICD-10 code is used at the highest level of specificity
- Ensure that an agency employee signs the UB-04 form
- Intermittent skilled service claims are billed as one unit equal to one visit
- Bill EPSDT Program care in 15-minute increments. For example, one unit equals 15 minutes, four units equal an hour, etc.

  Note: When services are over or under 15 minutes, then the agency is responsible for rounding the unit count up or down.

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 must give this information to 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

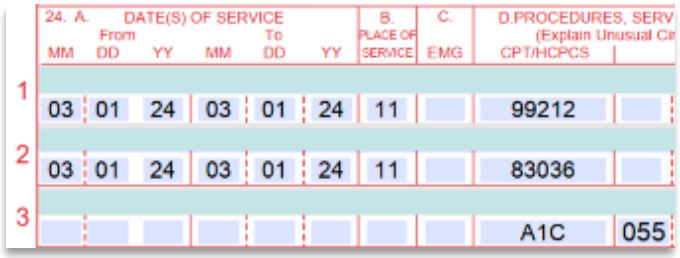
This information pertains to claims submitted by providers to Availity in the 837 Institutional formats. Place the A1c data in the PWK07 segment of the 2300 loop with the code qualifier of OZ and PWK02 of AA. Up to four test results per PWK segment, which can occur once. The data format is:

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

Examples:

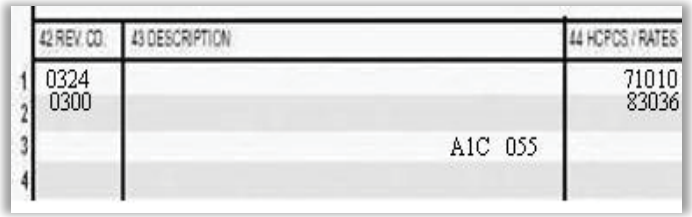
- A1c 055
- 20041028 A1c 042
- 20041029

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 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 view HCA/MAD Supplement 10-03: www.hsd.state.nm.us/wp-content/uploads/FileLinks/c78b68d063e04ce5adffe29376ff402e/MAD_SUPP_10_03_New_Requirements_for_Billing_for_Drug_Items.pdf.

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 for Turquoise Care Members

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 shall note the minor's objections or the unavailability of the parent in the minor's chart and meet other regulatory requirements as specified at MAD 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 441.258. 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.D.

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: _____

Submitting Hospice Care Services for Medicare Advantage Members

Effective Jan. 1, 2025, Presbyterian will no longer participate in the Value-Based Insurance Design (VBID) program.

Providers should submit claims for Presbyterian Medicare Advantage and Presbyterian Dual Plus (HMO D-SNP) members who have elected hospice coverage to Original Medicare, using guidelines published in the Medicare Managed Care Manual by CMS, the federal agency charged with oversight of the Medicare program.

Claims for services covered under Original Medicare related to hospice (the member's terminal condition) should be filed with the local Medicare intermediary (for Medicare Part A benefits) and carrier (for Medicare Part B benefits). Please do not file these claims with Presbyterian, as they will be denied.

Claims for services covered under Original Medicare but **not** related to the terminal illness should also be filed with the local intermediary and carrier. Please do not file these claims with Presbyterian, as they will be denied.

Once providers have received their remittance advice from Original Medicare, submit the claim for non-hospice related services with the remittance advice to Presbyterian.

Presbyterian is responsible for paying the practitioner or provider any difference between what the member's cost sharing is as a Medicare Advantage member and the cost sharing under fee-for-service (FFS) Medicare for non-hospice related services. The member's cost sharing is based on their Medicare Advantage plan/coverage.

Claims for services covered by Presbyterian's Medicare Advantage Plans, above and beyond those of Original Medicare, should be filed to Presbyterian for processing. Examples of these services include routine (not medically necessary) eye and vision exams, routine podiatry and outpatient prescription drug coverage not already covered under Original Medicare.

Medicare Part D Description Drug Coverage

Medicare Part D Prescription Drug Coverage is available to individual Medicare-eligible beneficiaries in Presbyterian Medicare Advantage and Presbyterian Dual Plus (HMO D-SNP) plans. Some Employer Group plans also include Medicare Part D coverage in their plans.

Medicare Part B Coverage Only

When a member only has Medicare Part B coverage 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 the Medicare Part B 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.

ACA Grace Period for Health Insurance Marketplace Members

Grace Period Window

The ACA ensures members have a grace period before their health insurance coverage can be terminated for non-payment of their premium. If an enrollee's premium payment has not been received by Presbyterian on or before the first day of the coverage month, then a grace period is triggered.

The grace period is different for enrollees who receive an Advance Premium Tax Credit or APTC:

- With APTC, the grace period is 90 days
- Without APTC, the grace period is 31 days

Partial premium payments will not adjust a grace period. If an enrollee is eligible for an APTC but elects not to receive the credit in advance, then they do not qualify for the 90-day grace period. The 90-day grace period only applies to enrollees who are receiving an APTC.

Affordable Care Act Grace Period Process

The following information regarding the ACA grace period is only applicable to following Presbyterian HMO products:

- Individual and Family or Group HMO/POS
- Individual Select HMO
- Individual Select Silver HMO

The ACA includes a provision that allows health insurance marketplace members who receive the advance premium tax credit (APTC), a three-month grace period to pay their premium – provided they have already paid at least one month's premium in full. It is important to note that not all members who purchase coverage on the health insurance marketplace will receive the APTC.

The provision requires Presbyterian to process claims (for covered services rendered) in the first month of the grace period for members who qualify for the APTC subsidy. For covered services rendered during the second and third month of the grace period, Presbyterian will pend claims. Upon member's payment of all outstanding premium, claims will be adjudicated according to Presbyterian's standard process. Should payment of premium not be received by Presbyterian, or the member is ineligible for coverage, claims will be denied for reason of ineligibility. Presbyterian will designate grace period denials as "claim denied due to non-payment of premium."

For those members not receiving an APTC subsidy, claims will be pended on or before the first day of the coverage month after the premium is due.

During the three-month grace period, members are eligible for covered services under their plan; however, Presbyterian is not obligated to pay claims for the second or third month of the grace period unless and until the member has paid all outstanding premiums.

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, the primary carrier's EOP must be provided when submitting the claim to Presbyterian for consideration. Presbyterian requires all coordination of benefit (COB) claims to 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. The primary carrier's itemized EOP is required to be submitted with the claim or submitted electronically in an 837 compliant transaction. 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 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 EOB/EOP are denied for lack of the EOB/EOP. Claims may also be denied if other insurance carriers' requirements are not met.

Providers submitting claims to Original Medicare as the primary insurance do not need to also submit the claim to Presbyterian. Presbyterian receives a Medicare crossover file from CMS which allows us to process the secondary claim. It is not necessary to send to both Medicare and Presbyterian.

When the member's primary carrier is Medicare Part B only and an inpatient confinement exists, the inpatient ancillary services UB-04 claim, type of bill 012X, is received from CMS through the Medicare crossover file. Benefits are coordinated with Medicare Part B for the inpatient ancillary services. Submit bill type 011X with the Medicare Part B EOP to receive reimbursement for the inpatient room and board services (and any other service not covered by Medicare Part B). An adjustment will be performed to recoup any monies paid on the 012X claim. The 011X claim will be reimbursed according to the per diem, Diagnosis Related Group (DRG), or outlier contract less the Medicare Part B payment.

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

Presbyterian providers may bill the member for applicable copays, coinsurance and/or deductibles.

Adjustment Requests Involving Coordination of Benefits

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. Corrected claims must be submitted with the appropriate resubmission code or frequency type within the timely submission guidelines and include all charges with the corrections clearly indicated to be considered. A copy of the EOP must be included along with the provider's corrected claim.

Turquoise Care Coverage of Benefits

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, then providers must file a claim and obtain an EOP from the other insurance plan, as required by their 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 payment 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, claims are processed in accordance with NMAC 8.302.3.10.

Third-Party Liability

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 the 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.

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.

HCA's TPL contractor, Health Management Services, Inc., is 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 was 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 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 was 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 was recouped from Presbyterian Turquoise Care pursuant to Article 6.2.4, whereupon Presbyterian Turquoise Care shall 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 the claim was processed incorrectly or they need to know their payment status, they can contact our Provider Care Unit or the provider portal for an explanation. 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. When Presbyterian or another entity identifies an overpayment, the time frames below are followed. The time frame for recovery is based on the notification to the provider or their representative by EOP or other communication type (i.e., 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's name
- The member's ID number
- Date of service
- Presbyterian claim number
- The overpayment reason

Note: If there are 20 claims or more associated with one request, a spreadsheet is required with the information above.

If the provider voluntarily sends a refund check to Presbyterian and later determines that the check was sent in error, the request to correct the error must be submitted within 12 months from the date of the check.

Exceptions to these guidelines may occur due to government regulations or cases of suspected fraud and abuse activities. Claim overpayments are recovered through the EOP process whenever possible. This appears as a payment reduction or negative claim payment on the provider's EOP.

Acceptable Time Frames for Recovery of Overpayment

- Turquoise Care: One year from the date of payment
    - Exception: When COB is involved, 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 IHS providers, in network and out of network, a two-year filing limit applies
- Commercial and ASO: One year from the date of payment

  - Exception: When COB is involved, there is no time frame for recovery of any overpayments if Presbyterian has documented verification that the provider received payment from the other insurance carrier
  - Exception: Claims for U.S. Office of Personnel Management (OPM) members
- Medicare Advantage (Presbyterian Senior Care [HMO/HMO-POS] and Presbyterian Dual Plus [HMO D-SNP]): Three years from the date of payment

Acceptable Time Frames for Recovery of Member Retro-Terminations

- Turquoise Care: Two years from the date of payment
  - Exception: When COB is involved, there is no time frame for recovery of any overpayments
- Commercial and ASO: One year from the date of payment
  - Exception: Claims for U.S. OPM members
- Medicare Advantage (Presbyterian Senior Care [HMO/HMO-POS] and Presbyterian Dual Plus [HMO D-SNP]): Three years from the date of payment

Acceptable Time Frames for Recovery of Confirmed Fraud and Abuse Activity

- Turquoise Care: Four years from the date of payment
- Commercial and ASO: Six years from the date of payment
  - Exception: Claims for U.S. OPM members
- Medicare Advantage (Presbyterian Senior Care [HMO/HMO-POS] and Presbyterian Dual Plus [HMO D-SNP]): No time limit

Timely Submission Guidelines

Guidelines for Original Claim Submissions

Presbyterian requires that claims from in-network providers be received within three months of the date of service. Failure to adhere to the timely submission guidelines results in the denial of the provider's 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 three months of the date of the denial letter or EOP from the other insurance carrier.

When billing claims for inpatient facility charges, the three-month filing limit begins from the date of discharge.

The provider is responsible for submitting the claim timely, for tracking the status of the claim and for determining the need to resubmit the claim.

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 (only acceptable as paper claims)

Presbyterian requires that all claim resubmissions, corrections and adjustment requests for additional payment must be submitted within 12 months of the date of service. If a resubmission, corrected claim, or adjustment request for additional payment is not received within this time frame, the original decision is upheld.

If a provider's claim is not in the system, then the claim must be resubmitted.. Providers should maintain a record of their resubmission and any contacts with Presbyterian. If the resubmission is past the three-month filing limit, then providers must 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 receive no payment or documentation on their claim, they can 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 EOPs 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 applies to clean claims only. Interest will be paid at the current rate, for the period beginning on the day after the claim-received date and ending on the date on which payments are made.

- ASO: Interest does not apply to ASO products
- Commercial and Medicare Advantage: Interest is paid on clean claims not paid with 30 calendar day if submitted electronically, or 45 calendar days if submitted manually (by mail or in person). Interest is

paid at the applicable rate according to the Wall Street Journal Prime lending rate (Variable Rate) as defined under NMAC 13.10.22.12 (O). The rate is reviewed and updated on a quarterly basis. Turquoise Care: Interest payments are paid as directed in the Turquoise Care Managed Care contract on clean claims. Interest shall accrue from the 31st calendar day from the clean claim received date for electronically submitted claims, and on the 46th day from the clean claim received date for manual claims. Interest is paid in accordance with 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 New Mexico Amendment Five to Medicaid Managed Care Agreement currently directs payment of interest as required in NMAC Section 8.308.20.9 (E), which further outlines the provision of payment of interest as follows:

- The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of 1.5% 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 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. 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. Providers are reminded 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 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 is most appropriate for the services that were provided and matches the registration record of the individual provider with New Mexico Medicaid
        - 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. 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 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, and to check the CMS website for recent NCCI edits at:
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.

Payment Dispute Resolution

When a provider has not been paid within 30 days of receipt of a clean electronic claim or within 45 days of receipt of a clean paper claim, or when a provider needs to resolve a dispute regarding payment of claims when a credentialing decision was delayed beyond 45 calendar days, they should contact Presbyterian in writing to ensure the appropriate supporting documentation was provided and to determine the status of the claim and whether Presbyterian considers it a clean claim.

Presbyterian will respond to the inquiry regarding the status of an unpaid claim within 15 days of receiving the inquiry. Presbyterian will explain its failure or refusal to pay and the expected date of payment if payment is pending. if there is not any question of liability or special treatment, Presbyterian shall pay interest in the amount of 1½ % for each full or partial month for any full or partial month, beginning on the 31st day after the claim was submitted electronically and on the 46 day for claims submitted manually.

Note: Any 30-day period is the equivalent of one month, except that a calendar year shall only be equal to 12 months.

Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. Presbyterian is not required to pay any interest calculated to be less than two dollars. The interest shall be paid within 30 days of the payment of the claim. Interest can be paid on the same check or electronic transfer as the claim payment, or on a separate check or electronic transfer. If Presbyterian combines interest payments for more than one late clean claim, the check or electronic transfer shall include information

identifying each claim covered by the check or electronic transfer and the specific amount of interest being paid for each claim.

Filing a Complaint With Superintendent

If Presbyterian fails to respond, or the provider believes that payment is being denied, delayed or calculated in error and the matter has not been successfully resolved within 45 days, then the provider may file a complaint, either individually or in batches, with the superintendent using the form found on the OSI website. Complaints filed with the superintendent shall contain the following information:

- The provider's name, identification number, address, daytime telephone number
- The claim number
- The date that the provider's request for credentialing was complete
- The name and address of Presbyterian
- The name of the patient and employer (if known)
- The date(s) of service
- The date(s) the claims were submitted to Presbyterian
- Relevant correspondence between the provider and Presbyterian, including requests to Presbyterian for additional information that the provider believes would assist in the superintendent's review
- Specific excerpts from provider contracts that are minimally necessary to resolve the dispute

The complaining provider shall furnish to Presbyterian a complete copy of the complaint and submitted documentation concurrently with the provider's submission to the superintendent. Presbyterian shall be afforded 10 business days after the provider's submission to resolve the matter or to submit additional information that Presbyterian believes would be of assistance to the superintendent's review.

The superintendent may issue an order resolving the dispute, with or without a hearing. If the superintendent determines that a hearing is necessary, then the provider and Presbyterian may appear and may elect to be represented by counsel at the hearing. The superintendent's decision will be issued within 30 days of receiving a payment complaint if a hearing is not required, or within 30 days of the hearing if a hearing is held. The superintendent may order Presbyterian to reimburse a provider at the standard reimbursement rate for covered services provided to members, subject to out-of-network costs, deductibles, co-payments, co-insurance or other cost-sharing provisions due from the member.

Claims and Payment Resources

myPRES and PROVIDERConnect

myPRES and the PROVIDERConnect Portal are available 24/7 and enables providers and their 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 facility
- Check summaries (listing of EOPs that were mailed, with access to all claims associated with that remittance including the address of where the check was mailed)

Provider Care Unit

The Provider Care Unit was established to handle complex inquiries from providers, including web-based inquiries, written inquiries, adjustment requests and telephone calls that were not resolved through myPRES, IVR, www.phs.org or one of our electronic submission vendors. The Provider Care Unit accesses myPRES when assisting providers with their inquiries. Please contact (505) 923-5757 or 1-888-923-5757 for assistance.

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 addresses in the box below.

Claim Type	Address
Medical/physical Health	Presbyterian Health Plan P.O. Box 27489 Albuquerque, NM 87125-7489
Behavioral Health Commercial and Medicare	Presbyterian Health Plan P.O. Box 2216 Maryland Heights, MO 66043

Behavioral Health Turquoise Care	Presbyterian Health Plan P.O. Box 25926 Albuquerque, NM 87125-25926

Coding Information and Resources

Name	Website Links and Contact Information
AMA CPT Products	https://commerce.ama-assn.org/store/ui/catalog/subCategoryDetail?category_id=cat1150004&navAction=jump Phone: 1-800-621-8335 (toll-free) Address: 515 North State St., Chicago, IL 60654
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
NCCI Edits	www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
CMS Carriers Manual and Hospital Manual	Carriers Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1821B3.pdf Hospital Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R782HO.pdf
Novitas Solutions Inc.	www.novitas-solutions.com/
Palmetto GBA for HCPCS Information and the DMERC Manual	www.palmettogba.com/
Provider Compliance Group Interactive Map (click the state of New Mexico on the map)	www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html
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 provide outstanding service to every customer, every contact, every time.

Member Contacts for Presbyterian Customer Service Center

Members can contact PCSC by calling the local or toll-free number on the back of their identification (ID) card, emailing info@phs.org, or visiting the "Contact Us" page on www.phs.org. Providers can call the Provider Care Unit at (505) 923-5757 or 1-888-923-5757 for assistance with complex inquiries.

Presbyterian Customer Service Center Hours of Operation for Members	
Presbyterian Commercial, ASO, Interagency Benefits Advisory Committee (IBAC) and PIC	7 a.m. to 6 p.m. Monday through Friday
Presbyterian Medicare Advantage and Dual Plus	Oct. 1 to March 31: 8 a.m. to 8 p.m. Sunday through Saturday (except holidays) April 1 to Sept. 30 Monday through Friday (except holidays)
Turquoise Care	8 a.m. to 6 p.m. Monday through Friday (except holidays)

Member Communication and Welcome Packets

Upon enrollment, new enrollees receive a welcome packet, including group subscriber agreements, member handbooks, a 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 contact 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 relationship team's 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 member ID card to the provider's office; however, services should not be denied if no card is presented. Members can also show their digital ID cards through the myPRES application accessed from a smartphone or mobile device. The ID card does not guarantee that the member is still eligible. To verify eligibility, providers should use the PROVIDERConnect Portal accessed through the myPRES platform or Presbyterian's IVR system. The IVR system can be accessed by calling (505) 923-5757 or 1-888-923-5757. However, 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 ID card against another form of identification, such as a driver's license or other photo identification. This type of verification deters fraudulent use and 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 PCP

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, Presbyterian may attempt to place an outbound call to 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 PCP

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. Such duties must be within the scope of the participating specialist's certification and 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 via email to pcscmemberadvocate@phs.org with the member's name in the subject line. Upon receipt of the completed form, it is reviewed by the Health Services department for approval.

PCP 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 a Provider's Panel

A PCP may determine that it is in the member's best interest to be removed from their 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 our policies and procedures. The PCP must send the member a letter advising them of the decision to end the patient/provider relationship. Upon contact by the provider or the member, 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.

Turquoise Care Member Eligibility and Enrollment

Eligibility for Presbyterian Turquoise Care is determined by the HCA Income Support Division.

Presbyterian Turquoise Care is assigned to 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 is hospitalized in an acute care setting while not enrolled, until discharge to a lower level of care.

If the member not yet enrolled with Presbyterian 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 for Turquoise Care Members

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)

Medicare Annual Notification of Change Meetings

Each year, before and during the Medicare Annual Enrollment Period, members and their guests can attend a Presbyterian Medicare Plans Annual Notification of Change (ANOC) meeting. The meetings are designed to meet our members' needs by providing information about changes to the Presbyterian Medicare Advantage plan benefits and services for the upcoming year. This is also a time when Presbyterian can address members' personal questions regarding the benefit plans. For our members' convenience, meetings are available throughout the Medicare plan service area. Members are encouraged to attend annually.

Medicare Advantage Plans New Member Education, Verification and Welcome Calls

Outreach to all new Presbyterian Medicare Advantage plan members is conducted within 15 calendar days of receipt of the member's request for enrollment. The primary purpose of the call is to welcome the new member and ensure that they understand the product type and plan in which they are enrolling. Key plan elements are reviewed, and members are provided an opportunity to ask questions about their new Presbyterian Medicare Advantage plans.

SilverSneakers Fitness Program

Presbyterian Medicare Advantage plan members are offered the SilverSneakers Fitness Program or SilverSneakers Steps benefit at no additional cost. With the SilverSneakers Fitness Program, members have access to basic fitness center membership at no additional cost. This membership includes access to amenities such as treadmills, weights, a heated pool and fitness classes. Members can take signature SilverSneakers classes designed specifically for older adults and taught by certified instructors. Additional SilverSneakers options may be available at select fitness centers as members' fitness levels progress. A designated, specifically trained Program Advisor assists members along the way with enrollment and getting started. SilverSneakers members have access to more than 10,000 participating fitness centers, including women-only Curves locations. Once members enroll in SilverSneakers, they can use any participating location in the nation. The SilverSneakers Fitness Program is available to all eligible members. To find a location, providers can visit www.silversneakers.com or call 1-888-423-4632.

SilverSneakers Steps is a personalized fitness program that fits the lifestyle of members who do not have convenient access to a SilverSneakers location (location is 15 miles or more from the member's home). This self-directed, pedometer-based physical activity and walking program provides the equipment, tools and motivation for members to measure, track and increase their activities and achieve a healthier lifestyle. After registering as a Steps member through www.silversneakers.com, the member will receive their kit at their home address. Members can get fit, have fun and make friends.

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. This includes information about services, 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 patient rights. Understand that doing this does not cause Presbyterian and its contracted providers or HCA to treat them in a negative way
- 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
- 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. 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 protected health information (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 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 and 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 2
- 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
- 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 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, providers can 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 This notice helps members understand how Presbyterian protects the privacy of their health information and also informs members of their health information rights.

Member Health Information Rights

The rights described below are subject to limitations and conditions.

Legal Authority to Make 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.

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 a member may access and print an authorization form for release of PHI by visiting: 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. 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.

As for myPRES, the platform's security features only allow information pertaining to the 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 Sensitivity

The ability to communicate effectively with 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 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 CinéMed, 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 members. PCSC is also available to assist providers with interpreter services for 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 members 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 CLI operator will ask for the physician's name, NPI number, the patient's member number and your customer code. The Presbyterian customer code is 72PHP.

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

myPRES is the quick and easy way of accessing real-time information. This service is available 24/7 to ensure that the information providers and their office staff needs is at their fingertips. This tool is provider's most efficient way of getting the information they need when they need it. Information available through myPRES 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 EOPs with access to all claims associated with that remittance, including the address of where the check was mailed)
- Benefit certification submission and status
- Pharmacy exception submission and status
- Electronic access to the Provider Care Unit

Each employee in a provider's office that uses myPRES must have their own individual user name and password. Under no circumstances should the myPRES username and password 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 they can 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 Customer Service phone number on the back of their member ID card.

Web-Based Inquiries

Presbyterian may contact PNO 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. When calling the Provider Care Unit, providers should have the following information available:

- Their NPI or TIN
    - The Provider Care Unit will be unable to assist providers 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
- 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 can contact their PNO relationship team if the issue affects more than five claims (for example, incorrect contract payment, or charge for a specific code is being denied when it should be 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
Attn: Provider Grievance Coordinator
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

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 65 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 it 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.

At the first level of an operational grievance, a provider shall have the right to present their concerns to a committee responsible for the substantive area addressed by the grievance. The substance of the first level grievance will also be conveyed to the health plan's governing body. The health plan's governing body shall be

provided the opportunity to direct the committee's review and resolution of the grievance. The governing body may also dictate who serves on the grievance review committee.

Grievances shall be resolved within 30 calendar days. If the provider grievance is not resolved within 30 calendar days, Presbyterian requests a 14-calendar-day extension from the provider. If the provider requests the extension, the extension is approved by Presbyterian. Presbyterian reviews grievances in accordance with all federal and state regulatory guidelines and Presbyterian's policies and procedures.

For Turquoise Care providers, a copy of the Provider Appeals and Grievance policies and procedures may be provided to contracted providers. For a list of the applicable regulations, please access the Appeals & Grievances page at www.phs.org/providers/resources/appeals-grievances.

Provider Grievances for Interagency Benefits Advisory Committee (IBAC), Fully-Insured and Commercial Plans

Providers have the right to file a grievance related to the following within 90 days from the incident:

- Credentialing deadlines
- Claim payment amount or timing
- Claim submission requirements or compliance
- Network adequacy, including participation determinations based on network composition
- Network composition including provider qualifications
- Utilization management practices
- Provider contract construction or compliance
- Patient care standards or access to care
- Surprise billing reimbursement amount, rate or timing
- Termination
- Operations of the plan including compliance with any aw enforceable by the superintendent, or of any directive of the superintendent
- Discrimination

A written acknowledgment letter will be sent to the provider within five days of receipt. Providers have the right to present oral or documentary evidence to a Presbyterian committee review panel responsible for the substantive area addressed by the concern. If the grievance raises a quality-of-care concern, then the panel will include a New Mexico-licensed medical professional who practices in the general area of concern. Presbyterian will issue a decision to the provider pursuing a grievance within 45 calendar days after the

committee has obtained all information concerning the provider's grievance. No person with a conflict of interest shall participate in a decision to resolve a grievance. For a list of the applicable regulations, please access the Appeals & Grievances page at www.phs.org/providers/resources/appeals-grievances.

Right to Request Review From Superintendent

A provider who is dissatisfied with the results of Presbyterian's grievance procedure and has exhausted the internal grievance process may file a complaint with the superintendent regarding the subject of the grievance. A provider seeking the superintendent's review of Presbyterian's grievance decision shall file a written request with the superintendent within 30 days from the receipt of the written decision from Presbyterian concerning the grievance. After investigation, the superintendent may schedule and conduct a hearing pursuant to Article 4 of the Insurance Code.

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 member is requested by a provider and denied by Presbyterian, a provider may act on the member's behalf and may file a request for an expedited appeal if the provider feels that the member's health or welfare are in immediate jeopardy. Presbyterian then determines if it meets expedited criteria. If the case is deemed expedited, Presbyterian processes the expedited appeal within 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 member appeals and grievance process is published in the member handbooks. 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
    - Medicare members should submit a grievance and or appeal to the Presbyterian grievance and appeals coordinator within 65 calendar days of the date the dissatisfaction occurred or from the denial date
    - Medicaid members should submit an appeal to the grievance and appeals coordinator within 65 days from the date of denial and can submit a grievance at any time from the date of the dissatisfaction occurred
    - Commercial members should submit an appeal and or grievance to the grievance and appeals coordinator within 180 from the date of denial or the date of the dissatisfaction occurred

Provider Termination

Providers should refer to their service agreement with Presbyterian for specific time frames and obligations regarding terminations.

Presbyterian has the right to suspend, deny, refuse to renew, or terminate any provider agreement in accordance with the terms of the service agreement and applicable statutes and regulations. HCA has the right to direct Presbyterian to terminate or modify Turquoise Care program agreements when HCA determines it to be in the best interest of the state. In the event of termination of the agreement, providers shall immediately make available to HCA or its designated representative, in a usable form, any or all records, whether medical or financial, related to their activities undertaken pursuant to the agreement. The provision of such records shall be at no expense to HCA.

Circumstances Giving Rise to a Provider Fair Hearing

Presbyterian must give reasonable advance notice if a provider's agreement is terminated for cause, unless it is for quality of care issues. The minimum advance notice is determined by federal and state regulatory guidelines unless the provider's contract states otherwise.

Providers may appeal a decision to deny, suspend or terminate their participation in the Presbyterian network. If the provider disputes any such action, they must submit a written request for a hearing. A provider has the right to a fair hearing upon receipt of a written notice from Presbyterian, or its agent, pursuant to the

termination, for terminating the agreement either immediately or after notice. During the fair hearing process, a provider has the right to:

- Appear in person before a fair hearing officer or committee appointed by Presbyterian prior to the proposed termination date
- Present their case to the fair hearing officer or fair hearing committee
- Submit supporting material both before and at the fair hearing
- Ask any questions of any representative of Presbyterian who attends the hearing
- Be represented by an attorney or any other person of the provider's choice
- An expedited hearing in instances where Presbyterian has not provided advance written notice of termination to the provider because Presbyterian has a good faith and reasonable belief that further care by the provider would result in imminent and significant harm to members

Presbyterian shall issue a written decision within 20 days after the fair hearing.

Initiation of an Appeal Hearing

A provider may initiate a fair hearing within 30 calendar days of receiving written notice of termination from Presbyterian, by delivering or sending by certified mail a written request for a fair hearing to Presbyterian or its agent. Failure to deliver a written request by certified mail for a fair hearing within those 30 days constitutes a waiver by the provider of any hearing regarding their termination. If a request for a hearing is not filed by that time, then the provider contract ends.

Turquoise Care Member Fair Hearing

A member may request a state fair hearing within 90 calendar days for expedited or standard 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 be 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

If a request for a fair hearing is received by HCA within 10 calendar days, Presbyterian's final decision will be upheld until the outcome of the hearing is decided. However, if the hearing officer agrees with Presbyterian's final decision, the member may have to pay for the continued services if those services were the reason for the hearing.

Non-Retaliation

Presbyterian will ensure that all providers will not be subject to any form of retaliation or discrimination as a result of filing an appeal or grievance.

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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:

1. **The provider is contracted with Presbyterian.**
   The provider has an active contract or is included under a contracted group or delegated arrangement.
2. **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
3. **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
4. **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
5. **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:

1. **Credentialing is not complete.**
   Providers undergoing credentialing, recredentialing or review are not displayed until approved.
2. **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
3. **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
4. **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
5. **All of the provider’s locations are invalid.**
   If a provider has no active validated service location, they cannot be displayed publicly.
6. **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

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AACAP	American Academy of Child and Adolescent Psychiatry
AAP	American Academy of Pediatrics
ABP	Alternative Benefits Plan
ACA	Patient Protection and Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADHD	Attention Deficit and Hyperactivity Disorder
ADL	Activities of Daily Living
AMA	American Medical Association
APA	American Psychiatric Association
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Only

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BADL	Basic Activities of Daily Living
BFCC	Beneficiary and Family Centered Care

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CAGE	Cut, Annoy, Guilty, Eye Opener
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCS	Correct Coding Standards
CCSS	Comprehensive Community Support Services
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHR	Community Health Representative
CHW	Community Health Worker
CLI	Certified Language International
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

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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

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eCOB®	Electronic Coordination of Benefits
ECT	Electronic Claims Transmission
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
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
ERA	Electronic Remittance Advice

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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

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GSA	Group Subscriber Agreement; Government Services Administration

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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
HCA	New Mexico Health Care Authority

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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

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LEP	Limited English Proficient
LPN	Licensed Practical Nurse
LRI	Legally Responsible Individual

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MA	Medicare Advantage
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

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NANM	NurseAdvice New Mexico
NCCI	National Correct Coding Initiative
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NF LOC	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

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OIG	Office of the Inspector General
OSI	New Mexico Office of the Superintendent of Insurance

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P&T	Pharmacy & Therapeutics
PCA	Personal Care Attendant
PCMH	Patient-Centered Medical Homes
PCSC	Presbyterian Customer Service Center
PCP	Primary Care Provider/Practitioner
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
PNO	Provider Network Operations
PPA	Provider Participation Agreement
PPO	Preferred Provider Organization

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QI	Quality Improvement
QIO	Quality Improvement Organization
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
QRM	Quality Resource Management

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RAC	Recovery Audit Contractor
RN	Registered Nurse

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SAM	System for Award Management

SDCB	Self-Directed Community Benefit
SNF	Skilled Nursing Facility

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TAC	Technology Assessment Committee
Tx	Medical treatment

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UNM	University of New Mexico
USC	United States Code
USPSTF	United States Preventive Services Task Force

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VFC	Vaccines for Children
VPA	Vaccine Purchase Act

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WEDI	Workgroup on Electronic Data Interchange

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Appendix B. Definitions

Please note that the definitions provided 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, New Mexico Statutes Annotated (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 Code of Federal Regulations (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 managed care organization (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 Health Care Authority (HCA) regulations. See also basic activities of daily living (BADL) and instrumental activities of daily living (IADL).	HCA
adult	Means an individual age 19 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	HCA

Term	Definition	Source
	proposed to be furnished, to a member are not medically necessary or not appropriate.	
adverse event	Means an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.	
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
Baldrige Healthcare Criteria for Performance Excellence	Criteria provided by the Baldrige Performance Excellence Program that supports healthcare organizations in their efforts to reach goals, improve results and become more competitive by aligning plans, processes, decisions, people, actions and results. www.nist.gov/baldrige/publications/hc_about.cfm#	see link
Basic activities of daily living (BADL)	Means 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; and toilet hygiene (completing the act of relieving oneself) http://en.wikipedia.org/wiki/Activities_of_daily_living.	see link
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
Behavioral Health (BH) High-Volume Practitioners	Any practitioner licensed/certified as a psychiatrist, psychologist, clinical social worker, marriage/family/child counselor, nurse, or other licensed healthcare professional with appropriate training and experience in behavioral health services to treat chemical dependency and/or mental disorders.	
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 ABCB and the SDCB 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

Term	Definition	Source
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 Health Insurance Portability and Accountability Act-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
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

Term	Definition	Source
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 person, the health of the pregnant person or their unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the member.	HCA
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

Term	Definition	Source
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. A 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 SDCB. 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 Federal Unemployment Tax Act (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.	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 themselves 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)	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 the 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
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	Means the tool used by health plans to measure performance of certain health are criteria developed by NCQA.	HCA

Term	Definition	Source
and Information Set (HEDIS)		
high-volume specialty care providers	Means providers of 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)	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 (NF LOC) assessment.	HCA
Indian Health Service (IHS)	Means the division of 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)	Means doing housework; taking medications as prescribed; managing money; shopping for groceries or clothing; use of telephone or other form of communication; using technology (as applicable); and using 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. It also consists of the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the instructional support and vocational rehabilitation division of the public education department; and the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. The Collaborative is chaired by the Secretary of Human Services with the respective secretaries of Health (Services) and Children, Youth and Families (CYFD) alternating annually as co-chairs.	see link

Term	Definition	Source
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
levels of care	The care coordination process addresses three levels of care, levels one, two and three. • **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 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 International Classification of Functioning (ICF)/ Mentally Retarded (MR)/Developmentally Disabled (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 Presbyterian Healthcare Services 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.	HCA
medical error	Defined by the Institute of Medicine as "the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim."	
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 healthcare 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	HCA

Term	Definition	Source
	member and are not primarily for the convenience of the member, the provider, or the MCO.	
member	Means a person who is determined eligible for Presbyterian Healthcare Services and who has enrolled in the MCO's health plan.	HCA
member materials	All materials distributed to members including but 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 shall assess member satisfaction with the quality, availability and accessibility of care.	HCA
near miss	Defined as "an occurrence with potentially important safety-related effects, which, in the end was prevented from developing into actual consequences."	
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 Contractor	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
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 providers, 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 provider assistants and certified nurse practitioners, as well as other specialists that elect to perform in the role of primary care.	HCA

Term	Definition	Source
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 community health workers (CHWs), 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, provider, 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 SDCB.	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 MCOs, HCA, the Collaborative and providers who 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
recipient	Means an individual who is eligible for Presbyterian Healthcare Services but has not yet enrolled in a 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 unemancipated 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

Term	Definition	Source
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	Shall 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 that 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
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.	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

Term	Definition	Source
Waiver 1115 Turquoise Care	According to information provided by the state, Turquoise Care designed 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 previously the umbrella name for New Mexico's Medicaid managed care program. Salud! Services were provided by contracted MCOs to provide Medicaid services to eligible and enrolled citizens. Clients enrolled into the Salud! program 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 were unable to change for the next nine months. Two months before the end of their nine-month enrollment period, clients got a letter that let them change their MCO.	CMS
Waiver 1915(c) NM Mi Via-ICF/MR (0448.R01.00)	Provides consultant/support guidance, 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 with autism, DD, MR ages 0 – no max age.	CMS
Waiver 1915(c) NM Mi Via NF (0449.R01.00)	Provides consultant/support guidance, 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, occupational therapy (OT) for adults, physical therapy (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, intellectual disability (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 with 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
Allscripts Payerpath	www.payerpath.com/
American Psychiatric Association (APA) and the American Academy of Pediatrics (AAP) Resources and Guidance	https://psychiatryonline.org/guidelines
Appeals and Grievances Webpage	www.phs.org/providers/resources/appeals-grievances
Availity®	www.availity.com
Become a Contracted Provider	www.phs.org/providers/our-networks/health-plan/Pages/default.aspx
Behavioral Health Clinical Practice Guidelines, Tools and Resources	www.phs.org/providers/resources/reference-guides/Pages/medical-pharmacy-behavioral.aspx
Care Continuum Alliance	https://thepcc.org/members/care-continuum-alliance/
CAQH Website	www.caqh.org/
Change Healthcare (Optum)	www.changehealthcare.com/
Claim.MD	www.claim.md/
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/index.html
CLIA Waived Test List	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

Name	Website Location
Coding and Reimbursement Store (AMA)	www.ama-assn.org/practice-management/ama-store
Contact Presbyterian	www.phs.org/providers/contact-us/
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
Depression Recognition Tools: PHQ-9 and Other Information	www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001006.pdf
Drug Prior Authorization Request Form	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=OB_00000029118
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/enews
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/
Health Services Resources and Forms	www.phs.org/providers/authorizations
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 **HHS** www.hhs.gov/ocr/privacy/hipaa/administrative/omnibus/index.html
HIPAA Resources	**American Medical Association** www.ama-assn.org/practice-management/hipaa

Name	Website Location
	HHS www.hhs.gov/ocr/privacy/index.html **Centers for Medicare & 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_00000018213
List of Excluded Individuals and Entities, Department of Health and Human Services/Office of the 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
Medicare Promoting Interoperability Programs	**Official Web Site for the Medicare Promoting Interoperability Programs** https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs?redirect=/EHRIncentivePrograms/40_MedicaidStateInfo.asp
Medical Policy Manual	www.phs.org/medicalpolicymanual
Medicare Learning Network (CMS)	https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training
MyChart Information Page	www.phs.org/tools-resources/patient/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

Name	Website Location
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/
Office Ally	www.officeally.com
Office of the Inspector General: US Department of Health and Human Services Website	https://oig.hhs.gov/
Palmetto GBA for Healthcare Common Procedure Coding System (HCPCS) information and the DMERC Manual	www.palmettogba.com/
Pharmacy Resources and Forms	www.phs.org/providers/authorizations
Physical Health Clinical Practice Guidelines, Tools and Resources	www.phs.org/providers/resources/reference-guides/Pages/clinical-practice-guidelines.aspx
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
Preventive Health Guidelines Website	www.phs.org/providers/resources/reference-guides/medical-pharmacy-behavioral
Prior Authorization Guide	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00179220
Provider Compliance Group Interactive Map	www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html
Provider Directory Update	https://www.phs.org/providers/resources/provider-portals/update-provider-directory-profile
Presbyterian Health Plan Provider Homepage	www.phs.org/providers/

Name	Website Location
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
SilverSneakers®	www.silversneakers.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 and Fax Numbers
Adult Protective Services	Phone: 1-866-654-3219
Air Transportation Request	Phone: (505) 923-5757 or 1-888-923-5757 (option 4)
American Medical Association (AMA) CPT Products	Phone: 1-800-621-8335
Availity® Client Services	Phone: 1-800-282-4548
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	Phone: (505) 923-5678
Behavioral Health Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 5) Turquoise Care Fax: (505) 843-3019 Commercial / Medicare Fax: 1-888-656-4967
Care Coordination Unit	Phone: (505) 923-8858 or 1-866-672-1242 Fax: (505) 843-3150
CDC Immunization Hotline	Phone: 1-800-232-4636
Change Healthcare (Optum)	Phone: 1-866-817-3813
Children, Youth and Families Department (CYFD)	Phone: 1-800-797-3260
Claim.MD	Phone: 1-877-757-6060
Department of Health/Division of Health Improvement (DOH/DHI)	Phone: 1-800-445-6242
DentaQuest (Dental Care)	Phone: 1-855-343-4276 Fax: 1-262-241-7150
Durable Medical Equipment (DME) Requests	Fax: (505) 843-3047
E-Help Desk	Phone: (505) 923-5590 or 1-866-861-7444
Emdeon Business Services	Customer Support Phone: 1-877-469-3263 Corporate Office Phone: 1-615-932-3000
Federal Funded Pregnancy Termination Request	Fax: (505) 923-5489
Gateway EDI, Inc.	Phone: 1-800-969-3666
Health Services	Phone: (505) 923-5757 or 1-888-923-5757 (option 4)

Name	Phone and Fax Numbers
Healthy Solutions Disease Management Program	Phone: 1-800-841-9705
HealthEC	Phone: 1-877-444-7194
HealthXnet® User Administration and Help Desk	Phone: (505) 346-0290 or 1-866-676-0290 Fax: (505) 346-0278
Home Healthcare Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 559-1150
Inpatient Concurrent Review or Inpatient Hospital Admission	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 843-3107 or 1-888-923-5990
Inpatient Prior Authorization Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 843-3107 or 1-888-923-5990
Interactive Voice Response (IVR)	Phone: (505) 923-5757 or 1-888-923-5757 (option 1)
Magellan EDI Support	Phone: 1-800-450-7281
Long-Term Care Prior Authorization Request	Fax: (505) 843-3107 or 1-888-923-5990
MedAssets	Main Office Phone: 1-678-323-2500 Product Information Phone: 1-888-883-6332 Tech Support Phone: 1-866-658-1629
New Mexico Health Care Authority Office of Fair Hearings	Phone: (505) 476-6213 or 1-800-432-6217 (option 6) Fax: (505) 476-6215
NurseAdvice® New Mexico	Turquoise Care Phone: (50) 923-5677 or 1-888-730-2300 Presbyterian Senior Care (HMO/HMO-POS) Phone: 1-800-887-9917 Presbyterian Commercial Phone: 1-866-221-9679 Presbyterian Employees and Dependents Phone: 1-800-905-3282
Office Ally	Phone: 1-866-575-4120 Fax: 1-360-896-2151
Outpatient Services	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 843-3047
Payerpath	Phone: 1-877-623-5706
Pharmacy Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 3)
Pharmacy Services Helpdesk	Phone: (505) 923-5500 or 1-888-923-5757 Fax (toll-free): 1-877-640-5814
Provider Care Unit	Phone: (505) 923-5757 or 1-888-923-5757

Name	Phone and Fax Numbers
Provider Network Operations e-Business Analyst	Phone: (505) 923-8726
Presbyterian Customer Service Center (PCSC)	Phone: (505) 923-5200 or 1-888-977-2333
Presbyterian ePayment Center	Phone: 1-855-774-4392
Prior Authorization Line	Phone: (505) 923-5757 or 1-888-923-5757 (option 4)
Quality and Population Health Management Resource Line	Phone: (505) 923-5017 or 1-866-634-2617
Quality Management Department	Phone: (505) 923-5516
Radiology/Diagnostic Imaging Requests through Stanson Health	Phone: 1-888-487-0733 Fax: 1-646-502-5041
RelayHealth	Phone: 1-800-527-8133 (option 2)
SilverSneakers® Fitness Program	Phone: 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	Phone: (505) 923-5959 or 1-800-239-3147
Superior Medical Transport	Phone: (505) 341-0042 or 1-877-735-0111 (toll-free)
Superior Vision Services	Phone: 1-800-507-3800
University of New Mexico Case Managers	Phone: (505) 272-2910
University of New Mexico Prior Authorization Requests	Phone: (505) 923-5757 or 1-888-923-5757 (option 4) Fax: (505) 843-3108
Vaccines for Children (VFC) Program Director (PHS)	Phone: (505) 827-2898

Name	Phone and Fax Numbers
TriCore Telephone Numbers	Main Phone Numbers: (505) 938-8888 (24 hours) 1-800-245-3296 (24 hours) Client Services Phone: (505) 938-8922 or 1-800-245-3296 (24 Hours) Client Supplies: Phone: (505) 938-8957 or 1-800-245-3296, ext. 8957 Fax: (505) 938-8472 Supply Order Desk Phone: (505) 938-8957 or 1-800-245-3296, ext. 8957 Logistics/Couriers Phone: (505) 938-8958 or 1-800-532-2649 Santa Fe Logistics/Couriers Phone: (505) 954-3780 IS Help Desk (printer, TriCore Express TriCore Direct and computer-interface assistance) Phone: (505) 938-8974 or 1-800-245-3296, ext. 8974 Sales and Service Phone: (505) 938-8917 or 1-800-245-3296, ext. 8917 Billing/Business Office: Phone: (505) 938-8910 or 1-800-541-9557 Fax: (505) 938-8640
University of New Mexico (UNM) Case Management Program	Phone: (505) 272-2910
Vaccines for Children (VFC) Program Director (PHS)	Phone: (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 8.310.2.13 New Mexico Administrative Code (NMAC), 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		applicable city, county, or state regulations governing transportation services. This service is 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		health. The assisted living program is responsible for all of these services at the assisted living facility and are included in the cost of room and board.
Behavior management skills development services	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 Utilization 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Community health workers	No	
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 SDCB
Day treatment services	No	Member must be less than 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 NMAC 8.324.5.14 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.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 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 shall 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.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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; NMAC 1, 8.325.6 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 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 (RN) 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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
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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 NMAC 8.301.3, 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 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 RNs 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 SDCB
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	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
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 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 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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
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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 SDCB.
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 freestanding psychiatric hospital	Yes for partial hospitalization, No for outpatient	
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 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	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
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 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	
	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 RN or a

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Private duty nursing for adults **(ABCB service**)** **(SDCB service***)**		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 NMAC 8.301.3, 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 NMAC 8.301.3, General Non-Covered Services [MAD-602]. In addition to the services identified in NMAC 8.301.3 (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 serious emotional disturbance (SED).
Radiology facilities (for imaging)	No prior authorization for the facility is needed. The specific service to be provided may	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
	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 SDCB
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 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:

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		▪ 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		performed for the sole purpose of 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), Depo-Provera 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 NMAC 8.301.3, 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	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
	RHC have same requirements as other providers	
School-based services	No	Services furnished in school settings are subject to the limitations and coverage restrictions that exist for other Medicaid services. See NMAC 8.301.3 (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 SDCB
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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 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 SDCB
Treatment foster care	Yes	Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See NMAC 8.310.2.13, 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 NMAC 8.310.2.13, General Non-Covered Services. Presbyterian does not cover the following services: A. Room and board

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 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 NMAC 8.310.6.12 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 (SDCB and ABCB), 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 addiction	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 USPTF "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 Lab Lists

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
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 one or two	
80322	Alcohols Biomarkers three or more	
80323	Alkaloids Nos	
80324	Drug Screen Amphetamines 1/2	
80325	Amphetamines three or four	
80326	Amphetamines five or more	
80327	Anabolic Steroid one or two	
80328	Anabolic Steroid three or more	
80329	Analgesics Non-Opioid one or two	
80330	Analgesics Non-Opioid three to five	
80331	Analgesics Non-Opioid six or more	
80332	Antidepressants Class one or two	
80333	Antidepressants Class three to five	
80334	Antidepressants Class six or more	
80335	Antidepressant Tricyclic ½	
80336	Antidepressant Tricyclic three to five	
80337	Tricyclic & Cyclicals six or more	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
80338	Antidepressant Not Specified	
80339	Antiepileptics Nos one to three	
80340	Antiepileptics Nos four to six	
80341	Antiepileptics Nos seven or more	
80342	Antipsychotics Nos one to three	
80343	Antipsychotics Nos four to six	
80344	Antipsychotics Nos seven or more	
80345	Drug Screening Barbiturates	
80346	Benzodiazepines one to 12	
80347	Benzodiazepines 13 or more	
80348	Drug Screening Buprenorphine	
80349	Cannabinoids Natural	
80350	Cannabinoids Synthetic one to three	
80351	Cannabinoids Synthetic four to six	
80352	Cannabinoid Synthetic seven or 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 one or more	
80362	Opioids & Opiate Analogs ½	
80363	Opioids & Opiate Analogs ¾	
80364	Opioid &Opiate Analog five or more	
80365	Drug Screening Oxycodone	
80366	Drug Screening Pregabalin	
80367	Drug Screening Propoxyphene	
80368	Sedative Hypnotics	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
80369	Skeletal Muscle Relaxant ½	
80370	Skel Musc Relaxant three or more	
80371	Stimulants Synthetic	
80372	Drug Screening Tapentadol	
80373	Drug Screening Tramadol	
80374	Stereoisomer Analysis	
80375	Drug/Substance Nos one to three	
80376	Drug/Substance Nos four to six	
80377	Drug/Substance Nos seven or 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	
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	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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	
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	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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	
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	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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
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	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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	
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 blood feces one to three tests	
82274*	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, one to three simultaneous determinations	
82310*	Assay of calcium	
82330*	Assay of calcium	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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 the FDA specifically for home use	
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)	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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	
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	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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	
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)	

In-Office Lab List * Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments		
Code	**Description**	**Limitation**
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
83880	Natriuretic peptide

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
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
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

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
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
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

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
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)
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)

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
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
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

Presbyterian Behavioral Health Covered Lab Codes	
Code	**Description**
G0478	Drug test presump opt inst
G0479	Drug test presump not opt
G0480	Drug test def one to seven classes
G0481	Drug test def eight to 14 classes
G0482	Drug test def 15 to 21 classes
G0483	Drug test def 22 and more 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
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous

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Appendix H. Commercial Health Services

Please note that the information within this appendix is being restated to clarify expectations for commercial providers.

Prior Authorization Guide

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Acute Medical Detoxification	Yes, See “Hospital inpatient”	Authorization in an emergency situation must be obtained within 48 hours following the admission.
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.
Anesthesia services	Yes for select services	Anesthesia for pain management and dental procedures may 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		B. An anesthesia service is not payable if the medical or surgical procedure is not a benefit C. Separate payment is not allowed for qualifying circumstances; payment is considered bundled into the anesthesia allowance 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.
Ankle Subtalar Arthoereisis	Yes	www.phs.org/providers/Documents/Investigative-List-Non-Covered-Services-MPM-36-0.pdf
Bariatric Surgery	Yes	www.phs.org/providers/Documents/Bariatric-Surgery-Non-Medicare-MPM-2-81.pdf
Behavioral health professional services: outpatient behavioral health and substance abuse services	No	
Blepharoplasty/Brow Ptosis Surgery	Yes	www.phs.org/providers/Documents/Blepharoplasty-Ptosis-Surgery-MPM-2-7.pdf
Breast Reconstruction following Mastectomy	Yes	www.phs.org/providers/Documents/Breast-Surgical-Procedures-MPM-27-0.pdf
Breast reduction for gynecomastia	Yes	www.phs.org/providers/Documents/Breast-Surgical-Procedures-MPM-27-0.pdf
Cancer Clinical Trials (Investigational/Experimental)	No	www.phs.org/providers/Documents/Cancer-Clinical-Trials-MPM-3-7.pdf
Care coordination	No	
Case management	No	
Certified Hospice Care	See "Hospice services"	
Community health workers	No	
Computed Axial Tomography (CAT) scans in an outpatient setting	Yes	See Advanced Imaging Guidelines: www1.radmd.com/solutions/advanced-imaging-solution
Dialysis services	Yes, for non-contracted facilities within New Mexico	Dialysis at non-contracted facilities within New Mexico will require a prior authorization. Dialysis outside of New Mexico will not require prior authorization.
Durable medical equipment (DME)	Yes	Benefit managed by Presbyterian Care Review team using Evolent's Medical

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		Specialty Solutions program, which has published criteria. A. Special requirements for purchase of wheelchairs: Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to an 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. I. The provider assumes responsibility for correcting defects or deficiencies in wheelchair and seating systems that make them unsatisfactory for use by the eligible recipient II. 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. III. 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 New Mexico Administrative

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		Code (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 IV. Presbyterian does not pay for special modifications or replacement of customized wheelchairs after the wheelchairs are furnished to the eligible recipient. V. 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): I. 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. II. 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 (continued on next page) 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 III. Presbyterian does not pay for supplies for AACDs, such as but not limited to paper, printer ribbons and computer discs. IV. Prior authorization is required for equipment repairs V. A provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have in excess of a 15-calendar-day supply of the item before releasing the next supply order to the eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement
Electroconvulsive Therapy (ECT)	Yes	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Emergency services (including ER visits and psychiatric ER)	No	
Endoscopy Nasal/Sinus balloon dilation	Yes	www.phs.org/providers/Documents/Balloon-Dilation-ENT-Procedure-MPM-2-12.pdf
Epidural Injections for Back Pain	Yes	www.phs.org/providers/Documents/Epidural-Corticosteroid-Injections-Back-Pain-MPM-5-9.pdf
Family planning	No	
Federally qualified health center services	No	
Foot Orthotics	Yes, see “Prosthetics and Orthotics”	www.phs.org/providers/Documents/DME-Orthotics-Prosthetics-MPM-4-6.pdf
Gender Dysphoria/Gender Identity Treatment	Yes	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00201972
Genetic and Genomic Testing	Yes	www.phs.org/providers/Documents/Genetic-Genomic-Testing-MPM-7-1.pdf
Genetic Testing: Cologuard for Colorectal Cancer Screening		https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=WCMPROD1030593
Hearing aids and related evaluations	No	Hearing Aids and the evaluation for the fitting of Hearing Aids are not covered except for school-aged children under 18 years old (or under 21 years of age if still attending high school). • Every 36 months per hearing impaired ear for school-aged children under 18 years old (or under 21 years of age if still attending high school) Shall include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, as provided by a Practitioner/Provider licensed in New Mexico.
Home health care services/Home health intravenous drugs	Yes	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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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 intellectually disabled 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 (RNs) G. Services not included in written plans of care established by providers in consultation with the home health agency staff
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 180 days, the hospice must obtain a written recertification statement from the hospice medical director or the providers at the hospice interdisciplinary group before the 180-day period expires.
Hospital inpatient (including detoxification services)	Yes	Eligible inpatient hospital services are acute care services provided when you are a registered bed patient and there is a room and board charge. Admissions are considered inpatient based on medical necessity, regardless of the length of time spent in the hospital. Inpatient hospital benefits also includes acute medical detoxification.

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		Authorization in an emergency situation must be obtained within 48 hours following the admission.
Hospital outpatient	No	
Hyperbaric Oxygen	Yes	www.phs.org/providers/Documents/Hyperbaric-Oxygen-Therapy-MPM-8-6.pdf
Hysterectomy	Yes	www.phs.org/providers/Documents/Hysterectomy-MPM-8-9.pdf
Indian Health services	No	
Injectable Drugs (includes Specialty Medications and Medical Drugs)	Yes	
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.
Lab services	No	Genetic Testing does require preauthorization.
Lumbar/Cervical Spine Surgery	Yes	See Musculoskeletal Surgery Guidelines: www1.radmd.com/solutions/musculoskeletal-surgery-solution
Magnetic Resonance Imaging (MRI) in an outpatient setting	Yes	See Advanced Imaging Guidelines: www1.radmd.com/solutions/advanced-imaging.aspx
Medical services providers	No	
Medication assisted medical treatment (Tx) for opioid dependence	Yes for Specialty Drugs	Please refer to the Commercial formulary for Specialty Drugs: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00236101 and/or the Specialty Pharmaceuticals and Medical Drugs list: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739.
Mental Health Services – Inpatient, Partial Hospitalization and select outpatient services	Yes, See "Hospital inpatient", "Outpatient hospital based psychiatric services and partial hospitalization", and "Behavioral Health professional services: outpatient behavioral health and substance abuse services"	
Midwife services	No	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Mobile Cardiac Outpatient Telemetry and Real Time Continuous Attended Cardiac Monitoring Systems	Yes	www.phs.org/providers/Documents/MCOT-MPM-13-2.pdf
Musculoskeletal Surgery (Spine) Ordering Program	Yes, see Evolent Advanced Imaging Guidelines (link in the column to the right)	Benefit managed by Presbyterian Care Review team using Evolent's Medical Specialty Solutions program, which has published criteria listing exclusions and limitations. See Advanced Imaging Guidelines: www1.radmd.com/solutions/advanced-imaging-solution
Newborn Delivery and Hospital Obstetrical services	Yes	Authorization in an emergency situation must be obtained within 48 hours following the admission.
Non-emergency care when traveling outside the U.S.	Yes	
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
Nutritional Supplements	Yes	
Observation services greater than 24 hours	Yes	Authorization does not exceed 48 total hours.
Occupational services (therapy)	No	
Orthotics	Yes, See "Prosthetics and orthotics"	www.phs.org/providers/Documents/DME-Orthotics-Prosthetics-MPM-4-6.pdf
Outpatient hospital based psychiatric services and partial hospitalization	Yes for partial hospitalization, No for outpatient	
Outpatient and partial hospitalization in freestanding psychiatric hospital	Yes for partial hospitalization, No for outpatient	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Outpatient healthcare professional services	No	
Panniculectomy	Yes	www.phs.org/providers/Documents/Panniculectomy-and-Abdominoplasty-MPM-16-5.pdf
PET (Positron Emission Tomography) scans in an outpatient setting	Yes	See Advanced Imaging Guidelines: www1.radmd.com/solutions/advanced-imaging-solution
Pharmacy services	Yes for Specialty Drugs	For Pharmacy Resources: www.phs.org/tools-resources/member/Pages/pharmacy.aspx For the Commercial formulary: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00236101 For the Specialty Pharmaceuticals and Medical Drugs list: https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=pel_00052739
Physical health services	No	
Physical therapy	No	
Podiatry services	No	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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		correction of a flat foot condition. “Flat foot” is defined as a condition in which one or more arches of the foot have flattened out C. Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics D. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot E. Orthotropy is not a covered service
Pregnancy termination procedures	No	
Preventative services	No	
Prosthetics and orthotics	Yes	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. www.phs.org/providers/Documents/DME-Orthotics-Prosthetics-MPM-4-6.pdf
Proton Beam Irradiation	Yes	www.phs.org/providers/Documents/Radiation-Oncology-Proton-Beam-MPM-16-14.pdf
Reconstructive and potentially cosmetic procedures	Yes	www.phs.org/providers/Documents/Restorative-Reconstructive-Cosmetic-MPM-18-5.pdf
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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		furnish services B. Educational programs or vocational training not part of an active treatment plan for residents in an intermediate care facility for the intellectually disabled 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 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
Reproductive health services	No	A. Sterilization services: Presbyterian covers medically necessary sterilizations only under the following conditions I. Recipients are at least 21 years old at the time consent is obtained II. 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 III. 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 IV. 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 V. Recipients seeking sterilization must also be instructed that their consent can be withdrawn at any time before the

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		performance of the procedure VI. 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

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
		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: Presbyterian does not cover hysterectomies performed for the sole purpose of sterilization. See 42 CFR Section 441.253 I. Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by recipients (continued on next page) before the operation II. 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 III. An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency
Residential Facility – Specialty Unit Less Than 21 (e.g., deaf unit)	Yes	
Residential Treatment Centers	Yes	
Respite	Yes	
Rhinoplasty	Yes	www.phs.org/providers/Documents/Restorative-Reconstructive-Cosmetic-MPM-18-5.pdf
Rural health clinic (RHC) services	Services provided by RHC have same requirements as other providers	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Skilled Nursing Facility care or swing bed hospital services	Yes	
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.
Special Inpatient services (private room and board, special duty nursing, etc.)	Yes	
Special Medical Foods	Yes	
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 F. Cervical Posterior Decompression (without fusion) G. Cervical Artificial Disc Replacement. H. Cervical Anterior Decompression (without fusion) See Musculoskeletal Surgery Guidelines: www1.radmd.com/solutions/musculoskeletal-surgery-solution
Substance use disorder services, Inpatient	Yes, See “Hospital inpatient”	
Telehealth services (provider telehealth, not home-based telehealth)	No	
Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)	Yes	

Covered Services	Is Prior Authorization Required?	Exclusions and Limitations*
Tonsillectomy	Yes	www.phs.org/providers/Documents/Tonsillectomy-MPM-20-0.pdf
Tot-to-teen health checks	No	
Total Ankle Replacement	Yes	www.phs.org/providers/Documents/Total-Ankle-Replacement-MPM-20-10.pdf
Total Hip Replacement	Yes	www.phs.org/providers/Documents/Total-Joint-Replacement-MPM-20-14.pdf
Total Knee Replacement	Yes	www.phs.org/providers/Documents/Total-Joint-Replacement-MPM-20-14.pdf
Transcranial Magnetic Stimulation Treatment – Planning, Delivery and Management	Yes	www.phs.org/providers/Documents/Transcranial-Magnetic-Stimulation-MPM-20-11.pdf
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.	
Virtual Colonoscopy	Yes	See Advanced Imaging Guidelines: www1.radmd.com/solutions/advanced-imaging-solution
Wireless Capsule Endoscopy	Yes	https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=WCMPROD1029755

* Presbyterian edits the prior authorization list as updates are needed. To view the more recent version of this list, please visit the following web address: www.phs.org/providers/authorizations.

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Appendix I. ABP-Exempt Medically Frail Conditions List

In order for a category of eligibility (COE) 100 (Other Adult Group) Medicaid recipient to be exempt from the Alternative Benefit Plan (ABP), they must have a documented medical diagnosis of one of the conditions or services listed below.

Condition
Acquired Immune Deficiency Syndrome (AIDS)
ALS (Lou Gehrig's Disease)
Angina Pectoris
Arteriosclerosis Obliterans
Artificial Heart Valve
Ascites
Assistance with one or more activities of daily living (ADLs)
Cancer (current diagnosis/treatment, within five years)
Cardiomyopathy
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+

Condition
Hodgkin’s Disease
Huntington’s Chorea
Hydrocephalus
Intermittent Claudication
Juvenile Diabetes
Kidney Failure
Lead Poisoning with Cerebral Involvement
Leukemia
Lupus Erythematosus Disseminate
Malignant Tumor (if treated or occurred within the previous five years)
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 (if treated within previous three years)
Polyarteritis (Periarteritis Nodosa)
Polycystic Kidney
Posterolateral Sclerosis
Renal Failure
Serious Mental Illness
Sickle Cell Anemia
Silicosis

Condition
Splenic Anemia (True Banti's Syndrome)
Still's Disease
Stroke (CVA)
Syringomyelia
Tabes Dorsalis (Locomotor Ataxia)
Thalassemia (Cooley's or Mediterranean Anemia)
Topectomy and Lobotomy
Wilson's Disease

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