

Network Connection

Information for Presbyterian
Healthcare Professionals,
Providers, and Staff

NOVEMBER 2016



NEWS FOR YOU

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

Enhanced Quality Incentive Program for Primary Care Providers

Presbyterian's enhanced Provider Quality Incentive Program (PQIP) rewards primary care providers who provide the highest quality of care to our members. The program encourages providers to ensure that patients receive the recommended screenings and services, based on the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is a widely used set of performance measures in managed care, developed and maintained by the National Committee for Quality Assurance (NCQA). The enhancement of PQIP includes a larger quarterly bonus and adds additional measures.

When patients and members do not receive necessary screenings measured by HEDIS standards, they are considered to have a gap in care. Once a provider is enrolled in PQIP, Presbyterian will provide a list of patients identified as having a gap in care and who meet one of the following criteria:

- Missing recommended or preventive screenings.
- Need recommended interventions.
- Require medications for chronic conditions.

How the program works

A list of members with these conditions and care gaps seen by or paneled to a provider will be posted on the reports page of the myPRES Provider Portal. Presbyterian is offering providers a pay-for-performance incentive based on the percentage of care gaps closed for those members listed.

The program does not require a contract and there is no risk to the provider. Presbyterian simply wants to reward providers for the care they provide. Detailed information about the PQIP is available from Presbyterian's Quality department, which you can reach at (505) 923-5017 or performanceimp@phs.org.

HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA). <http://www.ncqa.org>.



Expanding Coordinated Care in Central New Mexico

Quality healthcare depends on continuous growth and development of patient care. Beginning January 2017, Presbyterian will maximize coordination and integration of care across the continuum of services and settings for central New Mexico's most vulnerable populations by offering Presbyterian Dual Plus (HMO SNP), a Medicare Advantage plan for dual-eligible special needs members. This plan will be available to individuals who reside in Bernalillo, Sandoval, Torrance, and Valencia counties.

The team-oriented care coordination model for Presbyterian Dual Plus is designed to meet the medical, behavioral, and long-term care needs of eligible individuals. Presbyterian Dual Plus-eligible individuals have distinct healthcare needs and may be considered medically fragile, elderly, and/or disabled. They may also reside

in an assisted living facility or receive services at home. These individuals must meet the eligibility criteria for both Medicare and Medicaid (Centennial Care). Through improved coordination of care and increased benefits that focus on integrated care, Presbyterian Dual Plus members will receive health assessments that help determine the level of care needed.

How does this impact you as a provider in the Presbyterian network?

The main difference with Presbyterian Dual Plus is that all provider types will play a support role in a member's integrated care team (ICT). This means that providers will work together with a team of other providers to deliver whole-person health. A typical ICT consists of a primary care provider and one or more specialists who work with a care coordinator, who combines each provider's care strategy into one comprehensive plan. The goal of care coordination is to ensure appropriate services for members along the continuum of care, which starts with facility or program admission and continues through different settings of

care, including discharge to a lower level of care or home.

Does this change the way I submit dual-eligible claims?

Even though this is a new benefit plan, there will be no changes in the way Presbyterian processes dual-eligible claims. For example, if a member is enrolled in Presbyterian Dual Plus and Presbyterian Centennial Care, the claim will be processed under the Presbyterian Dual Plus plan, which will reduce the amount of time it takes to receive payment for services.

How do I learn more about Presbyterian Dual Plus?

All providers who are rendering services to Presbyterian Dual Plus members are obligated to participate in annual training for the new plan. For information about online and in-person training, please go online to <http://phs.swoogo.com/DSNP16>.

For more information, you can contact your Presbyterian Provider Network Management relationship executive at www.phs.org/ContactGuide.

Clear Claim Connection

In November 2016, Presbyterian introduced Clear Claim Connection, a web-based solution that enables us to share information about our claims processes such as auditing rules, payment policies, and clinical rationale.

Through the myPRES provider portal, providers are able to enter a claim and view the results before they submit it. To ensure claims are submitted correctly, providers can also request an edit clarification.

As a reminder, checking your claim through Clear Claim Connection does not substitute for submitting claims. Providers must still submit through the appropriate method for their practice.

For more information on submitting claims, please review the "Claims and Payments" chapter in the provider manual.

Presbyterian Customer Service Center Will No Longer Provide Confirmation/Reference Numbers for Claims Status Inquiries

Access to accurate and timely claims information is something very important to us and our providers. To ensure we are providing you with the best customer service experience, we encourage you to use the myPRES provider portal for claim status research. The portal is the most efficient option for obtaining claims information.

After careful review, Presbyterian determined that the confirmation/reference number is not used as a means of retrieving information and is not acceptable proof of timely filing. Therefore, as of Nov. 1, 2016, the Presbyterian Customer Service

Center (PCSC) is no longer providing a confirmation/reference number for claims status inquiries.

To ensure proof of timely filing, it's important for providers to maintain a record of their claim submissions and any contact they have with Presbyterian. Acceptable documentation includes computer ledgers, written logs, and records of calls to Presbyterian (include date and contact name). The exception report from Presbyterian or a contracted clearinghouse is required for electronic claims submissions. Submitted documentation must be legible and clearly identify members, charges in

question, date of service, and 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.

For more information, refer to the "Timely Submission Guidelines" in the provider manual, or contact your Provider Network Management relationship executive.

Medicare Part D Prescriber Enrollment Requirement Delayed by CMS

The Centers for Medicare & Medicaid Services (CMS) issued new requirements for organizations offering Part D prescription drug coverage plans to confirm providers are eligible to write Part D prescriptions. Previously, CMS announced that enforcement of the prescriber enrollment requirement would begin on Feb. 1, 2017; however, full enforcement of this requirement will now begin on Jan. 1, 2019.

In accordance with Medicare regulatory requirement 42 CFR § 423.120 (c) (6), providers who write prescriptions for Part D drugs are required to enroll as active in the Provider Enrollment, Chain and Ownership System (PECOS), or have a valid opt-out affidavit on file with the Medicare Administrative Contractor (MAC).

Presbyterian will begin notifying providers individually who are identified as not enrolled. A delay in enrolling will prevent Medicare members from obtaining prescription drugs prescribed to them. Presbyterian will notify members when a provider is not able to prescribe Part D drugs. A one-time provisional fill of a three-month supply will be provided to members impacted by this requirement.

Providers can verify an approved enrollment or a valid opt-out status using the following link:

<https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx>.

To enroll with Medicare, please complete the CMS-855O application.

- Online application: <https://pecos.cms.hhs.gov/pecos/login.do>
- Paper application: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html>

Prescribers identified as "other authorized prescribers" are exempt from this enrollment requirement. These prescribers are individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions.

For questions about this new requirement, please contact your relationship executive at www.phs.org/ContactGuide.



PresRN Is a Resource for Health Plan Members

One of Presbyterian's highest priorities is ensuring adequate access to healthcare providers. To help ensure patients and members have access to a healthcare professional for questions or as needed, Presbyterian offers a free nurse advice line, PresRN.

PresRN is an easy way for members to speak with a Presbyterian registered nurse (RN) if they are not feeling well and do not know what to do. The experienced RNs listen to health concerns and provide answers members need to care for themselves and their family. Features of the service include:

- 24/7 year-round triage advice.
- Initiatives for better health outcomes.
- Outbound calling initiatives for population health teams.
- Capturing health assessment data.

- Identifying members who can benefit from disease management and/or care coordination.

As this service is available through Presbyterian, RNs are able to share

information with the member's care team – including their doctor, care coordinator and/or health coach – so they will have appropriate continuity of care and follow-up, if necessary.

PresRN
Telephone Numbers

Centennial Care
 (505) 923-5677 or
 1-888-730-2300

Commercial
 (505) 923-5570 or
 1-866-221-9679

**Presbyterian Senior Care (HMO)
 and MediCare Preferred
 Provider Organization (PPO):**
 (505) 923-5573 or
 1-800-887-9917



Screening Teens for Depression

Mood swings are often considered synonymous with adolescence, and severe depression is an illness that is not uncommon in this age group. Affecting up to one in five teenagers – girls twice as often as boys – this illness can result in severe disability including the following:

- Decreasing interest in friends, activities, and school.
- Demonstrating withdrawn, aggressive, or reckless behavior.
- Engaging in drug or alcohol abuse.
- Exhibiting signs of suicidal behavior.

In February 2016, the U.S. Preventative Services Task Force published recommendations for adolescents ages 12 to 18 for routine screenings for a major depressive disorder, and that adequate systems should be in place to ensure accurate diagnoses, effective treatment, and appropriate follow-up measures.

The screening tools most often used to determine the severity of depression are the Patient Health Questionnaire for Adolescents (PHQ-A) and the primary care provider (PCP) version of the Beck Depression Inventory. Due to the infrequency of adolescent healthcare visits, it is recommended that opportunistic screening is performed during a PCP visit.

Clinical interviewing should follow a positive screen, and, if applicable, a

treatment plan should be implemented. Treatment options for adolescents include the following:

- Pharmacotherapy.
- Psychotherapy.
- Collaborative care.
- Psychosocial support interventions.
- Complementary and alternative approaches.

Providers can contact Presbyterian Care Coordination to begin this process. Once in treatment, the use of depression severity scales, including the aforementioned screening tools, can provide an objective way for the PCP to monitor treatment progress. It is important for PCPs to communicate with the adolescent's care coordinator throughout treatment to ensure that the patient is receiving appropriate care.

BEHAVIORAL HEALTH CARE COORDINATION

Commercial and Medicare:
 (505) 923-5221 or 1-866-593-7431

Centennial Care:
 (505) 923-8858 or 1-866-672-1242

Imaging for Lower Back Pain

Lower back pain is the most common cause of job-related injuries and lost productivity due to absence. According to the American Academy of Family Physicians (AAFP), lower back pain is the fifth most common reason for all provider visits. The AAFP's recommendation, supporting information, and helpful patient communication concepts are found at www.aafp.org.

Patients should be treated conservatively for the first six weeks from onset of lower back pain. Patients should not receive an imaging study during that time because, according to the AAFP, imaging of the lower spine within six weeks of onset does not improve outcomes. The only time imaging should be immediately performed is for diagnostic purposes for which imaging is clinically appropriate, including an underlying condition like cancer, recent trauma, IV drug abuse, and neurologic impairment.

Patients can take steps to limit risks for lower back pain and injury. Regular

exercise that targets and strengthens the lower back, buttocks, and legs will help to prevent future injury. It's a good idea for providers to talk more with their patients about exercises that will best help them.

The North American Spine Society has a few tips to minimize back pain:

- Push – don't pull – heavy objects.
- To pick up an object, bend at the knees – not the waist. Pick up the object close to the body and lift with the legs – not the back.
- Avoid twisting the body to pick up the object. If it's too heavy, seek help.
- Stand on a sturdy stool to reach things above shoulder level.
- Place pillows under the knees if you sleep on your back, or lie on your side with a pillow between the knees. A firm mattress is often best for the back.
- Control weight.
- Don't smoke. Smoking restricts blood flow to the disks that cushion the vertebrae.
- Exercise regularly to keep muscles strong and flexible.



OIG Work Plan: Risk Areas

Each year, the Office of the Inspector General (OIG), along with the Centers for Medicare and Medicaid Services (CMS), monitor trends and develop a list of services that are most often billed, coded, or documented in the medical record incorrectly.

The OIG identifies these services in their Work Plan, which also describes OIG audits, evaluations, and certain legal and ongoing investigative initiatives. It's important for providers to familiarize themselves with the services identified in the Work Plan to ensure they are coding, documenting, and billing services correctly.

The OIG's Work Plan also lists all parts of Medicare (A, B, C, and D) and Medicaid services they are monitoring. Even though the items listed on the table of contents may not appear to affect certain practices or specialty types, it is still a good compliance practice to review them as there may be an item or two for which providers may be responsible.

To learn more about the OIG's focus areas, visit the following link and view the OIG's 2016 Work Plan: <https://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf>

Follow-Up Care for Children on ADHD Medication

Close monitoring and follow-up measures are important parts of the treatment plan for all children who are newly prescribed medication to treat attention-deficit/hyperactivity disorder (ADHD). Children need at least three follow-up visits within a 10-month period when taking ADHD medication. Recommended visits include one within 30 days of beginning ADHD medication, and at least two follow-up visits with a practitioner within nine months after starting ADHD medications. These appointments are helpful to address any side effects and medication dosage adjustments.

Working with the family to establish a plan of care can help the child attain improved functioning in all areas of life, including at home, at school, and in the community. In addition, parent training and family therapy can help everyone adapt to living with a person who has ADHD.

It can be a challenge for the family when a child has ADHD. Everyone can feel overwhelmed at times. Providing the

following tips to patients can help their families better manage ADHD:

- Help children stay on a regular daily schedule for meals, naps, and bedtime.
- Try to make sure children get plenty of rest.
- Look ahead and plan for difficult situations.
- Give clear, basic instructions when it's time to move from one thing to the next.
- Help children to become more organized with schoolwork at home.
- Maintain a neat workspace that is free of distractions.
- Work as closely as possible with children's teachers; know what classroom strategies they are using to help the children.
- Praise children for every success, no matter how small, and remember to do so for other siblings, too.
- Take breaks to cut down on stress and do not hesitate to ask for help.
- Set aside time for your relationship with your parental partner.



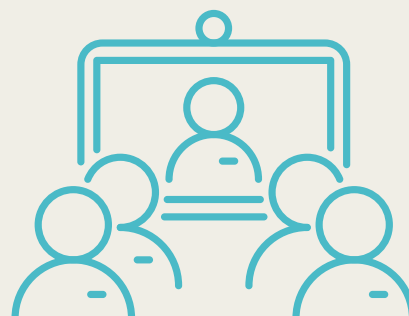
Provider Education Conference Webinars

As a reminder, our 2016 Annual Provider Education Convention and Conference Series is wrapping up in December. We will offer two last-chance webinars that will cover any recent changes in the health plan, current policies and procedures, and many other requirements from the Center for Medicare & Medicaid Services and the National Committee for Quality Assurance.

Webinar dates and times:

- Tuesday, Dec. 6, 2016 – 9 a.m. to 11 a.m.
- Thursday, Dec. 8, 2016 – 1 p.m. to 3 p.m.

To view more details and to register, please visit phs.swoogo.com/PHP16.



Simple Tips for a Healthy Holiday

It's easy to overindulge during the holidays, especially with the abundance of cookies, cakes, pies, and other holiday treats. In fact, according to the Calorie Control Council, the average American may consume more than 4,500 calories during a typical holiday gathering. That's about 2,000 calories more than many people need in a day. In order to burn off those calories, a 160-pound person would have to run at a moderate pace for four hours or walk 30 miles. To help your patients stay on track this season, provide the five tips listed below.

1. **Eat what you love.**

Instead of putting a little bit of everything on your plate, only pick the foods that you truly enjoy. Ask yourself, "Do I really want to eat this?" If the answer is no, then don't put it on your plate.

2. **Enjoy yourself.**

Allow yourself to indulge in the holiday foods you love without feeling guilty. Feeling guilty about eating food that you don't eat on a daily basis or depriving yourself of the foods you really enjoy can take a toll on your self-esteem and lead to unhealthy behaviors, such as overeating.

3. **You can say no.**

You don't have to eat something just because it's the holidays or because it's available. You can say no, and if it's not something you really enjoy, then you should say no.

4. **Wait 30 minutes.**

After dinner, it is best to wait about 30 minutes before you go back for a second helping, because

this is how long it takes for your brain to register that your body is full. Then your second helping will most likely be smaller because you can more accurately gauge how full you feel.

5. **Take a walk.**

After an extravagant holiday meal, it's a great idea to take a walk. You can even get the whole family involved and make it a new tradition. Walking not only aids digestion, but it also can help decrease the fat your body stores.



Sticking to your wellness goals during the holidays doesn't mean you have to deprive yourself of your favorite treats. Instead, remember these simple tips and indulge in moderation.

Help us measure our readership by filling out a quick survey about our newsletters. All respondents will be entered to win a gift card! Drawing will be held in December 2016.
<https://www.surveymonkey.com/r/PHPnewsletter>

REMINDER

CMS Requirement for Formulary-Level Cumulative Opioid Point-of-Sale Edits

Safety regarding medication management and reducing overutilization is a priority for Presbyterian. Beginning Jan. 1, 2017, Medicare Part D sponsors, including Presbyterian, will implement cumulative opioid edits at the point of sale.

Edits prospectively prevent opioid overutilization. The parameters proposed for these edits by the Centers for Medicare & Medicaid Services (CMS) in the 2017 Call Letter include the following:

- A soft edit rejection that can be overridden by the pharmacist when a prescription claim results in the beneficiary's active or overlapping opioid prescriptions to reach or exceed a certain daily morphine equivalent dose (MED) threshold (90 mg to 120 mg MED).
- Hard edits for daily cumulative MED threshold at or above 200 mg MED.

Additional information regarding this CMS requirement can be found on Page 207 of the 2017 Announcement online at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>.

SilverSneakers® Fitness Program

Many patients will begin to focus on their health and fitness goals as the New Year approaches. When recommending exercise to patients and members, remind Medicare members about the SilverSneakers fitness program. SilverSneakers is a benefit available at no charge to Presbyterian Medicare Advantage members, which helps older adults get the activity they need for overall health and well-being.

With the SilverSneakers fitness program, Medicare members have access to a basic fitness center membership. This membership includes access to fitness-related equipment and programs, such as signature SilverSneakers classes



designed specifically for older adults and taught by certified instructors. Additional SilverSneakers options may be available at select fitness centers as a member's fitness levels improve. SilverSneakers members have access to more than 10,000 participating fitness centers.



The benefit also includes SilverSneakers Steps (Steps), a personalized fitness program that fits the lifestyle of members who do not have access to a SilverSneakers location within 15 miles of their 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 with Steps, members will receive their kit at their home address.

Members are more likely to use their SilverSneakers benefit when reminded to use it. Members can visit www.silversneakers.com or call 1-888-423-4632 to find a fitness location near them.