PRESBYTERIAN

Network Connection

Information for Presbyterian Healthcare Professionals, Providers, and Staff

MARCH 2017

NEWS FOR YOU

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

Measuring an Exceptional Provider Experience

Since 2001, Presbyterian has conducted an annual practitioner and provider satisfaction survey to gain insight into how we can better partner with our statewide network of providers. In 2016, with guidance from the New Mexico Human Services Department (HSD), the survey questions were streamlined for more consistency, improved data measurement, increased accuracy, and closer alignment with other Centennial Care managed care organizations.

HSD revised the questions to get a better sense of overall satisfaction of providers participating in the Centennial Care program. These questions include but are not limited to topics such as overall satisfaction, provider network, provider relations, and claims.

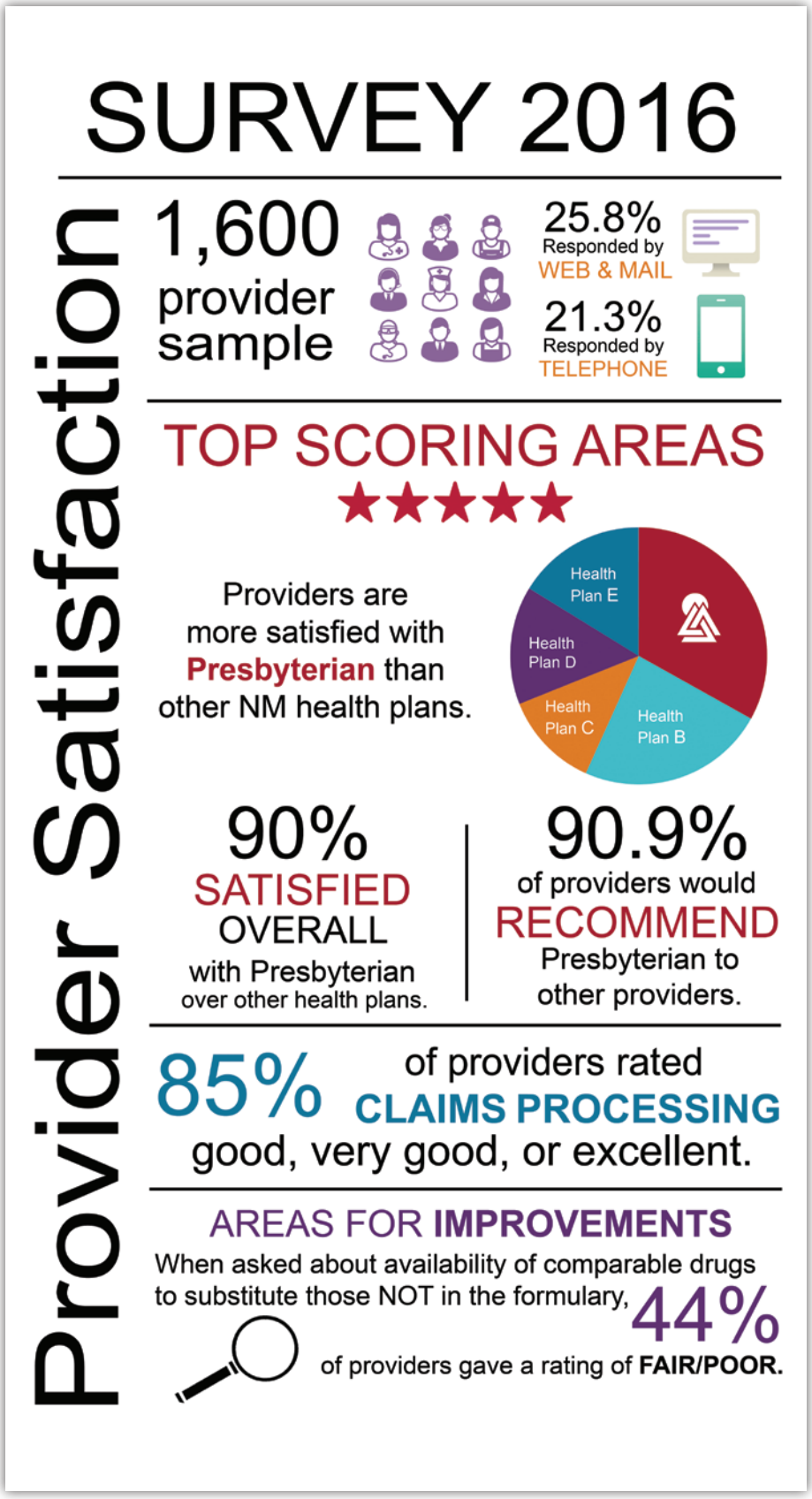
The changes in the survey questions as well as the rating system mean we are not able to compare 2016 results to trended data from past surveys. We will need a few more years to gain sufficient data to trend and benchmark our results.

We are pleased that of those providers responding, when asked to rate their overall satisfaction with Presbyterian, 90.9 percent responded that they are satisfied, and 91 percent responded that they would recommend Presbyterian to other providers with whom they work.

Some of our other highest scoring questions were for the accuracy and timeliness of claims processing. In 2016, Presbyterian processed more than 6 million claims. Claims submitted by electronic claims transmission (ECT) averaged 5.6 days to process versus claims that were submitted on paper, which averaged 15 days to process.

The responses from the annual survey are very important to us. We measure the results against our goal to create an exceptional provider experience, and we use the results to focus on improvements that will ensure more time for patient care by reducing administrative obstacles. Through your feedback, we are able to recognize opportunities for improvements. We share the results with other departments at Presbyterian to work together to improve the overall provider experience.

An image on Page 2 illustrates the results of the 2016 survey.



Provider Education Conferences and Webinar Series

Presbyterian Health Plan's 2017 annual Provider Education Conferences and Webinar Series will be held in Albuquerque and Las Cruces, and will include four live webinars for those who are unable to attend in person or for those who prefer to participate via webinar.

The first two webinars are:

- Tuesday, March 28, 2017, from 9 a.m. to 11 a.m.
- Thursday, March 30, 2017, from 1 p.m. to 3 p.m.

Register: http://phs.swoogo.com/PHP17

This conference is for all contracted healthcare professionals, providers, and staff including physical health, behavioral health, and long-term care providers.

If you have any questions about the upcoming conferences, please email Erica Krause Munoz at ekrause@phs.org, or contact your Provider Network Management relationship executive.

2017 Fee Schedule Effective Dates and Distribution

The table below lists the effective dates for updated 2017 fee schedules. The updated fee schedules are available upon request by contacting your Provider Network Management relationship executive.

FEE SCHEDULE	EFFECTIVE DATE
PHP-RBRVS Fee Schedule	January 1, 2017
NM-RBRVS Fee Schedule	January 1, 2017
All Ambulatory Surgical Center Fee Schedules	February 1, 2017
Medicare Durable Medical Equipment Fee Schedule	January 1, 2017
Medicare Anesthesia Conversion Factor	January 1, 2017
Medicare Average Sales Price Drug Fee Schedule	January 1, 2017
Average Wholesale Price Fee Schedule	February 1, 2017
Medicare Clinical Lab Fee	January 1, 2017

The 2017 New Mexico Resource-Based Relative Value Scale (RBRVS) Fee Schedule was released by the Centers for Medicaid & Medicare Services (CMS). The fee schedule has a conversion factor of $35.8887, which is a 0.24 percent increase over the 2016 conversion factor of $35.8043.

For more information on the RBRVS fee schedule and the application of guidelines, please use the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Medicaid Registration Required to Receive Claims Payment for both Group and Individual Centennial Care Providers

Presbyterian understands how important it is to ensure timely and accurate claims payments. We want to remind all of our providers that the New Mexico Human Services Department (HSD) requires both New Mexico group and individual providers to register and enroll through the New Mexico Medicaid portal to become a Medicaid provider. Enrollment and approval ensure reimbursement for providers rendering services to Centennial Care members.

Presbyterian now denies claims when the group and/or individual providers are not registered and approved with Medicaid.

It is both the individual provider's and the provider group's responsibility to submit application materials within a sufficient time frame to allow completion of the enrollment process and submission of the claim within the Medical Assistance Division (MAD) timely filing limits. Providers are also responsible for verifying their status with HSD. Presbyterian will use the MAD approval date on the Medicaid file to determine timely filing. For more information, view Supplement 15-01 at http://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx.

If you have not enrolled with New Mexico Medicaid, please complete your Provider Participation Agreement (PPA) MAD 312 or 335 online at https://nmmedicaid.acs-inc.com/webportal/enrollOnline. To print out or submit a Medicaid application electronically, go online to https://nmmedicaid.acs-inc.com/webportal/enrollOnline. Once MAD approves the application, providers have 90 days to submit claims for dates of service that do not exceed 210 days.

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

New Fax Numbers for Presbyterian Care Coordination

The fax numbers associated with Presbyterian Care Coordination changed Jan. 1, 2017.

The table below is a useful reference to post near your fax machine to ensure the new fax numbers are used. If you have questions about the new numbers, please contact your Provider Network Management relationship executive at www.phs.org/ContactGuide or by calling (505) 923-5141.

DEPARTMENT	REQUEST TYPE	OLD FAX NUMBER	NEW FAX NUMBER
Care Coordination	Home Modifications	(505) 214-5348	(505) 843-3080
Care Coordination	Presbyterian Referral	(505) 213-0063	(505) 843-3150
Care Coordination	Presbyterian Transplant	(505) 213-0296	(505) 843-3110
Presbyterian Medical Directors	Medical Directors	(505) 213-0247	(505) 843-3054
Quality Department	Population Health Management	(505) 213-8450	(505) 843-3017
Quality Department	Population Health Management	(505) 213-0185	(505) 843-3018
Quality Department	Critical Incident	(505) 213-0686	(505) 843-3011
Risk Management	Medical Risk Management	(505) 213-0383	(505) 843-3097
Utilization Management (UM)	Main Benefit Certification	(505) 213-0246	(505) 843-3047
Utilization Management	Behavioral Health	(505) 213-0169	(505) 843-3019
Utilization Management	UM Authorization – Long-term Care	(505) 213-0240	(505) 843-3195
Utilization Management	PICS Out-of-state, Out-of-plan Review	(800) 886-0713	(855) 594-7737
Utilization Management	UM Inpatient Physical Health Transfers	(505) 213-0121	(505) 843-3155
Utilization Management	UM Medical Records Request – Providers	(505) 213-0229	(505) 843-3154
Utilization Management	Medical Records	(505) 213-0251	(505) 843-3151
Utilization Management	Inpatient Regional Review	(505) 214-5945	(505) 843-3149
Utilization Management	Retro Review	(505) 213-0267	(505) 843-3147
Utilization Management	Prior Authorization – UNM	(505) 213-0149	(505) 843-3108
Utilization Management	Inpatient Utilization Review (UR)	(505) 213-0181	(505) 843-3107
Utilization Management	UM Surgical Benefit Certification	(505) 213-0108	(505) 843-3086

Centennial Care Baby Benefits Program

Prenatal and postpartum care helps improve the overall quality of life for both mother and baby. Presbyterian engages with pregnant members through the Centennial Care prenatal incentive program, Baby Benefits. The program promotes early and regular prenatal care, identifies member needs and obstacles members may face with getting the care they need, and provides a three-tiered incentive approach for completing recommended visits and screenings.

When an expectant mother receives recommended prenatal care, she is eligible for up to three different gift cards through tiered rewards for completing visits. The gift cards are provided to help expectant mothers with expenses related to pregnancy, postpartum care, and baby-related supplies. Members must complete the visits as outlined below to receive each gift card.

- The first prenatal visit during the first trimester – $25.
- At least 10 regular prenatal visits or at least 80 percent of recommended visits – $75.
- A postpartum visit within three to six weeks after delivery – $50.

Providers are encouraged to recommend this program to Centennial Care members. Members can enroll in one of the following ways:

- Online: www.phs.org/CentennialCare/BabyBenefits
- Email: PerformanceImp@phs.org
- Phone: (505) 923-5017 or toll-free 1-866-634-2617

Medical Record Review Reimbursements

Presbyterian is committed to reducing administrative burden, and we know that medical record requests can be time consuming and sometimes expensive. We only request the minimum amount of medical records needed for review. The information below clarifies when we will ask for medical records and which records are reimbursable.

Reimbursed Medical Records:
Per your services agreement with Presbyterian, providers are reimbursed up to reasonable and customary fees for copying medical records related to utilization management. Record review may also include special utilization or quality studies, or as required by regulatory agencies such as the New Mexico Human Services Department (HSD) or the Centers for Medicaid & Medicare Services (CMS). In these instances, providers are reimbursed $30 for the first 15 pages of medical records and $0.15 per page thereafter (based on the New Mexico Administrative Code [NMAC], Title 16, Chapter 10.17.8).

Non-reimbursed Medical Records:
Providers will not be reimbursed for copying medical records required for claims payment. When providers contract with a third-party entity to maintain medical records, Presbyterian will not reimburse any fees charged by a third-party entity above the statutory amounts.

For more information about the reimbursement of medical records, please see Page 6-12 of the 2017 Presbyterian Practitioner and Provider Manual at www.phs.org/ProviderManual.

Behavioral Health Provider Portal

Did you know that behavioral health providers have an additional provider portal at www.magellanprovider.com? This portal can save valuable time when verifying eligibility and submitting authorizations. It can also be used to ensure directory information is up to date.

New guidelines from the Centers for Medicaid & Medicare Services (CMS) require that provider information is validated quarterly to ensure directory accuracy. If the portal is not used to validate information, providers may receive quarterly verification calls from Presbyterian Behavioral Health staff. By logging on and attesting to practice information on the portal, providers will not need to respond to verification calls. Providers can also customize their practice information for clinical referrals.

The behavioral health provider portal allows providers to grant secure access to staff by logging into the portal and clicking "Administrator Setup." This includes creating passwords for other users. Your network management specialist can assist you with tips to unlock and access the features in the portal that can save you time, effort, and money in managing your practice. Training is provided monthly, or you can make an appointment for an individual session by calling (505) 923-8883.

The Skinny on Wearable Technology

An activity tracker, sometimes called a fitness tracker or health tracker, is a wearable device or a computer application that records a person's daily physical activity and reports fitness- or health-related metrics, such as distance walked, calories burned, heartbeat, and/or quality of sleep. Over the last few years, the demand for these trackers has skyrocketed. Even though it may be too early to predict if trackers are going to stick around and be a factor in long-term health, it is still a very popular trend that is helping people get up and get moving. As a provider, we know you are constantly faced with new and changing options for healthy living and have a lot to consider when talking to your patients about incorporating a tracker into their care plans.

What we know about trackers is that they create a new level of awareness in terms of daily movement and activity. There are hundreds of clinical trials underway that hope to show that this trend is here to stay and that it's making a positive difference for individuals. Though some devices simply monitor steps taken, others record calories burned and/or

consumed, track sleep quality, remind individuals to stand up or move after periods of being sedentary, and allow users to participate in health or fitness challenges with their friends.

One of the biggest drawbacks of these devices is the high price tag. More than half of physicians surveyed by Mobile Strategies 360 said they would recommend trackers more if the devices were less expensive. The good news is that there are lower-priced models of many of these devices, and there are many free smartphone apps individuals can use to support their health goals.

According to Presbyterian Healthcare Services Health and Wellness executive director Susan MacLean, MS, trackers can be a great way for providers to interact with their patients.

"Wearable devices have the potential to function as an avenue for increased touchpoints between patients and providers," MacLean said. "Patients listen to their physicians and turn to them for advice, and if a provider uses a wearable device, he or she can speak to the benefit and encourage the patient to purchase a wearable activity tracker."

To help patients choose a device that's right for them and that fits their budget, use the comparison chart below, which features the lowest-priced versions of each device.

DEVICE	JAWBONE UP2	FITBIT FLEX	SAMSUNG GEAR FIT	APPLE WATCH 1
Starting Price	$29.99	$59.99	$149.99	$269
Friend Challenges	Yes	Yes	No	No, but you can share your activity.
Calorie Counter	Yes	Yes	Yes	Yes
Step Counter	Yes	Yes	Yes	Yes
Sleep Tracker	Yes	Yes	Yes	No
Heart Rate Monitor	Yes, resting rate only with software update.	No	Yes, all-day rate.	Yes, all-day rate.
Stand Reminders	Yes	No	No	Yes
Smartphone App	Yes, compatible with Android and iOS.	Yes, compatible with iPhone and Android.	Yes, compatible with Android only.	Yes, compatible with iOS only.

Prohibition on Balance Billing Dual-Eligible Members

Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (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].

If Medicaid holds these individuals harmless for Part A and Part B cost sharing, balance billing prohibitions may likewise apply to other dual-eligible beneficiaries in Medicare Advantage plans. Providers are required to accept the Medicare Advantage payment in full for dual-eligible members or bill Medicaid as the secondary.

Balance billing restrictions apply regardless of whether the state Medicaid agency is liable to pay the full Medicare cost-sharing amounts.

Ways to Improve Processes Related to Dual-Eligible Members

To promote compliance with balance billing requirements, the following tips can help providers identify dual-eligible members and services.

1. Research identification cards issued to dual-eligible individuals to familiarize practice staff with easily identifying dual-eligible plans.
2. Search state systems to verify dual-eligibility for patients.
3. Contact Presbyterian to determine how to identify Medicare Advantage plan dual-eligible enrollees.
4. Be mindful of which services are covered under the member's Medicare plan versus which services are covered under the Medicaid plan so the appropriate cost-sharing can be billed if applicable.
5. When the service/benefit is applicable, make sure that billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Provider and Staff Awareness about Plan Participation and Demographic Information

To reduce frustration, confusion, and uncertainty experienced by patients and members, we would like to remind you that it is extremely important for providers and office staff to know which Presbyterian insurance plans your office participates in as well as your office's phone number, address, and the name most commonly used by your practice. The Centers for Medicaid & Medicare Services (CMS) will also be conducting ongoing audits of provider offices and may ask questions relating to some of the following areas:

Plan Participation

All providers and staff need to be aware of which Presbyterian insurance plans are accepted at the practice in which you work. As an example, even though your practice accepts Presbyterian

Medicare, it may not mean your office accepts every Medicare plan we offer to members.

Panel Status

All staff should be informed of the office's phone number, address, hours of operation, the practice name most commonly used by the clinic, languages spoken, and panel status.

The Name on the Building or in the Provider Directory

Please be sure that the name used for the practice 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.

If you or someone from your practice is unsure about what plans you accept or about updating demographic information, please contact your Provider Network Management relationship executive so he or she can verify your Services Agreement, product attachments, and directory information.

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TAKE NOTE

Readership Survey

Thank you to those who filled out the readership survey and offered feedback in 2016. All respondents were entered in a drawing to win a prize, and at the end of 2016, we randomly selected a winner. Congratulations to Nancy Terpening from J&J Homecare, Inc.

We are going to continue conducting a readership survey throughout 2017. We invite you to provide feedback by using the link below to complete a quick survey about our newsletter. All respondents will be entered in a drawing for a prize in December 2017.

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

TALK TO US

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