PRESBYTERIAN

Network Connection

Information for Presbyterian Healthcare Professionals, Providers and Staff

JANUARY 2018

NEWS FOR YOU

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

It's In Your Blood to Save a Life

The nation's blood supply was heavily affected by recent hurricanes and the incident in Las Vegas. According to the Red Cross, nearly 36,000 units of blood are needed daily, and a single blood donation can help as many as three people. Since donated blood has a short shelf-life, blood should be donated on a regular basis.

Providers can help increase blood supply donations by donating blood and encouraging patients to donate. In addition, providers can partner with United Blood Services (UBS) to host a blood drive at their clinic. UBS is a national nonprofit blood organization and the only blood provider in New Mexico and the Four Corners region that provides blood to local hospitals.

In an interview with the Albuquerque Journal, Michele Moore Wright, senior donor recruitment representative for UBS, talked about how much blood local hospitals need. "We need to collect 300 units a day to meet the needs of our hospitals," said Moore. "The holidays are difficult due to the decrease in donations. People are busy, more people travel, the weather turns nasty and many organizations close or have minimal staff toward the end of December."

UBS seeks donors of all blood types, but especially type O-negative, which can be transfused to everyone. For more information, please visit www.unitedbloodservices.org/NM/ or www.bloodhero.com to find the closest blood donation location.

Centennial Care Clinical Operations Overview

Presbyterian's Centennial Care Clinical Operations department is available to help members improve their health and to make it easier for providers to connect with a member's care team. Our Clinical Operations staff includes doctors, nurses, social workers, and other health professionals. They are trained to support the member, the member's primary care provider (PCP) and other providers to make sure our members stay healthy and as independent as possible in the community.

Please see the categories below for more detailed descriptions about how the Clinical Operations department works.

Care Coordination

Presbyterian Centennial Care manages care coordination for the member's medical, behavioral and long-term care needs, whether in a clinical setting or at home. Our Care Coordination team is comprised of nurses, licensed social workers and other health experts. Our care coordinators conduct both home and telephone visits with members to complete a comprehensive needs assessment (CNA) and to provide follow-up care. A member-centric, comprehensive care plan is then developed with the member, caregiver and provider to ensure the identified needs are addressed. Members who are appropriate for Care Coordination are those who have complex needs, functional concerns, or physical or behavioral needs. To refer a member to Care Coordination, please call our intake line at (505) 923-8858 or toll-free at 1-866-672-1242.

Utilization Management

Presbyterian follows utilization management guidelines to ensure that our members receive the right care, in the right place, at the right time.

Utilization management decision-making is based on appropriateness of care and services as well as the benefits covered under the member's plan. This process includes the following:

- Prior authorization
- Concurrent review
- Retrospective review

Prior Authorization

Some healthcare services require prior authorization from Presbyterian Centennial Care. This means that Presbyterian Centennial Care nurses check to make sure that the service is a covered benefit and medically necessary. A list of services that require prior authorization can be found at www.phs.org/providers or can be obtained by contacting the Presbyterian Customer Service Center at (505) 923-5757 or 1-888-923-5757, Monday through Friday, 8 a.m. to 5 p.m.

Concurrent Review

Through concurrent review, nurses work with discharge planners at hospitals or other facilities. They ensure the member is at the appropriate level of care for his or her needs.

Retrospective Review

During retrospective review, nurses review insurance claims to make sure that the member received the most appropriate healthcare. Presbyterian does not reward practitioners for issuing denials of coverage. Financial incentives do not encourage decisions that result in underutilization by utilization management decision-makers.

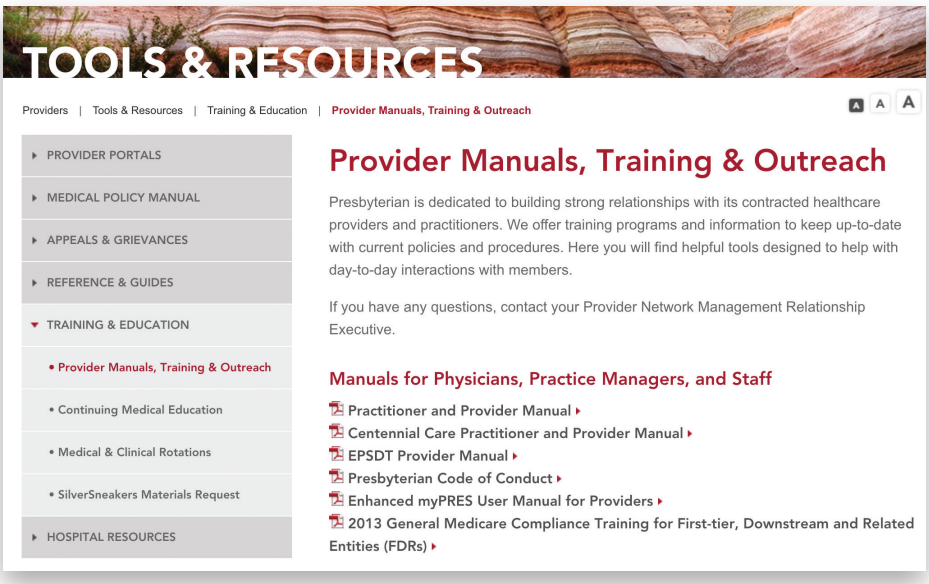
Reminding Providers about New and Revised Code Sets

Each year in the United States, healthcare insurers process more than five billion claims for payment, according to the Centers for Medicare & Medicaid Services (CMS). For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, the following recognized code sets were established under the Health Insurance Portability and Accountability Act (HIPAA):

- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Disease, Tenth Edition (ICD-10)

These code sets are updated and republished annually. Providers may view the new and revised CPT and ICD-10 codes by logging in to myPRES at https://mypres.phs.org/Pages/default.aspx. New and updated HCPCS codes may be viewed by visiting the CMS website at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

2018 Practitioner and Provider Manuals Are Available on PHS.org



Presbyterian's 2018 Practitioner and Provider Manuals are now available. Presbyterian's Universal Practitioner and Provider Manual covers programs, policies and guidelines for Commercial, Medicare and Medicaid products. Presbyterian also publishes a Centennial Care Practitioner and Provider Manual that provides detailed information and requirements specific to Presbyterian Centennial Care. The manuals are an extension of a provider's contract with Presbyterian. The manuals are updated quarterly and as needed. Providers can find the following information and more in the manuals:

- How to submit pharmacy, medical and behavioral health prior authorization requests
- How to access prior authorization criteria and medical policies at PHS.org or by telephone or fax
- How to access utilization management staff (pharmacy, medical and behavioral health) to discuss prior authorization requests
- How to access Presbyterian formularies and updates, including restrictions (e.g., quantity limits, step therapy and prior authorization criteria), online at: https://www.phs.org/providers/formularies/Pages/default.aspx
- How to access clinical practice guidelines at PHS.org
- A list of our members' rights and responsibilities

The manuals are readily available online at http://www.phs.org/ProviderManual. You may also request a printed copy of the both manuals at no cost by contacting your Provider Network Management relationship executive at www.phs.org/ContactGuide.

Use V1 Demonstration Modifier for Wound Care Claims

Presbyterian is committed to ensuring accessible and affordable healthcare options for all members. One way we accomplish this goal is by sharing information with providers regarding appropriate billing guidelines.

Effective March 1, 2018, providers must use the V1 Demonstration modifier for wound care claims. Claim modifiers are two-digit codes that further describe a service or procedure, ensuring the claim generates the correct copay for members, as applicable, based on the member's benefit plan.

If you have any questions or concerns, please contact your Provider Network Management relationship executive at www.phs.org/ContactGuide.

Empowering the Community with Mobile Health Apps

As an extension of electronic health (ehealth), mobile health (mhealth) leverages the use of mobile devices to broaden access to healthcare services and improve health outcomes through mobile apps. Mobile health apps empower patients to better manage their health and help providers deliver more efficient care. Due to the high demand of mobile health apps, well known organizations are partnering to address the need for oversight and resources that guide providers and developers in the creation of secure, effective and efficient mobile apps.

According to the mHealth App Economics 2017 (HAE) report by Research2Guidance, there were 78,000 new health apps released in 2017 and an estimated 3.6 billion downloads, which is a 16 percent increase from 2016. Xcertia, a mobile health company made up of developers from the DHX Group and providers from the American Heart Association, American Medical Association and Healthcare Information and Management Systems Society, collaborated to address the need for comprehensive guidelines that ensure the safety and effectiveness of mobile health apps. Xcertia does this through a member-driven, online resource that allows professionals in healthcare and technology to collaborate to create and maintain a strong set of standards that govern mobile health apps.

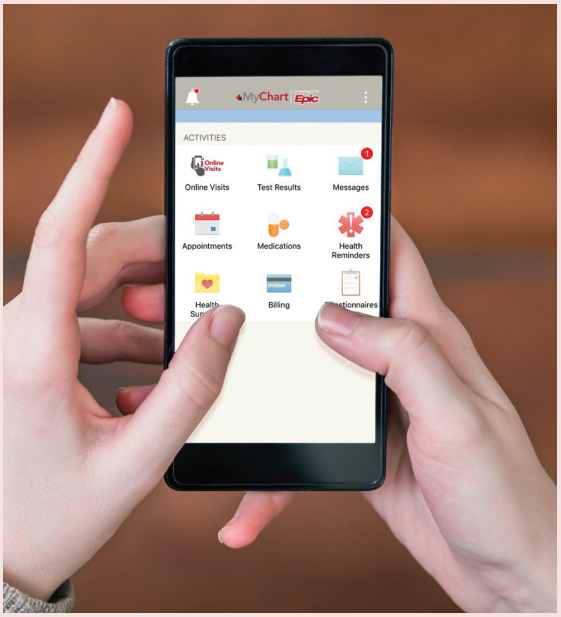
Health apps serve a wide spectrum of health needs, from tracking exercise to diagnosing certain cancers. In addition, patients save time and money when they use a mobile health app to schedule appointments, meet their providers online and request prescription refills all through their mobile devices. Providers are also better equipped to monitor their patients and ensure they adhere to recommended treatments.

The popularity of mobile devices will continue to power the demand for mobile health apps. According to the HAE report, there are 325,000 health apps related to health and wellness — more than ever before. As guidelines and standards make production more comprehensible and practical, providers will be able to integrate and recommend the best mobile health apps to care for their patients.

MyChart
PRESBYTERIAN

Presbyterian developed **MyChart**, an online resource that allows members to manage care for themselves and their families. Through the app, members have access to the following services:

- Sending and receiving messages with their care team
- Viewing test results
- Requesting prescription renewals
- Scheduling appointments
- Verifying registration information
- Accessing health summaries
- Receiving health reminders
- Paying bills



Hospice Rate and Revenue Code Updates

In October 2016, the Centers for Medicare & Medicaid Services (CMS) published hospice rates for 2017 that indicated hospice providers will be paid at two different daily rates. One daily rate applies to the first 60 days of a hospice election and is referred to as a "high rate." The second daily rate, referred to as a "low rate," applies to days after the initial 60 days of a hospice election, regardless of whether the member switches to another managed care organization (MCO).

Providers should continue to use the current revenue code 0651 to bill high- and low-rate routine home care days for hospice routine home care services. In addition, providers are required to bill HCPCS codes Q5001 through Q5010 and HCPCS codes T2042 through T2046 on the UB-04 medical form along with the revenue code 0651. The HCPCS code will depend on where the hospice services are provided or upon which most appropriately describes the services provided.

Claims for hospice care require providers to include the admission date. When the encounter is 60 days or less, then the higher rate will be paid. When the encounter on the claim is greater than 60 days from the admission date on the claim, then the lower rate will be paid. Providers should submit one claim for hospice care that accounts for less than 60 days and a separate claim for care that extends beyond 60 days. Providers do not need to resubmit hospice claims for 2017. Additional communication will follow if any adjustments are required.

Manual EVV Claim Entries Require Supporting Documentation

We are committed to ensuring providers have the tools and resources they need to provide personal care services (PCS) to Centennial Care members. The primary tool used to manage visits and ensure timely payment of claims is the Electronic Visit Verification (EVV) system, AuthentiCare.

Effective Jan. 1, 2018, any claim that is manually entered (i.e., web-entered) into AuthentiCare requires the submitting agency to gather and maintain supporting documentation. Claims manually entered and submitted to Presbyterian may require this supporting documentation before payment is issued. It is the submitting agency's responsibility to maintain this documentation and establish record-retention policies that are compliant with a provider's Services Agreement with Presbyterian Centennial Care and the Medicaid Participation Agreement with the State of New Mexico Human Services Department. Providers should enter the documentation in the notes area in AuthentiCare. The table below lists the exceptions and the appropriate documentation needed to issue payment for manual claim entries.

Exception	Required Documentation
Tablet malfunction	The issue reference number and/or other documentation that demonstrates outreach to Mobility Exchange (ME) or AuthentiCare.
Smartphone malfunction	The issue reference number from the mobile network carrier, such as Verizon.
Interactive voice response (IVR) system is unavailable or landline is disconnected	The issue reference number that indicates outreach to either AuthentiCare for IVR issues or to the member's landline network carrier.
Tablet order was not delivered prior to services being rendered	The confirmation of the date the tablet was ordered and the date the tablet was delivered from ME. **Note:** Five to seven business days is the timeline provided for tablet delivery.
Inclement weather	Documentation from the PCS agency that supports use of manual claim entries. Explain the reason for the manual entry.
Electrical outage unrelated to inclement weather	Documentation from the PCS agency that supports use of manual claim entries. Explain the reason for the manual entry.
Authorization issue	Documentation that supports outreach to the MCO for assistance in researching the issue. Include the date of discussion.
Substitute caretaker	Documentation from the agency that indicates a change in caretakers. **Note:** Manual claim entries should only be used if notification of substitution was not received in a timely manner and providers are unable to reschedule the service in AuthentiCare.

PRESBYTERIAN

Presbyterian Health Plan, Inc.
Provider Network Management
P.O. Box 27489
Albuquerque, NM 87125-7489
www.phs.org

PRESRT STD
U.S. Postage
PAID
Albuquerque, NM
Permit No. 1971

TAKE NOTE

TALK TO US

Send your questions or comments to our *Network Connection* editor at:

EMAIL:
providercomm@phs.org

PHONE:
(505) 923-8787

MAIL:
PO Box 27489
Albuquerque, NM 87125-7489
Attn: Provider Network Management

READERSHIP SURVEY

We would be extremely grateful if you would take two minutes to fill out our Readership Survey and provide us your feedback. Please use the link below to let us know how you think we can improve our newsletter and what you would like to read about in future issues. One lucky person who responds to our survey will win a **$50 Starbucks gift card**.

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