**PRESBYTERIAN**

# Network Connection

Information for Presbyterian Healthcare Professionals, Providers and Staff

SEPTEMBER 2020

NEWS FOR YOU

UP FRONT

Authorization Letters for Advanced Radiology Services and Lumbar/ Cervical Spine Surgeries . . . . . . . . 2

2020 Annual Provider Training Events Overview . . . . . . . . . . . . . . 3

TAKE NOTE

Good Measures Diabetes Prevention Program. . . . . . . . . . . . . . . . . . . . . 4

REGULATORY UPDATES

Medical Records Documentation Standards. . . . . . . . . . . . . . . . . . . . 5

Member Rights and Responsibilities. . . . . . . . . . . . 6

Appeals and Grievances Information . . . . . . . . . . . . . . . . . . 6

"Incident To" Services. . . . . . . . . . 7

Compliance with On-call Support and After-hours Messaging . . . . . . 7

Affirmative Statements about Incentives. . . . . . . . . . . . . . . . . . . . 7

PRESBYTERIAN WORD SEARCH . . . . . . . . . . . . . 8

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

## New Routine Agreements with Superior Vision and Secure Transportation Company, Inc.

Presbyterian is pleased to announce that it has entered into two new agreements to ensure members receive the care they need, when they need it.

Effective July 1, 2020, Superior Vision offers routine vision services and Secure Transportation Company, Inc. offers non-emergent transportation services to Presbyterian Centennial Care and Medicare Dual Plus members. Non-emergent transportation services are also available to Medicare members who have access to a transportation benefit through Presbyterian's Hospital Readmission Program.

Both Superior Vision and Secure Transportation Company have statewide networks of providers that include Native American service professionals. Secure Transportation Company's network also includes a network of both owned and brokered transportation providers.

Please note that Presbyterian will continue to pay claims for both the owned and brokered transportation providers. The only change to reimbursement will be the discontinuation of the gross receipts tax (GRT) as the New Mexico Human Services Department transportation fee schedule rates include GRT.

Providers may contact Superior Vision directly at svmedicalmanagementnetwork@versanthealth.com to become a contracted provider or to verify their contract status.

To arrange non-emergent transportation services, providers may contact Secure Transportation Company, Inc. directly at PM@securetransportation.com.

Providers are encouraged to contact their Provider Network Operations relationship executive with any questions they may have. His or her contact information can be found in the Presbyterian Provider Network Operations Contact Guide at www.phs.org/ContactGuide.

# Authorization Letters for Advanced Radiology Services and Lumbar/Cervical Spine Surgeries

Presbyterian is aware that authorization letters for advanced radiology services and lumbar/cervical spine surgeries were recently sent with new authorization numbers and missing authorization date spans. The intent of the letters was to communicate authorization extensions issued on or after March 20, 2020. Extensions were granted to allow additional time for the services to be rendered in the event that the services had to be cancelled or postponed due to COVID-19 response efforts. Authorizations issued on or after March 20, 2020 for these services will be valid through Sept. 30, 2020.

We recognize that issuance of new authorization numbers, as well as missing date span information, has caused confusion and inconvenience during an already challenging time and we sincerely apologize.

Please note the following procedures addressed in these letters:

- **If the service was rendered and billed prior to the date of the letter**, then the initial authorization number for the service is valid and no further action is needed to ensure appropriate payment for these services.
- **If the service was rendered prior to the date of the letter but was billed after the date of the letter**, then the initial authorization number may no longer be valid. Please contact National Imaging Associates at 1-866-236-8717 for assistance.
- **If the service was rendered after the date of the letter or if the service has not yet been rendered**, then the new authorization number is valid and will be used for claim processing. The authorization is valid through Sept. 30, 2020.

Please contact (505) 923-5757 or 1-888-923-5757 Monday through Friday, 8 a.m. to 5 p.m., with any questions or concerns regarding this information.

# 2020 Annual Provider Training Events Overview

Presbyterian offers a variety of informative and useful provider trainings to ensure members receive the most appropriate care in the most cost-effective setting. Below is an overview of the 2020 training events Presbyterian is offering providers. Please note that some trainings are required, as identified in the following overview.

**Provider Education Conference & Webinar Series**

All contracted physical health, behavioral health and long-term care providers and staff are invited. *Please note that due to the COVID-19 health crisis, all in-person conferences have been changed to webinars to ensure the safety of attendees and staff.*

**Providers are only required to attend one of these trainings.

| Training Date | Training Times | Training Format | Registration Link |
|---|---|---|---|
| To be determined | To be determined | Webinar | phs.swoogo.com/2020PEC |
| To be determined | To be determined | Webinar | |
| Thursday, Dec. 17 | 12 - 2 p.m. | Webinar | |

**Presbyterian Dual Plus Training**

All contracted providers who render services to Presbyterian Dual Plus members are required to complete this training.

**Office staff cannot complete the training on behalf of the provider.

| Training Dates and Times | Training format and/or location | Registration Link |
|---|---|---|
| Available 24 hours a day, seven days a week throughout the year. | Online, self-guided training module. | phppn.org |

**Indian Health Services and Tribal Conversations**

All contracted physical health, behavioral health and long-term care providers and staff are invited.

| Training Date | Training Times | Training Format | Registration Link |
|---|---|---|---|
| Thursday, Sept. 24 | 10 - 11:30 a.m. | Webinar | phs.swoogo.com/IHS2020 |
| Thursday, Dec. 17 | 1:30 – 3 p.m. | Webinar | |

**Critical Incident Training**

All Centennial Care 2.0 providers are required to attend one Critical Incident training per year.

| Training Date | Training Times | Training Format | Registration Link |
|---|---|---|---|
| Tuesday, Sept. 22 | 9 - 11 a.m. | Webinar | phs.swoogo.com/2020criticalincidenttraining |
| Thursday, Sept. 24 | 2 - 4 p.m. | Webinar | |

If providers have questions about the upcoming trainings, they are encouraged to contact their Provider Network Operations relationship executive. His or her contact information can be found at www.phs.org/ContactGuide.

# Good Measures Diabetes Prevention Program

According to the Centers for Disease Control and Prevention (CDC), approximately 88 million adults have prediabetes and are at risk for developing Type 2 diabetes. To help delay or prevent the onset of Type 2 diabetes, Presbyterian has partnered with Good Measures, a wellness program with a state-of-the-art digital platform that helps people make positive changes in eating and exercise behavior. This program delivers diabetes prevention services at no additional cost to eligible Centennial Care members with a prediabetes diagnosis.

The Good Measures program is a year-long program that is available online and by phone. It combines food and activity tracking capabilities with group support and personalized one-on-one coaching facilitated by trained lifestyle coaches. This approach helps keep members engaged and accountable as they learn to incorporate healthier habits into their lives.

Regular physical activity and weight loss can help delay or prevent the onset of Type 2 diabetes, according to the CDC. On average, participants in the Good Measures program lost 6.8% of their body weight. Also, 74% of participants achieved or exceeded their physical activity goal of 150 minutes per week. Furthermore, some participants saw an improvement in biomarkers for blood pressure, blood glucose and cholesterol.

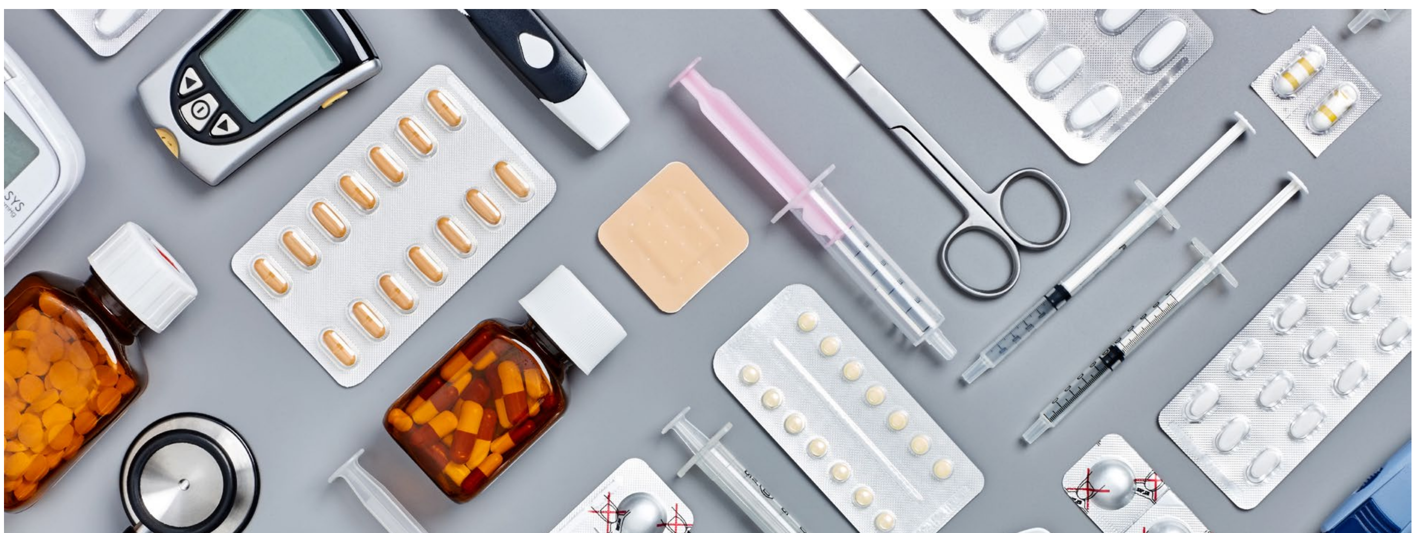
Eligible Centennial Care members must be 18 years old or older, have a body mass index (BMI) greater than 25 kg/m2 (greater than or equal to 23 kg/m2 if a person is Asian), and have a history of gestational diabetes (may be self-reported) or have a blood test in the prediabetes range that includes one of the following results:

- Hemoglobin A1c between 5.7% and 6.4%
- Fasting plasma glucose 100 to 125mg/dL
- Two-hour plasma glucose after a 75mg glucose load 140 to 199mg/dL

Providers can refer members and members can self-refer to the Good Measures program. Please note that members who already have been diagnosed with diabetes do not qualify for this program. Providers can refer members in one of the following ways:

- Complete and submit an online form at www.goodmeasures.com/physicians
- Send an email to Good Measures at phpdpp@goodmeasures.com
- Call Good Measures at 1-855-249-8587

When contacting the Good Measures team, please provide the member's first and last name, date of birth, Centennial Care number, phone number and list "Diabetes Prevention" as the reason for referral.



# Medical Records Documentation Standards

A medical record contains important information that is vital to a member's health history and the care they receive. As part of our regulatory requirements, Presbyterian ensures its members' medical records are secure, complete, accurate and consistent by using standard documentation practices.

Presbyterian reports compliance with medical record and documentation standards to several agencies, including the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and the New Mexico Human Services Department (HSD). These agencies require that specific information be documented in every member's chart, including medical history and advance directive information.

All providers are held to the minimum standards as identified by Presbyterian, state and federal regulatory agencies, national accrediting organizations, and provider service agreements. Presbyterian provides these standards to practices, which address the following:

- Confidentiality of medical records
- Documentation
- Organization of record keeping systems
- Standards for availability of records
- Participation in quality improvement activities

Presbyterian regularly assesses compliance with these standards and requests that providers submit any and all medical records selected for review. Records are scored on a myriad of components, such as response timeliness, patient information documentation, allergy identification, and advanced directives. A passing score for a medical record review is 85%. Results are shared with providers and various quality improvement teams to address any issues that may be identified.

### Record Request Turnaround Time

Presbyterian's mutual Primary Care Services Agreement states that providers will release records to Presbyterian in a secure manner within 15 days of the request. In 2019, Presbyterian received 97.4% of the 109 records requested; however, not all records were received within the 15-day time frame and required additional requests. Providers who were non-compliant were contacted to ensure a timely response to future record requests.

### Advance Directive Documentation

The Federal Patient Self-Determination Act (PSDA) encompasses end-of-life care, also known as advance directives. The PSDA requires managed care organizations (MCOs) to provide information on advance directives to members upon enrollment. When members are admitted to inpatient settings, MCOs must also provide the information to health facilities, including hospitals, skilled nursing facilities, and home health agencies.

Presbyterian requires providers to indicate whether a patient has completed an advance directive. This can be accomplished by noting "Yes" or "No" in a prominent location within the member's hard copy or electronic medical record for that date of service. Presbyterian strongly encourages providers to discuss advance directives with members and answer questions in outpatient settings to ensure members understand all decisions. In addition, if a member presents an advance directive to a provider, then the provider should add a copy of the document to the member's medical record.

We evaluate provider compliance with advance directive requirements when we perform a medical record standards review. The score for 2019 was 42.7%. We determined that the life planning conversation occurs, but the information is not documented or our record request is not precise enough to draw attention to the need for this information.

Providers may access advance directive forms at the following link: http://docs.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/pel_00133737.pdf.

Presbyterian appreciates providers' commitment to complying with these standards. For questions about medical record documentation standards, please call Presbyterian's Hospital Medical Records department at (505) 841-1944.

# Member Rights and Responsibilities

Presbyterian has written policies and procedures regarding members' rights and responsibilities and implementation of such rights. All Presbyterian members or their legal guardians have rights and responsibilities, and Presbyterian expects its network of providers to respect and support these rights and responsibilities.

To view all member rights and responsibilities, go to www.phs.org/Pages/member-rights.aspx. Please note that this list comprises the rights and responsibilities as dictated by the New Mexico Human Services Department and the National Committee for Quality Assurance. The list also includes information specific to different product lines.

# Appeals and Grievances Information

Presbyterian is committed to providing excellent service to its providers and members. We welcome all feedback and, in collaboration with our regulatory agencies, we have implemented comprehensive processes to ensure that our members and providers have grievances and appeals rights.

### Member Appeals and Grievance Information

Members have the right to voice grievances or appeals with Presbyterian or its regulatory bodies about Presbyterian or the care it provides. If prior authorization for services for any Presbyterian member is requested by a provider and denied by Presbyterian, and the provider feels that the member's health and/or welfare is in immediate jeopardy, a provider may act on the member's behalf and file a request for an expedited authorization. Presbyterian will then determine if the request meets expedited criteria. If it is deemed expedited, Presbyterian will process the expedited appeal within 72 hours of receipt. Time extensions may apply with written consent from the member.

All members also have the right to file a grievance if they are dissatisfied with the services rendered through Presbyterian. Member grievances may include but are not limited to the following:

- Dissatisfaction with services rendered
- Availability of services
- Delivery of services
- Reduction and/or termination of services
- Disenrollment
- Any other performance that is considered unsatisfactory

Members should submit their appeals and/or grievances to Presbyterian's appeals coordinator within the time frames indicated in the following table.

### Provider Appeals and Grievance Information

Providers have the right to file a formal appeal and grievance with Presbyterian for any reason. An appeal may be filed when a prior authorization decision has been denied 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 immediately referred to a medical director who was not previously involved in the case for resolution. These requests are handled according to the member appeal guidelines.

Contracted providers have one year from the date of service to file an appeal regarding a claim denial. When filing a provider appeal, the provider needs to document the reasons for the reconsideration request and attach all supporting documentation for review. If the issue involves coding, then it is helpful to include supporting medical records, such as office notes and operative reports, if applicable.

These requests may be electronically submitted to Presbyterian's Appeals and Grievance department at www.phs.org/providers/resources/appeals-grievances/Pages/form.aspx.

| Lines of Business | Appeal Time Frame | Grievance Time Frame |
|---|---|---|
| **Presbyterian Centennial Care** (New Mexico Medicaid Managed Care) | Within **60 days** from the date of receiving the denial | At **any time** after the date of occurrence |
| **Presbyterian Senior Care** and **Presbyterian Medicare PPO** (Medicare Advantage) | Within **60 days** from the date of denial | Within **60 days** after the event |
| **All Other Plans** | Within **180 days** from the date of denial | Within **180 days** after receiving the administrative decision |

# “Incident To” Services

The Centers for Medicare & Medicaid Services (CMS) defines “incident to” services as services that are furnished incidents to physician professional services in the physician’s office, whether located in a separate office suite, within an institution, or in a member’s home.

To qualify as an “incident to” services, the service must be part of a member’s normal course of treatment during which a physician, within the legal entity receiving payment, personally performed an initial service and remains actively involved in the course of treatment. Providers do not need to be physically present in the member’s treatment room while these services are provided, but they must provide direct supervision. The physician must be present in the office suite to provide assistance. Providers should also document the essential requirements for “incident to” services in the member’s record. More specifically, these services must meet all of the following requirements:

- Be an integral part of the member’s treatment course
- Be commonly rendered without charge (included in the physician’s bills)
- Be of a type commonly furnished in a physician’s office or clinic (not in an institutional setting)
- Be an expense to the physician or physician’s office

Services provided by a non-physician but supervised by a physician must follow CMS guidelines to qualify for “incident to” care. The physician, as defined earlier, must perform the initial visit and be in the office or facility when services are rendered to provide supervision and assistance.

As outlined in the services agreement with Presbyterian, all providers must be credentialed with Presbyterian before seeing any Presbyterian members. All services should be billed under the rendering provider.

The Presbyterian Program Integrity Department performs random claims validation audits on claims submissions to verify that the services billed were rendered and accurate. More information on these requirements can be found on the CMS website at the following links:

- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0441.pdf.
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

# Compliance with On-call Support and After-hours Messaging

Presbyterian appreciates its partnership with providers and their commitment to ensure members can access the care they need, when they need it. In the spirit of collaboration, we would like to remind providers that they must inform members of their hours of operation and give instructions on how to access care after hours.

In addition, Presbyterian requires primary care providers (PCPs) to have or arrange on-call and after-hours care to support members who experience emergencies. Such coverage must be available 24 hours a day, seven days a week. When providers are unavailable to provide on-call support and care, providers must offer members messaging about how to access care after hours. Furthermore, Presbyterian requires that the hours of operation providers offer to Medicaid members must be no less than those offered to commercial members.

Presbyterian requests that all PCPs ensure their contact information and after-hours messaging is up to date and gives members the information they need to seek appropriate care outside of regular office hours. Providers can update their information by logging into the myPRES Provider Portal at www.phs.org/providers. For additional assistance, providers can contact their assigned Provider Network Operations relationship executive. His/her contact information can be found at www.phs.org/ContactGuide.

# Affirmative Statements about Incentives

For more than 100 years, Presbyterian has maintained high-level services to ensure members receive the most appropriate care at the right time and in the best setting. Prior Authorization (PA) is one of the utilization management (UM) processes we use to help our members receive appropriate care. This process is also referred to as benefit certification, concurrent review, or post-service review.

UM decision-making is based solely on the appropriateness of care and service and the existence of coverage. Presbyterian does not specifically reward providers or other individuals for issuing denials of coverage. Furthermore, financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

For more information about Presbyterian’s PA processes, refer to the Care Coordination chapter of the 2020 Presbyterian Practitioner and Provider Manual at www.phs.org/ProviderManual.

**PRESBYTERIAN**

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Albuquerque, NM 87125-7489
www.phs.org

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## PRESBYTERIAN WORD SEARCH

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|---|---|---|
| Appeals | Call | Grievances |
| Diabetes | Documentation | Prevention |
| Incentives | Incident | Responsibilities |
| Radiology | Records | Support |
| Rights | Superior | |
| Vision | Compliance | |

# TALK TO US

Send your questions or comments to Presbyterian's Provider Network Operations department:

CONTACT GUIDE:
www.phs.org/ContactGuide

PHONE:
(505) 923-5757 or (505) 923-5141

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

## Let Us Know Your Thoughts

### Readership Survey

We appreciate receiving your feedback. Please use the link below to let us know how you think we can improve our newsletter and any topics you would like to read about in future issues.

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