

Welcome!

Presbyterian Health Plan and
Presbyterian Insurance Company, Inc.
2009 Provider Education Conference



Agenda

- Provider Services – Territory list on Web
- Credentialing
- Member Rights and Responsibilities
- Presbyterian Customer Service Center
- Enterprise-wide Complaint Management (A&G)
- Health Services
- Pharmacy
- Behavioral Health
- HIPAA
- Coding and Reimbursement

Packet Materials – Left Side

- Quality Improvement Program
- Salud EPSDT / NM HSD EPSDT Screening Services
- Cultural Sensitivity Competencies
- 1500 Claim Form Map to 837 Electronic Form
- Nurse Advice Line
- Synagis Information
- Provider Responsibilities to PHP/PIC and Members
- Care Coordination Intake Form / Benefit Certification Form
- Provider Services Territory Assignment List
- Provider Phone Line Menu Options
- Pres Online Application Location
- Claims Section from the 2008-2009 Provider Manual
- ECT Clearinghouse Contact Information
- Provider Change of Information Form
- Technology Assessment Questionnaire

Packet Materials – Right Side, Provider Communications

- Medical Records Standards and Audit Letter
- RBRVS Update
- Walgreens Purchases McKesson
- Walgreens Specialty Drug Request Fax Form
- A1C Test Results
- Medicare ABN Revision Reminder
- NM HSD Behavioral Health Claims Transition Supplement
- Salud Fluoride Varnish Program - Chaves County Providers
- Behavioral Health 7-day Follow-Up Visit Copay Waived
- 2009 Autism Mandate
- Medicare Part C & Part D Required Fraud, Waste, & Abuse Training for Providers
- Salud Notification of Birth Form
- Notice of Non-Medicare Coverage Letter and Form

Provider Services



Online Territory Assignment List

List provides assignments of coordinators, representatives, and manager for Multi-specialty groups, hospitals, specialties, Behavioral Health providers by first letter of last name, staff phone numbers and e-mail addresses.

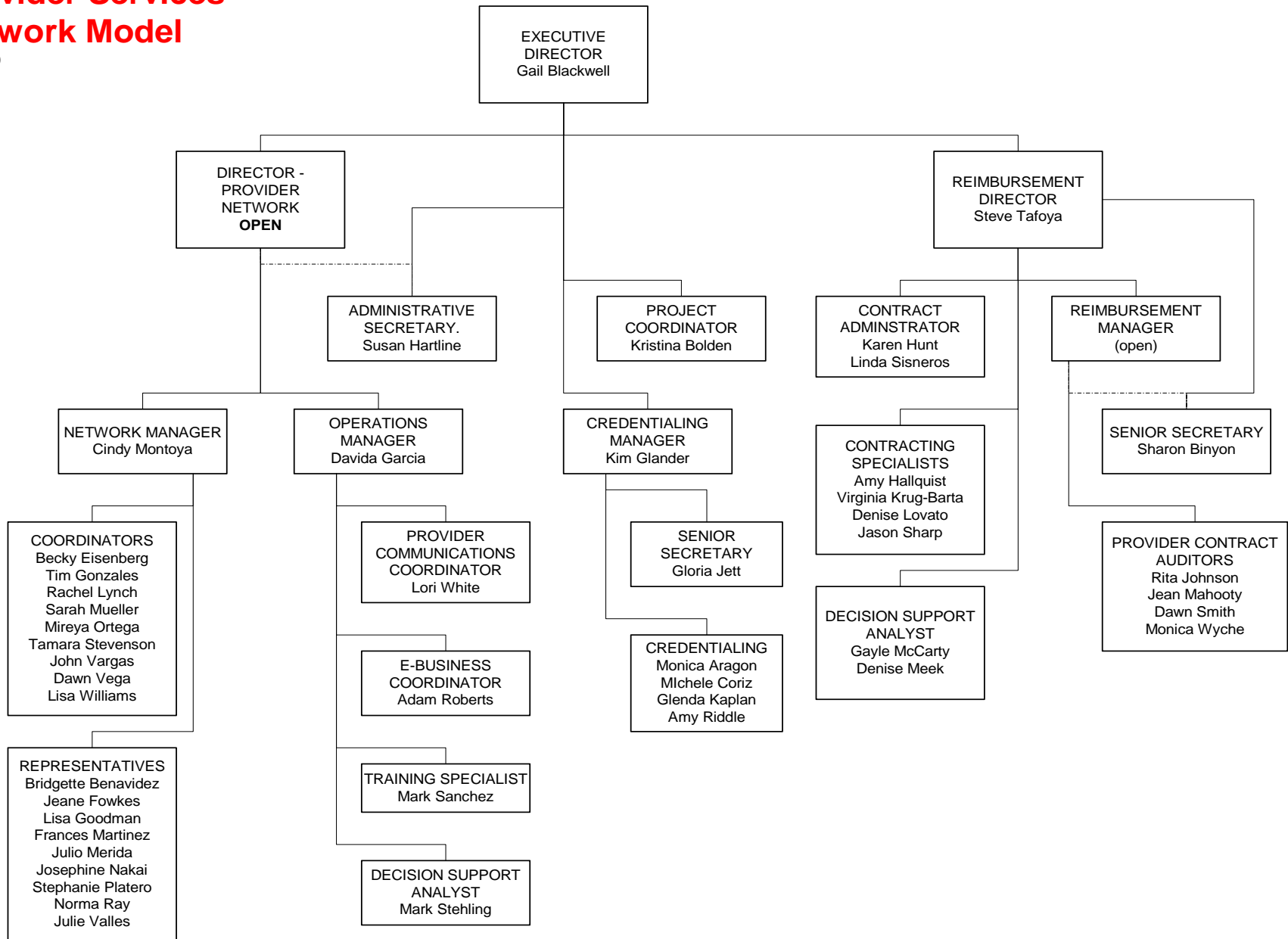
- <http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1001499.pdf>

OR

- www.phs.org
- Health Plans
- For Providers (left)
- Presbyterian Provider Services Staff (center)

Provider Services Network Model

09/18/09



Practitioner and Provider Manual

Presbyterian Health Plan (PHP) and Presbyterian Insurance Company, Inc. (PIC) are contractually required by New Mexico Human Services Department and other various regulatory agencies to provide education to our network Practitioners and Providers on various important subjects.

Practitioner and Provider Manual

The Practitioner and Provider Manual is:

- An extension of your contract with PHP/PIC
- Designed to assist you and your staff in partnering with PHP and PIC to deliver quality healthcare to our Members
- Educates Practitioners and Providers on regulatory compliances and processes

The 2008-2009 Practitioner and Provider Manual is available:

- On CD-ROM - mailed to your office annually
- On Presbyterian's website at:

<http://www.phs.org/PHS/healthplans/info/providermanual/index.htm>

Practitioner and Provider Manual (continued)

Or online at

- www.phs.org
 - Health Plans
 - For Providers (left)
 - 2008-2009 Provider Manual (right, Quick Links)
 - From Web page (above),
 - Click
 - 2008-2009 Provider Manual (.pdf) (center) or
 - Behavioral Health Utilization Management (.pdf) (center)

Credentialing



Credentialing - Initial Credentialing

- PHP/PIC Credentialing notifies Hospital Services Corporation (HSC) to send you a request to go online and complete an application
- You complete application online at www.nmhsc.com
- HSC Contact Information
Hospital Services Corporation
P.O. Box 92200
Albuquerque, NM 87199-2200
Telephone: (505) 343-0070
Fax: (505) 343-0068
- HSC performs primary source verification and forwards the application to PHP/PIC Credentialing for processing.

Recredentialing

- Recredentialing is performed a minimum of every three years as required by regulations established by the Department of Insurance (DOI) and the National Committee of Quality Assurance (NCQA).
- HSC will send you a letter directing you to their website, www.nmhsc.com, to complete an online application prior to your expiration date.
- HSC performs primary source verification and forwards the application to PHP/PIC Credentialing for processing.

Credentialing Application Review

- PHP/PIC Credentialing reviews your application and confirms all necessary documentation is received
- If additional information is required, PHP/PIC Credentialing will contact you directly.
- Credentialing decisions are made by the PHP/PIC Credentialing/Peer Review Committee (C/PRC).
- Applications with no credentials concerns or issues are submitted weekly to be approved.

Credentialing Application Review

(continued)

- Applications with credential concerns or issues are submitted monthly to be reviewed by our C/PRC.
- PHP/PIC Credentialing will notify you by mail of the credentialing decision within 30 days of our decision.
- You are not a contracted Practitioner/Provider and **may not see PHP or PIC Members** until the contracting and credentialing processes are complete.

Site Visits

- Presbyterian contracts with MedAssurant to conduct both credentialing visits and HEDIS® data collection.
- Primary Care Practitioners, Obstetrician-Gynecologists, and high volume Behavioral Health Practitioners and Providers will require an initial site visit.
- MedAssurant conducts site visits for PHP/PIC and will contact you to schedule a site visit, if required.

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

Site Visits (continued)

- If you have any questions regarding MedAssurant, the site visit or the medical record review process, please contact:

Jennifer Griewahn, Credentialing Review
Coordinator

jgriewahn@medassurant.com

1-800-390-3180, Ext. 5706

Practitioner Office Site Quality

- New NCQA measurement – assess quality, safety, and accessibility of office sites where care is delivered, ensuring offices of all practitioners meet health plan office site standards.
- Practitioner Office Quality Report includes tracking complaints related to PHP/PIC office site quality criteria received by Enterprise-Wide Complaint Management and PCSC.
- Credentialing reviews complaint descriptions in Practitioner Office Quality Report for each office criteria to detect deficiencies in office sites where care is delivered.
- Any practitioner office receiving two complaints, within 12 months for any office site criteria, will receive a site visit.

Practitioner Office Site Quality (continued)

Office Site Criteria Categories:

- Physical Accessibility
 - Facility is easily accessible
 - Patient/Handicapped Parking
 - Wheelchair access
- Physical Appearance
 - Facility is clean and well lit
 - There are posted office hours
- Adequacy of Waiting Room or Exam Room Space
 - Waiting area is clean with adequate seating
 - Exam rooms provided for physical and auditory privacy

Practitioner Office Site Quality (continued)

Office Site Criteria Categories:

- Availability of Appointments
- Adequacy of Treatment Record Keeping
 - Medical Records are protected from public access and ensure confidentiality
 - Records are legible and organized
 - Records are identified by patient name and/or number

Practitioner Office Site Quality (continued)

1. A Provider Services Representative performs an office site visit within 60 calendar days of receiving two complaints for any office site criteria within 12 months.
2. Practitioner's office site is notified by letter of deficiency and provided a copy of the complaints.
3. The Practitioner Office Quality Site Visit Tool will include the office site criteria categories, specific criteria for each category and a method for scoring the office site.

Practitioner Office Site Quality (continued)

4. Practitioner office site visit results shared with practitioner and/or his/her designee in writing.
5. Office sites scored below 85% will be asked to implement a corrective action plan to include at a minimum:
 - The corrective action
 - The planned date of completion.

Practitioner Office Site Quality (continued)

- Provider Services Representative re-evaluates effectiveness of corrective action plan at least every six months until deficient office meets established thresholds. Provider Services Representative documents his/her findings in Practitioner Office Quality Tracking Log
- All related documentation for office site visits and corrective action plans will be maintained by the Credentialing Department.
- Practitioner Office Quality Tracking Log is reviewed monthly to identify opportunities to improve member satisfaction throughout the network.

Contact Information

PHP/PIC Credentialing Staff

Kim Glander

Credentialing Manager

(505) 923-5141 fax (505) 923-5450

kglander@phs.org

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maragon@phs.org

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Credentialing Coordinator, South

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ariddle@phs.org

The Presbyterian Customer Service Center



Member Rights and Responsibilities

Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) are committed to treating all Members in a manner that respects their rights.

Presbyterian expects its employees as well as participating and non-participating health professionals to treat each Member without bias and discrimination in accordance with general community standards, the American Disabilities Act and other Federal and State law requirements for the delivery of health care.

Member Rights and Responsibilities

(continued)

Presbyterian encourages open dialogue between the Practitioner and Member, and has no policies to restrict this dialogue.

Presbyterian monitors and promotes compliance with the policies by the staff and affiliated Providers.

Member Rights and Responsibilities

(continued)

At the same time, Presbyterian expects Members to cooperate by honoring Member Responsibilities as outlined in policies distributed through the following;

- Member Handbooks,
- Group Subscriber Agreements (GSAs),
- Certificates of Insurance,
- Evidence of Coverage (EOC),
- Summary Plan Descriptions (SPD), and
- The Presbyterian website.

These standards are written at the language level required by the regulatory agencies.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

1. To receive information needed to make informed decisions about the Managed Care Organization, health plan, or insurance company, including but not limited to; its healthcare services, how to access them, detailed benefit information, prescription medications, policies and procedures, its Practitioners and Providers, and the Members' rights and responsibilities.
2. To be treated equitably and with respect and recognition of their dignity and right to privacy.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

3. To participate with Practitioners in decision making regarding all aspects of the Member's health care, treatment plan development, and including refusal of treatment as well as the following:
 - a) Knowing the names and professional status of individuals participating in the Member's treatment, having timely access to the Practitioner primarily responsible for care, and referrals to specialists when medically necessary.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- b) Obtaining information about diagnoses, treatments, and expected outcomes to make informed decisions, unless the Practitioner or Provider determines that the information could be detrimental to the Member. (In this case, the information will be given to a person designated by the Member or a person legally authorized to receive such information.) In emergency cases, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- c) Giving informed consent based on information sufficient to permit a reasonably prudent person to make an informed decision about the proposed treatment, the inherent and potential hazards of the proposed treatment and hereby result if the condition remains untreated.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- d) Obtaining a second opinion for surgery or clarification of the treatment plan, utilizing Practitioners and Providers within the HMO network or arrange 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.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- PIC PPO Members who request a second opinion will be subject to the office visit deductible, copayment and co-insurance according to their plan. PIC PPO Members may see any Provider. If a PIC PPO Member receives services from a non-participating Practitioner/Provider, the Member is responsible for any charges above the reasonable and customary amount even if a participating Practitioner/Provider referred the services.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- e) Refusing treatment, medications, the services of a specific Practitioner or Provider, or leave a medical facility, even against the advice of the Practitioner(s), and accepting responsibility and consequences of the decision.
- f) Reasonable continuity of care and to know in advance the time and location of an appointment as well as the Practitioner providing care.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- g) Being advised if a Practitioner proposes to engage in experimentation affecting care or treatment and having the right to refuse to participate in such research projects.
- h) Being advised of continuing healthcare requirements following discharge from inpatient or out patient facilities.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- i) Obtaining prompt notification of termination, decreases or changes in benefit(s) or the Practitioner/Provider network that directly impact the Member's care.
- j) Be advised of their financial responsibility when seeking care from a Non-Participating Practitioner or Provider or in the event services are obtained without required benefit certifications that may be required under their plan.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

4. Members have a right to clear, private, and candid discussion or explanation of appropriate or medically necessary treatment options for their conditions or health decisions regardless of cost or benefit coverage and including payment structure or billing explanation for non-covered services.

Have the explanation provided to next of kin, guardian, agent or surrogate if available, when the Member is unable to understand. Have all explanations recorded in the Member's medical record, including where appropriate, a signed medical release authorizing release of medical information by the Member.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

5. To voice complaints or appeals about Presbyterian or the care provided. Each Member is entitled to use the avenues outlined in the PHP/PIC Member Handbooks, Group Subscriber Agreements, or Certificates of Insurance, Annual Notice of Change (ANOC), Evidences of Coverage, or Summary Plan Descriptions, for presenting questions and concerns about his or her health care, including use of the grievance process.
 - Commercial and PIC Members may request the assistance of the Superintendent of the New Mexico Department of Insurance as applicable.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- Medicaid Members have the right to file a concurrent grievance with the New Mexico Human Services Department (NMHSD).
- Medicare Advantage Members may also file an appeal to the Quality Improvement Organization (QIO) to request immediate QIO review if PHP/PIC determines that inpatient hospital care is no longer necessary and the Member disagrees. Medicare Advantage Members may also file quality of care grievances with the QIO.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

6. To make recommendations regarding Presbyterian's Members' Rights and Responsibilities Policy.
7. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

8. To receive healthcare services in a non-discriminatory fashion. No Member may be denied the benefits of, or participation in, covered services on the basis of gender, age, race, color, sexual orientation, physical or mental disability, cultural or educational background, religion or national origin, ancestry, marital status, economic or health status, genetic information, history of the frequency of the use of healthcare services, source of payment for care, or if a Member has filed a grievance or utilization management appeal. Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

9. To be free from harassment by Presbyterian or its network Providers in regard to contractual disputes between Presbyterian and Providers.
10. To choose from the available Practitioners and Providers within the limits of the Presbyterian network for their plan and its referral and benefit certification requirements and have adequate access to qualified health professionals near where they live or work within the Service Area.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

- (Indemnity plan Members are not required to be treated by network Providers.
- Medicaid Members have a right to choose any Provider for family planning services.)
- 11. To select an MCO and exercise switch enrollment rights without threats or harassment
 - (applies to Presbyterian Salud and SCI).

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

12. To formulate advance directives consistent with federal and state laws and regulations, living will or other directive to give to the contracted Practitioner or Provider, including the right to withhold resuscitative service or to forgo or withdraw life-sustaining treatment, and/or to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

13. To access his or her medical and financial records according to applicable federal and state laws and regulations. Members are entitled to confidentiality of medical and financial records. Records will be released only with the written consent of the Member or legal guardian or as otherwise allowed by law.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

14. To use emergency services when the Member believes and or their authorized representative believes they (the Member) have a medical condition that could seriously jeopardize health, cause serious impairment to bodily functions, or create a serious dysfunction of any bodily organ or part.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

15. To have access to translation services for Members who do not use English as their first language, and translation services for hearing-impaired Members for communication with Presbyterian.
16. To refuse care, treatment, or medications after the Provider or Practitioner has explained the care, treatment or provided other advice in a language that they understand.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

17. To receive information from their Provider or Practitioner, in language that they understand, including an explanation of their complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives appropriate to the Member's condition irrespective of Presbyterian's position on treatment options.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

18. To continue an ongoing course of treatment for a period of at least 30 days if the Member's Provider or Practitioner leaves the Presbyterian provider network or if a new Member's provider is not in the Presbyterian Practitioner or Provider network
 - (HMO benefit only - does not apply to indemnity Plan or PPO Members).

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

19. To know upon request of any financial arrangements or provisions between the healthcare insurer and its providers who may restrict referral or treatment options or limit the services offered to Members.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

20. To affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating Practitioner/Provider, and an explanation of a Member's financial responsibility when services are provided by a non-participating Practitioner/Provider or provided without required Benefit Certification.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

21. To detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that a Member must follow for prior authorization and utilization review.

Each Presbyterian Member and/or Legal Guardian has the Right: (continued)

22. To obtain prescription drug coverage within a reasonable period of time and information about their drug coverage and costs.
23. To receive a Certificate of Creditable Coverage when a Member's enrollment in Presbyterian terminates.

Members' Rights with Respect to Protected Health Information (PHI)

Members have the right to:

1. Have their personal health information protected and maintained in a confidential manner
2. Request restrictions on certain Uses and Disclosures of PHI, including a statement that PHP/PIC is not required to agree to a requested restriction
3. Receive confidential communications of PHI from PHP/PIC
4. Inspect and receive a copy of PHI

Members' Rights with Respect to Protected Health Information (PHI) (continued)

Members have the right to:

5. Amend incorrect or incomplete PHI; Members have the right to receive an accounting of certain Disclosures of PHI
6. Obtain a paper copy of the Notice from PHP/PIC upon request (even if the Member previously agreed to receive the Notice(s) electronically)

Members have the right to file a complaint if the Member believes PHP/PIC is not complying with the *HIPAA Standards for Privacy Of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 Subpart E*.

Each Presbyterian Member and/or Legal Guardian has the Responsibility:

Members have certain responsibilities regarding their health care, including the following responsibilities:

1. To provide, to the extent possible, complete information about matters relating to the Member's health and information that treating Practitioners and Providers need in order to care for them.

Each Presbyterian Member and/or Legal Guardian has the Responsibility: (continued)

2. To follow Presbyterian's policies, procedures, for obtaining services and follow plans and instructions for care medications, diet, and exercise that have been agreed upon with their Practitioners. A Member may, for personal reasons, refuse to accept treatment recommended by treating Practitioners or Providers. Practitioners/Providers may regard such refusal as incompatible with the continuance of the practitioner-patient relationship and as obstructing the provision of proper medical care.

Each Presbyterian Member and/or Legal Guardian has the Responsibility: (continued)

3. To understanding their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
4. To inform the Practitioner if he/she does not understand the Practitioner's explanation concerning the Member's medical care and raise questions to the treating Practitioner, Presbyterian, or Presbyterian Customer Service Center for suggestions, concerns, or payment issues.

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

5. To schedule and cancel appointments including transportation. If the Member cannot keep a scheduled appointment, he/she must call the provider if possible 24 hours in advance to reschedule or cancel the appointment. Members should not fail to keep an appointment without notifying the Practitioner or Provider ahead of time.

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

6. To treat Providers, Practitioners and other healthcare employees with respect and courtesy.
7. To pay all required copayments at the time services are rendered if applicable, and show the ID card prior to receiving medical services or be billed for rendered services. If a plan premium is applicable, each Member is responsible to pay such required plan premiums.
 - (does not apply to Presbyterian Salud Members)

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

8. To refuse to allow any other person to use his/her Presbyterian Identification card.
9. To notify Presbyterian immediately of any loss or theft of his/her Presbyterian Identification card.
10. To ensure that information given in application for enrollment, questionnaires, forms or correspondence is true and complete. To be informed of the potential consequences of providing incorrect or incomplete information to Presbyterian.

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

11. To notify Presbyterian of any changes in names, address, phone number, marital status, newborns that affect eligibility.
 - Salud Members must notify the Human Services Department.
 - Commercial Members must notify the Health Plan of changes within 31 days unless otherwise agreed to in the Group Letter of Agreement.

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

12. To advise a treating Practitioners/Providers of coverage with Presbyterian at the time of service. Members may be required to pay for services if they do not inform their treating Practitioner or Provider of their Presbyterian coverage.
13. To behave in a manner that supports the care provided to other patients—and the general functioning of the facility.

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

14. To safeguard the confidentiality of their own care and that of other patients.
15. To accept the financial responsibility, as applicable, associated with services received while under the care of a Provider or Practitioner. Be responsible for the payment of all services obtained prior to the effective date of the Agreement and subsequent to its termination or cancellation.

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

16. To review information regarding covered services, policies and procedures as stated in their applicable combined Evidence of Coverage, Member Handbook, GSAs, and to contact the Presbyterian Customer Service Center for clarification of benefits, benefit limitations, and exclusions outlined in these documents. Medicare Advantage members will also receive and be required to review their Annual Notice of Change (ANOC).

Each Presbyterian Member and/or Legal Guardian has the Responsibility (continued):

17. To request and obtain information about any financial arrangements between Presbyterian and its Providers or Practitioners which might restrict referral or treatment options or limit services offered to Members.
18. To change Primary Care Practitioners by following the rules described in their Member Handbook, GSA, SPD, or EOC.

The Presbyterian Customer Service Center



The Presbyterian Customer Service Center

- Web-based Inquiries:
 - Log on to the Providers Web page at www.phs.org, and click on the Provider CARE Unit under “Quick Links” (top right) to contact the Provider CARE Unit.
 - Log on to Pres Online and click on the “Contact the Provider CARE Unit” link.

Note: Bookmark this as a favorite for quicker access.

The Presbyterian Customer Service Center

- Mailing Address for Corrected Claims, Resubmitted Claims, and Claims with Proof of Timely Filing:

Presbyterian

P.O. Box 27489

Albuquerque, NM 87125-7489

The Presbyterian Customer Service Center

- Dedicated Unit for your complex inquiries
 - Web inquiries / e-mails
 - Phone Calls (505) 923-5757, toll-free 1-888-923-5757
 - Monday through Friday, 8:00 a.m. to 5:00 p.m.
- Other services offered by Presbyterian:
 - Pres Online
 - IVR (eligibility, benefits, PCP verification, copayments, etc.)
 - Electronic Claims Submission (ECT)

Enterprise-Wide Complaint Management



Provider Grievances

Providers have the right to file a grievance if he/she:

- Is dissatisfied with a PHP/PIC decision to terminate
- Is dissatisfied with a PHP/PIC decision to suspend
- Disagrees with PHP's or PIC's general operations

Provider Grievances

Formal grievances:

- Should be submitted by e-mail at www.phs.org or in writing
- Challenging a decision or policy other than a claim denial will be completed within 30 days from the date of receipt
- Challenging a claim denial, claim adjudication, claim submission or claim resubmission not acted upon need to be submitted within 12 months from the date of service

Provider Appeals

Providers may appeal:

- The denial of a Benefit Certification or a concurrent review decision by submitting further documentation to support medical necessity.
For all Benefit Certification appeals - Provider must obtain the Member's consent (exception-expedited appeal requests).
- Correct Coding denials by submitting further documentation to support the coding
- Denials you feel may be inappropriate

Appeals challenging a claim denial will be completed within 30 days from date of receipt.

Provider Appeals

Appeals challenging a claim denial will be completed within 30 days from date of receipt.

Providers have 1 year from the date of service to appeal a claim or the denial will be upheld as past the filing limit. For overpayments identified by PHP, an appeal may be filed within 12 months of the date of service or 60 days of the notification, whichever is the later date.

***Note: Corrected claims, proof of timely filing, new claims or adjustment requests need to be submitted to the Provider CARE Unit.**

Member Appeals and Grievances

All Members have the right to make a complaint if they have concerns or problems related to their coverage or care.

Two types of complaints a Member can make are:

1. “ Appeals”
2. “Grievances”

Member Appeals

Appeal: The type of complaint Members make when they want us to reconsider and change a decision we have made about what services are covered for them or what we will pay for.

- **Medical Director Appeal:** filed when Member is not satisfied with a Presbyterian Medical Director decision that either denied or limited a medical service.

Member Appeals (continued)

- **Initial Appeal Review:** filed when Member is not satisfied with any other Presbyterian decision that was not made by a Medical Director, and did not deny or limit a medical service. Example: How Presbyterian paid a claim.

Member Appeals (continued)

- **Fast Appeal:** Requested only when it is an emergency medical issue. This type of appeal is for those cases in which a longer time to reach a decision may increase the medical risk to the Member and not apply to issues such as the request to change a decision regarding how a claim was paid.

With a Member's written consent, practitioners may also file an appeal on the Member's behalf.

Member Appeals (continued)

To file an Initial Appeal or Fast Appeal, Members may:

- Call our Presbyterian Customer Service Center:
 - (505) 923-5678 or toll-free 1-800-356-2219
 - TTY users should call 1-877-298-7407
 - Monday through Friday, 7:00 a.m. to 6:00 p.m.
- Fax appeals to (505) 923-5124
- Send a written appeal request letter to:

Grievance and Appeals Coordinator
P.O. Box 27489
Albuquerque, NM 87125-7489

Member Appeals (continued)

- Presbyterian must receive the Member's appeal request within 60 days of the action or decision that is being appealed.
- The appeal request should clearly explain the nature of the Appeal. Members should include any of the following that they feel may help their appeal:
 - Medical records,
 - Medical literature,
 - Medical bills,
 - Expense records; and
 - Written statements or letters from the Member or a healthcare Provider.

Salud Member Appeals

Salud Member Appeals: A request for review by Presbyterian Salud of a Presbyterian Salud action.

Action defined as:

- A physical healthcare service the Member or Member's Provider requests is limited or denied
- A physical healthcare service that a Member has already been authorized to receive is limited or denied
- Presbyterian Salud decides not to pay for all or part of a physical healthcare service

Salud Member Appeals (continued)

- Presbyterian Salud does not give a Member good service or does not respond to their complaints
- Presbyterian Salud does not complete a benefit certification (authorization) for routine care within 14 days, or for urgent care within 72 hours

Salud Member Appeals (continued)

Salud Members have the right to file an appeal.

The legal guardian of the Member for minors or incapacitated adults, a representative of the Member as designated in writing to Presbyterian Salud, or a Provider acting on behalf of the Member with the Member's written consent, has the right to file an appeal of an action on behalf of the Member.

- Filed within 90 calendar days of the date Member received notice of the decision

Salud Member Appeals (continued)

- Filed verbally by calling Presbyterian Customer Service Center
 - (505) 923-5200 or toll-free 1-888-977-2333
 - TTY users should call 1-888-872-7568
 - Monday through Friday, 7:00 a.m. to 6:00 p.m.
- Fax appeals to (505) 923-5124
- Send a written appeal request letter to:
Presbyterian Salud
Grievance and Appeals Coordinator
P.O. Box 92085
Albuquerque, NM 87199-2085

Salud Member Fair Hearing Process

Salud Members may ask for a fair hearing through NM HSD before, during, or after filing and resolving an appeal with Presbyterian Salud. If a Salud Member decides to ask for a fair hearing, they must do so within 90 calendar days of receiving notice of the decision with which they disagree.

Salud Member Fair Hearing Process

(continued)

To request a fair hearing, Salud Members write to:

Fair Hearings Bureau
37 Plaza La Prensa
P.O. Box 2348
Santa Fe, NE 87507

Or call:

(505) 476-6213

Toll-Free 1-800-432-6217, and then press 6

Fax (505) 476-6215

Salud Member Fair Hearing Process

(continued)

Salud Members may request a fair hearing for up to 90 calendar days after Presbyterian Salud's decision to deny or limit a physical healthcare service.

Salud Members may request an extension of the benefit. Requests should be made within 13 calendar days of the decision by Presbyterian Salud. Presbyterian Salud will continue the service and wait for the outcome of the fair hearing.

Salud Members may have to pay for services received if the fair hearing is resolved in favor of Presbyterian Salud.

Salud Member Fair Hearing Process

(continued)

To request an extension of the benefit while waiting for the Fair Hearing outcome, Salud Members may:

- Call Presbyterian Customer Service Center
 - (505) 923-5200 or toll-free 1-888-977-2333
 - TTY users should call 1-888-872-7568
 - Monday through Friday, 7:00 a.m. to 6:00 p.m.
- Send a request letter to:
Presbyterian Salud
Grievance and Appeals Coordinator
P.O. Box 92085
Albuquerque, NM 87199-2085

Salud Member Fair Hearing Process

(continued)

Members may speak for themselves at the hearing, or have a friend, relative, spokesperson, or attorney speak for them.

Members may also ask the Hearing Bureau to show the Member their file.

Presbyterian Salud will not tell anyone about the Member's appeal or fair hearing without their permission or unless we are required by law. We will still give Salud Members the physical health care that they need, even if they disagree, file an appeal or ask for a fair hearing. Salud Members are not punished for disagreeing with Presbyterian Salud, for filing an appeal or for requesting a fair hearing.

Member Grievances

Grievance: The type of complaint made if a Member has a problem with Presbyterian Health Plan, Presbyterian Insurance Company, Inc., Presbyterian Senior Care or one of our plan Practitioners and Providers, such as:

- Quality of the Member's care
- Waiting times for appointments or in the waiting room
- The way the Member's doctors or others behave
- Being able to reach someone by phone or get the information the Member needs
- The cleanliness or condition of the doctor's office.

Member Grievances (continued)

A Practitioner/Provider may represent a Member in a grievance with written consent from the Member.

To file a Grievance:

- Members are encouraged to first call the Presbyterian Customer Service Center with any questions at:

- (505) 923-5678

- Toll-Free 1-800-356-2219

- TTY users should call 1-877-298-7407

Monday through Friday, 7:00 a.m. to 6:00 p.m.

We will try to resolve any complaint the Member may have over the phone.

Member Grievances (continued)

- Members may submit a written complaint (grievance request letter) to:

Grievance and Appeals Coordinator
P.O. Box 92085
Albuquerque, NM 87199-2085

- Or Fax to: (505) 923-5124

Member Grievances (continued)

A formal grievance process exists to review Member complaints.

- Once Member grievance is received, Presbyterian notifies Member in writing within fifteen (15) working days after we receive their grievance regarding how we have addressed their concern.
- In some instances, we may need additional time to address the concern. If additional time is needed, Presbyterian keeps Member informed of how their grievance is being handled.

Salud Member Grievances

Salud Member Grievance: A Salud Member's expression of dissatisfaction about any matter or aspect of Presbyterian Salud or its operation other than a Presbyterian Salud action.

Salud Member Grievances (continued)

To file a Salud Member Grievance, Salud Members may call Presbyterian Customer Service Center at:
(505) 923-5200

Toll-Free 1-888-977-2333

TTY Users 1-888-872-7568

Monday through Friday, 7:00 a.m. to 6:00 p.m.

Salud Members may also submit grievances to NM HSD by calling:

Local (505) 476-6800

Toll-Free 1(888) 957-2583

Fax (505) 476-6825

Salud Member Grievances (continued)

- If needed, Presbyterian Customer Service Center provides assistance to Salud Members with filing the grievance or translating the grievance into English or to answer any questions the Salud Member may have.
- We will try to resolve any Member complaint over the phone.

Salud Member Grievances (continued)

Submit a written complaint (grievance request letter) to:

Grievance and Appeals Coordinator
P.O. Box 27489
Albuquerque, NM 87125-7489

Fax to: (505) 923-5124

Grievance must be filed within 90 calendar days of the date that the Salud Member had the problem with their health care.

Salud Member Grievances (continued)

A formal grievance process exists to review Member complaints

- Presbyterian Salud will resolve the Member Grievance within 30 calendar days
- If needed, Presbyterian Salud may request a 14 (calendar) day extension.
- Salud Members may also request a 14 (calendar) day extension.
- NM HSD must approve any 14 day extensions

Salud Member Grievances (continued)

Upon resolution of the grievance, Presbyterian Salud will send the Salud Member a letter explaining:

- What information was used to resolve the grievance
- How we resolved the grievance
- Will also state that we have finished working on the grievance

Salud Member Grievances (continued)

Unless they are involved in the Salud Member's grievance, Presbyterian Salud staff will not tell anyone about the Member's grievance without the Member's permission or unless we are required to by law.

Physical health care needed will still be provided, even if a grievance is filed.

Salud Members are not punished for filing a grievance with Presbyterian Salud.

Presbyterian Salud keeps copies of all filed grievances. Members may ask to see copies of their grievances any time by using the contact information previously provided.

Salud Behavioral Health Member Grievances

If a Salud Member has a complaint or grievance about their Behavioral Health Provider or the statewide entity, OptumHealth New Mexico, they should call Customer Support Services. Any staff member can help get the grievance process started. If Members prefer, a Peer or Family Support Specialist can help them with the filing.

Salud Behavioral Health Member Grievances (continued)

They also can send their complaint or grievance in writing to:

OptumHealth New Mexico
Compliance Manager
8801 Horizon Boulevard NE
Albuquerque, NM 87113

Or call anytime for confidential help:

Phone: 1-866-660-7185

TTY users: 1-800-855-2881

Salud Behavioral Health Member Grievances

(continued)

The Medical Assistance Division also has a special number or address:

Call:

Behavioral Health Ombudsman

1-877-247-2583

Monday through Friday, 8:00 a.m. to 5:00 p.m.

Or write to:

Behavioral Health Ombudsman

Medical Assistance Division

2025 South Pacheco Street

Santa Fe, NM 87505

Appeals and Grievances Timelines

Presbyterian must render a written decision to the Member and/or appropriate Provider within **strict timelines** set by various regulatory agencies.

So we need your help - please respond to our requests for additional information within **2 business days.**

Appeals and Grievances Contacts

Lisa Gallegos: (505) 923-6031

or

Patricia Rivera: (505) 923-8767

Fax: (505) 923-5124

Health Services



Benefit Certification (continued)

PHS website

- Benefit Certification Guide
- Benefit Certification Forms
- Medical Policy Manual

www.phs.org

- Health Plans
- For Providers
- Health Services

Benefit Certification (continued)

Pres Online

- Submit certification requests
- Auto-approvals for specific services
- Check status of certification request
- Check eligibility

For Access, log on to:

<http://www.phs.org/phs/healthplans/content/ProviderAccessstoPresOnline/index.htm>

Benefit Certification Guide

- List of Services requiring Benefit Certification
- Updated quarterly
- Fax Numbers
- Link to website for Pres Online
- Advanced Imaging / HealthHelp

Benefit Certification Requirements

Documentation

- Clinical Information
 - Symptom
 - Previous Treatment
 - Comorbidities
- Diagnosis Code
- Procedure Code(s)
- Diagnostic Test Results

Pharmacy Services



Pharmacy Services

Hours of Operation:
Monday through Friday,
8:00 a.m. to 5:00 p.m.

Telephone:
In Albuquerque: (505) 923-5757
Outside of Albuquerque: 1-888-923-5757

On-Call Pharmacist Available:
24 hours a day, 7 days a week

What Do We Want To Accomplish?

Mission: Improve the health of individuals, families, and communities by providing quality, cost-effective administration of pharmacy benefits for our Members

- Give you an understanding of how our Pharmacy Services Department operates and can be used as a resource
- Provide additional resources that you may find helpful in the future
- Help patients get medications as quickly and easily as possible

Pharmacy Services Responsibilities

- Pharmacy Eligibility
- Plan Benefits Setup
- Formulary Development and Maintenance
- Manage Pharmacy and Therapeutics Committee (Bi-Monthly)
- Provide Clinical Pharmacy, Drug Utilization Review and Disease Management
- Administer Medication Therapy Management (MTM) Program

Rx Benefits and Formulary

Commercial Plans: Four (4) -Tier formulary structure (most)

- Tier 1: Preferred Generics
- Tier 2: Preferred Brands
- Tier 3: Non-Preferred Drugs
- Tier 4: Specialty Pharmaceuticals

Medicare Part D – Four (4) -Tier formulary structure

- Tier 1: Preferred Generics
- Tier 2: Preferred Brands
- Tier 3: Non-Preferred Drugs
- Tier 4: Specialty Pharmaceuticals

Rx Benefits and Formulary (continued)

Salud, NMRx*, SCI: Two (2) - Tier formulary structure (most)

- Tier 1: Preferred Generics
- Tier 2: Preferred Brands
- *Presbyterian provides Rx coverage (no medical benefits)

PIC Plans – vary by benefit;

- some have the 4-Tier structure,
- some have a generic only plan,
- while others have no pharmacy for behavioral health medications.

Please refer to a patient's specific summary of benefits to determine what Rx coverage they may have.

Formulary Definitions

- **Prior Authorization (PA)**: A drug is on the formulary but requires a prior authorization request from the physician via fax, phone, or regular mail. If the patient meets established criteria for approval, the medication will be covered. Documentation of treatment failures and clinical justification is required for all requests.
- **Step Edit (ST)**: An automatic online review of certain medications that are available to patients if they meet established criteria. Coverage of the medication at the pharmacy requires the patient to have a prescription history of specific drugs.

Formulary Definitions (continued)

- **Specialty Edit (SP)**: Applies to indicated medications prescribed by specific specialties. Online coverage of medication at the pharmacy requires the prescription to be written by a physician specialist.
- **Quantity Limit (QL)**: A coverage limit on the medication quantity covered per a defined days' supply (usually 30 or 90 days) based on safety, efficacy and/or dose optimization issues.
- **Age Limitation (AG)**: A coverage limit based on minimum or maximum age of the Member imposed as a result of safety, efficacy or dosage form considerations.

Communications

Pharmacy Services operates a Call Center that is available Monday through Friday from 8:00 a.m. to 5:00 p.m. in order to assist:

- Pharmacies in claims adjudication
- Providers with formulary questions
- Pharmacies/providers with the Prior Authorization process
- Providers/care managers with drug utilization

Medication Therapy Management (MTM) - Medicare

Members are eligible if they meet the following criteria:

- Have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure)
- Take multiple drugs

Program has been rolled out to all product lines, does not just apply to Medicare.

Enrolling in the MTM Program

- Patients can self enroll
- Physicians can refer patients into the program
- Care Coordinators can refer patients
- Patients should call Presbyterian Customer Service Center
- Physicians and Care Coordinators should call the Presbyterian Pharmacy Services Help Desk for any questions regarding enrolling a Member

Pharmacy Resources on www.phs.org

Some of the following resources are available to providers on our website:

- Formularies/Structures/Tiers
- Prior Authorization Criteria and Forms
- Specialty Pharmaceutical List
- Respiratory Syncytial Virus (RSV) Season
- Request an addition to the Presbyterian Health Plan Formulary
- Epocrates
- Micromedex
- Professional Links, such as Center for Disease Control and Medwatch

Behavioral Health



Behavioral Health – Care Coordination

State regulation requires physical and behavioral health providers to have access to relevant medical records for mutually served Members, to ensure maximum benefits of services to the Member. The sharing of information with any entity requires written consent by the Member.

Behavioral Health – Care Coordination

Care Coordination with the PCP must:

- Be within 7 days of admission to a behavioral health service
- Be upon any significant change in Member's behavioral health status
- Be upon discharge from a BH service
- Show documentation evidence of the communication in the Member's medical record

PHP has developed a form that can be used to exchange clinical information about care being provided to a Member.

Behavioral Health – Care Coordination Form

The form is found on our website,
go to www.phs.org,
click on “**Health Plans**” (top of Web page),
click on “**For Providers**” (left side),
click on “**Behavioral Health**” (under For
Providers)
click on “**Coordination of Care Form**”
(middle of page)

Providers may also use their own means of documenting coordination of care in the medical record chart.

Co-Management – What is it?

- A contractual agreement with HSD of New Mexico to assure that coordination between physical and behavioral health practitioners occurs with all Salud Members who have both Behavioral Health and Physical Health Needs
- The avenue of communication between PHP and OptumHealth New Mexico
- Involves BH Liaison, Nurse Care Coordinators (NCC), Specialized Care Coordinators, OptumHealth and PHP Medical Directors
- Requirement of all four MCOs

Components of Co-Management

- Referrals to and from OptumHealth New Mexico
- Managing Co-managed Cases
- Joint Monthly Co-Managed Meetings
- Ongoing Communication
- Documentation
- Operational Meetings

Referral Process for Co-Management

- Salud Members can Self-Refer to OptumHealth New Mexico by calling:
 - 1-866-660-7185
 - TTY 1-800-855-2881
- Provider can refer Member
- NCC can call OptumHealth New Mexico with Member
- NCC can propose OptumHealth New Mexico coordination to Member and complete referral

Urgency of Referral – OptumHealth NM

- Emergent/High Priority: Refer member to 911 or the Emergency Room. Provider may call the 24 hour Provider line at (888) 660-7182, explain that the situation is a crisis, and ask to speak with a clinician. Once the Member is stabilized, the Provider can then refer the member once they are stabilized as an “Urgent” or “Routine” referral.
- Urgent/Medium Priority: When this type of referral is made, a CC will be assigned within 1 business day from the day the fax is received
- Routine/Low Priority: When this type of referral is made, a CC will be assigned within 5 business days.

Examples of Appropriate Referrals

- Member in need of contracted BH provider in area
- Nurse clinical opinion of Member's symptoms lead them to believe BH services may help
- Safety of Member appears at risk
- Medication adherence or Medication seeking
- Treatment adherence issues
- History of chronic BH diagnosis
- Member could benefit from BH/PHP team approach

Overall Goals

- To ensure the total Members' needs are met
- Create a collaborative process
- Communicate with all players
- Resolve complex issues together
- To provide the best quality of care to Members

Behavioral Health Referral Information: NMAC 18 Indicators

Presbyterian Health Plan encourages you to make a direct behavioral health referral for any of the following 18 indicators listed in the New Mexico Administrative Code (NMAC).

1. Suicidal/homicidal ideation or behavior
2. At-risk of hospitalization due to a behavioral health condition
3. Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement

Behavioral Health Referral Information: NMAC 18 Indicators (continued)

4. Trauma victims including possible abused or neglected Members
5. 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
6. Request by Member, parent, or legal guardian of a minor for behavioral health services
7. Clinical status that suggests the need for behavioral health services

Behavioral Health Referral Information: NMAC 18 Indicators (continued)

8. Identified psychosocial stressors and precipitants;
9. Treatment compliance complicated by behavioral characteristics
10. Behavioral, psychiatric, and/or substance abuse factors influencing a medical condition
11. Victims or perpetrators of abuse and neglect
12. Non-medical management of substance abuse
13. Follow-up to medical detoxification

Behavioral Health Referral Information: NMAC 18 Indicators (continued)

14. An initial PCP contact or routine physical examination indicates a substance abuse or mental health problem
15. A prenatal visit indicates a substance abuse or mental health problem
16. Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse

Behavioral Health Referral Information: NMAC 18 Indicators (continued)

17. A pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions
18. The persistence of serious functional impairment

Behavioral Health Referral Information

If you feel your Presbyterian patients need a behavioral health referral, contact one of the following:

| Presbyterian Plan | Contact Information |
|---|---|
| Salud | OptumHealth New Mexico: Toll-free: 1-866-660-7182 nm_provider_relations@optumhealth.com www.optumhealthnewmexico.com |
| Statewide Coverage Ins. (SCI) Commercial/PIC, Senior Care (HMO) MediCare PPO | Presbyterian: (505) 923-5221 Toll-free: 1-866-593-7431 |

Please note: If a patient is in imminent danger or there is an urgent/emergent situation, call 911 and have the patient treated immediately.

Behavioral Health

Mental Health Parity and Addiction Act
of 2008



Mental Health Parity and Addiction Equity Act of 2008

What is the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008?

- Enacted on October 3, 2008 as part of H.R. “Emergency Economic Stabilization Act of 2008”
- Amends existing federal mental health parity requirements found under the Employee Retirement Income Security Act of 1974 PHSA (ERISA), the Public Health Service Act (PHSA), and Internal Revenue Code (IRC)
- What does it do and what does this mean?
 - Requires “parity” for Substance Abuse (SA) coverage
 - Parity is defined as: Equality, as in amount, status, or value

MHPAEA Specifics

- **New Mexico Mental Health Parity**: You must provide MH benefits and Parity must apply (2-49 employees exempt)
- **MHPAEA (federal)**: If you provide MH services, you must provide SA services and parity applies
- Health plan insurers that provide group coverage to group health plans are subject
- Employers with 51 or more employees (50 or less employees exempt)
- Commercial and ASO Employers (except Government Agencies)
- New or renewing groups on or after October 3, 2009

MHPAEA Specifics (continued)

- Apply same financial requirements for MH/SA benefits as for medical and surgical benefits
 - Financial requirements cannot be more restrictive, and includes; deductibles, copays, co-insurance, and out-of-pocket expenses
 - Treatment limitations cannot be more restrictive
 - Predominant requirements/limitations applied to substantially all medical and surgical benefits

Proposed Changes to Existing Commercial Plans

For those plans affected;

- Substance Abuse benefits will mirror current Mental Health benefits (both Inpatient and Outpatient)
- Current limitations (30 days, 30 visits) will be removed
- SA benefits will be incorporated into Schedule of Benefits (Rider will “go away”)

American Recovery and Reinvestment Act of 2009

Summary for Providers of Key HIPAA Provisions of the Stimulus Bill



Major Implications for Health Care

- The American Recovery and Reinvestment Act (ARRA) of 2009 (a.k.a., the “Stimulus Bill”) became law on February 17, 2009
- Numerous provisions that have significant and long-ranging impact on the healthcare industry

Major Implications for Health Care

(continued)

- Key areas affected include:
 - Medicaid Programs and Providers (\$87 billion increase in matching funds to states, with a corresponding increase in scrutiny, reporting and regulatory enforcement)
 - Health Information Technology (HIT) (\$19 billion, including provider incentives for adoption, and related privacy/security regulation)
 - Comparative Effective Research Funding (\$1.1 billion aimed at identifying best practices and reducing ineffective or inappropriate care)

Health Information Provisions

This portion of the presentation will focus on the many ARRA provisions that relate to health technology and the privacy and security of protected health information:

“Medicare (and Medicaid) reimbursement is again being used as a tool to change providers’ behavior, and this time the government is shooting for widespread adoption of electronic health records (EHRs).”

“The American Recovery and Reinvestment Act of 2009: HealthCare Industry Implications,” Erin Trompeter and Susan Namovicz, Editors, Atlantic Information Services, Inc., 2009.

A Few of the Key Provisions

- **Goal:** “The utilization of a ‘certified’ electronic health record for each person in the United States by 2014.”
- **Voluntary:** Adoption of standard technology is “voluntary” for private entities
- **Incentives for adoption:** Will make it impractical for most not to adopt
- **Eligibility for incentives:** Payments made only for “meaningful use” of EHR by provider

National Coordinator will implement programs to “certify” health information technology

- Technologies will include:
 - Electronic Health Record Systems
 - Privacy technology – including segmentation of “sensitive” information (behavioral, reproductive, etc.)
 - Health information exchange technology
 - Accounting of all and any disclosures
 - Quality reporting and care coordination
 - Encryption

National Coordinator will implement programs to “certify” health information technology (con’t)

- Technologies will include:
 - Comprehensive collection of patient demographic data
 - Technologies to address needs of “vulnerable populations”
- Deadline for government to establish standards:
 - » **December 31, 2009**

Incentives for Adoption

- Government agency contracts will require providers and plans to adopt technology systems that meet standards when they acquire or upgrade
- Incentive payments added to regular Medicare reimbursement – if provider is determined to be a “meaningful” user of EHR
- Immediate funding for training of current practitioners
- HIT “Extension Program” to assist private and public sector implementation
- Grants to States and Tribes
- Funds to train students: Clinical and IT Professionals

Beefed Up Privacy and Security

- Extensive public notification requirements when there is a breach by provider, plan, or business associate.
 - Notify individual in writing
 - If more than 500, post in media
- Changes to your Business Associate Agreements
- Prohibition of sale of Protected Health Info (PHI); greater scrutiny of “marketing” uses of PHI
- Tracking of all disclosures within EHR, including those for treatment, payment, and healthcare operations
- Immediate increase in penalties

Deadlines

| Date | Requirement |
|-------------|---|
| 02/17/2009 | <ul style="list-style-type: none">• Increase in monetary penalties;• HIPAA coverage expanded from just “entities” to include individuals within entities |
| 09/23/2009 | Breach notification requirements take effect (Guidance issued 4/17/2009) |
| 12/31/2009 | Government to adopt standards for EHR certification |

Deadlines (continued)

| Date | Requirement |
|------------|---|
| 02/17/2010 | <ul style="list-style-type: none">• Entities must agree to certain restriction requests from patients paying out of pocket• Stricter minimum necessary provisions take effect• New requirements for Business Associates take effect |
| 08/18/2010 | Guidance due from HHS re: minimum necessary (will replace provisions mentioned above) |

Deadlines (continued)

| Date | Requirement |
|--|--|
| Whichever comes later, 01/01/2011 or date EHR was acquired | If provider acquires EHR <u>after</u> January 1, 2009, must comply with new tracking and accounting for disclosure requirements by this date (rules assume that recent technology already meets the certification standard). |
| 06/30/2011 | HHS to issue specifics re: which disclosures must be tracked in EHR, and what info about disclosures must be recorded |

Deadlines (continued)

| Date | Requirement |
|-------------|--|
| 01/01/2014 | If provider acquires EHR <u>on or before</u> January 1, 2009, must comply with new tracking and accounting for disclosure requirements by this date (rules assume that earlier technology already meets the certification standard). |

Resources for More Information

- General Info and text of the Act:
www.whitehouse.gov/the_press_office/arra_public_review/
- Information regarding 04/17/09 Encryption and Breach Notification Guidance (including link to Guidance text):
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/guidance_breachnotice.html
- National Committee on Vital and Health Statistics (NCVHS): *<http://www.ncvhs.hhs.gov/>*

Resources for More Information (continued)

- Health Human Services – Health IT Support:
<http://healthit.hhs.gov/portal/server.pt>
- Workgroup on Electronic Data Interchange
(WEDI): *<http://www.wedi.org/>*

Coding and Reimbursement



Provider Coding Information

The information included in the following slides is intended to provide you with information on how claims may be adjudicated by Presbyterian Health Plan and Presbyterian Insurance Company, Inc.

It is not intended to provide advice regarding specific individual claims, compliance of federal or state law, of other insurance, or other payers.

Hot Topics

- National Correct Coding Initiative (NCCI) Edits
 - Column 1/Column 2 Code Pairs
 - Mutually Exclusive Code Pairs
- Surgical Status Indicators
 - Multiple Surgery
 - Bilateral Surgery
- Other Pertinent Modifiers
- PHP Coding Updates
- Questions

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NCCI Edits

- Purpose of the development of the NCCI Edits:
- To promote national correct coding methodology
- Based on coding conventions defined by the CPT manual, national and local policies, national societies, standards of medical/surgical practice, and current coding practices
- Ensure that most comprehensive groups of codes are billed rather than the component parts
- As a check for mutually exclusive code pairs to ensure that only appropriate codes are grouped and priced.
- <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

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NCCI Column1/Column 2 Edits

| Column1/Column 2 Edits | | | | | |
|------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date *=no data | Modifier 0=not allowed 1=allowed 9=not applicable |
| 10021 | 64470 | | 20021001 | * | 1 |
| 10021 | 64475 | | 20021001 | * | 1 |
| 10021 | 76000 | | 20030701 | * | 1 |
| 10021 | 76003 | | 20030101 | 20061231 | 1 |
| 10021 | 76360 | | 20030101 | 20061231 | 1 |

- Column 1 is considered the more comprehensive code
- Column 2 is generally an integral component of the comprehensive code
- An * in the third column indicates that this rule has been in effect since prior to 1996

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| 10021 | 64470 | | 20021001 | * | 1 |
| 10021 | 64475 | | 20021001 | * | 1 |
| 10021 | 76000 | | 20030701 | * | 1 |
| 10021 | 76003 | | 20030101 | 20061231 | 1 |
| 10021 | 76360 | | 20030101 | 20061231 | 1 |

- The fourth column indicates the date when the edit became effective
- The fifth column indicates the date when this rule was terminated
- The sixth column indicates whether this edit can be overridden by a modifier

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NCCI Mutually Exclusive Edits

- Code pairs that can not reasonably be done in the same session.
- Based on medical impossibility/improbability that procedures can be performed in the same session.

| Mutually Exclusive Edits | | | | | |
|--------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date *=no data | Modifier 0=not allowed 1=allowed 9=not applicable |
| 10061 | 11626 | | 19960101 | * | 1 |
| 10061 | 11642 | | 19960101 | 19960101 | 9 |
| 10061 | 11643 | | 19960101 | * | 1 |

The information included in this slide is intended to provide you with information on how claims may be adjudicated by Presbyterian Health Plan and Presbyterian Insurance Company, Inc.

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NCCI Mutually Exclusive Edits

| Mutually Exclusive Edits | | | | | |
|--------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date *=no data | Modifier 0=not allowed 1=allowed 9=not applicable |
| 10061 | 11626 | | 19960101 | * | 1 |
| 10061 | 11642 | | 19960101 | 19960101 | 9 |
| 10061 | 11643 | | 19960101 | * | 1 |

- Column 1 is considered the comprehensive code
- Column 2 is generally an integral component of the comprehensive code

The information included in this slide is intended to provide you with information on how claims may be adjudicated by Presbyterian Health Plan and Presbyterian Insurance Company, Inc. It is not intended to provide advice regarding specific individual claims, compliance of federal or state law, of other insurance, or other payers.

NCCI Mutually Exclusive Edits (continued)

| Mutually Exclusive Edits | | | | | |
|--------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date *=no data | Modifier 0=not allowed 1=allowed 9=not applicable |
| 10061 | 11626 | | 19960101 | * | 1 |
| 10061 | 11642 | | 19960101 | 19960101 | 9 |
| 10061 | 11643 | | 19960101 | * | 1 |

- An asterisk (*) in the third column indicates that this rule has been in effect prior to 1996
- The fourth column indicates when the edit became effective

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NCCI Mutually Exclusive Edits (continued)

| Mutually Exclusive Edits | | | | | |
|--------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date *=no data | Modifier 0=not allowed 1=allowed 9=not applicable |
| 10061 | 11626 | | 19960101 | * | 1 |
| 10061 | 11642 | | 19960101 | 19960101 | 9 |
| 10061 | 11643 | | 19960101 | * | 1 |

- The fifth column indicates the date when the edit was terminated
- The sixth column indicates whether the edit can be overridden with a modifier

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NCCI Medically Unlikely Edits (MUE)

- CMS developed MUEs as part of their automated prepayment edit system to help prevent inappropriate payments.
- The MUEs are not meant to establish CMS payment policy, documentation should support the number of units billed. They are meant to improve the accuracy of payment based on criteria such as anatomic area, code description, CPT coding instructions, nature of service/procedure and clinical judgment.

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NCCI Medically Unlikely Edits (MUE) (continued)

- MUEs do not exist for all HCPCS/CPT codes so the document on the website that follows is not an all inclusive list.
- Most MUEs are set at between 1 (one) and 3 (three) and are updated quarterly.
- CMS has been using MUEs since January 2007, but did not publish them until recently.

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NCCI Medically Unlikely Edits (MUE) (continued)

- PHP/PIC does not have any units set lower than the MUEs established by CMS. On codes where no CMS MUE has been established, our clinical staff has reviewed and set a unit value based on the same criteria as CMS as well as the history of claims we have received from all providers. There will be cases where the unit value billed is higher than our normal allowable, but these should be exceptions and as such will be reviewed on a case by case basis. Medical records will be necessary for the individual case reviews.

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NCCI Medically Unlikely Edits (MUE) (continued)

<http://www.cms.hhs.gov/transmittals/downloads/R178PI.pdf>

| HCPCS\CPT Code | Practitioner or DME Supplier MUE |
|-----------------------|---|
| 11954 | 1 |
| 11960 | 3 |
| 11970 | 2 |
| 11971 | 2 |
| 11976 | 1 |

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NCCI Narrative Information

- Provides the policy behind the NCCI Edits
- Defines “Unbundling” of procedures for correct coding
- Defines
 - Bilateral procedure coding
 - Downcoding
 - Related service coding standards
- This information can be found at the following website under the heading “NCCI Policy Manual for Part B Medicare Carriers”
- http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage

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CMS Surgical Status Indicators

- Modifier 50: Bilateral Surgery/Bilateral Procedures
 - Procedure is performed on a body part on each side of the body
- Modifier 51: Multiple Surgery/Multiple Procedures
 - More than one procedure is performed on the same day by the same physician
- Modifiers 80, 81, 82, and AS: Assistant Surgeon
- Modifier 62: Co-surgeons
- Modifier 66: Team Surgeons
- Modifier 26–TC: Professional and Technical Components

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CMS Surgical Status Indicators (continued)

- Important: Be sure to log in when accessing the Fee Schedules. The time allowed for accessing many features, such as Fee Schedules, is limited unless the user is logged in. Please ensure you have logged in to avoid receiving the CPT licensure agreement numerous times during your session.

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CMS Surgical Status Indicators (continued)

| Fee Schedule Search | | | |
|---------------------|---------------------|-----------------|---------------------------------------|
| Year: | [Select Year] v | Procedure Code: | <input type="text"/> |
| State: | [Select State] v | Modifier: | [v] |
| Locality: | [Select Locality] v | | <input type="button" value="Search"/> |

Locality in PDF Format

Locality in CSV Format

*Indicator Report in PDF Format

Indicator Report in CSV Format

Help File in PDF Format

*This report contains all of the data for each code and which modifiers are allowed with that code.

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CMS Surgical Status Indicators (continued)

| Fee Schedule Search | | | |
|---------------------|---------------------|---------------------------------------|----------------------|
| Year: | [Select Year] v | Procedure Code: | <input type="text"/> |
| State: | [Select State] v | Modifier: | [v] |
| Locality: | [Select Locality] v | <input type="button" value="Search"/> | |

<http://www.trailblazerhealth.com/Tools/Fee%20Schedule/MedicareFeeSchedule.aspx>

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PHP and PIC Coding Update

1) EPSDT or HSD Update

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EPSDT/HSD Update

Human Services Department (HSD) requests the following guidelines be used when billing Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT) visits for children from birth to 21 years old.

- EPSDT screening
 - CPT codes 99381-99385, 99460-99465
- Immunization screening
 - CPT code 90714

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EPSDT/HSD Update (continued)

- Interperiodic Hearing screening
 - CPT codes 92551, 92552, 92553, 92555, or 92556 along with diagnosis code V50.8
- Interperiodic Vision screening
 - CPT code 99173
- Blood Lead screening
 - CPT code 83655

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EPSDT/HSD Update (continued)

- EPSDT Evaluation and Management CPT codes
 - New Patient 99201-99205
 - Established Patient 99211-99215
 - Must be billed with one of the following diagnosis codes:
 - V20.0 Foundling Health Care
 - V20.1 Care of Healthy Child NEC
 - V20.2 Routine Child Health Exam
 - V70.0 Routine Medical Exam

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EPSDT OR HSD Update (continued)

Must be billed with one of the following diagnosis codes (continued):

- V70.3 Admin Exam – School, Camp
- V70.4 Exam – Medicolegal Reasons
- V70.5 Health Exam – Defines Subpopulation
- V70.6 Health Exam – Population Survey
- V70.7 Exam Participant in Clinical Trial
- V70.8 General Medical Exam Other Specified
- V70.9 General Medical Exam Unspecified

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Helpful Websites

- <http://www.cms.hhs.gov/home/medicare.asp>
- <http://www.cms.hhs.gov/MLNMArticles/>
- <http://www.hsd.state.nm.us/mad/providerinfo.html>
- <http://www.trailblazerhealth.com/Medicare.aspx>
- <http://www.cignagovernmentservices.com/jc/coverage/fees/index.html>

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