PRESBYTERIAN

Health Care Professional and Provider Manual 2012 - 2013

Your Guide to Presbyterian Programs, Policies and Procedures

PRESBYTERIAN

Using your 2012 - 2013 Health Care Professional & Provider Manual

The 2012 - 2013 Health Care Professional and Provider Manual is both a resource for essential information and an extension of your contract. This manual contains information about Presbyterian programs, policies and procedures for HMO, POS, PPO, ASO, Indemnity, Presbyterian Senior Care, Medicare PPO, Presbyterian Salud and Presbyterian SCI.

In this manual and many of our other communications, Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. are referred to as "Presbyterian" on second reference.

Presbyterian distributes updated manuals to all contracted practitioners and providers on an annual basis. Updates to our programs, policies and procedures will be reflected quarterly in the online version of the manual, located at http://www.phs.org/PHS/healthplans/info/providermanual/index.htm.

Presbyterian updates and news will also be communicated periodically through the *Presbyterian Network Connection* newsletter and the Provider Communications section of www.phs.org.

Thank you for your continued partnership in improving the health of our members and the community.

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Introduction

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

Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. (Presbyterian) are part of Presbyterian Healthcare Services, New Mexico's largest, locally-owned integrated healthcare system. Established on October 24, 1908 as the Southwest Presbyterian Sanatorium, Presbyterian began as a treatment center and refuge for tuberculosis patients. Through the years Presbyterian grew and expanded into the statewide integrated healthcare system it is today. A few key services include:

- Eight not-for-profit, Presbyterian operated hospitals, located in Albuquerque, Clovis, Espanola, Rio Rancho, Ruidoso, Socorro and Tucumcari.
- The Presbyterian Medical Group – more than 500 physicians and practitioners providing medical care throughout New Mexico.
- Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc., New Mexico's largest managed care organization, providing commercial health insurance, Medicaid and Medicare products.

Presbyterian Health Services: A statewide managed care delivery system

Presbyterian offers a statewide healthcare delivery system that provides your patients and our members with a comprehensive practitioner and provider network, a quality medical management program and cost-effective, consumer-driven managed healthcare services. Presbyterian is committed to providing exceptional customer service to its practitioners, providers and members. In all that we do, Presbyterian strives to ensure members can access primary and specialty care services as needed and receive quality healthcare services in the most cost-effective setting. Unlike most managed care organizations, which are accountable to shareholders, Presbyterian is ultimately accountable to a board of directors comprised of volunteers from our communities. Presbyterian's enduring purpose is to improve the health of the patients, members, and communities we serve.

Our statewide network exists because of the partnerships and relationships we build with you, our physicians, practitioners and providers. Presbyterian's statewide network is comprised of:

- 36 general acute-care hospitals (8 of the 36 are currently owned, leased or managed by Presbyterian Healthcare Services)
- over 10,000 health care professionals
- more than 300 retail pharmacies comprised of locally owned stores as well as most major chains

Presbyterian offers a range of health care insurance products and programs to members, including commercial products, New Mexico Medicaid managed care programs, the State Coverage Insurance program (SCI), Presbyterian Senior Care, and Presbyterian Medicare PPO.

Commercial Products

Presbyterian Health Plan, Inc. offers a portfolio of products for employers, including Health Maintenance Organization (HMO), Point-of-Service (POS), and Administrative Service Only (ASO) products. Presbyterian Insurance Company, Inc. offers a Preferred Provider Organization (PPO) product for groups and individuals as well as Medicare Supplement products.

New Mexico Medicaid Managed Care Programs

Since its inception in 1997, Presbyterian Salud has been a leader in providing healthcare insurance to New Mexico Medicaid Managed Care (SALUD!) recipients throughout New Mexico. Benefits include medical, dental, and behavioral health coverage as well as preventive health services and a unique program for children and individuals with special healthcare needs.

State Coverage Insurance (SCI) Program

Presbyterian also participates in the State Coverage Insurance (SCI) program. SCI is one of the programs offered under Insure New Mexico!, a division of the Human Services Department (HSD). SCI provides affordable health care coverage to individuals and small employer groups. The program is available to adults between the ages of 19 and 64 who have no other type of health care coverage and who meet certain criteria. Benefits for this limited plan include inpatient hospitalization, preventive care, office visits and

prescription drug coverage.

Medicare Advantage: Presbyterian Senior Care
Presbyterian Senior Care is a Medicare Advantage (MA) program for seniors and other Medicare eligible beneficiaries. The program is designed to meet the special healthcare and financial needs of Medicare beneficiaries who are enrolled in either an individual or Employer Group Plan and who live in our service area of Bernalillo, Valencia, Sandoval and Torrance counties, along with parts of Cibola and Santa Fe counties. Presbyterian's Individual and Employer Group benefit plans offer more benefits than Original Medicare and include prevention and wellness benefits. Presbyterian offers a network of practitioners and providers with a wide range of specialties to fit the unique needs of Medicare beneficiaries. Presbyterian Senior Care has plans available that include Medicare Part D Prescription Drug coverage. Presbyterian members will need to receive their care and services from the Presbyterian network of practitioners and providers.

Medicare Advantage: Presbyterian MediCare PPO
Presbyterian MediCare PPO is a Medicare Advantage (MA) program for seniors and other Medicare eligible beneficiaries. The program is designed to meet the special healthcare and financial needs of New Mexico employers and individual Medicare beneficiaries who live in our service area, which includes all counties in the state of New Mexico. The Individual and Employer Group benefit plans offer more benefits than original Medicare and include prevention and wellness benefits. Presbyterian offers a network of practitioners and providers with a wide range of specialties to fit the unique needs of Medicare beneficiaries. Presbyterian MediCare PPO has plans available that include Medicare Part D Prescription Drug coverage. Members can use doctors, hospitals and providers outside the Presbyterian network for an additional cost.

Regulatory Agency Websites
The 2012-2013 Health Care Professional and Provider Manual incorporates information from regulatory agencies about requirements for Presbyterian's product lines. For more information about regulatory requirements, please visit the following websites:

State of New Mexico Human Services Department Medical Assistance Division
www.state.nm.us/hsd

Center for Medicaid and Medicare Services (CMS)
www.cms.hhs.gov

State of New Mexico Regulations & Licensing Department
www.rld.state.nm.us

National Provider Identifier (NPI)
https://nppes.cms.hhs.gov

Provider Network Management

Presbyterian has an internal team dedicated to working with its network of practitioners and providers, known as Provider Network Management (PNM). The PNM department is committed to delivering an exceptional provider experience through relationship management and engagement, timely and informative communications, modern resources and services and good customer service. We develop and share programs, tools and communications that provide our network with critical information, managed-care related training and education, facilitation and support. As part of the Health Plan, we are constantly evaluating new services and tools that may increase efficiency; add value and lower costs for our network and all other stakeholders.

What we do
PNM team members provide their expertise and service to the following areas: practitioner and provider relationship management and training/education, credentials verification, practitioner and provider e-business resources, network communications and business analysis.

The PNM practitioner and provider relationship management team completed an internal service-model restructure during 2011 in order to provide you with superior customer service and an exceptional provider experience. Each practitioner or provider within the Presbyterian network has a designated PNM Relationship Executive who is available as your advocate within the Health Plan. Our Relationship Executives are reaching out to their assigned practitioners and providers through in-person visits, phone calls and emails. They are your first and dedicated resource for questions and support relating to Presbyterian products, services and initiatives.

Keep us updated: Provider Change Notification Form
The PNM team is dedicated to maintaining and providing up-to-date information about Presbyterian's network of practitioners and providers. Help us maintain accurate practitioner and provider data and keep automated processes running smoothly by providing us with up-to-date information about your office.

Your contract with Presbyterian requires you to submit changes to your Relationship Executive in writing. This includes any changes related to your practice, such as an address change, tax ID change, panel status and contract status. This information is used in electronic and paper provider directories, and for regulatory reporting purposes.

Expanding contracted services
All contracted practitioners and providers interested in contracting for an additional location, services or specialty must comply with the applicable Presbyterian policies and procedures for network development. Therefore, before adding any new locations, services and/or specialties, please contact your Provider Network Management Relationship Executive.

The addition of practitioners and or providers of the same specialty does not require formal compliance with the Presbyterian network development process. However, you must notify Presbyterian prior to allowing any new practitioner or provider to provide services to a Presbyterian member until the credentialing process has been completed, if applicable.

Network training and education
If you are new to the Presbyterian network, or could use an update on one of our resources, programs or initiatives, please contact your PNM Relationship Executive. They can provide training and information about billing, coding, appeals and grievances, PresOnline and many other topics. They will serve as your guide and advocate in connecting you with other Health Plan personnel as necessary.

Presbyterian's Annual Conference for Health Care Professionals, Providers and Staff
In addition to the ongoing training provided by your PNM Relationship Executive, Presbyterian hosts a conference and webinar for healthcare professionals and providers. During the conference and webinar, Provider Network Management distributes new, updated and important regulatory information to our contracted healthcare professionals and providers. The purpose of

the conference is to give our network the most current regulatory information as it relates to Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. and other key information to ensure a successful partnership for your patients and our members.

Network Communications

Presbyterian utilizes a variety of publications and communication methods to provide the network with accurate, timely, relevant and engaging information about changes and initiatives at the health plan and other news affecting the network. Communication topics include, but are not limited to: notification of internal process changes, notification of regulatory requirements and changes, clarification of coding issues, education regarding utilization of the health management programs available to our members, and information about product-line specific policies and procedures as required by the specific regulatory agencies (e.g., New Mexico Human Services Department, the Centers for Medicare and Medicaid Services and the Department of Insurance).

Presbyterian publishes a bi-monthly practitioner and provider communications program newsletter titled "Presbyterian Network Connection." Prior to the Network Connection, "In Brief" was published and distributed quarterly. The practitioner and provider newsletter contains articles about new resources and programs at Presbyterian, important business updates and changes, and regulatory updates and requirements. Effective June 1, 2012, the newsletter is distributed through mail in February, April, June, August, October and November of each year. The newsletter is also posted in the "For Providers" section of phs.org, along with updated copies of this manual and an archive of recent faxed and mailed letters. Please keep your PNM Relationship Executive updated with any changes in your contact information.

Provider Satisfaction Survey

Provider Network Management contracts with a third-party independent healthcare survey group to administer an annual provider and practitioner satisfaction survey to a random sample of participating practitioners and providers across all of Presbyterian's product lines.

The survey offers our network of practitioners and providers the opportunity to provide feedback about administrative services and the quality of services provided to them by each functional area within Presbyterian.

The Provider Satisfaction Survey process was developed to ensure that:

- A sample of Presbyterian's network of participating practitioners and providers for all product lines are surveyed on an annual basis.
- The information obtained from the survey report compiled by the third-party independent health insurance survey group is used to enhance the level of service to Presbyterian's participating practitioners and providers.

Overview for Health Care Professionals

Presbyterian's statewide practitioner and provider network is comprised of over 10,000 health care professionals. A health care professional is defined as a professional licensed and/or certified by the State and by Presbyterian, who provides healthcare services.

Primary Care

Primary care practitioners(PCPs) are defined as in-plan physical health practitioners who meet certain objective criteria established by Presbyterian's managed care plans, accept the responsibility for rendering primary physical health care 24 hours a day, seven days a week, and coordinate referral care for specified members during the year. Presbyterian's network of credentialed PCPs include Family Practice, General Practice, and General Internists, Pediatricians, Certified Physician's Assistants, and Certified Nurse Practitioners, as well as other specialists that are credentialed and elect to perform in the role of a PCP.

Role and Responsibilities of the Primary Care Practitioner

Our PCPs play an integral role in helping us meet our objectives. These objectives focus on the total well being of the member, while providing a "medical home" where the member can readily access preventive healthcare services and treatment, as opposed to episodic, health-crisis management. Members will also be encouraged to become more involved in their own healthcare maintenance and wellness. The PCP is responsible for teaching members how to use available health services appropriately. Please educate members to seek your services before accessing any other sources of health services, except in emergent or urgent situations.

The PCP is responsible for:

- Providing or arranging for the provision of covered services and telephone consultations during normal office hours, and on an emergency basis, 24 hours a day, seven days a week
- Providing preventive health services in accordance with the program requirements and related medical policies, including provision of Early Periodic Screening Diagnostic Treatment (EPSDT) services as applicable
- Vaccinating members in their office and not referring them elsewhere for immunizations
- Ensuring coordination and continuity of care for all covered services to members
- Maintaining current medical records
- Initiating referrals to network specialty care practitioners, facilities and contractors, when appropriate (as described later in this section)
- Monitoring the member's progress and facilitating the member's return to the PCP when medically appropriate
- Documenting communication with the specialty care practitioner in the medical record
- Educating members and their families regarding their health issues
- Following utilization and quality management guidelines
- Adhering to Presbyterian's administrative policies and procedures
- Meeting Presbyterian's credentialing and recredentialing requirements
- Notifying Presbyterian of changes in address, licenses, liability insurance, contracting status or any other issue which could affect his or her ability to effectively render medical care
- Advising patients of their right to know about all treatment options related to their condition or disease, regardless of whether or not it is a covered benefit under their insurance plan. The Presbyterian Customer Service Center (PCSC) is available to assist with confirming covered benefits.
- Reporting any misappropriation of property, abuse or neglect of a child or vulnerable adult revealed to a provider or suspected by a provider to proper regulatory authorities pursuant to state law utilizing the Statewide Central Reporting Intake (1-800-797-3260). Further information regarding state reporting requirements for suspected abuse, neglect or misappropriation of property of children and vulnerable adults can be obtained from the New Mexico Department of Health, Division of Health Improvement.

The PCP is also responsible for contacting Presbyterian to verify member eligibility and benefit certifications for covered services. You can quickly and easily verify

member eligibility through Pres Online at www.phs.org (locate the Pres Online Log-in box) or through our Interactive Voice Response (IVR) system by calling (505) 923-5757 or 1-888-923-5757. You can also request benefit certification/prior authorization of covered services through Pres Online at www.phs.org (locate the Pres Online Log-in box).

Coverage Requirements & After Hours Care
PCPs must be available to members 24 hours a day, seven days a week. When the PCP is unavailable, coverage should be arranged through a participating Presbyterian health care professional, or with an on-call health care professional who has signed a coverage arrangement with a participating PCP. They are also responsible for providing or arranging for the provision of covered services and telephone consultations during normal office hours and on an emergency basis, 24 hours a day, seven days a week.

Requirement to Utilize Contracted Providers
PCPs are expected to be aware of Presbyterian's contracted (participating) providers, labs, Durable Medical Equipment (DME) and other services so as to minimize inconvenience and billing problems for Presbyterian members. If you are unsure of whether services you would like made available to Presbyterian members are within Presbyterian's network, you can call the Provider CARE Unit at (505) 923-5757 or 1-888-923-5757 for assistance.

Lab Services
You are responsible for sending all labs to Presbyterian's preferred lab provider, TriCore, unless there are clinical circumstances which require the use of a different lab, in which case, you should immediately seek a benefit certification/prior authorization as outlined in the Care Coordination section of this manual.

Durable Medical Equipment (DME) Services
You are responsible for referring members to contracted (participating) DME providers. For a complete listing of contracted DME providers please visit our website at www.phs.org and click on "Find A Doctor" at the top of the page.
If you do not comply with these requirements related to contracted providers, Presbyterian reserves the right to hold you responsible for up to 150% of the following:

- The difference between the amount that would have been paid by Presbyterian had a contracted provider been utilized and the total amount actually paid by Presbyterian to the non-contracted provider OR
- The entire cost of such services.

If Presbyterian elects to utilize this right, you understand and agree that these amounts will be withheld automatically and offset against any future claims payments owed by Presbyterian to you.

Primary Care Practitioner Termination
Please refer to your Presbyterian provider contract for specific time frames and obligations regarding terminations.

Specialty Care Practitioners
Specialists are other in-plan physical and behavioral health practitioners not identified as a PCP, and may also include Obstetricians and Gynecologists, who agree to accept referrals of members from other in-plan practitioners to provide more specialized service(s) for the member.

Role and Responsibilities of the Specialty Care Practitioner (SCP)
The specialty care practitioner accepts referrals of members from other in-plan practitioners to provide more specialized service(s) for the member (please see "Coordinating Care: Benefit Certification and Care Coordination," in the Care Coordination section for more detailed information on referrals). The Specialty Care Practitioner is responsible for:

- Providing medically necessary services to members who have been referred by their PCP, another in-plan health care professional or who have self referred when appropriate for specified treatments or diagnoses
- Referring members to other in-plan health care professionals, as needed. To include lab, Durable Medical Equipment (DME) providers and other in-plan specialists.
- Communicating with the PCP or other in-plan health care professionals regarding services

rendered, results, reports and recommendations to ensure the continuity and quality of care
- Documenting communication with the PCP or other in-plan health care professionals in the medical records
- Obtaining benefit certification from Presbyterian's Health Services Department for non-emergency inpatient and outpatient services in accordance with the member's benefit package
- Following utilization and quality management guidelines
- Adhering to Presbyterian's administrative policies and procedures
- Meeting Presbyterian's credentialing and recredentialing requirements
- Notifying Presbyterian of changes in address, licenses, liability insurance, contract status or any other issue which could affect his or her ability to effectively render medical care

Specialty care practitioners are also responsible for reporting any misappropriation of property, abuse or neglect of a child or vulnerable adult revealed to a provider or suspected by a provider to proper regulatory authorities pursuant to state law utilizing the Statewide Central Reporting Intake (1-800-797-3260). Further information regarding state reporting requirements for suspected abuse, neglect or misappropriation of property of children and vulnerable adults can be obtained from the New Mexico Department of Health, Division of Health Improvement.

In addition, specialty care practitioners are responsible for verifying member eligibility before rendering services. This can be easily and quickly done through Pres Online at www.phs.org or through our Interactive Voice Response (IVR) system by calling (505) 923-5757 or 1-888-923-5757. You can also request benefit certification of covered services through Pres Online at www.phs.org.

Requirement to Utilize Contracted Providers
PCPs are expected to be aware of Presbyterian's contracted (participating) health care professionals, labs, Durable Medical Equipment (DME) and other services so as to minimize inconvenience and billing problems for Presbyterian members. If you are unsure of whether services you would like made available to Presbyterian members are within Presbyterian's network, you can call the Provider CARE Unit at (505) 923-5757 or 1-888-923-5757 for assistance.

Lab Services
You are responsible for sending all labs to Presbyterian's preferred lab provider, TriCore, unless there are clinical circumstances which require the use of a different lab, in which case, you should immediately seek a benefit certification/prior authorization as outlined in the Care Coordination section of this manual.

Durable Medical Equipment (DME) Services
You are responsible for referring members to contracted (participating) DME providers. For a complete listing of contracted DME providers please visit our website at www.phs.org and click on "Find A Doctor" at the top of the page.

If you do not comply with these requirements related to contracted health care professionals, Presbyterian reserves the right to hold you responsible for up to 150% of the following:
- The difference between the amount that would have been paid by Presbyterian had a contracted provider been utilized and the total amount actually paid by Presbyterian to the non-contracted provider, OR
- The entire cost of such services.

If Presbyterian elects to utilize this right, you understand and agree that these amounts will be withheld automatically and offset against any future claims payments owed by Presbyterian to you.

Specialty Care Practitioner Termination
Please refer to your contract for specific time frames and obligations regarding terminations.

Referrals to non-participating practitioners/ facilities
A member will not be held liable for payment of services if the PCP has mistakenly made a referral to a non-participating practitioner/facility provider, unless the member has been notified in writing concerning the

use of non-participating practitioners/facility providers and informed the member that Presbyterian will not be responsible for future payments.

For PHP HMO and POS plans, in the event that medically necessary covered services are not reasonably available in-plan, Presbyterian will approve certifications to non-participating practioners/facility providers. This determination will be made within the timeframes listed in Health Services/Behavioral Health policy on monitoring timeliness of UM Decisions.

Medicare Advantage members may request approval for certification directly. All other plans require that the practitioner/facility provider submit requests to the Health Services department via fax, online, mailed, or by telephone.

For behavioral health, the request may come in writing directly from the behavioral health practitioner. A brief medical history, treatments prescribed, and a detailed reason for the out-of-network referral can be faxed, mailed or entered into Pres Online to the Presbyterian medical director/behavioral health medical director.

Certifications to out-of-plan practitioners/facility providers must have approval from Presbyterian before the member receives care.

The determination of whether medically necessary covered services are not reasonably available in-plan will be based on the following:

- **Availability:** There is no contracted practitioner/facility provider within the network who is reasonably available, as determined by Presbyterian, to treat the member's health condition.
- **Competency:** The Presbyterian contracted practitioner/facility provider does not have the necessary training required to render the service or treatment.
- **Geography:** Where there is no participating health care professional in Presbyterian's network for the services requested, within a reasonable distance.

Accessibility of Services Standards

As required by our regulators and the National Committee for Quality Assurance (NCQA), Presbyterian is required to provide and maintain appropriate access to primary care, specialty care and behavioral health care services. It is the policy of Presbyterian to communicate its accessibility of services standards to our network of participating health care professionals and monitor compliance with these standards. Presbyterian's accessibility of services standards are consistent with regulatory requirements and exist to ensure that our members receive reasonable, appropriate and timely access to care from participating network health care professionals. The information contained online defines the accessibility of services standards for Presbyterian's physical and behavioral health care professionals. You may access the Accessibility of Services and Geographic Availability Standards at the following Web addresses:
http://www.phs.org/resources/documents/accessibility.pdf
http://www.phs.org/resources/documents/geographic.pdf

Gross Receipts Tax and Copayments

Effective January 1, 2005 New Mexico enacted a deduction from gross receipts tax for certain medical services. However, co-pays, co-insurance and deductibles are not covered by this deduction. Your contract with us and applicable Department of Insurance regulations prohibits you from charging our members any amount in excess of the established copayments, co-insurance or deductibles specifically provided for in the member's benefit materials. Therefore, you may not add gross receipts tax to applicable copayments, co-insurance or deductible.

Treatment of Self or Family Members

Presbyterian supports the following position of the American Medical Association (AMA) on this topic: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion819.page.

Presbyterian will not reimburse for claims submitted for treatment of self or family members.

E-8.19 Self-Treatment or Treatment of Immediate

Family Members:
Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as primary or regular care providers for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. *Issued June 1993. (I, II, IV).*

Preventive Healthcare

Presbyterian exists to improve the health of the patients, members, and communities we serve. To this end, health education information is distributed to our members in a variety of ways, including at health fairs and community meetings and in member newsletters and handbooks.

Presbyterian encourages members to access preventive healthcare services through the development and distribution of Preventive Healthcare Guidelines. Presbyterian also offers a provider manual on the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program services for Presbyterian Salud members, which includes recommended adult and childhood immunization schedules and periodicity schedules.

Nurse Advice Line

All Presbyterian members and Presbyterian employees have access to a Nurse Advice Line through NurseAdvice® New Mexico that is available 24 hours a day, 7 days a week, to answer their health care questions. The nurses do not take the place of practitioners, but provide helpful information on how to feel better and stay healthy or when it is appropriate to go to the Emergency Department.

Nurse Advice Line Telephone Numbers:

- Presbyterian Salud members may contact the Nurse Advice Line at 1 888-730 2300.
- Presbyterian State Coverage Insurance (SCI) members may contact the Nurse Advice Line at 1-888-730-2300.
- Presbyterian Senior Care and MediCare PPO members may contact the Nurse Advice Line at 1-800-887-9917.
- Presbyterian Commercial Members may contact the Nurse Advice Line at 1-866-221-9679.
- Presbyterian employees and their dependents may contact the Nurse Advice Line at 1-800-905-3282.

Preventive Healthcare Guidelines and Screening

Preventive Healthcare Guidelines are systematically developed statements designed to give practitioners and providers the most current, nationally promoted information about preventive healthcare screenings and counseling and immunizations for all age groups.

Presbyterian adopts preventive healthcare guidelines that are relevant to the enrolled population and are based on reasonable medical evidence. The Presbyterian Preventive Healthcare Guidelines are based on a variety of resources including, but not limited to, the following:

- United States Preventive Services Task Force (USPSTF)
- Centers for Disease Control (CDC)
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- American Congress of Obstetricians and Gynecologists (ACOG)
- National Cancer Institute (NCI)

Presbyterian expects that practitioners and providers, to the extent possible, provide the following preventive screenings for all asymptomatic members within six months of enrollment or within six months of a change in screening standards, as necessary:

- Screening for breast cancer
- Screening for cervical cancer
- Screening for colorectal cancer
- Blood pressure measurement
- Serum cholesterol measurement
- Screening for obesity
- Screening for elevated lead levels
- Screening for tuberculosis
- Screening for rubella
- Screening for Chlamydia
- Screening for type 2 diabetes
- Prenatal screening
- Newborn screening
- Tot-to-Teen Health Checks

Presbyterian has adopted immunization guidelines approved by the American Academy of Pediatrics (AAP), the Advisory Council on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP). The Preventive Healthcare Guidelines for Children, published by the New Mexico Human Services Department's Medical Assistance Division, were adopted by Presbyterian for members from birth through age 20. All preventive healthcare guidelines are reviewed at least every two years and are

updated when clinically appropriate.

All member households receive preventive healthcare guidelines as part of their member handbooks or explanation of benefits, which are distributed at least once every two years. The guidelines are also distributed annually in the member news magazines.

Presbyterian's Preventive Healthcare Guidelines for practitioners/providers are available on the Presbyterian Healthcare Services website at: http://www.phs.org/wcm/groups/public/@phs/@php/documents/phscontent/wcmdev1001475.pdf.

Presbyterian Health Plan, Inc. also informs practitioners/providers of updates to the guidelines via the Network Connection provider newsletter. Written copies of the Preventive Healthcare Guidelines are available upon request.

Measurement Activities
Presbyterian conducts measurement activities at least annually based on the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®) and other clinically based measurement rules. Measures are collected from claims and other data sources made available to Presbyterian, such as lab results and medical record review. This data provides feedback on the levels of preventive health and health maintenance services members receive. Presbyterian uses these measurement results to identify members with or at risk for specific health problems, and to inform their practitioners/providers that prevention and/or treatment services may be needed. For selected measures, Presbyterian provides individual scores on selected measures to practitioners/providers who act as Primary Care Practitioners. Along with the scores, Presbyterian includes lists of members who might not be receiving the care needed according to these clinical guidelines. Practitioners/providers are encouraged to use these lists to engage members in their care and/or to provide Presbyterian with updated information that may correct the data reported, such as lab results or a qualifying event.

Personal Health Assessments
Presbyterian encourages members to participate in Personal Health Assessment (PHA) surveys (formerly, Health Risk Assessment surveys). The PHA includes a series of questions designed to identify potential health risks and determine if new members require focused case management for physical or behavioral health, or if they would benefit from one of Presbyterian's health or disease management programs. The surveys are also used to identify Individuals with Special Healthcare Needs (ISHCN).

Screening for Alcohol and Drug Abuse
Primary Care Practitioners are requested to use a standardized alcohol and drug abuse screening tool for high-risk members. The frequency of screening is determined by the results of the first screen and other clinical indicators. Primary Care Practitioners may use the CAGEAID or any other standardized tool for alcohol and drug abuse screening test.

Presbyterian has adopted the CAGEAID standardized alcohol and other drug abuse screening tool developed by Brown and Rounds. The CAGEAID questions can be used in the clinical setting in an informal manner. It has been demonstrated that the questions are most effective when used as part of a general health history and should not be preceded by questions about how frequently the patient drinks or uses illegal drugs. Responses on the CAGEAID screening tool are scored at either 0 or 1, with a higher score indicating possible alcohol or drug abuse problems. A total score of 2 or greater is considered clinically significant. Please see Appendix [x] for a copy of this document that you can use and print.

Presbyterian Salud Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program
Children experience numerous health and developmental milestones that should be assessed in a timely manner. Early detection and treatment can avoid or minimize the effects of many childhood conditions. The federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program emphasizes the early discovery of illness and the need for comprehensive care. One component of the EPSDT program is complete and timely immunizations (see

Preventive Healthcare

Immunizations and Vaccines for Children information below). Presbyterian serves to support practitioners/providers in coordinating these services.

EPSDT benefits include comprehensive medical and behavioral screening and treatment services available to all Medicaid children from birth through age 20. The EPSDT well-child check ups are also referred to as Tot-to-Teen Health Checks.

EPSDT training for practitioners/providers is available through the Provider Network Management department. Information regarding the Vaccines for Children (VFC) program may be obtained from the program director at (505) 827-2898 or the Immunization hotline at (888) 231-2367. The EPSDT Provider Training Manual can be accessed on the Presbyterian Healthcare Services Web site at http://www.phs.org/resources/documents/epsdt.pdf. For a printed copy of the EPSDT Manual, contact your Provider Network Management Coordinator.

Immunizations
All Presbyterian contracted primary care practitioners are requested to provide and document all immunizations according to the accepted immunization schedule. The schedule can be accessed on the Presbyterian Healthcare Services Web site at www.phs.org/shots (see immunization schedule in the "Quick Links" section).

Immunizations for Presbyterian Salud Members
The New Mexico Medicaid Managed Care program, in 8 NMAC 8.305.6.12.A (5) requires primary care practitioners contracted with Presbyterian Salud to vaccinate members in their offices and not refer members elsewhere for immunizations.

Vaccines for Children (VFC)
Presbyterian participates in the federal VFC Program and supports the program goals to:

- Improve vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers; and
- Ensure that no VFC-eligible child contracts a vaccine-preventable disease because of his or her parent's inability to pay for the vaccine or its administration.

VFC-eligible children are those children from birth through 18 years who:

- Are eligible for Medicaid
- Have no health insurance
- Are American Indian/Alaska Native
- Have health insurance, but it does not cover immunizations, and they go to a Federally Qualified Health Center

Under the VFC Program, New Mexico is categorized as a Universal State, which is defined as a state which offers all vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP) to all healthcare providers to serve all children, including those who are fully insured.

Additional VFC information is available in the Presbyterian EPSDT Provider Training Manual, through the New Mexico Department of Health, or through the Centers for Disease Control (CDC).

- EPSDT Training Manual: http://www.phs.org/resources/documents/epsdt.pdf
- New Mexico Department of Health: http://www.health.state.nm.us/immunize/provider.html
- CDC: http://www.cdc.gov/vaccines/programs/vfc/default.htm

Primary care practitioners who are contracted with all other Presbyterian product lines, and who provide coverage to children, are encouraged to utilize the VFC program.

For additional information about health education and preventive healthcare services that are available to Presbyterian members contact Quality and Population Health Management at (505) 923-5017 or toll-free at 1 866-634-2617.

Care Coordination

Care Coordination exists to support you and your Presbyterian patients. We are here to assist you with coordination of care and services for your patients with chronic and/or catastrophic illnesses and injuries and in promoting healthy lifestyles.

Care Coordination also serves to provide you and your Presbyterian patients with proactive tools and resources to help them improve their health, stay healthy and live with chronic disease by:

- Assisting providers and members to prevent or reduce the burden of disease
- Assisting individual members with accessing medical and behavioral health care
- Identifying health needs and risks
- Improving the health of member populations with selected health conditions
- Assisting members to obtain appropriate medications
- Predicting and managing healthcare costs
- Facilitating appropriate and cost-effective care
- Ensuring privacy and confidentiality of medical information

Presbyterian's Care Coordination program includes utilization management (UM), for the evaluation of the appropriateness, medial need, and efficiency of health care services procedures and facilities, according to established criteria and guidelines. Care Coordination UM processes comprise a comprehensive set of integrated components including prior authorization, concurrent review, continued stay review, retrospective review, discharge planning and individual medical case management as required to determine medical necessity.

Affirmation Regarding Decision Making

For utilization management (UM), the National Committee for Quality Assurance (NCQA) requires that: "The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following.

- UM decision making is based only on appropriateness of care and service and existence of coverage
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization."

Coordinating Care: Prior Authorization Referrals

For Commercial, Presbyterian Senior Care (HMO), Salud, and select ASO plans, the model is "no referral required" for most care rendered by contracted specialists. This includes referrals from one contracted specialist to another contracted specialist. Refer to specific plans for any special requirements (e.g., Senior Care, MediCare PPO, SCI, and Commercial plans). For ASO plans not participating in the open access model and for Presbyterian Salud and SCI, members need to continue to see their primary care practitioners (PCP) for a specialist referral. PCPs, however, are not required to get referral authorization numbers from Presbyterian. The form of communication between the PCP and specialist (prescription, phone call, or note in medical record) is at the discretion of the PCP and the specialist.

For all plans, members may self-refer for emergency care, urgent care, and contracted women's health care. Presbyterian Salud has additional benefits for self-referral for women's health care, which are explained in another section of this chapter.

Prior Authorization Process

Presbyterian wants your patients to get the best care, in the best place, at the right time. One of the processes we use to help our members get the best care is called prior authorization (also known as benefit certification).

Authorizations of coverage

Prior authorizations may be necessary for certain procedures, items, and services. Either the practitioner/provider or the member would need to obtain the prior authorization prior to obtaining the service. This ensures that the practitioner, provider (facility) and member know if services are covered. Practitioners, providers, and members should review the Prior Authorization Guide and the member's Group Subscriber Agreement (GSA), Individual Subscriber Agreement (ISA), Summary Plan Description (SPD) or Evidence of

Care Coordination

Coverage (EOC) to determine if a service requires prior authorization.

The prior authorization process is also used to identify members who might benefit from Care Coordination services. Presbyterian does not utilize criteria as the sole basis for rendering determinations. Individual patient situations, risk factors, service availability, and local resources must be considered, as criteria often reflect guidelines relevant to the least complicated case and the most complete delivery system.

The following individual factors are also taken into consideration:

- Recommendation(s) of treating physician
- Age
- Co morbidities
- Complications
- Mental status
- ADL/IADL functionality
- Financial status
- Polypharmacy
- Progress of treatment
- Psychosocial and cultural situation
- Home environment
- Availability of services including, but not limited to, skilled nursing facilities or home care in Presbyterian's service area to support the member after discharge
- Presbyterian's coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care
- Ability of local hospitals to provide all recommended services within the estimated length of stay

Requesting a Prior Authorization

To serve our practitioners/providers, Presbyterian has a dedicated Prior Authorization line. Call Health Services at (505) 923-5757 or 1 888-923-5757 (option four).

Prior authorizations, including auto-generated approvals for specific services, may be obtained through Pres Online located at www.phs.org. You may also access the status of prior authorization requests, claims, and eligibility information through Pres Online 24 hours a day, 7 days a week. For more information about Pres Online see the e-Business section of this manual. Using Pres Online to obtain prior authorizations is the easiest, least intrusive method for your office or facility. You may also contact us via the following:

- Inpatient prior authorization requests may be faxed to (505) 213-0181 or 1 888-923-5990
- Outpatient services and Durable Medical Equipment (DME) requests may be faxed to (505) 213-0246
- Mail to Health Services:
- Presbyterian Prior Authorization Team
- P.O. Box 27489
- Albuquerque, NM 87125-7489

Urgent/Expedited Requests

Following is the criteria for requests that require a quick decision (urgent and expedited) from Presbyterian. An urgent/expedited decision turnaround for care or treatment is appropriate in the following circumstances:

- The life, health, or safety of a covered person would be seriously jeopardized due to the member's psychological state, and/or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- The covered person's ability to regain maximum function would be jeopardized.
- The medical exigencies of the case require an expedited decision.

When you have a situation that meets the definition of an urgent or expedited determination, we suggest that you call Health Services. To reach Health Services, call (505) 923-5757 or 1 888 923-5757, Option 4.

What this means for the practitioner/provider office

All urgent and expedited prior authorization requests that the practitioner/provider sends should meet one or more of the criteria listed above. If the request does not meet the urgent and expedited criteria, it may be processed as a routine prior authorization request.

Verify a member's eligibility and benefits

Eligibility can be checked easily and quickly through

Care Coordination

Pres Online at www.phs.org or through the Interactive Voice Response (IVR) system by calling (505) 923-5757 or 1-888-923-5757, option one.

Verify if prior authorization is required by referencing the Prior Authorization Guide

The guide is available on the Provider page of www.phs.org.

- Select "Health Plans" from upper menu
- Select "For Providers" from left menu
- Select "Health Services"
- Under "Prior Authorization Guide and Request Form," select "Prior Authorization Guide" or go to:
- http://www.phs.org/wcm/groups/public/@phs/@php/documents/phscontent/wcmdev1001400.pdf

You may also obtain prior authorization for an inpatient concurrent review or inpatient hospital admission by calling (505) 923-5757 or at 1-888-923-5757, option four. You will need to either fax the request to the number designated in the message for your type of request or leave a message.

- Use Pres Online for all prior authorization requests and notification of deliveries.
- Hours of Operation: Presbyterian Medical Directors, Nurses, and Behavioral Health Licensed Professionals are available 24 hours a day, seven days a week to assist you with coordinating care or verifying benefits.

Prior Authorization for Radiology/Advanced Imaging

In May 2007, Presbyterian implemented an advanced imaging ordering program for outpatients through HealthHelp®. The program applies to all Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. members who have medical benefits for in plan radiology facilities (some employer groups may decide not to participate). The program is designed to improve health care, patient safety, utilization, and cost by applying clinical criteria when ordering Computed Tomography (CT), Magnetic Resonance Imaging/Angiography (MRs), and Positron Emission Tomography (PET).

What is HealthHelp?

HealthHelp is an educational and consultative resource between the ordering physician and experienced specialty radiologists. Guidelines for ordering CTs, MRs, and PET scans are in the HealthHelp booklet, Medical Imaging Consultant (MIC), and are updated annually.

What this means to Ordering Offices

When ordering CT, CTA, MRs, or PET scans, you or your office staff must submit patient demographics, diagnosis, patient history (such as prior treatment and associated symptoms) and procedure codes to HealthHelp through a web-based ordering system, by telephone, or by fax. HealthHelp reviews the request against published guidelines and issues an authorization number, which then becomes the Presbyterian Prior Authorization number. A direct link to HealthHelp's web-based program is available through Pres Online. No additional sign-on or password is needed to access the program.

What this means to facilities providing these radiology services

If you are a radiology facility, hospital, or provide these procedures in your office, confirm that HealthHelp has processed and approved the request before scheduling an appointment. This will ensure payment of the claims you submit.

Instructions and Reference Guides

Detailed information is available on Presbyterian's website at: http://www.phs.org/phs/healthplans/providers/ProviderResources/index.htm and includes:

- Scope
- Current list of procedure codes that HealthHelp manages
- Process Steps and Contract Information
- Frequently Asked Questions (FAQs), which include routine, expedited, retroactive, and emergent requests
- Clinical Information/Fax Form
- A demonstration of HealthHelp's web-based process

Contacting Presbyterian

If you have questions or concerns about the program, contact your Provider Network Management Coordinator. To determine who your Coordinator is,

please access the following guide at: http://www.phs.org/wcm/groups/public/@phs/@php/documents/phscontent/wcmdev1001499.pdf.

Coordinating Care: Assistance Offered by Presbyterian
Presbyterian Care Coordination assists and supports practitioners and members to improve continuity and coordination of care across the healthcare network through the following activities:

Care Coordination
Care Coordination is a system of member and provider assistance that is available to all members and providers. Care Coordination supports, educates, and reduces barriers to ensure that the medical and behavioral health needs of members are identified, coordinated, and provided as appropriate. Care Coordinators/Case Managers advocate for and connect the member with necessary services, as established by the treating practitioners.

Care Coordination also supports providers and practitioners in their management of members with catastrophic, high-cost, high-risk or complex illnesses, injuries or conditions, and for Individuals with Special Health Care Needs (ISHCN). This individualized care serves to help and guide members through the healthcare continuum in a coordinated, caring, cost-effective and quality-oriented manner.

Both acute and chronic conditions are referred to this program via multiple sources through appropriate care coordination diagnostic "triggers." Such referral sources may include member self-referrals, family members, practitioners/providers, utilization management, discharge planning personnel and Customer Service Representatives. Please contact Care Coordination within Integrated Care Solutions to initiate care coordination services for a Presbyterian member by calling our Intake Coordinators at 1-866-672-1242.

Paula Casey/Jane Bergquist
Disease Management
Presbyterian serves to support practitioners/providers in their management of chronic illnesses. The Care Continuum Alliance defines disease management as a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. More information about the Care Continuum Alliance is available on their website at http://www.carecontinuum.org.

In an effort to provide resources for practitioners/providers in their care and coordination for members with chronic conditions, Presbyterian offers comprehensive disease management programs for diabetes, coronary artery disease, asthma and obesity. The programs include distribution of free blood glucose meters for all members with diabetes, free peak flow meters for members with asthma, and educational materials for members and practitioners/providers.

Presbyterian provides comprehensive care to our members statewide through our network of services. The Presbyterian Disease Management Program includes Care Coordination, Complex Case Management, Inpatient Case Management, Population Health Management, the Healthy Solutions health coaching program, and the Healthy Advantage Prevention and Wellness program.

This comprehensive Disease Management Program:
- Supports the practitioner/patient relationship and plan of care
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Through the Presbyterian Disease Management Program we:
- Work to try and identify members before problems occur. We proactively work to identify individuals potentially in need of these services through medical and pharmaceutical data available through the Presbyterian claims data systems.
- Stratify members by risk criteria. We utilize a predictive modeling tool to identify members' risk

level. Using these criteria for initial stratification, members' needs are matched to an appropriate level of intervention.

Provide meaningful interventions through case management and Healthy Solutions telephonic Health Coaching:

- Nurse Case Managers manage members with the highest risk score and who need more intensive/ multisystems medical or nursing interventions.
- Members with moderate risk scores are managed by our Presbyterian Healthy Solutions team. They provide telephonic health coaching different from the traditional educational model which identifies and focuses on members who meet "readiness to change." This behavioral change methodology ensures we focus our efforts on developing a personalized health improvement plan for these members. In turn, the staff provides support and education for the health behavioral change.

Healthy Solutions offers a member-focused program to meet the medical, behavioral, and educational healthcare needs for all of our members. Health Coaches work with individuals on lifestyle issues for those with a moderate risk score.

Improve health outcomes

Presbyterian understands the importance of improving outcomes. By tailoring the frequency and intensity of outreach to the members based on risk and severity of disease, as well as to their readiness to change, our staff will be more effective with interventions. Members with chronic illness learn to manage their health in order to lead a more productive life.

Members who are considered at-risk learn to minimize problems with ongoing education. Utilization of healthcare resources becomes more appropriate and effective. To refer your Presbyterian patients to the Presbyterian Disease Management program, contact us at the following:

- Phone: 1-800-841-9705
- E-mail: PHP referral@phs.org

Clinical Practice Guidelines and Tools

Clinical Practice Guidelines are systematically developed statements designed to give practitioners/providers the most current, nationally recognized recommendations regarding the care of specific clinical circumstances. Presbyterian adopts clinical practice guidelines that are relevant to the enrolled population and are based on reasonable scientific evidence. All clinical practice guidelines are reviewed at least every two years and are updated when clinically appropriate.

Clinical Practice Guidelines for Primary Care Practitioners/Providers

Presbyterian recommends the guidelines below, which are available on the Provider page of www.phs.org. You may access them the following ways:

The online version of the Provider Manual, click on the following link:
http://www.phs.org/healthplan/providers/index.shtml and choose "Provider Manual" from the Quick Links section

Go to www.phs.org

- Select "Health Plans"
- Select "For Providers" in the menu
- Select "Health Services"
- Scroll down to "Clinical Practice Guidelines"

You may also contact Presbyterian Quality and Population Health Management by phone at (505) 923-5017 or 1-866-634-2617 or e mail PopulationHlthMgt@phs.org.

Clinical Practice Guidelines

Asthma

- Guidelines for the Diagnosis and Management of Asthma (National Asthma Education and Prevention Program, National Heart, Lung, and Blood Institute): http://www.nhlbi.nih.gov/ guidelines/asthma/asthsumm.pdf
- General Guidelines for Referral to an Asthma Specialist (National Heart, Lung, and Blood Institute):
- http://www.phs.org/resources/documents/asthma_ specialist.pdf Guidelines for the Diagnosis and Management of Asthma – Full Report Change Page (National Heart, Lung, and Blood Institute) http://

www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031055.pdf

Coronary Artery Disease

- Coronary Artery Disease Clinical Practice Guidelines (American College of Cardiology and the American Heart Association): http://www.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev1000934.pdf
- Coronary Artery Disease Clinical Recommendations for Prevention of Heart Disease in Women (American Heart Association): http://www.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev1000935.pdf
- Update on Cholesterol Management (National Cholesterol Education Program): http://www.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev1000918.pdf
- Assessing Your Patient's Risk: Framingham Point Scores (National Heart, Lung, and Blood Institute: http://www.phs.org/idc/groups/public/@phs/@marketing/documents/phscontent/wcmdev1001076.pdf
- AHA/ACC Secondary Prevention for Patients with Coronary and Other Vascular Disease: 2006 Update (American College of Cardiology and the American Heart Association): http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052254.pdf

Diabetes

- Diabetes Clinical Practice Guidelines for Providers –Healthy Non-Pregnant Adult (American Diabetes Association and New Mexico Health Care Takes on Diabetes): http://www.phs.org/wcm/groups/public/@phs/@php/documents/phscontent/wcmdev1001010.pdf
- Diabetes Clinical Practice Guidelines for Members – Healthy Non-Pregnant Adult (American Diabetes Association and New Mexico Health Care Takes on Diabetes): http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1030537.pdf

Obesity

- Guide to the Prevention & Treatment of Adult Overweight & Obesity in Primary Care (Clinical Prevention Initiative): http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1030683.pdf
- Quick Discussion Guide for Adult Weight Counseling in Primary Care (Clinical Prevention Initiative): http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031068.pdf
- Getting in Balance Worksheet to Identify Overall Weight-Related Health Risk (Clinical prevention Initiative): http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmprod1031069.pdf

Clinical Practice Guidelines for Behavioral Health Practitioners/Providers

Presbyterian has adopted behavioral health clinical practice guidelines for depression and Attention Deficit/Hyperactivity Disorder. For more detailed information for behavioral health practitioners/providers, Presbyterian recommends the clinical practice guidelines of the American Psychiatric Association (APA) and the American Academy of Pediatrics (AAP).

Depression

Guidelines for Primary Care Practitioners Treating Adult Patients with Depression (created jointly by Presbyterian Health Plan, Inc. and Lovelace Health Plan, based primarily on the American Psychiatric Association's Guideline for Major Depression in Adults): http://www.phs.org/resources/documents/depression.pdf.

Attention Deficit/Hyperactivity Disorder (ADHD)

- ADHD Diagnosis and Evaluation Guidelines: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/5/1158.pdf
- Treatment of School Aged-Children with ADHD: http://pediatrics.aappublications.org/cgi/reprint/108/4/1033
- ADHD Quick Reference Guide: http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/wcmdev1000899.pdf

American Psychiatric Association (APA) and the American Academy of Pediatrics (AAP) Guidelines

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- APA Bipolar Disorder: http://www.psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx
- APA Major Depression: http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx
- APA Schizophrenia: http://www.psychiatryonline.com/pracGuide/pracGuideTopic_6.aspx
- AAP Attention Deficit Hyperactivity Disorder (ADHD): http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/5/1158.pdf and http://pediatrics.aappublications.org/cgi/reprint/108/4/1033

As guidelines are updated, Presbyterian notifies practitioners/providers in a subsequent issue of the "In Brief" provider newsletter. In addition, updates are posted on the Presbyterian website at http://www.phs.org/PHS/healthplans/providers/healthservices/index.htm.

Predictive Modeling

Predictive modeling is a tool that applies risk factors to claims, utilization patterns, pharmaceutical and lab data using a mathematical formula, which is then used to predict future risk of costs and utilization. Using this tool, we are able to offer your patients proactive intense care coordination interventions and assistance with navigation of the health care system. Predictive modeling is also useful in member stratification for disease management interventions.

Medical Records and Confidentiality Assurance

There may be instances where records from your office or facility are requested to ensure that correct and timely coverage decisions are rendered, to review records for a special utilization/quality study, or as required by regulatory agencies (for example, the New Mexico Medical Review Association (NMMRA)). Presbyterian is committed to requesting the minimum amount of information required and assisting with either on site review or telephone discussions to minimize administrative burdens. We currently reimburse providers $30.00 for the first 15 pages and $0.15 per page after the first 15 pages, (based on the New Mexico Administrative Code, Title 16, Chapter 10.17.8).

Presbyterian ensures that Health Insurance Portability and Accountability Act (HIPAA) requirements are met and maintains confidential records files. All information and medical records obtained during the course of review activities shall be treated as confidential, in compliance with all applicable state and federal regulations. Presbyterian uses reasonable diligence to prevent inappropriate disclosure. This obligation excludes disclosure of information that is required by state or federal law or is in the public domain.

Practitioner Profiles

Presbyterian is committed to working with you to improve the quality of care provided to our members. Part of this commitment includes sending a Physician Performance Assessment (PPA). The PPA is based on the data submitted on claims processed and paid by Presbyterian and goes to PCPs who have large enough panels and claims activity to make a PPA report statistically meaningful. The data adjusts for severity of illness of the members on a provider's panel and reports on quality measures associated with prioritized initiatives. Data is processed through clinical informatics software to analyze utilization, costs and clinical indicators and includes case mix index and comparative peer data.

Presbyterian also sends lists of members who may be due for health maintenance testing, immunizations, preventive healthcare screenings (such as mammograms), or pharmaceuticals. The PPAs and member lists are intended to be tools for you to aid in the improvement of the health of your patients. We encourage your feedback on the information contained in the PPAs and member lists so that we can continue to improve these tools and the data contained in them. When you have questions regarding a PPA or a member list, please call the number in the cover letter included with your packet. At present, PPAs and member lists are available for primary care practitioners only.

Under and Over Utilization Analysis

Annually, Presbyterian chooses at least four relevant types of utilization data to monitor for each product line to detect potential under and over utilization of services. Examples might include emergency room visits

per thousand, hospital days per thousand, or behavioral health admissions. Presbyterian monitors these data elements, compares them to national benchmarks, and tracks them over time to identify trends. If under utilization or over utilization problems are identified, Presbyterian will take action to address causes of the trend.

Technology Assessment
The Technology Assessment Committee (TAC) provides a process for reviewing all technology recommendations, and new medical, experimental, investigational or behavioral therapies or procedures. Following a formal application process, the TAC evaluation includes a literature search, review of governmental and regulatory publications and expert opinion. The TAC also recommends clinical policies and procedures. This includes procedures, drugs, and devices. The TAC is chaired by a Presbyterian Senior Medical Director and membership includes Care Coordination management staff.

Medical Policy Development and Dissemination
Coverage decisions are based on 1) eligibility, 2) member's contractual benefits, 3) Presbyterian Health Plan, Inc. Medical Policy Manual, and 4) individual, community, and/or local delivery considerations. If there is a conflict between the member's contract and the Medical Policy Manual, the contract will govern.

Presbyterian utilizes nationally recognized medical review criteria to assist in certifying benefit coverage. Medical policies are reviewed by practicing New Mexico practitioners and must be approved by the Presbyterian Clinical Quality Committee, consisting of local practitioners as well as Presbyterian clinical staff. Review criteria may include:

- Hayes, Inc. (a nationally recognized and independent health technology assessment company)
- Centers for Medicare and Medicaid Services (CMS) Medical Policy Guidelines
- The CMS Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Jurisdiction C
- Local Medical Review Board Medical Policies
- Milliman Care Guidelines (a nationally recognized company specializing in best practice continuum of care recommendations)
- New Mexico Medical Assistance Division Program Guidelines
- Oregon Outpatient Therapy Guidelines for Children with Special Healthcare Needs
- Apollo Guidelines for Managing Physical/Occupational/Speech Therapy and Rehabilitation Care
- American Psychiatric Association Levels of Care
- American Academy of Child and Adolescent Psychiatry Levels of Care
- American Society of Addiction Medicine Levels of Care
- Health Plan's Uniform Level of Care Guidelines
- Presbyterian Behavioral Health Level of Care Guidelines
- Presbyterian Health Plan, Inc. Medical Policy Manual

Presbyterian encourages practitioners/providers and members to contact us for information about the Medical Policies and/or for copies of the Medical Policies used for specific coverage determinations. The Medical Policy Manual is available at http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm.

Continuity of Care
Health Services/Integrated Care Solutions staff assists members whenever possible in making a smooth transition between practitioners and/or providers as follows.

- A new member enrolls from a previous insurer to Presbyterian.
- A member's healthcare provider leaves or is terminated from Presbyterian's network.
- A member voluntarily switches or is switched to another health plan.
- A member's coverage ends or benefits are exhausted.

The transitional period will be administered in accordance with all applicable law, rules and regulations. Currently, the period will continue for a period of time that is sufficient to permit coordinated transition planning consistent with the member's condition and needs relating to the continuity of the case, and will

not be less than 30 days and may be extended for a period of active treatment or up to 90 days, whichever is shorter.

Transition of care is covered for women in their second or third trimester of pregnancy and for transplant patients. Practitioners/providers or members may call the Presbyterian Customer Service Center or Care Coordination within Integrated Care Solutions for assistance with transition of care.

Family Planning (Presbyterian Salud Only)
Presbyterian Salud must allow members the freedom of choice, and the methods of accessing family planning services, without requiring a referral from the PCP. Clinics and practitioners/providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by Presbyterian Salud for all family planning services regardless of whether they are participating or non-participating practitioners/providers. Unless otherwise negotiated, Presbyterian Salud shall reimburse practitioners/providers of family planning services at the New Mexico Medicaid fee schedule. Family planning services are defined as follows:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated
- Screening, testing and counseling of at-risk individuals for Human Immunodeficiency Virus (HIV) and referral for treatment
- Follow-up care for complications associated with contraceptive methods issued by the family planning practitioner/provider
- Provision of, but not payment for, contraceptive pills (refer to formulary)
- Provision of devices/supplies
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

Presbyterian Salud will not and is not obligated under any Human Services Department (HSD) initiated obligation to reimburse non-participating family planning practitioners/providers for non-emergent services outside the scope of these defined services.

Dental Care (Presbyterian Salud Only)
Routine dental exams and prophylaxis (cleanings) do not require a referral. Members may access in-plan dental practitioners/providers without obtaining a referral or Prior Authorization from Presbyterian Salud. Practitioners and providers may contact DentaQuest at 1-800-233-1468. Members may call the Presbyterian Customer Service Center for information about in-plan dental practitioners/providers.

Medicare Notices
Important Message to Medicare Beneficiaries
Upon admission to a cntracted or non-contracted acute care hospital, the hospital will provide Medicare Advantage members with the Centers for Medicare and Medicaid Services (CMS) document entitled, "An Important Message to Medicare Beneficiaries." This document explains the Medicare Advantage member's appeal rights when receiving care in an acute hospital setting.

Once the Medicare Advantage member has signed the document, the hospital must deliver a follow-up copy as far in advance of discharge as possible but not more than two calendar days before the planned date of discharge except when the original Important Message from Medicare was delivered within two calendar days of discharge.

Detailed Notice of Discharge
Presbyterian will communicate in an expeditious manner with the Quality Improvement Organization (QIO) in order to facilitate appeals. When a QIO notifies Presbyterian that a member has requested an immediate review, Presbyterian will directly or by delegation deliver a "Detailed Notice of Discharge" to the member. This document provides a detailed explanation of why acute care hospital services are no longer covered.

Care Coordination

Notice of Medicare Non-Coverage (NOMNC)
Presbyterian Medicare Advantage beneficiaries and Medicare recipients receiving home health care or those in a Skilled Nursing Facility (SNF) must be given a CMS-approved written notice informing them that their covered home health care or SNF services are ending. The notice must be given two days in advance of services ending. If services are expected to be less than two days, the notice must be given upon admission to the provider (facility). In a non-institutional setting, if the span of time between services exceeds two days, the provider should deliver the notice no later than the next to last time that services are furnished. The notice includes the date the enrollee's financial liability for continued services begins and a description of the member's right to an expedited appeal to a Quality Improvement Organization (QIO). Care Coordination will ensure that providers have the appropriate CMS approved forms to give to members.

Home Skilled Nursing Facility (SNF) Rule under Medicare
The "Home SNF Rule" refers to provisions affecting the choices Medicare Advantage members have when needing SNF care, following discharge from a hospital stay. The rule allows a hospitalized Medicare Advantage member who requires skilled nursing care and is ready for discharge, to elect one of the following three options:

- The Member can return to the SNF from where they came.
- They may go to the SNF where their spouse is.
- They may go back to their Continuing Care Retirement Community (CCRC) SNF, if applicable. If the "Home SNF" is a non-participating provider (facility), Presbyterian Medicare Advantage beneficiaries or the delegated entity must attempt to contract with the non-participating practitioner/provider.

Sterilization and Termination of Pregnancy – Presbyterian Salud
For sterilization procedures, members must be informed of the risks and benefits associated with the procedure and that the procedure is final and irreversible. The appropriate federal consent form must be signed and recipients must be at least 21 years of age at the time consent is obtained. The consent form must be signed by the recipient at least 30 days before the procedure is performed. In the case of premature deliveries or emergency abdominal surgery, the consent must be signed not less than 72 hours before the time of the premature delivery. The federal consent form is available at http://www.hhs.gov/forms/HHS-687.pdf.

For termination of pregnancy, voluntary informed consent by an adult or emancipated minor recipient (as determined by the court systems) must be given to the practitioner/provider prior to the procedure to terminate pregnancy except in certain circumstances.

New Mexico Medicaid covers services to terminate pregnancy only when the treating practitioner/provider certifies that in their best medical judgment:

- The procedure is necessary to save the life of the mother as certified in writing by a practitioner/provider.
- The pregnancy is a result of rape or incest, as certified by the treating practitioner/provider and/or the appropriate reporting agency, or if not reported, the patient is not physically or emotionally able to report the incident.
- The procedure is necessary to terminate an ectopic pregnancy.
- The procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical or mental health of an individual.

Individuals with Special Health Care Needs (ISHCN) – Presbyterian Salud and SCI
Individuals with Special Health Care Needs (ISHCN) require a broad range of primary specialized medical, behavioral health and related services. Presbyterian defines Adult Individuals with Special Health Care Needs as follows:

- 21 years and older
- Have ongoing physical, mental, neurobiological, emotional and/or behavioral health conditions
- Require health care and related services that are

different from the services required by most individuals
- Have low to severe functional limitations

Presbyterian defines Children with Special Health Care Needs as follows:
- 20 years old and younger
- Have or are at an increased risk for an ongoing physical, developmental, neurobiological, mental or behavioral/emotional health condition
- Require health care and related services that are different from the services required by most children
- Children who are eligible for Social Security Insurance (SSI) as disabled under Title XVI
- Children identified in the Department of Health (DOH) Title V Children's Medical Services Program
- Children participating in the Home and Community Based Waivers
- Children receiving foster care or adoption assistance support through Title IV E
- Other children in foster care or out-of-home placement
- Children who are eligible for services through the Individuals with Disabilities Education Act
- Other children whose clinical assessment shows that they have special health care needs

Practitioners who serve ISHCN members are encouraged to help educate those members, their families, and their caregivers regarding special considerations and needs for their care, including Care Coordination, special transportation needs, therapy services, durable medical equipment and coordination of emergency inpatient and outpatient ambulatory surgery services with facilities and hospitalists.

Individuals identified as having special health care needs receive a handbook describing services that are available to them. Medically necessary services or supplies may be authorized for up to one year.

Individuals with Special Health Care Needs often need to access services from practitioners/providers who may not be familiar with their history. Presbyterian includes a Medical Summary form in the member Handbook for Individuals with Special Health Care Needs or in the SCI Member Handbook to assist members in providing their medical histories. Members are asked to carry this Medical Summary with them at all times and to present it when accessing care. Presbyterian encourages the member to update the Medical Summary as needed.

Appeals
If we are unable to prior authorize/certify a request, the practitioner/provider or facility may appeal this decision. The practitioner/provider is not prohibited from advocating on behalf of the member. The criteria used to make this determination will be made available to the practitioner/provider. In addition, the practitioner/provider may speak directly to the Medical Director. Refer to the Appeals and Grievances section of this manual for information on filing appeals.

Specialists as PCPs for Members with Special Health Care Needs
On an individual basis, specialists treating members with disabilities or chronic/complex conditions may serve in the capacity of PCP. The specialist is credentialed as a PCP/Specialist and performs all PCP duties within the scope of the participating specialist's certification. Contact your Provider Services Coordinator to initiate this process.

Behavioral Health Care Coordination
Members may access the Behavioral Health network of contracted practitioners/ providers without a referral or prior authorization. They do not need a referral for most outpatient services. Behavioral Health Services for Salud members are administered through OptumHealth New Mexico. For assistance in finding behavioral health practitioners/providers, you or your patients may contact the following:
- For Commercial/Senior Care members: (505) 923-5221 or (866) 593-7431
- For Medicaid members: OptumHealth: 1-866-660-7185 (customers) or 1-866-660-7182 (providers)

Presbyterian encourages PCPs and Behavioral Health Practitioners to communicate with one another regarding individual cases.

Presbyterian Salud
A Presbyterian Salud member may access behavioral

health services through:

- A direct contact with OptumHealth New Mexico
- A referral from Presbyterian Salud
- A referral from his or her primary care or other health care practitioner
- By going directly to a behavioral health practitioner/provider

For your Presbyterian Salud patients, you can make a direct behavioral health referral for any one of the following eighteen (18) indicators listed in the New Mexico Administrative Code (NMAC). The NMAC citation is 8.305.9.10F, "Coordination of Physical and Behavioral Health Services Benefits." http://www.nmcpr.state.nm.us/nmac/parts/title08/08.305.0009.htm

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;
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 behavior health services;
7. Clinical status that suggests the need for behavioral health services;
8. Identified psychosocial stressors and precipitants;
9. Treatment compliance complicated by behavioral characteristics;
10. 1Behavioral, psychiatric 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;
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;
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; and
18. The persistence of serious functional impairment.

Medical Record Reviews

Medical record reviews are performed for primary care practitioners, OB/GYN practitioners, and high volume behavioral health specialists. The following criteria apply:

- A passing score of 85 percent is required
- If the medical record review score is less than 85 percent, Presbyterian may choose to do any or all of the following:

1. Identify deficiencies and send a letter to the practitioner/provider that identifies compliance issues.
2. Suggest an action plan for improvement, and send an example education form.
3. Publish best practices for medical record documentation in the provider newsletter.
4. Coordinate with Provider Services for medical record review follow-up.

Practitioner Access to Medical Records

Presbyterian has adopted the following medical record access standards from Title 8 and Title 13 of the New Mexico Administrative Code, the Medicare Managed Care Manual, and the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information. Practitioners and providers agree to comply with the following:

- The primary care practitioner must maintain a primary medical record for each member that contains sufficient medical information from all practitioners/providers involved in the member's care to ensure continuity of care.
- All practitioners involved in the member's care shall have access to the member's primary medical record.
- Practitioners shall request information from other treating practitioners, with a signed consent from the member, as necessary to ensure continuity of care.
- Medical records shall be available to practitioners

for each clinical encounter. Each specialty care practitioner shall forward a record to the member's primary care practitioner of the services provided.

Practitioners shall ensure the confidential transfer of medical, dental, or behavioral health information to another primary medical, dental, or behavioral health practitioner when a primary medical, dental or behavioral health practitioner leaves Presbyterian or when the member changes primary medical, dental or behavioral health practitioners. The information forwarded shall include, but is not limited to, the following:

- A list of the member's principal physical and behavioral health problems, as applicable;
- A list of the member's current medications, dosage amounts, and frequency;
- The member's preventive health services history;
- EPSDT screening results (for Presbyterian Salud members under age 21); and
- Other information necessary to ensure continuity of care.

Practitioners shall ensure that they have policies and/or plans in place for medical record authorized access and coordination in the event that they are incapacitated in some way.

Practitioners and providers shall make any and all member medical records available to Presbyterian Health Plan, Inc., Presbyterian Insurance Company, Inc. the New Mexico Superintendent of Insurance, the Centers for Medicare & Medicaid Services (CMS), the New Mexico Human Services Department (NMHSD), and other state and federal regulatory agencies or their agents, for the purpose of quality review, annual National Committee for Quality Assurance (NCQA) HEDIS® audits, and for investigation of member grievances or complaints.

Minimum Medical Record Standards

Presbyterian has adopted medical records standards from the National Committee for Quality Assurance (NCQA); the New Mexico Administrative Code, Title 8, Section 305.8.17, and the Medicare Managed Care Manual. These standards apply to both physical and behavioral health unless otherwise noted. They are listed below:

1. Confidentiality

Patient records must be maintained and managed in a confidential manner in accordance with all applicable state and federal laws, including, but not limited to, the privacy and security rules as provided for under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

2. Legibility and Practitioner/Provider Identification

- Patient records must be maintained in a timely, legible, current, detailed, and organized manner to permit effective and confidential patient care and quality review.
- The patient record must be legible to persons other than the writer.

3. Entries

All entries must be dated and include date of entry and date of encounter. The entries, including dictation, must be identified by the author and authenticated by his/her entry. Authentication may include signature or initials verifying that the report is complete and accurate. Patient record notes generated/stored electronically by computer are considered authenticated if there is a demonstrated password protected entry with a time-limited edit capability.

4. Organization/Patient Identification

Patient records must be organized systematically and uniformly. Paper documentation must be firmly secured or attached in the patient record/medical record. Patient identification information must be present on each page or electronic file.

Individual patient records are recommended as opposed to family records. If family records are used, each patient's component of the record must be clearly distinguishable and organized. Each page in the patient's record must contain patient name or patient identification number.

5. Personal Biographical Data

This may include age, sex, date of birth, address,

employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms, and guardianship information.

6. Allergies
- Allergies must be documented in a uniform location on the patient record.
- Adverse reactions must be listed, if present.
- Document no known allergies (NKA), if applicable.

7. Documentation of Tobacco, Alcohol, and Substance Abuse
Notation concerning tobacco, alcohol, or recreational/illicit substance use (all patients over 12 years of age).

8. Problem List (as appropriate for practitioner/practice type)
Identification of current problems, significant illness, and medical conditions are documented on the problem list. If the patient has no known medical illness or condition, the medical record must include a flow sheet for health maintenance.

9. Medication List and History (as appropriate for practitioner/practice type)
Reflects current medications and medication history, including what has been effective and what has not.

10. Periodic Health Examinations (Physical Health Only)
- Examination content following the Presbyterian Health Plan, Inc. Preventive Healthcare Guidelines at: http://www.phs.org/wcm/groups/public/@phs/@php/documents/phscontent/wcmdev1001475.pdf
- Following the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program services for New Mexico Medicaid Presbyterian Salud members under 21 years of age.

The Presbyterian EPSDT Program Provider Training Manual contains the New Mexico Medical Assistance Division's Preventive Health Guidelines and anticipatory Guidance schedules. The Presbyterian EPSDT Program Manual is available at: http://www.phs.org/wcm/groups/public/documents/phscontent/wcmdev1001063.pdf or go to:
- www.phs.org
- Select "For Presbyterian Providers" from the Resources box on the lower right
- Select "Provider Resources" from menu on left
- Select EPSDT Provider Training Manual from list in center

11. Prevention Screening, Patient Education and Counseling (Physical Health Only)
Documentation is present as applicable for problems and current diagnosis. For Medicaid recipients, the status of preventive services, or at least those specified by the New Mexico Human Services Department, are summarized on a single sheet in the medical record within six months of enrollment. Lifestyle management and preventive healthcare information is documented and includes, but is not limited to, the information in the list below. A comprehensive list of screening and counseling topics is available in the Presbyterian Preventive Healthcare Guidelines for practitioners on www.phs.org (http://www.phs.org/wcm/groups/public/@phs/@php/documents/phscontent/wcmdev1001475.pdf).
- Family planning
- Cancer prevention and detection (e.g., sun exposure and breast, cervical, testicular, and colon cancer screenings, as appropriate)
- Injury prevention – at least one of the following:
- Vehicle safety belts
- Occupational Hazards
- Home safety
- Smoke alarms
- Promotion of Preventive Health Care Screening and Counseling
- HIV infection and other sexually transmitted diseases
- Tobacco use
- Alcohol and substance use/abuse
- Osteoporosis and heart disease in menopausal women
- Motor vehicle injuries
- Household and recreational injuries
- Dental and Periodontal disease
- Unintended or mistimed pregnancies

- Obesity
- Physical activity
- Healthy diet

12. Durable Power of Attorney/Advance Directives (Physical Health Only)
Documentation is present in the medical record that each adult patient was offered information on durable power of attorney/advance directives. The documentation should be signed and dated by the patient and the practitioner and be maintained in the patient medical record. An advance directive form is available on the Presbyterian website at: http://www.phs.org/PHS/patients/info/advdirectiveform/index.htm.

13. Patient Notification of Abnormal Diagnostic Test Results (Physical Health Only)
Patients are notified of abnormal diagnostic test results and scheduled follow-up visit, plans and/or directions.

14. Consultations/Referrals
- Documentation is present in the medical record regarding medical care/services and results for consultations.
- Referral Information. The patient's past medical or surgical history and results of previous diagnostic tests are recorded in the medical record. Documentation is present in the patient record indicating that pertinent medical and/or behavioral information is communicated from the specialist to the primary care practitioner.

15. X-Ray, Lab, and Imaging Reports - Referrals - Diagnostic Information (Physical Health Only)
- Reports are filed in the medical record and initialed by the primary care practitioner signifying review.
- Consultation and abnormal lab imaging study results should have an explicit notation in the medical record for follow-up plans.
- Referrals, past medical records, hospital records (e.g., operative and pathology reports, admission and discharge summaries, consultations and emergency room reports should be filed in the medical record).

16. Past Medical History (as appropriate for practitioner/practice type)
- Obtained on first visit for patients under age 21. For patients age 21 or older, obtained when seen two or more times.
- Past medical history should be easily identifiable and include serious accidents, operations, illnesses, and familial/hereditary disease/mental illness.

17. Medically Appropriate Care (as appropriate for practitioner/practice type)
Diagnosis and treatment plans are documented and are medically appropriate.

18. Hospital and Outside Clinical Records (as appropriate for practitioner/practice type)
Pertinent documents are present in order to facilitate continuity of care for hospital, ambulatory surgical facility, behavioral health facility, emergency room visits, etc.

19. Immunization Status (Physical Health Only)
Appropriate immunizations for children, adolescents, and adults are noted.

Individual Clinical Encounters
At a minimum, the patient's record must include the following detail as appropriate for practitioner/practice type:
- History and physical examination for the presenting complaint, including relevant psychological and social conditions affecting the patient's medical and psychiatric status.
- Subjective patient information and objective physical findings.
- Working diagnosis is consistent with findings (practitioner's medical impression).
- Documentation of plan of action and treatment are consistent with diagnoses.
- Diagnostic tests and/or results.
- Drugs prescribed including the strength, amount, and directions for use and refills.
- Therapies and other prescribed regimes and/or results.
- Follow-up plans and/or directions such as time for return visit or symptoms that should prompt a return visit.
- Consultations and referrals and/or results.

- Patient compliance/non-compliance (e.g., canceled and/or missed appointments, no-show or other indications of patient noncompliance).
- Documented patient follow-up.
- Counseling session start and stop time (Behavioral Health Only).
- Any other significant aspects of patient care.

Behavioral Health Practitioners

For patients who receive three or more services within a 12-month period, the following is documented in the behavioral health record:

- A mental status evaluation which documents affect, speech, mood, thought content, judgment, insight, concentration, memory, and impulse control.
- DSM-IV diagnosis consistent with the history, mental status examination, or other assessment data.
- A treatment plan consistent with diagnosis, which has objective and measurable goals and timeframes for goal attainment or problem resolution.
- Documentation of progress toward attainment of the goal.
- Preventive services such as relapse prevention and stress management.

Laboratory

In an effort to simplify laboratory information for your office, Presbyterian and TriCore Reference Laboratories have consolidated the In-Office Lab List. The In-Office Lab List applies to all Presbyterian product lines, and is for dates of service on or after 05/01/2010. Reimbursement for these pathology/laboratory services is based on Presbyterian's Clinical Lab fee schedule, unless your contract states otherwise. Please note that certain Current Procedural Terminology (CPT) codes are restricted to specific specialties.

Below is an "In-Office Lab List" of pathology/laboratory services that may be performed in the physician's office. The list includes a description identifying codes along with any limitations for each service. It is your responsibility to establish appropriate Clinical Laboratory Improvement Amendments (CLIA) Certification, or to apply for a CLIA Waiver, should you choose to perform any of these services. Reimbursement for these services will remain at the current Presbyterian fee schedule and payment is subject to the member's eligibility, benefit plan and benefit limitations. Please see the table below for TriCore contact information. Your Provider Services Coordinator is available to assist you with any issues you may have.

TriCore Key Contact Information

Client Services (test results, TriCore locations, specimen requirements, general information)	(505) 938-8922 (24 hours) 1-800-245-3296 (24 hours)
Client Supplies	For phone or fax orders : (505) 938-8957 1-800-245-3296 ext. 8957 (505) 938-8472 (fax) For online supply orders : Call the Supply Order Desk for assistance (505) 938-8957 1-800-245-3296, ext. 8957
Logistics/Couriers	(505) 938-8958 1-800-532-2649 (505) 954-3780 (Santa Fe)
IS Help Desk (printer, TriCore Express TriCore Direct and computer-interface assistance)	(505) 938-8974 1-800-245-3296, ext. 8974
Sales and Service	(505) 938-8917 1-800-245-3296, ext. 8917
Billing/Business Office	(505) 938-8910 1- 800-541-9557 (505) 938-8640 (fax)
Main Numbers	(505) 938-8888 (24 hours) 1-800-245-3296 (24 hours)

Pharmacy

The Presbyterian Pharmacy Benefit is an essential element in providing patients the medication they need while appropriately managing costs. As the patient's practitioner/provider, you are the key to the appropriate use of pharmaceuticals, which includes:

- Choosing the best, most cost effective drug and dosage form to treat the patient's condition
- Making sure each patient clearly understands the use of the drug, the correct dose and possible side effects
- Looking for key drug interactions and discontinuing ineffective drugs
- Reviewing each patient's medication list and dosages at every visit
- Carefully monitoring therapeutic drug levels as necessary

Please take time to become familiar with the Presbyterian Prescription Program and the Presbyterian Formularies. These are helpful tools to manage both quality and cost for our members. Practitioners/providers may obtain a copy of the formularies by downloading them onto a hand-held device from www.ePocrates.com or by visiting the pharmacy page on our website at www.phs.org.

You may also call us for additional assistance. Following is a list of phone numbers to expedite service:

Pharmacy Prior Authorization phone number	(505) 923-5500 1-888-923-5757, Pharmacy Option (outside of the Albuquerque area)
Pharmacy Services Toll Free Fax Number	1-877-640-5814

ASKRX

ASKRX@phs.org is an email box we have created to better serve our practitioners/providers. Any questions or concerns can be emailed directly to this box that is monitored hourly by one of our clinical pharmacists. Any email sent to ASKRX will be answered within 24 hours.

National Drug Code (NDC) Information

Beginning in September 2010, all Medicaid practitioners and providers were required to begin supplying the 11-digit NDC when billing for injections and other drug items. As of February 15, 2011, Presbyterian began requesting that ALL practitioners and providers supply this information as part of the claim submission process. Following is information you may find helpful in submitting claims with NDCs.

Understanding the National Drug Code

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 claim form or in the 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item. The complete NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format such as "12345-1234-12."

However, sometimes the NDC as printed on a drug item omits a leading zero in one of the segments, requiring a leading zero to be entered on the claim form and the hyphens to not be used. Instead of the digits and hyphens being in a 5-4-2 format, the NDC may be indicated in a 4-4-1 as in "1234-1234-1", or in a 5-3-2 format as in "12345-123-12", or less commonly in a 5-4-1 format as in 12345-1234-1."

A leading zero must be added to make the 5-4-2 format. See the following examples:

- NDC 12345-1234-12 is complete – it is reported as 12345123412.
- NDC 1234-1234-12 needs a leading zero in the first segment to be in the 5-4-2 digit format, to become 01234-1234-12 – it is reported as 01234123412.
- NDC 12345-234-12 needs a leading zero in the second segment to be in the 5-4-2 digit format, to become 12345-0234-12 – it is reported as 12345023412.
- NDC 12345-1234-1 needs a leading zero in the third segment to be in the 5-4-2 digit format, to become 12345-1234-01 – it is reported as 12344512301.

Presbyterian may reject claims with a date of service on or after January 1, 2011, that do not indicate a valid NDC for the following HCPCS or CPT codes:

- Codes in the range J0120 - J9999 (various injections and chemotherapy)

- Codes in the range S0012 - S0197 and S4990 - S5014 (various items)
- Codes in the range S5550 - S5571 (insulin injections)
- Codes in the range 90281 – 90399 (immune globulins)

The same requirement applies to providers billing revenue codes on the UB04 claim form. HCPCS or CPT codes are required whenever the provider bills one of the following revenue codes and the claim is an outpatient hospital, emergency room facility, dialysis facility, other outpatient facility which uses the UB04 claim form. When the reported HCPCS or CPT code is one of the above, the NDC code must also be reported for:

- Pharmacy revenue codes 0250, 0251, 0252, and 0254.
- Pharmacy revenue codes 0631, 0632, 0633, 0634, 0635, and 0636.

For complete instructions on where the NDC information is to be supplied for a CMS-1500, a UB04, or 837 transactions, please use the following link: http://www.hsd.state.nm.us/mad/registers/2010.html. This information will be found under the header "Supplements" and it is Supplement Number 10-03.

Additionally, you may view the NDC Procedure Manual by accessing the following link: http://www.phs.org/PHS/healthplans/providers/index.htm.

Benefit Guidelines

The following describes the general administration of the Presbyterian pharmacy benefit. Although all product lines vary in structure, for example, some follow a closed, generics-based formulary while others use a multi-tier formulary structure, they all follow the same basic limitations.

Generic substitution is generally mandatory for all government programs (i.e. Medicaid and Medicare) for drugs that have generic FDA-AB rated equivalents available. All drugs are subject to generic substitution when an approved generic becomes available. For the Commercial product line, if the member or practitioner/provider requests the brand name in place of the generic, the member will be responsible for the generic copayment plus the difference in cost (if any) between the generic and brand drug.

The formularies apply only to prescription medications obtained by outpatients through a participating retail pharmacy. The formularies do not apply to inpatient medications.

Not all dosage forms and strengths of a medication may be covered (e.g., sustained release, micronized, enteric coated). See the comment section of the formularies . Drugs are constantly being developed and new versions released or made available in generic or other forms. As a result, please obtain copies of Presbyterian's complete and most up to date drug formularies aon the pharmacy page of our website at www.phs.org.

Commercial, PPO Copayment/Coinsurance Structures

Presbyterian offers numerous pharmacy benefit copay structures for our members under the Commercial and PPO plans. Most commercial groups utilize a multi-tier (4 Tier) benefit formulary that increases access and eliminates restrictions on most medications. This multi-tier structure (please see the table below) offers our members a greater number of options.

The member's out-of pocket expenses are lowest when they fill prescriptions for preferred generic medications (Tier 1) and preferred brand-name drugs (Tier 2). They are highest when prescriptions for non-preferred drugs (Tier 3) are obtained. Specialty pharmaceuticals (Tier 4) are specialized medications that may be required to be obtained through the designated specialty pharmacy vendor.

Some medications on the formulary may requireprior authorization. The prior authorization process is available once a member has tried and failed all formulary agents and it is deemed medically necessary to have access to a non-formulary agent. (See Prior Authorization Process). The formularies, pharmacy prior authorization forms, specialty pharmaceuticals listing and specialty drug request form are available on

the pharmacy page at: www.phs.org.

- Visit www.phs.org
- Click on "Programs & Services"
- Click on "Pharmacy" from the menu on the left
- From dropdown menu on right, select "Presbyterian Pharmacy for Providers" (under Quick Links)

You may also call the Pharmacy Department directly at (505) 923-5500 or outside Albuquerque at 1-888-923-5757, and select the "Pharmacy" option.

Prescription Copay Structure

Tier 1	Preferred Generic Drugs	These drugs are the preferred generics that offer the most affordable way to obtain quality medications at the lowest copayment level.
Tier 2	Preferred Brand-Name Drugs	*These are the preferred brand-name drugs that have no generic equivalent available.
Tier 3	Non-Preferred Drugs	*These are non-preferred generic and brand drugs. Non-preferred drugs have a therapeutic equivalent alternative in Tier 1 or Tier 2. These drugs are available to members for a higher copayment.
Tier 4	Specialty Pharmaceuticals	(Tier 4 medications obtained through the Pharmacy benefit): Specialty Pharmaceuticals are defined as high cost (greater than $600 per 30 day supply) injectable, infused, oral or inhaled drugs that generally require complex care and supervision. These medications involve unique distribution and are usually provided by a specialty pharmacy vendor. Specialty Pharmaceuticals are used to treat serious chronic, often rare diseases. Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient or to the patient by a family member or care-giver. Some Specialty Pharmaceuticals may require Prior Authorization before they can be obtained. For a complete list of Specialty Pharmaceuticals to determine which require Prior Authorization and what drugs are mandated through our specialty vendor, please see the Presbyterian Pharmacy web site at: http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052739.pdf

	Mandatory Generic Substitution Requirement	Substitution of generic products is mandatory when an FDA-AB rated generic is available. For Commercial members, if the brand name version of a drug is desired when a generic version is available, the member will pay the generic copayment plus the difference in cost between the generic and brand medications.
	Specific Limitations and Exclusions	Quantity limitations, as well as specific exclusions apply. Examples of exclusions are medications used for cosmetic purposes. Please refer to member-specific materials for the limitations and exclusions.

Please note that specialty pharmaceuticals are not available through mail order of retail pharmacies, and must be obtained through our Specialty Pharmaceutical vendor.

For each prescription drug purchased at a Presbyterian participating retail pharmacy, applicable co-pays will apply. The copayment required for each type of prescription or refill, whether it is an oral tablet/capsule, liquid, ointment, cream or lotion, will be one applicable copayment per 30-day supply not to exceed the manufacturer's prescribing recommendation.

Specialty Pharmaceuticals, obtained through our designated specialty pharmacy vendor, require co-insurance up to a maximum dollar amount, for most plans, except when administered in an inpatient hospital setting when medically necessary. These products may require a prior authorization.

Mail Order for Commercial and PPO
Under the Mail Order Pharmacy Benefit, maintenance medications can be obtained through the Mail Service Pharmacy identified by Presbyterian. The copayment required for each type of prescription or refill, whether it is an oral tablet/capsule, liquid, ointment, cream or lotion, will be one applicable copayment per 90-day supply not to exceed the manufacturer's prescribing recommendation.

Copayments vary, depending on which benefit structure a member falls under. Under the multi-tier drug listing structure, members usually pay the following:

Tier	Copayment
Tier 1 (preferred generics)	2 x retail copayment
Tier 2 (preferred brand)	2.5 x retail copayment
Tier 3 (non-preferred medications)	3 x retail copayment
Tier 4 (Specialty Pharmaceuticals)	Not available through mail order – must use our specialty vendor; limited to 30-day supply

Retail for Commercial and PPO
90-day Supply at the Pharmacy (Voluntary)
For your convenience, members have the option to pick up a 90-day supply of your maintenance medication(s) at a local participating pharmacy. Members will be charged three retail copayments for a 90-day supply up to the manufacturer's usual maximum recommended dosing for the medication.

Maximum Dosing Quantity for 30-day Supply
Under this pharmacy benefit enhancement, a member's 30-day prescription supply will be filled, up to the maximum dosing recommended by the manufacturer, without charging any additional copayments. The prescription will still be subject to one of the three (preferred generic, preferred brand, non-preferred) applicable copayments.

Medicaid Managed Care (SALUD!) Pharmacy Structure
We recognize that you play a vital role in the success of the Salud! Program and we appreciate your support. We are focused on the present challenges facing the state and need your assistance in implementing the numerous changes in our state's Medicaid managed care program.

Pharmacy

All membership under the Salud structure follows a strict, closed formulary. Adherence to the formulary is required, but the pharmacy prior authroizaion process is available for members who have a documented trial and failure of all formulary alternatives (see Pharmacy Prior Authorization section).

Generic Based Formulary

- The Presbyterian Salud Program is a generic-based formulary. Please note that online versions of all Presbyterian formularies are available on the pharmacy page of our Web site at www.phs.org. All formularies may also be downloaded through the ePocrates Rx software.
- Formulary brand name drugs will only be covered when a generic equivalent drug is not available.
- If there is more than one brand name equivalent drug for a given medical condition, only the least expensive brand name drug will be covered.

Strict Formulary Policy

- The Presbyterian Salud formulary includes medication to cover all medically necessary treatments. Only drugs that are listed on the formulary will be covered. The formulary includes medications in all therapeutic categories.
- Presbyterian has a "pharmacy prior authorization process" that will allow members access to non-covered medications if they meet the medical necessity criteria.
- Practitioners/providers and members can initiate the pharmacy prior authroization process if a medical necessity review is indicated.

Limited Over The Counter (OTC) Formulary

Coverage for OTC medications will be limited to the OTC formulary and subject to strict adherence to the approval criteria guidelines. Refer to the formulary for a listing of the OTC products that are covered.

OTC Switch Program

OTC versions of prescription strength medications will be covered when they are more cost effective than the prescription version.

State Coverage Insurance (SCI) Pharmacy Structure

State Coverage Insurance (SCI) offers affordable health care coverage to low-income working adults primarily through an employer-based system. SCI is available to uninsured, low-income adults, ages 19 through 64, with countable family incomes of up to 200% of federal poverty level and who are not eligible for certain government health insurance benefits, such as Medicaid (Title XIX), Medicare, private health insurance, CHAMPUS, and other public or private health insurance programs. There are no asset requirements required for eligibility or preexisting condition limitations.

Some members in the SCI program will pay $3 per prescription, for both brand and generic medications, while some members have no copay on drugs. Generics are mandatory if an FDA AB-rated version of the drug is available. All other Medicaid formulary edits apply as well.

Note: No OTC products will be covered for members in the SCI program per regulatory guidelines.

Medicare Prescription Drug Benefit

The Medicare Modernization Act of 2003 established the new voluntary outpatient prescription drug benefit program (Medicare Part D). The Medicare Part D prescription drug benefit became available to beneficiaries beginning on January 1, 2006. The Medicare Part D prescription drug benefit will allow all Medicare beneficiaries to enroll in drug coverage through a prescription drug plan or Medicare Advantage Plan with Medicare paying approximately 75 percent of the premium on average (more for qualifying, low-income beneficiaries). The Medicare Part D drug benefit includes beneficiary protections intended to ensure that all beneficiaries have coverage for medically necessary drugs through nearby pharmacies. Drug plans are subject to many of the existing beneficiary protections that are available in Medicare, including requirements to meet strict pharmacy access standards to give beneficiaries access to retail pharmacies and needed drugs.

Medicare Part D Prescription Drug Coverage

In 2006, Presbyterian launched prescription drug plans for our Medicare eligible beneficiaries. These plans are

also known as Medicare Part D. This prescription drug coverage is available to any individual who is Medicare eligible. Some of the Employer Group plans also have Medicare Part D coverage already built in. Presbyterian offers both HMO and PPO Senior Care plans with prescription drug coverage.

Please verify the information on the member's identification card at the time of service. If the member's coverage and plan includes prescription drug coverage, it will be noted on the member's ID card, as identified by specific plan and benefit coverage noted above.

Medicare plans consist of the following stages of coverage:

- **Annual deductible:** The amount the beneficiary will pay out of pocket for their prescription(s) each year before the initial coverage begins. There are currently no deductibles for Presbyterian's senior plans.
- **Coverage:** Initial coverage begins at first dollar coverage. Presbyterian covers the cost of the medications after the member has met their copayment requirement.
- **Coverage gap (Donut hole):** After the benefits paid out by both Presbyterian and the member reaches a yearly specified amount, the member is fully responsible for 100 percent of the costs until their true out-of-pocket cost (TrOOP) reaches the catastrophic stage.
- **Catastrophic coverage:** Coverage begins after the beneficiary expends the CMS set amount (specified yearly) of their own money. The beneficiary will then pay greatly reduced copays until the end of the contract year.

Additional assistance is available for qualifying beneficiaries with low incomes and limited assets. If beneficiaries qualify, they will only pay a small copayment for each prescription. Assistance is based on income limits. Beneficiaries may contact the Presbyterian Customer Service Center at (505) 923-6060 or 1-800-797-5343 for information and forms.

Presbyterian Senior Care and Presbyterian MediCare PPO plans offer a multi-tier pharmacy benefit structure. The beneficiary's out of pocket expenses are lowest when filling prescriptions for preferred generic drugs (Tier 1) and preferred brand name drugs (Tier 2). They are highest when prescriptions for non-preferred (Tier 3) drugs are obtained. Specialty pharmaceuticals (Tier 4) are specialized medications and may be required to be obtained through our designated specialty pharmacy vendor. Some medications may require pharmacy prior authorization. The complete Formulary, Pharmacy Prior Authorization forms, Specialty Pharmaceutical Listing, and Specialty Drug Request forms are available on the pharmacy page at www.phs.org.

Medicare Part D
Prescription Co-Pay Structure
Tier 1 Preferred Generic Drugs
These drugs offer the most affordable way to obtain quality medications at the lowest copayment level.
Tier 2 Preferred Brand-Name Drugs
These are the preferred brand-name drugs that have no generic equivalent available.
Tier 3 Non-Preferred Brand/ Generic Drugs
Non-preferred brand/generic drugs have a therapeutic equivalent alternative in Tier 1 or Tier 2. These drugs are available to members for a higher copayment.
Tier 4 Specialty Pharmaceuticals
(Tier 4 medications obtained through the Pharmacy benefit): Specialty Pharmaceuticals are defined as high cost (greater than $600 per 30 day supply) injectable, infused, oral or inhaled drugs that generally require complex care and supervision. These medications involve unique distribution and are usually provided by a specialty pharmacy vendor. Specialty Pharmaceuticals are used to treat serious chronic, often rare diseases. Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient or to the patient by a family member or care-giver. Some Specialty Pharmaceuticals may require Prior Authorization before they can be obtained. For a complete list of Specialty Pharmaceuticals to determine which require Prior Authorization and what drugs are mandated through our specialty vendor, please see the Presbyterian Pharmacy web site at: http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052739.pdf

Pharmacy

Specialty Pharmaceuticals are not available through mail order and must be obtained through our Specialty Pharmaceutical vendor.

***Mandatory Generic Substitution Requirement**

Substitution of generic products is mandatory when an FDA-AB rated generic is available.

Specific Limitations and Exclusions

Quantity limitations, as well as specific exclusions apply. Examples of exclusions are medications used for cosmetic purposes. Please refer to member-specific materials for a listing of limitations and exclusions.

Additional Medicare Part D Information

Formulary Requirements

- Formularies must be approved by the Centers for Medicare and Medicaid Services (CMS).
- Formularies must be developed by the Pharmacy and Therapeutics Committee.
- Drugs may be added to or deleted from the formulary at any time during the plan year.
- Members/Practitioners are notified if drugs are removed from the formulary, if tier placement changes or if criteria changes.
- Transition period: beneficiaries are allowed to obtain a transition supply of their current non-formulary drug when they enroll in a Part D plan or move from one Part D plan to another. This transition fill allows new beneficiaries sufficient time to establish with the new practitioner to switch to a formulary alternative or initiate the prior auth process.

Mail Order for Medicare Plans

Mail order is available to all of our Medicare Part D members.

Medication Therapy Management (MTM)

MTM is designed to improve care, enhance communication among patients and practitioners/providers, improve collaboration among practitioners/providers, and optimize medication use that leads to improved patient outcomes. The patient meets with the pharmacist for a comprehensive medication therapy review and has additional visits with the pharmacist throughout the year to address ongoing medication monitoring issues and event-based medication therapy problems. The program for qualified members may assist people who:

- Take multiple prescription drugs
- Have chronic illnesses
- Expect to spend a significant amount of money on prescription drugs each year

MTM will help identify potential errors and gaps in care by assisting with the following:

- Reducing the risk of medication errors, especially for patients who have chronic conditions, take several medications or see multiple doctors and other care providers;
- Providing current information on proven medical practices to help patients and their doctor determine the most effective treatment;
- Helping the patient understand their condition and medications, so they can take an active role in managing their health.

MTM includes five core components:

- Medication therapy review
- A personal medication record
- A medication action plan
- Intervention and referral
- Documentation and follow-up

Medicare Part D – Excluded Drugs

- Agents when used for anorexia, weight loss, or weight gain
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
- Barbiturates
- Benzodiazepines
- Diapers
- Erectile dysfunction medications

Pharmacy

Specialty Pharmaceuticals (Tier 4 medications obtained through the Pharmacy benefit)
Specialty Pharmaceuticals are defined as high cost (greater than $600 per 30 day supply) injectable, infused, oral or inhaled drugs that generally require complex care and supervision. These medications involve unique distribution and are usually provided by a specialty pharmacy vendor. Specialty Pharmaceuticals are used to treat serious chronic, often rare diseases. Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient or to the patient by a family member or care-giver. Some Specialty Pharmaceuticals may require Prior Authorization before they can be obtained. For a complete list of Specialty Pharmaceuticals to determine which require Prior Authorization and what drugs are mandated through our specialty vendor, please see the Presbyterian Pharmacy web site at: http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052739.pdf

Medical Drugs (Medications obtained through the medical benefit)
Medical drugs are defined as medications administered in the office or facility that require a health care professional to administer. These medications include, but are not limited to, injectable, infused, oral or inhaled drugs. They may involve unique distribution and may be required to be obtained from our specialty pharmacy vendor. Some Medical Drugs may require Prior Authorization before they can be obtained. Office administered applies to all outpatient settings including, but not limited to, physician's offices, emergency rooms, urgent care facilities and outpatient surgery facilities. For a complete list of Medical Drugs to determine which require Prior Authorization and what drugs are mandated through our specialty pharmacy, please see the Presbyterian Pharmacy website at: http://www.phs.org/idc/groups/public/@phs/@php/documents/phscontent/pel_00052739.pdf

All information regarding formularies and other helpful pharmacy information can be found on our website:
- Visit www.phs.org
- Click on "Programs & Services"
- Click on "Pharmacy" from the menu on the left
- Scroll down to "Presbyterian Pharmacy Information" (center column)
- Click on PHP Formularies by Therapeutic Class

You may also call Presbyterian's Pharmacy Services Department directly at (505) 923-5500 or outside Albuquerque at 1-888-923-5757, Pharmacy Option, if you need assistance.

Exclusions (for most plans)
Specific exclusions are in place for all product lines, however the following are not a covered benefit for most plans:
- Prescription drugs requiring a pharmacy prior authorization when prior authorization was not obtained.
- Prescriptions ordered by a non-participating practitioner/provider or purchased at a non-participating pharmacy unless required due to emergent or urgent care encounters.
- Over-the-counter (OTC) medications and drugs for which there is a non-prescription equivalent available, except Presbyterian Salud/Medicaid which covers certain non-prescription drug items without prior approval when prescribed by a licensed physician or other licensed practitioner.
- Compounded prescriptions
- Replacement prescriptions resulting from loss, theft, or destruction.
- Medications (listed as covered in member materials) received upon hospital discharge, provided by a hospital pharmacy unless a participating outpatient pharmacy is not available.
- Disposable medical supplies, except when provided in a hospital or physician's office or by a home health professional.
- Medications and treatments for the purpose of weight reduction or control except for medically necessary treatment for morbid obesity.
- Nutritional supplements unless for prenatal care as prescribed by the attending physician or as sole source of nutrition.
- Infant formula, unless the need is warranted as a result of inborn errors of metabolism.
- Medications used for the treatment of sexual dysfunction.
- Medications used for cosmetic purposes.

- New medications for which the determination of criteria for coverage has not yet been established by Presbyterian's Pharmacy and Therapeutics Committee.

Experimental Drugs

The experimental nature of drug products or the experimental use of drug products will be determined by the Pharmacy and Therapeutics Committee using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage. Criteria are as follows:

- The drug cannot be marketed lawfully without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug is furnished.
- Reliable evidence shows that the consensus of opinion among experts regarding the drug is that further studies of clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

Pharmacy and Therapeutics (P&T) Committee Organization, Scope and Function

The P&T Committee is composed of primary care and medical specialty providers and practitioners in order to adequately represent Presbyterian providers and practitioners. Other members include Presbyterian Medical Directors, Pharmacy Department Directors, Presbyterian Clinical Pharmacists and retail pharmacy representatives.

Purpose of the P&T Committee

- Serve in an advisory capacity to the Presbyterian panel of medical providers and practitioners and Presbyterian management in all matters pertaining to the use of drugs.
- Develop formularies/Preferred Drug Lists (PDL) accepted for use by Presbyterian providers and practitioners and provide for its constant revision. The Presbyterian P&T Committee uses the following criteria in the evaluation of product selection:

o The drug must demonstrate unequivocal safety for medical use based on sound clinical data.
o The drug must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition based on sound clinical data.
o The drug must demonstrate a positive therapeutic outcome.
o The drug must be accepted for use by the medical community.
o The drug must provide a cost-effective alternative for the treatment of the medical condition.
o The drug must not be experimental or investigational.
o Recommendations of national organizations, committees, and/or specialty societies will be strongly considered.
o The drug is mandated as the result of national or local coverage determinations for Medicare beneficiaries, State Medicaid mandates, or Commercial mandates.

The Committee will make recommendations for changes to the formularies. The Committee will develop forms to be completed when requesting an addition of a drug to the formularies/, and will define procedures and responsibilities for documenting the need for a formulary addition or replacement.

The Committee may propose and approve certain mechanisms for approved formulary agents that are designed to promote appropriate usage. These mechanisms would include but not be limited to:

- Prior Authorization by medical criteria approved by the Committee.
- Step edit – A requirement for a trial of another appropriate formulary/drug listing agent prior to coverage of the targeted drug.
- Quantity Limits – Based on manufacturer's recommended maximum daily dosing.

Establish or plan suitable educational programs for the Presbyterian panel of medical providers and practitioners and Presbyterian enrollees on matters relating to drug therapy.

Review the utilization of drugs or drug classes by Presbyterian providers and practitioners and members to detect both under utilization and over utilization. Make

recommendations to improve medically appropriate and cost-effective drug utilization.

Review adverse drug reactions occurring in the ambulatory care setting, investigate possible causes, and make recommendations to minimize the occurrence of adverse drug reactions. The committee will report serious adverse drug reactions to the U.S. Food and Drug Administration when appropriate.

Participate in quality assurance activities related to the distribution, administration and use of medications.

Review and approve all Presbyterian guidelines and policies related to the use of medications.

Review and Approval of Requests for Formulary Changes

All requests should be documented on the "Request for addition of a drug to the Presbyterian Formulary" form. This is available on our website at www.phs.org.

- Visit www.phs.org
- Click on "Programs & Services"
- Click on "Pharmacy" from the menu on the left
- From dropdown menu, select "Request-Add drug to Health Plan Formulary"

You may also call the Pharmacy Department directly at (505) 923-5500 or outside Albuquerque at 1-888-923-5757, Pharmacy Option. Once the request has been received, a letter will be sent to the requesting practitioner or provider acknowledging receipt of the request and advising of the status of the request (i.e. when it will be reviewed). Additional information may be solicited to support the request. The requesting practitioner/provider may be invited to attend the P&T meeting and present their case for the addition of a drug, although attendance is not mandatory.

A Presbyterian pharmacist will review all requests and prepare a written review of the drug for the P&T Committee. Formulary changes and the rationale of the changes will be communicated to all appropriate parties via memorandum or newsletter. P&T committee actions regarding deletions will take effect 60 days following the decision. Additions will be effective 30 days following the decision. Any removal of a formulary drug will be associated with all of the following procedures:

- Identify members who are currently on the agent.
- Notify the member of the change in benefit with at least 60 days notice.
- Ensure that the affected member has continued coverage of the drug during the 60 day notification period.

Practitioners/providers may obtain a copy of the formulary by downloading the formulary from ePocrates.com, or visiting our Web site at www.phs.org. Formulary changes will be communicated to providers following each P&T Committee meeting.

Pharmacy Prior Authorization Process

The purpose of this section is to define Presbyterian's pharmacy Prior Authorization process including intake, evaluation, decision-making, and response to the requesting provider. This section will also include accountability for decision-making and expected response standardsWe now use an automated prior authorization system where you can submit pharmacy prior authorizationrequests online through Pres Online. Protocols with criteria are built into the system, so in many instances, you will receive the decision in real-time as soon as you finish submitting the required information. To access Pres Online, go to www.phs.org and locate the Pres Online Login box. This process ensures the following:

- Appropriate and timely services to Presbyterian members will be ensured as part of the pharmacy prior authorization process
- That non-formulary requests will be evaluated by the Pharmacy Services Department for medications not listed in the current Presbyterian formularies, requests for drugs for which Presbyterian requires prior authorization and for quantities which are in excess of those defined by the product line benefit description documentsDeterminations will be made on a timely basis as required by the urgency of the situation, in accordance with sound medical principles, and regulatory requirements.
- The Pharmacy Services Department is under the direct supervision of at least one full-time, clinical pharmacist who is accountable to a medical director.

Types of Pharmacy Prior Authorization Requests

- Medications listed on a Formulary that requires prior authorization with application of specific clinical criteria.
- Request for an exception to a Formulary 0Non-formulary request.
- Requests for a quantity or frequency (including vacation) override.

General Processing – Routine Pharmacy Prior Authorization Requests – By Fax, Mail or On-Line

- Participating practitioner generates request for a medication requiring prior authorization, using Pharmacy Services' prior authorization form.
- All requests are submitted directly into our automated prior auth system or manually entered into the system by the technician if they did not come on-line or via fax.
- Verification of eligibility and benefits, including the verification of the Plan to which the member belongs and the original effective date is required for all requests and in on-line submissions, this is an automated feature.
- Evaluate the Benefit Plan to assure that the request is for a covered benefit.
- Gather all pertinent medical information including request for required medical documentation.
- Evaluate requests utilizing appropriate criteria including member claim history.

Revised requests

Following discussion with the practitioner by the pharmacy benefit technicians or clinical pharmacist, the request may be changed to a mutually agreed upon alternative medication. All changes are documented on the original form.

Processing of Approved Pharmacy Prior Authorization Requests

When a request is approved, the practitioner office (requestor) is notified by telephone or fax. If approved, authorization for medication is entered into the online system (PBM) for claims processing.

Processing of Pended Pharmacy Prior Authorization Requests

If the request is pended, the reason why will be indicated on the Pharmacy Prior Authorization form (i.e., additional medical information needed). If additional information is needed to determine if criteria for coverage is met, additional information will be requested by phone or fax. A phone call will be made every 24 hours to the requesting practitioner/provider to obtain updated information. If no additional information to support the request is received after three (3) business days, a denial will be issued.

Processing of Denied Pharmacy Prior Authorization Requests

The denial form and a copy of the Pharmacy Prior Authorization request, along with all pertinent medical information available are presented to a medical director for review and signature. All requests, which are denied based on medical necessity, must be reviewed by the pharmacist and by a medical director. The requesting practitioner/provider shall be advised of the denial, rationale and alternatives available including notification of the availability of the Medical Director to discuss the case by phone.

Under no circumstance may this responsibility be delegated to non-medical personnel. A denial letter is sent to the member within 24 hours of determination. Copies are also sent to the requesting practitioner/provider as well as a copy which is stored in our automated system. All denial letters include appeals rights language to assist the member in filing an appeal, should a member wish to do so, or the practitioner on behalf of the member.

Expedited Pharmacy Prior Authorization Requests

A request for an expedited Pharmacy Prior Authorization will be prioritized by the Pharmacy Department staff for immediate action. Determination shall be made within 24 hours of receipt of the request for emergency requests. Pharmacy Department benefit technicians will immediately evaluate and apply the appropriate criteria, which if approved will be immediately communicated to the requester by phone and will be entered into the system. If the request does not meet criteria for approval, the request will be immediately routed in person to the Clinical

Pharmacist, who will approve the request if justified. If not, the request will be taken in person to the Medical Director for a determination. If the request is denied, notification is given to the requester by phone, including notification of the availability of the Medical Director to discuss the case by phone, and of their right to appeal the decision. A written notice of the Pharmacy decision (approved or denied) will also be issued to the member with a copy sent to the provider.

Appeals Process

An appeal may be submitted orally or in writing if a patient is not satisfied with our decision to deny a pharmacy prior authorization request. The provider may submit an appeal for Salud and Commercial plan members with the patient's consent (patient consent is not required for members of Presbyterian senior plan). Coverage of pre-existing therapy (medication) will be continued during the appeals process until such time as a final determination is made.

Behavioral Health

Presbyterian Health Plan, Inc.'s Behavioral Health's (PHPBH) mission statement is: "To assist our customers in maximizing their health by helping to maintain a safe community and productive workforce; making access to behavioral health care easy and user friendly, and helping people to improve the quality of their lives." Its purpose is: "to improve the quality of behavioral health care and ensure that the necessary resources are accessible by current enrollees and future generations."

PHPBH's core processes are:

- Utilization Management
- Care Coordination
- •Disease Management
- Consultation (as subject matter expert)
- Customer and partner management
- Program development assistance

PHPBH measures its success by:

- Enhanced customer satisfaction as measured and indicated by customer focus groups, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and other customer satisfaction tools
- Enhanced provider satisfaction as measured and indicated by provider focus groups, CAHPS® survey, and other provider satisfaction tools.
- Improvement in Healthcare Effectiveness Data and Information Set (HEDIS®) measures of seven (7) day and thirty (30) day follow-up after hospitalization
- Improvement in HEDIS clinical effectiveness Antidepressant Medication Management measures including: 1) acute phase, 2) continuation phase and 3) optimal contacts
- Improvement in HEDIS clinical effectiveness Attention Deficit Hyperactivity Disorder (ADHD) follow-up care measures including: 1) initiation phase and 2) continuation and maintenance phase
- Improvements in NCQA scores related to behavioral health and care coordination
- Continuous decrease in the utilization of facility-based inpatient levels of care, and increase in community-based outpatient levels of care as evidenced by a decrease / increase in the associated utilization and health care costs figures
- Development of evidence-based practices along the full continuum of behavioral health care

Presbyterian's Behavioral Health system provides an internal behavioral health management system for benefits administration and care through an, open network model and care coordination. Our contracted providers consist of a large statewide network with both, individual and group providers as well as most psychiatric hospitals. It is a user-friendly system that provides easy access for members and places responsibility for interacting with Presbyterian on the behavioral health practitioner rather than the member. The system has produced high-quality performance, low operating administrative costs, and almost no member or practitioner complaints. Although no "gate-keeping" is necessary, we still encourage you to contact us when needed.

Presbyterian's Behavioral Health system coordinates a variety of psychiatric and chemical dependency benefits. Our phone lines are directly available to members, practitioners and providers 24 hours a day, seven days a week. The Behavioral Health Department has its own medical director, a board-certified psychiatrist, who supervises all clinical care. We are open to suggestions from you and members to continue growth in all areas.

Presbyterian's Behavioral Health system supports mental health parity laws. As part of parity, the member's benefit will be managed using Managed Behavioral Healthcare Organization techniques. We feel that the joint efforts of our practitioners, providers, and the Behavioral Health department staff will allow for the appropriate use of services.

Commercial, ASO, and Senior Programs
System Description

Presbyterian's system for Commercial, ASO and Medicare Advantage Behavioral Health can be easily reached by calling the local access number for Albuquerque, (505) 923-5221, or the statewide phone number, 1-800-453-4347. Behavioral Health Intake staff will refer practitioners, providers and members to appropriate behavioral health professionals within the network. Behavioral Health practitioners and

providers have a variety of responsibilities for our members, including obtaining and maintaining benefit certification when required and communicating with the managed care member's PCP. Please see Practitioner-PCP Communication (later in this section) for more information about communication requirements.

Phone Numbers and Address
Our local telephone number for practitioners and providers is: (505) 923-5757 or 1-888-923-5757. All correspondence, including claims, should be sent to our mailing address:

Presbyterian Health Plan, Inc. Behavioral Health
P. O. Box 27489
Albuquerque, NM 87125-7489

Benefit Certification/Prior Authorization
Behavioral health practitioners and providers are responsible for obtaining and maintaining benefit certification/prior authorization numbers. Most outpatient behavioral health services do not require certification when provided by a participating practitioner or provider. The member is only responsible for making the appointment and paying the applicable copayment and/or co-insurance at the time of service.

Benefit Certification for Residential and Inpatient Services
Call our Intake Department at (505) 923-5221 or 1-866-593-7431. Ask to speak with a Care Manager regarding your request for residential or inpatient services.

The Presbyterian Behavioral Health Care Manager will assess the appropriate type of setting (level of care) and specialty services needed using the Presbyterian Health Plan, Inc. Level of Care Guidelines, other applicable nationally accepted guidelines for care (i.e. American Society of Addiction Medicine (ASAM) and clinical information submitted.

The Care Manager categorizes the urgency of need as one of the following:

- Acute Emergency - Dial 911. Keep the member on the phone until help arrives
- Emergent - Member must be seen immediately for service for a face-to-face evaluation by a licensed practitioner
- Urgent - Member must be seen within 24 hours of the request for service for a face-to-face evaluation by a licensed practitioner
- Routine - Member must be contacted by the practitioner within three days of the date of request for service. The member must be seen for a face-to-face evaluation within 14 days after the request for service

If the Care Manager is unable to determine medical necessity or the appropriate level of care, he/she may request additional information or will refer the case to a Medical Director for determination.

If the Care Manager has received sufficient information to make a determination based upon the initial telephonic assessment, they will then makes a certification decision for a specific level of care. The decision includes the type of service(s), number of sessions or days approved, and a date range for the start and end of authorized services. The certification decision is communicated to the practitioner or facility. This certification allows the practitioner to bill for the certified services rendered.

After the initial review, individual case requirements will be considered in making a determination as to whether services and the certification shall be extended. Again, criteria will be referenced to ensure that the member is receiving services at the most appropriate level of care. Practitioners may be required to perform telephonic review on the specified date for concurrent review. Failure to provide a review may result in denied days or services.

Authorization for Disclosure of Information
Presbyterian will not use or disclose member information without valid written authorization from the member (or their legally authorized personal representative), unless allowed or required by law, or as described in the plan's Notice of Privacy Practices. Federal law allows members' personal health information (PHI) to be used or disclosed

without written authorization for a number of reasons, including:

- Treatment and coordination of care
- Disease management and population-based health care initiatives
- Claims payment
- Benefit certification of care, pharmacy exception and utilization review
- Determination of benefits and coverage
- Quality assessment and improvement activities
- Accreditation, certification, licensing and credentialing activities
- Fraud and abuse detection and prevention
- Regulatory compliance
- Performance evaluation and training for employees, practitioners, providers and others
- Customer service, grievance resolution and certain other business management activities

Court-Ordered Evaluations
Benefit plans generally do not cover any form of court-ordered evaluations or treatment. Please call for member benefit information.

Psychiatric and Chemical Dependency Treatment
Psychiatric and chemical dependency benefits vary greatly from plan to plan. Please call for member benefit information.

Detoxification
Detoxification is a medical benefit; however, if provided on a psychiatric unit it may be covered through Behavioral Health and may require benefit certification.

Second Opinions
A second opinion is available to any practitioner who requests one. Second opinions will be provided by in-network practitioners and providers. Out-of-network requests must be approved by the Behavioral Health Medical Director. The member pays for member-requested second opinions except for Medicare-covered members. Medicare covers second opinions, so in these cases, member cost-sharing would be limited to the applicable copayment and/or co-insurance.

Treatment of Chronic Conditions
Please keep in mind that behavioral health managed care benefits are brief, focused interventions. Members with chronic conditions will be evaluated for their therapeutic needs, and a referral to care coordination is likely.

Behavioral Health Quality Improvement Activities
Behavioral Health is endeavoring to improve the health of New Mexicans through activities directed at identification and appropriate treatment of individuals with behavioral health conditions. Two of the most prevalent conditions are depression in adults and attention deficit hyperactivity disorder (ADHD) in children. These two conditions are the primary focus of current quality improvement activities.

Quality improvement activities include analyses and interventions to support providers in diagnostic and prescribing practices, and in follow-up treatment. For members, interventions are designed to educate, and to facilitate adherence to medication, appointments, and the overall treatment plan. The following is a list of recent and planned interventions:

Providers

- Distribution of Clinical Practice Guidelines and Quick Reference Guides
- Screening and Diagnostic Tools
- Analysis of prescription and follow-up practices for patients treated for depression and ADHD, and feedback to providers via mailed patient lists and Provider Profile reporting
- Disease management program for depression
- Depression brochures and patient education materials (for distribution via provider offices)
- Provider Focus Groups and Surveys
- "Network Connection" provider newsletter articles

Members

- Online interactive Web tools on various behavioral health conditions and general interest topics such as wellness and women's and men's health issues
- Online Depression Screening Self-Test with automatic scoring and feedback at: http://www.phs.org/PHS/healthplans/providers/behavioralhealth/index.htm
- Depression Care Coaching disease management program (specific plans only at this time; please call for additional information)

- Educational materials (e.g., health tip flyers, brochures)
- Member Focus Groups and Surveys
- Member newsletter articles

Referrals
Frequently, a member will call Presbyterian Behavioral Health in search of a practitioner for services. In these instances, the Intake Department will try to match the member with a practitioner who can meet the member's clinical, cultural and geographic needs. You can reach the Behavioral Health Intake department by calling (505) 923-5221 or 1-866-593-7431.

Presbyterian Behavioral Health uses practitioner information supplied at the time of application for credentialing to identify areas of expertise.

In the case of crisis or urgent appointments, the Presbyterian Behavioral Health Care Manager (PBHCM) may contact the practitioner directly to arrange an appointment for the member. If a routine appointment is required, the member will be encouraged to call the practitioner to arrange an appointment themselves

Practitioner-Member Education
It is anticipated that participating practitioners and providers will help in educating members about his/her rights during their initial and subsequent visits. Listed below are some of the elements required to be discussed with members:

- Member rights and responsibilities
- Fees (if applicable)
- Copayments (if applicable)
- Co-insurance (if applicable)
- Procedures to follow if an emergency arises
- Confidentiality, the scope and limits (includes when a signed Release of Information form to disclose pertinent information is required)
- Treatment options
- Medication risks and potential side effects, if any
- Communication with the PCP and other relevant healthcare providers and practitioners

Discharge Process and Aftercare Follow-Up
Facility practitioners and providers must notify Presbyterian Care Managers within one (1) working day of any discharged patients. The steps in the discharge process are as follows:

- Facility Utilization Management staff notify Presbyterian Care Managers within one (1) working day of discharge. In the normal course of events, Care Managers will be involved in the discharge planning effort
- Facility practitioners and providers will provide the member and Presbyterian Behavioral Health with a specific discharge plan for follow-up care, including practitioner names, dates and times of after-care appointments
- The practitioner completes a Discharge/Closing Summary at the end of treatment and mails/faxes the summary to the PCP in addition to the Care Manager
- The Presbyterian Care Coordinator will monitor the follow-up care that is clinically necessary for the member

Non-discrimination
Practitioners and providers may not discriminate against a member and must furnish covered services to all members in the same scope, quality and manner as provided to the general public. Specifically, practitioners and providers may not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, sexual orientation, cultural or educational background, economic or healthcare status, or source of payment.

Reimbursement for Services
Reimbursement to practitioners and providers for services or procedures is based on the established fee schedule in place at the time the services were furnished by the practitioner or provider. Practitioners and providers are reimbursed for performing a service or procedure ONLY if required benefit certification, documentation or acknowledgement has been obtained prior to rendering the service. Services or procedures must be medically necessary.

Access Standards
Timely access to clinical services is essential to the delivery of care. Therefore, the practitioner is expected

to conduct face-to-face evaluations according to the following timeliness standards:

- Immediately for acute emergency cases
- Immediately for emergent cases
- Within 24 hours of the referral for urgent cases
- Within 14 days of the referral for routine cases

Care Coordination

Presbyterian believes that providing a member with appropriate, available service is optimal for quality, cost-effective health care. Care Coordination is a service to assist members with multiple complex, special physical, neurobiological, emotional and/or cognitive and behavioral health care needs. By providing care coordination, Presbyterian will facilitate timely access to and utilization of appropriate services reducing unnecessary services, and reducing the incidence and costs of inappropriate emergent and inpatient care. The PBHCM will do this through coordination and advocacy for the referred member. Care coordination is provided on an as needed basis. Care Coordination is a member-centered, family-focused (when appropriate), culturally competent and strength-based service. Care coordination employs advocacy and integration of internal and external health and psycho-social services to ensure that:

- the medical and behavioral health needs of members are identified
- related services are provided and coordinated on behalf of and/or with the individual member and family
- duplication of services is prevented

Care Coordination Communication Requirements

We require that communication take place between the behavioral health practitioner and the managed care member's Primary Care Practitioner (PCP), within seven (7) days of admission to a behavioral health service, upon any significant change in the member's behavioral health status and upon discharge from services. Documentation of this communication must be evident in the managed care member's medical record. Presbyterian has policies and procedures in place to help with such communication, such as the Coordination of Care form. If used, Presbyterian's Coordination of Care form meets the documentation requirements and can be accessed through the Provider Web page at: http://www.phs.org/healthplan/providers/behavioral.shtml. The form is a valuable tool, not only for practitioner-to-practitioner communication, but also for practitioner-patient discussion of the benefits of care coordination. The reasons for coordinating care should be explained to patients, so that they take an active role in managing their care and sharing critical information. If the patient prefers not to release information, the form allows the provider to document this and remain in compliance with the standard. Presbyterian will audit compliance related to this communication periodically as well as at the time of recredentialing. The managed care member's PCP is responsible for reciprocal communication with the behavioral health professional.

Practitioner-PCP Communication

A written report of the outcome of any referral containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health practitioner within seven (7) calendar days after the screening and evaluation of visits. The behavioral health practitioner is also responsible for keeping the PCP informed of ongoing treatment such as drug therapy, lab and x-ray results, sentinel events such as hospitalizations, emergencies or incarceration, including discharges and transitions in level of care. The PCP likewise shall inform the behavioral health practitioner of concurrent drug therapy, lab and x-ray results, medical consultations with other disciplines, and sentinel events such as hospitalizations and emergencies. PHP BH Care Managers will also work to ensure that the above information is exchanged as required.

Monitoring Access

Presbyterian is charged with monitoring timeliness of access to services; therefore, the practitioner will be asked to document the following:

- First appointment time offered to the member
- First appointment time kept by the member
- Appointments that are canceled or missed
- Attempts to contact patients who terminate treatment without notification

Practitioners may be required to perform telephonic review on the specified date for concurrent review.

Failure to provide a review may result in denied days or services.

Claims Submission
Presbyterian encourages its network of practitioners/providers to take advantage of our electronic claims transmission (ECT) process. Electronic claims submission has become the preferred method of claims submission for the majority of our network.

Benefits of Filing Electronically
Generally, Presbyterian processes electronically-submitted claims in an average of seven (7) days, whereas hard copy claims are generally processed in an average of 14 days. Electronic submission saves you postage and paper and also provides you with the following:

- quicker confirmation of claims receipt and integrity of the data
- higher percentage of claims accuracy, resulting in faster payment
- formatting of claims data into the HIPAA required ANSI-X12 837 claims format

The Provider Services Department is dedicated to providing any assistance needed by you and your office in regards to the electronic claim filing process. Please refer to the Claims section of this manual to review the most frequently asked questions regarding our ECT process. Should you have any further questions regarding electronic claims submission, please contact your Provider Services Coordinator. Though we encourage you to file your claims electronically, you may mail your Behavioral Health claims to:

PHP Behavioral Health
P. O. Box 27489
Albuquerque, NM 87125-7489

Medicaid Behavioral Health
Behavioral health services to SALUD! Program participants will be administered by Optum Health, the Statewide Entity for behavioral health services. Optum Health is responsible for the provision of all behavioral health services for members enrolled in Medicaid managed care, SALUD! The Optum Health toll-free numbers are as follows:

Customer: 1-866-660-7185/TTY 1-800-855-2881
Provider: 1-866-660-7182

Home Health

Homecare services for Presbyterian are managed through the Presbyterian Home Healthcare Statewide Network (PHHSN). PHHSN supports the mission of Presbyterian Healthcare Services to improve the health of individuals, families and communities throughout New Mexico by ensuring the provision of the highest quality and affordable homecare services to patients in their home. The PHHSN provides utilization management through review of Prior Authorization/ Benefit Certification requests for homecare services. The review is to ensure that the right services are provided at the right frequency, duration and level needed. PHHSN is also accountable to guide the denial process to the Presbyterian Health Plan Medical Director and track all homecare denials. PHHSN also collects data and performs analyses on a monthly, quarterly and annual basis to measure quality outcomes. Additionally, utilization results will be reported to the PHHSN Quality Subcommittee.

The PHHSN Director of Finance, Business Operations, Decision Support and Statewide Network and the PHHSN Lead QRM Analyst are available to assist agencies in learning and implementing the policies, procedures and benefits outlined in this section of the manual. To the extent there are any direct conflicts between the provisions of this Home Healthcare section and any contract with Presbyterian Home Healthcare Statewide Network, those provisions of the contract will prevail. This practitioner/provider manual can be accessed through Presbyterian's website on the Provider page of www.phs.org.

The Synagis Program
The Synagis (Palivizumab) program is coordinated for all Presbyterian eligible children that meet qualifying criteria, statewide through PHHSN.

Agency Credentialing Policy
Accredited and non-accredited Home Healthcare Agency Providers within the state of New Mexico or in surrounding states that are within 100 miles of the New Mexico state boundary and that carry a New Mexico homecare license may request to contract with PHHSN. PHHSN will, among other things confirm that the requesting home healthcare agency:

- Is in good standing with state and federal regulatory bodies
- Has been reviewed and approved by a recognized accrediting body
- Will ensure, at least every three years, that the home healthcare agency provider continues to be in good standing with state and federal regulatory bodies
- Meets Presbyterian Home Healthcare Statewide Network Credentialing Standards.

Presbyterian Health Plan, Inc.'s Credentialing Department is responsible for reviewing the required credentialing documents and information as provided by the agency. The credentialing packet is presented to the Peer Review Credentialing Committee at Presbyterian Health Plan, Inc. for approval. PHHSN maintains the security and confidentiality of the Credentialing files. At least every three years all contracted agencies need to comply with the Presbyterian re-credentialing process, in order to maintain participation with PHHSN.

For those non-licensed Home Healthcare agencies providing only hourly care under the SALUD - EPSDT benefit, PHHSN has developed a list of criteria to be met in order to qualify as a PHHSN agency provider. Once the required information has been submitted and reviewed, a subcontract must be signed before a request for configuration can occur. All agencies must be configured into the PHP computer system to allow PHHSN to certify care and for an agency to submit claims to PHP for payment.

Agency Contracting Policy and Process
PHHSN is responsible to ensure statewide home care coverage by contracting with qualified home care providers throughout the state of New Mexico. Before any home care services may be provided to Presbyterian members, a written, fully executed contract developed by Presbyterian's Legal Department must be signed by all necessary parties. PHHSN maintains the security and confidentiality of the contract files.

New Agency Orientation
Upon successful completion of the credentialing and contracting processes, PHHSN's Director of Finance and Statewide Network and/or Lead QRM Analyst

will schedule orientation with the new agency. The orientation will include explanation of the "Prior Authorization/Benefit Certification" process, the appeals and grievance process, reporting requirements, the team conference process, and completion of the annual self-audit and claims submission process. Each agency will be provided access to this manual.

Patient Eligibility

Upon initial receipt of a referral or Prior Authorization/Benefit Certification request, PHHSN will verify patients' eligibility and benefits. When reviewing for ongoing certification, a letter indicating non-eligibility will be sent within 24-hours if PHHSN determines the patient is no longer a current Presbyterian member.

Qualifying Homecare Criteria Policy

Applies to plans that have a home healthcare benefit which include: Commercial/ASO, Presbyterian Senior Care, Salud, State Coverage Insurance (SCI) and Presbyterian Insurance Company, Inc. plans.
Upon receipt of a referral or Prior Authorization/Benefit Certification request, PHHSN will review the referral/request against qualifying criteria for homecare services, which may include:

- Ensuring that a patient is homebound. At the time this manual was published, "homebound" is defined as a person meeting all of the following:

1. The condition of these patients should be such that a normal inability to leave home exists and, consequently, leaving home would require a considerable and taxing effort.
2. Absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program. Attending a religious service shall be deemed to be an absence of infrequent or short duration.
3. Occasional absences from the home for non-medical purposes, e.g., an occasional trip to the barber, a walk around the block, a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are on a infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain health care services outside rather than in the home.
4. The patient has a condition due to an illness or injury that restricts the patient's ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if leaving home is medically contraindicated.
5. When determining if a patient is homebound their condition must be reviewed over a period of time. A patient may leave the home more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

- Ensuring requests for services are medically necessary requiring a skilled service (i.e., Nursing, Physical Therapy, Occupational Therapy, and Speech Language Pathology).
- Ensuring that intermittent part-time services will meet the patient's needs.
- Ensuring that all care is ordered and under a physician's direction through the course of care.

Qualifying Homecare Criteria Policy – SALUD!

Presbyterian Salud Intermittent Skilled Services admission criteria are modeled from Medicaid as follows:

- Recipient must have documented medical need to receive care at home.
- Services are needed on an intermittent basis.
- All care must be ordered and under physician direction throughout the course of care.

Presbyterian SALUD members are not required to be homebound to be eligible for homecare services.

Presbyterian Salud Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services Medically Fragile Home and Community-Based Services (HCBS) Waiver Program

Home Health

These services are case managed through the University of New Mexico (UNM) Case Management Program for children less than 21 years of age. Referrals to this program are directed to UNM Case Managers at (505) 272-2910. The case manager with the interdisciplinary team evaluates the child and determines the level of care required. Services include hourly Private Duty Nursing (PDN) and/or hourly Home Health Aide care.

PHHSN prior authorizes care as directed by UNM Case Manager's assessment and budget.

Personal Care Services
EPSDT, personal care services admission criteria, is as follows:

- Recipient must be under 21 years of age.
- Recipient must have a need for assistance with at least two physical requirements such as eating, bathing, dressing or toileting acts, appropriate to his/her age.
- Personal care services must be medically necessary and prescribed by their physician and included in the plan of treatment.
- The need for personal care services is evaluated based upon formal and informal support, availability of family members, other community resources and/or friends, who can assist in providing such care.
- Personal care must have the consent of recipient's parents or guardians, if under the age of 18 years, and the recipient's consent, if over the age of 18.
- Personal care services that are medically necessary are furnished in the recipient's home or outside the home when medically necessary and are not available through traditional programs. These services cannot be provided to people who are in a hospital, nursing facility, intermediate care facility or facility for the mentally retarded or an institution for mental disease.
- Personal care services that are medically necessary for attending school are furnished in partnership with the recipient's school as an alternative to participation in a homebound program, with the services fostering the child's independence. Personal care services are furnished based on approval by the designated utilization review agent.
- A personal care attendant (PCA) who is trained and demonstrates competency to provide assistance with personal care must provide services. The PCA must be employed by the agency and work under the supervision of a Registered Nurse (RN).
- The supervising RN must have one year direct patient care experience and must make home visits every sixty two (62) days or as often as needed to assess the recipient's progress, the PCA's performance and to update the care plan in conjunction with the recipient's case manager.

A Presbyterian Case Manager will determine the child's eligibility. An assessment of the child's needs' will be conducted and a level of care and budget developed. PHHSN will collaborate with the Presbyterian Case Managers to identify a home healthcare provider. PHHSN will certify based on budgetary guidelines.

Initial Prior Authorization/Benefit Certification
PHHSN will process all referrals for homecare services through a comprehensive review process against admission criteria, in conjunction with the referral sources and/or agency. The patient's eligibility and benefits will be verified. PHHSN may provide prior approval for homecare services for admission and ongoing care for up to two (2) weeks on all initial requests.

Prior Authorization/Benefit Certification for Additional Services
PHHSN requires that the requesting agency submit supporting documentation including physician's orders with the PHHSN Prior Authorization/Benefit Certification Request Form for ongoing care. Requests for re-certifications will be reviewed prior to completion of the current certification period if requested by the agency.

If a service under Intermittent Skilled Services (ISS) has been ordered by a physician and an agency does not provide that service, the agency must let PHHSN know of the order. A PHHSN Quality Review nurse has the option to find an alternative local agency to provide all home healthcare services or just the additional services.

Home Health

Prior Authorization/Benefit Certification - Presbyterian Salud / EPSDT
Medically Fragile Home and Community-Services (HCBS) Waiver Program – Upon receipt by PHHSN of recipients' medically fragile budget, PHHSN reviews the indicated number of hours/month and designated homecare provider(s). PHHSN contacts the designated agencies to discuss staff availability. PHHSN provides Prior Authorization/Benefit Certification to all providers who will be providing services. Services may be approved for 6 month to 12 month time-periods.

Long-hour nursing care is requested in "hours," not "visits," as indicated on the PHHSN Prior Authorization/Benefit Certification Form. For billing/payment purposes, the discipline authorized must match the discipline on the claim submission (i.e. LPN on claim must match LPN on certification). As LPN and RN availability change, the agency must notify PHHSN so a revision to the authorization/certification can be processed. The number of hours identified on the EPSDT budget is developed by the Medically Fragile EPSDT Case Manager.

Personal Care Services
Upon receipt of a referral from a Presbyterian Case Manager, PHHSN will secure a Home Healthcare provider to initiate services as outlined on the Case Manager's assessment and plan of care. Personal Care is requested in hours, not visits, on the PHHSN Prior Authorization/Benefit Certification Form. SALUD members under 21 years of age only are eligible for these services. Services may be approved for 6 month time-periods.

Retroactive Authorizations/Certifications
Retroactive authorizations/certifications are not provided as a general rule. For those medically necessary homecare visits ordered by a physician during normal business hours for a same day visit or a new referral requiring a same day visit, a Prior Authorization/Benefit Certification will be provided if the request is received on the next business day.

Also, in those cases when medically necessary but unscheduled visits are ordered by the physician after business hours or on a weekend/holiday, a Prior Authorization/Benefit Certification will be issued when requested by the end of the next business day. Agencies should normally request Prior Authorization/Benefit Certification for Home Healthcare services prior to providing the services.

Co-payments, Co-insurance and Deductibles
The agency will be informed by PHHSN of any Presbyterian Commercial Plan member's co-payments, co-insurance or deductible or applicable co-payments under Medicaid State Children's Health Insurance Program (CHIP) or Working Disabled Insurance (WDI). The agency is responsible for informing the patient of his/her financial responsibility prior to initiation of homecare services. The agency is responsible for billing the member and collecting all co-payments and deductibles as they relate to homecare services. Co-payments are based upon an agency's Presbyterian contracted rates, not upon an agency's charges.

Transition of Care
PHHSN allows for the transition of Presbyterian Health Plan, Inc. members who are in need of homecare services. This transition may involve members who are changing from another insurer to Presbyterian Health Plan, Inc. for members whose homecare provider leaves the PHHSN network of agencies.

PHHSN will facilitate continuity of homecare services while members transition to or from PHP or if the member changes homecare providers within the plan. Members will be offered the following transition of care benefits:

- If the member's home healthcare provider leaves the Statewide Network of homecare providers, PHHSN will permit the member to continue an ongoing course of treatment with the original homecare provider for a transitional period.
- The transitional period will continue for a time that is sufficient to permit coordinated transition planning consistent with the member's condition and needs relating to the continuity of the care. The transition period may be extended for a period of up to 90 days.
- PHHSN will not be required to permit the member

to continue treatment with a current homecare provider if the provider is no longer affiliated with PHHSN due to reasons related to professional behavior or provider competence.

- PHHSN will authorize continued care as required by applicable law or regulation, currently not less than 30 days. If the transitional period exceeds 30 days, PHHSN will authorize continued care only if the provider agrees to all of the following:

1. Accept reimbursement from Presbyterian at the rates applicable prior to the start of the transitional period.
2. Adhere to PHHSN's quality assurance requirements and provide the PHHSN with necessary medical information related to such care.
3. Adhere to PHHSN's policies and procedures, including but not limited to procedures regarding referrals, Prior Authorization/Benefit Certification, treatment approved by PHHSN, cultural competency and confidentiality.

Denials

All referrals and requests for Home Healthcare services that do not meet treatment requirements and/or medical necessity criteria, as determined by PHHSN Quality Review Nurses, will be referred to the Presbyterian Medical Director to review for a decision regarding appropriateness of care through a Home Healthcare agency.

Additionally, all referrals and requests for services, including requests for new technologies, will be reviewed by the PHHSN Quality Review Nurse.

There are several situations that would result in a patient being denied for care by PHHSN. The following are examples of these situations identified through an initial screen:

- Some patients will not be eligible for care because our network is not the designated contractor for the patient's payer sources; the agency may inform the patient that they may choose to go "out of plan" and pay for services privately; the PHHSN does not need to approve these cases.
- The care request is for a service not provided by the network.

Additional situations in which PHHSN Quality Review Nurses may perform administrative denials are:

- Failure of a provider or practitioner to provide medical or other individualized information needed to establish medical necessity.
- Failure to comply with contract requirements in non-urgent/non emergent situations.
- All requests that lack physician orders.
- The Quality Review Nurse will clearly document the reason for each denial on the Prior Authorization/ Benefit Certification Request Form.

When any of the above situations occur, the referral source will be notified by PHHSN, as appropriate. Documentation is kept on file.

If a patient refuses services, the agency is responsible for contacting the physician, who may discuss with the patient the rationale for home care services. If the patient subsequently agrees, the patient may need to reenter the system through PHHSN.

If the PHHSN Quality Review Nurse questions the medical necessity of the request for authorization, discussion between the PHHSN Quality Review Nurse and the agency and/or referral source will be initiated. If consensus cannot be reached, a "Presbyterian Medical Director Review Form" will be completed immediately and sent to a Presbyterian Medical Director. The PHHSN Quality Review Nurse will inform the agency or referral source as to "pending status" of the request. If the agency, member or physician disagrees with the decision, they may initiate the appeals process through Presbyterian.

A written Notice of Action will be issued to the member and the requesting provider for any review decision related to a request for services which results in the denial or limited authorization of a requested service (to include a reduction in services), including the type of level of service; the reduction, suspension or termination of a previously authorized service.

Appeals

For information on filing an appeal or grievance, please refer to the Appeal & Grievance section of this manual.

Home Health

Utilization Management
The goal of the Quality Management/Utilization Management Program is to ensure that the appropriate allocation of resources for the provisions of high quality homecare is available. PHHSN Quality Review Nurses will ensure that the homecare services being provided are done in a cost effective and time efficient manner that will enhance the achievement of superior clinical outcomes and improve the care recipient's quality of life.

The PHHSN Quality Review Nurse will monitor the agency's adherence to the requirements and criteria presented in the Medicare Conditions of Participation and licensing regulations for home healthcare agencies, particularly as interpreted by:

- The Medicare HIM 11 (a guide that defines regulatory standards), the Medicare homecare interpretive guide and Presbyterian Senior criteria manuals
- The New Mexico Human Services Department, Medical Assistance Division manual sections on homecare and on the EPSDT program for long-hour care
- The Presbyterian Commercial Plan's benefit descriptions
- Any addendum related to state law

In addition, Milliman Care Guidelines will be used as a reference to ensure appropriate utilization is occurring and that access to care for Presbyterian members is available.

All patients, regardless of payer source, will have access to any homecare services covered under their policy benefit that are appropriate and provided by the agency. Services are provided based on a combination of factors, including diagnosis and current clinical status, appropriateness of the services to meet the patient's needs, physician orders, and/or, in some cases specific arrangement with payer sources.

Those staff members involved in the formation of the policies, protocols and procedures, and any patient education materials that are part of these programs, will have associated relevant experience, training, education or certificate related to the program. (For example: the practice guidelines for the management of decubitus ulcers for the Agency for Healthcare Policy and Research (AHCPR).

Data collected by agencies from required reporting and from PHHSN Prior Authorization analysis will be used to generate the Quality/Utilization summaries. The Utilization/Quality management program will be overseen by the Quality Sub-Committee of the PHHSN. This committee will act as a Utilization/Quality Committee that is responsible to provide oversight, review and recommendations regarding homecare practice relative to utilization benchmarks, credentialing, grievances and recommendations for improvements. If a need for improvement is identified for an agency, PHHSN will work with the agency to identify the root cause and develop a corrective action plan. Periodic follow-up reporting will be done by PHHSN.

Outcome measurement will be monitored as it relates to utilization management. Quarterly/annual reporting of measurements will be conducted through the Presbyterian Home Healthcare (PHH) Albuquerque Professional Advisory Board, which will consist of physicians, clinicians, Presbyterian representatives and the PHHSN Director.

The measurements that will be reviewed are as follows:

- Individual agency's random annual chart audit results
- Patient satisfaction survey results
- Utilization reports relative to unduplicated census, admits and visits, which will be benchmarked
- Agency satisfaction with PHHSN survey results
- Denials/appeals related to medical necessity
- Grievances and complaints as received by Presbyterian, including care recipient or their authorized representative disagreement with the discharge date of service.

Reporting Requirements
Reporting of statistical data by agencies to PHHSN is required to:

- effectively identify issues and trends by agencies;
- complete root-cause analysis of the trends;
- support the development of an action plan by the agency to enhance or modify accepted-practice

methodologies; and
- re-evaluate the data following implementation of changes (to note changes in trends).

Reports must be sent to PHHSN within the identified time frames. Results will be sent out in the PHHSN Newsletter. Each agency must provide PHHSN random concurrent review self-audits on a yearly basis.

Each agency must complete a monthly audit on all Presbyterian Medicare members to ensure that the Medicare Notice of Non-Coverage (NOMNC) was provided to members per Medicare regulation. The audit results are sent to PHHSN monthly.

Patient Care Conferences

Monthly patient care conferences will be conducted via telephone. PHHSN Quality Review Nurses will identify those patients who will benefit from a care conference. Identification of these patients is based upon complexity of the case, need for coordination with other healthcare practitioners/providers, patients utilizing greater than 20 visits within a Prior Authorization/Benefit Certification period and/or patients with recidivism to the hospital or homecare.

Participants in the care conferences may be a PHHSN Quality Review Nurse, agency staff, physician and/or other healthcare practitioners/providers. The PHHSN Quality Review Nurse on the case-conference report will complete documentation of care conferences and results. The case-conference report will be faxed to the agency with a copy maintained in the PHHSN patient's record.

Claims Processing

The agency should submit all claims on a UB-04 form, completing all fields per standard home health billing requirements. Please refer to the Claims section of this manual for detailed information on the claims submission processes and policies.

The following revenue codes should be used:

RN visit	0551
Dietitian visit	0581
Physical Therapy visit	0421
Occupational Therapy visit	0431
Speech Therapy visit	0441
MSW visit	0561
Home Health Aide visit	0571
Supplies	0270
RN per hour	0552
LPN per hour	0582
PCA per hour	0590
HHA per hour	0572

Please keep in mind the following when submitting claims:
- Attach an itemized supply list to the UB-04 when billing under revenue code 0270.
- Record accurate federal tax identification number on the UB-04 under form locator #5.
- Record the Prior Authorization/Benefit Certification number on the UB-04 under form locator #63. It is not necessary to attach a hard copy of the approval to the claim.
- Ensure that all claims contain the agency's NPI number and the correct taxonomy code.
- Ensure that the correct ICD9 Code is used.
- When billing EPSDT Long Hour Care, the time must be billed in 15-minute increments. When services go over or under 15 minutes, the agency is responsible for rounding up or rounding down. All claims will be processed as one (1) unit equal to 15 minutes.
- Ensure that an agency employee signs the UB-04 form
- Mail paper claims to :

Presbyterian Health Plan, Inc.
P.O. Box 27489
Albuquerque, NM 87125-7489

Complete billing adjustments per Presbyterian's Adjustment Procedures that are detailed in the Claims section of this manual. Direct all payment and/or adjustment questions to Presbyterian's Provider CARE Unit at 1-888-923-5757.

Homecare Agency Contract Termination Policy

An agency requesting a termination of their contract will provide written notification to the PHHSN Director of Finance and Statewide Network a minimum of 120 days prior to the effective termination date as

stipulated in their contract with PHHSN. The PHHSN Director of Finance and Statewide Network will notify all appropriate parties. PHHSN will assist with the transition of members to other network agencies if needed.

Quality Improvement Program

The Presbyterian Quality Improvement (QI) Program provides the infrastructure needed for continuously improving the quality and safety of clinical care processes and the quality of services offered to all members through practitioners and providers. It is designed to support both physical and behavioral health care services for all members with the following exceptions:

- Salud Members – The New Mexico Statewide Entity for Behavioral Health is responsible for behavioral health services.
- State Coverage Insurance (SCI) – Presbyterian Health Plan, Inc. currently manages the behavioral health services for SCI members. This agreement may be subject to change in the State contract cycle.

New activities are selected each year to help improve the quality and safety of care and services Presbyterian offers. The scope of the QI Program includes all operational functions within Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc., all applicable members, and all practitioners/providers contracted with Presbyterian to provide care and services.

Contracted services include, but are not limited to, behavioral health care, care coordination. case management, diagnostic studies, emergency care, home health care, inpatient and outpatient services, nurse advice and triage for medical care, pharmacy services, prevention programs, primary medical care, school-based health care centers, skilled nursing care, specialty medical care, rehabilitation services, urgent care, and web support resources.

A Quality Improvement Program Evaluation is conducted annually to assess the overall effectiveness of the QI Program. Where the evaluation demonstrates that the QI Program has not met established targets/goals and benchmarks, recommendations for change will be made in the subsequent QI Program. A report of our success and progress is available to practitioners/providers upon request.

The success of the QI Program and related activities requires the cooperation and support of the practitioner/provider network. Practitioners/providers are invited to participate in QI Program activities. Examples of participation include providing input for Disease Management Program activities; clinical, service and safety improvement activities; cooperating with medical record data abstraction; quality of care reviews; participating in satisfaction surveys; serving on ad hoc quality improvement teams; and serving as QI Committee members.

Several internal QI Committees meet routinely to review data and discuss and share ideas for improving health and service to our members. Clinical practitioners are invited to participate as members on the following committees:

- Clinical Quality Committee
- Pharmacy & Therapeutics Committee
- Credentialing Review Committee
- Professional Practice Evaluation Committee

For additional information about the QI Program or opportunities for participation, please contact the Quality and Population Health Management Department at (505) 923–5516.

National Committee for Quality Assurance (NCQA)
Presbyterian Health Plan, Inc. has participated in the NCQA accreditation program since 2000 and Presbyterian Insurance Company, Inc. has participated since 2009. Presbyterian's goal is to achieve national excellence by earning an "Excellent" NCQA Health Plan status in all HMO and PPO products. This goal can only be achieved with the combined efforts of health plan employees, network practitioners and providers. In addition, PHP participates in the NCQA Medicare Advantage HMO and PPO Deeming program, which is available for health plans participating with the Centers for Medicare and Medicaid Services (CMS) regulatory requirements.

An "Excellent" accreditation status is awarded to health plans that provide service and clinical quality that meets or exceeds rigorous requirements for quality improvement. Evidence shows that health plans with an Excellent NCQA status do more to improve the health of their members.

Quality Improvement Program

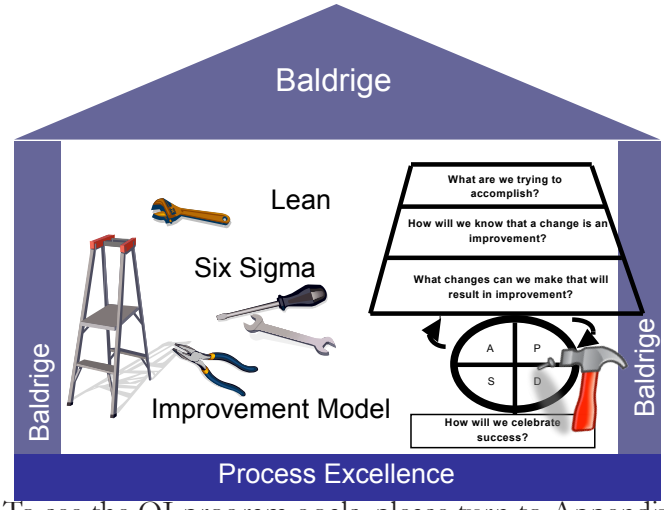
An NCQA Health Plan accreditation survey includes a review of quality improvement, utilization management, credentialing and recredentialing, member rights and responsibilities and innovative communications using the Internet, delegation activities, improvement in clinical effectiveness of care measures, and improvement in member satisfaction. Health plans that participate in NCQA Accreditation are re-evaluated annually to monitor quality care and service.

Focus on Excellence

Presbyterian is guided by principles and practices that promote the continuous improvement of business operations, medical care, behavioral health care, and all services provided to members and practitioners/providers. Quality improvement structures and processes are planned, systematic, and clearly defined. Presbyterian uses the Baldrige criteria as the framework for performance excellence and employs process improvement tools such as the Improvement Model and Lean Six Sigma. Using the Baldrige criteria ensures that we have a balanced focus on our employees, members, and partners as we target benchmark performance in clinical, service, and operational excellence.

The Improvement Model is a process improvement tool used to gain and apply knowledge. It is designed to help employees effectively think through problems and processes that will ultimately result in improved outcomes. Focusing on Improvement Model questions accelerates the building of knowledge by emphasizing a framework for learning, for using data, and for designing effective tests or trials.

The focus of Lean is improved efficiency and the reduction of waste. The focus of Six Sigma is improved effectiveness. Lean Six Sigma for improvement follows a disciplined course of action with each project. The process most commonly used is called DMAIC, where problem boundaries are identified (Define), opportunities quantified (Measure), root causes determined (Analyze), solutions identified and implemented (Improve), and process improvements hardwired (Control).



To see the QI program goals, please turn to Appendix [x]. The QI program goals are reviewed and revised annually.

QI Program Activities

1. Availability of Practitioners

Availability of practitioners/providers is measured to assess sufficient numbers of primary care and specialty care practitioners by geographic distribution and in ratios of members per practitioner. Results are compared to established standards to identify opportunities for improvement. State and federal regulations determine the geographic standards for Commercial, Medicaid, and Medicare.

Definitions

Primary Care Practitioners (PCP): Family practitioners, general practitioners, general internists, pediatricians, certified physician assistants, and certified nurse practitioners, as well as other specialists that elect to perform in the role of a PCP.

High-Volume Specialty Care Providers: Anesthesia, cardiology, gastroenterology, general surgery, OB/GYN, oncology, ophthalmology, orthopedics, and radiation oncology. High-volume specialists are identified as in-plan practitioners not identified as PCPs who are paid the highest amount per year based on claims submitted, encounter data, and the inclusion of healthcare costs across all product lines.

Behavioral Health (BH) High-Volume Practitioners: Any practitioner licensed/certified

as a psychiatrist, psychologist, clinical social worker, marriage/family/child counselor, nurse, or other licensed health care professional with appropriate training and experience in behavioral health services to treat chemical dependency and/or mental disorders.

Pharmacy Network: Any licensed retail pharmacies, long-term care pharmacies, home infusion, Indian Health Services and Tribal Urban Organization, school-based centers, mail order pharmacy, and specialty pharmacies. The ratio of providers to members is determined by state and federal regulators.

2. Accessibility of Services (Appointment Availability)
Access to care is measured to assess the timeliness in which a member can obtain an appointment for services. Results are compared to established standards to identify opportunities for improvement.

Data Collection
- CAHPS® results for questions related to accessibility of services for primary care, behavioral health, and specialty care.
- Mystery Shopping Surveys as supplemental data to the CAHPS® results.

3. Credentialing and Recredentialing
Presbyterian credentials and recredentials individual practitioners and organizational providers. The credentialing program ensures compliance with credentialing policies and procedures, NCQA standards, and state and federal requirements for verification of credentials including but not limited to license, board certification, and education.

Delegation
Presbyterian may delegate to designated entities all or some of the credentialing responsibilities. The performance of the entity is monitored on an ongoing basis for compliance with Presbyterian requirements and all applicable regulatory and accreditation standards. Presbyterian retains the right based on quality issues, to approve, suspend, and terminate individual practitioners/providers in situations where it has delegated decision-making. Performance by the Delegate is evaluated in accordance with regulatory requirements and results are reported to the Credentialing Review Committee.

Site Visits
Site visits are included as part of the initial credentialing for primary care practitioners, OB/GYN practitioners, and high-volume behavioral health specialists. Site visits are also performed for organizational providers who have not been approved by an accrediting body.

Initial applicants whose site visit score is below an acceptable threshold are notified that the credentialing process will be discontinued. The applicant may contact Presbyterian for information about how to improve their site and to restart the credentialing process once the deficiencies have been corrected.

If a practitioner/provider receives two or more complaints regarding their site within a 12-month period, a site visit is scheduled. If during the site visit an issue is identified, the practitioner/provider must develop a corrective action plan to address the deficiencies. A follow-up review is conducted within six months to determine compliance. If the practitioner/provider fails to submit the corrective action plan within the specified timeframe, it is considered a breach of contract and may result in termination from the network.

Ongoing Monitoring
The Office of Inspector General Exclusion Program database, as well as applicable state licensing agencies, is monitored monthly for sanctions or licensure limitations. The Medicare Opt Out website is also checked monthly to ensure that practitioners/providers contracted for Medicare Advantage have not opted out of Medicare. Interventions are implemented as appropriate.

4. Quality of Clinical Care
The Quality Management (QM) Department investigates and resolves all quality of clinical care complaints/referrals. Investigations include, but are not limited to, obtaining medical records, practitioner/provider responses, and/or subject matter expert responses.

Quality Improvement Program

Sources of Quality of Clinical Care referrals are primarily from the Enterprise Wide Complaint Management Department (EWCM). Where appropriate, the QM Department may also receive direct referrals from practitioners/providers, Presbyterian Medical Directors, Presbyterian Pharmacy, and/or the Special Investigative Unit (SIU).

The Quality Management Department monitors all practitioners/providers monthly for trends in the number and nature of complaints referred to the Quality of Care Process. When a practitioner/provider has three or more complaints in a in a 12-month period, he or she is referred to the Presbyterian Professional Practice Evaluation Committee for review for a possible pattern of conduct or behavior that is contrary to good patient care. Other criteria for reporting a case at the Professional Practice Evaluation Committee includes cases that meet certain outcome levels and/or cases identified by a Presbyterian Medical Director.
Any suspected inappropriate practice pattern concern will be investigated. A medical record chart audit will be performed and if determined to be a quality of care issue will be reported to the Professional Practice Evaluation Committee. All quality of clinical care investigations and resolutions are referenced as part of the credentialing and recredentialing process.

5. Peer Review
The PHP/PIC Board of Directors has designated the Professional Practice Evaluation Committee to serve as a Review Organization under the New Mexico Review Organization Immunity Act, Section 41 9 5. Its membership includes practicing members of the provider panel. Peer review activities include practitioners within the same discipline and area of clinical practice and documentation in the meeting minutes. The Professional Practice Evaluation Committee has the authority to act immediately on the results of any quality of clinical care investigation. Where necessary, action taken can be as simple as continuing to track and trend the practitioner/provider or as severe as recommending termination from the network.

6. Continuity and Coordination of Care
Continuity and coordination of care that members receive is monitored to improve communication across the health care network and between medical and behavioral health care practitioners. Information exchange between medical and behavioral practitioners must be member-approved and be conducted in an effective, timely, and confidential manner. Primary care practitioners are encouraged to make timely referral for treatment of behavioral health disorders commonly seen in their practices. Drug use evaluations of psychopharmacological medications are conducted to increase appropriate use, or decrease inappropriate use, and to reduce the incidence of adverse drug reactions. Data is collected and analyzed to identify opportunities for improvement. Collaborative interventions are implemented when opportunities for improvement are identified.

7. Standards of Care
Presbyterian has processes in place to assure that health care services provided to members are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. This is monitored through the credentialing/recredentialing and quality of clinical care processes.

8. Service Quality Concerns
Service quality concerns from members, practitioners, and providers are tracked both individually and in aggregate to identify potential problems with quality of services. Provider Network Management investigates service related complaints that involve practitioners/providers. Interventions are identified, developed, and implemented, as appropriate.

9. Clinical Practice Guidelines
Clinical practice guidelines for acute and chronic medical conditions and behavioral health disorders have been adopted using current and evidence-based nationally recognized sources. The clinical practice guidelines are reviewed at least every two years and are appropriately updated and disseminated. Practitioners are involved in the review and approval of all guidelines. The use of guidelines is measured annually using NCQA HEDIS®, the Physician Performance Assessment, or by

an internally developed methodology.

10. Preventive Healthcare Guidelines
Presbyterian adopts Preventive Healthcare Guidelines from nationally recognized, evidence-based guidelines for all age groups. The use of guidelines is measured annually using NCQA HEDIS®, the Physician Performance Assessment, or by an internally developed methodology.

11. Member Medical Records
To ensure that the Presbyterian practitioner/provider network meets a minimal set of standards for medical record documentation, individual practitioner adherence to standards is monitored and compared to performance goals. Presbyterian regularly assesses compliance with these standards and a written report is mailed to the practice outlining the results of the evaluation. Strengths and opportunities for improvement are reported to the Clinical Quality Committee and are shared with practitioners/providers along with educational information for areas needing improvement.

12. Integrated Care Management Program
Presbyterian provides an Integrated Care Management Program (ICM) that includes care coordination, complex case management, and disease management components. The program is designed to assist members with multiple complex, physical, neurological, emotional and/or cognitive and behavioral health care needs.

By identifying members with moderate risk and offering disease management, the intent is to slow or prevent the progression of complications of chronic conditions. By providing Integrated Care Management, Presbyterian facilitates timely access to and utilization of appropriate services thereby reducing unnecessary services and the incidence and costs of inappropriate emergent and inpatient care. Integrated Care Management is a member-centered, family-focused (when appropriate) culturally competent and strength-based service..

The Integrated Care Management Program also supports providers and practitioners in their management of members with catastrophic, high-cost, high-risk, or complex illnesses, injuries, or conditions. Nurse Case Managers may be assigned to Complex Case Management members and/or members who meet the criteria for care coordination. This individualized care serves to help and guide members through the health care continuum in a coordinated, caring, cost-effective, and quality oriented manner. In addition to measuring member satisfaction, two clinical measures are identified annually to monitor the effectiveness of the complex case management program.

Effective care coordination with the statewide behavioral health contractor to HSD facilitates timely and appropriate access to behavioral health services for Presbyterian Salud members. This individualized care serves to help and guide members through the health care continuum in a coordinated, timely, caring, cost-effective, and quality oriented manner.

13. Continuum of Care
Presbyterian believes that providing a member with appropriate, available service is optimal for quality, cost-effective health care. Presbyterian is dedicated to helping members meet their health care needs across the continuum of care through programs and services that address the preventive, acute, and chronic care needs of our members. Interventions and tools are developed from evidence-based guidelines to work with members and to create and implement plans of care that provide members with the tools needed to move toward self-management. Staff works collaboratively with members, practitioners, and other health care providers to promote a seamless delivery of health care services.

14. Individuals with Special Health Care Needs
The identification of ISHCN members in Medicaid Programs enables Presbyterian to facilitate timely and appropriate health care through effective care coordination. Presbyterian uses guidelines that promote coordination and access to care. Compliance with ISHCN guidelines is measured annually to monitor services that are provided. Member satisfaction surveys include questions specifically designed to address ISHCN members. Complaints, grievances, and appeals are tracked in aggregate to identify trends and opportunities for improvement. The aggregate report is reviewed quarterly by the Integrated Care Solutions

Management Team. Trends are tracked and addressed. Where indicated, action plans are developed to address opportunities for both procedural and individual case activities. The use of guidelines is measured annually using NCQA HEDIS®, the Physician Performance Assessment, or by an internally developed methodology.

15. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Tot-to-Teen Health Check Program is in place for Salud members as required by the New Mexico Human Services Department. EPSDT services are measured annually using NCQA HEDIS® and the Physician Performance Assessment.

16. Personal Health Assessment

All members who are new to Presbyterian Salud, SCI, and Medicare Advantage products are encouraged to complete an initial Personal Health Assessment (PHA) of their physical and behavioral health needs. Results of these assessments enable Presbyterian to determine if new members would benefit from care coordination, case management, and/or disease management program services.

The employer groups that participate in the Healthy Advantage Wellness Program have access to WebMD® for the PHA. The assessment covers a wide range of common illnesses and risk factors. Members can use their PHA score to determine which tools would be of help to them, including web-based interactive consumer health tools, printed educational materials, and public or private resources related to their specific health needs. They can also receive advice about improving behaviors that impact their health. Referrals to care coordination, case management, and disease management programs are available for members with chronic illnesses and members who need help obtaining care.

17. Healthy Advantage Wellness Program Goals/Vision

The Healthy Advantage program was developed for Presbyterian large employer groups. The comprehensive program provides employees with the resources they need to implement a healthier lifestyle. Employees are encouraged to participate in screenings and assessments for early identification of behavior modification needs.

Components

The Healthy Advantage program includes the following key components:

- Annual Employer specific clinical report that identifies the top five areas of focus.
- A Personal Health Assessment (PHA) tool through WebMD® that helps members identify personal health risks, provides recommendations for improving those risks, and offers other easy-to-use tools to help make healthy lifestyle changes.
- WebMD® high risk coaching, which is only provided to Healthy Advantage Employer groups.
- Health Fairs - Offer annually a customized health fair and assess Wellness Initiative Needs for this event based on clinical and PHA findings.
- Onsite Wellness Initiative Needs, such as Body Mass Index (BMI), blood pressures, body fat percentage, full lipid panels, glucose screenings, and flu shots (if serum is available).
- Educational pieces covering areas of focus based on both clinical and PHA findings.

18. Culturally Appropriate Services

Presbyterian supports culturally competent and sensitive services. Culturally appropriate services begins with an understanding and respect for language, ethnic/race, age and gender-based differences. It is essential that these differences are recognized and shared with are employees when interacting with members verbally, non-verbally, and in writing. Without effective interactions, members may not understand their health care benefits or be able to participate fully in the recommended course of prevention and treatment.

At all levels of operations, Presbyterian acknowledges and promotes the importance of and respect for culture and language and the traditions associated with different people and communities in the delivery of services. Clinical and non-clinical services are accessible to all members and are provided in a culturally competent manner with sensitivity to the member's religious beliefs, values, traditions, diverse culture, and ethnic background as well as limitations with English proficiency or reading skills, physical or mental disabilities and state of homelessness.

Quality Improvement Program

Presbyterian's objectives for serving a culturally and linguistically diverse membership include 1) An annual assessment to describe diversity among the health plan membership, 2) The use of customer feedback in the form of complaints and survey data to identify disparities and 3) development of work plan activities to address identified opportunities for improvement. At a minimum, work plan activities include:

- Maintaining a Cultural Competency/Sensitivity policy to provide direction for Presbyterian services and operations.
- Maintaining a Translation Services policy to ensure that customer information and services are available in languages other than English by offering translation services to members.
- Tracking bias and discrimination issues that hinder or prevent culturally sensitive services and care in accordance with the Americans with Disabilities Act, and other applicable Federal and state laws.
- Conducting an annual assessment of languages and cultural background within the practitioner/provider network to determine if practitioners/providers meet the needs and preferences of our members.
- Developing an annual plan to adjust the practitioner/provider network if it does not meet the members' language needs and cultural preferences.
- Providing annual cultural competency training for Presbyterian employees.
- Providing cultural competency educational materials and training for practitioners/providers throughout the year.
- Assisting members in locating practitioners/providers who correspond with their language, cultural, and gender preferences.
- Developing communication tools and strategies to address identified race, ethnicity, age, gender and language needs; such as subscriber materials, member handbooks, newsletters, physician directory, educational materials, telephone outreach, TTY assistance and multilingual employees.

19. Delegation/Subcontractor/High Volume/ Single Source Provider Oversight

Presbyterian may delegate and/or subcontract for specific administrative functions (e.g. credentialing, quality management, disease management, utilization management, claims payment functions, nurse advice line services, and pharmacy benefit information) to third party entities. All delegates and/or subcontractors must meet Presbyterian requirements as well as applicable accreditation and regulatory standards prior to and during delegation. Delegates are subject to appropriate oversight activities to ensure that services are compliant with regulatory, contractual, and accreditation requirements.

Delegated, subcontracted, and high volume and/or single source provider's functions are monitored at least semiannually to review policies, procedures, operational reports, and activities to ensure that the delegate or subcontractor continues to meet Presbyterian requirements as well as applicable contractual, accreditation and regulatory standards. Audit findings, and applicable Corrective Action Plans are reported to, and monitored by, the appropriate quality committee.

20. Nurse Advice Line

NurseAdviceSM New Mexico (NANM) provides 24/7 telephone triage of symptoms, medical advice/information and medical/behavioral health referrals. NANM also serves as a community link between providers and patients regarding health information, flu clinics, health alerts, community resource information, links to 911 services, poison control, social services, and Behavioral Health. NANM employs registered nurses who are located within the State of New Mexico and are knowledgeable about state and county resources. NANM is also able to receive questions/concerns via their website. Although NANM does not have an audio health library feature, written health information is available to members upon request.

21. Utilization Management Program

The Presbyterian Utilization Management (UM) Program identifies the authority and accountability for all UM activities, including physical health, behavioral health, and pharmacy. The UM Program is under the direction of the Chief Medical Officer, and Medical Directors and utilization management staff have substantial involvement in developing and implementing

the UM Program. The annual evaluation of the Utilization Management Program is contained in the annual Quality Improvement Program Evaluation. A separate Utilization Management Program Description is reviewed annually, updated as needed, and approved by the Clinical Quality committee.

Any entities delegated for UM functions must meet all requirements set forth by Presbyterian as outlined in Delegation Agreements and/or Service Level Agreements. Accountabilities for pre and post-auditing and oversight by Presbyterian, as well as provisions for Corrective Action Plan requirements and de-delegation conditions, are set forth in the delegation agreement.

The criteria resources used to determine medical necessity, including the method by which criteria are developed or chosen, and the method by which criteria are reviewed, are updated and modified as appropriate. Annual medical director and nurse inter-rater reliability agreement audits are performed to ensure consistent application of review criterion and consistent decisions.

Presbyterian continually assesses member and provider satisfaction with the UM processes to identify areas needing improvement. Under utilization and over utilization of pharmacy, physical, and behavioral health care services is monitored quarterly to facilitate the delivery of appropriate care. Results are compared to established thresholds.

22. Web Resources

The Presbyterian Healthcare Services (PHS) website, www.phs.org, has been enhanced to improve member access to information that can be useful when making health care decisions. Enhancements include quick and easy access to personal health assessments for Commercial members and interactive resources to help members actively manage their health. Many services and information is available on Presbyterian's website including the following:

- Information about claims payments, medical benefits, and pharmacy benefits.
- Members may request identification cards and can make PCP changes
- The Provider Directory and hospital directories are available to help current and prospective members choose providers, pharmacies, and hospitals.
- Web technology is available for members for e appointments, e consultations, e referrals, online personal health information, and to request lab reports.
- Presbyterian evaluates website functionality to improve usability. Processes for posting and maintaining accuracy and currency of content and information are monitored.

23. Voice of the Customer

Presbyterian understands the importance of obtaining feedback from our members and practitioners/providers. Presbyterian collects feedback from members and providers to improve satisfaction and loyalty through improved processes and communication. We collect feedback in a variety of ways as listed below.

Survey Data

We conduct relationship surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the annual Provider Satisfaction Survey, and the internally developed Quarterly Member Survey. Reasons for conducting a relationship survey are to trend results over time, compare performance against external benchmarks when available, identify drivers of satisfaction and loyalty, and identify opportunities for improvement.

In addition, we occasionally conduct transactional surveys to evaluate the performance of specific interactions with Presbyterian such as a post customer service call survey or a web survey.

Complaint and Inquiry Data

Whenever a member contacts the health plan (e.g., calls, e mails, letters), the transaction is logged into the Advocate system. Complaints, appeals, and grievances are captured in a similar manner. This data is aggregated and reported at least annually to identify trends and opportunities for improvement. The data can be filtered in many different ways (e.g., product type, employer group, inquiry type, and customer type) to perform various analyses.

Qualitative Research
Presbyterian also uses qualitative research methodologies including focus groups, formal and informal interviews, usability studies, and mystery shopping, as appropriate. Consumer advisory boards are also used to evaluate the quality of our service and the customer experience.

Service Quality Committee and Delegated Teams
The Service Quality Committee and delegated teams use the data above to identify opportunities for improvement, make recommendations to the appropriate areas, and create action plans.

Member and Provider Satisfaction Prioritization Processes
Presbyterian conducts a formal prioritization process to select the critical areas for improvement activities for the following year. This objective process allows for the "voice of the customer" to help determine the areas of greatest concern and the biggest driver of satisfaction.

24. Patient Safety Program
The Patient Safety Program improves the quality of care through the identification, analysis, and reduction of risks that could cause, or have caused, preventable patient injury or impairment.

Objectives
- Identify opportunities to improve safety performance.
- Manage identified risk by timely intervention, corrective preventive action, and educational activities.
- Provide information on identified risk to appropriate departments and committees.
- Analyze adverse events, identify themes across events, and use themes to drive quality improvement priorities.
- Establish a non-punitive culture for sharing information and lessons learned.

Definitions
- Medical error is defined by the Institute of Medicine as "the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim."
- Adverse event is defined as "an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient."
- Near miss is defined as "an occurrence with potentially important safety-related effects, which, in the end was prevented from developing into actual consequences."

Focus
The Patient Safety Committee focuses on both practitioner/provider and health plan process- related risks. As a health plan, we recognize that our processes can create or contribute to medical errors.

The near miss and adverse event data is compiled and analyzed monthly to identify risks and track trends and is reviewed by the Patient Safety Committee at bi-monthly meetings. Risks identified in the data are communicated to the appropriate health plan department and/or quality committee to outline the steps to be taken to improve the at-risk process.

Performance Monitoring
1. Priority consideration for the implementation of patient safety performance improvement strategies is given to:
- Processes that affect a large percentage of members;
- Processes that place members at risk if not performed well, if performed when not indicated, or if not performed when indicated; and
- Processes that have been or are likely to be problem prone.

2. The Quality of Clinical Care process provides ongoing monitoring and identification of trends and potential sentinel events.

QI Program: HEDIS® Medical Record Data Abstraction
What is HEDIS®?
Healthcare Effectiveness Data and Information Set (HEDIS®) is a standardized set of performance measures that was designed to focus on health care quality. HEDIS® data is collected annually and is designed to provide purchasers and consumers with the information they need to compare the performance of

health plans. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA) and was established by NCQA in 1992. The HEDIS® report could not be prepared without the continued cooperation and support of the practitioner community.

NCQA originally designed HEDIS® for private employers so that they could compare health plan services before making purchase decisions. The use of HEDIS® data has expanded to include public purchasers, regulatory agencies, and consumers. NCQA conducts surveys to assess a health plan's ability to meet specific standards and guidelines for quality improvement, utilization management, credentialing and recredentialing, member rights and responsibilities and member communications using the internet.

When a health plan is accredited by NCQA, it is required to prepare and submit an annual HEDIS® report as a way of continuously measuring quality care. The New Mexico Human Services Department (NMHSD) requires HEDIS reporting for health plans contracted to provide Medicaid benefits. The Centers for Medicare and Medicaid (CMS) require HEDIS reporting for health plans contracted to provide Medicare benefits.

What quality performance measures are included in the reports?

Effectiveness of Care Measures look at clinical quality of care, such as:

- Childhood immunizations
- Breast and cervical cancer screening
- Chlamydia screening
- Controlling high blood pressure
- Cholesterol management
- Diabetes care
- Use of appropriate asthma medications
- Follow-up after hospitalization for a mental illness
- Antidepressant medication management
- Colorectal screening

Access and Availability of Care measures look at how members access services from their health care system, such as:

- Adults' access to preventive/ambulatory services
- Children's access to Primary Care Practitioners
- Prenatal and postpartum care
- Annual dental visits

Satisfaction with the Experiences of Care measures look at the members' experience with their health plan, such as:

- Rating of all health care
- Rating of the health plan
- Rating of personal practitioner
- Rating of specialist seen most often
- Claims processing
- Customer service
- Getting care quickly
- Getting needed care

Use of Services measures look at information about how health plans manage the care provided to their members, such as:

- Frequency of ongoing prenatal care
- Frequency of selected procedures
- Inpatient/Outpatient utilization
- Mental Health utilization

Where does HEDIS® data come from?

HEDIS® data is collected from a sample of health care claims and encounters, enrollment forms, surveys and medical records. Most of the data includes information from the previous calendar year and a few performance measures require health plans to find and report on data for previous years. The HEDIS® data requirements are very specific and cannot be changed by the health plan. Before submitting the report to NCQA, NMHSD, and CMS, it is thoroughly reviewed by NCQA certified auditors to ensure that it was prepared correctly. NCQA and regulatory agencies frequently publish HEDIS® results in public forums so that existing and potential health plan purchasers and members can compare results.

How does HEDIS® reporting impact the practice setting?

Health plans rely on the claims submitted by practice sites to prepare the HEDIS® report and, when claims are not coded correctly, they cannot be used for reporting purposes. When a health plan cannot find the claims data, a medical record search begins by

identifying those practitioners that provided a service to members selected for the HEDIS® report. These practitioners are given a list of patient names and asked to make available the medical records for health plan staff to review or, when this is not possible, make copies of selected medical record pages. Since medical records are confidential, many health plans obtain authorization to review medical records when a member signs up for benefits. Health plans submit the audited HEDIS® reports to NCQA in June of each year, and typically begin preparing at least six months before the June deadline. Medical record data collection can begin anytime during the first quarter of the calendar year.

How does Presbyterian use the HEDIS® reporting system?

For the past several years, Presbyterian has integrated the HEDIS® performance measures into its Quality Improvement program to gauge the success of its clinical and service activities. For example, HEDIS® measures are used to determine the success of Presbyterian's disease management programs for, diabetes and coronary artery disease. The annual member satisfaction survey measures known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is used to monitor improvement activities in customer service and getting care quickly. Selected HEDIS® and CAHPS® measures were included in the Presbyterian Quality Incentive Program to reward the practitioner network for providing quality care.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the U.S. Department of Health and Human Services (DHHS) create regulations to address several key concerns relating to electronic health information:

- Standardization of electronic health insurance transactions
- Privacy of protected health information in any medium
- Security of electronic protected health information

As a result, many HIPAA regulations have been finalized in the last decade. This section of the Presbyterian Practitioner and Provider Manual is intended to briefly summarize some of the requirements of these regulations, and to address the more common questions and concerns regarding HIPAA that providers may have.

Presbyterian expects all providers to comply with HIPAA requirements. This information should not be construed as legal advice; please consult your own legal counsel for an opinion as to how these requirements apply to your office or facility. Presbyterian does not assume any responsibility for ensuring that providers are compliant with HIPAA regulations.

HIPAA Administrative Simplification Regulation Overview

The following is a list of the HIPAA Administrative Simplification regulatory standards that have either been finalized, proposed or are under discussion. We expect each practitioner/provider to consider and determine the applicability of each of the following. A brief description of each standard is given along with final or proposed compliance deadlines.

I. General Administrative Requirements

General Administrative Requirements (45 CFR 160.101 - 312)

- General provisions and definitions pertaining to all HIPAA Administrative Simplification rules; rules for pre-emption of state law; and compliance and enforcement rules.
- Compliance Deadline: April 14, 2003.

Enforcement Standards (45 CFR 160, Subparts C, D, and E)

- These standards establish administrative procedures for enforcement of HIPAA Administrative Simplification standards, including the imposition of civil monetary penalties for violations.
- Compliance Deadline: March 16, 2006.
- Revised by "HITECH Act," with various effective dates beginning: February 17, 2009.

II. Privacy and Security Standards:

Standards for Privacy of Individually Identifiable Health Information (45 CFR 164.501 - 532)

- (See the PCSC section for more details) Standards regarding who should have access to an individual's "protected health information," and for what purposes. Also establishes rights for individuals regarding health information, including the right to access and request amendment of their own health information.
- Compliance Deadline: April 14, 2003.
- Revised by "HITECH Act," with various effective dates beginning: February 17, 2009.
- Proposed Rule regarding Accounting for Disclosures published May 31, 2011 in the Federal Register.
- Proposed Rule to amend CLIA and HIPAA regarding Patient's Access to Test Results: published in September 14, 2011 Federal Register..

Breach Notification for Unsecured Protected Health Information Standards (45 CFR 164.400 - 414)

- Standards for determining whether a "breach" of "unsecured" protected health information has occurred, and for notifying the affected individual(s) in the event a breach did occur.
- Compliance Deadline: September 23, 2009.

Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals:

Approved methods and technologies for "securing" protected health information. Published at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brguidance.html , and revised annually by the US Department of Health and Human Services, Office of Civil Rights.

Security Standards (45 CFR 164.302 – 318)

- Includes administrative, physical and technical safeguards that must be implemented to safeguard

electronic protected health information.
- Compliance Deadline: April 20, 2005.
- Revised by "HITECH Act," with various effective dates beginning: February 17, 2009.

III. Standardization of Electronic Health Insurance Transactions:

Standards for Electronic Transactions (45 CFR 162.100, 103, 900 – 1802)
- (see Claims section for more details)
- Format and content standards for eight electronic health insurance transactions (for example, electronic claims should be sent in a standard format - the ANSI 837 for both professional and facility claims).
- Original Compliance Deadline (4010): October 16, 2003.
- Revised Standards (5010) Published: January 16, 2009
- Compliance Deadline for Revised Standards: January 1, 2012 (NOTE: CMS announced in March of 2012 that enforcement of this standard will not begin until June 30, 2012)

Claims Attachment Standards
- Proposed regulations for various types of claims attachments were issued September 23, 2005. The new standard would create standard electronic format and content for various common types of claims attachments.
- Compliance Deadline: No final standards established as of the date this provider manual was published.

Revised Standard Diagnostic and Procedural Codes (ICD-10-CM) (45 CFR 162.1000 – 1011)
- Consists of more than 68,000 codes, compared to approximately 13,000 ICD-9-CM codes. ICD-10-CM incorporates greater specificity and clinical detail to provide information for clinical decision making and outcomes research. Will be required in HIPAA compliant electronic transactions.
- Revised Standards (ICD-10) Published: January 16, 2009
- Compliance Deadline for Revised Standards: October 1, 2013 (NOTE: In February of 2012, the Secretary for the Department of Health and Human Services announced her intent to seek a postponement of this date, but a new deadline has not yet been specified.)

IV. National Identifier Standards

A "standard national identifier" means a unique national identifying number that would be assigned to various types of persons, entities and organizations used in electronic health insurance transactions. HIPAA

Standard National Identifiers include:

Standard Employer Identifier (45 CFR 162.600 – 610): Standard identifier is the same as current "Employer Identification Number" (EIN) used by the IRS.
Compliance Deadline: July 30, 2004.

Standard Provider Identifier (45 CFR 142.101 – 106; 142.402 – 410):

Providers apply for a National Provider Identifier (NPI) online. The NPI replaces the UPIN and certain other provider identifiers which had been in use. CMS currently requires that the NPI be included on all claims.
Compliance Deadline: May 23, 2007.

Standard Identifier for Health Plans:

Proposed regulations not yet issued. New standard would create a unique identifier for all entities performing health plan functions.
Compliance Deadline: Not established as of the date this provider manual was published.

Standard Identifier for Individuals:

Initially, so controversial that proposed regulations were not drafted. Homeland security and "Electronic Health Record" (EHR) concerns may bring this issue back to the table in the future.

V. Standards for Electronic Health Records Establishment of Certification Programs for Health Information Technology (45 CFR 170.400 – 490; 500 – 570)

Establishes two certification programs (one temporary for the initial phase; the second permanent) for purposes of testing and certifying health information technology (including electronic health record systems).
Compliance Deadline: .

o Temporary Certification Program – Final Rule issued June 2010; program sunsets when Permanent Certification Program is operational – expected to be sometime in 2012.

o Permanent Certification Program – Final Rule issued 76 FR 1262, Jan. 7, 2011; will be ongoing once it

is operational.

Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology (45 CFR 170.100 - 306)

Establishes the capabilities and related standards that certified electronic health record (EHR) technology will need to include in order to, at a minimum, support the achievement of the proposed meaningful use Stage 1 (beginning in 2011) and Stage 2 (beginning in 2014) by eligible professionals and eligible hospitals under the Medicare and Medicaid EHR Incentive Programs.

Compliance Deadline:

o 2011 Edition EHR certification criteria (Stage 1) - Interim Final Rule effective February 12, 2010;

o 2014 Edition EHR certification criteria (Stage 2) - Proposed Rule published in Federal Register / Vol. 77, No. 45 / Wednesday, March 7, 2012

Standards for the Electronic Health Record Incentive Program (42 CFR 495.2 – 370):

Establishes the eligibility criteria, and processes for documenting and applying for EHR incentives, for providers and Medicare Advantage programs.

Compliance Deadline:

- Stage 1 – Final Rules Published July 28, 2010; criteria must be met in 2011 to qualify for incentive payments.
- Stage 2 – Proposed Rule published in Federal Register / Vol. 77, No. 45 / Wednesday, March 7, 2012; criteria must be met in 2014 to qualify for incentive payments.

HIPAA websites with Additional Information

Check with your specialty trade organization. They will have the most specific information on HIPAA compliance issues that affect your particular specialty or service.

At a national level, the Workgroup on Electronic Data Interchange (WEDI) has organized a collaborative, industry-wide approach called Strategic National Implementation Process (SNIP) for implementation of Health Information Technology (HIT), clinical initiatives and standards including those for security, privacy, EDI transactions, code sets and identifiers. Please visit their website at: http://www.wedi.org/snip/public/articles/index%7E4.shtml.

The following websites also have information that you may find helpful or valuable:

Department of Health and Human Services, Office of Civil Rights (OCR): includes information about Privacy regulations and guidance, FAQ's and educational tools: http://www.hhs.gov/ocr/privacy/

CMS HIPAA website (overall CMS HIPAA Web page): http://www.cms.gov/HIPAAGenInfo/

Department of Health and Human Services, Office of the National Coordinator for Health Information Technology (ONCHIT): includes information about certification of, standards and incentive payments for Electronic Health Records http://healthit.hhs.gov/portal/server.pt

Information on the Medicare and Medicaid Electronic Health Record (HER) Incentive Programs can be found at http://www.cms.hhs.gov/EHRincentiveprograms.

WEDI also provides resources on Electronic Health Record Systems: http://www.wedi.org/ehrecords/public/articles/dis_viewArticle.cfm?ID=736

CMS Website on the new ICD-10 codes and 5010 Transaction Standards: https://www.cms.gov/ICD10/

National Center for Health Statistics – Information regarding new ICD-10-CM and ICD-10-PCS coding system: http://www.cdc.gov/nchs/icd/icd10cm.htm

American Medical Association HIPAA resource page: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act.shtml

American Hospital Association HIPAA page: http://www.aha.org/advocacy-issues/hipaa/index.shtml

The Substance Abuse and Mental Health Services Agency of the Department of Health and Human Services has a special website set up to address HIPAA issues in a Behavioral Health context: http://www.

samhsa.gov/healthprivacy/

For behavioral health providers, the American Psychological Association has HIPAA resources on their website : http://www.apapracticecentral.org/business/hipaa/index.aspx

The American Psychiatric Association website has resources for members on HIPAA. You can access these resources at http://www.psych.org and search for HIPAA.

Business Associates
Overview for HIPAA Privacy Standard Compliance
This section provides a brief overview of the concepts behind, and requirements for, Business Associate contracts as described in the HIPAA Privacy and Security regulations. This information should not be construed as legal advice; please consult your own legal counsel for an opinion as to how these requirements apply to your office or facility. Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. does not assume any responsibility for ensuring that non-employed providers are compliant with HIPAA regulations.

What do the HIPAA Privacy Standards require?
The HIPAA Privacy and Security Standards require any provider who is considered a "covered entity" under HIPAA to have contractual agreements to ensure that the "Business Associates" of that provider meet certain privacy requirements. See 45 CFR §164.504(e) and §164.314(a) for the Privacy and Security business associate requirements.

What is a "Business Associate?"
A "Business Associate," according to the HIPAA Regulations, is an organization or individual that:

- Is NOT part of your organization's workforce, and
- Performs, or assists in the performance of an activity on behalf of your organization that involves the use or disclosure of "Protected Health Information."

Examples include people or organizations that perform services on behalf of your office such as: legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. Similarly, people or organizations providing subcontracted services on your behalf, (such as billing, practice management, repricing, quality assurance, or utilization review) may also be considered your business associates as defined by HIPAA.

Refer to 45 CFR §160.103 for the complete definition of Business Associate. You may want to work with an attorney to ensure you have identified all your business associates and have appropriate agreements in place.

Do I need a "Business Associate" contract with Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc.?
Most providers will not need a "Business Associate" contract with Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. A Business Associate contract would be needed if a provider were to perform a service on behalf of Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. (rather than on behalf of the patient) involving protected health information (for example, credentialing or quality assurance review, or any other function or activity specified in the definition of Business Associate at 45 CFR §160.103).

The need for a Business Associate contract between Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. and a provider may change over time. In order to provide for those instances where a provider may be a business associate of Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc., the following two provisions apply:

- Business Associate Standard Language may be included in your contract to address specific issues or concerns
- Business Associate Language has been included in this section of the Provider Manual (see "Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. Business Associate Standard Contract Language" below) and will apply to all Presbyterian providers in any situation where he/she may be acting as a "Business Associate." It does not apply if the provider is not a Business

Associate of Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc.

Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. Business Associate Standard Contract Language

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Regulations promulgated hereunder impose a number of obligations on health plans and providers regarding use and disclosure of protected health information (PHI). One of those obligations is that each covered entity enter into a business associate agreement with any individual or entity that acting on its behalf, performs or assists in the performance of a function or activity involving the use or disclosure of PHI. Depending on the specific activities performed, a provider may therefore be considered a business associate of Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc.

TO THE EXTENT THAT A PROVIDER IS CONSIDERED A BUSINESS ASSOCIATE OF PRESBYTERIAN HEALTH PLAN, INC. OR PRESBYTERIAN INSURANCE COMPANY, INC., THE PROVIDER SHALL COMPLY WITH THE FOLLOWING TERMS AND CONDITIONS:

Business Associate Agreement

For purposes of this section of the Provider Manual, any reference to "Business Associate" shall mean the Provider and any reference to "Covered Entity" shall mean Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc., or both. In addition, for purposes of this section of the Provider Manual only, the term "Agreement" shall mean the provisions of this section which constitute the Business Associate Agreement between the Provider and Presbyterian. The Provider acknowledges that during any period that the Provider is providing services to Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. as a Business Associate, the following provisions shall apply and shall constitute a valid and binding "Business Associate Agreement" as such term is defined under HIPAA.

Definitions: except as otherwise defined in this Agreement, the terms used in this Section shall be defined as they are defined in HIPAA, 45 CFR §§160 and 164.

- "Breach" means the unauthorized acquisition, access, use or disclosure of Protected Health Information that compromises the security or privacy of such Protected Health Information.
- "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated there under.
- "HIPAA Privacy Regulations" means the privacy regulations promulgated under HIPAA and published in the Code of Federal Regulations ("C.F.R.") at Title 45, Sections 160 and 164.
- "HIPAA Security Regulations" means the security regulations promulgated under HIPAA and published in the C.F.R. at Title 45, Sections 160, 162 and 164.
- "Other Terms" Capitalized terms not otherwise defined herein shall have the meaning assigned to them by the HIPAA Privacy Regulations and HIPAA Security Regulations.

WHETHER A PROVIDER IS ACTING AS A BUSINESS ASSOCIATE WILL DEPEND ON ALL OF THE FACTS AND CIRCUMSTANCES SURROUNDING THE SPECIFIC ACTIVITIES BEING PERFORMED ON BEHALF OF PRESBYTERIAN HEALTH PLAN, INC. OR PRESBYTERIAN INSURANCE COMPANY,INC. EXAMPLES OF ACTIVITIES THAT WOULD REQUIRE A BUSINESS ASSOCIATE AGREEMENT INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING: LEGAL, ACTUARIAL, ACCOUNTING, CONSULTING, DATA AGGREGATION, MANAGEMENT,ADMINISTRATIVE, ACCREDIATION, FINANCIAL OR OTHER SERVICES INVOLVING THE USE OF PROTECTED HEALTH INFORMATION. THE FULL DEFINITION OF A BUSINESS ASSOCIATE CAN BE FOUND AT 45 CFR §160.103 AND WILL BE APPLIED IN DETERMINING WHETHER THE PROVIDER IS A BUSINESS ASSOCIATE OF PRESBYTERIAN HEALTH PLAN, INC. OR PRESBYTERIAN INSURANCE COMPANY, INC.

Use of Protected Health Information (PHI)
Business Associate may use and disclose PHI only as permitted by this Agreement, or as required by law, but shall not otherwise use or disclose any PHI. Business Associate shall not use or disclose PHI and shall ensure that its directors, officers, employees, contractors and agents do not use or disclose PHI received from the Covered Entity in any manner that would constitute a violation of the HIPAA Privacy Regulations or the HIPAA Security Regulations. Covered Entity and the Business Associate agree that the Business Associate may only use or disclose PHI as follows: (a) for the purpose described in Section 2 of this Agreement; (b) for the Business Associate's proper management and administration; (c) to carry out the legal responsibilities of the Business Associate; or (d) to provide Data Aggregation services relating to the health care operations of the Covered Entity if required under a Contract(s). Except for such use, the Business Associate agrees to hold all PHI strictly confidential.

Disclosure of PHI
To the extent the Business Associate discloses PHI (including PHI in an electronic format) to a third party, the Business Associate must obtain, prior to making any such disclosure (a) reasonable assurances from the third party that such PHI will be held confidential as provided in this Agreement and only disclosed as required by law or for the purposes for which it was disclosed to such third party, provided that such reasonable assurances shall require that Business Associate enter into a written agreement pursuant to which such third party agrees to be bound by all of the same restrictions and conditions that apply to the Business Associate pursuant to this Agreement; and (b) an agreement from such third party to immediately notify the Business Associate of any breaches of the third party's confidentiality obligations with respect to the PHI.

Safeguards against the Misuse of Information
The Business Associate agrees that it will implement appropriate safeguards to prevent the unauthorized use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement. To the extent Business Associate will create, maintain, transmit or receive PHI in an electronic format, Business Associate shall implement administrative, physical and technical safeguards consistent with the HIPAA Security Regulations that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI.

Reporting of Disclosures of PHI
The Business Associate shall report to the Covered Entity, as soon as practicable, but in no event later than within two (2) days of becoming aware of any Security Incident or use or disclosure of PHI not provided for in this Agreement or in violation of the Agreement by the Business Associate, its officers, directors, employees, contractors or agents or by a third party to which the Business Associate disclosed PHI pursuant to this Agreement. In such event, the Business Associate shall, in consultation with the Covered Entity, mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of such improper use or disclosure. In addition, Business Associate must report to Covered Entity any unauthorized acquisition, access, use or disclosure of Protected Health Information (whether electronic, oral or in any other medium and whether secure or unsecured) within three (3) business days of the date on which Business Associate first becomes aware of such unauthorized acquisition, access, use or disclosure. Business Associate shall also, as a part of such notification, provide Covered Entity with the name and phone number of a contact person, authorized to act on behalf of Business Associate, to work with Covered Entity in ensuring that all required HIPAA obligations are met as efficiently and accurately as possible. Business Associate will reimburse Covered Entity for all costs, expenses and damages (including reasonable attorneys fees) associated with any notification process that may be required under the "HITECH BA Provisions" (as defined in the Amendment section below) with respect to any Breach of unsecured Protected Health Information caused by Business Associate or its agents or subcontractors.

Access to Information
Within five business days of a request by the Covered Entity for access to PHI about an individual, the Business Associate shall make PHI available to the Covered Entity in accordance with the requirements

of 45 CFR §164.524 in the medium and format in which such PHI is maintained by Business Associate for as long as such PHI is maintained. In the event any individual requests access to PHI directly from the Business Associate, the Business Associate shall within two business days forward such request to the Covered Entity. Any denials of access to the PHI requested shall be the responsibility of the Covered Entity.

Availability of PHI for Amendment
Within ten (10) business days of receipt of a request from the Covered Entity for the amendment of an individual's PHI, the Business Associate shall provide such information to the Covered Entity for amendment and incorporate any such amendments in the PHI as required by 45 CFR §164.526.

Accounting for Disclosures
Within ten (10) business days of notice by the Covered Entity to the Business Associate that it has received a request for an accounting of disclosures of PHI regarding an individual during the six (6) years prior to the date on which the accounting was requested, the Business Associate shall make available to the Covered Entity such information as is in the Business Associate's possession and is required for the Covered Entity to make the accounting required by 45 CFR §164.528. Business Associate is not required to account for disclosures made prior to April 14, 2003. At a minimum, the Business Associate shall provide the Covered Entity with the following information: (a) the date of the disclosure; (b) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (c) a brief description of the PHI disclosed; and (d) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. In the event the request for an accounting is delivered directly to the Business Associate, the Business Associate shall, within two business days, forward such request to the Covered Entity. It shall be the Covered Entity's responsibility to prepare and deliver any such accounting requested.

The Business Associate hereby agrees to implement an appropriate record keeping process to enable it to comply with the requirements of this section. To the extent the Business Associate maintains or operates an electronic health record system on behalf of Covered Entity, Business Associate shall also maintain information for the preceding three (3) year period (but no earlier than the Applicable Effective Date (as defined in the Amendment section below)) sufficient to enable Covered Entity to make an accounting of disclosures for treatment, payment and health care operations.

Availability of Books and Records
The Business Associate hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity available to the Covered Entity and to the Secretary for purposes of determining the Covered Entity's and the Business Associate's compliance with HIPAA. In addition, upon Covered Entity's request, Business Associate shall make its internal practices, books and records relating to compliance with the HITECH BA Provisions available to Covered Entity for purposes of determining the Business Associate's compliance with the HITECH BA Provisions. Without limiting the generality of the foregoing, Business Associate acknowledges and agrees that as of the Applicable Effective Date, Business Associate shall have policies and procedures that are sufficient to comply with the applicable requirements of the HITECH BA Provisions.

Amendment
Upon the enactment of any law or regulation affecting the use and/or disclosure of PHI, or the publication of any court decision relating to any such law, or the publication of any interpretive policy, opinion or guidance of any governmental agency charged with the enforcement of any such law or regulation, the Covered Entity may, by written notice to the Business Associate, amend this Agreement to comply with such law or regulation by providing thirty (30) days' written notice to the Business Associate. Such amendment shall be binding upon the Covered Entity and the Business Associate at the end of the thirty (30) day period and shall not require the consent of the Business Associate unless (a) the Business Associate provides the Covered Entity with notice of objection

within the thirty (30) day period; (b) the change has a material adverse economic effect upon the Business Associate as reasonably determined by the Business Associate; and (c) the Business Associate delivers written notice to the Covered Entity during such 30 (day) period terminating the Contract(s). Covered Entity and Business Associate acknowledge and agree that the Health Information Technology for Economic and Clinical Health Act ("HITECH") was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH imposes new requirements with respect to privacy, security and security breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the Department of Health & Human Services ("DHHS"). The HITECH provisions applicable to business associates will be collectively referred to as the "HITECH BA Provisions." The provisions of HITECH and the HITECH BA Provisions are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entireties. Notwithstanding anything to the contrary, the HITECH BA Provisions will be effective: (a) with respect to any security breach notification provision, on the date of this Agreement; and (b) with respect to the other HITECH BA Provisions, on February 17, 2010 or such subsequent date as may be specified in HITECH or applicable final DHHS regulations ("Applicable Effective Date").

Breach

Notwithstanding the rights of the parties pursuant to other provisions of the Contract(s) or this Agreement, if the Business Associate breaches its obligations under this Agreement, the Covered Entity may, at its option (a) exercise any of its rights of access and inspection under this Agreement; (b) require the Business Associate to submit to a plan of monitoring and reporting, as the Covered Entity may determine necessary to maintain compliance with this Agreement and such plan shall be made part of this Agreement; (c) terminate this Agreement and the Contract(s) after expiration of a twenty (20) day opportunity to cure; or (d) if termination of this Agreement or the Contract(s) is not feasible report Business Associate's breach or violation to the Secretary of the Department of Health and Human Services. The Covered Entity's remedies under this Paragraph shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

Procedure upon Termination

Business Associate's obligations under this Agreement will terminate only upon the termination of all the Contract(s), provided that upon termination of this Agreement, the Business Associate shall return or destroy all PHI that it maintains in any form and shall retain no copies of such information or, if the parties agree that return or destruction is not feasible, the Business Associate shall continue to extend the protections of this Agreement to such information and limit further use of the information to those purposes that make the return or destruction of the information not feasible. The provisions of this Agreement shall survive termination of the Contract(s).

Legal

The healthcare environment is both dynamic and heavily regulated. As a result, it is often necessary for Presbyterian to: (i) obtain assurances from its contracted practitioners/providers that they are in compliance with certain requirements or (ii) to be able to demonstrate that it has required its practitioners/providers to meet certain requirements. This section of the provider manual therefore contains terms and conditions that are part of your contractual agreement with Presbyterian. Additional information will be added and updated to this section as regulatory requirements are added or changed.

Salud! and State Coverage Insurance (SCI) Contracting Requirements

Presbyterian Salud participates in the State of New Mexico's managed Medicaid program, called Salud! Because this program is jointly funded by both the federal and state governments, there are numerous legal and other regulatory requirements that Presbyterian Salud is required to comply with or otherwise verify compliance with by its network of providers and practitioners. Presbyterian Salud's contract with the New Mexico Medicaid program is referred to as the "Salud Agreement" in this section. This section also addresses Presbyterian's participation in New Mexico's State Coverage Insurance Program, more commonly referred to as SCI. As a participant in the Presbyterian Salud and SCI networks you are agreeing to each of the following:

No Conviction of Crimes Under Section 1128: You are not an individual provider, an entity, or an entity with an individual who is an officer, director, agent, manager or person with more than five percent (5%) of beneficial ownership of an entity's equity, that has been convicted of crimes specified in the Section 1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128.

Provider disclosure of current or previous affiliation with excluded provider(s)

Providers are required to submit, within 35 days of the date of request, information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous 12 month period, and any significant business transactions between the provider and any subcontractor during the 5-year period ending on the date of request. Reimbursement for expenditures for services furnished during the period between the due date and the date the information was actually supplied will be denied.

Background Checks: You will perform criminal background checks for all required individuals providing services pursuant to your agreement(s) with Presbyterian as specified in 7.1.9 NMAC.

Hold Harmless: You agree to hold harmless the Presbyterian. This hold harmless provision shall survive the effective termination of your agreement with Presbyterian for authorized services rendered prior to the termination of the agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the members.

Delegation (if applicable): You agree that our written agreement specifies activities, reporting responsibilities and any delegated functions, including provisions for the revocation of delegated functions and/or for the imposition of other sanctions for inadequate subcontractor performance. You understand and agree that Presbyterian has policies and procedures to ensure that:

o a delegated entity meets all standards of performance mandated by the State for the Salud! or SCI programs, as applicable and that these include, but are not limited to, use of appropriately qualified staff, the application of clinical practice guidelines and utilization management, reporting capability, and ensuring members' access to care.

o for the oversight of the delegated entity's performance of the delegated functions. o include the frequency of reporting (if applicable) and the process by which the CONTRACTOR evaluates the delegate.
o ensures consistent statewide application of all Utilization Management (UM) criteria when UM is delegated.

Cooperation with Medicaid Fraud Control Unit (MFCU): You agree that you will cooperate fully in any investigation by the MFCU or subsequent legal

action that may result from such investigation. Upon request, you will make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services under this Agreement and allow MFCU access during normal business hours, and with reasonable notice, to the place of business, except under special circumstances, as determined by the MFCU, when after hours access shall be allowed.

Employee Education: If you are paid five million dollars, or more, in the aggregate in Medicaid payments annually, you agree that you must establish written policies for all employees, including management, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. These written policies must include a specific discussion of the applicable laws and detailed information regarding your policies and procedures for detecting and preventing fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers. You understand and agree that you must also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of your policies and procedures for detecting and preventing fraud, waste and abuse.

Credentialing Requirements: You understand and agree that Presbyterian has policies and procedures for verifying that the credentials of all its providers and subcontractors meet applicable standards as stated in Presbyterian's agreement to participate in the Salud! program, including any and all attachments thereto.

Review Requirements: You understand and agree that Presbyterian is obligated to and shall maintain fully executed originals of all subcontracts, including your agreement with Presbyterian, which will be made accessible to the Human Services Department/Medical Assistance Division, upon request.

No Debarment: You represent and warrant to Presbyterian that neither you nor any of your employees or subcontractors have been:

o charged with a criminal offense in connection with obtaining, attempting to obtain, or performance of a public (federal, state or local) contract or subcontract,

o listed by a federal governmental agency as debarred o proposed for debarment or suspension or otherwise excluded from federal
program participation

o been convicted of or had a civil judgment rendered against you or them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property

o within a three (3) year period preceding the date of this Agreement, had one or more public transactions (federal, state or local) terminated for cause or default. You also agree that you will immediately notify Presbyterian if any of the above referenced representations change. You agree that any misrepresentation of your status or any change in your status may be grounds for immediate termination of your agreement with Presbyterian.

False Claims. You agree that you have or will establish written policies and procedures for all of your employees, agents, or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978 §§ 27-14-1, et seq., and the Federal False Claims Act established under Sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste and abuse in federal health care programs as defined in Section 1128 of the Social Security Act.

Other Provisions: You agree that your agreement with Presbyterian will also be deemed to contain the following provisions:

- The agreement has been and shall be considered to be executed in accordance with all applicable federal and state laws, regulations, policies, procedures and rules

- The agreement identifies the parties of the contract and their legal basis of operation in the State of New Mexico
- The agreement includes procedures and specific criteria for terminating the subcontract
- The agreement identifies the services, activities and reporting responsibilities to be performed by you and those services performed under any other agreement(s). The agreement includes provision(s) describing how services provided under the terms of the agreement are accessed by members
- The agreement includes the reimbursement rates and risk assumption, if applicable You shall maintain all records relating to services provided to members for a ten (10) year period and shall make all enrollee medical records or other service records available for the purpose of quality review conducted by the State, or their designated agents both during and after the contract period
- You agree that all member information will be kept confidential, as defined by federal and state law
- You agree that authorized representatives of the State will have reasonable access to facilities and records for financial and medical audit purposes both during and after the contract period
- You agree to release to Presbyterian any information necessary for Presbyterian to perform any of its obligations and acknowledge that Presbyterian shall be monitoring your performance on an ongoing basis and conducting formal periodic reviews
- You agree to accept payment from Presbyterian as payment for all services included in the benefit package, and you agree that you cannot request payment from the State for services performed under your agreement with Presbyterian
- You agree that if your agreement with Presbyterian includes the provision of primary care, then the provisions for compliance with PCP requirements delineated in the Salud Agreement shall also apply to you
- Your requirement to comply with all applicable state and federal statutes, rules, and regulations
- You agree that Presbyterian may institute corrective action plans if indicated, sanctions and/or termination for any violation of applicable HSD/MAD, state or federal statutes, rules, or regulations
- You agree that your agreement with Presbyterian does not prohibit you or any one you subcontract with (with the exception of third-party administrators) from entering into a contractual relationship with another MCO
- You agree that your agreement with Presbyterian does not include any incentive or disincentive that encourages you or any other subcontractor not to enter into a contractual relationship with another contractor
- You agree that your agreement with Presbyterian does not contain any gag order provisions that prohibit or otherwise restrict covered health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act or in contravention of NMSA 1978, § 59A-57-1 to 59A-57-11, the Patient Protection Act
- If you are a pharmacy provider, you agree that payments are being made consistent with 1978 NMSA § 27-2-16B, unless there is a change in law or regulation
- You agree that you shall submit electronic claims, unless you have been granted a hardship extension
- You agree that your agreement with Presbyterian includes the HSD/MAD contractual provisions related to the State of New Mexico Executive Order 2007-049 concerning subcontractor health coverage requirements, as further defined in Article 37
- You agree that you will comply with the State of New Mexico's Statewide Immunization Information System (NMSIIS) initiative
- You agree that you have not been restricted from participating in a federal entitlement program (i.e., Medicare, Medicaid)

Medicare Requirements
Definitions:

- The terms MA Plan Enrollees, Medicare Advantage (or MA), Downstream Entities, Related Entities, First Tier Entities and any other capitalized terms not otherwise defined in this Amendment or the Agreement(s) shall have the same meanings as defined by the Centers for Medicare and Medicaid Services ("CMS") in 42 CFR § 422.2.
- The term "Subcontractor" means all Downstream

Entities and Related Entities which practitioner/provider utilizes to perform the Services.

Nondiscrimination: Practitioner/provider agrees, and will require all Subcontractors to agree, not to differentiate or discriminate in the treatment of MA Plan Enrollees on the basis of health status or on the basis of color, race, creed, sex, age, religion, place of residence, health status, sexual orientation, disability, place of origin, type of illness or condition, source of payment, including, but not limited to, Medicare, Medicaid, or any other basis prohibited by federal law and to observe, protect and promote the rights of MA Plan Enrollees as patients. (Source: 42 CFR § 422.110).

Privacy of Medical Records: Practitioner/provider will treat, and will require all Subcontractors to treat, all MA Plan Enrollees' medical records or other health and enrollment information as confidential and protected against unauthorized disclosure so as to comply with all state and federal laws regarding the privacy, security, confidentiality and disclosure of MA Plan Enrollees' health information. The practitioner/provider will ensure maintenance of such information in an accurate and timely manner and ensure that MA Plan Enrollees may timely access of such information upon request. (Source: 42 CFR § 422.118).

Cooperation with Client's Programs: Practitioner/provider shall use its best efforts to cooperate with and participate in, and to require all Subcontractors to cooperate with and participate in, Client's quality improvement programs, member grievance systems, medication therapy management, and utilization management programs to the extent applicable to the Services provided by practitioner/provider, including, but not limited to, credentialing, recredentialing, quality assurance, prospective, concurrent, and retrospective utilization review and management, medical records maintenance, claims payment review and management peer review, and provider and member grievance procedures. Practitioner/provider shall be bound by the appeal procedures of Client's utilization review and quality assurance program. (Source: 42 CFR §§ 422.152, 422.202(c)).

Communication with MA Plan Enrollees: Client encourages the practitioner/provider, and practitioner/provider shall encourage Subcontractors, to freely communicate with MA Plan Enrollees regarding appropriate treatment alternatives, regardless of benefit limitations, in a culturally competent manner and in compliance with requirements of 42 USC § 12101, as amended (otherwise known as the "American with Disabilities Act of 1990"). Client shall not penalize its employees, contractors, or Subcontractors for discussing medically necessary or appropriate care with MA Plan Enrollees. (Source: 42 CFR § 422.206(a)(1) & (2)).

Indemnity: Practitioner/provider shall indemnify, defend and hold Client harmless from and against any loss, damage or costs (including reasonable attorneys' fees) incurred in connection with claims arising out of or resulting from practitioner/provider's or a Subcontractor's failure to comply with all applicable Medicare Advantage requirements.

MA Plan Enrollee Hold Harmless: Practitioner/provider hereby agrees, and will require all Subcontractors to agree, to seek payment for covered prescription drug services only from Client. In no event, including, but not limited to, termination of the Agreement(s) or this Amendment, non-payment by Client, Client's insolvency or breach of the Agreement(s) or this Amendment, shall practitioner/provider or a Subcontractor bill, charge, collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against MA Plan Enrollees, MA Plan Enrollees' families, or persons (other than Client) acting on their behalf for covered prescription drug services provided pursuant to the Agreement(s) or this Amendment. The foregoing sentence shall not prohibit collection by practitioner/provider or a Subcontractor of applicable Copayments, Coinsurance, and Cost-Sharing, as described in the MA Plan Enrollees' individual contract, certificate of coverage, or summary plan description and charges for non-covered services from MA Plan Enrollees. (Source: 42 CFR § 422.504(g)(1)(i) & (i)(3)).

Continuation of Services beyond Termination: In the event your Agreement with Presbyterian is

terminated or you otherwise cease to operate, you and your Subcontractors shall continue to provide Services in accordance with the terms of your Agreement(s) until the end of the period of time during which Presbyterian is obligated to CMS to provide such services This provision shall survive the termination of your Agreement(s). (Source: 42 CFR § 422.504(g)(2)).

Federal Funds Used: Payments under your Agreement are made, in whole or in part, from federal funds, and subject you and your and Subcontractors to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all applicable Medicare laws, Medicare Advantage laws, regulations, CMS instructions, and all other laws applicable to the individuals or entities who receive federal funds. You acknowledge that you and your Subcontractors may also be subject to any applicable civil and criminal laws for fraud perpetrated in the delivery of the Medicare Advantage benefit. (Source : 42 CFR § 422.504(i) (4) (v)).

Access to Books and Records: Practitioner/provider agrees that it shall provide, and shall require Subcontractors to provide, Client, the Comptroller General, the U.S. Department of Health and Human Services, or other regulatory authorities with jurisdiction over the subject of the Agreement, or their designees, with access to books, contracts, computer or other electronic systems, including records of claims, and medical records, patient care documentation, financial, administrative and other such related claims records that specifically pertain to the transactions for MA Plan Enrollees. Practitioner/provider agrees to maintain such records and provide access to such records as required by this paragraph until the later of ten years following termination of the Agreement(s) and this Amendment or completion of an audit by CMS (which is commenced during such ten-year period). This provision shall survive the termination of the Agreement(s) and this Amendment. (Source: 42 CFR § 422.504(i)(2)), 423.505(i)(4)(iii)).

Exclusion from Federal Health Care Programs: Practitioner/provider hereby represents and warrants that neither it nor, to the best of Practitioner/provider's knowledge, its employees, agents or independent contractors involved in the provision of Services to Client (the "Servicing Employees") or Subcontractors have been excluded from participation in any Federally-funded health care programs, including, but not limited to, Medicare and Medicaid. Practitioner/provider agrees to immediately notify Client if it or any of its Servicing Employees or Subcontractors are threatened or excluded from any such program. In the event that Practitioner/provider or a Subcontractor is excluded from participation in any such program during the term of the Agreement(s) or this Amendment, Client may terminate the Agreement(s) or this Amendment as of the effective date of such exclusion. In the event that Practitioner/provider or any of practitioner/provider's Servicing Employees or Subcontractors are excluded from participation in any such program during the term of the Agreement(s) or this Amendment, practitioner/provider shall immediately remove such employee or Subcontractor from providing any Services in connection with the Agreement(s) or this Amendment and shall notify Client's Compliance Officer in writing, stating the information known by practitioner/provider regarding the basis for the exclusion and the steps taken to remove the excluded Servicing Employee or Subcontractor from providing any Services in connection with the Agreement(s) or this Amendment. If practitioner/provider cannot so remove such Servicing Employee or Subcontractor, Client shall have the option to terminate the Agreement and any other agreements with practitioner/provider as of the effective date of such exclusion. (Source: 42 CFR § 422.752(a)(8)).

Subcontractors and Participating Pharmacies Adequate Network Coverage: SXC shall ensure that all MA Plan Enrollees have adequate access to pharmacies in compliance with the requirements of 42 CFR §§ 423.120, 423.124 and any other Medicare Advantage requirements.

Monitoring: Practitioner/provider shall permit Client to monitor the performance of practitioner/provider, Participating Pharmacies, and any Subcontractor on an ongoing basis. (Source: 42 CFR § 422.504(i)(4)(iii)

Credentialing: Practitioner/provider shall, in contracting with Participating Pharmacies, credential such pharmacies using a process that has been reviewed and approved by Client, and that shall include, but not be limited to, ensuring that the pharmacy is licensed to operate in the state(s) in which it operates and is in compliance with all applicable State or Federal requirements. Practitioner/provider shall immediately notify Client in writing of any changes in its Participating Pharmacy credentialing process or procedure. Client retains the right to suspend or terminate Practitioner/provider's obligation to contract with Participating Pharmacies if Client determines, in its sole discretion that the delegation of this network function is adversely affecting Client's Medicare Advantage program. Practitioner/provider shall notify Client and all MA Plan Enrollees of any delegation of a Participating Pharmacy from the network at least thirty (30) days prior to the effective date. (Source: 42 CFR §§ 422.204(b)(1), 422.504(i)(4))

Standard of Conduct: Practitioner/provider and Subcontractors will provide all Services in a manner consistent with professionally recognized standards of health care and, for MA Plan Enrollees, as prescribed by CMS. (Source: 42 CFR § 422.504(a)(3)(iii)).

Fraud Waste and Abuse Control Compliance Program: In accordance with Prescription Drug Benefit Manual Chapter 9: Part D Program to Control Fraud, Waste and Abuse ("Chapter 9"), practitioner/provider shall establish and maintain a comprehensive compliance program for the purpose of corporate integrity, fraud prevention, and detection. Such program shall include all elements set forth in Chapter 9 that are required by a First-Tier Entity providing the Services set forth in the Agreement(s) or this Amendment.

Practitioner/provider Training and Education: In accordance with Chapter 9, practitioner/provider shall implement annual compliance training and education of all employees, independent contractors, agents, Participating Pharmacies and Subcontractors with any Medicare Advantage or Part D responsibilities on behalf of Client. Such training shall include, at a minimum, all topics included in Section 50.2.3 of Chapter 9. Upon request, practitioner/provider shall report to Client certified, fact-specific information on the training and the practitioner/provider's education compliance. (Source: 42 CFR §§ 422.503(b)(4)(vi)(C)).

Practitioner/provider Communications: Practitioner/provider shall report to Client's Compliance Officer via telephone and follow up electronic mail communication any suspected or potential fraud or other misconduct by Practitioner/provider (or an employee, agent of practitioner/provider) or a Subcontractor (or an employee or agent of a Subcontractor) or of any other person or entity of which it becomes aware. Practitioner/provider shall also have an internal reporting process for practitioner/provider and Subcontractor employees and agents to report suspected or potential fraud to practitioner/provider's compliance officer. Practitioner/provider shall report to Client any potential fraud or other misconduct by practitioner/provider or a Subcontractor. This report shall be made as soon as the practitioner/provider becomes aware of the potential fraud or other misconduct.

Reasonable Assurances: Practitioner/provider will, as of the Effective Date of this Agreement, and thereafter as reasonably requested by Client provide reasonable assurances to Client that practitioner/provider's and Subcontractors' performance of these fraud waste and abuse requirements. Such assurances may include, among other things, providing written certification that the Subcontractors are in compliance with all Medicare requirements or providing Client with copies of practitioner/provider's policies and procedures, compliance program, documentation of training, and any other information necessary to provide Client with reasonable assurances of Subcontractor's compliance with all applicable Medicare Advantage requirements. Such written assurances or copies must be provided as soon as it is available. days of request by Client.

Revocation of Delegation or Termination of the Agreement(s) or this Amendment: Client may revoke its delegation of any Medicare Advantage duties to practitioner/provider or terminate the Agreement(s)

if Client determines, in its sole discretion after a good faith investigation, that practitioner/provider or a Subcontractor is not satisfactorily performing its Medicare Advantage duties or responsibilities to the extent that it may cause harm to MA Plan Enrollees or may cause Client to be in non- compliance with any Medicare Advantage requirements. (Source: 42 CFR § 422.504(i)(4)(ii)).

Prompt Pay

By Client: Client shall make payment in full to practitioner/provider for clean claims within the time period specified under applicable state law. (Source: 42 CFR § 422.520(b))

By SXC: Practitioner/provider shall pay participating pharmacies for all clean claims for MA Plan Enrollees no later than the time required by Medicare Advantage rules, as applicable. (Source: 42 CFR s 423.50, Medicare Managed Care Manual, Chapter 11, § 100.4)

- Reimbursement - Practitioner/provider shall update the pricing standard used for reimbursement to participating pharmacies on July 1, 2009 and at least every seven (7) days thereafter.
- Payment rate - Practitioner/provider shall establish payment rates for plan covered items and services, reimburse Participating Pharmacies on a fee- for-service basis and make information on payment rates available to providers.
- LTC claims - Practitioner/provider shall pay long-term care pharmacy claims consistent with the timeframes established in Section 42 CFR § 423.505(b)(20)

Certifications

Subcontractor Certification of Data Accuracy, Completeness & Truthfulness: To the extent applicable to the Services provided under the Agreement(s) or this Amendment, practitioner/provider warrants and represents, and upon request will certify, to Client and to CMS that all data, including, without limitation, encounter data, it submits to Client is accurate, complete and truthful and agrees to submit all data necessary to characterize the content of purpose of each encounter with MA Plan Enrollees. (Source: 42 CFR §§ 422.310, 422.504).

OIG Exclusion Certification: Practitioner/provider shall, and shall require all Subcontractors to, review the OIG and GSA exclusions lists upon initially hiring and annually thereafter to ensure that any employee or manager responsible for administering or delivering Part D or Medicare Advantage benefits is not excluded from Federal health care programs. Practitioner/provider and Subcontractors shall immediately remove any work related directly or indirectly to all Federal health care programs and the entity will take appropriate corrective actions that an employee responsible for the administration of delivery of any Part D or Medicare Advantage benefits who is on such lists. Practitioner/provider and subcontractors shall annually provide Client with written certification of compliance with these requirements. (Source: 422.752(a)(8); Chapter 9, Sec. 50.2.1.2).

COI Certification: Practitioner/provider and a Subcontractor's officers, directors and managers shall annually thereafter sign a statement, attestation or certification stating that: (1) the individual has reviewed Client's and practitioner/provider's conflict of interest policies; (2) the individual has disclosed any potential conflict of interests; and (3) the individual has obtained management approval to work despite any conflicts or has eliminated the conflict. (Source: Chapter 9, Sec. 50.2.1.2).

Offshore Contracting: Practitioner/provider will annually submit an offshore subcontractor attestation to Client and CMS for each offshore subcontractor it uses to perform Services. Practitioner/provider will require all Subcontractors to report such information about any Offshore Subcontractors they use to practitioner/provider, Client and CMS. (Source: HPMS Memos dated: 07/23/07, 09/20/07 and 08/26/08).

Fraud, Waste & Abuse

Special Investigative Unit (SIU)
As a health plan, we are required to cooperate with regulatory and law enforcement agencies in reporting any activity that appears to be suspicious in nature. According to the law, any information that we have concerning such matters must be turned over to the appropriate governmental agencies.

By identifying areas of concern relative to fraud, waste and abuse, and working with physicians and other health care practitioners to make improvements, Presbyterian is able to dedicate more resources to our goal of improving the health of patients, members and communities.

In accordance with regulatory definitions:

- **Fraud** is defined as intentional deception or misrepresentation made by an entity or person, including but not limited to a subcontractor, vendor, provider, member or other customer with the knowledge that the deception could result in some unauthorized benefit to a person or an entity. Fraud includes any attempt to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by or under the custody or control of, any healthcare benefit program. It includes any act that constitutes fraud under applicable state and federal law. For example, fraud may exist when a practitioner or provider bills for services not rendered, and the service cannot be substantiated by documentation.
- **Waste** is defined as an act involving payment or the attempt to obtain payment for items or services where there was not intent to deceive or misrepresent, but that the outcome of poor or inefficient methods resulted in unnecessary costs to the plan.
- **Abuse** is defined as incidents or practices that are inconsistent with accepted, sound business, fiscal or medical administrative practices. Abuse may, directly or indirectly, result in unnecessary costs to the health plan, improper payment, or payment for services that fail to meet professional standards of care that is medically unnecessary. Abuse consists of payment for items or services when there is no legal entitlement and the recipient has knowingly misrepresented the facts to receive the benefit / payment. Abuse often takes the form of claims for services not medically necessary or not medically necessary to the extent provided. Abuse also includes practices by subcontractors, providers, members, or customers that result in unnecessary costs to the health plan. For example, abuse may exist when the practitioner or provider fails to appropriately bill new and established patient office codes. The practitioner or provider bills a "new" patient code both on the initial visit and subsequent visits.

While true fraud involves only a small percentage of individuals, the costs associated with it are high. We realize that the majority of practitioners and providers conduct their practices in accordance with proper business standards. Presbyterian's Special Investigative Unit (SIU) is responsible for the detection and investigation of any suspected fraudulent activities or abuse involving any members, subcontractors, practitioners, providers, brokers, agents or employer group representatives.

The SIU takes a proactive approach to identifying fraud and abuse by utilizing the claims database for research to detect fraudulent activities. The SIU may contact the provider/practitioner office or facility to assist with the investigation of any type of suspicious activity. A review of medical records for claims validation may be conducted at the provider/practitioner office or facility. If a suspicious pattern is identified, our Chief Medical Officer may contact the practitioner, provider or subcontractor to discuss the specifics of the case.

Medical Record Documentation
Presbyterian follows policies and procedures that govern the standardization and maintenance of medical records by its contracted providers. Presbyterian expects providers to maintain the following medical record information:

Physical Health Practitioner Medical Record Documentation

- Date of service
- Type of service (i.e., 99212, 99213, etc.)

- Medications/interventions
- Modalities and frequencies of treatment furnished with start and stop times
- Clinical test results and summaries of any of the following: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

Behavioral Health Practitioner Medical Record Documentation

- Date of service
- Type of service (i.e. 90801, 90806, etc.)
- Medications/interventions
- Counseling session start and stop time
- Modalities and frequencies of treatment furnished with start and stop times
- Clinical test results and summaries of any of the following: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Documenting Timed CPT Codes

Healthcare professionals provide a number of services that are strictly time dependent. For accurate coding, please remember that your documentation must reflect the actual face-to-face time spent with the patient. This section provides guidance for documenting timed CPT codes for the following services:

- Physical therapy
- Occupational therapy
- Chiropractic services
- Acupuncture
- Counseling services/behavioral health

Physical therapy, occupational therapy, chiropractic services and acupuncture services must have proper documentation for the time or duration of each service performed, as well as the time of the general session. Documentation of the total therapy time, including un-timed codes, is required per Centers for Medicaid and Medicare Services (CMS) guidelines, the American Medical Association (AMA) CPT Manual and Presbyterian's Practitioner and Provider Manual. Counseling services/behavioral health must also provide documentation for the face-to-face time spent with the patient. Presbyterian Since Behavioral Health CPT codes are time based, documentation must include the recommends documents actual start and stop times for therapy.

The CMS Medicare Benefit Policy Manual (chapter 15, page 184, section E) gives the following guidelines for physical therapy, occupational therapy, acupuncture service and chiropractic services:

The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. The format shall not be dictated by contractors and may vary depending on the practice of the responsible clinician and/or the clinical setting.

The Treatment note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the Progress Reports and are allowed, but not required daily. Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff member may be reported voluntarily as additional information if they are relevant and not billed. Specifics such as number of repetitions of an exercise and other details included in the plan of care need not be repeated in the Treatment Notes unless they are changed from the plan.

Documentation for each treatment shall include the following required elements:

- *Date of treatment; and*
- *Identification of each specific intervention/modality provided and billed for, both timed and untimed codes*
- *Total timed code treatment minutes and total treatment time in minutes*
- *Signature and professional identification of the qualified professionals who furnished or supervised the services and a list of each person who contributed to that treatment*

CMS Medicare Claims Processing Manual, Chapter 5, section 20.3 – Determining What Time Counts Towards 15-Minute Timed Codes – All Claims:

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant under the supervision of a physician or therapist)

is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

AMA CPT Manual, Physical Medicine and Rehabilitation, Therapeutic Procedures:
P*hysician or therapist [are] required to have direct (one-to-one) patient contact.*

These services are generally timed. Below is an example of a CPT code with its guidelines:
97110 Therapeutic procedures, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.

Under your existing contract, Presbyterian reserves the right to audit our members' records for purposes that may include, but are not limited to:

- Accuracy of Claims
- Coverage of Services
- Appropriateness of Services
- Appropriateness of Billing

Presbyterian routinely conducts claims validation audits. To ensure accurate payment, please ensure that complete and accurate supporting documentation exists in the patient's medical record that includes the following required elements:

- Date of treatment; and
- Identification of each specific intervention/modality provided and billed for, both timed and untimed codes in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and
- Total timed code treatment minutes and total treatment time in minutes.
- Total treatment time included the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g. rest periods). The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, section 20.2 for description of billing timed codes; and
- Signature and professional identification of the qualified professionals who furnished or supervised the services and a list of each person who contributed to that treatment (i.e. the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law).

Claims Validation Audits

These determine compliance with appropriate billing practices and ensure appropriate charting which must support medical necessity and covered services of specific codes billed. Additionally, these audits may identify other problematic concerns where greater understanding and compliance can be achieved through education. All audits are performed in accordance with the members' contracts and the provider/practitioner existing Presbyterian provider contract.

Under the practitioner/provider's existing contract, Presbyterian reserves the right to audit member records for purposes that may include, but are not limited to:

- Accuracy of Claims
- Coverage of Services
- Appropriateness of Services
- Appropriateness of Billing

Throughout the auditing process a number of tools are utilized to ensure accuracy and consistency. The tools may include but are not limited to:

- Current Procedural Terminology (CPT), American Medical Association
- International Classification of Diseases (ICD-9-CM & ICD-10-CM Manuals)
- HCPCS Medicare Level II code book

- Benefit and Contract Language
- Presbyterian Health Plan, Inc. Practitioner and Provider Manual
- Presbyterian Health Plan, Inc. Reimbursement Guidelines
- Medical Director Review
- Documentation from Patient Charts Obtained During the Audit

Claims validation audits may be conducted either onsite at the provider/practitioner office or by desk audit.

For desk audits, the provider/practitioner office will be contacted in writing with a request to submit the specified medical record information to Presbyterian Health Plan, Inc. SIU. The office representative will be asked to sign a form that the records submitted are complete.

When an onsite audit is conducted and completed, the auditors will briefly meet with provider/practitioner or a representative to discuss the general findings and impressions of the audit. The provider/practitioner or representative will be asked to sign a form that all of the documentation was in the patient records at the time of the audit and that the auditors returned the file to you in the same condition that it was provided to the auditor.

All documentation required to justify the billings must be present in each file at the time of the audit. The files that we will request for review may cover up to a two-year retrospective time period. Please understand that additions to the documentation, and/or the production of missing chart notes or files at a later date cannot be accepted.

Upon completion of the data-gathering portion of the audit, all of the information obtained will be organized and reviewed. The provider/practitioner office will receive an Audit Findings Report within 30 calendar days. Inquiries as to the results of the completed audit cannot be answered until all of the preliminary findings have been thoroughly reviewed by the Presbyterian Health Plan, Inc. Medical Director and compiled into a finalized reporting document.

The audit findings report will detail the claim information such as member name, date of service, CPT code, amount paid, amount billed and amount to be recovered, if any. The Presbyterian Claims or Financial Recovery Departments will handle all recovery requests.

The provider or office representative will be requested to sign, date, and indicate agreement or disagreement with the audit findings within 30 calendar days from date of receipt of the certified findings letter. The provider options are to either:

- agree with the audit, or
- disagree with the audit and provide additional information/documentation, or
- disagree with the audit findings and waive his/her right to an Administrative Officer Review, or
- disagree with the audit findings and request an informal Administrative Officer Review. If the Review option is chosen, the provider or representative will have the opportunity to participate either by attendance or teleconference to present their case. If the provider waives the right to participate, the Review will convene to review the request and render a decision.

During the course of an investigation, many cases are found to be unintentional errors in which the practitioner or provider was unaware of the appropriate billing criteria. In these instances, Presbyterian's Provider Services Department is available to assist the practitioner or provider in rectifying the error and providing education to prevent such errors in the future.

Medical Identity Theft and Identity Misrepresentation Prevention

- **Medical identity theft** occurs when someone uses a person's name and sometimes other parts of their identity such as insurance information without the person's knowledge or consent to obtain medical services or goods, or uses the person's identity information to make false claims for medical services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records, and can involve the creation of fictitious medical records in the victim's name.

- **Identity Misrepresentation** is the intentional use of another's insurance card or the intentional "loaning" of an insurance card to an individual other than the enrolled member in order to access services.

According to the National Health Care Anti Fraud Association approximately 250,000 to 500,000 individuals have been victims of medical identity theft in the United States. A victim of financial identity theft may also be a victim of medical identity theft.

Medical identity theft occurs when an individual uses:
- another person's name which may include the victim's insurance information or Social Security number without the victim's knowledge or consent to obtain medical services or goods, or
- the victim's identity to obtain money by falsifying claims for medical services and falsifying medical records to support those claims.
- It is one of the most damaging and potentially dangerous forms of identity theft and is a crime that causes harm to the victim resulting in:
- Receiving the wrong medical treatment,
- Finding their health insurance benefits have been exhausted, and potentially becoming uninsurable for both life and health insurance coverage.
- Unexpectedly failing a physical exam for employment because a disease or condition for which the victim has never been diagnosed or received treatment has been unknowingly documented in his health record.
- The creation of a fictitious medical record using the victim's name or erroneous entries in the victim's existing medical records, and
- Leaving a trail of falsified information in medical records that can plague victims' medical and financial lives for years.

The outcomes related to medical identity theft includes any of the following:
- Filing false health insurance claims, medical and pharmaceutical bills,
- Denials of health insurance claims and/or coverage, and life insurance claims and/or coverage,
- Denied employment due to a false medical history, and
- Unnecessary loss of time and expense spent correcting false patient records and insurance records.

In addition, member initiated identity theft is also increasing. In this theft type, the health plan member "lends" his/her health plan identification card to a friend or relative who does not have insurance to obtain unauthorized medical care which is ultimately billed to the health plan under the member's name.

As a provider you may help mitigate potential identity theft by:
- Verifying that the patient scheduled for the encounter is the correct person with the correct insurance information by asking for a photo identification card or driver's license, in addition to the health insurance identification card.
- Verifying that the patient's name, address, telephone and date of birth match the identification provided.
- Making copies to retain in the patients file including but not limited to health plan insurance cards, Medicare or Medicaid cards and driver's licenses.
- Asking the parent or adult accompanying a minor child to the appointment to provide his/her photo identification. Making copies and retaining all the adult's forms of identification provided in the minor child's medical record

Medicare Part D Prescription Drug Benefit Fraud Prevention

Presbyterian Health Plan, Inc. is contracted with The Centers for Medicare and Medicaid Services (CMS) to administer the Part D Medicare Prescription Drug Benefit. As a condition of the contract, we are required to investigate and notify the Medicare Prescription Drug Integrity Contractor (MEDIC) of any suspicious activity related to the Part D program.

As a Presbyterian practitioner or provider, please be advised that in the event you suspect or a Medicare beneficiary or their representative report to you any of the following examples of Part D Medicare Prescription Drug Benefit Fraud, you should immediately notify the Presbyterian Special Investigative Unit:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks the Medicare beneficiary for his/her Medicare or social security number, bank account number, credit card number, money, etc.
- Someone asks the Medicare beneficiary to sell his/her Medicare prescription drug card
- The Medicare beneficiary feels that a Medicare prescription Drug Plan has discriminated against him/her, including not letting him/her sign up for their plan because of age, health, race, religion, income
- The Medicare beneficiary was encouraged to disenroll from his/her plan.
- The Medicare beneficiary was offered cash to sign up for a Medicare prescription drug plan
- The Medicare beneficiary was offered a gift worth more than $15 to sign up for a Medicare prescription drug plan
- The pharmacy did not give the Medicare beneficiary all of their drugs
- The Medicare beneficiary was billed for drugs that they didn't receive
- The Medicare beneficiary believes he/she was charged more than once for the premium costs.
- The Medicare prescription drug plan did not pay for the Medicare beneficiary's covered drugs
- The Medicare beneficiary received a different drug than the doctor ordered

Medicare Part C and Part D Fraud, Waste, and Abuse Provider Training

What Are Medicare Part C and Part D?

The Medicare Advantage program (formerly known as "Medicare+Choice") was established by the Balanced Budget Act of 1997 to give beneficiaries the option of enrolling in a variety of private plans including health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high deductible insurance plans. Medicare+Choice evolved into what is now called Medicare Managed Care or Medicare Advantage (MA). This is Medicare Part C, which combines Part A (hospital coverage) and Part B (generally outpatient services). In December of 2003 the Medicare Modernization Act was passed, changing "Medicare+Choice" to "Medicare Advantage" and creating Medicare Part D, a voluntary prescription drug program for Medicare beneficiaries, which became effective January 2, 2006. Also, in January of 2009, the requirement mandating fraud, waste and abuse training for Medicare Part C and Part D providers became effective.

Federal regulations, 42 CFR § 422.503(b)(4)(vi)(C) and 42 § CFR 423.504(b)(4)(vi)(C) require that Medicare Advantage Organizations (MAOs) and Prescription Drug Plan (PDPs) provide fraud, waste and abuse annual training that must be completed by December 31st of each year. In order to fulfill this requirement and ensure consistency and reduce burden on providers, suppliers, contractors and organizations, the Centers for Medicare and Medicaid Services (CMS) has developed a comprehensive web-based training module that will satisfy the FWA training and education requirements. Presbyterian Health Plan is requiring that all providers complete the CMS training by December 31st of each year. Please follow the instructions below from CMS to access the training site:

Instructions for Accessing the FWA Medicare Learning Network® (MLN) Training Module

1. To take a web-based training course, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html?redirect=/MLNProducts on the CMS website.
2. Under "Related Links", at the bottom of the page, click on "Web-Based Training (WBT) Courses".
3. Click on Medicare Parts C and D Fraud, Waste and Abuse Training, not the icon next to it.
4. At the top of the Course Description Window, you will be able to click on either "Login" or "Register".
5. If you already have an MLN account, click "Login" and enter your User ID and Password.
6. If you do not have an MLN account, click "Register". You will be re-directed to a page with an e-mail address field stating "Please type

your E-mail address and press Submit". Enter an e-mail address and click "Submit". The next screen will read: "No account was found matching your search criteria. Please click here to proceed with registration". Click the word "Here" to continue with registration.
7. After logging in or completing the registration, you will be re-directed to your home page.
8. Click on the "Web-Based Training Courses" link.
9. Click the Medicare Parts C and D Fraud, Waste and Abuse Training title, not the icon next to it.
10. Scroll to the bottom of the page and click the "Please click here to access Provider Compliance Web Page" not the "Take Course" button.
11. You will be re-directed to the Provider Compliance Web Page.
12. Under "Downloads" click on Medicare Parts C and D Fraud, Waste and Abuse Training.
13. You will be asked whether you would like to "Open" or "Save the File". Choose which option you prefer.
14. After you unzip the file, you will see two versions of the same training slides – one in PDF format and the other in PPT format. Choose either version to access the training.
15. Once you have finished the training, go to slide 59 for a "Certificate of Completion" template that can be used to document course completion. If you choose to use this certificate, click on slide 59 in the PowerPoint format, clear the existing fields - "Type Your Name Here" and "Insert Today's Date" - and replace the contents with your name and the date that you completed the training.
16. Congratulations! You have successfully accessed the Medicare Parts C and D Fraud, Waste and Abuse Training!

Medicare Part C and Part D Program Standards
The specific Code of Federal Regulations related to Part C and Part D Standards are 42 CFR § 423.504. You may access these at the following Web link: www.gpoaccess.gov/fr/index.html.

Federal Register (FR) and the Code of Federal Regulation (CFR)
Published by the office of the Federal Register, National Archives and Records Administration (NARA), the Federal Register is the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as executive orders and other presidential documents. It is updated daily by 6 a.m. and is published Monday through Friday, except federal holidays.

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis.

Medicare Part C and Part D Fraud, Waste, and Abuse Guidance
The Prescription Drug Benefit Manual, Chapter 9 is the document that outlines the specific regulatory requirements for the administration of the Medicare Part D program. The information in this manual are found as final regulations in the Code of Federal Regulation.

The document provides guidelines for Part C and Part D plan sponsors on how to implement the regulatory requirements under 42 CFR §423.504(b)(4)(vi)(H) to have in place a comprehensive fraud and abuse plan to detect, correct and prevent fraud, waste and abuse as an element of the compliance plan.

The document applies to Health Plans and their "downstream entities" down to the level of ultimate provider of both health and administrative services.

In addition, CMS has decided that until fraud, waste and abuse regulations can be written specifically for Part C, the Part D regulations will apply. Since Part C and Part D often go hand in hand it makes sense that these requirements should be shared. The Prescription Drug Benefit Manual, Chapter 9 is available at:

https://www.cms.gov/Medicare/Prescription-Drug-

Coverage/PrescriptionDrugCovContra/PartDManuals.html

Government Initiatives

The agencies responsible for oversight are the Office of Inspector General (OIG), Department of Justice (DOJ), and The Centers for Medicare and Medicaid Services (CMS). Due to the identified risks surrounding the Medicare Advantage and Part D programs, CMS is responding with intense oversight and increased funding for the Department of Health and Human Services Office of Inspector General. Included in this oversight are additional fraud and abuse laws, audits and investigations including over 140 Assistant US Attorneys trained on health care fraud. CMS has contracted with the Medicare Drug Integrity Contractor or "MEDICS" in each region to assist in program oversight.

It is important to review and monitor activities within your practice to determine that your practice is free from potential fraud, waste, and abuse. Keep in mind that often, if left unchecked, waste and abuse can become fraud!

Federal False Claims Law

The Federal False Claims Law prohibits knowingly:

- Presenting to the government a false claim for payment
- Causing someone else (health plan or plan sponsor) to submit to the government a false claim for payment
- Making or using a false record or statement to get a claim paid by the government
- Conspiring to get a false claim paid by the government
- Making or using a false record to avoid or decrease an obligation to pay or reimburse the government

Penalties for submitting a false claim are:

- Fines up to $11,000 for each false claim
- Plus treble damages (3x) suffered by the government
- Trial costs
- Exclusion from Medicare & Medicaid
- The possibility that it can lead to criminal prosecution

For example: a false $100 claim submitted for payment with government funds would result in the following penalties:

- 1 False Claim = $11,000 penalty
- Treble damages = 3x$100 or $300

This now equals $11,300 in fines for the $100 claim. Add to that any trial costs and the potential to be excluded from participating in any government health plan.

What are Whistleblower Lawsuits ("Qui Tam"):

- Employee or private citizen sues on behalf of the government
- Plaintiff receives as much as 30% of the total award and the remainder goes to the government.

How are Whistleblowers Protected:

- Employers may not retaliate against employees who report or help investigate false claims
- No negative employment consequences such as being fired, demoted, suspended or harassed
- Remedies against retaliation include job reinstatement with double back pay and other "special" damages

Historically, most whistleblowers actually reported their concerns to someone in their workplace before they went to the government with the issue. Employees and private citizens can file suit on behalf of the government. That's why it's important to be open and listen to complaints when one of your staff or patients raises a concern. If you don't take appropriate action, they will. And they can receive as much as 30% of the total award, if the government's prosecution is successful.

New Mexico Medicaid False Claims Act (Dual Eligible)

The NM Medicaid False Claims Act (NMMFCA) signed into law in 2004 is applicable to Medicare beneficiaries who are also covered under the New Mexico Medicaid (dual eligible). The purpose of NMMFCA is to deter persons from causing or assisting to cause the state to pay Medicaid claims that are false and to provide remedies for obtaining treble damages and civil recoveries for the state.

The NMMFCA increases the states ability to bring a lawsuit for Medicaid fraud and recoup funds. New Mexico's Attorney General prosecutes Medicaid fraud.

The NMMFCA contains a whistleblower provision that provides incentives for people who come forward with knowledge and evidence of false claims submitted to Medicaid.

Whistleblowers may receive up to 25% of the amount recovered. Employee whistleblowers are entitled to all relief necessary to make the employee whole, including reinstatement, double the amount of back pay, and compensation for any special damages sustained.

Many states have their own False Claims Act, including New Mexico and Texas. Information on the New Mexico false claims act may be found at the following web link: www.taf.org/newmexicofca.htm.

Anti-Kickback Laws

Anti-kickback laws prohibit anyone from knowingly and deliberately offering, giving or receiving remuneration in exchange for referrals of health care goods or services that will be paid for in whole or in part by Medicare or Medicaid. In addition to criminal penalties, violators are subject to exclusion from participation in most federal healthcare programs including Medicare and Medicaid. Congress added to the law provisions that designate certain provider activities as "safe harbors" which are specified as not constituting violations of the statute.
Penalties include:

- Criminal: jail time, $25,000 fine, mandatory exclusion
- Civil: penalties & fines, permissive exclusion

The anti-kickback laws may be found at: oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm.

Anti-Kickback Safe Harbors

Safe harbors allow certain activities to take place that may appear on the surface to be violations of the law, but those activities are very restricted and must take place only when all of the safe harbor conditions are met.
There are many complicated exceptions ("Safe Harbors")

- Personal services contracts
- Payment based on fair market value of services, not value of referral
- Sale of practice
- Proper discounts and rebates

Examples

- Drug "switching" programs-if structured incorrectly
- Drug rebate programs-if structured incorrectly
- Pharmacy paid to "steer" patients to specific Part D plan

The Anti-Kickback Safe Harbors laws may be found at the following web link:
http://oig.hhs.gov/compliance/safe-harbor-regulations/index.asp

Self-Referral Laws

The physician self-referral law, commonly referred to as the "Stark Law," prohibits a physician from referring patients for certain "Designated Health Services" to an entity in which the physician (or an immediate family member of that physician) has an ownership interest or with which the physician (or an immediate family member of that physician) has any compensation or other relationship that involves remuneration or other benefit unless certain prescriptive requirements are met. If those requirements are not met, the entity may not bill for any Designated Health Service furnished pursuant to the prohibited referral. Examples of Designated Health Services are inpatient and outpatient hospital services, outpatient prescription drugs, home health services, DME equipment and supplies, and clinical laboratory services. The assumption underlying the statute is that allowing such referrals would lead to unnecessary tests and increase costs. The statute is violated regardless of whether the physician or the entity providing the Designated Health Service has any intent to or even knows that the referral is prohibited.
Penalties include:

- $15,000 fine per claim and possible exclusion
- Potential anti-kickback liability (if intentional violation)

Physician self referral laws may be found at the following web link: www.cms.hhs.gov/physicianselfreferral/

Beneficiary Inducement Civil Monetary Penalty Law

The Beneficiary Inducement Law prohibits providers from incentivizing a beneficiary who is enrolled in a government health care program to see a particular provider because it could encourage the overutilization of health care supplies and services. Violations of this law can result in substantial penalties.

Penalties include:

- Fines up to $10,000 per violation plus treble damages
- Potential exclusion from participation in government programs

Examples of Beneficiary inducement include the waiving of co-payments which:

- "May" if does not advertise waiver;
- "May" if does not routinely waive; AND
- "May" if waiver is based on a good faith assessment of the patient's financial needs

Information regarding the beneficiary inducement civil monetary penalty law may be found at the following web link: http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf

Program Exclusion Lists

The Federal Exclusion Law allows the Office of the Inspector General (OIG) to exclude individuals and organizations from participating in Medicare, Medicaid and other government programs. Reasons for exclusion include violating fraud and abuse laws, licensing board actions (e.g., suspended license), defaulting on federal student loans and controlled substances violations, as well as other crimes, etc.

Providers and subcontractors who participate in Medicare and Medicaid programs are required to verify that their employees are not on the following Federal Exclusion Lists (meaning the individual is prohibited from participating in Medicare and Medicaid funded services).

Physicians, non physician practitioners and employees must not be identified on the Office of Inspector General or General Services Administration (GSA) lists. You may log on to the following OIG/GSA websites listed to verify the eligibility of individuals:

Me**Department of Health and Human Services/ Office of Inspector General, List of Excluded Individuals/Entities (DHHS OIG LEIE)**

www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp
List is updated monthly

General Services Administration Excluded Party List

http://epls.gov/

Insurance companies (sponsors) will not pay for drugs prescribed or other services provided by a provider who is excluded by either the Office of Inspector General (OIG) or General Services Administration (GSA). Additionally, excluded providers may not contract with or perform services related to any government contract such as the Federal Employee Benefit Program, Medicare or Medicaid.

According to the OIG, pharmacies can't bill for "services performed by, prescribed by, processed by or involved in any way in filling prescriptions," individuals who are excluded from federal and state programs to Medicare beneficiaries.

The prohibition "also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to federal and state program beneficiaries."

You may not employ any individual who is listed as being excluded or debarred, so it is important to check the listings before hiring.

Not only will you not receive payment for services furnished by an excluded person but you will also face a fine of $10,000 for EACH item or service plus 3 times the amount of actual damages! This is another very good reason to check the listings on a regular basis.

Presbyterian requires that all contracted providers review all of their employees and contractors or vendors against the GSA and OIG lists at least twice each year. Providers should retain written or hard copy proof that this activity has been completed and is accessible during

an audit. In addition, providers should create a policy and procedure identifying the timeline for completion, the format and the handling of employees identified as excluded.

Medicare Part C and Part D Fraud, Waste and Abuse (FWA) Risks for Prescribing Provider

The following are examples of Part D FWA related to prescribing provider risk areas. These risk areas are targeted by CMS and are subject to audits:

- Illegal remuneration schemes: Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- Prescription drug switching: Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others
- Script mills: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- Provision of false information: Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services. Prescriber prescribes more medication per month than the patient requires, but verbally instructs the patient to take less than prescribed to save money.
- Theft of prescriber's DEA number or prescription pad: Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market. In the context of e-prescribing, includes the theft of the provider's authentication (log in) information.

Part C and Part D FWA Risks for Medicare Beneficiaries

These Medicare Beneficiary Part D FWA risks have been listed for your information. It is important to report any potential beneficiary FWA that may come to your attention.

- Misrepresentation of status
- Identity theft
- TrOOP (True Out of Pocket costs) manipulation
- Prescription forging or altering
- Prescription diversion and inappropriate use
- Resale of drugs on black market
- Prescription stockpiling
- Doctor shopping
- Improper coordination of benefits
- Marketing schemes

There are also risks associated with Part C, and these are the types of things that you might encounter with commercial insurance as well:

- Medical identity theft
- Billing for services that were never provided
- Unbundling of services
- Certifying medical necessity where it does not really exist.

Avoiding Waste

The following are methods used to avoid the waste of Medicare Part D dollars.

- Drug utilization review (DUR)
- Federal law requires states to establish DUR programs
- Prospective DUR programs review prescriptions before filled to prevent drug therapy problems and abuse
- Retrospective DUR review claims data after prescriptions have been filled to identify FWA
- Educational outreach to enhance provider knowledge

Tiered co-pays

- Tier 1 Preferred Generic
- Tier 2 Preferred Brand
- Tier 3 Non-preferred Generic and Brand
- Tier 4 Specialty drug

FWA Prevention

The OIG has a recommended compliance plan for individual providers/small groups that can be found at their web site at www.oig.hhs.gov. While this program

is a voluntary program, we highly recommend the adoption of your own Compliance Program which includes the following seven elements identified by OIG:

1. Implement written policies and procedures
2. Compliance officer and committee
3. Conduct effective training and education
4. Develop effective lines of communication
5. Conduct internal monitoring and auditing
6. Enforce standards through well-publicized disciplinary guidelines
7. Corrective Action

CMS Part C Appeals Process

One of the biggest issues that CMS has identified in the Medicare Part C and Part D programs are the appeals processes. The Part C appeals process has three levels with longer time frames than the Part D appeals process. The Part C appeals process levels are:

- 72 hours for an expedited appeal
- 30 days for a standard, pre-service appeal
- 60 days for a standard post service appeal.

Organizational Determination

- 72 hrs for an expedited appeal pre-service
- 14 calendar days for a standard appeal pre-service
- 30 calendar days for post services

Extensions

- 14 calendar days, if in the beneficiary's best interest

CMS Part D Appeals Process

The appeals process for obtaining prescriptions (Part D) is shorter than Part C due to the nature of the product and has only two request levels. It is important to be aware of these request levels and the timeframes associated with each level.

Re-determinations are expected to be completed within 72 hours if expedited or 7 days if standard. There are no extensions for Part D appeals. If the time frame for the standard or expedited appeals is missed, the appeal must be referred to an Independent Review Entity (IRE).

Two Request Levels

- 24 hours for an expedited appeal
- 72 hours for standard determinations

Re-determinations

- 72 hours "expedited"
- 7 days "standard"

No Extensions

- If time frame is missed, must be forwarded to an Independent Review Entity (IRE)

An appeal request may be made by the prescribing provider. A coverage determination, or initial decision, can also be requested by a beneficiary or by a beneficiary's appointed representative.

The prescribing provider may also request an expedited redetermination, which is a first level appeal, on behalf of a beneficiary.

However, a prescribing provider may not request a standard redetermination (first level of appeal) or reconsideration (second level of appeal) unless they are the appointed representative of the beneficiary.

The prescribing provider plays an important role in the exceptions process. When a beneficiary requests a formulary or tiering exception, the prescribing provider must provide the insurance plan with an oral or written statement in support of the exception request. The time frame for an exception request begins once the prescribing provider's supporting statement is received by the plan.

SIU Contact Information

As a practitioner or provider, you can assist us in this effort by letting us know about any suspicious activity, which appears to be potential fraud, waste and abuse. Contact telephone numbers are provided below. Please contact us to report suspicious activity:

The SIU Confidential Hotline phone numbers are:
(505) 923-5959 (local)
1-800-239-3147 (toll-free)
E-mail address: PHPFrau@phs.org

Or, you may file a Suspected Fraud and Abuse Report online at:
http://www.phs.org/phs/healthplans/info/fraudabuse/index.htm

Credentialing

Presbyterian credentials individual practitioners and organizational providers. The credentialing process focuses on verifying adequate training, experience, licensure, and competence, and assessing data and information collected, to determine if a practitioner/provider is qualified to render quality care to our members.

Credentialing Review Committee

The Presbyterian Credentialing Review Committee is a subcommittee of the Presbyterian Quality Improvement Committee and serves as a credentialing review body. Its purpose includes the following:

- To provide expertise about current credentialing practices in the medical and behavioral health community and to provide advice on modifying criteria, as appropriate.
- To maintain a review process for credentialing and recredentialing that allows Presbyterian to participate in the activities of national reporting entities such as the National Practitioner Data Bank.
- To evaluate and improve the quality of healthcare services rendered by health care practitioners and providers. To review the nature, quality or cost of health care services provided to enrollees or members of Presbyterian.
- To make recommendations to Presbyterian regarding whether individual health care practitioners/providers should be included in Presbyterian's Provider Panel to provide health care services to Presbyterian members, or whether the provider's/practitioner's membership on the Presbyterian Provider Panel should be limited, suspended or revoked.
- To provide input to the corrective action plan process and to review and make determinations on the appropriateness of the responses to requests for corrective action by individual providers or practitioners.
- To provide oversight for all delegated credentialing functions and entities.

Definitions

Practitioner: The National Committee for Quality Assurance (NCQA) defines practitioner as a professional who provides health care services.

Provider: The National Committee for Quality Assurance (NCQA) defines provider as an institution or organization that provides health care services for managed care organization (MCO) members.

Program Scope

The Presbyterian credentialing program applies to health care providers and practitioners that are contracted with Presbyterian to provide health care services to its members. The following contractual relationships require providers and practitioners to be credentialed prior to rendering services to Presbyterian Health Plan, Inc. members.

- Practitioners who have an independent relationship with Presbyterian. An independent relationship exists when Presbyterian selects and directs its members to see a specific practitioner, including all practitioners that members can select as primary care practitioners.
- Practitioners/providers who see members outside of the inpatient hospital setting or outside ambulatory freestanding facilities.
- Practitioners who are hospital-based but see Presbyterian members because of their independent relationship with Presbyterian.
- Dentists who provide care under Presbyterian's medical benefits.

Confidentiality

Presbyterian maintains the confidentiality of all information obtained about the practitioners/providers it credentials and recredentials, as required by state and federal law.

Right to Review

All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate credentialing staff. Practitioners may utilize any or all of the following to ensure accurate file information:

- The right of practitioners to review certain information submitted to support their credentialing application.
- The right of practitioners to correct erroneous information.
- The right of practitioners to be informed of the

status of their credentialing or recredentialing application upon request.
- The right of practitioners to be notified of these rights.

Delegation
Presbyterian may delegate to designated entities all or some of the credentialing responsibilities. The performance of the entity is monitored on an ongoing basis for compliance with Presbyterian's requirements and all applicable regulatory and accreditation standards. Presbyterian retains the right, based on quality issues, to approve, suspend and terminate individual practitioners/providers even in situations where it has delegated credentialing responsibilities.

Standard Eligibility Criteria—Practitioners
Practitioners must meet the following standard eligibility criteria that includes, but is not limited to:
- A current unrestricted license to practice within the state(s) where services are provided. Temporary licenses are not acceptable to fulfill this requirement for behavioral health or medical practitioners.
- Appropriate training within the area of practice.
- Absence of felony convictions.
- Provision of quality, appropriate, and timely care.
- Confirmation of the primary care practitioner's (PCP) ability to meet applicable required access and availability standards.
- No sanctions, suspensions, or terminations imposed by Medicare, Medicaid or other designated federal/regulatory bodies.
- When contracted to see Medicare or Medicaid patients, has not opted out of the Medicare or Medicaid program.
- Practitioners who serve Medicare members must be Medicare-approved.
- Valid Drug Enforcement Agency (DEA) certificate and applicable state pharmacy registration for controlled substances, if applicable.
- Current malpractice insurance coverage in the required amount (as described in greater detail later in this section)
- Acceptable malpractice history within the five-year period immediately preceding the date of application.
- Acceptable office practices and a safe office environment that requires a score of 90% on the initial site visit.
- Work history that reflects a consistent pattern of professional activity in good standing for the past five years.
- Absence of evidence that the applicant might be unable to perform the contracted duties.
- Absence of suspension, restriction, or termination of hospital privileges.
- National Provider Identifier (NPI)

Standard Eligibility Criteria—Organizational Providers
Organizational Providers must meet the following standardized criteria, which includes, but is not limited to:
- Current good standing with state and federal regulatory bodies and certified by the appropriate state certification agency, as applicable; and
- Has been reviewed and accredited by a recognized accrediting body; or
- If not approved by an accrediting body, meets Presbyterian Health Plan, Inc.'s standards of participation.
- Current applicable state license and/or certification.
- No sanctions, suspensions or terminations imposed by Medicare, Medicaid, other designated federal/regulatory bodies, or the State where services are rendered.
- When contracted to see Medicare or Medicaid patients, has not opted out of the Medicare or Medicaid program.
- Providers who serve Medicare members must be Medicare-approved.
- Current malpractice insurance coverage in the required amount (as described in greater detail later in this section)
- Acceptable malpractice history within the two-year period immediately preceding the date of application.
- Valid DEA Certificate and applicable state pharmacy registration for controlled substances, if applicable.

Malpractice Insurance Requirements
Practitioners and providers are required to maintain,

at their sole cost and expense and at all times, both comprehensive general liability insurance and professional liability insurance. This insurance must contain provisions and be written by companies reasonably acceptable to PHP/PIC (Presbyterian). Practitioners and providers must demonstrate compliance with this requirement by providing Presbyterian with certificates evidencing dates that this insurance is in effect, as well as amounts. Notwithstanding these guidelines, Presbyterian reserves the right, on a case by case basis, to require either higher or lower limits, or other terms and conditions depending upon circumstances or other facts that Presbyterian, in its sole discretion, deems necessary to meet its legal and regulatory obligations.

Currently, Presbyterian requires the following amounts of coverage:

New Mexico Practitioners/Providers:

- Qualified under the New Mexico Medical Malpractice Act – for the practitioners and providers that are qualified under the New Mexico Medical Malpractice Act, Presbyterian requires that the practitioner/provider maintain professional liability insurance in the amounts required by the Act, currently $200,000/each occurrence and $600,000/aggregrate.
- Practitioners and providers NOT qualified under the New Mexico Medical Malpractice Act – for those practitioners and providers that are NOT qualified under the New Mexico Medical Malpractice Act, Presbyterian requires that the practitioner or provider maintain professional liability insurance in the following amounts: $1 million/each occurrence and $3 million/aggregate.

Practitioners/Providers outside of New Mexico:
For those practitioners and providers located outside of New Mexico, we will accept insurance in the amounts and types required by the law of the jurisdiction in which the practitioner or provider is located, or in the absence of a legal requirement, the following amounts: $1 million/each occurrence and $3 million aggregate.

Site Visit

Site visits are included as part of the initial credentialing process for primary care practitioners, OB/GYN practitioners, and high volume behavioral health specialists. In addition to the initial site visit, a site visit will be conducted on any provider that receives two or more complaints within 12 months, regarding their office/practice.

Initial applicants who fail a site visit, will be notified that the credentialing process has been discontinued. The applicant may contact Presbyterian for information about how to improve their site and to restart the credentialing process once the deficiencies have been corrected.

Any provider that receives two or more complaints regarding their office/practice within 12 months will have a site visit scheduled immediately. Should the provider's office fail the site visit, they will be notified and the practitioner/provider must develop a corrective action plan within 30 days to address the deficiencies. A follow-up review will be conducted within six months to determine compliance. If the practitioner/provider fails to submit the corrective action plan within the specified time frame, it is considered a breach of contract and may result in termination from the network.

Ongoing Monitoring
The Office of Inspector General (OIG) Exclusion Program databases, as well as applicable state licensing agencies, are monitored monthly for sanctions or licensure limitations. The Medicare Opt-out website is also checked monthly to ensure that practitioners/providers contracted for Medicare Advantage organizations have not opted out of Medicare.

Investigations are conducted on all quality of care and service complaints. For quality of clinical care complaints, appropriate clinical staff, including Presbyterian Health Plan, Inc. Medical Directors, are consulted in conjunction with the review of the complaint, and may include a review of relevant medical records. Upon completion of the initial investigation, the findings may be reported to the appropriate Medical Director(s), the Credentialing/Peer Review Committee, the Provider Services Director and/or the Legal

Department, depending on the nature of the findings.

Corrective action plans are developed in situations where there is an identified need for improvement in quality of care or service. Presbyterian offers a formal appeal process and reports the action as appropriate whenever a practitioner or provider is terminated or suspended for quality of care concerns.

Fair Hearing
In the course of the credentialing decision making process, applicants are given the opportunity to provide additional information that may address concerns raised by the Credentialing Review Committee that may lead to denial of the application.

Initial applicants who have been denied membership to Presbyterian's panel are not afforded Presbyterian's Fair Hearing Process and may not reapply for at least two years following the date of the denial. At that time, a detailed explanation must be provided by the applicant that fully demonstrates that the Credentialing Review Committee's initial concerns have been satisfactorily addressed.

Practitioners and providers that are denied membership at recredentialing time or are terminated for cause, have the right to appeal the decision through the Fair Hearing Process.

Credentialing and Recredentialing Processes
Listed below is information related to these processes:

- Ensure that all information on the application is complete and correct. Any unexplained gaps, missing information or incomplete information will delay the application processing
- Include the beginning and ending month and year for each work experience under work history and explain any gaps exceeding six months
- Include a written explanation for any "yes" answer to the Professional Practice Questions. If office staff completes the application, ensure that the answers are correct
- Ensure that all required documents are submitted with the completed and signed application
- Practitioners can obtain an application at any time by contacting their Provider Services Coordinator or Credentialing Coordinator at the health plan. They may also go to www.phs.org or www.nmhsc.com and either print out an application or complete an online application. If you fill out an application, Hospital Services Corporation (HSC) will not start the verification process until a request is made from Presbyterian Health Plan, Inc. It is important to notify your Provider Services Coordinator that you would like to become an in-network provider. A "Letter of Intent" can be accessed online at http://www.phs.org/phs/healthplans/info/join/index.htm
- Organizational providers will receive their application packet in the mail directly from Presbyterian Health Plan, Inc.
- Ensure timely completion of the application. After three requests for an application with no response, HSC places the application request on hold. For recredentialing applications, the practitioner/provider is at risk for termination

Practitioners should submit the completed application and all required documents to:

Hospital Services Corporation (HSC)
P.O. Box 92200
Albuquerque, NM 87199-2200
https://www.nmhsc.com/cvsapp/logon.aspx

Organizational providers should submit the completed application and all required documents to:

Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc.
Provider Services Credentialing Department
P. O. Box 27489
Albuquerque, NM 87125-7489

e-Business

Presbyterian defines e-Business as any tool or resource that allows information to be stored, displayed or transmitted electronically. We strive to offer online resources that save time, energy, and provide our network with improved efficiency resulting from immediate access to current and accurate information. Following is a list of current and planned e-Business tools available to our network:

- **Pres Online**: A password-protected portal (website) that allows your office to access a variety of Presbyterian resources, as well as member, benefit and claim information.
- **Interactive Voice Response System**: This system complements Pres Online by providing you access to member eligibility, copayment and primary care practitioner information over the phone.
- **Electronic Claims Transmission**: Save time and money by sending your claims electronically to Presbyterian through one of our five contracted clearinghouses. A list of these clearinghouses can be found later in this section.
- **Electronic Data Interchange Remittance Advice** EDI-RA will enable you to receive electronic explanation of payments (EOP). Presbyterian is currently developing this resource; its expected availability date is the fourth quarter of 2012.
- **Electronic Funds Transfer:** EFT will enable you to receive direct deposit of payments into the provider's specified banking account. Presbyterian is currently developing this resource; its expected availability date is the fourth quarter of 2012.
- **HealthXnet**: A third party vendor of Presbyterian that provides you with access to a variety of information and functions over the Internet related to eligibility verification.
- **Online Provider Directory**: For the convenience of you and your patients, Presbyterian has improved its online provider directory by including information about our network of primary care practitioners, specialists and other providers.
- **ePocrates**: A web platform that allows the user to access current Presbyterian formulary information.
- **The Provider Web Page**: The Presbyterian Health Plan practitioner and provider web page includes recent communicatins, benefit and criteria information, appeals and grievances, online submissions and the online provider directory.

HIPAA Regulations and e-Business

Claims status, member eligibility and benefit and pharmacy certification requests are some of the transactions covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations. Conducting these transactions via the Internet qualifies as conducting these transactions "electronically" according to HIPAA, and may therefore cause you to qualify as a covered entity subject to the HIPAA regulations.

If you are not already considered a covered entity under the HIPAA regulations, you may want to consider carefully before initiating these transactions over the web. Any practitioner or provider that wants to determine whether they are a covered entity under HIPAA can use the CMS tool at the following link: http://www.cms.hhs.gov/HIPAAGenInfo/.

Pres Online

It is our goal to make Pres Online your first choice when accessing information from Presbyterian. This web platform provides you with free online access to current claims status, member eligibility and benefit certification information and much more. Pres Online also enables you to submit online certification requests and provides the ability to email the Provider CARE Unit via the web for more complex issues that require research.

In direct response to network feedback, Pres Online now has the capability to auto review the following benefit certification requests for participating practitioners:

- Specialized Blood Glucose Monitors

- Bone Growth Stimulators
- Breast Pumps
- Durable Medical Equipment (DME), with the exception of specialized equipment including wheelchairs and rehabilitation devices
- Foot orthotics
- Gynecomastia Surgery - Male
- PET Scans
- Reduction Mammoplasty - Female
- Meniscal Transplants
- Breast Repair and Reconstruction for Breast Cancer
- Surgery for Gynecomastia
- Arthrolereisis Subtalar
- Speech Therapy (evaluation)

How do I get a Pres Online User ID and password?
Obtain a User ID and password by entering the link below into the Internet address bar:
http://www.phs.org/phs/healthplans/content/ProviderAccesstoPresOnline/index.htm.
You can also follow the steps below:

- Go to www.phs.org
- Click "Health Plans" at the top of the web page
- Click "For Providers" on the left side of the web page
- Click "Request access to Pres Online" located under Other Online Provider Resources on the right side of the web page

This allows you to request User IDs and passwords for multiple users. Fill out the application and click the submit button at the end of the application. Remember that your User ID and password are case-sensitive and the correct case must be used when logging in to the application.

Each employee in your office that utilizes Pres Online must have their own individual user ID and password. Under no circumstances should the Pres Online user ID and password be shared. It is your responsibility to contact the Presbyterian Customer Service Center (PCSC) to terminate access of employees who are no longer employed by your office. If you have any employee who no longer requires access to Pres Online, please contact the PCSC to terminate their access.

How do I access Pres Online?
If you are reading this manual on your computer, simply move your mouse over the link below and click. If you are reading a hard copy manual, just type the address below in the address bar of your Internet browser.

Locate the Pres Online log-in box on the right side of our website and enter your User ID and password to log on to Pres Online.
http://www.phs.org/phs/index.htm.

If you have problems locating or completing the enrollment form, you may contact the Presbyterian Provider E-Help Desk by:

- Phone at (505) 923-5590 or toll-free at 1-866-861-7444, Monday – Friday from 8 a.m. to 5 p.m. (MST)
- Email: ehelpdesk@phs.org

What if I forget my Pres Online User ID or Password?
User IDs and passwords are easily reset online. When at the log in screen, simply click on "Forgot / Reset Password" or "Forgot User ID." Then follow the easy steps to get your User ID or password reset. Should this fail to work, please contact the E-Help desk at ehelpdesk@phs.org or (505) 923-5590, 1-(866)-861-7444 for further assistance.

What computer and software requirements does Pres Online require?
In order to take full advantage of Pres Online's capabilities you will need:

- A PC or Macintosh computer that is capable of running either Internet Explorer 5.5 (or higher) or Netscape Navigator 6.2
- Macromedia Flash Player
- An Internet Service Provider (ISP) connection

What should I do if I receive an error message when logging in, stating that I have an incompatible or unsupported browser?
You may have to download a browser that is compatible with Pres Online. Contact the Presbyterian E-Help Desk if you need assistance with the download.

e-Business

What does it cost to use Pres Online?
Pres Online is provided free of charge because we want to make doing business with us easier. Your only costs are the computer and the ISP connection.

What benefits should I expect from Pres Online?
All Pres Online users will save time and energy, and receive improved efficiency as a result of this immediate access to information. Practitioners and providers will give their patients better service through improved speed and accuracy at all levels of service, from the time the patient makes an appointment to the time you receive payment. You can access member eligibility, member benefit plan information, claims status, and submit benefit certification/prior authorization requests as well as check their status with a simple mouse click.

When can I access Pres Online?
Pres Online offers continuous availability 24 hours a day, seven days a week, including holidays. As with any Internet platform, problems with availability may arise due to heavy Internet traffic.

How current is the information I see on Pres Online?
The information available through Pres Online is updated in real-time and is connected to our claims processing system.

Who do I contact if I disagree with the information I see in Pres Online?
Please direct these types of issues to the Provider CARE Unit by Web form (e-mail) located at: https://secure.phs.org/PHS/Contact/Forms/Providers/index.htm. For questions concerning benefit certification/prior authorization information, please call the Provider Line at (505) 923-5757 or 1-888-923-5757, and select the Health Services option from the menu.

What type of Pres Online support or training can I expect for my office staff?
Online help is available at the touch of a button once you are in the application and the Presbyterian E-Help Desk provides phone support Monday through Friday, 8 a.m. to 5 p.m. The Provider Network Management department is also available to assist you.

Interactive Voice Response System
Our Interactive Voice Response (IVR) System complements Pres Online and allows you to check member eligibility as well as obtain copayment and primary care practitioner (PCP) information over the telephone. You may access the IVR system by calling (505) 923-5757 or 1-888-923-5757 and choosing option one. Transactions done through the IVR system are not covered under the HIPAA regulations. Use of the IVR system does not qualify practitioners and providers as conducting HIPAA electronic transactions and use of the IVR system does not qualify practitioners and providers as covered practitioners and providers subject to HIPAA regulations.

Electronic Claims Transmission
If your office is not currently filing claims electronically, we encourage you to take advantage of Presbyterian's Electronic Claims Transmission (ECT) system and capitalize on the time and savings realized from a paperless system. If you would like to submit electronic claims directly to PHP, we now offer our Fast Claim direct entry portal. Fast Claim is designed to accommodate lower volume claim submitting practices that would like to submit claims electronically directly to PHP at no cost. If you are interested in learning more about ECT or Fast Claim, please contact the Provider Network Management e-Business Analyst at (505)923-8726. A list of clearinghouses is also available at the end of this section.

Electronic Data Interface Remittance Advice
For practitioners and providers utilizing the Electronic Claims Transmission system, you may be eligible to also take advantage of Electronic Data Interface Remittance Advice (EDI-RA). If your office chooses to use EDI-RA, you will receive Explanation of Payment (EOP) data and payment funds faster because EOP data is sent electronically to your office and payment funds are directly deposited to your bank account. If you are currently submitting claims electronically and are interested in using EDI-RA, please contact your Provider Network Management Coordinator to check availability.

e-Business

HealthXnet

HealthXnet allows you to check member eligibility, claims and benefit certification status as well as submit claims online. For more information, visit HealthXnet on the Internet at www.healthxnet.com or contact them by phone, fax or email as follows for User Administration and Help Desk (Log-on ID, Password and Technical assistance):

- Local: (505) 346-0290
- Toll Free: 1-866-676-0290
- Fax: (505) 346-0278
- Email: healthxnet@nmhsc.com

ePocrates

Presbyterian is the first New Mexico health plan to integrate its Commercial, New Mexico Medicaid Managed Care and Medicare Advantage formularies with the ePocrates Rx drug reference information for you to access on your handheld device. This free service offers you a convenient way to access current formulary information whenever and wherever you need it. With ePocrates Rx, you can use your handheld device to quickly determine which drugs Presbyterian covers before you write a prescription. As a result, you can prescribe more efficiently while continuing to provide quality care for your patients.

Making Prescribing Easier

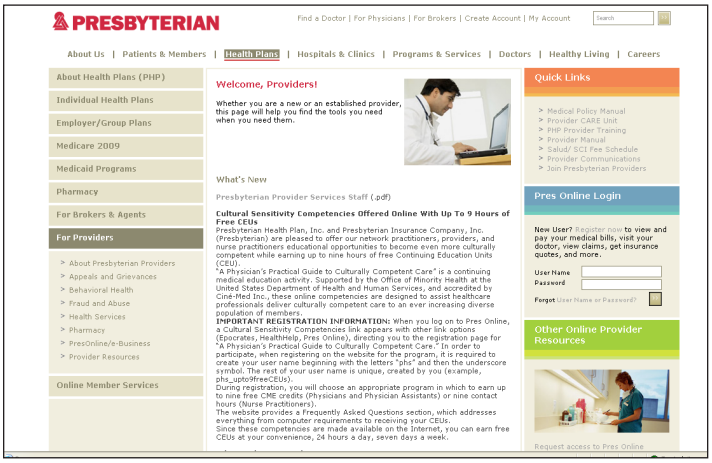
The ePocrates Rx software also provides you with information about adult and pediatric dosing, drug interactions, adverse reactions, contraindications, tables and regimens on more than 3,300 of the most commonly prescribed medications. ePocrates updates their references at least weekly. With this information at your fingertips, you can help your patients avoid complications that could result from inappropriate drug combinations. This tool will also have your patients leaving your office knowing the coverage status for their prescriptions, eliminating problems for them at the pharmacy.

Sign-up for this Free Service

Presbyterian's partnership with ePocrates is just another way Presbyterian makes it easier for you to focus on patient care. To use ePocrates Rx you need a Palm or Pocket PC handheld device, a Windows PC and an Internet connection of any speed. Visit the ePocrates Web page at www.epocrates.com to obtain specific device and system requirements and to download the free clinical and formulary application.

If you already have the ePocrates Rx or ePocrates ID software, you can easily add the Presbyterian formularies to your handheld device. Simply visit the ePocrates web page, click on "Add Formularies" at the top of the page and follow the displayed instructions.

Provider Network Management Web Page



Visit the provider page at http://www.phs.org/phs/healthplans/providers/index.htm to access useful information, documents and forms, as well as to send online requests to Presbyterian.

To access the provider page:

- Go to www.phs.org
- Select Health Plans from the top of the screen
- Click on For Providers on the left side of the screen

Medical Policy Information

Presbyterian's Medical Policy Committee (MPC) has the responsibility of creating, revising, interpreting, and disseminating benefit information in a uniform and organized manner for use by Presbyterian employees and service partners. As part of this process, the MPC has created the Medical Policy Manual to assist in administering plan benefits. The Medical Policy Manual is available on the Presbyterian website and is updated when new or revised pages are approved by the MPC and/or the Clinical Quality Committee.

e-Business

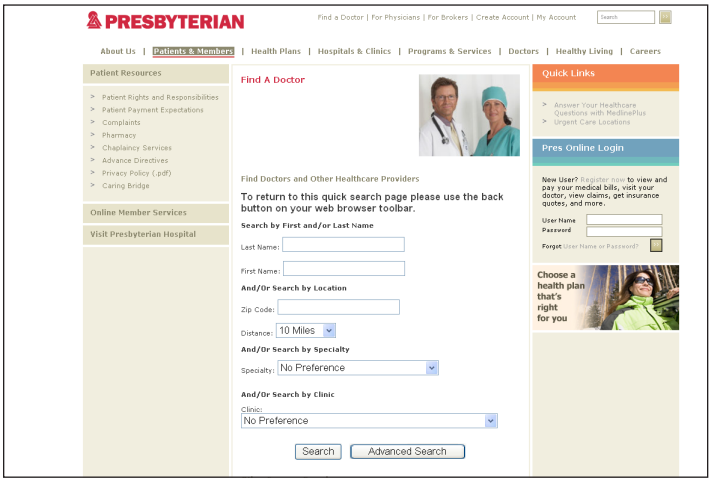
Not every Presbyterian plan contains the same benefits; therefore, the member's contract must be reviewed before using the Medical Policy Manual, to determine if a specific benefit is available to a member. Information contained in the Medical Policy Manual does not replace the member's Group Subscriber Agreement (GSA), Summary Plan Description (SPD), or Evidence of Coverage (EOC). To access the Medical Policy Manual, visit: http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm.

Appeals and Grievances

Presbyterian has implemented a very comprehensive process, in conjunction with our regulatory agencies, to ensure that our members and providers have a simple method to exercise their appeal and grievance rights. In order to make this process as simple and effective as possible, you are able to file an appeal or report a grievance by using our website. Should you wish to file an appeal or report a grievance, you may do so online at: http://www.phs.org/phs/healthplans/providers/appeals/index.htm. Click on "File an Appeal or Grievance online" link. If you are interested in learning more about Appeals and Grievances, please refer to the Appeals and Grievances section of this manual.

In order to file an appeal or grievance on behalf of a member, you must have the written consent of the member.

Online Provider Directory



For the convenience of you and your patients, Presbyterian has improved its online provider directory by providing information about our network of primary care practitioners, specialists and other providers. You may search for practitioners by specialty, gender, zip code and more. Simply visit www.phs.org and click on Find a Doctor at the top of the page.

Clearinghouse Contact Information

Clearinghouse	Contact Information
Availity P. O. Box 550857 Jacksonville, Florida 32255-0857	1-800-AVAILITY (282-4548) Website: www.availity.com
MedAssets 100 North Point Center East, Suite 200 Alpharetta, GA 30022	Main Office: (678) 323-2500 Product Information: 1-888-883-6332 Tech Support: 1-866-658-1629 www.MedAssets.com e-mail: solutions@medassets.com
HealthXnet 7471 Pan American Freeway NE Albuquerque, NM 87109	1-866-676-0290 (505) 346-0290 Website: www.healthxnet.com
Emdeon Corporate Office 3055 Lebanon Pike Nashville, TN 37214	1-877-469-3263, Option 2 (615) 932-3000 Website: www.emdeon.com
ClaimMD P.O. Box 1177 Pecos, NM 87552	(505) 757-6060 www.Claim.MD.com

Claims

Presbyterian's Claims Department ensures that claims submitted by our practitioners and providers are processed accurately and in a timely manner. The primary reimbursement tools used in this process are:

- The application of correct coding guidelines in accordance with the standards set by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA)
- Individual practitioner or provider contractual arrangements
- The application of specific member benefits

The requirements in this section of the Practitioner and Provider Manual can help you ensure that your claims are submitted correctly.

Requirements for the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as we understand them today, are included. Periodic updates will be sent to your office as necessary throughout the year.

You are required to submit claims for all services rendered, whether they are capitated or fee-for-service. If you require assistance with your claim submissions, please contact your Provider Network Management Relationship Executive, who can arrange for helpful technical assistance and training sessions.

Electronic Claims Transmission (ECT)
Electronic claims are claims that are transmitted electronically to Presbyterian using a clearinghouse or Web application. Presbyterian highly recommends that you take advantage of the electronic claims transmission process. Since October 16, 2003, electronically transmitted claims must meet the HIPAA Transaction Standards with regard to format and content. Corrected claims should not be submitted electronically.

Benefits of Filing Electronically
Presbyterian processes electronically submitted claims faster than hard copy claims. Electronic submission saves you postage, paper, and provides you with the following:

- Quicker confirmation of claims receipt and integrity of the data
- Higher percentage of claims accuracy, resulting in faster payment
- Formatting of claims data into the HIPAA required ANSI-X12 837 claims format

The service is typically free for claims submitted to Presbyterian.

Requirements
If you are a participating Presbyterian practitioner or provider authorized to provide services for our members, you will need:

- A computer system upon which your Practice Management Software resides. Check with your clearinghouse technical representative for PC/Macintosh compatibility information
- Check with your clearinghouse technical representative to determine if your billing system can produce the data required by the HIPAA compliant claim format (ANSI X12 837 version 4010)
- A modem or Internet connection

Two important aspects of Presbyterian's relationship with the clearinghouses are compliance and data protection. New Mexico legislation enacted during 2001 requires stringent approaches to protecting both personal health information and personal financial information. HIPAA legislation requires even more exacting procedures and processes to ensure data is protected. Presbyterian and those clearinghouses with which we are contracted, work together to ensure that all data is appropriately protected as it moves through the electronic environment needed to foster rapid and accurate payment.

How to Begin Filing Electronically
You may begin filing electronically by calling one or several of the clearinghouses listed at the end of this section. Presbyterian has contracted with these companies to provide you with the software that will enable you to transmit claims electronically. All of these companies are endorsed by Presbyterian and they will help you get started and provide timely and accurate processing of your claims.

The clearinghouse will ask you some questions, will

more than likely send you an informational packet, and may ask you to fill out and send in a questionnaire to help determine your needs. You may compare the services available through each clearinghouse. The service is free for claims submitted to Presbyterian.. There may be additional services the clearinghouse can provide at an additional cost to your office, including the submittal of claims to other payors. The clearinghouse will evaluate your system, set up a test and instruct you in the use of their system. You should be up and running quickly, barring any major problems.

You do not need to notify Presbyterian to start billing electronically. However, you do need your Presbyterian assigned provider number and you must have a National Provider Identifier (NPI). You must also provide your tax identification number to submit an electronic claim. If you have special concerns or billing issues, you should first contact your Provider Network Management Relationship Executive for advice. Presbyterian will not pay claims for which an NPI is NOT submitted. More information regarding NPI is discussed later in this section.

You will receive either an acceptance or rejection report from the clearinghouse within one (1) day of submission. Claims listed on the acceptance report are transmitted to Presbyterian. You will then receive either an acceptance or rejection report from Presbyterian via the clearinghouse.

If You Encounter Problems

If. . .	Then . . .
An electronic claim is rejected by the clearing-house as "unclean"	Call the clearinghouse within 48 hours of receipt of the rejection report
An electronic claim is accepted by Presbyterian but does not show as paid in your system	Check the claim status online or contact the Provider CARE Unit via their online Web form within 30 days from the date of service
A claim is rejected by Presbyterian with an error message that you don't understand	Contact your clearing-house or your Provider Network Management Relationship Executive within 48 hours of receipt of the rejection report for the needed information so that you can submit your claim
You consistently submit claims that are not showing in Presbyterian's claims system and that are not recorded on your error reports that you received from your clearing-house and Presbyterian	Contact your Provider Network Management Relationship Executive and discuss the issue within 30 – 45 days of the date of service. immediately/48 hours. If the issue is determined to be a technical problem, your Provider Network Management Relationship Executive will coordinate contact with Presbyterian's Information Services Department. It is important to check on a regular basis to ensure that the claim(s) will not deny for lack of timely filing. Also, please make sure that you keep detailed records regarding this activity

Paper Claims Submission Process

Paper claims are printed on a form and mailed to Presbyterian. Presbyterian requires all practitioners and providers to use one of two forms when billing hard copy paper claims, the CMS 1500 (08-05) or the UB-04.

A full itemization is required for all claims with billed amounts of $100,000.00 or greater. Payment may be delayed if an itemization is not submitted.

CMS 1500

The CMS 1500 billing form is used when submitting

claims for all professional services, including ancillary services and professional services billed by a hospital. The CMS 1500 (08-05) was available to providers as of October 1, 2006 and is the only acceptable version of this form.

UB-04
The UB-04 billing form is used when submitting claims for hospital inpatient and outpatient services, dialysis services, nursing home room and board, and hospice services.

National Provider Identifier (NPI)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all healthcare providers acquire a National Provider Identifier (NPI). Providers may only use their NPIs to identify themselves in standard transactions where the NPI is called for. In order to properly adjudicate and correctly direct reimbursement, all fields containing practitioner information as identified above require an NPI. All providers, with the exception of sole practitioners, must acquire and submit the appropriate Type 2, organization NPI (e.g. physician group practices, hospitals, DME suppliers, etc.) in the appropriate field indicated above. Additional information on Type 1 and Type 2 NPI is available at https://nppes.cms.hhs.gov/.

A provider that does not have an NPI will not be able to:
- Submit claims for payment
- Receive payments from a Health Plan
- Access information from a Health Plan

You can apply for an NPI online at https://nppes.cms.hhs.gov

Interim Billing Process
Interim billing is to be used when a patient is confined in a facility for an extended period of time.
- Interim billings should be submitted on a monthly basis

Presbyterian encourages the submission of these monthly billings within 45 days of the beginning of the period for which you are billing. This will enable Presbyterian to identify any members that may need additional care coordination services.

Submitting Late Charges (only acceptable as paper claims)
Late charges can be billed on UB-04 billing forms only, and must be submitted as a paper claim. CMS 1500 forms can only be used for the submission of late charges for facility services from Ambulatory Surgical Centers.

On UB-04 billing forms, the bill type (field 4) must end with a "5" except for late charges for inpatient services. Late charges for inpatient services must be submitted as a replacement claim with a bill type ending with "7."

Do not include the original charges when billing late charges. If the original charges must accompany late charges:
- Clearly indicate that the claim contains late billing charges
- Do not lump late charges together with the original charges, ensure that the late charges are easily identifiable or easy to identify to avoid a duplicate payment
- Specify the original date(s) of service
- Late charges must be submitted within twelve (12) months of the date of service.

Submitting Unlisted/Unclassified Codes
An unlisted/unclassified CPT or HCPCS code may be billed if no other appropriate code exists or a code has not been assigned. If a CPT/HCPCS code exists for a service or procedure you are performing, you must use the correct code and not the unlisted/unclassified procedure code. This includes both CPT and HCPCS Level II (alpha numeric) codes.

Unlisted/unclassified CPT/HCPCS codes can be accepted in the electronic 837 claim format. Information may be entered as a service line or claim level note. However, Presbyterian may require written documentation with the operative/office report and/or the invoice which will be routed for manual review and pricing of covered services.

Guidelines for Submitting Hemoglobin A1c Claims and Test Results

Presbyterian requires the reporting of the actual result of Hemoglobin; glycated, A1c tests (CPT code 83036) so that we will have an accurate assessment of the degree of control of the Presbyterian diabetic member's blood glucose. This will help Presbyterian in developing or maintaining diabetes related Quality Improvement Programs.

When submitting charges for the A1c test, please follow these guidelines:

- Report the test result as a three-digit number with no decimal point and a leading zero. For example: A test result of 5.8 will be entered as 058
- Presbyterian will edit for valid values between 3.0 and 20.0 (030 and 200). If the result is not within this range, the test is invalid
- For UB-04 claims, the test date is the service date (form locator 45, SERVICE DATE). If a service date is not entered, the test date is the From date (form locator 6, STATEMENT COVERS PERIOD)

The following information outlines where the A1c test results need to be reported in the 837 professional and institutional electronic claim transactions. This information should be provided to your software vendors in order to properly configure your electronic claims submission software.

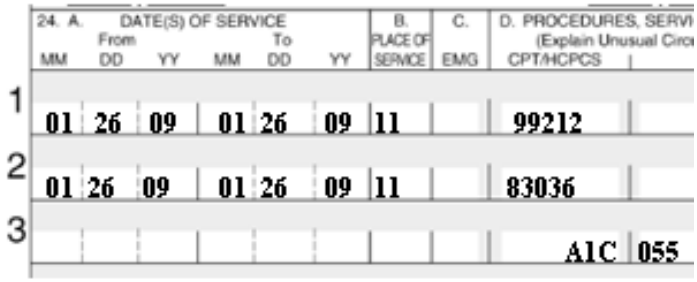
Requirement for 837 Professional	This information pertains to claims submitted by Practitioners and Providers to the Clearinghouse in the 837 Professional formats. • Place the A1C data in the NTE02 segment of the 2400 loop with the code qualifier of ADD. • The data format is: • A1C nnn ccyymmdd - nnn is the test result and ccyymmdd is the date of the test • Example: A1C 055 20041028
Requirement for 837 Institutional excluding Availity	This information pertains to claims submitted by Providers to the Clearinghouse in the 837 Institutional format excluding Availity. • Place the A1C data in the PWK07 segment of the 2300 loop with the code qualifier of OZ and PWK02 of AA. • One test result per PWK segment, which can occur up to 10 times • The data format is: A1C nnn ccyymmdd - nnn is the test result and ccyymmdd is the date of the test Example: A1C 055 20041028

Requirement for 837 Institutional for Availity	This information pertains to claims submitted by Providers to Availity in the 837 Institutional formats. • Place the A1C data in the PWK07 segment of the 2300 loop with the code qualifier of OZ and PWK02 of AA. • Up to 4 test results per PWK segment, which can occur once • The data format is: • A1C nnn ccyym-mdd - nnn is the test result and ccyymmdd is the date of the test • Examples: A1C 055 20041028 A1C 042 20041029

For Paper Claims

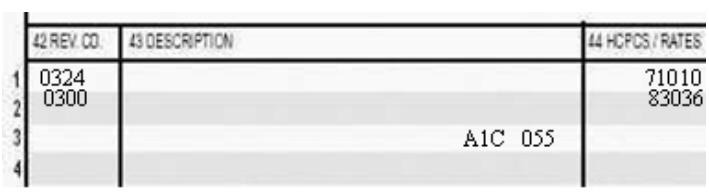
Below are examples of how the A1c test results will need to be reported on paper claims for both a CMS 1500 and a UB-04 form.

For CMS 1500 Paper Claims



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVI (Explain Unusual Circ CPT/HCPCS
1	01	26	09	01	26	09	11		99212
2	01	26	09	01	26	09	11		83036
3									A1C 055

For UB-04 Paper Claims



	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES
1	0324		71010
2	0300		83036
3		A1C 055	
4			

Guidelines for Submitting Immunization Claims

Claims data plays a vital role in helping Presbyterian improve the health of the patients, members and communities we serve. Presbyterian uses the vaccine information gathered from claims data to meet the reporting requirements of immunization registries, vaccine distribution programs and regulatory agencies.

The health plan also participates in the New Mexico Department of Health (NMDOH) Vaccines for Children (VFC) program. This program includes children from birth through age 18 who are NOT eligible for Medicaid and have health insurance coverage with Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. Presbyterian reimburses the NMDOH for vaccines furnished to the providers at no cost.

In order to capture the vaccine data, we ask that for both electronic and paper claims, you use the code for the exact vaccine administered and enter zero for the billed charge.

The immunization administration codes 90471 and 90472 MUST be used in addition to the vaccine code as follows:

- 90471 is used for the first immunization administration (includes percuatneous, intradermal, subcutaneous, intramuscular and oral; one vaccine (single or combination vaccine/toxoid) and is entered as one (1) unit charge.
- 90472 is used as an add-on code, meaning that it is listed separately for all additional vaccine administrations (single or combination vaccines) administered. Billing of multiple vaccine administrations is represented by unit increases rather than repeating 90472 on your claim.

National Drug Code (NDC) Information

Presbyterian requires ALL practitioners and providers to supply the 11-digit NDC when billing for injectables, infusibles and other pharmaceuticals paid under the medical benefit.

Understanding the National Drug Code

The NDC is found on the label of a prescription drug item and must be included on paper and electronic claim transactions. The NDC is a universal number that identifies a drug or related drug item. The complete NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format such as "12345-1234-12."

However, sometimes the NDC as printed on a drug item omits a leading zero in one of the segments, requiring a leading zero to be entered on the claim form and the hyphens to not be used. Instead of the digits and hyphens being in a 5-4-2 format, the NDC may be indicated in a 4-4-1 as in "1234-1234-1", or in a 5-3-2 format as in "12345-123-12", or less commonly in a 5-4-1 format as in 12345-1234-1."
A leading zero must be added to make the 5-4-2 format. See the following examples:

- NDC 12345-1234-12 is complete – it is reported as 12345123412.
- NDC 1234-1234-12 needs a leading zero in the first segment to be in the 5-4-2 digit format, to become 01234-1234-12 – it is reported as 01234123412.
- NDC 12345-234-12 needs a leading zero in the second segment to be in the 5-4-2 digit format, to become 12345-0234-12 – it is reported as 12345023412.
- NDC 12345-1234-1 needs a leading zero in the third segment to be in the 5-4-2 digit format, to become 12345-1234-01 – it is reported as 12344512301.

Presbyterian will reject claims with a date of service on or after January 1, 2011 that do not indicate a valid NDC for the following HCPCS or CPT codes:

- Codes in the range J0120 - J9999 (various injections and chemotherapy).
- Codes in the range S0012 - S0197 and S4990 - S5014 (various items).
- Codes in the range S5550 - S5571 (insulin injections).
- Codes in the range 90281 – 90399 (immune globulins).

The same requirement applies to providers billing revenue codes for facility claims. HCPCS or CPT codes are required whenever the provider bills one of the following revenue codes and the claim is an outpatient hospital, emergency room facility, dialysis facility, other outpatient facility which submits a facility claim. When the reported HCPCS or CPT code is one of the above, the NDC code must also be reported for:

- Pharmacy revenue codes 0250, 0251, 0252, and 0254.
- Pharmacy revenue codes 0631, 0632, 0633, 0634, 0635, and 0636.

For complete instructions on where the NDC information is to be supplied for a CMS-1500, a UB04, or 837 transactions, please use the following link: http://www.hsd.state.nm.us/mad/registers/2010.html. This information will be found under the header "Supplements" and it is Supplement Number 10-03.

Additionally, you may view the NDC Procedure Manual by accessing the following link: http://www.phs.org/PHS/healthplans/providers/index.htm.

Submitting Claims for Women's Care Services (Presbyterian Salud)
Billing Guidelines for Obstetrical Services
Global maternity billing (by covered practitioners or providers; for example, primary care obstetricians and specialists):

If the delivery of the newborn is greater than three (3) months past the mother's eligibility date, Presbyterian Salud will pay the global fee.

If the delivery is within three (3) months of the mother's eligibility, a breakdown of services (prenatal visits, delivery, and postpartum visits) from the first day of eligibility is needed from the practitioner or provider.

The following procedure must be followed when submitting fragmented, non-global OB delivery claims to Presbyterian Salud:

- Use generic Evaluation and Management (E/M) or OB visit codes to report prenatal visits
- The beginning date of service is equal to the initial prenatal visit
- The number of units equals the total number of

prenatal visits
- The appropriate charge should be entered into the charge column

Pregnancy Termination

Coverage for pregnancy termination includes psychological counseling. Voluntary, informed consent by an adult or emancipated minor recipient must be given to the practitioner or provider prior to the procedure to terminate pregnancy, except:
- In a medical emergency
- Recipient is unconscious, incapacitated, or otherwise incapable of giving consent
- If pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the recipient

Informed written consent for a minor who is not emancipated to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or other acting "in loco parentis" to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating physicians shall note the minor's objections or the unavailability of the parent in the minor's chart and meet other regulatory requirements as specified at 8 NMAC 8.325.7.15.

Federally Funded terminations

CPT codes – 59840, 59841, 59850, 59851, 59852, 59855, 59856, and 59857. Federally funded terminations of pregnancy (those that are represented by the above CPT codes) are limited to those situations where:
- The procedure is necessary to terminate an ectopic pregnancy
- The procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical or mental health of an individual; or
- The procedure is necessary due to rape, incest, or threat to the life of the mother (modifier G7 is required).

Please note that payment of claims for terminations of pregnancy under these codes is conditioned upon receipt of a physician's certification. A copy of the certification form is displayed in the following paragraphs. HSD currently requires that Presbyterian receive a hard copy of the certification before the claim is paid. You may fax the certification on the date of service or submit this certification any time prior to submitting the claim in one of the following ways:

1. Submit your certification by fax to (505) 923-5489 or
2. Submit your certification by mail at the address listed below:

Presbyterian Health Services
P.O. Box 27489
Albuquerque, NM 87125-4789
Attention: Medical Records

Please understand that Presbyterian is requiring the certification for purposes of processing the claim only, and not for purposes of prior authorization.

Physician Certification of Medical Necessity for Pregnancy Termination (Form)

Patient Name_____
Medicaid or SALUD! Identification Number _____
After reviewing the patient chart and consulting with the patient, as the treating physician, I certify that, in my best medical judgment, pregnancy termination is medically necessary for this patient for the following reason(s):

_____ To save the life of the mother
_____ The pregnancy is a result of rape or incest
_____ To terminate an ectopic pregnancy
_____ The pregnancy aggravates a pre-existing condition
_____ The pregnancy makes treatment of a condition impossible
_____ The pregnancy interferes with or hampers a diagnosis
_____ The pregnancy has a profound negative impact upon the physical or mental health of an individual

Practitioner's Name _____
Practitioner's Signature_____
Date _____

Claims

State-Funded terminations
HCPCS codes – S2260, S2262, S2265, S2266, and S2267. All pregnancy terminations for Salud or SCI members that do not meet the criteria for federal funding described above, but are covered under Salud and SCI, will require that the provider retain the certification form in the member's medical record. However, it is not necessary to submit the certification form with the claim.

Sterilization Consent Forms
If the practitioner is performing a sterilization procedure, for payment of Medicaid claims a Sterilization Consent Form must be completed in accordance with 42 CFR 441.251. The consent is valid for thirty (30) days from the date of signature, unless withdrawn by the recipient prior to the procedure. Federal government regulators monitor the proper and timely completion of the consent form. Presbyterian Salud is required to ensure proper adherence to the requirements.

Submitting claims for Hospice Care (Medicare Advantage)
Presbyterian asks that you file claims for Presbyterian Senior Care/Presbyterian MediCare PPO members who have elected hospice coverage to Original Medicare, using guidelines published in the Medicare Managed Care Manual by CMS, the federal agency charged with oversight of the Medicare program.

Claims for services covered under Original Medicare related to hospice (the member's terminal condition) should be filed with the local Medicare intermediary (for Medicare Part A benefits) and carrier (for Medicare Part B benefits). Please do not file these claims with Presbyterian, as they will be denied.

Claims for services covered under Original Medicare but NOT related to the terminal illness should also be filed with the local intermediary and carrier. Please do not file these claims with Presbyterian, as they will be denied.

Once you have received your remittance advice from Medicare, submit the claim for non-hospice related services with the remittance advice to Presbyterian. Presbyterian is responsible for paying the practitioner or provider any difference between what the member's cost sharing is as a Medicare Advantage member and the cost sharing under Fee-for-service (FFS) Medicare for non-hospice related services. The member's cost sharing is based on their Medicare Advantage plan/coverage.

Claims for services covered by Presbyterian's Medicare Advantage Plans, above and beyond those of Original Medicare, should be filed with Presbyterian Senior Care/ Presbyterian MediCare PPO for processing. Examples of these services include routine (not medically necessary) eye and vision exams, routine podiatry, and outpatient prescription drug coverage not already covered under Original Medicare.

Filing Claims with Coordination of Benefits (COB)
Presbyterian requires that all COB claims be submitted within 90 days from the date on the primary carrier's Explanation of Benefit (EOB) or Explanation of Payment (EOP). Once you have billed the other carrier and received an EOB/EOP, you may then submit the completed claim to Presbyterian. Please attach a copy of the EOB/EOP to the submitted claim.

The EOB/EOP must be complete in order to understand the paid amount or the denial reason. Claims submitted without an EOB/EOP will be denied for lack of the EOB/EOP. Claims may also be denied if other insurance carriers' requirements are not met.

Presbyterian Commercial, ASO, and Medicare Advantage
Presbyterian will coordinate benefits in accordance with CMS regulations and National Association of Insurance Commissioners (NAIC) guidelines.

Presbyterian contracted practitioners and providers may bill the member for applicable co-pays, coinsurance and/or deductibles.

Presbyterian Salud
Presbyterian Salud is, by law, the payor of last resort for SALUD! Program members. Therefore, if a Presbyterian Salud member is eligible for benefits under another insurance plan, you must file a claim and

obtain an EOB/EOP from the other insurance plan, as required by your contract.

In coordinating benefits between the primary insurance carrier and Presbyterian Salud, Presbyterian Salud will still act in the same capacity that the Human Services Department (HSD) Medical Assistance Division (MAD) has in the past as the payor of last resort.

As a secondary payor, Presbyterian Salud does not require a benefit certification or referral in the following circumstances:

- When the member's primary insurance does not include a benefit that is covered by Presbyterian Salud.
- When the member's primary insurance has reached annual plan maximums, or maximums on specific benefits that are covered by Presbyterian Salud.

For further information regarding these services please visit the following website: http://www.hsd.state.nm.us/mad/feeschedules.html.

Medicare Part D Prescription Drug Coverage
Medicare Part D Prescription Drug Coverage is available to individual Medicare eligible beneficiaries in two of the three Presbyterian Senior Care plans and two of the three plans offered by Presbyterian MediCare PPO. Some of the Employer Group plans also have Medicare Part D coverage already built in.

Please verify the member's identification card at the time of service. If the member's coverage and plan includes prescription drug coverage, it will be noted on the member's ID card, identified by specific plan and benefit coverage as noted above.

Questionable Claim Payment or Denial (only acceptable as paper claims)
Review all explanation codes on your Explanation of Payment (EOP) to determine if the denial was because of insufficient information or if the claim was submitted incorrectly.

Please resubmit all requested documents or a corrected claim. Corrected claims should be clearly marked as "corrected," include all charges to be considered with the corrections clearly indicated, and must meet the timely submission guidelines. A copy of the EOP should be included along with your corrected claim.

Requesting an Adjustment
If you feel the claim was processed incorrectly, contact our Provider CARE Unit for an explanation. They will advise if an adjustment is necessary and will request an adjustment on the claim. You may be advised to resubmit the claim with additional information. (only acceptable as paper claims)

Recovery of Claim Overpayments
Presbyterian will accept all voluntary refunds and pursue the recovery of all claim overpayments that are identified by the practitioner, provider or their representative. Presbyterian will pursue the recovery of claim overpayments when identified by Presbyterian or another entity other than the practitioner, provider or their representative if the overpayment is identified and the provider notified within the time frames as outlined in the following charts.

Claim Overpayments

Lines of Business	Time Frame
Commercial and Administrative Services Only (ASO)	1 year from the date of payment. Exception: When coordination of Benefits (COB) is involved, there is no time frame for recovery of any overpayments if PHP/PIC has documented verification that the provider received payment from the other insurance carrier
Medicare Advantage (Presbyterian Senior Care/Presbyterian MediCare PPO)	3 years from the date of payment

Lines of Business	Time Frame
Salud and State Coverage Insurance (SCI)	1 year from the date of payment Exception: When Coordination of Benefits (COB) is involved, there is no time frame for recovery of any overpayments if Presbyterian Health Plan, Inc. or Presbyterian Insurance Company, Inc. has documented verification that the provider has received payment from the other insurance carrier.

Member Retro-Termination Activity

Lines of Business	Time Frame
Commercial and Administrative Services Only (ASO)	1 year from the date of payment.
Medicare Advantage (Presbyterian Senior Care/Presbyterian Medicare PPO)	3 years from the date of payment
Salud and State Coverage Insurance (SCI)	Presbyterian will recoup payments consistent with the financial recoveries performed by the State of NM Human Services Department (NMHSD), in accordance with the Medicaid Managed Care Agreement

Confirmed Fraude/Abuse Activity
As Authorized by the Special Investigative Unit or Legal Department

Lines of Business	Time Frame
Commercial and Administrative Services Only (ASO)	6 years from the date of payment
Medicare Advantage (Presbyterian Senior Care/Presbyterian Medicare PPO)	No time limit
Salud and State Coverage Insurance (SCI)	4 years from the date of payment

The time frame for recovery is based on the notification to the practitioner, provider or their representative by Explanation of Payment (EOP) or other communication type (i.e. letter, fax, phone call).

Exceptions to these guidelines may occur due to government regulations or in cases of suspected fraud and abuse activities. Claim overpayments will be recovered through the EOP process whenever possible. This will appear as a payment reduction or negative claim payment on your EOP.

Timely Submission Guidelines
Guidelines for Original Claim Submissions
Presbyterian requires that all claims be received within three (3) months of the date of service. Failure to adhere to the timely submission guidelines will result in the denial of your claims.

If a claim has been submitted to the wrong carrier, submit the claim and denial letter or EOP from the other carrier to Presbyterian within three (3) months of the date of the denial letter or EOB/EOP from the other insurance carrier.

When billing claims for inpatient facility charges, the three (3) month filing limit will begin from the date of discharge.

The provider is responsible for submitting the claim timely, for tracking the status of the claim, and for

determining the need to resubmit the claim.

Guidelines for Claim Resubmissions, Corrected Claims and Adjustment Requests for Additional Payment (only acceptable as paper claims)
Presbyterian requires that all claim resubmissions, corrections and adjustment requests for additional payment must be submitted within twelve (12) months of the date of service. If a resubmission, corrected claim or adjustment request for additional payment is not received within this time frame, the original decision will be upheld. For adjustment requests related to COB, please refer to COB section for timeframes.

If your claim is not in the system, please resubmit it. Maintain a record of your re-submission and any contacts with Presbyterian.

If the re-submission is past the three (3) month filing limit, include the original filing documentation with your re-submission.

- Acceptable documentation includes computer ledgers/written logs, and records of calls to Presbyterian (include date and contact name). The exception report from Presbyterian or the ECT clearinghouse is required for ECT claims.
- Documentation that is not acceptable includes a regenerated claim

Submitted documentation must be legible and clearly identifies the member, the charges in question, date of service and original billed date. Proof of timely filing may be rejected if the submitted documentation can not be clearly linked to the claim in question. Any proof of timely filing must be submitted within twelve (12) months of the date of service. We encourage you to follow-up on the status of your request every 30-45 days. If you continue to receive no payment or documentation on your claim, contact the Provider CARE Unit.

If a member fails to notify the practitioner or provider that he/she is covered through Presbyterian at the time of service, documentation that attempts were made to determine the member's coverage will be required. Acceptable documentation includes:

- A copy of the patient information sheet that indicates that insurance information was not provided
- Written communication from the member verifying that he/she failed to notify the provider of coverage at the time of service

A change in the practitioner's or provider's office billing personnel is not a valid reason to resubmit claims. You are encouraged to contact members regarding past due payments if the member does not respond to billing statements. This will help you determine if the member is covered by Presbyterian.

"Clean" Claims
Presbyterian has adopted CMS claims processing guidelines to ensure timely and accurate claims payment by Presbyterian on behalf of Presbyterian members. The timeliness for processing a claim can be driven by whether or not the claim is "clean." Accuracy and completeness of the information provided determine if the claim is considered "clean" or "unclean."

A claim is defined as "clean" if it contains all of the required data elements necessary for accurate adjudication without the need for additional information from a source outside of Presbyterian; and if it has no defect or impropriety, including but not limited to:

- The failure of an electronically transmitted claim to meet the HIPAA Transaction Standards with regard to format or content.
- The lack of required substantiation or particular circumstances requiring special treatment that prevents timely payment being made on the claim.

A claim may be "clean" even though Presbyterian refers it to a medical specialist within Presbyterian for examination.

"Unclean" Claims
A claim is defined as "unclean" if additional substantiating documentation (e.g., medical record, encounter data, emergency room reports, primary insurance explanation of payments and full itemization where necessary) is required from an external source.
Correct Coding Standards (CCS)

Claims

Presbyterian uses a Correct Coding Standards (CCS) claim editing system to ensure consistent processing of professional claims and decrease manual intervention. This interface applies pattern recognition and intelligent reasoning to identify potential incorrect payments before claims are paid.

Presbyterian applies the National Correct Coding Initiative (NCCI) policy manual, McKesson edits, and other edits based on coding industry standards for consistency in the processing of certain code pairs. Center for Medicare and Medicaid Services (CMS) standards require that practitioners/providers must code correctly even if CCS edits do not exist. This promotes consistency of claims submission and reimbursement and prevents the use of inappropriate code combinations.

There are times when Presbyterian will review certain edits and determine that they may not be appropriate to our current purpose - to improve the health of the patients, members and communities we serve. Most of these reviews are the result of appeals that are received by the Appeals and Grievance Department at Presbyterian. Presbyterian will review these edits to determine if they are clinically appropriate for situations that may arise when providing care to our members. If it is determined that a certain edit does not support our purpose, Presbyterian will either remove the edit or revise it. Presbyterian is supportive of allowing practitioners and providers to provide services that are clinically sound and defensible.

National Correct Coding Initiative (NCCI)
CMS developed the CCI to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed by the National Correct Coding Council and are based on coding conventions defined in the American Medical Association's Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analyses of standard medical and surgical practice, and reviews of current coding practice.

The CCI is administered through CMS, which issues updates on a quarterly basis. The edits on claims may vary depending on what version of the CCI is being used. For this reason, Presbyterian encourages you to obtain further information regarding this manual and subsequent updates. CMS has recently posted the CCI edits on-line on their website at the following address: http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage

You should be aware that the CCI edits and policies do not include all possible combinations of correct coding edits or all types of unbundling that exist.

Interest Payment
Presbyterian (Commercial, Presbyterian Salud, Presbyterian SCI and Presbyterian Medicare Advantage) must pay interest on clean claims not paid within thirty (30) calendar days if submitted electronically, or forty five (45) calendar days if submitted manually (by mail or in person). Interest is paid at the applicable rate as defined under the New Mexico Insurance Code, or as required by applicable state or federal law or regulation.

Interest will be paid at the current rate, for the period beginning on the day after the claim-received date and ending on the date on which payment is made. Interest payments for Presbyterian Salud will begin on the 31st day from the claim received date for electronically submitted claims, and on the 46th day from the claim received date for manually submitted claims, in accordance with HSD Guidance Memorandum #108, dated May 5, 2003.

The following formula is provided as an example of the process for calculating the interest penalty:

- 365 days divided into an interest rate of 18% (1.5% x 12 months) equals .0004932, which is the daily interest rate
- The daily interest rate is multiplied by the number of days from the claim-received date to the claim payment date
- The total figure from the previous step should be multiplied by the claim paid amount to determine the amount of interest payable for a specific claim
- For example: an electronically filed Commercial claim amount of $500 that is 5 days late equates as follows: .0004932 x 35 days = .01726

- .01726 x $500 = $8.63

Contacts
Pres Online
Pres Online is available 24 hours a day, seven days a week and enables you and your office staff to perform the following functions electronically:

- At-a-glance Coinsurance, Deductible and Out of Pocket Amounts (the member's responsibility and the amounts that have been met to date that are in our system at the time of your inquiry).
- Other Insurance information regarding the member
- Detailed demographic information on the member's Primary Care Practitioner
- Find a Doctor, Provider or Facility functionality enhanced
- Check Summaries (listing of Explanation of Payments that were mailed, with access to all claims associated with that remittance including the address of where the check was mailed)

Provider CARE Unit
The Provider CARE Unit was established to handle "complex" inquiries from our practitioner/provider community including Web-based inquiries, written inquiries, adjustment requests and telephone calls that you are unable to resolve through Pres Online, Interactive Voice Response (IVR), www.phs.org or one of our electronic submission vendors. The Provider CARE Unit accesses Pres Online when assisting you with your inquiries.

Mailing Address for Claims, Corrected Claims and Claims Resubmissions
In an ongoing effort to increase the timeliness of provider payment and maximum efficiency and resources in provider offices, Presbyterian strongly encourages the use of electronic claims submissions. In the event that it becomes necessary to submit a paper claim (new, re-submission or corrected), please direct it to the following mailing address:

Medical/Physical/Behavioral Health Claims and Encounter Information:
Presbyterian Health Plan, Inc.
P.O. Box 27489
Albuquerque, NM 87125-7489

Coding Information and Resources
American Medical Association (AMA)
CPT Products
515 North State Street
Chicago, IL 60610
800-262-3211
www.ama-assn.org

Center for Medicare & Medicaid Services (CMS) www.cms.gov
Provider updates: http://www.cms.hhs.gov/center/provider.asp
http://www.cms.hhs.gov/QuarterlyProviderUpdates/EmailUpdates/list.asp

National Correct Coding Initiative (CCI) edits: http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage
CMS Carriers Manual and Hospital Manual: http://cms.hhs.gov/manuals

Trailblazer Health Enterprises, LLC (effective 3/1/2008)
http://www.trailblazerhealth.com/

Palmetto GBA for HCPCS information and the DMERC Manual
www.palmettogba.com/index.html Please verify this resource with Melissa Barker email sent 1/21/11

National Center for Health Statistics www.cdc.gov
Classifications of Diseases www.cdc.gov/nchs/icd9.htm

McKesson
www.McKesson.com

Presbyterian Customer Service Center

It is the Presbyterian Customer Service Center's objective to deliver a consistent customer experience and to provide outstanding service to every customer, every contact, every time.

Presbyterian Customer Service Center Contact Information
Hours of Operation for Members

Presbyterian Commercial, ASO, IBAC and PIC	7:00 a.m. to 6:00 p.m. Monday through Friday
Presbyterian Medicare Advantage	8:00 a.m. to 6:00 p.m. Monday through Sunday
Presbyterian Salud and State Coverage Insurance (SCI)	7:00 a.m. to 6:00 p.m. Monday through Friday

Member Contacts for Customer Service

Members can contact Customer Service electronically by visiting the "Contact Us" page at: http://www.phs.org/PHS/healthplans/info/contact/index.htm. Members can also email Customer Service at info@phs.org.
Members are advised to call the number listed on the back of their ID cards (if available). Practitioners/providers should call (505) 923-5757 or 1-888-923-5757 for assistance.

Member Communication/Welcome Packets
Upon enrollment, new enrollees receive a welcome packet, including Group Subscriber Agreements, Member Handbooks, Summary of Benefits, or Evidence of Coverage as appropriate. New and existing members may access and print this information from our website at www.phs.org or they may contact Customer Service to request a printed copy.

Practitioners/providers may obtain a copy of a Member Handbook, Group Subscriber Agreement, Summary of Benefits or Evidence of Coverage, by contacting their Provider Services Coordinator.

Identification Cards
After enrollment with Presbyterian, each member is issued an identification card showing the member's name, ID number, the selected PCP's name and phone number (if applicable), and basic benefit information. Members enrolled in non-HMO plans do not need to select a PCP, therefore a PCP will not be indicated on their ID card. Members should not be denied service if a PCP is not listed on their card.

The member's ID card should be presented to the practitioner's/provider's office each time the member presents for service, however, services should not be denied if no card is presented. The ID card does not guarantee that the member is still eligible. Practitioners/providers should utilize Pres Online, or the Interactive Voice Response (IVR) System by contacting the Customer Service Center to verify eligibility. However use of these services does not guarantee payment.

Practitioners/providers are also encouraged to take the precaution of verifying the identity of the person presenting the ID card against another form of identification, such as a driver's license or other photo identification. This type of verification not only deters fraudulent use, but also protects the practitioner/provider from performing a service for which payment may be denied. The Federal Trade Commission recently issued their final ruling regarding Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003. These regulations require applicable businesses to incorporate processes and procedures in compliance with the final ruling. You are encouraged to determine if your business is subject to these regulations and implement processes to protect patient identity theft as applicable.

To report suspicion of fraud and abuse, please refer to the Fraud and Abuse Section.

Choosing a Primary Care Practitioner (PCP)
To receive care under a Presbyterian HMO plan, a PHP Member must select a PCP to manage his/her healthcare needs. The PCP will be able to meet most of these needs. As a Member of the Presbyterian HMO plan, the member may choose any participating PCP with an open panel.

If a member does not designate a PCP on his/her enrollment form, PHP will either place an outbound call to the member to provide assistance with the selection or automatically select a PCP for them. The selection is based on the member's physical zip code and the member's age. The choice of a PCP may include those practicing in a variety of areas, such as Family Practice, General Practice, Internal Medicine, and Pediatrics.

PCPs are not required for Presbyterian Insurance Company, Inc. members and Preferred Provider Organization (PPO) members. For certain specific and limited HMO plans, Presbyterian has made the decision that members of these plans are not required to select a PCP. For additional details, please contact the Customer Service Center.

Specialist Assigned as a Primary Care Practitioner (PCP)

On an individual basis, Presbyterian may allow a specialist, currently treating a member with disabilities or chronic/complex conditions, to serve in the capacity of a PCP. The network specialist must agree to perform all PCP duties and such duties must be within the scope of the participating specialist's certification and in accordance with the program requirements and related medical policies.

When a request for a specialist as PCP is received, Customer Service will assist the member by providing them with the "Specialist as a PCP" form. This form is completed by the member who returns the form to Presbyterian. Upon receipt of the completed form, it is reviewed by the Health Services Department for approval.

Primary Care Practitioner Changes

Members may request to change their PCP at any time, for any reason throughout the month. PCP changes become effective the following business day of the receipt of the request or at the date requested by the member, provided the date is not retroactive.

Presbyterian Salud members may request a PCP change at any time, for any reason, however the effective date will vary depending on when the request was made.

If the request was made by the 20th of the month, it becomes effective on the 1st of the following month. If the request was made after the 20th of the month, the change becomes effective the 1st of the month after the following month.

Removing Members from Your Panel

If a PCP determines it is in the best interest of the patient and the practitioner for the member to be removed from his/her panel due to the member's non-compliance or disruptive behavior in the office, the PCP can request the member's removal in accordance with our policies and procedures. The PCP must send the member a letter advising them of the decision to end the patient/provider relationship. Upon contact by the practitioner/provider or the member, Customer Service can help reassign the member to a new PCP. The current PCP is responsible for providing care according to the Transition of Care policy until the member can be reassigned.

Presbyterian Salud
Member Eligibility and Enrollment

Presbyterian Salud serves members of the New Mexico Medicaid Managed Care Program - the SALUD! Program. Eligibility for Medicaid, including Medicaid managed Care, or SALUD!, is determined by the New Mexico Human Services Department (NMHSD), Income Support Division (ISD).

Presbyterian Salud is assigned SALUD! Program eligible participants once a month. Presbyterian Salud is notified before the first of the month that a member will be enrolled. Presbyterian Salud is responsible for managing the member's care on the first effective day of the member's enrollment until the member is disenrolled from Presbyterian Salud or, if hospitalized in an acute care setting while disenrolled, until discharge to a lower level of care.

If the member requires health care in the days prior to the effective date of enrollment with Presbyterian Salud, the State of New Mexico, or another managed care organization (and not Presbyterian Salud) is the financially responsible party.

Presbyterian Customer Service Center

Medicaid Behavioral Health
Effective July 1, 2009 behavioral health services for SALUD! Program participants will be administered by Optum Health, the Statewide Entity for behavioral health services. Optum Health is responsible for the provision of all behavioral health services for members enrolled in Medicaid managed care, SALUD! The Optum Health toll-free numbers are as follows:

- Customer: 1-866-660-7185/TTY 1-800-855-2881
- Provider: 1-866-660-7182

If transportation to behavioral health appointments is required, contact Safe Ride Services directly at 1-800-797-7433 or the Presbyterian Customer Service Center at (505) 923-5200 or 1-888-977-2333.

Transportation Services
Presbyterian covers medically necessary transportation for Presbyterian Salud members, however limitations and exclusions apply for certain services.

Presbyterian Salud or its contractor will arrange transportation for appropriate services. The Presbyterian Customer Service Center's Transportation Coordinator will assist in arrangements and appropriate authorizations. Rides for routine scheduled office visits or medical services require 48 to 72 hours advance notice.

Presbyterian Salud covers emergency transportation by ground ambulance, air ambulance, or by a special equipped van, when medically appropriate. If members need emergency transportation for a life-threatening situation, call 911 or the emergency telephone number in the area.

Same day transportation is available for urgent health care services or urgent referrals made by a PCP. To schedule a ride, contact Safe Ride Services directly at 1-800-797-7433 or the Presbyterian Customer Service Center at (505) 923-5200 or 1-888-977-2333.

Presbyterian State Coverage Insurance (SCI) - Member Eligibility and Enrollment
SCI offers affordable healthcare coverage to low-income working adults, who meet the SCI eligibility criteria, either through their employer or as an individual.

To become eligible for a State Coverage Insurance (SCI) Plan, a member must:

- Not have voluntarily dropped insurance coverage for 6 months (individual) or 12 months (group)
- Be a New Mexico resident between the ages of 19 and 64
- Earn a family income of up to 200% of the federal poverty level, or other criteria as established by Insure New Mexico/NM Human Services Department
- Not be eligible for certain government health insurance benefits, such as Medicaid (Title XIX), Medicare, TRICARE, and not have other public or private health insurance

For more information on enrolling with Presbyterian SCI, please visit the following website: www.insurenewmexico.state.nm.us.

Medicare Enrollment Information
Medicare Enrollment and Renewal Periods
Each year, enrolled Medicare beneficiaries are given the opportunity to review and assess their current Medicare coverage. Presbyterian assists its Medicare Advantage Program enrollees in this annual review period by sending to current members The Center for Medicare and Medicaid Services approved Annual Notice of Change (ANOC) and Explanation of Coverage (EOC) benefit documents. These materials are required to be provided to Medicare enrollees 10 days prior to the first date of the Annual Enrollment Period. The ANOC includes any changes in coverage or services, costs, or service area that will be effective the next January. The EOC contains the details about what the plan covers, how much a beneficiary is required to pay ("cost sharing") and more.

Annual Medicare Enrollment Period
Presbyterian issues its annual ANOC and EOC plan documents to its members in advance of the Medicare Annual Enrollment Period, which is currently held from October 15th to December 7th . As a result of Health Care Reform, the Annual Medicare Enrollment dates may change. Presbyterian will issue

a notification to both Medicare Advantage enrollees and our practitioners/providers should the dates of the enrollment period change.

Also during this period, Medicare enrollees may make changes to their plan choices by selecting another company in which to enroll, or enrolling or disenrolling in any plan of their choice. They can also select another Medicare plan offered by Presbyterian. If a Medicare member does not want to make any changes, they do not have to do anything. If they do not let Presbyterian or CMS know they want to make changes, no changes will be made to their current coverage and they will continue with the same program/plan as previously selected. They will not be able to make any changes to their Medicare plan until the next Annual Enrollment Period except as specified by the Medicare Open Enrollment Period guidelines.

Medicare Open Enrollment Period
Between January 1st and February 14th , a Medicare beneficiary may only choose to disenroll from a Medicare Advantage plan and return to original Medicare. If they choose to return to Original Medicare, they are allowed to choose a separate Medicare Part D Prescription Drug Coverage plan. After the Open Enrollment Period ends the member can only make plan changes if they qualify for a Special Enrollment Period exception.

Medicare Annual Notification of Change (ANOC) Meetings
Each year, prior to and during the Medicare Annual Enrollment Period, members and their guests have the opportunity to attend a Presbyterian Medicare Plans Annual Notification of Change meeting. The meetings are designed to meet our members needs by providing information about changes to the Presbyterian Medicare Advantage plan benefits and services for the upcoming year. This is also a time when we can address members personal questions regarding the benefit plans. For our members' convenience, meetings are available throughout the Medicare plan service area. Members are encouraged to attend annually.

Medicare Advantage Plans New Member Education, Verification, and Welcome Calls
An outreach to all new Presbyterian Medicare Advantage plans' members is conducted within fifteen (15) calendar days of receipt of the member's request for enrollment. The primary purpose of the call is to welcome the new member and to ensure that they have an understanding of the product type and plan in which they are enrolling. Key plan elements are reviewed and members are provided an opportunity to ask questions about their new Presbyterian Medicare Advantage plans.

Medicare Member Appreciation Events
Every year, Presbyterian invites all Presbyterian Medicare Advantage plan members and their guests to join us at a Member Appreciation Event. Presbyterian senior leadership takes this opportunity to thank our members for their membership in Presbyterian's Medicare Advantage plans and to answer members' questions. Members are also informed about the latest developments at Presbyterian.

Additional Medicare Benefits
Medicare Social Service Coordinators
Social Service Coordinators (SSC) are trusted partners whose sole service is providing expert coordinated outreach services to Presbyterian Medicare Advantage plan members. SSC assists members in learning about and taking advantage of programs that provide financial assistance to seniors and disabled individuals with limited income. Members appreciate the personal support SSC provides with enrolling members into the Medicare Savings Programs and the Medicare Part D "Extra Help" program, as well as other federal and state financial assistance programs or services.

Through these efforts, SSC help to improve the quality of life for our members who are most financially at-risk. Participation is entirely voluntary and provided at no cost to our members.

SilverSneakers Fitness Program®
Presbyterian Medicare Advantage plan members are offered the SilverSneakers® Fitness Program or SilverSneakers® Steps benefit at no additional cost!

With the SilverSneakers®Fitness Program, members

have access to basic fitness center membership at no additional cost. This membership includes access to amenities such as treadmills, weights, heated pool and fitness classes.. Members can take signature SilverSneakers®classes designed specifically for older adults and taught by certified instructors. Additional SilverSneakers®options may be available at select fitness centers as members' fitness levels progress. A designated, specifically trained Program Advisor SM assists members along the way with enrollment and getting started. SilverSneakers®members have access to more than 10,000 participating fitness centers, including women-only Curves locations. Once members enroll in SilverSneakers®, they can use any participating location in the nation. The SilverSneakers® Fitness Program is available to all eligible members. To find a location you can visit, www.silversneakers.com; or call 1-888-423-4632

SilverSneakers®Steps is a personalized fitness program that fits the lifestyle of members who don't have convenient access to a SilverSneakers location (location is 15 miles or more from the members home).. This self-directed, pedometer-based physical activity and walking program provides the equipment, tools, and motivation for members to measure, track and increase their activities and achieve a healthier lifestyle. After registering as a steps member through www.silversneakers.com, the member will receive their kit at their home address. Members can get fit, have fun, and make friends.

Members' Rights and Responsibilities

Presbyterian has written policies and procedures regarding members' rights and responsibilities and implementation of such rights. As a member of Presbyterian's network we expect you to respect, support and recognize these rights and responsibilities.

Member Rights

Each Presbyterian Member and/or legal guardian has the right:

1. To receive information needed to make informed decisions about the managed care organization, including, but not limited to: its health care services, how to access them, detailed benefit information, prescription medications, policies and procedures, its practitioners and providers and Members' rights and responsibilities.
2. To be treated equitably and with respect and recognition of their dignity and right to privacy.
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.

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.

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.

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.

Presbyterian Insurance Company (PIC) Preferred Provider Organization (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.

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.
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 health care requirements following discharge from inpatient or outpatient facilities.
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.
4. Members have a right to clear, private, and candid discussion(s) or explanation(s) 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. Or, 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.
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 (G/SA), or Certificates of Insurance, Annual Notice of Change (ANOC), Evidences of Coverage (EOC), or Summary Plan Descriptions, for presenting questions and concerns about his or her health care, including use of the grievance process. Commercial members may request the assistance of the Superintendent of the New Mexico Department of Insurance as applicable. 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.
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.
8. To receive health care 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 health care 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.
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. (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 a Managed Care Organization (MCO) and exercise switch enrollment rights without threats or harassment (applies to Presbyterian Salud and SCI).
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.
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.
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.
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.
17. To receive information from their Provider or Practitioner, in a 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.
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 (does not apply to indemnity plan or PPO members - HMO benefit only).
19. To know upon request of any financial arrangements or provisions between the health care insurer and its providers who may restrict referral or treatment options or limit the services offered to members.
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.
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 benefit certification and utilization review.
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' Responsibilities

Members have certain responsibilities regarding their health care, including the following:
1. To pay all required co-payments 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).
2. 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.
3. To follow Presbyterian's policies and 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.
4. To understanding their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
5. 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 Member Services for suggestions, concerns, or payment issues.
6. To schedule and cancel appointments including transportation (Presbyterian Salud). 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.
7. To treat providers, practitioners and other health care employees with respect and courtesy.
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.
11. To be informed of the potential consequences of providing incorrect or incomplete information to Presbyterian.
12. To notify Presbyterian of any changes in names, address, phone number, marital status, newborns that affect eligibility. Salud Members must notify 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.
13. To advise 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.
14. To behave in a manner that supports the care provided to other patients—and the general functioning of the facility.
15. To safeguard the confidentiality of their own care and that of other patients.
16. 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.
17. To review information regarding covered services, policies and procedures as stated in their applicable combined Evidence of Coverage, member handbook, G/SA's, and to contact the Member Services Department 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).
18. 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.
19. To change Primary Care Practitioners by following the rules described in their member handbook, G/SA, SPD, or EOC.

Note: Members' rights and responsibilities are also available on our website at www.phs.org, or a member may call Customer Service to request a printed copy.

Confidentiality
Presbyterian is committed to protecting members' "Protected Health Information (PHI)" and safeguarding confidential medical information through the implementation of the Presbyterian Confidentiality Policy. For a printed copy of the policy, please contact your Provider Services Coordinator.

Upon enrollment and annually thereafter, Presbyterian provides each member with a Joint Notice of Privacy Practices. This Notice describes the privacy practices of Presbyterian Health Plan, Inc., Inc. and Presbyterian Insurance Company, Inc. ("Presbyterian"). This Notice helps members understand how we protect the privacy of their health information and also informs members of their health information rights.

Member Health Information Rights
The rights described below are subject to limitations and conditions:

Legal Authority to Make Health Care Decisions for Minors or Others
Usually, the health information rights described in this Notice may be given to a person with legal authority to make health care decisions for a child or other person (for example, a parent or legal guardian). There are exceptions. For example, under New Mexico law, there are a number of circumstances in which minors (i.e. under the age of eighteen) may consent to receive health care services without parental consent, including the

following:

- Examination and treatment for sexually transmitted diseases
- Pregnancy, Prenatal, Delivery and Postnatal care
- Family planning services
- Behavioral health services
- Treatment in a licensed facility for substance abuse
- Life sustaining treatment
- Anatomical Gifts (must be 16)

Right to See and Get a Copy of Health Information
Members have the right to see and get a copy of most of their health information. Their request to see or get a copy of health records must be made in writing.

Right to Amend Incorrect or Incomplete Health Information
Members have the right to request that we change incorrect or incomplete health information kept in our records. The member may be required to make the request in writing. Presbyterian may deny the request if we believe that the information in our records is correct and complete. If the request is denied, the member will receive written notice including the reason for the denial and how the member may appeal our decision.

Right to Request Confidential Communications of Health Information
Members have the right to request that we deliver health information in a certain way or at a certain location. We must agree to a reasonable request. We may deny the request if it is against the law or our policies.

Right to Request Restrictions of Health Information
Members have the right to request that health information is not used or shared for certain purposes. We are not required by law to agree to the request. For example, we will not agree to limit the use or sharing of health information during a health emergency.

Right to Request an Accounting of Disclosures
Members have the right to request an Accounting of Disclosures Report. This report will show when health information was shared by us and others without written authorization.

Right to Receive a Paper Copy of this Notice
Members have a right to receive a printed copy of the Joint Notice of Privacy Practices upon request.

Use of Consents/Authorizations to Obtain Protected Health Information (PHI)
When the member signs a plan enrollment form, they are authorizing Presbyterian (including its authorized agents, regulatory agencies and affiliates) to obtain limited information about the member for underwriting or enrollment purposes. We will not re-disclose this health information without valid authorization from the member (or their legally authorized personal representative) unless required by law or as otherwise described in the plan's Joint Notice of Privacy Practices.

Presbyterian expects that a provider will make member records available to the plan in accordance with federal and state regulations and the practitioner and provider contract that exists between Presbyterian and the provider.

There may be situations where Presbyterian requests PHI from the provider for Presbyterian's health care operations. In these situations, the provider agrees to provide the requested PHI or make a good faith attempt, within a reasonable time period, to obtain a valid authorization from the member, and to provide Presbyterian, upon request, with written documentation of such attempts.

HIPAA Privacy regulations also permit health care providers to obtain consent from individuals to use or disclose their PHI for purposes of treatment, payment or health care operations. Please note that the regulations do not require that providers obtain consent to use or disclose PHI for these purposes.

If a provider opts to obtain consent as described above from the member, the provider agrees to provide a copy of that consent to Presbyterian as part of a response to a request for PHI from Presbyterian.

A member may access and print an Authorization Form from our website at www.phs.org or contact Customer Service to request a printed copy. Authorization

Forms will be kept in the member's medical record or enrollment file.

Members Who Are Unable to Give Consent/ Authorization
For children and people who are incapacitated and unable to make health decisions for themselves, health information rights are usually given to a person with legal authority to make healthcare decisions on their behalf (such as a custodial parent, legal guardian or person holding health care power of attorney). In these situations, when we need authorization to use or disclose PHI, we will have the Authorization Form signed by a person with legal authority to make healthcare decisions for the individual.

Presbyterian Case Management Staff will coordinate case(s) with appropriate agencies, such as Children, Youth, and Families Department (CYFD) for those children who are under CYFD jurisdiction, Adult Protective Services (APS) with an open case on a member, Juvenile Justice, and any other applicable agency and/or case manager for any individual who is unable to make decisions due to being incapacitated or is unable to give informed consent, consistent with federal and state laws.

Member Access to Protected Health Information Contained in Plan Records
Protected Health Information (PHI) is kept in a physically secure location with access limited to authorized personnel only. Members have the right, with certain exceptions, to see and obtain a copy of most PHI about them that is contained in our records. To request access to inspect or obtain a copy of PHI, the member must submit their request in writing to:

Presbyterian Customer Service Center
P.O. Box 27489
Albuquerque, NM 87125-7489

Requests for medical records must be made by the member directly to the treating practitioner/provider.

Safeguarding Oral, Written and Electronic Protected Health Information across Presbyterian
To ensure internal protection of oral, written, and electronic PHI across Presbyterian, the following rules are strictly adhered to:

- Protected Health Information is accessed only if such information is necessary to the performance of job related tasks
- All employees, volunteers, and any external entity with a business relationship with Presbyterian that involves health information will be held responsible for the proper handling of Presbyterian's confidential business information and protected health information, and are required to sign a confidentiality statement or business associate agreement, respectively

Violation of the above rules by an employee may be grounds for immediate dismissal.

Pres Online /website Internet Information
Presbyterian enforces security measures to protect PHI that is maintained on our website, network, software, and applications. We collect information from visitors to our website, which includes:

- Website traffic statistics:
- Where visitor traffic comes from
- How traffic flows within the website
- Browser type

These statistics help up improve the website and find out what visitors find interesting and useful.

Presbyterian uses personal information to reply to concerns. We save this information as needed to keep responsible records and handle inquiries. We do not sell, trade, or rent our visitors' personal information to anyone.

Pres Online: The security features of the program allow only information pertaining to that particular member or provider to be accessed.

Website (www.phs.org): The Presbyterian website does not contain any PHI, but rather is a source for general policy statements such as member rights and responsibilities, forms, listings of participating providers, and Presbyterian's Notice(s) of Privacy Practices.

Protection of Information Disclosed to Plan

Presbyterian Customer Service Center

Sponsors, Employers or Government Agencies
Federal law limits the information that Presbyterian may disclose to employers regarding their employees to "summary information" and "information regarding enrollment and disenrollment." Presbyterian may provide more detailed PHI regarding employees to "plan sponsors" (self-insured employer groups) only when the employer has certified to Presbyterian that they have informed employees about this use of their information by making certain amendments to the plan documents or the employee (or their legally authorized representative) consents to the release of information.

Cultural Competency
The ability to communicate effectively with patients and members affects their ability to understand information about their healthcare, complete a prescribed course of treatment, and be involved in healthcare decisions that affect them. Being culturally competent, sensitive, and aware is key to Presbyterian's mission to improve the health of the patients, members and communities we serve.

Cultural competency enhances communication and treatment effectiveness. For healthcare practitioners, being culturally competent includes awareness of the existence of culturally diverse populations and the potential for racial and ethnic healthcare disparities. All cultures have unique views and practices in regard to illness and well-being that affect the healthcare decisions they make.

Presbyterian requires all employees to complete an annual Cultural Competency training, to educate staff on the importance of respecting diversity, including culture and language preferences.

Presbyterian provides members information in a culturally sensitive manner including those limited in English proficiency, reading skills, diverse cultural ethnic backgrounds, and/or physical or mental disabilities. Presbyterian recommends registering for online Cultural Sensitivity competencies at www.ThinkCulturalHealth.hhs.gov or by using the "Cultural Sensitivity Competencies" link when you log in to Pres Online. Supported by the Office of Minority Health at the United States Department of Health and Human Services, and accredited by Ciné-Med Inc., the online competencies offered are designed to assist healthcare professionals deliver culturally competent care to an ever increasing diverse population of members.

Translation Services
Presbyterian offers translation services for members who need information in a language other than English. Translation services are available in over 170 languages including, but not limited to, Spanish, Navajo, Vietnamese, Portuguese, Russian, American Sign Language and others.

If a practitioner/provider does not offer or contract for translation services for members, the Presbyterian Customer Service Center can be contacted to coordinate these services. Practitioners/providers are financially responsible for language interpretation services provided in their office settings and/or related office visits and practitioner/provider services, except as otherwise provided by applicable law, rule or regulation.

Advance Directive
Members have the right to make health care decisions and to execute advance directives. They also have the right to accept or refuse treatment. An Advance Directive is a formal document, completed by a member in advance of an incapacitating illness or injury, which indicates the member's preferences regarding healthcare treatment. Once an Advance Directive is created, both the member and the practitioner/provider should have a copy. If a member is admitted to a hospital, the hospital should also have a copy.

As long as a member can speak for themselves, practitioners and providers must honor their wishes, except as a matter of conscience. Practitioners and providers must document in a prominent part of the member's current medical record whether or not an individual has executed an Advance Directive.

Under the New Mexico Uniform Healthcare Decisions Act, if a healthcare practitioner or provider declines to comply with a member's instruction or healthcare decision as a matter of conscience, the practitioner or

provider must continue to provide care to the member until a transfer can be executed. The practitioner or provider must promptly inform the member, if possible, or an agent then authorized to make healthcare decisions for the member. Unless the member or the agent refuse assistance, the practitioner or provider must immediately make all reasonable efforts to assist in the transfer of the patient to another healthcare practitioner or provider that is willing to comply with the instruction. Presbyterian does not have conditions under which they cannot implement advance directives as a matter of conscience, and as such, have not filed a conscience protection waiver with the Centers for Medicare and Medicaid Services. Presbyterian is not required to provide care that conflicts with an advance directive.

A member can obtain the brochure, Making Healthcare Decisions, from Customer Service, which provides information and forms for completing an Advance Directive. These are important legal documents, however, and a member should consider consulting an attorney to assist them in preparing an Advance Directive.

Types of directives include:

- Living will. This lets members detail which treatments they want and don't want if they can't speak for themselves.
- Durable power of attorney for health care. This lets members appoint a friend or relative to make medical decisions for them if they can't do it themselves.
- Do-not-resuscitate order. This lets caregivers know they don't want to receive CPR if their heart stops beating.

Provider CARE Unit

The Provider CARE Unit is now a part of the Presbyterian Customer Service Center (PCSC) and is designed to handle "complex" inquiries from our practitioner/provider community that are unable to be resolved through self-help options.

Self-Help Options

Pres Online is your quick and easy way of accessing real-time information. This service is available 24 hours a day, seven days a week to ensure the information you and your office staff needs is at your fingertips. This tool is your most efficient way of getting the information you need, when you need it.

Each employee in your office that utilizes Pres Online must have their own individual user name and password. Under no circumstances should the Pres Online user name and password be shared. It is your responsibility to contact the PCSC to terminate access of employees who are no longer employed by your office. If you have an employee who no longer requires access to Pres Online, please contact the PCSC to terminate their access.

Violation of the Terms and Conditions for Utilization of Pres Online may result in revocation of Pres Online access.

Functions Available Through Pres Online:

- Member eligibility
- Member benefits
- Copayment, Co-insurance, Deductible and Out of Pocket Amounts (*the member's responsibility and the amounts that have been met to date that are in our system at the time of your inquiry).
- Information regarding a member's other insurance (if applicable)
- Primary Care Practitioners (PCPs) Verification (including demographic information)
- Member Rosters (for PCPs)
- Find a doctor, provider or facility
- Claims status/inquiry/verification
- Check summaries (listing of Explanation of Payments that were mailed, with access to all claims associated with that remittance including the address of where the check was mailed)
- Benefit certification submission and status
- Pharmacy Exception submission and status
- Contacting the Provider CARE Unit (electronically)

Presbyterian's Interactive Voice Response (IVR) system is available to assist you with member eligibility verification, benefits, claim status, benefit certifications, pharmacy exceptions, and behavioral health services.

Presbyterian Customer Service Center

Web-based Inquiries
You may contact the Provider CARE Unit electronically by going to www.phs.org and selecting Contact Us from the menu at the bottom of the page.

Helpful Tips
Mailing Address for New Claims, Corrected Claims, Claim Resubmissions and Encounter Information:

In the event that it is necessary to submit a paper claim (new, re-submission or corrected) or when submitting Claims and Encounter information, please direct it to the following mailing address:

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489

For complete information regarding the following:
- Questionable claim payment or denial – Refer to the Claims section
- Reimbursement and coding questions – Refer to the Provider Services section
- Benefit Certification – Refer to the Health Services section
- Health Help – Refer to the Health Services section
- Appeals and Grievance – Refer to the Appeals and Grievance section
- Timely submission guidelines – Refer to the Claims section

Contacting the Provider CARE Unit
Note: Please contact your Provider Services Coordinator if the issue you have is affecting more than 10 claims (i.e., incorrect contract payment, charge for a specific code is denying when it should be paying, etc.).

Telephone Inquiries
Members:
If a member/patient needs to request a PCP change or wishes to speak with a Customer Service Representative, please have them call the Customer Service phone number on the back of their Presbyterian member ID card.

Providers:
Provider CARE Unit Specialists are available to assist you with your complex inquiries Monday through Friday from 8 a.m. to 5 p.m. The Provider CARE Unit can be contacted at the following provider numbers:
- Local (505) 923-5757
- Toll-free 1-888-923-5757

When calling the Provider CARE Unit, please have available the following information:
- Your National Provider Identifier (NPI); a requirement for you to provide as of January 1, 2008
- *When calling please note that you must provide your NPI or we will be unable to assist you.
- The member's Presbyterian ID number, date of service, procedure code, billed amounts and claim number (if known).

Appeals & Grievances

A practitioner/provider has the right to file an appeal if he/she is dissatisfied with a decision made by Presbyterian to terminate, suspend, reduce or not provide approved services to a member, or to deny payment for services, or if the provider disagrees with any policy or adverse action made by Presbyterian. Additionally, if a practitioner/provider is dissatisfied with any of Presbyterian's general operations, he/she may file a grievance. In order to file an appeal or grievance on behalf of a member, you must have the member's written consent.

If the issue involves a utilization management decision, a practitioner or provider must obtain the written consent of the member to act on his/her behalf during the appeal process, unless the matter is determined to be an expedited appeal.

Provider Appeals and Grievance Process
Any practitioner/provider has the right to file a formal grievance or appeal with Presbyterian. The practitioner/provider should submit their grievance or appeal to the Presbyterian Grievance and Appeals Coordinator within the following timeframe.

Grievances/Appeals	Time Frame
Grievances/Appeals challenging a claim denial, claim adjudication, claim submission or claim resubmission not acted upon by Presbyterian	Within 12 months of the date of service
Overpayments identified by Presbyterian	Within 12 months of the date of service or 60 days from the notification, whichever is the later date

Standard Appeal
Presbyterian encourages practitioners/providers to file claims correctly the first time or, if time allows, resubmit the claim through the Claims Activity Review and Evaluation (CARE) Unit to resolve an issue. A practitioner/provider is encouraged to contact his/her Provider Services Coordinator to help clarify any denials or other actions relevant to the claim and to help with a possible resubmission of a claim with modifications.

Remember, once a claim is initially submitted in a timely manner, a practitioner/provider has one year (12 months) from the date of service to correct any defects in the initial claim submission and to resubmit the claim for reprocessing. A contracted practitioner/provider has one year (12 months) from the date of service to file an appeal regarding a claim denial or the denial will be upheld as past the filing limit for initiating an appeal.

When filing an appeal, please remember to document the reasons for your reconsideration request and attach all supporting documentation for review of the issue. If the issue involves a claims denial appeal, and you previously submitted the claim electronically, please include a hard copy of the claim in question for review of your appeal. If the appeal is related to a claim coding matter, it is helpful to include supporting medical records such as office notes and operative reports, if applicable.

Formal Grievances
A grievance may be filed orally or in writing and must state with particularity the factual and legal basis and the relief requested, along with any supporting documents (i.e. claim, remittance, medical review sheet, medical records, correspondence, etc.). Particularity usually means a chronology of pertinent events and a statement as to why the practitioner/provider believes the action by Presbyterian was incorrect. Grievances shall be resolved within 30 calendar days.

Presbyterian will review grievances in accordance with all Federal and State regulatory guidelines and Presbyterian's policies and procedures. For a list of the applicable regulations, please access the Appeals & Grievances page at: http://www.phs.org/PHS/healthplans/providers/appeals/index.htm.

Circumstances Giving Rise to a Provider Fair Hearing
Practitioners/providers may appeal a decision to deny, suspend or terminate their participation in the Presbyterian network. If the practitioner/provider disputes any such action, he/she must submit a written request for a hearing. The Credentialing Subcommittee or its designee will conduct the fair hearing. The

practitioner/provider may appeal the decision of the hearing to the Presbyterian Board of Directors or Executive Committee.

A Presbyterian practitioner/provider has the right to a fair hearing upon receipt of a written notice from Presbyterian, or its agent, pursuant to the termination for policy terminating the Agreement either immediately or after notice. The Managed Health Care Plan must give reasonable advance notice if the agreement is terminated for cause, unless it is for quality of care issues. The minimum advance notice is determined by Federal and State Regulatory guidelines unless the practitioner/provider's contract states otherwise.

Initiation of an Appeal Hearing to the Credentialing Sub-Committee

The Presbyterian practitioner/provider may initiate the Credentialing Sub-Committee Hearing Plan by submitting a written request for a hearing to Presbyterian or its agent within 30 calendar days after the Presbyterian practitioner/provider receives a written notice of termination. Such written notice will be delivered to the practitioner/provider at least 90 days in advance of the effective date of the termination, unless the practitioner/provider's contract states otherwise. If the practitioner/provider does not submit a written request for hearing to Presbyterian within 30 days of receiving the Notice of Termination, that constitutes a waiver by the practitioner/provider of any hearing under this Credentialing Sub-Committee Hearing Plan procedure.

The plan practitioner/provider is entitled to be represented by an attorney or by any other person of the practitioner/provider's choice. If the plan practitioner/provider wants to be represented by an attorney or by any other person of the practitioner/provider's choice, the practitioner/provider must notify Presbyterian 72 hours in advance of the hearing date.

Member Appeals and Grievances

Practitioners/providers may appeal a denied benefit certification or a concurrent review decision to deny authorization that was made by the Medical Director, with written consent from the member to act as their representative during the appeal process. At the time of the decision, a practitioner/provider or member may request that Presbyterian reconsider the denial by submitting further documentation to support medical necessity. Such requests will be referred immediately to a Medical Director not previously involved in the case for resolution and will be handled according to the Member Appeal guidelines.

If benefit certification/prior authorization for services for any Presbyterian member is requested by a practitioner/provider and denied by Presbyterian, a practitioner/provider may act on the member's behalf and may file a request for an expedited appeal if the practitioner/provider feels that the member's health and/or welfare are in immediate jeopardy. Presbyterian will then determine if it meets expedited criteria. If the case is deemed expedited, Presbyterian will process the expedited appeal within 72 hours of receipt (time extensions may apply with written consent from the member).

The Presbyterian Member Appeals and Grievance process is published in the member's Group Subscriber Agreement (GSA), Summary Plan Description (SPD), Evidence of Coverage (EOC), the Presbyterian Salud Member Handbook, and the Presbyterian Senior Care Evidence of Coverage and Disclosure Information/ Member Handbook.

Presbyterian provides a process that ensures all members have the right to exercise their right to an appeal and that they receive the decision within the appropriate and proper time frames for resolution of their appeals. The process applies to the following product lines:

- New Mexico Commercial and Administrative Services Only (ASO) contracts
- Presbyterian Salud (New Mexico Medicaid Managed Care)
- Presbyterian Senior Care (Medicare Advantage)
- Presbyterian MediCare PPO (Medicare Advantage)
- Presbyterian SCI (State Coverage Insurance)
- Presbyterian Insurance Company, Inc. (PIC)

Any member also has the right to file a grievance if he/she is dissatisfied with the services rendered through

Appeals & Grievances

Presbyterian. In respect to grievances, the member is defined as any individual enrolled in Presbyterian or their designated representative. A practitioner/provider may represent a member in a grievance or appeal with written consent from the member.
Member grievances may include, but are not limited to: dissatisfaction with practitioners/providers, appropriateness of services rendered, timeliness of services rendered, availability of services, delivery of services, reduction and/or termination of services, disenrollment or any other performance that is considered unsatisfactory. The member should submit their grievance or appeal to the Presbyterian Grievance and Appeals Coordinator as outlined in the table below.

Grievances/Appeals challenging an adverse action, decision or policy other than a claim denial:

Lines of Business	Time Frame
Presbyterian Salud (New Mexico Medicaid Managed Care) and Presbyterian SCI (State Coverage Insurance)	Within 90 days from the date of denial
Presbyterian Senior Care (Medicare Advantage) and Presbyterian MediCare PPO (Medicare Advantage)	Within 60 days from the date of denial
All other Plans	Within 180 days from the date of denial

Contact List
Should a practitioner/provider disagree with any policy, decision or adverse action made by Presbyterian, he/she should contact the following individuals.

Issue	Contact
Appeal of Utilization Management decisions with written consent from the member	Member Appeals/Grievance Coordinator
Appeal of denial, suspension or termination of network participation and initiation of Fair Hearing Plan	Credentialing Sub Committee
Expedited Appeal requests on behalf of a member	Member Appeals/ Grievance Coordinator
Dispute of claims adjudication	CARE Unit Specialist
Challenge of any other adverse action, decision or policy	Provider Appeals/Grievance Coordinator
Initiation of a Level II Provider Appeal Hearing	Provider Appeals/Grievance Coordinator

Appendix I: CAGE Questions

Date:

Patient Name:

Date of Birth:

The CAGE Questions Adapted to Include Drugs (CAGEAID)

	No (0)	Yes (1)
Have you felt you ought to **C**ut down on your drinking or drug use?		
Have people **A**nnoyed you by criticizing your drinking or drug use?		
Have you felt bad or **G**uilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started? (**E**ye-opener)		

Sources:

Brown R. L. and Rounds L. A. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wis Med J., 94(3): 135-40.

Brown, R.L. (1992). "Identification and Office Management of Alcohol and Drug Disorders." In: Fleming, M.F., and Barry, K.L., eds. Addictive Disorders. St. Louis: Mosby Yearbook.

Mayfield, D., McLeod, G, and Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism instrument. Am J Psychiatry, 131:1121-1123.

Appendix II: In-Office Lab List

In-Office Lab List

Below is a descriptive listing of pathology/laboratory services and identifying codes along with any limitations for each service. (* Denotes tests granted waived status under the Clinical Laboratory Improvement Amendments (CLIA)

Code	Description	Limitation
36415	Collection of venous blood by venipuncture	
80047	Metabolic panel ionized ca	
80051	Electrolyte panel	
80061	Lipid panel	
80069	Renal function panel	
81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated with microscopy	
81005	Urinalysis; qualitative or semi-quantitative, except immunoassays	
81015	Urinalysis, microscopic only	
82040	Assay of serum albumin	
82043	Microalbumin quantitative	
82150	Assay of amylase	
82247	Bilirubin total	
82271	Occult blood other sources	
82272	Occult bld feces 1-3 tests	
82310	Assay of calcium	
82330	Assay of calcium	
82374	Assay blood carbon dioxide	
82435	Assay of blood chloride	
82465	Assay bld/serum cholesterol	
82550	Assay of ck (cpk)	
82948	Glucose; blood, reagent strip	
82977	Assay of GGT	
82985	Glycated protein	
83037	Glycosylated hb home device	
83880	Natriuretic peptide	
84075	Assay alkaline phosphatase	
84132	Assay of serum potassium	
84155	Assay of protein serum	
84295	Assay of serum sodium	
84450	Transferase (AST) (SGOT)	
84550	Assay of blood/uric acid	
84702	Gonadotropin, chorionic (hCG); quantitative (second or repeats require PA)	
85002	Bleeding time	

Appendix II: In-Office Lab List

Code	Description	Limitation
85007	Blood smear, microscopic examination with manual differential WBC count	
85009	Manual differential WBC count, buffy coat	
85025	Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	
85049	Platelet, automated	
85576	Blood platelet aggregation	
85660	Sickling of RBC, reduction	
86403	Particle agglutination; screen, each antibody	
86485	Candida skin test	
86486	Skin test, unlisted antigen (used for mumps skin test)	
86490	Coccidioidomycosis	
86580	Tuberculosis, intradermal	
86677	Helicobacter pylori, antibody	
86901	Blood typing, Rh (D)	
87081	Culture, presumptive, pathogenic organisms, screening only	
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail	
87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail, other source (except blood)	
87106	Culture, fungi, definitive identification, each organism; yeast	
87110	Culture, chlamydia, any source	
87205	Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi or cell types	
87206	Smear, primary source, with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	
87207	Special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)	
87220	Tissue examination by KOH slide of samples from skin, hair, nails for fungi or ectoparasite ova or mites (e.g., scabies)	
87270	Chlamydia trachomatis	
87320	Chlamydia trachomatis	
87400	Influenza, A or B, each	
87430	Streptococcus, group A antigen, detection by enzyme immunoassay technique, qualitative or semi-qualitative, multi-step method	
87490	Chlamydia trachomatis, direct probe technique	
87491	Chlamydia trachomatis, amplified probe technique	
87591	Neisseria gonorrhoeae, amplified probe technique	
87807	Rsv assay w/optic	
87808	Trichomonas assay w/optic	
87809	Adenovirus assay w/optic	

Appendix II: In-Office Lab List

Code	Description	Limitation
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis	
87899	Agent nos assay w/optic	
87905	Sialidase enzyme assay	
88304	Level III surgical pathology, gross and microscopic examination	Can only be performed by Certified Dermatopathologist
88305	Level IV surgical pathology, gross and microscopic examination	Can only be performed by Certified Dermatopathologist
88321	Consultation and report on referred slides prepared elsewhere	Can only be performed by Certified Dermatopathologist
89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)	
89190	Nasal smear for eosinophils	
89310	Semen analysis; motility and count (not including Huhner test)	
89321	Semen anal sperm detection	
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	
80048*	Basic metabolic panel	
80053*	Comprehensive metabolic panel	
80061*	Lipid panel	
80101*	Drug screen, single drug class method (e.g., immunoassay, enzyme assay, each drug class)	
81002*	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated without microscopy	
81003*	Urinalysis, automated, without microscopy	
81007*	Urinalysis, bacteriuria screen, except by culture or dipstick	
81025*	Urine pregnancy test, by visual color comparison methods	
82010*	Acetone or other ketone bodies, serum; quantitative	
82044*	Albumin, urine, microalbumin, semi-quantitative (e.g., reagent strip assay)	
82055*	Alcohol (ethanol); any specimen except breath	
82120*	Amines, vaginal fluid, qualitative	

Appendix II: In-Office Lab List

Code	Description	Limitation
82270*	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)	
82274*	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	
82523*	Collagen, cross links, any method	
82565*	Creatinine; blood	Can only be performed by Nephrology
82570*	Creatinine, other source	
82679*	Estrone	
82947*	Glucose; quantitative, blood (except reagent strip)	
82950*	Post glucose dose (includes glucose)	
82951*	Tolerance test (GTT), three specimens (includes glucose)	
82952*	Tolerance test, each additional beyond tree specimens	
82962*	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use	
83001*	Gonadotropin; follicle stimulating hormone (FSH)	
83002*	Gonadotropin; luteinizing hormone (LH)	
83026*	Hemoglobin; by copper sulfate method, non-automated	
83036*	Hemoglobin; glycated, A1c (Test result required on claim submission for reimbursement)	
83518*	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semi-quantitative; single step method (eg, reagent strip)	
83605*	Lactate (lactic acid)	
83718*	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	
83986*	pH, body fluid, except blood	
84443*	Thyroid stimulating hormone	
84460*	Transferase; alanine amino (ALT) (SGPT)	
84478*	Triglycerides	
84520*	Urea nitrogen, quantitative	Can only be performed by Nephrology
84703*	Gonadotropin; chorionic (hCG); qualitative	
84830*	Ovulation tests, by visual color comparison methods for human luteinizing hormone	
85013*	Spun microhematocrit	
85014*	Blood count; hematocrit (Hct)	
85018*	Hemoglobin	
85610*	Prothrombin time	
85651*	Sedimentation rate, erythrocyte; non-automated	

Appendix II: In-Office Lab List

Code	Description	Limitation
86294*	Immunoassay for tumor antigen, qualitative or semi-quantitative (eg, bladder tumor antigen)	
86308*	Heterophile antibodies; screening	
86318*	Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method (eg, reagent strip)	
86618*	Borrelia burgdorferi (Lyme Disease)	
86701*	Rapid HIV-1 antibody test	
86703*	HIV-1 and HIV-2, single assay	
87077*	Aerobic isolate, additional methods required for definitive identification, each isolate	
87210*	Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)	
87449*	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semi-quantitative; multiple step method, not otherwise specified, each organism	
87804*	Influenza	
87880*	Streptococcus, group A	
89300*	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	
Q0111	Wet mounts, including preparation of vaginal, cervical or skin specimens	
Q0112	All potassium hydroxide (KOH) preparations	
Q0113	Pinworm examination	
Q0114	Fern test	
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous	

Appendix III: Quality Improvement Goals

QI Program Goals are reviewed and revised annually. A complete table of goals is listed below.

Category	Goal #	Measure	Population	Target
NCQA Accreditation	1	Improve from Commendable to Excellent	Commercial HMO/POS	Excellent
	2	Maintain Commendable status and improve overall score moving towards Excellent	Commercial PPO	Commendable
	3	Improve from Commendable to Excellent	Medicaid HMO	Excellent
	4	Maintain Excellent Status	Medicare HMO	Excellent
	5	Maintain Excellent Status	Medicare PPO	Excellent
NCQA Health Insurance Plan Rankings	6	Maintain as highest ranked plan in NM	Commercial	Highest NM Rank
	7	Maintain as highest ranked plan in NM	Medicare	Highest NM Rank
	8	Move from 3rd to highest ranked plan	Medicaid	Highest NM Rank
Medicare Star	9	Overall Star Rating	PHP HMO	≥ 4 Stars
	10	Overall Star Rating	PHP PPO	≥ 3.5 Stars
HSD Performance Measures	11	Improve the number of points earned from 22 out of 100	Medicaid HMO	54 points
	12	Maintain and improve the number of points earned from 38 out of 50	SCI	38 points
PCP Availability	13	Populations ≥ 50,000	Commercial HMO/POS Medicare HMO Medicare PPO	90.00%
	14	Populations ≤ 50,000	Commercial HMO/POS Medicare HMO Medicare PPO	90.00%
	15	Urban	Medicaid HMO	90.00%
	16	Rural	Medicaid HMO	90.00%
	17	Frontier	Medicaid HMO	90.00%
Specialty Availability	18	Urban	Commercial HMO/POS Commercial PPO Medicare HMO Medicare PPO Medicaid HMO	90.00%
	19	Rural	Commercial HMO/POS Commercial PPO Medicare HMO Medicare PPO Medicaid HMO	90.00%
	20	Frontier	Commercial HMO/POS Commercial PPO Medicare HMO Medicare PPO Medicaid HMO	90.00%
Pharmacy Availability	21	Urban	Commercial HMO/POS Commercial PPO Medicaid HMO	90.00%

Appendix III

	22	Rural	Commercial HMO/POS Commercial PPO Medicaid HMO	90.00%
	23	Frontier	Commercial HMO/POS Commercial PPO Medicaid HMO	90.00%
	24	Urban	Medicare HMO Medicare PPO	90.00%
	25	Rural	Medicare HMO Medicare PPO	90.00%
	26	Frontier	Medicare HMO Medicare PPO	90.00%
Accessibility of Service (Appointment Availability)	27	Primary Care (Annual CAHPS® Question Getting Routine Care)	Commercial HMO/POS Commercial PPO Medicare HMO Medicare PPO Medicaid HMO	National Average
	28	Specialty Care (Annual CAHPS® Question Getting Appointments with Specialists)	Commercial HMO/POS Commercial PPO Medicare HMO Medicare PPO Medicaid HMO	National Average
Member Satisfaction	29	Rating of Health Plan – Annual CAHPS® Survey	Commercial HMO/POS Commercial PPO Medicare HMO Medicare PPO Medicaid HMO	55th %tile 55th %tile 90th %tile 90th %tile 90th %tile
	30	Rating of Health Plan – Quarterly Member Survey	Commercial Medicaid Medicare Overall	81.6% 85.3% 87.6% 73.2%
Provider Satisfaction	31	Rating of Health Plan – Annual Provider Survey	All provider	50th %tile
Patient Safety	32	Near Miss/Adverse Events	All product lines	0.29