



EPSDT Waiver Provider Training Guide 2006/2007

PROVIDER TRAINING GUIDE

Overview

The guide will assist the EPSDT Waiver Providers interested in joining Presbyterian Health Plan (PHP) better understand the credentialing, contracting, and claims processes and guidelines. Also provided in this guide is a copy of a Presbyterian Health Plan Member Identification Card and a department/person contact list.

Thank you for your interest in becoming a Presbyterian Health Plan Provider. We look forward to working with you.

CREDENTIALING

PROCESSES AND TIMELINES

WHO HAS TO BE CREDENTIALLED?

- Practitioners – All licensed practitioners providing services for Presbyterian Health Plan Members. Therapists: Physical, Occupational, and Speech. **NOTE**: Certified Occupation Therapy Assistants are not credentialed or paid by Presbyterian.
- Health Delivery Organizations (HDOs) – Home Health Agency or Rehab Agencies or Facilities

APPLICATION, LETTER OF INTEREST, & W-9

- All therapists listed above **must** be credentialed and complete:
 1. Letter of interest that includes the type of service(s) provided, addresses (physical, mailing & billing), telephone number(s) and fax numbers;
 2. Completed & signed W-9 and CRS-1 form;
 3. Copies of any certifications related to their specialized services;
 4. An application at http://www.nmhsc.com/credentials_verifications/new_mexico_statewide_application_privileges_and_forms.html, please contact Kim Glander at 505-923-5141 at Presbyterian Health Plan, Provider Services when your application is completed (hardcopies available upon request);
 5. Current Malpractice/Liability Insurance coverage.
- All Home Health or Rehab Agencies must submit:
 1. An application; (see attached titled “Organizational Provider Application Check Sheet”)
 2. Letter of interest that includes the type of service(s) provided, addresses (physical, mailing & billing), telephone number(s) and fax number(s);

3. Completed & signed W-9
4. Current operating license issued by the state;
5. Copy of most recent accreditation (JCAHO, CARF);
6. Current certification from the Department of Health (DOH) for all applicable programs/facilities

Licensed Home Health Agencies will be contracted through the Presbyterian Health Plan Statewide Network for Home Health.

Contact Information:

Karen Thompson
505-559-7036
kthompso@phs.org

CREDENTIALING STEPS

- **Therapists:** Once you have completed all of the information outlined, please submit hardcopy applications to Presbyterian Health Plan, Provider Services at the address noted below:

Kim Glander
Presbyterian Health Plan, Provider Services
PO Box 27489
Albuquerque, NM 87125-7489
Fax 505-923-5400
Phone 505-923-5141
Kglander@phs.org

- **Home Health Agencies:** Submit the information outlined to the fax or mailing address above.

WHO DOES THE CREDENTIALING?

- **Therapists:** Hospital Services Corporation (HSC) performs primary source verification for Presbyterian Health Plan. Once this is completed, Presbyterian Health Plan will present at their

Credentialing Peer Review Committee. The committee meets the first Wednesday of each month.

- Home Health and Rehab Agencies: presents credential information at the Credentialing Peer Review Committee. The committee meets the first Wednesday of each month

HOW LONG DOES THE CREDENTIALING PROCESS TAKE?

- The entire process takes an average of 30-45 days – **with completed information.**

NOTE: Completing the credentialing process does not mean a practitioner or provider is contracted.

CONTRACTING **PROCESSES AND TIMELINES**

CONTRACT PROCESS

Existing Contracted Group

- If you are with an existing contracted group, you will not receive a contract. When the credentialing process is complete, you will receive a letter that informs you of the credentialing decision and your contact person.

New Group or Individual Practitioner

- If you are a new group and/or new individual practitioner, you will become contracted when the **credentialing process is complete**, and the Credentialing Committee **approves your application**, and a contract between both parties (provider and Presbyterian Health Plan) is **agreed upon and signed**.

- The contract becomes **effective on the contract execution date**.
- **Exhibit A** – signature page sample from Presbyterian Health Plan Model Contract

CONTRACT TIMELINE

- The provider can review contracts as soon as all credential information has been received and the credentialing process begins.
- The agreed upon contract can be signed by both parties the day after the Credentialing Peer Review Committee meets.

CONTRACT NEGOTIATIONS

- Contract negotiations should occur during the credentialing process. Presbyterian Health Plan bases payment schedules on the NM Medicaid Fee Schedule.

WHAT HAPPENS AFTER THE CONTRACT IS SIGNED?

- Provider information is loaded into Presbyterian Health Plan claims system for claims processing and provider database for provider directories and geo-access reports.
- A welcome letter and Provider Manual will be sent with your signed contract. The letter will introduce your designated Provider Services Coordinator (PSC) and encourage you to contact your PSC to schedule an orientation with you and/or office staff.

LETTER OF AGREEMENT

- To ensure that there is not an interruption of care for Presbyterian Health Plan members, a Letter of Agreement may be obtained during the credentialing and contracting process.

1. Contact the Presbyterian Health Plan Health Services Department and request a Letter of Agreement or Benefit Certification.
2. Inform the Presbyterian Health Plan Health Services Department at the time of the request that you are in the process of credentialing/contracting.

CLAIMS

PROCESSES AND TIMELINES

CLAIM REQUIREMENTS

- **Timely Filing** – All claims must be submitted and received by Presbyterian within ninety (90) days from the date of service when Presbyterian is the Member's primary insurance. All claims must be submitted within one year from the date of service when Presbyterian is the secondary insurance.
- **Coordination of Benefits (COB)**
 - Providers should keep current coverage information for all members;
 - Presbyterian Health Plan will always be the payor of last resort;
 - When submitting COB claims, you must attach a copy of the Primary Carrier Insurance's Explanation of Benefits (EOB);
 - If the Primary Payor bundles the charges (enters all charges on one line), payment will be considered by Presbyterian in the same manner;
 - Payment will be made upon determination of the allowable amount minus the primary insurance payment; and
 - The member must follow the Primary Carrier Insurance's guidelines for claims payment (i.e.: obtaining prior authorization).
- **Adjustment Requests/Claims Reconsideration and Resubmission** – Must be submitted and received by Presbyterian Health Plan within twelve (12) months from date of service.

- If the re-submission is past the 90-day filing limit, include the original filing documentation with your re-submission (i.e. computer ledgers or exceptions report from Presbyterian for ECT claims).
- **Secondary Payor** – Ninety (90) days from the EOP date from the primary payor.
- **Appeals** – 90 days from the date of initial denial.
- Any proof of timely filing must be submitted within twelve (12) months of the date of service.
- Providers are encouraged to follow up every 30-45 days on claims submissions to verify receipt by Presbyterian Health Plan by logging on to PresOnline.

Please refer to the Presbyterian Health Plan Provider Manual for detailed information regarding timelines.

CLEAN CLAIM CRITERIA

- Claims must include the following to be considered “clean”:
 - New CMS 1500 form;
 - Provider’s National Provider Identifier (NPI);
 - Member’s name;
 - Correct Member Date of Birth;
 - Complete diagnosis code carried out to the highest degree (4th or 5th digit);
 - Valid date of birth;
 - Valid Current Procedural Terminology (CPT-4) or Health Care Procedure Coding System (HCPCS) code;
 - Valid Revenue (REV) Codes – please refer to Section I-7;
 - Valid modifiers (if applicable);
 - All other requirements as specified in 13 NMAC 10.13.25, (O).

CLAIM TURN-AROUND TIME

- Clean Claims – 30 days for claims submitted electronically; 45 days for claims submitted on paper.

G CODES

- G Codes will be processed as long as the services are provided in the home or natural environment (not center based or provider location). Some primary insurance carriers may not cover G Codes. If the primary carrier denies this code as not a covered benefit, Presbyterian Health Plan will reimburse, as long as the EOB indicates this as the denial reason. Please submit the claims (with the G Code) to the primary insurance even if you know it is not a covered benefit and submit the claims and denial EOB to Presbyterian Health Plan for payment.

GROSS RECEIPTS TAX

Sales/Gross Receipts tax cannot be added to the charges of any patient who is a Member of a Health Plan or insurer of which a practitioner/provider has made an agreement to accept their reimbursement Division of Insurance Regulation, 13 NMAC 10.13.27.

Presbyterian has a policy of reimbursing our eligible contracted practitioners an amount to offset the Gross Receipts Tax, which consists of a state average (current rate as of 6/1/07 as 6.99%). The practitioner will need to provide Presbyterian with a copy of their CRS-1 form to verify that the practitioner is eligible for this additional reimbursement.

CLAIM SUBMISSION

- **Paper claims:**

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

- **Electronic Data Interchange (EDI)**

Please refer to the Presbyterian Health Plan Provider Manual or the Presbyterian Health Plan Provider Web page at www.phs.org for a complete listing of EDI Vendors or see Exhibit B.

Please refer to the Presbyterian Health Plan Provider Manual or Presbyterian Health Plan's Provider Web page at www.phs.org for detail information regarding claims, resubmission and appeals.

NEW FORM SAMPLE: CMS 1500
(sample inserted here)

NEW FORM INSTRUCTION: 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 (12-90) form has been revised and replaced with CMS 1500 (08-05). This form was available to providers as of October 1, 2006. Providers may use either the current (12-90) version or the revised (08-05) version when submitting claims for the transitional period of October 1, 2006 through May 4, 2007.

Effective May 4, 2007, the current version (12-90) will be discontinued and only the revised version (08-05) will be accepted. Presbyterian follows HSD guidelines and will only accept the new version (08-05) effective on May 4, 2007 for the billing of new claims and the rebilling of older claims.

When filing a claim on a CMS 1500 form, certain fields must be completed. The following table indicates those fields, on both form versions, that are required to ensure correct and timely processing.

Information	New Form (08-05)
<i>Insured's ID</i> Obtain the patient's most current Presbyterian insurance card and verify the correct ID number. The submission of an incorrect ID number WILL delay the processing of your claim or result in a claim denial.	1 a
<i>Patient's name</i>	2
Patient's date of birth and gender Verify the correct patient date of birth. The submission of an incorrect date of birth may delay the processing of your claim or result in a claim denial.	3
Patient's address (number, street, city, state and zip)	5
Other Insured's name and address (only if 11d is checked "yes")	9 a-d
Other Insured's policy/group information (only if 11d is checked "yes")	11 a-c
Is there another health benefit plan?	11 d
Diagnosis related to visit to the highest specificity (use the most current ICD9-CM)	21
Date(s) of service	24 a
Place of service (use appropriate code accepted by CMS)	24 b
Valid CPT/HCPCS codes and modifiers when required (use the most current coding books). If unable to provide a valid procedure code, or when using an unlisted/unclassified procedure code, please provide a description of the service and any appropriate medical records.	24 d
Diagnosis Code reference from Box 21 to relate diagnosis to the service performed	24 e
Charges	24 f
Units/Days (if required by contract or to pay the claim)	24 g
Rendering Provider Taxonomy	24 j (upper)

Rendering Provider NPI	24 j (lower)
Federal Tax ID (must be in Presbyterian's claims processing system)	25
Accept assignment	27
Physician's or supplier's name and signature, or signature of the authorized representative	31
Service Facility name and address	32
Enter Service Facility NPI number in this space.	32a
Enter Service Facility Taxonomy number in this space	32b
Physician's or supplier's billing name and address	33
Enter your NPI number in this space.	33a
Enter your Taxonomy number in this space	33b

APPEALS AND GRIEVANCES

- Presbyterian Health Plan encourages providers/practitioners to file claims correctly the first time or, if time allows, resubmit the claim through the Provider CARE Unit to resolve an issue.
- A provider/practitioner 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, a provider/practitioner has one year (12 months) from the date of services 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, a provider/practitioner must be able to show documentation that timely follow-up was conducted into the matter. Timely follow-up includes proof of contact with the plan, such as patient ledgers or copies of written communications.

The following link is for submitting an appeal or grievance online

<https://secure.phs.org/healthplan/providers/complaint.shtml>

MEMBER IDENTIFICATION

ID CARD INFORMATION

Presbyterian Health Plan Member Identification Information:

- Member Name
- Member Social Security Number/Unique ID Number
- PCP Name, Address & Phone Number
- Back of Card: Presbyterian Salud Contact Phone Numbers, Value Options Phone Number and Transportation Information

CONTACT INFORMATION

Physical and Mailing Addresses

Mailing Address:

Presbyterian Health Plan
P.O Box 27489
Albuquerque, NM 87125-4789

Physical Address:

2501 Buena Vista SE
Albuquerque, NM 87106

CONTACT INFORMATION

Telephone & Fax Numbers & E-Mail Addresses

Once a provider has been credentialed and contracted with Presbyterian, your primary contact will be your assigned Provider Services Coordinator. The Provider Services Coordinator can assist you with any questions or concerns you may have that can not be addressed by Pres Online or the Provider CARE Unit. Provider Services Coordinators are assigned based on geographic location. The following is a list of contact information for the Provider Services Coordinators by region:

Central Region

Amy Hallquist
(505) 923-5075
ahallqui@phs.org

Northern Region

Tim Gonzales
(505) 923-8374
tgonzale@phs.org

Territories Include: Santa Fe, Espanola, Los Alamos, Taos

Miranda Tso
(505) 923-6205
Mtso@phs.org

Territories Include: Farmington, Las Vegas, Raton, Gallup, Tucumcari

Southern Region

Michael Alfaro
(505) 923-5414
malfaro@phs.org

Territories Include: Alamogordo, Deming, Silver City

Mireya Ortega
(505) 923-5429
meortega@phs.org

Territories Include: Las Cruces, Ruidoso, Hatch

Lisa Williams
(505) 923-5428
liwillia@phs.org

Territories Include: Roswell, Clovis, Carlsbad, Hobbs, Socorro,
T or C

Health Services

Contact Information:

(866) 923-5757 or (505) 923-5757 - Option 4

PresOnline for Benefit Certification Submission or Status

Member Services

Contact Information:

(888) 977-2333 or (505) 923-5200

EXTENDED CONTACT LIST

**Interactive Voice Response (IVR), PresOnline & Provider
Care Unit**

IVR

(866) 923-5757 or (505) 923-5757

Pres Online

Pres Online is a free service offered by Presbyterian to assist practitioners and their staff with administrative tasks. This information is accessed by logging on to

<http://www.phs.org/healthplan/providers/index.shtml> selecting, Pres Online, Providers.

Please use PresOnline when inquiring about:

- Benefit Certification (formerly medical/physical Prior Authorization) Status
- Benefit Certification Submission
- Claims Status
- Claims Submission
- Contact Provider CARE Unit (see below)
- Copayment Amounts
- Pharmacy Exception (formerly Pharmacy Prior Authorization) Status
- Pharmacy Exception Submission
- Member Eligibility
- Primary Care Practitioners (PCPs) Verification

Provider Services CARE Unit

Provider CARE Unit Specialists are trained to answer your questions and, when necessary, conduct research regarding claims adjustments. For complex inquiries, such as claims adjustments and claim reviews, that cannot be answered through Pres Online, IVR (Interactive Voice Response, or one of our Electronic Submission Vendors, you can [contact the Provider Services CARE Unit](#) (Web inquiry) Monday through Friday, 8 a.m. to 5 p.m. or:

Presbyterian Health Plan “Dedicated” Provider Line
(866) 923-5757 or (505) 923-5757
E-mail: provcare@phs.org

PresOnline e-Help Desk for access and assistance to PresOnline:
(866) 861-7444 or (505) 923-5590
E-mail: provcare@phs.org
Fax: (505) 923-5124

Exhibit A

PRESBYTERIAN NETWORK, INC. ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement (this “Agreement”) is dated as of the date specified below and is by and between Presbyterian Network, Inc., a New Mexico corporation (“PNI”) and


(the “Provider”).

RECITALS:

A. PNI acts as agent for Presbyterian Health Plan, Inc. (“PHP”) and for other Payors, as hereinafter defined.

B. PNI desires to engage Provider to provide certain services in support of the Health Benefit Programs that PHP and other Payors offer and which are designated in this Agreement.

C. PNI and Provider desire to set forth the arrangements between them concerning the responsibilities of each party to this Agreement.

AGREEMENTS:

1. *Agreement.* PNI and Provider hereby agree to be bound by each of the General Provisions attached to and made a part of this Agreement.

2. *Ancillary Services.* Provider agrees to provide those Ancillary Services described in the attached Exhibit A at each of those Service Locations listed on the attached Exhibit A.

PRESBYTERIAN NETWORK, **LEGAL ENTITY NAME**
INC.

By: _____
Authorized Representative

David Scrase, M.D., **ADDRESS**
President Albuquerque, New Mexico 87110

P.O. Box 27489
Albuquerque, New Mexico 87125-7489
Facsimile No.: _____
Execution Date: _____

Facsimile No.: (505) 923-5400
EIN: **TAX ID #**

Execution Date: _____

Effective Date: _____

Exhibit B

CLEARINGHOUSE CONTACT INFORMATION

Clearinghouse	Contact Information
NaviNet Claims, a Service of NaviMedix 4001 Office Court Drive, Building 200 Santa Fe, NM 87507	Gina Romero 505-982-6775 x3922 www.NaviNetClaims.com
Availity, LLC (formerly known as The Health Information Network or THIN, Inc.) 12400 Coit Road, Suite 700 Dallas, TX 75251	Daniel L. Garcia Market Development Representative 6565 America's Parkway NE, Suite 250 Albuquerque, NM 87110 (505) 563-5850 (phone) (505) 563-5851 (fax) Daniel.garcia@availity.com www.availity.com
HealthXnet 2121 Osuna Road NE Albuquerque, NM 87113	HealthXnet Support & General Info 505-346-0290 or 1-866-676-0290 healthxnet@nmhsc.com www.healthxnet.com
Medifax / Emdeon 1283 Murfreesboro Rd. Nashville, TN 37217	Professional Medical Sales: 877-469-3263, option 3 BusinessServicesSales@Emdeon.com Emdeon Sales Dept. 3055 Lebanon Road, Bldg 2, Nashville, TN 37214

Clearinghouse	Contact Information
	Customer Service: 1-877-469-3263, option 2 www.Emdeon.com
XactiMed (formerly ECS) 901 International Parkway Suite 200 Richardson, TX 75081	Contact Information 1-877-922-8463 info@xactimed.com www.xactimed.com