BlueCross BlueShield of New Mexico

Long Term Services & Supports

Blue Cross Community Centennial℠ • Provider Training • 2022

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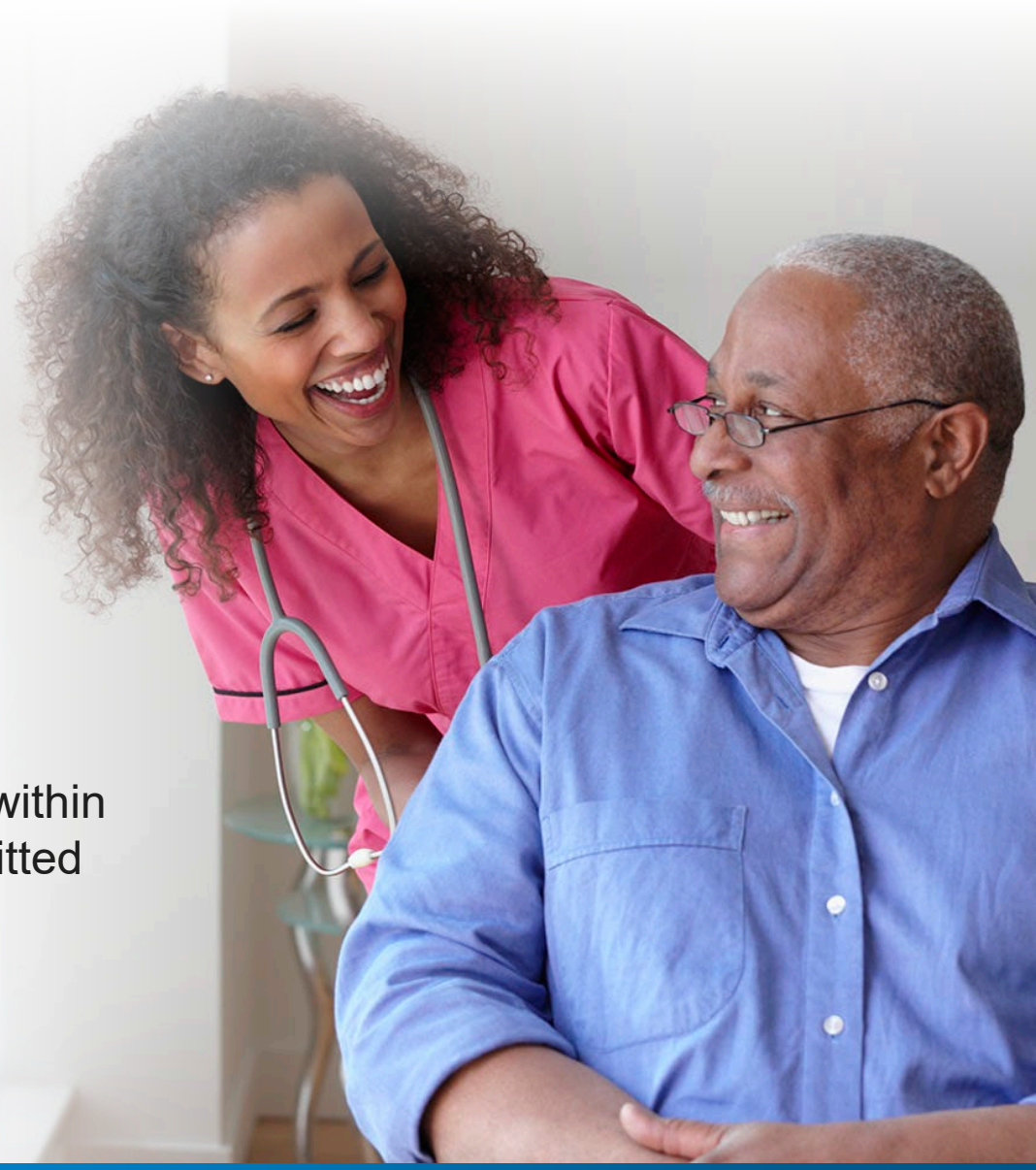
Nursing Facility (NF) Admissions and Discharges

Nursing facilities are required to notify Blue Cross and Blue Shield of New Mexico (BCBSNM) within 24 hours of a member's:

- Admission or request for admission including short-term stays
- Discharge:
  - Notify UM within 24 hours of the discharge
  - Facilities should notify their assigned Nursing Facility Care Coordinator or Reintegration Specialist as soon as possible to start the process of a safe reintegration
  - Has left Against Medical Advice
  - Hospital and/or Emergency Room encounters
  - Death
- Pending discharge
- Please call **877-232-5518**

Nursing Facility Level of Care (NFLOC) packets should be faxed within 30 days of admission and 60 days **prior** to expiration. If not submitted in a timely manner, it will affect the member's Medicaid eligibility.
Note: NFLOC should not be submitted for short-term stays.

- Long Term Care (LTC): 505-816-2093
- Clinical documentation: 505-816-3854



Important Reminders to Nursing Facilities

Initial Determinations

- All Services must be medically necessary
- Please refer to the Managed Care Policy Manual regarding procedures for prior approval

Redeterminations

- Medical documentation must be received by BCBSNM at least 60 calendar days prior to the start date of the new certification period for Low Nursing Facility (LNF) and 30 calendar days for High Nursing Facility (HNF)

Retroactive Medicaid Eligibility

- Written requests for prior approval based on resident's financial eligibility must be reviewed within 30 calendar days of the date of the eligibility determination

NFLOC Packet Components

Preadmission Screening and Resident Review

NFLOC Notification Form

- All requests for prior approval will be submitted on the NFLOC Notification Form
- Please document the type of review being requested at the top of the NFLOC Notification Form:
  - Initial
  - Continued Stay
  - Medicaid Pending
  - Transfer
  - Readmit
  - Reconsideration
- All other required fields must be completed

NFLOC Packet Components (cont.)

Minimum Data Set (MDS)

- An MDS and other appropriate documentation must be completed for each resident for every situation requiring prior approval
- All locator fields must be clearly marked on the MDS
- When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process
- Appropriate documentation must accompany the MDS including a valid order and must:
  - **be signed** by a physician, nurse practitioner, clinical nurse specialist or physician assistant;
  - **be dated**; and
  - **indicate the Level of Care (LOC)** – either high NF (HNF) or low NF (LNF)

Please refer to the **New Mexico Medicaid Nursing Facility (NF) Level of Care (LOC) Criteria and Instructions**.

Procedure for Transfers Between Nursing Facilities

The receiving NF must notify BCBSNM by telephone that a transfer to its NF is to occur and the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid.

- If there are **more than** 30 calendar days on the resident's current authorization, BCBSNM will fax the receiving NF the completed notification form which will include the prior authorization and date span.
- If there are **less than** 30 calendar days remaining on the current authorization, the receiving NF will request a continued stay on the notification form. BCBSNM will make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay.
- Please write "TRANSFER" in the type of request box on the notification form.

The NF receiving the resident will obtain the status of resident's reserve bed days from BCBSNM through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records.

Agency-Based Community Benefit (ABCB) Covered Services

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Personal Care Services – Consumer Directed
- Personal Care Services – Consumer Delegated
- Private Duty Nursing for Adults
- Nursing Respite
- Respite (hourly and per diem)
- Skilled Maintenance Therapy Services
  - Occupational Therapy for Adults
  - Physical Therapy for Adults
  - Speech Therapy for Adults

Self-Directed Community Benefit (SDCB) Covered Services

- Behavior Support Consultation
- Customized Community Supports
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Private Duty Nursing
- Related Goods
- Respite
- Respite RN
- Self-Directed Personal Care
- Skilled Maintenance Therapy Services for Adults
- Specialized Therapies
- Start-up Goods
- Transportation (non-medical)

Self-Directed Community Benefit

SDCB Coverage Limitations	
Environmental Modifications	$5,000 every 5 years
Related Goods	$2,000 every year
Respite	300 hours per care plan year
Respite RN	300 hours per care plan year
Specialized Therapies	$2,000 per year
Start-up Goods	One-time coverage up to $2,000
Non-Medical Transportation	$1,000 per year

Home and Community-Based Services (HCBS) Settings Rule

- Purpose is to ensure that individuals receiving long-term services and supports through HCBS programs under the 1915(c), 1015(I) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.
- To enhance the quality of HCBS and provide opportunity and protection to individuals in these settings.
- If the provider fails to meet HCBS requirements, BCBSNM may impose corrective actions as detailed in the provider's New Mexico Medicaid Medical Services Agreement or the New Mexico Medicaid Centennial Care Amendment, whichever is applicable. In Rare circumstances this includes corrective actions including termination of contractual agreements.

HCBS Settings Rule Details

The Home and Community-Based settings should:

- Be integrated in and support access to the greater community
- Provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home- and community-based services
- Be selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
- Be person-centered service plans with documented options based on the individual's needs, preferences; and for residential settings, the individual's resources
- Ensure an individual's rights of privacy, dignity, respect and freedom from coercion and restraint
- Optimize individual initiative, autonomy and independence in making life choices
- Facilitate individual choice regarding services and supports, and who provides them

Electronic Visit Verification (EVV)

EVV was established to ensure that members are receiving authorized personal care services (PCS) on the day and time approved.

- EVV for the Agency-Based Community Benefit population was implemented statewide in 2016.
- EVV implementation for Early and Periodic Screening, Diagnostic and Treatment – Personal Care Services (EPSDT PCS) on January 1, 2020, and for the Self-Directed Community Benefit population beginning on January 1, 2021.
- EVV implementation for Home Health will go live on January 1, 2023. The EVV requirements are federally mandated by Section 12006 of the 21st Century Cures Act.

EVV Access Options

Multiple Authenticare® Access Options Available

- Option #1: Member's home phone/landline or cell phone – If allowed by the member, caregivers will use their member's home phone/landline or cell phone to call into the AuthentiCare Interactive Voice Response (IVR) system; or
- Option #2: Caregiver's Mobile Device (smartphone or tablet) with Stipend – Each managed care organization (MCO) will provide a stipend to the provider agency to create an incentive for caregivers to utilize their personal mobile device (smartphone or tablet) and existing data plan when using the AuthentiCare mobile application for data transfer. The entire stipend must be paid to the caregiver and the agency may not retain any of it. All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT); or
- Option #3: Tablets – The option to order a BCBSNM-owned WiFi-enabled tablet for those caregivers who do not have access to a personal mobile device (smartphone or tablet) or a member's home phone/landline or cell phone. Provider agencies can place orders through mobilityexchange.us. Please ensure all orders include a valid BCBSNM member ID number (including prefix YIF) or Medicaid ID.
- Additional terms and conditions may apply.

Additional Notes on EVV

Manually Entered Web Claims

In April 2018, a new enhancement deployed within the Authenticare system required the Centennial Care Managed Care Organizations to review all manually entered web claims. This enhancement will also require Personal Care Service agencies to collect and maintain documentation for every manually entered transaction and use of an exception.

Providers are required to provide detailed notes on each manually entered web claim.
If BCBSNM has any questions regarding a web-based claim, either the assigned BCBSNM EVV contact, or a provider representative will request you to supply supporting documentation further justifying the reason for the manual entry.

Worker Relationships

You are required to identify the worker relationship (spouse, parent, other, etc.) in Authenticare for each member.

Authenticare User Guides and Trainings

When logged into the Authenticare system, the agency can find helpful resources under the Custom Links tab on the main screen. These include the Authenticare User Manual, Provider Documents and the SDCB Training.

Important Reminders to HCBS Providers

Information you provide helps BCBSNM and other providers to better serve members. Please remember to:

- **Complete and submit the Critical Incident Report when a member has an adverse event**
- **Assist members with contacting BCBSNM Member Services and/or their care coordinator when they move or change phone numbers**
- **Provide the Individualized Plan of Care when requested**
- **Notify the member's care coordinator if you become aware of any issues that may affect a member's health and safety**

BCBSNM LTC Key Contacts

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Electronic Visit Verification
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Authorizations
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Personal Care Service and Nursing Facility Meetings

BCBSNM holds regular PCS and NF meetings with providers. This allows providers to collaborate with BCBSNM and identify trends and issues that need resolution. It also allows providers an opportunity to request specialized trainings.

If you are interested in attending or need to update your agency's contact information, please reach out to your assigned provider representative.

Questions