BlueCross BlueShield of New Mexico

ENTENNIALCARE

Indian Tribal Urban Claims Reimbursement Process Provider Training

Blue Cross Community Centennial℠

A Centennial Care Plan

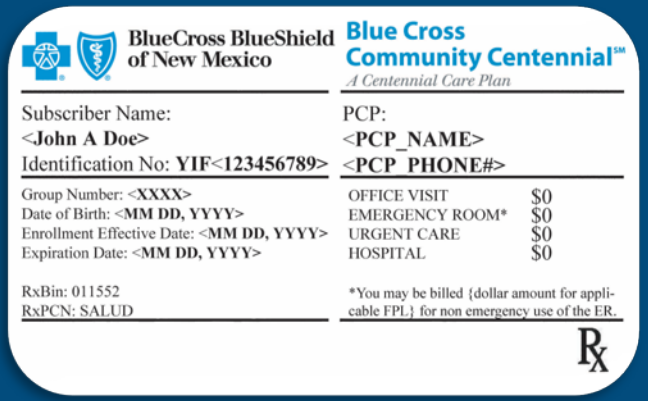
2017

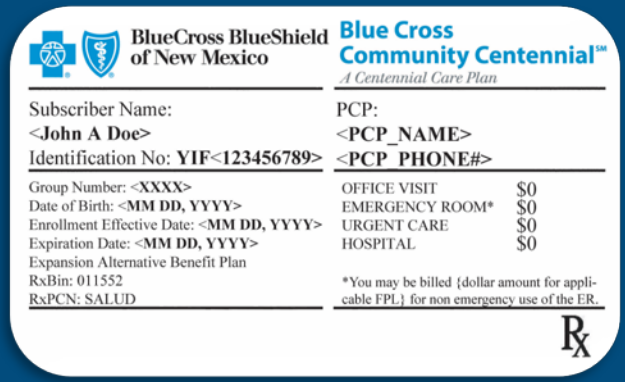
Table of Contents

Member Eligibility

State plan ID Card
Member Eligibility
At each office visit, your office staff should:
Ask for the member's ID card.
Copy both sides of the ID card and keep the copy with the patient's file.
Determine if the member is covered by another health plan and record information for coordination of benefits purposes, including Medicare coverage.
If the member is covered by another health plan, the provider must submit to the other carrier(s) first.
After the other carrier(s) pay, submit the claim to BCBSNM.
Refer to the member's ID card for the appropriate telephone number to verify eligibility and applicable co-payments specific to the member's coverage. (Native American's are exempt from co-payment amounts and prior authorization requirements to I/T/U's).

https://www.bcbsnm.com/pdf/benefits/cc_member_handbook_nm.pdf


BlueCross BlueShield of New Mexico
Blue Cross Community Centennial℠
A Centennial Care Plan
Subscriber Name:
<John A Doe>
Identification No: YIF<123456789>
PCP:
<PCP_NAME>
<PCP_PHONE#>
Group Number: <XXXX>
Date of Birth: <MM DD, YYYY>
Enrollment Effective Date: <MM DD, YYYY>
Expiration Date: <MM DD, YYYY>
RxBin: 011552
RxPCN: SALUD
OFFICE VISIT $0
EMERGENCY ROOM* $0
URGENT CARE $0
HOSPITAL $0
*You may be billed {dollar amount for applicable FPL} for non emergency use of the ER.
Rx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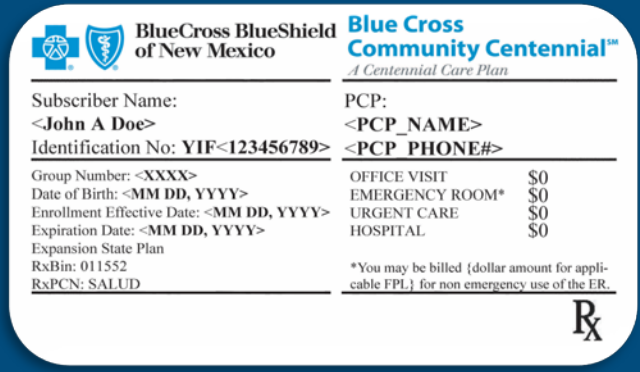
Expiration Date: <MM DD, YYYY>
Expansion Alternative Benefit Plan
RxBin: 011552
RxPCN: SALUD
OFFICE VISIT $0
EMERGENCY ROOM* $0
URGENT CARE $0
HOSPITAL $0
*You may be billed {dollar amount for applicable FPL} for non emergency use of the ER.
Rx


bcbsnm.com
BlueCross BlueShield of New Mexico
For care received in/outside of NM:
BCBSNM Claims Dept
PO Box 27838
Albuquerque NM 87125-7838
Prior authorization required for some in-network and most out-of-network services.
Special Beginnings® members must call in the first Trimester of pregnancy. For emergencies, call 911 or go to the closest emergency room.
After treatment call your PCP.
PRIME THERAPEUTICS®
Customer Service 1-866-689-1523
Special Beginnings 1-888-421-7781
24/7 Nurseline 1-877-213-2567
Ride Assist* 1-866-418-9829
ReserveTransport* 1-866-913-4342
*Group contracts directly
Blue Cross Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross Blue Shield Association
Pharmacy Benefits Manager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Expansion State Plan
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RxPCN: SALUD
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EMERGENCY ROOM* $0
URGENT CARE $0
HOSPITAL $0
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Rx

Claim and Reimbursement Process

Top 10 Claim Denials

Current I.H.S Tribal 638 Requirements

- For I.H.S and Tribal 638 facilities, most services are paid at the Office of Management and Budget (OMB) Rate, using the UB claim form and either a revenue code for dental clinic (0512) or for physical health clinic (0519). For a Behavioral Health practitioner service revenue code 0919 is used.
- Some services are not part of the OMB rate and are billed on the CMS 1500 form and paid at regular fee schedule rates.

Claims

Claims Submission

- Electronically : Use Payer ID 00790
- For information on electronic filing of claims, contact Availity at 1-800-282-4548.
- Paper claims must be submitted on the Standard CMS-1500 (Physician/Professional Provider) or CMS-1450 (UB-04 Facility) claim form to:

  Blue Cross Community Centennial

  P.O. Box 27838

  Albuquerque, NM 87125-7838

Duplicate Claims

- Verify claims receipt with BCBSNM prior to resubmitting to prevent denials.

Claims

Clean Claims

To expedite claims payment, the following information must be submitted on all claims:

- Member's name, date of birth and gender
- Member's ID number (as shown on the member's ID card, including the 3-digit alpha prefix: YIF)
- Individual member's group number, where applicable
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-10 diagnosis codes
- CPT® procedure codes
- NDC codes in accordance with Medicaid requirements
- Date(s) of service(s)
- Charge for each service
- Provider's Tax Identification Number (TIN)
- Provider NPI number (Type 1 and Type 2 if applicable)
- Name and address of participating provider
- Signature of participating provider providing services
- Place of service code
- Preauthorization number, if required
- The Blue Cross Community Centennial electronic payer ID # for participating providers is 00790.

Friendly Reminders

- In September 2010, NM HSD/MAD began requiring all Medicaid practitioners and providers to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions.

www.hsd.state.nm.us/mad/pdf_files/Registers/Registers2010/10%2003%20pharmacy.pdf

- Federal Deficit Reduction Act of 2005 (signed in 2006) requires Medicaid providers to report the 11-digit National Drug Code (NDC) on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions when billing for injections and other drug items administered in outpatient offices, hospitals, and other clinical settings. Providers were first notified of this requirement in November 2007, in the supplement information available on the New Mexico Human Services Department, Medical Assistance Division (NM HSD MAD) website at:

  www.hsd.state.nm.us/mad/pdf_files/Supplements/MAD_REG_S_07-09.pdf

Claims

Timely Filing

- Indian Health Service providers (I/T/U) have up to 2 years from the date of the service to file claims.

Non I/T/U Providers:

- Submit claims within 90 days of the date of service
- All claims submitted after 180 days will not be eligible for reimbursement.
- Providers may not seek payment from members for claims filed after the 180 day filing deadline.

Claims

Coordination of benefits:

- Blue Cross Community Centennial is always the payer of last resort.

- For members with both Medicare and Medicaid, Medicare is considered the member's primary insurance.

Encounter reporting:

- BCBSNM is required by New Mexico Human Services Department (HSD) , to report ALL services rendered to Centennial Care Members.

Encounters

Multiple Encounters:

- More than one OMB charge can be billed in a day if the patient has different distinct services such as going to a dentist, then to an eye exam on the same day, or goes a second time to the same facility on the same day with a different diagnosis, (For continuity of care, please follow your internal guidelines)
- If a recipient returns for lab work or radiology services on a day without any other billable encounter, the lab or radiology can still be billed as one encounter and paid at the OMB rate

OMB Inpatient Payment Rates:

- For inpatient stays, payment is made at the OMB inpatient daily rate using a revenue code (0100). No other services are itemized on the UB04 form
- The inpatient OMB rate is a daily rate. The discharge date is not paid. Billing of interim claims during a hospital stay is acceptable
- The physician or other practitioner inpatient visits are not included in the inpatient OMB rate, so they are billed separately on the CMS 1500 format and paid at fee schedule rates

Standardized Billing

- For services not paid at the OMB rate, the rate paid by MCO's cannot be less than the Medicaid fee schedule rate
- To bill an OMB encounter rate, the recipient must be seen, or supervised by a practitioner who could be enrolled as a practitioner, physician, dentist, CNP, PA, dental hygienist, clinical pharmacy specialist, etc.

Standardized Billing

OMB Outpatient payment rates (Continued):

- The OMB rate can be billed when the physician or other practitioner reviews and signs a medical record after a nurse provides or completes:
  - EPSDT screening
  - Reviewing a radiology image taken by a technician
  - An immunization

CMS Non-OMB Billing and Reimbursement

- Services billed on the CMS 1500 and reimbursed at the Fee schedule are:
- Anesthesia (professional charges)
- Ambulatory surgical center facility services
- Case management (targeted case management)
- DME
- Hearing aids (hearing testing is reimbursed at the OMB rate)
- Lab charges (this may be new for some I.H.S. and Tribal facilities; some bill this way now)
- Radiology/imaging
- Physician inpatient hospital visits and surgeries
- Smoking cessation
- Telehealth (telemedicine)

ITU Claims and Reimbursement

The following are services billed on the CMS 1500 and reimbursed at the non-OMB fee schedule:

- Anesthesia (professional charges)
- Ambulatory surgical center facility services
- Case management (targeted case management)
- Hearing aids
  (hearing testing is reimbursed at the OMB rate)
- Physician inpatient hospital visits and surgeries
- Smoking cessation
- Telehealth charge (telemedicine)
- Transportation
- Vision appliances, frames, lenses, dispensing glasses, contacts, etc. (The exams are in the OMB rate)

ITU Claims and Reimbursement

- For I.H.S and Tribal 638 facilities, most outpatient services are paid at the Office of Management and Budget (OMB) Rate, using the UB04 claim form and one of the following revenue codes:
  - (0512) dental clinic/dental service
  - (0519) Physical health clinic/and all other services
  - (0919) Behavioral Health practitioner service
- Select services are not part of the OMB rate and are billed on the CMS 1500 form and paid at regular fee schedule rates.

Standardize Billing and Reimbursement

- **OMB OUTPATIENT PAYMENT RATES:**
- On the UB form for outpatient services, payment is made at the OMB encounter rate using revenue code 0512 for a dental service, 0919 for a BH practitioner, or 519 for everything else. No other services are itemized on the claim form.
-
- To bill an OMB encounter rate, the recipient must be seen by a provider who could be enrolled as a practitioner – such as a physician, dentist, CNP, PA, dental hygienist, etc.

Standardized Billing and Reimbursement

- **OMB INPATIENT PAYMENT RATES**:
- For inpatient stays payment is made at the OMB inpatient daily rate using a revenue code (0100). No other services are itemized on the UB form.
- The rate is a daily rate. The discharge date is not paid. Billing of interim claims during a hospital stay is acceptable.
- The physician or other practitioner inpatient visits are not included in the rate and are billed separately on the CMS 1500 format.
- IHS and Tribal 638 Medicare Cross Over claims:
- Currently and IHS or tribal facility is paid the full co-insurance, deductible, or copayment as calculated by the Medicare payer.
-

Standardized Billing and Reimbursement

- The OMB rate cannot be billed when the recipient sees only an RN, LPN, or community health worker, for example, unless the MCO covers these as enhanced (value added service).
-
- The OMB rate can be billed when the physician or other practitioner reviews and signs a medical record after a nurse provides an EPSDT screening, or reviews a radiology image taken by a technician.
- More than one OMB charge can be billed in a day if the recipient has different distinct services such as going to a dentist then to an eye exam on the same day or goes a second time to the same facility on the same day with a different diagnosis.
-
- When an EPSDT screening is performed, that can be billed at the OMB rate, using revenue code 0519, as well as another 0519 for any treatment or other service provided that same day.

Medicare Cross Over Claims

- **Medicare vs Medicaid Outpatient Revenue Code**
- Note that the revenue code on outpatient cross over claims is 0510 (the code that Medicare uses for I.H.S. and Tribal 638 facilities.)
- This creates some confusion when an I.H.S/Tribal 638 files a crossover claim directly with the MCO if the provider uses code 0519 inadvertently.

- **Professional Medicare Cross Over claims:**
- There are no special issues associated with I.H.S. professional cross overs. The claim is paid like any other professional cross over, evaluating the claim for payment of the co-insurance, deductible, and copayment.

Hold Member Harmless

Participating providers and any sub-contractors of providers agree that in no event, including but not limited to non-payment by Blue Cross and Blue Shield of New Mexico, insolvency of Blue Cross and Blue Shield of New Mexico, or breach of signed Agreement, shall participating providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a member to whom health care services have been provided, or person acting on behalf of the member for health care services provided.

Recoupment Letters

Please save your recoupment letters to assist you in balancing your payments.

Overpayments can be returned to:

Blue Cross and Blue Shield of New Mexico

Attention: Collections Department

P.O. Box 27630

Albuquerque, NM 87125-7630

Recoupment Information

Should an auto recoupment occur from a future payment the Provider Claim Summary (PCS) will show the following :

- Patient name, patient account number (if available), BCBSNM group and member number.
- Overpaid claim number, dates of service, amount taken, and an abbreviated overpayment reason.
- It may be necessary to offset an overpayment from multiple checks
- Due to system constraints, checks will always show a balance of $50 remaining, and the claims summary will only reflect the collection being taken on the check; it will not reflect the entire negative balance owed by the provider.

Paper Refund Requests

Paper Refund Requests

When an overpayment on a claim has occurred, BCBSNM will initiate a refund request. We will provide physicians, facilities, and practitioners with at least 30 days written notice, explaining the reason for the overpayment, before engaging in recovery efforts.

- A remittance form and postage-paid envelope will be enclosed for your convenience.
- If there is no response to us in writing or by phone within 30 days, the overpayment will be eligible for collection by auto-recoupment.
- If a provider requests an appeal within 30 days of receipt of a request for repayment of an overpayment, BCBSNM will not require repayment until the appeal is concluded.
- Must be requested by provider within 90 calendar days from the date of receiving the notice of action.

Appeals will be acknowledged within 5 business days for receipt and will be resolved within 30 calendar days unless it is in the best interest of the member to extend the time by 14 calendar days.

- If extended, notification of extension will be sent within 2 business days of the decision.

Billing Audits

We will conduct both announced and unannounced site visits and field audits to Contract Providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, Behavioral Health, and transportation services) to ensure services are rendered and billed correctly.

Behavioral Health Services

Behavioral Health

- **IHS/Tribal 638 Behavioral Health services are paid at regular fee schedule rates using the claim form as billed by other providers, unless a separate higher fee has been negotiated.**

- **BH services not paid at the OMB rate include ACT, BMS, day treatment, medication, assisted treatment center services (methadone programs), MST, ARTC, RTC, and TFC**
  - **This excludes: Basic evaluation and therapy or comprehensive community support services**

Behavioral Health Services

- Physical, occupational, and speech therapies
- Transportation
- Vision appliances - frames, lenses, dispensing, contacts, etc. (vision exams are in the OMB rate)
- Behavioral Health services (other than the basic evaluation and therapy or comprehensive community support services) are paid at fee schedule or other rates, not at the OMB rate.
- BH services that are not part of the OMB rate are paid at regular fee schedule rates using the claim form the service is billed on from other providers.
- BH services not paid at the OMB rate include ACT, BMS, day treatment, medication assisted treatment center services (methadone programs), MST, ARTC, RTC, and TFC.

Pharmacy

Pharmacy

Pharmacy services are not part of the OMB rate and are billed using the National Council for Prescription Drug Programs (NCPDP) point of sale transaction (POS) .

- The “point of sale or POS” transaction is often entered after dispensing
- Pharmacy claims are not subject to the preferred drug list (PDL), or authorization, and may exceed days supply limitations if the recipient lives far from the I.H.S. or Tribal 638 pharmacy

Pharmacy Services

- Pharmacy services are not part of the OMB rate and are billed using the NCPDP point of sale transaction (POS) though the “point of sale or POS” transaction may be entered after the dispensing rather than at the time of dispensing.

- I.H.S./Tribal 638 pharmacy claims are paid like any other pharmacy claims but are not subject to the PDL and may exceed days supply limitations if the recipient lives far from the I.H.S. or Tribal 638 pharmacy.

- Note that MAD must approve I.H.S. and Tribal 638 facilities to provide each of these specialized behavior health services.

- Few I.H.S. and Tribal 638 providers render these BH services and some of these services are not rendered by any I.H.S. and Tribal 638 provider.

Dental

Dental Services

A few special clarifications regarding dental services:

- Dental services are billed on the UB claim using revenue code 0512 and are paid at the OMB rate.

- Orthodontia is also billed like any other IHS or Tribal 638 dental service but unlike other orthodontia providers, payment is made for each dental visit at the OMB rate – not at a full prospective orthodontia rate. Prior-authorization is not required.

Nutritional Services

Nutritional Counseling:

- Nutritional counseling services (for pregnant women and children) are payable to IHS or a tribal facility
- MCO's providing value added or additional nutritional services must also pay IHS for the services
- Nutritional services are billed and paid at an OMB outpatient encounter rate

Availity

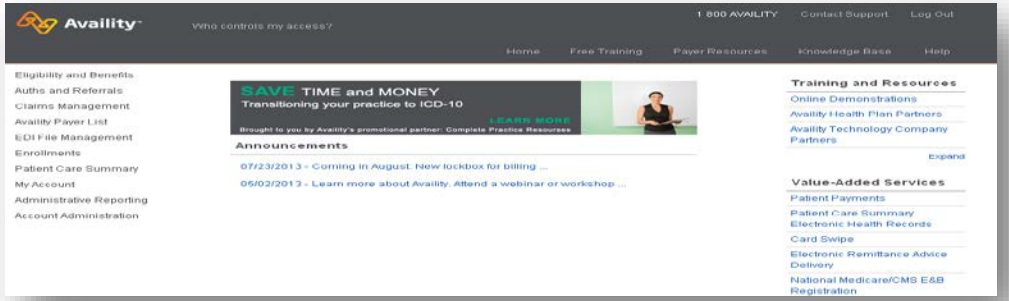
- To access information about Availity and other provider tools select the Providers tab on our public website. Then choose tools under the Education and Reference tab.
- To Log in or get registered choose the Self-service through Availity options.
- www.bcbsnm.com/provider
- www.availity.com/providers/registration-details/
-

Availity is a secure website to access a variety of information:

- Verify eligibility and benefits
- Request prior authorization
- Obtain detailed claim status
- Submit claim reconsideration inquiries
- Manage refund requests
- …And more
- BCBSNM's Availity transactions are available 24 hours a day, Monday through Saturday, and until 7pm Mountain Time on Sundays
-

Availity's home page contains pertinent announcements, and allows users to access ongoing training opportunities, as well as additional payer resources.

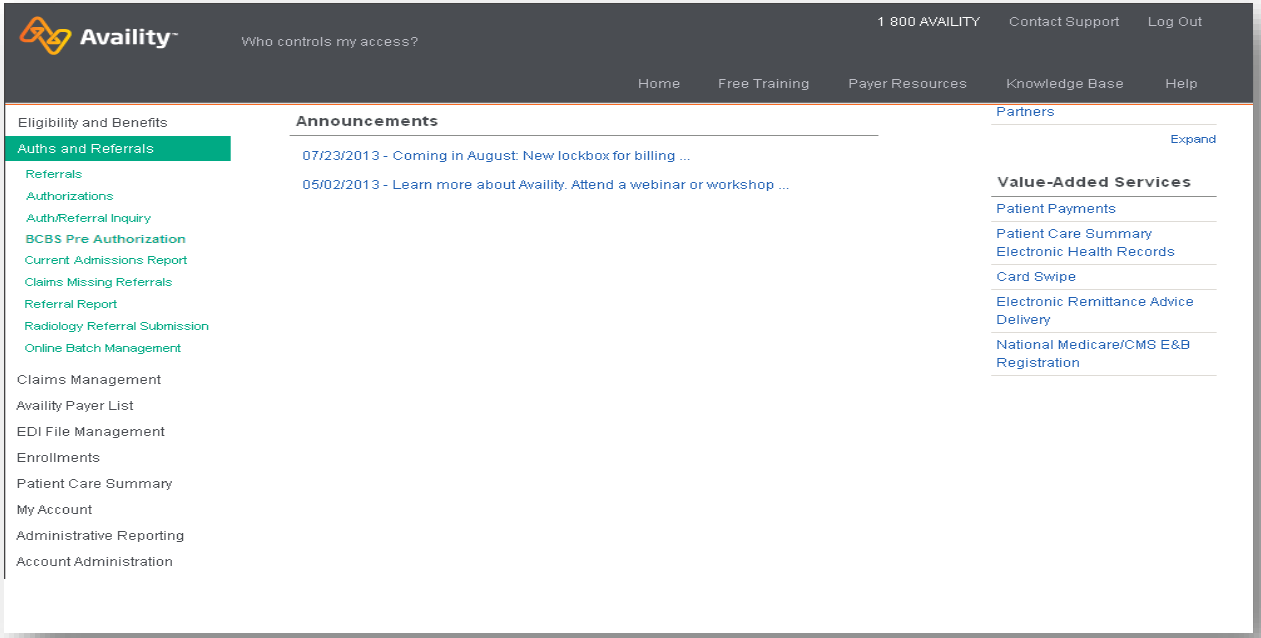
- The left side navigation menu remains in one constant location, allowing users to intuitively conduct multiple transactions with efficiency.
-
-
- Multi-payer faceted
- Real-time search results
- Multiple benefit category selections
-



- Availity Tip Sheets

iExchange

- **iEXCHANGE**
- supports prior authorization requests and approval of benefits online for BCBS.
- Organizations registered with Availity can sign-up for iEXCHANGE by selecting Auths and Referrals │BCBS Pre Authorization from the Availity left-hand menu. Once registration is complete, users can select Auths and Referrals │BCBS Pre Authorization to access the tool.
- Organizations not registered with Availity can also register for iEXCHANGE through the BCBSNM website: bcbsnm.com/provider.
- Note: iEXCHANGE is available 24 hours a day, 7 days a week – with the exception of the third Sunday of every month when the system will be unavailable from 10 a.m. to 1 p.m. MT.
- To access iExchange from Availity select Auths and Referrals and then select BCBS PRE Authorization. You will be redirected to iExchange.



Electronic Refund Management

Electronic Refund Management (eRM)

Electronic Refund Management (eRM) is an online tool that centralizes a provider organization's refund management and reconciliation process. It is accessible through the Availity portal.

Advantages of using eRM:

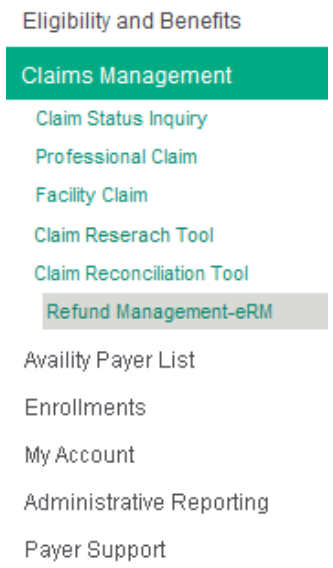
- Receive electronic notifications of overpayments
- View detailed overpayment requests
- Inquire/Dispute/Appeal a request
- Deduct from future payments or pay by check
- Submit unsolicited refunds
- Receive check alerts

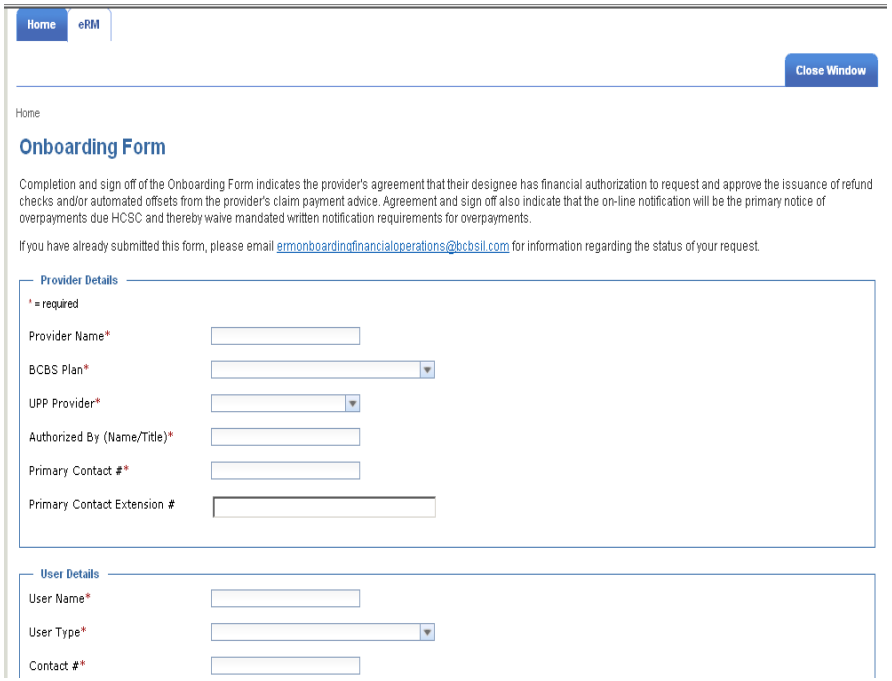
Note: BCBSNM offers complimentary training webinar's for eRM every week. Visit our website at www.bcbsnm.com to register for your session today!

Electronic Refund Management (eRM)

The first time Refund Management-eRM is accessed, users will be prompted to complete and submit a brief onboarding form.

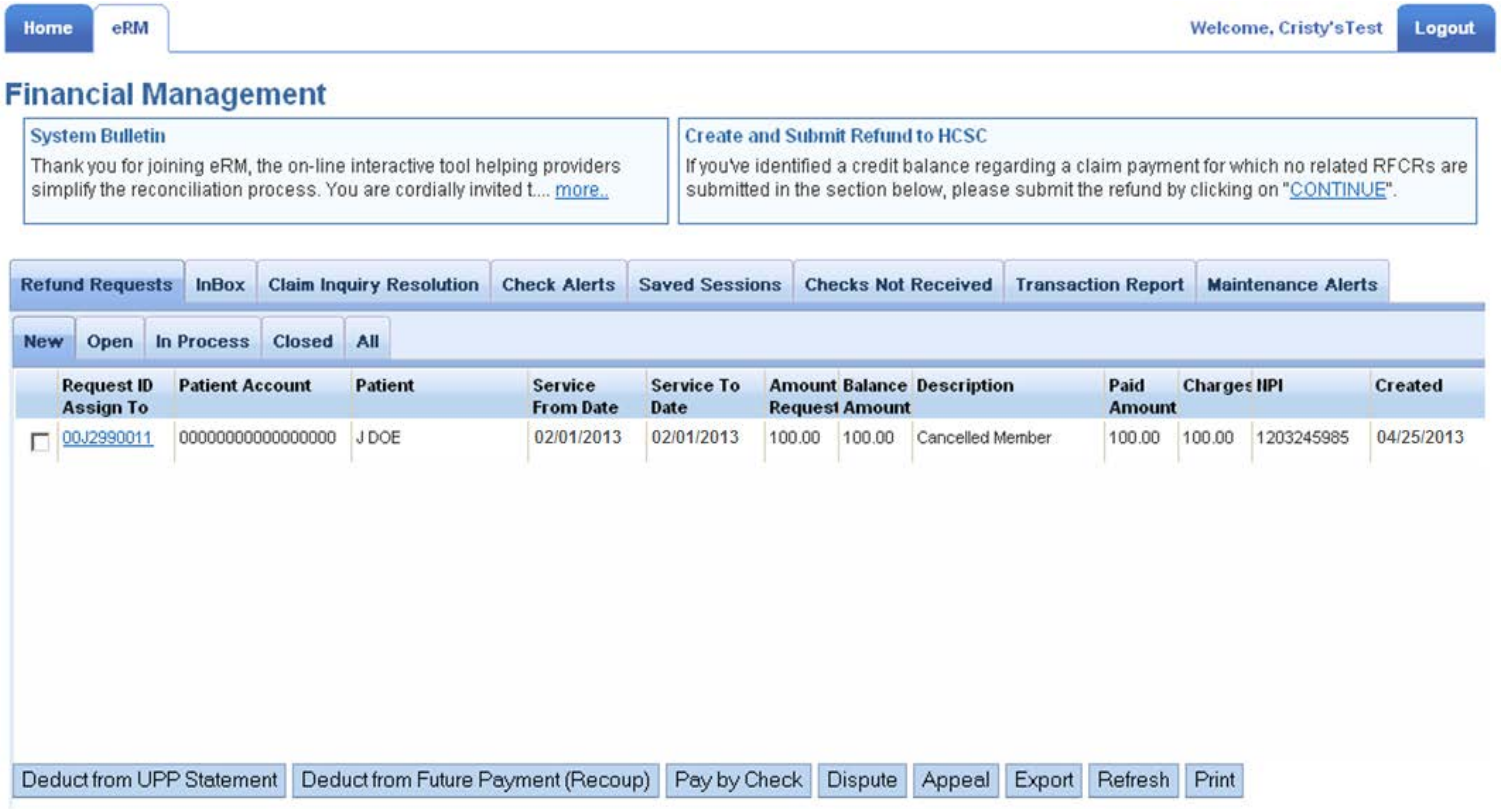
User's will receive a validation email approving their access within 24 hours.





Refund Request

- The Refund Requests tab will allow user's to efficiently handle their overpayment reconciliations in one centralized location.



Claim Inquiry Resolution
(CIR) is also accessible through Refund Management-eRM Web portal. The CIR tool allows users to communicate online with our Customer Advocates in situations where a provider would like a claim reconsidered. This includes:
Medicare / Other Insurance EOB
Duplicate Denials
Additional Information
Corrected Claim*
Fee Schedule / Pricing Inquiry
*Electronic claim submitters should utilize Billing Frequency Code 7 via their clearinghouse to submit a correct claim for more efficient processing.

Electronic Funds Transfer (EFT)

When using EFT, your payments are delivered directly to your financial institution. Therefore, your funds are available as soon as the payment is deposited. The following schedule should be used as a guideline to help you determine when funds will be available at your bank:

Claims Processed	Bank Transfer Occurs*	Funds Become Available*
Monday	Tuesday	Thursday
Tuesday	Wednesday	Friday
Wednesday	Thursday	Monday
Thursday	Friday	Tuesday
Friday	Monday	Wednesday

*Add one day if the normal day falls on a bank holiday.

Indian Health Services/Tribal 638/Urban Indian Health

ITUs Dental Claims

IHS submits dental claims directly to BCBSNM and not DentaQuest. At this time we advise claims to be submitted in any one of the following forms:
ADA
1500
UB

Provider Conditions for Participation

Participating providers acting within the lawful scope of practice are advised to inform members about:

The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered, and any abnormal medical or lab test results), including the provision of sufficient information to provide an opportunity for the patient to make an informed decision from all relevant treatment options

The risks, benefits, and consequences of treatment or non-treatment

The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Value Added Services

The following is the chart from HSD, showing our value added services as well as the other MCOs. Each MCO has chosen a unique set of Value Added services.

CENTENNIAL CARE MCO Value Added Services*

VALUE ADDED	BCBS	MOLINA	PRESBYTERIAN	UNITED HEALTH CARE
Acupuncture	**N**	N	N	Y-Available through Traditional Healing Benefit ($100/year for any type, not based on ethnicity)
Adult Vision - Extended	**Y**-1 eye exam, 1 set lenses/frames per year	N	N	N
Baby diapers	**Y**-1 box of 144/272 per child, after completion of 6 week postpartum visit	N	N	N

VALUE ADDED	BCBS	MOLINA	PRESBYTERIAN	UNITED HEALTH CARE
Adult Chemical Dependency Residential Treatment Center (RTC) Services	**Y** - This benefit offers RTC services that are appropriate for adults with severe medical disorders currently complicated by alcohol and substance abuse related issues that need concentrated therapeutic services in a 24-hour supervised treatment setting prior to a returning to community residence. The patient must meet established ASAM guidelines and be approved for admission by an In Network Residential Treatment facility in the state of New Mexico. The focus of these services is to stabilize the individual and provide a safe, supportive living environment during detox and/or recovery from addictions. This setting offers a high degree of security, supervision, and structure. **Benefit Limit:** Members with comorbid serious medical illness and active chemical dependency issues in need of 24 hour supervised treatment in a CD Residential setting. Length of stay not to exceed 30 days (continued...) annually. Annual expenditures not to exceed $125,000. **Eligibility:** RTC services for adult members with severe medical disorders and patients with alcohol/ substance abuse problems.	N	N	N

VALUE ADDED	BCBS	MOLINA	PRESBYTERIAN	UNITED HEALTH CARE
Annual Adult Physical Exams **	Y	N	N	Y
Caregiver Support Classes	N	N	N	Y
Cell Phone	N	Y-High risk members levels 2 and 3, on case by case basis. Limit 250 minutes/month. Excludes SPCP	N	N
Disease Management	N	N	N	Y - for members enrolled in a disease management program and are 21 years of age or older in addition to the required Centennial Care Disease Management programs. Which provides Blood Pressure Cuffs for members with Hypertension and Weight Scales for members with Congestive Heart Failure (one scale and one blood pressure cuff and one replacement cuff allowed per member's lifetime).

VALUE ADDED	BCBS	MOLINA	PRESBYTERIAN	UNITED HEALTH CARE
Electroconvulsive Therapy (ECT) – Only available at UNMH: This benefit is offered as the preferred treatment of choice for certain psychiatric conditions. These conditions may include treatment of resistant major depressive disorder, depressed patients with certain comorbid medical conditions, and patients with treatment resistant mania secondary to bipolar disorder or schizoaffective disorder. In these situations ECT may be the safest and most effective treatment.	**Y** – Clinical condition must meet necessity for ECT, authorization is required.	Y – Clinical condition must meet necessity for ECT, authorization required.	N	Y-Clinical condition must meet necessity for ECT, authorization required.
Expectant Mothers Program	**N** This is a standard benefit offered as part of our prenatal program, not considered VAS.	N	N	Y - Baby Blocks - reminds and rewards members for attending appointmentss during their pregnancy.
Inpatient Detox at Facility not a Hospital	**Y** - This service would allow for reimbursement to be arranged with contracted chemical dependency treatment centers to perform detoxification services for chemically dependent members. Based on our experience, this benefit should provide a lower cost alternative to hospital based detox. **Benefit Limit:** Time-limited, medically- monitored detoxification benefit, subject to ASAM detoxification medical necessity criteria. This VAS does not include social	N	N	N

VALUE ADDED	BCBS	MOLINA	PRESBYTERIAN	UNITED HEALTH CARE
	detoxification. Members cannot have comorbid medical conditions requiring detoxification in a hospital based setting. **Eligibility:** Chemically dependent members.			
Infant Mental Health: Family Training and Counseling for Child Development is a comprehensive behavioral health program for children birth through 3 and their families. The program provides early intervention, family training and counseling for child development provided for the bio-psychosocial and emotional well-being of infants, toddlers and children in relationship with their caregivers, environment and culture, and with respect for each child's uniqueness	**Y – Benefit Limit:** Time-limited benefit subject to medical necessity criteria. Eligible members are those members who no longer have CYFD funding sources available to them; annual expenditures for IMH will not exceed $125,000. **Eligibility:** Members birth to age 3 or clear symptoms of a mental health disorder.	Y – available to parents, foster parents, caregivers of members 0-3 years. Total of $200,000 max per calendar year. Not available in all locations.	N	N

Member Rights and Responsibilities

For more information about member rights and responsibilities, Please refer to the Centennial Care Reference Manual PG-S89 under Members Rights and Responsibilities Section.

Appeal and Grievance Process

Grievances

To request an appeal on behalf of a member, providers should call 800-693-0663 or use the form located at www.bcbsnm.com.
If a provider feels that he has not been paid according to his contract they can request an appeal on their own behalf by calling :
BCCC Provider Service line 800-693-0663.
Blue Cross Community Centennial
ATTN: Appeals Coordinator
P.O. Box 27838
Albuquerque, NM 87125-7838
FAX : 1-888-240-3004
For an Expedited BH Appeal Only, call: 1-877-232-5520
Members have the right to submit a grievance if they have concerns or problems related to their coverage or care. All participating providers must cooperate in the Blue Cross Community Centennial Appeals and Grievances process.

Grievances

To file a grievance, call 1-800-693-0663, or write:

Blue Cross Community Centennial
ATTN: Grievance Coordinator
P.O. Box 27838
Albuquerque, NM 87125-7838
FAX: 1-888-240-3004

Quality Improvement Programs and Incentives

The following composites are measured annually for member satisfaction:

Getting Care Quickly
Getting Needed Care
Claims Processing
Customer Service
Rating of Health Plan
How Well Providers Communicate
Rating of All Health Care
Rating of Personal Provider
Rating of Specialist Seen Most Often

Cultural and Linguistic Competency

BCBSNM will soon offer a Cultural Competency course – you'll find it on the BCBSNM Provider page under training. The Health & Human Services department has a very robust CC training available on their website: https://cccm.Thinkculturalhealth.hhs.gov

Care Coordination

Care Coordination is a BCBSNM service to assist members (and their families) with chronic, multiple, complex, cognitive, physical or special health care needs. The care is member-centered, family-focused (when appropriate), and culturally competent.

Care Coordination is a process that reviews, plans, and helps members find options and services to meet their health and/or social needs.

BCBSNM has a team of medical and behavioral health case coordinators to provide these services.

Care Coordination works closely with participating providers, and members of the inter-disciplinary care team (ICT) to develop a member care plan designed to meet member needs.

See Key Contacts for Phone Numbers to contact our Care Coordination group.

Integrated Care for Physical Health, Behavioral Health, and Long Term Care

Under Blue Cross Community Centennial, BCBSNM will provide a seamless program for Medicaid eligible individuals to meet their health care needs across the full array of Medicaid services, including acute and long term care, behavioral health care, and home and community based services.

A fundamental focus of the Integrated Care model will be to identify members at highest risk of poor health outcomes by:

Using a person-centered approach

Developing personalized plans

Ensuring that necessary services are provided.

Additional Materials

Key Contacts

Provider Customer Service: 1-800-693-0663

Network Services : 1-800-567-8540

Contract Representative & Provider Network Specialists: bcbsnm.com/provider /contact_us.html

Electronic Claim Questions or Problems: 1-800-746-4614

Availity Health Information Network: 1-800-282-4548 Email: www.availity.com

Utilization Management (UM)

Care Coordination Phone: 1-877-232-5520

Referrals: 1-800-325-8334, option 3

Preauthorization Phone: 1-877-232-5520 Fax: 1-505-816-3854

Utilization Management Member Appeals: 1-877-232-5520

Case Management (CM) Programs: Phone: 1-800-325-8334, option 4; Fax: 1-505-816-3861

Condition Management/Disease Management Programs : Phone: 1-866-874-0912 Fax: 1-505-816-3856

Davis Vision : 1-800-584-3140

DentaQuest : 1-800-417-7140

LogistiCare (Transportation services) 1-866-913-4342

“Ride Assist” 1-866-418-9829

Add Community Social Services 1-866-689-1523 Opt. 6

Fraud and Abuse

BCBSNM actively participates in inquiries and investigations to accurately identify and appropriately address potential fraudulent activities.

Each year, fraud costs the health care industry over $54 billion, contributing to the rising cost of health care for all Americans.

BCBSNM has established a Special Investigations Department (SID), one of the most aggressive and effective health care fraud investigation programs in the industry.

SID is committed to fighting fraud, reducing health care costs, and protecting the integrity of the BCBSNM provider network.

Fraud & Abuse is not limited to Medical Providers. As the Health Care industry continues to evolve many other parties can commit Health Care Fraud that must be reported, including:

Medical Providers

Medical equipment/supplies Providers(DME)

Behavioral Health Providers

Non-traditional Providers, such as construction companies, home care, emergency response services, transportation services, etc.

Patients/Members

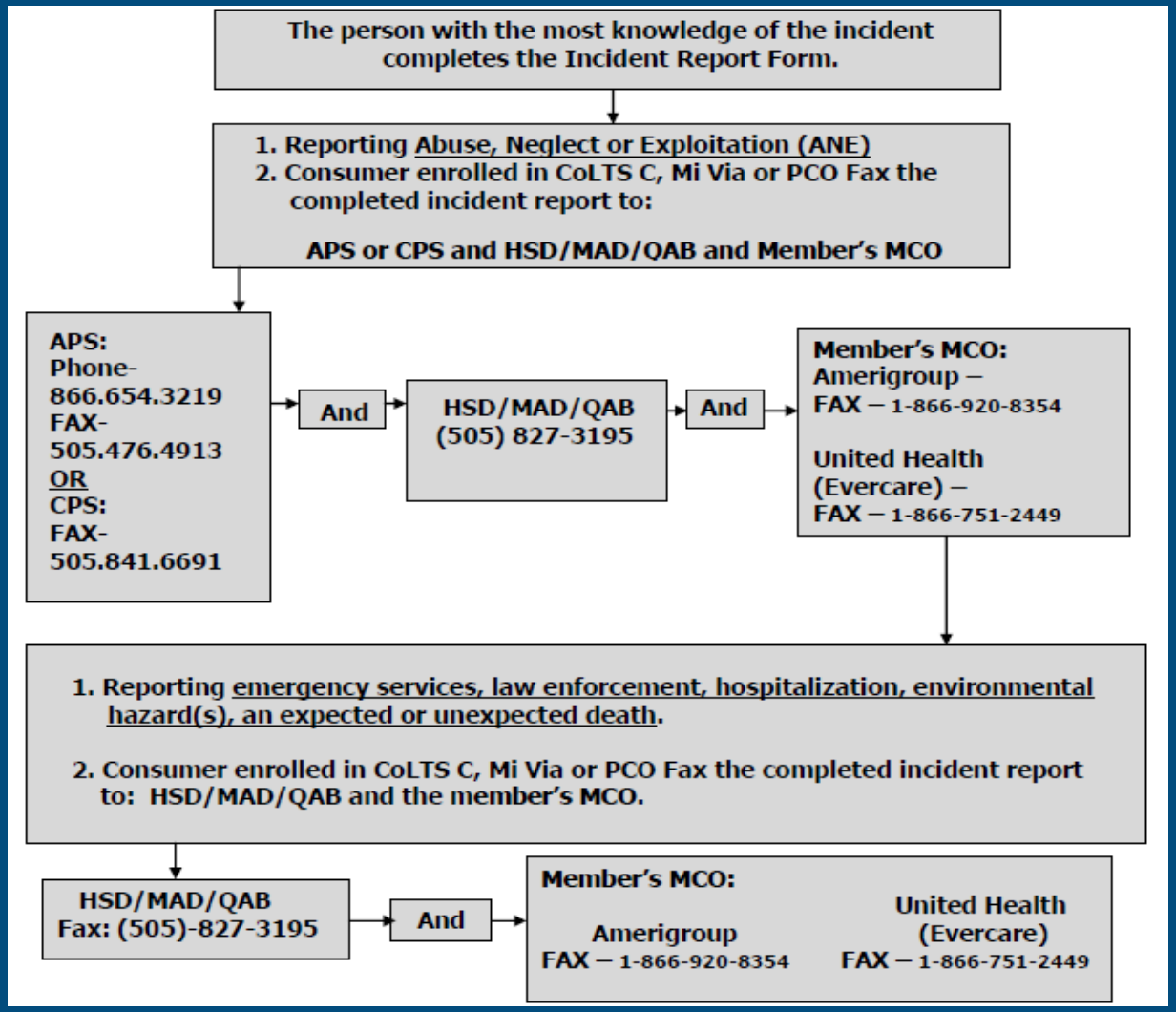
Employees of health care insurance companies

Billers

To help you understand what health care fraud is, how it affects you, and how you can report health care fraud to the SID, BCBSNM offers a free online Fraud Awareness Training Tutorial at bcbsnm.com in the Education & Reference section.

Critical Incident Reporting

All adults and children receiving Home and Community Based services should be able to enjoy a quality of life that is free of abuse, neglect, and exploitation.
New Mexico State law mandates requirements for reporting alleged incidents.
Incident reporting is a mechanism to ensure the health and safety of consumers receiving Medicaid services.
Encouraging reporting improves service quality by identifying improvement opportunities.
Incidents must be officially reported in order to be investigated.


The person with the most knowledge of the incident completes the Incident Report Form.
1. Reporting Abuse, Neglect or Exploitation (ANE)
2. Consumer enrolled in CoLTS C, Mi Via or PCO Fax the completed incident report to:
APS or CPS and HSD/MAD/QAB and Member's MCO
APS:
Phone-
866.654.3219
FAX-
505.476.4913
OR
CPS:
FAX-
505.841.6691
And
HSD/MAD/QAB
(505) 827-3195
And
Member's MCO:
Amerigroup –
FAX – 1-866-920-8354
United Health
(Evercare) –
FAX – 1-866-751-2449
1. Reporting emergency services, law enforcement, hospitalization, environmental hazard(s), an expected or unexpected death.
2. Consumer enrolled in CoLTS C, Mi Via or PCO Fax the completed incident report to: HSD/MAD/QAB and the member's MCO.
HSD/MAD/QAB
Fax: (505)-827-3195
And
Member's MCO:
Amerigroup
FAX – 1-866-920-8354
United Health
(Evercare)
FAX – 1-866-751-2449

The State of New Mexico provides statutes and individual program regulations which define the expectations and legal requirements for properly reporting recipient –involved incidents in a timely and accurate manner.

Adult Protective Services - NMSA 1978, Section 27-7-30
http://law.justia.com/codes/new-mexico/2009/chapter-27/article-7/
Centennial Care -State of New Mexico Human Services Department Medicaid Managed Care Services Agreement. 4.12.16
Department of Health - 7.1.13 NMAC
http://dhi.health.state.nm.us/elibrary/regs/7.1.13NMAC_Incident_REP_INTAKE.pdf

It is required to report all incidents involving:
Abuse
Neglect
Exploitation
Natural or unexpected deaths
Emergency Services
Law enforcement
Environmental Hazards
For additional information regarding critical incident reporting and training material please visit www.bcbsnm.com

Fraud and Abuse

Fraud & Abuse is not limited to Medical Providers.

BCBSNM offers a free online Fraud Awareness Training Tutorial at bcbsnm.com/Provider. Click on Education & Reference, link to the training will be on the left side of the screen under Related Links

EPSDT

EPSDT:

- When an EPSDT screening is performed, it can be billed at the OMB rate using revenue code 0519, as well as another 0519 encounter rate for treatment or other service provided that same day for services that are not part of the EPSDT screen, such as treating the recipient

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services

Early Periodic Screening Diagnostic and Treatment (EPSDT) - The EPSDT program is a federally mandated program ensuring comprehensive health care to Medicaid recipients from birth to 21 years of age.
These items must be documented in order to fulfill the requirement of an EPSDT exam:
Comprehensive health and development history.
Comprehensive unclothed physical exam.
Appropriate immunizations according to the most current Advisory Committee on Immunization Practices (ACIP) schedule.
Measurements – height, weight, and body mass index (BMI)
Laboratory tests, including an appropriate lead blood level completed at 12 months and 24 months (filter paper test may be used).
Health Education

HIPAA

- As a provider for BCBSNM, you are obligated to be aware of and to uphold our members' rights, and to be informed regarding the members' responsibilities. Our health plan members may refer to their benefit booklet for a listing of member rights and responsibilities; you and most members can also access these documents on our website at bcbsnm.com.

Questions?

Tribal Liaisons

Blue Cross Community Centennial has taken the steps to make available to you, four Tribal liaisons to assist you with your claims questions.

- **Bonnie Vallo, Laguna/Acoma Pueblo**
  Sr. Supervisor Community Relations/Tribal Liaison
  Phone: 505-816-2210
  Mobile: 505-999-0379
  Email: Bonnie_Vallo@bcbsnm.com
  CC: Bonnie Vallo with all requests sent to Tribal Liaisons.
- **Julia Platero, Dine'**
  Native American Community Relations Specialist
  Phone: 505-816-2131
  Mobile: 505-639-3749
  Email: Julia_Platero@bcbsnm.com
  Responsible for All I/T/Us located along the I-40 Corridor West from Albuquerque and Alamo
- **Nicole Hopkins, Dine'**
  Native American Community Relations Specialist
  Phone: 505-816-2692
  Mobile: 505-639-3749
  Email: Nicole-hopkins@bcbsnm.com
  Responsible for All I/T/Us located Highway 528 north to Shiprock, Including Jicarilla and Albuquerque Service Unit.
- **Winona Gishal, Dine'**
  Native American Community Relations Specialist
  Phone: 505-816-2116
  Mobile: 505-604-7047
  Email: Winona_gishal@bcbsnm.com
  Responsible for all I/T/Us along I-25 corridor beginning at Isleta north to Taos, NM including Mescelaro Apache

BlueCross BlueShield of New Mexico

CENTENNIALCARE

Thank you for attending!

Blue Cross Community Centennial℠
A Centennial Care Plan

Such services are funded in part with the State of New Mexico. ■ The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. ■ Limitations and restrictions may apply. ■ Benefits, formulary, and network are subject to change. ■ BCBSNM's Programs, such as Disease Management and Care Coordination, do not replace your doctor's care. Always talk to your doctor about any health questions or concerns.