BlueCross BlueShield of New Mexico

Long Term Services & Supports(LTSS) Provider Training 2021

Blue Cross Community Centennial℠

Nursing Facility Admissions and Discharges

Nursing Facilities are required to notify BCBSNM within 24 hours of a member's (**Please call (877) 232-5518)**:

- Admission or request for admission including short term stays
- Discharge:
  - Notify UM within 24hrs of the discharge
  - Facilities should notify their assigned Behavioral Health Care Coordinator, as soon as possible, in order to start the process of a safe reintegration.
  - Has left Against Medical Advice(AMA)
  - Hospital and/or Emergency Room(ER) encounters
  - Death
- Pending discharge

NFLOC packets should be faxed within 30 days of admission and 60 days prior to expiration. If not submitted timely, it affects the member's Medicaid eligibility.

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

Note: NFLOC should not be submitted for short term stays.

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 LNF and 30 calendar days for 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

1. **Preadmission Screening and Resident Review** (PASRR)

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

NFLOC Packet Components

3. **Minimum Data Set (MDS)**
   A. An MDS and other appropriate documentation must be completed for each resident for every situation requiring prior approval.
   B. All locator fields must be clearly marked on the MDS.
   C. When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process.
   D. 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 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

1. 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.

   A. If there are **more than** thirty (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.

   B. If there are **less than** thirty (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.

Procedure for Transfers Between Nursing Facilities

C. Please write “TRANSFER” in the type of request box on the notification form.

2. 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.

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 & per diem)
- Skilled Maintenance Therapy Services
  - Occupational Therapy for Adults
  - Physical Therapy for Adults
  - Speech Therapy for Adults

Agency-Based Community Benefit (ABCB)

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)

Self-Directed Community Benefit (SDCB)

Self-Directed Community Benefit 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 Requirements

BCBSNM has designed a checklist to help guide the assessment of each provider's compliance with the final rule. The checklist includes the following sections:

1. **Rights and Autonomy**

This section ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. It also assesses whether the setting optimizes, but does not regiment, individual initiative, autonomy, and independence including but not limited to daily activities, physical environment, and with whom to interact. If the setting is residential and provider-owned or –controlled, it assesses additional criteria for such settings.

2. **Informed Choice**

This section assesses whether the setting is selected by the individual including non-disability specific settings and an option for a private unit in a residential setting and whether the setting facilitates individual choice regarding services and supports, and who provides them.

3. **Community Integration and Institutional Characteristics**

This section assesses whether the setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community. This section also assesses whether the setting has characteristics that may cause CMS to presume that it is institutional.

HCBS Settings Requirements

- The checklist is to be completed by HCBS providers and Support Broker agencies on an annual basis. All HCBS providers seeking a new contract with BCBSNM must complete the checklist during the initial provider orientation.
- 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 (NMMSEA) or the New Mexico Medicaid Centennial Care Amendment, whichever is applicable. In rare circumstances this includes corrective actions including termination of contractual agreements.
- BCBSNM will monitor providers and notify HSD of those who are not meeting HCBS settings requirements. Providers will not be allowed to provide services until identified issues are rectified.
- The checklist can be completed at the annual provider training, during a visit with a BCBSNM Provider Representative, or upon request.

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 (CIR) 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 (IPOC) when requested
- Notify the member's care coordinator if you become aware of any issues that may affect a member's health and safety

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 (ABCB) population was implemented statewide in 2016. In addition, the EVV requirement for EPSDT PCS on January 1, 2020, and for the Self-Directed Community Benefit (SDCB) population beginning on January 1, 2021. The EVV requirements are mandated by Section 12006 of the 21st Century Cures Act.

- **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 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 BCBS owned Wi-Fi enabled tablet for those caregivers that 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 www.mobilityexchange.us. Please ensure all orders include a valid BCBS member ID (YIF) or Medicaid ID. Additional terms and conditions may apply.

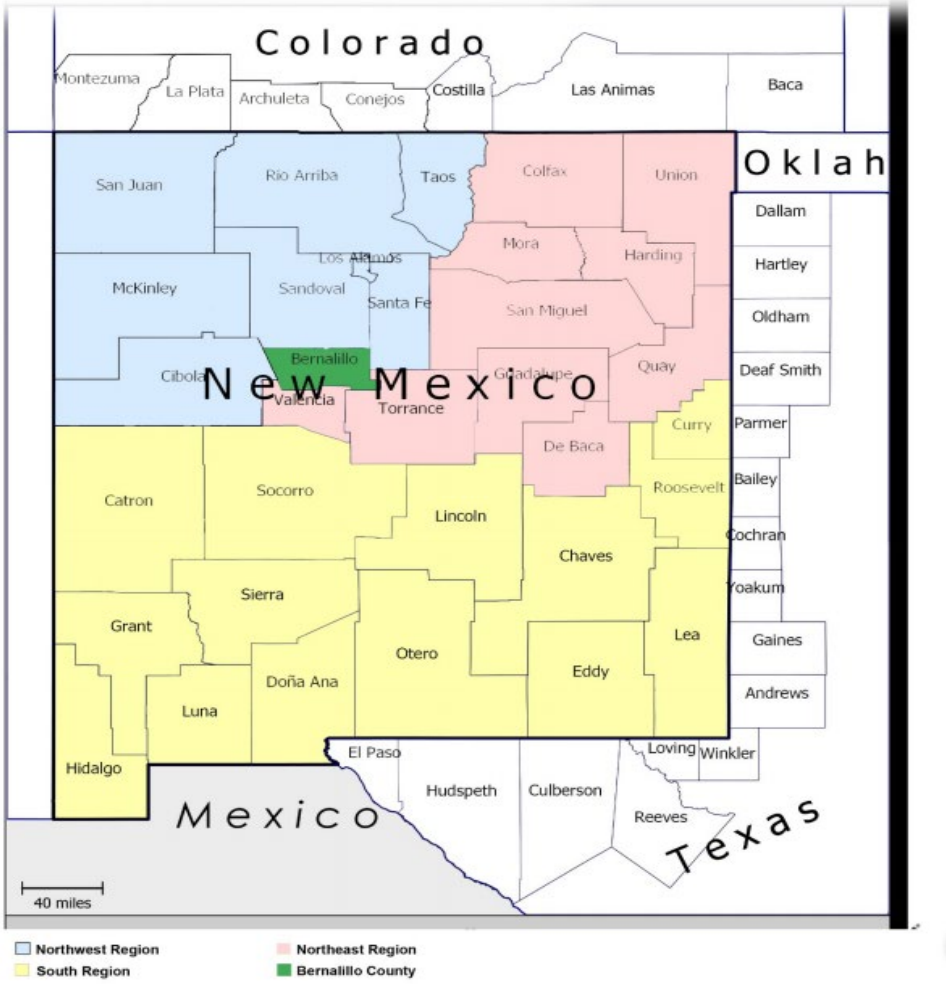
Manually Entered Web-Claims

In April 2018, a new enhancement was deployed within the Authenticare® system that will require the Centennial Care Managed Care Organizations (MCOs) to review all manually entered web claims. This enhancement will also require PCS 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.

BCBSNM LTC Key Contacts



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Personal Care Service(PCS) and Nursing Facility(NF) Meetings

BCBSNM holds regular Personal Care Service(PCS) and Nursing Facility(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.

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Questions?

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