BlueCross BlueShield of New Mexico

Centennial Care Provider Training 2021

Blue Cross Community Centennial℠

Today's Agenda – Provider Responsibilities

This training is intended for providers only. Members should be directed to the BCBSNM Centennial Member Handbook. This training, and the material presented herein, is accurate as of the date of publication and is subject to change. Please refer to the BCBSNM website and other source documents for updates.

Nothing in this training constitutes medical advice. Providers will exercise their independent medical judgement in rendering care to members. All providers referenced in this training are independent from and not employed by BCBSNM.

- Participating with BCBSNM
- Covered Services
  - Integrated Care
  - Adult Benefit Plan
  - Value Added Services
  - Help with Finding Housing
- Members
  - Rights & Responsibilities
  - Member Services Contact
  - Enrollment
  - Ombudsman
  - PCP Assignment
  - ID Cards
- Care Coordination
- Billing and Claims
- Cultural and Linguistic
- Credentialing/Recredentialing
- Provider Resources
- Prior Authorizations
- Appeals and Grievances
- Critical Incident Reporting
- Fraud, Waste and Abuse

Additional trainings

All provider trainings are available on our website at, **https://www.bcbsnm.com/provider/.**

You can request an additional training from your BCBSNM provider representative or complete a self-lead review of the materials at your convenience.

Please let us know if there are topics you wish to discuss.

- Behavioral Health
- Cultural Competency Training *(annual requirement*
- Depression Screening and Outpatient Provider Incentives
- Dual Special Needs Population(DSNP)
- HEDIS Measures for Quality
- Indian Tribal Urban (ITU)
- Information for Hospitals
- Long-Term Care Services and Support
  - Nursing Facilities
  - Home and Community Based Services, ABCB, SDCB, EVV
  - ABCB Program Recruitment
- Primary Care Provider Responsibilities
- Telehealth
- Pregnancy and Family Planning

Additional Information

- Provider Reference Manual (PRM) – The PRM lists all provider responsibilities and is an extension of a provider's contract with BCBSNM.
  - There is a list of key phone numbers in the "Contacts List" section
  - It contains complete lists of Covered Services
  - The content in the PRM is subject to change due to new federal or state regulations or new requirements or a Letter-of-Direction from the New Mexico Human Services Department
- Members' Rights and Responsibilities
- Cultural Linguistics
- Fraud, Waste, and Abuse
- Today's Training Presentation
  - This information is also subject to change due to new federal or state regulations or new requirements from the New Mexico Human Services Department
  - Provider Training Modules may be found on our website at https://www.bcbsnm.com/provider/training/index.html

Participating with BCBSNM

- Providers applying for network participation with BCBSNM are required to register with the HSD's fiscal agent Conduent.
- Must register as a Managed Care-only provider, or as a Fee-for-Service and Managed Care provider
- If a provider fails to enroll, BCBSNM will deny claims. Registration ensures that billing and rendering providers can be identified on claims and encounter reports.

Four Easy Ways to Register

NM Medicaid Portal: https://nmmedicaid.acs-inc.com/webportal/enrollOnline

Email: NMProviderSUPPORT@Conduent.com

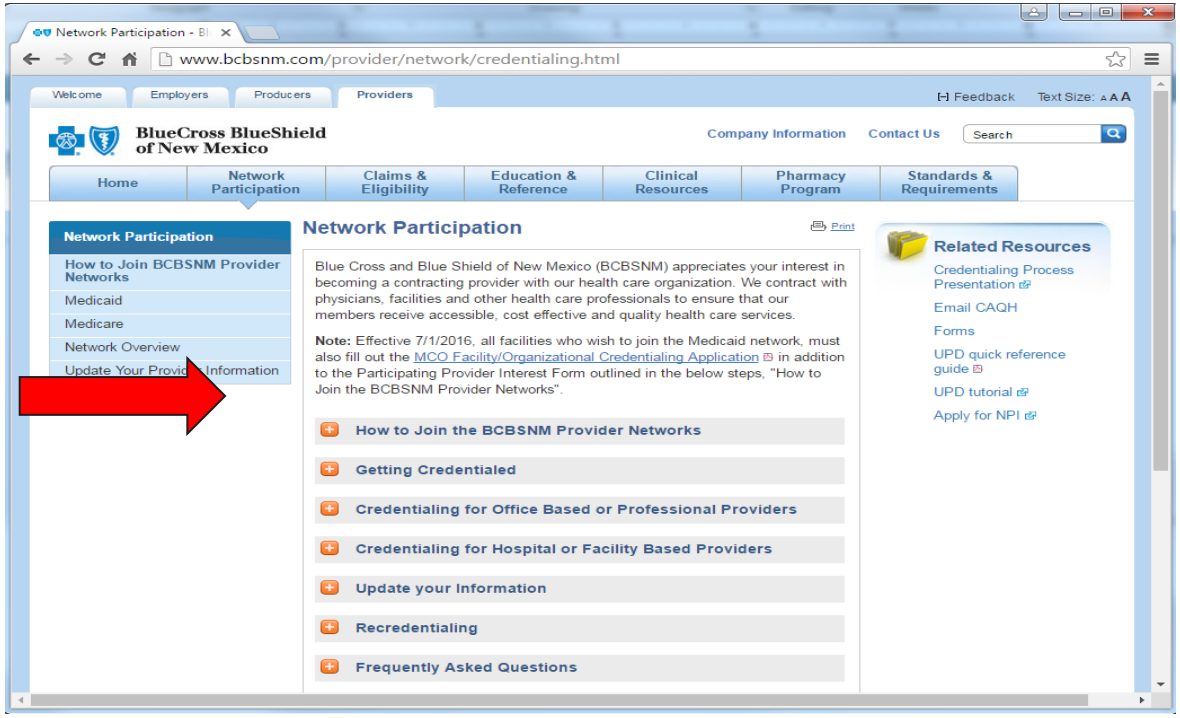
Phone: (505) 246-0710 or (800) 299-7304

Fax: (505) 246-9085

Onboarding Process

- Process for both typical and atypical providers can be found on our provider website under the Network Participation section.
- Some providers still go through the Participating Provider Interest form (PPIF). PPIFs for both typical and atypical providers can be found on our provider website under the Network Participation section at this link:

  https://www.bcbsnm.com/provider/network/credentialing.html



Disclosure of Ownership and Control Interest Form

- Completion and submission is a condition of participation as a credentialed or enrolled provider.
- Form needs to be completed by the disclosing solo practitioners or the disclosing contracting entity.
- Look for this form at https://www.bcbsnm.com/pdf/forms/provider_disclosure_form.pdf

Submit the Disclosure of Ownership and Control Interest Form

- **With your MCO application**
- **At initial and renewal of a contract or agreement**
- **Any time there is a revision to the information**
- **Within 35 calendar days of a request for the disclosure**
- **Within 35 calendar days of a change in ownership**

Alternative Benefit Plan

The Alternative Benefit Plan (ABP) is a part of the New Mexico Medicaid Centennial Care program.

The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 138% of the Federal Poverty Level (FPL), which includes the Medicaid Expansion Population and Transitional Medical Assistance categories.

ABP Covers:

- Doctor Visits
- Preventive Care
- Hospital Care
- Emergency Department
- Urgent Care
- Specialist Visits
- Behavioral Health Care
- Substance Abuse Treatment
- Prescriptions
- Certain Dental Services
- More…

Alternative Benefit Plan

Individuals may choose to receive services under the ABP or Standard Medicaid if they have any of the following:

- Serious or complex medical condition
- Terminal illness
- Chronic substance use disorder
- Serious mental illness
- Disability that significantly impairs their ability to perform one or more activities of daily living (ADL)

Members will be covered by ABP unless they meet criteria and choose to move to the Expansion State Plan\ABP Exempt Plan.

Pregnancy and Family Planning Services

- Pregnancy-related care and family planning services are Covered Services that do not require prior authorization. Members may self-refer for care.

- Family Planning includes pregnancy testing and counseling. Members may self-refer to contracted *and non-contracted* family planning providers in New Mexico. Family planning providers include PCPs, OB/GYNs, Planned Parenthood clinics, and Department of Health clinics.

- Coverage due to pregnancy only: Some women are eligible for Medicaid because they are pregnant. Coverage for these members lasts for two months after the pregnancy has ended.

Special Beginnings ®

- Special Beginnings program registration is available to all expecting BCBSNM Members. Successful program registration includes a risk screening, general pregnancy education, and provides access to program benefits such as YoMingo online learning platform and VAS (crib, car seat, Moby Wrap, etc.)

- Special Beginnings® prenatal Care Coordination management is available to any BCBSNM member who is an at-risk expectant mother, at no cost.

- The Blue Cross and Blue Shield of New Mexico (BCBSNM) Special Beginnings® team is comprised of experienced Registered Nurses, Social Workers, and Health Coordinators who strive to offer members access to, and coordinate, timely interventions by contracted providers during and after pregnancy.

Special Beginnings ®

- In addition, the BCBSNM Special Beginnings team provides comprehensive Care Coordination to Neonates admitted directly to the Neonatal Intensive Care Unit after delivery and up to the first year of life.

- Please direct pregnant members to call **1-888-421-7781** if they have not already enrolled in the program.

- Providers can directly refer members to NMCNTLSpecialBeginnings@bcbsnm.com or provide the email for a self-referral.

- Program information can also be found on the BCBSNM Special Beginnings website: https://www.bcbsnmcommunications.com/special_beginnings/2054953/483419.html

Reminders about Newborns

- When a child is born to a mother enrolled with Blue Cross Community Centennial, a Notification of Birth form must be submitted by the hospital or other Medicaid provider prior to or at the time of discharge, to ensure that Medicaid-eligible newborn infants are enrolled and medically covered as soon as possible.
- It is very important for the mother to call the HSD ISD caseworker to notify them of the newborn. (They should also call ISD if they have adopted a child or wish to place their child for adoption.)
- *Please do not submit claims for a newborn with the mother's identification (ID) number.*

Value-Added Services

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service?
Physical Health Services					
Home Meal Delivery	Members who are transitioning from a nursing facility into the community	✓	✓	✓	No
Native American Traditional Healing and Wellness (reimbursement for traditional healing practices used to treat medical conditions)	Native American members	✓	✓	✓	No
Remote Monitoring Program	Members with chronic conditions	✓	✓	✓	Member must participate in the Paramedicine Program; requires an assessment for need
Respite Bed	Certain members discharging from an emergency room or hospital	✓	✓	✓	Yes
Maternity Services					
Full Medicaid Benefits for Pregnant Women in COEs 301 and 035 (full benefits including dental, vision, prescription drugs, and behavioral health)	Certain pregnant members	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard ABP benefits apply	Only if a particular service should require one
Infant Car Seat*#	Pregnant members	✓	✓	✓	Yes
Portable Infant Crib*^#	Pregnant members	✓	✓	✓	Yes
Prenatal Education (in person)* Prenatal Education (online))*^	Pregnant members	✓	✓	✓	No
Behavioral Health Services					
Electroconvulsive Therapy (ECT) (treatment for psychiatric conditions)	Members who meet standard ECT medical necessity criteria	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard benefits apply	Yes
Transitional Living for Chemically Dependent/Psychiatrically Impaired Adults 18 Years Old or Older	Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues	✓	✓	✓	Yes
Wellness/Drop-in Centers and Family Support Centers	Medicaid members	✓	✓	✓	No

*Must participate in BCBSNM's Care Coordination program to redeem
^Must join the Safe Sleep program to redeem
†Must complete postpartum follow-up appointment to redeem
#Must complete prenatal visit requirements to redeem

Value-Added Services (VAS) are not Covered Services and are not Medicaid-funded. There are no appeal rights for these services. VAS differ for ABP members and members on the standard Medicaid plan (Centennial Care) and are subject to change.

What is EPSDT?

- Provides comprehensive and preventive health care services for children under age 21
- Helps children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services

Early
Assessing and identifying problems early

Periodic
Checking children's health at periodic, age-appropriate intervals

Screening
Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic
Performing diagnostic tests to follow up when a risk is identified

Treatment
Control, correct or reduce health problems found

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit Requirements

Well-Child Health Check

The EPSDT well child check-up may include the following:

- Physical screening
- Medical Screening
- Developmental/Behavioral Screenings
- Nutritional Screening
- Immunizations
- Lead Testing
- Hearing/Vision and Dental Exams
- School-Based Services
- Private Duty Nursing
- Personal Care Options
- Other necessary health care or diagnostic services

The New Mexico Tot-to-Teen Healthcheck Schedule

✓ under age 1: 6 screening/examination visits (1, 2, 4, 6, 9 and 12 mo.);

✓ ages 1-5: 6 screening/examination visits (15, 18 and 24 mo.; 3, 4 and 5 yrs.);

✓ ages 6-14: 5 screening/examination visits (6, 8, 10, 12 and 14 yrs.);

✓ ages 15-20: 3 screening/examination visits (16, 18 and 20 yrs.).

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Non-Emergency Medical Transportation (NEMT)

- Non-Emergency Medical Transportation (NEMT) is a Covered Service for all Centennial Care BCBSNM members. ModivCare is our contracted vendor.

  - ModivCare provides rides to and from medical appointments or mileage reimbursement. Special needs are accommodated.
  - ModivCare may obtain or ask the member (or member's parent or representative) to obtain verification that an appointment has taken place.
  - NEMT helps to lower "no-shows" for appointments.
  - NEMT is NOT for emergencies or transfers between facilities, cannot be used for trips to a pharmacy.
  - Members are educated to make a reservation at least three days in advance by calling **1-866-913-4342**.
    - To return home they call **1-866-418-9829** after their appointment. They may also call this number to get a ride to Urgent Care after hours.

Supportive Housing

BCBSNM has a Housing Specialist to help members find resources.

- Finding and applying for housing
- Checking that the living area is safe and ready for move-in
- Getting necessary household supplies
- Creating a housing plan
- Coaching on how to keep good relationships with neighbors and landlords
- Coaching about how to follow rules from the landlord
- Education on renter's rights and responsibilities
- Assistance in fixing renter issues
- Regular review and updates to housing plan
- Helping find community resources to keep the house or apartment in working order

To receive this service, members must meet certain requirements. To find out if a member qualify for these services, please call the **BCBSNM Supportive Housing Specialist** at **1-877-232-5518**.

Identification of Substance Use Disorder and Serious Mental Illness

BCBSNM has internal Peer Support Specialists who can help engage members with complex needs.

- They use their lived experiences to help members meet their treatment goals and try to engage them in required treatment.
- They can help providers identify needed resources for members who struggle with Mental Health and Substance use needs.

BCBSNM also has Liaisons in all Psychiatric facilities. These Liaisons help facilities and members with discharge planning to identify gaps, barriers and resources.

They make sure appointments are set and help with any needed transportation. Their goal is to help members with a more successful discharge back to the community.

If you have identified a member who needs extra help with their mental and/or substance use needs, please contact BCBSNM Member Services at 1-866-689-1523,

and ask to speak to a Behavioral Health Coordinator or a Recovery Support Assistant.

Member Enrollment

1. Centennial Care income determination and enrollment processes are completed by the Income Support Division of HSD.

2. Individuals choose a Managed Care Organization (MCO) or are auto-assigned* to one.

3. Members have the opportunity to change MCOs within the first three months following enrollment. If a member changes MCOs, they will remain with the new MCO until the next open enrollment period.

4. Members may submit requests to HSD to change prior to the next open enrollment for unique or special circumstances.

*The percentage of members given to any one MCO is determined by HSD based on factors such as the MCO is new to Centennial Care, quality measures, cost or utilization management performance or other determinants at HSD's discretion. HSD attempts to assign a new member, e.g. newborn, to a family member's MCO, returns members to their former MCO within certain time frames. When all of that has been met, then they are randomly auto-assigned.

Member Services Contact Information

- Members may call, write, or visit our webpage for questions regarding Centennial Care. Our phone number is listed on the back of Member ID cards.
- **Phone: 1-800-693-0663**

  Members with hearing or speech loss can call the TTY/TDD line at 711
- **Write to Member Services:**

  Blue Cross Community Centennial

  P.O. Box 27838

  Albuquerque, NM 87125-7838
- **Website:** https://www.bcbsnm.com/community-centennial/pdf/cc-member-handbook-nm.pdf

Member Rights and Responsibilities

- Members have specific rights and responsibilities
- They are educated about them in the Member Handbook, at community events with Community Outreach and at Member Advisory Groups
- Please review these as they set forth some of the important expectations of your interactions with members
- Member responsibilities include how they should conduct themselves when dealing with providers and their staff

NM Centennial Care Ombudsman

The BCBSNM Ombudsman Specialist advocates for members' rights by fairly exploring problems and utilizing Medicaid guidelines and BCBSNM resources at no cost.

Ombudsman Contact Information

Phone: 1-888-243-1134

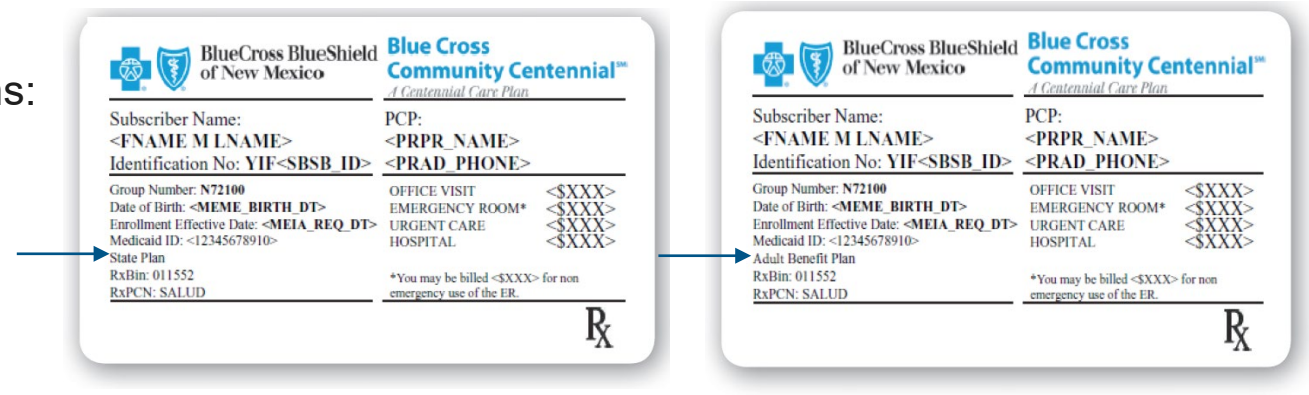
Email: NMCentennialCareOmbudsman@bcbsnm.com

Primary Care Provider (PCP) Assignment

- Members may select a participating PCP within 15 days of enrollment.
- If a PCP has not been selected within 15 days, members will be auto-assigned to a PCP:
  - Members will be auto-assigned to a particular PCP, e.g. PCP is of record for one or more family members.
  - Auto-assignment is based on age, gender, and zip code.
- Members may change PCPs at any time for any reason.
- Dually Eligible Medicare and Medicaid Members:
  - Members dually enrolled with BCBSNM must select a Blue Cross in-network Medicare Advantage PCP.
  - Members not dually enrolled with BCBSNM may see any Medicare-participating PCP and present both ID cards.
  - For dually eligible Medicare and Medicaid members, BCBSNM will be responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's Medicare PCP.

Member ID Cards – Centennial Care and ABP

- The front of the card contains:
  - ✓ Member name
  - ✓ ID number
  - ✓ Benefit information
  - ✓ Type of plan



The back of the card contains:

- ✓ Important phone numbers to coordinate services, e.g. transportation scheduling and ride assist
- ✓ Prior authorization request instructions

ID Cards Guidelines

At each office visit and admission:

- Ask for the member's ID card
- Copy/scan 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 first submit the claim to the other carrier(s). After the other carrier(s) pay, submit the claim to BCBSNM.

- A BCBSNM ID card **is not** a guarantee of eligibility. Eligibility should be checked prior to the appointment/procedure.
- Refer to the member's ID card for the appropriate:
  - telephone number to verify eligibility
  - copayment specific to the member's coverage/type of plan

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Care Coordination

Care Coordination

The Care Coordination team assists members and their families with access to health care services to help meet their healthcare needs.

The Care Coordination team consists of:

- Non-Clinical Member Care Coordinators and Health Coordinators
- Clinical Care Coordinators with Healthcare backgrounds: Registered Nurses, Social Workers (LMSW, Clinical SW) and others
- Community Health Workers

Reasons for Care Coordination Referrals include:

- Qualifying change in condition
- Non-compliance with medication or treatment plan
- Untreated or unaddressed medical, behavioral health, and substance abuse needs
- Disengagement
- Social concerns
- Polypharmacy use of six or more different medications
- Concerns regarding Self Directed Community Benefits (SDCB)
- A patient in need of community benefits such as but not limited to Personal Care Services, Behavior Support and Assisted Living

Care Coordination

Longitudinal Care Coordination

- Members with chronic conditions that are not stable and/or complex social issues

Complex Care Coordination

- Assists members with complex needs
- Members will be assigned a Complex Care Coordinator if they:
  - ✓ Have co-occurring or co-morbid health condition needs
  - ✓ Have a high-risk pregnancy
  - ✓ Have frequent ER visits
  - ✓ Need a transplant

For questions regarding BCBSNM's Care Coordination services, call 1-877-232-5518.

Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) is a standardized health screening which evaluates the health risks and allows for identification of the Member's current health needs. If the Member is agreeable to Care Coordination, a more comprehensive assessment is completed by the Care Coordinator and at that time the Members level of care is established.

The HRA may be conducted via telephone or in person.

Members who are not determined to meet the Moderate or High level of care, are reviewed through quarterly claims mining. If at that time the Member has or had a change in health status, the Member is assigned to a Care Coordinator and a Comprehensive Needs Assessment is attempted.

Comprehensive Needs Assessment (CNA)

- The CNA is a face-to-face assessment performed in the home* to identify areas of need and to help develop a care plan to address individualized needs.
  - Includes the member and several team members such as providers, school representatives, homemakers, family members, and other people who are part of the member's life
  - Can be performed outside of home if HSD has granted an exception
- A new CNA will be attempted **bi-annually for high-risk members**, **annually for moderate risk members** and at any time if there is a change in the member's health condition.
- PCPs and members will have a copy of the care plan

*The CNA may be conducted outside of the Member's primary residence if the member is homeless, or in a transition home; part of the jail involved population preparing for release; or is in a Health Home or a Full Delegation Model.

BCBSNM Supports an Integrated Care Approach

BCBSNM offers a seamless program for BCBSNM's Medicaid members to help meet their health care needs across the full array of Medicaid Covered Services:

- Acute and long-term care
- Behavioral health care
- Home- and community-based services - Members must meet Nursing Facility Level of Care (NFLOC) criteria to be eligible for home- and community-based services.

Members will have the opportunity for all Covered Services and Value-Added Services to be delivered in an integrated manner:

- Using a person-centered approach
- Developing personalized plans
- Furnishing appropriate access to Medicaid covered services

BCBSNM has specific teams to support our members:

Dedicated Care Coordination Teams to Support

- Special Beginnings (High-Risk pregnancies)
- Dual Special Needs (DSNP) Members
- Refugees
- Behavioral Health
- Members in Nursing Facilities
- Medically Fragile Members in collaboration with UNMH
- Members with Developmental Disabilities
- Justice (Incarcerated Members)
- Transitions of Care

Specialized Programs

- Complex Care Coordination Program
- Disease Management Program
  - Focusing on Adult Diabetes and Pediatric Asthma
- Brain Injury Program
- Emergency Room Reduction Program

Community Health Worker/Peer Support Specialists

- Identify Mental Health and Substance Use Resources
- Identifies resources for housing for low income and homeless
- Identifies resources for meals, wood for wood stoves in the winter, water for those without running water
- Multiple community resources for heating, electricity, etc.
- Decrease Emergency Room utilization by linking Members up with providers for care

Paramedicine Team

- Our team works with an Independent ambulance provider that goes to the Member's home following certain hospital discharges

Assessments to Improve Delivery Systems

There are many evidence-based quick assessments that BCBSNM utilizes. Below are some examples of assessments:

Assessments

- ❑ Health Risk Assessments (HRA)
- ❑ Comprehensive Needs Assessment (CNA)
- ❑ Monitor claims to identify members who might have high needs.

Below are examples of other types of assessments and resources the providers can utilize in their practice:

- ❑ **The Patient Health Questionnaire (PHQ)-9** is a 9 question self-reported assessment that is easy to use and quickly scored. It is used to assess for major depressive disorder (MDD).
- ❑ **General Anxiety Disorder (GAD)-7** is used to screen for Anxiety, social phobia's, Post Traumatic Stress Disorder and Panic. Like the PHQ-9 it is a self-reported assessment with 7 quick questions that are asked. It also is quickly scored to determine if a referral to treatment is needed.
- ❑ **SAMHSA (Substance Abuse and Mental Health Services Administration**) *This website is full of tool for providers around finding Treatment, resources and assessment for members.*

  SAMHSA.gov has different evidence-based screening tools to help quickly screen for Substance Use needs. A couple are NIIDA-Modified ASSIST, S2BI, Brief Screener for Alcohol, Tobacco and other drugs.

BCBSNM Supports the Improvement of Delivery Systems

- **Treatment/Service Plans**

  Some patients have substance use and/or mental health comorbidities, but without screening for them when indicated, they may be overlooked. There are evidence-based assessments that providers can utilize to efficiently assess a member's mental health or substance use needs. Those needs may include a referral for services from other providers. If a member's physical and mental health needs are addressed, their overall health is more likely to improve.

- **Discharge Planning**

  When indicated, BCBSNM staff collaborate with the facility for discharge planning (i.e., transition to a lower level of care when treatment plan goals are met and reintegration into the community is appropriate). A comprehensive discharge plan typically includes transitional planning, including an outpatient appointment with a PCP, psychiatrist or other specialist. This also includes assessing the need for Durable Medical Equipment (DME), medications, and resources when discharged home from an acute care or nursing facility. Attempts are made to schedule an appointment that is **within seven (7) days of discharge**

BCBSNM Supports the Improvement of Delivery Systems

- **Models of Care (Member Centered/Trauma Informed)**

  BCBSNM makes available certain care model(s) (i.e. Clinical Guidelines) that have been designed so that providers may better manage the care of the Blue Cross Community Centennial population (including DSNP), focusing on known service utilization patterns.

- **Behavioral Health Level of Care Guidelines**

  BCBSNM offers many Clinical Resources on our Provider Webpage (https://www.bcbsnm.com/provider/). These resources detail information on our Behavioral Health Care Management Program and Behavioral Health Level of Care Guidelines and resources. These programs help BCBSNM clinical staff identify members who could benefit from co-management earlier, and may result in:

  - Improved Outcomes
  - Enhanced continuity of care
  - Greater clinical efficiencies
  - Reduced costs over time

How Care Coordinators can work in tandem with providers for our members

- Care Coordinators help connect members with providers to meet their healthcare needs to help improve their quality of care
- Care Coordinators conduct a Comprehensive Needs Assessment for all Members in Care Coordination
- Care Coordinators develop care plans
- Educate members to better manage their conditions
- Help build continuity of care
- Care Coordinators may be part of a member's multi-disciplinary care team
- Care Coordinators receive alerts when their members are hospitalized to help with coordinating discharge planning and timely follow up.

Native American Care Coordinators

- Native American Care Coordinators are available upon request.
- If a Native American member requests a Native American Care Coordinator and one is not available, a Community Health Worker (CHW) will be present for all in-person meetings with the member and a non-Native American Care Coordinator.
- Blue Cross Community Centennial facilitates a language translation service called “Language Line.” The provider's staff will need to contact Member Services and request this service at 1-866-689-1523.

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Claims

Claims – Timely Filing

- Should file within 90 days, must file **no later than 180 days.**
- If there is a primary carrier, timely filing requires (1) filing with the primary carrier **within 180 days from the date of service**; and (2) filing with BCBSNM within 180 days from the date of the primary Explanation of Benefits (EOB).
- If there is not a primary carrier and no documentation furnished that the claim was sent to the wrong carrier within 180 days from the date of service, all claims submitted after 180 days from date of service will be denied.
- Indian Health Service, Tribal or Urban Indian (I/T/U) providers have up to two years from the date of the service to file claims.

Claims Submission Best Practices

Member Information

- 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

Participating Provider Information

- Provider's Tax Identification Number
- Provider NPI number and Taxonomy (Type 1 and Type 2 if applicable)
- Participating Provider Name and address
- Place of service code
- Preauthorization number, if required

Visit Information

- 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

Claims Submission

Electronic Submission

- Payer ID MC721- effective 05/20/17
- For information on electronic filing of claims, contact Availity at 1-800-282-4548

Paper Submission

- Must be submitted on the CMS-1500 or CMS-1450(UB-04) claim form

Duplicate Claims

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

- **Submit forms to:**

  Blue Cross Community Centennial
  PO Box 27838
  Albuquerque, NM 87125

Hold Members Financially Harmless

- Participating providers and sub-contractors of providers agree that in no event...will 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.
- Participating providers are prohibited from collecting any payment for non-covered services from the member.
- Providers must not bill members or accept payment from members for non-covered services unless all requirements of Section 8.302.1.16 NMAC have been satisfied: (1) provider advised member before furnishing a non-covered service that it is not covered; (2) provider gave member information about necessity, options and charges for the non-covered services; and (3) member agreed in writing to receive the non-covered services with knowledge that s/he will be financially responsible for payment.

Claims

- **Coordination of Benefits (COB)**
- Blue Cross Community Centennial is always the payer of last resort.
- Claims should be submitted with the complete primary insurance Explanation of Benefits.
- For members with both Medicare and Medicaid, Medicare is considered the member's primary insurance.

- **Encounter Reporting**
- BCBSNM is required by the New Mexico Human Services Department (HSD), to report ALL services rendered to Centennial Care members.

- **Billing Audits**
- We will conduct both announced and unannounced site visits and field audits to contracted 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.

National Drug Code (NDC)

11-digit NDC is required:

- When billing for injections/other drug items on CMS1500 and UB04 claim forms, and 837 electronic transactions
    - NM HSD requirement as of Sept. 2010

- When reporting injections/other drug items administered in outpatient offices, hospitals, and other clinical settings on CMS1500 and UB04 claim forms, and 837 electronic transactions
    - Federal Deficit Reduction Act of 2005 (signed 2006)

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.

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

BlueCross BlueShield of New Mexico

Cultural and Linguistic Competency

Cultural and Linguistic Services – Health Literacy

The Care Environment

- Create a Welcoming Setting
- Make sure Signs are Understandable
- Give Patients Help with Paperwork
- Watch for Clues that a Patient May Need Help
- Make your Environment Accessible

Providing Culturally Competent Care

- Have trained bilingual/bicultural staff and interpreters available.
- Communicate in ways that can be easily understood by different audiences.
- Provide equal access to services for all groups.
- Weave knowledge of patient's culture and community into policy and practice.
- Provide print materials in the languages of the community.

Clear Communication

Using AIDET in a Health Literate Care Environment

- **A –Acknowledge**. Welcome the patient by name. This helps patients feel confident that you know and care about them and understand why they are here.
- **I-Introduce.** Introduce yourself by position or role in terms people understand. This creates confidence you are the right person for the job. And they know who to follow up with, if needed.
- **D-Duration.** Tell the patient how long this will take. Patients want to know how long they will be here or how long it will be until they get answers. When you respect a person's time, they become less anxious and can concentrate on what you are saying.
- **E-Explanation.** Use plain language to explain the need-to-know information about what is going to happen. Using plain language allows the person to understand what is about to happen, how it will feel, and what it is for. It allows for questions before things progress. This is a time to use **teach-back** if needed.
- **T-Thank you**. Thank the patient for allowing you to care for them. Include an open-ended question regarding follow-up or other issues. Use teach-back on last time, if needed. People have choices. Let them know you appreciate their confidence and trust.

Annual Cultural Competency Training Requirement

- Annual Cultural Competency Training is required by the New Mexico Human Services Department for all providers contracted within Blue Cross Community Centennial.
- The training is available on our BCBSNM Provider Website, along with the Cultural Competency Training Attestation.

Resources

- Always use Teach-back! Toolkit – http://teachbacktraining.org/
- Building Health Literate Organizations: A Guidebook to Achieving Organizational Change – https://www.unitypoint.org/health-literacy-guidebook.aspx
- Health Literacy Universal Precautions Toolkit – AHRQ Publication No. 10-0046-EF – http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html
- Health Literacy Video – American College of Physicians Foundation. http://acpfoundation.org/hl/hlvideo.htm
- Assess Your Practice Toolkit – http://www.nchealthliteracy.org/toolkit/tool2A.doc
- Angela Gonzales, MA, BCBSNM Community Health Educator 505-816-3022, angela_gonzales@bcbsnm.com

Provider Credentialing - CAQH Application

- Every three years, BCBSNM requires:
  - Compliance with all state and federal licensing and regulatory requirements
  - An active license that has not been revoked, terminated, probated, or suspended

Site Visits

- Facilities and practitioners may require a site visit
- BCBSNM Network Services contacts the provider to schedule and conduct site visits

Failure to maintain credentialing status can result in provider's termination from all networks.

Provider Re-Credentialing

- The process of re-credentialing is similar to the initial credentialing process. The provider can continue servicing members until otherwise notified.
- CAQH will send providers a notification every 120 days instructing them to confirm the information is accurate and complete on their website.

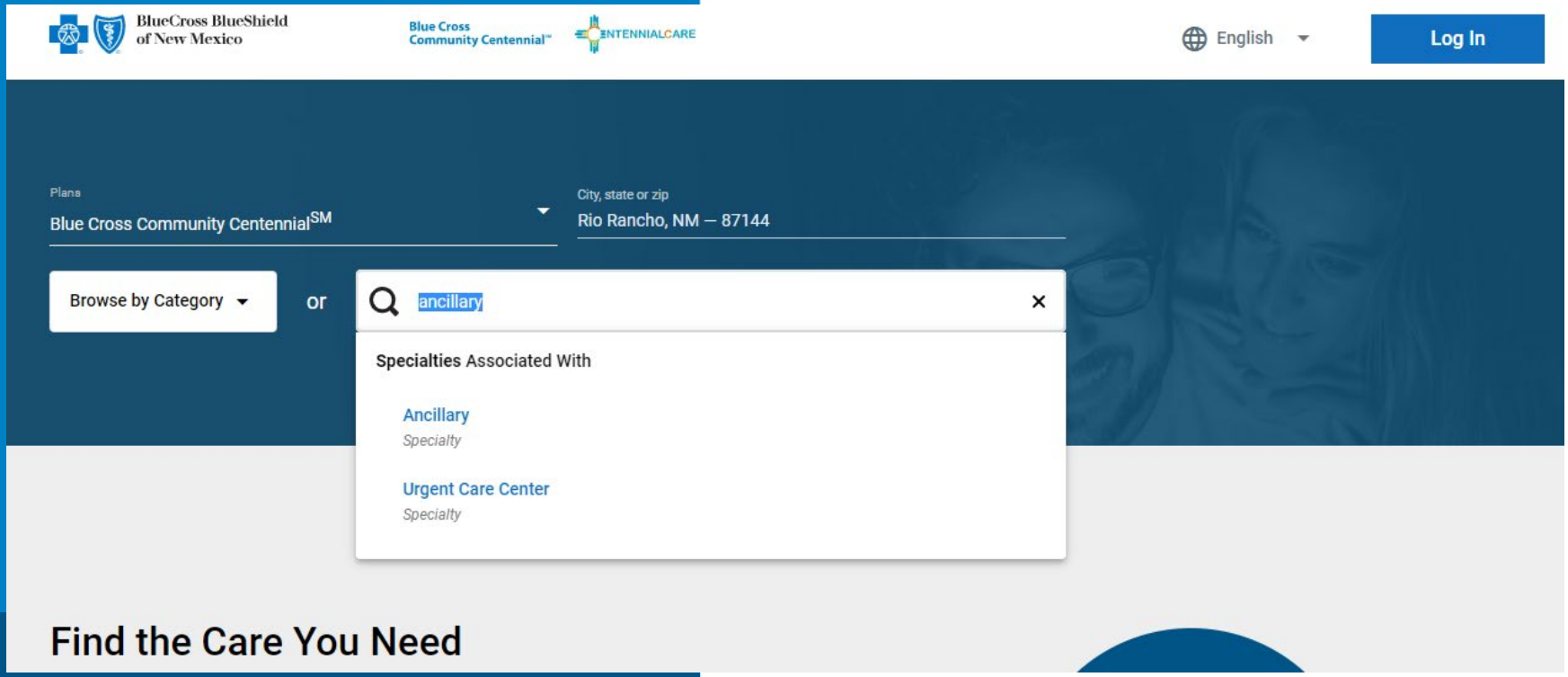
CAQH Website:
https://www.caqh.org/solutions/caqh-proview-providers-and-practice-managers

Provider Resources

- BCBSNM's Provider Website offers many resources, trainings, and information for our providers: https://www.bcbsnm.com/provider/
- Update your demographic information
- Review our Provider Reference Manual (**PRM**)
- Access and/or request **specialized training**
- Review and/or sign up for our monthly Provider Newsletter (**Blue Review**)

Provider Resources

- ✓ Search our Online and Printed **Provider Directories**
- ✓ Select the appropriate “Plan” **Blue Cross Community Centennial℠**
- ✓ Select the City, state or zip
- ✓ Browse by **Category** or Search by **Provider Specialty**
- ✓ Results can be sorted
  - Best Match
  - Distance
  - Quality
  - Rating
  - A-Z
  - Z-A
  - Tier
- ✓ Results can be viewed by “List” or “Map” view.



Prior Authorization

- Unless otherwise prohibited by law, prior authorizations are required for certain services before they are rendered. Prior authorizations are based on:
  - Benefits and medical necessity
  - Nationally recognized, peer-reviewed, evidence-based criteria
  - New Mexico Administrative Code (NMAC)
  - Other nationally recognized medically necessary care guidelines

- Long-Term Supports and Services (LTSS) have different prior authorization requirements.
- Native Americans are exempt from the prior authorization process when utilizing Indian Health Service, Tribal or Urban Indian (I/T/U) facilities.

Prior Authorization

Prior authorization requirements are listed in the Precertification Section of the Provider Reference Manual on our BCBSNM Provider Website:

https://www.bcbsnm.com/provider/index.html

- Prior authorization criteria are reviewed annually by the BCBSNM Medical Directors.
- Providers are notified of changes to prior authorization criteria at least 30 days in advance of implementing changes.

Prior authorizations *(with the exception of LTSS services)* can be obtained:

1. By calling **1-877-232-5518**
2. By faxing the NM Uniform Prior Authorization Form found on our provider website at: https://www.bcbsnm.com/pdf/forms/nm-uniform-pa-form.pdf
3. Availity https://www.availity.com/
4. AIM Provider Portal https://aimspecialtyhealth.com/providerportal/

Prior Authorization

As of 1/1/2021, BCBSNM has contracted with AIM Specialty Health* (AIM) to provide pre-service authorization for various services. Please visit our website for a complete list of procedures which require prior authorization through AIM

Please use Availity® for all other services that require a referral and/or preauthorization

Services performed without preauthorization may be denied for payment, and the rendering provider may not seek reimbursement from members.

The AIM web portal is available 24/7.
Please call 1-(800) 859-5299 from 5:00 a.m. – 5:00 p.m. M-F
8:00 a.m. – 11:00 a.m. on Weekends and Holidays

*AIM Specialty Health is an independent company that provides specialty medical benefits management for BCBSNM.

Prior Authorization

Please notify BCBSNM at **1-877-232-5518** regarding:

- Elective hospitalizations
- Emergent Hospitalizations – In the event that the service is due to an emergency or following a visit to the Emergency Department, the facility must notify BCBSNM within one working day of the admission

Prior Authorization

BCBSNM complies with applicable legal and accreditation requirements for prior authorizations, including, but not limited to the New Mexico Prior Authorization Act and NCQA, such that BCBSNM accepts the standard prior authorization form promulgated by the NMOSI and makes prior authorization decisions within:

- **Seven (7) business days** after receipt of standard request;
- **Twenty-four (24) hours** after receipt of expedited request.

It is critical that the provider furnish all relevant documentation and information in support of the request, because we will make a decision based on what we have by the time of the deadline for a decision.

For select categories; Radiology, Molecular Genetics, Outpatient PT/OT/ST, Spine, Joint and Pain, Radiation Therapy and Sleep, Medical Oncology(effective 10/01/21), PA requests should be sent to AIM which may have minimally different processes that remain compliant with all applicable laws and accreditation requirements, see https://aimspecialtyhealth.com/providerportal for more information.

Referrals

- BCBSNM does not require a referral when members see any in-network medical, behavioral, or long-term care provider.
- Referrals are also not needed for;
  - Emergency services
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
  - Women's services
  - Vision
  - Dental
- Members can request a second opinion from a provider in the Blue Cross Community Centennial Care network without a referral
  - ✓ Prior authorization may be necessary based on the type of service
  - ✓ Prior authorization from BCBSNM is required to see an out of network provider.
  - ✓ Third or fourth opinions require prior authorization from BCBSNM.

Reminder about Payment for Admission

- If a member is hospitalized at the time of enrollment, disenrollment, or suspension into or from managed care, the payor at the date of admission will be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, non-psychiatric specialty unit, or hospital until the date of discharge.
- Upon discharge, the Member becomes the financial responsibility of the HSD or the MCO.

Appeals and Grievances (A&G)

Appeal

A request for review of an ”action” taken by BCBSNM about a service. An action is when BCBSNM denies, delays, limits or stops a service. This can be regarding a medical, behavioral health, prescription, transportation, vision or dental service. Providers should use the form located at https://www.bcbsnm.com/pdf/forms/prov-appeal-medicaid-mem.pdf Call 1-800-693-0663 (must be followed with a written request within 13 days) Or Fax to 1-888-240-3004

Providers may check appeals by calling **1-800-693-0663.**

For an expedited behavioral health appeal, call **1-877-232-5520.**

Grievance

An expression of dissatisfaction by a member or a participating provider about any matter or aspect of BCBSNM, or its Blue Cross Community Centennial operation, e.g. wait times, cleanliness of office, quality of care received, etc.

To file a grievance:

- Call 1-800-693-0663
- Fax 1-888-240-3004
- Write:

Blue Cross Community Centennial
Appeals and Grievances
ATTN: Grievance Coordinator
PO Box 27838
Albuquerque, NM 87125-7838

Appeals and Grievances (A&G)

Providers may request an appeal on behalf of a member with the member's authorization.

Appeals

- Need to be requested by the provider within 90 calendar days from the date of receiving the notice of action
- Acknowledgement will be made within 5 calendar days of receipt
- 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
- HSD must approve extension requests that are requested by the plan

Grievances

- Will be resolved within 30 calendar days

Internal Provider Grievance Process

When the A&G Department receives a grievance from a provider, it is electronically or manually date stamped to indicate the corporate received date.

The A&G Department sends a written acknowledgement letter to the provider within **(5) business days.**

The A&G staff ensure that the person who reviews and resolves the grievance was not involved in the initial determination.

The A&G staff conducts an investigation and notifies the provider if an extension is required.

The A&G staff send a resolution letter to the provider within **(30) calendar days.**

The Appeals Staff updates the electronic system with the resolution information.

Appeals and Grievances – Provider Responsibilities

- Providers should instruct the member to contact Member Services at the number listed on the back of the member's ID card if they have a complaint or concern.
- Participating providers must cooperate with BCBSNM and members in providing necessary information to resolve the appeal/grievance within the required time frames.
- Providers need to submit the pertinent medical records and any other relevant information. In some instances, providers must give information in an expedited manner to allow BCBSNM to make an expedited decision.
- Providers cannot use a statement signed by the eligible recipient or their authorized representative to accept responsibility for payment of a denied claim if services have been rendered unless such billing is allowed by MAD rules.

Appeals and Grievances – Provider Responsibilities

Providers must not request an expedited appeal unless the normal 30 days puts the members health at risk. Blue Cross Community Centennial plan automatically provides an expedited review for all requests related to a continued hospital stay or other health care services for a member who has received emergency services and is still in the hospital.

Providers need to submit the pertinent medical records and any other relevant information. In some instances, providers must give information in an expedited manner to allow BCBSNM to make an expedited decision.

Critical Incident and Abuse/Neglect Reporting

- Please refer to this section in the Provider Reference Manual
- Allegations of abuse, neglect (including self-neglect), exploitation, deaths (expected and unexpected), emergency services, law enforcement, environmental hazards, and elopement/missing for select Categories of Eligibility (COEs) must be reported to HSD through the Critical Incident Reporting system portal at https://criticalincident.hsd.state.nm.us. Additional COEs may be reported outside of the portal.
- If providers suspect abuse, neglect or exploitation of members, they are mandated by law to contact:
  - Adult Protective Services by phone at 1-866-654-3219 or via Fax at 505-476-4913; or
  - Children, Youth, and Families Department 1-855-333-7233; and/or
  - Contact law enforcement or the appropriate tribal entity.

For more information and helpful training documents on what and how to report, go to https://www.hsd.state.nm.us/providers/critical-incident-reporting/

Fraud, Waste, and Abuse

Reporting Fraud, Waste, and Abuse:

- Suspected fraud, waste, and abuse should be reported to BCBSNM by health care providers, subcontractors, vendors, members, and other departments to the Special Investigative Department (SID)
  - **Fraud**: An intentional deception or misrepresentation by a person or an entity with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person
  - **Waste/Abuse**: Inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.
- Report Fraud, Waste, and Abuse to the SID toll-free Fraud Hotline **(1-800-543-0867**) which is staffed and operational 24 hours a day, seven days a week.
- Suspected fraud can also be reported at https://www.incidentform.com/BCBSFraudHotline.jsp

Questions?
Feedback?