Indian Health Service, Tribal 638, and Urban Indian Health (ITU) Provider Training Handout

Maximizing the health status of Medicaid eligible individuals for New Mexico by breaking down the financial, cultural, and linguistic barriers preventing low-income families and individuals from accessing health care.

1/7/2014

This manual is meant as a notetaking device during the Provider Training. It is not all inclusive of the information that is included in our Provider PowerPoints.

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Blue Cross and Blue Shield of New Mexico refers to HCSC Insurance Services Company (HISC), which is a wholly owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company. Both HISC and HCSC are Independent Licensees of the Blue Cross and Blue Shield Association.
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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 ).

**Expansion Alternative Benefit Plan ID**

**Expansion State Plan (ABP Exempt) Card**
**NM Copayments Medicaid Program (Final Version from HSD as of 12-10-2013)**

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<td>Copayment only applies when the federal match code is 1</td>
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**PHARMACY COPAYMENT:**

- **$2 per drug item** - Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

**PRACTITIONER SERVICES COPAYMENTS:**

- **$5 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session** - This copayment is not applied to emergency room professional charges because there is a separate emergency room facility copayment that applies, see “hospital copayments” below. Only one copayment is applied per visit or session.

When the “visit” takes place in an outpatient hospital or urgent care center, which typically involves both a facility component as well as a professional (physician) component charge, the outpatient copayment is applied to the professional charge, not to the facility charge.

**HOSPITAL COPAYMENTS:**

- When the copayment is applied to an inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.

**$15 outpatient emergency room** - Does not apply if the copayment for non-emergent use of the ER is assessed.

**$25 inpatient admission** – Not applied when the hospital receives recipient as a transfer from another hospital.

**EXEMPTIONS**

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Family planning services, procedures, drugs, supplies, and devices
4. Medicare Cross Over claims including claims from Medicare Advantage Plans
5. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc.) – See note section on page 8, item 7.
6. Prenatal & postpartum care and deliveries, and prenatal drug items
7. Provider preventable conditions
8. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8.
9. Federal match 3 for COE’s 071 and COE’s 420, and 421 because they are presumptively eligible children.

**COPAYMENTS FOR UNNECESSARY SERVICES:**

- **$5 for a brand name drug** when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. – See note section on page 7, note 3.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

**$50 for non emergent use of ER** – See note section on page 6, note 2.

**EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:**

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions.
5. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8 of note 4; and on page 9, item 12 of note 4.
## WDI RECIPIENT COPAYMENTS
### Working Disabled Individuals

**Category of eligibility: 074**

### PHARMACY COPAYMENT:

$5 per drug item - Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

### PRACTITIONER SERVICES COPAYMENTS:

$7 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session - This copayment is not applied to emergency room professional charges because there is a separate emergency room facility copayment that applies, see “hospital copayments” below. Only one copayment is applied per visit or session.

When the “visit” takes place in an outpatient hospital or urgent care center, which typically involves both a facility component as well as a professional (physician) component charge, the outpatient copayment is applied to the professional charge, not to the facility charge.

**HOSPITAL COPAYMENT:**

When the copayment is applied to any inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.

$20 outpatient emergency room - Does not apply if the copayment for unnecessary use of the ER is assessed.

$30 inpatient admission - Not applied when the hospital receives recipient as a transfer from another hospital.

### EXEMPTIONS

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Family planning services, procedures, drugs, supplies, and devices
4. Medicare Cross Over claims including claims from Medicare Advantage Plans
5. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc. – See note section on page 8, item 7.
6. Prenatal & postpartum care and deliveries, and prenatal drug items
7. Provider preventable conditions
8. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.

### COPAYMENTS FOR UNNECESSARY SERVICES:

$8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. See note section on page 7, note 3.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

$28 for non emergent use of ER - See note section on page 6, note 2.

### EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions
5. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.
ABP - ALTERNATIVE BENEFIT PLAN COPAYMENTS Category of Eligibility

APPLIES ONLY TO ABP RECIPIENTS WHO ARE 101% - 138% FPL

(For ABP recipients who are at an FPL of 100% or below, or who are ABP Exempt, the only copayments that can apply are for unnecessary use of a brand name drug and unnecessary use of an ER, see page 6)

PHARMACY COPAYMENT:

$5 per drug item Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items and some behavioral health drugs.

PRACTITIONER SERVICES COPAYMENTS:

$8 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session.

This copayment applies in places of service such as offices, outpatient hospitals (other than emergency rooms), clinics, and urgent care centers. It is applied to the professional service, not to any facility charge.

These practitioner services copayments do not apply to emergency room facility or emergency room professional charges because of the exemption for emergency services.

HOSPITAL COPAYMENTS

$25 Inpatient admission - A copayment is not applied when the hospital is receiving the recipient as a transfer from another hospital or when the recipient is admitted through the emergency room.

When the copayment is applied to an inpatient service, the copayment is always applied to the hospital charge, not the professional charge.

EXEMPTIONS for ABP

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code services. See note section on page 6, note 1.
3. Family planning services, drugs, procedures, supplies, and devices
4. Hospice patients
5. Medicare Cross Over claims including claims from Medicare Advantage Plans
6. Pregnant women - all services unless MAD gets approval from CMS to exempt some services as not pregnancy related; so currently all services for pregnant women are exempt.
7. Prenatal & postpartum care and delivery services, and prenatal drug items
8. Mental health (behavioral health) and substance abuse services, including psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.)

COPAYMENTS FOR UNNECESSARY SERVICES:

$8 For a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

See note section on page 7, note 3.

$8 For non emergent use of ER
See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions When the maximum family out of pocket expense has been reached, see note section on page 8, item 8.
10. All preventive services
11. Provider preventable conditions
12. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.
13. Emergency services

Note: The usual ABP copayments do not apply to an ABP-exempt recipient. The only copayments that apply to the ABP exempt recipient or to an ABP recipient at 100% FPL or below are those for unnecessary use of a brand name or an ER. See page 6, other recipients.

The ABP exempt recipient is identified by having a “disability type code” on the eligibility file of ME or PH.

Emergency Services Exemption for Above ABP Copayments

- The ABP copayments do not apply when treatment is for an “exempt emergency service” as described in the Social Security Act and CFR.

- These provisions clearly exempt all medically necessary emergency room services from copays. However, there may be additional situations that qualify as emergency services.

- For additional information on this provision, see note section on page 6, note 1.
OTHER MEDICAID RECIPIENTS

Note that if the FPL is not available on January 1, 2014, use the lower copayment until the FPL is available.

Applies to:

1. ABP recipients who have an FPL at 100% or below
2. ABP Exempt recipients
3. Other standard Medicaid recipients except for recipients in foster care, adoption programs, or institutional categories of eligibility

These recipients who have “standard” Medicaid eligibility, so they generally do not have copayments on services. However, they can be assessed a copayment for non-emergent use of the ER or for unnecessary use of a brand name, unless they are one of the following categories of eligibility.

CATEGORIES OF ELIGIBILITY FOR WHOM THE COPAYMENTS FOR NON EMERGENT USE OF THE ER AND UNNECESSARY USE OF BRAND NAMES DO NOT APPLY:

- 014 foster care
- 017 adoption
- 037 adoption
- 046 foster care
- 047 adoption
- 066 foster care
- 081 institutional care
- 083 institutional care
- 086 foster care
- 084 institutional care

OTHER EXEMPTIONS:

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. For psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.)
5. Provider preventable conditions
6. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8, and on page 9, item 12 of note 4.

Note:

- There is no copayment for drug items other than the unnecessary use of a brand name.
- There are no payments for practitioner services, hospital services, or emergency room services other than the non emergent use of the ER.

COPAYMENTS FOR UNNECESSARY SERVICES:

$ 3 For a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. – See note section on page 7, note 3.

FOR NON EMERGENT USE OF THE EMERGENCY ROOM -

- Varies by FPL:
- $ 8 for 150% FPL or below
- $50 for greater than 150% FPL

See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare
4. Provider preventable conditions
When the maximum family out of pocket expense has been reached.
See note section on page 8, item 8.

Note 1: Alternative Benchmark Plans: Notes on the Exemption from Copayments for Emergency Services

**Exempt emergency services (federal definitions):** "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

*Emergency services* means covered inpatient and outpatient services that are as follows:

1. Furnished by a provider that is qualified to furnish these services under this title.
2. Needed to evaluate or stabilize an emergency medical condition.

**Provider Responsibilities:**
- The MCO is responsible for setting up their process which may include requirements for the provider to identify when a copayment is exempt because the service is an emergency.

**MCO Responsibilities:**
- To not apply the ABP copayment to services in emergency rooms. Unless, the non-emergent use of the emergency room copayment is assessed, an emergency room service is presumed to be an emergency. Very likely, an inpatient hospital stay when the admission is through an emergency department, the inpatient hospital stay qualifies as an emergency.
- To develop their own rules and process consistent with the federal requirements. MAD can provide direction as necessary.
- To recognize when other providers report the service as exempt from the copayment because it is an emergency. In which case the MCO does not deduct the ABP copayment from the amount paid to the provider.
Note 2: Assessing a Copayment for Non-Emergent Use of the Emergency Room

Hospital Responsibilities:

- The hospital provider will determine if the recipient is using the emergency room for a non-emergent service. In making this determination, the hospital must consider the medical presentation of the recipient, age, and other factors, as well as alternatives that may be available in the community, the time of day, etc.

- The hospital must provide an appropriate level of screening to determine whether the service constitutes an emergency. Before assessing the copayment, the hospital must provide the individual with the name and contact information for an alternative provider that can provide the services in a timely manner with a lesser or no copayment (depending on the recipient’s category.) If the recipient chooses to go to the alternative provider, the hospital assists with making an appointment for the recipient. Depending on the day and the time, this may include helping contact the alternative provider or providing the name(s) and phone number(s) of the providers, directions, etc. If geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.

- The hospital must tell the recipient the amount of the copayment. If the recipient agrees to go with an alternative, the copayment for non-emergent use of the ER is not assessed by the hospital.

- If the recipient wants to continue to receive emergency room services beyond that initial screening, the hospital assesses the co-payment.

- When the hospital assesses the copayment, it is reported to the MCO, and the MCO reduces the payment to the hospital by the copayment amount. If the hospital is not able to collect the copayment amount, the copayment amount should not be deducted from the hospital payment.

MCO Responsibilities:

- To recognize when the copayment has been assessed by the hospital and collected from the recipient, and only then to reduce the payment to the hospital by the copayment amount.

Note 3: Assessing a Copayment for Unnecessary Use of a Brand Name Drug

The copayment for unnecessary use of a brand name drug is applied to a brand name drug that is NOT on the PDL, with the following limitations:

- If in the prescriber’s estimation, the alternative drug item available on the PDL is either less effective for treating the recipient’s condition, or would have more side effects or higher potential for adverse reactions, the copayment cannot be applied. Presumably, if the MCO approved the use of a brand name drug NOT on the PDL for one of these reasons, then the copayment cannot be applied.

- If the prescriber has stated the brand is medically necessary and therefore the claim is billed with a dispense as written indicator, the copayment
cannot be applied unless the MCO ascertains the reason for the brand being medically necessary is something other than the fact that the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the recipient.

MCO Responsibilities:
- The MCO should consider how to construct a PDL in order to apply this copayment. For example, maybe only a first tier drug item is called the “PDL” while a second tier is maybe called something else, maybe “Alternatives”.
- The MCO must determine the means by which a copayment on a brand name drug will not be applied when the above conditions are met.

Note 4: General Rules for all copayments

1. Native Americans are always exempt from all these copayments.

2. A provider is NOT able to refuse services to the recipient when the recipient is unable to pay the copayment at the time of service. However, the provider is still required to apply the copayment by billing the recipient or trying to collect it at a future visit.

3. Only one copayment can be charged per visit or encounter. There are no other copayments applied during an inpatient stay other than the one applied for hospital admission.

4. Except for non-emergent use of the ER, the MCO must assume the copayment applies and must deduct the applicable copayment from the claim prior to paying the provider regardless of whether the copayment was actually collected by the provider unless:
   - The recipient or service is exempt from copayment per the criteria on this chart, or
   - The service is exempt based on information from the provider (such as a service to an ABP recipient being an emergency) or
   - The recipient is exempt from the copayment because the total copayments paid by the family exceed 5% of the family’s income in which case this information is communicated to the MCO.

5. For non-emergent use of the ER, the MCO should assume the copayment for the unnecessary use does not apply, unless indicated by the hospital provider that the copayment has been assessed.

6. There may be instances where the MCO may not know when the use of a brand name drug item should not be subjected to the unnecessary use of a brand name copayment. The MCO must formulate their procedures for this process.

7. Ideally, the concept of what constitutes preventive care will be standard across all MCO’s, but the effort to accomplish this will have to come in the future, probably after the implementation Centennial Care. MAD will give direction as necessary. Note that this concept of “preventive care” is not necessarily the same as the list produced by CMS for the ABP plan, which is often limited by age or frequency and does not generally consider risk factors and other conditions that may make a service preventive in nature.
8. Exceeding the 5% of the family income:
   In order to determine if an individual is exempt from copayment, the MCO will have to accumulate the amount of copayments for every member in the family using the case number. When those accumulated copayments reach the family out of pocket maximum expense, then all members of the family are exempt from copayments.

   - Example: If John Jr. had a $50 copayment, and Suzie Jr. had a $50 copayment, and the family out of pocket maximum for the quarter is $100, when little Robbie has a service and the copayment is $5, the family out of pocket maximum for the quarter has already been met. Little Robbie doesn’t have to make a copayment. In other words, it is the total amount that has been deducted from provider payments as copayments for all members of the family, not the individual, that are accumulated and compared to the family out of pocket maximum for the quarter.

   Copayments for unnecessary use of brand name drugs or ER non-emergency use are also included in the accumulation of the total family out of pocket maximum for the quarter.

9. When other insurance has paid for the service and the amount being paid by an MCO is toward the co-insurance and deductible, copayments are not applied.

10. Copayments are never applied to services that are considered Community Benefits under the MCO contract and rules.

11. Copayments are not applied to services that were rendered prior to eligibility being established, even though retroactive eligibility later covers the time period during which the service was rendered.

12. The MCO must track, by quarter, all copayments applied to claims for each individual member in the household family to ensure that the family does not exceed the aggregate out-of-pocket maximum (OOP). The OOP is five percent of countable family income for all individual members in a household family calculated as applicable for a quarter. The MCO must be able to provide each member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

13. The MCO must report to the provider when a copayment has been applied to the provider’s claim and when a copayment was not applied to the provider’s claim. This is done, at a minimum, using the remittance advice, EOB, or equivalent electronic transaction. The MCO shall be responsible for assuring the provider is aware that:

   - The provider shall be responsible for refunding to the member any copayments the provider collects after the eligible recipient has reached the co-payment out-of-pocket maximum (five percent of the eligible recipient’s family’s income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from copayment due to the timing of claims processing.

   - The provider shall be responsible for refunding to the member any copayments the provider collects for which the MCO did not deduct the payment from the provider’s payment whether the discrepancy occurs because of provider error or MCO error.
Claim and Reimbursement Process

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.
- I/T/Us have two years to submit claims.

IHS/Tribal 638 Multiple Encounters

- For multiple or offsite encounters, Medicare will only cover one encounter which is billed with revenue code 0510, and this claim will be reimbursed up to the Medicare OMB rate.
- Medicaid is responsible for the remaining encounters, if there are more.
- The IHS or tribal facility is paid the full co-insurance, deductible, or copayment as calculated by the Medicare payer.

ITU Multiple Encounters and Reimbursement Dual Eligible

If recipient is a dual eligible (Medicare and Medicaid) and has received more than one encounter for that day, the first claim is billed to Medicare with revenue code 0510 reimbursed up to the Medicare OMB rate. Medicaid is responsible for the remaining encounters, if there are more. These encounters are billed with revenue code 0519.

For claims billed to Medicare with revenue codes 636 and 771, there will be no additional reimbursement unless there is a Medicare calculated amount.

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-9 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.

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
**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.

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**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:
• 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!

- The first time Refund Management-eRM is accessed, users will be prompted to complete and submit a brief onboarding form.
- Users will receive a validation email approving their access within 24 hours.

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.

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*

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<tr>
<th>VALUE ADDED</th>
<th>BCBS</th>
<th>MOLINA</th>
<th>PRESBYTERIAN</th>
<th>UNITED HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Medicaid Benefits for COE 035 Members - Pregnancy related Services</td>
<td>Y – Full Medicaid benefits for course of pregnancy and up to 2 months postpartum – including dental and vision</td>
<td>Y - Full Medicaid benefits for course of pregnancy and up to 2 months postpartum including dental and vision</td>
<td>Y - Full Medicaid benefits for course of pregnancy and up to 2 months postpartum including dental. (No Vision)</td>
<td>Y - Full Medicaid benefits for course of pregnancy and up to 2 months postpartum including dental and vision</td>
</tr>
<tr>
<td>VALUE ADDED</td>
<td>BCBS</td>
<td>MOLINA</td>
<td>PRESBYTERIAN</td>
<td>UNITED HEALTH CARE</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------</td>
<td>--------</td>
<td>--------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Adult Vision - Extended</td>
<td>Y-1 eye exam, 1 set lenses/frames per year</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Baby diapers</td>
<td>Y-1 box of 144/272 per child, after completion of 6 week postpartum visit</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Adult Chemical Dependency Residential Treatment Center (RTC) Services</td>
<td>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. <strong>Benefit Limit:</strong> 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. <strong>Eligibility:</strong> RTC services for adult members with severe medical disorders and patients with alcohol/ substance abuse problems.</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Annual Adult Physical Exams **</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Caregiver Support Classes</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Cell Phone</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Dental Varnish</td>
<td>Y – Up to 6 applications</td>
<td>Y – Children 0 to 3 years old</td>
<td>Y - Age 6 months-3 years, 6 applications</td>
<td>Y</td>
</tr>
<tr>
<td>VALUE ADDED</td>
<td>BCBS</td>
<td>MOLINA</td>
<td>PRESBYTERIAN</td>
<td>UNITED HEALTH CARE</td>
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<td>-------------------------------------</td>
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</tr>
<tr>
<td>Disease Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>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).</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td>Y – Clinical condition must meet necessity for ECT, authorization is required.</td>
</tr>
<tr>
<td>Expectant Mothers Program</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y - Baby Blocks - reminds and rewards members for attending appointments during their pregnancy.</td>
</tr>
<tr>
<td>Inpatient Detox at Facility not a Hospital</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>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. <strong>Benefit Limit:</strong> Time-limited, medically- monitored detoxification benefit, subject to ASAM detoxification medical necessity criteria. This VAS does not include social</td>
<td></td>
<td></td>
<td>N</td>
</tr>
<tr>
<td>VALUE ADDED</td>
<td>BCBS</td>
<td>MOLINA</td>
<td>PRESBYTERIAN</td>
<td>UNITED HEALTH CARE</td>
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</tr>
<tr>
<td></td>
<td>detoxification. Members cannot have comorbid medical conditions requiring detoxification in a hospital based setting. <strong>Eligibility:</strong> Chemically dependent members.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>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 biopsychosocial 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</td>
<td><strong>Y – Benefit Limit:</strong> 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. <strong>Eligibility:</strong> Members birth to age 3 or clear symptoms of a mental health disorder.</td>
<td></td>
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<tr>
<td></td>
<td>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.</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Y - This benefit provides nutritional supplements, such as Ensure® to community benefit members. For SDCB members, this VAS applies independent of their budget. If the need arises for additional supplements after the VAS benefit has been exhausted, the member can then use their budget for additional supplements. Maximum of two cans per day for 90 days, or 180 cans per calendar year. Members eligible under the Community Benefit who meet criteria.</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Nutritional Supplements</td>
<td><strong>Y</strong> - $50 reimbursement per year for non-prescription items for dual eligible members receiving PCO benefits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Reimbursement Benefit</td>
<td><strong>N</strong></td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Portable infant crib benefit</td>
<td><strong>Y</strong> - One crib/child. Must be enrolled in Special Beginnings, complete pre-natal visit requirements, complete Back to Sleep program. Must have a pregnancy diagnosis.</td>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Post Hospitalization-Homeless lodging</td>
<td><strong>Y</strong> - Lodging for discharged members who require home health services at least 2x/week.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite Care (Enhanced)</td>
<td><strong>Y</strong> - Up to 72 additional hours above the standard benefit.</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>School Sports Physicals</td>
<td><strong>N</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toddler/Booster/Car Seat Program</td>
<td><strong>Y</strong> - One care seat/child. Must complete pre-natal visit requirements.</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Eligibility</td>
<td>Benefit Limit</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Traditional Healing Benefit</td>
<td><strong>Y</strong> – Two grants/calendar year; $100 inpatient; $250 outpatient. The benefit does not cover previous ceremonies, and does not cover large group ceremonies such as a squaw dance. Members identified as Native American/Alaska Native (NA/AN). SDCB can use the benefit and not have to utilize their budget.</td>
<td></td>
<td>Y - $200/year for in home services; $100/year for services in clinic or hospital setting. Excludes SDCB.</td>
<td></td>
</tr>
<tr>
<td>Transitional Living for Chemically Dependent / Psychiatrically Impaired Adults</td>
<td><strong>Y</strong> – This benefit would be an emergent time-limited transitional living arrangement resulting from a step down from a higher level of care (i.e., 24 hours unsupervised care) to an identified community placement to stabilize individuals with an identified plan to return to independent living. This is considered a short term emergency placement and should not exceed 30 days. <strong>Benefit Limit:</strong> Any member evaluated for this benefit will be expected to participate in the recommended psychiatric or chemical dependency treatment while in this level of care. Annual expenditures for this level of care will not exceed $125,000.  <strong>Eligibility:</strong> Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues.</td>
<td></td>
<td>Y – age 21 and over; 180 days max per member per calendar year, $400,000 total program costs; age 17-21: 180 days max per member per calendar year, $700,000 total program costs. Avg LOS 3-5 months per member.</td>
<td></td>
</tr>
<tr>
<td>Transportation - Enhanced</td>
<td>N</td>
<td></td>
<td>Y-Transportation to and from pharmacy or mileage reimbursement for medical or pharmacy transport</td>
<td></td>
</tr>
<tr>
<td>Weight Watchers</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For Medicare beneficiaries, if Medicare reimburses for the service, the MCO and FFS will reimburse the co/insurance/deductible.**

List subject to change yearly

Value added services are not available through Fee For Service.

*Source from the Final Value Added Services Chart from HSD dated 11/06/2013*
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

- 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 Initiatives

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 interdisciplinary 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.
Behavioral Health Delivery of services to Children

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.

**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
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 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
- 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
# MCO Vs Fee for Service benefits*

## CENTENNIAL CARE MCO vs. Fee For Service

### Standard Benefit Comparison Grid

<table>
<thead>
<tr>
<th>Service</th>
<th>MCOs</th>
<th>FFS/EXEMPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Ambulatory Surgical Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MCO Care Coordination</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Case Management</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Dental</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
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<tr>
<td>Emergency Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Immunizations (adult &amp; children)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Lab and X-Ray Service</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Language Interpreter Services</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Nutritional</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Transportation (Non-Urgent)</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Physical, Occupational, and Speech</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Podiatry Services</td>
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<td>Y</td>
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<tr>
<td>Prenatal Care</td>
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<tr>
<td>Primary Care and Specialist Service</td>
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<tr>
<td>Prosthetics and Orthotics</td>
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<tr>
<td>Rehabilitation Services</td>
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<tr>
<td>Reproductive Health Services</td>
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<tr>
<td>Smoking Cessation</td>
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<td>N</td>
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<tr>
<td>Telehealth</td>
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<tr>
<td>Transplant Services</td>
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<td>Y</td>
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<tr>
<td>Urgent Care</td>
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<td>Y</td>
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<tr>
<td>Vision</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Well Child Visits</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Women’s/Men’s Health Visits</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*Benefits are subject to change under Centennial Care*

*Sourced from the Final Value Added Chart from HSD dated 11/06/2013*
**Fraud and Abuse**

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