BlueCross BlueShield of New Mexico

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Blue Cross New Mexico Medicaid℠

A Section of the Provider Reference Manual

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Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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1 – Introduction

HCSC Insurance Services Company (HISC), a wholly-owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, has contracted with the State of New Mexico Health Care Authority (HCA), Medical Assistance Division, to offer a Medicaid managed care plan. Blue Cross and Blue Shield of New Mexico, a Division of HCSC, has contracted with HISC to administer this program.

This section applies to physicians, professional providers (including laboratory and ancillary providers), agency-based community benefit, self-directed community benefit, and facility providers who have agreed to participate as a Medicaid managed care plan provider and who have signed agreements in place to include single case agreements. This addendum, along with the Blues Provider Reference Manual, explains the policies and procedures of the BCBSNM network. It provides you and your office staff with important information as you serve Medicaid managed care plan members and is incorporated by reference into your New Mexico Medicaid Managed Care Amendment or Agreement, as applicable, with BCBSNM. The information is likely to apply in most situations your office will encounter while participating in these programs. BCBSNM participates in regular provider workgroups in collaboration with other Medicaid Managed Care Organizations, state regulatory agencies, provider or other key stakeholders. The provider workgroups allow all MCOs to come together to streamline documents, processes, forms, and templates to reduce the administrative burden on providers.

This section of the *Blues Provider Reference Manual* is applicable only to the operation of the Medicaid managed care plan.

Turquoise Care Network

Turquoise Care is a Medicaid Managed Care Plan that focuses on breaking down the financial, cultural, and linguistic barriers preventing low-income families and individuals from accessing health care. BCBSNM maintains and monitors a network of participating professional, facility, and ancillary providers (including physicians, hospitals, behavioral health providers, long-term care providers, skilled nursing facilities, and other health care providers) through which members obtain covered services.

2 - Program Overview

Turquoise Care Plan Overview

Turquoise Care is the modernization of the New Mexico Medicaid managed care program as developed by State of New Mexico Health Care Authority under an 1115 waiver application to Centers for Medicaid & Medicare Services (CMS). Under Turquoise Care, BCBSNM provides 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 (HCBS). A fundamental focus of the Turquoise Care plan is to identify members at highest risk of poor health outcomes, using a person-centered approach, developing personalized care plans, and providing appropriate access to covered services.

This integrated care approach focuses on health literacy, utilization of community supports and resources to assist members in navigating the health care system, comprehensive care coordination, patient-centered medical homes, and the continuous development of health homes. This infrastructure helps to provide members access to the care they may need in a timely manner while enabling increased quality and better health outcomes.

For new members to the BCBSNM Medicaid program or for existing members who may have encountered a health change status, BCBSNM makes reasonable efforts to contact these members to offer a Health Risk Assessment (HRA) or a Comprehensive Needs Assessment (CNA). The HRA screens for physical health, behavioral health, sexual orientation gender identity, pregnancy and long-term health care needs and can determine if a member requires a face-to-face CNA. The CNA further informs BCBSNM of the needs and service gaps of the member and allows BCBSNM to assist the member to address these needs. These assessments will determine if the member will be assigned to a BCBSNM Care Coordination level one (1) or level two (2). If a member has been identified as being in a child in state custody, they will be enrolled to Presbyterian Health Plan. For children in state custody that are Native American they can choose which MCO they wish to join. Care for these members will be managed by a trained team of care coordinators to meet the special needs of the members.

A Care Coordinator will use the information collected during the CNA process to develop a care plan. This assessment is used to help connect members with providers who can help with their identified needs. The Care Coordinator will seek input from providers during the needs assessment process in order to develop a care plan that is comprehensive. Collaboration between Medicaid managed care plan contracted providers and BCBSNM Care Coordination staff is necessary and is a condition of provider participation with BCBSNM.

Ongoing Care Coordination will be offered to members to facilitate the appropriate delivery of health care services. Care Coordinators will assist the member by helping connect them

to the appropriate providers, identify service gaps, and assist the member to resolve any identified service-related needs in a timely manner.

Care Coordination activities will be provided at the level needed by the individual member but at least minimally as follows:

- Initial Health Risk Assessment, health education and referrals as requested, quarterly review of claims, and utilization data to screen for potential higher-level needs.
- Level 1: Member is assigned a specific Care Coordinator, annual comprehensive needs assessment, semi-annual face-to-face visits, two telephonic contacts with member at (1) 60-90 Calendar Days and (2) 240-270 Calendar Days from the most recent CNA completion date, care plan development and monitoring, health and disease management education, and potential assignment to a health home.
- Level 2: Member is assigned a specific Care Coordinator, semi- annual comprehensive needs assessment, quarterly face-to-face visits, four telephonic contacts with members as follows; (1) 25-30 calendar days; (2) 55-60 calendar days; (3) 115-120 calendar days; and (4) 145-150 calendar days, from the most recent CNA completion date, care plan development and monitoring, health and disease management education, and potential assignment to a health home. The CNA completion date serves as the anchor date for assessing the timeliness of follow-up in-person visits and telephonic contacts. When a new CNA is conducted, that date becomes the new anchor date.

Whether directly providing Care Coordination or some other health care service, providers throughout the system of care will be better prepared to provide quality care by understanding and participating in Care Coordination activities. The level of participation may vary depending on individual member needs but might include sharing or receiving information from an assigned Care Coordinator, being aware of the member's overall care plan, participating in integrated care planning, as well as other activities that promote progress towards member's health goals. Through this process, BCBSNM will monitor member level data and provide reports to providers as appropriate. Participation in the Care Coordination activities described above is a condition of provider participation with BCBSNM.

In addition, Community Health Workers (CHWs), Community Health Representatives (CHRs) and Certified Peer Support Workers (CPSWs) provide a bridge between you and the member and his/her Care Coordinator. They work with different agencies to develop a bond to help you and the member. Members can call Member Services to receive helpful information on how to contact a CHW, behavioral health CPSW or wellness center.

Supportive Housing is a service to help members with housing needs. The goal of this service is to first determine housing needs and then find the right community resources to help.

Some of these services include:

- Finding and applying for housing
- Checking the home for safety features such as smoke detectors.

- Getting necessary household supplies
- Creating a housing plan
- Coaching on how to keep good relationships with neighbors and landlords
- Coaching on how to follow rules from the landlord
- Education on renter rights and responsibilities
- Assistance in fixing renter issues
- Regular review and updates to housing plan
- Helping find community resources to help with keeping the house in working order

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

For more information regarding the Care Coordination program and the role of the provider, please contact BCBSNM Network Services at 505-837-8800 or 1-800-567-8540.

You may also contact BCBSNM Health Care Management at 505-291-3585 or 1-800-325-8334.

This is an important partnership between providers, members, and BCBSNM. We look forward to working with you to meet the health care needs of the BCBSNM Medicaid members.

Member Enrollment Period Lock-in

After a member enrolls with a Medicaid Managed Care Organization (MCO) (whether as the result of selection or auto- assignment), members have one opportunity during the first three months following their effective date to request to change to another MCO. After exercising this right to change MCOs, a member will remain with the MCO until the next annual choice period unless the member is disenrolled.

Medicaid managed care plan members are allowed to change MCOs every 12 months at the time of the member's redetermination. Members who do not select another MCO during their annual choice period will be deemed to have chosen to remain with their current MCO. Members who select a new MCO during their annual choice period shall have one opportunity any time during the 90 calendar-day period immediately following the effective date of enrollment in the newly selected MCO to request to change MCOs.

Member Enrollment and Eligibility

Managed care plan participation: A Medicaid member will have the opportunity to pick an MCO at the Income Support Division (ISD) office. All members, except for Native American members who do not receive long term care services, must participate in a Medicaid managed care plan, and be enrolled with an MCO.

Auto-assignment: If a member does not pick an MCO while filling out their Medicaid application, they will be assigned to one according to HCA protocols.

Reenrollment: Most members must renew Medicaid coverage every 12 months. This can be done through the ISD office or, in some cases, by calling HCA at 1-888-997-2583.

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

Newborns: Medicaid-eligible newborns have coverage for 13 months starting with the month of birth. If the mother is enrolled in an MCO, the child is enrolled in the same MCO. The baby's MCO can be changed if the mother (or legal guardian) requests it for up to 3 months after the newborn's birth. After the baby is born, the hospital will complete the Notice of Birth form, which is sent to the mother's MCO and the ISD office. It is very important for the mother to tell the ISD caseworker right away that the baby has been born. They will work with the MCO to order and mail ID cards to the member.

Change in eligibility and/or contact information: A significant amount of important information is mailed to the address the member gives to the ISD office. If the member changes their address or phone number, it is very important they call their ISD office right away or go to YESNM (www.yes.state.nm.us) and provide their new information. BCBSNM cannot make these changes for the member.

When the member should contact their ISD case worker: The patient will need to call their county ISD case worker if they:

- Change their name
- Move to another address
- Change their phone number
- Have a new child or adopt a child; place their child for adoption
- Get other health insurance, including Medicare
- Move out of New Mexico
- Have any questions about Medicaid eligibility

Medicaid eligibility is determined based on how many people are in the member's family. If there is a change in family size, it is important for the member to report this to the ISD office right away.

Waiver eligibility: All individuals determined to be Medicaid-eligible are required to participate in the Medicaid managed care plan program unless specifically excluded by the 1115(a) Waiver. Recipients in the Developmental Disabilities 1915(c) Waiver and recipients with developmental disabilities in the Mi Via 1915(c) Waiver will continue to receive Home- and Community-Based Services (HCBS) through those waivers but are required to enroll with an MCO for all non-HCBS.

Recipients in the Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver unless and until such services are transitioned into a Medicaid managed care plan.

Recipients in the Medically Fragile 1915(c) Waiver are required to enroll with an MCO for all non-HCBS.

Retroactive Eligibility Changes: In some circumstances a member's eligibility may change retroactively to include MCO enrollment. In instances where a member is retroactively disenrolled from BCBSNM any claims paid to a provider for dates of service impacted by the retroactivity shall be recouped by BCBSNM. Recoupments are generally completed with 12 months of the date BCBSNM is made aware of the retroactivity. Providers may be able to submit claims to the member's new insurance carrier. Providers should contact the new carrier for instructions.

In instances where a member is retroactively enrolled with BCBSNM, providers may submit claims for dates of service impacted by the retroactivity within 90 days from the enrollment date. In these instances, BCBSNM reviews the Category of Eligibility (COE) add date in the Medicaid portal. If the claim is received within 90 days from the COE add date, the claim is adjudicated accordingly without timely filing being calculated from the date of service.

High Volume Provider

High Volume Specialists are identified by an annual high-volume claims report which reflects the number of claims filed. High Volume Specialists will include a minimum of three specialties in addition to mandatory inclusion of Obstetrics/Gynecology. Specialties analyzed can include but are not limited to: Orthopedics (including Orthopedic Surgery), Rheumatology, Allergy/Immunology, Cardiovascular Disease, and Ear Nose Throat (aka Otolaryngology). Other specialties may be identified based on the sub-populations, specific products/product lines, or geographies.

High Impact Specialists are identified by an annual claims report which reflects dollars paid. High Impact Specialists will include any specialties determined as high-impact but not already captured by high-volume analysis or other mandatory inclusion. High Impact Specialists will include at a minimum specialty of Oncology.

Primary Care Provider (PCP)

A PCP must be a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to members, initiating and/or facilitating the use of appropriate specialist care, and maintaining the continuity of the member's care. Individuals with Special Health Care Needs (ISHCN) may designate a specialist as their primary care provider as long as that specialist agrees to act in that role.

The PCP, to the extent possible, must also ensure coordination and continuity of care with other Medicaid managed care plan providers including Behavioral Health and Long-Term Care providers and ensure that members receive the appropriate preventative services for the member's age group.

PCP's are responsible for making appropriate referrals for behavioral health services. Examples of indicators for a referral are, but are not limited to:

- Suicidal/homicidal ideation or behavior
- At-risk for hospitalization due to a behavioral health condition
- Trauma victims
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility
- Serious threat of physical or sexual abuse or risk to life or health due impaired mental status and judgement, or other intellectual and developmental disabilities
- Victims of, or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect
- Request by member or representative for behavioral health services
- Clinical status that suggests the need for behavioral health services
- Identified psychosocial stressors and precipitants
- Treatment compliance complicated by behavioral characteristics
- Behavioral and psychiatric factors influencing medical condition
- Non-medical management of substance abuse
- Follow-up to medical detoxification
- An initial PCP contact or routine physical examination indicates a substance abuse problem
- A prenatal visit indicates substance abuse problems
- Positive response to questions indicates substance abuse
- Observation of clinical indicators or laboratory values that indicate substance abuse
- A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other behavioral health conditions; and/or
- The persistence of serious functional impairment

PCP and Pharmacy Lock-in

PCP Lock-Ins: BCBSNM monitors the potential for abuse or overuse of services and may require a member to visit a certain provider when identification of continuing utilization of unnecessary services has been made. BCBSNM may contact the PCP or attending physician to request the member be “locked” into that provider for all prescriptions, and if that provider agrees to this, BCBSNM will place the lock-in. A PCP or attending physician can also contact the BCBSNM Care Coordinator and request a PCP lock-in on a member who is seeing multiple providers for the same services. A PCP lock-in can be done for more than one provider if indicated. Prior to placing the member on lock- in, the member will be notified by mail of the intent to lock-in. The letter will include the reason for lock-in as well as the grievance procedure. The lock-in will be removed when utilization problems have been resolved and the recurrence is judged to be improbable.

Pharmacy Lock-Ins: BCBSNM monitors the potential for abuse or overuse of services and may require that a member visit a certain pharmacy provider when member compliance or drug-seeking behavior is suspected. The PCP or attending physician can also contact the BCBSNM Care Coordinator and request a pharmacy lock-in on a member

who is using multiple providers or pharmacies for the same prescriptions. Prior to placing the member on lock-in, the member will be notified by mail of the intent to lock in. The letter will include the reason for lock-in as well as the grievance procedure. The lock-in will be removed when the non- compliance or drug-seeking behavior has been resolved and recurrence is judged to be improbable.

Review: BCBSNM will conduct ongoing monitoring of members who have been placed on a lock-in. Each quarter the BCBSNM Care Coordinator, Pharmacist and Medical Director will review for compliance and make a determination on whether to continue with the lock-in or to release from lock-in. These decisions are reported to HCA.

HCA is notified of all PCP and pharmacy lock-ins in accordance with the timeframe indicated in the contract and when the lock- in is removed.

24-Hour Coverage

Participating PCPs are expected to provide coverage for members 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has arranged for coverage from another PCP. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers. Please refer to the Medicaid managed care plan Provider Finder® online at www.bcbsnm.com to identify providers participating in the Medicaid managed care plan network. You may also contact the Customer Service Department at the number listed on the back of the member's identification card with questions regarding which providers participate in the Medicaid managed care plan network. Core Service Agencies (CSAs) are expected to provide behavioral health crisis intervention 24 hours a day, 7 days a week.

Emergency Services

Emergency services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical or behavioral health conditions manifesting themselves by acute symptoms of sufficient severity (including severe pain). An emergency medical condition is a behavioral or physical health condition that is bad enough for an average person to think that without immediate help, there is serious danger to:

- Their health, bodily functions, body parts, organs, or appearance
- Their unborn child's health, bodily functions, body parts, organs, or appearance

Copayments should not be charged for emergency medical conditions.

Emergency care services necessary to evaluate and stabilize an emergency medical condition are covered by the Medicaid managed care plan. Members with an emergency medical condition should be instructed to go to the nearest emergency provider. Evaluation and stabilization of an emergency medical condition in a hospital or comparable facility does not require preauthorization.

The attending emergency physician or the provider actually treating the Medicaid managed care plan member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the entities identified in 42 C.F.R.

§ 438.114(b) as responsible for coverage and payment. In addition, BCBSNM is financially responsible for post-stabilization services administered to maintain, improve, or resolve the member's stabilized condition if:

a) BCBSNM does not respond to a request for pre-approval within one hour;
b) BCBSNM cannot be contacted; or
c) BCBSNM's representative and the treating physician cannot reach an agreement concerning the member's care and a BCBSNM-contracted professional provider is not available for consultation. In this situation, BCBSNM must give the treating physician the opportunity to consult with a BCBSNM-contracted professional provider and the treating physician may continue with care of the member until a BCBSNM contracted professional provider is reached or one of the criteria of 42 C.F.R. § 422.113(c)(3) is met.

See also "Emergency and Post-Stabilization Services" and "Notification for Post-Stabilization Care following an Emergency Admission" in the Reimbursement Methodologies topic below.

Acute general hospitals are reimbursed for emergency services provided in compliance of federal mandates, such as the "anti- dumping" law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. Section 1935dd. (1867 of the Social Security Act).

CSAs must provide crisis intervention 24 hours a day, 7 days a week to triage and intervene if their members present in a behavioral health crisis.

Experimental Procedures and Items

Experimental or investigational procedures, technologies, or therapies, as defined in NMAC 8.311.2, "Experimental or Investigational Procedures, Technologies or Non-Drug Therapies" are not covered.

In general, experimental, investigational, or unproven means the procedure, technology, or therapy meets any of the following conditions:

- Current authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of drug(s), biological product(s), other product(s), or device(s) for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy, and risks, especially as compared with standard or established methods or alternatives for diagnosis and/or treatment outside an investigational setting.

- The drug, biological product, other product, device, procedure, or treatment (the "technology") lacks final approval from the Food and Drug Administration (FDA) or any other governmental body having authority to regulate the technology.
- The medical, surgical, other health care procedure, or treatment, including the use of drug(s), biological product(s), other product(s), or device(s) is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose, or toxicity, especially as compared with standard or established methods or alternatives for diagnosis and/or treatment outside an investigational setting.

Medically Necessary Services

In interpreting medical necessity for the Medicaid managed care plan, BCBSNM follows Section 8.302.1.7 NMAC and the Medicaid managed care plan contract with HCA (as may be recompiled and/or amended) where medically necessary services are, as of January 2024, defined as:

1. Clinical and rehabilitative physical or behavioral health services that:
   - Are essential to prevent, diagnose, or treat medical conditions or are essential to enable the individual to attain, maintain, or regain functional capacity
   - Are delivered in the amount, duration, scope, and setting that is clinically appropriate to the specific physical, mental, and behavioral health care needs of the individual
   - Are provided within professionally accepted standards of practice and national guidelines
   - Are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, provider, or payer; and
   - Are reasonably expected to achieve appropriate growth and development as directed by HCA
2. Application of the definition:
   - A determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification, or expansion of a covered benefit.
   - The department or its designee making the determination of the medical necessity of clinical, rehabilitative, and supportive services consistent with the Medicaid benefit package applicable to an eligible individual shall do so by:
     a) Evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice; who have taken into consideration the individual's clinical history, the individual's unique circumstances, including the impact of previous treatment and service interventions; and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate

b) Considering the views and choices of the individual or the individual's legal guardian, agent, or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views, and
c) Considering the services being provided concurrently by other service delivery systems

3. Physical and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration, or scope to an otherwise eligible individual solely because of the diagnosis, type of illness, or condition.
4. Decisions regarding benefit coverage for children shall be governed by the Early & Periodic Screening, Diagnosis & Treatment (EPSDT) coverage rules.

Eligibility and Benefits

Eligibility and Benefits

Patient eligibility and benefits should be verified prior to and at the time of service and re-verified throughout periods of ongoing services. Failure to verify eligibility and benefits may result in denial of claims. Eligibility and benefit quotes from BCBSNM or its designee include membership verification, coverage status and other important information, such as applicable copayment, coinsurance, and deductible amounts. It is strongly recommended that providers ask to see the member's ID card for current information and photo ID in order to guard against medical identity theft. When services may not be covered, members should be notified before services are furnished; members may be billed directly only upon compliance with Section 8.302.1.16 NMAC, as it may be amended and/or recompiled.

Checking Online

Each provider is strongly encouraged to use availity.com or the provider's preferred vendor for eligibility* and benefit verifications. With Availity Essential's Eligibility and Benefits Inquiry, users can access printable results that include up-to-date benefit information.

- Patient/Subscriber information
- Group Number
- Group Name
- Plan/Product
- Current Effective Dates
- Copayment**
- Coinsurance
- Deductible (original and remaining amounts)
- Out-of-pocket (original and remaining amounts)
- Limitations/Maximums**
- Preauthorization indicators and contacts

For some patients, your Web transactions may instruct you to call Provider Customer Service to obtain benefit details. Our staff remains available to assist with these benefit inquiries as needed.

*Medicaid eligibility and the MCO to which the enrollee is assigned may also be checked via HCA's on-line Medicaid portal.

**These benefit categories will only appear if applicable to the services being rendered.

Checking via Telephone
If you cannot submit your eligibility and benefit inquiries online, this information can also be easily obtained through BCBSNM's Interactive Voice Response (IVR) automated phone system at 1-888-349-3706, available Monday through Friday, 5 a.m. to 10:30 p.m., MT, and Saturday, 5 a.m. to 2:30 p.m., MT. For additional details, refer to the Eligibility and Benefit IVR Caller Guide. Providers may also telephone Conduent's Eligibility Help Desk at 1-800-705- 4452 or 505-246- 2056, available Monday through Thursday, 8 a.m. to 5 p.m., MT, and Friday, 8 a.m. to 4 p.m., MT, to verify the enrollee's eligibility and to which MCO they are assigned.

Alternative Benefit Plan
Members enrolled in the Alternative Benefit Plan (ABP) are eligible to receive services as indicated in Attachment #1. If a member is ***ABP Exempt*** they have the option of selecting to either receive services as indicated in Attachment #1 or the general Medicaid managed care plan Covered Services (see Attachment #2).

Covered Services

A list of covered services available for the Standard Medicaid Plan and Alternative Benefit Plan (ABP) is included in the table below. The "✓" in the column will tell you if the service(s) are covered for the Standard Medicaid Plan and the ABP.

The ABP is a part of the New Mexico Medicaid managed care plan program. The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 133% of the Federal Poverty Level (FPL), which includes the Medicaid Expansion Adults, and may include Parents and Caretakers and Transitional Medical Assistance categories. If a member is eligible for ABP covered services, please refer to the services listed under the column titled, "ABP Covered Service."

BCBSNM shall notify its network providers before adding a new prior authorization requirement.

BCBSNM may remove a prior authorization requirement at any time and shall notify its network providers of the change as soon as practicable, and no more than 60 days after the requirement is removed.

ABP members who have a physical or behavioral health condition that meets certain criteria, may be eligible for covered services under the column titled, "Standard Medicaid Plan Covered Service."

In the chart below, it sometimes says that prior authorization is "dependent on exact service." That means Members will need to call Member Services to find out if the exact service they are checking on requires prior authorization.

The following services are covered when medically necessary.

Note: Covered Services are subject to change.

PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**Prior Authorization?**
Allergy care, including tests and serum	✓	✓	Dependent on exact service
Anesthesia services	✓	✓	No
Bariatric surgery	✓	Lifetime limit	Yes
Breast pumps and replacement supplies	✓	✓	No
Cancer clinical trials	✓	✓	Yes
Chemotherapy and radiation therapy	✓	✓	Yes
Community interveners for deaf and blind	✓	✓	Yes
Covered services provided in school-based health clinics	✓	✓	No
Hemodialysis	✓	✓	Yes, Dependent on exact code and if more than 3 times a week
DME and supplies	✓	✓ Limits Apply	Dependent on exact service
Early and Periodic Screening, Diagnosis and Treatment	✓	✓ Age limited	No
Emergency dental care	✓	✓	No
Emergency services	✓	✓	No
EPSDT personal care services	✓	✓ Age limited	Yes - if your child is disabled, they may qualify for more services; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information
EPSDT private duty nursing	✓	✓ Age limited	Yes - if your child is disabled, they may qualify for more services; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information

PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**Prior Authorization?**
EPSDT rehabilitation services	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information
Family planning	✓	✓	No
Ground and air ambulance	✓	✓	No
Hearing services and devices	✓	✓ Age limited	Yes
Home birthing	✓	✓	Dependent on exact service. Please call Member Services
Home health care and intravenous services	✓	✓ Limits Apply	Yes
Hospice services	✓	✓	Yes
Hospital services (inpatient, outpatient, and skilled nursing)	✓	✓	Dependent on exact service. Please call Member Services
Inhalation therapy services	✓	✓	No
Injections	✓	✓	Dependent on exact service. Please call Member Services
Inpatient rehabilitative facilities	✓	✓ Skilled nursing or acute rehab facility only	Yes
IV outpatient services	✓	✓	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	✓	✓	Dependent on exact service. Please call Member Services
Long-term services and supports	✓	✓	Yes - please call Member Services and ask to speak with a Care Coordinator for more information
Molecular genetics	✓	✓	Dependent on exact service. Please call Member Services
Nursing facility services	✓	✓	Yes

PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**Prior Authorization?**
Nutritional counseling services	✓	✓	Dependent on exact service. Please call Member Services
Nutritional services	✓		Dependent on exact service. Please call Member Services
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	✓	✓	No
Organ and tissue transplant services	✓	✓ Lifetime limit	All transplant and pre-transplant evaluations require prior authorization
Orthotics and prostheses	✓	✓ Limits Apply	Dependent on exact service. Please call Member Services
Outpatient professional services	✓	✓	No
Outpatient surgery	✓	✓	Dependent on exact service. Please call Member Services
PET, MRA, MRI, and CT scans	✓	✓	Dependent on exact service. Please call Member Services
Pharmaceutical gender reassignment services	✓	✓	Yes
Physical therapy	✓	✓ Limits Apply	Dependent on exact service. Please call Member Services
Podiatry (foot and ankle) services	✓	✓ Limits Apply	Dependent on exact service. Please call Member Services
Pregnancy-related and maternity services, including pregnancy termination procedures	✓	✓	No
Primary gender reassignment (male-to- female or female-to- male) chest and/or genital surgeries	✓	✓	Yes
Routine physicals, children's preventive health programs and Tot- to-Teen checkups	✓	✓	No
Smoking cessation services	✓	✓	No

PHYSICAL HEALTH SERVICES			
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**Prior Authorization?**
Special rehabilitation services, such as physical therapy, occupational therapy, speech therapy, cardiac rehabilitation,	✓	✓ Limits Apply	Dependent on exact service. Please call Member Services
pulmonary rehabilitation	✓	✓	No
Telemedicine services	✓	✓	Dependent on exact service. Please call Member Services
Treatment of diabetes	✓	✓	No

BEHAVIORAL HEALTH SERVICES				
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**BH Age**	**Prior Authorization?**
Accredited Residential Treatment Center Services for Adults with Substance Use Disorders	✓	✓	18 years and older	Yes
Accredited Residential Treatment Center Services for Youth	✓	✓	Under age 21	Yes
Applied Behavior Analysis (ABA)	✓	✓		Yes* ** For Adaptive Behavior Treatment by Protocol (97153) and Adaptive Behavior Treatment with Protocol Modification (0373T)
Assertive Community Treatment	✓	✓	18 years and older	No
Behavior Management Services	✓	✓	Under age 21	No
Cognitive Enhancement Therapy	✓	✓	18 years and older	No
Comprehensive Assessments	✓	✓	All Ages	No
Comprehensive Community Support Services (CCSS)	✓	✓	All Ages	No
Crisis Intervention	✓	✓	All Ages	No
Crisis Triage Centers	✓	✓	All Ages	No

BEHAVIORAL HEALTH SERVICES				
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**BH Age**	**Prior Authorization?**
Day Treatment	✓	✓	Under age 21	No
Electroconvulsive Therapy		✓	All Ages	No
Emergency Services	✓	✓	All Ages	No
Family Peer Support Services	✓	✓	All Ages	No
Family Support (Behavioral Health)	✓	✓	All Ages	No
Group Home	✓	✓	Under age 21	Yes
Inpatient Psychiatric Service	✓	✓	All Ages	Yes
Inpatient Substance Abuse Services	✓	✓	All Ages	Yes
Integrated Care and Interdisciplinary Teaming	✓	✓	All Ages	No
Intensive Outpatient Programs for Mental Health and Substance Use Disorders	✓	✓	11 years and older	No
Medication Assisted Treatment: Buprenorphine for Opioid Use Disorder	✓	✓	All Ages	No
Multi-Systemic Therapy	✓	✓	Ages 10 to 18	No
Non-Accredited Residential Treatment Center Services for Youth	✓	✓	Under age 21	Yes
Opioid Treatment Program	✓	✓	All ages	No
Outpatient Crisis Stabilization Center	✓	✓	14 years and older	No
Outpatient Professional Services	✓	✓	All ages	No
Partial Hospitalization	✓	✓	5 years and older	Yes, requires prior authorization beyond 45 days
Peer Support Services	✓	✓	All ages	No
Psychological/Neuropsychological Testing	✓	✓	All ages	No
Psychosocial Rehabilitation (PSR) Program	✓	✓	18 years and older	No
Recovery Services	✓	✓	All ages	No
Respite Care	✓	✓	Under age 21	Yes, for services beyond 30 days or 720 hours in a calendar year

BEHAVIORAL HEALTH SERVICES				
Service	**Standard Medicaid Plan Cover Service**	**ABP Covered Service**	**BH Age**	**Prior Authorization?**
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services	✓	✓	Age 11 and older	No
Smoking Cessation	✓	✓	Under age 21 OR for pregnant members	No
Standard Office Visits to Mental Health Specialists (which could include counselors, social workers, psychiatrists, or psychologists)	✓	✓	All ages	No
Sub Acute Residential Treatment Center for Youth	✓	✓	Under age 21	Yes
Supportive Housing	✓	✓	All ages	No
Telemedicine Services	✓	✓	All ages	No
Treat First	✓	✓	All ages	No
Treatment Foster Care	✓	✓	Under age 21	Yes

VISION SERVICES		
Covered Service	**Time Limit**	**Age Applies To**
Minor repairs to eyeglasses	Any Time	All ages
Lens tinting if certain conditions are present	Any Time	All ages
Lenses to prevent double vision	Any Time	All ages
Eye exam for medical conditions (diabetes, cataracts, hypertension, and glaucoma)	Every 12 months	Under age 21
One routine eye exam	Every 12 months	Under age 21
Frames	Every 12 months	Under age 21
Replacement lenses, if lost, broken, or have deteriorated	Any Time	Under age 21
Corrective lenses	1 set every 12 months	Under age 21
One routine eye exam	Every 36 months	Age 21 and older
Frames	Every 36 months	Age 21 and older
Replacement lenses for members with a developmental disability, if lost, broken, or have deteriorated	Any Time	Age 21 and older
Corrective lenses	1 set every 36 months	Age 21 and older

ABP Members
ABP members do not have routine vision benefits.

The ABP plan only covers vision services that are medically necessary for the diagnosis of and treatment of eye diseases. One eye exam will be covered every 36 months only for the detection of an eye disease or injury. Refractions or eyeglasses are not covered under the ABP plan, except for aphakia following the removal of the lens.

DENTAL SERVICES			
Covered Service	**Time Limit**	**Age Applies To**	**Prior Authorization?**
Dental services in a hospital	N/A	Under age 21; unless over the age of 21 with a developmental disability	No – Dentist Yes – Facility
Emergency services	No limit	All ages	No
Fillings; prefabricated stainless steel crown per permanent or deciduous tooth; one prefabricated resin crown per permanent or deciduous tooth; and one recementation of a crown or inlay; and one recementation fixed bridge	N/A	All ages	No
Fixed space maintainers (passive appliances)	N/A	Under age 21	Yes
General anesthesia and IV sedation, including nitrous oxide	N/A	Under age 21	Yes
General anesthesia and IV sedation, not including nitrous	N/A	Age 21 and older	Yes
Incision and drainage of an abscess	N/A	All ages	No
One cleaning	Every 6 Months	Under age 21	No
One cleaning	Every 12 months; every 6 months for members with developmental disabilities	Age 21 and older	No
One complete oral exam	Every 6 Months	Under age 21	No
One complete oral exam	Every 12 Months	Age 21 and older	No
One complete series of intraoral X-rays (with one added set of bitewing X-rays)	Every five years; added set of bitewing X-rays once every 12 months	All ages	No

DENTAL SERVICES			
Covered Service	**Time Limit**	**Age Applies To**	**Prior Authorization?**
One fluoride treatment	Every 6 Months	Under age 21	No
One fluoride treatment	Every 12 Months	Age 21 and older	No
One sealant for each permanent molar (replacement of a sealant within the five- year period requires prior authorization)	Every 5 years	Under age 21	No
Orthodontic services (braces)	N/A	Under age 21	Yes
Periodontic scaling and root planning	N/A	All ages	Yes
Reimplantation of permanent tooth	N/A	Under age 21	No
Therapeutic pulpotomy	N/A	Under age 21	No
Tooth extractions (pulling of teeth)	N/A	All ages	No
Two denture adjustments	Every 12 Months	All ages	No

Note: Federally Qualified Health Center members will not need prior authorization on any dental service.

TRANSPORTATION SERVICES		
Covered Service	**Prior Authorization?**	**Prior Notice to MotivCare**
Ride to routine appointment	No	3 working days up to two weeks
Ride to behavioral health appointment	No	3 working days up to two weeks
Mass transit	No	4 working days
Mileage reimbursement	Yes	Call at least 14 calendar days prior, up to the day of the appointment
Meals	Yes	3 working days
Lodging	Yes	3 working days
- For Justice-Involved Members with a valid, current, and unfilled prescription, one trip within 7 days of release from jail or prison to pharmacy and then home within the same city limits as pick up.	No	Within 7 days after release

TRANSPORTATION SERVICES		
Covered Service	**Prior Authorization?**	**Prior Notice to MotivCare**
Type of County	**County Name**	**Distance Between PCP's Office and Member's Home**
Urban	Bernalillo, Doña Ana, Los Alamos, Santa Fe	30 miles
Rural	Chaves, Curry, Eddy, Grant, Lea, Luna, McKinley, Otero, Rio Arriba, Roosevelt, Sandoval, San Juan, Taos, Valencia	45 miles
Frontier	Catron, Cibola, Colfax, DeBaca, Guadalupe, Harding, Hidalgo, Lincoln, Mora, San Miguel, Sierra, Socorro, Torrance, Quay, Union	60 miles

Community Benefit

The Medicaid managed care plan is focused on facilitating access to care to meet members' needs along the continuum of their health care, including long-term care. BCBSNM has developed a means to identify members in the community who would benefit from long- term care services (to include medical, social, and behavioral health services). Members and/or their caregivers will be able to actively participate in the determination-of-need process and subsequent identification of available resources that would be aligned to address the identified needs. The objective is to provide the member as much autonomy in the process as possible while assuring that the member benefits from a comprehensive program that would enhance and/or maintain the member's well-being and safety.

BCBSNM provides Community Benefits, as determined appropriate based on the comprehensive needs assessment. Eligible members have the option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit. The Self-Directed Community Benefit can be selected once the member has received 120 days of services through the Agency-Based Community Benefit. Services are generally intended to meet the needs of members with disabilities or who are vulnerable, frail, and/or chronically ill.

The **Agency-Based Community Benefit** is the consolidated benefit of Home and Community Based Services (HCBS) and personal care services that are available to eligible members meeting the nursing facility level of care. The services available include:

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

The **Self-Directed Community Benefit** is certain Home and Community-Based Services that are available to eligible members meeting nursing facility level of care. Self- direction gives members the opportunity to have choice and control over how their Community Benefits services are provided. Members can also choose who provides the services and how much providers are paid in accordance with SDCB-approved rates.

A Support Broker provides support to a member and their family in arranging, directing, and managing your SDCB services. The Support Broker supports, as well as develops, monitors, and implements the Member's SDCB care plan and budget.

A list of the services available for the Community Benefit is included in the table below. Please remember that some of these services are only covered for agency-based community benefits and some for self-directed community benefits.

COMMUNITY BENEFIT SERVICES				
Service	**ABCB**	**SDCB**	**Prior Authorization?**	**Details**
Assisted Living	✓		Yes	These services will not be covered for individuals in Assisted Living Facilities, Personal Care, Respite Environmental Modifications, Emergency Response, or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.
Behavioral Support Consultation	✓	✓	Yes	
Community Transition (community reintegration members only)	✓		Yes	**Limit**: Coverage for these services is limited to $4,000 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a nursing facility stay at least 90 days prior to transition into the community.

COMMUNITY BENEFIT SERVICES				
Service	**ABCB**	**SDCB**	**Prior Authorization?**	**Details**
Customized Community Supports		✓	Yes	
Emergency Response	✓	✓	Yes	
Employment Supports	✓	✓	Yes	
Environmental Modification	✓	✓	Yes	**Limit**: Coverage for these services islimited to $6,000 every 5 years
Home Health Aide	✓	✓	Yes	
Nutritional Counseling	✓	✓	Yes	
Personal Care Services (Consumer Directed and Consumer Delegated)	✓		Yes	
Private Duty Nursing Services for Adults (RN or LPN)	✓	✓	Yes	
Related Goods (phone, internet, printer etc.)		✓	Yes	**Limit**: Coverage is limited to $2,000 every year (this is separate from the one-time funding for start-up goods). Experimental or prohibited treatments and goods are not covered.
Respite	✓	✓	Yes	**Limit:** Coverage is limited annually to 300 maximum hours per care plan year.
Respite RN	✓	✓	Yes	**Limit:** Coverage is limited annually to 300 maximum hours per care plan year.Additional hours may be requested if an eligible member's health and safety needs exceed the specified amount. Nursing respite services must not be provided by a member of the member'shousehold or by any relative approved as the employed caregiver.
Self-Directed Personal Care (Homemaker)		✓	Yes	
Skilled Maintenance Therapy Services (occupational, physical, and speech therapy)	✓	✓	Yes	A signed therapy referral for treatmentnotice must be provided from the member's Primary Care Provider.

COMMUNITY BENEFIT SERVICES				
Service	**ABCB**	**SDCB**	**Prior Authorization?**	**Details**
Specialized Therapies (acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, hippotherapy, massage therapy, naprapathy, Native American healers)		✓	Yes	**Limit:** Coverage is limited to $2,000 every year (annually) for all combined therapy services (Value-Added Servicehave separate limits)
Start-up Goods		✓	Yes	**Limit:** One-time coverage up to $2,000
Transportation Non-Medical		✓	Yes	**Limit:** Only vehicle mileage and bus/taxi passes are covered. Coverage is limited to a total of $1,000 every year for vehicle mileage and bus/taxi passes. Not a covered service for minors. Limited to a 75-mile radius of the member's home.

Electronic Visit Verification

Use of the Electronic Visit Verification (EVV) system is mandatory for Personal Care Service (PCS) and Respite services through the Agency Based Community and Self-Directed Benefits. The requirement is inclusive of Consumer Delegated and Consumer Directed models, as well as EPSDT services. EVV is also mandatory for Home Health services, which include skilled nursing, home health aide, social worker visits, speech therapy, physical therapy and occupational therapy. EVV is a telephonic or other technology-based system that monitors member receipt and utilization of PCS, Respite and Home Health services.

All claims and caregiver activities are subject to audit by BCBSNM. Although providers do have the ability to edit the arrival and departure time of caregivers from a member's home, providers must clearly document the reason for the manual edits and retain those records. Agencies needing to make mass adjustments or manual edits should contact BCBSNM prior to submitting them and provide rationale.

All claims for PCS, Respite and Home Health services must be submitted through the EVV system. BCBSNM may, in rare or unusual circumstances, approve short term exceptions to this policy. There are no universal or extended policy exceptions, and no agency will be granted an exception from the requirement to use EVV. Examples of circumstances that may qualify for a short-term exception include:

- Weather conditions or road conditions make caregiver travel dangerous or impossible
- Caregiver is too ill to travel
- Caregiver has a family emergency
- Temporary loss of technological infrastructure needed to support EVV due to weather conditions, vandalism, accident, etc.

All claims submitted using an exemption code are subject to BCBSNM edit and review prior to releasing those claims for payment. Agencies are strongly encouraged to use the exceptions listed only as appropriate and maintain records that validate reasons for use to avoid delay in claims payment.

The EVV requirements detailed in this section are subject to change. Providers are strongly encouraged to refer to the BCBSNM provider web portal specific to EVV which contains all provider communications, program updates and links to the Authenticare® training manual as well as Mobility Exchange® for information on tablet ordering and troubleshooting guides.

The BCBSNM website for EVV requirement can be found using the URL address below.

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

In addition to the above, the EVV system will:

- Log the arrival and departure time and location of the caregiver
- Verify that services are being delivered in the correct location (e.g., the Member's home)
- Verify the identity of the individual providing the service to the Member
- Match services provided to a member with services authorized in the Member's care plan
- Ensure that the provider delivering the service is authorized to deliver such services
- Establish a schedule of services for each member identifying the time at which each service is needed, as well as the amount, frequency, duration, and scope of each service, and to ensure adherence to the established schedule
- Reconcile paid claims with service authorizations.

To accommodate for areas of the state with limited technology or member's lack of a traditional home phone BCBSNM provides three options for agencies and caregivers to use EVV system:

- Option 1: Members Home Phone – Member must give permission to the caregiver to use their landline or the member's personal cell phone.
- Option 2: Caregiver's Smart Phone with Stipend – This option is available only when the member does not have a landline; or if the member does not allow the caregiver to use their landline. Caregivers use their personal smart phone (Apple or

Android) and can receive reimbursement for data usage. There is no stipend payment for use of the member's cell phone as described in Option 1.

- Option 3: Tablet with Cellular and Wi-Fi Connectivity – BCBSNM will provide a tablet for caregivers to use. This is the final option and is considered a last resort if neither Option 1 nor Option 2 is used. This is an Android based restricted use tablet that will only run the EVV application used by caregivers. Agencies needing a tablet for a BCBSNM member may order tablets directly from Mobility Exchange. BCBSNM will review and approve or deny order requests within three (3) business days. Only in very rare and unusual circumstances will BCBSNM approve "extra" tablets for an agency. Agencies must include the Member's Medicaid ID in order to receive approval for a tablet.

For Options 2 & 3, caregivers must travel to an area of the state with Verizon Wireless cellular service or connect to any Wi-Fi every seven days. Options may not be combined (e.g., a caregiver may not receive a stipend and also have a tablet).

Value-Added Services

In addition to covering the services stipulated in the State Plan, BCBSNM provides additional services that bring value and improved health to our members. The Medicaid managed care plan provides coverage for value-added services that include integrated services specific to physical health, behavioral health, and long-term care. Certain services are dependent on annual dollars available and are not always available throughout the year to all consumers. Value-added services are subject to change without notice annually or as otherwise directed or authorized by HSD. The current list of value-added services for 2024 are outlined below.

VALUE ADDED SERVICES		
Service	**Description**	**Prior Authorization?**
Infant Car Seats	Pregnant Members who complete prenatal visit requirements and are engaged in care coordination.	Prior authorization (PA) required - annual VAS program maximum one car seat per member.
Learn to Live	VAS targets members 13 years and older and caregivers. Learn to Live is a Cognitive Behavioral Therapy digital solution for multiple conditions, including unlimited one-to-one coaching sessions for Members 13 years and older and their caregivers. Confidential, 24/7/365, user-paced solution that increases access for depression, stress and worry, resilience, anxiety, insomnia, and more, with a consistent focus on resilience and mindfulness; health equity approach; multimedia and interactivity; crisis protocol.	PA not required.

VALUE ADDED SERVICES		
Service	**Description**	**Prior Authorization?**
Portable Infant Cribs	VAS targets pregnant members who complete prenatal requirements and engage in Care Coordination. Members will receive a portable crib and SIDs related educational materials for parents, caregivers, and health care providers.	PA required- annual VAS program maximum one per lifetime.
Prenatal Education	VAS targets pregnant members engaged in care coordination. Prenatal community classes in-person at partner hospitals within Albuquerque and Roswell. Classes include childbirth, labor and prep, newborn education and breastfeeding.	PA required- annual VAS program maximum one per lifetime.
Infant Diapers	VAS targets pregnant members or new moms. Available for pregnant members and new moms. Diapers are available for the 1st month from birth.	PA: To qualify for infant diapers, the member must complete prenatal requirements and must be engaged in care coordination. Once this is complete, an authorization is issued for the infant diapers.
Assistance with SDoH	VAS targets members with socioeconomic needs in their care plan that cannot be resolved by other means, such a new pair of shoes, mattress, clothing for an interview after release/discharge from a facility, bus passes to work, sporting gear, other tangible goods.	PA required; one occurrence per year or until funds are exhausted.
Electroconvulsive Therapy (ECT)	VAS targets members 18 years and older with appropriate diagnosis. ECT is offered when it is the safest and most effective treatment per guidelines for certain psychiatric conditions such as resistant major depressive disorder, depression with certain comorbid medical conditions, treatment-resistant mania secondary to bipolar disorder or schizoaffective disorder.	PA not required.
Heading Home + Health Partnership Program	VAS targets members in Bernalillo County that area experiencing chronic homelessness with severe mental illness, typically co-occurring with substance abuse disorder and physical ailments, and combination of frequent ED, hospital, and justice admissions. This program includes individualized program assistance, intensive case management, housing referrals, move-in support, navigation assistance for employment, financial literacy, and medical and non-medical transportation.	PA required - Limited to 10 Members for one year of housing plus extensive case management and wraparound services.

VALUE ADDED SERVICES		
Service	**Description**	**Prior Authorization?**
Home Meal Delivery	VAS targets members who are transitioning from an inpatient or long-term facility to the community, receiving community benefits and unable to prepare their meals or purchase groceries, or who are pregnant with diabetes. Gestational pregnant members will be offered three (3) meals per day for a total of four (4) weeks. Additional weeks or meals may be provided as authorized by the case manager.	PA) required - members who have been discharged from a facility will be offered the option of ordering twenty-one (21) meals. The meal benefit consists of three (3) meals per day for seven (7) days.
Remote Monitoring Program	VAS targets high risk members with chronic conditions with a need for frequent monitoring. Tablet and related medical devices such as blood pressure cuff, pulse oximeter, and scale are provided for members to receive care from their home. Paramedicine professionals monitor the member's medical condition and vital signs such as blood pressure and oxygen levels in real time and may coordinate with the Member's provider(s) as necessary.	PA required.
Respite Bed	VAS targets members who are medically vulnerable and chronically homeless who are being discharged from an ER or hospital in need of a temporary respite bed.	PA required- Annual VAS program maximum one 30 day stay per year.
Friends and Family Circle	VAS targets parents/caretakers that are caring for family members with complex needs that struggle to do basic routine things like going to a movie, restaurant, or shopping. The VAS will pay a friend or family member to provide respite care for the member.	PA required- gift card will be issued by the SDOH vendor. $45 per day with a limit of 10 days per year.
Transitional Living for Chemically Dependent / Psychiatrically Impaired Adults	This VAS is for members 18 years or older enrolled in an outpatient substance abuse center or in active treatment for psychiatric issues. Transitional living step down from a higher level of care to an identified community placement to stabilize members with an identified plan to return to independent living.	PA required- annual VAS program maximum 180 days stay per year.
Wellness Centers	This VAS is for adults, children, adolescents, families with behavioral health needs. Wellness/Drop-in centers and Family support centers provide peer driven/family driven BH recovery services, education on resources, and support in accessing resources such as housing, food, substance use disorder treatment, and other needed assistance.	PA not required- VAS program maximum 4 hours per week per Member.

VALUE ADDED SERVICES		
Service	**Description**	**Prior Authorization?**
Traditional Healing	Will only be offered if traditional healing is not approved as a covered benefit for Turquoise Care. This VAS is available to Native American Members for Traditional Healing practices.	PA not required.
After School Youth Activities	VAS targets members under 18 years old to pay for after school or sports activities. The VAS would cover registration fees, equipment purchases uniform fees, etc.	PA required- limited to $50 per member per year.
Care Giver Thank You Packages	Caregivers will be offered a thank you gift packages that includes games and other necessities. The package will also include important phone numbers and caregiver educational material.	PA not required- VAS limited to caregivers who specialize in Long Term Services and Supports, Home and Community Based Services
Shower Chairs	VAS targets elderly or members with disabilities who need a convenience shower chair.	PA not required- limited to one shower chair per member per year.
Virtual Health Partners	VAS targets members in need of a nutrition, fitness, and a lifestyle modification program. The program provides on demand individualized care with 24/7 access to Dieticians and Health coaches, live group events, unlimited messaging with experts, monitoring tools, and on-demand access to a variety of media supports (meal plans, recipes, fitness videos, cooking demos, and lifestyle modification module) and two to four one-on-one appointments with a dietician to support and encourage a healthy lifestyle.	PA required- Members will be identified for the program based on diagnosis such as pregnancy status and/or specific diagnoses such as prediabetes, diabetes, hypertension, obesity, and/or kidney disease.
Resource Tool Kit (Justice/Homeless)	VAS targets justice involved members and members experiencing homelessness. A “Tool Kit” notebook will contain both pre-identified statewide and national resource listings, and space to add personalized notes and resources. The tool kit will include preprinted resource information on the first several pages, such as the NMCAL, Utility help and support, food banks, housing, etc. The member and team can add additional information to the remainder of the notebook.	No PA required.

Some value-added services require preauthorization by BCBSNM. The criteria for preauthorization may be updated from time to time within BCBSNM’s discretion. Preauthorization is not a guarantee of benefits or eligibility. All services are subject to additional requirements and limitations and set forth in the BCBSNM Medicaid Managed Care Member Handbook and/or Provider Reference Manual. Nothing herein constitutes

medical or legal advice and regardless of any authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

Additional Information

It is the vision of BCBSNM that, coupled with the benefit package offered statewide through the Medicaid managed care plan, this range of value-added services will provide comprehensive support to all Medicaid managed care plan members to fit their behavioral health, physical health, community social services, and long-term care needs.

We encourage providers to help us promote these value-added services. Please refer members to our website, member newsletter, mailings, and other communications. We can also provide you with brochures with this information.

Another resource for obtaining assistance in treating some of your more complex patients is The University of New Mexico Project ECHO® (Extension for Community Healthcare Outcomes), which has a program to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas, and to monitor outcomes of this treatment. Providers can be reimbursed by BCBSNM to present and discuss their more complex Medicaid managed care plan members to an ECHO Clinic.

Telemedicine

Telehealth (or Telemedicine) means the use of electronic information, imaging, and communication technologies to provide and support health care deliver, diagnosis, consultation, treatment, transfer of medical data and education. BCBSNM promotes broad based utilization of statewide access to HIPAA compliant telemedicine services systems, including the following modalities:

- Live audio/video - real-time, two-way audiovisual connection between a Member and Provider (synchronous);
- Store and forward – transmission of recorded health history to a Provider (asynchronous);
- Remote Member monitoring – use of electronic tools to monitor and record a Member's physiological status which then transmit the data to a Provider in a setting other than where the Member is physically located;
- Other telehealth visits – any other services delivered via telehealth; and
    - Telephone visits - used for limited professional services delivered by telephone without video, as permitted by HCA.

Where available and all conditions of coverage are met, including following state guidelines for telemedicine equipment and connectivity, telemedicine services are covered for all Medicaid managed care plan members.

Telemedicine services are subject to the same criteria for medical necessity and program compliance that would be used if the same services were provided during an in-person encounter. This includes:

- Developing and implementing trainings for accepted Telemedicine practices
- Participating in the needs assessment of the organizational, developmental and programmatic requirements of Telemedicine programs;
- Report to HCA on the Telemedicine outcomes of Telemedicine projects and submit a Telemedicine Report as directed by HCA;

Additional coverage requirements for telemedicine service also apply (see Sections 8.308.9.18 and 8.310.2.12 NMAC, as may be recompiled and/or amended).

Member Rewards

Every member of a Medicaid managed care plan is able to enroll in the Turquoise Rewards Program. The Rewards Program allows members to earn “credits” by just taking part in certain healthy actions.

To use credits, enrollment is required by the Member. Members can enroll at turquoiserewards.com or call Turquoise Rewards Wellness Services at **1-877-806-8964**. Credits can be used by making choices from a catalog. Members can order catalog items through BCBSNM’s website or by calling Turquoise Rewards Wellness Services at **1-877-806-8964**.

Members will get Turquoise Rewards Program catalog when they earn their first credits. Below are the Healthy Actions and the Reward Benefits (also called “credits”). Check turquoiserewards.com for any new Healthy Actions throughout the year.

To learn more about this program, please call toll-free **1-877-806-8964**.

Behavioral Health

BCBSNM works closely with New Mexico’s Behavioral Health Collaborative to cooperate with providers for resiliency and recovery services in all geographic regions and diverse communities throughout the state.

The BCBSNM Integrated Behavioral Health Program is a portfolio of resources that helps Medicaid managed care plan members access benefits for behavioral health (mental health and chemical dependency/substance abuse) conditions as part of an overall care management program. BCBSNM has integrated behavioral health care management into our member medical care management program to provide better care management service across the health care continuum.

The Integrated Behavioral Health Program includes:

- Care/Utilization Management for inpatient, outpatient, and partial hospitalization and residential behavioral health care

- Condition Case Management (seven conditions)
    - Depression
    - Alcohol and substance abuse disorders
    - Anxiety and panic disorders
    - Bipolar disorders
    - Eating disorders
    - Schizophrenia and other psychotic disorders
    - Attention Deficit and Hyperactivity Disorder (ADD/ADHD)
- Intensive Case Management
- Patient Safety Program

Early & Periodic Screening, Diagnosis & Treatment (EPSDT)

The EPSDT program is a federally mandated program ensuring access to comprehensive health care to Medicaid recipients from birth to 21 years of age. EPSDT is defined as:

- **Early**: Assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated.
- **Periodic**: Assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development.
- **Screening**: The use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.
- **Diagnostic**: The determination of the nature or cause of conditions identified by the screening.
- **Treatment**: The provision of services needed to control, correct, or lessen health problems.

The screening segment of EPSDT is the Tot-to-Teen HealthCheck, which includes the following components:

- Comprehensive health and development history* (including an assessment of both physical and behavioral health or social emotional development)
- Comprehensive unclothed physical exam*
- Appropriate immunizations, according to age and health history, unless medically contraindicated at the time*
- Laboratory tests, including an appropriate lead blood level assessment*
- Health education, including anticipatory guidance*
- Dental screening
- Vision and hearing testing

* These items must be documented in order to fulfill the requirement of an EPSDT exam and to meet Healthcare Effectiveness Data and Information Set (HEDIS®) criteria. An appropriate lead blood level assessment should be completed at 12 months and 24 months.

The Centers for Medicare & Medicaid Services (CMS) has mandated that the following visit codes be used to capture all EPSDT visits:

- 99381 – New patient under one year 99382 - New patient (ages 1 – 4 years)
- 99383 – New patient (ages 5 – 11 years)
- 99384 – New patient (ages 12 – 17 years)
- 99385 – New patient (ages 18 – 39 years)
- 99391 – Established patients under one year
- 99392 – Established patients (ages 1 – 4 years)
- 99393 – Established patients (ages 5 – 11 years)
- 99394 – Established patients (ages 12 – 17 years)
- 99395 – Established patients (ages 18 – 39 years)
- 99460 – Initial hospital or birthing center care for normal newborn infant.
- 99461 – Initial care in other than a hospital or birthing center for normal newborn infant

The following Current Procedural Terminology (CPT®) codes must be used in conjunction with at least one of the following "Z" diagnosis codes: Z00.00 through Z00.129, Z00.8, Z02.89, and Z76.1-Z76.2:

- 99202-99205 New Patient
- 99213-99215 Established Patient

Screenings are encouraged based on the New Mexico Tot-to-Teen Healthcheck periodicity schedule:

- Under age 1: 6 screening/examination visits (3-5 days, 1, 2, 4, 6, and 9 months)
- Ages 1-30 months: (12, 15, 18, 24 and 30 months)
- Ages 3-21 Each year

The established schedule must be followed unless the patient's medical condition warrants a brief deviation.

Providers can perform additional screenings at intervals other than those listed above if a patient receives care at a time not listed on the periodicity schedule, or if any components of the screen were not completed at the scheduled ages. Providers also can use additional screenings to put the patient on the periodicity schedule when possible.

When a provider is seeing an ill child and a Tot-to-Teen Healthcheck is due, the provider may perform and bill for the health check as an additional service if the illness does not interfere with it.

Family Planning

Family Planning Services include but are not limited to:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision- making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider/practitioner
- Provision of contraceptive pills
- Provision of devices/supplies
- Tubal ligations
- Vasectomies
- Pregnancy testing and counseling

Children with Special Health Care Needs (CSHCN)

The CSHCN program is defined as individuals less than 21 years of age, who have or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological, or emotional condition, and require health and related services of a type or amount beyond that generally required by children. Examples of common diagnoses include:

- Asthma
- Diabetes
- Congenital anomalies
- Metabolic disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Other behavioral health diagnoses
- Congenital heart disease

Individuals with Special Health Care Needs (ISHCN)

The ISHCN program is defined as individuals who have or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological, or emotional condition, or have low to severe functional limitations, and require health and related services of a type or amount beyond that generally required by individuals. Examples of common diagnoses include:

- Asthma
- Diabetes
- Congenital anomalies
- Metabolic disorders

- Attention Deficit Hyperactivity Disorder (ADHD)
- Other behavioral health diagnoses
- Congenital heart disease

Native Americans

Native American Medicaid beneficiaries who meet nursing facility level of care, or who are both Medicaid and Medicare eligible, are required to enroll with a Medicaid managed care plan MCO. Native American Medicaid beneficiaries who do not require nursing facility level of care or who are not dual eligible can choose to remain in fee-for-service or may choose to enroll with an MCO. Native American MCO enrollees do not have copays.

Newborn Enrollment

Medicaid-eligible and enrolled newborns of a Medicaid managed care plan-eligible enrolled mothers are eligible for a period of 13 months starting with the month of birth. When a child is born to a mother enrolled with Medicaid managed care plan, a Notification of Birth (MAD Form 313) must be completed 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 following the birth. The child will be enrolled in the same MCO as the enrolled mother. Do not submit claims for a newborn with the mother's identification number.

Financial Responsibilities

Providers who participate in the Medicaid managed care plan network agree to accept the amount paid as payment in full per 42 CFR Section 447.15 and cannot bill the member a remaining balance other than copayment, coinsurance, or deductible, if any. Providers may not deny services to Medicaid managed care plan members on account of the member's inability to pay the cost sharing amount, if any.

The general rule is that providers participating with BCBSNM for a Medicaid managed care plan may not bill a member for any unpaid portion of the bill or for a claim that is not paid by BCBSNM. In addition to member cost sharing, exceptions to this rule include:

- Informed member consent. The provider must inform the member prior to rendering the service of its cost and payment terms and that the service is not covered by the Medicaid managed care plan and obtain a signed statement from the member acknowledging such notice and the member's financial responsibility for payment. Note, it is the provider's responsibility to understand or confirm the member's benefits and to inform the member when the service is not a benefit. The provider may not bill a member for a covered benefit for which prior authorization was required if the provider failed to obtain the required authorization without the covered person's informed and documented consent.

- Member's failure to timely notify provider of eligibility. The member failed to notify the provider of Medicaid eligibility in a timely manner to allow the provider to meet claim filing limits.

For additional information regarding circumstances under which a Medicaid managed care plan member may be billed by the provider, see Section 8.302.2.11.C NMAC.

Specific circumstances in which participating providers may not bill a member include, but are not necessarily limited to:

- The provider's claim was denied because the provider has not met the timely filing or other administrative requirements.
- The provider's claim was denied for lack of medical necessity or not being an emergency unless the provider determined prior to rendering the service that medical necessity or emergency requirements were not met and satisfied the informed member consent requirement, above.

Note: When the provider has been informed of the member's eligibility or pending eligibility, the account cannot be turned over to collections or any other entity intending to collect from the member. It is the provider's responsibility to retrieve the account turned over for collection and to accept the disposition of the claim by BCBSNM.

Provider Satisfaction Survey

BCBSNM will conduct an annual Provider Satisfaction Survey for providers that participate with BCBSNM for a Medicaid managed care plan following HCA and NCQA guidelines. Results of the annual survey are reported to the HCA and the Medical Assistance Division (MAD). Summary results are also published in the Blue Review provider newsletter and on the provider website at bcbsnm.com.

Health Information Exchange

BCBSNM requires providers to use the Health Information Exchange for secure sharing of clinical information between physical and behavioral health providers.

SYNCRONYS is the vendor used for HIE in New Mexico.

3 – Claims

ID Cards & Verification of Coverage

Each member receives an ID card containing the member's name, ID number, and information about his or her benefits.

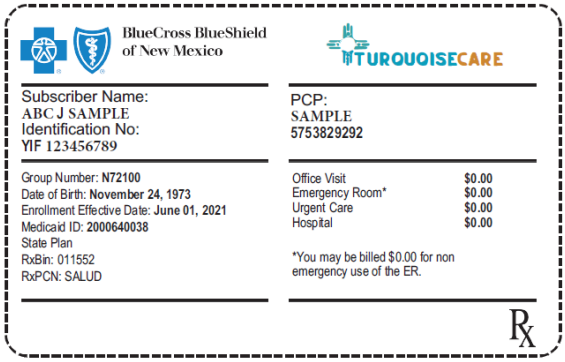
At each office visit, your office staff should:

- Ask for the member's ID card,
- Copy both sides of the ID card and keep the copy with the patient's file, and
- Determine if the member is covered by another health plan and record information for coordination of benefits purposes. 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 with the other carrier's Explanation of Benefits attached.

Refer to the member's ID card for the appropriate telephone number to verify eligibility.

Sample of ID Card

Front of Card



Back of Card

Claim Requirements

Participating providers are expected to submit claims within 90 days of the date of service, using the standard CMS-1500 or UB-04 claim form or electronically as discussed below. Services billed beyond 180 days from the date of service are not eligible for reimbursement. Claims denied for untimely filing may not be billed to the member. Indian Health Service providers have up to 2 years from the date of service to file claims. All necessary provider NPIs also require provider enrollment with the state of New Mexico HSD.

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
- Indication of 1) job-related injury or illness, or 2) accident- related illness or injury, including pertinent details, where applicable
- ICD-10 diagnosis codes
- CPT codes and/or Healthcare Common Procedure Coding System (HCPCS) codes, including CPT Modifiers, as appropriate
- National Drug Code (NDC) codes in accordance with Medicaid requirements, including Units, and Units of Measure
- Date(s) of service(s)
- Admission date and patient discharge status, where applicable
- Charge for each service
- Days or units, where applicable
- Value codes, where applicable
- Total charge for the sum of all service lines
- Provider's Tax Identification Number (TIN)
- Provider National Provider Identification (NPI) number (Type 1 or Type 2) for all Billing, Attending, Ordering, Operating, Referring, and Rendering, as required
- Taxonomy code of Billing and/or Rendering Provider, as required
- Name and address of participating provider
- Signature of participating provider providing services
- Place of service code or type of bill and indicate if a corrected/replacement claim, as required
- Preauthorization number, if required
- Third party health insurance plan details, including other insured's name, policy number, and payment details, as appropriate
- The electronic payer ID # for participating providers is MC721.

BCBSNM's goal and intention is to pay Clean Claims within time frames specified by the New Mexico Medicaid managed care program.

Duplicate claims may not be submitted prior to the applicable 30-day claims payment period. As a condition of the capitation payment, providers with a sub-capitated reimbursement arrangement are required to submit all utilization or encounter data in the same standards of completeness and accuracy as outlined above. This allows proper adjudication of claims to include fee-for-service Medicare claims.

Submitting Claims

Claims should be submitted electronically through Availity® Essentials Health Information Network for processing. For information on electronic filing of claims, contact Availity® Essentials at 1-800-282-4548.

BCBSNM will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to BCSBNM should comply with those requirements.

BCBSNM will reimburse family planning clinics, School-Based Health Centers, and Department of Health public health clinics for oral contraceptive agents and Plan B when dispensed to members and billed using HCPCS codes and CMS-1500 forms.

Paper claims must be submitted on the CMS-1500 (Physician/ Professional Provider) or CMS- 1450 (UB-04 Facility) claim form to:

Medicaid
P.O. Box 650712
Dallas, TX 75265-0712

Self-directed provider community benefit claim submittals: Claims from self-directed providers cannot be submitted to BCBSNM. Claims from self-directed providers must be submitted to the Fiscal Management Agency (FMA) contracted with the State of New Mexico.

Community Support Brokers contracted with BCBSNM may submit claims directly to BCBSNM following the criteria outlined in this section.

- Members must review and approve timesheets of their providers to determine accuracy and appropriateness.
- No Self-Directed Community Benefit provider shall exceed 40 hours paid work in a consecutive 7 calendar day period.
- Timesheets must be submitted and processed on a two-week pay schedule according to HSD’s prescribed payroll payment schedule.
- The FMA is responsible for processing payments for approved Medicaid managed care plan services and goods.

- BCBSNM reimburses the FMA for authorized Self-Directed Community Benefit services provided by providers at the appropriate rate for self-directed Home and Community Based Services, which includes applicable payroll taxes.

Nursing Facility Billing Requirements

HCA has standardized the Nursing Facility (NF) billing requirements for all Medicaid payers. Please bill these services on the UB-04 form with the codes outlined below.

Revenue Codes:
Bill with the following revenue codes for the services listed.

- 0182 – Home Visit or Discharge Reserve Bed Day (to allow for accurate calculation and limitation of these reserve bed days)
- 0185 – Inpatient Hospital Reserve Bed Day
- 0190 – Subacute Care Long Term Care Services – Nursing Facility
- 0199 – High Nursing Facility Level of Care

Value Codes:
Value code 23 (patient estimated responsibility) should be billed to indicate the Medical Care Credit (MCC) for each recipient.

Non-covered reserve bed days must be billed as value code 80 for non-covered days. Non-covered days plus covered days, billed as value code 81, must equal total days.

Patient Discharge Status:
Use the appropriate patient discharge status code to indicate the recipient's status on the last day of the period for which payment is requested.

When using the discharge status code 30 (still a patient) the TO date of service is counted in the days billed.

For more information, refer to: NMAC Section 8.312 - Long term care services - nursing services, Part 2 - nursing facilities.

Coordination of Benefits

By law, the Medicaid program is the payer of last resort. Thus, without limitation, if a Medicaid managed care plan member has coverage with another plan or Medicare that is primary to Medicaid, submit a claim for payment to that plan first. The amount payable by a Medicaid managed care plan, if any, will be governed by the amount paid by the primary plan and Medicaid secondary payer law and policies.

When a Medicaid managed care plan is not primary, claims must be submitted to BCBSNM within 180 days from the other insurance paid date. Attach a copy of the primary payer's EOB. The primary payer's EOB must match the submitted claim so that charges can be appropriately processed. If the primary plan denies the claim due to the provider or member not following that plan's prescribed procedures, including but not limited to, failure

to obtain a prior authorization and untimely filing, payment will not be made by a Medicaid managed care plan. A provider who chooses not to participate in Medicare or accept assignment on a Medicare claim must inform the member or his or her authorized representative that the provider is not a Medicare provider or will not accept assignment; and because of those provider choices, a Medicaid managed care plan cannot pay for the service.

When a Medicaid managed care plan is primary, please do not indicate Medicaid as an additional payer as BCBSNM is the Medicaid payer.

For care coordination, the provider should notify BCBSNM of all Acute Admissions even if Medicaid is secondary.

Billing for Non-Covered Services

The general rule is that providers participating with BCBSNM for a Medicaid managed care plan may not bill a member for any unpaid portion of the bill or for a claim that is not paid by BCBSNM. In order to bill the member for non-covered services, the provider must inform the member prior to rendering the service of its cost and payment terms and that the service is not covered by the Medicaid managed care plan and obtain a signed statement from the member acknowledging such notice and the member's financial responsibility for payment. Note, it is the provider's responsibility to understand or confirm the member's benefits and to inform the member when the service is not a benefit.

Billing Audits

BCBSNM will conduct both announced and unannounced site visits and field audits to contracted providers as deemed necessary by BCBSNM, including but not necessarily limited to those defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, behavioral health, telehealth, private nursing facilities and transportation services) to ensure services are rendered and billed correctly.

Hold Member Harmless

Participating providers and any sub-contractors of providers agree that in no event, including but not limited to non-payment by the Corporation, insolvency of the Corporation, or breach of signed Agreement, shall participating providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a member to whom health care services have been provided, or person acting on behalf of the member for health care services provided. The foregoing does not prevent the provider from collecting member share (deductible, coinsurance, or copayment) if applicable.

Remaining balances after adjustments by BCBSNM and member share, if any, shall be treated as contractual adjustments by participating providers and shall not be billed to the member. Members may also not be charged for any unpaid portion of the bill or for a claim that is not paid because of a provider administrative error or failure.

Participating providers are prohibited from collecting any payment for non-covered services from the member unless all requirements for such have been met (see “Billing for Non-Covered Services”).

Encounter Reporting

BCBSNM is required by the HCA to report all services rendered to Medicaid managed care plan members. The reporting of these services, also known as, encounter data reporting, is a critical element to the success of BCBSNM. HCA uses encounter data reporting to evaluate health plan compliance on many vital measures.

Whether the service provided is capitated or fee-for-service, claims from contracted providers should be submitted to BCBSNM within 180 calendar days from the date of service. Non-contracted providers must submit within 1 year from the date of service. IHS providers must submit claims within 2 years from the date of service. In instances of retro enrollment, the claim must be submitted within 90 calendar days from the date enrollment is added, based on the category of eligibility (COE) code in the NM Medicaid portal. Proof of timely exceptions may apply. Untimely filing will result in claims that are ineligible for reimbursement. This is to ensure compliance with the HCA request for timely, complete and accurate encounter data. BCBSNM is required to submit encounter data to the HCA within 30-60 days from claim adjudication, with no more than a 3% error rate. Encounters will not be accepted by the state past 2 years from the BCBSNM received date. This would also include claims for which the provider expects no reimbursement from BCBSNM, because another payer has previously paid the claim in full.

Claim submissions that do not contain accurate or required data elements and/or do not meet the criteria for acceptance as an encounter (e.g. required provider enrollment with HCA, services not within scope of practice for the provider type), may result in an upfront or retroactive denial of the claim. This also includes services that may be considered a duplicate claim submission (e.g. overlapping or exact dates of service).

Provider Claim Summary

Provider Claim Summaries for the Medicaid managed care plan are generated no differently than our other lines of business. The member’s share is calculated based on the type of service, benefits, etc. The Explanation of Benefits (EOB) will not be sent to members for the Medicaid managed care plan line of business.

Claim Disputes

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the BCBSNM Provider Customer Service Department at the number listed on the Key Contacts page. Claims returned as a dispute or with additional information must be returned to BCBSNM within 30 days of

receipt. If corrected claims are not resubmitted within 30 days, there is a risk of being denied for timely filing if the original date of service is greater than 180 days.

If a claim is suspended due to a credible allegation of fraud and it is deemed that the payment can eventually be sent to the provider, BCBSNM is not responsible for interest payment.

Deficit Reduction Act

In an effort to deter and prevent waste and abuse, health care entities who receive or pay out at least $5 million in Medicaid funds per year must now comply with the Deficit Reduction Act (DRA) Section 6032, Employee Education about False Claims Recovery.

Participating providers must establish written policies for all employees, including management, providing detailed information about false claims, false statements, and whistleblower protections under applicable federal and state abuse laws. These written policies must include a specific discussion of the applicable laws and detailed information regarding the detection and prevention of waste and abuse, as well as the rights of employees to be protected as whistleblowers. The provider shall include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the provider/subcontractor's policies and procedures for detecting and preventing waste and abuse.

Reporting Fraud and Abuse

For additional information on reporting fraud, waste and abuse, see Section 18 of the Blues Provider Reference Manual. The Special Investigations Department maintains a 24-hour fraud hotline, through which you can report any suspicions of fraud. All calls are confidential, and you may report your information anonymously. To file a report, call the hotline at 1-800-543-0867 (24/7) or go to www.bcbsnm.com/sid/reporting.

Additionally, BCBSNM expects providers perform self-audits to assess, correct and maintain controls to promote compliance with applicable laws, rules, and regulations. Self-audits can help reduce fraud and improper payments, improve patient care, lower chances of an external audit and create a robust culture of compliance. In the course of a self-audit, if a provider uncovers possible fraud or material noncompliance with Medicaid requirements, they should self-disclose the information. Self-disclosure should be made within sixty (60) days of the date on which the provider uncovers the matter. The self-disclosure should be reported to the New Mexico Health Care Authority Office of Inspector General (HCA OIG) and BCBSNM and include the following minimum requirements: (i) provider's name; (ii) provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance Claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid Claim control number, as appropriate; (viii) description of corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether

the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time- span) within which the problem existed that caused the Overpayment; (xi) whether a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

Providers may request that BCBSNM permit installment payments of the refund of overpayments; such request shall be agreed to by BCBSNM and the Provider.

Overpayments that have been identified by a Provider and not self-reported within the 60 Calendar Day time frame may be considered false Claims and may be subject to referrals as credible allegations of fraud. BCBSNM reports suspected fraud, waste and abuse to the HCA OIG.

4 – Reimbursement Methodologies

Overview

The Blues Provider Reference Manual plus this section, explain the provider payment policies. The following is a description of the basic reimbursement methodologies used to reimburse providers. BCBSNM bases provider reimbursement, for medically necessary services, on the HCA fee schedule and reimbursement methods.

Professional Reimbursement Methodology

Fee Schedule
This reimbursement method is tied to the filing of a CMS-1500 claim form for services provided as designated by CPT or HCPCS codes.

The BCBSNM fee schedule is based on the Medicaid Fee Schedule using CPT and HCPCS codes. On occasion, HCA will update the Medicaid fee schedule. It is the policy of BCBSNM to make updates to our fee schedules within 60 days of our receipt of the notification of the update.

Fee Schedule Requests

Providers can obtain an entire fee schedule or request fee information for specific codes by filling out a Fee Schedule Request Form available on the bcbsnm.com provider website under Forms.

Note: The BCBSNM fee schedule is not a guarantee of payment. Services represented are subject to provisions of the health plan including, but not limited to: membership, eligibility, claim payment logic, provider contract terms and conditions, applicable medical policy, benefits limitations, and exclusions, bundling logic, and licensing scope of practice limitations. Maximum allowable may change from time to time subject to notice requirements of applicable law and regulations and prevailing provider agreement. Additional provider information is available on the website at bcbsnm.com.

Out-of-Network Payment

When an out-of-network non-contracted provider submits a request for coverage of services, BCBSNM determines if the service is medically necessary and if the member can receive the same service from an in-network (contracted) provider. If we determine that the covered service is medically necessary but is not available from an in-network provider, the Utilization Management (UM) staff works with Provider Contracting to negotiate a single case agreement with the out-of-network provider. BCBSNM enters the authorization into the medical management platform for claims payment and documentation of clinical rationale for approval.

Unless otherwise provided by a single case agreement, if any, BCBSNM reimburses non-contracted providers 95% of the Medicaid fee schedule rate for the covered services provided except as otherwise required by HSD, precluded by law and/or specified for Indian Health Services/Tribal Health Providers/Urban Indian Providers (I/T/Us), Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC), family planning providers, and emergency services providers. Non-contracted Nursing Facilities are reimbursed at 100% of the Medicaid fee schedule rate for covered services provided except as otherwise required by HSD. Non- contracted Nursing Facilities must be enrolled and active in the NM Medicaid portal with fees assigned by HCA in order to receive this level of reimbursement.

FQHC and RHCs

BCBSNM shall reimburse both contracted and non-contracted FQHCs and RHCs at a minimum of the Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act.

The following guidelines may be helpful in billing these services.

Federally Qualified Health Clinics

- The PPS rate includes all practitioner services, pharmacy, lab, radiology, behavioral health, and dental services that take place at the FQHC. (Dental claims must be billed to DentaQuest.)
- A clinic administratively associated with an FQHC is only reimbursed at the FQHC encounter rate if that clinic is actually part of the certified FQHC.
- An FQHC cannot have separate provider numbers for professional, dental, pharmacy, or behavioral health claims. An FQHC should not have separate provider numbers for pharmacy, physician, or dental services. A separate pharmacy claim is not billed or reimbursed; the encounter rate is inclusive of dispensing the drug items from the FQHC.
- The encounter will be paid:
    - When the recipient sees a practitioner at the FQHC,
    - When the practitioner makes an inpatient hospital visit or goes to a nursing facility, or
    - When the practitioner renders a service at a hospital such as delivering a baby.
- FQHC must bill on a UB-04 claim form with type of bill 771.
- FQHC must bill the Managed Care Organization (MCO) for the revenue codes and procedure codes on the UB-04 form, listing all the services provided at the encounter, and the MCO should pay the single encounter rate. Listing the procedure codes is very important. Payment is made at the FQHC encounter rate.
- Effective September 1, 2016, FQHCs may bill for Long Acting Reversible Contraception Products (LARC) and may receive reimbursement in addition to their encounter rate. LARC items may be billed on a separate line on the UB-04, and

must contain the revenue code 0636, appropriate procedure code, and a corresponding NDC code.
- Only if the FQHC cannot bill that way, should an FQHC use the revenue code of 0529 for a physical health or dental service, and revenue code 0919 for a behavioral health service.

Free-Standing Rural Health Clinics

- The revenue code for free-standing health clinics is 0521. The provider should also include the primary procedure code.
- Effective Sept. 1, 2016, Free-Standing Rural Health Clinics may bill for Long Acting Reversible Contraception Products (LARC) and may receive reimbursement in addition to their encounter rate. LARC items may be billed on a separate line on the UB-04, and must contain the revenue code 0636, appropriate procedure code, and a corresponding NDC code.
- Unlike an FQHC, free-standing or hospital-based RHCs can have a separate provider number for pharmacy and for dental services that are paid just like other pharmacies and dentists.

Hospital-Based Rural Health Clinics

- In fee-for-service Medicaid, a hospital-based RHC bills revenue code 0510, an outpatient clinic visit, but they can also bill other services at that visit such as laboratory with appropriate revenue codes. FFS pays the hospital-based RHC at a percent of billed charges.
- MCOs pay the set encounter rate to a hospital-based RHC (HB- RHC). The HB-RHC should bill all revenue codes along with a procedure code. The MCO pays the encounter rate on the 0512 revenue code for medical and 0919 revenue code for behavioral health, similar to what is being done with FQHCs.
- Effective Sept. 1, 2016, hospital based rural health clinics may bill for Long Acting Reversible Contraception Products (LARC) and may receive reimbursement in addition to their encounter rate. LARC items may be billed on a separate line on the UB-04, and must contain the revenue code 0636, appropriate procedure code, and a corresponding NDC code.

Indian Health Services (IHS), Tribes and Tribal Organizations and Urban Indian Organizations (I/T/U)

BCBSNM reimburses both contracted and non-contracted provider I/T/Us at a minimum of 100% of the rate currently established for the IHS facilities or federally leased facilities by the Office of Management and Budget (OMB). If a rate is not established by OMB for a particular service, then reimbursement shall be at an amount not less than the Medicaid fee schedule. Services provided within I/T/Us are not subject to prior authorization requirements.

Family Planning Non-Contract Providers

BCBSNM shall reimburse non-contracted family planning providers for the provision of services to members at a rate set by HSD.

Pregnancy Termination

BCBSNM pays claims submitted by qualified and credentialed providers for state and federally approved pregnancy termination procedures rendered to eligible members.

Reimbursement for Members Who Disenroll While Hospitalized

If a member is hospitalized at the time of enrollment or disenrollment from an MCO or upon an approved switch from one MCO to another, the originating MCO is responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospital as designated by the New Mexico Department of Health until the date of discharge. Upon discharge, the member becomes the financial responsibility of the MCO receiving capitation payments.

BCBSNM is not responsible for payment of any covered services incurred by members transferred to BCBSNM prior to the effective date of transfer.

Emergency Services

Emergency services are available to members 24 hours a day, 7 days a week. Any provider of emergency services that is a non-contracted provider must accept, as payment in full, no more than the amount established by HCA for such services. This rule applies whether or not the non-contracted provider is within the state.

BCBSNM reimburses acute general hospitals for emergency services, which they are required to provide because of federal mandates such as the “anti-dumping” law in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 and 42 U.S.C. § 1395(dd), and section 1867 of the Social Security Act.

BCBSNM pays for both the services involved in the screening examination and the services required to stabilize the member, if the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists. BCBSNM may not refuse to cover emergency services based on an emergency room provider, hospital, or fiscal agent not notifying the member’s PCP or BCBSNM of the member’s screening and treatment within 10 calendar days of presentation for emergency services. If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, BCBSNM will pay for both the services involved in the screening examination and the services required to stabilize the member. The member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

BCBSNM pays for all emergency services and post-stabilization care that are medically necessary services until the emergency medical condition is stabilized and maintained.

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation. In these cases, BCBSNM will review the presenting symptoms of the member and pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

BCBSNM may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. If the member believes that a claim for emergency services has been inappropriately denied by BCBSNM, the member may seek recourse through the Appeal and Fair Hearing process.

Emergency and Post- Stabilization Services

BCBSNM is financially responsible for post-stabilization services obtained within or outside BCBSNM's provider network that are pre- approved by BCBSNM. BCBSNM's financial responsibility for post- stabilization services that have not been pre-approved shall end when: (i) a contracted provider with privileges at the treating hospital assumes responsibility for the member's care; (ii) a contracted provider assumes responsibility for the member's care through transfer; (iii) a representative of BCBSNM and the treating physician reach an agreement concerning the member's care; (iv) the member is discharged. Notwithstanding and without waiving the foregoing, BCBSNM's financial responsibility for post-stabilization services shall also end when a contracted hospital fails to comply with the requirements set forth in the "Notification for Post-Stabilization Care following an Emergency Admission" section below.

BCBSNM reviews and approves or disapproves claims for emergency services based on the definition of Emergency Medical Condition. BCBSNM bases coverage decisions for emergency services on the severity of symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. BCBSNM does not impose restrictions on the coverage of emergency services that are more restrictive than those permitted by the prudent layperson standard.

BCBSNM provides coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contracted provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services are provided without prior authorization in accordance with 42 C.F.R. §438.114. BCBSNM does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Notification for Post- Stabilization Care Following an Emergency Admission

Post-stabilization notification of inpatient admissions allows BCBSNM to evaluate the appropriateness of the setting of care and other criteria for coverage purposes. It aids in early identification of members who may benefit from specialty programs available from BCBSNM, such as Case Management, Care Coordination and Early intervention (CCEI), or Longitudinal Care Management (LCM). Notification also allows BCBSNM to assist the member with discharge planning. Thus, for stabilized members, BCBSNM requires notification of admission for post- stabilization care services within one business day following treatment of an emergency medical condition. Failure to timely notify BCBSNM and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post- stabilization care services, charges for which cannot be billed to the member pursuant to your provider agreement with BCBSNM. In the event of a claim denial that includes emergency care services, the provider is instructed to rebill the claim for the emergency services (including stabilization services), as well as post-stabilization care services for which BCBSNM may be financially responsible pursuant to 42 CFR Section 422.113(c), if any, for adjudication by BCBSNM. You can submit a notification for post stabilization care services through our secure provider portal via Availity, or by phone, using the number on the member's ID card. Timely post stabilization notification of inpatient admission does not guarantee payment.

Timely Payments to All Providers

BCBSNM and any of its subcontractors shall make timely payments to both its contracted and non-contracted providers as defined below. BCBSNM and any of its subcontractors or providers paying their own claims are required to maintain claims processing capabilities to comply with all state and federal regulations.

HCA's regulations and contract with BCBSNM specify interest payments at the rate of 1.5% for each month or portion of any month on a prorated basis on the amount of a clean claim electronically submitted by a contracted provider and not adjudicated within 30 calendar days. Interest shall accrue from the 31st calendar day.

HCA's regulations and contract with BCBSNM specify interest payments at the rate of 1.5% for each month or portion of any month on a prorated basis on the amount of a clean claim manually submitted by a contracted provider and not adjudicated within 45 calendar days of the date of receipt. Interest shall accrue from the 46th calendar day.

BCBSNM accepts from providers and subcontractors only national HIPAA-compliant (Health Insurance Portability and Accountability Act of 1996) standard codes and editing to ensure that the standard measure of units is billed and paid for.

BCBSNM reviews claims to ensure that services being billed are provided by providers licensed to render these services, that services are appropriate in scope and amount, that members are eligible to receive the services, and that services are billed in a manner consistent with HSD-defined editing criteria and national coding standards.

General Payment Policies for All Providers

BCBSNM will not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid, or SCHIP sanctions, except for emergency services.

Contracted providers will accept payment or appropriate denial made by BCBSNM (or, if applicable, payment by BCBSNM that is supplementary to the member's third-party payer) plus the amount of any applicable member cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable cost sharing responsibilities.

If a member is in a facility at the time of disenrollment (not including loss of Medicaid eligibility), BCBSNM will be responsible for the payment of all covered services until there is a change to a lower level of care, until the date of discharge or until the date of disenrollment, whichever occurs first.

BCBSNM participates in Payment Reform Projects to begin the process of recognizing and rewarding providers based on outcomes, rather than the volume of services delivered. In addition to those projects outlined below, BCBSNM has the option to develop other pay for performance initiatives for physical health, behavioral health and long- term care with the approval of HSD.

5 – Health Care Management

Quality Improvement Program

Quality improvement is an essential element in the delivery of care and services to members.

To define and assist in monitoring quality improvement, the Quality program's goal is to improve members' health status and improved outcomes through a variety of meaningful quality improvement activities that are implemented across all care settings and aims at improving the quality of care and services delivered to our members – your patients.

The Quality Improvement/Quality Management (QI/QM) Program encompasses all clinical care and services furnished to our members, inclusive of medical, behavioral and long-term care and services. The scope of the quality improvement process includes the process and outcomes of medical, behavioral and long-term care and services; ancillary services; pharmacy services; dental, transportation and vendor services; member services and experience, patient safety and efficient use of resources. The QI/QM program is comprehensive and includes effective mechanisms of ongoing identification, monitoring, and evaluation, all of which rectifies issues that impact the safety, accessibility, availability, continuity and quality of care and services provided to our members.

Utilization Management Program

The Utilization Management (UM) program includes:

- Prospective review (preauthorization)
- Concurrent review
- Discharge planning
- Retrospective review

The Utilization Management Program is described in the Utilization Management, Case Management, and Condition & Lifestyle Management section of the *BCBSNM Blues Provider Reference Manual*.

Complex Case Management

BCBSNM Care Coordinators who are medical management specialists provide individual Complex Case Management for members with the highest needs who have multiple chronic, complex, catastrophic conditions, or need a transplant. Complex Case Management activities are based on national standards of practice from the Case Management Society of America, clinical care guidelines and other evidence-based materials. The overall goal is to help members regain optimum health and or improved functional capability, in the right setting and in a cost-effective manner.

Providers, facility discharge planners, pharmacists, and caregivers can refer members to the Complex Case Management Program, and members can refer themselves to the Complex Case Management Program. All identified members are eligible to participate in the program and have the option to end their participation in the program at any time.

Eligible members for Complex Case Management would include those with multiple chronic conditions (e.g. diabetes, stroke, heart disease, chronic kidney disease, chronic lung disease, dementia) transplants or complex condition experiencing a high number of emergency room visits or hospital admissions, members who require transplants, have congenital heart disease requiring surgery, or those with co-morbid complex physical and behavioral health conditions, complex medical conditions impacted by social issues and or functional limitation. Complex Case Management activities supplement care coordination activities when a member has a complex issue requiring, for example, care from an out-of-state center of excellence or services from multiple specialists, and providers in multiple settings of care.

Members enrolled in Complex Case Management will receive close monitoring and intensive management. The medical management specialist will complete a comprehensive assessment of the member's conditions, identify barriers to care, and develop a comprehensive care plan which prioritizes goals. Intensive case management will include member education and guidance on self-management, communication with providers, and ongoing care planning from an interdisciplinary care team. The medical management specialist will connect members to a variety of programs and community resources and work with the member's providers. Member experience will also be collected to identify opportunities to improve the program.

To learn more about CCM Program or to refer a member to CCM Program, please call BCBSNM at 1-877-232-5518 (TTY:711)

Individual Case Management is described in the Utilization Management, Case Management, and Condition & Lifestyle Management section of the *BCBSNM Blues Provider Reference Manual*.

Referral Guidelines

- PCPs do not need to notify BCBSNM for referrals to contracted (in-network) specialists.
- Preauthorization is required from BCBSNM for services to non- contracted (out-of-network) specialists before the services are rendered.
- Services rendered to members by non-contracted providers without appropriate medical referrals or pre-authorizations will not be considered for reimbursement.
- Providers are encouraged to utilize BCBSNM's online Provider Finder, Printed Provider Directory, or to call Customer Service (**1-800-693-0663**) to identify contracted (in- network) providers and their contact information for referrals and care coordination.

Obstetrical/Gynecological Services
Female members can self-refer to contracted providers for routine OB/GYN services.

Family Planning Services
Members can self-refer to contracted and non-contracted family planning providers in the State of New Mexico. Family planning providers include PCPs, OB/GYNs, Planned Parenthood clinics, and Department of Health clinics.

Out–of-Network Medical Services
Non-Contracted, non-emergent medical services are not a covered benefit in most circumstances. All non-emergency services rendered by a non-network or non-contracted provider require preauthorization. Contracted providers must request preauthorization when referring members to non-contracted providers. Requests are reviewed to determine medical necessity, and whether the existing BCBSNM provider network is adequate to meet the member's needs in a timely manner.

Please contact BCBSNM's Utilization Management Department to coordinate care if needed.

Behavioral Health Referrals

If you have Medicaid managed care plan patients who need behavioral health services, please contact the BCBSNM behavioral health team at 1-800-693-0663.

Behavioral health referrals may be routine, urgent, or emergent and should be addressed as quickly as clinically indicated. If a member is in an emergency situation (e.g., actively suicidal), the provider may determine it is clinically indicated to call 911 or have an escort to an emergency services location.

The following are common indicators for a referral to the BCBSNM behavioral health team.

- Suicidal or homicidal ideation or behavior
- At risk of hospitalization due to a behavioral health condition
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement
- Trauma victims, including possible abuse or neglect
- Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities
- Request by member or a representative for behavioral health services
- Clinical status that suggests the need for behavioral health services
- Identified psychosocial stressors and precipitants
- Treatment compliance complicated by behavioral characteristics
- Behavioral, psychiatric, or substance abuse factors influencing a medical condition
- Victims or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect
- Non-medical management of substance abuse

- Follow-up to medical detoxification
- An initial PCP contact or routine physical examination indicates a substance abuse or mental health problem
- Prenatal visit indicates a substance abuse or mental health problem
- Positive response to questions or observation of clinical indicators or laboratory values that indicate substance abuse
- A pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions
- The persistence of serious functional impairment

Additionally, if a PCP would like to consult a psychiatrist or other behavioral health clinician with prescriptive authority in the use of psychopharmacotherapy and diagnostic evaluations, the PCP can contact the BCBSNM Provider Service Unit at 1-888-349-3706 directly for assistance.

Preauthorization

Unless otherwise prohibited by law, preauthorizations, also referred to as prior authorization, prior approval, or certification, are required for certain services before they are rendered. Authorizations are based on benefits as well as medical necessity, which are supported through clinical information supplied by requesting physicians. Preauthorizations can be obtained by using the Availity self-service portal, faxing a request to 888-530-9809 for Physical Health, 888-530-9809 for Behavioral Health or by calling the BCBSNM Medicaid program number at **1-877- 232-5518**.

Note: Medical necessity must be determined before an authorization number will be issued. Claims received that do not have a preauthorization number will be denied. Providers may not seek payment from the member when a claim is denied for lack of a preauthorization number. To be covered by the member's Medicaid managed care plan, all services to be furnished by out-of-network providers must be preauthorized by BCBSNM, in addition to meeting all other conditions of coverage. Preauthorization requirements are subject to change.

Additional Note Regarding Notification for Post-Stabilization Care following an Emergency Admission. Post-stabilization notification of inpatient admissions allows BCBSNM to evaluate the appropriateness of the setting of care and other criteria for coverage purposes. It aids in early identification of members who may benefit from specialty programs available from BCBSNM, such as Case Management, Care Coordination and Early intervention (CCEI), or Longitudinal Care Management (LCM). Notification also allows BCBSNM to assist the member with discharge planning. Thus, for stabilized members, BCBSNM requires notification of admission for post stabilization care services within one business day following treatment of an emergency medical condition. Failure to timely notify BCBSNM and obtain pre- approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services,

charges for which cannot be billed to the member pursuant to your provider agreement with BCBSNM. In the event of a claim denial that includes emergency care services, the provider is instructed to rebill the claim for the emergency services (including stabilization services), as well as post-stabilization care services for which BCBSNM may be financially responsible pursuant to 42 CFR Section 422.113(c), if any, for adjudication by BCBSNM. You can submit a notification for post stabilization care services through our secure provider portal via Availity, or by phone, using the number on the member's ID card. Timely post-stabilization notification of inpatient admission does not guarantee payment.

A list of services that require prior authorization can be found in the Program Overview Section.

Community Benefit

The Medicaid managed care plan is focused on facilitating access to care to meet members' needs along the continuum of their health care, including long-term care. BCBSNM has developed a means to identify members in the community who would benefit from long- term care services (to include medical, social, and behavioral health services). Members and/or their caregivers will be able to actively participate in the determination-of-need process and subsequent identification of available resources that would be aligned to address the identified needs. The objective is to provide the member as much autonomy in the process as possible while assuring that the member benefits from a comprehensive program that would enhance and/or maintain the member's well-being and safety.

BCBSNM provides the Community Benefit, as determined appropriate based on the comprehensive needs assessment. Eligible members have the option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit. The Self-Directed Community Benefit can be selected once the member has received 120 days of services through the Agency-Based Community Benefit. Services are generally intended to meet the needs of members with disabilities or who are vulnerable, frail, and/or chronically ill.

The Agency-Based Community Benefit is the consolidated benefit of Home and Community Based Services (HCBS) and personal care services that are available to eligible members meeting the nursing facility level of care. The services available include:

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

- Physical (PT)

The Self-Directed Community Benefit SDCB is certain Home and Community-Based Services that are available to eligible members meeting nursing facility level of care. Self-direction gives members the opportunity to have choice and control over how their Community Benefits services are provided. Members can also choose who provides the services and how much providers are paid in accordance with SDCB-approved rates.

Role of the Support Broker in the Self-Directed Community Benefit

Collaboration between BCBSNM and Support Brokers ensures that members receiving services through the SDCB are successful in the self- directed care delivery model.

Support Broker services provide a level of support to SDCB members that is unique to the member's individual needs and maximize the member's ability to self-direct. Support Broker agencies shall comply with all applicable federal and state rules and all HCA requirements for Support Broker services. These requirements include those detailed from time-to-time in the New Mexico Medicaid Managed Care Policy Manual and Medicaid Managed Care Services Agreement, both of which are available on HCA's website. Some of those requirements are excerpted below for ease of reference, but they are not exhaustive and may not be up-to-date. In the event of a conflict between the criteria described in this section and the New Mexico Medicaid Managed Care Policy Manual or Medicaid Managed Care Services Agreement, the Policy Manual and Medicaid Managed Care Services Agreement shall prevail.

Administrative Requirements

Support Broker Agencies shall meet the following minimum requirements:

- Have a current business license issued by the state, county or city government as required
- Maintain financial solvency
- Ensure that employees providing Support Broker services attend all State of New Mexico required orientation and trainings and demonstrate knowledge of and competent with the SDCB rules, policies and procedures, philosophy, financial management process and responsibilities; Comprehensive Needs Assessment (CNA), person centered planning and SDCB care plan development
- Adherence to all other training requirements as specified by the State
- Ensure all employees are trained and competent in the use of the FMA and Palco system
- Ensure all employees providing services under the scope of service defined herein are trained on how to identify and where to report critical incidents abuse, neglect, and exploitation
- Ensure compliance with the Caregivers Criminal History Screening as required in NMAC 7.1.9 for all employees

- Develop a quality management plan to ensure compliance with regulatory and program requirements and identification of opportunities for continuous QI.

Member Access to Support Brokers

It is important that members receiving services through the SDCB model of care have access to their individual Support Broker. The Support Broker agency shall ensure that SDCB members have access, this requirement includes the following:

- The Support Broker agency must maintain a physical presence in each region for which they are providing services
- The Support Broker agency must maintain a consistent way (i.e., phone, pager, email, fax) for the SCCB member to contact the Support Broker during typical business hours (Monday – Friday, 8 a.m. – 5 p.m.)
- The Support Broker agency must maintain a consistent way (i.e., phone, page, email, fax) for the SDCB member to contact the Support Broker during non-business hours to include weekends and holidays
- The Support Broker agency must provide a location to conduct confidential meetings with SDCB members when it is not possible to do so in the member's home. The alternative location must be convenient for the member and be compliant with ADA
- The Support Broker agency must maintain an operational fax machine at all times
- The Support Broker agency must maintain an operational email; address, internet access and the necessary technology to access SDCB related systems
- The Support Broker agency must maintain a local/state community resource manual
- Adhere to NMAC 8.302.1; Medicaid General Provider policies
- Adhere to NMAC 8.349.2.11 to ensure the development of a written grievance procedure
- Adhere to NMAC 8.304.12

In addition, the Support Broker agency shall maintain HIPAA compliant primary records for each member including, but not limited to:

- Current and historical SDCB care plan and budget
- Contact log that documents all contacts with the members
- Completed and signed quarterly visit forms
- BCBSNM, or other MCO when applicable, documentation of approvals and denials, including SDCB care plan and revision requests
- BCBSNM, or other MCO when applicable, correspondence (i.e., requests for additional information)
- Copy of current and all historical CNAS including the assessor's individual specific health and safety recommendations
- Notification of medical and financial eligibility

- SDCB budget utilization reports from the FMA
- Environmental modification approvals/denials
- LRI approval/denials
- Documentation of SDCB member and employee incident management training
- Copy of legal guardianship or representative papers and other pertinent legal designations where applicable
- Copy of the approval form for the AR and or AA
- Copies of completed EOR self-assessments

Minimum Requirements for Support Brokers

Per the New Mexico Managed Care Policy Manual, Support Broker agencies shall ensure that all employees providing Support Broker services to SDCB members meet the following minimum criteria:

- Be at least 18 years of age
- Possess a minimum of a bachelor's degree in social work, psychology, human services, counsel, nursing, special education, or a closely related field; and
- Have one year of supervised experience working with seniors and/or people living with disabilities; or
- Have a minimum of six (6) years of direct experience related to the delivery of social services to seniors and/or people living with disabilities
- Complete all required SDCB orientation and training courses; and
- Pass a nationwide caregiver criminal history screen pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. And 8.11.6 NMAC; and the National Sex Offender Registry

Conflicts of Interest

The Support Broker agency may not provide any other direct services for SDCB members that have an approved SDCB care plan and are actively receiving services in the SDCB. The Support Broker agency may not employ, as a Support Broker, any immediate family member or guardian of a member in the SDCB that is served by the Support Broker agency.

Critical Incident Management Responsibilities and Reporting Requirements

All incident reports for the HCBS and BH services population involving abuse, neglect, self- neglect, exploitation, environmental hazard, law enforcement involvement, and emergency services, must be reported to BCBSNM, Support Broker and/or APS. The Support Broker agency shall provide training to SDCB members related to recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards, and member deaths. This SDCB member training shall also include reporting procedures for SDCB employees, members/member representatives, and other designated individuals.

The Support Broker agency will also maintain documentation that each SDCB member has been trained on the critical incident reporting process. This member training shall include reporting procedures for SDCB members, employees, member representative, and/or other designated individuals. The Support Broker agency shall report incidents of abuse, neglect and/or exploitation as directed. The Support Broker agency will maintain a critical incident management system to identify, report, and address critical incidents. The Support Broker is responsible for follow-up and assisting the individual to help ensure health and safety when a critical incident has occurred.

Supports Provided to SDCB Members

Support Broker services provide a level of support to SDCB members that are unique to the member's individual needs and maximize the member's ability to self-direct. Supports provided to SDCB members include, but are not limited to, providing assistance and guidance to the members as follows:

- Education of members on how to use self-directed supports and services and provide information on program changes or updates
- Review, monitor and document progress of the member's care plan – this does not include approval of the member's care plan
- Assist in managing budget expenditures and complete and submit care plan revisions
- Assist with EOR functions including, but not limited to recruiting, hiring and supervising SDCB providers
- Assist with developing job descriptions for the SDCB direct support caregivers
- Assist with completing forms related to SDCB employees
- Assist with approving timesheets and purchase order or invoices for related goods, obtaining quotes for services and related goods as well as identifying and negotiating with vendors
- Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties
- Facilitate resolution of any disputes regarding payment to providers for services rendered
- Develop the care plan based on the SDCB budget amount determined by the annual CNA; and
- Assist in completing all documentation required by the FMA.

Support Broker services begin with the enrollment of the member in SDCB and continue throughout the member's participation in SDCB. Additionally, as part of SDCB transition and orientation, the Support Broker will:

- Conduct a transition meeting, including the transfer of program information prior to the SDCB enrollment meeting, for those members transitioning from the ABCB

- Assist members to transition from/to ABCB/SDCB
- Provide the SDCB member with information, support, and assistance during the annual Medicaid eligibility processes, including the annual CNA and the annual medical/financial eligibility processes
- Assist existing members with annual LOC requirements within 120 calendar days prior to the expiration of the LOC; and
- Schedule member enrollment meetings within five business days of notification and Support Broker agency selection. The actual enrollment meeting should be conducted within 30 calendar days. Enrollment activities include but are not limited to:
    - Ensure the member has received and reviewed the SDCB Rules and the Manual and provide responses to their questions and/or concerns
    - General overview of the SDCB including key agencies, their responsibilities and contact information
    - Discuss the annual Medicaid eligibility requirements and offer assistance in completing these requirements as needed
    - Discuss and review SDCB member roles and responsibilities
    - Discuss and review the EOR roles and responsibilities
    - Discuss and review the processes for hiring SDCB employees and contractors and required paperwork
    - Discuss and review the requirements, process, and paperwork for hiring LRIs as employees
    - Discuss and review the background check and other credentialing requirements for SDCB employees and vendors
    - Referral for accessing training for the Palco system; and to obtain information on the FMA
- Schedule the date for SDCB care plan meeting within 10 business days of the SDCB enrollment meeting
- Provide information on the SDCB care plan including covered services and related goods, and community resources available
- Assist the members in utilizing all program assessments including CNA, to develop each SDCB care plan
- Educate members regarding SDCB covered services, supports and related goods
- Assist member to identify resources outside SDCB that may assist in meeting his/her needs as identified in the CNA
- Assist the member with the application for LRI as employee process; submit the application to the MCO/UR
- Assist members with the environmental modification process
- Serve as an advocate for the SDCB member, as needed, to enhance his/her opportunity to be successful in the SDCB

- Assist the member with reconsiderations of services or related goods denied by the MCO/UR, submit documentations as required, and participate in MCO appeals process and State Fair Hearings as requested by the MCO, SDCB member or state
- Orient and educate Members on the program and utilization of self-directed supports, including individual member roles and responsibilities
- Assist members to transition to another Support Broker agency when requested. Support Broker transitions should occur within 30 calendar days of SDCB member's written request but may occur sooner based on the needs of the SDCB member. Support Broker agency transitions may not occur if there are less than 120 days remaining in the current LOC; and
- Assist members to identify and resolve issues related to the implementation of the SDCB care plan

Minimum Member Contact Requirements

Support Brokers will contact members in person or by telephone at least monthly for a routine follow-up. Support Brokers must meet in person at least once per quarter. At a minimum at least one visit per year must take place in the member's home.

At a minimum, during the monthly visits, the Support Broker will:

- Review member's spending pattern(s)
- Document progress of care plan implementation
- Document purchase of goods

At a minimum, during the quarterly visits, the Support Broker will:

- Document progress on implementation of the SDCB care plan
- Document use and effectiveness of the member's back-up plan as applicable
- Review member's spending pattern(s) for over/under utilization
- Document member's access to SDCB related goods requested, and approved, in the member's care plan
- Review and document any incidents or events that have impacted the member's health and welfare or ability to access and utilize service(s) approved in the member's care plan; and
- Identify other concerns or challenges stated by member or their representative/EOR

BCBSNM Oversight of Support Broker Agency

BCBSNM Care Coordination shall collaborate with the Support Broker agency to facilitate the member's transition into the SDCB and provide aid to the member and Support Broker in the development of a care plan that is person-centered and meets the member's health and safety needs.

At any time, BCBSNM may conduct an oversight audit of Support Broker agency compliance with the requirements described in this section and in the New Mexico Managed Care Policy Manual. These audits may be conducted in-person at the Support Broker agency's physical location, or the Support Broker agency may be asked to submit information demonstrating compliance to BCBSNM.

BCBSNM shall provide a minimum of 15 business days' notice to the Support Broker agency prior to any audit activity; all rights reserved. Exceptions to the 15 business day notification are made if BCBSNM believes or has reasonable suspicion that a member's health and safety may be in jeopardy or fraudulent activity has occurred.

Support Broker agency must submit the reports in the manner and timeframe outlined in the Table below. Support Broker agency may request training or guidance from BCBSNM on any report or requirement listed herein. Such training shall be provided within 10 business days unless a later date is requested by the Support Broker agency.

SDCB Support Broker Agency Reporting Requirements

Report	Frequency
Reports, including but not limited to, the following: • PHI disclosure • Material changes in provider guidelines • Catastrophic events (24-hour toll-free line and 8 a.m. to 5 p.m. hours of operation) • Grievances/appeals • Staff to member ratio • Operational staff compliance training reports Specific Support Broker operational reporting: • Total number of critical incidents • Total critical incidents reported in 24 hours • Total critical incidents not reported in 24 hours • Critical incident follow-up report Support Broker guidelines reporting: • Total number of members in program • Total number of new members • Total number of members that went through orientation • Total number of new members that went through initial training • Total number of members trained annually • Total number of members monthly contacts • Total number of initial home visits • Total number of quarterly home visits • Total number of budget reviews • Total number of back-up plans created • Total number of guide books distributed	Monthly – due first Friday of each month unless a holiday; if a holiday, report will be due the first business day immediately following the holiday.

Report	Frequency
• Total number of demographic or legal representative updated information • Report members unable to contact within 30 days • Total number of forums held • Additional information, reports, or data requested by regulatory agencies or determined by BCBSNM to be necessary for program or accreditation requirements	
Quarterly reports, including but not limited to, the following: • Current license/certificate renewals for staff and/or provider • Quality Management and Improvement evaluation/ audits • Additional information, reports, or data requested by regulatory agencies or determined by BCBSNM to be necessary for guidelines or accreditation requirements	Quarterly – due the 25th day of the month following the end of a quarter, unless a holiday or weekend; if a holiday or weekend, report will be due the first business day immediately following the holiday. **Quarter 1: January – March** Quarter 1 report due: April 25 **Quarter 2: April – June** Quarter 2 report due: July 25 **Quarter 3: July – September** Quarter 3 report due: October 25 **Quarter 4: October – December** Quarter 4 report due: December 28
Provide annual operational and program documents, including but not limited to, the following: • Responsibilities Annual Member satisfaction • List of program revisions • Program policies and procedures • Program description and work plan (Quality Management and Improvement Plan) • Program evaluation if applicable (Quality Management and Improvement Plan update for previous year) • Completed and ongoing Quality audits/studies/ initiatives • Training program • Disaster recovery policy and procedures • Compliance policy and procedures • Insurance cover page • Additional information, reports, or data requested by regulatory agencies or determined by BCBSNM to be necessary for program or accreditation requirements	Annually – due by January 30 of each year.

A grid showing a list of covered services for SDCB can be found in the Program Overview section.

Carelon Medical Benefits Management (Carelon) Preauthorization Program

Carelon Preauthorization Program

BCBSNM has contracted with Carelon Medical Benefits Management (Carelon) to provide certain utilization management services for the Medicaid managed care plan. Carelon is an independent company that provides specialty medical benefits management for BCBSNM.

Preauthorization Requirements

Effective for services furnished on and after January 1, 2024, BCBSNM requires preauthorization (for medical necessity) through Carelon for Medicaid managed care plan members:

- Advanced imaging/Radiology – only for members aged 18 and older

Select Outpatient Procedures (to utilize CPT Code list in the links below)

- Use the Carelon ProviderPortal for Pre & Post-Service Review

Contact Information

Carelon preauthorizations can be obtained using one of the following methods:

- The Carelon Provider Portal is available 24 hours per day, 7 days per week. After a one- time registration, you are able to initiate a case, check status, review guidelines, view authorizations/eligibility and more. The Web Portal is the quickest, most efficient way to obtain information.
- Providers can call the Carelon Contact Center at 800-859-5299 Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a.m. to noon, CT on weekends and holidays.
    - More specific program-related information can be found on the Carelon implementation website.

* Preauthorization determines whether the proposed service or treatment meets the definition of medical necessity under the applicable benefit plan. Preauthorization of a service is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions (if applicable), amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

Timeliness of Decisions & Notifications

The table below describes the timelines needed for review of routine and urgent/expedited preauthorization.

Routine Preauthorization	• **Decision** – To be rendered within 7 calendar days from receipt of request forservices. • **Durable Medical Equipment (DME)** – Decision to be rendered within 7 working days. • **Notification** – Provider shall be notified within one working day of making decision for authorization or denial of non-urgent (routine) care.

	• **Denial confirmation** – For non-urgent (routine) care,the member and provider will be given written or electronic confirmation for the decision within 2 business days.
Urgent/Expedited Preauthorization	• **Decision and notification** – Shall occur 24 hours afterreceipt of request. For denials of urgent care, the member and provider will be notified of the denial and that an expedited appeal can be initiated immediately. • **Denial confirmation** – The member and provider will begiven written or electronic confirmation for the decision within 2 working days of making the decision. The UM department will automatically file an appeal for the member on a denial of an expedited preauthorization review. The denial letter also directs the member on how to file an appeal.

A preauthorization or concurrent decision about whether BCBSNM will cover future behavioral or medical care can be a "standard decision" that is made within the standard time frame (typically within 7 calendar days) or an expedited decision that is made more quickly (typically within 24 hours).The time frames for preauthorization and/or concurrent reviews may be extended by BCBSNM to the extent allowed by law, program requirements, and/or accreditation rules.

A member, member's authorized representative, or provider can ask for an expedited decision only if the member or the member's provider communicates to BCBSNM the reasons that waiting for a standard decision could seriously jeopardize the life or health of the member, affect the member's ability to regain maximum function, or subject the member to severe and intolerable pain. If the member's provider indicates that an expedited decision is indicated, BCBSNM will automatically expedite its review process.

If BCBSNM does not render a preauthorization decision within the time frame provided by the New Mexico Prior Authorization Act, authorization will be deemed granted.

Clinical Review Criteria

The Utilization Management/Case Management Committee reviews and approves the utilization management processes and clinical review criteria used to determine medical necessity. BCBSNM currently uses MCG Care Guidelines, clinical protocols, BCBSNM Medical Policy, and screening criteria to screen preauthorization and concurrent review requests. For more information, contact the UM Department at 1-877- 232-5518.

For members who are receiving home- and community-based services (HCBS), their Care Coordinator will include all HCBS in the member's Individualized Care Plan and Individual Service Plan (ISP). Care Coordinators may include services up to certain levels without

requiring utilization review. BCBSNM determines reasonable service levels for members receiving HCBS, which the Care Coordinators use as a guide for determining whether or not the member's service plan requires utilization review. If the plan is within the guidelines, the Care Coordinator will submit the care plan to the utilization management department as a notification only, easing the administrative burden for providers who have members services included in the plan. The utilization review department will notify the providers, based on the members Care Coordination plan, of the authorization for services eliminating the need for the provider to request services individually that are included in the HCBS care plans.

Our licensed behavioral health clinicians base authorization decisions on medical necessity as defined by the State of New Mexico Human Services Department and Medical Assistance Division as further informed by other resources, including, but not limited to MCG Care Guidelines, Medicaid managed care plan Behavioral Health Level of Care Guidelines and American Society of Addiction Medicine (ASAM).

For more information about behavioral health services, contact the BCBSNM Provider Service Unit at 1-888- 349-3706 directly for assistance.

BCBSNM may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to participating providers via the BCBSNM website and Blue Review provider newsletter. Clinical Practice Guidelines are published in the *Blues Provider Reference Manual* and are located on BCBSNM's website at www.bcbsnm.com.

Utilization Management Appeals

Member appeals regarding authorization or termination of coverage for a health care service should be mailed or faxed as follows:

- To file a grievance, call **1-866-689-1523**, or write to:
  Blue Cross and Blue Shield of New Mexico
  ATTN: Medicaid Appeals and Grievances
  P.O. Box 660717
  Dallas, TX 75266-0717
  Fax: 1-888-240-3004
- To file an appeal, call **1-866-689-1523**, email GPDAD GPDAG@bcbsnm.com use Availity® Essentials or write to:
  Blue Cross and Blue Shield of New Mexico
  ATTN: Medicaid Appeals and Grievances
  P.O. Box 660717
  Dallas, TX 75266-0717
  Fax: 1-888-240-3004

For an afterhours request for an appeal or grievance, call: 1-877-232-5520

Health Risk Assessment

Attempts compliant with HCA requirements will be made to conduct Health Risk Assessments (HRAs) for new-to-Medicaid members within 30 days of enrollment and for members with a change in condition who are identified through our data mining process or through a referral from providers. The purpose of the HRA is to:

- Introduce the Medicaid managed care plan to the member,
- Obtain basic health and demographic information about the member,
- Assist in determining the member's risk stratification and indicate the level of Care Coordination needed by the member, and
- Determine the need for a nursing facility level of care assessment.

Completion of the HRA is the responsibility of BCBSNM in collaboration with the member and/or the member's caregiver/POA.

Disease Reporting

As required by the State of New Mexico, Human Services Department (HSD), all participating providers are required to report all applicable diseases as listed in the Notifiable Diseases/Conditions in New Mexico. Any confirmed or suspected diseases require immediate reporting by telephone to the Office of Epidemiology at 505-827-0006.

All reports must include the following:

- The disease or problem being reported
- Patient's name, date of birth, age, gender, race/ethnicity, address, and telephone number
- Physician's (or laboratory) name, NPI number, and telephone number
- Other conditions of public health importance

Condition Management/Disease Management Programs

The Condition Management/Disease Management (DM) programs include but are not limited to:

- Asthma for adults and children
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Hypertension
- Obesity
- Depression
- Alcohol and substance abuse disorders
- Anxiety and panic disorders

- Bipolar disorders
- Eating disorders
- Schizophrenia and other psychotic disorders
- Attention Deficit and Hyperactivity Disorder (ADD/ADHD)

Member participation is voluntary, and they receive:

- Telephonic health coaching,
- Assessment of educational needs,
- Notice of identified gaps in care,
- Psychosocial needs and assessment of readiness to change, and
- Hard copy educational information to enhance self- management of their condition.

To increase compliance with medications and other treatment regimens as ordered by their treating physicians, members are encouraged to track their own symptomology and vital signs. The treating provider is an integral part of the DM program.

In addition, Special Beginnings® prenatal care management is included to reduce the risk of premature babies. Any member who is an expectant mother with maternity coverage may enroll in Special Beginnings at no cost. It includes a health risk assessment; educational materials; a 24-hour Nurseline (1-877-213-2567); and OB case management for high and low risk pregnancies. For additional information about Special Beginnings, call 1-888-421-7781.

BCBSNM also has a postpartum expansion program wherein care coordination is provided to postpartum mothers at risk for maternal mortality.

Care Coordination

Care Coordination is a BCBSNM service to assist members (and their families) with multiple, complex, cognitive, behavioral, physical, social, or special health care needs. The care is member-centered, family-focused (when appropriate), and culturally and linguistically 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 physical health and behavioral health Care Coordinators to provide these services. Care Coordination works closely with participating providers to develop a Member Care Plan designed to meet member needs. Providers' participation in, and cooperation with Care Coordination activities, are expected conditions of participation with BCBSNM. Providers are expected to participate in this process to help see that the member's needs are being met as part of the Health Care Continuum to include any changes in the member's status. This process will include, but is not limited to, coordination with other providers, subcontractors, or HCA contractors. The Care Coordination team also works closely with the Community Social Services team to ensure that non-Medicaid benefit services are accessible in order to improve opportunities for desirable health outcomes.

Care Coordination helps to better identify the member's physical health, behavioral health, and social needs and that access to the necessary services is provided and coordinated by:

- Performing a telephonic HRA upon initial enrollment to BCBSNM and when the member experiences a change in condition
- Providing member access to the BCBSNM Care Coordination unit for assistance and reviewing for potential triggers to a higher risk stratification level when the member is initially stratified into the low-risk category during the HRA process
- Providing a designated Care Coordinator who is primarily responsible for coordinating the member's health care services for members who are risk stratified as Moderate or High Risk
- Completion of a Comprehensive Needs Assessment (CNA) for members who are risk stratified as Moderate or High Risk, on an annual or semi-annual basis respectively
- Development of a Comprehensive Care Plan (CCP) in coordination with the member, their caregiver, and their providers based on the results of the CNA
- Ensuring access to providers who are experts for members with special needs
- Assisting with coordination of medical and behavioral health services
- Assisting members who select the Self-Directed Community Benefit in developing their Comprehensive Care Plan (CCP) and budget, hiring their own caregivers, and ensuring that their provider services remain within their budget on an ongoing basis
- Providing chronic disease management education and services
- Assisting the member in accessing social resources that are not covered benefits
- Interfacing and collaborating with members' Complex Case Managers when applicable. The Care Coordinator may also refer the member to Case Management as needed; and
- Assigning a Care Coordinator who speaks the Member's preferred language if he/she is a non-English speaking member
- Working with Community Health Workers who help members with Social Determinants of Health such as housing, food and transportation

For questions regarding the Care Coordination services of BCBSNM, contact Case Management Programs at **1-877-232-5518, option 3, option 2**.

Cooperation

Participating providers must comply and cooperate with all Medicaid managed care plan Medical Management policies and procedures as well as the Care Coordination, Quality Assurance, and Performance Improvement programs, including but not limited to coordination with BCBSNM Care Coordinators and/or other providers, subcontractors, or HCA contractors. In addition, participating providers must cooperate with BCBSNM and requests from the External Quality Review Organization (EQRO) retained by HSD/MAD,

HealthInsight New Mexico, as well as any medical review agencies authorized by HCA to perform medical review or investigations.

Provider One Call

In order to help providers and their office staff with the care coordination of our members, we offer a Provider One Call unit. This program is staffed by highly trained Health Coordinators who assist providers on a range of issues, including:

- Locating contracted specialty services
- Locating non-contracted specialty providers where a service gap exists within the state of NM
- Coordinating physical health, behavioral health, and social services for Medicaid managed care plan members.

For example, if a PCP is concerned about the respiratory status of a member and has not been able to find a pulmonologist to see the member, by calling our One-Call Unit they can ask for our assistance to identify, make an appointment with, and arrange transportation for the member to see a pulmonologist. BCBSNM will also help the PCP receive a report of the specialist's findings and recommendations after the appointment.

The Health Coordinators also reach out to behavioral health providers on behalf of a physical health provider who needs assistance in finding a service for one of his or her members.

This is a service unit meant to handle administrative issues for purposes of, assisting providers in coordinating care for members. If the member is identified as having a social need, the provider can also call the One-Call Unit for assistance and the Community Social Care Services Department for resource assistance. The service greatly reduces the provider's administrative burden while helping to ensure members receive timely access to all needed care.

Our Provider One Call can be reached at **1-855-610-9833**.

Long-Term Care

As part of the Medicaid managed care plan, BCBSNM provides Home and Community Based Services and personal care services that are available to members meeting the nursing facility level of care.

BCBSNM's goal is to work with providers and community resources to identify and facilitate the transition and/or implementation of services for our members who otherwise would qualify for placement in a long- term care (LTC) facility at a nursing facility level of care. The intent is to provide an alternative living arrangement by providing personal care and other appropriate services to help these members maintain as independent a lifestyle as possible, safely in the member's preferred place of residence.

Providers with a member who is either currently institutionalized but has expressed a desire to live in the community or is a candidate for long-term care/nursing facility placement but with some assistance could remain in their preferred place of residence, should contact one of BCBSNM's care coordinators for assistance.

BCBSNM will work with providers, LTC providers and facilities, and other key stakeholders to coordinate a safe and sustainable transition that best meets the needs of the member.

Clinical Guidelines

Preventive and clinical practice guidelines are based on the health needs and opportunities forimprovement identified as part of the Quality Improvement Program. Whenever possible, BCBSNM adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions as well as state- wide collaborative and/or a consensus of healthcare professionals in the applicable field.

These guidelines are developed using the following criteria:

- Valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of the Members;
- Are adopted in consultation with Contract Providers; and
- Are reviewed and updated every two (2) years.
- Disseminate the guidelines to all affected Contract Providers and, upon request, to Members; and
- Ensure that decisions for Utilization Management, Member education, coverage of services, and other applicable areas are consistent with the guidelines.

Adult Preventive Care

- U.S. Preventive Services Task Force Recommendations
- Adult Immunization Schedule, Center for Disease Control and Prevention (CDC)

Cardiac Conditions

- Diagnosis and Evaluation of Chronic Heart Failure
- ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults

Disease Management (Diabetes, Asthma and Chronic Obstructive Pulmonary Disease (COPD))

- Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung, andBlood Institute
- Guidelines for the Diagnosis and Management of Asthma
- Standards of Medical Care in Diabetes
- Executive Summary: Standards of Medical Care in Diabetes— 2010
- Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease

(COPD)
- Clinical Practice Guidelines for Chronic Obstructive Pulmonary Disease (COPD)

Behavioral Health

Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD)

- "Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder". (2004) American Psychiatric Association
- "Guideline Watch: Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder" (2009) American Psychiatric Association
- "VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder" (2017) Department of Veterans Affairs/Department of Defense
- "Post-traumatic Stress Disorder" National Institute for Health and Care Excellence

Alzheimer's and Other Dementias

- "Treatment of Patients with Alzheimer's Disease and Other Dementias 2nd edition" (2007) American Psychiatric Association
- "Guideline Watch: Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias" (2014) American Psychiatric Association
- "The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia" (2016) American Psychiatric Association
- "Practice Guideline Update Summary: Mild Cognitive Impairment" (2018) American Academy of Neurology
- "Dementia: Assessment, Management and Support for People Living with Dementia and Their Carers" (2018) National Institute for Health and Care Excellence
- "Neuropsychological Evaluation in Adults" (2019) American Family Physician
- "APA Guidelines for the Evaluation of Dementia and Age Related Cognitive Change" (2021) American Psychological Association
- "Objective subtle cognitive difficulties predict future amyloid accumulation and neurodegeneration" (2020) Neurology

Attention-Deficit/Hyperactivity Disorder (ADHD)

- "Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents" (2019) American Academy of Pediatrics
- "Attention Deficit Hyperactivity Disorder: Diagnosis and Management" (2018) National Institute for Health and Care Excellence
- "Society for Developmental and Behavioral Pediatrics Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Complex Attention-Deficit/Hyperactivity Disorder" (2020) Journal of Developmental & Behavioral Pediatrics

Autism

- "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorder" (2014) American Academy of Child and Adolescent Psychiatry
- "Autism Spectrum Disorder in Adults: Diagnosis and Management" (2012) National Institute

for Health and Care Excellence

- "Practice Parameter: Screening and Diagnosis of Autism" (2000) American Academy of Neurology
- "Early Screening of Autism Spectrum Disorder: Recommendations for Practice and Research" (2015) American Academy of Pediatrics
- "Identification, Evaluation, and Management of Children with Autism Spectrum Disorder" (2020) American Academy of Pediatrics

Bipolar

- "Practice Guideline for the Treatment of Patients with Bipolar Disorder 2nd Edition" (2002) American Psychiatric Association
- "Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder, 2nd Edition" (2005) American Psychiatric Association
- "Evidence-Based Guidelines for Treating Bipolar Disorder: Revised Third Edition Recommendations from the British Association for Psychopharmacology" (2016) Journal of Psychopharmacology
- "Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder" (2018) Bipolar Disorders

Depression

- "Practice Guideline for the Treatment of Patients with Major Depression Disorder 3rd Edition" (2010) American Psychiatric Association
- "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders" (2007) American Academy of Child and Adolescent Psychiatry
- "VA/DoD Clinical Practice Guideline for The Management of Major Depressive Disorder" (2022) Department of Veterans Affairs/Department of Defense
- "Nonpharmacologic Versus Pharmacologic Treatment of Adult Patients With Major Depressive Disorder: A Clinical Practice Guideline from the American College of Physicians" (2016) American College of Physicians
- "Depression in Adults: Treatment and Management" (first published 2009, updated 2022) National Institute for Health and Care Excellence
- "Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts" (2019) American Psychological Association
- "Depression in Children and Young People: Identification and Management" (2019) National Institute for Health and Care Excellence
- "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (2018) American Academy of Pediatrics
- "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management" (2018) American Academy of Pediatrics
- "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Major and Persistent Depressive Disorders" (2023) American Academy of Child and Adolescent Psychiatry

Eating Disorders

- "Practice Guideline for the Treatment of Patients with Eating Disorders Third Edition" (2006) American Psychiatric Association
- "Guideline Watch: Practice Guideline for the Treatment of Patients with Eating Disorders Third Edition" (2012) American Psychiatric Association
- "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders" (2015) American Academy of Child and Adolescent Psychiatry
- "Eating Disorders: Recognition and Treatment" (May 2017) National Institute for Health and Care Excellence
- "Identification and Management of Eating Disorders in Children and Adolescents" (2021) American Academy of Pediatrics
- "Practice Guideline for the Treatment of Patients with Eating Disorders Fourth Edition," (2023) American Psychiatric Association

General

- "Practice Guidelines for the Psychiatric Evaluation of Adults" (2015) American Psychiatric Association
- "APA Guidelines on Evidence-Based Psychological Practice in Health Care" (2021) American Psychological Association
- "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" (1997) American Academy of Child and Adolescent Psychiatry
- "Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers" (2010) American Academy of Child and Adolescent Psychiatry
- "Clinical Update: Child and Adolescent Behavioral Health Care in Community Systems of Care" (2023) American Academy of Child and Adolescent Psychiatry
- "Clinical Update: Collaborative Mental Health Care for Children and Adolescents in Pediatric Primary Care" (2023) American Academy of Child and Adolescent Psychiatry
- "Prevention and Treatment of Anxiety, Depression, and Suicidal Thoughts and Behaviors Among College Students" (2021) Substance Abuse and Mental Health Services Administration (SAMHSA)
- "Psychosocial Interventions for Older Adults With Serious Mental Illness" (2021) SAMHSA
- "Psychiatric Assessment and Diagnosis in Older Adults" (2009) Geriatric Psychiatry

Generalized Anxiety and Panic Disorders

- "Practice Guideline for the Treatment of Patients with Panic Disorder Second Edition" (2009) American Psychiatric Association
- "Clinical Practice Review for GAD" (2015) Anxiety and Depression Association of America
- "Diagnosis and Management of Generalized Anxiety Disorder and Panic Disorder in Adults" (2015) American Family Physician
- "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders" (2020) American Academy of Child & Adolescent Psychiatry
- "VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder" (2023) Department of Veterans Affairs/Department of Defense

Obsessive Compulsive Disorder

- "Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder" (2007) American Psychiatric Association
- "Guideline Watch: Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder" (2013) American Psychiatric Association
- "Clinical Practice Review for OCD" (2015) Anxiety and Depression Association of America
- "Obsessive-Compulsive Disorder: Diagnosis and Management" (2015) American Family Physician
- "Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder" (2012) American Academy of Child and Adolescent Psychiatry
- "Deep brain stimulation for chronic, severe, treatment resistant obsessive-compulsive disorder in adults" (2021) National Institute for Health and Care Excellence (NICE)
- "Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology" (2014) Journal for Psychopharmacology

Schizophrenia

- "Practice Guideline for the Treatment of Patients with Schizophrenia Third Edition" (2021) American Psychiatric Association
- "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia" (2013) American Academy of Child and Adolescent Psychiatry
- "Psychosis and Schizophrenia in Adults: Prevention and Management" (2014) National Institute for Health and Care Excellence
- "Evidence-based guidelines for the pharmacological treatment of schizophrenia: Update recommendations from the British Association for Psychopharmacology" (2019) Journal of Psychopharmacology
- "Psychosis and schizophrenia in children and young people; recognition and management" (updated 2016) National Institute for Health and Care Excellence
- "VA/DoD Clinical Practice Guidelines: Management of First-Episode Psychosis and Schizophrenia (SCZ)" (2023) Department of Veterans Affairs/Department of Defense

Substance Use Disorders
- General

- "Practice Guideline for the Treatment of Patients with Substance Use Disorders 2nd Edition" (2006) American Psychiatric Association
- "Guideline Watch (April 2007): Practice Guideline for the Treatment of Patients with Substance Use Disorders 2nd Edition" (2007) American Psychiatric Association
- "VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders" (2021) Department of Veterans Affairs/Department of Defense
- "Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide" (2014) National Institute on Drug Abuse
- "TIP 31 Screening and Assessing Adolescents for Substance Use Disorders" (2012) Substance Abuse and Mental Health Services Administration (SAMHSA)
- "TIP 42 Substance Abuse Treatment for Persons with Co-occurring Disorders" (2013, revised 2020) SAMHSA

- "Treatment of Stimulant Use Disorders" (2020) SAMHSA

- Opioid

- "The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update" (2015) American Society of Addiction Medicine
- "Medications for Opioid Use Disorder TIP 63" (2018, revised 2019) SAMHSA
- Pain Management Best Practices inter-Agency Task Force Report (2019) U.S. Department of Health and Human Services

- Alcohol

- "Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder" (2018) American Psychiatric Association
- "Medication for the Treatment of Alcohol Use Disorder: A Brief Guide" (2015) SAMHSA
- "Alcohol Screening and Brief Intervention for Youth, A Practitioner's Guide-produced in collaboration with the American Academy of Pediatrics" (Revised 2015, Reprinted 2019) National Institute on Alcohol Abuse and Alcoholism
- "The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management" (2020) American Society of Addiction Medicine

Suicidal Behaviors

- "VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide" (version 2.0, 2019) Department of Veterans Affairs/Department of Defense
- "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth" (2020) SAMHSA
- "Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors" (2010) American Psychiatric Association

Telehealth

- "Best Practices in Videoconferencing-Based Telemental Health" (2018) American Psychiatric Association and American Telemedicine Association
- "General Provider Telehealth and Telemedicine Tool Kit" (2020) Centers for Medicare and Medicaid Services
- "Telepsychiatry Toolkit" (2020) American Psychiatric Association
- "Practice Guidelines for Telemental Health with Children and Adolescents" (2017) American Telemedicine Association
- "Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders" (2021) SAMHSA
- "Clinical Update: Telepsychiatry with Children and Adolescents" (2017) American Academy of Child and Adolescent Psychiatry

Gender Diversity

- "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" (2015) American Psychological Association
- "Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents" (2018)

- "Supporting and Caring for Transgender Children - Human Rights Campaign Foundation" (2016) American College of Osteopathic Pediatricians and American Academy of Pediatrics

Multicultural Counseling

- "Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality" (2017) American Psychological Association
- "The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults: Guideline V. Assessment of Cultural Factors" (2016) American Psychiatric Association
- "Cultural Diversity and Mental Health: Considerations for Policy and Practice" (2018) Frontiers Public Health

Electroconvulsive Therapy

- "American Psychiatric Association: Practice Guideline for the Treatment of Patients With Major Depressive Disorder," Pages 44-46(2010) American Psychiatric Association

Reproductive, Prenatal and Postpartum Mental Health

- "Resource Document on Psychiatric Aspects of Infertility" (2019) American Psychiatric Association
- "Guidance on Qualifications for fertility counselors: a committee opinion" (2021) Fertility & Sterility, Practice Committee and Mental Health Professionals Groups of the American Society for Reproductive Medicine
- "Recommendations for practices using gestational carriers: a committee opinion" (2022) Fertility & Sterility Practice Committee of the American Society for Reproductive Medicine

Trauma-Informed Care

- "TIP 57: A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services" (2014) SAMHSA
- "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach " (2014) SAMHSA
- "Key Ingredients for Successful Trauma-Informed Care Implementation" (2016) SAMHSA
- "Stress & Trauma Toolkit for Treating Historically Marginalized Populations in a Changing Political and Social Environment" American Psychiatric Association

Pharmacy

- American Society of Health-System Pharmacists' Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System

Community Reintegration & Support

- The Guide to Community Preventive Services
- Clinical Guidelines for Seniors Falls Prevention
- Management of Adult Stroke Rehabilitation Care
- Clinical Practice Guidelines for Quality Palliative Care

Long-Term Care Residential Care Coordination

- Transitions of Care in the Long-term Care Continuum

Dental

- Oral hygiene Care for Functionally Dependent and Cognitively Impaired Older Adults

6 – Provider Performance Standards and Compliance Obligations

Provider Compliance with Standards of Care

Participating providers must comply with all applicable laws and licensing requirements. Covered services must be furnished in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Standards must be complied with, which include but are not limited to:

- Guidelines established by the Centers for Disease Control and Prevention (or any successor entity)
- All federal, state, and local laws regarding the conduct of their profession

Policies and procedures must also be complied with regarding:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Preauthorization requirements and time frames
- Credentialing requirements
- Care Management, Care Coordination and Condition Management/Disease Management Program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of the Medicaid managed care plan
- Providing treatment to patients at the appropriate level of care
- Maintaining a collegial and professional relationship with BCBSNM personnel and fellow participating providers
- Providing equal access and treatment to all members

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

Such actions shall not be considered non-supportive of the Medicaid managed care plan and BCBSNM will never adopt any policy or practice that prohibits providers from advising members about their health status, medical care, or treatment options.

Primary Care Physician (PCP) Responsibilities

PCP responsibilities include the following:

- Assure access to care 24 hours a day, 7 days a week
- Coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy, including all behavioral health and long-term care providers
- Maintenance of current medical records for the member, including documentation of services provided to the member by the PCP and specialty or referred service
- Ensuring the provision of services under the EPSDT program is based on the periodicity schedule for members under age 21
- Vaccinating members in their office and not referring members elsewhere for immunizations
- Ensuring the member receives appropriate preventive services for their age group
- Assisting with a member's HRA completion
- Ensuring that care is coordinated with other types of health and social program providers
- Governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed
- Governing how coordination with the PCP and hospitalists will occur when an individual with a special health care need is hospitalized
- Identify and report Critical Incidents as defined in the Provider Performance Standards and Compliance Obligations section of this manual
- Participating in the member's care planning process when requested by the BCBSNM Care Coordinator
- Ensuring that a member receives appropriate prevention services based on the Member's age group, self-identified gender, and risk factors.
- Ensuring that a member is referred to a behavioral health provider based on the following indicators:
    - Suicidal/homicidal ideation or behavior
    - At risk of hospitalization due to a behavioral health condition
    - Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility
    - Trauma victims
    - Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities
    - Request by member or representative for behavioral health services

  - Clinical status that suggests the need for behavioral health services
  - Identified psychosocial stressors and precipitants
  - Treatment compliance complicated by behavioral characteristics
  - Behavioral and psychiatric factors influencing medical condition
  - Victims or perpetrators of abuse and/or neglect and members suspected of being subject to abuse and/or neglect
  - Members suspected of being subject to abuse and/or neglect
  - Non-medical management of substance abuse
  - Follow-up to medical detoxification
  - An initial PCP contact or routine physical examination indicates a substance abuse problem
  - A prenatal visit indicates substance abuse problems
  - Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse
  - A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other behavioral health conditions and/or the persistence of serious functional impairment
  - The persistence of serious functional impairment associated with a primary BH disorder.
- Ensuring that care is coordinated with a member's behavioral health provider when the member has given written permission to do so.

Home Health Agency Documentation

Home Health Agencies are required to document face-to-face encounters as indicated in the Medical Assistance Program Manual Supplement 11-07. Also visit the Centers for Medicare and Medicaid Services' Home Health Agency Center website.

Nursing Facility Requirements

Nursing Facility providers must meet the following requirements:

- Nursing Facility providers shall promptly notify BCBSNM of:
  - A member's admission or request for admission to the Nursing Facility regardless of payer source for the Nursing Facility stay
  - A change in a member's known circumstances
  - A member's pending discharge
- Nursing Facility providers shall also notify the member and/or the member's Representative in writing prior to discharge in accordance with State and federal requirements
- Nursing Facility providers meet CMS nurse staffing levels in Nursing Facilities
  - Minimum nurse staffing levels of 3.48 hours per resident day including .55 hours per resident day for a registered nurse for and 2.45 hours per resident day for a nurse aide
  - An RN on duty 24 hours a day, 7 days a week

Laws Regarding Federal Funds

Payments that participating providers receive for furnishing services to members are, in whole or part, from federal funds. Therefore, participating providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84,
- Age Discrimination in Employment Act of 1975 as implemented by 45 CFR part 91,
- Rehabilitation Act of 1973, and
- The Americans with Disabilities Act.

Provider Disclosure Regarding Certain Criminal Convictions, Ownership and Control Information

Before entering into or renewing a Medicaid provider contract, within 35 days after a change in ownership, or at any time on request, contracted providers are required to complete, sign, and return the Provider Disclosure form regarding certain criminal convictions, ownership and control information. The Provider Disclosure form can be found in the Attachment Section at the end of this manual and on our website and should be submitted with the application packet to contract for the Medicaid managed care plan in addition to other times described herein.

Providers are required to collect and maintain disclosure information regarding certain criminal convictions, ownership and control information as described in this Section and set forth on the form.

Sanctions under Federal Health Programs and State Law

Participating providers certify that to the best of their knowledge neither they nor their employees or subcontractors have been:

(a) Charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (federal, state, or local) contract or subcontract

(b) Listed by a federal governmental agency as debarred

(c) Proposed for debarment or suspension or otherwise excluded from federal program participation

(d) Convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust (including but not limited to the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, tax evasion, or receiving stolen property); or

(e) Within a three-year period preceding the date of this Agreement, had one or more public transactions (federal, state, or local) terminated for cause or default

(f) Not excluded from participation from Medicare, Medicaid, federal health care programs, or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7 and other applicable federal statutes

Participating providers certify that public sources of information are checked to confirm that its vendors have not been:

(a) Listed by a federal governmental agency as debarred; or

(b) Proposed for debarment or suspension or otherwise excluded from federal program participation.

Participating providers must disclose to BCBSNM whether the provider, staff member, or subcontractor has any prior violation, fine, suspension, termination, or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of New Mexico; the federal government; or any public insurer. BCBSNM must be notified immediately if any such sanction is imposed on a participating provider, staff member, or subcontractor.

Note: Federal Exclusion website: http://oig.hhs.gov/exclusions/index.asp

Provider Preventable Conditions

BCBSNM complies with regulations issued by the Centers for Medicare and Medicaid Services, under Section 2702 of the Affordable Care Act, which calls for non-payment for provider preventable conditions (PPCs) including health care acquired conditions (HCACs) and Never Events. BCBSNM will not pay claims for members receiving care related to HCACs and Never Events in any health care setting.

See Section 6.5 Facility and Ancillary Providers in the Commercial portion of this manual as well as Supplement 12-05 on the New Mexico Human Services website for a description of HCACs and Never Events.

Cultural Competency and Cultural Humility

Participating providers are required to complete the computer-based training on Cultural Competency annually, that can be located in the Provider Section of our website at bcbsnm.com under Network Participation/Medicaid. Select the Provider Training tab to display the training link. The provider training incorporates elements of the National Culturally and Linguistically Appropriate Services (CLAS) standards. Additional information related to CLAS standards can be found at: https://thinkculturalhealth.hhs.gov/

Once providers complete the training, an attestation of completion is reported from the online provider training tool, and the attestation date added to the provider data system so it is reflected in the online provider directory.

Providers should be aware of and appreciate a Member's customs, values, socioeconomic considerations, and beliefs and incorporate them into the their screen assessments and

treatments for all Member/family interactions in an attempt to increase the quality of health care services and improve health outcomes. Cultural Humility is a necessary component of cultural competence, including recognition of power dynamics and imbalances, and a desire to fix those power imbalances and to develop partnerships with people and groups who advocate for others. Cultural competency and humility involves the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes. Providers must take into consideration the member's racial and ethnic group, including their language, histories, traditions, beliefs, and values when rendering or referring members for medical services.

Participating providers are also encouraged to respect and value human diversity and make a good faith, reasonable effort to utilize minority, women, and disabled owner business enterprises in the performance of services provided under the Medicaid managed care plan.

Participating providers are expected to provide an interpreter when the member does not speak or understand the language that is being spoken.

BCBSNM provides members with access to a bilingual customer service staff, a Language Interpreter Line, and Relay New Mexico - a teletypewriter TTY service. All of these numbers are found on the back of each member's ID card as well as in the Contact List.

Critical Incident Management

All allegations of abuse, neglect (including self-neglect), exploitation, incidents involving emergency services, hospitalization, expected or unexpected deaths, environmental hazards, and any incidents involving law enforcement, and elopement/missing must be reported to HCA by use of the Critical Incident Reporting system.

Incident Reports are submitted to HCA for each recipient through the NMHCA Critical Incident Management website: https://criticalincident.hsd.state.nm.us

Members' health and wellbeing are of utmost importance. Therefore, BCBSNM expects all CIRs due from providers to be filed accurately, completely and timely.

Reporting abuse, neglect, or exploitation to HCA does not relieve a provider of mandated reporting requirements to Adult Protective Services (APS) and/or to other applicable agencies.

Please refer to NMAC for further requirements and information regarding CIR reporting. All agencies must follow the state and federal regulations including but not limited to NMAC 7.1.13, NMAC 7.1.14, and NMAC 8.308.21

Providers that do not comply with incident reporting requirements are in violation of State statute and Medicaid regulations and may be sanctioned up to, and including, termination of their provider agreements by BCBSNM or by the HCA Medical Assistance Division.

Reporting Suspected Abuse, Neglect and Exploitation of Members

If providers suspect abuse, neglect, or exploitation of members, they are mandated by law to contact Adult Protective Services or Children, Youth and Families Department at:

- Adult Protective Services Statewide Central Intake
  Telephone: 1-866-654-3219
  Fax: 1-855-414-4885

- Children, Youth, and Families Department
  Telephone: 1-855-333-7233

And/or contact law enforcement or the appropriate tribal entity.

Reporting Abuse and Critical Incidents

In addition, providers are required to report all allegations of suspected abuse, neglect, or exploitation and critical incidents regarding the Medicaid managed care plan members to BCBSNM by calling any of the following numbers:

- (Preferred) Case Management (CM) Programs: 1-800-325- 8334
- Provider One Call: 1-855-610-9833
- Provider Customer Service: 1-888-349-3706

BCBSNM will contact, as appropriate, any or all of the following agencies for assistance or intervention:

- Adult Protection Services
- Child Protection Services: CYFD Statewide Central Intake, law enforcement, or appropriate tribal entity
- New Mexico HCA, Medical Assistance Division Quality Bureau
- New Mexico Ageing and Long-Term Services Department/Elderly and Disability Services Division

Reporting to, or action taken by, BCBSNM does not relieve providers of their other reporting obligations, such as to Adult Protective Services or to CYFD.

If there appears to be an issue of an urgent or emergent nature which endangers a member, the health care professional should report the incident to the Child Protective Services or Adult Protective Services after calling 911.

Notwithstanding any provision of this manual, it remains the responsibility of all participating health care professionals to independently know and comply with their reporting obligations per statute, regulation, and/or applicable licensing board rules regarding incidents of child, adult, or elder abuse or neglect. BCBSNM reports these incidents as it may be required by HCA or by law.

Critical Incident Management and Reporting Suspected Abuse, Neglect and Exploitation of Members

If abuse issues are noted by a BCBSNM Care Coordination team member at an on-site visit or discussed telephonically, these issues are reported to a health care professional in the team at that facility.

If the incident is received from a non-BCBSNM-employed health professional (a provider of services such as PCP or physical therapist), they will be encouraged to make the report since they are the direct provider of health care, closer to the situation and member and the most appropriate professional to notify the agency. Health Services staff will follow up on the situation.

BCBSNM applies the following principles to our Critical Incident Management Program:

- Participants should have a quality of life that is free of abuse, neglect, and exploitation
- Any individual who, in good faith, reports an incident or makes an allegation of abuse, neglect, or exploitation will be free from any form of retaliation
- A provider's incident management system must emphasize prevention and staff involvement in order to provide safe environments for the individuals they serve
- Quality starts with those who work most closely with persons receiving services

Reportable Critical Incidents include:

- Reports are submitted via the HCA Critical Incident Portal for members with a qualifying COE. There are 13 qualifying COEs for members of any age:
    - 001 – SSI Aged
    - 003 – SSI Blind
    - 004 – SSI Disabled
    - 081 – Institutional Aged
    - 083 – Institutional Blind
    - 084 – Institutional Disabled
    - 090 – HIV/AIDS
    - 091 – Home and Community Based Waiver – Aged
    - 092 – HCBS Brain Injury
    - 093 – HCBS Aged and Disabled
    - 094 – HCBS Disabled
    - 100 – Adult Group Ages 19-64; Must also have "NFLOC"
    - 200 – Parent/Caretaker Relative; Must also have "NFLOC"
- For adults, 18 and older: abuse, neglect, and exploitation; death; other reportable incidents such as hospitalization, environmental hazards, law enforcement intervention, emergency services, and elopement/missing.

- For children, under 18 years: physical abuse; sexual abuse; neglect; death; other reportable incidents such as, hospitalization, environmental hazards, law enforcement intervention, emergency services, and elopement/missing.

Child Welfare Information Gateway has identified the signs of child abuse, neglect, sexual abuse, and mental maltreatment as follows:

- Signs of Physical Abuse – consider the possibility of physical abuse when the child
    - Has unexplained burns, bites, bruises, broken bones, or black eyes
    - Has fading bruises or other marks noticeable after an absence from school
    - Seems scared, anxious, depressed, withdrawn, or aggressive
    - Seems frightened of the parents and protests or cries when it is time to go home
    - Shrinks at the approach of adults
    - Shows changes in eating and sleeping habits
    - Reports injury by a parent or another adult caregiver
    - Abuses animals or pets
- Signs of Physical Abuse - consider the possibility of physical abuse when the parent or other adult caregiver exhibits the following:
    - Offers conflicting, unconvincing, or no explanation for the child's injury or provides an explanation that is not consistent with the injury
    - Shows little concern for the child
    - Sees the child as entirely bad, burdensome, or worthless
    - Uses harsh physical discipline with the child
    - Has a history of abuse as a child
- Signs of Neglect - consider the possibility of neglect when the child
    - Is frequently absent from school
    - Begs or steals food or money
    - Lacks needed medical or dental care, immunizations, or glasses
    - Is consistently dirty and has severe body odor
    - Lacks sufficient clothing for the weather
    - Abuses alcohol or other drugs
    - States that there is no one at home to provide care
- Signs of Neglect - consider the possibility of neglect when the parent or other adult caregiver
    - Appears to be indifferent to the child
    - Seems apathetic or depressed
    - Behaves irrationally or in a bizarre manner
    - Is abusing alcohol or other drugs
- Signs of Sexual Abuse - consider the possibility of sexual abuse when the child
    - Has difficulty walking or sitting
    - Experiences bleeding, bruising, or swelling in their private parts
    - Suddenly refuses to go to school
    - Reports nightmares or bedwetting

  - Experiences a sudden change in appetite
  - Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
  - Suddenly refuses to change for gym or to participate in physical activities
  - Becomes pregnant or contracts a venereal disease, particularly if under age 14
  - Runs away
  - Reports sexual abuse by a parent or another adult caregiver
  - Attaches very quickly to strangers or new adults in their environment
- Signs of Sexual Abuse - consider the possibility of sexual abuse when the parent or other adult caregiver
  - Tries to be the child's friend rather than assume an adult role
  - Makes up excuses to be alone with the child
  - Talks with the child about the adult's personal problems or relationships
- Signs of Emotional Maltreatment - consider the possibility of emotional maltreatment when the child
  - Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
  - Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
  - Is delayed in physical or emotional development
  - Has attempted suicide
  - Shows signs of depression or suicidal thoughts
  - Reports an inability to develop emotional bonds with others
- Signs of Emotional Maltreatment - consider the possibility of emotional maltreatment when the parent or other adult caregiver:
  - Constantly blames, belittles, or berates the child
  - Is unconcerned about the child and refuses to consider offers of help for the child's problems
  - Overtly rejects the child

The Institute on Aging has identified the possible signs of elder abuse as the following:

General Indicators

- Reluctance to provide access or answer questions
- Implausible or vague explanations for situations
- Unexplained pressure marks, bruises, burns, cuts, or scars
- Irregular pattern of behavior Home
- Hazardous, unsafe, or unclean living conditions
- Newspapers/mail accumulating
- Lack of attention to house
- Large numbers of people using home
- Drug activity

- Odd noises, bad odors

Financial

- Irregular pattern of spending/withdrawals
- Frequent purchases of inappropriate items; withdrawals made in spite of penalties; bills not paid; utilities turned off; talks about meeting a "new best friend"

Physical Signs

- Multiple bruises
- Pattern injuries
- Elder lacks necessary helping devices
- Mental Health/Emotional Signs
- Elder is depressed, appears to have dementia, shows signs of anxiety, fears a caregiver, and/or is isolated by the caregiver
- Develop preventable conditions such as bedsores (open sores that can develop when a person stays in one position for a long time, such as being confined to a bed)

Caregiver

- Caregiver is excessively concerned about costs of services or supplies, attempts to dominate elder, is verbally abusive of elder or you, and/or shows evidence of substance abuse or mental health problems. Financial dependence on the elder is also a warning sign

Employee Abuse Registry Act

In accordance with the New Mexico Employee Abuse Registry Act, NMSA 1978, Sections 27- 7A-1 to 27-7A-8, all participating providers are required to inquire the Department of Health's Employee Abuse Registry ("Registry") as to whether an employee is included in the Registry before hiring or contracting with the employee.

Participating providers must document that they have checked the Registry for each applicant before the applicant was considered for employment or contract.

Participating providers cannot hire or contract with an employee in a direct care setting who is included in the Registry.

Marketing or Outreach Activities

Participating providers cannot engage in any marketing or outreach activities without prior approval from BCBSNM. All marketing or outreach activities must comply with state and federal guidelines.

List of Excluded Individuals/Entities

Providers are required to screen all employees against the List of Excluded Individuals/Entities monthly to ensure they are not employing or contracting with excluded individuals.

Ending Patient Relationship - Provider Notification Responsibilities

Providers shall not abandon members as patients. Providers must notify BCBSNM and members under active care of their intent to terminate the relationship between the member and the provider. Notice is required even if the provider is leaving a group practice because the provider-patient relationship is between the provider and the member. Notice to the member should be given in writing and should notify member(s) ideally 90 days but no less than 30 days prior to terminating the relationship. A copy of the notice to the member should be emailed to the provider's assigned BCBSNM Network Representative. Notice is required if a provider is leaving a practice, a practice is closing, or an individual member's care is being discontinued by the provider for any reason. (If the practice is closing, there are additional notification requirements to BCBSNM elsewhere in this Manual.) At a minimum, the notice should state: (1) a brief reason for the termination of the relationship; (2) agree to provide treatment and access to services for a reasonable period of time, at least 30 days, during which the member can continue to receive services as they transition to another in-network provider's care; (3) resources and/or recommendations to help the member locate another in-network provider, including reminding them of the customer service phone number on the back of their BCBSNM ID card; and 4) other transition resources that might be appropriate including information on emergency services or on transferring medical records to their new in-network provider.

7 – Selection and Retention of Participating Providers

Participation and Required Background Checks

To participate in the Medicaid managed care plan, all providers:

- Must be a participating provider with BCBSNM.
- Must have privileges at one of the Medicaid managed care plan participating hospitals (unless inpatient admissions are uncommon or not required for the provider's specialty).
- Must have a valid National Provider Identifier (NPI). Atypical providers (e.g., Personal Care Service Agencies, Environmental Modification Contractors) do not require an NPI.
- Must sign a New Mexico Medicaid Managed Care Agreement and or a Medicaid Amendment to his or her Medical Services Entity Agreement with BCBSNM.
- Cannot have any sanctions or reprimands by any licensing authority or review organizations. Participating providers cannot be named on the Office of the Inspector General (OIG) or Government Services Administration (GSA) lists which identify providers found guilty of fraudulent billing and/or misrepresentation of credentials.
- Background checks including verification of sanctions prohibiting participation within government programs will be run prior to employment. Review of the List of Excluded Individual Entities (LEIE) and the System of Award Management (SAM) will be utilized in this review.
- Cannot be sanctioned by the Office of the Personnel Management or prohibited from participation in the Federal Employees Health Benefit Program (FEHBP).

Websites:
https://www.fsd.gov/gsafsd_sp
http://oig.hhs.gov/exclusions/index.asp

Registration Requirement

The Human Services Department (HSD) requires any provider who files a New Mexico Medicaid claim with a Managed Care Organization (MCO) for the Medicaid managed care plan and is not currently enrolled as either a Fee for Service (FFS) or Managed Care only provider to register on the NM Medicaid Provider Web Portal.

MCO-only registration is located within the provider enrollment section that includes the MCO network only option and the Non-Network MCO option. Select one of these options and complete the enrollment process. The following providers must be registered:

- All providers submitted on the claim must be registered, included but not limited to, referring, rendering, attending, or ordering.
- Solo providers type 1 NPI
- Groups type 2 NPI (includes ancillary, facility, professional, etc.)
- Individuals within a group
- Providers with multiple NPI numbers that render services to NM Medicaid members must register each applicable NPI number
- Atypical providers that are not required to have an NPI but are required to register (personal care services, environmental modification, etc.)

If you have multiple NPI numbers that are utilized to render services to NM Medicaid members, each NPI must be registered. Regardless of participation status with an MCO, the State requires you to be enrolled in order to receive Medicaid reimbursement.

If you are already registered, re-registration will not be required. Please ensure that each practitioner in your practice is registered. All enrollment information (changes to demographics, licensure or certification, provider status, etc.) must be updated on the NM Medicaid Provider Web Portal.

Refer to the HCA Frequently Asked Questions document for more information.

Credentialing of Participating Providers

Credentialing is the process by which BCBSNM ensures that the physicians and certain other providers meet the professional standards that are described in the Credentialing Policy. The credentialing standards cover areas such as education, advanced training, board certification, licensure, disciplinary action, and legal action.

BCBSNM continuously reviews and evaluates professional provider information and re-credentials participating providers every three years. The credentialing guidelines are subject to change based on industry requirements and the Medicaid managed care plan standards.

BCBSNM also continuously reviews and evaluates institutional provider information and recertifies institutional providers every three years. The certification guidelines are subject to change based on industry requirements and the Medicaid managed care plan standards.

Credentialing is not synonymous with participation in a BCBSNM network. Only physicians or other providers who are determined by the Credentialing Committee or Medical Directors having met credentialing standards are eligible for participation with BCBSNM. Due to state regulations and National Committee for Quality Assurance (NCQA) standards, we are required to perform primary source verification, where applicable, on a number of elements used for establishing credentials.

Provider Rights:

- In the event that the credentialing information obtained from other sources varies substantially from that attested to by the provider, and the discrepancy affects or is likely to adversely affect the credentialing or recredentialing decision, we will notify the provider of the discrepancy.
- The provider will have the right to review information provided in support of his/her application and to correct erroneous information. Providers have the right to review information obtained by BCBSNM at any time except for information or recommendations that are protected by peer review.
- The provider has the right to receive the status of his/her credentialing or recredentialing application, upon request.

Refer to Section 16 – Credentialing of the Blues Provider Reference Manual for a complete description of the BCBSNM credentialing process.

Home and Community-Based Services

Atypical providers are those who care for members requiring long-term care services also known as Home- and Community-Based Services (HCBS). HCBS providers include but are not limited to:

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

If you are interested in contracting with BCBSNM, please visit our BCBSNM Provider Website on "How to Join the BCBSNM Provider Networks".

Network Terminations

A provider who does not continue to meet credentialing standards will no longer be eligible for participation in the network. In those cases, BCBSNM will terminate the provider's participation with BCBSNM. Termination may also result from the other events or conditions specified in the provider's participation agreement with BCBSNM.

Notification to Members of Provider Termination

BCBSNM will make a good faith effort to provide written notice of a termination of a participating provider to all members who are patients seen on a regular basis by that

provider at least 15 calendar days before the termination effective date, regardless of the reason for the termination.

Change in Provider Information

Changes in provider demographic information should be reported immediately upon availability to BCBSNM Network Services via https://www.bcbsnm.com/provider/network-participation/network-participation/update-info and to HSD's New Mexico Medicaid provider web portal.

Appeal Process for Provider Participation Decisions

If BCBSNM decides to suspend, terminate, or non-renew a provider's participation status, BCBSNM will give the affected provider written notice of the reason for the action.

When BCBSNM terminates a provider from the network, it notifies the provider in writing at least 60 calendar days in advance of the effective date of the termination, unless termination is for cause, due to default, or BCBSNM determines there is imminent risk to the health and safety of its members.

The provider will be allowed to appeal the action to a hearing panel (a recommendation by which may be considered advisory and not binding on BCBSNM), given written notice of his/her right to an appeal hearing and the process and timing for requesting a hearing as further described in, and subject to, Section 15.6 of the BCBSNM Provider Reference Manual; provided, however, that providers who are part of groups or entities, the participation of which is terminated for only Medicaid and/or Medicare Advantage, will not be entitled to submit a grievance nor receive separate notices or hearings, which instead will be available to only the terminated group or entity, the final decision as to which shall be binding on its providers.

If a reduction, suspension, or termination of a participating provider's participation is final and is the result of quality of care deficiencies, BCBSNM will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician/professional provider groups must certify that these procedures apply equally to providers within those subcontracted groups.

(**Note**: Refer to the BCBSNM Blues Provider Reference Manual, Section 15.6 for further instructions on the appeal process for provider terminations. If there is a conflict between Section 15.6 of the PRM and the above Appeal Process, such Appeal Process shall control as to Medicaid participation and termination.)

8 – Medical Records

Medical Record Review

BCBSNM requires that its providers maintain their medical records in accordance with the medical record documentation standards. The Quality Improvement (QI) Department provides oversight for the medical records review program.

Member medical records are reviewed yearly, from randomly selected providers, for documentation per regulatory and BCBSNM established medical record documentation standards. Results of the reviews are communicated to the provider and an action plan is requested when a provider does not meet 80% compliance. Providers who do not meet the required threshold will be included in the next annual medical record review.

Standards for Medical Records

Participating providers must have a system in place for maintaining medical records for a period of not less than ten years that conforms to regulatory standards meeting confidentiality and HIPAA requirements. Each medical encounter whether direct or indirect must be comprehensively documented in the member's medical chart.

Refer to the Medical Records Documentation Standards in Section 4 and Section 18 of the Blues Provider Reference Manual, or in the Standards & Requirements section of our provider website. For additional information on HIPAA compliance standards and medical records, see Section 7.3, HIPAA Compliance.

In addition to the NMAC, HCA and BCBSNM standards, providers must have appropriate administrative safeguards, physical safeguards, technical safeguards, Policies and Procedures and documentation requirements and security standards in place to protect the confidentiality of the medical record in compliance with applicable state and federal laws. Records must be stored in a centralized secure location, accessible only to authorized personnel and retrievable in a timely manner by office staff and practitioners. Provide periodic office staff and practitioner training for maintaining the confidentiality and security of patient information and only release confidential information in accordance with applicable state and federal laws.

Transfer of Medical Records

The physician or physician group practice is responsible for making appropriate arrangements for the disposition of medical records when a practice closes.

The recommended period for record retention is:

- Adult patients—10 years from the date the patient was last seen.
- Minor patients—28 years from the patient's birth.
- Mammography patients—10 years from last mammography.

- Deceased patients—five years from the date of death.

Refer to Section 4.4, Professional Provider Responsibilities of the *Blues Provider Reference Manual* for more information about transferring medical records.

9 – Appeals and Grievances

Appeals and Grievances

Members and participating providers have the right to submit grievances and appeals as described in Section 8.308.15 NMAC (as may be amended and/or recompiled). All participating providers must cooperate in the BCBSNM appeals and grievances process.

- An "appeal" is a request for a review of an Adverse Benefit Determination made by BCBSNM. Adverse Benefit Determination is defined as the denial or limited authorization of a requested service including determinations based on the type or level of service requirements for medical necessity, appropriateness, setting or effectiveness of a covered service; the denial in whole or part of a payment for service, the failure to provide service in a timely manner as defined by the state, the failure of BCBSNM to act within the required timeframes for the standard resolution of a grievance or an appeal.
- A "grievance" is any expression of dissatisfaction about any matter or aspect of BCBSNM, or its Medicaid managed care plan operation made by a member or a participating provider. For example, a grievance concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating providers' facilities are grievances. Members can receive assistance in filing a grievance by calling 866-689-1523.
- An "authorized representative" is the individual designated to represent and act on the member's behalf during the appeal process.
- See Section 8.308.15 NMAC for complete definitions of an appeal, grievance, authorized representative, and related terminology, as well as a more comprehensive description of appeals/grievances rights and limitations that apply.

BCBSNM tracks all appeals and grievances to identify areas of improvement for the Medicaid managed care plan. This information is reviewed by the Quality Improvement Committee.

Appeals and Grievance Contacts

Appeals regarding Adverse Benefit Determinations of a health care service should be mailed, phoned, or faxed as follows:

- For member appeals or grievances: Medical and Behavioral Health Care:
  Blue Cross and Blue Shield of New Mexico
  ATTN: **Medicaid Appeals and Grievances**
  P.O. Box 660717
  Dallas, TX, 75266-0717
  Telephone: 1-866-689-1523
  Fax: 1-888-240-3004
  For an expedited appeal, 1-888-349-3706
- For provider appeals or grievances, contact: BCBSNM Provider Service Unit (PSU) at 1-888-349-3706 or file through the Availity® Essentials portal.
- **For Pharmacy Appeals**
  Prime Therapeutics Appeals Department
  2900 Ames Crossing Road

Eagan, MN 55121
Fax: 855-212-8110
Telephone: 888-840-3044
For Electronic Submission: MyPrime.com or CoverMyMeds.com.

Resolving Grievances

If a member has a grievance about the Medicaid managed care plan, a provider, or any other issue, participating providers should instruct the member to contact the Customer Service Department at the number listed on the back of the member's ID card.

If a provider has a grievance about the Medicaid managed care plan, another provider or any other issue, participating providers should contact the Provider Service Unit at 1-888-349-3706.

Provider Rights and Limitations

Contracted provider rights and limitations in connection with the Medicaid managed care plan appeals include, but are not limited to:

- Contracted providers may file an appeal either orally or in writing in accordance with BCBSNM's procedures and processes.
- Contracted providers have the right to file an appeal with BCBSNM related to the provider's payment and/or Utilization Management decisions.
- Contracted providers may act as a spokesperson for the member during the member's appeal process; however, the provider who is also the spokesperson may not file an appeal on his or her own concerning an adverse benefit determination intended or taken against a member; appeals of adverse benefit determination intended or taken against a member remain the sole responsibility of the member or the member's authorized representative.

Resolving Appeals

An appeal must be filed within 60 calendar days of BCBSNM's notice of adverse benefit determination and will be resolved in 30 calendar days or sooner if the member's health condition requires. A member appeal may be extended by 14 calendar days if the member requests an extension or BCBSNM determines it is in the member's best interest to request an extension. In this case, BCBSNM will request the extension from HCA. Once BCBSNM receives approval, a written notice will be sent with the extension and the reason for extension within two business days of the decision to extend the timeframe.

If the normal time period for an appeal could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the member or the member's provider can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time-period. See Section 8.308.15.16 NMAC (as may be amended and/or recompiled) for more information about

expedited member appeals. Members can receive assistance for filing an appeal by calling 866-689-1523.

Provider Grievances or Appeals shall be resolved within 30 Calendar Days. If not resolved within 30 Calendar Days. BCBSNM will request a 14 Calendar Day extension from the provider. As a provider, you can also request an extension and it will be approved. A provider can request a continuation of benefits on the member's behalf when they are authorized by the member. The request for a continuation of benefits during the appeal process or the HCA administrative hearing must be made prior to the date the initial denial goes into effect or within 10 calendar days after denial date on the letter mailed to the members. The result of the appeal or the HCA administrative hearing could be the same as BCBSNMs' first decision to terminate modify, suspend, reduce, or deny a service. In this event, members are responsible for paying for the services used. BCBSNM may recover the cost of the services furnished to members (request a refund from the provider or the member). BCBSNM ensures that punitive or retaliatory action is not taken against providers who file a grievance or appeal or support a member in their appeal/grievance process.

Participating Provider Obligations – Appeals

Participating providers must also cooperate with BCBSNM and members in providing necessary information to resolve the appeal or the grievance within the required time frames. Providers must provide pertinent medical records and any other relevant information. In some instances, providers must provide the records and information in an expedited manner to allow BCBSNM to make an expedited decision.

10 – Member Rights and Responsibilities

Member Rights

Members have been informed that they have the following rights, including, but not limited to:

- Health care when medically necessary as determined by a medical professional or BCBSNM; 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined in the member handbook.
- Receive health care that is free from discrimination.
- Be treated with respect and recognition of your dignity and right to privacy.
- Choose a primary care physician (PCP) or provider from the BCBSNM network and be able to refuse care from certain providers (a preauthorization may be necessary to see some providers).
- Receive a copy of, as well as make recommendations about BCBSNM's member rights and responsibilities policy.
- Be provided with information about BCBSNM's member rights and responsibilities, policies and procedures regarding products, services, providers, appeals procedures, and other information about the company and get information about how to access covered services and the providers in our network.
- Receive a paper copy of the official Privacy Notice from the Human Services Department upon request.
- Be assured that the Member's MCO is in compliance with applicable federal state laws including Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehab Act of 1973, Education Amendments of 1972, Americans with Disabilities Act (ADA), and Section 1557 of the Patient Protection and Affordable Care Act
- Be given the name and professional background of anyone involved in your treatment and the name of the person primarily responsible for your care.
- Choose a surrogate decision-maker to be involved and assist with care decisions as appropriate. This can be done by you or your legal guardian.
- Have an interpreter present when you do not speak or understand the language that is being spoken.
- Participate with your provider in all decisions about your health care, including gaining an understanding of your physical and/or behavioral condition, being involved in your treatment plan, deciding on acceptable treatments, and knowing your right to refuse health care treatment or medication after possible consequences have been explained in a language you understand. Family members, legal guardians, representatives, or decision-makers also have this right, as appropriate.
- Talk with your provider about treatment options, risks, alternatives, and possible results for your health conditions, regardless of cost or benefit coverage and have

this information documented in your medical record. If you cannot understand the information, the explanation will be provided to your family, guardian, representative, or surrogate decision-maker.
- Give informed consent for physical and/or behavioral health medical services.
- Decide on advance directives for your physical and/or behavioral health care. These decisions can be made by you, or your legal guardian as allowed by law.
- Access your medical records in accordance with the applicable federal and state laws, which means that you have the right to receive communications about your private records, request a change or addition if you feel they are incomplete or wrong, and request restricted disclosure of your medical records, and the right to be notified if accidental disclosure occurs. If the member has a legal guardian, the legal guardian has the right to access the member's medical records.
- Request a second opinion from another BCBSNM provider. This can be done by you or your legal guardian.
- File a grievance about BCBSNM or the care that you received or file an appeal about coverage for a service that has been denied or reduced by BCBSNM. After finishing your appeal, you can request an HCA administrative hearing. The grievance, appeal, and HCA administrative hearing processes can be used without fear of retaliation.
- Receive prompt notification of termination or changes in benefits, services, or provider network.
- Be free from harassment from BCBSNM or its network providers regarding contractual disputes between BCBSNM and providers.
- Select a health plan and exercise switch enrollment rights without threats or harassment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or New Mexico regulations on the use of restraints and seclusion.
- Exercise rights without concern that care will be negatively affected.
- Receive information on available treatment options and alternatives in an understandable manner.

Member Responsibilities

Members and member representatives have the following responsibilities:

- Give complete health information to help the provider give the member the care needed.
- Follow the treatment plan and instructions for medications, diet, and exercise as agreed upon by the member and provider.
- Do their best to understand their physical, long-term care, and/or behavioral health conditions and take part in developing treatment goals agreed upon by the member and provider.

- Make appointments ahead of time for provider visits.
- Keep their appointment or call the provider to reschedule or cancel at least 24 hours before the appointment.
- Tell providers if they do not understand explanations about their health care.
- Treat the provider and other health care employees with respect and courtesy.
- Show their ID card to each provider before getting medical services (or they may be billed for the service).
- Know the name of their PCP and have their PCP provide or arrange their care.
- Call their PCP or the 24/7 Nurseline before going to an emergency room, except in situations that they believe are life threatening, or that could seriously jeopardize their health, or if they are having thoughts of harm to themselves or others.
- Provide information to HCA and BCBSNM of:
    - Current mailing address
    - Current phone number, including any landline and cell phone, if available
    - Current emergency contact information
    - Current email address
- Tell the New Mexico Human Services Department and BCBSNM about changes to their phone number or address.
- Tell BCBSNM if they have other health insurance, including Medicare.
- Give a copy of their living will and advance directives regarding their physical and/or behavioral health to their PCP to include in their medical records.
- Read and follow the member handbook.

Language Interpretation and Specialized Communication Services

Participating providers must furnish covered services in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating providers must cooperate in meeting this obligation.

Customer Service (the phone number is listed on the back of the member's ID card) has the following services available for members:

- Teletypewriter (TTY) services
- Language services
- Spanish-speaking Customer Service Representatives

Advance Directives

Members have the right to complete an "Advance Directive" statement. This statement indicates, in advance, the member's choices for treatment to be followed in the event the member becomes incapacitated or otherwise unable to make medical treatment decisions.

BCBSNM suggests that participating providers have Advance Directive forms in their office and available to members.

Adult members and emancipated minors have the right to have a mental health or psychiatric advance directive (PAD). For these persons with a mental illness, this directive is designed to preserve their autonomy during times when the mental illness temporarily compromises their ability to make or communicate mental health treatment decisions.

Note: A sample New Mexico Optional Advance Health Care Directive Form is included at the end of this Section. For more information on PADs in New Mexico and for a copy of a sample PAD form, view the NRC PAD website.

Fair Hearing (also known as HCA Administrative Hearing)

A member or their authorized representative may request a State Fair Hearing if he/she is dissatisfied with an Action that has been taken by BCBSNM or the decision is not resolved wholly in favor of the member. The BCBSNM appeal process must be exhausted prior to requesting a State Fair Hearing. The member or their authorization representative has to request a State Fair Hearing within ninety (90) Calendar Days of the final appeal decision. The Representative, attorney, the estate representative of a deceased Member, or a provider acting on behalf of the member and with the member's written consent, may request a State Fair Hearing on behalf of the member. Members have the right to request a Fair Hearing through the HCA/Fair Hearings Bureau after exhausting the internal appeals process. Members can have a Fair Hearing if BCBSNM's final decision stops, reduces or suspends coverage for a service. Fair Hearings are processed by the Fair Hearings Bureau at HCA/MAD, not BCBSNM.

All requests for hearings must go to the State. If a Fair Hearing is held, the decision made by the State is the final decision. BCBSNM must follow the State's decision. BCBSNM will not retaliate against a member requesting a Fair Hearing. Members must exhaust BCBSNM internal grievance/appeals processes before requesting a Fair Hearing.

Providers who or which appealed for themselves do not have the right to request an HCA Fair Hearing.

The Fair Hearings Bureau may be reached at:
1-800-432-6217; Option #6; or
505-476-6213

See Section 8.352.2 NMAC (as amended and/or recompiled) for a more comprehensive description of the rights and limitations of the Fair Hearing process.

11 – Obligation to Provide Access to Care

Member Access to Health Care Guidelines

The following appointment availability and access guidelines represent the minimum standards for appointments to be used to ensure timely access to medical, dental, behavioral health and other health care for Medicaid managed care plan patients:

- Routine, asymptomatic, member-initiated, outpatient appointments for primary medical care – within thirty (30) calendar days unless patient requests a later time
- Routine, asymptomatic, member-initiated, outpatient appointments for non-urgent primary dental care – within sixty (60) calendar days, unless patient requests a later time
- Routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care – request-to-appointment time no greater than fourteen (14) calendar days unless patient requests a later time
- Non-urgent behavioral health care, initial assessment or care following an initial assessment – request-to-appointment time no greater than seven (7) calendar days unless patient requests a later time
- Primary medical, dental, and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours
- Emergency care – 24 hours a day, 7 days per week
- Non-urgent behavioral health care, follow-up appointments – within thirty (30) calendar days of the request
- Behavioral health care, Crisis services, face-to-face appointments within ninety (90) minutes of the request
- Maternity Care (Prenatal Care)
    - Urgent – appointment within no more than twenty-four (24) hours,
    - Routine appointments within first trimester – appointment within no more than fourteen (14) calendar days,
    - Routine appointments within second trimester – appointment within no more than seven (7) calendar days, and
    - Routine appointments within third trimester – appointment within no more than three (3) business days.
- Specialty outpatient referral and consultation appointments, excluding behavioral health, all request-to-appointment times shall be consistent with the clinical urgency and
    - Urgent – no more than twenty-four (24) hours unless the patient requests a later time,
    - Symptomatic appointment – no more than fourteen (14) calendar days unless the patient requests a later time, and

  - Routine, asymptomatic appointments – no more than forty-five (45) calendar days, unless the patient requests a later time.
- Routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments – request-to-appointment time shall be consistent with the clinical urgency, but no more than fourteen (14) calendar days unless patient requests a later time
- Outpatient diagnostic laboratory, diagnostic imaging, and other testing – if a walk-in rather than an appointment system is used, the member wait time shall be consistent with the severity of the clinical need
- Urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing – appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours
- In-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes
- Sufficient non-emergency medical transportation shall be available to meet the needs of the members.
- New durable medical equipment (DME) and repairs to existing DME owned or rented by the member – approve or deny the request within seven working days of the request date.
  - All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.
  - All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.
  - All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.
  - All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.
  - The MCO shall have an emergency response plan for non- customized DME needed on an emergent basis.
- The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:
  - Members can access prescribed medical supplies within 24 hours when needed on an urgent basis
  - Members can access routine medical supplies within a time frame consistent with the clinical need; and
  - Subject to any requirements to procure a physician’s order to provide supplies, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly, and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

- The MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the MCO/SE or its subcontractor.

BCBSNM has established standards for providers to use for all members that adhere to the most stringent regulations and allow consistency across benefit plans. Please refer to the primary BCBSNM Provider Reference Manual Section 4 Provider Responsibilities for the standards BCBSNM will use to measure provider compliance with appointment access guidelines.

Adherence to member access guidelines will be monitored through the office site visits and the tracking of grievances related to access and availability, which are reviewed by the Clinical Quality Improvement Committee.

All participating providers will treat all members with the same dignity and consideration as they do their non-Medicaid managed care plan patients.

Provider Availability

Participating providers shall provide coverage 24 hours a day, 7 days a week. When a provider is unavailable to provide services, the provider must ensure that another participating provider is available. Hours of operation must not discriminate against Medicaid managed care plan members relative to other members.

Participating providers' standard hours of operation shall allow for appointment availability between the normal working hours of 9 a.m. and 5 p.m.

After-hours access shall be provided to ensure a response to after-hours phone calls. Individuals who believe they have an emergency medical condition should be directed to seek emergency services immediately.

BCBSNM will conduct semi-annual appointment access and availability surveys. In most instances, these will be blind surveys meaning the surveyor will identify themselves as a BCBSNM member seeking an appointment and recording the date of the appointment offered.

Provider Office Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information that comply with HIPAA requirements. Participating providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Patient Self-Determination Act

The PCP must comply with federal government regulations concerning the Patient Self-Determination Act (PSDA).

- PCPs must comply with all applicable state and federal laws regarding advance directives.
- PCPs must ask if adult members or emancipated minors have advance directives and include existing advance directives in the member's medical record.
- PCPs cannot require a member to have an advance directive in order to receive medical care, nor can they prevent a member from having an advance directive.
- Minors should not be treated without the consent of a parent or other legal guardian or legally authorized surrogate decision- maker.

Note: New Mexico law provides exceptions to parental or guardian consent for minors of certain ages when treating certain conditions such as sexually transmitted diseases and behavioral health conditions or when providing family planning services. Providers furnishing such treatments and services to minors are expected to know and comply with terms and conditions of these exceptions.

When treating Medicaid managed care plan members that fall under the jurisdiction of the Children, Youth, and Family Department (CYFD), BCBSNM case managers work in conjunction with the CYFD caseworkers to meet care needs.

Prohibition against Discrimination

BCBSNM or participating providers may not deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status, including, but not limited to:

- Medical condition, including behavioral as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Race, ethnicity, national origin
- Religion
- Sex, sexual orientation
- Age
- Mental or physical disability
- Source of payment

Participating providers must have practice policies demonstrating that they accept for treatment any member in need of health care services they provide.

Vaccines for Children Program

A federal program called Vaccines for Children (VFC) provides free vaccines to eligible children, including those without health insurance coverage, those who are enrolled in

Medicaid, and Native Americans. The State of New Mexico provides additional funding to purchase vaccines for all VFC-non-eligible children so that all New Mexico children from birth to 18 years old can receive free vaccines.

Providers may participate in the VFC program without participating in Medicaid if they are qualified to administer vaccines under applicable state law. However, such providers will not be reimbursed by Medicaid for their services in administering vaccines.

Under the VFC program, a provider may impose a fee for the administration of a qualified pediatric vaccine if the fee, in the case of a federally vaccine-eligible child, does not exceed the cost of such administration (as determined by the secretary based on actual regional costs for such administration). However, a provider may not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child's parents or legal guardian to pay the administration fee.

BCBSNM will reimburse VFC-participating providers for vaccine administration, depending on your contracted reimbursement rate with the Medicaid managed care plan. We encourage all contracted BCBSNM providers to participate so that all New Mexico children from birth to 18 years old receive the necessary vaccines to prevent vaccine-preventable diseases. If you have any questions about reimbursement for vaccines, please call 1-800-693-0663.

Coordination with Providers, Major Subcontractors, or HCA Contractors

Participating Providers shall coordinate with other providers, vendors contracted with BCBSNM to deliver or arrange for the delivery of Covered Services, and HCA contractors, as needed, in furtherance of providing Medicaid members access to Covered Services in compliance with all contractual and legal requirements.

12 – Pharmacy Services

Introduction

The following policies apply to members who have BCBSNM prescription benefits. Prime Therapeutics is the Pharmacy Benefit Manager (PBM) for drug benefits for BCBSNM members. The PBM name and telephone number is listed on the back of the member's identification card.

Drug List

The Medicaid managed care plan drug list is available on the BCBSNM website at https://www.bcbsnm.com/turquoise-care/plan-details/drug-coverage

BCBSNM utilizes Prime Therapeutics National Pharmacy and Therapeutics (P&T) Committee, which is responsible for drug evaluation for the Medicaid drug list. The P&T Committee consists of independent practicing physicians (including behavioral health specialists) and pharmacists from throughout the country who are not employees or agents of Prime Therapeutics. BCBSNM will have one voting member on the committee. The P&T Committee meets quarterly to review new drugs and updated drug information based on the current available literature.

Prime Therapeutics is responsible for the determination of benefit coverage and approvals for prior authorizations, quantity exceptions, and/or step therapy for Medicaid managed care plan members.

Pharmacy prior authorizations may be requested by:

- Submitting an electronic prior authorization request for drugs covered under the pharmacy benefit through CoverMyMeds®
- Submitting an electronic prior authorization request for drugs covered under the medical benefit through Availity
- NM Uniform Prior Authorization Form
- Faxing a request to 1-877-243-6930
- Calling 1-855-457-0755 for pharmacy benefits and/or 1-877-232-5518 for medical benefits.

BCBSNM provides notification to Medicaid managed care plan members and physiciansof additions and changes made to the Medicaid managed care plan drug list by direct mailings, newsletters, and/or on the BCBSNM website. The drug list is updated quarterly and a link to the updates is published in the *Blue Review.*

Members who are identified as taking a medication that has been removed from the BCBSNM drug list receive a letter detailing the change at least 60 days prior to the deletion effective date. BCBSNM and Prime Therapeutics also provide pharmaceutical safety notification to dispensing providers for members regarding point-of-dispensing drug-drug interaction, and FDA drug recalls.

The Medicaid managed care plan drug list is provided as a guide to our participating providers to help them in selecting cost-effective drug therapy. Members have a closed pharmacy benefit. **Non-formulary drugs are generally considered a non-covered benefit.**Most generics and listed brand name products are covered.

Please refer to the Medicaid managed care plan drug list when prescribing for our members.

Generic Drugs

The FDA has a process to assign equivalency ratings to generic drugs. An “A” rating means that the drug manufacturer has submitted documentation demonstrating equivalence of its generic product compared to the brand name product.

BCBSNM supports the FDA process for determining equivalency and strongly advises its participating providers to prescribe drugs that have generic alternatives available. The Medicaid managed care plan is a “generics first” program. Requests for brand-name agents will be considered on a case-by-case basis (via the standard prior authorization process) and require written documentation that the member has been unable to tolerate multiple generic agents or that multiple generics have been ineffective in treating the member’s condition.

Drug Utilization Review

BCBSNM and Prime Therapeutics conduct prospective, concurrent, and retrospective Drug Utilization Reviews (DUR) for Medicaid managed care plan members to improve the safe use of the appropriate and cost-effective drugs. Prospective DUR entails provider education through newsletters and personal contact.

Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Pharmacies are electronically linked to Prime Therapeutics’ claims adjudication system. This system contains various edits that check for drug interactions, over-utilization (i.e., early refill attempts), drug interactions, and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use his or her professional judgment and call the prescribing provider if a potential adverse event may occur.

Retrospective DUR uses historical prescription claims data and may address a wide range of medication therapy issues. The data is evaluated to determine compliance with the clinical practice guidelines approved by the P&T Committee. Individual letters are mailed to providers with members identified as potential drug therapy concerns, together with a profile listing the prescription medications filled during the study period, and a response form to be mailed or faxed to the BCBSNM PBM. A provider’s timely response is very important to BCBSNM.

Guided Health℠ (offered through BCBSNM's PBM) is a drug utilization platform that has the ability to integrate medical and pharmacy data to facilitate better outcomes, improve medication adherence, and reduce the incidence of adverse events. Guided Health supplies providers with a single tool that identifies multiple member-specific medication issues.

BCBSNM also supplies other provider-facing communications to assist with medication therapy management, including mailings/electronic notifications that address topics such as polypharmacy, asthma adherence, and drug-specific laboratory monitoring.

Covered & Non-covered Pharmacy Services

The following list describes the typically covered and non-covered Medicaid managed care plan pharmacy services.

Covered Pharmacy Services

- Generic drugs as listed on the Medicaid managed care plan drug list
- Branded drugs as identified in the Medicaid managed care plan drug list
- Glucagon and anaphylactic kits
- Insulin, syringes, lancets, and test strips
- Oral contraceptives
- Plan B (dispensing limits apply)
- Diaphragms and condoms
- Over-the-counter (OTC) medications (selected products only)

Non-covered Pharmacy Services

- Non-formulary medications (without prior authorization)
- Any charge for most therapeutic devices or appliances (e.g., support garments and other non-medical substances), regardless of their intended use
- Investigational use of medication
- Medications specifically excluded from benefit (e.g., drugs used for cosmetic purposes and infertility)
- Certain injectable drugs (other than insulin, glucagon, and anaphylactic kits) that are obtained at a pharmacy without prior authorization from the BCBSNM Health Services department. (Injectables received through a member's physician are covered if the drug meets all other criteria for coverage.)
- Nutritional supplements (coverage may require prior authorization)
- Prescriptions obtained at an out-of-network pharmacy, unless in an emergency
- Take-home drugs provided by a provider's office
- Lost, stolen, damaged, or destroyed medications
- Drug Efficiency Study and Implementation (DESI) medications

Drugs Requiring Prior Authorization

Drugs with a high potential for experimental or off-label use may require prior authorization. Review the detailed prior authorization requirements found on the Prime site below.

https://www.myprime.com/en/forms/coverage-determination/prior-authorization.html

BCBSNM allows for certain off-label uses of drugs when the off-label uses meet the requirements of the BCBSNM policy. Please contact the Medicaid Health Services department for more information on the BCBSNM off-label and investigational use policy.

Opioid Prescription Guidelines

In collaboration with Prime Therapeutics, BCBSNM has implemented many standard opioid safety edits to limit coverage for opioids to medically necessary purposes only, reducing risks of diversion and inappropriate use. These safety edits help to ensure compliance with the SUPPORT Act (Public Law No: 115-271).

To further encourage proper utilization of opioids we recommend each opioid prescription have a valid and appropriate diagnosis (defined below) written on the hard copy or provided in the electronic prescription in order for BCBSNM to provide coverage for opioid prescription. The benefits of this include faster and improved care management and disease management engagement with our members. Goals are to enhance appropriateness of opioid prescriptions and awareness of pharmacists to the patient's pain treatment needs. Excluded from this recommendation will be buprenorphine products used for treating opioid addiction.

- Valid Code: Current ICD10 diagnosis codes can be found in the CMS coding database https://www.cms.gov/medicare/coding/icd10/2019-icd-10-cm.html.
- Appropriate Code: A Valid ICD10 Dx code that is an appropriate indication for the use of opioids (i.e., G89.3 Neoplasm related pain).

As a reminder if you are a provider that is a Part 2 Program under the Substance Abuse and Mental Health Services Administration (“SAMHSA”) 42 CFR Part 2 Rules (the “Rules”) you may have obligations to obtain a patient consent and provide notices related to the use or redisclosure of the diagnosis information to the dispensing pharmacy.

Pharmacy Network

BCBSNM members with a “pharmacy card” prescription drug benefit must use a pharmacy on the approved list of participating pharmacies. Most pharmacies in New Mexico, including Indian Health Service pharmacies, are contracted to provide pharmacy services under BCBSNM. Please encourage your patients to use one pharmacy for all of their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

BCBSNM contracts with Express Scripts mail order pharmacy and allows members of the Medicaid managed care plan to receive up to a 90-day supply of maintenance medication

(e.g., drugs for arthritis, depression, diabetes, or hypercholesterolemia). If you believe that a Medicaid managed care plan member will continue on the same drug and dose for an indefinite period of time, please consider writing the prescription for a 90-day supply with three refills.

Note: Members may receive a longer day supply of medication at an Indian Health Service pharmacy without being restricted to a 30-day supply on the initial fill and without approval from BCBSNM.

High-risk drugs that are FDA approved for patient self-administration must be acquired through a specialty pharmacy provider designated by the plan.

Specialty Pharmacy Program

Specialty medications are used to treat serious or chronic conditions such as multiple sclerosis, hemophilia, hepatitis C, and rheumatoid arthritis. These medications are often injectable and sometimes may be administered by the patient or a family member. One or more of the following may also be true about these medications:

- They are generally injected, but some may be taken by mouth
- They have unique storage or shipment requirements
- Additional education and support is required from a health care professional
- Frequently are not stocked at retail pharmacies

All specialty medications require prior authorization. Medicaid managed care plan members must use a contracted specialty pharmacy that has been designated by BCBSNM to fill their prescriptions. The pharmacists, nurses, and care coordinators in specialty pharmacies that participate with BCBSNM are trained and prepared to supply medications and related services to patients with complex health conditions.

For those medications that are FDA-approved for self-administration, members are required to use their pharmacy benefit and acquire the medication through contracted specialty pharmacies – not dispensed through the physician's office. Self-administered drugs can include oral, topical and injectable products.

Accredo is the preferred specialty pharmacy for most BCBSNM members. To obtain specialty medications through the Specialty Pharmacy program (after prior authorization is obtained):

1. **Collect patient and insurance information**
   Use the fax form or your own prescription form, along with your office's fax cover sheet. Be sure to include the physician's signature and any clinical data that may support the approval process.
2. **Fax signed forms to 1-888-302-1208**

Accredo's team of pharmacists and benefit specialists will handle the details, from checking eligibility to coordinating delivery.

Accredo specialty provides safe and efficient delivery of specialty medications. As a service to your patients, Accredo can deliver those drugs that are approved for self-administration directly to the patient's home or alternate location.

Covered specialty drugs are listed on the Medicaid Drug List on our website:

For more information, contact **Accredo specialty pharmacy at 1-833-721-1619**.

Glossary of Terms

Term	Definition
Abuse	(i) any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with the Resident Abuse and Neglect Act, NMSA 1978, 30-47-1, et seq.; or (ii) provider practices that are inconsistent with sound fiscal, business, medical or service-related practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary Services or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to the Medicaid program pursuant to 42 C.F.R. § 455.2.
Advance Directives	Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the State of New Mexico, and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known. Advance directives may also be utilized to provide advance instructions regarding mental health treatment decisions. **Note:** A sample New Mexico Optional Advance Health Care Directive Form is included at the end of this Section.
Adverse Benefit Determination	(i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of BCBSNM to act within the required timeframes for the standard resolution of Grievances and Appeals; or (vi) the denial of a member's request to dispute a financial liability.
Appeal	A request for review by BCBSNM for services for a member that are reduced, denied, or limited, or a request for review where BCBSNM did not complete an authorization on time.

Term	Definition
Behavioral Health Planning Council (BHPC)	The body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico.
Code of Federal Regulations (CFR)	The codified set of regulations published by the Office of the Federal Register, National Archives and Records Administration.
Copayment	The portion of the claim or medical expense that members must pay out of their pocket for the services.
Collaborative	The interagency behavioral health purchasing collaborative,established under NMSA 1978, § 9-7-6.4, responsible for planning, designing, and directing a statewide Behavioral Health system.
Core Service Agencies (CSA)	Multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for members with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for members to have a single point of accountability for identifying and coordinating their behavioral health, health, and other social services.
Covered Services	Services covered as defined in the Medicaid managed care plan Provider Reference Manual, the Medical Assistance Division Program Policy Manual, or other applicable rules, regulations, or guidelines.
Emergency Medical Condition	Medical or behavioral health conditions manifesting themselves by acute symptoms of sufficient (including severe pain), that would lead a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention to result in 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 of the patient's health • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part • Serious disfigurement
External Quality Review Organization (EQRO)	The External Quality Review Organization (EQRO) retained byHCA/MAD. HealthInsight New Mexico is the EQRO for the Medicaid managed care plan.

Term	Definition
Grievance	Any expression of dissatisfaction about any matter or aspect of BCBSNM or its Medicaid managed care plan.
HCA	New Mexico Health Care Authority
HIPAA	Health Insurance Portability and Accountability Act and its implementing regulation, as amended
MAD	Medical Assistance Division
Member	A recipient who is currently enrolled in the Medicaid managed care plan.
MHSIP	The mental health statistics improvement project.
PAD	Psychiatric advance directive
External Quality Review Organization (EQRO)	The External Quality Review Organization (EQRO) retained byHCA/MAD. HealthInsight New Mexico is the EQRO for the Medicaid managed care plan.
Participating Provider	Any professional person, organization, health facility, hospital,or other person or institution licensed and/or certified by the State of New Mexico and Medicaid to deliver or furnish healthcare services. This individual or institution has a written agreement to provide services directly or indirectly to Medicaid managed care plan members pursuant to the termsof the Agreement.
Primary Care	All health and laboratory services customarily furnished by ageneral practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or certifiednurse practitioner.
Primary Care Provider (PCP)	A provider who agrees to manage and coordinate the careprovided to members.
SED	Serious emotional disturbance
SPMI	Severe persistent mental illness
State	Refers to the State of New Mexico
Turquoise Care	The Medicaid managed care program.

For additional procedures and information, please refer to the *BCBSNM Blues Provider Reference Manual*.

Contacts List

Medicaid Managed Care Plan Contacts List	
Carelon Medical Benefits Management (Carelon)	1-800-859-5299 https://providerportal.com/
Availity	1-800-282-4548 www.availity.com
Behavioral Health	1-877-232-5518
Claims Address *(For submission of paper claims)*	Blue Cross New Mexico Medicaid P.O. Box 650712 Dallas, TX 75265-0712
Case Management (CM) Programs	1-800-325-8334
Case Management Programs Fax	505-816-3861
Condition Management/Disease Management Programs	1-866-874-0912
Condition Management/Disease Management Programs Fax	505-816-3856
Community Social Services	1-877-232-5518
Davis Vision	1-800-584-3140
DentaQuest	1-800-417-7140
Electronic Claim Questions or Problems	1-800-746-4614
Fraud Hotline BCBSNM Special Investigations Department (toreport suspected fraud and abuse)	1-800-543-0867 www.bcbsnm.com/sid/reporting
Language Interpreter Line	1-800-874-9426
• Relay NM (TTY deaf, hearing and/or speech impaired)available in Spanish upon request	1-800-659-1779
• Bilingual (English-Spanish) Member Services	1-866-689-1523
ModivCare (Transportation Services)	1-866-913-4342
Network Services Representative	https://www.bcbsnm.com/docs/provider/nm/network-contacts.pdf
Pharmacy Utilization Management Intake	1-855-457-0177
Prime Pharmacy Help Desk	1-888-840-3044
Provider Customer Service (claims, benefits, etc.)	1-800-693-0663
Provider One Call	1-855-610-9833
Provider Resources	Network Participation/Medicaid
Quality Improvement Department	1-855-699-0042 Fax: 1-866-651-9636
Utilization Management (UM) • Preauthorization and Out-of-Network Referrals	1-877-232-5518

• Preauthorization Fax	**Medical:** 505-816-3854 **Pharmacy:** 505-816-3867 **Behavioral Health:** 1-877-232-5518 (Outpatient service requests only)
• Utilization Management Member Appeals	1-866-689-1523

ATTACHMENT 1: Alternative Benefit Plan Covered Services

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Allergy testing and injection	
Annual physical exam and consultation	Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.
Autism spectrum disorder (through age 22)	
Bariatric surgery	Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight BMI and health status.
Behavioral Health professional and substance abuse services, evaluations, testing, assessments, therapies, and medication management	Please reference ABP BH Covered Services chart on page 57 & 58
Cancer clinical trials	
Cardiovascular rehabilitation	Limited to short-term therapy (two consecutive months) per cardiac event.
Chemotherapy	
Dental services	Services for adults are covered in accordance with 8.310.7 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.
Diabetes treatment, including diabetic shoes, medical supplies, equipment, and education	
Dialysis	
Diagnostic imaging	
Disease management	
Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization, and intensive outpatient program (IOP) services	

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices, including repair or replacement	Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.
Electroconvulsive therapy	
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19-20	
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies, and emergency dental care	
Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives	Sterilization reversal is not covered. Infertility treatment is not covered.
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services	
Genetic evaluation and testing	Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.
Habilitative and rehabilitative services, including physical, speech and occupational therapy	Limited to short-term therapy (two consecutive months) per condition.
Hearing screening as part of a routine health exam	Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20.
Holter Monitors and cardiac event monitors	
Home health care, skilled nursing, and intravenous services	Home health care is limited to 100 visits per-year. A visit cannot exceed four hours.
Immunizations	Includes ACIP-recommended vaccines.
Inhalation therapy	

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Inpatient physical and Behavioral Health hospital/medical services and surgical care	Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. The ABP does not include inpatient drug rehabilitation services. Free-standing psychiatric hospitals (or Institutions for Mental Disease) are not covered under the ABP or ABP-exempt benefit package, except for recipients age 19-20. Surgeries for cosmetic purposes are not covered.
Inpatient rehabilitative services/facilities	Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.
IV infusions	
Lab tests, x-ray services and pathology	
Maternity care, including delivery and inpatient maternity services and pre- and post-natal care	
Medication assisted therapy for opioid addiction	
Non-emergency transportation when necessary to secure covered medical services and/or	
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity	
Organ and tissue transplants	Two per lifetime.
Osteoporosis diagnosis, treatment, and management	
Outpatient surgery	

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions	Other over-the-counter items may be considered for coverage only when the item(s) is considered more medically or economically appropriate than a prescription drug, contraceptive drug, or device, or for treating diabetes.
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings	Includes US Preventive Services Task Force “A” and “B” recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.
Physician visits	
Podiatry and routine foot care	Covered when medically necessary due to malformations, injury, acute trauma, or diabetes.
Prescription medicines	
Primary Care to treat illness/injury	
Pulmonary therapy	Limited to short-term therapy) two consecutive months) per condition.
Radiation therapy	
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects, or disease	
Skilled nursing	Subject to the 100-visit home health limit when provided through a home health agency.
Sleep studies	Limited to diagnostic sleep studies performed by certified providers/facilities.
Smoking cessation treatment	
Specialist visits	
Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)	The ABP does not cover behavioral health supportive services: Family Support, Recovery Services, and respite Services.
Telemedicine services	
Urgent care services/facilities	

ALTERNATIVE BENEFIT PLAN	
Covered Service	**Service Limitation(s)**
Vision care for eye injury or disease	Refraction for visual acuity and routine vision care are not covered, except for recipients age 19-20.
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware is covered for recipients age 19-20 following a periodicity schedule.

ATTACHMENT 2: General Medicaid Covered Services

Medicaid Covered Services (Non-Community Benefit Services)	
Covered Service	**Service Limitation(s)**
Accredited Residential Treatment Center Services	
Applied Behavior Analysis (ABA)	
Adult Psychological Rehabilitation Services	
Ambulatory Surgical Center Services	
Anesthesia Services	
Assertive Community Treatment Services	
Bariatric Surgery	No limitation on number of surgeries, as long as medical necessity is met.
Behavior Management Skills Development Services	
Behavioral Health Professional Services: outpatient mental health and substance use services	
Case Management	
Community Interveners for the Deaf and Blind	
Comprehensive Community Support Services	
Day Treatment Services	
Dental Services	
Diagnostic Imaging and Therapeutic Radiology Services	
Dialysis Services	
Durable Medical Equipment and Supplies	
Emergency Services (including emergency room visits and psychiatric ER)	
Experimental or Investigational Procedures, Technology or Non-Drug Therapies	Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	
EPSDT Personal Care Services	

Medicaid Covered Services (Non-Community Benefit Services)	
Covered Service	**Service Limitation(s)**
EPSDT Private Duty Nursing	
EPSDT Rehabilitation Services	
Family Planning	
Family Support (Behavioral Health)	
Federally Qualified Health Center Services	
Hearing Aids and Related Evaluations	
Home Health Services	
Hospice Services	
Hospital Inpatient (including Detoxification services)	
Hospital Outpatient	
Inpatient Hospitalization in Freestanding Psychiatric Hospitals	
Intensive Outpatient Program Services	
IV Outpatient Services	
Laboratory Services	
Medication Assisted Treatment for Opioid Dependence	
Midwife Services	
Multi-Systemic Therapy Services	
Non-Accredited Residential Treatment Centers and Group Homes	
Nursing Facility Services	
Nutritional Services	
Occupational Services	
Outpatient Hospital based Psychiatric Services and Partial Hospitalization	
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	
Outpatient Health Care Professional Services	
Pharmacy Services	
Physical Health Services	
Physical Therapy	
Physician Visits	
Podiatry Services	

Medicaid Covered Services (Non-Community Benefit Services)	
Covered Service	**Service Limitation(s)**
Pregnancy Termination Procedures	
Preventive Services	
Prosthetics and Orthotics	
Psychosocial Rehabilitation Services	
Radiology Facilities	
Recovery Services (Behavioral Health)	
Rehabilitation Option Services	
Rehabilitation Services Providers	
Reproductive Health Services	
Respite (Behavioral Health)	
Rural Health Clinics Services	
School-Based Services	
Smoking Cessation Services	
Speech and Language Therapy	
Swing Bed Hospital Services	
Telemedicine Services	
Tot-to-Teen Health Checks	
Transplant Services	
Transportation Services (medical)	
Treatment Foster Care Treatment Foster Care II	
Vision Care Services	

Agency-Based Community Benefit Services **(Member must meet NFLOC to be eligible for services.)**
Adult Day Health
Assisted Living
Behavioral Support Consultation
Community Transition Services
Emergency Response
Employment Supports
Environmental Modifications ($6,000 limit every five years)
Home Health Aide
Nutritional Counseling
Personal Care Services (Consumer Directed and Consumer Delegated)
Private Duty Nursing for Adults
Respite (annual limits may apply)
Respite RN (annual limits may apply)
Skilled Maintenance Therapy Services

Self-Directed Community Benefit Services **(Member must meet NFLOC to be eligible for services.)**
Behavioral Support Consultation
Customized Community Support
Emergency Response
Employment Supports
Environmental Modifications ($5,000 limit every 5 years)
Home Health Aide
Nutritional Counseling
Private Duty Nursing for Adults
Related Goods (annual limits may apply)
Respite (annual limits may apply)
Respite RN (annual limits may apply)
Self-Directed Personal Care (formerly Homemaker)
Skilled Maintenance Therapy Services
Specialized Therapies (annual limits may apply)
Start-up Goods
Transportation (non-medical) (annual limits may apply)

ATTACHMENT 3: New Mexico Optional Advance Health Care Directive Form

New Mexico Optional Advance Health Care Directive Form
EXPLANATION FOR MEMBERS

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

2. Select or discharge health care providers and institutions;

3. Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and

4. Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(name of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

_____
_____
(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I am unable to make my own health care decisions. If I initial this box [_____], my agent's authority to make health care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

[___] I CHOOSE NOT To Prolong Life

I do not want my life to be prolonged.

[___] I CHOOSE To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

[___] I CHOOSE To Let My Agent Decide

My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[___] I DO NOT want artificial nutrition OR

[___] I DO want artificial nutrition.

[___] I DO NOT want artificial hydration unless required for my comfort OR

[___] I DO want artificial hydration.

(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

_____
_____

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[___] I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[___] I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

_____

_____

[___] I REFUSE to make an anatomical gift of any of my organs or tissue.

[___] I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____
_____
(Add additional sheets if needed.)

PART 3
PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health care provider and any health care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health care provider.

(14) SIGNATURES: Sign and date the form here:

_____
(date) (sign your name)

_____
(address) (print your name)

_____
(city) (state) (your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness:

_____
(print name)

_____
(address)

_____
(city) (state)

_____
(signature of witness)

_____
(date)

Second witness:

_____
(print name)

_____
(address)

_____
(city) (state)

_____
(signature of witness)

_____
(date)

ATTACHMENT 4: Provider Disclosure Form

Disclosure of Ownership and Control Interest Form

Purpose: In compliance with 42 CFR 457.935, 42 CFR §455.104, §455.105, and §455.106, providers/*disclosing entities* are required to disclose including, but not limited to, information regarding (1) the identity of all *persons with an ownership or control interest* in the provider/*disclosing entity*, or in any *subcontractor* in which the provider/*disclosing entity* has a direct or *indirect ownership* of 5 percent or more including the identity of *managing employees*, and *other disclosing entities*; (2) certain business transactions and *significant business transactions* between the provider/*disclosing entity* and *subcontractors/wholly owned suppliers*; and (3) the identity of any *person with an ownership or control interest* in the provider/*disclosing entity* or who is an *agent*, or a *managing employee* of the provider/*disclosing entity* that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. **Any authorized/designated representative of the provider/*disclosing entity* may complete and sign this form on behalf of the provider/*disclosing entity*.**

Instructions for Completing the Ownership & Control Interest Disclosure Form

1) Read all definitions and instructions outlined throughout the form and then reference the definitions and instructions while completing the form. Terms with corresponding regulatory definitions are italicized and underlined throughout this form. Please review the applicable definition before responding to the question.
2) Definitions for Disclosure of Ownership and Control Interest Form - See Appendix A
3) Completion and submission of this statement/disclosure is a condition of participation as a credentialed or enrolled provider in the New Mexico Medicaid Managed Care Network or the State Children's Health Insurance Program (CHIP) network for services to members under Medicaid and CHIP benefit plans.
4) Answer all questions as of the current date i.e. request date.
5) If there is no information to include, indicate "None" or "Not applicable" (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete forms will be reported back to HSD.
6) If more space is needed, please attach additional sheets.
7) In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
8) Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
9) Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.
10) This statement/disclosure should be submitted with your MCO application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A statement must also be provided within 35 calendar days of a request for this information.
11) Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

How to Determine Ownership or Control Percentages (42 CFR 455.102).

12) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
13) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Disclosure of Ownership and Control Interest Form

NAME OF PROVIDER/*DISCLOSING ENTITY* BEING CONTRACTED: _____

NAME OF GROUP WHERE MEMBERS WILL BE SEEN: _____
TAX ID # OF PROVIDER/*DISCLOSING ENTITY*: _____

Section 1 –Disclosure Regarding *Managing Employees* (42 CFR 455.104(b) (4))

1) Does the provider/*disclosing entity* have any *managing employees*? ☐ Yes ☐ No
If Yes, provide the following details for any *managing employee* of the provider/*disclosing entity.*
See the definition of *managing employee*

NAME	SSN	Birthdate	Complete Address (street/city/state/zip)	NPI	Position

Section 2 – Criminal Offense Disclosure (42 CFR 455.106)

2) Has the provider, or any *person* (individual or entity) *who has ownership or controlling interest* in the provider/*disclosing entity*, or who is an *agent* or *managing employee* of the provider/*disclosing entity*, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs? ☐ Yes ☐ No (verify exclusion through the applicable federal and state specific exclusion databases.)
If Yes, provide the following details and a description of offense(s). Use additional pages if necessary.

NAME	SSN/TIN	Birthdate	Description

Section 3 – Person(s) with Ownership or Control Interest Disclosure (42 CFR 455.104(b) (1))

3) Are there any *persons* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity*?
☐ Yes ☐ No
If Yes, provide the following details and include the title (for example, CEO, owner, board member etc.).
* For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address.
See the definition of *person with an ownership or control interest* and *disclosing entity*

NAME	**TIN or SSN, as applicable	Birthdate	Title	Address (street/city/state/zip)	% Ownership Interest

Section 4A – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b) (1))

Disclosure of Ownership and Control Interest Form

4A) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ Yes ☐ No
If Yes, provide the following details about the *subcontractor*.
See the definition of the following terms: *subcontractor* and *indirect ownership interest*

Name of Subcontractor	**TIN or SSN, as applicable	Birthdate	Address (street/city/state/zip)	% Ownership Interest

Section 4B – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b) (1))

4B) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*?
☐ Yes ☐ No
If Yes, provide the information below about any *person (individual or entity) with an ownership or control interest*, in any *subcontractor* in which the provider/ disclosing entity has a 5 percent or more direct or *indirect ownership or control interest*.
See the definition of the following terms: *subcontractor* and *indirect ownership interest*

Name of Subcontractor (from section 4A)	Name of Person(s) with an ownership or control interest in the *subcontractor*	**TIN or SSN, as applicable of Person(s) with an ownership or control interest in the *subcontractor*	Birthdate of Person(s) with an ownership or control interest in the *subcontractor*	Address (street/city/state/zip)of Person(s) with an ownership or control interest in the *subcontractor*	% Ownership Interest

Section 5A – Relationships Disclosure (42 CFR 455.104(b) (2))

5A) Are any of the individuals disclosed in Section 3 above related to each other as a spouse, parent, child, or sibling?
☐ Yes ☐ No If Yes, provide the following details:

NAME(From Section 3)	Nature of Relationship (e.g., spouse)	Related to Name(From Section 3)

Disclosure of Ownership and Control Interest Form

Section 5B – Relationships Disclosure (42 CFR 455.104(b) (2))

5B) Are any of the individuals disclosed in **Section 3** above related to any of the individuals disclosed in **Section 4B** as a spouse, parent, child, or sibling? ☐ **Yes** ☐ **No** (spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Use additional pages if necessary. If **Yes**, provide the following details:

NAME(From Section 3)	Nature of Relationship (e.g., spouse)	Related to Name (From Section 4B)

Section 6 – *Other Disclosing Entity* Disclosure (42 CFR 455.104(b) (3))

6.1) Does the provider/*disclosing entity or any one named in Section 3* have an Ownership or Control Interest in any other Medicaid provider? ☐ Yes ☐ No ☐ N/A

6.2) Does the provider/*disclosing entity or any one named in Section 3* have an Ownership or Control Interest in any *other disclosing entity* that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services) , or Title XXI (State Children's Health Insurance Program) of the Social Security Act? ☐ Yes ☐ No ☐ N/A

If Yes to Items 1 or 2 of this Section 6, provide the following details:

See the definition of the following terms: *other disclosing entity* and *ownership interest*

NAME (From Section 3)	Name of *other disclosing entity or other Medicaid Provider*	**SSN and/or TIN**, as applicable of the *other disclosing entity or other Medicaid Provider*

Section 7A – Business Transactions Disclosure (42 CFR 455.105)

7A) **Business Transactions - Subcontractors**: Has the provider/*disclosing entity* had any business transactions with a *Subcontractor* totaling more than $25,000 in the previous twelve (12) month period (12-month period ending as of the date on this request)? ☐ **Yes** ☐ **No** If **Yes**, provide the following details:

**See the definition of *subcontractor* **

Name of *subcontractor*	**TIN or SSN, as applicable of *subcontractor*	Birthdate	Address (street/city/state/zip)	Transaction Amount

Disclosure of Ownership and Control Interest Form

Section 7B – Significant Business Transactions Disclosure (42 CFR 455.105)

7B) **Significant Business Transactions**: Has the provider/*disclosing entity* had any *Significant Business Transactions* with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending as of the date on this request)? ☐ **Yes** ☐ **No If Yes**, provide the following details:

See the definition of the following terms: *subcontractor*, *wholly-owned supplier*, and *significant business transactions*

Type of entity	Name	**TIN or SSN, as applicable	Birthdate	Address (street/city/state/zip)	Transaction Amount
☐ Wholly Owned Supplier ☐ Subcontractor					
☐ Wholly Owned Supplier ☐ Subcontractor					

Section 8 – Attestation

8) Through signature below, I hereby certify that persons with ownership and control interest in the provider/*disclosing entity* or in a *subcontractor*, *agents*, *subcontractors*, *managing employees*, and any employees providing healthcare services as part of this application are screened with the applicable background check including, but is not limited to, verification against the applicable state and federal exclusion databases. I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract. I further understand completion of this form does not guarantee participation with the Managed Care Organization.

Name: _____ **Title:** _____
(Print or Type: First/Middle/Last) **(Print or Type)**

Signature: _____ **Date (MM/DD/YYYY):** _____
(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

Disclosure of Ownership and Control Interest Form

APPENDIX A

DEFINITIONS

#	Term/Words	Definition
1	***Agent***	**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2	***Disclosing entity***	**Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. * For purposes of completing the Medicaid Disclosure Form, solo practitioners and the group contracting entity are also treated as a "disclosing entity." **Group Providers - The contracting group entity should complete the Form on behalf of the group.
3	***Fiscal agent***	**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4	***Group of practitioners***	**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
5	***Health Insuring Organization (HIO)***	Health insuring organization (HIO) has the meaning specified in § 438.2.
6	***Indirect ownership interest***	**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
7	***Managed care entity***	**Managed care entity** (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
8	***Managing employee***	**Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

Disclosure of Ownership and Control Interest Form

9	*Other disclosing entity*	Other disclosing entity **means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:** **a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);** **b. Any Medicare intermediary or carrier; and** **c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.**
10	***Ownership interest***	**Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in: **a.** The capital, the stock or the profits of the entity, or **b.** Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
11	***Person with an ownership or control interest***	**Person with an ownership or control interest** means a person or corporation that: a) Has an ownership interest totaling 5 percent or more in a disclosing entity; b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; e) Is an officer or director of a disclosing entity that is organized as a corporation; or f) Is a partner in a disclosing entity that is organized as a partnership?
12	***Prepaid ambulatory health plan (PAHP)***	Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.
13	***Prepaid inpatient health plan (PIHP)***	Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.
14	***Primary care case manager (PCCM)***	Primary care case manager (PCCM) has the meaning specified in § 438.2.
15	***Significant business transaction***	**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.
16	***Subcontractor***	**Subcontractor** means: **a.** An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or **b.** An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

17	*Supplier*	Supplier **means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).**
18	***Termination***	**Termination** means – a) For a-- i.Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and ii.Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. b) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. c) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.
19	***Wholly owned supplier***	**Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

BlueCross BlueShield
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