new mexico health connections

# PROVIDER HANDBOOK

myNMHC.org

# INTRODUCTION

New Mexico Health Connections (NMHC) is committed to providing the highest quality of care to its members, and driving improvements in quality more broadly in the community. The vision of NMHC, as a non-profit Consumer Operated and Oriented Plan (CO-OP), is to bring a life-improving revolution in health to New Mexicans through partnerships with our members, providers, and communities.

NMHC is a non-profit Consumer Operated and Oriented Plan (CO-OP) that serves New Mexicans starting in 2014. Created by the Affordable Care Act (ACA), CO-OP plans give consumers and small businesses more options for health insurance, providing required ACA essential health benefits (EHBs) and other federal or state mandated benefits, while complying with regulations defined by state and federal law.

A key concept of the CO-OP program is to drive implementation of integrated care and payment models producing improved health outcomes while "bending the cost curve," if not actually lowering aggregate costs. NMHC understands the importance of building programs that will influence our members' health behaviors, resulting in positive, sustainable health outcomes. In partnership with our members, provider network, and communities, we seek to ensure a clinically integrated approach to improving health care quality and access to care statewide.

This handbook is an important part of your Contractual Agreement with NMHC and is intended to provide NMHC network practitioners, their staff, and the larger health care delivery system the information, tools, and guidance needed to facilitate care and services for NMHC members.

# CONTACT INFORMATION

**Address**
**New Mexico Health Connections**
**P.O. Box 36719**
**Albuquerque, NM 87176**

**Provider Portal Login**
Providers contracted with NMHC can locate eligibility and benefits, claim status and referral inquiry, contracted medical providers, medical and administrative policies, and much more through our provider portal. If your facility does not yet have access, register now at http://mynmhc.org/. Click on *My Account Login.*

| Area | Phone (Toll-Free) | Fax | Web |
|---|---|---|---|
| **Customer Care** | 1-855-7MY-NMHC (1-855-769-6642) | 1-361-904-0187 | http://www.mynmhc.org/Contact_Us.aspx |
| **Customer Care for Albuquerque Public Schools, New Mexico Retiree Healthcare Authority, and New Mexico Public School Insurance Authority Members** | APS: 1-877-210-8339<br>NMRHCA: 1-877-210-8239<br>NMPSIA: 1-877-210-8213 | | APS: www.mynmhc.org/aps<br>NMRHCA: www.mynmhc.org/nmrhca<br>NMPSIA: www.mynmhc.org/nmpsia |
| **Credentialing** | 1-855-7MY-NMHC (1-855-769-6642) | 1-800-947-8701 | http://www.mynmhc.org/credentialing-re-credentialing.aspx |
| **Provider Services** | | 1-888-282-3483 | http://www.mynmhc.org/Health_Care_Professionals.aspx |
| **Medical Management** | | 1-866-628-3047 | http://www.mynmhc.org/medical-management.aspx |
| **Prior, Concurrent, and Expedited Authorizations** | | 1-866-628-3047 | |
| **Pharmacy Administration, Including Prior, Concurrent, and Expedited** | 1-855-577-6550 | 1-866-511-2202 | https://www.optum.com/landing/rx/pharmacycareservices/physicians.html |

| | | | |
|---|---|---|---|
| **Authorizations for Medications** | | | |

**Paper Claims Submission Address**
New Mexico Health Connections
P.O. Box 3828
Corpus Christi, TX 78463

**Change Healthcare (previously known as Emdeon) NMHC Payer ID**: 45129

**Language Line**
We offer translation and interpretation services in Spanish, Navajo/Diné, and more than 200 other languages. If you need translation or interpretation services during a visit with one of our members, call the Customer Care Center toll-free at 1-855-7MY-NMHC (1-855-769-6642) for help.

# QUALITY PROGRAM

The goal of the NMHC Quality Improvement Program (QIP) is to develop, implement, and maintain a quality program that meets the unique and diverse needs of our membership, New Mexico communities, and of the health care delivery system. The program's intent is to deliver care that exceeds expectations, promotes innovation in reimbursement strategies and opportunities to change health behaviors, and incorporates highly integrated clinical care approaches to improve health outcomes.

Implementation of NMHC's quality plan supports service delivery, quality health care, and patient safety for our members. The promotion of quality, enabled, and sustained through the creation of appropriate infrastructure, requires the following:

- Ensuring Qualified Health Plan (QHP) and National Committee for Quality Assurance (NCQA) Accreditation status.
- Ensuring compliance with ACA and state regulations, rules, and legislation.
- Developing an integrated set of core services, programs, and interventions to improve health outcomes of members while actively engaging providers.
- Developing effective monitoring and evaluation programs of health care services to meet or exceed current standards while identifying opportunities for continuous improvement and subsequent implementation of solutions.
- Developing effective processes and educational opportunities to reduce medical errors and improve patient safety.
- Identifying and responding to health care disparity issues to improve quality of care.
- Developing and implementing programs in alignment with ACA.
- Implementing and evaluating the quality improvement program and activities to be aligned with the National Strategy for Quality Improvement in Health Care.

The NMHC QIP activities are integrated within all health plan operations and provide mechanisms for the coordination of quality improvement, medical and behavioral health management, member services, and all essential plan functions that contribute to the quality of member care, services, and experience. The QIP is reflective of the local health care delivery system and provides for a systematic approach to continuous improvement, encompassing the quality of evaluation and improvement activities across the continuum of health care services that impact members and providers.

The following program components are essential in the promotion of quality health care delivery and plan services and are covered as part of the QI Program:

**Service Quality**

- Complaints and Appeals Processes
- Member Satisfaction (CAHPS®, Qualifying Health Plan [QHP] Enrollee Experience Survey, and other)
- Customer (member, producer, practitioner/provider, employer) Communications
- Member Services

**Integrated Clinical Management**

- Disease Management/Chronic Condition Management/Complex Case Management
- Community Health Worker Program
- Utilization Management
- Clinical Practice Guidelines
- Pharmacy and Therapeutics
- New Technology Evaluation

**Population Health**

- HEDIS® Measurement Set
- CMS Quality Rating System
- Continuity and Coordination of Care (Medical and Behavioral)
- Culturally and Linguistically Appropriate Services
- Wellness and Health Promotion
- Patient Safety

**Provider Network**

- Network Management and Credentialing/Re-credentialing
- Provider/Practitioner Satisfaction
- Contracting: Provider/Practitioner
- Accessibility and Availability

**Plus:**

- Delegation
- NCQA Accreditation
- QHP and Exchange Requirements

# CREDENTIALING AND RE-CREDENTIALING

NMHC is dedicated to providing our members with access to effective, high-quality, affordable health care. To ensure we maintain the highest integrity throughout our provider network, we verify and review the credentials of our participating practitioners and facilities initially, and again, every three years. This process helps us maintain and improve the quality of care and services delivered to our members.

NMHC's credentialing processes and standards have been designed to be consistent with broadly adopted standards, including NCQA and New Mexico statutory and regulatory requirements.

NMHC prefers that physicians wishing to participate in the NMHC network are board-certified or board-eligible in their area of specialty; however, all practitioners applying for participation in the NMHC network must meet, at a minimum, the following NMHC eligibility criteria for initial credentialing and for re-credentialing:

- Current, valid, and unrestricted license to practice in the state in which the practitioner will treat NMHC members.
- For prescribing practitioners: Current and unrestricted Drug Enforcement Administration (DEA) registration and current unrestricted state Controlled Dangerous Substance (CDS) certificate, if applicable, in the state in which the practitioner practices. If a prescribing practitioner does not prescribe medications, he or she must submit a written description of a formal arrangement for medication prescription for his or her patients should any of them require medication.
- Graduation from medical school or professional school.
- For physicians: Completion of residency program approved by the Accreditation Council for Graduate Medical Education (ACGME).
- For non-physicians: Completion of master's degree and state mandated clinical hours, and certification, if appropriate.
- Current professional liability (malpractice) insurance.
- For physicians and other practitioners with hospital privileges: Clinical privileges in good standing at the facility designated by the practitioner as the primary admitting facility. If a practitioner does not have admitting privileges, he or she must submit a written description of a formal arrangement for inpatient coverage for his or her patients should any of them require hospitalization.

**Credentialing Applications**

NMHC prefers the CAQH Universal Provider DataSource (UPD) application for gathering data about practitioners initially, and then every three years thereafter for re-credentialing. Practitioners are encouraged to update their online CAQH applications prior to credentialing or re-credentialing with NMHC.

**Credentialing/Contracting**

Providers who have not completed the credentialing process and have not been approved by the NMHC Credentialing Committee are considered Non-Contracted or "out of network" with NMHC. Claims for services rendered by Non-Credentialed, Non-Contracted providers may be denied payment.

**Practitioners must have in their possession a signed agreement and the credentialing approval letter to begin to treat NMHC members.**

**Practitioner Rights Related to the Credentialing Process**

Physicians and other health care practitioners applying for participation in the NMHC provider network have the following rights regarding the credentialing process:

- The right to review the information submitted to support the credentialing application;
- The right to correct erroneous information; and
- The right to be informed of the status of the credentialing or re-credentialing application, upon request.

# PROVIDER ROLES AND RESPONSIBILITIES

**Primary Care Overview**

NMHC values the relationship between a patient and their Primary Care Practitioner (PCP) and believes access to PCPs is critical for the overall well-being of our members. The PCP plays a critical role in care management and the success of members who are encouraged to be engaged in their own health care maintenance and wellness.

In our continuing efforts to offer affordable health care coverage, NMHC will work with our practitioners and members to avoid uncoordinated, episodic care by encouraging close relationships between the member and the PCP, and offering readily accessible preventive health care services and treatment. NMHC will also ensure that members with chronic health care needs have the information they need to manage their conditions.

**Primary Care Practitioner Selection**

NMHC encourages members to select a PCP within 30 days of enrollment onto one of our plans. NMHC will monitor for members that have not selected a PCP and conduct an outreach to the member to encourage PCP selection as soon as possible. Members are encouraged to call their intended PCP office and to establish with the PCP through a new patient visit.

NMHC's network of PCPs includes practitioners in the fields of family medicine, internal medicine, and pediatrics, including physician assistants and nurse practitioners practicing primarily in these areas of medicine. Other practitioners, such as OB/GYNs, may be considered for designation as PCPs if their scope of practice includes all aspects of primary care and they elect to practice in the role of a PCP. PCP designation for other specialists must be approved by the NMHC Medical Director.

The member's PCP will not be indicated on his or her ID card. Validation of the member's eligibility can be completed through the Provider Portal, HealthXnet, or by calling Customer Care at 1-855-769-6642.

**Specialty Care Practitioners**

Specialty Care Practitioners are trained to provide services in specialized fields of medicine. To participate in our network, Specialty Care Practitioners must agree to accept patients from other in-network providers and to provide specialized services for the member.

The table on the next page outlines the responsibilities of NMHC participating providers, whether PCP, Specialty Care, or Behavioral Health.

**In-Network Specialists**

Members may self-refer to in-network specialists. Prior authorization must be obtained for services requested for non-contracted providers.

**Referrals to In-Network Providers**

Providers should always refer NMHC members to other in-network practitioners and facilities for care. Referring NMHC members to out-of-network providers often results in the out-of-network provider balance-billing our member. Special care should be taken to ensure that NMHC members are referred to in-network laboratories, radiology centers, hospitals, and other ancillary providers. A complete list of in network providers can be found on NMHC's website at http://mynmhc.org/find_a_doctor.aspx or by clicking on "Find a Provider" from the home page.

**Referrals to Out-of-Network Providers**

In-Network providers should make best efforts to direct members to In-Network specialists. Authorizations for referrals to out-of-network providers must be obtained through NMHC and are subject to the prior authorization process.

***Referring NMHC members to out-of-network providers always requires prior authorization.***

**Responsibilities of NMHC Providers**

| Responsibility | PCP | Specialist | MH/BH |
|---|---|---|---|
| Meet NMHC's credentialing and re-credentialing requirements. | X | X | X |
| Notify NMHC of changes that could affect the ability to effectively render medical care, including but not limited to changes in address, licensure, liability insurance coverage, and contracting status. | X | X | X |
| Refer to the NMHC provider contract for termination policies including time frame specifics and obligations. | X | X | X |
| Adhere to NMHC utilization and quality management procedures. | X | X | X |
| Follow NMHC's administrative policies and procedures including compliance with all Health Insurance Portability and Accountability Act (HIPAA) regulations. | X | X | X |
| Adhere to NMHC prior authorization procedures and requirements. | X | X | X |
| Ensure continuity of care for members by coordinating all care, referrals, and follow-up treatment of members. | X | | |
| Initiate referrals to in-network specialty care providers, hospitals, and facilities as clinically appropriate. | X | X | X |
| Provide medically necessary services to members who have been referred by their PCP, another in-network health care practitioner, or who have self-referred appropriately for specific health concerns, diagnoses, and treatments. | | X | X |
| Communicate with members, referring providers, and other in-network providers regarding services rendered, results, reports, and recommendations to ensure continuity and quality of care, including but not limited to prompt notification of abnormal test results. | X | X | X |
| Be aware of NMHC's in-network participating providers, labs, Durable Medical Equipment (DME) providers, and other service providers in order to minimize delays, inconvenience, and billing problems for NMHC members. | X | X | X |

| Responsibility | PCP | Specialist | MH/BH |
|---|---|---|---|
| Maintain current medical records in accordance with state and federal regulatory requirements, and document communication with other providers in the member's medical record. | X | X | X |
| Collect specified copayments and verify member eligibility and benefit certification for covered services. | X | X | X |
| Confirm benefit eligibility from NMHC for non-emergent inpatient and outpatient services in accordance with the member's benefit package. | X | X | X |
| Agree to treat all patients equally, without discriminating on the basis of gender, age, ethnicity, sexual orientation, disability, race, religion, place of residence, health status, member status, income level, without regard to source of payment made for services rendered, or on any basis prohibited by federal or state law. | X | X | X |
| Respect the cultural and religious concerns of patients. Determine if members have any special cultural needs (e.g., concerns regarding blood or blood products, transplants, end-of-life care) special language needs, etc. | X | X | X |
| Report abuse or neglect of a child or vulnerable adult (revealed to a provider or suspected by a provider) to proper regulatory authorities pursuant to state law and contacting Children, Youth and Families at (505) 841-6100 or Statewide Central Reporting Intake at 800-797-3260. | X | X | X |
| Provide routine office visits (including evaluation, diagnosis, and treatment of illness and injury) and preventive health services in accordance with practice guidelines and medical policies. | X | | |
| Communicate with the other in-network referring providers regarding services rendered, results, reports and recommendations to ensure continuity and quality of care. | X | X | X |
| Guide members in self-management, goal setting and planning. | X | | |
| Guide members on how to use available health care services and treatment. | X | X | X |
| Provide or arrange for the provision of services to designated laboratory, radiology, and pharmacy facilities. | X | X | X |
| Provide health education services for members and their families. | X | X | X |
| Prescribe generic pharmaceuticals, where medically appropriate, and within NMHC's formulary and formulary exceptions process. | X | X | X |
| Administer injections, including adult and pediatric immunizations, in accordance with medical practice standards. | X | | |
| Provide or arrange for the provision of medically related social services including behavioral health or chemical dependency. | X | X | X |
| Inform patients of their right to know about all treatment options related to their conditions or disease processes, whether or not recommended services are covered benefits. | X | X | X |
| Maintain admitting privileges at a participating hospital within the service area or have a mechanism for admitting panel members. | X | X | X |

| Responsibility | PCP | Specialist | MH/BH |
|---|---|---|---|
| Provide or arrange for the provision of covered services and telephone consultations during normal office hours and on an emergency basis, 24 hours a day, seven days a week. | X | | |
| When the PCP is unavailable, coverage should be arranged through a participating NMHC health care professional or with an on-call health care professional who has signed a coverage arrangement with a participating PCP. | X | | |

# MEDICAL MANAGEMENT

## Utilization Management Process

The NMHC Medical Management Team evaluates requests for coverage in order to ensure that services rendered to members are medically necessary and/or appropriate, are occurring in the appropriate setting, and are included in the member's benefit coverage. We utilize nationally recognized criteria (including InterQual®), evidence-based guidelines, and NMHC medical policies for clinical decision making. Utilization Management encompasses services rendered in ambulatory, inpatient, and transitional settings.

Upon request, NMHC will provide a copy of the clinical rationale and medical criteria used to make a determination. There is no charge for this request. To obtain a copy, you may call our Medical Management Department at 1-855-769-6642, option 3, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Mountain Time, or send a written request to: New Mexico Health Connections, P.O. Box 17874, Austin, TX 78760.

If you have questions, you may call the plan's pharmacy benefit manager customer support at 1-855-577-6550, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Mountain Time.

## Prior Authorization

Prior authorization is the process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member's plan. Prior authorization is part of the utilization management process and case management model. Determinations for medical appropriateness are made by evaluating information from the requesting physician, the member's medical records, consultations, and relevant laboratory and radiological information.

NMHC requires prior authorization for all elective hospitalizations, transfers to non-participating facilities, skilled nursing facility admissions, acute rehabilitation facility admissions, and advanced radiology services (CT, MRI, and PET scans). Prior authorization is also required for certain ambulatory services and DME.

NMHC will make a determination for services where a prior authorization is required and will notify the member and the provider of the determination by phone and in writing. A standard (non-urgent) determination regarding prescription drugs will be made within three (3) working days, and five (5) working days for all other services of the receipt of request.

***Please refer to the Prior Authorization List, located in the Forms section, for a complete list of services that require prior authorization.***

## Concurrent Review

Concurrent review is an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. NMHC will make a determination if a concurrent approval is required

and will notify the member and provider by phone and in writing. The determination will be made within five (5) working days of the receipt of the request.

**Post-Service Review**
Post-service review is any review for care or services that have already been received, e.g., retrospective review. Post-service determinations include any requests for coverage of care or service that a member has already received. Determinations will be made within thirty (30) calendar days of receipt of the request.

**Expedited Review**
The expedited review will be conducted when NMHC determines, or when a provider indicates a delay would seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum functions. The determination will be made within twenty-four (24) hours of the receipt of the request. This includes urgent pre-service and concurrent determinations.

**Adverse Determinations**
While all requests for services that require prior or concurrent authorization will be reviewed by an appropriate clinical professional, all adverse determinations will be referred to a NMHC medical director for an adverse determination decision. Prior to a formal appeal, providers may discuss the decision with the applicable NMHC medical director who made the adverse determination, which includes a peer-to-peer conversation around the clinical evidence involved in the case.

**Obtaining Authorization for Pre- and Concurrent Services**
For all services that require an authorization, the provider must contact the NMHC Medical Management department at 1-855-769-6642, option 3.

Authorization requests may be phoned in to NMHC Medical Management during normal business hours, Monday through Friday, 8:00 a.m.to 5:00 p.m. MST, or faxed to 1-866-628-3047. If providers require assistance for urgent (expedited) determinations after business hours, please call 1-855-769-6642 to reach an on-call nurse case manager.

Requests for authorizations must be made before the anticipated procedure, transfer, admission, or service is provided.

Please include the following information in a Request for Authorization or for Concurrent Review for continued coverage of care:

- Member's name and subscriber number
- Scheduled date of procedure, transfer, admission, or service
- Name of attending, referring, or ordering physician
- Location of service and rendering physician
- Diagnosis
- Procedure
- Supporting clinical/medical information for request

Please refer to the Prior Authorization Request Form located in the Forms section.

For detailed information regarding determinations, please visit our Medical Management page at http://www.mynmhc.org/medical-management.aspx or contact us at 1-855-769-6642.

Note: Due to circumstances regarding member eligibility and timeliness standards, an authorization is not a guarantee for payment. Prior authorization does not guarantee payment in cases of fraud and/or misrepresentation. Such cases may include the addition of procedures that were not originally authorized and/or information not originally provided.

**Case Management Program**

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet complex health needs of our members. Case Management is an integral part of NMHC's Medical Management program because it allows us to partner with providers to prevent fragmented, episodic care for our members. Research and experience show that a higher-touch, member-centric care environment for at-risk members supports better health outcomes.

Keys to Case Management are:

- Coordination
- Monitoring of Service Delivery
- Advocacy
- Evaluation
- Reassessment

NMHC is committed to the delivery of high-quality case management programs to our members. We place our members either into Level 1 Case Management or Complex Case Management. The level of case management is determined by an assessment of the member's needs using an evidenced-based assessment tool, which develops a coordinated, member-focused, and multi-disciplinary plan of care. The plan of care is designed to meet the specific health needs of the member with the ultimate goal of helping members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

The NMHC Case Management program is available to all NMHC members. While NMHC monitors claims, utilization patterns, and other health plan data, we accept referrals into any level of case management from members, caregivers, discharge planners, nurse advice line staff, and providers.

**Levels of Case Management**

- Level 1 Case Management
- Complex Case Management

**Level 1 Case Management Criteria (includes both medical and behavioral health Case Management)**

- Recent, self-limiting, acute injury, or illness

- Exacerbation of a chronic condition, and may be at risk for complications or readmission
- Inappropriate utilization of services such as repeated emergency department visits
- Medication non-adherence

**Complex Case Management Criteria**

- Major organ transplant
- Catastrophic illness
- Multiple medical problems
- Non-compliance or resistance to treatment
- Inability to follow treatment plan
- Repeated or unexpected readmissions
- Members with multiple providers
- Complex medical condition such as acute brain injury or respiratory failure
- Complex psychosocial needs that are interfering with member's ability to obtain appropriate medical care

**Case Management Value to Providers**

The Case Manager:

- Obtains information about the home environment regarding barriers to recovery.
- Evaluates family dynamics and the family's impact on the patient's response to the treatment you have prescribed.
- Assesses the member's/family's degree of motivation toward achieving optimal function.
- Provides education on the member's disease process.
- Monitors progress towards treatment goals and the need for additional education and/or clarification of information.
- Explains and maximizes the member's available health plan benefits.
- Provides coordination of health care services.
- Connects members with community resources.

Providers receive the following when their patients/NMHC members enroll in Case Management:

- Written or telephonic notification when a member who is the provider's patient is enrolled in a Case Management program.
- A copy of the individualized care plan created for the member.
- Communication from the Case Manager on the member's progress toward goals.

**Referral to Case Management**

To refer a member:

- By phone: Please contact Case Management at 1-844-691-9984.
- By fax: Complete the Practitioner/Provider Complex Case Management Referral Form on http://www.mynmhc.org/provider-resources.aspx and fax to 1-866-628-3047.

**How to Contact Us**

- Phone: 1-844-691-9984
- Fax: 1-866-628-3047

**Transition of Care**

If a member is receiving an ongoing course of treatment from a Non-Participating Provider when he/she enrolls in the Plan, or with a Participating Provider whose contract ends during a course of treatment, the member may be eligible to continue to receive services and have them covered by the Plan. This is called a Transition of Care. Determinations for Transition of Care are made based on established medical criteria. The Transition of Care Period will be for a period of no less than thirty (30) days. Transition of Care also applies to members who have entered the third trimester of pregnancy, including post-partum care directly related to the delivery.

**Disease Management**

NMHC is committed to supporting providers in the management of chronic conditions. NMHC Disease Management programs play an integral role in improving the quality of life and promoting cost effective outcomes for NMHC members with asthma and diabetes. Following are brief descriptions of the NMHC Asthma and Diabetes Disease Management programs:

**Asthma** is a chronic disease that can be controlled with client education, medication management, and identification and elimination of asthma triggers in the environment. NMHC's Asthma Management Program is designed to identify and improve clinical outcomes for our members with asthma, through the development and promotion of strategies that lead to better quality health care, cost effective outcomes, and higher member satisfaction. The program incorporates a structured process that defines goals, interventions, and outcome measures and provides guidance and focus for improvement. Interventions are based on best practices designed to address the obstacles and unique complexities that this vulnerable population faces and is consistent with the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, dated 2007, of the National Heart, Lung, and Blood Institute, adopted by NMHC in April 2013.

The overall program goal is to control asthma by reducing impairment and risk, resulting in improved clinical outcomes and decreased health care costs.

This goal is accomplished through:

- Proactively identifying members with asthma.
- Analyzing and stratifying risks factors to determine which level of intervention member will receive.
- Outreaching, educating, and engaging asthmatic members and their families in interventions to improve their health care outcomes and to develop asthma self-management strategies.
- Facilitating communication, teamwork, coordination and management of necessary health care services.
- Assisting members requiring community resources such as transportation and food stamps.

Outcomes measures used to assess the effectiveness of the program include:

- Reduction in asthma-related emergency room utilization.
- Reduction in asthma-related inpatient hospital admissions.
- Improvement in appropriate medication treatment for members with asthma.
- Member program satisfaction and self-reported improvement in asthma management.

**Diabetes** is a chronic disease that can be controlled with client education, medication management, and identification and elimination of triggers in the environment. NMHC's Diabetes Management Program (program) is designed to identify and improve clinical outcomes for our members with diabetes, through the development and promotion of strategies that lead to better quality health care, cost effective outcomes, and higher member satisfaction. The program incorporates a structured process that defines goals, interventions, and outcome measures and provides guidance and focus for improvement. Interventions are based on best practices designed to address the obstacles and unique complexities that this population faces, and are consistent with the American Diabetes Association, Diabetes Care, Standards of Medical Care in Diabetes, 2012 adopted by NMHC in April 2013.

The overall program goal is to control diabetes by reducing impairment and risk, resulting in improved clinical outcomes and decreased health care costs.

This goal is accomplished through:

- Proactively identifying members with diabetes.
- Analyzing and stratifying risks factors to determine which level of intervention member will receive.
- Outreaching, educating, and engaging diabetic members and their families in interventions to improve their health care outcomes and to develop diabetes self-management strategies.
- Facilitating communication, teamwork, coordination and management of necessary health care services.
- Assisting members requiring community resources such as transportation and food stamps.

Outcomes measures used to assess the effectiveness of the program include:

- Reduction in diabetes-related emergency room utilization.
- Reduction in diabetes-related inpatient hospital admissions.
- Improvement in appropriate screenings such as low-density lipoprotein, hemoglobin A1c, and microalbuminuria (dependent on available client data).
- Member program satisfaction and self-reported improvement in diabetes management.

Referrals to the disease management program can be initiated by contacting the NMHC Medical Management department at 1-855-769-6642. For more information about NMHC Disease Management program, please call 1-855-769-6642.

**NMHC Care Connect Line**

NMHC has a nurse advice line available exclusively to NMHC members 24 hours per day, 7 days per week, 365 days per year. Experienced registered nurses answer questions and provide confidential

medical advice, at no cost. Nurses also refer callers to NMHC Case Management and Disease Management programs when appropriate.

Members can call the NMHC Care Connect Line at 1-844-308-2552.

**Attestation Regarding Decision-Making and Compensation**

NMHC does not provide incentives for Care Management staff based on any utilization review decisions. All review decisions are based upon appropriate care and benefit coverage.

**Utilization Management Affirmation Statement**

Utilization management decision making is based only on appropriateness of care and service, and existence of coverage. There are no rewards to practitioners or other individuals for issuing denials of coverage, or requested services. There are no financial incentives for any utilization management decision makers that encourage decisions that result in underutilization.

Initial or continued requests for treatment or length of stay may be approved by the designated Care Management Staff, based on the clinical information provided and reviewed against explicit criteria. All utilization adverse determinations/ denial decisions are made by Medical Directors.

# PHARMACY

NMHC offers a formulary or preferred drug list for all benefit plans. The NMHC pharmacy benefit is provided and managed by OptumRx®, one of the industry's largest and most experienced Pharmacy Benefit Managers (PBM).

**Pharmacy & Therapeutics Committee**

The NMHC formulary and the policies and procedures regarding managing the formulary are reviewed and approved by the NMHC Pharmacy & Therapeutics (P&T) Committee, which is comprised of actively practicing physicians, actively practicing pharmacists and other licensed health care professionals. P&T Committee members exercise their professional judgment in making determinations based on clinical and scientific evidence and analyses. The P&T Committee reviews the formulary and policies annually, and updates occur as information from the Food and Drug Administration (FDA), Centers for Medicare & Medicaid Services (CMS), or when sound clinical evidence becomes available.

In its evaluation, review, guidance and clinical recommendations, the P&T Committee shall:

- Make recommendations on the therapeutic placement and appropriate prescribing guidelines for prescription drug products, and as appropriate, medical device products, intended for use in an ambulatory care setting.
- Provide ongoing review and monitoring of the safety, effectiveness, and quality of care of products contained within the formulary and in NMHC's clinical programs.
- Initiate and/or review recommended DUR and DUE programs.
- As necessary, review, advise, and approve utilization management guidelines, including prior authorization, step therapies and quantity limits.
- Advise NMHC on suitable educational programs (e.g., for health care provider networks, Plan Participants, and pharmacy providers).
- Make recommendations for the implementation of effective product utilization control procedures.

In addition to making clinical recommendations to the formulary, the P&T Committee shall provide information to medical, health care, and related pharmacy benefit professionals on matters pertaining to the clinical management of prescription drug and medical device usage by:

- Establishing policies and procedures to educate and inform health care professionals about products, product usage, and the P&T Committee's clinical recommendations;
- Overseeing quality improvement programs that employ product use evaluation;
- Providing recommendations for implementation of generic substitution and therapeutic interchange programs based upon clinical and medical analysis and assessment; and
- Evaluating, analyzing and reviewing protocols for the use of and access to non-formulary products.

Additional responsibilities may be established and delegated to the P&T Committee, as determined by the Chief Medical Officer.

**NMHC Formulary**

The P&T Committee maintains the formulary for outpatient medications, which may be prescribed by any NMHC provider without Prior Authorization. NMHC providers are required to use formulary medications whenever medically appropriate. Specialty medications must be received from BriovaRx®. Pharmacists will not fill prescriptions for NMHC members for non-formulary drugs unless an approval has been received from OptumRx. Limits and quotas on drugs are set as needed by the P&T committee based on best medical evidence and communicated to providers through regular provider updates such as newsletters or other communications.

***NMHC's formulary is available on our website at http://www.mynmhc.org/Formulary.aspx. If you need assistance with the formulary or in obtaining authorization, call OptumRx at 1-855-577-6550. Formulary exceptions are processed by OptumRx based on medical necessity.***

Covered medications include:

- Up to a 30-day supply of drugs requiring a prescription under state or federal law.
- Up to a 90-day supply of drugs when purchasing through the mail order program.
- Generic drug coverage at no cost for hypertension, depression, bipolar disorder, chronic obstructive pulmonary disease, coronary artery disease, hypercholesterolemia, diabetes, congestive heart failure, asthma, and medications for oral chemotherapy.
- Specialty medications with prior approval.

The prescription drug benefits for NMHC members are listed on the member ID card. For member convenience, we also offer a mail order prescription service for ongoing maintenance medications.

Exclusions include but are not limited to:

- Non-prescription drugs
- Compound medications
- Medications excluded by regulation as described by the Centers for Medicare & Medicaid Services (CMS)
- Personal care items
- Cosmetic drugs
- Appetite suppressants, dietary supplements, prescription vitamins (other than prenatal), fluoride products
- Experimental drugs

**Formulary Changes**

Participating practitioners may request the addition of a product to the formulary by submitting a request along with any supporting information to the NMHC Medical Management Team. The request will be presented at the subsequent P&T Committee for review and consideration. The P&T Committee decision will be provided to the requesting practitioner within fifteen (15) days following the P&T Committee meeting.

**Formulary Exceptions, Prior Authorizations, and Appeals**

All requests requiring approval for formulary exceptions should utilize the Drug Prior Authorization Request Form and should be faxed to OptumRx at 1-866-511-2202. Any questions can be directed to OptumRx at 1-855-577-6550. In all cases, the review and approval/denial of formulary exceptions will be executed as expeditiously as possible (but generally will not take longer than 48 hours). A provider requesting an exception should provide the following information:

- Patient's name
- Patient's date of birth
- Patient's member ID
- Medication requested
- Name of pharmacy the patient accesses to fill prescriptions
- Medical indication for request
- Alternative medicines tried in the past
- Provider contact information

Prospective review procedures and guidelines for formulary exceptions are developed and updated by and in conjunction with the NMHC P&T Committee and other specialist providers who have agreed to work with NMHC and OptumRx to provide expert guidance. In the event that a request for a coverage determination cannot be approved with the available clinical information, the prescriber, and the member are notified telephonically and in writing of the coverage determination. The written notification to the provider and the member will contain the rationale for the determination and a description of the appeal process. Additionally, the drug use by NMHC members is reviewed to determine if use is appropriate, safe, and meets current medication therapy standards.

The prescribed drug will be considered for coverage under the pharmacy benefit program when the following criteria are met:

- A formulary alternative is not appropriate for this patient (e.g., patient has a contraindication or intolerance to the formulary alternative, etc.); and
- The medication is being prescribed for an FDA approved indication OR the patient has a diagnosis that is considered medically acceptable in the approved compendia* or a peer-reviewed medical journal; and
- The patient does not have any contraindications or significant safety concerns with using the prescribed drug.

A lifetime approval will be granted for patients who meet the above criteria. If the patient does not meet the above criteria, the prescribed use is considered experimental/investigational for conditions not listed in this coverage policy section.

**Generic Substitutions**

NMHC utilizes the OptumRx Essential Health Benefits formulary. When a new generic comes to market, the formulary is automatically updated. The brand-name equivalent drug will be removed from the formulary. NMHC will notify providers and members of these changes.

**Therapeutic Interchange**
A therapeutic interchange will only be made if a provider has received and approved a recommendation for a medication change. OptumRx does not automatically perform therapeutic interchanges.

**Step Therapy**
OptumRx notifies NMHC of changes to all Utilization Management programs, including Step Therapy, on a monthly basis. NMHC will notify members who may be negatively affected by these changes.

**Online Tools**
NMHC members and providers are encouraged to use online tools available at https://campaign.optum.com/landing/rx/pharmacycareservices/members.html. Some actions a member or provider may perform online include:

- Determine copay or coinsurance amount for a medication
- Initiate the exception process
- Order a refill for an existing, unexpired mail order prescription
- Locate in-network pharmacies
- Determine potential drug interactions or side effects
- Look for generic substitutes

*The **approved compendia** includes:

- American Hospital Formulary Service (AHFS) Compendium
- Thomson Reuters (Health Care) Micromedex/DrugDex (not Drug Points) Compendium
- Elsevier Gold Standard's Clinical Pharmacology Compendium
- National Comprehensive Cancer Network Drugs and Biologics Compendium

## CLINICAL PRACTICE GUIDELINES

NMHC has established criteria and processes to adopt, update, and disseminate clinical practice guidelines (CPGs) that are relevant to the needs of our members. It is intended that CPGs support decision-making of practitioners and members as applicable to specific clinical and behavioral health service needs. Our CPGs provide "best practice" evidence-based resources and form a basis for our efforts to monitor and address the delivery of health care and outcomes for our members.

| 2016 Clinical Practice Guidelines | | | |
|---|---|---|---|
| **Condition** | **Evidence** | **Reference** | **URL** |
| **Diabetes** | Standards of Medical Care in Diabetes – 2016 | **American Diabetes Association (ADA)** ***Diabetes Care*; 39 (Supplement 1):S4-S5 (2016)** ***Diabetes Care*; 39 (Supplement 1):S1-112 (2016)** | Executive Summary: http://care.diabetesjournals.org/content/39/Supplement_1/S4.full.pdf+html<br><br>Full Report: http://care.diabetesjournals.org/content/39/Supplement_1 |
| **Asthma** | National Heart Lung and Blood Institute (NHLBI), Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma | **National Institutes of Health (NIH) NHLBI, NIH Publication No. 08-4051 (2007)** | Summary Report: http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf<br><br>Full Report: http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf |
| **Depression** | Health Care Guideline for Major Depression in Adult in Primary Care – 2016 | **Institute for Clinical Systems Improvement (ICSI), Seventeenth Edition (2016)** | https://www.icsi.org/_asset/fnhdm3epr-Interactive0512b.pdf |
| **Attention-Deficit Hyperactivity Disorder** | Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents – 2011 | **American Academy of Pediatrics (AAP)** ***Pediatrics*; 128 (5):1007-1022 (2011)** | http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/14/peds.2011-2654.full.pdf |

| 2016 Preventive Health Guidelines | | | |
|---|---|---|---|
| **Prevention** | **Evidence** | **Reference** | **URL** |
| **Pediatric** | Prevention and health promotion for infants, children, adolescents, and their families. | **American Academy of Pediatrics (AAP) Bright Futures, 3rd Edition Guidelines, Tool and Resource Kit (2008) Bright Futures, Pocket Guide (2008)** | Tool Kit: http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html<br><br>Pocket Guide: http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf |
| **Adult** | Preventive Services Recommendations for Adults | **United States Preventive Services Task Force, (Various dates)** | Full Report: http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations<br><br>Pocket Guide: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html |
| **Immunization** | Centers for Disease Control and Prevention, Vaccines and Immunizations | **Advisory Committee for Immunization Practices (ACIP), (2016)** | http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html |
| **Perinatal** | Routine Prenatal Care | **Institute for Clinical Systems Improvement (ICSI), Fifteenth Edition (2012)** | https://www.icsi.org/_asset/13n9y4/Prenatal-Interactive0712.pdf |

# REIMBURSEMENT POLICY

**Reimbursement and Fee Schedules**
These policies apply to all NMHC plan products. The member's contracted health plan benefits must be in effect on the date that services are rendered. NMHC reserves the right to review and update our Reimbursement Policies periodically.

NMHC typically reimburses its providers based on the current CMS Medicare fee schedule. However, we may negotiate other reimbursement based on NMHC or provider needs. We may adopt reimbursement or methodology changes required by CMS guidance or federal or state laws/regulations, and we may incorporate **annual** CMS increases or decreases to the fee schedule. Although we primarily use the CMS fee schedule, we occasionally may process claims outside of the standardized CMS payment logic.

The primary fee schedules are:

- CMS Inpatient Prospective Services (IPPS)
- CMS Outpatient Prospective Services (OPPS)
- Physician Fee Schedule (MPFS)
- Durable medical equipment, prosthetics and orthotics, and supplies (DMEPOS)
- CMS Clinical Laboratory Fee Schedule
- CMS Average Sales Price (ASP)
- Home Health PPS
- Hospice PPS
- Other applicable CMS fee schedules

***To calculate your reimbursement, go to the easy-to-use CMS lookup tool: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html.***

This link will open in a new window. Enter a CPT or HCPCS code to calculate 100 percent of reimbursement. Be sure to apply your contracted allowable percentage, if applicable.

In all cases, it is NMHC's policy to reimburse providers the **lesser** of the provider's billed charge or the provider's contracted reimbursement rate.

**Reimbursement of Covered Non-Contracted Goods and Services**
It is NMHC's policy to reimburse, rather than to deny claims payment to, contracted network providers when the provider submits claims for goods or services without a negotiated provision for those specific goods and services within the provider's contract with NMHC.

Reimbursement is contingent on the goods or services being a covered benefit, and contingent on the provider following NMHC guidelines for obtaining health plan authorization for the good or service, or providing the appropriate notification to the health plan prior to the service rendered. Providers must also treat members within their scope of practice specialty. The following are a few examples of covered non-contracted goods or services:

- Durable Medical Equipment (DME) (goods) issued to a member without a negotiated DME provision within the provider's contract with NMHC.
- Infusion drugs (goods and/or services) administered to a member without a negotiated provision for drugs or "J" codes within the provider's contract with NMHC.
- Lab tests drawn and/or tested by provider or provider's lab with no negotiated lab provision within the provider's contract with NMHC.

While NMHC is not a CMS entity, NMHC will utilize the lesser of the provider's billed charge, or CMS's reimbursement methodology and fee schedules, to administer usual and customary payment for covered non-contracted goods and services.

The following are examples of, but not limited to, the fee schedules NMHC uses use to administer payment of covered non-contracted goods and services:

- CMS DMEPOS: Durable Medical Equipment and Prosthetics and Orthotics
- CMS ASP: Drugs, Infusion, Injectables
- CMS CLFS: Clinical Laboratory Fee Schedule

**Facility "Overhead" Reimbursement Policy**

While NMHC may utilize Medicare fee schedules and CMS methodology to adjudicate claims, NMHC is not a Medicare entity, and does not recognize or reimburse Facility Overhead Charges.

A Facility Overhead Charge is a clinic charge for any technical component or overhead that is billed by a facility when a professional provider renders covered services to NMHC members in a facility clinic setting.

NMHC defines a facility clinic visit as a preventive, curative, diagnostic, rehabilitative, and/or education service provided to an ambulatory patient in an outpatient setting, whether in a freestanding or attached facility that is either owned, operated, leased, or controlled by the facility.

Some examples of a facility clinic visit include, but are not limited to a member:

- Having blood drawn for lab work at a facility draw station
- Seeing a behavioral health provider on a hospital campus
- Getting an X-ray at a diagnostic center
- Seeing his or her PCP
- Receiving education from a nutritionist

NMHC reimburses professional providers for covered services provided in a facility clinic setting when filed on a CMS-1500 form with place of service codes to include, but not limited to, place of service 11, 20, or 22 (Office, Urgent Care, Outpatient). This reimbursement will always include both the professional services and the associated overhead.

NMHC **will not separately** reimburse a facility for facility clinic visits and services billed on a UB-04, or any other form, when reported with revenue codes 510-525, 527-529 and any successor codes, including but not limited to the accompanying G Codes.

The technical and overhead component of the facility clinic visit will be included by NMHC in the reimbursement paid to the professional provider for professional services, as reported on the CMS-1500 form, with place of service codes to include, but not limited to, place of service 11, 20, or 22. These services may encompass but are not limited to Evaluation and Management health care services provided to NMHC members in a clinic setting.

The facility may not seek reimbursement for any technical or overhead component of the clinic charge from NMHC or from our members. The member is held harmless and may not be balance-billed by the provider for clinic facility charges.

In accordance with the terms of your Agreement with NMHC, we reserve the right to recover overpayments resulting from separately billed clinic/facility fees billed in combination with a professional office/clinic visit claim.

Find out more about NMHC's reimbursement policies and procedures on our website at http://mynmhc.org/provider-reimbursement-policy.aspx.

# CLAIMS SUBMISSION AND PAYMENT

NMHC has implemented claims program requirements to ensure timely and accurate processing of claims for our participating providers.

Members are also required to follow the applicable requirements of their plan to receive benefits.

**Member Eligibility and Benefits**

Providers must verify that a patient is an eligible member of the Plan and should verify benefits prior to rendering services.

NMHC encourages providers to verify a member's eligibility status throughout the period of continued and/or extended services as eligibility may change at any time. It is not uncommon for retroactive terminations to occur, which may affect the status of a member's eligibility. For this reason, verification of eligibility is not a guarantee of payment.

Provider offices should consider the following as a guide to help obtain verification of eligibility and benefits:

- All NMHC members must present their ID card at the time of service. Providers should further verify eligibility and benefits. Providers can use the link to the Provider Portal from our website at http://www.mynmhc.org/my-account-login.aspx.
- Providers should review the Prior Authorization Requirements prior to rendering services to determine whether or not prior authorization is required.
- Collect the member's cost-sharing requirement at the time of service.

**Billing Members for Services**

Providers should not bill members for any covered services, except for applicable copays, deductibles, and/or coinsurance amounts. Members may not be billed for services due to a provider's failure to obtain required authorizations. Any deductibles and/or coinsurance and charges for non-covered services should be billed to the member following the receipt of the Explanation of Payment (EOP) from NMHC.

Providers should not require payment from a Member for any non-covered service that the Member receives, unless the Member is informed that the services are non-covered and has agreed in writing, in advance of receiving the services, to pay for such services. A Member informed by the Provider that care is potentially non-covered, and proceeds with receiving the potentially non-covered service, may not be billed for the non-covered service by the Provider, unless the Member has previously agreed in writing to pay for the service.

Any waivers signed by the Member must be specific as to the details of the excluded or non-covered service and its cost. General agreements to pay, such as those signed by the Member at the time of service, are not evidence that the Member knew specific services were excluded or excludable or that the Member agreed to pay.

**Claims Submission**
Providers are required to submit clean claims for any services rendered to NMHC members. NMHC is required to process clean claims within thirty (30) days of receipt for electronic submissions, and forty-five (45) days for paper submissions. Providers will receive an Explanation of Payment (EOP) for all claims received.

A clean claim is a manually or electronically submitted claim that:

- Contains substantially all the required data elements necessary for accurate adjudication in accordance with the terms and conditions of the applicable plan and without the need for additional information;
- Is not materially deficient or improper, including lacking substantiating documentation currently required by the payor;
- Presents no mitigating or unusual circumstances (including the need for current coordination of benefits information) that prevent payment from being made in accordance with required time-frames; and
- Is submitted within NMHC's timely filing requirements.

Accurate and timely submission of claims for billing is a critical component to a provider's compensation.

**Additional tips for submitting claims are:**

- Submit clean claims on a CMS-1500 form or UB04 form that is compliant with the National Provider Identifier (NPI) and Health Insurance Portability and Accountability Act (HIPAA) regulations. Valid CPT, Revenue, HCPCS, ASA, and ICD-10 codes must be used and include appropriate modifiers, if applicable.
- Clean claim example includes the information listed on the attached link below. We may require additional information for particular types of services, or based on particular circumstances or state requirements.
- While some claims may require supporting information for initial review. NMHC will request additional information when needed.

For questions about claims, filing, or contracted reimbursement, please contact NMHC's Customer Care center at 1-855-769-6642.

**Timeframe for Filing Claims**

- Claims must be submitted no later than ninety (90) days after the provision of covered services.
- In cases in which NMHC is the secondary payor, claims must be filed ninety (90) days from the date of service or ninety (90) days from the date that the Provider receives notice of payment decision from the primary payor, whichever is later.

Only those charges for Covered Services billed in accordance with NMHC's standard claim coding and bundling methodology will be considered for payment. The Plan reserves the right to "re-bundle" billed charges that have been unbundled and to review claims for medical necessity determination prior to

payment. Only services that are medically necessary and covered by the plan will be considered for payment.

Providers must submit a claim for your services, regardless of whether you have collected the copayment, deductible, or coinsurance from the member at the time of service.

**Electronic Claim Submission**

NMHC understands how important it is for claim submissions to be processed timely and accurately. The quickest and most efficient way to file claims is electronically. If your office is not currently submitting claims electronically, we encourage you to do so. Electronic claim submission offers a number of benefits for a provider's office, including:

- Streamlined billing, which helps reduce paperwork;
- Faster claim delivery to NMHC instead of traditional mail delivery time;
- Improved feedback/correction capability for claims with missing or invalid data;
- One address for all NMHC claim submissions;
- Receipt acknowledging proof of acceptance by NMHC; and
- Quicker response/payment time for claims.

***NMHC uses Change Healthcare as its clearinghouse. Providers should work with their clearinghouses to ensure they can file to Change Healthcare.***

**NMHC Payer ID: 45129**

**Paper Claims Submission**

Although NMHC highly recommends filing claims electronically, provider offices can help timeliness and accuracy of paper claims filing by adhering to the following guidelines when completing and submitting paper claims:

- Use the current CMS-1500 or the current UB04 claim form as appropriate when submitting paper claims that are compliant with the National Provider Identifier (NPI) and HIPAA regulations. Generally, the CMS-1500 form is used for professional services and the UB04 is used for facility services. Please use original claim forms as opposed to copies of the forms.
- Make sure that all the fields are completed accurately. This will help avoid returned claims due to missing information.
- Refer to the member's current identification (ID) card to help ensure you have the appropriate member ID number as well as the correct address for submitting claims.
- Use machine/computer generated printed forms. NMHC will not accept hand written claims.
- Claims with altered information or markings will not be accepted for consideration.
- When submitting attachments or documents that are to be considered as part of the claim processing, please include the member's ID number.

All paper claims must be submitted to:
**New Mexico Health Connections**
**P.O. Box 3828**
**Corpus Christi, TX 78463**

**Claims Coding**
Industry standard will be applied to claims based on:

- CPT definitions or guidance
- CMS guidance (including, but not limited to Correct Coding Initiatives [CCI])
- Specialty society guidance
- Clinical consultant network – industry/specialty-specific subject matter experts
- Health Plan Policy (HPP) – Health Plans concur that these edits are consistent with current health plan policies.

It is not uncommon for CPT-4, Revenue, HCPCS, and/or ICD-10-CM codes to be added, deleted, or modified. Providers are encouraged to keep track of such changes and ensure that claims are submitted with valid codes. Any claims submitted with invalid CPT-4, HCPCS, or ICD-10-CM codes may be rejected for payment. ICD-10-CM codes requiring fourth and fifth digits must be indicated on claims. Additionally, appropriate modifiers should be included on claim submissions when applicable.

When a miscellaneous code must be used to identify a procedure, providers must include an explanation and/or the surgical procedure or operative notes supporting the use of the code. For miscellaneous or temporary pharmaceutical codes, providers must include the NDC number, drug name, and dosage and/or a copy of the invoice in order for the claim to be considered for payment.

**Checking Claims Status**
NMHC is required to process clean claims upon receipt within thirty (30) days for electronic submissions and forty-five (45) days for paper submissions. Providers will receive an Explanation of Payment (EOP) for all claims received. Claims may be rejected or be returned to the provider prior to acceptance into our claims system. Various reasons may cause this to occur; the most common being incomplete claims, invalid codes, electronic clearinghouse problems, or claims sent to the wrong address.

NMHC recognizes that there are a variety of reasons that may prevent a claim from entering the claims system to be processed. Therefore, if a provider submits a claim to NMHC and NMHC has not provided an EOP within the timeframes stated above, it is important for the provider to follow up with NMHC to check status of the claim(s) in question. Claims that are not followed up by provider within required time periods will not be processed for payment.

Providers should follow up at least every 30 days when checking status of any outstanding claims to ensure that both NMHC and providers identify and communicate issues preventing processing are resolved timely, so claims may be processed.

Any claims submitted outside the timely filing requirements as noted above will not be considered for payment unless the provider has documented proof of timely follow-up at least monthly from the date claim was submitted to NMHC.

Providers can verify claim status with NMHC in the following ways:

- Log in to the Provider Portal at http://www.mynmhc.org/my-account-login.aspx.
- Complete and fax the NMHC Claims Inquiry Form to (312) 548-9943.
- Contact NMHC Customer Care to check the status of claims. Customer Care can be reached 8:00 a.m. to 5:00 p.m. MST at 1-855-769-6642. Calls are limited to five (5) claims inquiries per call.

The most common claim submission errors are as follows:

- Missing, expired or misused, CPT, ICD-10, HCPCS, or Revenue codes;
- No Explanation of Benefits (EOB) submitted when the member has other insurance coverage or Medicare primary coverage;
- Missing anesthesia time;
- Itemized statement is not attached;
- Missing place of service, type of service, or bill type;
- Incorrect or missing member ID number;
- Missing NPI number (Rendering and/or Billing); and
- Incorrect date of birth for the patient.

**Reassessments/Adjustment Requests**

It is the responsibility of the provider offices to immediately post/track all claim payments and/or denials based on the Explanation of Payment (EOP) provided. It is not uncommon for a provider to request reassessment or adjustment following the processing of a claim(s). There are a variety of reasons that providers may request a reassessment or adjustment.

Some examples included are:

- Corrected claims
- Proof of timely filing
- Calculation of units billed
- Claim was submitted and paid twice
- Claim was paid at the wrong rate (contractual)
- Claim was paid for the wrong date(s) of service(s)
- Claim was paid at a wrong level of care
- Services were span billed with overlapping days on more than one claim
- A compliance audit was conducted
- Post payment recoveries
- Authorization was not applied accurately

However, regardless of the reason for the reassessment or adjustment request, providers must comply with the following timeframes and processes when submitting these requests:

- The request must be made within twelve (12) months after the date the claims were originally paid or the date NMHC discovered the overpayment.
- Requests for reassessment and adjustments can be made to Customer Care, 8:00 a.m. to 5:00 MST, at 1-855-769-6642.
- Providers are strongly encouraged to utilize the Claim Reassessment/Adjustment Request Form. Please refer to the Forms section for a copy of this form.

Corrected claims are handled as indicated below:

- Electronic adjustments for corrected claims – Service Loop CLM 05/03 Frequency Field "7" (I – Institutional or P – Professional) – this indicator will allow for an electronic claim adjustment.
- Paper – Providers file CMS-1450 or CMS-1500 paper forms to P.O. Box 3828, Corpus Christi, TX 78463. Providers must include any of the required/supporting documentation such as EOB, Original Paper Claim Form, and Clinical Documentation (if applicable).

**Coordination of Benefits**

Occasionally, claims for services rendered to members are the primary responsibility of other payors. Providers are requested to assist NMHC to maximize recoveries under coordination of benefits or subrogation and bill services to the responsible primary payor. For coordination of benefits, NMHC requires an explanation of payment (EOP) from the primary payor before considering payment of claims when we are secondary. If the EOP is not attached, the claim will be denied with the request of this additional information.

In cases in which NMHC is the secondary payor, claims must be filed ninety (90) days from the date of service or ninety (90) days from the date that the Provider receives notice of payment decision from the primary payor, whichever is later.

Please attach a copy of the primary payor's EOP to the submitted claim. EOPs are also required for services denied by the primary payor and should be submitted to NMHC for consideration. Any claims submitted without the primary payor's EOP will be denied with a request for the additional information.

NMHC follows the National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model rules in determining which payor's plan is primary and which is secondary.

**Subrogation**

NMHC conducts subrogation investigations for services that may indicate third party liability. When the member or provider receives money to compensate for medical or hospital care for injuries or illness caused by another party, NMHC must be reimbursed for any expenses that we may have paid in connection to the incident. If the member or provider does not seek damages, the provider must agree to allow NMHC to attempt recovery. For more information regarding subrogation policies and procedures, please contact Customer Care at 1-855-769-6642.

# FRAUD AND ABUSE

NMHC's Fraud and Abuse Program is overseen by the Chief Compliance Officer or his/her designee. The Program seeks to:

1. Prevent, detect, and investigate all forms of health insurance fraud;
2. Educate appropriate employees and other persons on fraud detection and the Company's anti-fraud plan;
3. Cover reports of insurance fraud to appropriate law enforcement and regulatory authorities; and
4. Pursue restitution, where appropriate, for financial loss caused by insurance fraud.

**Definitions**

**Fraud** is defined as "any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or him/her or some other person in a managed care setting." It includes any act that constitutes fraud under applicable federal or state law. Fraud may be found under the following conditions (the following list is intended as an example and not as a limitation):

- When a provider submits a bill for a service that was not provided; or
- When a provider bills for a time period greater than the time actually spent with the client; or
- When a provider bills for the provision of a service that did not meet the service definitions, performance specifications, state or federal regulations, or accreditation standards customarily recognized in behavioral health care; or
- Inappropriate or frequent referrals that may constitute a conflict of interest; or
- Authorizations for services to providers who may have personal or other financial relationships with care managers; or
- Other related claims or care management issues that may involve intentional deception or misrepresentation as referenced above.

**Waste** is defined by the OIG as the intentional or unintentional, thoughtless or careless expenditure, consumption mismanagement, use, or squandering of government resources to the detriment or potential detriment of government programs. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

**Abuse** is defined as "any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to NMHC, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care in a managed care setting." It also includes recipient practices that result in unnecessary cost to NMHC.

Examples: Altering claims, double billing, billing for services not provided, over-utilization; kickbacks, using fraudulent credentials and pharmacies billing for brand when generic drugs are dispensed.

**Federal and State Statutes and Regulations Applicable to NMHC Providers:**

- The New Mexico Insurance Fraud Act (59A-16C NMSA)
- The False Claims Act (31 U.S.C. 3729-3733)
- The Anti-Kickback Statute (42 U.S.C. 1320a-7b(b) and 42 C.F.R. 1001.952)
- The Physician Self-Referral Law (42 U.S.C. 1395nn and 42 C.F.R. 411.350)
- The Exclusion Authorities (42 U.S.C. 1320a-7; 1320c-5 and 42 C.F.R. 1001 and 1002)
- The Civil Monetary Penalties Law (42 U.S.C. 1320a – 7a and 42 C.F.R. 1003)
- The Health Care Fraud Statute (18 U.S.C. 1347 and 1349)
- The Patient Protection and Affordable Care Act

**Reporting Potential Fraud, Waste, and Abuse and Other Suspicious Activity**

Reports are confidential. When reporting suspicious behavior, you may remain anonymous. To report:

- Contact our Fraud, Waste, and Abuse hotline: 1-855-882-3903, or (505) 492-2058, extension 156
- Download our Fraud, Waste, and Abuse Report form from the Member Forms section of our website at http://www.mynmhc.org/forms-2.aspx and fax it to 1-866-231-1344
- Write to us:
  **New Mexico Health Connections**
  **ATTN: Compliance/FWA**
  **P.O. Box 36719**
  **Albuquerque, NM 87176**

# PROVIDER APPEALS AND GRIEVANCES

NMHC takes provider and practitioner complaints, in the form of grievances and appeals, seriously. Complaints are an important mechanism for identifying concerns and dissatisfaction within our provider network. Provider grievances and appeals are processed to ensure a timely and thorough investigation and according to federal and/or state regulatory requirements, as well as accreditation standards of the National Committee for Quality Assurance (NCQA).

Providers may file a grievance by:

- Calling the Customer Care Center at 1-855-769-6642
- Faxing us at: 1-800-747-9132, ATTN: Appeals & Grievances
- Writing to us:
  **New Mexico Health Connections**
  **ATTN: Appeals & Grievances**
  **P.O. Box 36719**
  **Albuquerque, NM 87176**

**Provider Grievances Regarding NMHC's Plan of Operation**

Generally, provider grievances involving the operation of our plan fall into two categories: Appeals and grievances.

**Appeals**

For appeals challenging a claim denial, claim adjudication, claim submission, or claim resubmission not acted upon, providers must file this appeal within 180 days from the date of the initial Explanation of Payment (EOP) denial. Grievances of this type must be submitted in writing, following claims processing and receipt of a formal denial from NMHC.

Please review the Reassessments/Adjustment Requests of the Claims Submission and Payment section of this handbook to determine if non-payment requires a reassessment or adjustment request or filing a formal, written appeal.

**Grievances**

**Informal NMHC Review of Grievances**

When verbal complaints or inquiries for non-payment issues are received by NMHC, they are initially forwarded to the NMHC Provider Services department. Provider Services' staff researches the issue, takes action if appropriate, documents any action taken and responds to the provider, usually within three (3) business days. If resolution is not forthcoming via this informal review process, the provider is notified that they can file a formal written Provider Grievance.

**Formal NMHC Review of Grievances**

If NMHC is unable to resolve a verbal complaint or inquiry to the provider's satisfaction, as described above, he/she may request, in writing, that the complaint be taken to the NMHC Provider Reconsideration Committee for review. This committee consists of NMHC management and/or other

staff. A written decision of the NMHC Provider Reconsideration Committee will be sent to the provider within twenty (20) working days, following receipt of all necessary information needed to respond.

**Review of Provider Grievances by the New Mexico Office of Superintendent of Insurance (OSI)**
Following this internal review, if the provider remains dissatisfied with the result of the internal appeal and grievance process, he/she may file a complaint with the OSI. The provider must file a written request with the OSI within thirty (30) days from receipt of the written decision of the NMHC Provider Reconsideration Committee.

Please contact us at 1-855-769-6642 for detailed information regarding our Provider Grievance program.

**Appeal Process for Provider Terminations**
Through a variety of sources, NMHC may discover that a practitioner is not meeting the standards of providing reliable, safe, quality care to his or her patients who are NMHC members. In these circumstances, there is a range of actions NMHC may pursue to ensure the provision of safe and effective care, including review of the practitioner's current status with a variety of Boards or oversight bodies (e.g., the New Mexico Board of Medical Examiners), the implementation of a corrective action plan to address the documented performance deficiency, or even the removal of the practitioner from the network, the latter referred to as "termination for cause." Providers should note that NMHC is required to notify appropriate authorities when it acts to limit, suspend, or terminate a practitioner's participation in the network. NMHC does offer a practitioner the opportunity to appeal such adverse participation decisions.

For a variety of reasons, NMHC may end its contractual relationship with a provider solely based on business needs, referred to as "termination without cause." Terminations without cause may include the periodic removal of a practitioner from the NMHC network when there are more practitioners than needed to meet NMHC's accessibility and availability standards. Such terminations are not related to practitioner performance, quality of care or service, or a material breach of contract. Nor are terminations without cause subject to an appeal process.

For detailed information regarding our policy and procedures regarding provider terminations, please visit our website at http://www.mynmhc.org/provider-grievances-appeals.aspx or contact us at 1-855-769-6642.

# MEMBER COMPLAINTS AND APPEALS

NMHC takes member complaints, in the form of grievances and appeals, seriously. Complaints are an important mechanism for identifying concerns and dissatisfaction among our membership. Member grievances and appeals are processed to ensure a timely and thorough investigation and according to federal and/or state regulatory requirements, as well as accreditation standards of the National Committee for Quality Assurance (NCQA).

Members have the right to file an appeal if they disagree with a NMHC decision to deny a service, in whole or in part. Members may also file a grievance related to our administrative practices, such as those decisions that appear to affect the availability, delivery or quality of health care services, including but not limited to claims payment or termination of coverage.

A complaint may be filed by a member or another person authorized to do so by the member. The member should initially contact the Customer Care Center at 1-855-769-6642. A Customer Care Center representative will make every effort to resolve the member's complaint to his or her satisfaction the first time it is brought to our attention. If the Customer Care Center representative is unable to resolve the concern or Complaint to the Member's satisfaction, the Member can request that a formal appeal or grievance be filed.

If a member exhausts the appeal or grievance process, he/she has the right to request an external independent review by the New Mexico Office of Superintendent of Insurance.

For detailed information regarding member grievances and appeals, visit our Member Rights and Responsibilities page on our website at http://mynmhc.org/member-rights-and-responsibilities.aspx or contact us at 1-855-769-6642.

# MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of this Plan, you are entitled to certain rights when you access coverage. There are also certain responsibilities that you hold. It is important that you understand these rights and responsibilities.

**As a Member of this Plan, you have the following rights:**

- You have a right to detailed information about your Plan. This may include benefits and services that are covered or excluded from the Plan, and all requirements that must be followed for Prior approval and Utilization Review.
- You have a right to always have available and accessible services for Medically Necessary and covered services; including 24 hours per day, 7 days per week for urgent and emergency care services, and for other health care services as defined by the Evidence of Coverage or the Summary of Benefits and Coverage.
- You have a right to information about your out-of-pocket expense limitations, and an explanation of your financial responsibility for services provided to you.
- You have a right to be treated in a manner that respects your privacy and dignity.
- You have a right to participate with your Providers in making decisions about your health care.
- You have a right to receive an explanation of your medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives from your Provider in a language that you understand, regardless of cost or your plan's benefits.
- You have a right to be informed about your treatment from your Participating Provider; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of the possible consequences of refusing such treatment. This right exists even if treatment is not a covered benefit or Medically Necessary according to the Plan. The right to consent or agree to treatment may not be possible in a medical emergency where your life and health are in serious danger.
- You have a right to voice Complaints, Grievances, or Appeals with the Plan or its regulatory bodies about the Plan and/or the care that we provide.
- You have a right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.
- You have a right to receive assistance in a prompt, courteous, and responsible manner.
- You have a right to the confidential handling of all communication and information maintained by the Plan. Your written permission will always be required for the release of medical and financial information, except:
    - When clinical data is needed by health care Providers for your care;
    - When the Plan is bound by law to release information;
    - When the Plan prepares and releases data but without identifying Members; and
    - When necessary to support the Plan's programs or operations, including for payment and to evaluate quality and service.
- You have a right to be promptly informed of termination or changes in benefits, services, or Participating Providers.

- You have a right to know, upon request, of any financial arrangements or provisions between the Plan and its Participating Providers, which may restrict referrals or treatment options or limit the services offered to you.
- You have a right to receive an explanation of why a benefit is denied; the opportunity to appeal the denial decision; the right to a second level of appeal with the Plan; and the right to request help from the New Mexico Superintendent of Insurance.
- You have a right to adequate access to health care providers near your home or work within the Plan's service area.
- You have a right to receive detailed information about requirements that you must follow for prior approval of certain services.
- You have a right to have access to a current list of Participating Providers in the Plan's network.
- You have the right to an example of the financial responsibility incurred by a Covered Person for services received from an Out-of-Network or Non-Participating Provider.
- You are responsible for learning how your Plan works. You should carefully read and refer to your Member Handbook and your Summary of Benefits and Coverage. Contact the Customer Care Center if you have questions or Concerns about your Plan.

**As a Member of the Plan, you have the following responsibilities:**

- You have a responsibility to provide honest and complete information to the Plan and to your Providers.
- You have a responsibility to read understand the information that you receive about your Plan.
- You have a responsibility to know the how to properly access coverage and utilize your Plan.
- You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your Providers.
- You have a responsibility to follow plans and instructions for care that you have agreed to with your Providers.
- You have a responsibility to present your Plan ID card before you receive care.
- You have a responsibility to promptly notify your Provider if you will be delayed or unable to keep an appointment.
- You have a responsibility to pay your applicable Deductible, Copayment, and Coinsurance amounts, including those for missed appointments.
- You have a responsibility to express your opinions, Concerns or Complaints in a constructive way to the Plan or to your Provider.
- You have a responsibility to inform the Plan and/or your Employer of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change.
- You have a responsibility to make Premium payments on time if they are not paid directly by your Employer.
- You have a responsibility to notify the Plan if you have any other insurance coverage.
- You have a responsibility to follow the Plan's Complaints and Appeals process when you are dissatisfied with the Plan or a Provider's actions or decisions.

# FORMS AND OTHER RESOURCES

The material contained in this section is for your reference.

- Individual Benefit Plans
- Small Group Benefit Plans
- Large Group Benefit Plans
- Prior Authorization List
- Sample ID Cards
- Claims and Eligibility Quick Reference Guide
- Online Provider Directory Guide
- Notice of Privacy Practices
- Frequently Asked Questions
- Prior Authorization Request Form
- Claims Inquiry Form
- Claims Reassessment/Adjustment Request Form
- Blank CMS-1500 Claim Example and Instructions
- Blank UB-04 Claim Example and Instructions