MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Independent Accountant's Report on Applying Agreed-Upon Procedures on Managed Care Organizations for Processing Medicaid Nursing Facility Claims

December 21, 2018

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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New Mexico Human Services Department

Managed Care Organizations: Blue Cross and Blue Shield of New Mexico
Molina Health Care of New Mexico, Inc.
Presbyterian Health Plan, Inc.
UnitedHealthcare Community Plan of New Mexico

PERIOD: July 1, 2016 through June 30, 2017

We have performed the procedures enumerated in the Medicaid Managed Care Nursing Facility Claims Processing Agreed-upon Procedures Program, which were agreed to by the New Mexico Human Services Department (HSD) related to the above referenced Managed Care Organizations (MCO's) compliance with the Centennial Care Program requirements on claims adjudicated during the period. The above MCOs' managements are responsible for the compliance with the Centennial Care Program policies and procedures. The HSD is responsible for Centennial Care Program requirements. The sufficiency of these procedures is solely the responsibility of the HSD. Consequently, we make no representation regarding the sufficiency of the procedures established by the Medicaid Managed Care Nursing Facility Claims Processing Agreed-Upon Procedures Program either for the purpose for which this report has been requested or for any other purpose. Our findings are contained in the accompanying schedules.

This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. We were not engaged to and did not conduct an examination or review, the objective of which would be the expression of an opinion or conclusion, respectively, on compliance with specified requirements. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the HSD as administrative agent for the Centennial Care Program and is not intended to be and should not be used by anyone other than this specified party.

Myers and Stauffer LC

Myers and Stauffer LC
Kansas City, MO

Project Background

Overview

Myers and Stauffer LC is engaged to assist the New Mexico Human Services Department (HSD), Medical Assistance Division (MAD), in reviewing the Managed Care Organizations (MCO) performance on the compliance with Centennial Care Program requirements for the following MCOs:

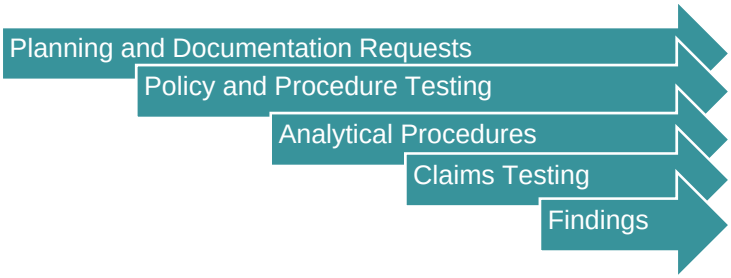
- Blue Cross and Blue Shield of New Mexico (BCBS)
- Molina Health Care of New Mexico, Inc. (MHC)
- Presbyterian Health Plan, Inc. (PHP)
- UnitedHealthcare Community Plan of New Mexico (UHC)

We performed agreed-upon procedures on the nursing facility (NF) systems and processes as related to the following areas of the Centennial Care Program: claims adjudication; prior authorization; provider credentialing; provider contract loading; and claims repricing.

The purpose is to provide oversight of the MCO processes through interviews, documentation requests, and sample testing based on adjudicated nursing facility claims data related to paid and denied claims for the period of July 1, 2016 through June 30, 2017. The section below outlines the scope of work completed by Myers and Stauffer related to this engagement. The report summarizes the testing methodologies utilized in the project, the testing results, and findings and recommendations related to compliance issues.

Scope of Engagement

- Obtain data and documentation from the MCOs and HSD
- Determine whether MCO policies and procedures selected by HSD are in compliance with contract requirements, Medical Assistance Division (MAD) Managed Care Policy Manual, Centennial Care MCO Systems Manual, and New Mexico Administrative Code
- Perform testing related to nursing facility claims as outlined in the agreed-upon procedures
- Select a statistically valid sample and verify timely credentialing, timely contract loading, and the accuracy of claims payments
- Provide a report to HSD that summarizes our findings and recommendations



Planning and Documentation Requests

The documentation requests to complete the objectives of this engagement were issued in two phases. The Phase I request was sent to the MCOs on November 15, 2017, which requested the claims data set and reconciliation to financial data to ensure all claims were captured in the data submission.

Phase II was sent on January 9, 2018, for which the MCOs were asked to provide:

- Policies and procedures for retroactive rate changes and adjustments to provider contracts
- Policies and procedures for contract loading and timeliness of contract loading into the claims system to allow for payment
- Policies and procedures for timely credentialing of providers
- Policies and procedures for crossover claim payments
- Policies and procedures for prior authorized services for retroactively enrolled members
- Policies and procedures for timeliness of claims payment adjustments
- Listing of nursing facilities and provider numbers with retroactive rate adjustments adjudicated between July 1, 2016 and June 30, 2017

HSD provided the following:

- MCO contracts and amendments.
- HSD Letters of Direction applicable to nursing facility claims, enrollment, provider credentialing, and contracting
- Provider complaints applicable to nursing facility claims, denials, prior authorizations, crossovers, and rate adjustments
- New Mexico Administrative Code (NMAC) applicable to the nursing facility testing
- Fee-for-service rate sheets
- Centennial Care MCO Systems Manual
- Medical Assistance Division (MAD) Medicaid Managed Care Policy Manual

Policies and Procedures

Testing and Results

Each MCO provided Myers and Stauffer with its existing policies and procedures as part of the Phase II documentation request. These policies and procedures were reviewed to determine if the policies were in accordance with the contract between HSD and the MCO and other identified guidance.

The key testing areas are as follows:

- Authorization of services
- Reimbursement for managed care
- Paying of clean claims in a timely manner
- Utilization management
- Nursing facility level of care
- Nursing facility level of care for not otherwise Medicaid eligible
- Nursing facility level of care determinations
- Retroactive enrollment of members
- Acceptance and accurate payment of Medicare crossover claims
- Payment of crossover claims
- Provider contract and claims system loading

A webinar conference was conducted with each MCO to give the opportunity for an overview of any specified areas and address questions. After the conclusion of the webinar, follow-up requests were sent to the MCOs regarding any missing policies and procedures or other outstanding items that came to attention during the meeting.

Once submissions from the MCOs were deemed complete, each MCO's level of compliance with testing requirements were determined to be compliant, non-compliant, partially compliant, or missing. The table below identifies the key testing requirements and results by MCO.

Table 1

Policy Review				
	BCBS	**MHC**	**PHP**	**UHC**
Authorization of Services: Contract Section 4.12.12				
Written policies for processing authorization requests utilizing consistent criteria	Compliant	Compliant	Compliant	Compliant
Requirement than any decision to deny or authorize less service than requested be made by a healthcare professional with appropriate clinical expertise such as medical director	Compliant	Compliant	Compliant	Compliant
14 day authorization decision for a new service	Compliant	Compliant	Compliant	Compliant
10 day authorization decision for an ongoing service	Compliant	Missing	Compliant	Compliant
72 hour authorization expeditious decision	Compliant	Compliant	Compliant	Compliant
Extension of 14 days for authorization decision can be granted if requested by a member or if justified by the contractor	Compliant	Missing	Compliant	Compliant

Policy Review				
	BCBS	**MHC**	**PHP**	**UHC**
If contractor requests an extension, the contractor must provide the member written notice and inform the member of the appeal rights	Compliant	Missing	Compliant	Missing
Reimbursement for Managed Care: NMAC 8.308.20.9(E)				
90% of clean claims paid within 30 days and 99% paid within 90 days based on receipt date and check date	Compliant	Compliant	Partially Compliant	Compliant
MCO is responsible for payment for all covered emergency and post stabilization claims at a rate no more than the Medicaid fee-for-service rate for all non-contracted providers	Compliant	Compliant	Missing	Compliant
MCO shall pay interest on electronic claims paid after 30 days and manual claims paid after 45 days	Compliant	Compliant	Compliant	Partially Compliant
No contract between the MCO and a participating provider shall have a clause relieving either party of liability	Missing	Missing	Missing	Missing
Good faith effort to notify the provider if payment is not to be made within the payment timeframes if Medicaid's liability cannot be determined	Missing	Missing	Missing	Missing
Paying Clean Claims in a Timely Manner: Contract Section 4.19.1.6.1				
95% of clean claims for listed providers (includes nursing facility) must be paid within 15 days and 99% within 30 days	Partially Compliant	Compliant	Missing	Compliant
90% of clean claims adjudicated within 30 days and 99% within 90 days of receipt	Compliant	Compliant	Missing	Compliant
Utilization Management: NMAC 8.308.21.17				
MCO shall have utilization management (UM) program to evaluate medical necessity, appropriateness and efficiency of care.	Compliant	Compliant	Compliant	Compliant
Nursing Level of Care: Contract Section 4.4.5.7				
Contractor shall perform a Level of Care (LOC) evaluation of members otherwise Medicaid eligible for members who have indicators that may warrant	Compliant	Missing	Compliant	Compliant
Contractor shall perform a LOC evaluation of members not otherwise Medicaid eligible in accordance with Contract Section 4.1.2	Compliant	Missing	Compliant	Compliant
Nursing Level of Care Not Otherwise Medicaid Eligible: Contract Section 4.1.2				
Contractor shall perform a LOC evaluation of members not otherwise Medicaid eligible for members who have indicators that may warrant through a preliminary screening	Compliant	Missing	Compliant	Compliant
Contractor shall use tools approved by HSD	Compliant	Missing	Compliant	Compliant

Policy Review				
	BCBS	**MHC**	**PHP**	**UHC**
Contractor shall notify HSD of LOC determination	Compliant	Missing	Compliant	Compliant
If the individual meets nursing facility LOC, contractor shall notify HSD to continue eligibility determination process	Compliant	Missing	Compliant	Compliant
NF LOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6				
Level of Care Packet requirements	Compliant	Missing	Compliant	Partially Compliant
LOC Determination within 5 business days	Compliant	Missing	Compliant	Compliant
MCO must make 3 attempts to receive documentation	Compliant	Missing	Compliant	Compliant
If required documentation not submitted in 14 days, LOC is denied	Compliant	Missing	Compliant	Compliant
Denial of Request Prior Approval 5 day notification	Compliant	Missing	Compliant	Compliant
Denial letter must be sent to provider and member with denial reason determined by the doctor	Compliant	Missing	Compliant	Partially Compliant
Reserve Bed Days				
6 reserve bed days covered for hospitalization without prior approval per calendar year	Compliant	Missing	Compliant	Compliant
3 reserve bed days covered for brief home visit without prior approval per calendar year	Compliant	Missing	Compliant	Partially Compliant
6 reserve bed days covered for adjustment to new environment with prior approval as part of discharge plan	Compliant	Missing	Compliant	Partially Compliant
Initial Determination, Redetermination, and Medicaid Pending Eligibility				
Initial Determination documents must be submitted within 30 calendar days of admission	Compliant	Missing	Compliant	Partially Compliant
Redetermination High Nursing Facility (HNF) within 30 days prior; Low Nursing Facility (LNF) within 60 days prior	Compliant	Missing	Compliant	Compliant
Pending Medicaid; prior approvals can be done when the service is furnished before determination of the effective date of the resident's financial eligibility for Medicaid	Compliant	Missing	Compliant	Compliant
Retroactive Medicaid Eligibility				
Request for prior approval must be reviewed by the MCO within 30 calendar days of the date of eligibility determination	Compliant	Missing	Compliant	Compliant
Readmission Review				
Required after 3 midnight hospital stay if returns with a different LOC	Compliant	Missing	Compliant	Missing
Nursing facility must submit re-admit approval request form to the MCO within 30 days with accompanying	Compliant	Missing	Compliant	Missing

Policy Review				
	BCBS	**MHC**	**PHP**	**UHC**
documentation if more than 30 days left on resident's certification				
Nursing facility must submit redetermination request on the notification form to the MCO within 30 days with accompanying documentation if less than 30 days left on resident's certification	Compliant	Missing	Compliant	Missing
Retrospective Reviews				
Medicaid pending never considered late	Compliant	Missing	Compliant	Missing
Excused late review if beyond control of the NF	Compliant	Missing	Compliant	Missing
If delay was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO and NF cannot bill the member	Compliant	Missing	Compliant	Missing
Transfer from Another Nursing Facility				
Receiving NF must notify MCO of the transfer with the transfer date; without notification the claim will not be paid	Compliant	Missing	Compliant	Missing
<30 days remaining on the prior auth, MCO will make a new Nursing Facility Level of Care (NFLOC) determination	Compliant	Missing	Compliant	Missing
Change in Level Of Care				
Change in LOC must be submitted within 30 calendar days of the change	Compliant	Missing	Compliant	Partially Compliant
Must be signed and dated by physician, nurse practitioner or physician assistant	Compliant	Missing	Compliant	Compliant
Discharge Status				
Occurs when resident no longer meets LOC that qualifies for NF placement	Compliant	Missing	Compliant	Missing
Initial Discharge Status authorized at low NF for 90 days based on physician determination	Compliant	Missing	Compliant	Missing
Continued Stay Discharge Status authorized at low NF for 180-365 days must document ongoing attempts to find appropriate community placement	Compliant	Missing	Compliant	Missing
Reconsideration, Appeal, and Administrative Hearing				
Requests for reconsideration must be in writing and received within 30 days after the date on the re-review decision notice and included listed items	Compliant	Missing	Compliant	Compliant
MCO notified NF and member in writing of a decision within 11 business days of the receipt of the reconsideration request	Compliant	Missing	Compliant	Compliant
Written notice must include member's right to request an HSD administrative hearing after the MCO appeal process is exhausted	Compliant	Missing	Compliant	Compliant

Policy Review				
	BCBS	**MHC**	**PHP**	**UHC**
Members can appeal if a reconsideration decision is adverse with the MCO in accordance with NMAC 8.305.12	Compliant	Missing	Compliant	Compliant
Members can request an HSD administration hearing after the MCO appeal process in accordance with NMAC 8.352.2	Compliant	Compliant	Compliant	Compliant
Communication Forms				
MCO must use HSD approved communication forms with the NFs	Compliant	Missing	Compliant	Compliant
Retroactive Enrollment of Members: Centennial Care Systems Manual; Long Term Care Claims Rules				
MCOs should not deny nursing facility claims based on admit date, but should compare against date of enrollment	Compliant	Compliant	Compliant	Compliant
Accepting and accurately paying Medicaid crossover Claims: Contract Section 4.19.1.18.3				
Contractor shall ensure all claims not paid based on coordination of benefits (COB)/lesser of logic are paid to ensure Medicaid is payer of last resort	Compliant	Compliant	Compliant	Compliant
Payment of a Crossover Claim: Centennial Care Systems Manual				
Lower of logic not applied for an inpatient claim and when the billing provider type is 211- 218 (nursing facilities)	Compliant	Non-Compliant	Compliant	Compliant
Provider Contract and Claims System Loading: Contract Section 4.8.14.1.13				
Contractor must load and recognize provider as network provider in claims system no later than 45 days after provider credentialing	Partially Compliant	Compliant	Missing	Compliant

Compliant *= MCO's policies and procedures are in accordance with referenced requirements.*
Non-Compliant *= MCO's policies and procedures do not comply with referenced requirements.*
Partially Compliant *= MCO's policies and procedures are partially, but not fully, in accordance with referenced requirements.*
Missing *= MCO's policies and procedures submitted do not address the referenced requirements.*

Analytical Procedures

To ensure all paid claims were captured in the data submission, it was requested the MCO provide a reconciliation of the total nursing facility claim payments to financial data (internal financial statements, lag reports, etc.). Myers and Stauffer held a webinar conference with MCOs to clarify on the specific support necessary to verify the completeness of the data submission. Once a complete reconciliation of total nursing facility claim payments to financial data was received analytical procedures testing, as outlined below, was performed. The completeness of the denied claim population could not be assessed. Additionally, data elements included in testing

provided by the MCOs, such as dates related to payment, contracting, and provider credentialing could not be validated and were utilized as submitted by the MCOs.

Testing and Results

The following section includes testing and results for subsets of data included within the submitted nursing facility claims data universe for each MCO.

Definitions of Claim Subsets

Clean Claims

A clean claim is defined in the Medicaid Managed Care Services Agreement (contract) as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. All claims (paid and denied) submitted in the MCO's data sets were included as clean claims for purposes of this report due to the lack of any consistent identifier present in the MCO's data submissions that could be utilized to differentiate between claims requiring additional information for processing and those that did not.

Crossover Claims

A crossover claim is defined as any claim with a reported Medicare payment in the data sets for purposes of this report. Based on this logic some MCOs reflected a low volume of crossovers. To verify all crossover claims were included in the analytical procedures, it was requested that each MCO define how to identify crossover claims within the submitted claims data sets. The following identifying criteria, by MCO, was provided:

- BCBS – Claims with Medicare payments of zero or greater than zero represent Medicare crossover claims. Claims with blanks in the Medicare payment data field represent non-crossover claims.
- MHC – Claims with MCO_CLM_IDs containing a "S" represent Medicare crossover claims. Claims with MCO_CLM_IDs excluding a "S" represent non-crossover claims.
- PHP – Crossover claims with a reported Medicare payment.
- UHC – An additional column was added to the claims data set (CAID_CARE_DUAL_FLAG) by UHC as an indicator for crossover claims. If the column had a designation of "MEDICARE", the claim was for Dual Eligible Special Needs plan and should be considered a Medicare crossover claim. If this column had a designation of "MEDICAID", the claim was for Medicaid and should be considered a non-crossover claim.

After reviewing the identifying characteristics above, it was determined the expanded methodologies identified by MHC and UHC did not apply to the nursing facility population. The MCO defined criteria was associated to dual-eligible members related to other non-nursing facility services. Therefore, to maintain a consistent approach for analytical procedures, claims reflecting a Medicare payment was the criteria used to designate a crossover claim.

Denied Claims

A denied claim is a claim submitted by a Medicaid provider or non-contracted provider for reimbursement that is deemed by the MCO to be ineligible for payment. These claims were identified in the data set based on a "Denied" Reimbursement Status field in the MCO-submitted data sets.

BCBS, MHC, and UHC had two Reimbursement Status designations in the data set. All claims were designated as "Paid" or "Denied". PHP reported an additional designation of "Partially Approved". After follow-up correspondence, PHP stated claims with a partially approved designation reflected claims with detail lines that are approved and some that are denied. However, a review of claims data detail revealed that some partially approved claims reflected all approved lines of detail. Another clarification was needed and PHP responded stating partially approved claims may also reflect claims paid on a per diem basis. Per PHP, when a claim pays based on a per diem, only one line item is recorded as having a paid amount. All other line items are listed with a zero paid amount, but are not truly denied. Based on these factors, claims in the data set with the reimbursement status of partially approved for PHP were considered paid claims and excluded from denied claims for the analytical procedures testing.

The following table summarizes claims within the data sets that may be misclassified between "Paid" and "Denied" based on whether the claim reflected a payment. The data sets contained claims with a "Paid" reimbursement status reflecting a zero Medicaid payment and claims with a "Denied" status reflecting a payment was made on the claim. Zero paid claims represented below are based solely on whether a claim contained a Medicaid payment. Some of these zero paid claims may have third party payments or Medicare payments noted on the claim. The potential misclassification of zero paid claims as "Paid" rather than "Denied" would understate the denial rate for the nursing facility claims data population. The MCO's original claim classification was not changed based on the results reflected in the table below.

Table 2

Zero Paid Claims and Denied Claims with Payments				
	BCBS	**MHC**	**PHP**	**UHC**
Crossover Claims				
Paid Claims - Zero Paid				
Number of Claims	36	2	55	1,067
Billed Amount	$29,427.40	$2,367.61	$500,982.20	$4,921,203.39
Denied Claims with Payment				
Number of Claims	0	0	0	0
Paid Amount	$0.00	$0.00	$0.00	$0.00
Non-Crossover Claims				
Paid Claims - Zero Paid				
Number of Claims	164	136	808	2,225
Billed Amount	$129,814.68	$336,895.72	$5,891,401.78	$1,081,539.56
Denied Claims with Payment				
Number of Claims	0	0	0	6
Paid Amount	$0.00	$0.00	$0.00	$9,838.25
Totals				
Paid Claims - Zero Paid				
Number of Claims	200	138	863	3,292
Billed Amount	$159,242.08	$339,263.33	$6,392,383.98	$6,002,742.95
Denied Claims with Payment				
Number of Claims	0	0	0	6
Paid Amount	$0.00	$0.00	$0.00	$9,838.25

Adjusted Claims

An adjusted claim is a claim submitted by a Medicaid provider or non-contracted provider for reimbursement that is correcting data or providing additional data not included on the original claim. These claims were identified in the data set based on the Bill Type field. If the third digit, which refers to the timing or frequency of the claim, included a seven or eight the claim was identified as an adjusted claim.

- XX7 = Replacement of Prior Claim or Corrected Claim
- XX8 = Void or Cancel of a Prior Claim

Note, this definition may differ from the MCO's criteria used to identify adjusted claims as claim adjustments are made by the MCO related to items such as rate adjustments that do not require an adjusted claim to be submitted by the provider, but may categorize the claim as an adjustment in the MCO's claims system.

Analytical Testing Results

Based on definitions of the claim subsets identified above, clean crossover claims, denied crossover claims, clean non-crossover claims, and denied non-crossover claims are summarized by MCO in the following table. Testing was performed on the crossover and non-crossover populations below related to turnaround time and denials. In addition, testing was performed on the denied populations below related to denials with prior authorization.

The table below reflects denials compared to total crossover and non-crossover claims for each MCO's claims population.

Table 3

Analytical Procedures				
	BCBS	**MHC**	**PHP**	**UHC**
Crossover Denials Compared to Total Crossover Claims				
Number of Claims	2,107	151	513	7,355
Number of Clean Claims	2,107	151	513	7,355
Percent of Total Claims	100.00%	100.00%	100.00%	100.00%
Number of Denied Claims	0	3	2	1,482
Percent of Total Claims	0.00%	1.99%	0.39%	20.15%
Non-Crossover Denials Compared to Total Non-Crossover Claims				
Number of Claims	23,591	17,621	13,175	39,888
Number of Clean Claims	23,591	17,621	13,175	39,888
Percent of Total Claims	100.00%	100.00%	100.00%	100.00%
Number of Denied Claims	4,341	2,252	2,054	7,612
Percent of Total Claims	18.40%	12.78%	15.59%	19.08%

Adjudication Turnaround Times

To test and determine turnaround times, the following data elements were utilized:

- Claim Received Date
- Adjudication Date

Contract Requirement
Section 4.19.1.16.1

*For claims from nursing facility providers, 95% of clean claims must be adjudicated within a time period of **no greater than fifteen (15) calendar days of receipt** and 99% or more of clean claims must be adjudicated within a time period of **no greater than thirty (30) calendar days of receipt**.*

The table below displays the average and range of claims adjudication turnaround times by MCO segregated into the following categories:

- Original Crossover Claims
- Adjusted Crossover Claims
- Original Non-Crossover Denied Claims
- Adjusted Non-Crossover Denied Claims
- Total Claims Population

It also reflects the percentage of claims meeting the 15 and 30 day contract requirements.

The contract requirement above relates to the adjudication of clean claims, but does not address the timely adjudication of adjusted claims. After further review of the MCO contracts and the New Mexico Administrative Code, it was determined all guidance is silent related specifically to the timely adjudication of adjusted claims.

Additionally, BCBS, PHP, and UHC all stated when a claim is adjusted or reversed by the MCO after being finalized, the claim received date continues to indicate the original received date. This may skew the timeliness results as accurate turnaround times for adjusted claims adjusted by the MCO cannot be calculated. These claims differ from the adjusted claims submitted by the provider identified with bill type XX7 or XX8.

Table 4

Claims Turnaround Time				
	BCBS	**MHC**	**PHP**	**UHC**
Original Crossovers				
Number of Claims in Process	2,096	148	500	7,118
Average Turnaround Time (in days)	16	5	46	19
Turnaround Time Range (in days)	0 to 827	1 to 154	0 to 889	0 to 766
Percentage Meeting the 15 Day Requirement	72.23%	97.30%	82.00%	85.09%
Percentage Meeting the 30 Day Requirement	85.40%	97.97%	87.60%	88.75%
Adjusted Crossovers				
Number of Adjusted Claims	11	3	13	237
Average Turnaround Time (in days)	16	23	71	16
Turnaround Time Range (in days)	2 to 33	1 to 63	2 to 395	0 to 402
Percentage Meeting the 15 Day Requirement	54.55%	66.67%	61.54%	73.42%
Percentage Meeting the 30 Day Requirement	81.82%	66.67%	76.92%	89.45%
Original Non-Crossover Denials				
Number of Claims in Process	3,093	1,728	1,777	6,600
Average Turnaround Time (in days)	13	3	61	13
Turnaround Time Range (in days)	0 to 904	0 to 127	0 to 850	0 to 665
Percentage Meeting the 15 Day Requirement	85.81%	98.78%	44.23%	82.74%
Percentage Meeting the 30 Day Requirement	91.85%	99.65%	59.14%	90.12%
Adjusted Non-Crossover Denials				
Number of Adjusted Claims	1,248	524	277	1,012
Average Turnaround Time (in days)	10	2	43	14
Turnaround Time Range (in days)	1 to 264	0 to 27	0 to 912	1 to 454
Percentage Meeting the 15 Day Requirement	88.62%	98.85%	60.29%	76.68%
Percentage Meeting the 30 Day Requirement	94.23%	100.00%	70.40%	86.66%
Overall Population				
Number of Claims	25,698	17,772	13,688	47,243
Average Turnaround Time (in days)	11	2	50	38
Turnaround Time Range (in days)	0 to 912	0 to 212	0 to 1,056	0 to 1,075
Percentage Meeting the 15 Day Requirement	86.38%	99.18%	67.01%	81.69%
Percentage Meeting the 30 Day Requirement	93.41%	99.70%	75.56%	85.00%

Original Claims: Total claim count for identified subset excluding adjusted claims. Referred to as "claims in process" in the agreed-upon procedures program.
Adjusted Claims: Bill Type XX7 or XX8

Denials

The following data elements were utilized to summarize the top ten claim denial reasons and associated dollar amounts for crossover and non-crossover claims based on frequency of the denial code:

- Denial Reason Codes
- Denial Reason Descriptions
- Billed Amount

The Edits data set submitted by each MCO was utilized to identify the unique denial reason codes and denial reason descriptions to properly test the top ten denial reasons in terms of frequency in the data sets. This was achieved by combining the MCO_CLM_IDs and all associated denial reason codes and removing duplicates to allow only unique rows for analytical procedures testing. After further review, not all denial reason codes and denial reason descriptions were submitted in the original data submission. The claims with missing denial reason codes and denial reason descriptions were sent to each MCO to ensure all necessary data was included in the top ten denial reason analysis.

After the secondary denial reason codes and denial reason descriptions were received, an analysis was performed to determine the volume of each denial reason code reported for crossover and non-crossover claim denials, ranked by number of occurrence.

In response to the follow-up request, PHP stated it does not have adjustment codes, but rather free text fields for communicating denial reasons. These free text fields were provided for all claims with a denied status. Myers and Stauffer reviewed the free text fields and assigned a key word or phrase for each denied claim in an attempt to standardize the denial reasons and more accurately reflect the top ten denial reasons. The same methodology, as explained above, was applied to determine the volume of each denial reason reported for crossover and non-crossover claim denials, ranked by number of occurrence.

Billed amounts are reported for the denial reason codes based on claim ID and denied reimbursement status. When more than one denial reason code was reported on a claim, all codes were included in the analysis to determine the top ten denial reasons. Therefore, the billed amounts reflected below are reported in each applicable reason category, causing the billed amounts to be duplicated when multiple denial reason codes are associated with one claim.

Table 5

Top 10 Denial Reasons and Dollar Amounts					
	Rank	Reason	Dollar Amount	Reason	Dollar Amount
Entity		Crossovers		Non-Crossovers	
BCBS	1	No Denied Claims in the Data Set		Service/Charge is a Duplicate of a Previous Processed Claim.	$6,584,117.15
	2			Late Charge Denial (No EOB created for this claim)	$5,668,362.26
	3			Medical/Surgical Advisor was not Contacted Prior to Treatment	$1,423,851.60
	4			On or After Termination Date	$1,915,189.48
	5			Time Period for Filing Claim Has Expired. (XXX number of days from last date of service)	$693,732.99
	6			Hospital Claim; need Medicare's paid amount	$173,319.13
	7			Pricer has determined that the services billed are not reimbursable for this facility	$110,217.84
	8			Medical/Surgical Advisor Contacted but did not Approve Services/ Treatment	$49,703.47
	9			Medicare paid this amount	$64,988.95
	10			This service cannot be processed until charges are filed with other insurance carrier (for non its claims)	$34,839.39
MHC	1	Duplicate Claim (Provider/Member/DOS)	$29,895.56	Our records indicate there is not a prior authorization on file for this service on this date. Therefore, benefits are denied.	$2,262,246.85
	2	Contract Term Requires Manual Review	$12,573.49	Claims submitted after the plan's timely filing limit are not eligible for reimbursement.	$2,779,476.54
	3	This code is for a service not covered by New Mexico Medicaid.	$12,573.49	Duplicate Claim (Provider/Member/DOS)	$2,405,055.77
	4	Please resubmit this claim along with a completed Internal Revenue Service W-9 form to Provider Services, PO BOX	$12,573.49	Incorrect billing by the provider. Please review and resubmit the claim.	$1,441,968.98

Top 10 Denial Reasons and Dollar Amounts					
	Rank	**Reason**	**Dollar Amount**	**Reason**	**Dollar Amount**
		3887, Albuquerque, New Mexico, 87190.			
	5	Claims submitted after the plan's timely filing limit are not eligible for reimbursement.	$4,880.18	Missing/incomplete/invalid principal diagnosis.	$882,889.44
	6	Denied included in per diem	$4,880.18	Missing/incomplete/invalid acute manifestation date.	$807,168.83
	7			No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	$1,094,292.39
	8			Pend claim if COB is 0 on secondary enrollment claim	$500,939.67
	9			Contract Term Requires Manual Review	$577,353.16
	10			Duplicate Mem/DOS/Service code/Pay To/Modifier	$421,026.43
PHP*	1	Retro Eligibility - member ineligible on date of service	$4,288.50	Replacement Claim	$2,462,071.01
	2	Zero Allowed - Dual PHP	$1,316.50	No Authorization	$1,437,926.19
	3			Duplicate	$1,403,382.30
	4			Billed Incorrectly By Provider	$728,577.98
	5			Corrected Claim	$606,567.26
	6			Timely Filing	$590,810.41
	7			Member Not Eligible	$621,214.01
	8			Recoupment Requested	$212,010.35
	9			Missing or Incomplete EOB	$211,848.25
	10			Denied With Ex Code YI5	$101,910.00
UHC	1	Benefits Based on Admission Date	$6,317,655.85	Benefits Based on Admission Date	$13,276,616.43

Top 10 Denial Reasons and Dollar Amounts					
	Rank	**Reason**	**Dollar Amount**	**Reason**	**Dollar Amount**
	2	Service is not contracted	$1,616,508.80	No Authorization on File	$2,679,913.63
	3	Medi 2ndary Carrier	$1,633,690.53	Claim Preauth Requirement bypassed	$4,211,904.72
	4	COB applies - exceeds the fee schedule	$1,015,781.84	Claim forwarded to Medicaid	$4,732,136.80
	5	EOB Date Required for COB.	$2,232,677.77	Claim is a Duplicate	$3,182,417.43
	6	Claim Preauth Requirement bypassed	$387,626.04	Service is Not Contracted	$1,846,987.62
	7	Medi 2ndary Carrier	$511,458.16	Claim Filed After Time Limit	$3,268,017.34
	8	Auth overrode due to COB	$364,258.67	Our Records Show We Have Already Processed This Charge.	$3,468,988.97
	9	Approved Amt Paid by Medicare	$357,930.86	Requires Notification/Plan Not Notified	$2,694,566.59
	10	Coordinated w/Medicare- Pd in Full	$237,970.32	HIPPS Claim, see clinical notes	$2,253,780.15

Reason: *Denial reason description*
Dollar Amount: *Sum of billed amounts for denial reason*
**PHP denial reasons are based on Myers and Stauffer key word or phrase to standardize denial reasons for more accurate reporting of denials.*

Denials with Prior Authorization

The following data elements were utilized to test and determine the number and dollar amount of denied claims with prior authorizations for members with retroactive enrollment and to group the number of denied claims with a prior authorization by dollar amount and by denial reason code:

- Prior Authorization Number
- Date Member Added to the System
- Begin Date of Member Coverage
- Denial Reason Codes
- Denial Reason Descriptions
- Billed Amount

To ensure all denials with prior authorizations were included in the testing, the prior authorization numbers from the Prior Authorization data sets were utilized and linked based on claim ID and dates of service. Denied claims were identified with a Reimbursement Status of “Denied”.

The total number of denial codes and total billed amounts are summarized below by MCO for denied claims with prior authorizations. Reference Appendix A which provides a listing including all denial reason codes, denial reason descriptions and a count of each denial reason code.

Table 6

Denials with Prior Authorization				
	BCBS	**MHC**	**PHP**	**UHC**
Denial Reason Codes				
Total Number of Codes*	3,430	2,477	1,809	6,430
Total Billed Amount**	$11,750,039.61	$10,203,116.76	$7,425,747.53	$16,345,778.91

**The billed amounts represent unduplicated denials.*
***The number of codes may include more than one code per claim.*

To limit prior authorization denials to those with retroactive enrollment, the date each member was added to the system and the date when each member's coverage began was utilized to determine if the claim had standard or retroactive coverage. In the original data submission, each MCO only provided one of these necessary dates to determine coverage. A secondary request was made and once all dates were received, the difference in days between the member's system add date and the member's effective date was calculated. Coverage type was assigned based on the following specifications:

- Retroactive claims – member added to the system after the date coverage began
- Standard claims – member added to the system before the date coverage began

Claims with more than 90 days between the member's system add date and the member's effective date were identified for each MCO and the listing of claims was forwarded to the MCO. The request to the MCO included confirming the data components utilized in determining retroactive coverage were appropriate and provide an explanation for claims exceeding 90 days between add date and effective dates. Retroactive eligibility is limited to 90 days; however, retroactive enrollment can be approved back to the date of admission or month of application, which may exceed 90 days. The following responses were received and incorporated in the denials with prior authorization analysis:

- BCBS – Members could potentially have multiple coverage periods but are only ever added to the system once. Therefore, a member could potentially have retroactive coverage although it appears as standard coverage in the MCO system. Based on BCBS' recommendation, the earliest effective date for each member was utilized as it would be the most appropriate date to be associated with the system add date.
- MHC – MHC confirmed the data components utilized in determining coverage were appropriate and noted that retroactivity is prevalent in New Mexico Medicaid, explaining why members may have effective and add dates exceeding 90 days. Another reason could be that enrollment existed with a previous segment, but due to correction or retroactivity from the state, the previous segment was terminated.

- PHP – PHP originally stated the effective date is always on the first of the month, therefore, there were no retroactive enrollment of members greater than 30 days which was supported by its initial data submission. However, after follow-up, PHP indicated it does have retroactively-enrolled members. These members are identified monthly and retroactive claims are proactively adjusted. PHP provided revised data for all denied claims to properly determine retroactively-enrolled members with denied claims.
- UHC – The category of eligibility on a number of members was updated by UHC in its system after receiving an updated category of eligibility file from HSD, which caused the date the member was added to the system to change. The update within its system limits the ability to accurately calculate which denials are related to members with retroactive enrollment.

Based on responses above, the ability to identify retroactively enrolled members is compromised due to lack of reliable data the MCOs were able to provide when members have multiple coverage periods. All members with a member system add date after the member eligibility date are included as retroactively enrolled members. The number and billed amounts of denied claims with prior authorizations for members with retroactive enrollments are outlined in the table below.

Table 7

Denials with Prior Authorization for Retroactive Enrolled Members				
	BCBS	**MHC**	**PHP**	**UHC**
Members with Retroactive Enrollment				
Number of Claims	1,355	1,016	2	3,163
Dollar Amount	$4,636,767.84	$5,404,295.68	$5,895.06	$14,208,278.70

Dollar Amount *= Sum of billed amount*

Claims Sample

A statistically valid sample size was calculated for each plan based on the as-submitted data set for claims with a paid status. The sample size was based on a ten percent error rate and a five percent margin of error. The calculation of the sample size was performed in consultation with a qualified statistician. A statistically valid sample allows for the extrapolation of errors across the population. The table below displays the sample size for each MCO:

Table 8

Sample Size				
	BCBS	**MHC**	**PHP**	**UHC**
Number of Claims	91	106	98	132
Error Rate	10%	10%	10%	10%
Margin of Error	5%	5%	5%	5%

The UHC sample included two hospital claims which were erroneously submitted by UHC in its nursing facility claims data set. The claims were excluded from the sample testing as they should not have been part of the nursing facility claims population. Therefore, the UHC total sample size will be reflected as 130 in subsequent tables.

For each MCO, random sampling was used to select the claims for testing. The sample list with recipient and provider information was forwarded to the MCO. The request stated to submit the following documentation to support the selected sample:

- Contract loading
  - The request date for loading the contract into the system
  - The date the contract was loaded into the system
- Payment calculation
  - Applicable fee schedules and contracted rates
  - Provider contract
  - Payment method (Per diem, Percentage of charges, etc.)

Sample Testing Methodology

Timely Credentialing

Credentialing is the process of establishing the qualifications of licensed Medicaid providers, which may include the confirmation of their license, confirmation of their education, and determining eligibility to participate in government Medicaid programs.

Contract Requirement **Section 4.8.14.1.8**
Complete the credentialing process within forty-five (45) calendar days from receipt of completed application with all required primary source documentation.

Credentialing Testing

The following data elements were utilized to test and determine compliance related to the number of days required to complete credentialing:

- Date of Credentialing Application

- Date Credentialing was Completed

For each sample claim, the days between the date of the credentialing application and the date the credentialing was complete was calculated. This day calculation was compared to the 45 calendar day credentialing requirement. Reference *Table 14* for testing results.

Timely Contract Loading

Provider contract loading is the length of time required to load the contractual payment terms for each participating provider into the payment system.

Contract Requirement **Section 4.8.14.1.13 – Amendment 6**
MCOs must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than forty-five (45) calendar days after a provider is credentialed, if required.

Contract Loading Testing

The following data elements were utilized to test and determine compliance of the number of days required to load provider contracts:

- Date of the Provider's Request to Add the Contract
- Date the Contract was Loaded

For each sample claim, the days between the date of the provider's request and the date the contract was loaded into the system was calculated. This day calculation was compared to the 45 calendar day contract loading requirement. Reference *Table 14* for testing results.

Proper Payment

A mispayment is any excess or deficiency in funds received by an entity related to the Medicaid allowable amount of the MCO as negotiated with the provider.

To test and determine proper payment, the following data elements were utilized:

- Recalculated Number of Days / Units
- Contracted or Fee Schedule Rate
- Gross Receipts Tax
- Medical Care Credit
- Interest
- Recalculated Payment Formulas

Recalculated Number of Days/Units

Because the majority of the nursing facility claims are monthly interim bills, one day was added to the number of days between the admit date and the discharge date or last date of service to accurately recalculate the length of stay. This methodology was applied to all sample claims spanning an entire month except for claims with a bill type of XX1 or XX4 as these bill types represent an admit through discharge bill, or an interim last claim which would exclude payment for the day of discharge.

The recalculated days for each sample claim were compared to the MCO's originally submitted covered days. The number of days variances noted between recalculated days and covered days are outlined in the table below.

Table 9

Covered and Recalculated Day Variances			
BCBS	**MHC**	**PHP**	**UHC**
2	14	30	10

Day Variances: *Difference between recalculated days based on admit date and discharge date or last date of service and covered days*

Contract or Fee Schedule Rate

As stated above, applicable fee schedules and provider contracts were requested for each sampled claim. Submitted fee schedules and contracts were reviewed and determination of the correct reimbursement rate was based on the following criteria:

- The supported rate was effective for the sample claim dates of service
- The provider reflected in the sample support matched the sample claim provider
- For any providers using standard HSD reimbursement rates, all standard rate increases were taken into account, if applicable
    - July 1, 2014 – 3.65% HSD rate increase
    - July 1, 2015 – 4% HSD rate increase

There were instances where both the contract and rate schedule were submitted, but other instances where only one or the other was submitted. An error was only noted for claims with no documentation at all or if the matching criteria between the claims data and the supporting documentation did not reconcile.

Although contracts and rate schedules were requested for each claim, following is the documentation received from each MCO to support the contract rate used to recalculate the payments:

- BCBS
    - Contracts
    - Rate Letters

  - Statements of Understanding

- MHC
  - Contracts
  - Claims System Print Screen: MHC submitted print screens of its internal claim system as “fee schedule” support. The ability to confirm that the proper payment was made to the provider for claims where submitted documentation was limited to a print screen was compromised due to a lack of original supporting documentation for the per diem payment rates.
- PHP
  - Contracts
- UHC
  - Contracts
  - Rate Letters
  - Fee Schedules

Data components used to match documentation between claims data and supporting documentation:

- BCBS – Rendering Provider MCO ID
- MHC – Provider ID was not included on the documentation, matched on Provider Name only
- PHP – Provider Name, if not included, support was matched based on the Contract Name as reported by PHP
- UHC – Rendering Medicaid Provider ID

The supported rate utilized in recalculating the payment was reflected as $0.00 if any of the following instances occurred:

- No support was submitted
- If identifiers, as outlined above, between the claims data and the supporting documentation failed to match
- If the revenue code in the claims data was not included in the submitted documentation
- If the MCO identified the claim as a claim where Medicaid was the secondary payer, but no third party or Medicare primary payment was reflected on the claim

The following table outlines the number of claims with missing documentation needed to recalculate payments:

Table 10

Missing Rate Documentation				
	BCBS	**MHC**	**PHP**	**UHC**
No Contract or Fee Schedule Submitted	0	1	4	0
Support Not Effective for Claim DOS	0	1	2	0
Support Did Not Include Rate for Claim Revenue Code	0	2	4	0
Medicaid Listed as Secondary, but No Primary Payment	4	10	0	0

Gross Receipts Tax (GRT)

GRT is specific to New Mexico Medicaid and the MCOs are reimbursing it to for-profit New Mexico providers of Long Term Services and Supports who accepted 100% or less of the Medicaid fee schedule, including non-contracted providers. GRT reimbursement is accounted for through the payment rate negotiation process between the MCOs and providers, therefore paid differently to each provider and by each MCO. Meaning it may be an add-on to the payment rate or paid separately outside of the payment rate. The GRT rate may be based on the New Mexico Taxation and Revenue Department's respective taxable rate of a provider office location and municipality and determined by the claim's date of service, but the methodology may vary per MCO. If a member is dual-eligible, the MCO may or may not pay the provider the Medicaid portion of the reimbursement. For BCBS, MHC, and UHC, the GRT is not payable on the Medicaid portion of the reimbursement on a crossover claim. However, for PHP the GRT is payable on the Medicaid portion of the reimbursement on the crossover claim.

A review of claims data detail for MHC revealed that payments were made on lines of detail with revenue code 999 and many of these lines did not have a corresponding billed amount on the line. After follow-up correspondence, MHC stated that payments made for revenue code 999 are for gross receipts tax. This treatment of revenue code 999 is unique to MHC.

Based on submitted supporting documentation and correspondence with UHC, it was determined UHC does not employ a consistent methodology for GRT reimbursement. HSD Letter of Direction #26, granted MCOs permission to negotiate GRT reimbursement in the payment rate negotiation process with providers. It was noted during testing that the GRT amounts provided by UHC did not always align with the GRT rate listed in the submitted contract documentation. In some instances, average GRT rates were utilized by UHC to reimburse for the GRT by assigning a range of the standard New Mexico Taxation and Revenue Department rates into a banded spectrum, rather than using the actual tax rates. For Genesis Legacy Skilled HC providers, the all-inclusive negotiated rate was used to recalculate the payment, instead of using the GRT carved out of the base rate. In other instances, the carved out GRT rate was added onto the base rate to recalculate the payment. Based on the inconsistent treatment of GRT reimbursement mentioned above, the ability to verify the GRT was applied according to the agreement between the provider and UHC was limited.

The gross receipts tax methodology for each MCO is summarized in the table below. Detail of how the gross receipt tax is incorporated in the recalculation of the payment amount is further outlined in the section below.

Table 11

Gross Receipts Tax Methodology			
BCBS	**MHC**	**PHP**	**UHC**
Inclusive in Rate	Outside of Rate	Outside of Rate	Combination

Medical Care Credit (MCC)

When a Centennial Care member is eligible for nursing facility level of care (NFLOC), the New Mexico Income Support Division (ISD) determines if the member can financially contribute cost sharing or patient liability for nursing facility services. MCC is the name of the monthly patient responsibility when a member is an inpatient in a long term skilled nursing facility. The monthly amount is determined by ISD based on the member's income and is deducted from the Medicaid allowed amount each month a claim is submitted by the provider. As long as the member is still eligible to receive services, is still in the same facility, and still retains a monthly income, there is an applicable MCC, although the amount may vary if the member's monthly income changes. The MCC amount should be applied once monthly to the first claim that is received in the calendar month, in good faith that the provider will bill the remainder of the month. If the total MCC amount is not applied on the first claim, it should be applied on the subsequent claims until the total amount has been met for the month.

Each MCO reported the MCC amounts from its systems and the amounts were supplied by HSD as well based on information from ISD. Variances in MCC amounts reported by HSD and the MCO occurred for the following number of claims and dollar amounts, as displayed in the table below. Further detail on how the MCC is utilized in the recalculation of the payment amount is outlined in the section below.

Table 12

Medical Care Credit Variances							
BCBS		**MHC**		**PHP**		**UHC**	
Number of Claims	**Dollar Amount**	**Number of Claims**	**Dollar Amount**	**Number of Claims**	**Dollar Amount**	**Number of Claims**	**Dollar Amount**
26	$22,846	4	$3,473	27	$21,223	39	$22,870

Dollar Amount: *HSD MCC Amount – MCO MCC Amount*

Failure to properly apply the MCC to the MCO claim payment would result in MCO overpayments.

Interest

New Mexico Administrative Code 8.308.20.9(E) outlines payment of interest by the MCO.

NMAC Requirement Section 8.308.20.9(E)
The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current Medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

A request was made to each MCO to identify if the paid amount in the nursing facility claims data was inclusive of any applicable interest amounts in the claims data submission in order to recalculate proper payment. For BCBS, MHC, and PHP, the interest is excluded from the paid amount and reimbursed to the facility separately. However, for UHC the interest is included in the paid amount and is an add-on to the claim payment. These differing methodologies were taken into consideration in recalculating payments for each MCO, but accrued interest itself was not recalculated in our testing. The interest methodology for each MCO is summarized in the table below.

Table 13

Interest Methodology			
BCBS	**MHC**	**PHP**	**UHC**
Excluded from Payment	Excluded from Payment	Excluded from Payment	Included in Payment

Methodology of Payment Recalculation

BCBS

Based on contract support and correspondence with BCBS, it was determined the rates were inclusive of the GRT. The MCC was taken into consideration in recalculating payments. Payments were limited to the lesser of the provider's billed charges or the fee payable under the fee schedule as directed in the contract support. The following formulas were used when recalculating the sample payment amounts for BCBS sample claims:

- ***Non-Crossover Payment Recalculation (Rate Inclusive of GRT)*** = (Recalculated Days / Units * Supported Rate) – MCC Reported by the MCO

MHC

Based on contract support and correspondence with MHC, it was determined the rates were not inclusive of the GRT. The GRT amount was provided by the MCO and utilized in the repayment calculation. The MCC was also taken into consideration in recalculating payments. Payments were limited to the lesser of the provider's billed charges or the fee payable under the fee schedule as directed in the contract support. The following formulas were used when recalculating the sample payment amounts for MHC sample claims:

- ***Non-Crossover Payment Recalculation (Rate Not Inclusive of GRT; No Split Claim with MCC)*** = (((Recalculated Days / Units * Supported Rate) + GRT Amount Reported by the MCO) – MCC Reported by the MCO)
- ***Non-Crossover Payment Recalculation (Rate Not Inclusive of GRT; Split Claim with MCC)*** = (((Recalculated Days / Units * Supported Rate) + GRT Amount Reported by the MCO)

PHP

Based on the contract support and correspondence with PHP, it was determined the rates were not inclusive of the GRT. The GRT rate reported by the MCO was utilized in the repayment calculation. When applicable, the standard HSD rate increases referenced in the contract section above were incorporated into the supported contract rates. The MCC was also taken into consideration in recalculating payments. Payments were limited to the lesser of the provider's billed charges or the fee payable under the fee schedule as directed in the contract support. For some claims, PHP paid the provider based on Resource Utilization Group (RUG), which was indicated by a RUG code included on the claim. The following formulas were used when recalculating the sample payment amounts for PHP sample claims.

- ***Non-Crossover Per Diem Payment Recalculation (Rate Not Inclusive of GRT)*** = ((Recalculated Days / Units * Supported Rate * GRT Rate Reported by the MCO) – MCC Reported by the MCO)
- ***Non-Crossover RUG Payment Recalculation (Services Not Exceeding More Than 12 Days Above the Average Length of Stay)*** = (RUG Payment Rate – MCC Reported by the MCO)
- ***Non-Crossover RUG Payment Recalculation (Services Exceeding More Than 12 Days Above the Average Length of Stay) =*** *((Recalculated Days / Units * Payment Per Diem) – MCC Reported by the MCO)*

UHC

Based on contract support and correspondence with UHC, it was determined some rates were inclusive of the GRT, while other rates were not. When contract rates were not inclusive of the GRT, the GRT amount provided by the MCO was utilized in the repayment calculation. When applicable, the standard HSD rate increases referenced in the contract section above were incorporated into the supported contract rates. The MCC was also taken into consideration when recalculating payments. Payments were limited to the lesser of the provider's billed charges or the fee payable under the fee schedule as directed in the contract support. The following formulas were used when recalculating the sample payment amounts for UHC sample claims.

- ***Non-Crossover Payment Recalculation (Rate Inclusive of GRT)*** = (Recalculated Days / Units * Supported Rate) – MCC Reported by the MCO
- ***Non-Crossover Payment Recalculation (Rate Inclusive of GRT; Genesis Legacy Skilled HC Providers)*** = (Recalculated Days / Units * Supported Blended Rate) – MCC Reported by the MCO

- ***Non-Crossover Payment Recalculation (Rate Not Inclusive of GRT)*** = (Recalculated Days / Units * Supported Rate) + GRT Rate Reported by the MCO – MCC Reported by the MCO
- ***Non-Crossover, Non-Profit Payment Recalculation (Not eligible for GRT)*** = (Recalculated Days / Units * Supported Rate) – MCC Reported by the MCO

Reference *Table 14* for testing results and *Appendix B* for a summary of the number of (over)/underpayments noted during testing and the distribution of the dollar amounts.

Retroactive Rate Adjustments
As a part of the Phase II data request, the MCOs were asked to submit any documentation related to retroactive rate adjustments for the period under review. All four MCO's submitted responses stating that there were no applicable retroactive rate adjustments. Therefore, it was not necessary to perform testing procedures on retroactive rate adjustments.

Sample Testing Results

The table below outlines the results of the sample claims testing performed as described above. Note when utilizing the methodology of the greater of the lower bound of extrapolated one-sided 90% confidence interval or actual incorrect payments in the claim sample, all resulted in the actual mispayments. All MCOs reflected an overall overpayment result based on recalculation in payments. In addition, when factoring in the HSD MCC amounts, the results reflected even greater overpayments, as HSD reported higher MCC amounts in total than the MCOs.

Table 14

Sample Testing Results								
	BCBS		**MHC**		**PHP**		**UHC**	
Total Number of Sampled Claims	91		106		98		130	
Total Sample Payments	$356,391.74		$315,140.82		$364,642.53		$374,576.92	
Total Number of Sampled Crossover Claims	10		1		4		13	
Total Sample Crossover Payments	$1,446.02		$256.18		$6,741.40		$5,219.74	
Total Number of Sampled Non-Crossover Claims	81		105		94		117	
Total Sample Non-Crossover Payments	$354,945.72		$314,884.64		$357,901.13		$369,357.18	
Total Sampled Zero Paid Claims	0		0		5		5	
	Value	**Error Rate**	**Value**	**Error Rate**	**Value**	**Error Rate**	**Value**	**Error Rate**
Credentialing >45 Days								
Credentialing	13	14.29%	0	0.00%	98	100.00%	47	36.15%
Missing or Incorrect Documentation	6	6.59%	0	0.00%	5	5.10%	0	0.00%
Exceeds Contract Requirements	7	7.69%	0	0.00%	93	94.90%	47	36.15%
Range (in days)	0 to 367		1 to 35		1,075 to 1,095		0 to 1,097	
Contract Loading > 45 Days								
Contract Loading	58	63.74%	50	47.17%	0	0.00%	2	1.54%
Missing or Incorrect Documentation	46	50.55%	44	41.51%	0	0.00%	2	1.54%
Exceeds Contract Requirements	12	13.19%	6	5.66%	0	0.00%	0	0.00%
Range (in days)	0 to 3,659		(336) to 546		No Range		5 to 22	
<> $0 Variance Related to All Claims								
Total Mispayments	7	7.69%	20	18.87%	24	24.49%	13	10.00%
Missing or Incorrect Documentation	4	4.40%	14	13.21%	10	10.20%	0	0.00%

Sample Testing Results								
	BCBS		MHC		PHP		UHC	
Mispayments	3	3.30%	6	5.66%	14	14.29%	13	10.00%
Rounding	0	0.00%	1	0.94%	10	10.20%	7	5.38%
Overpayment Range	$16.22 to $3,731.40		$43.25 to $7,090.28		$0.01 to $8,466.00		$0.01 to $595.51	
Underpayment Range	No Range		$0.12 to $640.52		$0.01 to $10,300.00		$3.00 to $1,652.00	
Extrapolation of Incorrect Payments to Population	($5,390.59)		($29,561.49)		($35,922.48)		($84.07)	
Incorrect Payments with MCC Variances (*Table 12*)	($28,236.59)		($33,034.49)		($57,145.48)		($22,953.74)	

Value: *Number of claims with an error*
Error Rate: *Value / Total Number of Sampled Claims*
Missing or Incorrect Documentation: *No contract or rate sheet submitted or incorrect provider reflected*
Rounding: *Subset of total mispayments – mispayment errors less than or equal to $0.30*

Crossover Claims included in the Sample

Claims in the sample selection where the MCO identified Medicaid was the secondary payer were given the following designations in the claims testing:

- Patient Responsibility – The MCO paid the patient responsibility or coinsurance for the claim. Recalculation of the Medicaid payment related to these claims was not performed, as the MCO reimburses the nursing facility for the billed patient liability, and therefore does not calculate the payment for these claims.
- No Third Party / Medicare Payment on Claim – The MCO indicated that a claim was a Medicare claim, but no third party or Medicare payment was noted on the claim. Claims with this designation were included as missing documentation errors in *Table 14*.

The following table outlines the number of claims in the sample selection that fall into the categories summarized above:

Table 15

Medicaid Secondary Claims				
	BCBS	**MHC**	**PHP**	**UHC**
Patient Responsibility	10	1	4	13
No Third Party / Medicare Payment on Claim	4	10	0	0

Zero Paid Claims included in the Sample

As summarized in *Table 2* above, the data sets for all the MCOs contained claims with a "Paid" reimbursement status reflecting a zero payment. For both PHP and UHC, zero paid claims were selected as part of the claims sample. Four of the five zero paid claims in the sample selection for PHP had no payment noted on the claim since a replacement/corrected claim was received, replacing the original claim. The fifth zero paid claim was denied as a duplicate, but was not identified as a denied claim in the claims data submission. The zero paid claims in the sample selection for UHC either had no billing charges on the claim or the billing charges were equal to the MCC for the claim. All zero paid claims were reflected as a $0 payment variance in *Table 14* since the lack of Medicaid payment on the claim was deemed appropriate either due to reimbursement being limited to billed charges or due to the claims representing denials or replacement claims.

Summary of Findings and Recommendations

The findings and recommendations are limited to issues noted related to compliance with the MCO contract, NMAC, system's manual, and policy manual and do not encompass all testing results.

Summary of Findings and Recommendations – HSD		
Testing Area	**Finding**	**Recommendation**
Analytical Procedures	**Adjusted Claim Turnaround Time** MCO contracts do not contain any requirements specifically related to the turnaround time for adjusted claims submitted by the provider or adjustments made by the MCO due to issues such as retroactive rate changes.	HSD should include a provision in the contract which would require adjusted claims, including MCO adjustments to be adjudicated within a specific time period to ensure timely payment.
Analytical Procedures	**Clean vs Adjusted Claim Definition** Definition of clean vs adjusted claim differs between the plan and HSD. No universal, defined method for determining claim status.	HSD should include contract language that clearly defines what would be considered a clean claim and an adjusted claim and enforce the timely payment requirements for the respective claim type. The definition for each claim type should include an identifier within the claims data so timely adjudication can be measured by HSD.
Analytical Procedures	**Turnaround Times for Manual Nursing Facility Claims** 95% of nursing facility claims are required to be adjudicated within 15 days and 99% within 30 days of receipt by the MCOs based on contract requirements. There is a separate provision for manual claims of 45 days, but it is unclear whether this applied to nursing facility claims or if manual nursing facility claims must follow the 15 and 30 day requirement.	HSD should specifically address the timely adjudication of manual nursing facility claims within the contract so contract compliance can be monitored.
Analytical Procedures	**MCO "Paid" and "Denied" Claims Status** Payments may be misclassified between paid and denied status based on paid claims containing zero payments and denied claims reflecting payment amounts.	HSD should require each MCO to provide its criteria for classifying claims as paid or denied. Additionally, it should require each to assess whether the criteria are applied within its claims system to ensure accurate reporting.
Claims Testing	**Gross Receipts Tax** HSD does not have a standard requirement for how the GRT is reimbursed to nursing facilities by the MCOs and is not aware of each MCOs GRT policies.	HSD should require each MCO to provide its policies related to reimbursement of GRT including which nursing facilities are reimbursed GRT and the amounts to enable HSD to properly oversee the MCO nursing facility claims payment processes. HSD should require the MCOs to specifically communicate the amount of GRT as well as GRT increases due to each nursing facility to enable assessment of proper payment.

Summary of Findings and Recommendations – HSD		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures, Analytical Procedures, and Claims Testing	**MCO Compliance** Findings related to each testing area for each MCO were noted and are outlined separately in the pages below.	HSD should monitor each MCO's compliance with contract requirements, NMAC, the Centennial Care MCO Systems Manual, and the MAD Medicaid Managed Care Policy Manual related to the findings below and ensure recommendations are incorporated into each MCO's operations for proper oversight of nursing facility claims under Centennial Care.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that no contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that a good-faith effort must be made to notify the provider if payment is not to be made within the payment timeframes if Medicaid's liability cannot be determined.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Paying Clean Claims in a Timely Manner: Contract Section 4.19.1.6.1** For Claims from I/T/Us, day activity providers, assisted living providers, Nursing Facilities and home care agencies including Community Benefit providers, ninety-five percent (95%) of Clean Claims must be adjudicated within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims must be adjudicated within a time period of no greater than thirty (30) Calendar Days of receipt. **The MCO Submitted Policy:** Electronic clean claims from I/T/U (Indian Tribal/Urban Provider)s, day activity providers, assisted living providers, nursing facilities and home care agencies including community benefit providers should be paid within 15 calendar days of receipt whereas electronic clean claims from all other provider types should be paid within 30 calendar days of receipt. Manual clean claims from providers, regardless of provider type, should be paid within 45 days of receipt. **Non-Compliance:** Contract section does not stipulate manual claims are exempt from 15 day and 30 day provisions for these provider types.	The MCO should update its documented policies and procedures to remove the clause stating that manual claims are exempt from the 15 day and 30 day provisions for these provider types.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Provider Contract and Claims System Loading: Contract Section 4.8.14.1.13** MCOs must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than forty-five (45) calendar days after a provider is credentialed, if required. **The MCO Submitted Policy:** Provider Credentialing: Provider network values will be loaded on or before the 45th day of the completed credentialing Council for Affordable Quality Health (CAQH) application. Providers Joining Contracted Networks: The New Mexico Network Service Department will complete provider interest form review, initial standard contracting process, initiate the credentialing process and load provider network values with the following time frame: Forty-five days from corporate received date to completion of system maintenance. Note: Contract negotiations for non-standard contracts are an exception. **Non-Compliance:** Provider network values being loaded within 45 days may not include provider all contract terms or allow recognition in the system as a network provider. Additionally, for providers joining contracted networks, 45 days from corporate received date to completion of system maintenance may not be the same as 45 days after the provider is credentialed. This provision doesn't appear to cover non-standard contracts either.	The MCO should update its documented policies and procedures to state that a contract must be loaded and a provider recognized no later than 45 days after the provider credentialing date, instead of within 45 days of completion of system maintenance.
Analytical Procedures	**Calculation of Adjusted Claim Turnaround Times** For claims that are adjusted/reversed after being finalized, the Claim Received Date in the claims system continues to indicate the date when the claim was originally received by the MCO. The system therefore does not enable accurate reporting of claim turnaround time.	The MCO should update its claims system to allow for an adjustment notification date in addition to the claims received date to accurately report the turnaround times for adjusted claims.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6** The MCO does not meet the following requirements 95% of claims be adjudicated within 15 days 99% of claims be adjudicated within 30 days There are 3,499 claims with a turnaround time exceeding 15 days. Additionally, overall only 86.38% of claims were adjudicated within 15 days and 93.41% within 30 days of receipt.	The MCO should identify what is causing it to not meet the contract term requirement and implement a process improvement plan which should be communicated to HSD. It should monitor contract compliance on at least a monthly basis.
Analytical Procedures	**Member Coverage** The MCO's system does not allow for multiple member add dates for members with multiple coverage periods which doesn't allow for the accurate identification of all members with retroactive coverage.	The MCO should update its claims system to allow for multiple member add fields to properly capture members with retroactive eligibility.
Analytical Procedures	**Denials with Prior Authorization for Retroactive Enrolled Members** 1,355 claims representing $4,636,767.84 in billed charges were denied that had prior authorizations for retroactively enrolled members.	The MCO should investigate the denied claims and ensure the claims were properly denied and not related to the MCO's timely filing requirements.
Claims Testing	**Provider Credentialing Data** Provider credentialing dates are missing for 6 sample claims and 7 claims are related to providers the MCO did not credential within the 45 day contract credentialing requirements.	The MCO should take steps to improve the completeness of the provider credentialing data retained in the MCO's system. Additionally, the MCO should determine the cause for non-compliance related to the 7 providers in the sample claims and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** 43 claims are missing contract load dates, 3 claims had contract load dates prior to the request to load the contracts (46 claims classified as missing/incorrect documentation) and 12 claims related to contracts that weren't loaded within the 45 day contract loading requirement.	The MCO should take steps to improve the quality and completeness of contract loading data retained in the MCO's system. Additionally, it should determine the cause for non-compliance related to the 12 contracts in the sample claims and determine whether it is a systemic issue. It should implement steps to ensure timely contract loading for all providers.
Claims Testing	**Documentation Support** The MCO indicated that Medicaid was the secondary payer for 4 claims, but no Medicare payment or third party payment was noted on the claims. It did not submit support for the primary payer payment.	The MCO should determine the cause for the missing payment information in the sample claims and determine whether it is a systemic issue. It should implement procedures to ensure the maintenance of accurate documentation and information for all claims.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Claims Testing	**Payment Recalculation** Payment errors were noted in 7 of the 81 non-crossover sample claims based on the support provided.	The MCO should determine the cause of the payment errors in the sample claims and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Claims Testing	**Covered Days Recalculation - Variances** 2 claims had a days variance between the covered days and the recalculated days.	The MCO should provide an explanation for the variances between reported covered days and the recalculated days based on the dates of service and reprocess claims for proper payment if necessary.
Claims Testing	**Medical Care Credit** 26 of sample claims reflected variances between the Medical Care Credit amounts provided by HSD and the MCC utilized by the MCO in its payment calculation. Utilizing the HSD MCCs in the claims payment recalculations would have decreased the payments to the providers by $22,846. The MCC amounts were not included as coinsurance or deductibles in the claims data set received from the MCO.	The MCO should monitor and review its processes for identifying the related Medical Care Credit for each claim to ensure the Medical Care Credit is being properly included as co-insurance or a deductible and to ensure that the patient share of cost is being removed from the claim payment. In addition, it should be verifying Medical Care Credit amounts by reviewing the 834 eligibility files HSD sends to each MCO and the MAD 200 form.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Authorization of Services: Contract Section 4.12.12** For standard authorization decisions, provide notice as expeditiously as the Member's health condition requires, within fourteen (14) Calendar Days following receipt of a request for new services and within ten (10) Calendar Days following receipt of a request to continue ongoing services and within State prescribed parameters. The MCO's submitted policy references the 14 day decision requirement, but the 10 day decision for ongoing services is not referenced.	The MCO should update its documented policies and procedures to include a clause stating that a 10 day authorization decision is required for an ongoing service.
Policies and Procedures	**Authorization of Services: Contract Section 4.12.12** Extension of 14 days for authorization decision can be granted if requested by a member or if justified by the contractor. This contract requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause saying that an extension of 14 days for authorization decisions can be granted if requested by a member or if justified by the contractor.
Policies and Procedures	**Authorization of Services: Contract Section 4.12.12** If contractor requests an extension, the contractor must provide the member written notice and inform the member of the appeal rights. This contract requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that if a contractor requests an extension, the contractor must provide the member written notice and inform the member of the appeal rights.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that no contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that a good-faith effort must be made to notify the provider if payment is not to be made within the payment timeframes if Medicaid's liability cannot be determined.
Policies and Procedures	**Nursing Level of Care: Contract Section 4.4.5.7** For Members who are Otherwise Medicaid Eligible who have indicators that may warrant a nursing facility level of care, the CONTRACTOR shall conduct a nursing facility level of care evaluation. For Members who are Not Otherwise Medicaid Eligible, the CONTRACTOR shall conduct a nursing facility level of care evaluation in accordance with Section [4.1.2] of this Agreement. HSD shall approve the CONTRACTOR's tools and processes in conducting the nursing facility level of care evaluation for all Members. At a minimum, MDS shall be used as the basis for the evaluation and the CONTRACTOR shall interface with HSD's eligibility system for level of care in a file format prescribed and approved by HSD. This contract requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the nursing level of care.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Nursing Level of Care Not Otherwise Medicaid Eligible: Contract Section 4.1.2** The CONTRACTOR shall conduct a nursing facility level of care evaluation for individuals who are Not Otherwise Medicaid Eligible and who, through a preliminary screening conducted by HSD or its designee, are found to have indicators that may warrant a nursing facility level of care. The CONTRACTOR shall use the tools and processes that have been approved by HSD in conducting the nursing facility level of care evaluation. At a minimum, (i) MDS shall be used as the basis for the evaluation and (ii) the CONTRACTOR shall interface with HSD's eligibility system for level of care in a file format prescribed and approved by HSD. If a Not Otherwise Medicaid Eligible individual has met the nursing facility level of care determination, either because he or she is in a Nursing Facility or because HSD has capacity for Community Benefit services, the CONTRACTOR shall inform HSD of the individual's level of care determination. If the individual is determined to meet a nursing facility level of care, the CONTRACTOR shall notify HSD to continue the eligibility determination process. This contract requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the nursing level of care for Not Otherwise Medicaid Eligibles.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Level of Care Packet** The LEVEL OF CARE PACKET FOR NURSING FACILITIES INCLUDES: 1. PASRR 2. NF LOC Notification Form 3. MDS Once an order is signed and dated, it cannot be changed. If a change is required, a new order must be written, signed, and dated by the Physician, Nurse Practitioner or Physician Assistant. Verbal or telephone orders are permitted. The order must be taken by a RN or LPN who must also sign and date the order. It must be clearly indicated that the order is a telephone or verbal order with the name of the Physician, Nurse Practitioner or Physician Assistant who gave the order and LOC. The date of the call or verbal communication is the date of the order. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the level of care packet.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Level of Care Packet** The MCO approves the documentation and makes a LOC determination following the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria within five (5) business days of receiving a completed packet. The MCO shall review the documentation provided to determine the appropriate NFLOC. A packet that requests LNF but meets HNF criteria shall be upgraded to HNF; a packet that requests HNF but only meets LNF criteria shall be downgraded to LNF. A new doctor's order is not required. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the level of care packet.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Level of Care Packet** When required documentation is missing, a "Request for Information" (RFI) sheet will be generated by the MCO and sent to the provider. If the required documentation is not provided to the MCO within fourteen (14) business days of the request, it will be technically denied. The MCO will make three (3) attempts during the fourteen (14) business day period to contact the NF to obtain information. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the level of care packet.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Denial of Request for Prior Approval** If the LOC criteria are not met and the request for placement is denied, the MCO will send the referring party and the member a denial letter within five (5) business days of a completed packet, with the reason for denial as determined by the physician. The requesting parties then have an opportunity to request reconsideration or appeal. After the parties have exhausted the MCO appeal process, the member may request an administrative hearing of the MCO decision. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the denial of request for prior approval.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Reserve Bed Days** Medicaid pays to hold or reserve a bed for a resident in a Nursing Facility to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below. 1. Medicaid covers six (6) reserve bed days per calendar year for every long term care resident for hospitalization without prior approval. Medicaid covers three reserve bed days per calendar year for a brief home visit without prior approval. 2. Medicaid covers an additional six (6) reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan. Nursing facilities use the following procedures for prior approval for additional discharge reserve bed days. The NF must submit the request for prior approval for additional discharge reserve bed days to the MCO in which the resident is enrolled. The NF follows the written process of the MCO for submission of the request, and receipt of documentation of the approval. The written process of the MCOs must also indicate if any documentation or procedures are required of the NF to assure payment of claims for approved discharge reserve bed days. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to reserve bed days.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Initial Determination, Redetermination and Medicaid Pending Eligibility** 1. Initial Determination: All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the section NURSING FACILITY'S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30 calendar days of admission. 2. Redetermination: See 8.312.2UR. The medical documentation must be faxed and received by the MCO a minimum of sixty (60) calendar days prior to the start date of the new certification period for LNF and thirty (30) calendar days prior for HNF. 3. Length of Stay Periods: See 8.312.2UR. 4. Pending Medicaid Eligibility: Prior approval reviews can be done when the service is furnished before the determination of the effective date of the resident's financial eligibility for Medicaid. If the resident is applying for Medicaid, both financial and medical eligibility at the same time, please write "MEDICAID PENDING" in the type of request box on the Notification form. Please Note: A resident on Supplemental Security Income (SSI) is not Medicaid Pending. 5. The Prior Authorization form will be completed by the MCO and sent to the NF. This policy manual is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to initial determination, redetermination and Medicaid pending eligibility.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Retroactive Medicaid Eligibility** Written requests for prior approval based on a resident's retroactive financial eligibility must be reviewed by the MCO within thirty (30) calendar days of the date of the eligibility determination. The NF must submit medical documentation to the MCO. This policy manual is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to retroactive Medicaid eligibility.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Readmission Review** A re-admission review is required when the resident has left the NF and then returns, after three (3) midnights in a hospital, to a different LOC. The NF has to submit a re-admit MCO approval request form within thirty (30) calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident's admission note back to the NF. 1. When the resident is re-admitted to the NF and has more than thirty (30) calendar days left on his/her certification, days will be assigned from the re-admit date. The NF sends the notification form to the MCO along with supporting documentation. 2. If the resident has less than thirty (30) calendar days left on his/her certification, the NF will not submit a re-admit notification form. Instead the NF should submit redetermination (annual or continued stay) request on the notification form along with supporting documentation. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to readmission review.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Retrospective Reviews** Medical documentation for initial, redetermination, re-admit and changes in LOC reviews can be reviewed retrospectively if requested by the NF. Medicaid pending reviews are never considered late. A request for a retrospective review for initial, redetermination or re-admit reviews is considered in the following situations only: Excused Late Reviews: Prior authorization forms not submitted timely due to reasons beyond the control of the NF must be submitted with a detailed written explanation and documentation that supports the request for excusable late review. Reimbursement and retrospective reviews: 1. If the reason for the delay in documentation submission was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO. 2. Medicaid will not reimburse NFs for dates of service (DOS) not covered by the MCO prior authorization form. In addition, the Medicaid member cannot be billed for the service. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to retrospective reviews.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Transfer from Another Nursing Facility** If a resident is admitted to one NF from another NF, the following procedures apply: 1. The receiving NF must notify the MCO by telephone that a transfer to its NF is to occur. The receiving NF will provide the MCO with the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid by the MCO. A. If there are more than thirty (30) calendar days on the resident's current authorization, the MCO will fax the receiving NF the completed notification form which will include the prior authorization and date span. B. If there are less than thirty (30) calendar days remaining on the resident's current authorization, the receiving NF shall request a continued stay on the notification form to the MCO. The MCO shall make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay. Please write "TRANSFER" in the type of request box on the notification form. 2. The NF receiving the resident receives the status of resident's reserve bed days from the MCO through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to transfer from another nursing facility.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Change in Level of Care** All changes in LOC require a new notification form that should be submitted within thirty (30) calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write "LEVEL OF CARE CHANGE" in the type of request box on the notification form. The NF must provide a signed and dated order from the Physician, Nurse Practitioner or Physician Assistant as well as any documentation to support the LOC request (see New Mexico Nursing Facility Level of Care Instructions and Criteria). The date the LOC change occurred must be clearly stated. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the change in level of care.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Discharge Status** Discharge status occurs when a resident no longer meets the level of care that qualifies for nursing home placement, but there is no option for community placement of the resident at that time. Individuals are often already residing in a nursing facility at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in a nursing facility may clinically improve to the point that they no longer meet nursing facility LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the nursing facility. Community based health care and support services may be limited or unavailable. Residents may be at risk for failure to thrive outside the supportive structured environment of the nursing facility. Physically discharging the resident under such circumstances may put the resident's health at risk. To accommodate this health care issue the New Mexico Medicaid program allows for temporary continuation of coverage at Low NF level of reimbursement while the NF and the MCO address the development of community placement resources on an ongoing basis to meet the resident's lower level of need. The temporary continuation of coverage while discharge planning is taking place for a resident is termed "Discharge Status;" however, Discharge Status does not mean that the resident is being discharged from the facility. Families and residents should not be told that the resident is being discharged from the facility. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to discharge status.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Discharge Status** 1. Initial Discharge Status is authorized at Low NF for a maximum of ninety (90) calendar days, based upon the MCO physician determination. 2. Continued Stay Discharge Status is authorized at Low NF for not less than one hundred eighty (180) calendar days and up to three hundred sixty-five (365) calendar days. Submission of a continued stay on a prior authorization form for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility staff's and MCO care coordinator's ongoing attempts to find and develop appropriate community placement options for the resident. The facility should document why the resident must remain in a nursing home environment if the resident is at risk for failure to thrive upon discharge to a community placement. Failure to submit sufficient documentation specifying the facility's discharge planning efforts could result in the denial of prior authorization. The resident's inability to afford assisted living services may be a consideration in discharge planning. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to discharge status.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Reconsideration, Appeal and Administrative Hearing** 1. Reconsideration: Providers who disagree with a NF LOC determination can request reconsideration. Members who disagree with a NF LOC determination may request the provider to pursue reconsideration on his or her behalf. Requests for reconsideration must be in writing and received by the MCO within thirty (30) calendar days after the date on the re-review decision notice. The MCO performs the reconsideration and notifies the NF and Member in writing of a decision within eleven (11) business days of receipt of the reconsideration request. The written notice also includes information on a Member's right to request an HSD administrative hearing after the Member has exhausted his or her MCO's appeal process. The MCO's submitted policy states a member or their representative may file an appeal within 60 calendar days.	The MCO should update its documented policies and procedures to correct the discrepancy in the timeframe to file an appeal and to address the remaining managed care manual requirements not referenced.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Reconsideration, Appeal and Administrative Hearing** 2. The request for reconsideration must include the following: A. Statement that reconsideration is requested. B. Reference to the challenged decision or action. C. Basis for the challenge. D. Copies of any document(s) pertinent to the challenged decision or action; and E. Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a decision. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to reconsideration, appeal, and administrative hearing.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Reconsideration, Appeal and Administrative Hearing** 3. Appeal: If a reconsideration determination is adverse to the Member, the Member may request an appeal with his or her MCO in accordance with 8.305.12 NMAC. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to reconsideration, appeal, and administrative hearing.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Communication Forms** The MCO shall use the approved HSD forms for communication and notification with the NFs. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to communication forms.
Policies and Procedures	**Accepting and Accurately Paying Medicaid Crossover Claims: Contract Section 4.19.1.18.3** Lower of logic not applied for an inpatient claim and the billing provider type is 211- 218 (nursing facilities). **The MCO's Submitted Policy:** Centennial Care claims will represent the balance of the eligible amount minus the payment from the primary insurance company. The combined amounts will not exceed what would normally have been paid by MHC Healthcare in the absence of other coverage. **Non-Compliance:** The submitted policy does not stipulate that this does not apply to an inpatient claim for nursing facilities.	The MCO should update its documented policies and procedures to include a clause stating that the lower of logic is not applied for an inpatient claim and when the billing provider type is 211-218 (nursing facilities).

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6** The MCO did meet the following requirements: 95% of claims be adjudicated within 15 calendar days 99% of claims be adjudicated within 30 calendar days The average turnaround time for all claims in the submitted data was 2 days. There were 4,072 claims with a turnaround time of 0 days in the data set. 1,734 of these were for claim adjustments made by the MCO. The received date for the claim adjustments appears to be updated to the adjudication date rather than the received date for the original claim. A turnaround time of 0 days may be inaccurate based on the complexities involved in adjudicating nursing facility claims.	The MCO should investigate the claims with a turnaround time of 0 days and verify that the received dates and adjudication dates for the claims are properly reported. It should implement procedures to ensure the maintenance of accurate information for all claims.
Analytical Procedures	**Member Coverage** The MCO's claims system does not allow for accurate identification of retroactive enrolled members based on utilizing the date member added to the system and the begin date of member coverage.	The MCO should update its claims system to allow for fields to properly capture members with retroactive eligibility to ensure retroactively enrolled member's claims are properly adjudicated.
Analytical Procedures	**Denials with Prior Authorization for Retroactive Enrolled Members** 1,016 claims representing $5,404,295.68 in billed charges were denied that had prior authorizations for retroactively enrolled members.	The MCO should investigate the denied claims and ensure the claims were properly denied and not related to the MCO's timely filing requirements.
Claims Testing	**Contract Loading Data** 44 claims had contract load dates prior to the request to load contracts (classified as missing/incorrect documentation) and 6 claims related to contracts that weren't loaded within the 45 day contract loading requirement.	The MCO should take steps to improve the quality and completeness of contract loading data retained in the MHC system. Additionally, it should determine the cause for non-compliance related to the 6 contracts in the sample claims and determine whether it is a systemic issue. It should implement steps to ensure timely contract loading for all providers.
Claims Testing	**Documentation Support** The MCO did not provide a contract or payment rate sheet for 1 of the sample claims. It did not provide support for payment rates related to the proper dates of service for 1 claim, and did not submit support for the revenue codes applicable to 2 sample claims. The MCO indicated that Medicaid was the	The MCO should take steps to improve the quality and completeness of contract documentation it maintains. Additionally, it should determine the cause for the missing or incorrect contracts, payment rates, and Medicare payment information in the sample claims and determine whether it is a systemic issue. It should implement procedures to

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
	secondary payer for 10 claims, but no Medicare payment or third party payment was noted on the claims. It did not submit support for the primary payer payment. Additionally, the MCO submitted print screens from its internal claim system as support for the per diem rates for a portion of the sample claims rather than submitting the requested contracts and fee schedules.	ensure the maintenance of accurate documentation and information for all claims.
Claims Testing	**Payment Recalculation** Payment errors were noted in 20 of the 105 non-crossover sample claims based on the support provided.	The MCO should determine the cause of the payment errors in the sample claims and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Claims Testing	**Covered Days Recalculation - Variances** 14 claims had a days variance between the covered days and the recalculated days.	The MCO should provide an explanation for the variances between reported covered days and the recalculated days based on the dates of service and reprocess claims for proper payment if necessary.
Claims Testing	**Medical Care Credit** 4 of the sample claims reflected variances between the Medical Care Credit amounts provided by HSD and the MCC utilized by the MCO in its payment calculation. Utilizing the HSD MCCs in the claims payment recalculations would have decreased the payments to the providers by $3,473. The MCC amounts were not included as coinsurance or deductibles in the claims data set received from the MCO.	The MCO should monitor and review its processes for identifying the related Medical Care Credit for each claim to ensure the Medical Care Credit is being properly included as co-insurance or a deductible and to ensure that the patient share of cost is being removed from the claim payment. In addition, it should be verifying Medical Care Credit amounts by reviewing the 834 eligibility files HSD sends to each MCO and the MAD 200 form.

Summary of Findings and Recommendations – PHP		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** A clean claim shall be paid by the MCO to contracted and non-contracted providers according to the following timeframe: a) 90 percent within 30 calendar days of the date of receipt and b) 99 percent within 90 calendar days of the date of receipt, as required by federal guidelines in the code of federal regulations Section 42 CFR 447.45. The MCO's policy states that interest applies to electronic clean claims for providers other than I.H.S, tribal, urban Indian, day activity, assisted living, nursing facility, and home care agency providers not adjudicated within 30 days, but does not reference 90% or 90 day 99% requirement.	The MCO should update its documented policies and procedures to include a clause stating that 90% of clean claims must be paid within 30 days and 99% must be paid within 90 days based on receipt date and check date.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** The MCO shall be financially responsible for paying all claims for all covered, emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the Medicaid fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that the MCO is responsible for payment for all covered emergency and post stabilization claims at a rate no more than the Medicaid fee-for-service rate for all non-contracted providers.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that no contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

Summary of Findings and Recommendations – PHP		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim. This NMAC requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that a good-faith effort must be made to notify the provider if payment is not to be made within the payment timeframes if Medicaid's liability cannot be determined.
Policies and Procedures	**Paying Clean Claims in a Timely Manner: Contract Section 4.19.1.6.1** For Claims from I/T/Us, day activity providers, assisted living providers, Nursing Facilities and home care agencies including Community Benefit providers, ninety-five percent (95%) of Clean Claims must be adjudicated within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims must be adjudicated within a time period of no greater than thirty (30) Calendar Days of receipt. The MCO's policy states that interest applies to Nursing Facility electronic clean claims not adjudicated within 15 days, but does not reference 95% or 99% requirement. Timeliness of payment for manual NF claims isn't mentioned other than interest will be paid after 45 days. Contract section does not stipulate manual claims are exempt from 15 and 30 day provisions for NF provider type and it requires 95% of NF claims are paid within 15 days and 99% are adjudicated within 30 days, which would include manual NF claims.	The MCO should update its documented policies and procedures to include a clause stating that 95% of clean claims for listed providers must be paid within 15 days and 99% within 30 days.

Summary of Findings and Recommendations – PHP		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Paying Clean Claims in a Timely Manner: Contract Section 4.19.1.6.2** For all other Claims, ninety percent (90%) of all Clean Claims must be adjudicated within thirty (30) Calendar Days of receipt, and ninety-nine percent (99%) of all Clean Claims must be adjudicated within ninety (90) Calendar Days of receipt. The MCO's policy states that interest applies to electronic clean claims for providers other than I.H.S, tribal, urban Indian, day activity, assisted living, nursing facility, and home care agency providers not adjudicated within 30 days, but does not reference 90% or 90 day 99% requirement.	The MCO should update its documented policies and procedures to include a clause stating that 90% of clean claims must be adjudicated within 30 days and 99% within 90 days of receipt.
Policies and Procedures	**Contract Section 4.18.14.1.13 - Amendment 6** MCOs must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than forty-five (45) calendar days after a provider is credentialed, if required. This contract section is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that provider contracts must be loaded and the claims systems must be able to recognize the provider as a network provider no later than 45 calendar days after a provider is credentialed, if required.
Analytical Procedures	**Calculation of Adjusted Claim Turnaround Times** For claims that are adjusted/reversed after being finalized, the Claim Received Date in the claims system continues to indicate the date when the claim was originally received by the MCO. The system therefore does not enable accurate reporting of claim turnaround time.	The MCO should update its claims system to allow for an adjustment notification date in addition to the claims received date to accurately report the turnaround times for adjusted claims.
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6** The MCO did not meet the following requirements: 95% of claims be adjudicated within 15 days 99% of claims be adjudicated within 30 days There are 4,515 claims with a turnaround time exceeding 15 days. Additionally, overall only 67.01% of claims were adjudicated	The MCO should identify what is causing it to not meet the contract term requirement and implement a process improvement plan which should be communicated to HSD. It should monitor contract compliance on at least a monthly basis.

Summary of Findings and Recommendations – PHP		
Testing Area	**Finding**	**Recommendation**
	within 15 days and 75.56% within 30 days of receipt.	
Analytical Procedures	**Denial Code** No denial codes for denied nursing facility claims were submitted with the original Edits data set. The MCO does not have adjustment codes, but rather uses free text field. The MCO provided these free text fields for all claims with a denied status.	The MCO should strive to automate and standardize the denial process with the use of standard denial codes instead of free text fields. Denial codes on the remittance advice are imperative to communicate with providers and allow them to correct and resubmit denied claims.
Analytical Procedures	**Denials with Prior Authorization for Retroactive Enrolled Members** 2 claims representing $5,895.06 in billed charges were denied that had prior authorizations for retroactively enrolled members.	The MCO should investigate the denied claims and ensure the claims were properly denied and not related to the MCO's timely filing requirements.
Analytical Procedures	**Conflicting Reimbursement Header and Detail Status** Mismatches were noted between the reimbursement status listed in the submitted UB04 header and UB04 detail with regards to partially denied claims. Based on review of claims data detail, there were several claims with a reimbursement status of partially approved in the header that only had approved lines in the detail.	The MCO should apply consistent criteria related to claims status within its claims system to ensure accurate and consistent reporting.
Claims Testing	**Provider Credentialing Data** Provider credentialing dates are missing for 5 sample claims and 93 claims are related to providers the MCO did not credential within the 45 day contract credentialing requirements.	The MCO should take steps to improve the completeness of the provider credentialing data retained in the MCO's system. Additionally, the MCO should determine the cause for non-compliance related to the 93 providers in the sample claims and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** All 98 sample claims have the same contract system load dates and contract system request dates.	The MCO should take steps to improve the quality and completeness of contract loading data retained in the MCO's system so contract requirements can be measured and met.
Claims Testing	**Documentation Support** The MCO did not provide a contract or payment rate sheet for 4 claims. It did not provide support for payment rates related to the proper dates of service for 2 claims, and did not submit support for the revenue codes applicable to 4 sample claims.	The MCO should take steps to improve the quality and completeness of contract documentation it maintains. Additionally, it should determine the cause for the missing or incorrect contracts and payment rates in the sample claims and determine whether it is a systemic issue. It should implement procedures to ensure the maintenance of accurate documentation for all providers.

Summary of Findings and Recommendations – PHP		
Testing Area	**Finding**	**Recommendation**
Claims Testing	**Payment Recalculation** Payment errors were noted in 24 of the 94 sample claims based on the support provided.	The MCO should determine the cause of the payment errors in the sample claims and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Claims Testing	**Covered Days Recalculation - Variances** 30 claims had a days variance between the covered days and the recalculated days.	The MCO should provide an explanation for the variances between reported covered days and the recalculated days based on the dates of service and reprocess claims for proper payment if necessary.
Claims Testing	**Medical Care Credit** 27 of sample claims reflected variances between the Medical Care Credit amounts provided by HSD and the MCC utilized by the MCO in its payment calculation. Utilizing the HSD MCCs in the claims payment recalculations would have decreased the payments to the providers by $21,223. The MCC amounts were not included as coinsurance or deductibles in the claims data set received from the MCO.	The MCO should monitor and review its processes for identifying the related Medical Care Credit for each claim to ensure the Medical Care Credit is being properly included as co-insurance or a deductible and to ensure that the patient share of cost is being removed from the claim payment. In addition, the MCO should be verifying Medical Care Credit amounts by reviewing the 834 eligibility files HSD sends to each MCO and the MAD 200 form.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Authorization of Services: Contract Section 4.12.12.5.3** If the contractor extends the timeframe, the contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an Appeal in accordance with Section 4.16 of this agreement if he or she disagrees with the decision. This contract requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include a clause stating that if a contractor requests an extension, the contractor must provide the member written notice and inform the member of the appeal rights.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current Medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. No differentiation is made in the MCO's policy between paper and electronic claims.	The MCO should update its documented policies to include a clause differentiating between paper and electronic claims for purposes of interest payment.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions. This NMAC requirement is not referenced in the submitted policies and procedures	The MCO should update its documented policies and procedures to include a clause stating that no contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.
Policies and Procedures	**Reimbursement for Managed Care: NMAC 8.308.20.9(E)** If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.	The MCO should update its documented policies and procedures to include a clause stating that a good-faith effort must be made to notify the provider if payment is not to be made within the payment timeframes if Medicaid's liability cannot be determined.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
	This NMAC requirement is not referenced in the submitted policies and procedures	
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Level of Care Packet** Once an order is signed and dated, it cannot be changed. If a change is required, a new order must be written, signed, and dated by the Physician, Nurse Practitioner or Physician Assistant. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the Level of Care Packet.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Level of Care Packet** Verbal or telephone orders are permitted. The order must be taken by a RN or LPN who must also sign and date the order. It must be clearly indicated that the order is a telephone or verbal order with the name of the Physician, Nurse Practitioner or Physician Assistant who gave the order and LOC. The date of the call or verbal communication is the date of the order. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the Level of Care Packet.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Level of Care Packet** If the LOC criteria are not met and the request for placement is denied, the MCO will send the referring party and the member a denial letter within five (5) business days of a completed packet, with the reason for denial as determined by the physician. The requesting parties then have an opportunity to request reconsideration or appeal. After the parties have exhausted the MCO appeal process, the member may request an administrative hearing of the MCO decision. The MCO's submitted policy does not state that	The MCO should update its documented policies and procedures to include a clause stating that the denial reasons must be included in the denial letter.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
	the denial reasons will be included in the denial letter.	
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Reserve Bed Days** Medicaid pays to hold or reserve a bed for a resident in a Nursing Facility to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below. 2. Medicaid covers an additional six (6) reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan. Nursing facilities use the following procedures for prior approval for discharge reserve bed days to the MCO in which the resident is enrolled. The NF follows the written process of the MCO for submission of the request, and receipt of documentation of the approval. The written process of the MCOs must also indicate if any documentation or procedures are required of the NF to assure payment of claims for approved discharge reserve bed days. The Bed Hold Pricing procedure in the submitted policy stipulates payment will be made for bed hold days with approved notification, but doesn't specify the maximum number of days allowed. The procedure only stipulates plan will pay for 6 non-authorized bed hold days	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to reserve bed days.
Policies and Procedures	**Initial Determination, Redetermination and Medicaid Pending Eligibility** 1. Initial Determination: All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the section NURSING FACILITY'S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30	The MCO should update its documented policies and procedures to include a clause stating that initial determination documents must be submitted within 30 calendar days of admission.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
	calendar days of admission. The MCO's submitted policy does not reference the 30 calendar day requirement.	
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Readmission Review** A re-admission review is required when the resident has left the NF and then returns, after three (3) midnights in a hospital, to a different LOC. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to readmission review.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Readmission Review** The NF has to submit a re-admit MCO approval request form within thirty (30) calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident's admission note back to the NF. 1. When the resident is re-admitted to the NF and has more than thirty (30) calendar days left on his/her certification, days will be assigned from the re-admit date. The NF sends the notification form to the MCO along with supporting documentation. 2. If the resident has less than thirty (30) calendar days left on his/her certification, the NF will not submit a re-admit notification form. Instead the NF should submit redetermination (annual or continued stay) request on the notification form along with supporting documentation. This policy manual is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to readmission review.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Retrospective Reviews** Medical documentation for initial, redetermination, re-admit and changes in LOC reviews can be reviewed retrospectively if requested by the NF. Medicaid pending reviews are never considered late. A request for retrospective review for initial, redetermination or re-admit reviews is considered in the following situations only: Excused Late Reviews: Prior authorization forms not submitted timely due to reasons beyond the control of the NF must be submitted with a detailed written explanation and documentation that supports the request for excusable late review. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to retrospective reviews.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Retrospective Reviews** Reimbursement and retrospective reviews: 1. If the reason for the delay in documentation submission was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO. 2. Medicaid will not reimburse NFs for dates of service (DOS) not covered by the MCO prior authorization form. In addition, the Medicaid member cannot be billed for the service. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to retrospective reviews.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Transfer from Another Nursing Facility** If a resident is admitted to one NF from another NF, the following procedures apply: 1. The receiving NF must notify the MCO by telephone that a transfer to its NF is to occur. The receiving NF will provide the MCO with the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid by the MCO. A. If there are more than thirty (30) calendar days on the resident's current authorization, the MCO will fax the receiving NF the completed notification form which will include the prior authorization and date span. B. If there are less than thirty (30) calendar days remaining on the resident's current authorization, the receiving NF shall request a continued stay on the notification form to the MCO. The MCO shall make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay. Please write "TRANSFER" in the type of request box on the notification form. 2. The NF receiving the resident receives the status of resident's reserve bed days from the MCO through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to transfer from another nursing facility.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Change in Level of Care** All changes in LOC require a new notification form that should be submitted within thirty (30) calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write "LEVEL OF CARE CHANGE" in the type of request box on the notification form. The NF must provide a signed and dated order from the Physician, Nurse Practitioner or Physician Assistant as well as any documentation to support the LOC request (see New Mexico Nursing Facility Level of Care Instructions and Criteria). The date the LOC change occurred must be clearly stated. The MCO's submitted policy does not reference the 30 calendar day requirement.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to the change in level of care.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Discharge Status** Discharge status occurs when a resident no longer meets the level of care that qualifies for nursing home placement, but there is no option for community placement of the resident at that time. Individuals are often already residing in a nursing facility at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in a nursing facility may clinically improve to the point that they no longer meet nursing facility LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the nursing facility. Community based health care and support services may be limited or unavailable. Residents may be at risk for failure to thrive outside the supportive structured environment of the nursing facility. Physically discharging the resident under such circumstances may put the resident's health at risk. To accommodate this health care issue the New Mexico Medicaid program allows for temporary continuation of coverage at Low NF level of reimbursement while the NF and the	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to discharge status.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
	MCO address the development of community placement resources on an ongoing basis to meet the resident's lower level of need. The temporary continuation of coverage while discharge planning is taking place for a resident is termed "Discharge Status;" however, Discharge Status does not mean that the resident is being discharged from the facility. Families and residents should not be told that the resident is being discharged from the facility. This policy manual requirement is not referenced in the submitted policies and procedures.	
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Discharge Status** 1. Initial Discharge Status is authorized at Low NF for a maximum of ninety (90) calendar days, based upon the MCO physician determination. This policy manual requirement is not referenced in the submitted policies and procedures.	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to discharge status.
Policies and Procedures	**NFLOC Determinations: Medical Assistance Division Managed Care Policy Manual; Section 6: Discharge Status** 2. Continued Stay Discharge Status is authorized at Low NF for not less than one hundred eighty (180) calendar days and up to three hundred sixty-five (365) calendar days. Submission of a continued stay on a prior authorization form for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility staff's and MCO care coordinator's ongoing attempts to find and develop appropriate community placement options for the resident. The facility should document why the resident must remain in a nursing home environment if the resident is at risk for failure to thrive upon discharge to a community placement. Failure to submit sufficient documentation specifying the facility's discharge planning efforts could result in the denial of prior authorization. The	The MCO should update its documented policies and procedures to include all HSD contract requirements relating to discharge status.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
	resident's inability to afford assisted living services may be a consideration in discharge planning. This policy manual requirement is not referenced in the submitted policies and procedures.	
Analytical Procedures	**Calculation of Adjusted Claim Turnaround Times** For claims that are adjusted/reversed after being finalized, the Claim Received Date in the claims system continues to indicate the date when the claim was originally received by the MCO. The system therefore does not enable accurate reporting of claim turnaround time.	The MCO should update its claims system to allow for an adjustment notification date in addition to the claims received date to accurately report the turnaround times for adjusted claims.
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6** The MCO does not meet the following contract requirements: 95% of claims be adjudicated within 15 days 99% of claims be adjudicated within 30 days There are 8,648 claims with a turnaround time exceeding 15 days. Additionally, overall only 81.69% of claims were adjudicated within 15 days and 85% with 30 days of receipt.	The MCO should identify what is causing it to not meet the contract term requirement and implement a process improvement plan which should be communicated to HSD. It should monitor contract compliance on at least a monthly basis.
Analytical Procedures	**Member Coverage** A significant number of members are noted with retroactive coverage where the days between the effective date and the system add date exceeds 90 days. **The MCO Explanation:** It updated the category of eligibility on a number of members, after receiving an updated Category of Eligibility file from the State. The update within its system limits the ability to accurately calculate turnaround time for claims and claim coverage.	The MCO should update its claims system to allow for multiple member add fields to properly capture members with retroactive eligibility. Additionally, HSD should establish procedures to ensure the timely updating of a member's category of eligibility as close to real time as possible.
Analytical Procedures	**Denials with Prior Authorization for Retroactive Enrolled Members** 3,163 claims representing $14,208,278.70 in billed charges were denied that had prior authorizations for retroactively enrolled members.	The MCO should investigate the denied claims and ensure the claims were properly denied and not related to the MCO's timely filing requirements.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
Claims Testing	**Provider Credentialing Data** 47 sample claims are related to providers the MCO did not credential within the 45 day contract credentialing requirements.	The MCO should determine the cause for non-compliance related to the 47 providers in the sample claims and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** 2 claims are missing contract load dates.	The MCO should take steps to improve the quality and completeness of contract loading data retained in the MCO's system.
Claims Testing	**Payment Recalculation:** Payment errors were noted in 13 of the 117 non-crossover sample claims based on the support provided. Of these errors, 3 were related to claims with a negative billed amount and the error may be due to a reversal or adjustment of an improperly paid claim.	The MCO should determine the cause of the payment errors in the sample claims and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Claims Testing	**Covered Days Recalculation** - Variances 10 claims had a days variance between the covered days and the recalculated days.	The MCO should provide an explanation for the variances between reported covered days and the recalculated days based on the dates of service and reprocess claims for proper payment if necessary.
Claims Testing	**Medical Care Credit** 39 of sample claims reflected variances between the Medical Care Credit amounts provided by HSD and the MCC utilized by the MCO in its payment calculation. Utilizing the HSD MCCs in the claims payment recalculations would have decreased the payments to the providers by $22,869.67. The MCC amounts were not included as coinsurance or deductibles in the claims data set received from the MCO.	The MCO should monitor and review its processes for identifying the related Medical Care Credit for each claim to ensure the Medical Care Credit is being properly included as co-insurance or a deductible and to ensure that the patient share of cost is being removed from the claim payment. In addition, it should be verifying Medical Care Credit amounts by reviewing the 834 eligibility files HSD sends to each MCO and the MAD 200 form.
Claims Testing	**Nursing Facility Claims Population** The MCO included non-NF claims in its nursing facility claims data set and two claims were inadvertently was selected in the claims sample.	The MCO should establish procedures to provide accurate reporting by provider type for all claims data to enable internal monitoring in addition to monitoring by HSD.

Appendix A: Denial Reasons for Denials with Prior Authorization

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
BCBS	129	Service/Charge Is A Duplicate Of A Previous Processed Claim.	987
	LCD	Late Charge Denial (No EOB Created For This Claim)	958
	346	Medical/Surgical Advisor Was Not Contacted Prior To Treatment	900
	11	On Or After Termination Date	141
	41	Time Period For Filing Claim Has Expired. (Xxx Number Of Days From Last Date Of Service)	130
	T08	Pricer Has Determined That The Services Billed Are Not Reimbursable For This Facility	67
	343	Hospital Claim; Need Medicare's Paid Amount.	54
	347	Medical/Surgical Advisor Contacted But Did Not Approve Services/ Treatment	51
	C03	This Service Cannot Be Processed Until Charges Are Filed With Other Insurance Carrier (For Non Its Claims)	29
	354	Itemized Charge Breakdown Per Day Required	20
	360	Medical Records Required	18
	702	Adjustment: Void Claim Due To Returned Dollars	14
	SEQ	Sequestration Denial	13
	424	Medicare Paid This Amount	8
	10	Prior To Effective Date	7
	420	Additional Pricing Information Requested (E.G. Operative Report)	6
	299	This Service Is Not A Benefit Of The Contract (Provision Is Not Covered)	5
	711	Benefits Are Not Provided For Expenses That The Insured Has No Legal Obligation To Pay As Determined By Medicare.	4
	137	Member Not Covered For These Dates Of Service Due To Lapse In Coverage	3
	687	Electronically Submitted Claim Needs Medicare Information. (Bis Origin Code Mh Only) - Part A Provider.	2
	700	Adjustment: Credit Only - Reason Unknown	2

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	T91	Medicaid Participating Provider	2
	507	Service Not Eligible - Failed To Meet Group Guidelines	2
	281	EOB (Medicare) Required For This Service(S).	1
	P76	The Procedure/Diagnosis Code Submitted Is Invalid Because It Is Not Compatible With The Dates Of Service. Please Verify coding And Resubmit With Valid Procedure/Diagnosis Code.	1
	LCH	Late Charge Billed On The Ub92 Claim Form. The Operator Has Been Instructed To Adjust The Original Claim To Include This Charge. (No EOB Or Provider Claim Summary Is Created For This Claim).	1
	131	This Provider Is Not Eligible To Bill For These Services	1
	29	Retroactive Membership Change Results In A Denial And Rfcr	1
	No code	No Description	1
	314	Same Provider Billing Delivery, Normal Newborn Care And Or Anesthesia. Normal Newborn Care And Anesthesia Not Covered.	1
Total			3,430
MHC	D43	Claims submitted after the plan's timely filing limit are not eligible for reimbursement.	438
	D24	Duplicate Claim (Provider/Member/DOS)	337
	D14	Our records indicate there is not a prior authorization on file for this service on this date. Therefore, benefits are denied.	297
	IN002	Incorrect billing by the provider. Please review and resubmit the claim.	273
	N306	Missing/incomplete/invalid acute manifestation date.	135
	MA63	Missing/incomplete/invalid principal diagnosis.	118
	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	107
	252	Pend claim if COB is 0 on secondary enrollment claim	92
	531	Duplicate Mem/DOS/Service code/Pay To/Modifier	78
	543	Inpatient Claim Submission Window Exceeded (claim Thru date)	48
	M0030	Duplicate Claim Line	43
	N281	Missing/incomplete/invalid pay-to provider address.	37

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	N279	Missing/incomplete/invalid pay-to provider name.	31
	N152	Missing/incomplete/invalid replacement claim information.	31
	zM0054	Manually Pended Claim	30
	D53	Split billing required.	29
	D06	Resubmit claim with Medicare EOB.	27
	H01	Service code is not covered by contract.	22
	204	Invalid accommodation days	22
	216	No COB entered with a Secondary Enrollment	19
	M0041	Invalid Discharge Status	18
	636	Release of Information Required for UB04	17
	N434	Missing/Incomplete/Invalid Present on Admission indicator	16
	DDX	Please resubmit with a valid diagnosis code.	13
	D75	Prior Auth has no Units available	13
	D76	Prior Auth has Insufficient Units Remaining	13
	D55	Authorization number invalid for DOS.	12
	N290	Missing/incomplete/invalid rendering provider primary identifier.	11
	M64	Missing/incomplete/invalid other diagnosis.	11
	R05	Billed Unit(s) exceeded Unit(s) Authorized.	10
	N153	Missing/incomplete/invalid room and board rate.	8
	D0174	Prior Auth services do not match claim	7
	M0026	Invalid Bill Type	7
	217	Member has an active restriction on enrollment	7
	M0019	Benefit Requires Prior Authorization	5
	D29	This charge was previously considered.	5
	DAY	Please resubmit this claim along with a legible copy of the primary carrier's explanation of benefits.	5
	D73	Prior Auth is Denied	5
	M0023	Admit Date Required for Inpatient Claim	4
	D15	Member not enrolled on DOS.	4

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	D9L	The procedure billed is not the procedure that was authorized. Please refer to your authorization from the utilization management department.	4
	D25	Claim submit time exceeded.	4
	CRDRG	Please resubmit with a valid DRG code in box 71 of the UB-04 form.	3
	D07	Resubmit with primary EOB.	3
	AUTH001	Service not included in authorization given	3
	AUTH002	Date of service billed does not fall within date of service authorized	3
	DAI	Either the patient's date of birth or gender does not match eligibility information provided by the Human Services Department. Please make the appropriate correction(s) or ask your patient to contact HSD to correct their data.	3
	RREA119	The procedure billed is not the procedure that was authorized. Please refer to your authorization from the utilization management department.	3
	DAA	Benefits are not payable because procedures required by the primary payers plan were not followed.	3
	913	Manual Pend of Claim	3
	DRG	Please resubmit with a valid DRG code in box 78 of the UB-92 form.	2
	D13	The patient was not eligible for this service on the date(s) of the service.	2
	611	UM has no available units	2
	612	UM has insufficient units remaining	2
	CC20	Corrected claim resulted in an overpayment.	2
	915	Claim has been manually denied	2
	M0025	Claim Total Mismatch	2
	D77F	Place of service does not match authorized	2
	zM0011	Provider Not Active for Plan on DOS	2
	DAC	The primary payer's explanation of benefits does not match the submitted claim. Please resubmit this claim together with the correct primary payer's explanation of benefits.	2
	29	The time limit for filing has expired.	1
	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	1

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	ZZ08	Prior Auth is Closed.	1
	D9H	This code is for a service not covered by New Mexico Medicaid.	1
	M0033	Invalid Revenue Code	1
	MADNCB	Denied non covered benefit	1
	D52	Please submit this claim along with the primary carrier's explanation of benefits.	1
	D23	Unauthorized provider.	1
	N280	Missing/incomplete/invalid pay-to provider primary identifier.	1
	CR22	Adjusted - Corrected Claim Received	1
	M53	Missing/incomplete/invalid days or units of service.	1
	610	UM Services do not match Claim	1
	TIN02	Tax ID number does not match provider in box 1 of UB-04. Please resubmit with correct TIN owner information per W-9	1
	616	UM Service Line Denied	1
	M0032	Invalid CPT/HCPCS	1
	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1
	N345	Date range not valid with units submitted.	1
	9164	Missing, invalid, or inappropriate procedure	1
	D18	Included in other procedure.	1
	zM0073	Contract Term Requires Manual Review	1
Total			2,477
PHP	N/A - No Code In Edits Data	Replacement Claim	526
	N/A - No Code In Edits Data	No Authorization	309
	N/A - No Code In Edits Data	Duplicate	247
	N/A - No Code In Edits Data	Billed Incorrectly By Provider	175
	N/A - No Code In Edits Data	Corrected Claim	126
	N/A - No Code In Edits Data	Timely Filing	116

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	N/A - No Code In Edits Data	Member Not Eligible	56
	N/A - No Code In Edits Data	Recoupment Requested	53
	N/A - No Code In Edits Data	Denied With Ex Code Yi5	21
	N/A - No Code In Edits Data	Missing Or Incomplete EOB	21
	N/A - No Code In Edits Data	Zero Units Allowed	13
	N/A - No Code In Edits Data	Unable To Determine If Correction Or Duplicate	13
	N/A - No Code In Edits Data	Na	12
	N/A - No Code In Edits Data	Provider Not Contracted For Service	12
	N/A - No Code In Edits Data	Denied For Tf1	11
	N/A - No Code In Edits Data	Adjustment	10
	N/A - No Code In Edits Data	Services Disallowed By Um	7
	N/A - No Code In Edits Data	Units Exceed Authorization	6
	N/A - No Code In Edits Data	Invalid Bill Type	6
	N/A - No Code In Edits Data	LNF Authed, HNF Billed	5
	N/A - No Code In Edits Data	Refund Overpayment Request Received	4
	N/A - No Code In Edits Data	Um0	4
	N/A - No Code In Edits Data	Claim Was Denied Due To Provider Submitting A Refund	4
	N/A - No Code In Edits Data	Encounter Adjustment	4
	N/A - No Code In Edits Data	Invalid Procedure Or Diagnosis Code	3
	N/A - No Code In Edits Data	Denied For Units Exhausted	3
	N/A - No Code In Edits Data	Denied With Ex Code Zk2	3
	N/A - No Code In Edits Data	Claim Dos Over 1 Year	2

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	N/A - No Code In Edits Data	Denied In Error	2
	N/A - No Code In Edits Data	Denied As S23 Date Req. Prior To Subscriber Eff Dt.	2
	N/A - No Code In Edits Data	Paid On Adjustment	2
	N/A - No Code In Edits Data	Services Paid On Other Claim	2
	N/A - No Code In Edits Data	Corrected Medical Care Credit	2
	N/A - No Code In Edits Data	Lines Denied	2
	N/A - No Code In Edits Data	Coba Calc Allowed Amount Is Zero	2
	N/A - No Code In Edits Data	Proj 99951723 Reset To Apply HSD Lod Provider Update.Script	1
	N/A - No Code In Edits Data	No Lines Denied	1
	N/A - No Code In Edits Data	Claim Denied Due To Member Being In Hospice During Oct/Nov	1
	N/A - No Code In Edits Data	162700208 Disallowed	1
	N/A - No Code In Edits Data	Note: Original On File 16F524080500.	1
	N/A - No Code In Edits Data	Billed As A Voided Claim	1
	N/A - No Code In Edits Data	Denied Prior To Subscriber Eff Date	1
	N/A - No Code In Edits Data	Split Claim	1
	N/A - No Code In Edits Data	St - No Adjustment	1
	N/A - No Code In Edits Data	Denied For Violation Penalty For No Benefit Certificate - No Auth On File	1
	N/A - No Code In Edits Data	16E533405300 Paid	1
	N/A - No Code In Edits Data	Claim Processed On 10/28/2016	1
	N/A - No Code In Edits Data	Itemize By Procedure And/Or Rev Code	1
	N/A - No Code In Edits Data	Denied Yb5	1
	N/A - No Code In Edits Data	Denied With Ex Code Ye3	1

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	N/A - No Code In Edits Data	Claim Denied Due To Member Being In Hospice	1
	N/A - No Code In Edits Data	Different Dx	1
	N/A - No Code In Edits Data	Specialty Clm Resubmission To 17E155892000. Notes On That Clm By Nguyen: "Valid Auth Not On File For Claim.Auth Disallowed For Rev 199, Auth Not On File For LNF Rev 190 Jn, Qa" Ckd Auths: 170880129 Disallowed,No Other Auth	1
	N/A - No Code In Edits Data	Adj The Clm As This Is A Specialty Claim And Should Not Be Denied For EOB	1
	N/A - No Code In Edits Data	17E023554501 Paid	1
	N/A - No Code In Edits Data	Day ALOS And Should Be Priced As 0.00 Per Confirmation With Dart Lm.	1
	N/A - No Code In Edits Data	Zero Allowed	1
	N/A - No Code In Edits Data	Retro Eligibility	1
Total			1,809
UHC	SNF	Benefits Based On Admission Date	1,406
	C-695	Claim Filed After Time Limit	509
	C-284	Our Records Show We Have Already Processed This Charge.	377
	34	Claim Preauth Requirement Bypassed	349
	A02	No Authorization On File	266
	C-380	Duplicate-Original Claim In Process	214
	A12	Service Is Not Contracted	211
	J06	Suppress Member EOB	197
	MA2	Claim Forwarded To Medicaid	196
	C-040	Claim After Member Termination Date	176
	C-292	Requires Notification/Plan Not Notified	158
	J10	Claim Is A Duplicate	158
	25	Dates Of Service Matched	155
	J46	Missing Taxonomy Code	143
	G93	Medi Medi 2Ndary Carrier	127
	u51	Hipps Claim, See Clinical Notes	118

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	F27	Missing/Invalid Value Code	86
	PAI	Exceeds All Inclusive P/D Rate	85
	G65	Patient Liability Applies	82
	A27	Send Primary Carriers EOB	79
	H30	Cob Applies - Exceeds The Fee Schedule	75
	C-289	Claim Filed After Time Limit	71
	98	Duplicate Claim Level Override	69
	C-697	Reviewed Time Limit -Denial Upheld	67
	AA1	Corrections Applied To Original Claim	66
	w87	Manifestation Code Used As Principal Dx	54
	C-313	Resubmission Filed After Time Limit	51
	C-1090	EOB Date Required For Cob.	50
	O36	Ici	44
	A67	Override For Timely Filing	40
	C-1315	Inappropriate Principal Dx 7Th Digit	31
	C-047	Send Primary Carrier's EOB	31
	C1-934	Corrected Claim - No Add'l Payment Due	29
	C-022	Not Eligible Chg/Don't Bill Patient	29
	C-481	Incorrect Revenue Code / Resubmit	29
	PCO	Pca Pend Override	28
	B06	Additional Info Received	27
	u59	Tob To Patient Status Combo Not Allowed	26
	36	Line Level Preauth Requirement Bypassed	22
	C-1276	Unknown	20
	C-1120	Missing Value Code Required For Apg	18
	C-1036	Corrected Claim No Additional Payment Due	18
	C-942	Approved Amt Paid By Medicare	18
	A36	Auth Overrode Due To Cob	17
	C-041	Claim Before Memb Eff Date	16
	UM1	Units Exceed Um Authorization	16
	A47	No Authorization On File	16

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	C-794	Invalid Date Or Date Range	15
	C-166	Duplicate - Corrected Claim In Process	15
	C-950	Rug Code.Valid Rug Code Req For Pymt	14
	C-987	Coordinated W/Medicare- Pd In Full	14
	C1-1315	Inappropriate Principal Dx 7Th Digit	12
	A33	Duplicate Of Corrected Claim	11
	J48	Missing Taxonomy Code	11
	C-459	Proc Processed On Separate Audit Number	9
	C-482	Manually Split Claim-Do Not Bill Memb	9
	G94	Medi Medi 2Ndary Carrier	9
	C1-075	Ingenix/Subro Ineligible Provider	8
	O96	Claim Adjusted Per Contract Exception	8
	C-381	Reviewed Time Limit - Denial Upheld	8
	J61	Processor Error	7
	C-374	Nbr Of Units Don't Correspond W/Date Span	7
	C-087	Requires Notification	7
	AUD	Audit Completed	6
	O99	Manual Review For Chw Edit	6
	C-911	Complete Medical Records Needed	6
	OH8	Not A Valid Service For Provider Type	5
	C-1378	Medicaid Approved Amt Paid By Medicare	5
	20	Pay, Not A Duplicate Service	5
	A26	Send Primary Carrier's EOB	5
	B20	Bed Leveling Required	5
	PSR	Exceeds Rate Entered	5
	E43	Provider Not Eligible To Bill	5
	B71	Ices Edit Overridden	4
	41	Line Level Service Rule Override	4
	G95	Resubmit For Primary Payer Consideration	4
	C-076	Submit Original Billed Amount	4
	C-214	Forward To Correct Carrier	4

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	26	Dates Of Service Overlap	4
	12	Override Prompt Pay Discount	4
	C-891	Services Performed Are Not Included In Contract	3
	C-1113	Additional Length Of Stay Not Approved	3
	OH9	Taxonomy Not Valid For Provider	3
	E56	Included In Previous Payment	3
	100	Claim Adjustment Reason	3
	J52	Corrected Claim	3
	OPC	Override Pca Disallow	3
	No code	No Description	3
	I97	Timely Filing Limit Exceeded Postprocess	3
	987	Medicare Paid Above Allowable	3
	C-042	Claim Previously Processed	3
	C-089	Please Submit Itemization Of Services	2
	C-072	EOB Does Not Match Claim Info	2
	C-969	Hhrg Code/Valid Code Req'd For Payment	2
	C-1264	SNF Readmission Requires New Admit Date	2
	C-680	Our Records Indicate That The Enrollee Has Multiple Other In	2
	B59	Missing Required Documentation	2
	C-897	Paid As Primary To Servicing Provider	2
	C-115	Svc Date & Date Range Mismatch-Resubmit	2
	C-228	Exceeds Approved Length Of Stay/Resubmit	2
	A46	Auth On File Is Denied	2
	A28	Primary Denied Contractual	2
	J09	Service Is A Duplicate	2
	PDC	Agreement Discount	2
	CDD	Definite Duplicate Claim	2
	C-1019	SNF Placement Unable To Be Verified	2
	A31	Dup Claim- Original Pending	2
	0	Payment Applied To Soc	2

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	B76	Auth On File Is Denied	2
	A04	Not A Covered Service	2
	200	Audit In Progress	2
	A85	Resubmit To Secondary Carrier	2
	C-006	Service Not Covrd Notification Not Recvd	1
	C-604	Svc Denied For Insufficient Cob Info.	1
	A75	Please Submit A Complete EOB	1
	C-070	Automobile Insurer Verification-- Our Records Indicate That	1
	794	Invalid Date Or Date Range	1
	F23	Missing/Invalid Fac Admission Source	1
	w79	Other Diagnosis Is Not Allowed For Age	1
	C-5004	Hospice Member-Split/Rebill Fi And Ma	1
	C-095	Claim Already Processed	1
	B72	Itemized Bill Requested	1
	C-285	Ineligible Chg-Fehbp Sanctioned Provider	1
	C-436	Invalid Discharge Status	1
	E71	Unclean Claim	1
	UM2	Units Reduced By Um Authorization	1
	511	Reimbursable Allowable Amount	1
	w91	E-Code Not Allowed As Admit Diagnosis	1
	B13	Member Is Effective	1
	ICE	Ices Override	1
	F12	Member Out Of Pocket Met	1
	380	Duplicate	1
	A71	Provider Billed In Error	1
	M48	Billing Provider Not Found On State Prov	1
	C-1110	Service Already Pd. No Add'l Payment Due	1
	C-676	Forward To Correct Carrier	1
	C-704	Exceeds Allowable Units,Don't Bill Memb	1
	PBA	Benefits Based On Admission Date	1

Appendix A – Denial Reasons for Denials with Prior Authorization			
Entity	**Denial Reason Code**	**Denial Reason**	**Number of Codes**
	1315	Inappropriate Principal Diagnosis	1
	C-1104	Services Performed By Another Provider.	1
	O85	SNF Placement Unable To Be Verified	1
	C-1380	Unknown	1
	C-976	Oxyg Content Incld In Equip Rental	1
	B43	Paid Duplicate Claim In Error	1
	C-288	Corrected Claim - No Add'l Payment Due	1
	w60	Incomplete Num Of Digits In Diagnosis	1
	C-890	Benefit Max Met, Bill Patient	1
	I69	EOB Does Not Match Claim	1
	J16	Service Furnished By Another Provider	1
	214	Forward To Correct Carrier	1
	C-179	Cpt/Rev Code Invalid, Incorrect, Dltd Or Exprd	1
	C-177	Processed According To Allowable	1
Total			6,430

Appendix B: Sample Payment Results

Appendix B – Sample Payment Results (Excluding MCC Variances)				
	BCBS	**MHC**	**PHP**	**UHC**
Range of (Over)/Underpayment	**Claim Count**			
($12,000.00) to ($16,999.99)	0	0	0	0
($9,000.00) to ($11,999.99)	0	0	0	0
($5,000.00) to ($8,999.99)	0	2	4	0
($3,000.00) to ($4,999.99)	1	3	4	0
($1,000.00) to ($2,999.99)	0	2	0	0
($600.00) to ($999.99)	1	0	1	0
($400.00) to ($599.99)	1	1	1	3
($200.00) to ($399.99)	1	3	0	0
($100.00) to ($199.99)	1	2	0	0
($0.01) to ($99.99)	2	2	9	8
$0.00	74	85	70	104
$0.01 to $99.99	0	2	4	1
$100.00 to $199.99	0	1	0	0
$200.00 to $399.99	0	1	0	0
$400.00 to $599.99	0	0	0	0
$600.00 to $999.99	0	1	0	0
$1,000.00 to $2,999.99	0	0	0	1
$3,000.00 to $4,999.99	0	0	0	0
$5,0000.00 to $8,999.99	0	0	0	0
$9,000.00 to $11,999.99	0	0	1	0
$12,000.00 to $16,999.99	0	0	0	0
Total	**81**	**105**	**94**	**117**