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 Behavioral Health and Federally Qualified Health Center Claims

August 22, 2019

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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Independent Accountant's Report on Applying Agreed-upon Procedures

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: January 1, 2017 through December 31, 2017

We have performed the procedures enumerated in the Medicaid Managed Care Behavioral Health 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 Behavioral Health 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:

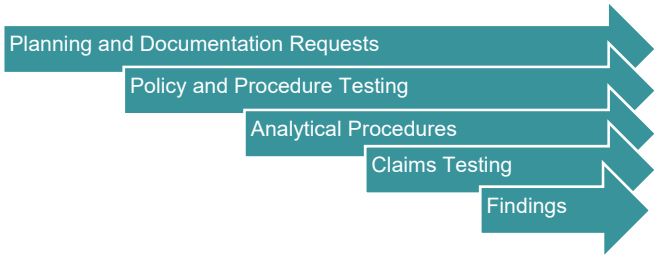
- Blue Cross and Blue Shield of New Mexico (BCBS)
- Molina Health Care of New Mexico, Inc. (MHC)
- Presbyterian Health Plan, Inc. (PHP)
- UnitedHealthcare Community Plan of New Mexico (UHC)

We performed agreed-upon procedures on the behavioral health (BH) and Federally Qualified Health Center (FQHC) claims systems, processes, and policies related to the following areas of the Centennial Care Program: claims adjudication; provider credentialing; provider contract loading; and claims repricing.

The purpose of the procedures is to provide oversight of the MCO processes through interviews, documentation requests, and sample testing based on adjudicated behavioral health and FQHC paid and denied claims data and provider roster additions for the period of January 1, 2017 through December 31, 2017. The section below outlines the engagement's scope of work completed by Myers and Stauffer. 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
- Collect policies and procedures related to the addition of non-independent licensed practitioners and new provider specialties to MCO provider rosters
- Perform testing related to behavioral health and FQHC claims as outlined in the agreed-upon procedures
- Select a random sample and verify timely credentialing, timely contract loading, and the accuracy of claims payments for BH and FQHC claims
- Provide a report to HSD that summarizes our findings and recommendations



Planning and Documentation Requests

The documentation request to complete the objectives of this engagement was sent to the MCOs on July 6, 2018, which included the following:

- Behavioral health claims data set
- Federally Qualified Health Center claims data set
- Non-independent licensed behavioral health practitioners rostered by a behavioral health agency
- Behavioral health specialized service providers added to agency rosters
- Policies and procedures for the recognition, billing, and payment of services provided by non-independent licensed practitioners in behavioral health agencies (provider type 432) to comply with HSD Letter of Direction #43
- Policies and procedures for the addition of provider(s) to the agency roster related to behavioral health specialized services as identified in New Mexico Administrative Code 8.321.2, including the recognition of provider type and provider specialty(ies) in the MCO claims system, what covered services each specialty can bill for, and all specialized behavioral health services billing instructions

HSD provided a specific listing of revenue codes and procedure codes to identify behavioral health claims which the MCOs were to include in their claims data submissions. MCOs were instructed to include all claims related to Federally Qualified Health Centers (FQHC), provider type 313, in their FQHC claims data submissions. The completeness of each claims data submission could not be assessed through reconciliation to financial data due to the granular nature of the data sets.

HSD provided the following:

- MCO contracts and amendments
- HSD Letters of Direction applicable to BH and FQHC claims, provider credentialing, and contracting
- New Mexico Administrative Code (NMAC) applicable to the BH and FQHC testing
- BH fee-for-service rate sheets
- Medicaid specific procedure code modifiers (U1-U8), descriptions, and use requirements
- FQHC encounter rate listing
- Listing of approved behavioral health agencies for non-independent licensed practitioners

Policies and Procedures

Testing and Results

Each MCO provided Myers and Stauffer with its existing policies and procedures as part of the 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:

- Provider credentialing and claims system loading
- Provider contract and claims system loading
- Non-independent licensed behavioral health practitioner additions to behavioral health agency rosters
- Provider additions to agency rosters related to behavioral health specialized services

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

Table 1

Policy Review				
	BCBS	**MHC**	**PHP**	**UHC**
Provider Credentialing: Contract 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.	Partially Compliant	Compliant	Compliant	Compliant
Provider Contract 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.	Partially Compliant	Compliant	Partially Compliant	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.*

No HSD authoritative requirements or guidance exists for the additions of non-independent licensed behavioral health practitioners to behavioral health agency rosters, or for the provider additions to agency rosters related to behavioral health specialized services. Therefore, each MCO's policies and procedures for the timeliness of roster additions are summarized below. Appendix A contains the MCO policies and procedures provided in full related to roster additions for these provider types.

Non-Independent Licensed Behavioral Health Practitioners

- BCBS - No policies and procedures with a timeframe for adding non-independent licensed practitioners to the roster exist.
- MHC - Non-independent licensed provider types would not fall under MHC's credentialing policies and procedures as there are no credentialing requirements for these provider types. No policies and procedures with a timeframe for adding non-independent licensed practitioners to the roster exist.
- PHP - Submitted documentation did not reference billing for non-independent licensed practitioners and claims system loading. No policies and procedures with a timeframe for adding non-independent licensed practitioners to the roster exist.
- UHC - No policies and procedures with a timeframe for adding non-independent licensed practitioners to the roster exist.

Behavioral Health Specialized Services

- BCBS - An MCO representative assigned to the provider will review the case and complete the necessary research to identify missing information for roster submission within seven days from receipt of roster request.
- MHC - Rostered providers would not be listed in MHC's credentialing system, but would fall under a facility's credentialing process. No policies and procedures with a timeframe for adding behavioral health specialized services to providers agency rosters were noted.
- PHP - No policies and procedures with a timeframe for adding behavioral health specialized service providers to agency rosters were noted.
- UHC - While UHC does track timeliness around the additions of provider requests once they are submitted, there were no policies and procedures submitted with a timeframe for adding behavioral health specialized service providers to agency rosters.

Analytical Procedures

As previously mentioned, Myers and Stauffer was unable to verify against specific financial reporting documents that all claims were captured in the data submission. 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 behavioral health and FQHC 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.

Behavioral Health Claims

A behavioral health claim is defined in the Medicaid Managed Care Services Agreement (contract) as a claim related to mental health (including psychiatric illnesses and emotional disorders) and substance abuse (involving addictive and chemical dependency disorders). The following criteria was sent to the MCOs to pull the behavioral health claims data set as agreed upon with HSD.

- Revenue Codes: 0190 & 0191 for provider types 216, 217, and 219; 1001, 1002, 1005, 0912, and 0919 for all provider types
- Procedure (Modifier) Codes: T1026, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0373T, 0374T, G0406, G0407, G0408, H0001, H0015, H0020, H0031, H0031 (U8), H0033, H0039, H2010, H2011 (U1), H2011 (U2), H2011 (U3), H2012, H2014, H2015, H2017, H2030, H2033, Q3014, S5110, S5145, S5145 (U1), T1005, T1007, 36591, 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90863, 90889, and 90885.

After reviewing the behavioral health claims data sets submitted by the MCOs, it was determined revisions were needed to the above procedures codes and revenue codes to more accurately capture only behavioral health claims. Based on direction from HSD, Myers and Stauffer excluded all claims that did not meet the revised criteria outlined below.

- H0033 should be limited to billing provider types 301, 306, 313, 316, 343, and 443
- H2010 should be limited to billing provider types 343, 446, 432 with servicing provider types 305, 316, 317, 320, 433, and 443
- H2011 should be included in the audit, regardless if a modifier is included on the claim
- H0031 should be included in the audit, regardless if the modifier included on the claim is not U8
- G0406, G0407, and G0408 should be limited to servicing provider types 431, 435, 436, 440, 443, 444, and 445
- Q3014 should be excluded from the audit

- T1026 should be limited to billing provider types 432, 433, 446 and 313 with servicing provider types 431, 441, and 445
- 36591 should be excluded from the audit

Additionally, Myers and Stauffer excluded claims outside of the requested adjudication period of January 1, 2017 through December 31, 2017 from the tested claims population submitted in PHP's BH claims submission.

BCBS's BH data set appeared to be missing procedure code modifiers based on comparison with other MCO data sets. A follow up request was made for any procedure code modifiers excluded from the data set submitted, as procedure code modifiers are necessary to pay the correct reimbursement rate for many BH claims. BCBS stated in a webinar conference held on October 23, 2018 that all procedure code modifiers were included in the original submitted data set. Additional procedure code modifiers were later provided for sampled claims during claims testing to ensure proper payment rates. However, they were not provided for the full claims population.

Reference *Table 2* for claim exclusions from the submitted claims data sets.

Federally Qualified Health Center (FQHC) Claims

An FQHC is defined in the Medicaid Managed Care Services Agreement (contract) as an entity that meets the requirements of, and receives a grant and funding pursuant to, the Public Health Service Act. An FQHC also includes an outpatient health program, a facility operated by a tribe or tribal organization under the Indian Self-Determination Act, and an Urban Indian Health organization receiving funds under Title V of the Indian Health Care Improvement Act. FQHC claims were identified by Myers and Stauffer and HSD as claims with provider type 313 included on the claim, which would include both behavioral health and non-behavioral health FQHC claims.

The following data issues were noted in PHP's FQHC claim submission:

- Claims were included with blank provider type values for billing and rendering provider type
- Claims were included outside the adjudication period under review
- The data set only included behavioral health FQHC claims. No non-behavioral health FQHC claims were noted. Additionally, the ratio of claim lines to unique claims was less compared to other MCOs.

A webinar conference was held on November 15, 2018 to offer the MCO an opportunity to explain the issues noted with the FQHC data set. PHP stated in the meeting that its system collapses claim numbers for FQHC claims, resulting in PHP being unable to provide line level information such as procedure code, procedure code modifier, and bill type. A follow up was sent to the MCO for confirmation that the FQHC claims data set submitted was the most comprehensive and accurate submission of FQHC data that can be provided based on PHP's system. After confirmation was received, PHP's claims data set was accepted as-submitted, with the exception of claims outside the adjudication period under review.

The total number of claims included in each MCO's claim submission, the number of claims that did not meet specified criteria outlined by Myers and Stauffer and HSD, and the number of adjusted claims after removing the claims that did not meet the specified criteria are outlined in the table below for the behavioral health and FQHC claims data sets. The number of adjusted claims for each MCO in *Table 2* is the total number of claims included in the analytical testing procedures below.

Table 2

Claim Data Sets				
	BCBS	**MHC**	**PHP**	**UHC**
Behavioral Health Claims				
Number of Claims*	325,806	415,802	463,855	268,487
Number of Claims Not Meeting Criteria	5,674	6,850	70,649	4,978
Number of Adjustment Claims Not Tested	0	0	1,563	3,110
Number of Adjusted Claims	320,132	408,952	391,643	260,399
FQHC Claims				
Number of Claims*	125,297	195,987	53,151	87,748
Number of Claims Not Meeting Criteria	0	0	124	0
Number of Adjustment Claims Not Tested	0	0	998	82
Number of Adjusted Claims	125,297	195,987	52,029	87,666

Count of paid, partially denied, denied, and adjustment claims submitted in the MCO data sets

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 sets based on a "Denied" Reimbursement Status field in the MCO-submitted data sets.

Partially Denied Claims

Partially denied claims do not have a consistent definition between the behavioral health and FQHC data sets due to instructions for FQHCs included in the State of New Mexico Medical Assistance Program Manual Supplement 16-13, which is outlined further below.

Partially denied claims are defined as follows for each of the data sets:

- For BH claims, partially denied claims exist if any service(s) on a paid claim are not paid. These claims were identified in the data sets when a claim had both a "Denied" line-level Reimbursement Status and a "Paid" line-level Reimbursement Status. This methodology

was utilized since the data sets included zero-paid claims, preventing accurate classification of claims based on if a Medicaid payment was included on the claim.

- For FQHC claims, partially denied claims exist when at least one claim line for a Medicaid member number on a date of service is reported as paid and at least one claim line for a Medicaid member number on a date of service is reported as denied, regardless if the visits are billed on the same claim or billed on separate claims. Separate claims for the same date of service where one is paid and one is denied would both be reflected as partially denied using this methodology.

The State of New Mexico Medical Assistance Program Manual Supplement 16-13 states that no more than one encounter rate can be paid per day unless the recipient went to the FQHC more than once in a day with a different diagnosis, or had two distinct types of visits such as:

1) A physical health visit and a dental visit on the same day.
2) A physical health visit and a separate behavioral health service provided by a different provider on the same day.
3) More than one distinct specialized behavioral health service which does not otherwise overlap or is prohibited from being billed in conjunction with another specialized BH service per the New Mexico Administrative Code for specialized BH services.

Based on this guidance, a listing of examples from the submitted FQHC claims data set was sent to each MCO to determine if separate encounters were billed on the same claim or billed on separate claims. After reviewing the claim-specific explanations provided by the MCOs, it was determined that there was not a consistent methodology utilized for billing separate encounters. Therefore, reimbursement classifications for FQHC claims were based on Medicaid member number and admit date, instead of claim number, to provide consistency within the data sets.

Because each MCO is reporting multiple encounters for the same dates of service differently, the percentages related to partially denied FQHC claims may not be able to be compared to each other MCO on the same basis. Additionally, some MCOs are reporting claim lines as both paid and denied on claims paid at the encounter rate, even though all billed claim service lines are included in the total paid encounter rate, while other MCOs report all claims lines in this instance as paid. Without a consistent billing and reporting methodology for FQHC claims, any analysis will be limited in its conclusion. FQHC billing guidance from HSD is not explicit on the reporting of multiple encounters for the same dates of service or the reporting of paid and denied lines on claims paid at the encounter rate.

Claim Adjustments

Claim adjustments identified in the data sets by Myers and Stauffer are claims that did not include a reimbursement status indicator of paid or denied on any of the claim lines. Therefore, the reimbursement status for the claim could not be determined since the MCO did not provide the paid or denied status of the claim. Adjustments were only identified in the BH and FQHC claims data sets submitted by PHP and UHC. These claims were identified based on an **"**Adjustment" Reimbursement Status field in UHC's submitted data sets and an "Adjusted" or "Backed-Out" Reimbursement Status field in PHP's submitted data sets. Adjustments were excluded from the analytical procedures testing. See *Table 2*.

Analytical Testing Results

Based on definitions of the claim subsets identified above, analytical testing was performed on the following claim types related to claim denials and claim turnaround times:

- Clean behavioral health claims
- Denied behavioral health claims
- Partially denied behavioral health claims
- Clean FQHC behavioral health claims
- Denied FQHC behavioral health claims
- Partially denied FQHC behavioral health claims
- Clean FQHC non-behavioral health claims
- Denied FQHC non-behavioral health claims
- Partially denied FQHC non-behavioral health claims

In addition, testing was performed on the populations below related to medication monitoring claims.

The table below reflects denials and partial denials compared to total behavioral health, total FQHC behavioral health, and total non-behavioral health FQHC claims for each MCO's claims population.

Table 3

Analytical Procedures				
	BCBS	**MHC**	**PHP**	**UHC**
Behavioral Health Denials Compared to Total Behavioral Health Claims				
Number of Claims	320,132	408,952	391,643	260,399
Number of Clean Claims	320,132	408,952	391,643	260,399
Percent of Total Claims	100.00%	100.00%	100.00%	100.00%
Number of Denied Claims	23,571	32,560	435	80,425
Percent of Total Claims	7.36%	7.96%	0.11%	30.89%
Number of Partially Denied Claims	1,879	3,472	2,887	4,600
Percent of Total Claims	0.59%	0.85%	0.74%	1.77%
FQHC Behavioral Health Denials Compared to Total FQHC Behavioral Health Claims				
Number of Claims	42,005	58,641	52,029	29,098
Number of Clean Claims	42,005	58,641	52,029	29,098
Percent of Total Claims	100.00%	100.00%	100.00%	100.00%

Number of Denied Claims	1,169	2,310	3,266	1,641
Percent of Total Claims	2.78%	3.94%	6.28%	5.64%
Number of Partially Denied Claims	5,361	2,203	704	9,513
Percent of Total Claims	12.76%	3.76%	1.35%	32.69%
FQHC Non-Behavioral Health Denials Compared to Total FQHC Non-Behavioral Health Claims				
Number of Claims	83,292	137,346	0	58,568
Number of Clean Claims	83,292	137,346	0	58,568
Percent of Total Claims	100.00%	100.00%	0.00%	100.00%
Number of Denied Claims	4,074	3,487	0	4,520
Percent of Total Claims	4.89%	2.54%	0.00%	7.72%
Number of Partially Denied Claims	36,880	11,223	0	34,274
Percent of Total Claims	44.28%	8.17%	0.00%	58.52%

Adjudication Turnaround Times

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

- Claim received date
- Adjudication date

The MCO-submitted BH and FQHC claims data sets were provided at detailed line level. To accurately calculate the turnaround time for each claim, the minimum claim received date and the maximum adjudication date noted on the claim were used for turnaround time calculations. Calculated turnaround times were used to test compliance with the contract requirements below.

Contract Requirement for Indian Health Providers
Section 4.19.1.6.1

For claims from I/T/Us [Indian Health Service, Tribal health providers, and Urban Indian providers, including facilities that are operated by a Native American/Alaskan Indian tribe]…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****.*

Contract Requirement for Non-Indian Health Providers
Section 4.19.1.6.2

For all other claims, 90% of clean claims must be adjudicated within ***thirty (30) calendar days of receipt*** *and 99% of clean claims must be adjudicated within* ***ninety (90) calendar days of receipt****.*

Table 4 below displays the average and range of claims adjudication turnaround times by MCO segregated into the following categories:

- Behavioral health claims
- Behavioral health Indian health claims

- Behavioral health non-Indian health claims

Table 5 below displays the average and range of claims adjudication turnaround times by MCO segregated into the following categories:

- FQHC claims
    - FQHC behavioral health (BH) claims
    - FQHC non-behavioral health (non-BH) claims
- FQHC Indian health claims
- FQHC non-Indian health claims

Both *Table 4* and *Table 5* reflect the percentage of claims meeting the 15 and 30 day contract requirements for Indian health providers and the percentage of claims meeting the 30 and 90 day contract requirements for non-Indian health providers. Adjustments, which were identified as claims without a paid or denied reimbursement status, were not included in the turnaround time tables below. Adjusted claims containing a paid or denied reimbursement status are included in the tables below.

The contract requirements above relate to the adjudication of clean claims, but do 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, UHC 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.

Table 4

Behavioral Health Claims Turnaround Time				
	BCBS	**MHC**	**PHP****	**UHC****
Behavioral Health Claims Overall Population				
Number of BH Claims***	320,132	408,952	391,643	260,399
Average Turnaround Time (in days)	16	1	3	33
Turnaround Time Range (in days)	0 to 1,320	0 to 1,072	0 to 346	0 to 860
Behavioral Health Indian Health Claims				
Number of BH Indian Health Claims	3,834	4,060	3	3,997
Average Turnaround Time (in days)	9	1	7	29
Turnaround Time Range (in days)	0 to 298	0 to 50	7 to 8	0 to 323
Percentage Meeting the 15 Day Requirement*	91.65%	98.62%	100.00%	70.05%
Percentage Meeting the 30 Day Requirement*	94.03%	99.73%	100.00%	75.13%
Behavioral Health Non-Indian Health Claims				
Number of BH Non-Indian Health Claims***	316,294	404,892	391,640	256,402
Average Turnaround Time (in days)	16	1	3	33
Turnaround Time Range (in days)	0 to 1,320	0 to 1,072	0 to 346	0 to 860
Percentage Meeting the 30 Day Requirement*	90.07%	99.57%	97.02%	71.07%

Percentage Meeting the 90 Day Requirement*	95.62%	99.86%	99.37%	88.17%

Indian Health Claims: Total claim count for identified Indian Health Service providers based on HSD provided listing
Non-Indian Health Claims: Total claim count excluding Indian Health claims.
**Compliance was tested based on the submitted behavioral health claims population and does not represent all provider types*
***Adjustments were not included in counts and analysis*
****Four claims with blank received dates in the BCBS data set were not included in turnaround time analysis as they could not be tested. As a result, total BH Indian health and non-Indian health claims above will not sum to total behavioral claims tested elsewhere.*

Table 5

FQHC Claims Turnaround Time				
	BCBS	**MHC**	**PHP****	**UHC****
FQHC Claims Overall Population				
Number of FQHC BH Claims	42,005	58,641	52,029	29,098
Average Turnaround Time (in days)	15	1	7	41
Turnaround Time Range (in days)	0 to 914	0 to 169	0 to 346	0 to 1,132
Number of FQHC Non-BH Claims	83,292	137,346	0	58,568
Average Turnaround Time (in days)	16	1	0	36
Turnaround Time Range (in days)	0 to 940	0 to 364	No Range	0 to 1,199
FQHC Indian Health Claims				
Number of FQHC Indian Health Claims	0	0	54	0
Average Turnaround Time (in days)	0	0	7	0
Turnaround Time Range (in days)	No Range	No Range	6 to 9	No Range
Percentage Meeting the 15 Day Requirement*	0.00%	0.00%	100.00%	0.00%
Percentage Meeting the 30 Day Requirement*	0.00%	0.00%	100.00%	0.00%
FQHC Non-Indian Health Claims				
Number of FQHC Non-Indian Health Claims	125,297	195,987	51,975	87,666
Average Turnaround Time (in days)	16	1	7	37
Turnaround Time Range (in days)	0 to 940	0 to 364	0 to 346	0 to 1,199
Percentage Meeting the 30 Day Requirement*	88.20%	99.33%	98.07%	74.07%
Percentage Meeting the 90 Day Requirement*	97.13%	99.53%	99.11%	84.93%

Indian Health Claims: Total claim count for identified Indian Health Service providers based on HSD provided listing
Non-Indian Health Claims: Total claim count excluding Indian health claims.
**Compliance was tested based on the submitted FQHC claims population and does not represent all provider types*
***Adjustments were not included in counts and analysis*

Denials

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

- Denial reason codes
- Denial reason descriptions
- Billed amount

The behavioral health and FQHC data sets submitted by each MCO were 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.

An analysis was performed to determine the volume of each denial reason code reported for behavioral health, FQHC behavioral health, and FQHC non-behavioral health claim denials and partial denials, ranked by number of occurrence. Denial code frequency was determined based on claim lines, not unique claims. Therefore, if a claim had several lines with the same denial code, the denial code would be counted every time it appeared on the claim.

In some instances, BCBS included multiple denial codes and denial reasons per claim line. As a result, the individual billing charges noted on the line could not be associated with a specific denial code. These instances where multiple denial codes were included on one line were treated as unique denial counts in the top ten denial reason analysis. Denial reason number six in *Table 7* for behavioral health partially denied claims was the only instance of this situation found in the top ten denial reasons for behavioral health and FQHC claims.

Billed amounts are reported for the denial reason codes based on claim number and denied and partially denied reimbursement statuses. Billed amounts listed in *Table 6* and *Table 7* were associated with the individual claim lines with the denial code included, not the total billed amount noted for the claim. Using this methodology results in no duplication of billed amounts when multiple denial reason codes were associated with one claim.

Table 6

Top 10 Denial Reasons and Dollar Amounts for Behavioral Health Claims							
	Rank	Reason	Count	Dollar Amount	Reason	Count	Dollar Amount
Entity		Denied Claims			Partially Denied Claims		
BCBS	1	Service/Charge is a duplicate of a previous processed claim.	23,008	$ 4,281,911.57	Medicaid Participating Provider	3,387	$ 436,373.82
	2	Late charge denial (No EOB created for this claim)	3,859	$ 923,693.69	Service/Charge is a duplicate of a previous processed claim.	1,622	$ 175,918.85
	3	Medical/surgical advisor was not contacted prior to treatment	3,218	$ 510,776.79	Benefits are not provided for expenses that the insured has no legal obligation to pay as determined by Medicare.	362	$ 17,298.07
	4	This service cannot be processed until charges are filed with other insurance carrier (For non its claims)	2,552	$ 610,744.77	Time period for filing claim has expired. (XXX number of days from last date of service)	257	$ 32,399.24
	5	Time period for filing claim has expired. (XXX number of days from last date of service)	2,321	$ 496,812.11	Pricer has determined that the services billed are not reimbursable for this provider (Professional Charges)	227	$ 11,709.26
	6	EOMB (Medicare) required for this service(s).	2,040	$ 213,963.15	EOMB (Medicare) required for this service(s).	203	$ 20,643.27
	7	Medical records required	730	$ 223,424.93	Durable Medical Equipment charge(s) exceeds the total rental allowance for this DME item. The participating provider may not bill you for the balance.	150	$ 11,762.26
	8	On or after termination date	552	$ 116,631.93	Services are mutually exclusive. The clinically more intense service has been reimbursed and the comparable service is mutually exclusive. Coding practice utilized by this participating provider is in.	128	$ 15,843.91
	9	This procedure code is not recommended for reimbursement.	406	$ 72,120.34	This procedure code is not recommended for reimbursement.	111	$ 17,336.56
	10	Adjustment: void claim due to returned dollars	357	$ 46,817.93	On or after termination date	97	$ 11,387.49
MHC	1	Claim has been manually denied	40,776	$ 7,218,720.28	Excluded Contract Term for Service	1,056	$ 79,471.32
	2	Excluded Contract Term for Service	16,197	$ 1,876,696.93	Claim has been manually denied	855	$ 115,984.66

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	3	Duplicate Mem/DOS/Service code/Pay To/Modifier	7,888	$ 1,217,043.08	Claim Line Submission Window Exceeded	627	$ 48,251.38
	4	Submission Window Exceeded for Claim Start Date	4,539	$ 569,214.80	(UNB/sUN/sUNf) Unbundled Procedure on Current Line	613	$ 60,174.18
	5	Claim Line Submission Window Exceeded	1,843	$ 394,922.43	Duplicate Mem/DOS/Service code/Pay To/Modifier	467	$ 51,529.61
	6	Benefit requires UM	864	$ 138,815.25	iHT-Adjusted Units Exceeded The Amount Allowed-ADJUN	340	$ 33,062.04
	7	Diagnosis code is not valid on DOS	452	$ 60,073.21	Medicare add-on procedure without primary procedure	317	$ 14,967.19
	8	(mMUE/MUEf/sMUE) Medically Unlikely- Exceeds Allowed Units	442	$ 59,859.98	Benefit requires UM	227	$ 27,091.45
	9	iHT-Duplicate Submission-PY060	420	$ 49,159.64	(mMUE/MUEf/sMUE) Medically Unlikely- Exceeds Allowed Units	200	$ 21,632.02
	10	Invalid diagnosis code for benefit	334	$ 38,847.70	Benefit is excluded from benefit plan	187	$ 4,388.89
PHP	1	Deny-service can't be billed on same day	306	$ 29,925.67	Deny-PAR PROV-bill rec'd after timely filing.	2,521	$ 164,862.36
	2	Deny-MCAID-NPI attestation needed/MCAID ID/NPI not on file	58	$ -	Deny-Services not covered under provider's contract.	959	$ 44,869.40
	3	Deny- Services not covered under provider's contract.	50	$ 1,386.35	Deny-Roster Provider not registered	535	$ 12,800.09
	4	Deny - SIU-Provider billing error	49	$ 4,559.94	Deny-custom edits-incidental procedure	513	$ 49,715.40
	5	Deny-Units exceed day maximum	48	$ 7,100.00	Deny-non covered code	485	$ 18,844.91
	6	Deny-COB Requested primary carrier's EOB.	25	$ 62,430.56	Deny-PAR PROV No authorization on file	374	$ 92,734.24
	7	Deny-Services Provided in this location are not covered	20	$ 935.09	Deny-Code can't be billed alone	274	$ 7,922.42
	8	Deny-non covered code	19	$ 380.00	Deny-MCAID-NPI attestation needed/MCAID ID/NPI not on file	213	$ 767.00
	9	Deny-Code can't be billed alone	15	$ 331.32	Deny-service can't be billed on same day	212	$ 19,817.16
	10	Deny-Non covered Behavioral Health DX	13	$ 2,903.76	Deny-NON PAR provider-no out of network benefit.	153	$ 7,381.94
UHC	1	Taxonomy not valid for provider	46,896	$ 151,463.39	Service is not contracted	2,247	$ 263,189.16

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	2	Missing Taxonomy Code	26,131	$	63,910.12	Duplicate-Original claim in process	1,456	$ 35,156.74
	3	Service is not contracted	21,353	$	1,265,173.08	Definite Duplicate Claim	1,412	$ 87,907.14
	4	Definite Duplicate Claim	20,684	$	2,196,239.58	Claim filed after time limit	665	$ 25,257.36
	5	Claim is a duplicate	12,243	$	1,671,846.55	Units and charge split for processing	658	$ 146,457.90
	6	Not a valid service for provider type	6,361	$	69,109.84	Claim already processed.	380	$ 37,198.98
	7	Send Primary Carriers EOB	5,251	$	420,228.03	NetworX Std Fee Sched	355	$ 52,678.47
	8	Termination	4,525	$	259,752.39	Previously processed	351	$ 27,375.55
	9	Previously Processed	3,686	$	186,588.70	Date range not valid with units.	321	$ 9,052.58
	10	NetworX Std Fee Sched	3,334	$	94,961.11	COB applies - exceeds the fee schedule	303	$ 69,831.45

Reason: *Denial reason description*
Count*: Number of denial code occurrence*
Dollar Amount: *Sum of billed amounts for denial reason*

Table 7

Top 10 Denial Reasons and Dollar Amounts for FQHC Claims							
	Rank	**Reason**	**Count**	**Dollar Amount**	**Reason**	**Count**	**Dollar Amount**
Entity: (BH/Non-BH)		**Denied Claims**			**Partially Denied Claims**		
BCBS: BH	1	On or after termination date	620	$ 84,372.67	Service/Charge is a duplicate of a previous processed claim.	1,263	$ 187,086.73
	2	This service cannot be processed until charges are filed with other insurance carrier (For non its claims)	247	$ 36,943.92	Pro-component charges cannot be billed on UB92. Provider instructed to resubmit on HCFA claim form.	114	$ 11,861.66
	3	Hospital claim need Medicare's paid amount.	186	$ 28,950.63	Medicaid Participating Provider	70	$ 9,022.04
	4	Service/Charge is a duplicate of a previous processed claim.	166	$ 29,252.67	This service cannot be processed until charges are filed with other insurance carrier (For non its claims)	67	$ 9,849.25
	5	Time period for filing claim has expired. (XXX number of days from last date of service)	53	$ 6,075.66	Late charge denial (No EOB created for this claim)	47	$ 7,158.31
	6	Electronically submitted claim needs Medicare information. (BIS Origin Code MH Only) - Part A Provider.	45	$ 5,513.53	Service/Charge is a duplicate of a previous processed claim, Service not eligible - failed to meet group guidelines	44	$ 7,128.25
	7	Medicaid Participating Provider	42	$ 5,661.90	Medicare paid this amount	34	$ 5,215.37
	8	Adjustment: void claim due to returned dollars	40	$ 7,515.13	Time period for filing claim has expired. (XXX number of days from last date of service)	31	$ 4,298.86
	9	This service is not covered for this diagnosis	24	$ 4,233.19	Hospital claim need Medicare's paid amount.	27	$ 4,244.26
	10	Additional information request to the provider requesting room and board charges.	17	$ 2,571.74	Benefits are not provided for expenses that the insured has no legal obligation to pay as determined by Medicare.	26	$ 3,240.55
BCBS: Non-BH	1	On or after termination date	3,695	$ 455,535.12	Service/Charge is a duplicate of a previous processed claim.	5,000	$ 666,806.18
	2	Service/Charge is a duplicate of a previous processed claim.	756	$ 97,929.48	Medicaid Participating Provider	4,117	$ 198,522.12

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	3	Hospital claim need Medicare's paid amount.	756	$ 75,807.33	Pro-component charges cannot be billed on UB92. Provider instructed to resubmit on HCFA claim form.	625	$ 18,882.75
	4	This service cannot be processed until charges are filed with other insurance carrier (For non its claims)	660	$ 60,035.59	This service is incidental to primary procedure code. Payment is included in allowance for primary service. Coding practice utilized by this participating provider is inconsistent with current coding	609	$ 10,349.18
	5	Medicaid Participating Provider	540	$ 58,320.04	Medicare paid this amount	331	$ 51,336.20
	6	Time period for filing claim has expired. (XXX number of days from last date of service)	335	$ 33,315.44	Benefits are not provided for expenses that the insured has no legal obligation to pay as determined by Medicare.	286	$ 31,925.13
	7	This service is not covered for this diagnosis	217	$ 20,939.42	Hospital claim need Medicare's paid amount.	286	$ 27,147.52
	8	Electronically submitted claim needs Medicare information. (BIS Origin Code MH Only) - Part A Provider.	97	$ 11,078.21	NDC Code is required. Please resubmit with correct NDC Code and/or NDC units.	197	$ 5,915.28
	9	EOMB (Medicare) required for this service(s).	77	$ 5,942.48	This service cannot be processed until charges are filed with other insurance carrier (For non its claims)	183	$ 17,331.90
	10	Medical/surgical advisor was not contacted prior to treatment	67	$ 7,205.94	Late charge denial (No EOB created for this claim)	146	$ 16,065.35
MHC: BH	1	Claim has been manually denied	1,889	$ 231,082.93	Claim has been manually denied	1,081	$ 126,470.65
	2	Excluded Contract Term for Service	241	$ 18,801.44	Duplicate Mem/DOS/Service code/Pay To/Modifier	250	$ 41,918.00
	3	Claim Line Submission Window Exceeded	186	$ 26,643.57	Diagnosis code is not valid on DOS	46	$ 6,348.73
	4	Submission Window Exceeded for Claim Start Date	121	$ 18,267.99	Invalid NDC Code	44	$ 481.85
	5	Diagnosis code is not valid on DOS	54	$ 4,428.02	Claim Line Submission Window Exceeded	16	$ 2,415.30
	6	Contract term requires UM	37	$ 5,568.54	Excluded Contract Term for Service	6	$ 347.84
	7	Duplicate Mem/DOS/Service code/Pay To/Modifier	9	$ 1,497.34	Submission Window Exceeded for Claim Start Date	5	$ 861.60
	8	(015MFD/sMUEf) Billed units exceed allowed	3	$ 540.33	Contract term requires UM	3	$ 387.78

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	9	Member has an active restriction on enrollment	2	$	320.00	Invalid Service Code on DOS	3	$ 124.20
	10	Diagnosis code does not exist	1	$	188.66	(015MFD/sMUEf) Billed units exceed allowed	2	$ 622.32
MHC: Non-BH	1	Claim has been manually denied	4,458	$	471,807.73	Invalid NDC Code	4,821	$ 52,086.26
	2	Submission Window Exceeded for Claim Start Date	494	$	46,392.75	Claim has been manually denied	4,007	$ 351,194.94
	3	Claim Line Submission Window Exceeded	471	$	46,775.02	Excluded Contract Term for Service	1,609	$ 227,145.54
	4	Excluded Contract Term for Service	322	$	36,092.81	Duplicate Mem/DOS/Service code/Pay To/Modifier	830	$ 102,623.69
	5	Diagnosis code is not valid on DOS	123	$	12,344.17	Invalid Service Code on DOS	316	$ 4,651.99
	6	POS not typical for procedure	50	$	12,971.00	iHT-Not Covered For Diagnosis Indicated-NCDIA	202	$ 6,324.81
	7	Duplicate Mem/DOS/Service code/Pay To/Modifier	41	$	5,584.05	Benefit is excluded from benefit plan	64	$ 334.14
	8	Inpatient Claim Submission Window Exceeded (claim Thru date)	31	$	4,963.72	Diagnosis code is not valid on DOS	57	$ 6,320.24
	9	Invalid NDC Code	14	$	1,101.00	Missing, invalid, or inappropriate procedure	41	$ 9,491.25
	10	Contract term requires UM	13	$	1,064.59	iHT-Diags On The Claim Do Not Support Billed Procedure-00231	37	$ 2,461.98
PHP: BH	1	Deny-COB Requested primary carrier's EOB.	702	$	108,687.55	Deny-COB Requested primary carrier's EOB.	126	$ 18,412.99
	2	Deny-Billing Provider NPI number missing or invalid	667	$	105,016.61	Deny-Services not covered under provider's contract.	66	$ 7,362.34
	3	Deny-Services not covered under provider's contract.	658	$	102,729.58	Deny-UB04-Source of Admission Code Missing/Invalid	60	$ 7,573.59
	4	Deny-Non covered Behavioral Health DX	472	$	62,096.26	Deny-Non covered Behavioral Health DX	55	$ 8,199.85
	5	Deny-PAR PROV-bill rec'd after timely filing.	319	$	50,998.58	Deny-FQHC-encounter data missing/invalid	53	$ 8,624.54
	6	Deny-UB04-Source of Admission Code Missing/Invalid	162	$	25,070.19	Deny-Roster Provider not registered	23	$ 2,140.68

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	7	Deny-Roster Provider not registered	104	$ 12,591.78	Deny-PAR PROV-bill rec'd after timely filing.	20	$ 816.17
	8	Deny-Missing/Invalid UB04 information	71	$ 9,000.75	Deny-bill type inconsistent srvc, admit date, discharge status	12	$ 1,623.90
	9	Deny-Dup-prev submit-info requested-not received	70	$ 11,278.86	Deny-Missing/Invalid UB04 information	12	$ 1,072.56
	10	Deny -forwarded medical chgs to med carrier	53	$ 19,553.00	Deny-Dup-prev submit-info requested-not received	9	$ 1,767.30
PHP: Non-BH	1	No Non-Behavioral Health Claims in the Data Set			No Non-Behavioral Health Claims in the Data Set		
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						
UHC: BH	1	Service is not contracted	578	$ 89,832.02	Missing Taxonomy Code	4,146	$ 468.00
	2	Send Primary Carriers EOB	237	$ 38,733.45	Taxonomy not valid for provider	1,260	$ 230.74
	3	Missing Taxonomy Code	212	$ 1,948.68	Service is not contracted	566	$ 28,689.32
	4	Unable to verify providers license	145	$ 24,725.95	Not a valid service for provider type	283	$ 1,059.95
	5	Unknown member	143	$ 18,990.69	Definite Duplicate Claim	271	$ 48,330.36
	6	Submitted After Provider's Filing Limit	112	$ 16,581.59	Unbundle relationship in history	218	$ 590.90
	7	CLAIM AFTER MEMBER TERMINATION DATE	106	$ 12,559.87	Claim is a duplicate	182	$ 27,958.97
	8	Taxonomy not valid for provider	77	$ 1,370.08	Billing Provider Not found on State Prov	162	$ -

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	9	Not a valid service for provider type	66	$	970.26	Send Primary Carriers EOB	138	$ 4,273.62
	10	Termination	57	$	7,398.80	COB applies - exceeds the fee schedule	125	$ 12,511.21
UHC: Non-BH	1	Unknown member	2,029	$	254,363.28	Missing Taxonomy Code	12,283	$ 2,051.40
	2	Send Primary Carriers EOB	942	$	96,488.54	Taxonomy not valid for provider	4,613	$ 3,825.04
	3	No plan selection event found	605	$	77,948.64	COB applies - exceeds the fee schedule	4,007	$ 375,395.40
	4	Service is not contracted	588	$	69,857.34	Not applicable	1,691	$ 378.84
	5	Termination	485	$	51,257.75	Coordinated W/Medicare- PD in full	1,558	$ 163,080.50
	6	Missing Taxonomy Code	334	$	-	Claim is a duplicate	1,481	$ 184,448.88
	7	Submitted After Provider's Filing Limit	325	$	37,807.42	Service is not contracted	1,252	$ 20,892.97
	8	COB applies - exceeds the fee schedule	302	$	34,709.23	Primary denied contractual	960	$ 109,045.89
	9	Resubmit for primary payer consideration	297	$	39,231.50	Not a valid service for provider type	834	$ 2,159.11
	10	Claim after Member Termination Date	274	$	35,225.52	Resubmit for primary payer consideration	808	$ 86,171.19

Reason: *Denial reason description*
Count*: Number of denial code occurrence*
Dollar Amount: *Sum of billed amounts for denial reason*

Medication Monitoring Claims

The State of New Mexico Medical Assistance Program Manual Supplement 16-11 states that HCPCS code H2010, medication monitoring, is reimbursable for services provided by Registered Nurses (RN) with either behavioral health experience or a psychiatric-mental health nursing certification (provider type 317 with a specialty of 059 or 096), Certified Nurse Specialists in Psychiatry (provider type 306), Certified Psychiatric Nurse Practitioners (provider type 316 with a specialty of 097) and Physician Assistants (provider type 305) to fee for service recipients and managed care members effective January 1, 2017 for practitioners enrolled in any of the allowed agencies listed below (outlined by HSD and HSD Supplement 16-13):

- Federally Qualified Health Centers (FQHC) – Provider Type 313
- Community Mental Health Centers (CMHC) – Provider Type 433
- Core Service Agencies (CSA) – Provider Type 446
- Behavioral Health Agencies (BHA) – Provider Type 432
- Methadone Clinics – Provider 343

The following data elements were utilized to test and determine the number and dollar amount of denied claims related to medication monitoring and to test if medication monitoring paid claims were being paid the correct fee schedule rate:

- Reimbursement Status
- Procedure Code
- Billed Amount

FQHCs are paid an encounter rate based on the facility, not based on a fee schedule rate for the procedure code on the claim. Therefore, FQHC information was excluded from the medication monitoring analysis, even though FQHCs are listed as one of the allowable agencies outlined in HSD Supplement 16-13. The table below reflects claim line denials for HCPCS H2010 compared to total claim lines with HCPCS H2010 related to specific provider types outlined in Supplement 16-11 and total billed amounts associated with the denials, and does not represent all claims data with H2010 included. Denied claims were identified with a Reimbursement Status of “Denied”.

Table 8

Medication Monitoring Claims for Specific Provider Types				
	BCBS	**MHC**	**PHP**	**UHC**
Medication Monitoring Claims				
Provider Type 305	0	0	0	0
Provider Type 306	0	0	0	0
Provider Type 316, Specialty 097	0	647	413	270
Provider Type 317, Specialty 059	0	670	232	404
Provider Type 317, Specialty 096	0	1,480	0	2,702
Medication Monitoring Denied Claims				
Provider Type 305	0	0	0	0
Provider Type 306	0	0	0	0
Provider Type 316, Specialty 097	0	72	0	261
Provider Type 317, Specialty 059	0	13	0	213
Provider Type 317, Specialty 096	0	95	0	833
Medication Monitoring Denied Claims Billed Amount				
Provider Type 305	$ -	$ -	$ -	$ -
Provider Type 306	$ -	$ -	$ -	$ -
Provider Type 316, Specialty 097	$ -	$ 8,379.98	$ -	$ 30,335.54
Provider Type 317, Specialty 059	$ -	$ 975.00	$ -	$ 9,025.08
Provider Type 317, Specialty 096	$ -	$ 10,359.66	$ -	$ 55,207.59
Medication Monitoring Denial Percentages				
Provider Type 305	0.00%	0.00%	0.00%	0.00%
Provider Type 306	0.00%	0.00%	0.00%	0.00%
Provider Type 316, Specialty 097	0.00%	11.13%	0.00%	96.67%
Provider Type 317, Specialty 059	0.00%	1.94%	0.00%	52.72%
Provider Type 317, Specialty 096	0.00%	6.42%	0.00%	30.83%

HSD Supplement 16-11 further outlines that the rendering provider name and National Provider Identifier (NPI) are not currently a requirement for billing when the service is provided by an RN, but may be a CMS requirement in the future. The agency NPI, therefore, can be placed in the rendering field. This guidance allows the MCOs to include the billing provider information in the rendering fields. Based on this guidance, BCBS included all billing provider information in the rendering fields for claims with HCPCS H2010 included. Therefore, no information was available for the specific rendering provider types outlined in *Table 8* above.

Testing of the accuracy of the claim payments excluded the following claim types: denied claim lines, zero paid claim lines, and claim lines with units equal to zero. The adjusted claim line counts for HCPCS H2010 for all provider types in the table below were tested to ensure medication monitoring claims were being paid the correct fee schedule rate.

Table 9

Medication Monitoring Payment Summary				
	BCBS	**MHC**	**PHP**	**UHC**
Medication Monitoring Claims				
Total Claim Line Count	2,157	3,609	1,303	4,745
Total Denied Claim Line Count	164	209	0	1,976
Total Claim Line Count with Payments Equal to Zero	22	15	0	0
Total Claim Line Count with Units of Service Equal to Zero	0	0	0	0
Total Adjusted Claim Line Count	1,971	3,385	1,303	2,769

The effective date for the fee schedule payment rate of $30.00 for HCPCS H2010 referenced in HSD Supplement 16-11 is January 1, 2017. Therefore, the table below is grouped by admit date to ensure claims were being tested for the correct fee schedule rate. Payment rates tested below were identified based on HSD supplements and fee schedules. The medication monitoring payment testing was performed in accordance with HSD requirements. However, if the MCOs negotiated rates other than the HSD required payment rates with specific providers, the negotiated rates would be reflected as errors.

Table 10

Medication Monitoring Payment Testing				
	BCBS	**MHC**	**PHP**	**UHC**
Admit Date Between January 1, 2017 through December 31, 2017*				
Total Claim Line Count	1,721	3,050	1,291	2,524
Total Claim Line Count Equal to $30.00	993	1,707	250	2,481
Total Claim Line Count Not Equal to $30.00	728	1,343	1,041	43
Percentage of Claims with Correct Payment to Total	57.70%	55.97%	19.36%	98.30%
Admit Date Between August 1, 2016 through December 31, 2016 (With U8 Modifier)**				
Total Claim Line Count with U8 Modifier	0	10	3	19
Total Claim Line Count (With U8 Modifier) Equal to $30.00	0	9	1	17
Total Claim Line Count (With U8 Modifier) Not Equal to $30.00	0	1	2	2
Percentage of Claims with Correct Payment to Total	0.00%	90.00%	33.33%	89.47%
Admit Date Between August 1, 2016 through December 31, 2016 (Without U8 Modifier)**				

Medication Monitoring Payment Testing				
Total Claim Line Count without U8 Modifier	169	272	9	197
Total Claim Line Count (Without U8 Modifier) Equal to $15.65	0	0	0	0
Total Claim Line Count (Without U8 Modifier) Not Equal to $15.65	169	272	9	197
Percentage of Claims with Correct Payment to Total	0.00%	0.00%	0.00%	0.00%
Admit Date Between January 1, 2015 through July 31, 2016* **				
Total Claim Line Count	81	50	0	29
Total Claim Line Count Equal to $57.03	2	41	0	12
Total Claim Line Count Not Equal to $57.03	79	9	0	17
Percentage of Claims with Correct Payment to Total	2.47%	82.00%	0.00%	41.38%
Admit Date Between August 1, 2014 through December 31, 2015**				
Total Claim Line Count	0	2	0	0
Total Claim Line Count Equal to $54.31	0	0	0	0
Total Claim Line Count Not Equal to $54.31	0	2	0	0
Percentage of Claims with Correct Payment to Total	0.00%	0.00%	0.00%	0.00%
Admit Date Between January 1, 2014 through July 31, 2014***				
Total Claim Line Count	0	1	0	0
Total Claim Line Count Equal to $50.52	0	0	0	0
Total Claim Line Count Not Equal to $50.52	0	1	0	0
Percentage of Claims with Correct Payment to Total	0.00%	0.00%	0.00%	0.00%

** Rate per HSD Supplement 16-11*
***Rates per HSD Supplement 16-11*
****Rate per HSD behavioral health fee schedule effective January 1, 2015*
*****Rate per HSD behavioral health fee schedule effective August 1, 2014*
******Rate per HSD behavioral health fee schedule effective January 1, 2014*

Addition of Non-Independent Licensed Practitioners to Agency Rosters

Effective October 1, 2015, Letter of Direction #43 allows for the billing for non-independent licensed behavioral health practitioners (Bils4Nils). The Behavioral Health Services Division of HSD began to accept applications from existing behavioral health agencies (provider type 432) to request certification for status as an agency that can provide clinical supervision and bill for non-independently licensed clinicians (NILs) who will then be rendering additional services not currently covered by Medicaid for NILs**.** This process was implemented as a temporary measure to allow for additional workforce to provide clinical treatment services within behavioral health programs across the state.

The MCOs were requested to submit all non-independently licensed behavioral health practitioners added to behavioral health rosters from January 1, 2017 through December 31, 2017 for testing purposes. To ensure that the rostering information provided by the MCOs was

only for behavioral health agencies approved to bill for non-independently licensed practitioners, a request was made to HSD to provide a listing of approved behavioral health agencies for the period to compare to the MCO data sets.

BCBS, MHC, and PHP each had provider additions included more than once in the submitted rostering data set. After follow-up correspondence, BCBS stated each provider group submits rosters at different intervals throughout the year. BCBS tracked the receipt of each roster received in 2017 in a database but was unable to track individual providers received on each roster in a way that was reportable from the database. Therefore, BCBS provided all the dates of each roster received from that provider group, not necessarily the dates associated with the specific practitioners. MHC and PHP stated that when a provider is added to a roster, there are multiple sites and services associated with that provider roster. MHC and PHP provided the additions to agency rosters for every site.

The table below summarizes the provider data sets submitted by the MCOs and identifies the data excluded from the Bils4Nils analysis and review. See the BCBS section below for an explanation regarding the 1,743 instances where the agency request date was after the system add date in the MCO-submitted data set.

Table 11

Non-Independent Licensed Practitioners Summary				
	BCBS	**MHC**	**PHP**	**UHC**
Exclusions				
Number of Provider Additions	2,021	309	82	46
Provider Type Not Equal to 432	0	0	0	1
Blank Practitioner Data	0	0	0	8
Not in Approved Behavioral Health Agency List	0	10	0	0
Agency Request Date Outside Review Period	0	0	1	0
Agency Request Date After System Add Date	1,743	1	0	5
Adjusted Number of Provider Additions	278	298	81	32
Adjusted Number of Unique Provider Additions	48	296	74	32

Based on the adjusted number of unique provider additions above, the turnaround time for adding non-independent licensed practitioners to the behavioral health agency rosters (provider type 432) was calculated and tested using the following data elements:

- Agency request add date
- Date the non-independent licensed practitioner was effective in the claims system to bill for services

To calculate the turnaround time for each practitioner, the minimum agency request add date and the maximum date the non-independent licensed practitioner was effective in the claims system to bill for services were used for turnaround time calculations.

Table 12

Non-Independent Licensed Practitioners				
	BCBS	**MHC**	**PHP**	**UHC**
Turnaround Time				
Number of Provider Additions	48	296	74	32
Average Turnaround Time (in days)	139	141	25	68
Turnaround Time Range (in days)	11 to 344	1 to 477	0 to 168	29 to 161

Average calculated turnaround times for the roster additions were forwarded to MHC, PHP, and UHC for their review. An additional request was made for each MCO to include an explanation of the MCO's process for adding practitioners to the agency roster, clarifying if there is an internal timeframe the MCO follows for adding practitioners to the roster, and confirming if the average calculated turnaround time appeared reasonable based on the MCO's system. The request was not forwarded to BCBS since BCBS explained in a webinar conference held on October 23, 2018 that its system is incapable of pulling the requested information in a reasonable timeframe. The webinar conference explanation from BCBS and the follow up request explanations from MHC, PHP, and UHC are summarized and outlined below.

- BCBS – It is a manual time-consuming process to track individual providers. When a roster is resubmitted, the system includes the group roster request and add dates for every practitioner included under that group instead of tracking the dates for each individual practitioner. The system has been updated over the years to solve this problem, but not for the time period under review. BCBS's system has difficulties tracking the individual practitioner dates since it is common for practitioners to move from group to group. It would take several weeks to get the original request date for the individual practitioner.
- MHC – While there is no contractual timeframe for roster providers to be added, MHC strives to follow similar timeframes as the credentialing process of 45 days. In late 2016 to August 2017, MHC implemented new standards and processes for configuring providers into the claims system. Along with revising these processes, MHC attempted to implement a new workflow system called UPIM (Unified Provider Information Management). After numerous months of configuring UPIM's application, it was determined the system was not sufficient to meet MHC's standards. The implementation of this project caused MHC to have a significant backlog of providers. The backlog created lengthy delays to provider additions beyond the preferred standard of 45 days. Additional resources were hired and the backlog inventory was cleared to the 45 day timeline by the beginning of 2018. Because of this, the turnaround time for adding providers to the agency rosters was longer than the 45 day preferred timeframe.
- PHP –The average calculated turnaround time for PHP was within a 45 day period, consistent with requirements for credentialing. No further request was made.
- UHC – Provider additions to the agency rosters are made as soon as possible upon receipt of a clean roster. UHC confirmed that the average calculated turnaround time

appeared correct based on its system data. The additional steps required to complete provider additions to the agency roster such as coordinating an onsite visit, primary source verification, etc. extend the timeframe for provider additions.

Based on responses above, the calculated turnaround times for the MCOs correlate with the MCO's system processes and issues.

Addition of Practitioners Related to Behavioral Health Specialties to Agency Rosters

The MCOs were requested to submit all provider additions to agency rosters related to behavioral health specialized services approved and added to the system during January 1, 2017 through December 31, 2017. The specialized behavioral health services were identified based on the following provider types as outlined in New Mexico Medical Assistance Program Manual Supplemental 15-01:

- 343 – Methadone Clinic
- 432 – Behavioral Health Agency
- 433 – Community Mental Health Clinic
- 446 – Core Service Agency

The submitted rostering data sets were compared to the Bils4Nils data sets submitted by the MCOs. After review, it was determined that all the practitioners included in the Bils4Nils data sets were also included in the rostering data sets for BCBS, MHC, and PHP. A follow up request was made to UHC to inquire why the rostering data set did not include all of the Bils4Nils provider additions, consistent with what was seen for the other MCOs. In response to the request, UHC stated that provider type 432 with additional specialties was not included in the original submission since they were outside the universe criteria of provider type. Based on the follow up, UHC submitted a revised data set, tested below. Since non-independent licensed practitioners are tested separately from rostering for behavioral health specialties, Bils4Nils practitioners included in the rostering data set were excluded from the rostering analysis below.

The total number of non-independent licensed practitioners in *Table 13* that were included in the Bils4Nils data set do not agree with to the number related to additions of non-independent licensed practitioners to agency rosters in *Table 11*. No explanation was provided by the MCOs for the small discrepancy in counts between the rostering data sets. Any practitioners in the provider rostering data set related to behavioral health specialties that were not included in the Bils4Nils data set and had provider type 432 included were tested in the practitioners related to behavioral health specialties turnaround time analysis.

The table below summarizes the provider data sets submitted by the MCOs and identifies the data excluded from the rostering analysis and review. The MCO responses related to instances where non-independent licensed practitioners added to agency rosters were included more than once in the submitted rostering data set outlined above, apply to the provider additions for behavioral health specialties summary as well.

Table 13

Practitioners Related to Behavioral Health Specialties Summary				
	BCBS	**MHC**	**PHP**	**UHC**
Exclusions				
Number of Provider Additions	16,777	735	876	37
Blank Practitioner Data	0	0	0	2
Included in Bils4Nils Data Set	2,131	313	89	13
Agency Request Date Outside Review Period	9	0	35	0
Agency Request Date After System Add Date	13,320	0	0	0
Adjusted Number of Provider Additions	1,317	422	752	22
Adjusted Number of Unique Provider Additions	173	348	616	22

Based on the adjusted number of unique provider additions above, the turnaround time for provider additions to agency rosters related to behavioral health specialized services was calculated and tested using the following data elements:

- Agency request add date
- Date the provider was effective in the claims system

To calculate the turnaround time for each practitioner, the minimum agency request add date and the maximum date the provider was effective in the claims system were used for turnaround time calculations.

Table 14

Practitioners Related to Behavioral Health Specialties				
	BCBS	**MHC**	**PHP**	**UHC**
Turnaround Time				
Number of Provider Additions	173	348	616	22
Average Turnaround Time (in days)	132	125	19	127
Turnaround Time Range (in days)	0 to 340	0 to 470	0 to 270	54 to 435

The MCO responses related to the policies and turnaround times for the addition of non-independent licensed practitioners to agency rosters outlined above, apply to the provider additions for behavioral health specialties turnaround times above as well.

Claims Sample Selection

A random sample of 75 behavioral health claims and a random sample of 25 FQHC behavioral health combined member claims with a single date of service were selected for each MCO. The FQHC sample was limited to revenue code 919 to test whether FQHC behavioral health claims

were being paid when a physical health encounter occurred on the same day. The behavioral health sample was selected based on claim number while the FQHC sample was selected based on member date of service and Medicaid member number. The combined claim methodology for the FQHC sample was utilized to test compliance with Medical Assistance Program Manual Supplement 16-13, which states that no more than one encounter rate should be paid per day unless the recipient went to the FQHC more than once in a day with a different diagnosis or had two distinct types of visits. Based on MCO responses, it was determined that separate encounters were not always billed on the same claim. Therefore, one FQHC combined claim in the sample selection contains all claims for a Medicaid member number for a specific date of service.

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:

- Provider credentialing
    - The date on the provider's credentialing application form
    - The date the provider was loaded and effective in the system
- 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 (Fee schedule, encounter rate)

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. The table below reflects the testing results.

Table 15

Credentialing Errors				
	BCBS	**MHC**	**PHP**	**UHC**
Behavioral Health Sample				
Total Billing Provider Credentialing Errors	45	12	33	21
Exceeds Contract Requirements	10	3	18	2
Missing or Incorrect Documentation	35	9	15	19
Total Servicing Provider Credentialing Errors	45	12	33	29
Exceeds Contract Requirements	10	3	8	0
Missing or Incorrect Documentation	35	9	25	29
FQHC Sample				
Total Billing Provider Credentialing Errors	25	20	0	0
Exceeds Contract Requirements	0	0	0	0
Missing or Incorrect Documentation	25	20	0	0
Total Servicing Provider Credentialing Errors	25	20	0	0
Exceeds Contract Requirements	0	0	0	0
Missing or Incorrect Documentation	25	20	0	0

Credentialing missing documentation errors were noted when reviewing the MCO-submitted credentialing date information for the following reasons:

- No consistent methodology was noted for all four MCOs regarding credentialing groups compared to individual practitioners.
    - BCBS – does not credential groups, but instead credentials individual practitioners resulting in missing documentation for group claims.
    - MHC – does not credential groups, but instead credentials individual practitioners resulting in missing documentation for group claims.
    - PHP – does not credential individual practitioners, but instead credentials groups resulting in missing documentation for individual practitioner claims
    - UHC – did not provide a clarification stating that the MCO only credentials groups or individual practitioners

- Delegates are not credentialed by the MCO; therefore, no credentialing dates are available. The Medicaid Managed Care Services Agreement (contract) directs the MCOs to have policies and procedures to ensure that delegated entities meet all standards of performance mandated for the Centennial Care program and implement the policies and procedures for the oversight of the performance of the subcontracted functions. MHC and UHC both listed "Delegate" for several providers in the requested credentialing date fields. No information was provided by the MCOs with relation to the delegated services.
- Information not available in the MCO's system. All four MCOs noted issues with extracting data from their systems for some of the credentialing providers included in the BH and FQHC samples.

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. The table below reflects the testing results.

Table 16

Contract Loading Errors				
	BCBS	**MHC**	**PHP**	**UHC**
Behavioral Health Sample				
Total Contract Loading Errors	58	11	57	71
Exceeds Contract Requirements	42	11	37	0
Missing or Incorrect Documentation	16	0	20	71
FQHC Sample				
Total Contract Loading Errors	24	1	19	25
Exceeds Contract Requirements	15	1	19	0
Missing or Incorrect Documentation	9	0	0	25

Contract loading errors were noted when reviewing the MCO-submitted contract loading date information for the following reasons:

- Date the contract was loaded into the system was reflected as January 1, 2014, the effective date for the Centennial Care program, resulting in large turnaround times for participating providers contracted in the previous Salud program. All four MCOs had several contract loading dates reflected as January 1, 2014 in the BH and FQHC samples.

- Date of the provider's request to add the contract is not available in the MCO's system for participating providers contracted in the previous Salud program. This was the explanation received by UHC for the high volume of missing or incorrect documentation errors related to contract loading noted in the BH and FQHC samples.

In addition, contract requirement 4.8.14.1.13 became effective July 1, 2016, which is subsequent to several of the contract loading dates provided by the MCOs.

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:

- Allowed Encounter Units/Units
- Contract, Fee Schedule, or Encounter Rate
- Gross Receipts Tax
- Interest
- Recalculated Payment Formulas

Allowed Encounter Units/Units

Because behavioral health claims and FQHC combined member claims are outpatient services which have a single date of service, allowed encounter units/units were utilized in the sample payment calculations to test proper payment. Detail of how the allowed encounter units/units are incorporated in the recalculation of the payment amount is further outlined in the section below.

Contract, Fee Schedule, or Encounter Rate

As stated above, applicable fee schedules and provider contracts were requested for each claim in the behavioral health sample and each encounter in the FQHC sample. 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 dates of service associated with the sample claim or encounter
- The provider reflected in the sample support matched the sample claim or encounter provider

Servicing provider NPI was used to match documentation between claims data and supporting documentation. If servicing provider NPI was not included in the provided documentation, provider name was used for matching purposes.

- BCBS, MHC, and PHP: Sufficient documentation was provided by BCBS, MHC, and PHP to support the rates used for payment calculations. No missing documentation errors were noted for these MCOs.
- UHC: UHC's process for establishing a contract with a behavioral health provider for Centennial Care is based on the fee schedule given to the provider at the time of the contract. There is no language in the provider contract that states the provider should be paid a certain percentage of the standard Medicaid fee schedule. If a provider is paid at a percentage higher than the standard Medicaid fee schedule rate, UHC's fee schedule will have the negotiated percentage incorporated into it. However, there is no contract language to support these non-standard rates. Due to a lack of contract language supporting a specific reimbursement rate, it was requested the MCO submit system screenshots to support any claims or encounters paid at a rate higher than the state fee schedule rate and the contract amendments for Centennial Care as documentation to support payment.

  There were instances for UHC where the payment appendix or the appropriate provider amendment were not provided to support the payment. The supported rate utilized in recalculating the payment for sample claims and encounters was calculated at 95% of the state Medicaid fee schedule, similar to a non-participating provider, for sample claims and encounters deemed missing documentation errors. There were five claims in the BH sample that had missing documentation; however, only four were identified as mispayments in *Table 18* for UHC. The claim not included in *Table 18* recalculated correctly using 95% of the state Medicaid fee schedule rate. Therefore, it was not classified as a mispayment.

  A narrative was provided by UHC to support that behavioral health providers are paid in accordance with the fee-for-service schedule set forth by HSD. A comparison of the fee schedules provided by UHC and HSD was performed to determine if UHC's fee schedules were in alignment with the schedules set forth by HSD. Exceptions were noted and a follow up request was sent to the MCO. Explanations received for the exceptions fell into two categories:

  1) the UHC fee schedule did not map correctly and should have paid the state Medicaid fee schedule rate, or
  2) the provider was paid based on the medical agreement for the hospital.

  UHC fee schedules were utilized for sample payment recalculations, with the exception for claims or encounters where the UHC fee schedule did not map correctly and the state Medicaid fee schedule rate should have been used, as stated by UHC. In these instances, the state Medicaid fee schedule rate was used for payment recalculations.

Gross Receipts Tax (GRT)

GRT is specific to New Mexico Medicaid and the MCOs are reimbursing it to for-profit New Mexico providers 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. Since FQHCs are required to be not-for-profit or public entities, GRT would not apply for FQHC reimbursement.

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 sample claims data was inclusive of any applicable interest amounts in the claims data submission in order to recalculate proper payment. For BCBS and MHC, the interest is excluded from the paid amount and reimbursed to the facility separately. However, for UHC and PHP 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 17

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

Methodology of Payment Recalculation – Behavioral Health

The GRT amount provided by the MCO was utilized in the repayment calculation for behavioral health sample claims. For instances in which the MCO did not provide the GRT amount, the GRT rate was based on the tax rate for the applicable county. Payments were limited to the lesser of the provider's billed charges or the fee schedule as directed in the contract support. Payment recalculations were based on the state standard Medicaid fee schedules for BCBS, MHC, and PHP. Due to the contracting process for UHC explained above, UHC fee schedules were used for payment recalculations. The following formula was used when recalculating the sample payment amounts for BH sample claims:

- ***Behavioral Health Fee Schedule Payments*** = ((Supported Fee Schedule Rate + GRT Amount Reported by the MCO) * Units)

Within the BH samples were claims where Medicaid was the secondary payer on the claim. The lesser of logic is applicable for BH claims to ensure Medicaid is the payer of last resort as it relates to third-party liability coverage. The lesser of logic is from HSD instructions on crossover claims, dated March 17, 2016, and is as follows:

- ***Allowed Charge*** = Medicare Coinsurance Amount + Medicare Deductible
- ***New Calculation*** = MCO's Calculated Allowed Charge – Medicare Paid Amount
    - MCO's Calculated Allowed Charge is the Medicaid allowed amount
    - When the New Calculation is less than the Allowed Charge, it is used as the MCO's allowed amount

In instances where the Allowed Charge was less than the New Calculation, the recalculated sample payment was made equal to the Allowed Charge, consistent with lesser of logic methodology outlined above. In instances where the New Calculation was less than the Allowed Charge, the sample payment was recalculated using the New Calculation, which correlates with the Behavioral Health Fee Schedule Payments formula above.

Methodology of Payment Recalculation – FQHC

Payments were limited to the lesser of the provider's billed charges or the fee schedule for FQHC services paid outside of the encounter rate based on the state standard Medicaid fee schedule. FQHC encounter rate payments were not limited to billing charges based on guidance from the State of New Mexico Medical Assistance Program Supplement 16-13. Payment recalculations were based on the FQHC encounter rate listing provided by HSD for samples paid the encounter rate and the state standard Medicaid fee schedules for samples paid outside of the encounter rate. The following formulas were used when recalculating the sample payment amounts for FQHC sample encounters:

- ***FQHC Encounter Rate Payments*** = (Supported FQHC Encounter Rate * Allowed Encounter Units)

Reference *Table 18* and *Table 19* for BH and FQHC testing results and *Appendix B* for a summary of the number of (over)/underpayments noted during testing and the distribution of the dollar amounts.

Sample Testing Results

The tables below outline the results of the sample claims and encounters testing performed as described above.

Table 18

Behavioral Health Sample Testing Results								
	BCBS		**MHC**		**PHP**		**UHC**	
Total Number of Sampled Claims	75		75		75		75	
Total Sample Payments	$30,598.78		$17,789.52		$32,164.87		$19,055.85	
	Value	**Error Rate**	**Value**	**Error Rate**	**Value**	**Error Rate**	**Value**	**Error Rate**
All Claims <> $0 Variance								
Total Mispayments	11	14.67%	4	5.33%	0	0.00%	11	14.67%
Total Mispayments - Dollar Value	($781.50)	-2.55%	$20.89	0.12%	$0.00	0.00%	($290.99)	-1.53%
Overpayment Range	$13.33 to $274.32		$2.42 to $4.60		No Range		$0.47 to $179.61	
Underpayment Range	$0.25 to $180.00		$8.66 to $19.25		No Range		$22.47 to $46.58	

Value: *Number of claims with an error*
Error Rate: *Value / Total Number of Sampled Claims*

Table 19

FQHC Sample Testing Results								
	BCBS		**MHC**		**PHP**		**UHC**	
Total Number of Sampled Encounters	25		25		25		25	
Total Sample Payments	$4,880.07		$4,808.74		$3,287.80		$4,174.85	
	Value	**Error Rate**	**Value**	**Error Rate**	**Value**	**Error Rate**	**Value**	**Error Rate**
All Claims <> $0 Variance								
Total Mispayments	2	8.00%	2	8.00%	0	0.00%	4	16.00%
Total Mispayments - Dollar Value	($375.43)	-7.69%	($324.22)	-6.74%	$0.00	0.00%	$144.50	3.46%
Overpayment Range	$161.83 to $213.60		$161.83 to $162.39		No Range		$72.16	
Underpayment Range	No Range		No Range		No Range		$1.95 to $107.89	

Value: *Number of encounters with an error*
Error Rate: *Value / Total Number of Sampled Encounters*

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**
Policies and Procedures	**Non-Independent Licensed Practitioners** MCO contracts do not contain any requirements specifically related to the turnaround time for adding non-independent licensed practitioners to the behavioral health agency rosters.	HSD should consider including a provision in the contract which would require non-independent licensed practitioners to be added to the behavioral health agency rosters within 45 days from the agency request date, similar to the guidelines outlined by HSD for credentialing. In addition, HSD should require the MCOs to submit written policies and procedures that outline how the 45 day contract provision is being met in their standard procedures and how the MCO system was updated to accurately capture the non-independent licensed practitioner rostering information.
Policies and Procedures	**Rostering for Behavioral Health Specialized Services** MCO contracts do not contain any requirements specifically related to the turnaround time for provider additions to agency rosters related to behavioral health specialized services.	HSD should consider including a provision in the contract which would require practitioners to be added to the agency rosters related to behavioral health specialized services within 45 days from the agency request date, similar to the guidelines outlined by HSD for credentialing. In addition, HSD should require the MCOs to submit written policies and procedures that outline how the 45 day contract provision is being met in their standard procedures and how the MCO system was updated to accurately capture the rostering for behavioral health specialized services information.
Analytical Procedures	**Medication Monitoring** The State of New Mexico Medical Assistance Program Manual Supplement 16-11 states that the rendering provider name and NPI are not a requirement for billing for medication monitoring when the service is provided by an RN. The agency NPI, therefore, can be placed in the rendering field.	HSD should consider issuing additional guidance to require the MCOs to capture the rendering provider information related to medication monitoring billing to confirm and monitor that only registered nurses with either behavioral health experience or a psychiatric-mental health nursing certification, certified nurse specialists in psychiatry, certified psychiatric nurse practitioners, and physician assistants are reimbursed for this service.

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	**Partially Denied FQHC Claims** HSD and MCO billing guidance for FQHCs do not explicitly state how multiple FQHC encounters on the same dates of service are to be billed and reported, resulting in some MCOs recognizing all encounters for the same dates of service as one claim while other MCOs treat each encounter as a separate claim. Additionally, some MCOs are reporting claim lines as both paid and denied on claims paid at the encounter rate, even though all billed claim service lines are included in the total paid encounter rate, while other MCOs report all claims lines in this instance as paid.	HSD should provide additional guidance to FQHC providers and MCOs related to billing and reporting FQHC encounters in a consistent manner, including claim line paid and denied status to allow for consistent reporting and monitoring of reimbursement.
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 and HSD supplemental guidance related to the findings below and ensure recommendations are incorporated into each MCO's operations for proper oversight of behavioral health and FQHC claims under Centennial Care.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Policies and Procedures	**Provider Credentialing and Claims System Loading: Contract 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. **The MCO Submitted Policies:** (1) 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:** This provision does not appear to cover nonstandard contracts.	The MCO should update its documented policies and procedures to state that the contract requirement of completing the credentialing process within 45 days applies to providers for both standard and non-standard contracts.
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 Policies:** (1) 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:	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.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
	Forty-five days from corporate received date to completion of system maintenance. Note: Contract negotiations for non-standard contracts are an exception. (2) Non-standard contracts can take months to negotiate so, there is not a standard process for contracting loading due to variance of negotiation timeframes. **Non-Compliance:** Provider network values being loaded within 45 days may not include all provider 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 does not appear to cover nonstandard contracts either.	
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6.1** The MCO does not meet the following requirements for Indian Health Service (IHS) providers for behavioral health claims: 95% of claims be adjudicated within 15 days 99% of claims be adjudicated within 30 days Of 3,834 IHS behavioral health claims, there are 320 claims with a turnaround time exceeding 15 days and 229 claims with a turnaround time exceeding 30 days. Additionally, overall only 91.65% of behavioral health claims were adjudicated within 15 days and 94.03% 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	**Turnaround Time Contract Section 4.19.1.6.2** The MCO does not meet the following requirements for non-Indian Health Service (non-IHS) providers for both behavioral health claims and FQHC claims: 90% of claims be adjudicated within 30 days 99% of claims be adjudicated within 90 days Of 316,294 non-IHS behavioral health claims, there are 31,423 claims with a turnaround time exceeding 30 days and 13,858 claims with a	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 – BCBS		
Testing Area	**Finding**	**Recommendation**
	turnaround time exceeding 90 days. Of 125,297 non-IHS FQHC claims, there are 14,782 claims with a turnaround time exceeding 30 days and 3,596 claims with a turnaround time exceeding 90 days. Additionally, overall only 95.62% of behavioral health claims were adjudicated within 90 days of receipt. Overall only 88.20% of FQHC claims were adjudicated within 30 days and 97.13% within 90 days of receipt.	
Analytical Procedures	**Denial Codes** In some instances, the MCO included several denial codes on one claim line, preventing an accurate allocation of the related billing charges to a specific denial code and preventing identification of the primary denial code used for the claim denial.	The MCO should take steps to update the process of capturing denial information in the MCO's system to properly identify the primary denial code and denial reason used to support the claim denial. Denial codes on the remittance advice are imperative to communicate with providers and allow them to correct and resubmit denied claims for the denial reason noted on the original claim.
Analytical Procedures	**Medication Monitoring Payment Testing** Of 1,721 paid claim lines with HCPCS H2010 included on the line for calendar year 2017, 42.30% did not pay the proper rate of $30.00.	The MCO should determine the cause of the incorrect payments noted for 42.30% of the 1,721 paid claim lines with HCPCS H2010 included on the line and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Analytical Procedures	**Procedure Code Modifiers** A large portion of the claims population submitted was missing procedure code modifiers, even in instances where a procedure code modifier is necessary for proper payment.	The MCO should enhance the data stored in its claims system to include all procedure code modifiers included on the claim as identified in the explanation of payment so the information can be extracted and reviewed to determine proper payment and enable data analysis.
Analytical Procedures	**Non-Independent Licensed Practitioners & Rostering for Behavioral Health Specialized Services** The MCO's system does not accurately capture rostering information for individual practitioners. When a roster update is submitted, the MCO adds the group roster dates in the provider request date and system add date fields to each individual practitioner in the group. The system therefore does not enable accurate reporting of rostering turnaround times for non-independent licensed practitioners and provider additions related to behavioral health specialized services.	The MCO should update its provider network system to capture the individual practitioner request date to be added to the agency roster and the effective date of the provider for that agency in the claims system to accurately report the turnaround times for adding individual practitioners to the agency rosters.

Summary of Findings and Recommendations – BCBS		
Testing Area	**Finding**	**Recommendation**
Claims Testing	**Provider Credentialing Data** Provider credentialing dates are missing for 35 behavioral health sample claims and 25 FQHC sample claims. Missing credentialing dates are primarily due to the MCO only credentialing individual practitioners, not groups or facilities. Ten behavioral health sample 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 and should update its credentialing processes to capture credentialing data for groups and facilities to test compliance with contract requirements. Additionally, the MCO should determine the cause for non-compliance related to the 10 providers in the behavioral health sample and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** Sixteen behavioral health sample claims and nine FQHC sample claims had contract load dates prior to the request to load the contracts. Forty-two behavioral health sample claims and 15 FQHC sample claims related to contracts which were not 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 42 contracts in the behavioral health sample and the 15 contracts in the FQHC sample to determine whether it is a systemic issue. It should implement steps to ensure timely contract loading for all providers.
Claims Testing	**Payment Recalculation - Behavioral Health** Payment errors were noted in 11 of the 75 behavioral health 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	**Payment Recalculation - FQHC** Payment errors were noted in two of the 25 FQHC 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.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Analytical Procedures	**Medication Monitoring Payment Testing** Of 3,050 paid claim lines with HCPCS H2010 included on the line for calendar year 2017, 44.03% did not pay the proper rate of $30.00.	The MCO should determine the cause of the incorrect payments noted for 44.03% of the 3,050 paid claim lines with HCPCS H2010 included on the line and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Analytical Procedures	**Non-Independent Licensed Practitioners & Rostering for Behavioral Health Specialized Services** The average calculated turnaround time for adding non-independent licensed practitioners to the behavioral health agency rosters is 141 days. The average calculated turnaround time for provider additions to agency rosters related to behavioral health specialized services is 125 days.	The MCO should strive to update the provider network system to add non-independent licensed practitioners and practitioners related to behavioral health specialized services to the agency rosters in a timeframe consistent with the credentialing timeframe of 45 days. In addition, the MCO should submit written policies and procedures to HSD that outline the rostering process and the timeframe for adding practitioners to the agency rosters.
Claims Testing	**Provider Credentialing Data** Provider credentialing dates are missing for nine behavioral health sample claims and 20 FQHC sample claims. Missing credentialing dates are primarily due to the MCO only credentialing individual practitioners, not groups or facilities. Three behavioral health sample 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 and should update its credentialing processes to capture credentialing data for groups and facilities to test compliance with contract requirements. Additionally, the MCO should determine the cause for non-compliance related to the three providers in the behavioral health sample and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** Eleven behavioral health sample claims and one FQHC sample claim related to contracts which were not 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 11 contracts in the behavioral health sample and the one contract in the FQHC sample to determine whether it is a systemic issue. It should implement steps to ensure timely contract loading for all providers.
Claims Testing	**Payment Recalculation - Behavioral Health** Payment errors were noted in four of the 75 behavioral health 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.

Summary of Findings and Recommendations – MHC		
Testing Area	**Finding**	**Recommendation**
Claims Testing	**Payment Recalculation - FQHC** Payment errors were noted in two of the 25 FQHC 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.

Summary of Findings and Recommendations – PHP		
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 Policies:** (1) Magellan Healthcare Policy - Quality monitoring staff conducts ongoing audits aggregated monthly to ensure a new contract is signed by the provider before entering rates into the system and other relevant contractual requirements are met. (2) Presbyterian Health Plan Policy - Affiliation: activation no later than 45 calendar days once a provider has been credentialed, if required. **Non-Compliance:** Submitted policy for Magellan Healthcare, a subcontractor for the MCO, speaks to the overall business process. Policy is not specific to New Mexico behavioral health providers. While the Presbyterian Health Plan policy references a 45 day timeframe for affiliation, it does not specifically reference contract loading.	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 limiting the policy language to provider affiliation. In addition, the MCO should require its subcontractor to update its documented policies and procedures to include contract loading requirements outlined above for New Mexico.
Analytical Procedures	**Federally Qualified Health Center (FQHC) Claims Data** The MCO only submitted behavioral health FQHC claims in the claims population submitted. In addition, the FQHC claims data often had minimal procedure code, revenue code, and adjudication date information included on the claim, limiting the analysis that could be performed based on these fields. For FQHC claims, the MCO's system collapses claim numbers into one line, resulting in a loss of line level detail for the claim.	The MCO should update its claims system to store FQHC claims data at line level and to capture all claims data included on the explanation of payment, including procedure code, revenue code, and adjudication date information. In addition, it should investigate the FQHC claims population for the period under review and provide an explanation to HSD for why there were not any non-behavioral health claims included in the claims population.
Analytical Procedures	**Medication Monitoring Payment Testing** Of 1,291 paid claim lines with HCPCS H2010 included on the line for calendar year 2017, 80.64% did not pay the proper rate of $30.00.	The MCO should determine the cause of the incorrect payments noted for 80.64% of the 1,291 paid claim lines with HCPCS H2010 included on the line and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.

Summary of Findings and Recommendations – PHP		
Testing Area	**Finding**	**Recommendation**
Claims Testing	**Provider Credentialing Data** Provider credentialing dates are missing for 15 billing providers and 25 servicing providers included on behavioral health sample claims. Missing credentialing dates are primarily due to the MCO only credentialing groups and facilities, not individual practitioners. Eighteen billing providers and eight servicing providers included on behavioral health sample claims are 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 and should update its credentialing processes to capture credentialing data for individual practitioners to test compliance with contract requirements. Additionally, the MCO should determine the cause for non-compliance related to the 18 billing providers and eight servicing providers in the behavioral health sample and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** Twenty behavioral health sample claims had missing contract load request dates or had contract load dates prior to the request to load the contracts. Thirty-seven behavioral health sample claims and 19 FQHC sample claims related to contracts which were not 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 37 contracts in the behavioral health sample and the 19 contracts in the FQHC sample to determine whether it is a systemic issue. It should implement steps to ensure timely contract loading for all providers.

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6.1** The MCO does not meet the following requirements for Indian Health Service (IHS) providers for behavioral health claims: 95% of claims be adjudicated within 15 days 99% of claims be adjudicated within 30 days Of 3,997 IHS behavioral health claims, there are 1,197 claims with a turnaround time exceeding 15 days and 994 claims with a	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 – UHC		
Testing Area	**Finding**	**Recommendation**
	turnaround time exceeding 30 days. Additionally, overall only 70.05% of behavioral health claims were adjudicated within 15 days and 75.13% within 30 days of receipt.	
Analytical Procedures	**Turnaround Time Contract Section 4.19.1.6.2** The MCO does not meet the following requirements for non-Indian Health Service (non-IHS) providers for both behavioral health claims and FQHC claims: 90% of claims be adjudicated within 30 days 99% of claims be adjudicated within 90 days Of 256,402 non-IHS behavioral health claims, there are 74,177 claims with a turnaround time exceeding 30 days and 30,324 claims with a turnaround time exceeding 90 days. Of 87,666 non-IHS FQHC claims, there are 22,733 claims with a turnaround time exceeding 30 days and 13,214 claims with a turnaround time exceeding 90 days. Additionally, overall only 71.07% of behavioral health claims were adjudicated within 30 days and 88.17% within 90 days of receipt. Overall only 74.07% of FQHC claims were adjudicated within 30 days and 84.93% within 90 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	**Medication Monitoring Payment Testing** Of 2,524 paid claim lines with HCPCS H2010 included on the line for calendar year 2017, 1.70% did not pay the proper rate of $30.00.	The MCO should determine the cause of the incorrect payments noted for 1.70% of the 2,524 paid claim lines with HCPCS H2010 included on the line and determine whether it is a systemic issue. Claims with errors should be reprocessed for accurate payment.
Analytical Procedures	**Non-Independent Licensed Practitioners & Rostering for Behavioral Health Specialized Services** The average calculated turnaround time for adding non-independent licensed practitioners to the behavioral health agency rosters is 68 days. The average calculated turnaround time for provider additions to agency rosters related to behavioral health specialized services is 127 days.	The MCO should strive to update the provider network system to add non-independent licensed practitioners and practitioners related to behavioral health specialized services to the agency rosters in a timeframe consistent with the credentialing timeframe of 45 days. In addition, the MCO should submit written policies and procedures to HSD that outline the rostering process and the timeframe for adding practitioners to the agency rosters.
Claims Testing	**Provider Credentialing Data** Provider credentialing dates are missing for 19 billing providers and 29 servicing providers included on behavioral health sample claims. Two billing providers included on behavioral	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 2 billing providers in

Summary of Findings and Recommendations – UHC		
Testing Area	**Finding**	**Recommendation**
	health sample claims are providers the MCO did not credential within the 45 day contract credentialing requirements.	the behavioral health sample and determine whether it is a systemic issue. It should implement steps to ensure timely credentialing of all providers.
Claims Testing	**Contract Loading Data** Seventy-one behavioral health sample claims and all 25 FQHC sample claims had missing contract load request dates.	The MCO should take steps to improve the quality and completeness of contract loading data retained in the MCO's system. It should implement steps to ensure timely contract loading for all providers.
Claims Testing	**Payment Recalculation - Behavioral Health** Payment errors were noted in 11 of the 75 behavioral health 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	**Payment Recalculation - FQHC** Payment errors were noted in four of the 25 FQHC 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	**Documentation Support** The MCO did not provide the relevant payment appendix, contract, or fee schedule support for five behavioral health 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 fee schedules 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.
Claims Testing	**Provider Contract Process** The MCO's process for establishing a contract with a provider for Centennial Care is based on the fee schedule given to the provider at the time of the contract which is not a part of the contract. There is no language in the provider contract that states the provider should be paid a certain percentage of the standard Medicaid fee schedule. If a provider is paid at a percentage higher than the standard Medicaid fee schedule rate, the MCO fee schedule will have the negotiated percentage incorporated into it. However, there is no contract language to support the rates paid. In addition, the MCO's fee schedules do not always align with the HSD standard Medicaid fee schedule rates, even though the MCO stated that the fee schedules given to providers are based on the HSD standard Medicaid fee schedule rates.	The MCO should strive to standardize the provider contract process by including language in the provider contracts that specifically outlines what percentage of the current HSD standard Medicaid fee schedule rates will be used for reimbursement to eliminate any ambiguity in expected payment between the MCO and the provider. Transparent reimbursement guidelines in the provider contract are imperative to communicate the expected payment for behavioral health services and to ensure proper payment.

Appendix A - MCO Policies and Procedures (BCBS)	
Policy Area	**Policies and Explanations**
Contract 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.	Provider network values will be loaded on or before the 45th day of the completed credentialing CAQH application. The New Mexico Network Services Department will complete provider interest form review, initiate standard contracting process, initiate the credentialing process, and load provider network values within the following time frame: • Forty-five (45) days from corporate received date to completion of system maintenance. • Note: Contract negotiations for non-standard contracts are an exception. Non-standard contracts can take months to negotiate so, there is not a standard process for contracting loading due to variance of negotiation timeframes. Non-standard contracts are documented as an exception in the attached timeliness policy. “NM NSD_023 NSD Inventory Timeliness Standards 03.01.2018-signed.pdf”
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.	Provider network values will be loaded on or before the 45th day of the completed credentialing CAQH application. The New Mexico Network Services Department will complete provider interest form review, initiate standard contracting process, initiate the credentialing process, and load provider network values within the following time frame: • Forty-five (45) days from corporate received date to completion of system maintenance. • Note: Contract negotiations for non-standard contracts are an exception. Non-standard contracts can take months to negotiate so, there is not a standard process for contracting loading due to variance of negotiation timeframes. Non-standard contracts are documented as an exception in the attached timeliness policy. “NM NSD_023 NSD Inventory Timeliness Standards 03.01.2018-signed.pdf”
LOD #43 – Billing for Non-independent licensed practitioners	Enroll as eligible Medicaid providers LMSWs, LPCs, LMHCs, Licensed Psychologist Associate, LPATs, LAMFTs and LADACs only if they are associated with the following Medicaid provider type agencies or facilities who bill for their services: Community Mental Health Centers; Core Service Agencies; Federally Qualified Health Centers; Indian Health Services; Tribal 638 Facilities; hospitals; and HSD designated Bil4Nils. Bil4Nils agencies can only use LADACs who have a master’s degree or above for professional services, whereas the other provider types can use LADACs with less than a master's degree. The following provider types can be used by behavioral health agencies to provide IOP services: LMSW, LMHC, LADAC, LSAA and Licensed Psychologist Associate;
Addition of New Specialty to provider Profile	Purpose: The purpose of this policy is to outline a process for provider roster submission and system maintenance. Policy Statement: Network Services Department (NSD) has agreed to roster Core Service Agencies (CSA), Bill4NILS, Applied Behavior Analysis (ABA) and supervisory protocol

Appendix A - MCO Policies and Procedures (BCBS)	
Policy Area	**Policies and Explanations**
	providers, per state directive. The roster submission includes but is not limited to; address changes, provider networks, pricing linking, provider additions and/or terminations. This policy provides guidelines for roster submission from the providers identified below. Scope: • Applied Behavior Analysis (ABA) • Bill4NILS • Core Service Agencies (CSA) • Supervisory Protocol Providers <u>Process:</u> Roster submission: Provider roster submissions will be received by NM Network Services at the following email: Network Roster Submission/NM/HCSC and flows directly into SalesForce using OmniChannel for case creation. Roster Submission and Review: Within 7 days from receipt of roster, the representative assigned to the provider will review the case and complete the necessary research to identify any missing information, as applicable. Once research has been completed, the roster will be submitted to the assigned Provider Data Operations (PDO) Representative: • After review of the submitted roster, the Provider Services Rep creates a child case and attaches the roster with maintenance instructions and comments. • The child case is then submitted to the assigned PDO representative. • The Case Subject should follow the specific format: o Subject = Date Received: (Provider Name) Roster- Detailed Action ▪ Example: 12/14/17: La Clinica De Familia Roster – 5 Adds, 10 Terms • PDO will complete any maintenance changes and/or updates to PPW within 21 days of receipt of roster. • If PDO needs to request additional information or clarification on the BH roster, they will send the child case back to the Provider Services Rep. • The Provider Services Rep will complete the additional research or clarification within 2 days of receiving the request from PDO.

Appendix A - MCO Policies and Procedures (BCBS)	
Policy Area	**Policies and Explanations**
	• Once PDO has completed the maintenance of the BH roster, PDO will assign the case back to the Provider Service Rep and add comments that the roster has been completed. The Provider Services Rep is responsible for reviewing and verifying that the requested updates were completed within 2 business days of receiving the case assignment. Once completed, the Provider Services Rep will close out the case which will automatically generate a letter that is emailed to the provider, notifying them that the case has been completed. • Inventory reports are pulled regularly for teams. The inventory workgroup monitors inventory to prioritize and escalate to management, as needed. **PDO:** PREMIER Provider Web (PPW) maintenance is based on the information provided on the roster, the PDO roster reference guide, and departmental policies and procedures, as applicable. **Qualification:** Provider maintenance can also occur from claims data submitted by the provider. **Roster Monitoring:** Monitoring of provider rosters is the responsibility of the Provider Servicing team. **Provider Network Adds:** BH providers will be added with the MCE network code (Medicaid Exception) to include pricing until credentialing has been approved. The effective date of MCE will be based on the effective date provided on the roster. Once provider is fully credentialed, MCE will be end dated and the MCD (Medicaid) network code is activated. Exceptions to the Policy: • Management may allow additional days to complete maintenance in PPW, as approved and documented by management. • PDO may encounter system issues which can delay system maintenance within the specified timeframe and is considered an exception to the timeliness guidelines stated above. <u>Affected Units and Departments:</u> • Network Contracting • Provider Data Operations • Network Reimbursement Services • Services Delivery Operations • Network Reporting • Health Care Management • Membership

Appendix A - MCO Policies and Procedures (MHC)	
Policy Area	**Policies and Explanations**
Contract 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.	The credentialing process shall be completed within 45 days from receipt of completed application with all required documentation unless there are extenuating circumstances. Within forty-five (45) calendar days after receipt of a completed application and with all supporting documents, Molina shall assess and verify the practitioner's qualifications and notify the practitioner of its decision.
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.	Once the process is complete, Provider Network Administration CCRF System will notify Contract Specialist that QNXT contract is complete, tested, and ready for deployment within thirty (30) days of the executed contract. Configuration for payment is completed within 45 days upon completion of credentialing.
LOD #43 – Billing for Non-independent licensed practitioners	Human Services Division (HSD) implemented has implemented standard guidelines for adding a provider to a non-independent licensed practitioners in behavioral health agencies (provider type 432) and for specialize behavioral services for provider groups in one of the following agencies: 1. A Community mental health center (CMHC) 2. A Federally Qualified Health Center (FQHC); 3. An Indian Health Services (IHS) hospital and clinic; 4. A PL 93-638 tribally operated hospital and clinic; 5. The Children, Youth and Families Department (CYFD); 6. A hospital and its outpatient facility; or 7. A Core Service Agency (CSA). 1) Access the PNA department SharePoint where the cumulative list for Non-Independent licensed BH practitioners/providers and Bils4Nils is located. a) Is group TIN identified on the list? 1. Yes, go to step # 2 2. No, is a “Letter of Certification” from BHSD is attached? b) Yes, go to step # 2. Also, add Group TIN to SharePoint list for future reference. c) No, refer to job aid for process on adding new rendering providers that require credentialing. 2) Submit Provider Configuration Workflow Flow request to attach rendering provider to be affiliated to the Group with appropriate contracts for claims payment. Professional non-independently licensed clinicians (NILs) (that is, LMHC, LMSW, LAMFT, and LADAC) must bill with NPI without the use of U7 modifier. The services within their scope of practice are: • 90791 - psychiatric diagnostic evaluation • 90832, 90833,90834, 90836, 90837, 90838 – psychotherapy

Appendix A - MCO Policies and Procedures (MHC)	
Policy Area	**Policies and Explanations**
	• 90846, 90847, 90849, 90853 - family and group psychotherapy
Addition of New Specialty to provider Profile	Human Services Division (HSD) implemented has implemented standard guidelines for adding a provider to a non-independent licensed practitioners in behavioral health agencies (provider type 432) and for specialize behavioral services for provider groups in one of the following agencies: 1. A Community mental health center (CMHC) 2. A Federally Qualified Health Center (FQHC); 3. An Indian Health Services (IHS) hospital and clinic; 4. A PL 93-638 tribally operated hospital and clinic; 5. The Children, Youth and Families Department (CYFD); 6. A hospital and its outpatient facility; or 7. A Core Service Agency (CSA). 1) Access the PNA department SharePoint where the cumulative list for Non-Independent licensed BH practitioners/providers and Bils4Nils is located. a) Is group TIN identified on the list? 1. Yes, go to step # 2 2. No, is a “Letter of Certification” from BHSD is attached? b) Yes, go to step # 2. Also, add Group TIN to SharePoint list for future reference. c) No, refer to job aid for process on adding new rendering providers that require credentialing. 2) Submit Provider Configuration Workflow Flow request to attach rendering provider to be affiliated to the Group with appropriate contracts for claims payment.

Appendix A - MCO Policies and Procedures (PHP)	
Policy Area	**Policies and Explanations**
Contract 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.	The entire credentialing process, including all primary source documentation, must be completed within 45 days, which is calculated from the date a complete application is received to the date of approval by the committee.
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.	Magellan Healthcare Policy - Quality monitoring staff conducts ongoing audits aggregated monthly to ensure a new contract is signed by the provider before entering rates into the system and other relevant contractual requirements are met. Frequency: Monthly Presbyterian Health Plan Policy - Affiliation: activation no later than 45 calendar days once a provider has been credentialed, if required.
LOD #43 – Billing for Non-independent licensed practitioners	55 BHP - Behavioral Health Provider • LADC / LADAC • LMHC • LMSW & provisional LMSW • LPAT • LPC • LAMFT
Addition of New Specialty to provider Profile	Roster Staff Effective Dates: 1. If the facility has been activated within the year, use the effective date of the facility. 2. If not, use an effective date one year prior to the received date listed on the PHP Roster. NOTES: 1. Staff Rosters for UNM/PHS are emailed to the contract status check email box to be worked and uploaded to OnBase. 2. Tribal Providers – Will not be contracted or credentialed. The TIN owner is denoted in IPD with a '5Y' nuance code. 3. SBHC providers receive 120 days timely filing Enter license type and number in Screen 8 IPD. • Status = Roster Staff • Source = Internet • No Expiration Date • Note: Enter a license type of 'Not Licensed' for paraprofessionals. NOTE: If the license is not listed on the roster, go to the NM Website to obtain and load. http://verification.rld.state.nm.us/ and http://docfinder.docboard.org/nm/

Appendix A - MCO Policies and Procedures (PHP)	
Policy Area	**Policies and Explanations**
	ABA roster staff effective data: Use date listed on roster if provided. Otherwise, use the effective date of the Medicaid Number on SMO 567 Presbyterian meets regularly and as necessary to assess network criteria and alignment with network strategies. NCMs are responsible for administering criteria and determining network participation based on established criteria. In certain special circumstances, an NDT meeting may be requested and scheduled to consider participation or consider modifications/adjustments to criteria. The requests NCMs evaluate include but are not limited to requests by: 1. Healthcare practitioners or providers to participate in the network. 2. Healthcare practitioners or providers of a different specialty who seek to be added to an existing single-specialty contracted group or practice for which the existing single specialty contracted group or practice does not currently contract (i.e., converting the existing contract to a multi-specialty group) may be subject to NDT review. 3. Healthcare practitioners or providers who seek to be added to an existing multi-specialty contracted group/practice or Physician Hospital Organization with a specialty or service that is not currently present within the group (i.e., anesthesia assistants, PET scans, etc.). 4. Contracted Independent Physician Association/Health Service Organization or Physician Hospital Organizations that seek to add a new group/practice to their existing multi-specialty contract. 5. Healthcare practitioners or providers who seek to add an additional location, service and/or specialty outside of the service area as stated in the provider's Services Agreement Upon receipt of a Letter of Interest (LOI) and required supporting documents, the Contract Administrator (CA) forwards the request and all supporting documents to the NCM or a member of NDT for review and consideration. In addition, the CA verifies that supporting information is complete and meets the criteria for physical health, long-term care or behavioral health, as appropriate. Presbyterian applies a consistent process for reviewing and selecting practitioners and providers who request to join the network. This process begins when a practitioner or provider submits an LOI online via a secured website. The information collected with the application, including required documents as described below, is used to evaluate and select licensed practitioners to provide covered services to Presbyterian's members. Healthcare practitioners and providers are required to submit the following electronically, by fax or mail to begin the process: Behavioral Health: 1. LOI 2. W-9 3. CRS-1 form (if applicable)

Appendix A - MCO Policies and Procedures (PHP)	
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	4. Behavioral Health Level and Care and NIL eligibility review (Exhibit D and E) 5. Specialty certifications when appropriate (e.g., Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavior Therapy (DBT)) 6. OCID form 7. Curriculum Vitae (CVs)/Resumes 8. Attestation form 9. Practitioner and provider identifiers, including NPI number for billing, ordering or rendering providers 10. Approval letters from the HSD 11. To receive Medicaid reimbursement for behavioral health services, contractors must be both enrolled and certified with HSD. 12. When Adding additional services to a provider contract that require additional HSD approval or certification. Behavioral Health Criteria: 1. Core service agencies (CSAs). 2. Availability of the full array of covered services by contract. 3. Specialized or additional services offered by healthcare practitioner and provider (e.g.., Neuropsych testing, substance abuse 4. M.D. and APCs with or without prescriptive authority. 5. Ph.D. with or without prescriptive authority. Presbyterian reserves the right to make the final determination about which practitioners participate in its network(s) and considers many factors when assessing requests. NCM and/or NDT may recommend denial or deny based on factors that include but are not limited to the following: 1. Requests for participation in the network where an exclusive contract for services exists. 2. The lack of network need based on analysis and assessment. 3. The specialty requested is identified as a closed network. 4. Providers who do not have inpatient privileges at a Presbyterian contracted facility in the geographic location or who do not have identified coverage. 5. Practitioners and providers who are not compliant with in-network referrals (e.g., laboratory service referrals). 6. Healthcare practitioners who are not eligible for re-contracting due to a prior breach of an agreement with Presbyterian 7. A provider, or an entity with an officer, director, agent or manager, who: a. Owns or has a controlling interest in the entity. b. Was convicted of crimes specified in Section 1128 of the Social Security Act. c. Was excluded from participation in any other state's Medicaid program, Medicare or any other public or private health or health insurance program. d. Assessed a civil penalty under the provision of Section 1128.

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	e. Has a contractual relationship with an entity convicted of a crime specified in Section 1128. 8. The use of different reimbursement amounts for different specialties or for different healthcare practitioners in the same specialty. 9. Failure to comply with measures designed to maintain quality and control costs consistent with the responsibilities of the managed care organization (MCO). 10. Healthcare practitioners who were debarred from the OPM's FEHBP. 11. Healthcare practitioners who have temporary or provisional licensure. 12. The Committee and/or designee assess the following factors, as appropriate, for network participation or development: 13. Requests, other than primary care providers (PCP), in the Central region that may have an impact on capitated healthcare practitioners/groups. 14. Requests in all other regions (i.e., non-Central region) that may have an impact on capitated healthcare practitioners/groups. 15. Key specialties as determined by the Committee occasionally. 16. Other requests deemed appropriate by the Committee and/or the chairperson of the NDT. 17. Issues related to retention of a network practitioner or provider are managed on a case-by-case basis to ensure the continuity of the network and the healthcare needs of the specific population affected. 18. Not withstanding anything in this policy to the contrary, the Committee and/or designee has the authority to make exceptions and/or overturn the NDT's determinations. Presbyterian may apply different reimbursement methodologies or reimbursement amounts for different specialties or different practitioners in the same specialty. **Network Development and Contracting Review** Process steps for review and consideration include the following: 1. A NCM reviews each completed application. 2. The assigned NCM makes a recommendation based on the criteria established and described in this policy above. 3. Further discussion takes place as necessary. 4. The NCM may request input from other NDT members to decide whether to accept or deny the request. 5. Discussion includes network strategy and recommendation(s) for new requests for specialties/services that Presbyterian has not previously managed (e.g., naprapathy, birthing centers, nutritionists, etc.) and may be referred to Presbyterian's medical director(s) for further review. Approved Requests: Upon approval, Contracting notifies the Credentialing team to begin the credentialing process. 1. The CA sends an acceptance letter to the approved healthcare practitioner or provider. 2. The CA enters the information into the contracting system.

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	3. Note: The credentialing process must be completed and approved in accordance with Presbyterian's Credentialing policy (PHP.QMCRD.001). Approval by the NDT does not necessarily result in network participation. Credentialing approval and completion of the contracting process are required before an agreement is fully executed. Denied Requests: Based on evaluation of the existing network, Presbyterian may not include healthcare practitioners and providers whose specialty and geographic location are identified as a closed specialty or area. 1. The CA documents the healthcare practitioners and providers who are denied network participation and prepares a written notification that includes a brief explanation for the decision. 2. Healthcare practitioners and providers who are denied network participation may request reconsideration after a period of six months. This period allows time for changes in network requirements that may warrant reconsideration and determination by NDT. 3. Healthcare practitioners may request consideration earlier than six months if there were changes in their scope of practice (i.e., licensure change) or their geographic location. Pended Requests: Healthcare practitioners and providers who have not provided the necessary requested documentation for review are notified and pended for 15 business days. When the practitioner or provider fails to return the necessary documents within the 15 business day time frame, the CA sends an email to notify the practitioner or provider that the request for network participation was abandoned due to lack of response. Administrative Review: After the NCM completes his or her review, the director of PNM and/or the Committee may conduct an additional administrative review when necessary. 1. The director of PNM or a designee will email the NCM to inform him or her of the actions and decisions made during this review. 2. In addition to the administrative review, network need, network strategy and/or network development are taken into consideration to determine whether to accept or deny the healthcare practitioner or provider network participation. 3. The director of PNM may request members to participate in this review, and members may request the Committee to participate in the review as necessary. Appeal Request: Healthcare practitioners and providers who disagree with the NDT's decision may submit a request for reconsideration in writing, via email or by telephone. 1. The manager of Provider Development or director of Reimbursement will review the request for reconsideration within five business days.

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	2. When a denial is overturned, the CA follows the approval process. 3. When a denial is upheld, the manager of Network Development or director of Reimbursement forwards the request for reconsideration as well as the recommendation for denial to the director of PNM. a. The director of PNM reviews the forwarded request for reconsideration within five business days and emails the CA, the manager of Network Development and the director of Reimbursement to notify them of the results. 4. The CA coordinates with the manager of Network Development and or director of Provider Reimbursement to send a letter that informs the healthcare practitioner or provider of the results of the appeal. a. When the decision of the director of PNM results in upholding the denial, then the healthcare practitioner or provider may reapply in six months. b. When the decision of the director of PNM results in an approval, then the CA follows the approval steps. 5. NOTE: All information and decisions are stored electronically for a minimum of 12 months after the date of decision made by NDT. 6. NOTE: Network development specific to health plan expansion activities may include active recruitment of providers based on specialties and geographic location. Based on strategic needs, health plan expansion activities may not be subject or limited to the NDT process in this policy.

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Contract 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.	Complete the Credentialing process within forty-five (45) calendar days from receipt of completed application with all required primary source documentation.
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.	MCO's 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.
LOD #43 – Billing for Non-independent licensed practitioners	This policy applies to UnitedHealthcare Community Plan New Mexico (UHCCP) and providers who maintain a roster of clinicians with UHCCP, including non-independently licensed clinicians (NILs). The policy is in accordance with New Mexico's Medicaid State Plan, the New Mexico Administrative Code (NMAC 8.321.2), Letter of Direction (LOD) #43, the Centennial Care 2.0 Contract and the Managed Care Policy Manual. Provider types that are eligible for reimbursement are defined in the NMAC, Section 8.321.2.9. Per LOD #43, BHAs must be approved by BHSD to provide clinical supervision and bill for services rendered by NILs. BHAs must meet one of the following criteria: 1. The BHA was previously approved under the OptumHealth Supervisory Protocol – these BHAs remain on the grandfathered list until such time as the NMAC rule is updated 2. The BHA applies for certification through BHSD The BHA must provide a copy of the certification letter to the Managed Care Organizations (MCOs); this is to be done with 60 days of receipt of the letter. 1. The letter is provided to the MCO at the time of credentialing or when the BHA obtains the certification. 2. The letter is maintained in the BHAs file
Addition of New Specialty to provider Profile	**I.SCOPE** This policy applies to UnitedHealthcare Community Plan New Mexico (UHCCP) and providers who maintain a roster of clinicians with UHCCP, including non-independently licensed clinicians (NILs). The policy is in accordance with New Mexico's Medicaid State Plan, the New Mexico Administrative Code (NMAC 8.321.2), Letter of Direction (LOD) #43, the Centennial Care 2.0 Contract and the Managed Care Policy Manual.

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	II.STATEMENT This policy outlines requirements related to maintenance of agency rosters, including allowed provider types. This policy also outlines requirements for Behavioral Health Agencies to provide clinical supervision and bill for services rendered by NILs. **III.DEFINITIONS** • Behavioral Health Agency – For the purpose of this policy, Core Service Agencies, Community Mental Health Centers, Behavioral Health Agencies (BHAs) and Applied Behavioral Analysis providers are considered agencies. • BHSD – Behavioral Health Services Division • ePUF – Electronic Provider Update Form • LOD – Letter of Direction • NMAC – New Mexico Administrative Code • Nil – Non-Independently Licensed clinician; acceptable license types are identified by BHSD • PDM – Provider Data Maintenance team • Plan – Refers to the UnitedHealthcare Community Plan New Mexico, Centennial Care 2.0. **IV.PROCEDURES** 1. All agencies are required to maintain a comprehensive roster that lists all of the clinicians that render services on their behalf. The roster includes, but is not limited to, the following elements: a. Agency information: name, service address, phone number, fax number, TIN, NPI b. Clinician information: name, license number (when applicable), individual NPI, Medicaid number, DEA number (when applicable), languages spoken and age group served. The type of update (add, term, update) is also included. i. Provider types that are eligible for reimbursement are defined in the NMAC, Section 8.321.2.9. 2. The roster must be submitted at the time of initial credentialing and when changes to their roster occur. a. The updated roster may be submitted through the provider portal (preferred method because the information is sent directly to the PDM team) or to the Provider Advocate (via e-mail or fax). i. The Provider Advocate will submit an ePUF to forward the roster update to the PDM team. 3. The license type of the individual clinician that is listed on the roster determines the reimbursement rate for each service. The license type is indicated in the provider database when the clinician is loaded. 4. The payment appendix for each agency lists the codes that are eligible for reimbursement. The payment appendix includes a description of the code,

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	which provider types are eligible to render the service and the reimbursement rate. a. Non--licensed provider reimbursement rates are listed under the MSW column within the payment appendix with corresponding modifiers b. The claim will follow standard claims processing. 5. Per LOD #43, BHAs must be approved by BHSD to provide clinical supervision and bill for services rendered by NILs. BHAs must meet one of the following criteria: a. The BHA was previously approved under the OptumHealth Supervisory Protocol – these BHAs remain on the grandfathered list until such time as the NMAC rule is updated b. The BHA applies for certification through BHSD 6. The BHA must provide a copy of the certification letter to the Managed Care Organizations (MCOs); this is to be done with 60 days of receipt of the letter. a. The letter is provided to the MCO at the time of credentialing or when the BHA obtains the certification. b. The letter is maintained in the BHAs file

Appendix B - Sample Payment Results (BH)				
	BCBS	**MHC**	**PHP**	**UHC**
Range of (Over)/Underpayment	**Claim Count**			
($200.00) to ($299.99)	3	0	0	0
($100.00) to ($199.99)	1	0	0	1
($0.01) to ($99.99)	1	2	0	8
$0.00	64	71	75	64
$0.01 to $99.99	5	2	0	2
$100.00 to $199.99	1	0	0	0
$200.00 to $299.99	0	0	0	0
Total	**75**	**75**	**75**	**75**

Appendix B - Sample Payment Results (FQHC)				
	BCBS	**MHC**	**PHP**	**UHC**
Range of (Over)/Underpayment	**Claim Count**			
($200.00) to ($299.99)	1	0	0	0
($100.00) to ($199.99)	1	2	0	0
($0.01) to ($99.99)	0	0	0	1
$0.00	23	23	25	21
$0.01 to $99.99	0	0	0	1
$100.00 to $199.99	0	0	0	2
$200.00 to $299.99	0	0	0	0
Total	**25**	**25**	**25**	**25**