Provider Questions and Answers

The following are questions adapted from the transcripts from the training: Provider Responsibilities for the Outside Review Process (OR) conducted on 11/7/2016.

Q. What is the most current Budget Worksheet (BWS)?

A. As of November 2016, the V. OR 2015 10-01 is the most current budget worksheet; there is only one. Enhancements to the BWS are underway based on feedback from case managers, the OR, and an *OR- Implementation** workgroup. When a new version of the BWS is issued, DDSD will provide instructions to case managers for the uptake of the new version and discontinuation of the older version.

Q. Where can I find a current rate table?

A. The current rate table is posted on the Human Services Department (HSD) website located at: http://www.hsd.state.nm.us/providers/fee-schedules.aspx .

Q. How are common errors identified and addressed?

A. The OR tracks common errors on a monthly basis related to both revisions and annual submissions. The error categories tracked include:

1	Budget worksheet Error: *ex*: missing fields, incorrect data, missing data
2	Clinical Criteria/Standards
3	Vision, Outcome, Goals, Meaningful day, or Action Plan
4	Incorrect format: *ex:* incorrect file type, bulk submission, password protected
5	Mathematical error: related to SPAR, BWS, other documentation
6	Documentation: incorrect, incomplete, or missing information
7	Credentials/Signature
8	Person Centered Assessment

The information provided in the webinar covers all **revisions** that the OR received from January 2016 through October 2016. DDSD works with directors of case management agencies, providers and the OR to retrain and reduce these errors.

*If you are interested in becoming part of the OR Implementation workgroup you should contact your Agency Director for more information. It is open to all provider agencies.

Q. What is Jiva?

A. The New Mexico Third Party Assessor (NM TPA), Qualis Health Provider Portal is called Jiva. For the DD waiver program, it is used:

- For submitting Level of Care (LOC) Requests
- For submitting budget requests for Jackson Class Members and children and,
- By UNM C.O.R.E. to submit OR-approved budgets

At this time, Jiva is only open to case managers and the OR. After clinical determination, the OR uses Jiva to securely submit the approved budget to Qualis for data entry. Not all case managers use Jiva; it is not currently a requirement. However, it is recommended as an efficient tool to track a budget reviewed by the OR and waiting for data entry.

Q. What is the NM Medicaid Portal?

A. The New Mexico Medicaid portal is used by providers to:

- Submit claims online
- Inquire on recipient, eligibility, claims, payments, and prior authorizations
- View or print remittance advices and other reports.

The New Mexico Third Party Assessor (NM TPA), Qualis enters OR- approved budgets into the official New Mexico Medicaid Management Information system, known as Omnicaid. Providers can view information through a secure log in to the NM Medicaid Portal.

Q. What can a provider do if there is an error identified in the NM Medicaid portal?

A. If the NM Medicaid Portal contains different service approvals, date spans and/or codes than what is reflected on the approved budget worksheet, providers should work with case managers to correct the issues. Case managers should follow the instructions provided in the memo dated 11/16/2016 found here: http://actnewmexico.org/downloads/InstructionsImprovingCommunication-DDSD.pdf

Q. What can a provider do if an error was on the Budget Worksheet (BWS) and the error was approved and entered in Omnicaid?

A. If there is an error on the BWS that was submitted and that error has been approved and entered in Omnicaid, a revision must be submitted by the case manager to correct this. Providers should work with the case manager to get the revision submitted quickly and correctly. If a provider reviews the budget worksheet (BWS) prior to submission this may be prevented.

Q. Should providers bill on incorrect codes while waiting for corrections?

A Providers should **not** bill if there is an error in service codes or modifiers, but should work to get the correction made. Billing on an incorrect service code or modifier will ultimately result in the need to a void, or a recoupment, of the claims paid in error.

Q. Should providers stop providing services if there is no approved BWS?

A. Providers should be in close communication with the case manager to monitor the approval of the BWS for annuals and revisions. Case managers receive approval **letters** from the OR prior to the receipt of the approved BWS and prior to the budget being entered into the Omnicaid system by Qualis. This letter can provide assurance of service approval to the providers even while data entry issues are still being resolved to allow billing to occur.

Q. How do providers avoid timely filing problems?

A. Providers can avoid timely filing if they bill within 90 days from the date of service. When a claim is filed past the timely filing requirement, an exception code is generated. If there are delays in entry due to OR implementation, providers should send the exception code for timely filing along with TCNs to Lydia Sanchez with HSD (Lydia.Sanchez1@state.nm.us) to research and assist in processing the claims.

Q. What should providers do when they think there is an error on the BWS

A. Providers should inform the case manager and the individual or guardian if there are issues on a BWS that do not reflect agreements made during the planning process.

Q. What can providers do when case managers do not have an ISP meeting 3-4 months prior to the ISP start date? Or do not send providers the BWS 48 hours prior to submission to the OR?

A. Providers should do their best to collaborate with case managers. Providers can contact agency directors and may submit a Regional Office Request for Intervention (RORI) if DDSD assistance is needed. Case managers are also encouraged to submit RORI's if providers are not turning in requested documentation when requested.

Q. What happens if a provider has not submitted complete documentation to the case manager in time for the submission to the OR?

A. A service cannot be approved by the OR without sufficient supporting clinical documentation or without a correctly completed BWS. If an incomplete or insufficient packet is submitted by the case manager, a request for information (RFI) may be issued or a denial of the service may result. Either circumstance is a disservice to the DD Waiver participant and requires follow up. Please review the two memos issued for further guidance: http://actnewmexico.org/downloads/DDW-CaseManagers-Providers-ResponsibilitiesUpdate-Memo.pdf and http://actnewmexico.org/downloads/Communication-IDT-RFI-Memo-20151028.pdf.

Q. Since DDSD will discontinue use of the Supports Intensity Scale®(SIS) (Letter from Cathy Stevenson, October 26, 2016), how are the NM DDW Group, Living Care Arrangement and related service categories completed on the BWS?

A. The correct Living Care Arrangement (LCA) category, service category and NM DDW Group assignments must still be entered into the BWS. SIS assessments and NM DDW Group Assignments are continuing until a transition plan is developed and issued by DDSD. This includes SIS assessments for individuals:

1. turning 18
2. transferring from Mi Via and who do not have a current SIS and NM DDW Group assignment
3. who are newly allocated to the DDW
4. who have experienced a significant change in condition which may affect intensity of support needs and rate categories for certain services (i.e. needs a SIS reassessment)

Q. What does it mean to have an RFI from the OR to a case manager and what can providers do about it?

A. The OR will issue Request for Information (RFI) to the case manager when the submission is incomplete. Case managers are instructed to inform providers of RFIs in writing within one day of receipt of the RFI from the OR. Case managers are required to securely send the **actual RFI letter** from the OR to all relevant providers within 24 hours. Two memos regarding how to handle RFI's are here: http://actnewmexico.org/downloads/DDW-CaseManagers-Providers-ResponsibilitiesUpdate-Memo.pdf and http://actnewmexico.org/downloads/Communication-IDT-RFI-Memo-20151028.pdf.

Q. What does it mean to have an RFI from Qualis to the OR and what can providers do about it?

A. There are times when the OR makes a determination but a technical problem with the BWS prevents Qualis from entering the approved BWS in Omnicaid (e.g. incorrect SSN, incorrect NM DDW group or incorrect proration of units. In cases where the OR needs additional information to respond to the RFI from Qualis, the OR will reach out to the case manager via CISCO. Case managers may in turn contact providers for the additional information. Case managers may look in Jiva to see if and why the BWS is in RFI status from Qualis to the OR; however, the response to this type of RFI from Qualis must come via the OR.

Q. What are the timelines for submissions to the OR?

A. Annuals should be submitted to the OR 60 days in advance of the ISP start date and revisions should be dated 30 days in advance of the service revision start date. if these timelines will jeopardize the individual, an Imminent Review may be requested by the case manager through the Regional Office Case Management Coordinator.

Q. What are the timelines for imminent review?

A. An Imminent Review consists of multiple steps and timelines:

1. Approval of the Imminent Review by the Regional Office Case Management Coordinator.
2. Submission of the Imminent Review Packet by DDSD Central Office to the OR. (Submissions with technical issues will be sent back for correction before OR accepts for Imminent Review).
3. OR issues an RFI or a determination in 3 or 5 days (RFI's from the OR to Case Manager are still considered imminent but can delay the 3 or 5-day timeline).
4. OR submission of BWS to Qualis.
5. Data entry by Qualis typically within 2-3 days. (An RFI from Qualis to OR may delay data entry).

Due to all of these steps and potential problems along the way, an Imminent Review may take more than 3-5 days to complete.

Q. Where would a provider get information regarding the transition date for a service?

A. The transition date must be a coordinated effort. A transition meeting must occur when someone moves from one provider to another. The date must be put on the BWS along with correct proration of units when the revision is submitted. The provider should be able to review the BWS and attend a transition meeting. If this is not happening, you may contact the case manager, the case management agency director, and/or the Regional Office for assistance.

If a provider bills more than what was agreed upon, or past the agreed upon transition date, it will cause delays and may result in requirement to void claims or recalculation of prorated units on the BWS.

Q. What documentation should be provided for OR submissions?

A. Providers should review the Clinical Criteria for guidelines located here: http://actnewmexico.org/downloads/IntroClinicalReviewServiceCriteria.pdf
In addition, all providers must also meet all reporting requirements and timelines as detailed in the DDW Service Standards.

Q. Can a provider request a fair hearing when a service is denied?

A Fair Hearings must be requested by the individual or guardian (when applicable) and cannot be requested by a provider. However, providers may be asked by the individual or guardian to participate in an agency conference or Fair Hearing.

Q. Can an administrative fair hearing be requested due to delays in reviews?

A. According to New Mexico Administrative code, a fair hearing can be requested due to failure to approve a service or item in a timely manner. However, there are many issues that require provider actions, which may prevent timely action by the OR or Qualis, including a Requests for Information (RFI). Providers should be in contact with case managers to monitor status of submissions and reviews and provide information needed to complete the review.