

CONDUENT



ISD Client Service Center

Procedure Manual

NM Medicaid Project

February 14, 2018
Version 2

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ISD Client Service Center Procedure Manual

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Section 1:

ISD Client Service Center

Section 1.1: Client Service Center

Introduction:

Members of the New Mexico ISD Client Service Center team provide assistance to Medicaid applicants and recipients as part of Conduent's contractual obligations with the State of New Mexico for various medical programs. Using computerized systems, the team responds to customer inquiries in a health care call center environment.

Departmental Duties

Daily:

- E-mail previous day's ISD Client Service Center statistical data to Deputy Account Director.
- Using standard scripts and procedures accept and respond to telephone inquiries and complaints in a timely manner.
- Mail out forms and information per client requests.

Weekly:

- Project Specialist completes the Claims Report and submits to Supervisor each Monday.

Monthly:

Compile monthly ISD Client Service Center statistical data and e-mail to Deputy Account Director.

Security and Confidentiality

- All Conduent employees are required to maintain security and confidentiality as outlined in the Conduent Employee Guidebook. Please refer to the following link: <H:\Policies\2013 Conduent Employee Guidebook.pdf>

Section 1.2: Staffing

ISD Client Service Center Agents

Functional Description:

New Mexico ISD Client Service Center Agents provide assistance to Medicaid applicants and recipients as part of Conduent's contractual obligations with the State of New Mexico for various Medicaid programs. Using computerized systems to access appropriate client information, Agents respond to customer inquiries in a health care call center environment.

May perform one or more of the following:

- Log customer calls, mail, e-mail and faxes.
- Respond to telephone inquiries and complaints using standard scripts and procedures.
- Respond to mail, email and fax inquiries and complaints.
- Gather information, research/resolve inquiries.
- Follow up on outstanding issues to ensure resolution, keep the customer informed on the status of research and close out case when complete.
- Communicate appropriate options for resolution in a timely manner.
- Inform customers about services available and assess customer needs.
- Provide functional guidance, training and assistance to lower level staff.
- Provide assistance, training and troubleshooting support to lower level staff.
- Schedule work to ensure accurate phone coverage; monitor priority of calls and shift escalated calls to supervisor to ensure resolution to all issues.
- Work to ensure all assignments are completed in a timely manner.
- Follow work arrival, departure, lunch and break schedule as directed by supervisor.
- Complete standardized report templates to track workload, response time and quality of input.
- Assist in planning and implementing department goals and make recommendations to management to improve efficiency and effectiveness.
- All other duties as assigned.
- Agents who do not meet the call center expectations will result in a Performance Improvement Review (PIR). Agents will be coached before a PIR is administered. A verbal warning will be issued and the agent will be placed on a probation period giving the agent an opportunity to improve performance. If

the agent does not meet the call center expectations with in their probation period will be placed on a written warning giving the agent an additional opportunity to improve performance, a written final will be administered if no improvement with 90 days from issuance.

ISD Client Service Center Supervisor

Functional Description:

New Mexico ISD Client Service Center Supervisors lead and manage all activities associated with the New Mexico ISD Client Service Center operations to include: employee performance management, assist in developing policies and procedures, maintaining accurate documentation to meet contractual obligations for the New Mexico Medicaid Operations program.

Qualifications:

College degree preferred

Prior experience with Medicaid and/or medical field preferred

Special Requirement:

Healthcare administration experience a plus

- May perform one or more of the following: Direct the daily activities of call center agents.
- Supervise, plan, and manage operations of the New Mexico ISD Client Service Center.
- Supervise, coach, train, discipline and review all Call Center Agents or operators.
- Monitor calls fielded by Call Center Agents or operators.
- Act as an information source and answer operator or agent questions, assign tasks, follow up and give instructions as needed.
- Following up and resolve customer complaints and questions.
- Ensure team members have the appropriate support needed to complete their tasks.
- Carry out performance measurement and evaluation of all agents to improve efficiency.
- Compile and maintain key schedules ensuring ample staff coverage to handle expected call volume.
- Communicate solutions, successes and opportunities to the Manager.
- Practice and ensure compliance with all policies and procedures.
- Monitor and spot check calls, mail, e-mail and faxes to ensure proper handling and quality.

- Provide reports to the Call Center Manager as needed.
- Communicate escalated issues to Conduent executive management, Conduent subcontractors, and/or State agencies following the chain of command.
- Deliver and monitor Performance Improvement Reviews to give employees the opportunity to improve performance.
- Develop, recommend, and implement process and/or operational improvements to enhance efficiency and effectiveness of operations.
- Manages timekeeping/payroll activities ensure all employees are paid accurately.
- All other duties as assigned.

ISD Client Service Center Manager Functional Description

New Mexico ISD Client Service Center Manager plans and implements Call Center strategies and operations to improve systems and processes. Manages Call Center staff.

Qualifications:

Education and Typical Years' Experience

College degree preferred

Years of experience: >2

Prior experience with Medicaid and/or medical field preferred

Healthcare administration experience a plus

- May perform one or more of the following: Manage Call Center staff.
- Prepare call center performance reports by collecting, analyzing, and summarizing data and trends.
- Maintain and improve call center operations by monitoring system performance, identifying and resolving problems, preparing and completing action plans.
- Plan and implement call center strategies and operations to improve systems and processes.
- Listen effectively to find the root cause of issues, communicate clearly to resolve the issue and keep the customer happy.
- Responsible for providing reports on various aspects of call-center performance to other members of the management team.

- Ensure team members have the appropriate support needed to complete their tasks.
- Meet call center objectives by projecting staffing requirements and evaluating variances to meet Service Level Agreements.
- Assist IT in the setup and management of the interactive voice response system workflow.
- Be familiar with and able to implement call queuing strategies.
- Train new employees and monitor supplemental training needs on an ongoing basis.
- Conduct quarterly evaluation of Call Center staff to determine eligibility for career advancement (Level Up).
- Handle time management for the department (i.e., time off requests, time sheet approvals, etc.)
- Coach and mentor staff.
- Counsel employees as needed.
- Maintain professional and technical knowledge by tracking emerging trends in call center management, attend educational workshops, and review professional publications, benchmark state-of-the-art practices and participate in professional societies.
- Conduct analyses of call quality and call center statistics and provide feedback and recommendations to Deputy regarding staffing levels, service level commitments, and process improvements.
- Assists with other projects as needed.

Section 1.3: Quality Assurance and Service Level Agreements

Quality Assurance

- Quality is an essential part of what we do; our work must be accurate and consistent. To help maintain our accuracy, calls are monitored and evaluated according to the Quality Assurance Call Monitoring form.
- <H:\Quality Assurance\Call Monitoring Form MMIS.xlsx>

Service Level Agreements (SLAs)

Service Level Agreements (SLAs) are performance standards determined by the State and included in Conduent’s New Mexico ISD Client Service Center contract to ensure we provide the level of service expected by all stakeholders.

(Department Name)
Monthly Call Abandonment Rate < 10 %
Monthly Call Hold Time < 2 minutes
Average Handle Time < 4 minutes

Section 1.4: Tools

Tools

Microsoft Dynamics CRM 2011 (CRM):

Software used to track all call interactions and manage contacts.

OmniCaid:

The Medicaid Management Information System (MMIS) used to verify eligibility or Centennial Care Managed Care Organization (MCO) choice. This system is also used by all MCOs and Providers.

Call Simplicity:

Conduent-developed software used to assist in the efficient routing of calls to optimize the customer experience. It helps to automate routine employee tasks and consolidate activities which result in a reduction of overall call times.

ASPEN:

Computer system used by the NM Human Services Department (HSD) to determine client eligibility for all HSD programs, including Medicaid.

Microsoft Outlook:

Email software.

AVAYA Phone:

Phone system used by Call Center agents to field inbound calls.

Abledoc/Workflow:

Document management tool that allows for efficient tracking and routing of work.

Procedures

Section 2.1: Authenticating Callers

Authenticating Callers to Protect Recipient Health Information

Description and Purpose

Protecting Conduent and Recipient data is a critical and essential part of our company security posture. Conduent and Governmental security procedures and policies address multiple methods for protecting proprietary and confidential data. Proper authentication of the caller addresses the validity of the caller and ensures they have the authority to access recipient data.

The purpose of this section is to outline the processes and procedures to properly authenticate a caller and protect a recipient's health information and privacy.

Steps

1. If the caller is a **Provider**, verify
 - a. Provider's Name and
 - b. Provider ID number, NPI
 - i. Institutional Waiver Calls
 1. Verify Agency on File
 2. Mad 344 on file
2. If the caller is a **Recipient**, verify
 - a. Name and ASPEN Case Number
 - b. Client's First name, last name and DOB
 - c. If the caller is calling about another person,
 - d. Check ASPEN to verify the caller is listed as an Authorized Representative or adult on the case.

- a. If the caller is not listed as an Authorized Representative or adult on the case, ask to speak with the Recipient so they may authorize you to speak to the caller on their behalf. You must validate the Recipient's information before this permission may be granted.

3. If the caller is a **State Employee**

- a. Note in the CRN with the following information
 - o State employee's name
 - o State employee's office
 - o State employee's contact number
 - o State employee **MUST** verify the client's information they are inquiring about

NOTE: If caller is asking about a bill:

1. Verify eligibility for date of service
 - a. If caller was eligible on date of service, ask the caller to let the provider know to resubmit the claim
 - b. If caller was not eligible on date of service, explain coverage dates and the date of service falls outside eligibility dates
 - i. If date of service falls between periods of eligibility suggest to the caller they contact their caseworker

If the caller is unable to provide any of the required validation information, they must call back when they have the necessary information.

If you are in doubt about the information received when authenticating a caller, please seek the help of your Call Center lead, supervisor, or manager.

Verifying an Authorized Representative in ASPEN

Description and Purpose

A Recipient's Authorized Representative is someone who has been designated or who has legal authority to act on behalf of the Recipient. Authorized representative may be a family member or other trusted person. Authorized Representatives may call to access recipient information. In ASPEN, they may also be referred to as an Alternate Payee.

This section outlines the process of verifying a Recipient's Authorized Representative in ASPEN.

Effective 2/20/2015, in financial assistance cases (such as Medicaid eligibility cases), confidential information is not released to the dependent children or the spouse (if not the other parent) of the specified relative, unless permission to do so is given by the specified relative. These same individuals, and not just the Head of Household, may request and we will honor, that certain changes be made to their case or benefit delivery.

See link for numbered memo 15-0223 and State email:

<H:\Procedures\Operating Procedures\Client Call Centers\State Numbered Memo 150223.pdf>
<H:\Procedures\Operating Procedures\Client Call Centers\2.20.15 Email Protocol Change - Russell Toal.pdf>

For verification in ASPEN; please note the following steps:

1. From the left navigation:
2. Data Collection
3. Wrap Up
4. Alternate Payee



Refer to Screen-print below Alternate Payee/Authorized Representative – Summary

Alternate Payee / Authorized Representative - Summary ? ★ [icon] [icon] [icon]

Case Name: [redacted] Case #: [redacted] Case Action: Case Status: Approved

[Add] [Previous] [Next]

Case #	Category of Eligibility	Grantee	Alternate Payee	Phone #	Address
[redacted]	MA - SSI	[redacted]	[redacted]	0	[redacted]

[Add] [Previous] [Next]

Read Only

Please Note: Alternate Payee/Authorized Representative information is provided via interface from Social Security.

Section 2.2 Verifying and Entering Recipient Eligibility

Verify Recipient Eligibility in ASPEN

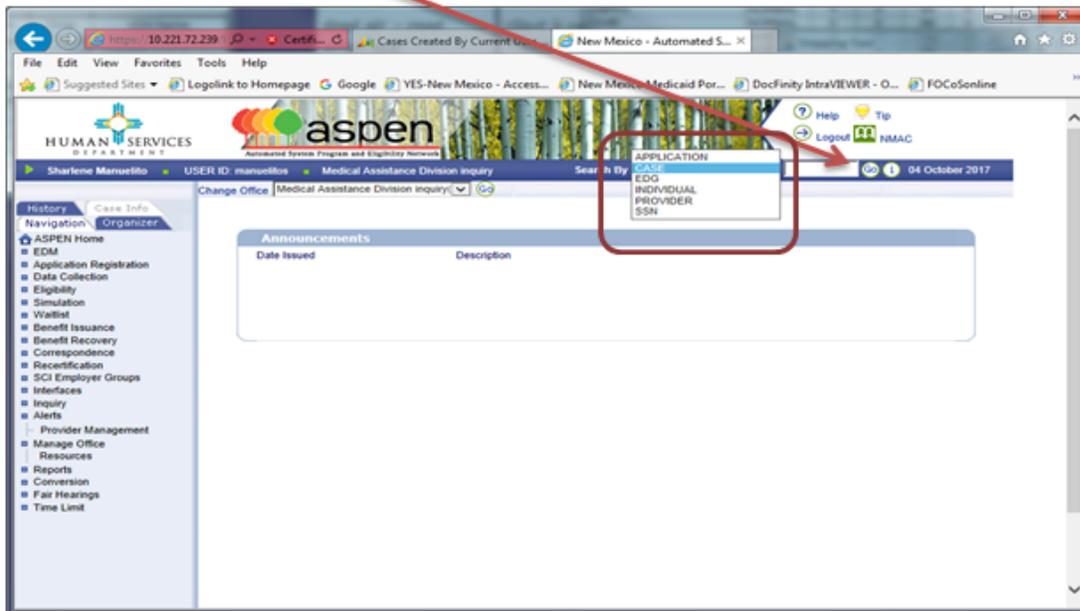
Description and Purpose

Conduent works closely with its business partners to ensure recipient information is accurate. One of the common resources we use is the ASPEN mainframe interface. This interface allows Conduent to access real-time eligibility information recorded on the NM Human Services Department's Income Support Division mainframe.

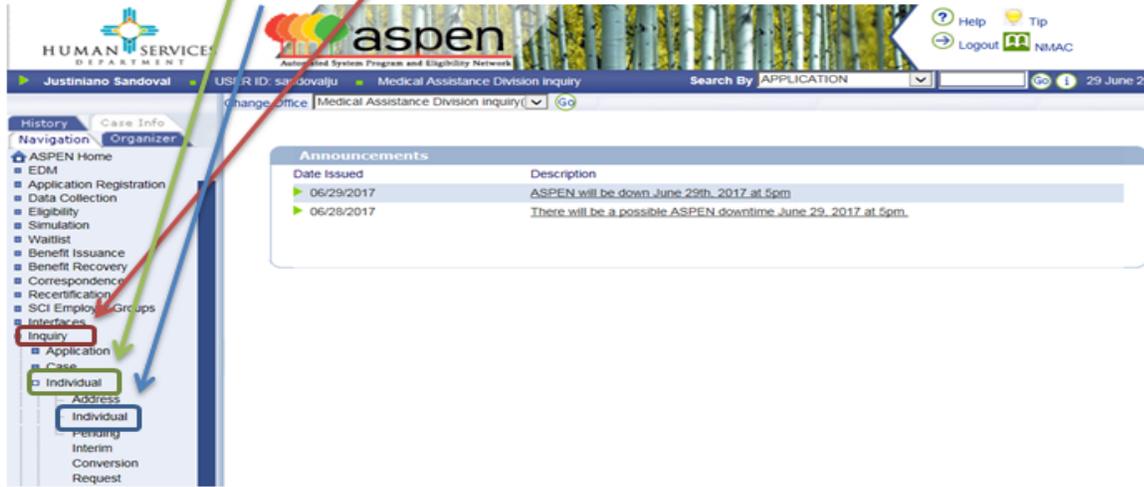
The purpose of this section is to outline the processes and procedures to be used by Call Center Agents to verify recipient eligibility information that has not filtered into OmniCaid from ASPEN.

Steps

1. From the ASPEN home screen go to the "search by" option at the top right of the screen and choose **Case Number** in the drop down, tab over and add the client case number in the search box
2. Select go



3. On the **left navigation** find **Inquiry** and Select to collapse the options list
4. Select on **Individual** to collapse the next options list and then
5. Select on **Individual** again



6. You will be directed to the **Individual Search** screen.
7. Enter in name and DOB
8. Select search
 - a. Locate the best match for the client (should be the first option).
9. Select on the **approved case**.
 - a. If you enter in the correct information it should be a **100% match**.
 - b. Make sure you verify Name and DOB are matching.

Individual - Search ? ☆ 🗑

Reset Search

Individual Search Criteria

Prefix: First: Middle: Last: Suffix:

SSN: - - Individual #: SSCN: - - -

DOB: Residency County: Gender:

Case #: Application #: Create System:

Reset Search

Search Results

100 % Match because of 'NAME' Match with no SSN entry.

Name	DOB	SSN	Individual #	Create System	Converted to ASPEN	Case / Application #	Case Status	% Match
Ta [redacted] Pe [redacted] M. [redacted] 46F	[redacted]	[redacted]	4334	Legacy	Conversion Complete	[redacted] 1271	Approved Closed Closed	100
[redacted]	[redacted]	[redacted]	[redacted]	Legacy	Conversion Complete	[redacted]	Approved	99
[redacted]	[redacted]	[redacted]	[redacted]	Legacy	Conversion Complete	[redacted]	Closed	99 (Alias)
[redacted]	[redacted]	[redacted]	[redacted]	Legacy	Conversion Complete	[redacted]	Approved	99 (Alias)
[redacted]	[redacted]	[redacted]	[redacted]	Legacy	Conversion	[redacted]	Closed	99

10. Steps 1 and 1-A will take you to the **Case – Search/Summary** screen.

- a. This screen will show you the head of household, client name, SSN, DOB, Gender, authorized representative, individuals associated on the case and benefit issuance.
- b. To view head of household, select the (+) sign, this will show you name and case number.
- c. To view case contact information select the (+) sign, this will show mailing/residential address contact phone number.

Case - Search/Summary ? ★ 📄

[Back](#)

Case/EDG Search Criteria

Case #: [REDACTED]1271 EDG #: [REDACTED] [Reset](#) [Search](#)

⊕ Case Action

⊖ Case Summary Information

Case #: [REDACTED]1271 Case Name: T[REDACTED] P[REDACTED] 46F
Case Status: Approved Case Action:
Office Name: Northwest Bernalillo County Office County: Bernalillo
ISD
Application Date : 04/12/2016

⊖ Case Contact Information

Current Residence County: Bernalillo

Case Residence Address: [REDACTED] Case Mailing Address: [REDACTED]

Home Phone#: [REDACTED] Work Phone#: [REDACTED]

- d. To view the authorized representative on the case, select the (+) sign.

⊖ Authorized Representative/Case Management Agency

Filing Representative: [REDACTED] Filing Representative Address:

Case Management Agency/Consultant Entity: Case Management Agency/Consultant Entity Address:

- e. To view all individuals associated on the case and approved categories, select the (+) sign.

Case Individuals

Name	Individual #	SSN	Birthdate	Active in Case?	Household Status	End Date																								
⊖ T. Pe 46F	334			Y	In/Joined Household																									
<table border="1"> <thead> <tr> <th>Case #</th> <th>EDG #</th> <th>COE</th> <th>Eligibility Begin Date</th> <th>Eligibility End Date</th> <th>Recertification Date</th> </tr> </thead> <tbody> <tr> <td>271</td> <td>2706</td> <td>SNAP</td> <td>01/03/2017</td> <td></td> <td>06/30/2018</td> </tr> <tr> <td>271</td> <td>9128</td> <td>Support Services</td> <td>10/01/2017</td> <td></td> <td>03/31/2018</td> </tr> <tr> <td>271</td> <td>2184</td> <td>MAGI Parent</td> <td>07/01/2016</td> <td></td> <td>07/31/2018</td> </tr> </tbody> </table>							Case #	EDG #	COE	Eligibility Begin Date	Eligibility End Date	Recertification Date	271	2706	SNAP	01/03/2017		06/30/2018	271	9128	Support Services	10/01/2017		03/31/2018	271	2184	MAGI Parent	07/01/2016		07/31/2018
Case #	EDG #	COE	Eligibility Begin Date	Eligibility End Date	Recertification Date																									
271	2706	SNAP	01/03/2017		06/30/2018																									
271	9128	Support Services	10/01/2017		03/31/2018																									
271	2184	MAGI Parent	07/01/2016		07/31/2018																									
⊕ R. Ky 28M	314			Y	In/Joined Household																									
⊕				N	Out/Left Household	12/31/2015																								
⊕ T. Ev 17M	270			Y	In/Joined Household																									

- f. To view eligibility details select the client you are searching and Select on the EDG #.

Current Associated EDGs

COE	EDG #	EDG Status	File Date	Review Date	IR Date
LIHEAP	2065	Approved	06/26/2017		
MA - Family Planning	2704	Denied	04/12/2016		
MAGI Adult	2725	Denied	04/12/2016	06/30/2018	
MAGI Adult	5181	Approved	04/12/2016	07/31/2018	
MAGI Children	2705	Closed	04/12/2016	03/31/2017	
MAGI Children	2951	Approved	04/12/2016	07/31/2018	
MAGI Parent	2184	Approved	04/12/2016	07/31/2018	
MC - QI-1	3166	Denied	09/01/2017		
SNAP	2706	Approved	01/03/2017	06/30/2018	12/31/2017
Support Services	9128	Approved	01/03/2017	03/31/2018	
TANF	0340	Closed	01/03/2017	12/31/2017	

- Selecting the EDG # will identify the category of eligibility approved, including benefit amount.
- Eligibility approved, locate the “eligible adult” or “eligible child” under the **Participation Status**.

EDG - Search/Summary ? ★ 📄

EDG # [REDACTED]:706 EDG Name : T [REDACTED] Pe [REDACTED]

[Back](#)

EDG Search Criteria

* EDG #:

EDG Summary Information

EDG #:	[REDACTED]2706	Case #:	[REDACTED]1271	EDG Name:	T [REDACTED] Pe [REDACTED] 46F
Program:	SNAP	Category of Eligibility:	SNAP	EDG Status:	Approved
Last Certified By Employee User ID:		Certified Children:	1	Certification Date:	08/24/2016
Certified Adults:	2	Type:		Reason:	Benefits decreased.
Alternate Payee:		Program Redetermination Date:	06/30/2018		
Action Effective Date:	10/01/2017	Negative Action Effective Date:	09/22/2017		
Last Month of Cert. Period:	06/30/2018	Benefit Mismatch:	NO		
Funding Indicator:	Federal				

EDG Address Information

EDG Mailing Address: [REDACTED] Home Phone#: [REDACTED] Work Phone#: [REDACTED]
 EDG Residence County: Bernalillo

Case Mailing Address:

EDG Benefit Information

Program Requested Date:	01/03/2017	Eligibility Begin Date:	01/03/2017	Penalties:	0.00
Certification Date:	08/24/2016	Prior Medical:		Suspended Benefits:	No
Benefit/Deductible Amount:	504.00	Recoupment:	0.00		

Current EDG Individuals

Individual #	Name	Date of Birth	Gender	SSN	Participation Status
194334	T [REDACTED] Pe [REDACTED] 46F	[REDACTED]	Female	[REDACTED]	Eligible Adult
456314	R [REDACTED] K [REDACTED] 28M	[REDACTED]	Male	[REDACTED]	Eligible Adult
1382270	T [REDACTED] E [REDACTED] 17M	[REDACTED]	Male	[REDACTED]	Eligible Child

- i. To identify the clients Medicaid eligibility refer to the [Category of Eligibility](#), this will include: MAGI Adult, MAGI Parent, MAGI Children, MA SSI, MA Terminated SSI, MA Family Planning, QMB, QI-1, SLIMB, a Medicaid Waiver, SNAP, TANF and LIHEAP.
- j. To view benefits issuance for SNAP and TANF, select (+) sign. This will identify benefit period, benefit type, payment amount, date issued and benefit status.

Benefit Issuance

Case Number	Grantee / Vendor Name	COE	Benefit Period	Benefit Type	Payment Amount	Recoupment Amount	Warrant/ EFT / Benefit#	Warrant / EBT Available Date	Benefit Status
1271	P	SNAP	08/01/2017 - 08/31/2017	Ongoing	\$511.00	\$0.00		08/19/2017	Paid
1271	P	SNAP	09/01/2017 - 09/30/2017	Ongoing	\$511.00	\$0.00		09/19/2017	Paid
1271	P	SNAP	10/01/2017 - 10/31/2017	Ongoing	\$504.00	\$0.00		10/19/2017	Paid
1271	P	TANF	09/01/2017 - 09/30/2017	Ongoing	\$327.00	\$0.00		09/01/2017	Paid
1271	P	TANF	08/01/2017 - 08/31/2017	Ongoing	\$327.00	\$0.00		08/01/2017	Paid
1271	P	TANF	08/01/2017 - 08/31/2017	Supplemental	\$100.00	\$0.00		08/01/2017	Paid

- k. To view case comments from case worker view notes under [case comment summary](#). The date and time of the incoming call will be notated along with the case workers comments and program name relating to reason of call.

Case Comment Summary

Serial No	Create Date	Created By	Case Mode	Comments	Comment Type
110	09/07/2017		Ongoing		Cash
109	09/07/2017		Ongoing		Cash
108	09/01/2017		Change Action		NMWorks
97	07/14/2017		Ongoing		Cash, SNAP, LIHEAP

Verifying Eligibility in the Web Portal

- Access the Medicaid Web Portal at <https://nmmedicaid.portal.conduent.com/static/index.htm>
- Click "Log in to"

Recipients

I AM ALREADY ENROLLED IN THE NEW MEXICO MEDICAID PROGRAM

Log in to:

- Click the box:

By checking this box, I confirm that I am authorized to access information for this Medicaid recipient and I have read and understand the statement listed above.

- Enter the clients information and click login:

Recipient Identifier

Medicaid ID: OR Social Security Number:

* Date of Birth:

* Last Name:

Login Clear

- Once you log in, you will be able to make the selection to "Check Eligibility"

RECIPIENT - Secure Options

- Request Replacement ID Card
- Enroll In/Change CCO
- Check Eligibility
- Ask Service Representative
- Reprint a 1095-B IRS Form

- Select the individual you are checking eligibility for and enter the service range and click submit:

* I need to check eligibility for :

Another Person

Date of Service Range

* From: To:

Submit Clear Cancel

- The client's information will appear:

Date of Service:	03/01/2018 To: 03/08/2018
-------------------------	---------------------------

For the requested date (or dates) of service, your inquiry returned the following eligibility information.

Please note that an end date of 12/31/9999 means that eligibility is currently active and will remain active until you are notified of a change or it is time to renew your eligibility.

Recipient Information			
Recipient Name:	[REDACTED] S	Date of Birth:	[REDACTED]
Sex:	Male	Medicaid Card ID:	[REDACTED]
Date of Death:			

Eligibility Information					
Eligibility Code	Benefit Description	Begin Date	End Date	COE Add Date	Co-Pay
100	Alternative Benefit Package limitations on some services	04/01/2017	12/31/9999	04/05/2017	

Enrollment Information			
Enrollment Type	Provider Name	Begin Date	End Date
CENTENNIAL CARE ENROLLMENT	BLUE CROSS BLUE SHIELD OF NM	05/01/2017	12/31/9999

CRM Notation – Transferred Calls

Description and Purpose:

A CRN is created in Microsoft Dynamics for all interactions, when transferring a call to a Case Worker (Income Support Division (ISD) or Institutional Care Waiver (ICW)) the subject line must be changed to reflect to reasoning of the transfer and complete notation must be noted.

- Transfer Call per Contractual Agreement – Transfer to be used within our scope of work.
- Transfer Call – Other Reason – Transfer to be used regarding an issue other than our scope of work. Please get with a Supervisor before using this drop down tab.

The screenshot shows the 'General' tab in Microsoft Dynamics CRM. The 'Subject' dropdown menu is open, displaying a list of call subjects. Two categories are highlighted with red boxes:

- LIHEAP - Transfer Call per Contractual Agreement**
- LIHEAP - Transfer Call - Other Reason**
- SNAP - Transfer Call per Contractual Agreement**
- SNAP - Transfer Call - Other Reason**

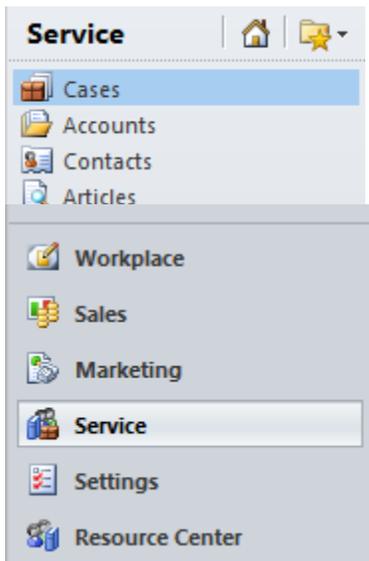
Other visible subjects in the dropdown include: Child Support---No additional question regarding Medicaid, Restitution---No additional question regarding Medicaid, TANF - Transfer Call per Contractual Agreement, TANF - Transfer Call - Other Reason, TANF-Approval Amount Assistance, TANF-Status, YES NM---Password Reset, NM Status - Status, NM Status - Transfer Call per Contractual Agreement, NM Status - Transfer Call - Other Reason, NM Works---Provided county information for assistance, PED---Eligibility Status inquiry, Paris Match---No additional question regarding Medicaid, SNAP - Transfer Call per Contractual Agreement, SNAP - Transfer Call - Other Reason, SNAP-Approval Amount Assistance, SNAP-Status, and Sanctions - No additional questions regarding Medicaid, call transferred.

How to Create a CRN for Eligibility – Manager Approved

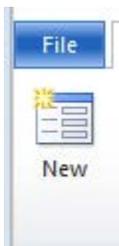
Description and Purpose:

A CRN is an audit record created in Microsoft Dynamics (CRM) for all interactions (ie: responding to emails, calls, processing paperwork, etc). When processing emergency eligibility the CRN is sent to the SME, Supervisor, or Manager to confirm OC was updated correctly according to Aspen.

1. The purpose of this section is to outline the proper processes and procedures to be used when creating a CRN for Eligibility and sending for management approval. Access CRM:
<http://agabq0vmcrrmpw01:5555/ConduentGHSCRM/main.aspx#>
2. Under Service select: **Cases** and **Service**



3. Select “New”



4. Enter Recipient’s name in all caps

Case
New
 CRN
 Customer

▼ **General**
Overview

Customer*

- 5. Using the drop down menu, select the following:
 - a. Subject: Eligibility – Manager Approved

▼ **General**
Overview

Customer*

Source*

Category*

Subject*

Provider ID

- 6. The agent must provide the SME, Supervisor, or Manager with the original CRN
- 7. The SME, Supervisor, or Manager will include this as a reference in the new CRN
- 8. The SME, Supervisor, or Manager will include the dates of eligibility authorized and COE in their notes
- 9. The SME, Supervisor, or Manager will attach an ASPEN eligibility screenshot to the CRN

Internal Notes

[Add a new note...](#)

Title: File Attachment
 Note created on 3/3/2015 7:33 AM by Carolyn Thompson Edited 3/3/2015 7:33 AM by Carolyn Thompson
 [icon] [redacted].docx (62,826 Byte(s))

Title: Note created on 3/3/2015 7:32 AM by Carolyn Thompson
 Note created on 3/3/2015 7:32 AM by Carolyn Thompson Edited 3/3/2015 7:32 AM by JAMES BRANNEN
 CRN 1602389 Loretta
 Caller: [redacted]
 Phone: (505) 503-8180
 Called to check eligibility for [redacted] ([redacted]). Informed caller that no eligibility was found for [redacted] for the date of 3/2/2015.
 ****I entered eligibility for 3/1/2015 - 12/31/9999 COE 100

- 10. SME, Supervisor, or Manager will resolve the CRN.

How to Complete a Merge

Each Medicaid recipient should have one medical account. Sometimes two accounts are created for one Client in error, when this occurs the accounts must be combined into one. The combining ensures the Client has the correct personal, demographic information, COE, and it also ensures claims are paid correctly. Refer to numbered memo 16-0416 or click link.

<H:\Procedures\Operating Procedures\Client Call Centers\Merge Procedures v2.docx>

[Numbered Memo 16-0416: **State Numbered Memo 160416 Update Date of Birth and Name in Omnicaid to Match ASPEN \(MERGES ONLY\).pdf**](#)

How to Complete an Unmerge

An unmerge is performed when two accounts were combined in error during the merge process that need to be separated. Unmerges can happen due to some of the following reasons:

- Accounts merged were two different Clients
- Date of Birth does not match
- Social Security Numbers were to two different individuals

<H:\Procedures\Operating Procedures\Client Call Centers\Unmerge v2.docx>

When processing a **merge with a different DOB or Name in Omnicaid and ASPEN** you must do the following:

- Verify DOB or Name in ASPEN for the recipient
- Go into Omnicaid and update the DOB or Name to match ASPEN
- Complete merge process
 - Please Note: Any cases received with similar issues (Update to DOB or Name) that are not part of the merge process should be addressed with MAD Systems Bureau (MAD). **Do not** complete an update action. See State Memo 16-0416 link: <H:\Procedures\Operating Procedures\Client Call Centers\Medicaid Recipient Call Center Procedure Manual 2.5.16.docx>

Section 2.3: Fulfilling Medicaid Card Replacement Requests

Description and Purpose

Recipients enrolled in the New Mexico Medicaid program receive a blue Medicaid ID card. Recipients who are enrolled with a Managed Care Organization (MCO) will receive a MCO-issued card from their MCO.

The purpose of this section is to outline the processes and procedures to be used by Call Center Agents to fulfill a recipient's request for a replacement Medicaid card.

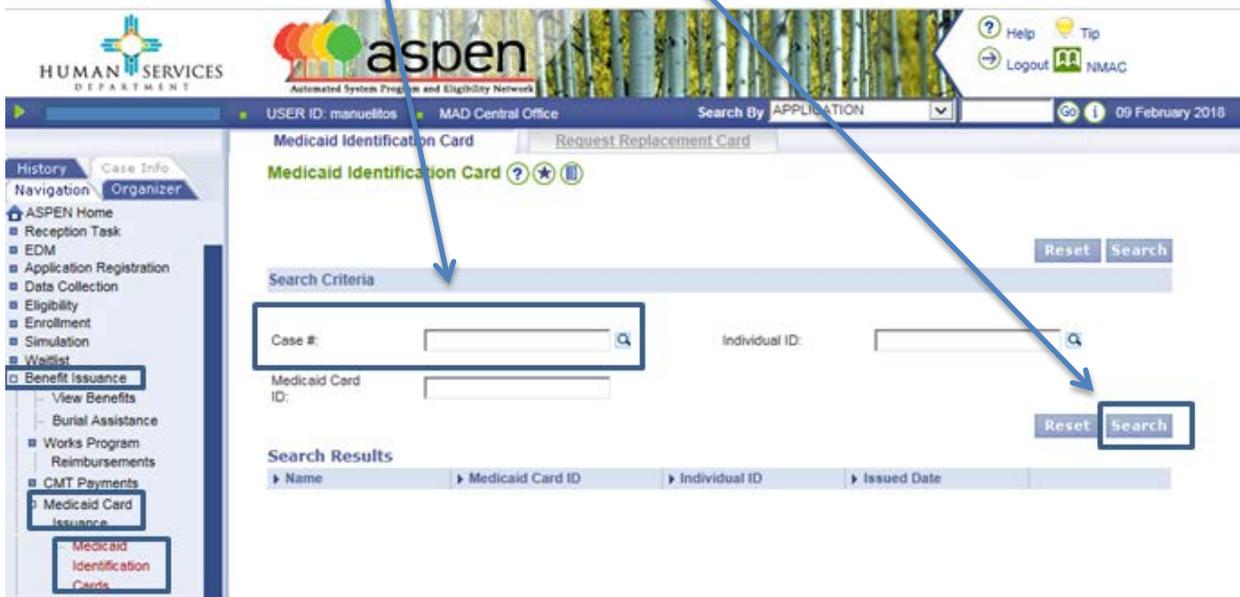
- NOTE: Requests for replacement cards issued by MCOs should be directed to the recipient's MCO.

As of December 2017, recipients who are enrolled in Centennial Care will no longer receive blue Medicaid card. A maximum of one Medicaid replacement card request per week may be processed for any Fee for Service (FFS) client with a maximum number of 52 cards issued in a 12 month span.

When requesting a replacement card, a recipient can have the replacement card sent to the Physical Address listed on their case or a Temporary Address. A request to have a replacement card sent to a Temporary Address will not update the clients address in ASPEN.

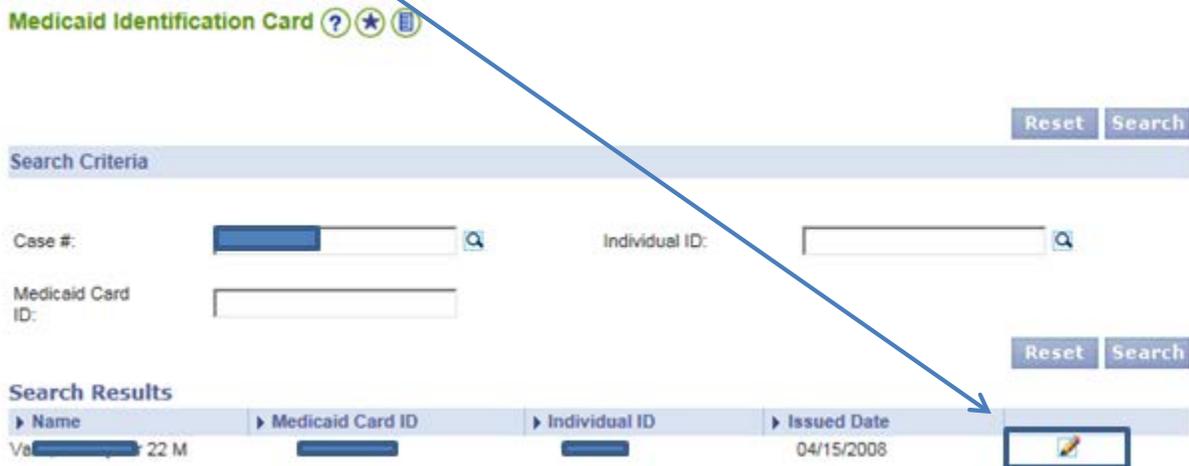
Requesting a replacement card in ASPEN:

- Select Benefit Issuance from left navigation in ASPEN
- Select Medicaid Card Issuance
 - Medicaid Identification Card
 - Enter case number and select search



The individual's information will appear for every household member on the case.

- Click on the edit pencil next to the individual's name to navigate to the Request Replacement Card page to view additional information about the Medicaid card.



- The “Request Replacement Card” page contains the individual’s information. Information above the address line is auto populated and cannot be edited.

Request Replacement Card ? ★ 📄

[Previous](#) [Reset](#)

Name: Va [redacted] Individual ID: [redacted] Medicaid Card ID: [redacted]

Control#: [redacted] Issued Date: 04-15-2008

Address

* Address Type: [dropdown]

* Address Line 1: [text] Address Line 2: [text]

* City: [text] * State: [New Mexico dropdown]

* Zip Code: [text] * Reason For Swipe Card: [dropdown]

Is address validation required? [YES dropdown]

[Previous](#) [Request Replacement Card](#)

- The prior Medicaid card information shows when replacement cards had previously been ordered, why they were issued and the address they were sent.

Prior Medicaid Card

▶ Control#	▶ Medicaid Card ID	▶ Issued Date	▶ Issuance Reason	▶ Deactivation Date	▶ Deactivation Reason	▶ Issued Addresses
[redacted]	[redacted]	12-21-2017	LOST			[redacted] Albuquerque NM [redacted]
[redacted]	[redacted]	01-01-2014	INITIAL	12-20-2017	LOST	

- To send a card to the case:
 - Physical Address, click on “Physical Address”
 - Mailing address, click on “Mailing Address”
 - Authorized Representative, click on “Authorized Representative”
 - Payee, click on “Payee”

In the Address Type drop down box and click on “Request Replacement Card”

The screenshot shows a web form titled "Address". On the left, there are fields for "Address Type:", "Address Line 1:", "City:", and "Zip Code:". A dropdown menu is open for "Address Type:", showing options: "AUTHORIZED REPRESENTATIVE", "MAILING ADDRESS", "PAYEE ADDRESS", "PHYSICAL ADDRESS", and "TEMPORARY ADDRESS". To the right, there are input fields for "Address Line 2:", a state dropdown menu (currently showing "New Mexico"), and a "For Swipe Card:" dropdown menu. At the bottom right, there are two buttons: "Previous" and "Request Replacement Card", with the latter being highlighted by a blue box.

- Once “Request Replacement Card” has been selected, the information for a new card will appear in the “Prior Medicaid Card” information field.

Eligibility Begin Date Prior to Date of Birth

Description and Purpose

Omnicaid cases with eligibility begin date prior to DOB:

- Once email is received, an email will be sent to the State requesting a numbered memo for each change.
- When receiving a request for a replacement card or the claims department not being able to update MSQ and process a TPL due to the eligibility begin date is prior to DOB please verify the following:
 - 1) Verify the DOB in ASPEN or Omnicaid for the recipient, if the DOB cannot be verified sent to State for verification.
 - 2) Go into Omnicaid and void out the span containing the eligibility span with the begin date prior to DOB.
 - 3) Reenter the span with the correct begin date for DOB.
 - 4) Document the action in Omnicaid.
 - 5) A numbered memo will need to be requested for each case.

Section 2.4 Entering Centennial Care MCOs (or CCOs) in ASPEN

Description and Purpose

Most individuals enrolled in a New Mexico Medicaid program receive their medical services from a Managed Care Organization (MCO).

Recipient contacts the ISD Client Service Center to make or change their current MCO selection within their 90 day enrollment or recertification period. Native Americans can opt to change from MCO to exempt at any time; however, the change will take effect for the prospective month.

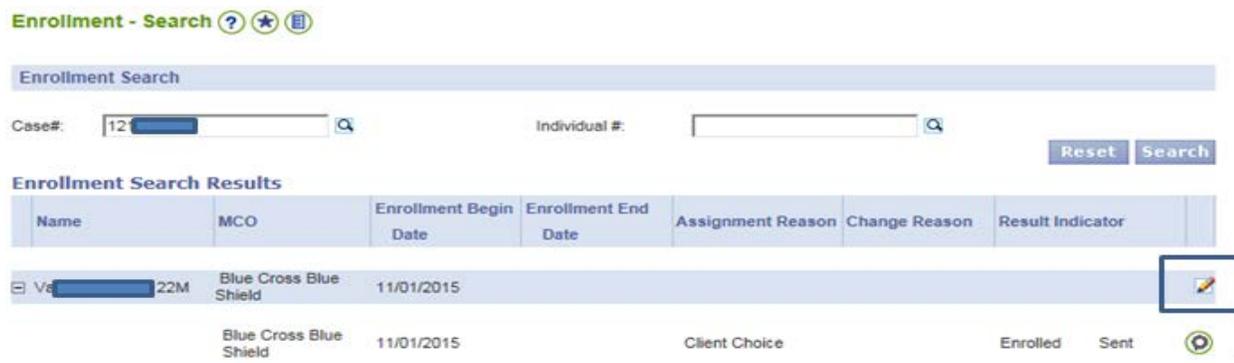
The purpose of this section is to provide instructions for Call Center Agents to accurately enter or change a recipient's MCO selection.

Steps

1. Go to the **Left Navigation** under **“Enrollment”** click the **View Enrollment:**
 - a) Enter Case Number
 - b) Select search



2. MCO Enrollment information will appear in the “Enrollment Search” results screen. To edit the results, click on the pencil:



3. The **“Enrollment Details”** page will open up:

- a. Choose an “MCO activity type” in the activity type box
- b. Select an MCO
- c. Click “Submit”

Enrollment - Details ? ☆ 📄

Reset Previous Submit

Individual Information

Name: [redacted] Individual #: [redacted]

Current Enrollment Information

Provider Id: 42101522 MCO: Blue Cross Blue Shield

Enrollment Begin Date: 11/01/2015 Enrollment End Date:

Modified Enrollment Information

• Activity Type: [dropdown menu]

Lock In Begin Date: [calendar icon]

• MCO: [dropdown menu]

Lock In End Date: [calendar icon]

Reset Previous **Submit**

Enrollment End Date: [calendar icon]

• MCO: [dropdown menu]

There are four MCO’s to choose from:

- Presbyterian
- United Health Care
- Blue Cross Blue Shield
- Molina

4. An “**Update Successful**” message will appear in the message box at the top of the page.

Enrollment - Details ? ☆ 📄

134 Update Successful

Reset Previous Submit

5. Click on the “**Previous**” button to see the new MCO Enrollment Begin Date, the Assignment reason (Client Choice) and “Enrolled” in the Result column.

Section 2.5: Managed Care Organization Switch Guidelines

State Notification: Managed Care Organization Switch Guidelines

Description and Purpose:

Recipients who phone the Conduent ISD Client Service Center to request a Managed Care Organization (MCO) switch should be screened to determine if they are within the 90 day Switch period.

The purpose of this section is to outline the processes and procedures for completing MCO switch requests.

For Centennial Care (lock in type CCO), a client has the first three months of a new enrollment to select another Centennial Care MCO. If the client does not select another MCO during those first 3 months, the client is locked in to their current MCO for another 12 months, and the system requires that the lockin span's end date for the span must be on an even 12 month break from the earliest contiguous span begin date for the same Centennial Care MCO plan. A user may override this 12-month lockin restriction by using the "Override 12 month lock in" (OV) or "Lock-Out" (LO) change reason when terminating the client's enrollment span. The State's policy for Centennial Care is that the client can only change their MCO once during the first 3 months of a new Centennial Care enrollment. This is not enforced on the window, but should be enforced procedurally by those handling Centennial Care MCO switch requests. The 12-month lock in restriction window edit is not applied when an enrollment span is ended using any of the following change reasons: "Disenroll-Death" (DD), "RAC Recoupment" (RC), "Disenroll-No Recert" (RN), or "Recoup-Death" (RX).

If the client is in compliance with the above then proceed to "Complete MCO change request" otherwise no changes can be performed.

Complete MCO change request:

- If the Client is requesting a prospective MCO conversion and is within the 90 days of the "begin date" the MCO can be switched, but only once with this 12-month period.
 - If the Client requests a change post capitation cycle the prospective change will happen for the subsequent month (Example; Capitation cycle for July ran June 25th if the Client request an MCO change on June 26th (post capitation) the MCO span will begin in August not July).

If the Client selected an MCO during enrollment, but the case worker did not enter the choice in ASPEN or entered the choice in error. Review detailed Numbered Memo 16-1293: [Link](H:\Procedures\Operating Procedures\Client Call Centers\State Numbered Memo 161293 Retro Updates for Valid Application Selection Errors.pdf)

- NO AGENT SHOULD BE USING OV in OC to correct or make a selection with the exception of the manager, supervisor, and/or SME. EXCEPTION: NAX moving from an MCO to FFS and vice versa.

- ALL MCO switch request exceeding 90 days form eligibility “begin date” must meet Just Cause (refer to section: Do not complete the MCO change request).
- MCO switch request to due to recipient’s application request was **not** entered, and allowed to auto assigned (AA). This request must be submitted to the State Contract Manager that oversees that MCO, with the following individuals cc’d: John Padilla, Client Call Center Manager, Supervisor, and SMEs. There must be a detailed documented CRN, and detailed notation to the State Contract Manager (of who they selected on the application) with detailed information. The request will be sent to the State Contract Manager by management, or SMEs via the DL-NM box. All attachments sent to the State Contract Manager will be in the CRN for future reference if needed.

– **State Contract Managers**

Blue Cross Blue Shield – Valerie.tapia@state.nm.us
 Molina Healthcare – Rose.Armijo@state.nm.us
 Presbyterian – Lesley.Urguhart@state.nm.us
 United Healthcare – Maria.Kniskern@state.nm.us

- Below is also a part of the regulation governing an MCO change:
 - ✓ Eligible recipient member lock-in: A member’s enrollment with a MCO is for a 12-month lock-in period. During the first 90 calendar days after his or her initial MCO enrollment (begin date), either by the member’s choice or by auto assignment, he or she shall have **one** option to change MCOs for any reason, except as described below.
 - ✓ If the member does not choose a different MCO during his or her first 90 calendar days (from “begin date”), the member will remain with this MCO for the full 12-month lock-in period before being able to switch MCOs.

Just Cause Eligible MCO change request

If the Client did not select an MCO during enrollment and is outside of the 90 day switch according to “begin date”. Review the “Just Cause” which is limited to:

- The MCO does not, because of moral or religious objections, cover the service the member seeks;
- The member requires related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all of the related services are available within the network, and his or her PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
- Poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs.
- Send the request to Armando Munoz per Switch policy if the Client qualifies for one of the “Just Cause” choices.

- If the caller meets this criteria they must submit their request via a letter (mailed or faxed) with the following information, and it **MUST** be signed.
 - Name of Person/Persons needing switch
 - Social Security number of each person
 - Reason they **NEED** to change
 - Dr's Name and Office Phone number
 - Current Mailing Address
 - Daytime Phone Number
 - What MCO to What MCO
 - **MUST HAVE** Signature of Case Head/Guardian or Representative

Send your request via fax or mail to:

- Attention Armando Munoz
- Fax to: 505-476-6825
- Mail to: Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
ATTN: Armando Munoz

Send the request to System Bureau for review if the request does not correspond to any of the scenarios outlined above. When approved, the change will become effective the 1st day of the following month. Human Services Department has a monthly deadline for all switch requests.

Section 2.6: Recipient Dental and Vision History

Dental History in ASPEN

Description and Purpose

Due to some restrictions of Medicaid-covered dental services, Fee for Service (FFS) Client's routinely request dental history when checking eligibility.

This section is to assist the Call Center Agent in identifying prior dental services rendered to an identified Medicaid recipient using Call Simplicity.

Steps

1. Identify caller to protect Personal Health Information (PHI)
2. Verify Client's name, social security, and date of birth
3. Request Client's call back number or enter caller identification number
4. Verify Client eligibility to ensure the Client is eligible to receive services
5. Once identity has been verified, proceed to Call Simplicity.

Dental History in Call Simplicity

Description and Purpose

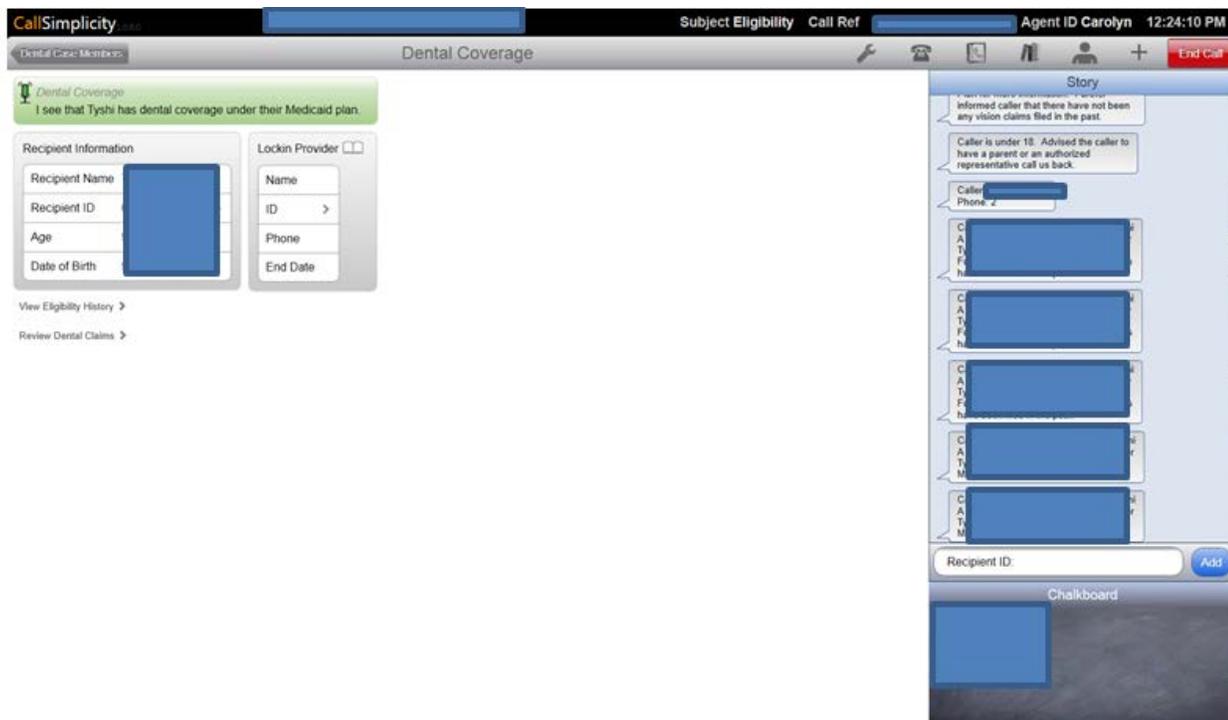
Due to some restrictions of Medicaid-covered dental services, Fee for Service (FFS) Client's routinely request dental history when checking eligibility.

This section is to assist the Call Center Agent in identifying prior dental services rendered to an identified Medicaid recipient using Call Simplicity.

1. Identify caller to protect PHI
2. Verify Client eligibility to ensure Client is eligible to receive services
3. Once the Client has been verified, proceed to Home Page Call Simplicity
4. Select the Check Dental Coverage Icon



- After selecting the "Check Dental Coverage" Icon you will see the current dental coverage



5. To view previous dental claims select "**Review Dental Claims**"
6. This page will reflect all pervious claims

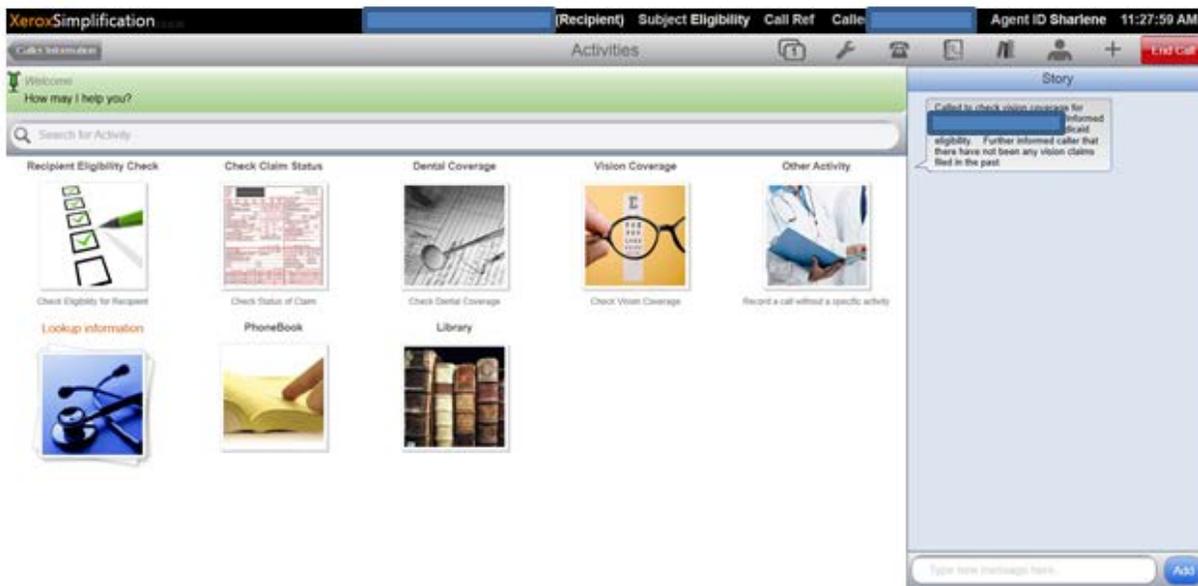
Vision History in Call Simplicity

Description and Purpose

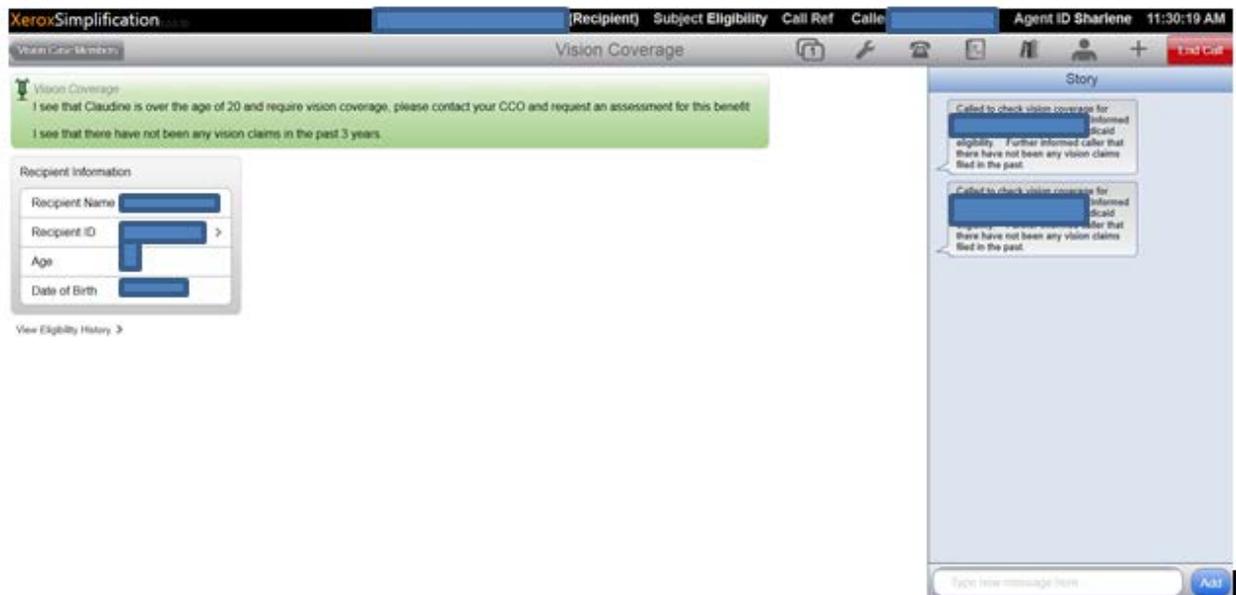
Due to some restrictions of Medicaid-covered vision services, Fee for Service (FFS) Client's routinely request history when checking eligibility.

This section is to assist the Call Center Agent in identifying prior vision services rendered to an identified Medicaid recipient using Call Simplicity.

1. Identify caller to protect PHI
2. Verify Client eligibility to ensure Client is eligible to receive services
3. Once the Client has been verified, proceed to Home Page Call Simplicity
4. Select the Check Vision Coverage Icon



- o After selecting the "Check Vision Coverage" Icon you will see the current vision coverage



7. To view previous dental claims select “**Review Vision History**”
8. This page will reflect all previous history (eye exam, materials, etc.)

Race Code Changes for Native American Recipients

Description and Purpose

An individual's Race and Ethnicity are not required for determining their Medicaid eligibility. Native Americans enrolled in Medicaid are not required to be enrolled with a Managed Care Organization (MCO). They are also exempt from all Medicaid co-pays. If a Medicaid recipient is not identified appropriately as Native American, they may be automatically enrolled with an MCO or may be inadvertently billed co-pays for Medicaid services. If a recipient's Race Code is entered incorrectly or not entered at all in ASPEN, it may need to be updated by a NM Human Services Department staff member in ASPEN so that it is uploaded correctly in OmniCaid. To initiate this update, the information is sent to daily to HSD via a spreadsheet.

This section provides the steps to have a Native American's race code updated by HSD staff in ASPEN.

Access the link provided below and complete the spreadsheet. All information must be completed.

<H:\Mad Daily\Native American and Race Code Updates.xlsx>

The spreadsheet is uploaded to the following email addresses from the DL-NM mailbox daily by 3:30pm (MST):

Kimberly.Lucero@state.nm.us

BerniceM.Sena@state.nm.us

JohnH.Padilla@state.nm.us

Linda.Gonzales@state.nm.us

MelindaA.Espinoza@state.nm.us

Carolyn.Thompson@Conduent.com

Sharlene.Vallo-Drummonds@Conduent.com

Darrell.Yonemoto@Conduent.com

Natali.Rubioromo@Conduent.com

Justiniano.Sandoval@Conduent.com

Jonhy.Munoz@Conduent.com

Section 2.7: Presumptive Eligibility

Presumptive Eligibility

Description and Purpose

Presumptive Eligibility (PE) is short-term Medicaid coverage for eligible individuals. The goal of PE is to provide access to immediate care for eligible recipients and to ensure assistance with application submission and possible ongoing Medicaid coverage for those individuals. Eligible screenings and enrollments of individuals in PE coverage can only be made by certified Presumptive Eligibility Determiners (PEDs). Individuals who are initially screened for PE are done so based on some of the same qualifying factors that help to determine ongoing eligibility. Individuals who are accurately screened for PE will most likely be approved for ongoing coverage.

The purpose of this section is to provide a brief overview of the New Mexico Medicaid PE program.

Presumptive Eligibility Categories of Eligibility

- PE is not available for every Medicaid category of eligibility (COE) but is available for many Medicaid categories of eligibility. The COEs that are eligible for PE are: **Children** (COEs 400, 401, 402, 403, 420 & 421 / Fed Match 3)
 - <H:\Medicaid Expansion Hotline\Knowledge Assistance>
- **Pregnancy** (COEs 300 & 301 / Fed Match 3)
 - <H:\Medicaid Expansion Hotline\Knowledge Assistance>
- **Parent/Caretaker** (COE 200 / Fed Match 3)
- **Other Adults** (COE 100 / Fed Match 3)
- **Breast and Cervical Cancer** (BCC – COE 52 / Fed Match 3)

Presumptive Eligibility Determiners

Eligible screenings and enrollments of individuals in PE coverage can only be made by certified Presumptive Eligibility Determiners (PEDs). PEDs must meet the PED certification requirements as established by HSD's Medical Assistance Division (MAD).

The purpose of this section is to outline the process that Call Center Agents use to verify the validity and identity of a PED.

Verifying a Presumptive Eligibility Determiner Number in ASPEN

Each PED is issued a unique PE number that must be used when submitting PE application screenings and/or approvals. Each person who is established as a valid PED will be certified with a provider specialty type. These specialty types, 170 or 171, dictate the COEs the PED is able to determine for PE.

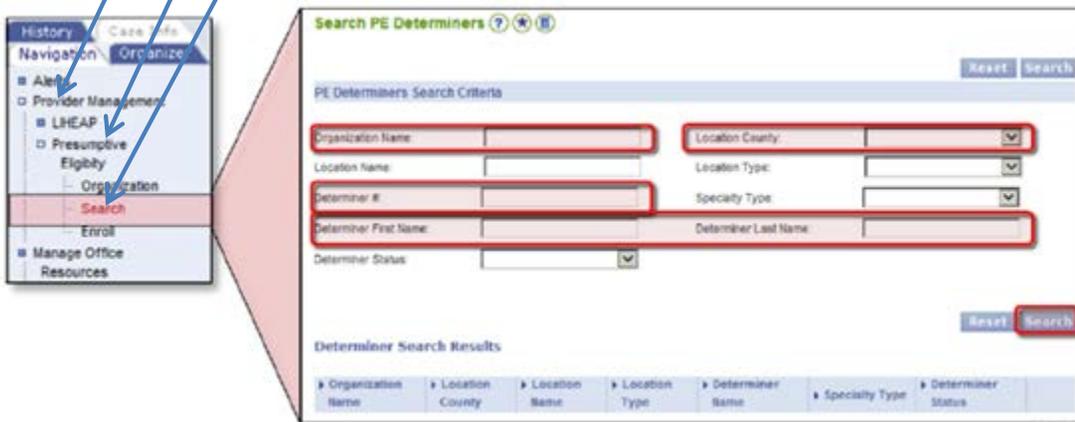
PEDs certified as **Specialty Type 170** are eligible to determine PE exclusively for children and pregnancy COEs.

PEDs certified as **Specialty Type 171** are able to screen for children and pregnancy but also for some other adult COEs.

Breast and Cervical Cancer (COE 52) PE determinations may only be made by Diane DaCamara from the NM Department of Health.

1. Determiner number cannot be a facility number. It must be an individual's number.
2. Access ASPEN
3. From Left Navigation

- a. Provider Management
- b. Presumptive Eligibility
- c. Search

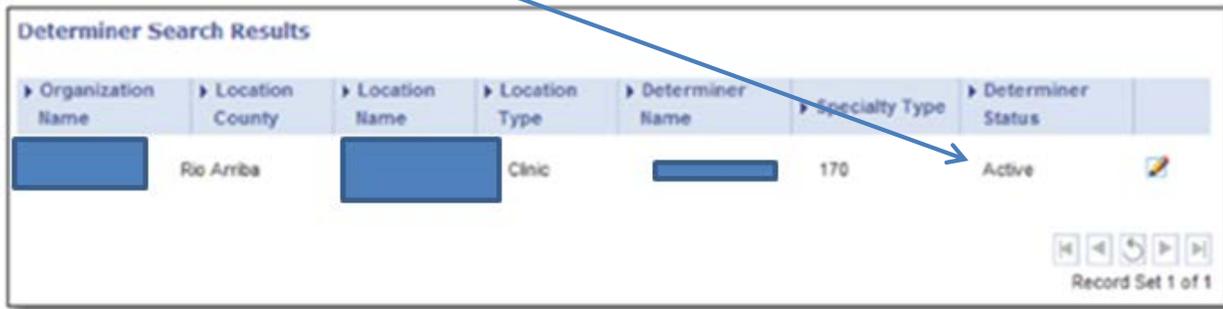


There are several ways to search for a PE Determiner:

- **Organization Name** allows you to search by the name of the organization or place employing the PE Determiner.
- **Location County** allows you to select a county using a dropdown list to search for a PE Determiner.
- **Determiner #** allows you to search by the unique number assigned to each PE Determiner.
- **Determiner First and Last Name** allows you to search by the PE Determiner's name.

The PE Determiner Search Results may display multiple results depending on the search criteria. This information includes the **Determiners Status**:

- **Active** means they have a current enrollment as a PE Determiner.
- **Inactive** means they have not renewed their enrollment and are not authorized to receive any information or discuss the case.



Organization Name	Location County	Location Name	Location Type	Determiner Name	Specialty Type	Determiner Status
[REDACTED]	Rio Arriba	[REDACTED]	Clinic	[REDACTED]	170	Active

Record Set 1 of 1

Section 3

Call Escalation and Referrals Outside of Conduent

3.1 Call Center Escalated Call Process

Description and Purpose

On occasion a caller will request to escalate an issue, this request can be made for a variety of reasons; however, at this point the caller feels that more attention needs to be brought to his or her issue.

The purpose of this section is to outline the procedures for Call Center Agent call escalation.

Steps

Once the identity of the caller has been verified, and the following conditions exist:

- If the Client cannot be verified, the agent will refer to step 1
- The employee cannot resolve the issue to the caller's satisfaction
- The caller has asked to speak with a supervisor

1. The employee will give the caller the name of the Lead / Supervisor
2. The employee will tell the caller the call will be transferred to the Lead / Supervisor
3. If the caller requests to speak to the lead's supervisor/manager, offer the supervisor's name and extension and/or email address
4. Set the expectation of a response within 2 business days if the caller reaches the voice mail of the supervisor
5. Do not transfer to the manager unless they request the manager by name
6. In the CRM Case, select Escalation from the Status Reason drop down menu and record details of the call
7. If repeat calls from same Client with same issues notify State and current Conduent Client Deputy

3.2 Referrals to an Income Support Division (ISD) Office

Description and Purpose

Although we will make every effort to support our providers and Recipients with a first call resolution, at times it will be necessary to refer them outside of Conduent to the Income Support Division (ISD).

This section is designed to help employees understand the procedure of when it is appropriate to make a referral to an ISD office.

Steps

1. Determine if this is an issue that cannot be resolved within our guidelines
2. If the discrepancy is incorrect information in ASPEN, advise the caller they must contact ISD to correct the issue
3. If the caller does not know the contact information for their local ISD office, use the outline below to assist the caller in locating the appropriate office
4. Inquire if there are any other issues that you can assist with today
5. Thank the caller for calling Conduent

3.3 Referrals to Medical Assistance Division (MAD) Staff Members

Description and Purpose

Although we will make every effort to support our providers and recipients with a first call resolution, at times it will be necessary to refer them outside of Conduent to the Medical Assistance Division (MAD).

This section is designed to instruct Call Service Agents how and when to make a referral to MAD staff members.

Steps

1. Determine if this is an issue that cannot be resolved within our guidelines
2. Advise the caller you will need to consult with your supervisor
3. Provide call reference number
4. Give the supervisor all relevant information for the caller's request
5. Once the supervisor has confirmed the caller should be referred to MAD, advise the caller of the correct contact person's name and contact information
6. If the supervisor states the caller should not contact MAD, obtain the caller's permission to contact the representative at MAD on their behalf
7. Call or e-mail MAD contact person and provide the caller's information and description of the situation
8. Inquire if there are any other issues that you can assist with today
9. Thank the caller for calling Conduent

3.4 Referrals to Children's Medical Services (CMS)

Description and Purpose

Although we will make every effort to support our providers and recipients with a first call resolution, at times it will be necessary to refer them outside of Conduent to the Department of Health's Children's Medical Services (CMS) unit.

This section is designed to help employees understand the procedure of when it is appropriate to make a referral to CMS.

Steps

1. Verify that the Recipient is a CMS Client (Medicaid category of eligibility 007)
2. Is this an issue that cannot be resolved within our guidelines?
3. If a provider needs authorization to render services, skip to step 5
4. If the caller needs additional services rendered outside of the \$15k max per year, go to step 5
5. Please refer the caller to CMS
6. Use the outline below to assist the caller in locating his or her case worker
7. Ask if there are any other issues that you can assist with today
8. Thank the caller for calling Conduent
9. CMS Clients are COE 007 with an Admin / Administrative County of 80

3.5 ISD County Field Office Staff (Caseworkers)

Description and Purpose

In New Mexico, the Human Services Department's (HSD) Income Support Division (ISD) determines eligibility for most HSD programs. ISD County Field Office staff who process applications for HSD benefits are caseworkers. Caseworkers can answer recipient inquiries regarding case status and documents that may be needed to determine Medicaid eligibility. ISD County Field offices are state-wide.

1. To locate the nearest ISD Field Office to the client
2. Access Aspen
3. Enter the case number
4. Select "Go"
5. In the case summary you will see their nearest ISD Field Office

Case - Search/Summary ? ★ 📄

[Back](#)

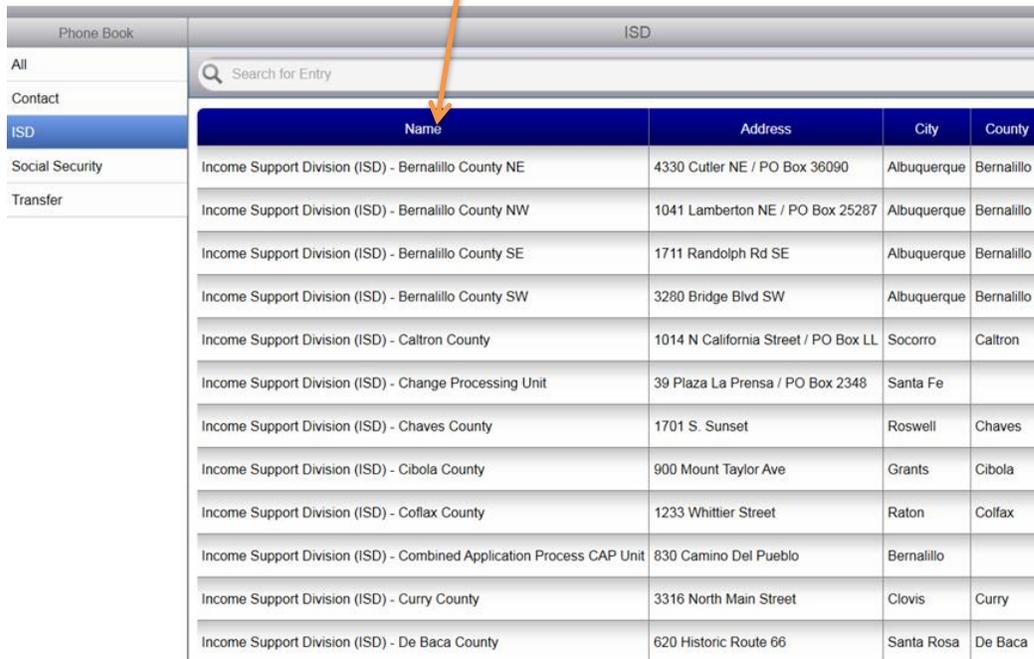
Case/EDG Search Criteria

Case #: EDG #:

Case Summary Information

Case #:	<input type="text"/>	Case Name:	<input type="text"/>
Case Status:	Approved	Case Action:	
Office Name:	South Dona Ana ISD	Office County:	Dona Ana
Current Residence County:	Dona Ana		
Case Residence Address:	<input type="text"/>	Home Phone#:	<input type="text"/>
		Work Phone#:	
Case Mailing Address:	<input type="text"/>	Filing Representative:	
		Case Management Agency/Consultant Entity:	

6. Using Call Simplicity select ISD. All counties will be noted with their contact information

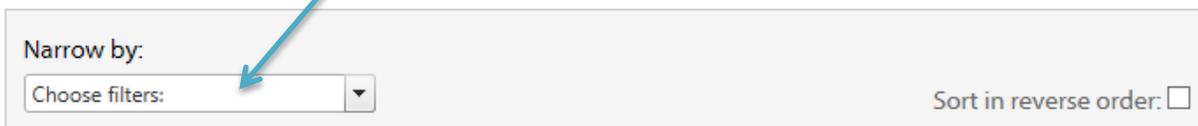


Phone Book		ISD			
All		Search for Entry			
Contact					
ISD					
Social Security					
Transfer					
		Name	Address	City	County
		Income Support Division (ISD) - Bernalillo County NE	4330 Cutler NE / PO Box 36090	Albuquerque	Bernalillo
		Income Support Division (ISD) - Bernalillo County NW	1041 Lamberton NE / PO Box 25287	Albuquerque	Bernalillo
		Income Support Division (ISD) - Bernalillo County SE	1711 Randolph Rd SE	Albuquerque	Bernalillo
		Income Support Division (ISD) - Bernalillo County SW	3280 Bridge Blvd SW	Albuquerque	Bernalillo
		Income Support Division (ISD) - Catron County	1014 N California Street / PO Box LL	Socorro	Catron
		Income Support Division (ISD) - Change Processing Unit	39 Plaza La Prensa / PO Box 2348	Santa Fe	
		Income Support Division (ISD) - Chaves County	1701 S. Sunset	Roswell	Chaves
		Income Support Division (ISD) - Cibola County	900 Mount Taylor Ave	Grants	Cibola
		Income Support Division (ISD) - Colfax County	1233 Whittier Street	Raton	Colfax
		Income Support Division (ISD) - Combined Application Process CAP Unit	830 Camino Del Pueblo	Bernalillo	
		Income Support Division (ISD) - Curry County	3316 North Main Street	Clovis	Curry
		Income Support Division (ISD) - De Baca County	620 Historic Route 66	Santa Rosa	De Baca

7. Once identifying the county select a web browser entering in:

<http://www.hsd.stat.ne.us/>

- o Select: looking for assistance
- o Select: income support
- o Select: field offices
- o Search: by county (enter the client's county)



Narrow by:

Choose filters:

Sort in reverse order:

Bernalillo County (Albuquerque Area)

Address

If you live in the Northwest part of the County/City

1041 Lamberton Place NE

Albuquerque, NM 87125

P.O. Box 25287

Albuquerque, NM 87125

Hours

Mon-Fri 8:00 AM to 4:30 PM

Contact

Section 3.6 Application Requests

Description and Purpose

The client has the ability to contact the ISD Client Service Center and request an application for services such as: SNAP, TANF, LIHEAP, etc. An email will be sent to HSD-CSCAdmin@state.nm.us and to include the following:

- Name
- Address
- Document type or Application name
- Case number
- Subject line must indicate “Application Request”
- Send requests to all ISD contacts per County
 - Edward Trimmer must be cc’d on all requests
 - Edward.Trimmer2@state.nm.us

Section 3.7 How to submit a Telecom Ticket

How to Open A Telecom Repair Ticket and Reporting to NMState

Created by: Manager, Carolyn Thompson

V3: 03.6.15

v2: 02.5.15

v1: 10.13.14

To open a telecom ticket you must send an email to the following address ITSS.Helpdesk@atos.net and also include the NMhelpdesk@atos.net. Also include ISG-SHC.TELECOM@xerox.com and rusty.wommack@atos.net

The technician will send you a ticket number via email. Make sure you include the following in the email:

- Telephone number effected
- Issue/Problem
- Contact person and contact number

If it’s an issue that requires immediate attention call the ITSS Helpdesk at 1.800.933.4672 (select opt 1, then option 3) advising the tech you need to open a “Priority 1” telecom ticket. You still need to notify NMhelpdesk@atos.net, as well. You must provide the following:

- Telephone number effected
- Issue/Problem
- Contact person and contact number

When a “Priority 1” ticket has been open you are required to remain on the bridge until the issue has been resolved. The Conduent technician will provide a bridge and ticket number for all involved regarding the issue.

If Conduent Telecom does not find the issue on our side the Telecom team will open an escalated ticket with effected number's carrier (if it's a NM State owned number it's through CenturyLink).

State must be notified – see procedures below

Contact Names:

David Izuo, Conduent Telecom Service Delivery Manager – p: 303.534.0109 x 8720 or c: 720.839.1327

Joe Prag, Conduent Voice Telecom Tarrytown, NY – p: 914.789.6929

Mark Sepulveda – Conduent ITO Telecom Group – p: 850.201.1212

Vince Padilla – NM State Telecom – vince.padilla@state.nm.us

State Notification

If the phone lines have been down for at least 30 minutes you must do the following:

1. Send email communication to:

Linda.Gonzales@state.nm.us

JohnH.Padilla@state.nm.us

Roy.Burt@state.nm.us

Shanita.Harrison@state.nm.us

Edward.Trimmer2@state.nm.us

Stephanie.Moore-Combs@state.nm.us

KristenA.Borderswoo@state.nm.us

Tamara.Sanchez@state.nm.us

USA 1720A NM ABQ GHS Site Managers

USA.1720A.NM.ABQ.GHS.Site.Manager@conduent.com

2. Supervisor/Manager must contact ISD Office to notify of issue. You must also notify once the issue has been resolved

a. XXXXXXXXXXXX

3. Your email must include:

a. The issue

b. What phone number(s), and call center (s) are affected

c. Start time of issue

d. ETR, if provided

4. Once the issue has been resolved, you must email the following with updates:

Linda.Gonzales@state.nm.us

JohnH.Padilla@state.nm.us

Roy.Burt@state.nm.usShanita.Harrison@state.nm.us

Edward.Trimmer2@state.nm.us

Stephanie.Moore-Combs@state.nm.us

KristenA.Borderswoo@state.nm.us

Tamara.Sanchez@state.nm.us

USA 1720A NM ABQ GHS Site Managers <

USA.1720A.NM.ABQ.GHS.Site.Manager@conduent.com

#800	QUEUE	Conduent Owned	
		Yes	No
855.637.6574	MEH	X	
888.997.2583	MAD		NM State Owned
855.637.6573	MAD	X	
505.247.1042	MAD	X	
866.507.1121	IC Waiver		NM State Owned
800.283.4465	ISD Client Service Center		NM State Owned
800.365.4944	Pharmacy routed to Henderson, NC	X	
505.246.0710	Provider Relations	X	
800.299.7304	Provider Relations/Provider Enrollment	X	
800.705.4452	Eligibility	X	
505.246.2056	Eligibility	X	
800.820.6901	Contact Solutions		X
877.568.0002	Contact Solutions		X

3.8 HIPAA Guidelines Albuquerque, NM

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health care providers, health plans, and clearinghouses to protect PHI and IIHI. Violations of HIPAA can result in the company and the individual who has violated HIPAA guidelines to be fined (up to \$250,000 per occurrence).

PHI- Protected health information: Any information that relates to the past, present or future physical or mental health or condition of an individual and identifies the individual.

IIHI- Individually identifiable health information: Any information, including demographic information collected from an individual that relates to the past, present or future physical or mental health or condition of an individual and identifies the individual or information which there is a reasonable basis to believe that the information can be used to identify the individual.

Internal violation: PHI/IIHI compromised within the office, but information did not leave the office.

External violation: PHI/IIHI compromised and information was sent out of the office.

HIPAA violations are actions that result in PHI/IIHI being compromised. Internal violations include (but are not limited to):

- Having PHI viewable on your desk when you are away from your desk for any amount of time.
- Not locking your computer when you are away from your desk for any amount of time.
- Disposing of information containing PHI/IIHI in a trashcan instead of a locked shred bin.

An employee that has violated **Internal** HIPAA guidelines will be subject to progressive corrective action guidelines as indicated below however circumstances dictate the option selected:

- First HIPAA violation
 - Formal Counseling (Verbal) with written confirmation
- Second HIPAA violation
 - Final Notice
- Third HIPAA violation
 - Termination of Employment

HIPAA violations are actions that result in PHI/IIHI being compromised. External violations include (but are not limited to):

- Mailing/emailing documents to the wrong provider or participant/employer/recipient
- Removing documents containing PHI/IIHI from the office, except in the case of transporting documents to a client location.

- Not correctly validating caller before releasing information to the caller.
- Releasing information over the phone to a validated caller that does not pertain to that provider/client.

An employee that has violated **External HIPAA** guidelines will be subject to progressive corrective action guidelines as indicated below however circumstances dictate the option selected:

- First HIPAA violation
 - Final Notice
- Second HIPAA violation
 - Termination of Employment

Corrective action violations are evaluated on a case by case basis based on the severity of the violation and the potential for harm.

Acknowledgement Statement

I completely understand all of the information covered in the **New Mexico HIPAA Policy**. I agree to comply accordingly with all instructions, policies, and procedures. I have also received a copy of the HIPAA procedure.

I have read and understand the policies, as well as my reporting obligations. I understand that if I have any questions about the policies or any of the information provided to me, that it is my responsibility to contact my supervisor, manager or appropriate trainer for further clarification.

Employee name (printed): _____ **WIN:** _____

Employee Signature: _____ **Date:** _____

Supervisor/Manager Signature: _____ **Date:** _____

Trainer/Witness Signature: _____ **Date:** _____

3.9 How to File an Incident Report

Neglect, Exploitation Incident Reporting Requirements:

First and foremost always ensure the safety of the Client. Call 911 if necessary.

Incidents of suspected/alleged Abuse, Neglect, Exploitation and unexpected death for adults, 18 and older must be reported **immediately** to:

Adult Protective Services and the Division of Health Improvement (DHI) Incident Management Bureau at the following:

- **Adult Protective Services Intake, 24 hours a day, 7 days a week**
 - Telephone: 1-866-654-3219
 - Facsimile: 1-505-476-4913
- **DHI Incident Management Bureau Intake**
 - Telephone: 1-800-445-6242
 - Facsimile: 1-800-584-6057
 - Email: incident.management@state.nm.us
 - On-line at <http://dhi.health.state.nm.us/IMB/index.php>

A completed ANE Incident Report Form must be submitted to DHI-IMB no later than 24 hours after the incident.

- **Reportable Incidents:**
- For Adults, 18 and older:
- “**Abuse**” including verbal abuse, means:

(1) Knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish;

(2) The intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person; or

(3) Sexual abuse, including criminal sexual contact, incest, and criminal sexual penetration.

- **Neglect** is the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision, and care for the physical and mental health of that person. Neglect causes, or is likely to cause harm to a person.
- **Exploitation, or Misappropriation**, is an unjust or improper use of a person's money or property for another person's profit or advantage, financial, or otherwise.
- **Unexpected Death** is a death caused by an accident or an unknown or unanticipated cause.
- For Children, Less than 18 years contact:
 - Child Protective Services, 24 hours a day, 7 days a week at:
 - **CYFD Statewide Central Intake: 1-800-797-3260 or**
 - **Law Enforcement** or the appropriate **Tribal Entity**.
 - If you have any questions please contact: Danny.Maxwell@state.nm.us.