

# Frequently Asked Questions

## (HB 53-Delivery of Necessary Diabetic Supplies Template)

What we need from you:

1. Completed the new excel template.
2. Submit a separate data narrative as a pdf, **the data narrative is different than the narrative tab in the HB53 excel template.**

**[Instructions on how the carrier gets the new template if the template is lost. (TBD) ]**

- ! Only current templates will be accepted this cycle. If the incorrect template is used the report will be rejected and a revised report will be requested.
- ! A report and a narrative must be submitted for each line of business/each NAIC company code.
- ! Important! Submit the HB53 template in its native Excel file format. Use the following naming convention for the reporting template: **NAIC Company Code\_HB53\_OSI\_Report\_Quarter (Q1, Q2, Q3, Q4)\_Rundate (as year month day).xlsx**
- ! For the PDF data narrative use the following naming convention: **NAIC Company Code\_HB53\_OSI\_Narrative\_Quarter (Q1, Q2, Q3, Q4)\_Rundate (as year month day).pdf**
- ! E-mail both the Excel report and the PDF narrative, to [lifehealthdata@osi.nm.gov](mailto:lifehealthdata@osi.nm.gov).
- ! If there are any changes in the methodology you use, gather the data for the Delivery of Necessary Diabetic Supplies you need to update your narrative.

## Part 1 — General Questions and Observations

**Q1:** If a claim is retroactively adjusted, should OSI expect earlier quarters to be fully rewritten?

**Answer:** When reporting by **finalized date**, retroactive adjustments should be incorporated into the data for the current refresh cycle. The only exception would be adjustments resulting from an appeal, which may require additional handling. OSI also encourages reporting any significant outlier issues that occur during the quarter to ensure transparency and accurate interpretation of trends.

**Q2:** For retroactive eligibility changes, should updates be reflected in previous quarters or only in the current quarter's snapshot?

**Answer:** Please report totals as of the end of the current quarter. OSI understands that fluctuations due to retroactive changes will occur.

**Q3:** When we refer to a “snapshot” for quarterly reporting, what does that mean, and how should claims processed after month-end be handled?

**Answer:** A snapshot represents month-end, point-in-time data for each month in the quarter. These monthly counts are then summed to produce quarterly totals.

Claims finalized after month end should be included using the finalized date approach, otherwise they will roll into next month's report.

Date of service does not determine claim selection; OSI's data requirement is based on the finalized date.

**Q4:** Given the short turnaround time for feedback and the assumption that this report will be used for Q1 2026, would OSI consider recommending a delay in implementing the new template, especially since these requirements may create additional operational work?

**Answer:** The Q2 2026 report will include a detailed walk-through and provide carriers with an opportunity to review and share feedback based on real data.

## Part 2 — Template Specific Questions

### Instructions Tab

**Q1:** Could OSI provide more prescriptive instructions on where Health Plans should submit reports, such as the specific folder paths within HCA's DMZ and OSI's Dropbox, to help avoid confusion in future reporting?

**Answer:** The preferred submission method is to use the secure email: [lifhealthdata@state.nm.us](mailto:lifhealthdata@state.nm.us)

### Reimbursement Tab: (Population, Member Reimbursement, Provider/Supplier Reimbursement)

**Q1:** For the population definition, should “total lives” and “total lives with a qualifying diagnosis” be reported as counts at the end of the quarter, as monthly snapshots summed for the quarter, or in another specified format?

**Answer:** Report month-by-month counts aggregated for the quarter.

Two counts are required each month:

- A report must be submitted for each NAIC company. Count one is the total members enrolled in the NAIC company.
- The second count is the subset of members that are enrolled with the NAIC company with a qualifying diabetes diagnosis.

**Q2:** Regarding “Total Lives that have a qualifying ICD Diagnosis Code,” should qualifying members be counted once per month or per qualifying claim?

**Answer:** Count all qualifying members each month, regardless of whether a claim exists.

**Q3:** For “Number of requests for reimbursement of out-of-pocket purchases,” should counts be based on:

Reimbursement requests received during the month, or requests processed/paid during the month?

Should denied, withdrawn, or pending requests be included in total request counts?

**Answer:** Include all reimbursement requests received during the month, regardless of status (paid, denied, withdrawn, pending). All finalized requests should also be reported.

**Q4:** How do we distinguish Provider/Supplier Reimbursement from Member Reimbursement?

**Answer:**

- Member Reimbursement: dollars issued directly to the member for self-paid expenses.
- Provider/Supplier Reimbursement: dollars issued to any non-member entity.

**Q5:** Does this requirement refer exclusively to member-submitted claims that were paid to the provider or supplier?

**Answer:** No, this refers to total claims or requests regardless of payment status, and not exclusively those submitted by members.

**Q6:** How to find out total number of requests that qualified for interest?

**Answer:** Under NMSA 1978, Sections 59A-22-41(F)(5), 59A-23-41(F)(5), 59A-56-41(F)(5), 59A-47-45.8(F)(5) and 59A-47-45.8(F)(5), carriers must pay interest at the rate of eighteen percent per year on the amount of reimbursement due to a subscriber if not paid within thirty days. Interest eligible reimbursements should be identifiable in your records.

## Timeliness Tab (Supplier/Provider Claim Aging, Member Order Concerns)

**Q1:** Could OSI provide clarification on how to interpret and report these requirements? Should the Minimum Date of Service fall within the paid/denied date range? Should the Maximum Date of Service also fall within the paid/denied date range?

**Answer:** Claims should be restricted by finalized dates. But the dates of service reported in that cohort might not match the finalized time frame.

Example:

Claims finalized 01/01/2026–03/31/2026 may include dates of service ranging 12/15/2025–02/01/2026 because of processing lag. OSI is also requesting the average and median time from submission to finalization, split by paid/approved and denied.

Average =

$$\text{Sum/size}=(a+b+c)/3$$

Median =

- *If n is odd: the middle value of the sorted list*
- *If n is even: the average of the two middle values*

**Q3:** Clarify what constitutes a “complaint” for this metric? Specifically, should this include only formal grievances and appeals submitted to the MCO, or also other types of complaints?

**Answer:** Include all diabetic service complaints, whether formal or informal, not only grievances and appeals.

## Utilization Tab: (Pharmacy, DME)

**Q1:** Should Top 10 ranking be based on unique claims regardless of product, quantity, or units billed?

**Answer:** OSI requires claim counts by product, but quantity/units do not need to be reported.

**Q2:** What claim status should be considered while ranking the Top 10?

**Answer:** All claims, regardless of status.

**Q3:** If a pharmacy claim fails, the Quantity Limit check should the claim be considered as a denied claim?

**Answer:** No. If a pharmacy claim does not enter adjudication, it does not count. Only finalized claims should be counted regardless of status.

### Narrative Tab:

**Q1:** Clarify whether the questions listed on the Analysis tab of the state report are intended for DME providers, pharmacy providers, or both?

**Answer:** OSI notes that this is for the health care insurers to compile data for all contracted services.

**Q2:** Does your organization track deliveries that failed to comply with delivery requirements for each contracted provider?

**Answer:** OSI seeks to understand how you monitor vendor compliance with delivery timeliness and how complaints from members are documented and addressed by contracted vendors.

OSI appreciates the continued collaboration with health insurance carriers and trusts that this guidance helps clarify several key questions raised. Should you have any additional questions or require further clarification, please do not hesitate to reach out [monica.snowden@osi.nm.gov](mailto:monica.snowden@osi.nm.gov)