BlueCross BlueShield of New Mexico

Provider Reference Manual

Updated March 2025

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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- BlueCard Program Provider Manual
- Medicare Advantage Section of the Blues Provider Reference Manual
- Medicaid section of the Blues Provider Reference Manual

1 – CONTACT LIST FOR IN-NETWORK PROVIDERS

Contact Name	Phone / Fax / Email / URL
Availity® Essentials Client Services Obtain eligibility, benefits, authorizations, claim status, remittance with multiple payers, and much more	Phone (800) 282-4548 Web availity.com
BCBSNM Behavioral Health Prior authorizations and/or Recommended Clinical Review (RCR), benefits, and eligibility	Phone (888) 898-0070 Fax (877) 361-7659 FEP (877) 783-1385
BCBSNM BlueCard® Hotline Out-of-state member benefits, eligibility, and authorizations	Phone (800) 676-BLUE (2583)
BCBSNM Electronic Commerce Center Electronic Data Interchange (EDI) products and electronic claim submissions	Email ecommerceservicesNM@bcbsnm.com Web bcbsnm.com/provider/claims/claims-and-eligibility/edi-commerce
BCBSNM Federal Employee Program® (FEP®) Verify eligibility and benefits and/or check claim status for FEP members	Phone (800) 245-1609
BCBSNM Fraud Hotline Report concerns to the BCBSNM Special Investigations Department (SID)	Phone (877) 272-9741 Web bcbsnm.com/sid/reporting
BCBSNM Health Services Medical prior authorizations and/or Recommended Clinical Review (RCR), pharmacy, case and condition management	Phone (800) 325-8334 or (505) 291-3585
BCBSNM Network Management Consultants/ Network Services Provider Representative Information on online tools, BCBSNM products and initiatives, provider education opportunities, and personalized office visits	To find the name of your Provider Network Representative, refer to the **Network Contact List** on our website: bcbsnm.com/provider/contact_us.html
BCBSNM Network Services Make demographic changes to your provider file, check new contract status, obtain existing contract copies, make changes to an existing contract (e.g., business name or tax ID), or terminate an existing contract	Fax (866) 290-7718 or (505) 816-2688 Web bcbsnm.com/provider/network-participation
BCBSNM Provider Service Unit (PSU) Obtain benefits and eligibility for BCBSNM member as well as out-of-state member benefits, eligibility, provider grievances and authorizations	Phone (888) 349-3706
Blue Review™ Submit letters to the editor or article ideas for the BCBSNM provider newsletter	Email NM_Blue_Review_Editor@bcbsnm.com
eviCore Prior authorization for select outpatient services	Phone (855) 252-1117
Carelon Medical Benefits Management Prior authorization and/or Recommended Clinical Review (RCR) for select outpatient services	Phone (800) 859-5299 Online Carelon ProviderPortal

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM.

Carelon Medical Benefits Management (Carelon) is an operating subsidiary of Anthem, Inc., an independent specialty medical benefits management company that provides utilization management services for BCBSNM.

eviCore is an independent company that provides specialty medical benefits management for BCBSNM.

BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors and the products and services they offer.

2 – INTRODUCTION

Thank you for participating in the Blue Cross and Blue Shield of New Mexico (BCBSNM) network of physicians, hospitals, facilities, and professional providers. We are most appreciative of your efforts in maintaining and promoting the health and wellness of the approximately 600,000 New Mexicans who carry the BCBS card. Our extensive network of state-wide professionals provides a high standard of care and access to our members that reflects the quality and security that is expected of BCBSNM.

This reference manual is designed for ease of use while providing a comprehensive resource tool for your office. We suggest that you access this manual in its most current form in the Provider area of bcbsnm.com, under Provider Reference Manual. (If your staff cannot access the Internet, contact your Network Services Provider Representative to request a paper copy).

Please check the Provider area of our website for many other resources for providers, including news and updates, drug list information, medical policy information, the Blue Review provider newsletter, electronic claims filing information, and provider forms.

"We at Blue Cross and Blue Shield of New Mexico are deeply committed and passionate about providing high quality health care services to all our members. We thank all of our contracted physicians, providers, and hospitals for the care you provide to our members."

Janice Torrez
President, New Mexico Division

Latha Raja Shankar M.D.

Vice President Health Care Delivery and Chief Medical Officer

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3 – NETWORK SERVICES

Overview

BCBSNM's Network Services Department is dedicated to building strong relationships with our network of independently contracted health care providers by providing:

- Valuable health information on BCBSNM products
- Claims enhancement programs
- Continuing education
- Accessibility to our staff through visits, telephone communication, and email
- Continuous enhancements to our various communication technologies
- Guidance for your office staff on policies and procedures
- Accurate claims payment by assuring accurate information in claims payment systems (e.g., tax identification, National Provider Identification (NPI) number, address, panel status)
- Citation to applicable contract language
- Compliance with state and federal regulatory requirements

BCBSNM is dedicated to building strong relationships with our network of independently contracted health care providers by providing:

- Contracting
- Provider Servicing
- Reimbursement and Pricing
- Communication and Education
- Network Audit, Accreditation, Quality & Compliance
- Value Based Contracting

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3.1 Provider Network Services Roles

3.1.1 Network Services Provider Representative

Network services provider representatives assist providers with questions regarding pricing, fee schedules, site visits, education, orientations, complex and escalated issues and more. Network services provider representatives work with network contractors and network support representatives to help providers participate in BCBSNM's various networks.

3.1.2 Network Contractors

BCBSNM's network contractors are responsible for contracting between BCBSNM and various provider types, such as medical and behavioral health providers and facilities. Network contractors are available to address general questions about contracting with BCBSNM or specific questions about your contract. If you have questions regarding your contract, please first contact your network services provider representative.

3.1.3 Network Representatives

Network representatives are a dedicated team who handle general service inquiries including, how to join the BCBSNM Network, status of credentialing and/or onboarding application, where to go to update demographic information, and other general services.

3.2 Service Level Goal

The Network Services Department is committed to timely and accurate responses to inquiries raised by our providers. Our goal is to resolve most complex issues within 30 days or less from receipt of the original request. Our resolution process for most issues is as follows:

- Practitioner or provider informs BCBSNM that there is an issue to be investigated*
- BCBSNM acknowledges receipt of the issue within seven working days
- Should there be any delays in the issue's resolution, the provider will be notified promptly, and a new expected date of resolution will be communicated.
- Once BCBSNM believes the issue has been resolved, BCBSNM will inform the provider, via phone or email, confirming that the issue is resolved, what was done, and ask the provider to inform BCBSNM if they agree that the issue has been resolved.

*Inquiries involving claims and formal grievances will be processed according to the method outlined in Section 15, Provider Service Inquiry and Grievance Process.

3.3 Provider Change Notification

Network Services strives to furnish our providers and their office staff with prompt access to the most current information regarding the network(s) in which they participate. To do so, it is important that we have the most current and accurate data from our providers within our systems.

As detailed in Section 4, Professional Provider Responsibilities, and as specified in your contract with BCBSNM, it is vital that Network Services be contacted via the Update Your Provider Information link on the Network Participation tab of our website of any changes related to your practice, including but not limited to demographic changes and panel status. This information is used for our online Provider Finder® as well as for regulatory reporting purposes. For taxpayer ID changes providers must contact their Provider Network Representative directly.

3.4 Provider Satisfaction and Other Provider Surveys

Network Services partners with vendors and other internal resources throughout the year to conduct numerous provider surveys to fulfill regulatory, accreditation, and other requirements.

PCPs and other professional providers, such as specialty and behavioral health providers who furnish Covered Services to BCSBNM's members, may be asked to participate in BCBSNM's Provider Satisfaction Survey and/or Appointment Availability Survey, which are conducted annually. The Provider Satisfaction Survey determines our providers' level of satisfaction with BCBSNM and the Appointment Availability Survey measures compliance with appointment availability standards.

Results are compared to previous surveys to identify areas of opportunity and drive improvement. Provider feedback helps us make changes that ultimately benefit contracted providers and BCBSNM's members.

3.5 Contracting

3.5.1 Contracting Team

BCBSNM's network contractors are responsible for contracting between BCBSNM and various provider types, such as medical and behavioral health providers and facilities. The contracting team at BCBSNM consists of, but not limited to, senior contractors, specialists and support representatives.

3.5.2 Contracting Process

The contracting process starts with submission of a Provider Onboarding Form from a provider who wants to contract with BCBSNM. See the Network Participation page at bcbsnm.com/provider for additional information regarding the steps involved. Meeting criteria for, or completion of, one or more step(s) in the contracting process is not a guaranty of participation in any BCBSNM network, nor does it confer any rights upon the provider applicant. No communication from BCBSNM during these steps constitutes an offer capable of acceptance. Participation requires BCBSNM's counter-execution of a participation agreement, as to which BCBSNM reserves unfettered discretion to the fullest extent allowed by applicable law. The foregoing clarification does not, however, diminish BCBSNM intent to fully comply with any reimbursement obligations that may arise as a result of the operation of Section 13.10.28.12 NMAC.

Providers interested in participating with BCBSNM for one or more of its networks will need to follow a series of steps which may vary from provider type to provider type. This includes adequate access and availability based on provider types. More information on the steps and documents required can be found on the Network Participation page of bcbsnm.com/provider.

3.5.3 Contracts with Providers in the State of New Mexico

Provider contracts with BCBSNM require compliance with laws by BCBSNM and the provider. Therefore, to the extent, if any, that a provider contract with BCBSNM does not conform the requirements of Section 13.10.22.12 NMAC (Contracts with Providers in the State of New Mexico), as it may be amended or recompiled, the applicable requirement of Section 13.10.22.12 shall, to the extent necessary for compliance, be incorporated by reference as if fully set forth in the provider contract and as applicable supersede any nonconforming provision therein.

3.5.4 Prohibited Contract Terms

BCBSNM does not include the following provisions in any of its contracts with providers:

- offering an inducement, financial or otherwise, to provide less than medically necessary services to a covered person;
- penalizing a provider that assists a covered person in appealing BCBSNM's decision to deny or limit benefits to the covered person;
- prohibiting a provider from discussing treatment options with covered persons irrespective of BCBSNM's position on treatment options, or from advocating on behalf of a patient or patients within the utilization review or grievance processes established by BCBSNM or a person contracting with BCBSNM;
- prohibiting a provider from using disparaging language or making disparaging comments when referring to BCBSNM;
- prohibiting providers from discussing cheaper treatment or drug options with covered persons.

3.6 Site Visits

Credentialing, Delegation Oversight, Quality, Special Investigations, Provider Network Services, other BCBSNM contracted vendors may need to visit your practice in furtherance of their roles and responsibilities. Site visits may be conducted to, without limitation, assess your practice's policies, processes, and/or performance related to safety, billing, care delivery and record keeping. Depending on the nature of the site visit, prior notice may or may not be furnished. Whether prior notice is or is not furnished, your practice must cooperate with site visits conducted by BCBSNM during regular business hours. Prior notice, if furnished will include information on the nature of the visit and what aspects of the site and/or care processes will be evaluated. For certain subject matters, a certain score related to the site visit (e.g., 90%) may be necessary for your practice to be in compliance with applicable standards.

The site visit is an excellent opportunity to meet face-to-face and share information. We may take advantage of such visits to provide practice support tools (guidelines, reminders). We hope you will also use these visits as an opportunity to get questions answered, give feedback, and get to know our staff. Our goal is to be as minimally intrusive and as helpful as reasonably possible.

3.7 Credentialing

BCBSNM credentials individual and organizational providers. The credentialing process focuses on verifying appropriate training, experience, licensure and competence, and assessing data and information collected, to determine if a provider is qualified to render quality care to our members. Refer to Section 16, Credentialing of this manual for more information.

3.8 Reimbursement and Coding

A dedicated and skilled reimbursement staff handles all reimbursement and configuration needs. The reimbursement staff:

- Configures the system for pricing
- Create and maintain all fee schedules
- Process CPT/HCPCS/DRG grouper and code updates
- Respond to audit requests to ensure accurate reimbursement for billed services rendered to BCBSNM members.
- Identify and resolve reimbursement-related issues that are received through the regional contractor/lead representative

Refer to Section 5, Professional Provider Reimbursement and Section 6, Facility and Ancillary Providers for more information pertaining to reimbursement.

3.9 Communication

3.9.1 Provider Communication

BCBSNM is committed to maintaining a proactive communications plan that helps keep our providers current on changes occurring within the organization as well as health insurance regulatory requirements that impact their practices. Provider communications encompass a variety of information including, but not limited to:

- Notification of BCBSNM process changes
- Clarification of coding issues
- Education regarding utilization of the health management programs available to our members
- Informing providers as required by specific regulatory agencies

BCBSNM is dedicated to environmentally-friendly green initiatives and endeavors to distribute information electronically whenever possible. We encourage the use of our provider website for frequently asked questions (FAQs), news and updates, downloadable forms, contact information and much more. We also encourage all providers, administrators and office managers, and other members of your practice or facility to register for the *Blue Review* monthly provider newsletter to help stay up to date with BCBSNM.

3.9.2 Blue Review

The *Blue Review* newsletter is distributed monthly via email and posted on our provider website. To ensure your office receives the Blue Review and other communications straight to your inbox, please update your email address using the Update Your Provider Information link on bcbsnm.com/provider. You may also have other office staff sign up to receive the *Blue Review* using our online *Blue Review* sign-up form. If your office is not able to receive email, you may order a printed copy of the *Blue Review* by calling Network Services at 505-837-8800 or 1-800-567-8540.

3.9.3 Provider Website

The provider website is monitored regularly for content by a website team that strives to keep BCBSNM's site as current and relevant as reasonably possible. See the News & Updates section on our website for on-going updates. Electronic options can be found in Section 9, e-Commerce Tools of this manual.

3.10 Provider Education

BCBSNM is proud to offer complimentary educational webinar sessions to our participating provider community and we are committed to providing personalized one-on-one education to our participating providers.

Providers may choose specific topics which focus on their own office or individual needs. Our provider education specialists are prepared to provide the personalized attention you have come to expect from BCBSNM.

Current education modules available for training:

- Availity Essentials
- Carelon Medical Benefits Management
- Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA), and Electronic Payment Summary (EPS)
- Electronic Refund Management (eRM)
- Fraud, Waste and Abuse
- Interactive Voice Response (IVR)
- Corrected claims requests
- Cultural Competency Training and Attestation

The latest training schedule and how to sign up is located under Education & Reference in the Provider section of the BCBSNM website.

4 – PROFESSIONAL PROVIDER RESPONSIBILITIES

Overview

A provider is a duly licensed facility, physician or other professional authorized to furnish health care services within the scope of licensure.

A professional provider is any health professional such as a physician, dentist, nurse practitioner, registered nurse, licensed practical nurse, podiatrist, optometrist, chiropractor, physician's assistant, behavioral health professionals and physicians, pharmacist, nutritionist, occupational therapist, physical therapist, practitioner of oriental medicine, or other professional engaged in the delivery of health care services who is licensed to practice in New Mexico or the state where services are rendered; is certified; and is practicing under the authority of a managed health care plan, medical group, hospital, independent practice association, or other authority authorized by applicable New Mexico law.

A facility provider is an alcohol or drug treatment center, day surgery center, home healthcare agency, skilled nursing facility, hospital, or other facility that is licensed or certified to perform designated, covered health care services by the state or jurisdiction where services are provided. See Section 6, Facility and Ancillary Providers, for further information.

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4.1 Provider Information

4.1.1 Required Provider Directory and Contact Information

Contracted providers are required to submit and maintain correct provider directory and contact information as outlined in this section of the Provider Reference Manual, to facilitate both data accuracy and member ability to search using various elements including but not limited name, location, specialty, and cultural and linguistic capabilities. In accordance with various regulatory requirements, BCBSNM will regularly validate applicable data for the professional providers listed in our provider directories including, but not limited to:

- National Provider Identifier (NPI)
- Office location(s)
- Business phone number
- Email address*
- Website URL (if applicable)
- Affiliations
- Accepting new patient status
- Specialties
- Hours of operation
- Cultural and linguistic capabilities

*An email address is a single, regularly-monitored email address will not be listed in the directory but is provided and maintained by the contracted Medical Services Entity. Medical Services Entity's provision and BCBSNM's use of such email address for any business communications does not absolve Medical Services Entity of monitoring other means of communications between the parties, including, without limitation, postings and updates available through www.bcbsnm.com or communications sent to other email addresses in use by the parties, by fax, by U.S. Mail, or by overnight courier or hand-delivery. This email address will not be listed in the provider directory.

4.1.2 Requests for Changes to Provider Information

Requests for changes to provider information may be sent to Network Services via the online provider Demographic Change Form. To update the claims payment system and the provider directories, you must provide us with requests for changes a minimum of **60 working days prior to the effective date of change**. Notwithstanding the foregoing, changes to provider directory information that currently need to be made will be reflected within two (2) business days of BCBSNM's receipt of the changes from the provider. Additionally, providers should update CAQH with any changes to their information.

You may not be reimbursed properly if you do not timely and appropriately report changes to the following provider information, in which case BCBSNM is not responsible for any related delay and cannot guaranty that reimbursement will be made differently when/if you appropriately report the changes:

- National Provider Identifier (NPI) changes
- Office location(s)
- Mailing/Billing addresses
- Tax ID Number (TIN)*
- Name change of provider or practice
- Business phone number
- Email address
- Fax number
- Affiliations
- Covering physicians
- Hours of operation
- Practice limitations (e.g., HMO panel size, ability to see new patients, etc.)

*BCBSNM must be informed of **all** Tax ID changes. A change in your Tax ID will require an Amendment to your current contract with BCBSNM. Not informing BCBSNM adversely affects claims payment as all monies paid must be tracked for IRS purposes. Your NPI does not replace your TIN.

Note: Click on the Update Your Provider Information link at bcbsnm.com to access a convenient email submission form that you can use to report any changes to your practice information.

4.1.3 Provider Data Verification Requests

BCBSNM is required to verify data for our provider directory. In addition to, and without waiving, Providers' obligation to update their information on file with BCBSNM as required elsewhere in this PRM, Providers must also satisfactorily respond to provider directory data validation requests within 90 days of the date of the request. If a provider's data cannot be verified 180 days after the last verification date, the provider's information shall be suppressed from the online provider directory. If the provider's data is later verified, the provider may be added back into the directory. BCBSNM may also terminate a provider's contract for cause based on the failure to maintain updated information with BCBSNM as required elsewhere in this PRM or repeated failures to timely verify or update required provider directory information, all further rights and remedies reserved.

4.2 Primary Care Providers (PCPs)

4.2.1 Types of PCPs

A PCP (M.D., D.O., or C.N.P., PA) may be a general practitioner, family medicine physician, internal medicine physician, OB-GYN, geriatrician, or pediatrician. BCBSNM also contracts with Certified Nurse Practitioners and Physician Assistants who may also be designated as PCPs.

Health Maintenance Organization members must choose a PCP who will be their primary contact with the medical care system. The PCP usually determines the nature and frequency of care that is necessary and appropriate.

4.2.2 PCP Responsibility of Access to Care

PCPs are responsible for the member's timely access to appropriate services and care which include, but are not limited to, the following services as defined by the member's benefits:

- Physician services
- Outpatient services
- Hospital services
- Home health services
- Diagnostic laboratory and/or radiology services and timely notification of results
- Family planning services
- Health education and medical social services, including mental health or drug dependency
- Vision and hearing examinations/screenings
- Emergency services
- Rehabilitation services, including physical, speech, and occupational therapies
- Skilled nursing services

4.2.3 PCP Administrative Responsibilities

For BCBSNM members, PCPs must:

- Use providers in the BCBSNM network that supports the Member's plan, including without limitation specialists, ancillary providers, hospitals, pharmacies, laboratories, radiologists, and behavioral health professionals and physicians. This means, for example, that a PCP who or which participates with BCBSNM is required to send BCBSNM Members' samples, images, and studies to, and admit, transfer to, or refer BCBSNM Members to, another professional provider, facility or ancillary provider who or which also participates with BCBSNM, except in emergencies or as may otherwise be required by applicable law and/or as prior authorized by BCBSNM.
- Comply with BCBSNM's Quality Management and Improvement (QMI) and Utilization Management (UM) requirements, as well as all state and federally mandated audits (e.g., HEDIS, Risk Adjustment Data Validation - RADV) within seven (7) business days of the request.
- Collect only deductible, coinsurance (based on contract allowable), and specified copayments from BCBSNM members for office visits; and charges for non-covered services.
- Submit claims on CMS-1500 forms (see Section 8, Claims Submission).

- Follow referral and prior authorization and/or Recommended Clinical Review (RCR) procedures (see Section 10, Prior authorization and Recommended Clinical Review).
- Submit claims information accurately and in a timely manner (see Section 8).
- Maintain confidentiality of all member records.
- Maintain medical records for members following regulatory guidelines (see Medical Record Documentation Standards at the end of Section 16, Credentialing).
- Follow all applicable federal and state statutes regulations and sub regulatory guidance.
- Notify BCBSNM of changes to provider information as defined in Section 4.1, Changes to Provider Information.
- Comply with BlueCard® requirements as set forth in the BlueCard Program Provider Manual.
- If participating as a Medicaid provider, comply with the requirements set forth in the Medicaid Section.
- Notify the BCBSNM Credentialing Department of state or federal sanctions, restrictions or limitations to license, or other contractually reportable events within 30 days of occurrence.
- Comply with appropriate professional standards and licensure requirements.
- Comply with the BCBSNM member/provider complaint and grievance procedure.

The PCP should ensure that patients are reminded of appointments to help them comply with treatment plans and preventive care. For example, the PCP should issue reminders of screenings needed, as appropriate for age and sex, including but not limited to mammograms, pap tests, and immunizations as listed in the "Preventive Health Guidelines" (at the end of Section 17, Quality Management and Improvement).

Other preventive health services should be made available to members only in those instances where the PCP, in consultation with BCBSNM, determines that such services are medically necessary and as outlined in the State of New Mexico Managed Health Care Rule.

The PCP is expected to furnish members with meaningfully lengthy visits as indicated by clinical needs. Accordingly, BCBSNM generally does not require PCPs to see any minimum number of members per hour and specifically does not require PCPs to see more than four members per hour.

4.2.4 Ending Patient Relationship - Provider Notification Responsibilities

Providers shall not abandon members as patients. Providers must notify BCBSNM and members under active care of their intent to terminate the relationship between the member and the provider. Notice is required even if the provider is leaving a group practice because the provider-patient relationship is between the provider and the member. Notice to the member should be given in writing and should notify member(s) ideally 90 days but no less than 30 days prior to terminating the relationship. A copy of the

notice to the member should be emailed to the provider's assigned BCBSNM Network Representative. Notice is required if a provider is leaving a practice, a practice is closing, or an individual member's care is being discontinued by the provider for any reason. (If the practice is closing, there are additional notification requirements to BCBSNM elsewhere in this Manual.) At a minimum, the notice should state: (1) a brief reason for the termination of the relationship; (2) agree to provide treatment and access to services for a reasonable period of time, at least 30 days, during which the member can continue to receive services as they transition to another in-network provider's care; (3) resources and/or recommendations to help the member locate another in-network provider, including reminding them of the customer service phone number on the back of their BCBSNM ID card; and 4) other transition resources that might be appropriate including information on emergency services or on transferring medical records to their new in-network provider.

4.2.5 On-Call Coverage

The PCP will ensure the availability of services to members 24 hours per day, 7 days per week. The PCP will also:

- Maintain weekly appointment hours that are sufficient (at least four days per week)* and convenient to serve members.
- Maintain on-call service capability with other physicians who are contracted with BCBSNM to perform appropriate and cost-effective evaluation and treatment of members when the PCP is unavailable.
- Ensure that PCP will have back up coverage by another provider.
- Ensure that any covering physician is a participating provider and agrees to abide by all the procedures, requirements, and reimbursement policies described in the Participating Provider Agreement or other contract with BCBSNM and in this manual.

*You must notify Network Services if your regular office hours are less than four days per week. Providers with insufficient weekly appointment/office hours will not be listed as available to our members in our provider directories.

4.2.6 After-Hours Communications with Patients

The following information must be provided after normal office hours by either an answering service or answering machine message:

- How to make an appointment
- Hours of operation (when to call back)
- Emergency instructions including phone numbers to call "911" or to go to the emergency room if patient is experiencing a life-threatening condition
- How to reach the on-call provider

4.2.7 Interpreter Services

Contracted providers are expected to provide an interpreter for limited English Proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Providers need to arrange for the service using an interpreter

service of their choice. Additional information regarding interpretative services can be found at the Education & Reference Tab under the Tools option on the Provider portal of BCBSNM's website. Once the service is provided, the provider may submit an invoice for reimbursement to:

Provider Servicing
PO Box 23151
Waco, TX 76702

If you have any questions, please call 817-826-8343.

4.2.8 PCP Access Standards

The following access standards define the minimum requirements of timely access to care. Individual cases will vary, and the standards represent the aggregate average of a provider's practice for the condition and care required. Employer groups and regulatory agencies frequently ask us to provide access audits. Please be prepared to respond if asked for access information.

Condition	For	Time to Appointment
Routine, asymptomatic, member-initiated, outpatient appointment for primary medical care (preventive or complete physical exam)	Primary and preventive medical care	No greater than thirty (30) calendar days or twenty-two (22) business days, whichever is less, unless member requests later date
Routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical care	Non-urgent primary medical care	No greater than nine (9) calendar days or seven (7) business days, unless member requests later date
Urgent care for primary medical care	Primary medical care	Within 24 hours of notification; 7-days-a-week, 24-hour availability and 24-hour access to triage (PCP triage can be via telephone)
Routine outpatient	Diagnostic laboratory, diagnostic imaging, and other testing appointments	Time will be consistent with the clinical urgency but no greater than fourteen (14) calendar days or ten (10) business days, unless member requests later date
Routine outpatient	Diagnostic laboratory, diagnostic imaging, and other testing services via "walk-in" system	Consistent with severity of the clinical need

Condition	For	Time to Appointment
Urgent outpatient	Diagnostic laboratory, diagnostic imaging, and other testing appointments	Time will be consistent with the clinical urgency but not greater than 48 hours

Waiting time for outpatient scheduled appointments: no more than 30 minutes after the scheduled time, unless there is an emergency or other urgent situation; in that case, the member will be given the opportunity to be seen by another provider in the office or to be rescheduled within 48 hours.

The timing of scheduled follow-up outpatient visits with providers will be consistent with the clinical need.

4.3 Specialists

4.3.1 Specialist Responsibilities

BCBSNM requires PCPs to refer members to in-network specialists, unless they have prior authorization from the Medical Director or his or her designee to refer the member to an out-of-network specialist. Follow the referral and prior authorization and/or Recommended Clinical Review (RCR) procedures (see Section 10, Prior authorization and Recommend Clinical Review).

For BCBSNM members, specialists must:

- Notify the BCBSNM Credentialing Department of state or federal sanctions, restrictions limitations to license, or other contractually reportable events within 30 days of occurrence (required by contract).
- Provide only those services requested by the PCP (exception: OB/GYN care).
- Contact the member's PCP to discuss the indicated treatment.
- Work closely with the PCP to enhance continuity of health services.
- Communicate findings and recommended treatment plans to the PCP.
- Use providers in the BCBSNM network that supports the Member's plan, including without limitation specialists, ancillary providers, hospitals, pharmacies, laboratories, radiologists, and behavioral health professionals and physicians. This means, for example, that a specialist who or which participates with BCBSNM is required to send BCBSNM Members' samples, images, and studies to, and admit, transfer to, or refer BCBSNM Members to, another professional provider, facility or ancillary provider who or which also participates with BCBSNM, except in emergencies or as may otherwise be required by applicable law and/or as prior authorized by BCBSNM.

- Comply with BCBSNM QMI and UM requirements, as well as all state and federally mandated audits (e.g., HEDIS, Risk Adjustment Data Validation) within seven (7) business days of the request.
- Collect only deductible, coinsurance (based on contract allowable), and specified copayments from BCBSNM members for office visits; and also charges for non-covered services.
- Submit claims on CMS-1500 forms (see Section 8, Claims Submission).
- Obtain a referral from the PCP for any service that requires prior authorization before services are rendered (see Section 10, Prior authorization).
- Submit encounter and claims information accurately and in a timely manner (see Section 8).
- Maintain confidentiality of all member records.
- Maintain medical records for members following regulatory guidelines (see Medical Record Documentation Standards at the end of Section 16).
- Follow all applicable federal and state regulations.
- Notify BCBSNM of changes to provider information as defined in Changes to Provider Information in this section.
- Comply with BlueCard® requirements as set forth in the BlueCard Program Provider Manual,
- If participating as a Medicaid provider, comply with the requirements set forth in the Medicaid Section.
- Comply with appropriate professional standards and licensure requirements.
- Comply with the BCBSNM member complaint and grievance procedure.

4.3.2 Ending Patient Relationship - Provider Notification Responsibilities

Providers shall not abandon members as patients. Providers must notify BCBSNM and members under active care of their intent to terminate the relationship between the member and the provider. Notice is required even if the provider is leaving a group practice because the provider-patient relationship is between the provider and the member. Notice to the member should be given in writing and should notify member(s) ideally 90 days but no less than 30 days prior to terminating the relationship. A copy of the notice to the member should be emailed to the provider's assigned BCBSNM Network Representative. Notice is required if a provider is leaving a practice, a practice is closing, or an individual member's care is being discontinued by the provider for any reason. (If the practice is closing, there are additional notification requirements to BCBSNM elsewhere in this Manual.) At a minimum, the notice should state: (1) a brief reason for the termination of the relationship; (2) agree to provide treatment and access to services for a reasonable period of time, at least 30 days, during which the member can continue to receive services as they transition to another in-network provider's care; (3) resources and/or recommendations to help the member locate another in-network provider, including reminding them of the customer service phone number on the back of their BCBSNM ID card; and 4) other transition resources that might be appropriate including information on emergency services or on transferring medical records to their new in-network provider.

4.3.3 Interpreter Services

Contracted providers are expected to provide an interpreter for limited English Proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Providers need to arrange for the service using an interpreter service of their choice. Additional information regarding interpretative services can be found at the Education & Reference tab under the Tools option on the Provider portal of BCBSNM's website. Once the service is provided, the provider may submit an invoice for reimbursement to:

Provider Servicing
PO Box 23151
Waco, TX 76702

If you have any questions, call 817-826-8343.

4.3.4 Specialist and Behavioral Health Access Standards

The following access standards define the minimum requirements of timely access to care. Individual cases will vary, and the standards represent the aggregate average of a provider's practice for the condition and care required. Employer groups and regulatory agencies frequently ask us to provide access audits. Please be prepared to respond if asked for access information.

Condition	For	Time to Appointment
Symptomatic, recipient-initiated, outpatient referral and consultation, (preventive or routine)	Specialty medical care	Consistent with clinical urgency, but no more than twenty-one (21) calendar days, or fifteen (15) business days, unless the member requests a later time
Specialty outpatient referral and consultation (symptomatic, needs medical attention)	Specialty medical care	Consistent with clinical urgency, but no more than 24 hours for urgent appointment, and nine (9) calendar days for non-urgent symptomatic, or seven (7) business days, unless the member requests a later time
Non-urgent, outpatient appointments, initial visits or follow-up for preventive or routine care	Behavioral health care	No greater than seven (7) calendar days or five (5) business days, whichever is less, unless the member requests a later time
Non-urgent, symptomatic, medical attention needed	Behavioral health care	No greater than nine seven (7) days or five (5) business days, unless the member requests a later time.
Routine follow up	Behavioral health care	Within 30 calendar days unless the member requests a later time

Condition	For	Time to Appointment
Urgent conditions, outpatient appointment	Behavioral health care	Within 24 hours of notification; 7-days-a-week, 24-hour availability and 24-hour access to behavioral triage
Crisis services, including non-life-threatening emergency care, face-to-face appointment	Behavioral health care	Care for crisis services including non-life-threatening emergency care within 90 minutes; 7-days-a-week, 24-hour access to triage or hospital emergency room
Routine outpatient	Diagnostic laboratory, diagnostic imaging, and other testing appointments	Time will be consistent with the clinical urgency, but no greater than fourteen (14) calendar days, unless the member requests a later date
"Walk-in" system	Diagnostic laboratory, diagnostic imaging, and other testing services via "walk-in" system	Consistent with severity of the clinical need
Urgent outpatient	Diagnostic laboratory, diagnostic imaging, and other testing appointments	Time will be consistent with the clinical urgency but not greater than 48 hours

Waiting time for outpatient scheduled appointments: no more than 30 minutes after the scheduled time, unless there is an emergency or other urgent situation; in that case, the member will be given the opportunity to be seen by another provider in the office or to be rescheduled within 48 hours.

The timing of scheduled follow-up outpatient visits with providers will be consistent with the clinical need.

4.4 Medical Records

4.4.1 Medical Records Requests

Providers will furnish medical, financial, and administrative information to BCBSNM that may be necessary for compliance with state and federal law (e.g., ACA Risk Adjustment) and without limitation, for QMI (e.g., HEDIS), UM (e.g., Medical Necessity), SID (e.g., Audits) and as may be otherwise provided in the Provider's participation agreement or this manual. Requested copies of medical records must be delivered to BCBSNM within seven (7) business days. BCBSNM does not pay for medical records.

Note: BCBSNM is compliant with the Health Insurance Portability & Accountability Act (HIPAA) regulations regarding required medical records.

4.4.2 Standards for Medical Records

Participating providers must have a system in place for maintaining medical records that conforms to regulatory standards. Each visit whether direct or indirect must be comprehensively documented in the member's medical chart.

Refer to the Medical Records Documentation Standards in the Standards & Requirements section of our provider website.

4.4.3 Transfer of Medical Records

The physician or physician group practice is responsible for making appropriate arrangements for the disposition of medical records when a practice closes.

The recommended period for record retention is:

- Adult patients—10 years from the date the patient was last seen.
- Minor patients—28 years from the patient's birth.
- Mammography patients—10 years from last mammography.
- Deceased patients—5 years from the date of death.

For situations where a physician is turning over their practice to another physician:

- There should be a written agreement that stipulates the recommended retention time and access capability
- If physicians choose to destroy clinical records after a set period of time, confidentiality must not be compromised. There are record destruction services that guarantee records are properly destroyed without releasing any information.
- When a practice closes and medical records are transferred, patients should be notified that they may designate a physician or other provider to receive their records.
- If a patient does not designate a physician, records may be transferred to a custodian (physician or commercial storage firm).

Custodians who agree to retain the records can be physicians, non-physicians, or commercial storage facilities. Custodial arrangements for retaining records are usually entered into for a fee and should be in writing. A written custodial agreement should guarantee future access to the records for both the physician and patients. A custodial agreement should include the following:

- Keep and maintain the medical records received for the same retention times as above.
- No right to access the information contained in the medical records without a signed release from the patient or a properly executed subpoena or court order.
- Notify the original physician or physician's personal representative of any change of address or phone number.
- Terms apply to all persons in the custodian's employment and facility.

- Release copies of the medical records to a person designated by the patient only with the patient's written request.
- Comply with state and federal laws governing medical record confidentiality, access, disclosure, and charges for copies of the records.
- Agreed-upon fees for maintaining the records.
- Language that addresses any personal practice decisions made by a custodian (retirement, selling, or moving) to ensure the safety of and continued access to the records by the original physician or physician's personal representative.

4.5 Medical Policy and Member Benefits

4.5.1 Overview

Providers are required to review BCBSNM medical policy information, as these policies may impact your reimbursement and your patients' benefits. Approved new or revised medical policies and their effective dates are posted on our website around the first and fifteenth of each month. To view Active Policies or Pending Policies, visit bcbsnm.com under Standards & Requirements. In addition, you may also click on Draft Policies to view policies that are under development or are being revised and submit your comments via email.

Medical policies are based on data from the peer-reviewed scientific literature, from criteria developed by specialty societies, and from guidelines adopted by other health care organizations. Medical policies are used to make benefit coverage determinations. In the event of conflict between a medical policy and any Plan document, the Plan document will govern.

Providers are responsible for being familiar with services that may not be covered by BCBSNM, such as procedures that may be considered experimental and/or investigational. If a procedure or diagnostic service is considered experimental and/or investigational, you must inform the member that they may incur financial responsibility.

Note: Federal Employment Program (FEP) utilizes a hierarchical review process that includes the FEP medical policies. These policies may be found at fepblue.org. If there is no FEP policy, then BCBSNM medical policies are followed.

4.5.2 Experimental, Investigational, or Unproven Services

Experimental, investigational, or unproven services include any treatment, procedure, facility, equipment, drug, device, or supply not accepted as **standard medical practice**, as defined below. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is considered experimental and will not be covered.

Standard medical practice means the use of services or supplies that are in general use in the medical community in the United States and that meet the following criteria:

- The services or supplies have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
- The services or supplies are appropriate for the hospital or other facility provider in which they were performed.
- The physician or other professional provider administering the services or supplies has had the appropriate training and experience to provide the treatment or procedure.

For a treatment, procedure, facility, piece of equipment, drug, device, or supply to be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.
- The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.
- The service must be medically necessary and not excluded by any other contract exclusion.

Note: Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol(s) used by the treating facility; or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. Experimental, investigational, or unproven does not include cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

4.5.3 Exclusions and Non-Covered Services

BCBSNM does not cover services for which the member has no legal obligation* to pay or that are free, including:

- Charges made only because benefits are available under the health care plan
- Services for which the member has received a professional or courtesy discount

- Volunteer services
- Services provided by the member for him or herself
- Services provided by a BCBSNM provider to a family member or immediate relative, or services provided to persons ordinarily residing in a family member's or immediate relative's household (**See below for definitions and related information from the Medicare Benefit Policy Manual).
- Physician charges exceeding the amount specified by the Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

When BCBSNM receives claims that fall into the above categories, they will be denied as non-covered services.

*The "No Legal Payment Obligation" exclusion above does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services or Medicaid.

**The Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 16, Section 130, Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household, provides the following definitions of an *immediate relative* and *members of the patient's household*:

An immediate relative includes the following degrees of relationship:

- Husband and wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild

Note: A step-relationship and an in-law relationship continue to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties.

Members of the patient's household are persons sharing a common abode with the patient as a part of a single-family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single-family unit. A mere roomer or boarder is not included in this definition.

Note: FEP has non-covered services that are defined in the benefit brochure.

4.5.4 FEP Exclusions

Standby Physicians – The Federal Employee Program (FEP) Plans do not provide benefits for standby services.

- FEP benefits are available when a physician becomes actively involved in a patient's care. In certain cases, such as neonatal intensive care, where the standby

physician is in attendance because of a medically appropriate diagnosis, benefits may be available. The standby physician must be requested by the attending physician.

- Benefits are not provided for physicians who are on call at the hospital when the medical condition of the patient does not support the indication that additional physician assistance would be necessary.

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5 – PROFESSIONAL PROVIDER REIMBURSEMENT

Overview

The following is a description of the basic fee schedule methodology used to reimburse professional providers and some ancillary providers. In general, this reimbursement method is tied to the filing of a CMS-1500 claim form for services provided as designated by Current Procedural Terminology (CPT®) or HCPCS codes.

Note: For facility provider reimbursement, see Section 6, Facility Providers and Ancillary Providers

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5.1 Fee Schedule

5.1.1 Overview

The BCBSNM Maximum Allowable Fee Schedule for PPO/HMO/PAR/POS networks utilizes certain aspects of the Medicare Resource Based Relative Value System (RBRVS) methodology as further described in the reimbursement attachment to your participation agreement with BCBSNM. RBRVS establishes Relative Value Units (RVUs) for most procedure codes based on the resources, knowledge, and cost needed to provide the service. It also provides a consistent method of determining the price for each code, relative to other codes. In most cases, to determine a fee for a procedure code, multiply the total RVU for the code by the applicable Conversion Factor (CF) in your participation agreement with BCBSNM (e.g., RVU of 1.234 x a CF of $39.36 = $48.57). BCBSNM may update RVUs based on and subsequent to changes made by CMS. BCBSNM may also make certain adjustments to RVUs such as, but not limited to, New Mexico's Geographic Practice Cost Indices (GPCIs) and Site of Service (SOS).

The BCBSNM Maximum Allowable Fee Schedules for Blue Preferred, Blue Advantage and Blue Community list prices for Covered Services furnished to Members with health plans supported by those networks.

5.1.2 Fee Schedule Requests

Providers can obtain an entire fee schedule or request fee information for specific codes by filling out a Fee Schedule Request Form (and related Confidentiality Agreement) available on the bcbsnm.com provider website under Forms.

Medicare Relative Values and fees are available on the Centers for Medicare & Medicaid Services (CMS) website, at cms.hhs.gov/home/medicare.asp. The RVUs on the CMS website are not adjusted for New Mexico GPCIs.

Note: The BCBSNM fee schedule is not a guarantee of payment. Services represented are subject to provisions of the health plan including, but not limited to: membership, eligibility, premium payment, claim payment logic, provider contract terms and conditions, applicable medical policy, benefits limitations and exclusions, bundling logic, and licensing scope of practice limitations. Maximum allowable may change from time to time subject to notice requirements of applicable law and regulations and prevailing provider agreement. CPT codes are copyright by the American Medical Association. Additional provider information is available on the website at www.bcbsnm.com.

5.1.3 Reimbursement for Specific Services

Durable medical equipment (DME) services - Fees for most DME services are updated annually based on a percentage of the Medicare flat fees, available on the CMS website. Correct pricing for DME equipment requires use of modifiers for rental (RR), used purchase (UE), new purchase (NU), and less than a full month rental (KR).

The rental of DME equipment with a capped rental as designated by CMS shall not extend more than a 10-month duration unless otherwise directed by the member's DME benefit provisions. No additional payments shall be made after 10 months.

Clinical laboratory services - Fees for most clinical laboratory services are updated annually based on a percentage of the Medicare flat fees, available on the CMS website.

Immunizations or injectable drugs (J-codes) - Fees for these services are established based on the BCBSNM Average Sale Price (ASP), which is based on the ASP published by CMS and are the same for all four networks (PAR, PPO, HMO, and POS).

- **NOTE:** Pursuant to the New Mexico Vaccine Purchasing Act, NMSA 1978, Section 24-5A-1, et seq. (2015), and Section 7.5.4.9 NMAC (2015), to avoid duplication of payment, providers must not bill for the cost of, and shall not be reimbursed by BCBSNM, for vaccines purchased by the New Mexico Department of Health and administered to insured children covered by a health plan underwritten by BCBSNM. Providers may, however, submit claims to BCBSNM for the administration of the vaccines using the appropriate CPT code(s), reimbursement for which, if any, will be determined by the provider's participation agreement with BCBSNM and all other conditions of coverage. Pursuant to notice from BCBSNM, if any, Participating Providers shall also furnish to BCBSNM any additional documentation or information, including claims based, necessary for BCBSNM to comply with the Vaccine Purchasing Act and regulations promulgated thereunder.

The allowable amount is based on the NDC and/or Generic Product Identifier (GPI) when the provider contract stipulates to do so.

Refer to Section 8, Claims Submission for billing drug codes.

5.2 Anesthesia Guidelines

5.2.1 Overview

Anesthesia procedures are generally reimbursed according to time units for the specific procedure, plus base units multiplied by the anesthesia conversion factor for that provider. BCBSNM defines anesthesia time units two ways:

Surgical procedures: One unit for each 15-minute increment, or a part of.

Labor and delivery codes: Vaginal delivery codes are reimbursed one unit per hour up to 16 hours. C-section delivery codes are reimbursed in 15-minute increments.

Base units are the relative value unit assigned by the American Society of Anesthesiologists (ASA).

An example of this equation is as follows: {(ASA base units) + (time units)} x Anesthesia Conversion Factor = Allowable.

5.2.2 Consultative, Diagnostic, and Therapeutic Services

Consultative, diagnostic, and therapeutic services, as recognized by the Current Procedural Terminology (CPT) book, include:

- Evaluation and management services
- Pain management and nerve blocks
- Other codes

These services are reimbursed according to the BCBSNM medical and surgical conversion factors multiplied by the base unit value (which could be the RVU or the ASA unit value depending on the provider contract) for that specific procedure code.

5.3 Pricing Modifiers

Some HCPCS and CPT modifiers have potential pricing impacts. Modifiers can affect pricing in multiple ways. The table below identifies commonly used modifiers and the potential pricing impacts. Actual fees are determined by contract criteria for any specific provider.

Modifier	Description	Potential Impact
26	Professional Interpretive Service – Used when the procedure has a technical and professional split between the full service	RVU for professional only services, when appropriate
TC	Technical Component – Used when the procedure has a technical and professional split between the full service	RVU for technical only services, when appropriate
50	Bilateral Surgery – Used when the description of the CPT or HCPCS codes doesn't already indicate a bilateral procedure	150% of fee
51	Multiple Surgery	50% of fee
52	Service or procedure that is partially reduced or eliminated	50% of fee
53	Discontinued Procedure	50% of fee
54	Surgical Care Only	75% of fee
55	Post-operative Management Only	12.5% of fee
56	Pre-operative Management Only	12.5% of fee
62	Co-surgery	62.5% of fee
78	Return to OP Room	75% of fee
80	Assistant Surgeon	20% of fee
81	Minimum Assistant Surgeon	20% of fee
82	Assistant Surgeon when qualified resident surgeon not available	20% of fee
AD	Medical Supervision, > four Anesthesia procedures	63% of fee
AS	Assistant at surgery service	12% of fee
NU	New DME being purchased	Purchase allowable for new equipment (1)
QK	Medically directed two to four concurrent anesthesia procedures	63 % of fee
QX	CRNA service with MD medical direction	37% of fee
QY	Medically directed CRNA	63% of fee

RR	Rental (DME)	Rental allowable/Monthly (2)
KR	Rental (DME)	Rental allowable/Daily – required for rentals of less than a full month (3)
UE	Used DME	Purchase allowable for used equipment (1)

(1) Purchase of equipment can be paid only one time.
(2) Monthly rental is for a full month, regardless of the number of actual days in the month being billed.
(3) Daily rental is calculated based on 1/30th of the monthly rental x the # of days the equipment was in the patient's home. The same calculation applies regardless of the actual number of days in the month being billed.

5.4 Professional Multiple Surgery Guidelines

5.4.1 Multiple Procedures, Same Operative Session

Standard consideration for multiple procedures (modifier 51) performed during the same operative session allows for an eligible amount of 100% of the provider's allowance for the procedure with highest allowance. Secondary and tertiary procedures appropriate for application of multiple surgery pricing (see note below) are allowed at 50% of the allowance for the procedure.

5.4.2 Bilateral Procedures

Standard consideration for bilateral procedures (modifier 50) allows for an eligible amount of 150% of the provider's allowance for both sides (100% for the first side and 50% for the second). The multiple surgery guidelines apply when multiple related and unrelated services are billed during the same operative session in addition to bilateral procedures.

Important Note: Surgical procedures defined by the American Medical Association as Modifier 51 exempt or an "add-on" code are not subject to the above Multiple Surgery Pricing Guidelines.

5.5 Member Share – Copay, Coinsurance, and Deductibles

5.5.1 Member Share

Providers contracted with BCBSNM must collect member share. It should be collected at the time the service is provided. Check the member's ID card for the proper member share amount to collect. If you are unaware of the status of the deductible, collect 10 percent of the service being provided. You may have to refund the member when the Provider Claims Summary arrives, and you can determine the exact member share. Member share is inclusive of State gross receipts tax, if applicable.

5.5.2 Office Member Share

An office member share is usually required for **all** office visits for which your office would ordinarily generate a charge, including blood pressure checks, educational sessions with a nutritionist, physical therapy, etc. If a charge is not generated for a visit, no member share should be collected.

Do **not** collect an office member share for non-surgical diagnostic procedures when there are no other office visit charges associated with those procedures. This includes lab, X-rays, mammograms, audiograms, and EKGs.

5.5.3 Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, BCBSNM will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSNM may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the covered persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSNM directly for any or all of an enrollee's premium.

5.5.4 Behavioral Health Cost Share

Notwithstanding the foregoing, effective January 1, 2022, in-network providers should not collect "cost sharing" from certain members for "behavioral health services" to the extent required by and defined in Senate Bill 317 (2021) as codified in the New Mexico Insurance Code and clarified by OSI Bulletin 2021-009 and OSI Notice (January 14, 2022), as the foregoing may be later amended or recompiled.

5.6 Attachments

Fee Schedule Request Form

6 – FACILITY AND ANCILLARY PROVIDERS

Overview

A facility provider is an alcohol or drug treatment center, day surgery center, home health care, hospice, home infusion agency, skilled nursing facility, hospital, or other facility that is licensed or certified to perform designated, covered health care services by the state or jurisdiction where services are provided.

An ancillary provider is a supplier of health care related equipment or services such as durable medical equipment (DME), prosthetics, orthotics, drugs, medical supplies, etc.

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6.1 Facility and Ancillary Responsibilities

6.1.1 Network Hospitals

BCBSNM members must select a hospital within the network of contracted BCBSNM facilities unless they have prior authorization from the Medical Director or his/her designee, or unless their plan allows their use of non-contracted services (usually at his/her out-of-pocket expense). BCBSNM members using network hospitals will receive a higher benefit level than they would if services were rendered in an out-of-network hospital.

6.1.2 Responsibilities

For BCBSNM members, facility and ancillary providers must:

- Participate in preadmission review processing for prior authorization.
- Participate in claims review for determination of medical necessity.
- Participate in length-of-stay monitoring and control.
- Assist in proper prior authorization processing for hospital services.
- Participate in utilization review, including responding to requests for information from BCBSNM personnel.
- Participate in peer review.
- Participate in quality improvement activities and efforts to systematically improve patient safety.
- Participate in facility credentialing activities.
- Comply with the BCBSNM member complaint and grievance procedure.
- Submit other insurance information to BCBSNM.
- Notify BCBSNM with new facility locations to initiate credentialing for network participation (each participation contract should be reviewed to determine if the new location(s) is/are included)
- Notify BCBSNM immediately of change in accreditation or licensing status or of federal sanctions.
- Use providers in the BCBSNM network that supports the Member's plan, including without limitation specialists, ancillary providers, hospitals, pharmacies, laboratories, radiologists, and behavioral health professionals and physicians. This means, for example, that a facility provider who or which participates with BCBSNM is required to send BCBSNM Members' samples, images, and studies to, and admit, transfer to, or refer BCBSNM Members to, another professional provider, facility or ancillary provider who or which also participates with BCBSNM, except in emergencies or as may otherwise be required by applicable law and/or as prior authorized by BCBSNM.
- Comply with BCBSNM Quality Management and Improvement (QMI) and Utilization Management (UM) requirements.

- Collect only deductible, coinsurance (based on contract allowable), and specified copayments from BCBSNM members for office visits, and charges for non-covered services.
- Submit professional claims on CMS-1500 forms and facility claims on the UB-04 form (see Section 8, Claims Submission).
- Obtain a referral from the PCP for any service that requires prior authorization before services are rendered (see Section 10, Prior authorization).
- Submit encounter and claims information accurately and timely (see Section 8, Claims Submission).
- Maintain confidentiality of all member records.
- Maintain medical records for members following regulatory guidelines (see Medical Record Documentation Standards at bcbsnm.com/provider).
- Follow all state regulations, such as Health Department reporting requirements.
- Notify BCBSNM of changes to provider information as defined in Section 4, Professional Provider Responsibilities.
- Comply with BlueCard® requirements as set forth in the BlueCard Program Provider Manual, included in this Provider Reference Manual.
- If participating as a Medicaid provider, comply with the requirements set forth in the Medicaid Section.
- Comply with appropriate professional standards and licensure requirements.

6.1.3 Interpreter Services

Contracted providers are expected to provide an interpreter for limited English Proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Providers need to arrange for the service using an interpreter service of their choice. Additional information regarding interpretative services can be found under Tools on the Provider portal of BCBSNM's website. Once the service is provided, the provider may submit an invoice for reimbursement to:

Provider Servicing
PO Box 23151
Waco, TX 76702

If you have any questions, please call 817-826-8343.

6.1.4 Provider Directory and Contact Information

Contracted facility and ancillary providers are required to submit and maintain correct provider directory and contact information as outlined in this section of the Provider Reference Manual. In accordance with various regulatory requirements, BCBSNM will regularly validate applicable data for the facility and ancillary providers listed in our provider directories including, but not limited to:

- National Provider Identifier (NPI)
- Office location(s)

- Business phone number
- Email address*
- Website URL (if applicable)
- Hours of operation

*An email address is a single, regularly-monitored email address will not be listed in the directory but is provided and maintained by the contracted Medical Services Entity. Medical Services Entity's provision and BCBSNM's use of such email address for any business communications does not absolve Medical Services Entity of monitoring other means of communications between the parties, including, without limitation, postings and updates available through www.bcbsnm.com or communications sent to other email addresses in use by the parties, by fax, by U.S. Mail, or by overnight courier or hand-delivery. This email address will not be listed in the provider directory.

BCBSNM is required to verify data for our provider directory. In addition to, and without waiving, Providers' obligation to update their information on file with BCBSNM as required elsewhere in this PRM, Providers must also satisfactorily respond to provider directory data validation requests within 90 days of the date of the request. If a provider's data cannot be verified 180 days after the last verification date, the provider's information shall be suppressed from the online provider directory. If the provider's data is later verified, the provider may be added back into the directory. BCBSNM may also terminate a provider's contract for cause based on the failure to maintain updated information with BCBSNM as required elsewhere in this PRM or repeated failures to timely verify or update required provider directory information, all further rights and remedies reserved.

6.2 Facility and Ancillary Reimbursement

6.2.1 Diagnosis Related Groups

The most common method of reimbursing inpatient care at hospitals is through Diagnosis Related Groups (DRGs). DRGs are a system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. DRGs are considered a fixed-fee arrangement for services rendered under a defined length of stay. Reimbursement under the DRG methodology can be altered based upon lower- or higher-than-usual lengths of stay.

Present on Admission (Section 6.5.3, below) indicator must be completed for each diagnosis code submitted on the claim.

6.2.2 Fixed-Fee Arrangements

Fixed-fee arrangements reflect a negotiated rate for services rendered in which the provider assumes a degree of financial risk or gain. Different fixed-fee arrangements include: inpatient hospital per diems, inpatient hospital case rates, outpatient case rates,

and outpatient maximum allowable fee schedules. The Resource Based Relative Value Scale (RBRVS) based fee schedule and DRG hospital rates are fixed-fee arrangements.

Note: For further information on RBRVS, see Section 5, Professional Provider Reimbursement.

6.2.3 Maximum Per Diem

Most home health care, hospice, or home infusion agencies, as well as skilled nursing facilities, are reimbursed billed charges up to the per diems as defined by the services rendered. Per diems are inclusive of all services and supplies based on the type of provider. Inclusive services are defined in the facility provider's Medical Services Entity Agreement.

6.2.4 Emergency Services

Acute general hospitals are reimbursed for emergency services provided in compliance of federal mandates, such as the "anti-dumping" law in the Omnibus Reconciliation act of 1989, P.L. (101-239) and 42 U.S.C. Section 1395dd. (1867 of the Social Security Act).

6.3 Member Share – Copay, Coinsurance, and Deductibles

6.3.1 Collecting Member Share

Facility and ancillary providers are required to collect member share at the time the service is provided. Check the member's ID card for the proper member share amount to collect. If you are unaware of the status of the deductible, collect 10 percent of the service being provided. You may have to refund the member after the Provider Claims Summary (PCS) arrives and you can determine the exact member share. Member share is inclusive of State gross receipts tax.

Note: Please see FEP's section for Copay information.

6.3.2 Emergency and Urgent Care Member Share

The emergency care member share is collected by the emergency room at an acute care hospital.

The urgent care member share is collected when a member is seen at an urgent care center. Check the member share amount on the member's ID card.

See Section 10, Prior authorization for additional information on emergency and urgent care services.

6.3.3 Inpatient Hospital Member Share

The inpatient hospital member share is collected by the hospital for an inpatient admission.

The inpatient surgery member share is collected by the hospital where inpatient surgery is performed. When pre- and post-operative visits are included in a global surgical fee, no office visit member shares are collected for those visits.

In maternity cases, the delivery member share is collected by the hospital.

6.3.4 Outpatient Member Share

When outpatient ambulatory surgery is performed in an ambulatory surgery unit, the copayment is equal to the outpatient copayment.

See Section 7, Member Information for restrictions, responsibilities, and exclusions.

6.3.5 Behavioral Health Cost Share

Notwithstanding the foregoing, effective January 1, 2022, in-network providers should not collect “cost sharing” from certain members for “behavioral health services” to the extent required by and defined in Senate Bill 317 (2021) as codified in the New Mexico Insurance Code and clarified by OSI Bulletin 2021-009 and OSI Notice (January 14, 2022), as the foregoing may be later amended or recompiled.

6.4 Medical Policy and Member Benefits

6.4.1 Medical Policy

Medical policies are based on data from peer-reviewed scientific literature, from criteria developed by specialty societies, and from guidelines adopted by other health care organizations. Medical policies are used to make benefit coverage determinations. In the event of conflict between a medical policy and any Plan document, the Plan document will govern.

Facility and ancillary providers are required to review BCBSNM medical policy information as these policies may impact your reimbursement and your patients’ benefits. Approved new or revised medical policies and their effective dates are posted on our website the first day of each month. To view all Active or Pending policies, visit bcbsnm.com/provider under Standards & Requirements. In addition, you may click on the Draft Medical Policies link to view policies that are under development or are being revised and submit your comments via email.

All providers are encouraged to contribute their constructive comments to the draft medical polices for consideration by the HCSC Medical Policy Group.

Note: Federal Employment Program (FEP) utilizes a hierarchical review process that includes the FEP medical policies. These policies may be found at fepblue.org. If there is no FEP policy, then BCBSNM medical policies are followed.

6.4.2 Experimental, Investigational, or Unproven Services

Facility and ancillary providers are responsible for being familiar with services that may not be covered by BCBSNM, such as procedures that may be considered experimental and/or investigational. If a procedure or diagnostic service is considered experimental and/or investigational, you must inform the member that they may incur financial responsibility. (See below for further information on experimental, investigational, or unproven services.)

Experimental, investigational, or unproven services include any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as defined below. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is considered experimental and will not be covered.

Standard medical practice means the use of services or supplies that are in general use in the medical community in the United States, and which meet the following criteria:

- The services or supplies have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
- The services or supplies are appropriate for the hospital or other facility provider in which they were performed.
- The physician or other professional provider administering the services or supplies has had the appropriate training and experience to provide the treatment or procedure.

For a treatment, procedure, facility, piece of equipment, drug, device, or supply to be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, or efficacy as compared with the standard means of treatment or diagnosis.

- The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.
- The service must be medically necessary and not excluded by any other contract exclusion.

Note: Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol(s) used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. Experimental, investigational, or unproven does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

6.5 Preventable Adverse Events

6.5.1 Overview

BCBSNM defines Preventable Adverse Events (PAEs) are defined as “adverse events that are serious, largely preventable, and of concern to both the public and health care providers for public accountability.” They include both Hospital-Acquired Conditions (HAC) as identified by the Centers for Medicare & Medicaid Services (CMS), as well as Serious Reportable Events (SREs) as defined by the National Quality Forum (NQF).

BCBSNM will apply the following five principles or guidelines when a serious hospital acquired condition or Never Event occurs:

- The error or event must be preventable.
- The error or event must be within control of the hospital.
- The error or event must be a result of a mistake by the hospital.
- The error or event must result in significant harm.
- Identification of non-payable events will incorporate case-by-case review and determination by a Medical Director, except when self-reported and without dispute.

6.5.2 Serious Reportable Events

SREs, as defined by the NQF, are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers. This list of SREs has since evolved to account for a range of clinical settings where patients receive care, including office-based practices, ambulatory surgery centers, and skilled nursing facilities.

Providers are required to report on a claim if a SRE occurs.

The SREs are:

1. Surgical or invasive procedure events
    a. Surgery or other invasive procedure performed on the wrong site
    b. Surgery or other invasive procedure performed on the wrong patient
    c. Wrong surgical or other invasive procedure performed on a patient
    d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
    e. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
2. Product or device events
    a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
    b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
    c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
3. Patient protection events
    a. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
    b. Patient death or serious injury associated with patient elopement (disappearance)
    c. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
4. Care management events
    a. Patient death or serious injury associated with a medication error
    b. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
    c. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
    d. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
    e. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
    f. Artificial insemination with the wrong donor sperm or wrong egg
    g. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
    h. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
5. Environmental events
    a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
    b. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
    c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
    d. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
6. Radiologic events

   a. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
7. Potential criminal events
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   b. Abduction of a patient/resident of any age
   c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
   d. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

6.5.3 Hospital Acquired Conditions

Hospital Acquired Conditions (HACs) are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital.

HACs selected by CMS must meet the following criteria:

- Conditions must be high cost, high volume or both.
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis.
- Could reasonably have been prevented through the application of evidence-based guidelines.

The 14 categories of HACs include:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and Trauma
   a. Fractures
   b. Dislocations
   c. Intracranial injuries
   d. Crushing injuries
   e. Burns
   f. Other injuries
6. Manifestations of poor glycemic control
   a. Diabetic ketoacidosis
   b. Nonketotic hyperosmolar coma
   c. Hypoglycemic coma
   d. Secondary diabetes with ketoacidosis
   e. Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection (UTI)
8. Vascular catheter-associated infection
9. Surgical site infection, mediastinitis, following Coronary Artery Bypass Graft (CABG)
10. Surgical site infection following bariatric surgery for obesity

   a. Laparoscopic gastric bypass
   b. Gastroenterostomy
   c. Laparoscopic gastric restrictive surgery
11. Surgical site infection following certain orthopedic procedures
   a. Spine
   b. Neck
   c. Shoulder
   d. Elbow
12. Surgical site infection following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures:
   a. Total knee replacement
   b. Hip replacement
14. Iatrogenic pneumothorax with venous catheterization

6.5.4 Present on Admission Indicator

To facilitate the identification of HACs not present on admission, new coding requirements were effective October 1, 2008. For every diagnosis code reported, one of the following Present on Admission (POA) indicators must also be reported:

- Y - Present on admission
- W - Based on data and clinical judgment, it is not possible to document when the onset of the condition occurred
- N - Not present on admission
- U - Documentation is insufficient to determine if the condition was present at the time of admission.
- 1 - Exemption from POA reporting*

Regardless of your contract reimbursement, BCBSNM does require that you file the POAs on all inpatient hospital claims.

At this time, the following hospitals are exempted by CMS from filing the POA Indicator:

- Long-Term Acute Care Hospitals (LTCHs or LTACs),
- Inpatient Rehabilitation Facilities (IRFs),
- Inpatient Psychiatric Facilities (IPFs),
- Cancer Hospitals
- Children's Hospitals

Note: Does not apply to Medicaid claims. Medicaid's HCAC includes Medicare's IPPS hospitals, as well as other inpatient hospital settings that may be IPPS exempt under Medicare.

* For a complete list of codes on the POA exempt list, see the ICD-10-CM Present on Admission Exempt List at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html

6.5.5 Reimbursement Policy

BCBSNM reserves the right in its sole discretion not to pay for any costs related to, or arising out of, a PAE. Without limitation and by way of examples only, any professional provider whose act or omission caused or materially contributed to the PAE may not be reimbursed nor may services in the operating or procedure room where the PAE occurs be reimbursable by BCBSNM.

Contracted providers will hold harmless members for any services related to, or arising out of, the PAE. A Provider whose act or omission caused or materially contributed to the PAE shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Member for identified PAEs.

6.6 Timely Delivery of Diabetes Supplies

On at least a quarterly basis, ancillary providers of medically necessary equipment, appliances, and supplies must fully and timely cooperate and comply with BCBSNM's requests for information and documentation related to their timely provision to Members of the foregoing.

7 – MEMBER INFORMATION

Overview

As a provider for BCBSNM, you are obligated to be aware of and to uphold our members' rights, and to be informed regarding the members' responsibilities. Our health plan members may refer to their benefit booklet for a listing of member rights and responsibilities; you and most members can also access these documents on our website at bcbsnm.com.

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7.1 Member Rights

BCBSNM members have the right to:

- Available and accessible services when medically necessary, as determined by the primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or emergency care services, and for other health services as defined by the member's benefit booklet.
- Be treated with courtesy and consideration, and with respect for their dignity and need for privacy.
- Have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- Be provided with information concerning BCBSNM's policies and procedures regarding products, services, practitioners and providers, appeals procedures, member rights and responsibilities and other information about the company and the benefits provided.
- All the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language they understand.
- Participate with their physicians or providers in making decisions about their health care.
- Receive from their physicians or providers, in terms that they understand, a candid explanation of their complete medical condition, recommended treatment, risks of the treatment, expected results and reasonable medical alternatives, irrespective of cost or benefit coverage. If they are not capable of understanding the information, the explanation shall be provided to their next of kin, guardian, agent or surrogate, if able, and documented in their medical record.
- Prompt notification of termination or changes in benefits, services or provider network.
- File a complaint or appeal with BCBSNM or with the New Mexico Superintendent of Insurance and to receive an answer to those complaints within a reasonable time.
- Request information about any financial arrangements or provisions between BCBSNM and its network providers that may restrict referral or treatment options or limit the services offered to members.
- Adequate access to qualified health professionals near their work or home within New Mexico.
- Affordable health care, with limits on out-of-pocket expenses, including the right to seek care from an out-of-network provider, and an explanation of their financial responsibility when services are provided by an out-of-network provider, or provided without required prior authorization.
- Detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that they must follow for prior authorization and utilization review.

- Make recommendations regarding BCBSNM's member rights and responsibilities policies.
- A complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review, the right to a secondary appeal, and the right to request the assistance of the Superintendent of Insurance.

7.2 Member Responsibilities

BCBSNM members have the responsibilities to:

- Supply information (to the extent possible) that BCBSNM and its network practitioners and health care providers need in order to provide care.
- Follow plans and instructions for care that have been agreed on with their treating provider or practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals with their treating provider or practitioner to the degree possible.

7.3 HIPAA Compliance

7.3.1 HIPAA Notice of Privacy Practices

The BCBSNM Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices has been included in this manual to inform you of the information we provide to our members. The Notice of Privacy Practices is available at bcbsnm.com. Providers, members, and others may view this information by selecting the Important Information link at the bottom of the home page.

This notice describes how medical information about the member may be used and disclosed and how the member can get access to this information. The member is advised to carefully review this information.

7.3.2 BCBSNM's Responsibilities

BCBSNM is required by applicable federal and state law to maintain the privacy of the member's protected health information. Protected Health Information (PHI) is information about the member, including demographic information, that may identify the member and that relates to the member's past, present, or future physical or mental health condition and related health care services. BCBSNM is also required to give the member this notice

about our privacy practices, our legal duties, and the member's rights concerning his/her PHI.

BCBSNM must follow the privacy practices that are described in this notice while it is in effect. BCBSNM reserves the right to make any changes to our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. BCBSNM reserves the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about BCBSNM privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

7.3.3 Use and Disclosure of PHI

BCBSNM uses and discloses PHI about the member for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment
We may use or disclose the member's PHI to a physician or other health care provider providing treatment to the member. We may use or disclose the member's PHI to a health care provider so that we can make prior authorization and/or Recommended Clinical Review (RCR) decisions under the member's benefit plan.

Payment
We may use and disclose the member's PHI to make benefit payments for the health care services provided to the member. We may disclose the member's PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations
We may use and disclose the member's PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer service, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, and establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the employer who is the plan sponsor of a group health plan. We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect the privacy of the member's PHI. We may disclose the member's PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with the member for its health care operations relating to quality assessment and improvement activities, reviewing the

competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing healthcare fraud and abuse.

Joint Operations
We may use and disclose the member's PHI connected with a group health plan maintained by the member's plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangement.

On the Member's Authorization
The member may give us written authorization to use his/her PHI or to disclose it to another person for the purpose the member designates. If the member gives us an authorization, the member may withdraw it in writing at any time. The member's withdrawal will not affect any use or disclosures permitted by the member's authorization while it was in effect. Unless the member gives us a written authorization, we cannot use or disclose his/her PHI for any reason except those described in this notice. We will disclose any psychotherapy notes we may have only if the member provides us with a specific written authorization or when disclosure is required by law.

Personal Representatives
We will disclose the member's PHI to the member's personal representative when the personal representative has been properly designated by the member and the existence of the member's personal representative is documented to us through a written authorization.

Disaster Relief
We may use or disclose the member's PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health-Related Services
We may use the member's PHI to contact the member with information about health-related benefits and services or about treatment alternatives that may be of interest to the member. We may disclose the member's PHI to a business associate* to assist us in these activities.

Public Benefit
We may use or disclose the member's PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law.
- For public health activities including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws.
- To report adult abuse, neglect, or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials pursuant to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person.

- To avert a serious threat to health or safety.
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities.
- To correctional institutions regarding inmates.
- As authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes only if the member provides us with a written authorization or when disclosure is required by law:

- To coroners, medical examiners, and funeral directors.
- To an organ procurement organization.
- In connection with certain research activities.

*A "business associate" is a person or entity who performs or assists BCBSNM with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.

7.3.4 Use and Disclosure of Certain Types of Medical Information

For certain types of PHI, we may be required to protect the member's privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of the member's PHI:

- *HIV Test Information.* We may not disclose the result of any Human Immunodeficiency Virus (HIV) test or that the member has been the subject of an HIV test unless required by law, or unless the disclosure is to the member or other persons under limited circumstances or the member has given us written permission to disclose.
- *STD or Viral Hepatitis Test Information.* We may not disclose the result of any Sexually Transmitted Disease (STD) or viral hepatitis test or that the member has been the subject of one of these tests unless required by law, or unless the disclosure is to the member or other persons under limited circumstances or the member has given us permission to disclose.
- *Genetic Information.* If any genetic test information is included in claims or records we receive, we may not use or disclose the member's genetic information unless the use or disclosure is made as required by law or the member provides us with written permission to disclose such information.
- *Mental Health and Developmental Disabilities Information.* We may not disclose the member's mental health or developmental disabilities information records from residential treatment except to the member and anyone else authorized by law, or unless the member provides us with written permission to disclose.

7.3.5 Individual Rights and Access

The member may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access
The member has the right, with limited exceptions, to view or get copies of his/her PHI contained in a designated record set. A "designated record set" contains records we

maintain such as enrollment, claims processing, and case management records. The member may request that we provide copies in a format other than photocopies. We will use the format the member requests unless we cannot practicably do so. The member must make a request in writing to obtain access to his/her PHI and may obtain a request form from us. If we deny the member's request, we will provide the member with a written explanation, if the reasons for denial can be reviewed, how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting
The member has the right to receive a list of instances for the 6-year period, but not before April 14, 2003, in which we or our business associates disclosed the member's PHI for purposes other than treatment, payment, health care operations, certain other activities, or as authorized by the member. If the member requests this accounting more than once in a 12-month period, we may charge the member a reasonable, cost-based fee for responding to these additional requests. We will provide the member with more information on our fee structure upon request.

Restriction
The member has the right to request that we place additional restrictions on our use or disclosure of his/her PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing, signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication
The member has the right to request that we communicate with him/her about his/her PHI by alternative means or to alternative locations. The member must make this request in writing. This right only applies if the information could endanger the member if it is not communicated by the alternative means or to the alternative location the member wants. The member does not have to explain the basis of his/her request, but the member must state that the information could endanger him/her if the communication means or location is not changed. We must accommodate the member's request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location the member requests.

Amendment
The member has the right, with limited exceptions, to request that we amend his/her PHI. The member's request must be in writing, and it must explain why the information should be amended. We may deny the member's request if we did not create the information the member wants amended and the originator remains available or for certain other reasons. If we deny the member's request, we will provide the member with a written explanation. The member may respond with a statement of disagreement to be attached to the information the member wanted amended. If we accept the member's request to amend the information, we will make reasonable efforts to inform others, including people the member names, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of this Notice

The member may request a copy of this notice at any time by contacting the Privacy Office or by visiting bcbsnm.com. If the member receives this notice via our website or by email, the member is also entitled to request a paper copy of the notice.

Forms
The Privacy Forms listed below are available to the member at bcbsnm.com:

- Standard Authorization Form
- Access Request
- Disclosure Accounting Request
- Amendment Request
- Response to Denied Amendment
- Confidential Communications Request
- Restriction Request
- Privacy and Security Complaint

Questions and Complaints
If the member wants more information about our privacy practices, or if the member has questions or concerns, the member may contact us using the information listed at the end of this notice. If the member is concerned that we may have violated his/her privacy rights, the member may submit a complaint using the contact information listed at the end of this notice. The member may also submit a written complaint to the U.S. Department of Health and Human Services (HHS); see information at hhs.gov. BCBSNM will provide the member, if requested, with the address for filing a complaint with HHS. We support the member's right to the privacy of his/her PHI. We will not retaliate in any way if the member chooses to file a complaint with us or with HHS.

Contact: Director, Privacy Office
Blue Cross Blue Shield of New Mexico
300 E Randolph St
Chicago, IL 60601-5014

The member may also contact us using the toll-free number located on the back of the member's BCBSNM identification card.

7.4 Verify Member Coverage – Member ID Cards

Verify member eligibility by checking the member's ID card at each visit. If a patient does not have an ID card, call Customer Service (see the contact information at the front of this manual).

If an individual's eligibility is not confirmed by BCBSNM, the patient is responsible for payment if services are provided.

Each BCBSNM member ID card displays the following information:

- Member's name
- Member's identification number
- PCP name (if applicable)

- Group number and/or Plan name
- Copayments, if applicable, for:
  - office visits
  - emergency/urgent care
- Pharmacy carrier information, if applicable
- Information on behavioral health benefits administration, if applicable

Instructions and important phone numbers are listed on the back of the ID card.

7.5 Membership Plan Benefits

7.5.1 Overview

BCBSNM members are offered many plans by their employers or can purchase a plan individually. The member share can range from a single copayment to a high deductible and coinsurance and everything in between.

7.5.2 Fully Insured Groups

When an employer provides fully insured health care coverage to its employees, the employer pays a monthly premium to an insurance company. Fully insured plan rates may be based on a pool of claims from a number of employers. The premium is due in advance of the coverage and is actuarially projected to cover anticipated claims cost. In exchange for the premium, the insurance company assumes the responsibility of providing health coverage. The premium paid monthly generally remains the same for a set period of time (e.g., 12 months).

7.5.3 Self-Funded Groups

Self-funded groups are referred to as Administrative Services Only (ASO) groups. The employer pays for its covered members' medical claims out of its own financial resources. Additionally, the employer pays a set fee for the cost of a plan administrator to process claims. A self-funded employer pays benefits based only on their employees' previous or potential claim experience. Employers retain control over the funds set aside to pay health claims. This allows employers to invest funds for maximum return until needed to pay for health claims.

7.6 Federal Employee Program (FEP)

7.6.1 Allowable Charges

The Preferred Provider Allowance (PPA) applies to charges from preferred professional providers and pharmacies; the Participating Provider Allowance (PAR) applies to charges from participating professional providers.

7.6.2 Out-of-Pocket Expenses

Members are responsible for only applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible and non-covered services.

7.6.3 Plan Options

Three health plans are offered to FEP members: FEP Blue Focus, Basic Option, and Standard Option

FEP Blue Focus
FEP Blue Focus is a PPO with a nationwide network including hospitals, physicians, and numerous ancillary/specialty providers. FEP Blue Focus is an in-network-only benefit program that requires members to use PPO providers in order to receive benefits. The plan offers unique design with services categorized by core, non-core, and wrap benefits. Core services include full coverage for preventive care, the first 10 office visits per year with a $10.00 copayment for both PCP and specialists. A $500/individual and $1000/family deductible applies to non-core benefits.

Basic Option
The Basic Option Plan is a PPO with a nationwide network including hospitals, physicians, and numerous ancillary and specialty providers. The Basic Option Plan is an in-network-only benefit program that requires members to use PPO providers in order to receive benefits. There is no calendar year deductible for Basic Option. Most services are reimbursed in full of the plan allowance after an applicable member copayment. The Basic Option office visit copayment is $35 for a Preferred Primary Care Physician and $45 for a Preferred Specialist.

Standard Option
The Standard Option Plan is a PPO with a nationwide network including hospitals, physicians, and numerous ancillary and specialty providers. Standard Option Plan members must use PPO providers to receive preferred (network) benefits. They may also use non-PPO providers, participating, or non-participating. **When a non-PPO provider is used, the member will receive a lower benefit level**. The Standard Option office visit copayment is $30 for a Preferred Primary Care Physician and a $40 copayment for a Preferred Specialist. Other non-preventive services are first subject to a $350/individual or $700/family calendar year deductible.

7.6.4 Prior Approval

You must call **1-800-325-8334 for medical services, or 1-877-783-1385** for mental health/substance abuse services for **PRIOR APPROVAL** before all **inpatient** hospital stays, residential treatment center admissions, or skilled nursing facility admissions.

There are other services that require prior approval before plan benefits are available. Please refer to fepblue.org for additional information or contact customer service at 800-245-1609.

7.6.5 Continuity of Care

FEP may provide transitional benefits for professional services when a physician had been Preferred at the onset of the treatment but becomes non-preferred before its conclusion. To determine qualification, please contact customer service at 1-800-245-1609.

7.6.6 Prescription Drug Program

Under Basic Option and FEP Blue Focus, prescriptions must be filled only at a Preferred Retail Pharmacy. Basic Option members with Medicare B as their primary payer are eligible for Mail Order Drug Program benefits.

Under the Standard Option program, members may obtain prescriptions through a Preferred Retail Pharmacy or the Mail Order Drug Program.

Retail Pharmacy Program phone number: **1-800-624-5060**
Mail Order Pharmacy Program phone number: **1-800-262-7890**

Note: The FEP program encourages the prescribing of generic drugs if possible, or brand-name drugs from our formulary list if the physician believes it is necessary. You can view a list of our formulary drugs for Standard Option, Basic Option, and FEP Blue Focus on our website or request a copy by mail by calling **1-800-624-5060**.

In 2024, FEP introduced a FEP Medicare Prescription Drug Program and members who have Part A and/or B are automatically enrolled but can opt-out. **FEP Medicare Prescription Drug Program** can be contacted at 1-888-338-7737. If you have any questions, please call 800-245-1609.

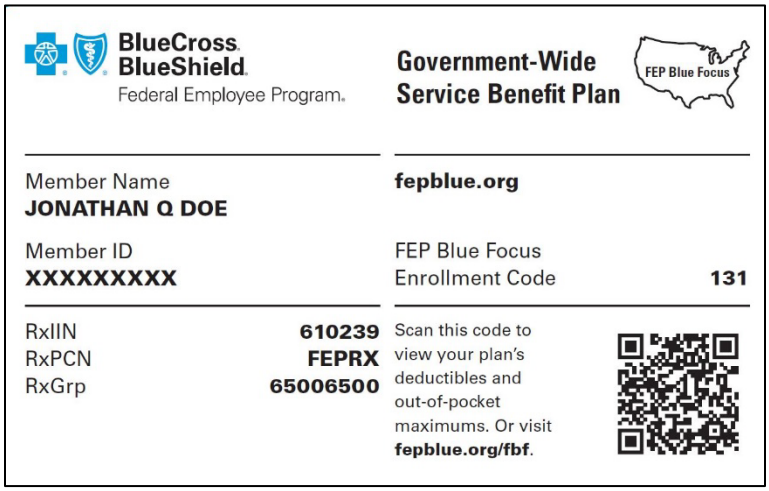
- Beginning 1/1/2025: There will be several new drugs requiring prior approval for FEP members. The Postal Service Health Benefits Program is a new, separate program within the Federal Employees Health Benefits Program.
- PSHB will provide health benefits plans to eligible Postal Service employees, Postal Service annuitants, and their eligible family members starting on Jan. 1, 2025. Please see the FEP website for information.

7.6.7 Claims Filing Questions

For additional information, please call Customer Service at **1-800-245-1609**, or you may also log on to fepblue.org.

7.6.8 Sample FEP Member ID Cards

To help you recognize the **FEP Identification cards** at a glance, we've included a sample below. There will be a QRC code on each card as well as Medicare RX if they are part of the Medicare Prescription Drug Program.



Blue Focus Enrollment Codes

131 – Blue Focus Option – Self only
133 – Blue Focus Option – Self plus one
132 – Blue Focus Option – Self plus family

Visit Copayments for first 10 visits

$10 – Office visit copayment for Preferred primary care provider services

$10 – Office visit copayment for Preferred specialists

Basic Option Enrollment Codes

111 – Basic Option – Self only
113 – Basic Option – Self plus one
112 – Basic Option – Self plus family

Visit Copayments

$35 – Office visit copayment for Preferred primary care provider services

$45 – Office visit copayment for Preferred specialists

Standard Option Enrollment Codes	Visit Copayments
104 – Standard Option – Self only 106 – Standard Option – Self plus one 105 – Standard Option – Self plus family	$30– Office visit copayment for primary care physicians $40 – Office visit copayment for Preferred specialists

8 – CLAIMS

Overview

This section describes both hard-copy and electronic claims submission processes. For those provider offices that are not submitting claims electronically, we encourage you to consider this faster, easier, and more accurate method for claims submission. We would be happy to help you make this transition.

See Section 9 – eCommerce Tools for more information.

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8.1 Contacts

The table below includes contact information for claims filing questions, electronic claims filing, and accessing eligibility and benefit information.

For…	Contact	Phone #	Internet
Claims questions – initial contact	Provider Service Unit	1-888-349-3706	
Electronic claims filing	Availity Essentials	1-800-282-4548	availity.com
	Electronic Commerce Services		ecommerceservicesNM@bcbsnm.com
Eligibility and benefits	Availity Essentials	1-800-282-4548	availity.com
	Interactive Voice Response (IVR)/ Provider Service Unit (claims questions)	1-888-349-3706	

8.2 Eligibility and Benefits

8.2.1 Overview

Providers have three ways to determine eligibility and benefits for our members. The Availity® Essentials portal provides real-time eligibility, benefits, and claim status information, at no cost to registered providers. Providers may also use the Interactive Voice Response System (IVR), or your preferred connectivity vendor.

8.2.2 Interactive Voice Response (IVR) System

To make it easier for our providers to find information on eligibility, benefits, prior authorization and/or Recommended Clinical Review (RCR) requirements and submission, we have an interactive voice response system. This self-service system allows our speech recognition technology to respond when the provider speaks, which saves administrative time.

Refer to Section 9, eCommerce Tools for more about the IVR System.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM. BCBSNM makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

8.2.3 Availity Essentials

Availity is a HIPAA compliant, nationwide, all-payer clearinghouse and Health Information Network that uses the Internet to exchange information in real-time between health care providers, payers, and other health care stakeholders. Availity also supports batch transactions. For more information, refer to Section 9, e-Commerce Tools.

8.3 Claims Submission Requirements

8.3.1 Claim Requirements

Submit claims within 180 days of the date of service. **Claims submitted beyond this time frame will be denied.** See more about Timely Filing in this section, 8.6. Each claim submitted must be for a single patient with services performed by one provider. Please do not include multiple patients or services by more than one provider on one claim form.

Accurate, complete claims are processed more quickly than claims that need research. If we are not able to complete processing because information is missing or unclear, your claims will be returned for the required information. When a claim is returned, please provide the missing or corrected information, and return the claim for processing within 30 days.

8.3.2 Claim Forms

Submit encounters and claims using the appropriate claim form: CMS-1500 form for professional claims; UB-04 (CMS-1450) form for facility claims. Submit encounter and claim information according to the instructions.

Samples of the CMS-1500 claim form and the UB-04 are included at the end of this section under Attachments. For detailed instructions on proper completion of these forms, please visit our website at bcbsnm.com (select Providers, Claims & Eligibility, and then Submitting Claims).

8.3.3 Splitting Charges on Claims

In general, all services provided on the same day for a member should be billed under one electronic submission. When required to bill on paper, utilize one CMS-1500 claim form when possible. When more than six services are provided, multiple CMS-1500 claim forms may be necessary

8.3.4 Provider-Based Billing

Provider-based billing is a type of billing for services provided in a clinic (provider-based location) that a hospital treats as an outpatient department.

BCBSNM does not allow hospital charges for facility services that are billed as a provider-based location on a UB04 (aka CMS-1450) claim form. Therefore, charges for services billed on a UB04 claim form using National Uniform Billing Committee (NUBC) revenue codes 0510-0519, 0761, 0910, 0914-0196, or 0924 will be given a zero allowable amount. These codes are identified for convenience and may change over time.

Charges for any services referred to or rendered by the hospital, such as lab and radiology, should be billed separately on a UB04 by the hospital and will be allowed, as applicable.

8.3.5 Procedure Codes

Use the American Medical Association Current Procedural Terminology (CPT®) or the Healthcare Common Procedure Coding System (HCPCS) codes, including appropriate modifiers, for professional claims and revenue codes for hospital claims. **Providers must bill with current codes.** Codes marked as deleted in any version of the CPT or HCPCS will not be accepted after the codes' effective date for deletion. Consistent with Medicare policy, there will be no "grace period" for recognizing deleted codes. The Health Insurance Portability and Accountability Act (HIPAA) regulations require the use of valid, nationally recognized codes. Claims that use deleted codes after the codes' effective date of deletion will be denied and returned to the provider for resubmission with current, valid codes. When billing for services provided, codes should be selected that best represent the services furnished.

When billing with a miscellaneous procedure code or a code that is used for a service that is not described in CPT, submit a clear description of the service or supply and supporting documentation with the claim.

CPT copyright 1995 – 2016 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

8.4 National Provider Identifier (NPI)

8.4.1 Using NPI Numbers

The National Provider Identifier (NPI), mandated by HIPAA regulations, is the single provider identifier that must be used by health plans for all standard electronic claim transactions. Refer to National Plan and Provider Enumeration System (NPPES) to obtain an NPI.

An individual (type 1 NPI) for the rendering provider is required on all professional claims. An organization (type 2 NPI) is required for all billing entities (medical groups, incorporated practices, facilities, durable medical equipment (DME) suppliers, etc.). Each DME supplier location out of which they are providing equipment is required to have a separate NPI per HIPAA regulations.

Note: BCBSNM requires NPIs on electronic **and** paper claims.

Additional information regarding NPIs can be found on the following websites:

- Centers for Medicare & Medicaid Services (CMS): cms.hhs.gov
- National Plan and Provider Enumeration System (NPPES): nppes.cms.hhs.gov

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8.5 Submitting Claims

8.5.1 Electronic Claims Submission

BCBSNM strongly encourages the electronic submission of claims. Claims may be submitted electronically 24 hours a day, 7 days a week. All BCBSNM facility (UB-04) and professional (CMS-1500) claims (excluding adjustments) can be filed electronically at no charge through the Availity Health Information Network.

For more information about submitting claims electronically, refer to Section 9, e-Commerce Tools.

8.5.2 Paper Claims Submission

Submit encounters and claims following the instructions given in Section 8.3, and mail to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 660058
Dallas, TX 75266-0058

8.5.3 BlueCard Program Claim Filing

For out-of-state claims filing, refer to the BlueCard Program Provider Manual.

8.6 Timely Filing and Payments

8.6.1 Overview

Providers must submit clean claims within 180 days of the date of service or as otherwise provided in this Section 8. Untimely claims will be denied, and providers are prohibited from balance billing Members.

Claims appeals must be submitted within 90 days of the Remittance Advice/Provider Claim Summary. Submit appeals along with the Claim Review Form. Refer to Section 15, Provider Service Inquiry and Grievance Process, for more information.

8.6.2 Timely Payments

Paper claims not paid within 45 calendar days and electronic claims not paid within 30 calendar days following receipt of a clean claim shall bear interest at the rate established pursuant to Section 13.10.28.9 NMAC, as it may be later amended and/or recompiled. The interest payment includes any and all applicable gross receipts taxes thereon.

This interest payment provision shall not apply to a Member's claims if the Member's coverage or benefits plan is not subject to the New Mexico Insurance Code and the New Mexico Office of the Superintendent of Insurance.

8.6.3 Proof of Timely Filing

Claims submitted along with **proof** of initial timely filing, which are within 180 days of the date of service, will be allowed. Claims received for timely filing reconsideration that are more than 180 days from date of service will be denied.

Claims submitted for consideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frame. **Acceptable proof** of claim filing within 180 days of the date on which service was rendered includes the following situations or documentation:

Proof	Examples
Paper Filer: Printout indicating the original date the claim was submitted and to whom	• Account ledger posting that includes multiple patient submissions • Patient ledger • BCBSNM returned claim sheet • UB-04 with date of original submission in box 86

Proof	Examples
Electronic Filer: Copy of BCBSNM or provider's clearinghouse confirmation report **with patient detail**	• EMC Input Transaction Report • Blue Cross Data Collection – BCBSNM • Accepted Claims Report **Note:** A BCBSNM rejection report or a report from the provider's clearinghouse **without patient detail** is not acceptable proof.
Coordination of Benefits (COB) information within 180 days from other insurance or Medicare processing date	• Medicare EOB • Other insurance EOB or EOP
Proof of follow-up with member for lack of insurance information **Note:** Member **is** responsible for providing current and appropriate insurance information to the provider	Copies of dated letters requesting information from member
Document indicating claim sent to wrong carrier within 180 days from date of service and received by BCBSNM within one year of service date	Copy of EOB from other insurance carrier showing denial
Enrollment issues are reviewed on a case-by-case basis	Member not enrolled; claim returned to provider
Third-party liability issues are reviewed on a case-by-case basis	Additional information will be requested from the member and/or provider of services
Legal incapacity issues are reviewed on a case-by-case basis	• Physical illness • Behavioral Health • Death of contract holder • Death of provider

8.7 Clinical Payment and Coding Policies

Clinical payment and coding policies are based on criteria developed by specialized professional societies, national guidelines (e.g. MCG Care Guidelines) and the CMS Provider Reimbursement Manual. Additional sources are used and can be provided upon request. The clinical payment and coding policies are not intended to provide billing or coding advice but to serve as a reference with which providers must comply in order to be eligible for reimbursement by BCBSNM. BCBSNM reserves the right to develop and

institute any and all systems, edits and other solutions to ensure provider compliance with clinical payment and coding policies. All such policies are incorporated by reference.

Certain policies may not be applicable to Members who are participants in an employer's self-funded employee benefit plan for which BCBSNM acts in an administrative capacity and certain insured products. Refer to the Member's Membership Certificate, Benefit Booklet, Benefit Plan, Summary of Benefits and Coverage, or other coverage document (together "Coverage Documents") to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. In the event of a conflict between any policy and the Member's Coverage Document, the Coverage Document will govern.

In the event of conflict between a clinical payment and coding policy and any Coverage Document, the Coverage Document will govern.

In the event of conflict between a clinical payment and coding policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to Member(s), the provider contract will govern.

Conformance to clinical payment and coding policy is not a guaranty of payment. All other requirements, including but not limited to eligibility at the time of service, medical necessity, and other terms, conditions, limitations and exclusions set forth in the Member's Coverage Document, continue to apply.

View the current policies online at bcbsnm.com/provider under the Standards & Requirements tab.

8.8 Dental Related Medical Claims

8.8.1 Covered Medical Services

Standard covered medical services **may** include surgeon's charges for the following (please check the individual group plan or contact customer service for a complete list as covered services may vary):

- Medically necessary orthognathic surgery
- External or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- Incision of accessory sinuses, salivary glands, or ducts
- Lingual frenectomy
- Removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required
- **Some plans cover** dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- **Most plans cover** standard diagnostic, therapeutic, surgical, and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders or accidental injuries

8.8.2 Coding

To avoid delays in claim processing, please follow these tips:

- Claims may be submitted on a dental claim form but should include a diagnosis code(s).
- If billing with medical code 41899, include a complete description of the dental procedure rendered, tooth number, or area of the mouth.
- If services are accident related, include the date and details of the accident, tooth number or area of the mouth.
- Prior approval should be requested for accident related services (except if emergency treatment was rendered within 48 hours of the accident).
- Refer to Section 10, Prior authorization, for more information about prior approval for oral surgery, hospital services, etc.

8.9 Immunizations and Injectable Drugs

8.9.1 Required Information

Providers will be required to submit claims with the National Drug Codes (NDCs) and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims. Professional/ancillary claims for drugs must include NDC data in order to be accepted for processing by BCBSNM.

This information may also be submitted on institutional/facility electronic (ANSI 837I) and paper (UB-04) claims. This includes drug-related Revenue Codes to report drug products used for services rendered at medical outpatient facilities as well as unlisted HCPCS/CPT codes that require additional NDC information.

Examples of revenue codes that may require detailed coding are: 630 (DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL STANDARD ABBREVIATION: DRUGS), 636 (DRUGS REQUIRING DETAILED CODING STANDARD ABBREVIATION: DRUGS/DETAIL CODE), 891 (DRUG/CELL THERAPY/SPECIAL PROCESSED DRUGS) and 892 (SPECIAL PROCESS DRUGS – FDA APPR GENETEIC THERAPY). Examples of unlisted HCPCS/CPT code descriptions that require additional NDC information are: J3490 (UNCLASSIFIED DRUGS) or C9399 (UNCLASSIFIED DRUGS OR BIOLOGICALS).

Providers should refer to their contract for additional revenue codes that may not be listed above but are required to be submitted on claims with corresponding HCPCS/CPT or revenue codes that require NDC. Even when not required by contract, BCBSNM would welcome voluntary reporting of NDC information. In those cases, it may be submitted with the related HCPCS/CPT or revenue code as additional information.

If the claim is received without the necessary information, the claim may be denied and returned with a request to resubmit the service along with the necessary information. To avoid a claim rejection, be sure to include:

- NDC number
- Drug name
- Strength of drug administered (e.g. 25 mg/ml, 10 mg/10 ml, etc.)
- Single dose vial or multi-dose vial
- Dosage administered (e.g. 5 mg, 10 mg, etc.)
- Number of units billed on the claim that are being administered (e.g. 5 mg = 1 unit, 10 mg = 5 ml, etc.)

The NDC is usually found on the drug label or medication's outer packaging. If the medication comes in a box with multiple vials, using the NDC on the box (outer packaging) is recommended. The number on the packaging may be less than 11 digits. An asterisk may appear as a placeholder for any leading zeros. The container label also displays information for the unit of measure for that drug. Listed below are the preferred NDC units of measure and their descriptions:

- **UN** (Unit) – Powder-filled vials for injection (needs to be reconstituted), pellet, kit, patch, tablet, device
- **ML** (Milliliter) – Ready to use liquid, solution, or suspension
- **GR** (Gram) – Ointments, creams, inhalers, or bulk powder in a jar
- **F2** (International Unit) – Products described as IU/vial, or micrograms

8.9.2 General Guidelines for Claims Submissions

Here are some quick tips and general guidelines to assist you with proper submission of valid NDCs and related information on electronic and paper professional claims:

- The NDC must be submitted along with the applicable Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code(s) and the number of HCPCS/CPT units.
- The NDC must follow the 5digit4digit2digit format (11-digit billing format, with no spaces, hyphens or special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
- The NDC must be active for the date of service.
- Also include the **NDC qualifier, NDC unit of measure, number of NDC units.**

Note: BCBSNM allows up to three decimals in the NDC Units (quantity or number of units) field. If you do not include appropriate decimals in the NDC Units field, it may lead to incorrect payments subject to review or audit. As a reminder, you also must include your billable charge.

8.9.3 Electronic Claim Guidelines

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field.	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered.	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (**UN**, **ML**, **GR**, or **F2**).	2410	CTP05

Note: The total charge amount for each line of service also must be included for the Monetary Amount SV102 Segment, 2400 loop.

8.9.4 Paper Claim Guidelines

In the **shaded portion** of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4 (left-justified), immediately followed by the NDC**. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (**UN, ML, GR, or F2**), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.

Example:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400409476586 ML120 0.14950													N		12345678901
01	01	13	01	01	13	11		J0744		1	17.94	6	N	NPI	123456789

The NDC pricing methodology applies to all BCBSNM commercial products, including the maximum allowable fee schedules for the Blue Advantage HMO Network℠ and Blue Community℠ HMO Network.

Contracted providers may access request the NDC Reimbursement Schedule through by emailing feeschedulerequests@bcbsnm.com along with “Request for Maximum Allowable Fee Schedule” in the subject line and their tax ID number in the body of the message.

Refer to Section 5, Professional Provider Reimbursement, for additional information about reimbursement for immunizations and injectable drugs.

Note: Details on our complete approved Wasted/Discarded Drugs and Biologicals Guideline can be found on the BCBSNM Provider page under Standards & Requirements, Clinical Payment and Coding Policies.

CPT copyright 2024 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

8.10 End Stage Renal Disease and Medicare

End-stage renal disease (ESRD) patients may be eligible for Medicare regardless of age, the number of employees, or the employment status (e.g., retired).

If the member's group health plan is primary because of disability, age, or another reason than ESRD, then the group coverage will continue to pay as primary during the first 30-month (for home dialysis) or 33-month (for center dialysis) coordination period from the first date of dialysis. Once the coordination period has been completed, Medicare becomes primary. If Medicare has been deemed primary because of disability, age, etc., and then the member develops ESRD, Medicare will remain primary and the ESRD guidelines will not be applicable. Medicare remains primary in this situation only.

In addition, if a kidney transplant occurs during the coordination period, the group health plan will continue to pay as primary until the 30 or 33 months have been completed. Once the coordination period has been completed and Medicare becomes primary and a transplant occurs during this time, Medicare will remain primary for 36 months from the transplant date. If the transplant is a success after the 36 months, the group health plan would again become primary.

BCBSNM will identify members with ESRD and store their Medicare coverage information. It is the provider's responsibility to keep track of the coordination period.

8.11 Coordination of Benefits (COB)

8.11.1 COB Calculation

When BCBSNM is the secondary insurance carrier, the calculation of the secondary payment is based on the provider's contractual arrangements with BCBSNM using the maximum allowable fee schedule. The payment from the primary insurer is used first to offset the member's copayment, coinsurance, or deductible. Coordination of Benefits Form

8.11.2 Order of Benefit Determination

To determine the order of benefits, use the first of the following rules that apply:

Rule	Example
1. Non-Dependent or Dependent The plan that covers the person as an employee, member, subscriber, or retiree (other than as a dependent) is primary and the plan that covers the person as a dependent is secondary.	Jim and Laurie are married and each carries a family policy through their employer. Jim's coverage will be primary for him and Laurie's coverage will be primary for her.
2a. Child Covered Under More Than One Plan – Birthday Rule	Josh and Amy are married and both carry family coverage. They have one child who is

Rule	Example
The primary plan is the plan of the parent whose birthday is earlier in the year (refers to month and day, not year). This is true if: • The parents are married • The parents are not separated (whether or not they ever have been married), or • A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.	also covered under both policies. Josh's date of birth (DOB) is 01/15/74 and Amy's DOB is 03/11/75. Josh's coverage would be primary for their child because his birthday is the earliest.
2b. Child Covered Under More Than One Plan – Longer Length of Coverage If both parents have the same birthday, the plan that has covered either of the parents longer is primary.	Pat and Michael are married and both carry family coverage. They have one child who is also covered under both policies. Michael's date of birth is 01/26/69 and Pat's DOB is 01/26/73. Pat has had her coverage in force effective 01/01/90, and Michael's coverage has been in force effective 06/01/01. Pat's coverage will be primary for their child.
2c. Child covered Under More Than One Plan – Court Decree If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.	Mike and Claire are divorced, and both carry family coverage for their two children. When they divorced, there was a court decree that indicated Mike was responsible for both children's health care coverage. Mike is required to provide health coverage for his two children. His coverage for them will be primary over any group health coverage provided by Claire.
2d. Child Covered Under More Than One Plan – Custodial Parent If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's healthcare services or expenses, the order of benefit determination among the plans of the parents and the parent's spouses (if any) is: (i) The plan of the custodial parent; (ii) The plan of the spouse of the custodial parent; (iii) The plan of the non-custodial parent; and then (iv) The plan of the spouse of the non-custodial parent.	John and Rose were never married, and no longer live together. They had one child who now lives with Rose. Both parents carry family coverage for their child. There is no divorce or court decree allocating responsibility. The child lives with her mother, and as a result, Rose is the custodial parent. Rose's insurance would be primary.

Rule	Example
3. Active or Inactive Employee The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.	John took early retirement from his job, and as part of his retirement benefit, he continued to carry their group health insurance. He is now working for another company that also provides group health insurance. (No Medicare involvement) John's new coverage through his active employment will be primary over his coverage as a retiree.
4. Continuation Coverage If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. These guidelines also apply when Medicare is the other insurance (except when End Stage Renal Disease is involved). If the other plan does not have the Continuation of Coverage rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.	Debra ended her employment with her company and elected to continue her health coverage by applying under COBRA. She has now started a new job that also provides group health coverage. Debra's new coverage through her active employment will be primary over her continuation coverage.
5. Longer or Shorter Length of Coverage If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.	Kelly has two different employers and maintains full health care coverage with both. Plan A was effective 01/01/01 and Plan B was effective 01/01/03. As both coverage's are received because of active employment by Kelly, the one covering her the longest (Plan A) will be primary.
6. None of the Preceding Rules Apply If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.	- -

8.11.3 Subrogation (Third Party Liability)

Subrogation occurs when one party is injured as a result of the actions or negligence of another (e.g., slip and fall accidents, assault, auto accident, etc.). BCBSNM has the right to reimbursement for all benefits provided from the third party for those expenses. If the insured does not file a claim, the insurer can still recover directly from the liable party.

Example: John Doe has health insurance with BCBSNM. John was at a family dinner and slipped on his cousin's front steps breaking his ankle. The carrier paid for the related medical expenses totaling $3,000. John's cousin had liability coverage though her homeowner's insurance. However, John did not want to file a claim against his cousin's policy and was satisfied with the carrier's payments. However, BCBSNM was entitled to file a claim to recover from the cousin's homeowner's insurance which was liable for the related treatment and filed a claim in order to seek recovery of the $3,000.

Subrogation recoveries may not be claimed by a participating physician or other health care provider in lieu of, or in addition to, making a claim for payment pursuant to the terms and provisions of your Agreement when a member has BCBSNM insurance. To do so constitutes balance billing, which is a breach of contract for participating physicians and providers.

Claims received with an injury-related diagnosis are processed in the usual manner with a letter requesting more information sent to the member. To expedite processing, include the type of injury (field 10 on the CMS-1500 or field 29 on the UB-04) and the date of injury (field 14 on the CMS-1500 or fields 31-36 on the UB-04).

8.12 Bundling Logic

8.12.1 Overview

BCBSNM utilizes McKesson's ClaimsXten™ software editing program to assist in the process of provider claim reimbursement decisions. ClaimsXten uses the coding criteria and guidelines of HCPCS and CPT, RBRVS Relative Value Units, and the practice standards of most physicians to determine appropriately billed procedures and services on claim submissions. ClaimsXten edits are supported by clinical studies published in professional journals or approved by national professional organizations.

Using ClaimsXten does not reflect a change in BCBSNM's payment policies. This software enables us to process your claims with less manual intervention, achieving a greater degree of efficiency and consistency.

ClaimsXten edits do not mirror those of the National Corrective Coding Initiative (NCCI), although they are often similar. Modifiers sometimes, but not always, alter the results of bundling based on the specific procedure codes and modifiers used in a particular claim scenario. Clear Claim Connection (C3) can be used to determine the result of ClaimsXten bundling edits for specific procedure code combinations (see Section 8.12 below).

ClaimsXten specifically addresses three CPT billing practices, which are described below.

Unbundling – Multiple individual CPT codes used instead of a single, comprehensive global procedure code.

Incidental / Inclusive Procedure – A procedure considered to be integral to another major, primary, or principle procedure.

Mutually Exclusive Procedures – Those procedure codes that, by normal practice standards, would not be performed on an individual patient on the same day.

To view the other rules, refer to the ClaimsXten Rule Descriptions on our website under the Claims & Eligibility/Submitting Claims tab. Also refer to the Tools section on our website for more information on C3 and ClaimsXten.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services.

8.12.2 Reconsideration Requests

If you have a question or dispute concerning a bundled or rejected charge that is related to a ClaimsXten edit determination, contact the Provider Service Unit (PSU) at BCBSNM within 180 days from the date of service at 1-888-349-3706. If the claim denied incorrectly, then the claim will be adjusted. If the claim denied correctly, the provider can request an appeal by competing the Claim Review Form and attaching supporting documentation.

8.13 Clear Claim Connection™

Clear Claim Connection (C3) is a Web-based code auditing reference tool that mirrors BCBSNM edits (i.e., unbundling, mutually exclusive, and incidental).

C3 is designed to make BCBSNM payment policies, rules, and edit rationale easily accessible for viewing via the website. C3 can increase your administrative efficiency by reducing manual inquiries, claims appeals, and misunderstandings regarding BCBSNM's edits.

Physicians and their office staff, registered with Availity Essentials, can review the claim payment methodology and reimbursement policies behind coding edits. While on the Availity website, go to our BCBSNM-branded Payer Spaces, select "Applications" and click on **"Research Procedure Code Edit**." Visit availity.com to sign up if you are not currently an Availity user.

8.14 Corrected Claims

Corrected claims must be submitted within 180 calendar days of the date of service. The BCBSNM claim system recognizes claim submission types on electronic claims by the frequency code submitted.

Professional corrected claims may be submitted electronically by using claim frequency code 7, which indicates the replacement of a prior claim. If you must file CMS-1500 corrections on paper, complete the Claim Review Form and attach the form to the top of the claim. Mail the form and the corrected claim to the address indicated on the form.

Claims that are submitted with a "corrected claim" stamp or notation are not recognized by our system and could delay the processing of your corrected claim. Refer to Section 8.6 for Timely Filing requirements.

Facility corrected claims should be submitted electronically whenever possible, using the appropriate Type of Bill indicating a corrected claim (e.g., 117 vs. 111). If you must file the UB-04 corrections on paper, please attach the Claim Review Form following the same instructions above as for the CMS-1500 claims.

When filing corrected claims on services for Medicare primary members, the corrected claims should be filed directly with Medicare, not BCBSNM. Filing the corrected claims with BCBSNM may cause a delay in processing or result in a denial stating either the claim must be filed with Medicare or the claim is a duplicate. Providers should follow the same process for filing corrected claims for Medicare-primary members just as if they were filing the claim for the first time with Medicare.

For more information, refer to the Electronic Replacement/Corrected Claim Submissions reference guide located in the Submitting Claims page on our website.

8.15 Recoupment Process

8.15.1 Paper Refund Requests

When an overpayment on a claim has occurred, BCBSNM will initiate a refund request, providing physicians, facilities, and practitioners with at least 45 days written notice, explaining the reason for the overpayment, before engaging in additional overpayment recovery efforts. A remittance form and postage-paid envelope are also enclosed for your convenience should you prefer to submit a refund check. However, if you do not respond to us in writing or by phone within 45 days, the overpayment will be eligible for collection by auto-recoupment. If a provider requests a reconsideration within 45 days of receipt of a request for repayment of an overpayment, BCBSNM will not require repayment of the alleged overpayment before the reconsideration is concluded.

There are two (2) levels of claim review reconsiderations available to you.

- The 1st reconsideration claim review must be requested within 45 days following the receipt of written notice of request for refund due to overpayment.
    - BCBSNM will complete the 1st claim review within 45 days following the receipt of your request for a 1st claim review. You will receive written notification of the claim review determination.
- If the 1st reconsideration claim review determination is not satisfactory to you, you may request a 2nd level claim review. The 2nd level claim review must be requested within 15 days following your receipt of the 1st level claim review determination.

- BCBSNM will complete the 2nd level claims review within 30 days following the receipt of your request for a 2nd level reconsideration claim review. You will receive written notification of the claim review determination.

The reconsideration claim review process for a specific claim will be considered complete following your receipt of the 2nd claim review determination.

The recoupment message that appears on the Provider Claim Summary (PCS) will show the patient name, patient account number (if available), BCBSNM group and member number, overpaid claim number, the dates of service, the amount taken toward the overpayment, and an abbreviated overpayment reason. It may be necessary to offset an overpayment from multiple checks. Due to system constraints, checks will always show a balance of $50 remaining, and the claims summary will only reflect the collection being taken on the check; it will not reflect the entire negative balance owed by the provider. Please save your recoupment letters to assist you in balancing your payments. Overpayments can be returned to:

Blue Cross and Blue Shield of New Mexico
Attention: Collections Department
P.O. Box 660058
Dallas, TX 75266-0058

8.15.2 Electronic Refund Management

Electronic Refund Management (eRM) is an online tool that can help simplify your claim overpayment reconciliation and related processes and is available at no additional charge.

In addition to single sign-on convenience, eRM enables you to:

- Receive electronic notification of overpayments
- View overpayment requests
- Inquire/dispute/appeal a request
- Deduct from future payments

For navigational assistance, visit our website under Education & Reference/Tools.

Note: You must be a registered user with Availity Essentials to take advantage of ERM. To register, visit the Availity website.

8.16 Claims Payment Grievances

For the provider grievance process, see Section 15, Provider Service Inquiry and Grievance Process.

Note: For medical appeals on behalf of members, see Section 11 Utilization Case, Population Health, And Condition & Lifestyle Management

A dispute can be submitted online or by mail using the Claim Review Form.

8.17 Provider Claim Summary

8.17.1 Overview

The Provider Claim Summary is a notification statement sent to providers after a claim has been processed. The content of each PCS may vary based on the member's benefit plan and the services provided.

Note: Electronic Payment Summaries are available; see Section 9, e-Commerce Tools.

The PCS includes:

- Patients 65 and older are noted (indicating Medigap)
- Combined reporting: multiple patients are listed on one PCS for ASO groups
- Multiple patient claims are listed on one summary for ASO groups
- Patient information
- Data elements specific to services rendered; e.g., begin/end dates, procedure code
- Informational messages
- The amount paid
- The amount of the bill that is the patient's share
- The amount of the bill that is the contractual allowance
- On facility forms, the DRG code is listed

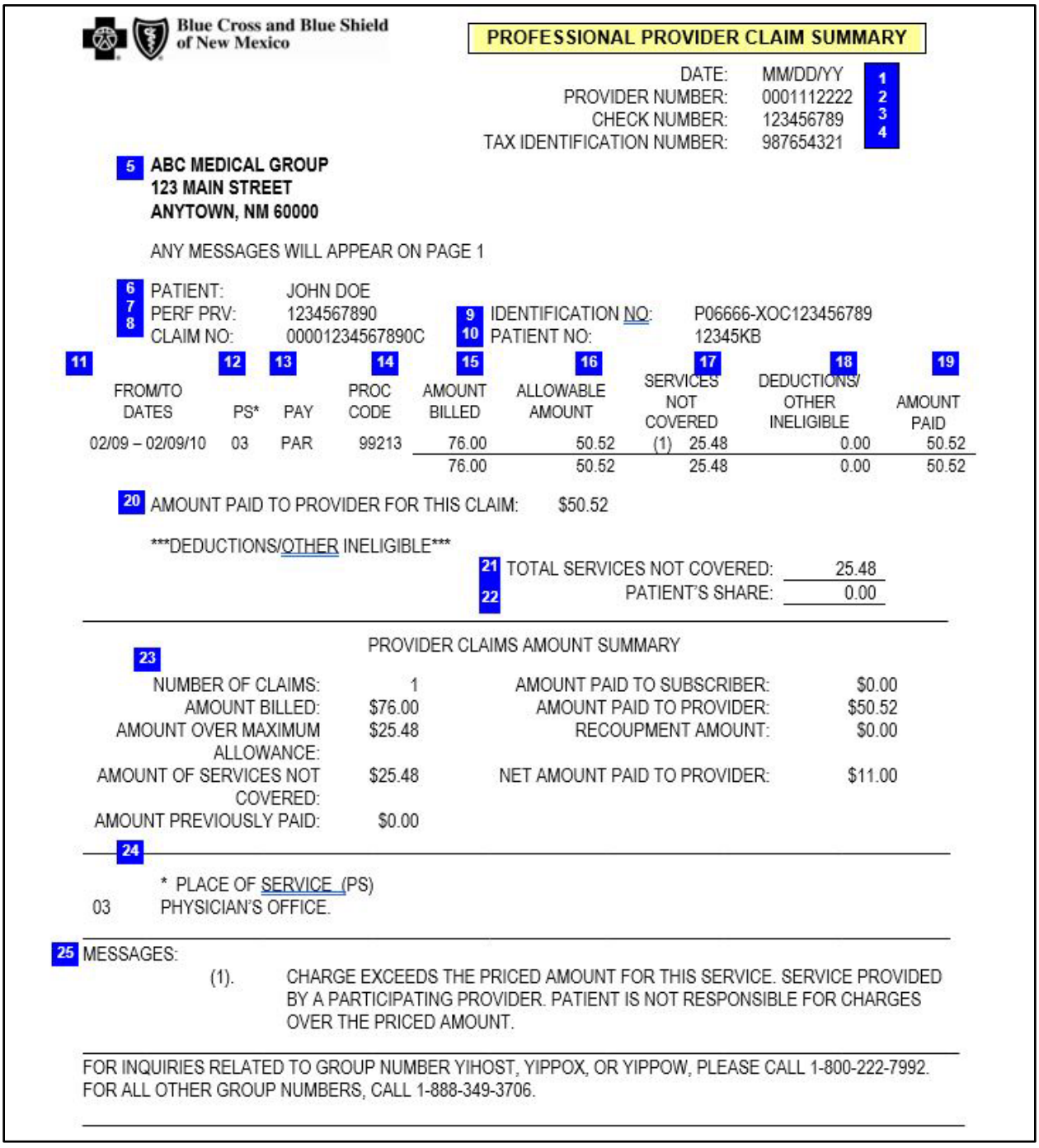
The patient's share may include:

- Any portion of the billed amount that is not covered
- The patient's deductible/copayment amounts
- PPO program coinsurance

The sample PCSs on the following pages are only a **reference**. Your summary may be slightly different than the samples.

It is important to review your PCSs to ensure your records are current and accurate. To inquire about patient membership, benefits, and claim status information, call the Interactive Voice Response/Provider Service Unit at 1-888-349-3706.

8.17.2 Sample Professional PCS and Field Explanations



Blue Cross and Blue Shield of New Mexico

PROFESSIONAL PROVIDER CLAIM SUMMARY

1 DATE: MM/DD/YY
2 PROVIDER NUMBER: 0001112222
3 CHECK NUMBER: 123456789
4 TAX IDENTIFICATION NUMBER: 987654321

5 **ABC MEDICAL GROUP**
123 MAIN STREET
ANYTOWN, NM 60000

ANY MESSAGES WILL APPEAR ON PAGE 1

6 PATIENT: JOHN DOE
7 PERF PRV: 1234567890
8 CLAIM NO: 00001234567890C
9 IDENTIFICATION NO: P06666-XOC123456789
10 PATIENT NO: 12345KB

11 FROM/TO DATES	12 PS*	13 PAY	14 PROC CODE	15 AMOUNT BILLED	16 ALLOWABLE AMOUNT	17 SERVICES NOT COVERED	18 DEDUCTIONS/ OTHER INELIGIBLE	19 AMOUNT PAID
02/09 – 02/09/10	03	PAR	99213	76.00	50.52	(1) 25.48	0.00	50.52
				76.00	50.52	25.48	0.00	50.52

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $50.52

DEDUCTIONS/OTHER INELIGIBLE

21 TOTAL SERVICES NOT COVERED: 25.48
22 PATIENT'S SHARE: 0.00

23 PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS:	1	AMOUNT PAID TO SUBSCRIBER:	$0.00
AMOUNT BILLED:	$76.00	AMOUNT PAID TO PROVIDER:	$50.52
AMOUNT OVER MAXIMUM ALLOWANCE:	$25.48	RECOUPMENT AMOUNT:	$0.00
AMOUNT OF SERVICES NOT COVERED:	$25.48	NET AMOUNT PAID TO PROVIDER:	$11.00
AMOUNT PREVIOUSLY PAID:	$0.00		

24

* PLACE OF SERVICE (PS)
03 PHYSICIAN'S OFFICE.

25 MESSAGES:
(1). CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICE PROVIDED BY A PARTICIPATING PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.

FOR INQUIRIES RELATED TO GROUP NUMBER YIHOST, YIPPOX, OR YIPPOW, PLEASE CALL 1-800-222-7992.
FOR ALL OTHER GROUP NUMBERS, CALL 1-888-349-3706.

Professional Provider Claim Summary Field Explanations

1	**Date**	Date the summary was finalized
2	**Provider Number**	Provider's NPI

3	**Check Number**	The number assigned to the check for this summary
4	**Tax Identification Number**	The number that identifies your taxable income
5	**Provider or Group Name and Address**	Address of the provider/group who rendered the services
6	**Patient**	The name of the individual who received the service
7	**Performing Provider**	The number that identifies the provider that performed the services
8	**Claim Number**	The Blue Shield number assigned to the claim
9	**Identification Number**	The number that identifies the group and member insured by BCBSNM
10	**Patient Number**	The patient's account number assigned by the provider
11	**From/To Dates**	The beginning and ending dates of services
12	**PS**	Place of service
13	**PAY**	Reimbursement payment rate that was applied in relationship to the member's policy type. (See list of value codes on the next page.)
14	**Procedure Code**	The code that identifies the procedure performed
15	**Amount Billed**	The amount billed for each procedure/service
16	**Allowable Amount**	The highest amount BCBSNM will pay for a specific type of medical procedure.
17	**Services Not Covered**	Non-covered services according to the member's contract
18	**Deductions/Other Ineligible**	Program deductions, copayments, and coinsurance amounts
19	**Amount Paid**	The amount paid for each procedure/service
20	**Amount Paid to Provider for This Claim**	The amount Blue Shield paid to provider for this claim
21	**Total Services Not Covered**	Total amount of non-covered services for the claim
22	**Patient's Share**	Amount patient pays. Providers may bill this amount to the patient.
23	**Provider Claims Amount Summary**	How all of the claims on the PCS were adjudicated
24	**Place of Service (PS)**	The description for the place of service code used in field 12
25	**Messages**	The description for messages relating to: non-covered services, program deductions, and PPO reductions

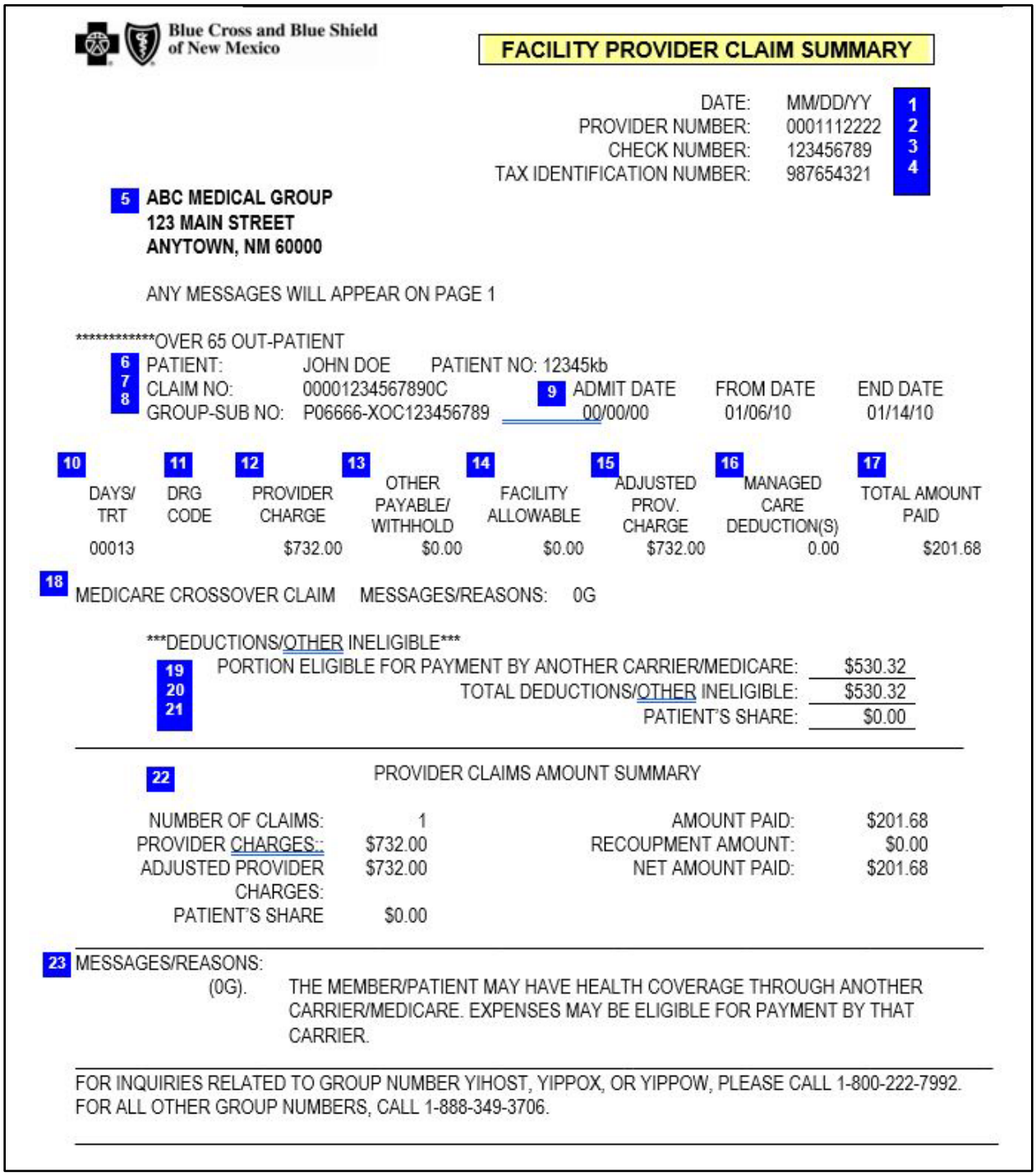
Note: Not all PCSs are the same; this PCS is provided as a sample.

PAY Field Value Codes

The table below lists the codes and descriptions for field 13 on the professional provider claim summary.

"PAY" Value	Description
EPN	Exclusive Provider Network
FEA	Federal Employee Program
FEP	Federal Employee Program Behavioral Health
HMO	Health Maintenance Organization
MCD	Medicaid Network
MCE	Medicaid Exception Network
NOM	Non-contracted otherwise Medicaid providers
NOP	Not A Network
PA1	Dental
PAR	Participating
POS	Point of Service
PPO	Preferred Provider Organization

8.17.3 Sample Facility PCS and Field Explanations



Blue Cross and Blue Shield of New Mexico

FACILITY PROVIDER CLAIM SUMMARY

DATE: MM/DD/YY (1)
PROVIDER NUMBER: 0001112222 (2)
CHECK NUMBER: 123456789 (3)
TAX IDENTIFICATION NUMBER: 987654321 (4)

(5) **ABC MEDICAL GROUP**
123 MAIN STREET
ANYTOWN, NM 60000

ANY MESSAGES WILL APPEAR ON PAGE 1

**********OVER 65 OUT-PATIENT

(6) PATIENT: JOHN DOE PATIENT NO: 12345kb
(7) CLAIM NO: 00001234567890C
(8) GROUP-SUB NO: P06666-XOC123456789
(9) ADMIT DATE 00/00/00 FROM DATE 01/06/10 END DATE 01/14/10

(10) DAYS/ TRT	(11) DRG CODE	(12) PROVIDER CHARGE	(13) OTHER PAYABLE/ WITHHOLD	(14) FACILITY ALLOWABLE	(15) ADJUSTED PROV. CHARGE	(16) MANAGED CARE DEDUCTION(S)	(17) TOTAL AMOUNT PAID
00013		$732.00	$0.00	$0.00	$732.00	0.00	$201.68

(18) MEDICARE CROSSOVER CLAIM MESSAGES/REASONS: 0G

DEDUCTIONS/OTHER INELIGIBLE

(19) PORTION ELIGIBLE FOR PAYMENT BY ANOTHER CARRIER/MEDICARE: $530.32
(20) TOTAL DEDUCTIONS/OTHER INELIGIBLE: $530.32
(21) PATIENT'S SHARE: $0.00

(22) PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS:	1	AMOUNT PAID:	$201.68
PROVIDER CHARGES::	$732.00	RECOUPMENT AMOUNT:	$0.00
ADJUSTED PROVIDER CHARGES:	$732.00	NET AMOUNT PAID:	$201.68
PATIENT'S SHARE	$0.00		

(23) MESSAGES/REASONS:
(0G). THE MEMBER/PATIENT MAY HAVE HEALTH COVERAGE THROUGH ANOTHER CARRIER/MEDICARE. EXPENSES MAY BE ELIGIBLE FOR PAYMENT BY THAT CARRIER.

FOR INQUIRIES RELATED TO GROUP NUMBER YIHOST, YIPPOX, OR YIPPOW, PLEASE CALL 1-800-222-7992.
FOR ALL OTHER GROUP NUMBERS, CALL 1-888-349-3706.

Facility Provider Claim Summary Field Explanations

1	**Date**	Date the summary was finalized
2	**Provider Number**	Provider identification number
3	**Check Number**	The number assigned to the check for this summary
4	**Tax Identification Number**	The number that identifies your taxable income
5	**Facility Name and Address**	Address of the facility that rendered the services
6	**Patient/Patient Number**	The name of the individual who received the service and the patient's account number assigned by the facility.
7	**Claim Number**	The Blue Cross number assigned to the claim
8	**Group/Sub Number**	The number that identifies the group and member insured by BCBSNM
9	**Admit, From, End Date**	The date of admission and beginning and ending dates of service
10	**Days/Treatment**	The number of days or treatments
11	**DRG Code**	The Diagnosis Related Group code used to adjudicate the claim
12	**Provider Charge**	The amount billed for the services
13	**Other Payable/Withhold**	Dollars in excess of the facility allowed amount
14	**Facility Allowable**	The amount allowed for the claim
15	**Adjusted Provider Charge**	Coincides with the facility allowable
16	**Managed Care Deduction(s)**	Utilized on managed care products if service guidelines / criteria was not met (i.e.; prior authorization was not obtained etc.)
17	**Total Amount Paid**	The amount paid for the services
18	**Messages/Reasons**	Any messages or reason codes related to the charges.
19	**Portion Eligible for Payment by Another Carrier/Medicare**	The amount of charges paid by another carrier
20	**Total Deductions/Other Ineligible**	The amount of other carrier payments and ineligible charges
21	**Patient's Share**	Amount patient pays. Providers may bill this amount to the patient.
22	**Provider Claims Amount Summary**	How this claim(s) were adjudicated
23	**Messages**	The description for messages relating to: non-covered services, program deductions, and PPO reductions

Note: Not all PCSs are the same; this PCS is provided as a sample.

8.18 Attachments

- Claim Review Form
- CMS-1500 User Guide
- Coordination of Benefits Form (COB)
- Provider Refund Form

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9 – ELECTRONIC COMMERCE TOOLS

Overview

Electronic Commerce can mean many different things to many different people. BCBSNM defines it as any tool or resource that allows information to be stored, displayed, or transmitted electronically.

Our online resources save time, energy, and make available to our providers the improved efficiency resulting from immediate access to current and accurate information.

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9.1 Interactive Voice Response (IVR) System

9.1.1 Overview

Enjoy the convenience of self-service inquiry resolution.

Our Interactive Voice Response (IVR) system uses voice recognition and touch-tone technology so that you can obtain automated information on member eligibility or benefits as well as prior authorization requirements and submission. All you need to do is speak your request – the IVR does the rest! Refer to the IVR Caller Guides posted on our website.

- You may access the IVR by calling our Provider Service Unit (PSU) at 1-888-349-3706. Hours of availability are: Monday through Friday, 5:00 a.m. - 10:30 p.m. (MT), and Saturday, 5:00 a.m. – 5:00 p.m. (MT).
- Simply provide your National Provider Identifier (NPI) when prompted (you may speak or enter your information by touch-tone).

Note: Providers who do not have an NPI or are calling from out-of-state may speak or enter their tax ID number (TIN) when prompted by the IVR; however, these providers will only be able to obtain limited information. If your NPI or TIN is unrecognized or invalid, you will have partial or no access to member eligibility, benefits, or claims status via the IVR system. Instead, you will be routed to a limited menu that includes instructions on how to obtain an NPI.

For additional information on the IVR phone system and instructional caller guides, refer to the IVR system page on our BCBSNM provider website

9.1.2 NPI Guidelines

The following guidelines were established to help support and clarify the use of NPI numbers when using the IVR:

- Physicians or solo practitioners must use the Type 1 NPI number
- Physicians or practitioners that have incorporated with both Type 1 & Type 2 NPI issues must use the Type 1 NPI number
- Physicians or practitioners that are part of a group practice must use the rendering provider's (Type 1) NPI number
- Radiologists, anesthesiologists and other medical providers must use the Type 1 NPI number
- Medical Groups must use the rendering provider's Type 1 NPI for the rendering provider
- DME suppliers must use the Type 2 NPI for the specific location
- Labs and other ancillary providers must use Type 2 NPI for the entity
- Facilities must use the Type 2 NPI number

9.2 Electronic Claims Submission

9.2.1 Electronic Claims Filing

BCBSNM strongly encourages the electronic submission of claims. Since editing begins prior to an electronic claim entering our processing system, electronic claims are less likely to be returned for additional information and are usually adjudicated more quickly than claims submitted via paper. Electronic submission also enables users to have same day access to their batch reports, which allows for quicker error resolution and expedites the overall revenue management cycle process.

The electronic payer ID for Blue Cross and Blue Shield of New Mexico (BCBSNM) is 00790 and is recognized by most clearinghouses in order to route electronic claims to BCBSNM. All electronic claims submitted to BCBSNM must be routed with payer ID 00790. You may need to contact your clearinghouse if they use a different BCBSNM payer ID.

Claims may be submitted electronically 24 hours a day, 7 days a week. All BCBSNM facility (UB-04) and professional (CMS-1500) claims (excluding adjustments) can be filed electronically via your preferred clearinghouse vendor or at no charge through Availity® Essentials.

Note: For any Electronic Funds Transfer and Electronic Remittance Advice questions, email our Electronic Commerce Services at ecommerceservicesNM@bcbsnm.com.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM. BCBSNM makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

9.2.2 Electronic Funds Transfer

Your BCBSNM payments can be directly deposited into your bank account when you enroll in Electronic Funds Transfer. When you enroll in EFT, you have the option of selecting daily EFTs or a bi-weekly payment schedule. In addition to the reduction of the amount of paper in your office, here are some of the many advantages of enrolling for EFT:

- Easy and convenient payments
- Safer than checks
- Elimination of lost or stolen checks
- No need to obtain and deposit or cash your check
- Facilitation of online banking at your bank

Faster access to funds, as many banks credit direct deposit faster than paper checks

9.2.3 Electronic Remittance Advice

The companion to the EFT is the Electronic Remittance Advice. The ERA is an electronic file that contains claim payment and remittance information such as which claims were

paid, the amount of each payment, and the status of the claims that were processed. This data can then be electronically posted to your accounts. The ERA conforms to the requirements of the American National Standards Institute and is used by providers and billing services for automatic posting. It is referred to by its HIPAA transaction number 835.

The primary advantage of ERAs is a significantly lower operating expense that is made possible by streamlined administration and decreased paper handling. In conjunction with practice management software packages that can handle an 835 file, the ERA can reduce manual posting of claims payments and reconciling patient accounts, thereby saving your practice time and money.

In addition to paper reduction in your office, the ERA provides convenience, greater safety, and increased privacy of patient information.

9.2.4 Electronic Payment Summary

If you are currently receiving the Electronic ERA, you will be automatically enrolled for the Electronic Payment Summary. The EPS is an electronic print image* of the Provider Claim Summary. The EPS is generated in a text format; therefore, no special programming is required, and it is already in an easy-to-read format. The benefit of the EPS is that the payment information is received in your office the day after the claim has been finalized and you may use EPS as an added tool when reconciling your payments.

Note: The EPS cannot be used for automatic posting and is only available in combination with the ERA.

For more detailed information and to get started with EFT, ERA and EPS, visit the Electronic Commerce section of our website to access the EFT/ERA enrollment instructions. You may also email our Electronic Commerce Services at ecommerceservicesNM@bcbsnm.com.

*You will need Adobe Acrobat Reader to view the EPS files; download it free of charge from Adobe's website.

9.2.5 Electronic Refund Management

This online refund management tool will help simplify claim overpayment reconciliation and related processes. The Electronic Refund Management application is available at no additional charge.

- **Enjoy single sign-on** through Availity Essentials. (Note: You must be a registered user with Availity to take advantage of eRM. To register, visit the Availity website.)
- Receive electronic notifications of overpayments to help reduce record maintenance costs.
- **View overpayment requests** – Search or filter by type of request, get more details, and obtain real-time transaction history for each request.

- Inquire about and/or dispute requests online.
- **Settle your overpayment requests** – Have BCBSNM deduct the dollars from a future claim payment. Details will appear on your Provider Claim Summary (PCS) or Electronic Payment Summary (EPS); information in your eRM transaction history can also assist with recoupment reconciliations.
- **Pay by check** – You will use eRM to generate a remittance form showing your refund details. One or multiple requests may be refunded to BCBSNM; check number(s) will show online.
- **Submit unsolicited refunds** – If you identify a credit balance, you can elect to submit it online and refund your payment to BCBSNM by check, or have the refund deducted from a future claim payment.
- **Stay aware with system alerts** – You will receive notification in certain situations, such as if BCBSNM has responded to your inquiry or if a claim check has been stopped.

How to Gain Access to eRM

Availity Users:

Click on the “Refund Management-eRM” link under the BCBSNM-Branded Payer Spaces Applications section in the Availity Essentials portal. If you are unable to access this link, please contact your Availity administrator. To identify your Availity administrator is, click on “My Administrators” link under My Account Dashboard on the Availity homepage. You may also contact Availity Client Services at 1-800-282-4548 for assistance or visit the Availity website for more information.

9.3 Availity Essentials

Availity Essentials is a HIPAA compliant, nationwide, all-payer clearinghouse and Health Information Network that uses the Internet to exchange information in real time between health care providers, payers, and other health care stakeholders. Availity also supports batch transactions.

In addition to an all-payer clearinghouse, Availity offers a secure Internet portal for providers to interact with the payers in the Availity network. Services offered free of charge to providers on the Availity Essentials portal include:

- Eligibility and benefit verification
- Quick claim - online claim entry and submission
- Research procedure code edit tool
- Claim Status Tool (enhanced claim line level detail)
- Electronic Refund Management tool
- Statistical reporting tools
- And more…

Availity does not distribute software for electronic medical claims submission; however, Availity does maintain a list of software vendors and claims clearinghouses that have been approved for electronic submissions.

Availity provides a toll-free electronic data interchange helpline staffed with EDI specialists and regional Availity representatives who can help assess your EDI needs and recommend the appropriate services that may decrease administrative costs. To speak to an Availity representative, call 1-800-282-4548.

You may also visit Availity's website at availity.com to access a fully functional demo, view a listing of vendors and clearinghouses that partner with Availity, or directly register your organization with the Availity Health Information Network.

9.4 Provider Finder®

BCBSNM has made finding the right provider easier than ever. The Provider Finder allows you and your patients to find information about Primary Care Practitioners, Specialists, and other providers 24 hours a day, 7 days a week. Search by specialty, gender, zip code and more.

Provider Rating/Ranking

BCBSNM may, in accordance with and subject to all applicable laws and regulations, rate and rank, providers using certain provider-specific information that includes but is not limited to comparisons of a provider's performance against certain standards, guidelines, measures, and performance of other providers. BCBSNM may publish and/or share such information to and with policyholders, members, and potential members, and other third parties. No such rating, ranking or other reference or statement by BCBSNM about a provider is intended as an endorsement or recommendation of, or referral to, such provider, nor as a guarantee related to future services provided by any provider, nor the anticipated outcome of such services.

9.5 Provider Home Page

The BCBSNM provider home page at www.bcbsnm.com/provider is updated regularly to provide the most current information available on a wide range of topics that includes the items below, plus much more:

- Blue Review newsletter
- Current communications in News & Updates
- Online forms
- Preservice Reviews

- Reference manuals for government and commercial business
- Contact information
- Electronic commerce information
- Claims filing information

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10 – PRIOR AUTHORIZATION AND RECOMMENDED CLINICAL REVIEW

Overview

BCBSNM has two types of preservice review to assess benefits and medical necessity: **prior authorization** and **Recommended Clinical Review**. Similarities predominate over differences between these two types of preservice review. The primary difference is that **prior authorization is required for certain services** whereas the provider has the **option of submitting a Recommended Clinical Review** request before services are rendered. Once requested, prior authorization and predetermination are processed in the same manner including, but not limited to, which reviewers are qualified to approve and deny, timelines, and notices, including appeal rights. Furthermore, neither prior authorization nor Recommended Clinical Review guarantee benefits or payment because, for example, member eligibility and benefits are reassessed as of the date of service and the circumstances represented in the request must have been complete and accurate and remain materially the same as of the date of service.

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10.1 Obtaining Prior Authorization

10.1.1 Requesting Prior Authorization

Participating Providers are required to request prior authorization on the member's behalf in accordance with the member's evidence of coverage; failure to do so may result in denial of the provider's claim and the member cannot be balance billed. Providers should complete the NM Uniform Prior Authorization form located in the attachments at the end of this section, and in the Forms section on our website or, at provider's election, such other prior authorization form available on bcbsnm.com.

- The BlueApprovR℠ application, in Availity Essentials at the BlueApprovR Tools Page, allows providers to submit inpatient and/or outpatient prior authorization requests for medical/surgical services, specialty pharmacy drugs, and behavioral health services for Blue Cross and Blue Shield of New Mexico (BCBSNM) commercial and individual/family members. BlueApprovR is designed to simplify and expedite the submission and decision process for a medical necessity determination. In many cases, BlueApprovR will approve medical necessity at the point of intake with near instantaneous approval. Cases that do not meet auto-approval criteria are sent to appropriate clinicians for determinations. For instructions on how to request prior authorization via BlueApprovR, refer to the BlueApprovR User Guide.
- Availity Authorizations may also be used for any inpatient or outpatient requests. This is an online prior authorization and concurrent review tool that allows facilities and admitting physicians to request, view, edit, and ultimately manage cases in real time. This functionality does not require any additional software or cost. Providers may submit any number of services within a single request for a member that will be delivered contemporaneously to the same Member. In Availity, the provider must specify if the service for which authorization is sought is for inpatient or outpatient setting. For instructions on how to enter a prior authorization request in Availity, refer to the Authorizations User Guide.
- Prior authorization may also be requested by calling the prior authorization phone number listed on the back of the member's ID card.
- If you are faxing or mailing in a request, please submit the completed form along with your supporting documentation to the contact information indicated on the prior authorization request form. Providers are expected to fax prior authorization's only from fax numbers to which prior authorization confirmations may also be returned in compliance with applicable laws, including HIPAA, as BCBSNM will fax the confirmation back to the same number from which the request came.
- **Behavioral health services**, authorizations, benefits and eligibility information must be obtained by calling 888-898-0070. For further information see Section 12, Behavioral Health Services, and on our website under the Clinical Resources tab.
- Prior authorization for certain services may be managed by a third party such as Carelon Medical Benefits Management (Carelon). For instructions on how to enter a prior authorization request in Carelon or, to access Carelon's Provider Training and/or Frequently Asked Questions refer to the Carelon Medical

Benefits Management website. Third parties managing prior authorization for BCBSNM will also accept the NM Uniform Prior Authorization form. For more information about third parties that may manage prior authorization for BCBSNM, see bcbsnm.com/provider/claims/preauth.html.

- BCBSNM does not make preservice medical necessity decisions for a member or provider until prior authorization is requested; for example, BCBSNM does not require a peer-to-peer consultation prior to submission of a prior authorization request.
- Peer-to-peer review regarding medical necessity may occur before or following an initial determination. Treating providers may request peer-to-peer review before an initial determination; provided, however, reviews shall not interfere with prior authorization timelines, including those required by the New Mexico Prior Authorization Act. Treating providers must request peer-to-peer reviews following an adverse initial determination within 30 calendar days after notification. As indicated by the label for these reviews, the peer-to-peer discussion should be limited to the treating and health plan providers. For additional information regarding the grievance procedures available to members and providers acting on behalf of members with health plans that are subject to the New Mexico Insurance Code and regulations thereunder, see the Grievance Procedures set forth in Sections 13.10.17.1, et seq., NMAC and refer to Section 11.4 *Appeal on Behalf of a Member for Medically Related Issues*.
- Note: FEP does not participate in BlueApprovR; FEP uses Availity and IVR; You may also fax in your requests to 800-441-9188. FEP does not use Carelon for UM reviews.

10.1.2 Supporting Information and Documentation

BCBSNM limits requests for medical information regarding the member's medical condition, diagnosis and treatment to only the information necessary to review an authorization request for admission, procedure/treatment, length of stay (LOS) or frequency/duration of service.

Information included with the provider's request for prior authorization, including information on the NM Uniform Prior Authorization form, may be sufficient to process the request. In some instances, however, additional information may be solicited (but not required) from the provider before processing the request, such as information called for on, but missing from, the NM Uniform Prior Authorization form. For some services, to optimize the appropriate disposition of the prior authorization request, the provider may be asked (but not required) to complete an additional form or furnish additional information by phone.

Supporting documentation to accompany the prior authorization request should include the clinical information to support coverage criteria as set forth in BCBSNM Medical Policy and the incorporated Carelon Medical Benefits Management Clinical Guidelines, (or medical policy or guidelines from other third parties that may manage prior authorization for BCBSNM), MCG Guidelines and/or ASAM criteria for determination of medical necessity and appropriateness of proposed level and place of service, length of stay (LOS) or frequency/duration of service. Some common medical records that may constitute documentation with clinical information include the:

- Admission note
- History and Physical
- Treatment plan and goal(s)
- Progress note(s)
- Discharge planning requirements
- Discharge summary
- Radiology report(s)
- Laboratory report(s)

This is a non-exhaustive list, and charting may vary from provider to provider such that providers requesting prior authorization are strongly encouraged to consult the previously mentioned policies and guidelines to determine and submit the documentation within their practice model that includes the requisite clinical information that is needed to process the prior authorization request.

The BCBSNM's Intake Unit will:

- Assign a reference number to the request for service (a reference number is not an authorization number; if the service is authorized a separate authorization will be issued)
- Certify a request for service if appropriate
- Transfer the request for authorization to the appropriate BCBSNM department or direct the provider to a third-party vendor as indicated

Some plans exclude reimbursement for services or do not allow for reimbursement where prior authorization is required and has not been obtained. To avoid claim denial for lack of prior authorization, providers and members must comply with the member's benefit plan requirements for prior authorization.

Note: Prior authorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if prior authorization is approved for treatment and/or a particular service, that authorization applies only to the medical necessity of treatment and may be rescinded if the prior authorization request and/or supporting documentation is fraudulently or materially deficient or misleading, whether by commission or omission. **Furthermore, coverage remains subject to all applicable limitations and exclusions, including those set forth in laws, the provider's participation agreement with BCBSNM (including this Manual), and the member's evidence of coverage**.

If it is determined that a favorable prior authorization decision was based on material misrepresentation or fraud, BCBSNM may refuse to pay the claim or seek recovery of paid claims. Charges for services that are not paid as the result of material misrepresentation or fraud by the provider shall not be collected from the member.

10.1.3 Medicaid and Medicare Requirements

Medicaid Prior authorization Requirements – Refer to the Medicaid section.

Medicare Prior authorization Requirements – Refer to the Blue Cross Medicare Advantage℠ section.

10.1.4 Members Using Network Facilities

Except for emergency care, members with HMO and EPO products must select a hospital within the network of contracted BCBSNM facilities. Members with PPO products using network hospitals will receive a higher benefit level than they would if services were rendered in an out-of-network hospital.

If the attending physician has privileges at more than one BCBSNM contracted facility, Customer Service may provide facility cost information that the provider and member may consider when selecting a facility.

10.1.5 Requests for Out-of-Network Providers

In the event medically necessary covered services are not reasonably available through Participating Providers care by an out-of-network professional may be necessary. However, to be covered, referrals for out-of-network provider services for HMO members require prior authorization by BCBSNM. If not obtained, the out-of-network service will not be covered.

These out-of-network referrals will only be preauthorized when a medically necessary covered service is not reasonably available through a Participating Provider.

To the extent required by 13.10.22.8(E) NMAC, before BCBSNM may deny such a referral to an out-of-network physician or health care professional, the request will be reviewed by a physician with sufficient knowledge of the services and specialty which the out-of-network request is for.

10.1.6 Prior Authorization Determinations

BCBSNM is committed to making timely prior authorization determinations in compliance with the New Mexico Prior Authorization Act and related regulations. Untimely determinations will therefore result in the deemed approval of the applicable request.

Non-Urgent PA. After receipt of the request, Non-Urgent Pre-service determinations and notifications must be issued within three (3) business days for prescription drugs and seven (7) business days for physical and behavioral health services. For fully insured including any form of self-insurance issued or renewed under the Health Care Purchasing Act (i.e., Interagency Benefits Advisory Committee), prior authorization shall be deemed granted for determinations not made within three (3) days for prescription drugs and (7) seven days for physical and behavioral health services; provided that: the adjudication timeline is not required to commence until BCBSNM receives all necessary and relevant documentation supporting the prior authorization request. ERISA Self-Funded and FEP: After receipt of the request, Non-Urgent Pre-service determination and notification must be issued within fifteen (15) calendar days.

Urgent PA. Within twenty-four (24) hours of receipt or sooner when a covered person's health care professional requests an expedited prior authorization and submits to BCBSNM a statement that, in the health care professional's opinion that is based on

reasonable medical probability, delay in the treatment for which prior authorization is requested could: (a) seriously jeopardize the covered person's life or overall health; (b) affect the covered person's ability to regain maximum function; or (c) subject the covered person to severe and intolerable pain. For fully insured including any form of self-insurance issued or renewed under the Health Care Purchasing Act (i.e., Interagency Benefits Advisory Committee), prior authorization shall be deemed granted if not made within twenty-four hours. The adjudication timeline is not required to commence until BCBSNM receives all necessary and relevant documentation supporting the prior authorization request. ERISA Self-Funded and FEP: as soon as possible based on the clinical situation, but in no case, later than seventy-two (72) hours of receipt of request.

Incomplete information. If a provider fails to supply sufficient information to evaluate a prior authorization request, BCBSNM shall allow the provider a reasonable amount of time, taking into account the circumstances of the covered person, but not less than 4 hours for expedited requests and two calendar days for standard requests, to provide the specified information.

Auto-Determinations. If a prior authorization request cannot be auto-approved, a live review will be performed. BCBSNM reserves the right to auto-deny requests: (1) that are materially incomplete or for which there is no coverage; and (2) for prescription drugs if information is provided about an appropriate covered alternative and how to file an exception request (which shall be treated as an appeal).

Retroactive Denials Prohibited. BCBSNM shall not retroactively deny authorization if a provider relied upon a prior authorization issued by phone, fax, email, letter or electronic portal, from BCBSNM received prior to providing the service, except in those cases where there was material misrepresentation or fraud.

Requests Prior to Delivery. BCBSNM will accept prior authorization requests submitted at any time prior to delivery of the service.

Retrospective Review Available. If a provider fails to obtain a prior authorization before delivering the service, retrospective review of medical necessity is available upon request if the request is made within three (3) business days of discharge for inpatient admissions and seven (7) business days of the service being rendered for outpatient services. The provider can request the retrospective authorization by phone, fax, mail or electronic portal (refer to section 10.1.1 Requesting Prior Authorization). A decision will be made for a retrospective authorization within thirty (30) calendar days of the receipt of request.

10.2 Services Requiring Prior Authorization

10.2.1 Services Requiring Prior Authorization

There are conditions for coverage, including, but not limited to, prior authorization for certain services. To be eligible for coverage, Participating Providers must obtain prior authorization in those circumstances where authorization is required (if the service is covered by the member’s plan), except in an emergency (Excludes FEP and other groups that may have selected additional prior authorization requirements not specified in this document).

To determine if a specific service or category requires Prior Authorization, check Availity® Essentials or your preferred electronic information technology vendor. You may also visit our website at https://www.bcbsnm.com/provider for the required Prior Authorization lists, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of the member's Identification Card to determine if Prior Authorization is required and/or to request a Prior Authorization.

The universe of services that must be preauthorized is not static. BCBSNM continuously evaluates which services require prior authorization and which do not. When a service no longer requires an authorization, or a prior authorization requirement is added to a service, Participating Providers are informed of updates to services that may require prior authorization in the Blue Review.

Note:

Federal Employee Program (FEP) Members
For FEP members, you must contact the local Blue Plan where services are being rendered for prior authorization, regardless of the state in which the member is insured. A prior approval review is required for the following services:

- Outpatient/inpatient surgery for morbid obesity;
- Outpatient/inpatient oral/maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth;
- Transplants of any type other than corneal;
- Gene Therapy and CAR-T therapies;
- Certain High Cost Drugs;
- Air Ambulance (non-emergent);
- Outpatient facility-based sleep studies;
- Applied Behavior analysis (ABA);
- Gender Affirming Surgery;
- Genetic Testing;
- Hearing Aids;
- Proton Beam, Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy;
- Reproductive Services and Sperm and Egg Storage;
- Hospice Care;

In addition, Blue Focus requires prior approval on all:

- CT, MRI and PET Scans;
- Breast reductions;
- Orthognathic surgery;
- Orthopedic surgeries, such as hip, knee, ankle and spine;

- Reconstructive surgeries;
- Cardiac and Pulmonary Rehab;
- Cochlear implants;
- Residential Treatment Center;
- Prosthetics and DME;
- Rhinoplasty, Septoplasty and Varicose Vein treatments

Blue Focus does not have Hearing Aid coverage and does not require prior approval for Sleep Study Outside of the home except for pediatric.

10.2.2 Length of Stay

If an extension of the initial length of stay is necessary, Participating Providers must, on behalf of the member, call the Medical Management department at 1-800-325-8334 before the initial approved length of stay expires. Failure to obtain approval for length of stay beyond that which has been approved may result in reduced payment to the provider and the member cannot be balance billed.

10.2.3 Course of Treatment

Prior authorizations for a course of treatment will be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, patient's medical history and provider's recommendation.

10.3 Emergency Care

Emergency services to screen and stabilize the patient are a benefit without prior authorization. Since the prudent layperson standard applies to members seeking emergency services, the member should dial “911” or go to the nearest emergency room if they believe emergency care is needed.

10.4 Urgent Care

When medically necessary care is provided to the patient in an urgent care facility for an illness or accidental injury, no prior authorization is required.

10.5 Obtaining Recommended Clinical Review

10.5.1 Obtaining Recommended Clinical Review

Recommended Clinical Reviews assess benefits and medical necessity before services are provided. Submitting the request prior to the services is optional and informs the provider of situations where a service may not be covered based upon medical necessity.

- There is no penalty if a provider does not elect to use Recommended Clinical Review, However, if the review is not requested and approved, the claim may be denied for lack of medical necessity.
- BCBSNM will accept RCR requests submitted at any time prior to delivery of the service.
- If a provider chooses not to request RCR before delivering the service, retrospective review of medical necessity is available upon request if the request is made within three (3) business days of discharge for inpatient admissions and seven (7) business days of the service being rendered for outpatient services. The provider can request the retrospective authorization by phone, fax, mail or electronic portal in the same manner as if RCR had been requested before the service. A decision will be made for a retrospective authorization within thirty (30) calendar days of the receipt of request.
- The general clinical criteria and list of supporting documents to accompany an RCR request is the same for a PA request, see section 10.1.2 for additional information.
- BCBSNM will review the request to determine if it meets applicable medical policy, American Society of Addiction Medicine (ASAM), or MCG Guidelines criteria before services are provided.
- Recommended Clinical Reviews will be made in seven (7) business days for standard and 24 hours for urgent, failing which the request will be deemed approved.
- Once a decision has been made on the services reviewed as part of the Recommended Clinical Review request, they will not be reviewed for medical necessity again on a retrospective basis absent material misrepresentation or fraud.
- If the Recommended Clinical Review determines the proposed service does not meet medical necessity, the provider and member will be notified of the adverse determination and will have the same appeal rights and process as they do for denied prior authorizations.
- Submitted claims for services not included as part of a request for Recommended Clinical Review, may be reviewed retrospectively.

Note: Recommended Clinical Review determinations are based on benefits and medical necessity and are not a guarantee of benefits or eligibility. Even if a review is approved for treatment and/or a particular service, that approval applies only to the medical necessity of treatment and may be rescinded if the request and/or supporting documentation is material misrepresentation or fraud, whether by commission or omission. Furthermore, coverage remains subject to all applicable limitations and exclusions, including those set forth in laws, the provider's participation agreement with BCBSNM (including this Provider Manual), and the member's evidence of coverage.

10.5.2 Requesting a Recommended Clinical Review

Recommended Clinical Review requests may be submitted electronically to BCBSNM through Availity Essentials. To learn more about Availity and other electronic options, visit the Provider Tools section in our online Education and Reference Center. For personalized online training regarding electronic tools, email our Provider Education Consultants at PECS@bcbsnm.com.

Use BlueApprovR in Availity Essentials to request Recommended Clinical Reviews at BlueApprovR Tools Page. BlueApprovR is designed to simplify and expedite the submission and decision process for a medical necessity determination. In many cases, BlueApprovR will approve medical necessity at the point of intake with near instantaneous approval. Cases that do not meet auto-approval criteria are sent to appropriate clinicians for determinations.

To submit paper Recommended Clinical Review requests, complete the Recommended Clinical Review Request form and fax or mail it to BCBSNM (fax number and address are on the form).

Important Tips for the Recommended Clinical Review Request Form:

- Fill out the entire Recommended Clinical Review Request form.
- Include provider/facility name, address, fax and phone numbers.
- Include ordering physician's name, address, fax and phone numbers.
- Provide contact name, address, fax and phone numbers.
- Always provide procedure code(s) and diagnosis code(s).
- If applicable, provide left, right or bilateral.
- Regarding major diagnostic tests, please include the patient's history, physical and any prior testing information.
- If indicated, include original photos or digital color copies that clearly show the affected area of the body. This information must be mailed to the address indicated on the Recommended Clinical Review Request form.

Recommended Clinical Review may also be requested by calling the phone number listed on the back of the member's ID card.

Recommended Clinical Review for certain services may be managed by a third party such as Carelon Medical Benefits Management (Carelon). Use the Carelon Provider Portal to

request Recommended Clinical Reviews for the care categories managed by Carelon (molecular and genomic tests, radiation therapy, advanced imaging, musculoskeletal, sleep studies, and medical oncology and supportive care).

10.6 Attachments

- Prior authorization Request Form
- Recommended Clinical Review Request Form
- NM Uniform Prior Authorization Form

Note: FEP accepts requests via fax, Availity, IVR. We do not participate in BlueApprovR and Carelon does not do any UM reviews for FEP.

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11 – UTILIZATION, CASE, POPULATION HEALTH, AND CONDITION & LIFESTYLE MANAGEMENT

Overview

The BCBSNM Utilization Management (UM), Well Being Management (WBM) (which includes Case Management (CM) and Condition & Lifestyle Management (DM)), and Population Health Management (PHM) programs are structured to evaluate, promote, and coordinate quality and cost-effective services. The BCBSNM Health Care Management (NM HCM) staff are responsible for assisting members with medically related services. A Medical Director is involved in implementing BCBSNM's UM program and oversees medical necessity decisions and medical reviews. Benefits are determined based on the member's benefit plan as described in the member's summary of benefits. Medical necessity determinations are based on nationally accepted, objective, and evidence-based criteria.

The BCBSNM UM and WBM programs are reviewed, updated and approved annually by the Quality Improvement Committee (QIC). This committee includes contracted network providers representing multiple specialties. Provider input to medical policy is welcomed and encouraged. The Quality Improvement Committee supports the Health Care Management programs; considers and makes recommendations to improve the UM program and process. The committee also reviews UM criteria and medical policies at a minimum of annually.

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11.1 Utilization Management

11.1.1 Overview

Utilization management at BCBSNM includes:

- Pre-service review (prior authorization)
- Recommended Clinical Review
- Concurrent review
- Discharge planning
- Retrospective review

Physicians and other providers are contractually obligated to supply a timely response to verbal and/or written inquiries from BCBSNM UM representatives regarding members' care needs or medical records. Timely responses afford BCBSNM the opportunity to assist members in receiving the full benefit of their health care coverage.

11.1.2 Accessibility

Intake staff members are available to receive incoming calls, make outbound calls, and discuss UM issues with members and providers Monday through Friday, between the hours of 8 a.m. to 5 p.m. (Mountain Time) toll-free at: 1-800-325-8334. A fax line, 505-816-3857, can receive authorization requests 24 hours a day, 7 days a week.

For UM staffing services including physical health, behavioral health, and prescription drugs, a UM nurse is available 24 hours a day, 7 days a week, toll-free at: 1-888-898-0070, with access to the Medical Director as needed. When communicating with members and providers, the UM staff members identify themselves by name, title, and as a BCBSNM employee.

11.1.3 Decision Making

BCBSNM refers to the resources listed below to render coverage determinations based on medical necessity or medical appropriateness. A Medical Director makes all denial decisions related to medical necessity and medical appropriateness.

When determining medical necessity or medical appropriateness, BCBSNM will use, in conjunction with independent medical judgment, the following which include but are not limited to:

- MCG care guidelines (MCG), a nationally-recognized evidenced-based criteria set.
- Health Care Service Corporation (HCSC)/BCBSNM Medical Policy developed through coordination with BCBS Association and/or review of medical literature. Policies are based on current medical literature research, consideration of new and evolving technologies, and input from a variety of medical specialists.
- Centers for Medicare & Medicaid Services (CMS) guidelines

- State guidelines
- Guidelines from recognized professional societies and advice from authoritative review articles and textbooks
- Carelon Medical Policy
- Federal Employee Program (FEP) medical policy

The definition of Medical Necessity may vary by line of business. For New Mexico insured commercial and retail business, medical necessity means health care services determined by a provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis, or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury or disease. It is not for the convenience of the member, the treating physician, the hospital, or any other health care provider.

All HCSC medical policies are incorporated by reference and are available online under the Standards & Requirements tab at bcbsnm.com/provider. All Federal Employee Program medical policies are available online by selecting the "Federal Employee Program (FEP)" link.

The criteria used in the UM decision-making process are available upon request. The Medical Director and the Plan Pharmacist (when cases involve pharmaceutical management) are available to discuss UM decisions. Please contact our UM department at 800-325-8334 to request specific criteria or to talk with a nurse.

11.1.4 Improving Appropriate Utilization

BCBSNM clinical leadership staff reviews data to assess resource utilization. This utilization information is used to determine if there are practices or practice patterns that may be improved to provide better quality care and/or more efficient utilization of services.

BCBSNM clinical staff ensures appropriate utilization of medical services by:

- Basing UM decisions on appropriateness of care and service and existence of coverage
- Ensuring that all members are afforded medically necessary benefits in accordance with their respective plans
- Not specifically rewarding practitioners, providers, or other individuals for issuing denials of coverage or service care
- Not offering financial initiatives to UM decision makers that could encourage decisions that result in under-utilization
- Not prohibiting physicians/professional providers from advocating on behalf of members within the utilization management process

11.1.5 24/7 Nurseline

BCBSNM members may call our 24/7 Nurseline toll-free at 800-973-6329 (For Medicaid members, call 877-213-2567), 24 hours a day, 7 days a week.

Members calling the 24/7 Nurseline can speak directly with a registered nurse who can help them identify their health care concerns and options in a matter of minutes. Members can also learn about more than 1,000 health topics in our audio library, from allergies to women's health, including more than 600 topics in Spanish.

Our members are encouraged to call whenever they have questions about health problems such as asthma, back pain, and other chronic conditions; headaches and fever; minor accidents (cuts and burns); and child care. (For medical emergencies, members are instructed to call 911 or their local emergency service first.)

The Condition Management nurses, known as Well Being Health Advisors (WBHAs), receive and review electronic reports of all members calling the 24/7 Nurseline. These reports are reviewed, and when appropriate, outbound calls are placed to these members to offer:

- Additional information regarding our Condition Management programs and the benefits of participation in the program
- WBHAs follow-up calls to address any remaining concerns

11.2 Individual Case Management

BCBSNM nurses provide individual case management for members with chronic, complex, or catastrophic conditions. Case management activities are based on national standards of practice from the Case Management Society of America. All BCBSNM case managers are certified or are working towards taking the certification examination.

Key points in case management include:

- Case management referrals are accepted and encouraged from physicians, members, facilities, and community providers.
- Early patient identification and intervention can support the member and improve coordination of care.
- Case managers work closely with physicians and ancillary providers and communicate with them by phone or in team conferences.
- Case managers, in conjunction with the treatment team and family, are advocates for the member.
- All transplants must be performed within the BCBSNM transplant network or appropriate BCBSA affiliated facilities. The case manager is available to work with the member and provider in order to assist with this process. Transplant services, including evaluations, must be preauthorized. Requests for these services can be submitted through the normal prior authorization process.

If you would like to refer a patient for case management, please call NM Health Care Management (see the phone directory at the front of this manual). A CM can also be contacted 24 hours a day, 7 days a week, by leaving a voice mail at 1-800-325-8334. You will be contacted the next working day.

11.3 Condition & Lifestyle Management

11.3.1 Overview

The BCBSNM Condition & Lifestyle Management (DM) program has been developed to assist and educate our members to improve self-care management of their chronic disease(s). Our DM programs are based on the belief that to optimize healthy outcomes, patients with chronic conditions are best served by a coordinated combination of professional clinical care: the care providers give, and patient self-care. The BCBSNM Well Being Management (WBM) program provides a continuum of care to all members through coordination between UM, CM, and DM.

The role of the Well Being Health Advisor (WBHA) is important to our Condition & Lifestyle Management program. Our WBHAs are a multidisciplinary team of Registered Nurses, Licensed Professional Counselors and Master Level Social Workers who provide telephonic outreach to at-risk and high-risk patients identified through claims analysis, predictive modeling, member self-referrals, provider referrals, internal UM/CM referrals, and completion of health assessments (HAs).

The WBHAs assess members' health status, chronic condition-specific educational needs, gaps in care, as well as assess the member's readiness to change. If the member chooses to actively engage with the WBHA, that clinician works with them and with the provider to provide education on daily and long-term management of chronic conditions, facilitate compliance with treatment plans and medication regimens, and monitor outcomes. The WBHAA is an adjunct to the care providers give to BCBSNM members.

11.3.2 Program Focus and Features

The BCBSNM Well Being Management program focuses on the following conditions that lend themselves to condition management:

Condition Management

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Cardiovascular Condition Clusters (coronary artery disease, peripheral artery diseases, angina and atherosclerosis)
- Diabetes

- Musculoskeletal Leading Indicators

Lifestyle Management

- Metabolic Syndrome (Leading Indicators of MetS, diabetes and coronary artery disease)
- Hypertension (HTN)
- Obesity (Weight Management)
- Tobacco Cessation

The BCBSNM WBM program is designed to support the physician or practitioner/patient relationship and plan of care in the following ways:

- Provide self-management education and skills to patients
- Provide telephonic health coaching and one-on-one support from a dedicated WBHA
- Assist patients with setting realistic, healthy lifestyle goals such as exercise programs, stress reduction techniques, etc.
- Telephonic reminders and support for obtaining medical services
- Provide patients with special monitoring equipment such as blood glucose monitors and peak flow meters
- Provide patients with interactive Web-based tools such as Health Risk Assessments (HA), Well onTarget Program, Well onTarget Life Points Program, Care onTarget Program, Online Member Care Profile, 24/7 Nurseline and Wellness Discounts
- Disseminate current, nationally accepted, evidence-based clinical guidelines
- Identify and refer certain high-needs patients to CM services
- Continually evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health and risk reduction

Components of the BCBSNM WBM program include:

- Population identification processes (medical claims, predictive modeling, pharmacy data, HA data, etc.)
- Evidence-based practice guidelines
- Collaborative practice models to include physician and support-service providers
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)
- Process and outcomes measurement, evaluation, and management
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)
- Provide members Emmi Health Online Tutorials (short, interactive videos on specific conditions and procedures designed to help member make more informed decisions).

Our Condition and Lifestyle Management programs are managed through the Well Being Management Program. For a more detailed description of current program features, visit our provider website at bcbsnm.com.

11.3.3 Physician Referrals

We invite all physicians to consider BCBSNM members for referral to our WBM program. Referrals can be made by calling 866-874-0912. Physician support enhances the chance the member will achieve full program benefit.

11.4 Appeal on Behalf of the Member for Medically Related Issues

This section applies to Adverse Determination Grievances, where the member requests assistance from their health care provider to pursue an Adverse Determination Grievance of medically related issues such as denial, reduction or termination of, or a failure to make full or partial payment for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The member/patient must provide written authorization for the provider to proceed on their behalf, as indicated by the member's signature and a statement to this fact. Use Provider Request for Appeal on Behalf of Member form. The request for review of an Adverse Determination Grievance must be received at BCBSNM within 180 days after the date the member is notified of the decision. For additional information regarding the grievance procedures available to members and providers acting on behalf of members for commercial and retail health plans subject to the New Mexico Insurance Code and regulations thereunder, see the Grievance Procedures set forth in Sections 13.10.17.1, et seq., NMAC. Information about the Adverse Determination Grievance process may also be obtained by calling the BCBSNM Provider Service Unit (888) 349-3706. For questions about an Adverse Determination Grievance that you have submitted on behalf of a member, contact the Appeals Specialist directly.

For urgent requests concerning an Individual and Family health plan member, please call 800-447-7828 (TTY/TDD: 711) or fax your request to 918-551-2011. For urgent requests concerning a group health plan member, please call 866-236-1702 (TTY/TDD: 711) or fax your request to 918-551-2011.

To appeal on behalf of a Medicaid member for an adverse action against that member by BCBSNM, use the Provider Request for Appeal on Behalf of a Medicaid Member form and see the Medicaid Section of this manual for more information.

Department of Labor (DOL)-ERISA
Members who received their appeal rights under DOL-ERISA receive one level of appeal called the DOL-ERISA committee appeal. The member or his or her representative can provide additional information to the committee, but the member does not participate in the actual committee meeting.

11.5 Confidentiality

Confidentiality of medical records and medical information is critical to BCBSNM. Medical records and information obtained by phone are held in confidence and used only to make the most appropriate determination for the member. Information pertaining to the diagnosis, treatment, or health of any member, including HIV/AIDS, behavioral health, and genetic testing, is held in strict confidence. This information is utilized and disclosed to the extent required or permitted by law under HIPAA regulations.

11.6 Attachments

- Provider Request for Appeal on Behalf of a Member
- Provider Request for Appeal on Behalf of a Medicaid Member

12 – BEHAVIORAL HEALTH SERVICES

Overview

The Integrated Behavioral Health (BH) program is a portfolio of resources that helps Blue Cross and Blue Shield of New Mexico (BCBSNM) members access benefits for behavioral health (mental health and substance use disorder) conditions as part of an overall care management program. BCBSNM has integrated behavioral health care management with our Well Being Management (WBM) medical care management program to provide better care management service across the health care continuum. The integration of behavioral health care management with medical care management allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions.

BCBSNM's Integrated Behavioral Health program supports behavioral health professionals and physicians in better assessing the needs of members who use these services and engages them at the most appropriate time and setting. This program is available only to members enrolled in a BCBSNM health plan that includes behavioral health benefits through a variety of group, government and retail products. Similar behavioral health programs are available across product lines, but requirements may vary. Please refer to the respective product provider manual for the most current information.

- Medicaid – behavioral health services are managed by BCBSNM.
- Blue Cross Medicare Advantage – behavioral health services are managed by BCBSNM.
- **Federal Employee Program (FEP)** behavioral health services are managed by BCBSNM.

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12.1 Program Components

12.1.1 Behavioral Health Program Components

The integrated Behavioral Health program includes:

- **Care/Utilization Management:**
  - **Inpatient Management** for inpatient, partial hospitalization and residential treatment center services
  - **Outpatient Management** for members who have outpatient benefits subject to prior authorization requirements as part of their behavioral health benefit plan through BCBSNM. The BH Outpatient Program includes management of intensive outpatient services.

- **Case Management Programs:**
  - **Intensive Case Management** provides more intensive levels of intervention for members experiencing a high severity of symptoms.
  - **Condition Case Management** for chronic BH conditions such as:
    - Depression
    - Alcohol and substance abuse disorders
    - Anxiety and panic disorders
    - Bipolar disorders
    - Eating disorders
    - Schizophrenia and other psychotic disorders
    - Attention Deficit and Hyperactivity Disorder (ADD/ADHD)
  - **Active Specialty Management** program for members who do not meet the criteria for Intensive or Condition Case Management but who have behavioral health needs and could benefit from extra support or services.
  - **Care Coordination Early Intervention (CCEI)®** Program provides outreach to higher risk members who often have complex psychosocial needs impacting their discharge plan.

- **Specialty Programs:**
  - **Eating Disorder Care Team** is an internal, multi-disciplinary team with expertise regarding eating disorders. The team works with eating disorder experts and treatment facilities as well as internal algorithms to identify and refer members to appropriate programs.
  - **Autism Response Team** is also an internal, multi-disciplinary team whose focus is to provide expertise and support to families in planning an appropriate course of Autism Spectrum Disorder (ASD) treatment for their family, including how to maximize their covered benefits.
    Risk Identification and Outreach (RIO) is an industry-leading model for leveraging robust data analytics to optimize solutions for complex healthcare priorities. This multi-disciplinary collaboration between Behavioral Health, Medical, Pharmacy and Clinical Data Technology groups is focused on mining, organizing and visualizing clinically actionable

data for at-risk member populations and implementing clinically appropriate and effective interventions at both member and provider levels.

- Referrals to other WBM medical care management programs and wellness and/or prevention campaigns

12.1.2 BH Management of Routine Outpatient Services

Management of *routine* outpatient services
Routine BH outpatient services (individual, family, group psychotherapy, psychiatric medication management) ***do not*** require pre-authorization.

Psychological/Neuropsychological Testing Program
The goal of this program is to ensure the member is receiving the medically necessary type and amount of testing. This program involves periodic auditing of providers to determine whether clinical testing practices are in alignment with BCBSNM Policies and the member's benefit plan design. Audits evaluate whether: a) testing meets medical necessity criteria, b) testing is consistent with presenting clinical issues and c) requested hours for the evaluation meet the established standards of practice and do not vary significantly from the provider's peer group performing similar services.

Providers may be subject to testing prior authorization if the audit concludes the provider's practice patterns do not align with BCBSNM policies, but that requirement may be waived once the provider has met and maintained alignment with BCBSNM policies for an established period of time. Our Psychological/Neuropsychological Testing Clinical Payment and Coding Policy is available as a reference on our provider website www.bcbsnm.com

Telehealth and Telemedicine Services
Telehealth or telemedicine services give our members greater access to care. Members may be able to access their medically necessary, covered benefits through contracted network providers who deliver services through telehealth or telemedicine services including intensive outpatient program (IOP) services. Check the member's eligibility and benefits for coverage information.

12.1.3 Clinical Screening Criteria

The BCBSNM Behavioral Health (BH) Team utilizes nationally recognized, evidence based and/or state or federally mandated clinical review criteria for its behavioral health clinical decisions.

For its group and retail membership, BCBSNM licensed behavioral health clinicians utilize the MCG care guidelines mental health conditions and the American Society of Addiction Medicine's *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* for addiction disorders. In addition to medical necessity criteria/guidelines, BH licensed clinicians also utilize BCBSNM Medical Policies, nationally recognized clinical practice guidelines (located in the Clinical Resources section of the BCBSNM website), and independent professional judgment to determine whether a

requested level of care is medically necessary. The availability of benefits will also depend on specific provisions under the member's benefit plan.

Guidelines used for utilization management are not a substitute for the exercise of professional judgement in an individual circumstance.

If a specific claim or prior authorization request is denied and there is an appeal, BCBSNM will provide the applicable criteria used to review the request by the behavioral health professional, physician or member.

If a behavioral health professional or physician engages in a particular treatment modality or technique and requests the criteria that BCBSNM applies in determining whether the treatment meets the medical necessity criteria set forth in the member's benefit plan, BCBSNM will provide the applicable criteria used to review specific diagnosis codes and Current Procedural Terminology (CPT®)/other procedure codes which are appropriate for the treatment type.

12.2 Prior Authorization Requirements and Recommended Clinical Review

Certain behavioral health services require prior authorization. Others may be eligible for Recommended Clinical Review. See Section 10 of this Manual for more information about prior authorization and Recommended Clinical Review and the services to which they apply.

12.3 Quality Indicators

12.3.1 Appointment Access Standards

Appointment Access Standards are available in Section 4, Professional Provider Responsibilities.

12.3.2 HEDIS Indicators

In addition to the appointment standards set forth in Section 4, Professional Provider Responsibilities, participating providers shall satisfy the appointment standards expressed in the Health Effectiveness Data Information Sets (HEDIS®) below.

- For members discharging from an acute mental health hospital admission:

    - We expect a member will have a follow-up appointment with a BH professional within seven days of a mental health inpatient discharge. If the seven-day time frame is missed, an appointment is expected within 30 days of discharge.
- For members treated with Antidepressant Medication:
    - Medication adherence for 12 weeks of continuous treatment (acute phase)
    - Medication adherence for 180 days (continuation phase)
- For children (6-12 years old) who are prescribed ADHD medication:
    - One follow-up visit in the first 30 days after medication dispensed (initiation phase)
    - At least 2 visits, in addition to the visit in the initiation phase, with provider in the first 270 days after initiation phase ends (continuation and maintenance phase)
- For members treated with a new diagnosis of alcohol or drug dependence:
    - Treatment initiation through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization program or telehealth or medication treatment within 14 days following the diagnosis (initiation phase)
    - At least 2 visits/services, in addition to the treatment initiation encounter, within 34 days of initial diagnosis (engagement phase)

12.3.3 Continuity and Coordination of Care

Continuity and coordination of care are important elements of care and as such are monitored through the BCBSNM quality improvement program. Opportunities for improvement are selected across the delivery system, including settings, transitions in care, patient safety, and coordination between medical and behavioral health care. Communication and coordination of care among all professional providers participating in a member's health care are essential to facilitating quality and continuity of care. When the member has signed an authorization to disclose information to a PCP, the behavioral health provider should notify the PCP of the initiation and progress of behavioral health services.

12.3.4 Clinical Appeals

For information about Behavioral Health Clinical Appeals:

Toll free for HMO and/or PPO: 888-898-0070
Toll free for FEP: 877-783-1385

Attention:
Appeal Coordinator
Blue Cross and Blue Shield of New Mexico BH Unit
P.O. Box 660240
Dallas, TX 75266-0240

12.4 Submitting Claims

BCBSNM strongly encourages the electronic submission of claims. Refer to Section 9 for more information in filing claims electronically.

Paper claims should be sent to:

Blue Cross and Blue Shield of New Mexico P.O. Box 660058
Dallas, TX 75266-0058

12.5 Forms

The forms below are available on the BCBSNM provider website under Education and Reference/Forms, or by calling toll free 1-888-898-0070.

Standard Authorization Forms (SAF) and other HIPAA Privacy Forms can also be located in the Forms section.

- Applied Behavior Analysis (ABA) Initial Treatment Request Forms:
  - Applied Behavior Analysis (ABA) Clinical Service Request Form
  - Applied Behavior Analysis (ABA) Initial Assessment Request
- Coordination of Care Form
- Electroconvulsive Therapy (ECT) Request
- Intensive Outpatient Program (IOP) Request
- Professional Areas of Expertise Form
- Facility Areas of Expertise Form
- Psychological/Neuropsychological Testing Request
- Repetitive Transcranial Magnetic Stimulation (rTMS) Form
- Supervision via Telehealth Request & Attestation
- Transitional Care Request-Behavioral Health Form
- NM Uniform Prior Authorization Form

13 – LABORATORY SERVICES

Overview

Bill all laboratory (lab) procedures performed in the provider's office for a BCBSNM member to BCBSNM. An appropriate diagnosis code must be present on all lab claims.

Filling out your patients' lab requisitions correctly and completely is critical for the labs that provide testing services for your practice. **When ordering tests from a participating lab, the following information must accompany the requisition:**

- Patient's full name, complete billing address, and telephone numbers
- Patient's date of birth and gender
- Party to be billed: patient or insurance company
- Subscriber's name, policy number, group number, and a copy of the insurance card (front and back)
- Responsible party (if patient is a minor)
- Complete and valid diagnosis code, narrative, and/or signs and symptoms that support the reason for the lab test
- When ordering a lab test, refer to the code and not the name of the test.

Always refer lab specimens to a BCBSNM participating lab when applicable. The lab performing the testing will bill for the resulting charges. See Subsection 13.4 for information about participating labs and draw stations.

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13.1 Reimbursement and Billing

13.1.1 Reimbursement and Billing Procedures

Covered lab services furnished in accordance with BCBSNM medical policy and other applicable reimbursement guidelines are reimbursed at a fee-for-service rate according to the BCBSNM maximum allowable fee schedule or as otherwise provided in the provider's contract with BCBSNM. The handling or drawing of the specimen is considered part of the lab procedure; therefore, an additional charge for drawing or handling will not be reimbursed. However, BCBSNM will reimburse the provider for drawing or handling when the specimen is sent to a lab other than the provider's office lab and the lab procedure is billed separately by the independent lab.

13.1.2 Pass-Through Billing

Pass-through billing of lab services is not permitted due to the potential negative financial impact to the member. Providers should only bill for the component of the lab services they perform: technical, professional, or both. This applies to all providers including hospitals and health systems with an ownership interest in an independent lab regardless of Medicare clinic status.

13.2 Non-Covered Services/Experimental, Investigational, or Unproven Lab Work

It is the responsibility of the provider ordering potentially experimental, investigational, or unproven lab work to inform the patient that this lab work may be a non-covered service, and that the patient may incur financial responsibility for such testing. The ordering provider should obtain a signed Non-covered Services, Experimental, Investigational, or Unproven Lab Work Consent and Waiver form from the patient and include it with any experimental, investigational or unproven lab work that is sent to a lab. Contracted labs are responsible for making a consent and waiver form available to providers.

See Section 4, Professional Provider Responsibilities for further details regarding standard medical practice and guidelines for how a treatment, procedure, piece of equipment, drug, device, or supply may be determined to be experimental, investigational, or unproven.

Medical policy related to these services is available on our website at bcbsnm.com (click on *Providers*, then select *Medical Policies* under *Standards & Requirements*).

13.3 Genetic Studies

Genetic studies are limited by medical policy and benefit language and may require prior authorization. Refer to *Medical Policies* related to genetic studies on our website.

13.4 Participating Clinical Labs (Pick-Up Service and Draw Station Sites)

Laboratory Corporation of America, Quest Diagnostics, and TriCore Reference Laboratories are the participating, independent clinical/full reference labs for BCBSNM. Please fill out lab requisitions completely, including insurance information and diagnosis. These labs should be used at every opportunity for members' laboratory needs, including needs that are stat. Pick-up service is available to your office by calling:

Lab Corp.	**1-800-788-9892**
Quest	**1-866-697-8378**
TriCore	**1-800-245-3296**

Draw station sites for Lab Corporation of America, Quest, and TriCore are located throughout the state. There are other genetic and specialized testing labs that participate with BCBSNM. Our lab panel can change periodically, so please refer to the Provider Finder located on our website at www.bcbsnm.com for an up-to-date list of our in-network labs and providers.

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14 – PHARMACY SERVICES

Overview

The following policies apply to members who have pharmacy benefits through a Blue Cross and Blue Shield of New Mexico Prescription Drug Rider. Depending on the member's individual contract, pharmacy services may or may not be provided through the BCBSNM pharmacy plan.

Prime Therapeutics is the Pharmacy Benefit Manager (PBM) that provides drug benefits and pharmacy solutions for BCBSNM. Some BCBSNM plans may be "carved out" to other PBMs. This would mean that these members do not have pharmacy benefits through BCBSNM. The PBM name is generally listed on the member's identification card. Please verify member's plan benefits prior to utilization of the Blues Provider Reference Manual for pharmacy services. Members who have FEP (Federal Employee Health Benefit Plan) use CVS Caremark as their PBM.

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14.1 BCBSNM Drug Lists

14.1.1 Overview

The BCBSNM drug lists are provided as a guide to our contracted providers to help them in selecting cost-effective drug therapy. In addition to the list of approved drugs, the drug list describes how drugs are selected, coverage considerations and dispensing limits. As a reminder, drugs that have not received U.S. Food and Drug Administration approval are not covered under the member's pharmacy benefit for safety concerns.

BCBSNM members may have a pharmacy benefit of up to six tiers. Listed drugs may be covered at generic, brand and specialty tier levels. Depending on the member's benefit plan, drugs may be split between preferred and non-preferred within these tiers. Based on the benefit plan, members may pay a lower member share (out of pocket expenses) for prescription drugs in the lower tiers (e.g. member share may be lower for generic than brand tier levels).

Some BCBSNM members' drug list may only list generics and lower cost brand drugs. Some BCBSNM members' drug list may reference all covered prescription drugs, and drugs not listed are not covered. If the drug is not covered, you may be able to submit a drug list coverage exception to BCBSNM for consideration (based on the member's benefit plan). Refer to the member's certificate of coverage for more details, including benefits, limitations and exclusions.

Please refer to the BCBSNM drug list when prescribing for our members. Our drug lists are available at bcbsnm.com (select *Providers*, then *Pharmacy Program*). Call the number on your patient's member ID card for assistance in determining the correct Drug List, if needed.

Note: For FEP, please see FEPblue.org website for pharmacy information.

14.1.2 Drug List Evaluation

BCBSNM uses Prime Therapeutics National Pharmacy and Therapeutics (P&T) Committee, which is responsible for drug evaluation. The P&T Committee consists of independent practicing physicians and pharmacists from throughout the country who are not employees or agents of Prime Therapeutics. The committee, which includes at least one representative from the BCBSNM health plan, reviews drugs regulated by the FDA. The P&T Committee meets quarterly to review new drugs and updated drug information based on the current available literature.

BCBSNM delegates Rx utilization management services to Prime Therapeutics for prior authorizations, quantity exceptions, and/or step therapy for members who have a BCBSNM Prescription Drug Rider. To request a prior authorization, refer to *Prior Authorization and Step Therapy* at bcbsnm.com for available forms (select *Providers*, then *Pharmacy Program*).

14.1.3 Drug List Updates

BCBSNM provides notification to physicians of additions and changes made to the BCBSNM drug lists by newsletters and on the BCBSNM website. Additions to the BCBSNM drug lists are posted on the BCBSNM website in the *Providers* section. Click on *Pharmacy Program* to view the updates. Deletions to the BCBSNM drug lists may occur up to quarterly and are also posted on our website.

Members who are identified as taking a medication that has been deleted from the BCBSNM drug lists are sent a letter detailing the change at least 60 days prior to the deletion effective date. It is important to remember that a medication deleted from the BCBSNM drug lists may still be available to members but at a higher copayment, or the medication may not be covered and the member is charged for the full amount of the drug cost. BCBSNM and Prime Therapeutics also provide pharmaceutical safety notification to dispensing providers and members regarding point-of-sale drug-drug interaction and FDA drug recalls.

Note: The BCBSNM drug list is a tool to help members maximize their benefits. The final decision about what medications should be prescribed is between the health care provider and the patient.

14.2 Generic Drugs

The FDA has a process to assign equivalency ratings to generic drugs. An “A” rating means that the drug manufacturer has submitted documentation demonstrating equivalence of its generic product compared to the brand name product.

BCBSNM supports the FDA process for determining equivalency. BCBSNM’s contracted providers should prescribe drugs that have generic equivalents available and should not add “dispense as written” unless clinical, and if applicable, coverage criteria that prevent use of a generic for a particular member have been met. Some plans may require members to pay the difference between the brand-name drug and generic drug plus the generic copayment.

If you determine that your patient cannot tolerate the available generic equivalent drug, some members’ plans may allow you to submit documentation for consideration to waive any cost share penalties that may be applied to the member otherwise. If approved, the member would only be responsible for their applicable cost share for the brand drug. Call the number on your patient’s ID card for assistance in completing this process.

14.3 Drug Utilization Review (DUR)

14.3.1 Overview

BCBSNM and Prime Therapeutics conduct concurrent and retrospective drug utilization reviews to promote appropriate, safe, and cost-effective medication usage.

Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Network pharmacies are electronically linked to Prime Therapeutics' claims adjudication system. This system contains various edits that check for drug interactions, overutilization (i.e., early refill attempts), and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use his or her professional judgment and call the prescribing provider if a potential adverse event may occur.

Safety checks on prescription opioids address permissible quantity and medication dose, as recommended by the Centers for Disease Control and Prevention (CDC) and other nationally recognized guidelines. The pharmacist will receive alerts advising if authorization may be required from BCBSNM before the full quantity of opioids as prescribed may be dispensed at the point of sale.

Retrospective DUR uses historical prescription and/or medical claims data to identify potential prescribing and dispensing issues after the prescription is filled. Examples of retrospective DUR include appropriate use of controlled substances, polypharmacy, adherence and generic utilization programs. These programs aim to promote safety, reduce overutilization, and close gaps in care. Retrospective DUR programs are developed based on widely accepted national practice guidelines. Individual letters may be mailed to providers identifying potential drug therapy concerns, together with a profile listing the member's prescription medications filled during the study period, references to national practice guidelines and/or an online survey to be completed.

14.3.2 Covered Pharmacy Services

The following is a list of typically* covered pharmacy services:

- Glucagon and anaphylactic kits
- Insulin, syringes, lancets, and test strips
- Any prescription drug unless specifically excluded by the benefit plan (e.g., obesity, infertility), provided that the drug is ordered by the member's PCP or a physician to whom the member has been referred
- The member's applicable prescription copayment applies for each prescription or refill for 30 days
- Oral contraceptives
- Diaphragms
- Preventive vaccinations (e.g., influenza, TDAP, shingles, etc.)
- Medications that are approved by the FDA for self-administration

- One applicable copay applies to most “packaged” items (e.g., inhalers)

*Not all BCBSNM plans include pharmacy benefits. For plans with pharmacy coverage, verifying member's benefits is highly recommended as each policy may have unique benefits.

14.3.3 Non-Covered Pharmacy Services

The following is a list of typically* non-covered pharmacy services:

- Any charge for most therapeutic devices or appliances (e.g., support garments and other non-medical substances), regardless of their intended use
- Investigational use of medication
- Medications specifically excluded from benefit (e.g., drugs used for cosmetic purposes)
- Any drug which, as required under the Federal Food, Drug and Cosmetic Act, does not bear the phrase: “Caution: Federal law prohibits dispensing without a prescription,” even if prescribed by a physician/provider (over-the-counter)
- Drugs that have not received approval from the FDA
- Injectable drugs (other than insulin, glucagon, and anaphylactic kits) that are obtained at a pharmacy without prior authorization
- Nutritional supplements (coverage requires prior authorization)
- Compound medications are not a covered benefit under most plans
- Prescriptions obtained at an out-of-network pharmacy, unless in an emergency
- Lost, stolen, damaged or destroyed medications

*Not all BCBSNM plans include pharmacy benefits. For plans with pharmacy coverage, verifying member's benefits is highly recommended as each policy may have unique benefits.

14.4 Drugs Requiring Prior Authorization

Certain drugs which are high cost and/or have the potential for off-label use or misuse may require prior authorization (also known as prior authorization). For drugs that require a prior authorization, step therapy or quantity limits, refer to *Prior Authorization and Step Therapy* at bcbsnm.com (select *Providers*, then *Pharmacy Program*) for links to available forms and program criteria summaries. Changes to the list of drugs requiring prior authorization are published in our *Blue Review* provider newsletter and on our website. If you have any additional questions, please call Prime Therapeutics at 800-544-1378.

If you are prescribing select infusion drugs, you may need to submit a prior authorization request to BCBSNM prior to administration of the drug.

While physician/provider fax forms are available, including the NM Uniform Prior Authorization form, you can also submit the request electronically via the CoverMyMeds® website. For instructions on how to enter a prior authorization request in CoverMyMeds® refer to https://www.covermymeds.com/main/support/pharmacy/where-can-i-see-a-demo-of-the-covermymeds-solution/. Additional information can be found on Prior Authorization and Step Therapy at bcbsnm.com

BCBSNM allows for certain off-label uses of drugs when the off-label uses meet the requirements of the BCBSNM policy. Please contact the Health Services department for more information on the BCBSNM off-label use policy. For more information about the prior authorization medical criteria, please review our Medical Policies in the Standards & Requirements section of our provider website.

Prior Authorization Exemption Program

As of Jan. 1, 2024, some BCBSNM contracted providers may be granted Gold Card status for certain outpatient drug services delivered to commercial fully insured and Individual & Family Market (Exchange) plan members.

Gold Card status is granted to providers who are the most frequent submitters of required prior authorizations and demonstrate a prior authorization approval rate of 90 percent or greater on eligible services during the previous calendar year and sign the Gold Card Alternative Agreement.

Providers approved with Gold Card status do not need to submit prior authorization requests for approved services as part of their agreement.

For more information about this program, please see the preservice reviews page in the Claims & Eligibility section of our provider website.

Note: FEP does not participate in the Gold Card program. Please see FEPblue.org for brochure regarding High Cost drugs requiring prior approval and CAR-T/ Gene Therapy drugs.

14.5 Pharmacy Network

BCBSNM members with a “pharmacy card” prescription drug benefit must use a pharmacy on the approved list of participating pharmacies to maximize their benefits. This pharmacy network can include retail for up to a 30-day or 90-day supply, mail-order for up to a 90-day supply, or specialty pharmacy for up to a 30-day supply (except for certain FDA-designated dosing regimens). Pharmacy networks and supply limits are dependent on the member’s benefit plan.

Some members' benefit plans may include an additional preferred pharmacy network, which offers reduced out-of-pocket expenses to the member if they use one of these pharmacies instead.

Please encourage your patients to use one pharmacy for all of their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

BCBSNM contracts for mail-order pharmacy services to augment our retail pharmacy network. Members of our plans may receive up to a 90-day supply of maintenance medication (e.g., drugs for arthritis, depression or diabetes) through the home delivery program, depending on the member's benefit. If you believe that a BCBSNM member will continue on the same drug and dose for an indefinite period of time, please consider writing the prescription for a 90-day supply with three refills. If the patient is starting a new medication for the first time, you should write two prescriptions. One for up to a 90-day supply with three refills and a starter supply for up to 30 days that the patient can fill right away at the local retail pharmacy.

Specialty drugs that are FDA approved for patient self-administration must be acquired through a contracted specialty pharmacy provider. The specialty drugs may also be billed under the member's pharmacy benefit to receive maximum coverage.

14.6 Specialty Pharmacy Program

14.6.1 Specialty Pharmacy Program

Specialty medications are generally prescribed for people with complex or ongoing medical conditions such as immune deficiency, multiple sclerosis and rheumatoid arthritis. Due to the unique storage and shipment requirements, some specialty medications may not be readily available at local retail pharmacies. The Specialty Pharmacy Program helps deliver these medications directly to providers, and sometimes directly to the member.

Most specialty medications will require prior authorization. Links to forms and program criteria summaries can be found on can be found on Prior Authorization and Step Therapy at bcbsnm.com.

BCBSNM members may be required to use contracted specialty network pharmacies to fill their prescription under the member's pharmacy benefit plan. The pharmacists, nurses, and care coordinators in our contracted specialty network pharmacies are experts in supplying medications and services to patients with complex health conditions.

For those medications that are approved by the FDA for self-administration, BCBSNM members are required to use their pharmacy benefit and acquire self-administered drugs (oral, topical, and injectable) through the appropriate contracted pharmacy provider and

not through the physician's office. Self-administered drugs must be billed under the member's pharmacy benefit for your patients to receive maximum benefit coverage.

If services are submitted on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500) claims for drugs that are FDA-approved for self-administration and covered under the member's prescription drug benefit, BCBSNM will notify the provider that these claims need to be re-filed through the member's pharmacy benefit. In this situation, the following message will be returned on the electronic payment summary or provider claim summary: "Self-administered drugs submitted by a medical professional provider are not within the member's medical benefits. These charges must be billed and submitted by a pharmacy provider."

If you have questions about the specialty program, a patient's benefit coverage and/or to ensure the correct benefit is applied for medication fulfillment, please call the number on your patient's member ID card.

For information about medical criteria, please review our Medical Policies in the Standards & Requirements section of our provider website.

Accredo is the preferred specialty pharmacy for most BCBSNM members to obtain specialty medications approved for self-administration. Please call the number on the member's ID card to confirm the preferred specialty pharmacy provider under the member's benefit plan.

To obtain specialty medications through Accredo, follow these steps:

1. **Collect patient and insurance information**
2. Contact Accredo at 833-721-1619 or e-prescribe the patient's prescription to Accredo.
3. You can find referral forms by therapy and e-prescribing information at accredo.com/prescribers.
4. If your patient has an existing prescription for a covered specialty medication, you can call 833-721-1619 to transfer the prescription.

Accredo specialty pharmacy's team of pharmacists and benefit specialists will handle the details, from checking eligibility to coordinating delivery. You also have access to varied support tools, such as physician concierge, ePA, interoperability with EHRs and visibility into the status for all of your Accredo patients through a provider portal.

BCBSNM contracts with select specialty pharmacies to obtain specialty medications for physician administration to our members. These medications that must be administered by a health care provider are typically covered under the member's medical benefit. Providers should only bill for the administration of the specialty medication(s) when received from these specialty pharmacies. Providers may not bill for the specialty medication. A list of these pharmacies can be found on the Specialty Pharmacy Program page at bcbsnm.com.

Note: FEP does not use Accredo, please see FEPblue.org for pharmacy information.

14.6.2 Split Fill Program

Some BCBSNM members may have the Split Fill Program as part of their benefit plan. This program applies to select medications that patients are often unable to tolerate. Under this program, members who are new to therapy (or have not had claims history within the past 120 days for the drug) are provided a partial, or “split”, fill for up to the first three months of therapy, giving them the opportunity to try the drug at a prorated cost. This allows the member to make sure they can tolerate the medication and any potential side effects before continuing ongoing therapy.

The Split Fill Program applies to a specific list of drugs known to have early discontinuation or dose modification. Each drug is evaluated using evidence-based criteria to determine the frequency and duration of a split fill. You will be able to find the current list of drugs in this program on our provider page at bcbsnm.com. Note: the list of drugs is subject to change from time to time.

Members must use an in-network pharmacy that can dispense the medication. Members will pay an applicable prorated cost share for each fill received for the duration of the program, up to three months. Once the member is able to tolerate the medication, the member will pay the applicable cost share amount for a full supply. All member share costs are determined by the member’s pharmacy benefit plan.

14.6.3 Point-of-Use Convenience Kits Billing

As a reminder, BCBSNM only reimburses the drug component of a point-of-use convenience kit used in the administration of injectable medications. These prepackaged kits include the medication as well as non-drug supplies, such as alcohol prep pads, cotton balls, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. These non-drug supplies are considered as part of the practice expense for the procedure performed and no additional compensation is warranted. Reimbursement for these kits may be updated based on FDA-approved drug component.

The relationship between BCBSNM and the specialty pharmacies is that of independent contractors.

Third-party brand names are the property of their respective owner. The list of medications included in this program may change from time-to-time.

CoverMyMeds is a registered trademark of CoverMyMeds LLC, an independent third party vendor that is solely responsible for its products and services. BCBSNM makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding the products or services they offer, you should contact the vendor(s) directly.

BCBSNM contracts with Prime Therapeutics, a separate company, to provide pharmacy solutions. BCBSNM, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Accredo is a specialty pharmacy that is contracted to provide services to BCBSNM members. The relationship between Accredo and BCBSNM is that of independent contractors. Accredo is a trademark of Express Scripts Strategic Development, Inc.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate

of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

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15 – PROVIDER SERVICE INQUIRY AND GRIEVANCE PROCESS

Overview

As part of BCBSNM's regular day-to-day business activities, BCBSNM endeavors to furnish providers with courteous, reasonably prompt and accurate resolutions to their various concerns or service inquiries. BCBSNM therefore welcomes and encourages providers to informally inquire of BCBSNM regarding concerns or service issues such as dissatisfaction with adjudication of the provider's claim(s) or with non-claim matters such as BCBSNM's processes for prior authorization, requesting medical records, and fee schedule updates, or performance of the provider's participation agreement with BCBSNM or reconsideration of its termination by BCBSNM. In most instances, the quickest and simplest way for providers to resolve their concerns or service inquiries is to informally communicate them to BCBSNM as described in this Section 15 or elsewhere in this Manual or by contacting their assigned BCBSNM Provider Network Representative by phone or email. Further information is provided below in this Section 15 about informal communication channels and forms for the resolution of providers' service inquiries.

This Section 15 also sets forth the rights of and process for providers to formally submit, and BCBSNM to resolve, regulatorily defined and governed grievances regarding group and retail business under the jurisdiction of the New Mexico Office of the Superintendent of Insurance (OSI) (see Sections 13.10.16.1, *et seq.*, NMAC). Resolutions by BCBSNM via this formal grievance process can take up to 65 or more days from the date BCBSNM receives the provider's grievance. Further information is provided below about formal grievance rights and process.

Please refer to the Medicare and Medicaid managed care sections of this Provider Reference Manual to determine whether and to what extent these processes are utilized for those lines of business.

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15.1 Service Inquiries

The most efficient and expeditious manner to resolve most provider concerns or service inquiries is by informal business engagement with BCBSNM. BCBSNM is committed to fostering open lines of communications with providers to that their concerns and service needs can be appropriately and reasonably promptly addressed as described in this Section 15.1 or elsewhere in this Manual. Additionally, participating providers are always invited to contact their assigned Provider Network Representative to help with their concerns and service needs.

15.1.1 Claims

Examples of concerns and service inquires for claims include, but are not limited to, dissatisfaction with BCBSNM's application of bundling, coding, edits, modifiers, or other billing and payment rules, Coordination of Benefits and medical policies. Providers who need a copy of the applicable electronic remittance advice to inform or support the Claims Grievance may use the BCBSNM Check and Voucher Request form.

Service inquires for claims may be initiated by phoning BCBSNM Provider Customer Service (PCS) at 1-888-349-3706 or the Federal Health Plan Unit at 1-800-245-1609, as applicable.

Service inquiries for claims may also be initiated online by utilizing the Claim Inquiry Resolution tool, accessible through Electronic Refund Management (ERM) on the Availity Web Portal at availity.com.

Finally, service inquiries for Claims may be initiated by submitting the BCBSNM Claim Review Form.

15.1.2 Non-Claims

Examples of concerns and service inquiries for non-claims include, but are not limited to, dissatisfaction with BCBSNM prior authorization and medical records processes, medical necessity, level of reimbursement, changes to applicable fee schedule(s), and disputes arising out of the Provider's participating agreement with BCBSNM.

Service inquires for non-claims may be initiated by phoning BCBSNM Provider Customer Service (PCS) at 1-888-349-3706 or the Federal Health Plan Unit at 1-800-245-1609, as applicable.

15.1.3 Credentialing and Payment Dispute

Providers may initiate a service inquiry or dispute any claim filed with BCBSNM for which payment is denied, delayed, or erroneously calculated when all of the following

criteria are met: (1) BCBSNM's credentialing decision regarding provider is delayed more than 30 or 45 days, as applicable, after receipt of a completed credentialing application ("Decision Due Date"); (2) provider furnished covered services after the Decision Due Date but prior to BCBSNM's approval or denial of the credentialing application, as applicable; and (3) the prompt payment deadline has passed and payment on the claim not yet made. Providers must submit such disputes in writing by including relevant provider, credentialing and claim identifiers and detailed information to explain the basis or bases for the dispute. Providers are encouraged to use the Credentialing and Reimbursement Dispute Form that is available on BCBSNM's website. BCBSNM will respond in writing within 15 days of receipt. If the decision is to pay, the response will include the expected date of payment (this date is estimated and can be a reasonable range of dates). If the decision is not to pay, the response will include an explanation for that decision. Use the following link to access the form: OSI Provider_complaint_form.pdf. For additional information regarding provider payment and provider credentialing requirements, see Sections 13.10.28.1, et seq., NMAC.

15.1.4 Termination

Providers may ask BCBSNM to informally reconsider terminations of participation agreements no later than the effective date of the termination. Providers may do so by contacting their assigned Provider Network Representative by sending a letter by fax toll free 1-866- 290-7718 BCBSNM, Attention: Network Contracting Manager, or mail to 5701 Balloon Fiesta Pkwy NE, Albuquerque, NM 87113

15.2 Grievances

The availability of BCBSNM's service inquiry process above in Section 15.1 is preferred and recommended as the best way to conduct ongoing day-to-day business with BCBSNM but does not preclude a provider from presenting a grievance through the formal grievance process.

15.2.1 Grievable Concerns

BCBSNM allows participating and non-participating providers to present Grievances related to the following concerns:

GRIEVANCE CONCERNS	PAR PROVIDER	NON-PAR PROVIDER
1. Credentialing deadlines	X	X
2. Claim payment amount of timing	X	X

3. Claims submission requirements or compliance	X	
4. Network adequacy, including network participation determinations based on network composition	X	X
5. Network composition, including provider qualifications	X	X
6. Utilization management practices	X	X
7. Provider contract construction or compliance	X	
8. Patient care standards or access to care	X	
9. Surprise billing reimbursement amount, rate, or timing	X	X
10. Termination	X	
11. Operation of the plan including compliance with any law enforceable by the OSI or any directive of the OSI	X	
12. Discrimination	X	X

Definitions:

- Termination - means the discontinuance of a provider's employment, contractual relationship, or other business relationship with, and initiated by BCBSNM. (Note: BCBSNM does not employ any health care providers who furnish covered services to members.)

15.2.2 Timeline to File

Provider grievances must be filed to BCBSNM within 90 days from the incident that is the subject of the grievance. Failure to timely file invalidates the grievance.

15.2.3 Filing Procedures and Response

In order to submit a written grievance that is subject to the provider grievance rights and process described in this Section 15.2, providers must file the grievance as described in this paragraph. Failure to do so invalidates the grievance. Providers must email grievances to BCBSNM at **NM_Provider_Grievance@bcbsnm.com** or manually to 7777 E 42nd Place, Tulsa OK 74145. Whether filed by email or manually, grievances must be directed to the attention of the **NM Provider Grievance Coordinator.** Additionally, the NM Provider Grievance team will refer the provider's concern (that is not grievable under this process) to the appropriate department(s) for further consideration and potential outreach to the provider.

The grievance should be labeled as such and describe in detail the history of, and prior contacts with BCBSNM regarding, the subject matter of the grievance, clearly express the relief requested from BCBSNM and all bases for it, and include any documentation that the provider wishes to offer in support of the grievance. It should also include the provider's preferred method of communication regarding the

grievance, absent which BCBSNM will presume that the preferred method is the same as the channel through which BCBSNM received the grievance.

BCBSNM shall send written acknowledgement of the grievance within five (5) business days of the receipt of the timely filed grievance (i.e., the date received by the designated email or physical address without regard to when the NM Provider Grievance team loads or processes the grievance in the grievance system).

15.3 Request for Supplemental Information

BCBSNM may request supplemental information pertinent to the resolution of the grievance from the provider within 10 calendar days of the receipt of the grievance. The provider is required to submit the information within the next 10 calendar days. If the supplemental information is not received, BCBSNM will render a decision based on available information, which may include denial for lack of information.

15.4 Review Panel

BCBSNM review panel shall be comprised of multiple persons with at least one person in a position of authority over the operations of the subject of the grievance. The review panel shall review the provider grievance including supplemental information to decide the provider grievance.

If the grievance raises a quality-of-care concern, the panel shall include a New Mexico-licensed medical professional who practices in the general area of concern. A New Mexico-licensed physician shall be included on a review panel considering complex quality-of-care concerns.

No person with a conflict of interest shall participate on the review panel for a grievance. Employment by BCBSNM standing alone is not a conflict of interest.

15.5 Response

BCBSNM shall respond to provider grievances in the method submitted (electronically or manually) within 45 days of the later of (a) receipt of the grievance, (b) receipt of supplemental information requested, or (c) the due date for submission of any requested supplemental information. The response shall include:

- Name(s), title(s), and qualification(s) of each person who participated in the grievance decision(s);
- A statement of the issue(s) decided and ultimate decision(s):
- A complete explanation of the rationale for the decision and summary of the evidence relied upon to support the decision(s);
- A summary of any proposed remedial action; and
- Information on the provider's appeal rights.

15.5.1 Extension of Deadlines

BCBSNM and a provider may agree to extend any deadline if confirmed in a documented communication.

15.5.2 Presentation of Evidence (Other than Terminations)

For grievances other than terminations, the provider may present oral or documentary evidence to the review panel. To present such evidence, the provider must notify BCBSNM in advance of the panel proceedings by furnishing the Provider Grievance Panel Form to BCBSNM as further described in the acknowledgement letter. The provider's presentation of evidence may be conference call, virtual, or, subject to any health orders, in person as indicated on the Provider Grievance Panel Form. The provider must furnish copies of documentary evidence that can be retained by the panel; originals will not be accepted. Unless otherwise permitted by the panel chair in his or her sole discretion, a maximum of 30 minutes shall be allowed for provider's presentation of evidence. Excessive, impertinent or redundant evidence may be disallowed by the panel chair and in the unlikely event that the provider behaves unprofessionally, the panel chair is empowered to end the provider's presentation of evidence. A provider's presentation of evidence may not be recorded or transcribed by the provider and does not include the right to question or make demands of panelists, although panelists are permitted but not required to ask questions and make requests of the provider. The provider is under no obligation to answer panelist questions or comply with panelist requests. Upon the end of the provider's presentation of evidence, the provider will be excused from further panel proceedings. For grievances involving terminations, see below.

15.5.3 Bundled or Group Grievances

Provider(s) may submit multiple related grievances at the same time, provided the grievances are not "unduly duplicative or repetitive". Additionally, a group of providers may submit a single grievance on behalf of multiple providers.

15.5.4 Non-Participating Providers

Non-participating providers must assert and explain in their grievance that BCBSNM's act or practice directly impacted the non-participating provider or patient of that provider.

15.6 Provider Terminations

15.6.1 Termination Notification

In the termination notification, BCBSNM shall provide a written explanation to the provider for the termination.

15.6.2 Terminations Based on Cause (Including Immediate Terminations)

Within 90 days of the date of BCBSNM's termination-for-cause letter (including immediate terminations), the provider must notify BCBSNM in writing of the provider's request for a fair hearing. Failing to submit a timely request for fair hearing waives that right. BCBSNM will acknowledge the request in writing by providing a date, time, and agenda for the hearing and by furnishing a Provider Termination Fair Hearing Attendance Form that must be completed, signed and returned to BCBSNM at least three (3) business days prior to the hearing. Use the following link or the link at the end of this Section 15 to access a sample of the Provider Termination Fair Hearing Attendance Form. Failure to timely submit a complete Attendance Form may result in the hearing proceeding as noticed or rescheduling. Subject to regulatory, contractual and accreditation deadlines, BCBSNM will make good faith efforts to accommodate one request to reschedule and absent extraordinary circumstances, BCBSNM will reschedule no more than once.

BCBSNM's fair hearing process provides for the following:

- the right of the provider to appear in person before the deciding panel;
- the right of the provider to present testimonial or documentary evidence at the hearing;
- the right to call witnesses and cross-examine any witness;
- the right of the provider to be represented by an attorney or by any other person of the provider's choice; and
- the right to an expedited hearing within 14 days of the termination in those instances where BCBSNM has not provided advance written notice of termination to the provider and the termination could result in imminent and significant harm to members.
- the right to a written decision within 20 days after the hearing, contemporaneously delivered via the provider's preferred method of

communication; and

- the individual right of each provider in a terminated group to have a hearing if a group of providers is terminated for cause. If any one provider submits a grievance for the termination, BCBSNM shall provide each similarly situated provider in the group with a hearing notice, and each such provider will be bound by BCBSNM's determination, subject to any appeal rights.

15.6.3 Fair Hearing Decision

BCBSNM shall issue a written decision within 20 days after the fair hearing, contemporaneously delivered via the provider's preferred method of communication.

15.6.4 Expedited Hearings for Immediate Terminations

The fair hearing process and provider rights in the case of an immediate termination are the same as the process and rights set forth in Sections 15.6.2 except that BCBSNM will offer the provider an expedited hearing date that is within 14 days of the termination so long as BCBSNM receives within five (5) days after the termination a request for expedited hearing from the provider stating that the termination could result in imminent and significant harm to a member.

15.6.5 No Cause Terminations

Nothing in this Section 15.6 or elsewhere in this Provider Reference Manual shall be construed to prohibit BCBSNM from terminating a provider without cause, so long as the notice requirements of Section 15.6.1 are met. Except as may be otherwise expressly provided by law or government program requirement, if any, the provider has no right to a hearing by BCBSNM unless the termination is for cause (including immediate).

BCBSNM shall notify providers at least 60 days prior to the termination effective date for no cause terminations and shall include an explanation for the termination. Such notice shall be communicated in writing via the format preferred by the provider.

15.7 Appeals

Providers may appeal certain types of grievances to the New Mexico Office of the Superintendent of Insurance (OSI).

15.7.1 Types of Grievances Subject to Appeal

OSI will conduct an external review of only the following 3 types of provider grievances:

- An alleged violation of the law enforceable by the OSI;
- Alleged noncompliance with an order of the OSI; or
- A termination based on providers' alleged failure to comply with a law or order enforceable by the OSI

15.7.2 Timeline for Filing Appeal

Providers shall file their appeal to OSI no later than 30 days after the provider received BCBSNM's response to the grievance, or the deadline for the response, whichever is earlier.

15.7.3 Additional Appeal Requirements and Information

Additional information about, and requirements for, appealing to the OSI are set forth in Section 13.10.16.10 NMAC (2023). There may also be more information and/or forms on the OSI's website: osi.state.nm.us. The information provided in this Section 15.7 is for provider convenience and is not a substitute for the provider's review of and compliance with Section 13.10.16.10.

15.8 Additional Information Regarding Provider Grievances

For additional information regarding provider grievances, use this link or the link at the end of this Section 15 to access Sections 13.10.16.1, et seq. NMAC.

For educational assistance with the grievance process, providers should please contact their assigned Provider Network Representative.

15.9 Attachments

- 13.10.16 NMAC
- 13.10.17 NMAC
- 13.10.28 NMAC
- 13.10.33 NMAC

- Claim Review Form
- Provider Grievance (Non-Termination) Panel Review Attendance Form
- Provider Termination Fair Hearing Attendance Form
- Credentialing and Reimbursement Dispute Form
- Check and Voucher Request Form

16 – CREDENTIALING AND RECREDENTIALING POLICY

Overview

Credentialing is the process by which Blue Cross and Blue Shield of New Mexico (BCBSNM) evaluates whether physicians and certain other providers meet required professional credentialing standards. The credentialing standards include, but are not limited to education, advanced training, board certification, licensure, disciplinary action, and legal action.

Credentialing is not synonymous with participation on a BCBSNM network. A physician or other provider may be denied participation in a BCBSNM network because the specialty or area of service is already adequately represented or for any other lawful reason. Only physicians or other providers who are determined by the Medical Director and/or Credentialing Committee as having met credentialing standards are eligible to participate with BCBSNM. Due to state regulations and National Committee for Quality Assurance (NCQA) standards, we are required to perform primary source verification on a number of elements used for establishing credentials. Please provide BCBSNM with your CAQH Provider ID.

The credentialing process for providers is initiated on the receipt of a **completed credentialing application** by BCBSNM. Once an applicant submits a credentialing application, BCBSNM will respond, via certified mail, to confirm receipt. The application is reviewed for completeness and accepted or identified as incomplete with missing information. BCBSNM will make a decision regarding the credentialing application and notify the applicant within 30 days after the receipt of a completed credentialing application. BCBSNM may extend this period by an additional 15 days (for a total of 45 days), if after review of a complete credentialing application, it is determined that the application requires additional consideration. Such circumstances include an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage. If the credentialing application decision is delayed beyond 30 (or, if 45 days, as applicable) days and the provider has submitted clean claims for covered services, the provider may then submit a Credentialing and Reimbursement Dispute Resolution Form. Approved providers are loaded into our provider payment systems within 30 days (or, if 45 days, as applicable) including all provider information needed to correctly reimburse newly approved providers according to the provider's contract. Approved providers will be added to the provider directory upon completion of loading all data into the provider payment systems. Additionally, claims for covered services will be processed and subject to all applicable terms and conditions (such as eligibility, benefits, and member share) and paid: (1) with dates of service more than 30 days (or 45 days, as applicable) after the date BCBSNM received a complete credentialing application that was approved, or (2) for which BCBSNM failed to approve or deny or (3) BCBSNM failed to load the approved provider's information into our provider payment system. For additional information regarding provider payment and provider credentialing requirements, see SB232 (2023) and Sections 13.10.28.1, et seq., NMAC.

In some cases, credentialing information obtained from other sources may vary substantially from that attested to by the applicant, i.e., physician or provider. If the discrepancy affects or may adversely affect the credentialing or recredentialing decision, BCBSNM Credentialing will notify the applicant in writing, prior to the final decision, of the discrepancy. The applicant will have the right to review information submitted to support their credentialing application including information obtained by the Health Plan from outside sources. However, information that is peer review protected, e.g., references, recommendations, other third-party information, will not be disclosed. BCBSNM Credentialing will allow the applicant thirty (30) calendar days to comment and/or correct the erroneous information. Credentialing decisions will not be made until the applicant has responded to, or if the response time has exceeded the thirty (30) calendar days allocated. Upon request, the applicant may receive the status of their credentialing or recredentialing application.

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16.1 Provisional Credentialing Process

16.1.1 Provisional Credentialing Criteria

BCBSNM may offer to provisionally credential certain professional providers. Provisional credentialing allows the provider to join the BCBSNM network and see our members as an in-network provider while completing the full credentialing process. Provisional credentialing does not apply to recredentialing. To be eligible for the provisional process, the provider must be a first-time applicant, submit a complete, current and signed credentialing application with attestation, have a current, valid license to practice, and provide an authorization to BCBSNM to verify the past five years of malpractice claims or settlements. For more information about the Provisional Credentialing process, refer to the Network Participation page on our Provider website.

16.1.2 Additional Information

- Provisional credentialing is applicable for practitioner providers only
- Practitioners are eligible for a one-time “provisional network participation”
- If the applicant does not meet the "provisional network participation" requirements, the applicant must be fully credentialed and approved prior to being made effective
- Providers who meet the “provisional network participation” criteria will be loaded in network but are directory excluded until fully credentialed

16.2 Initial Credentialing

16.2.1 Overview

Initial credentialing occurs when a provider has not previously been credentialed by BCBSNM. The Credentialing Committee evaluates whether the provider meets credentialing standards. Information used in this deliberation includes, but is not limited to the following:

- Adequacy of training
- Appropriate licensure
- Appropriate board certification status (if applicable)
- Appropriate hospital privileges (if applicable)
- Satisfactory record related to disciplinary, legal, licensing, substance abuse, and medical-legal history
- Adequate liability insurance coverage

Providers who do not meet credentialing standards may not participate in the BCBSNM networks.

Note: Before you can join the BCBSNM Provider Networks, you will need to be assigned a Provider Record. Please refer to Section 3, Provider Services, for more information.

16.2.2 Credentialing Process

Providers must use the Council for Affordable Quality Healthcare's (CAQH®) ProView™ for initial credentialing and recredentialing. CAQH ProView, ***a free online service***, allows providers to fill out **one** application to meet the credentialing data needs of multiple organizations. The CAQH ProView online credentialing application process supports our administrative simplification and paper reduction efforts. This solution also supports quality initiatives and helps to ensure the accuracy and integrity of our provider database.

All New Mexico providers applying for initial or continuing participation with BCBSNM will be required to complete and submit their credentialing and recredentialing applications through CAQH ProView by accessing the CAQH website. Providers that do not have internet access may submit their application via mail to CAQH by first contacting the CAQH Help Desk at 888-599-1771.

***Note**: BCBSNM's requirement of use of the CAQH ProView does not apply to physicians and other professional providers participating through delegated credentialing agreements/contracts.*

Additional Resources

CAQH Contact Information	
Help Desk Phone: (888) 599-1771 Help Desk Chat: proview.caqh.org/PR M-F 8:30am – 6:30pm EST	
CAQH ProView Log in: https://proview.caqh.org	
Help Desk E-mail Address:	providerhelp@proview.caqh.org
Help Desk Hours:	5 a.m. – 7 p.m., **MT**, Monday – Thursday 5 a.m. – 5 p.m., **MT,** Friday
Supporting Documentation:	Scanned copies of supporting documents should be submitted directly through CAQH ProView. From the “Documents” page on your data profile, you can upload a new document, replace an existing document, or delete a document.

Provider Quick Reference Guide:

CAQH is a not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH is solely responsible for its products and services, including CAQH ProView.

16.2.3 Obtaining Credentialing Status

Case Status Checker

If you have completed a Provider Onboarding Form, you can check the status of your application by entering the case number you received in your confirmation email in our Case Status Checker.

Credentialing Status Checker

To check the status of your credentialing process, enter your NPI or license number in our Credentialing Status Checker.

16.2.4 Office-Based Physicians or Other Professional Providers

BCBSNM requires full credentialing of the physicians and other professional providers including but not necessarily limited to those listed below for participation in the networks. Providers should contact their assigned Provider Representative regarding additional provider types who require credentialing.

- MDs and DOs
- DDSs (oral and maxillofacial surgery)
- licensed physical therapists, occupational therapists
- optometrists, audiologists, speech and language pathologists
- behavioral health providers*
- physician assistants, surgical assistants, advanced practice nurses, certified midwives, registered nurse first assistants, when required
- podiatrists
- chiropractors
- acupuncturists

*The licensing board for psychologists (PhDs) does not provide a quick verification method of a provider's license. PhDs will be fully credentialed and made effective after credentialing approval.

16.3 Getting Started with CAQH

16.3.1 Activating your CAQH ProView Registration

Participating providers must have a CAQH Provider ID to register and begin the credentialing process.

First Time Users

- **If you are not registered with CAQH** – When you obtain a BCBSNM Provider Record for claim payment and submit a current signed BCBSNM contract/agreement, BCBSNM will add your name to its roster with CAQH. CAQH will then mail the access and registration instructions to you, along with your unique CAQH Provider ID, allowing you to obtain immediate access to CAQH ProView via the Internet.
- When you receive your CAQH Provider ID, go to the CAQH website to register.

Note: *Registration and completion of the online application is free. Once registration is completed, you may use your CAQH ProView username and password to log in at any time.*

Existing Users
If you are already registered with CAQH and completed your CAQH ProView application through your participation with another health plan, log in to CAQH ProView and add BCBSNM as one of the health plans that can access your information.

Refer to Authorize Tab instructions in the CAQH Reference Guide.

16.3.2 Completing the CAQH Credentialing Profile

The CAQH ProView utility is a single, standard profile that meets the needs of all participating health care organizations. When completing the profile, you will need to indicate which participating health plans and health care organizations you authorize to access your profile data. All provider data you submit through CAQH ProView is maintained by CAQH in a secure, state-of-the-art data center.

When you are ready to begin entering your data, log in to CAQH ProView with your user name and password. The online guide will describe the materials and information needed to complete the profile.

For more information about how to complete your ProView profile, please refer to the CAQH ProView Provider User Guide and the Provider Quick Reference Guide

If you have any questions on accessing CAQH ProView, you may contact the CAQH Help Desk at (888) 599-1771 for assistance.

Note: BCBSNM may need to supplement, clarify or confirm certain responses on your profile with you. Therefore, you may be required to provide us with supplemental

documentation in some situations, in addition to the information you submit through CAQH ProView.

Visit the CAQH website for more information about CAQH ProView and the application process.

16.3.3 Updating Your Information

Keeping your information current with CAQH and BCBSNM is your responsibility.

Updating your BCBSNM provider file:
BCBSNM members rely on the accuracy of the provider information in our online Provider Finder®. This is why it's very important that you inform BCBSNM whenever any of your practice information changes. If you are a participating provider with BCBSNM, you may request most changes online by submitting an Demographic Change Form.

CAQH ProView:
You will be sent automatic reminders from CAQH to review and attest to the accuracy of your data. Use CAQH ProView to report any changes to your practice.

16.4 Recredentialing

16.4.1 Overview

Recredentialing occurs at regular intervals after initial credentialing. Currently the interval is 36 months, but this interval could change. Contact the Network Services Department for the most current information.

As a part of recredentialing, the Credentialing Committee evaluates whether the provider continues to meet credentialing standards. Information used in this deliberation includes, but is not limited to, the following:

- Disciplinary, legal, licensing, substance abuse, or medical-legal actions occurring since last review
- Maintenance of adequate malpractice insurance
- Member or patient complaints

Providers who do not meet recredentialing standards may not continue to participate in the BCBSNM networks.

16.4.2 Recredentialing Process

The process of recredentialing is identical to that for credentialing and is consistent with NCQA and State of New Mexico requirements.

Please provide BCBSNM with your CAQH Provider ID.

If you are not currently registered with CAQH, BCBSNM will add your name to its roster with CAQH. CAQH will then mail to you the access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to CAQH ProView via the Internet to complete and submit your application. This will help you to conform to the requirements of your provider contract/agreement to continue your participation with BCBSNM's networks.

If you are an existing user of CAQH, you are required to review and attest to your data once every six months. At the time you are scheduled for recredentialing, BCBSNM will send your name to CAQH to determine if you have already completed the CAQH ProView credentialing process and authorized BCBSNM or selected “global authorization”. If so, BCBSNM will be able to obtain current information from the CAQH ProView database and complete the recredentialing process without having to contact you.

Forward applicable completed form(s) to BCBSNM:
Fax to: 866-290-7718
or
Mail to:
Blue Cross and Blue Shield of New Mexico
Network Services Department
5701 Balloon Fiesta Parkway
Albuquerque, NM 87113

If you are unable to utilize the CAQH ProView utility, contact your BCBSNM Provider Network Representative to begin a manual credentialing process.

16.5 Appeals of Network Terminations

A provider who does not continue to meet credentialing standards will no longer be eligible for participation in the network. In those cases, BCBSNM will terminate its provider agreements with the provider. When a provider’s relationship is terminated, BCBSNM offers a full set of appeal rights, including the right to correct erroneous information and the right to an informal fair hearing in compliance with all applicable Office of Superintendent of Insurance regulations regarding provider terminations contained within the New Mexico Managed Health Care Plan Rule. These appeal rights are described in detail in Section 15, Provider Service Inquiry and Grievance Process.

16.6 Delegation

Under certain infrequent circumstances, some functions ordinarily assumed by BCBSNM are delegated. For example, as discussed above, primary source verification of credentials may be delegated to a Credentials Verification Organization (CVO). Credentialing functions, utilization management, and quality management may be delegated to other

entities such as Independent Practice Associations (IPAs). Such delegation is always established through written agreement.

Physicians and other providers who are contracted with entities to whom BCBSNM has delegated certain functions should be aware that BCBSNM retains ultimate authority for that function.

For example, a physician may be credentialed by an IPA that contracts its services to BCBSNM. If that IPA has been granted delegated status for credentialing, it would not be necessary for the physician to undergo separate credentialing by BCBSNM. However, the participation of that physician with BCBSNM remains subject to that physician meeting BCBSNM credentialing standards. Regardless of whether the physician has been credentialed by the IPA, if BCBSNM determines that the physician does not meet credentialing standards, that physician may be denied participation with BCBSNM.

If the IPA loses its delegated status for any reason (such as contractual changes), BCBSNM will re-assume responsibility for credentialing and recredentialing of providers who continue to serve on the BCBSNM network. However, the fact that a provider met credentialing standards with a delegated IPA does not assure or guarantee that BCBSNM credentialing standards are met, or that BCBSNM will pursue a contract with that provider.

Questions about delegation should be directed to the delegated entity or Enterprise Delegation Oversight Programs.

16.7 Attachments

- Credentialing and Reimbursement Dispute Resolution Form
- 13.10.28 NMAC
- SB 232 (2023)

17 – QUALITY IMPROVEMENT

Overview

The Blue Cross and Blue Shield of New Mexico (BCBSNM) Quality Improvement (QI) Program is based on a view that the process for delivery of medical care and services can be continuously improved. Monitoring and evaluation are an integral part of the quality improvement process by revealing opportunities for positive change that can benefit both members and health care practitioners.

The purpose of the QI Program is to provide the necessary focus and structure to monitor and evaluate members' experience and the quality of clinical care and services of health plan programs. The information gathered from the QI Program activities is used to identify opportunities and action for improvement of the QI Program. Through the QI Program activities and goals, BCBSNM measures performance and progress against defined objectives.

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17.1 Provider Rights and Responsibilities

17.1.1 Provider Rights

With regard only to this Quality Improvement section, and notwithstanding any other rights and responsibilities, physicians and other providers who participate with BCBSNM have the following rights related to the material discussed in this section:

- The right to information about our quality improvement, quality assurance, credentialing, and other programs that may affect their clinical practice and/or participation. Documents and communications occurring in the context of a quality review that qualify for peer-review statute protection are maintained as strictly confidential and non-disclosable to the extent permitted by law
- The right to receive updated information provided through our provider website, newsletter, and other forms of communications
- The right to receive updated clinical practice guidelines, preventive health, and information about condition (disease) management and related programs that may support the clinical management of patients
- The right to a fair, impartial, and objective evaluation related to any quality assurance or similar issue that may result in limitations placed on the provider or termination of the provider from the BCBSNM network
- The right to medical director and/or peer review of any issue that involves clinical issues prior to any final adverse determination
- The right to respectful and professional interactions by employees of BCBSNM
- The right to appeal adverse credentialing determinations in accordance with and subject to the rules of the BCBSNM credentialing program

17.1.2 Provider Responsibilities

As related to the material discussed in this section, physicians and other providers who participate with BCBSNM have the responsibility to:

- Reasonably respond to and comply with requests (such as requests for information) related to the areas of quality improvement and management, including quality assurance, member complaints, credentialing, NCQA accreditation, gathering of data for Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and condition management;
- Cooperate reasonably with BCBSNM in scheduling and accommodating site visits performed for credentialing, HEDIS, or other purposes, and to provide access to medical records to the extent permitted by state and federal law;
- Allow BCBSNM to use provider performance data for QI activities;
- Interact in a respectful and professional manner with BCBSNM employees
- Meet credentialing and recredentialing standards;
- Maintain adequate medical record documentation in accordance with Health Insurance Portability and Accountability Act (HIPAA) and BCBSNM medical record standards
- Communicate freely with patients about their treatment, regardless of benefit coverage limitations; and

- Cooperate with BCBSNM quality improvement activities to improve the quality of care and services, and member experience, including the collection and evaluation of data.

17.2 QI Program Management

The purpose of the Blue Cross and Blue Shield of New Mexico (BCBSNM) Quality Improvement (QI) program is to provide the necessary focus and structure to monitor and evaluate members' experience and the quality of clinical care and service of health plan programs. The information gathered from the QI program activities is used to identify opportunities and action for improvement of the QI program. Through the QI program activities and goals, BCBSNM measures performance and progress against defined objectives.

The QI program is managed under the direction of a designated physician (e.g., Chief Medical Officer (CMO), medical director, associate medical director or other physician assigned to this task) in collaboration with physicians, providers, health care professionals, employers and plan staff who directly or indirectly influence the delivery of care and service.

The BCBSNM Quality Improvement Committee (QIC) provides oversight for all QI activities to include the review, assessment, evaluation, and development of QI initiatives and the identification of opportunities for improvement and actions that will improve quality results. The QIC ensures that clinical and service QI activities are performed and communicated to plan leadership and departmental leads.

The BCBSNM QIC provides oversight for all QI sub-committees and work groups to carry out specified tasks related to the action of the QI Program.

Clinical aspects of the QI program are reviewed by network physicians who sit on one or more of the committees listed below (or their successor committees). Operations are managed by a Director and/or Manager of Quality and Accreditation and Chief Medical Officer. Close operational linkages are found between the QI Program and the programs for Utilization Management, Condition/Disease Management, Case Management, and Network Services that in turn form the basis for an Integrated Total Health Management program.

17.3 Professional Committees

All significant policies, procedures, and other activities that have substantive importance to providers or members' clinical care are reviewed by professional committees that include practicing physicians. The following table summarizes these committees:

Professional Committee	Responsibilities
Quality Improvement Committee (QIC)	Multi-disciplinary committee that provides oversight for all quality improvement (QI) activities to include the review, assessment, evaluation, and identification of actions that will improve quality results. • Chaired by the BCBSNM CMO or a BCBSNM Medical Director who reports to the CMO. • Provide quality improvement and peer review oversight and coordinates the QI Program with other committees such as Service Quality Improvement Committee (SQIC), Credentialing and Contract Review Committee (CCRC), and Policy and Procedure Committee. • Review and approve the annual BCBSNM QI Program Description, BCBSNM QI Work Plan and BCBSNM QI Program Evaluation. • Review and approve the annual BCBSNM Population Health Assessment, Population Health Management Strategy and Program Evaluation. • Review and approve the annual BCBSNM Utilization Management Program Description and Evaluation. • Monitor and act upon recommendations from the SQIC based on the annual assessment of member and provider satisfaction in coordination with other key management staff and departments. • Review the Service Quality Improvement Committee (SQIC) quarterly summary reports relating to member experience, availability, accessibility, continuity and coordination of care, quality of care, patient safety and opportunities for improvement identified through analysis and review of complaints and appeal information, member experience survey results (Consumer Assessment of Healthcare Providers & Systems (CAHPS®) and Enrollee Experience Survey (EES)). • Maintain regulatory compliance oversight with NCQA and in accordance with State and Federal laws and regulations. • Evaluate QI resources and determine allocations needed to support specific QI activities and make recommendations to senior leadership. • Review results of the HEDIS and Quality Rating System (QRS) annual reporting and provide strategic recommendations for deployment of key initiatives and interventions. • Evaluate, analyze, address opportunities, and provide recommendations for CQI projects employing key staff. • Monitor quality improvement studies, projects, performance measurement and program effectiveness by analyzing and evaluating reported results and making recommendations for improvement. • Analyze and evaluate the effectiveness of QI activities, identify needed actions, and ensure follow-up as appropriate. • Ensure practitioner participation in the QI Program through planning, design, implementation, or review. • Recommend policy decisions.

Professional Committee	Responsibilities
Service Quality Improvement Committee (SQIC)	The SQIC ensures that service-related QI activities are implemented, and outcomes reported to the BCBSNM QIC at least quarterly. • Chaired by a Director of BCBSNM Quality and Accreditation department and/or designee. • Review and identify opportunities for improvement and develop interventions that are related to BCBSNM service areas • Recommend employee training based on results of member and provider surveys. • Review, analyze and evaluate provider/practitioner access and availability results, member and provider telephone service metrics, and identify opportunities and make recommendations for implementing interventions aimed at improving compliance with service-related standards. • Analyze member and provider complaints and appeals data, identify trends and opportunities for improvement and make recommendations for interventions, as appropriate. • Evaluate questions and results from the member and provider surveys (CAHPS®, QHP EES and Provider Satisfaction) and make recommendations for interventions, as appropriate. • Recommend new initiatives as they may relate to member and provider experience as appropriate.
New Mexico Policy and Procedure Committee (NM P&P)	• Chaired by either the Manager of BCBSNM Quality and Accreditation and/or the Senior Director of BCBSNM Medicaid Quality and Accreditation. • Review and recommend changes to all policies and procedures brought to the committee. • Provide recommendations for updates/changes to policies or procedures to meet NCQA accreditation or State regulatory requirements, as needed. • Approve new policies and procedures brought to the committee. • Provide early identification of issues and opportunities that may impact accreditation or operations and make the necessary recommendations. • Recommend new policies be implemented, as appropriate. • Maintain a centralized repository of all finalized approved policies.
NM Credentialing Committee	• Comprised of network physicians from a broad range of specialties as appropriate to the BCBSNM network composition and BCBSNM Medical Directors. • Determine if the credentials of a provider applying to participate in a BCBSNM health plan meet the credentialing standards in force at the time. • Determine if providers participating with BCBSNM continue to meet credentialing standards. • May review Quality of Care cases brought forth by a BCBSNM Medical Director. • Review and makes recommendations regarding individual providers and policy to the Divisional Vice President (DVP) of Network Management.

Professional Committee	Responsibilities
Enterprise-wide Committees	Certain activities are consolidated into committees that are managed at an enterprise-wide level. • The BCBSNM-based Director of Pharmacy Services represents BCBSNM to the Enterprise-wide Pharmacy and Therapeutics Committee. • A BCBSNM Medical Director represents BCBSNM to the Enterprise-wide Medical Policy Committee. • The Enterprise Delegation Committee (EDOC) is responsible for reviewing performance of delegates and either approving continued delegation or making recommendations to address performance deficiencies or negative trends through a corrective action plan or revocation of delegation. EDOC recommendations are issued to each Plan's appropriate QI committee for inclusion in the quality report shared with the Board of Directors. • The HCSC Health Equity Steering Committee (HESC) is an Enterprise-wide committee that is responsible for raising Enterprise awareness regarding the business case for eliminating disparities in health and health care delivery, and to enable interdisciplinary actions which will improve health equity for HCSC members and the communities we serve. The goal of the HESC is to improve health equity for HCSC's members, reducing the impact that health disparities have on the business and members' quality of life.

17.4 Standards and Benchmarks

17.4.1 Overview

BCBSNM strives for a collaborative approach with the health plan, patients, physicians and other providers working together to achieve improved outcomes. By using accepted outcome measures, we can objectively evaluate our performance and the performance of our provider network. The major sources of standards and benchmarks we use are described below:

17.4.2 Accreditation Guidelines

National Committee for Quality Assurance (NCQA) is the major accrediting body for health plans. NCQA standards are a roadmap for improvement—organizations use them to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection." The NCQA Standards evaluate organizations on:

- Quality Management and Improvement.
- Population Health Management.

- Network Management.
- Utilization Management.
- Credentialing and Recredentialing.
- Member Experience.

17.4.3 HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is administered by NCQA and measures performance in health care where improvements can make a meaningful difference in people's lives. According to NCQA, "The use of HEDIS data allows the Health Plan to effectively measure care and service performance. This focuses attention on activities that keep members healthy." Because BCBSNM is not a direct provider of health care services, all outcomes related to patient care are a reflection on the performance of the physicians and providers in our network. Thus, HEDIS rates can help physicians and providers see how their clinical practice outcomes compare with others nationally.

Many of the clinical HEDIS measures require cooperation with providers related to billing and coding practices, submission of additional clinical information, including, the ability for us to obtain information directly from the medical record. Often, this means the provider needs to simply send a fax with the requested information timely or allow clinical staff to make on-site visits. These visits are always scheduled in advance and generally occur between February and mid-April. **Cooperation with the collection of HEDIS data by our quality improvement program staff is a required element under a provider's contractual obligation to cooperate with our quality improvement activities.**

HEDIS results related to clinical practice or outcomes are reviewed by physicians on our professional committees. HEDIS outcomes may be communicated to our providers to keep you informed of our Quality Improvement program through the *Blue Review* provider newsletter.

HEDIS is a registered trademark of the National Committee for Quality Assurance.

17.4.4 Blue Cross and Blue Shield Association

BSBCNM is a division of Health Care Service Corporation, a Mutual Legal Reserve Company that is an independent licensee of the Blue Cross and Blue Shield Association (BCBSA). We are accountable for a strict set of performance standards promulgated by the BCBSA, including standards for processing claims, customer satisfaction, business practices, and financial stability.

17.4.5 Federal Employee Program

As a subcontractor to the BCBSA, we administer aspects of the Federal Employee Program (FEP), one of the carriers for the Federal Employee Health Benefit Program of the U.S. government. We are accountable for all FEP standards, including but not limited to standards related to case management.

17.4.6 Public Entities

BCBSNM is committed to strict compliance with all applicable regulations of the NM Office of Superintendent of Insurance (OSI), as well as all applicable state or federal regulations and statutes.

17.4.7 BCBSNM Internal Standards

When external standards and benchmarks do not exist, we solicit input from practicing physicians and providers, members, and others to develop reasonable standards and benchmarks.

17.5 Quality Improvement Program

17.5.1 Overview

Quality Improvement (QI) refers to those systematic activities designed to improve processes and outcomes at the level of the population in a sustainable manner. QI activities fall into two major categories: clinical (e.g., improving rates of immunizations and mammography) and service (e.g., reducing waiting times and improving access). QI activities are overseen by the BCBSNM Medical Director and approved by the relevant quality committee.

17.5.2 Formal Initiatives and Studies

In accordance with standards established by NCQA and others, BCBSNM undertakes several formal QI initiatives and studies each year. These initiatives often relate to clinical measures. Examples in the recent past have included:

- Increasing the number of women who obtain mammography screening so that breast cancer can be diagnosed earlier
- Increasing the immunization rate of children
- Increasing the percentage of individuals with new diagnoses of major depression who are treated appropriately with medication

Whenever possible, the measures used for formal initiatives and studies are nationally validated measures, such as HEDIS.

The intention to improve the health of our members could never be realized without the participation of network physicians and providers. Participation in formal initiatives is an indicator of commitment to quality care and is documented and reviewed at the time of recredentialing as proof of cooperation and participation in the QI Plan (see Section 16, Credentialing).

17.5.3 Member Education and Support

BCBSNM recognizes that our members – your patients – play a critical role in achieving good health outcomes. Members can take an active role in their health care. While the best source of education and encouragement is the primary care physician, we also offer member education and support through our Integrated Total Health Management model called Wellbeing Management. Additionally, we provide support by:

- Annual publishing of health information in the Blue Access for Member (BAM) website. Publishing the quarterly health magazine Blue for Your Health (Medicaid product), for our members that includes useful health information
- Sponsoring community-based health events to improve education and understanding of key health issues; at these events, we provide special assistance to our members
- Maintaining a website, bcbsnm.com, that provides access to health information
- Encouraging our members to call our 24/7 Nurseline toll-free at 1-800-973-6329, which is available 24 hours a day, seven days a week, to speak to a registered nurse who can help them identify their health care options in a matter of minutes. By using the 24/7 Nurseline, members can also learn about more than 1,000 health topics in our audio library, from allergies to women's health.

We actively solicit the input and advice of our network physicians and providers as to how we can improve the education and support we provide.

17.5.4 Member and Provider Experience (Satisfaction)

We use validated survey tools to assess both member and provider experience, including the nationally utilized Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan Enrollee Experience Survey (QHP EES) which measures the experience of BCBSNM members. We also monitor certain indicators of experience, such as whether members are able to obtain appointments within a reasonable time. When opportunities for improvement are identified, we work with providers and members to find ways to improve services.

If you are selected for a provider experience survey, we encourage you to complete the survey and return it. All responses are confidential and are processed by a third-party vendor. We cannot determine areas for improvement without your valuable input.

17.5.5 Continuity and Coordination of Care and Patient Safety

We measure the extent to which the care received by our members demonstrates continuity and coordination across different health care settings (outpatient, inpatient) and between physical and behavioral health providers. Examples of initiatives are:

- improving the percentage of persons with substance abuse concerns who receive appropriate treatment
- improving primary care physicians' access to information for referrals to specialists, and

- improving primary care physician access to information from patient admissions

Many opportunities for improving continuity and coordination of care may have an impact on patient safety. Participating physicians are expected to cooperate and participate in BCBSNM quality improvement efforts aimed at improving continuity and coordination of care and reducing patient safety errors.

17.5.6 Identification of Potential Areas of Concern

Areas of potential concern are usually identified through internal Quality of Care (QOC) review or member complaints (see section 17.5 below).

Internal QOC review identifies potential quality concerns during the course of normal health care management operations. In some cases, clinical records in our possession may be screened for potential problems. Examples of conditions that may be screened include death during a hospitalization, infection following invasive procedures, and untreated asthma or diabetes.

We will seek medical records or other information when a medical director has determined that such information is necessary to resolve an issue. **Provider cooperation with QOC activities is considered a condition of participation with your BCBSNM contract.**

17.5.7 Resolution

All issues raised are reviewed in accordance with BCBSNM's formal Quality Review policy. Outcomes of the review are entered into a database for analysis. All documents and communications occurring in the context of the quality review that qualify for peer-review statute protection are maintained as strictly confidential and non-disclosable to the extent permitted by law.

QOC information related to a particular physician or provider is reviewed at the time of recredentialing review (see Section 16, Credentialing).

17.6 Member Complaints

17.6.1 Overview

BCBSNM investigates complaints made by our members that relate to access, service, and quality of care.

Member complaints are reviewed for reasonableness and the need for further investigation. BCBSNM will try to resolve complaints expeditiously and with the least possible intrusion into day-to-day practice. However, at times we must obtain records, explanations, or otherwise communicate with physicians, providers, or their office staff. **Cooperation with complaint investigation is considered an absolute condition of participation with BCBSNM**.

When a complaint requires in-depth investigation, we contact the provider in writing with an explanation of the member's concern. When responding to an inquiry, please reply objectively with the facts, as you understand them. Please respond within the time identified on the cover letter to the address provided. In most cases, the provider's response is sufficient to close the case. If an opportunity for performance improvement is determined, a description will be provided. In a small number of cases, particularly if there is concern about future care, an action plan will be requested. All clinical issues are reviewed by a medical director with additional peer consultants as appropriate.

Note: Members who file clinical care complaints are informed **only** that we will investigate their complaint and take action as appropriate. **We do not release our specific clinical quality review determinations to members**. This is in accordance with standard peer review practice. For similar reasons, we generally do not send correspondence to the provider at the close of a case unless we are requesting the provider to take an action.

17.6.2 Corrective Actions

When opportunities for improvement are identified during a review, they will be communicated to the physician or other provider involved if appropriate. In some cases, we will ask for follow-up to determine if the opportunity for improvement has been addressed. In certain cases, we may request that a formal corrective action plan will be developed. We are committed to making our quality improvement activities a collaborative endeavor and seek a cooperative resolution to any concerns. While we never anticipate having to take more substantial measures, we reserve the right to undertake additional corrective action, up to and including referral to legal or regulatory authorities and termination from the BCBSNM network in circumstances that are determined to pose a risk to the health and safety of our members; or in circumstances in which BCBSNM is placed at risk of adverse events including but not limited to adverse legal actions, adverse regulatory actions, or adverse effects on our business. Quality review of individual cases may result in actions by BCBSNM depending on severity and/or legal, accreditation or other requirements, including, but not limited to, termination from the network(s), reporting to State licensing agencies, the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB). **If the corrective action leads to for-cause or immediate termination from the network, the provider will be afforded all rights to appeal the action in accordance with the New Mexico Administrative Code (NMAC)**.

17.7 Practice Support Tools

BCBSNM provides practice support tools to our network physicians and other providers. The extent of these tools varies with the type of health care plan, as different health care plans are funded by the purchasers to provide slightly different supports.

The intent of practice support tools is not to dictate or prescribe care. The intent is to provide evidenced-based information and practice feedback to encourage practices that maximize quality, and that minimize the risk of underutilization or overutilization. Typically,

these tools take the form of guidelines, printed educational materials, and Internet resources. In addition, formal comparative reporting may be provided so that individual physicians have the opportunity to self-assess performance in the context of their peers' performance

17.8 Performance Recognition

BCBSNM recognizes the commitment and dedication of the physicians in our network. Those physicians whose practices use systematic approaches (particularly for chronic and preventive care) to maximize quality deserve recognition. BCBSNM has instituted a Performance Based Recognition program using validated metrics related to the care received by our members. However, because of the rapidly shifting issues related to the Patient Centered Medical Home, Accountable Care Organizations, Meaningful Use of Electronic Medical Records, and the effects of the 2010 Affordable Care Act, the nature of our performance recognition approach is anticipated to evolve. Providers engaged in Performance Based Recognition program will receive communication when appropriate.

Your practice patterns may be evaluated in the spirit of continuous quality improvement, and results may be reported to you. The standards and methods used to measure performance and provide recognition will be developed in collaboration with participating network physicians. Details will be made available on a regular basis through the *Blue Review* provider newsletter, direct contact from our Network Services Department, and the News and Updates section of bcbsnm.com/provider.

When possible, the feedback will include metrics related to the structure, process, and outcome parameters of clinical quality. Structural considerations refer to issues such as training, board certification by an ABMS board, and other evidence of development of expertise. Process considerations refer to the ability of the practice to implement a systematic approach to managing patients longitudinally. Outcomes refer to intermediary and ultimate clinical outcomes.

To the extent possible, measurement methodology will parallel nationally accepted methods promulgated by HEDIS, National Quality Forum, Ambulatory Care Quality Alliance, CMS, and recommendations published by the American Medical Association regarding "pay-for-performance" recognition programs.

17.9 Clinical Practice Guidelines

For certain clinical conditions, particularly those involving complex decisions or sequencing of decisions, clinical practice guidelines (CPGs) can help guide care. CPGs are updated annually, so please check for the most current version at bcbsnm.com/provider. These CPGs are available in PDF form as a free download for personal, noncommercial use in the Clinical Resources section of our website.

The intent of CPGs is to provide a “shared baseline” that, in the average case, will assist the physician or other provider in delivering care that is current, evidence-based, and generally recognized as appropriate. Individual variation based on patient-specific needs is expected. In most cases, BCBSNM will endorse a nationally accepted guideline rather than create a new one. CPGs are reviewed and approved by the practicing physicians who serve on our QI committees.

17.10 Preventive Care Guidelines for Clinicians

Our Preventive Care Guidelines (PCGs) for Clinicians are designed to summarize the wealth of data on prevention into a set of core services that form the foundation for good primary care practice. PCGs serve as a minimum recommendation for preventive services accepted as beneficial to **asymptomatic, average-risk patients**. Our PCGs do not apply to symptomatic or high-risk patients for whom a tailored approach would be indicated.

PCGs and their modifications are reviewed and approved by the practicing physicians who serve on our QI committees.

We have included the current PCGs in the attachment portion of this section. Because they are updated at least every two years, you should always check for current versions, which are available in the Clinical Resources tab at bcbsnm.com/provider.

We monitor the extent to which our members receive preventive services relative to PCGs. For example, we routinely measure our compliance rates for mammography and pap tests. When opportunities for improvement are identified, systematic approaches (often directed toward members and patients) may be taken to achieve better performance.

Important Note: There is an important distinction between recommended practice and covered services. Recommended clinical practice is based on clinical considerations. Whether or not a given preventive service is a covered benefit of a health plan is determined by the terms and conditions of the plan selected by the purchaser of that plan. Thus, inclusion of a service as a recommended health care service does not necessarily imply that the service is a covered benefit of a specific plan. For example, dental care may be recommended, but dental care is not a benefit of most of our medical health plans. Similarly, some public health recommendations may involve services or medications that are categorically excluded from a particular plan.

17.11 Comparative Reporting (Profiles)

BCBSNM may provide physicians with reports that allow them to compare certain aspects of their practice to their peers and, when available, to benchmarks and averages. Utilization information and information on the management of certain disease states may be provided. Comparative reporting information may be used in the future during

recredentialing reviews and other quality management activities, including any performance-based recognition programs developed in the future.

Because many physicians have a small number of BCBSNM members in their patient population, comparative reporting will not always be statistically feasible. Reporting may occur in conjunction with the Performance Recognition Program described above.

17.12 Appeals of Network Terminations

Based on certain quality concerns and actions, a provider's contract with BCBSNM may be terminated immediately or for cause. When a provider's participation is terminated immediately or for cause, BCBSNM offers appeal rights in compliance with all applicable Office of Superintendent of Insurance (OSI) regulations regarding provider terminations contained within the New Mexico Administrative Code (NMAC). These appeal rights are described in detail in Section 15, Provider Service Inquiry and Grievance Process.

17.13 Attachments

BCBSNM Clinical Practice Guidelines and Preventive Care Guidelines are updated annually. All guidelines can be downloaded for free*.

- Clinical Practice Guidelines
- Preventive Care Guidelines for Clinicians
- Adult Wellness Guidelines
- Children's Wellness Guidelines

* If you do not have access to the internet, contact BCBSNM Network Services for a copy of the guidelines by calling 505-837-8800, or 800-567-8540.

18 – FRAUD AND ABUSE

Overview

The primary mission of the Special Investigations Department at Blue Cross and Blue Shield of New Mexico is to identify, investigate and prevent fraudulent activities. The SID is committed to fighting fraud, controlling health care costs and protecting the integrity of our provider network. The SID follows the reporting requirements mandated by state and federal law as well as contractual obligation.

Each year billions of dollars are inappropriately paid due to health care fraud, waste, and abuse which contributes to the rising cost of health care. In response to this problem, we have an established SID – one of the most aggressive and effective health care fraud investigation programs in the industry.

Departmental investigators come from law enforcement, health care and insurance backgrounds to form an effective investigative team. The SID also includes a robust Data Intelligence Unit that data mines for anomalous billing, supports investigations and responds to requests from law enforcement agencies.

BCBSNM considers fraudulent billing to include, but not be limited to:

- Deliberate misrepresentation of the service provided in order to receive payment;
- Intentionally billing in a manner which results in reimbursement greater than what would have been received if the claim was properly filed.
- Billing for services which were not rendered.

When no FWA is found, the case may be closed with no further action. If investigations identify FWA, possible courses of action include, but are not limited to:

- Notifying and placing the provider on pre-payment review for questionable billing;
- Seeking a refund from the provider;
- Educating the provider about billing errors;
- Terminating the provider from the network; and
- Referring the provider to a state or federal law enforcement agency or to the appropriate state regulatory board.

Additionally, to help you understand what health care fraud is, how it affects your practice and how you can report health care fraud to the SID, BCBSNM offers a free online Fraud Awareness Training Tutorial.

The SID maintains a 24-hour fraud hotline, through which you can report any suspicions of fraud. All calls are confidential, and you may report your information anonymously. To file a report, call the hotline at 1-800-543-0867 or submit online.

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18.1 General Regulations

18.1.1 Overview

Participating providers shall submit all claims for payment for covered services performed for BCBSNM members, utilizing claim forms as set forth in Section 8 of this manual. In addition to the instructions in that section and other sections of the manual, participating providers shall adhere to the following policies with respect to filing claims for covered services to BCBSNM members:

18.1.2 Covered Services

A provider performing covered services for a BCBSNM member shall be fully and completely responsible for all statements made on any claim form submitted to BCBSNM by or on behalf of the provider. A provider is responsible for the actions of staff members and agents who prepare claims for submission to BCBSNM.

All covered services provided for and billed for BCBSNM members by providers shall be performed personally by the provider or under his/her direct and personal supervision and in his/her presence, except as otherwise authorized and communicated by BCBSNM. Direct personal supervision requires that a provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.

The determination as to whether any service is medically reimbursable, including, but not limited to, the application of BCBSNM medical policy or accepted standards of practice in the community, shall be made by a BCBSNM-designated clinician who is appropriately licensed according to applicable law. Fees for services deemed not to be medically reimbursable shall not be collected from the member absent strict compliance with pre-service communication and documentation with the member regarding non-covered services according to applicable law.

18.1.3 Non-Covered Services

A participating provider may bill a BCBSNM member for non-covered services if and only to the extent compliant with applicable law and the provider's contract with BCBSNM. The determination as to whether any services performed by a provider for a BCBSNM member are covered by a health plan underwritten or administered by BCBSNM, and the amount of payment for such services, if any, shall be made by BCBSNM.

18.1.4 Not Medically Necessary

BCBSNM has the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary. A provider shall render covered services as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or provider; and in the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.

Services should be provided in the most cost-effective manner and in the least costly setting required for the appropriate treatment of the members. Fees for covered services deemed not medically necessary shall not be collected from the member, unless the member requests the service(s), and the provider informs the member of his or her financial liability and the member chooses to receive the service(s). The provider should document such notification to the member in the provider's records. A determination as to whether any covered service is medically necessary shall be made by BCBSNM.

18.1.5 Filing Complete and Accurate Claims

A provider must file complete and accurate claims with BCBSNM. In the event any provider has received either from BCBSNM or from the member, an amount in excess of the amount determined by BCBSNM to be payable with respect to services performed for the member due to failure to file complete and accurate claims, such excess amount shall be returned promptly to BCBSNM or to the member, as the case may be. In the event such overpayments are not voluntarily returned, BCBSNM will be permitted to deduct overpayments (whether discovered by provider or BCBSNM) associated with the failure to file claims accurately and completely from future BCBSNM payments to the fullest extent allowed by applicable law and the provider's contract with BCBSNM.

Note: BCBSNM will not initiate overpayment recovery efforts more than 18 months after the payment was received by the provider. However, no time limit (or a different time limit) shall apply to the initiation of overpayment recovery efforts based on the following and as may be further provided by applicable law:

- A reasonable belief of fraud or other intentional misconduct
- Required by a self-insured plan
- Required by a state or federal government program

18.1.6 Splitting Charges on Claims

When billing for services provided, select codes that best represent the services furnished. In general, all services provided on the same day should be billed under one electronic submission or when required to bill on paper, utilize one CMS-1500 claim form when possible. When more than six services are provided, multiple CMS-1500 claim forms may be necessary.

Billing using multiple claim submissions to cause a reimbursement greater than would be received if the services were billed on a single claim form may be viewed as fraud, and likely will result in a demand for refund of the overpayment.

18.1.7 Procedure Codes

To the greatest extent possible, providers shall report services in terms of the procedure codes listed in the most recent version of Current Procedural Coding manuals and ICD-10 reference books. Providers and their staff members and agents are responsible for familiarizing themselves with the applicable Current Procedural Coding manuals and ICD-10 reference books. In unusual cases, a description of service, a copy of the hospital/medical records or other appropriate documentation should be submitted.

18.1.8 Coordination of Benefits (COB)

A provider is expected to complete all necessary information on the claim forms which will facilitate coordination of benefits with other third-party payers by BCBSNM.

18.1.9 Services and Supplies Provided to Family Members

BCBSNM member benefits exclude “services and supplies to a BCBSNM member for which the BCBSNM member is not required to make payment or would have no legal obligation to pay if the member did not have BCBSNM or similar coverage.” This policy therefore excludes a provider from billing for services and supplies provided to themselves or to a family member who may also be a BCBSNM member.

18.1.10 Charges Itemized and Distinguished from Professional Services

A provider shall not bill or collect from a member, or from BCBSNM, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, concierge fees, or fees for completing claim forms or submitting additional information to BCBSNM.

18.1.11 Audits

A provider shall permit BCBSNM representatives to make reasonable examination of the provider’s records as it relates to determining appropriate reimbursement levels, usual charges, or the costs associated with high-cost technology equipment.

18.1.12 Referrals

Referral to any other provider/facility, regardless of whether that provider/facility is a participating provider, with which the provider has a business interest, must be acknowledged to the patient in writing at the time of the referral.

A provider is prohibited from paying or receiving a fee, rebate, or any other consideration in return for referring a BCBSNM member to another provider or in return for furnishing services to a member referred to him or her by another provider.

18.1.13 Medical Records

BCBSNM may request medical records and/or conduct site visits to review, photocopy and audit a provider’s records, without prior notice, to verify medical necessity and appropriateness of payment without prior notice. Such a review may be delegated to contractors or governmental agencies. BCBSNM will not reimburse the provider for the cost of duplicating medical records for these purposes. Providers will produce records requested in the timeframe indicated in the request.

A provider will ensure that covered services reported on claim forms are supported by documentation in the medical record and adhere to the general principles of medical record documentation including the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible.
- Medical record documentation requirements are explained in detail in the Medical Records Documentation Standards available under the Standards and Requirements tab at bcbsnm.com/provider. At a minimum, each patient encounter should include:
  - Reason for the encounter and relevant history
  - Physical examination findings and prior diagnostic test results
  - Assessment, clinical impression, and diagnosis
  - Plan for care
  - Date and legible identity of observer
  - If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred

18.1.14 Pre-Payment Review

The SID and its internal partners may determine that it is appropriate to place a provider or specific codes on pre-payment review to prevent erroneous, fraudulent or otherwise unclean claims from being paid. In this process, the provider's claims undergo a further review to verify eligibility for reimbursement. Consistent with their contractual obligations to provide BCBSNM with access to medical, billing and financial records, a provider must supply documentation in support of the services billed on their claims. The documentation is reviewed by medical professionals and/or coding experts to determine whether the services were medically necessary, within terms of coverage according to the members' benefits, rendered as billed on the claim and billed in compliance with our reimbursement policies, including but not limited to the clinical payment and coding policies.

The SID employs numerous investigative techniques in its mission. These may include review of claims and supporting records, data mining and interviews. The SID may also use a statistical random sample to select a representative set (sample) of claims to evaluate the adherence to our requirements.

BlueCross BlueShield of New Mexico

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505-837-8800 or **800-567-8540**
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