BlueCross BlueShield of New Mexico

Blue Review℠

A Provider Publication

August 2017

You can find *Blue Review* online!

Ideas for articles and letters to the editor are welcome; email NM_Blue_Review_Editor@bcbsnm.com

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Do we have your correct information?

Maintaining up-to-date contact and practice information helps to ensure that you are receiving critical communications and efficient reimbursement processes. Please complete our quick and easy online form if you have:

- Moved to another location
- Left a group practice
- Changed your phone number
- Changed your email address
- Retired
- Any other changes to your practice information

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Medical Policy Updates

Approved new or revised Medical Policies and their effective dates are usually posted on our website the first and fifteenth of each month. These policies may impact your reimbursement and your patients' benefits. On our website, you may view active, pending and updated policies and/or view draft policies and provide comments. The policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Office Staff

Claims inquiries? Call the Provider Service Unit (PSU) at 888-349-3706

Our PSU handles all provider inquiries about claims status, eligibility, benefits, and claims processing for BCBSNM members. *For out-of-area claims inquiries, please call the BCBSNM BlueCard PSU at* ***800-222-7992***.

Network Services Contacts and Related Service Areas

Network Services Regional Map

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BCBSNM Website

It's important for you to stay informed about news that could affect your practice. Blue Cross and Blue Shield of New Mexico (BCBSNM) offers many ways to stay informed. When you visit our website, **bcbsnm.com/provider**, and sign up to receive email updates and our provider newsletter, *Blue Review*, you get better access to timely information on topics such as:

- Claims and billing
- Federal and State mandates
- HSD registration requirements
- Medical policies
- Utilization & Care Management Programs
- Educational webinars
- Provider Reference Manual updates
- Clinical Practice Guidelines – ADHD, Antibiotic Use in Pediatric URI, Asthma, Cardiovascular Disease, Diabetes, and Hypertension
- Pharmaceutical restrictions/preferences
- Preventive care guidelines
- HEDIS and CAHPS results
- Member rights and responsibilities
- Provider satisfaction survey results
- Quality improvement program
- Disease/Condition Management Programs – Asthma, Diabetes, CAD, COPD
- How to obtain clinical criteria
- How to access Utilization Management (UM) staff
- Our affirmative statement about incentives
- TDD/TTY services for members
- Language assistance for members to discuss UM issues
- Credentialing provider appeal rights

Signing up is easy. Go to **bcbsnm.com/provider**, select *Update Your Information*, complete the form, and click *Submit*.

We guard your privacy. BCBSNM treats your email address as confidential. We never sell or give your email address(es) to any third party without your permission.

Don't have email? If you do **not** have an email address, please call 1-800-567-8540 or (505) 837-8800. We can mail paper copies of *Blue Review* to providers.

The *Blue Review* is posted online after the email distribution date—go to **bcbsnm.com/provider**, then select *Blue Review*.

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Stay current with BCBSNM provider news and updates. Visit **bcbsnm.com/provider** regularly—look under *Education and Reference/News and Updates*.

We want your feedback on *Blue Review*! Have suggestions for future articles? Drop us a line anytime: NM_Blue_Review_Editor@bcbsnm.com.

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Member Rights and Responsibilities

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, providers, appeals procedures 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.
- Receive from their physicians or providers, in terms that they understand, an explanation of their complete medical condition, recommended treatment, risks of the treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. 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 preauthorization.

- 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 preauthorization 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. 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.

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Receipt of Credentialing Application Notification

Providers interested in becoming a contracted provider with Blue Cross and Blue Shield of New Mexico (BCBSNM) must complete the applicable BCBSNM Participating Provider Interest Form and CAQH Credentialing Application. Upon submission, BCBSNM will notify applicants by certified mail within 10 days of receipt that the credentialing request has been received and that:

- If the application is found to be complete, the credentialing process will begin according to the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC.
- If the application is found to be incomplete, the 45-day credentialing process **DOES NOT** commence until all requested information has been provided and application deemed complete by BCBSNM.

Additionally, providers can obtain the current status of their credentialing application by contacting the Provider Relations Representative assigned to the region.

A full list of Provider Relations Representatives is available in the Network Contact List under the Contact Us section of the BCBSNM Provider website, bcbsnm.com/provider.

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ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version.

Blue Cross and Blue Shield of New Mexico (BCBSNM) will normally load this additional data to the BCBSNM claim processing system within 60 to 90 days after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSNM Provider website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on the BCBSNM Provider website.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSNM's code-auditing software. Refer to our website at bcbsnm.com/provider for additional information on gaining access to C3.

For more details regarding ClaimsXten, refer to the C3 page. Additional information may also be included in upcoming issues of the *Blue Review.*

Checks of eligibility and/or benefit information are not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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.

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Code-Auditing Enhancement

Effective Nov. 12, 2017, Blue Cross and Blue Shield of New Mexico (BCBSNM) will be implementing a code-auditing enhancement.* This software will help improve auditing of professional and outpatient facility claims that are submitted to BCBSNM by clinically validating modifiers submitted on such claims. Upon implementation of the code-auditing enhancement, providers may use the Claim Research Tool, available on the Availity™ Web Portal, to research specific claim edits. For additional information, check the *Blue Review*, as well as the News and Updates section of our Provider website.

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The above notice does not apply to government programs claims.

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Visit Our Website for New Claim Payment and Remittance Resources

Blue Cross and Blue Shield of New Mexico (BCBSNM) recently updated the Claim Payment and Remittance page in the Claims and Eligibility section of our website at bcbsnm.com/provider. This section of our Provider website focuses on electronic transactions that may increase administrative efficiencies for your office while also helping to make it easier for you to conduct business with BCBSNM. Recent enhancements to the Claim Payment and Remittance page include resources to help you learn more about Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). In addition to new EFT and ERA Online Enrollment Tip Sheets, the page includes links to updated Companion Guides and other pertinent information.

Electronic options offer health care providers a more efficient alternative to the traditional paper methods. Providers are encouraged to enroll for EFT and ERA through the Availity™ Web Portal, which also permits users to make any necessary set-up changes online. Once an organization is enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This tool permits users to search, view, save and print remittance information, even if the ERA is delivered to a vendor and/or clearinghouse other than Availity.

Online EFT and ERA enrollment is available to registered Availity users. To register for Availity, simply go to availity.com and sign up today. There is no cost to register to become an Availity user. For providers who are unable to access Availity and complete the online EFT and ERA enrollment process, paper EFT and ERA enrollment forms are available in the Education and Reference Center/Forms section of our Provider website.

We encourage you to visit the Electronic Solutions page and other pages in the Claims and Eligibility section of our Provider website for additional information on electronic options. For assistance with EFT and ERA enrollment through Availity, or to learn more about how to use the remittance viewer tool, contact a BCBSNM Provider Education Consultant at ECommerceHotline@bcbsnm.com or 800-746-4614.

endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

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EFT and ERA Update for Non-Contracted Government Programs Providers

Effective July 24, 2017, if you are an independently contracted commercial Blue Cross and Blue Shield of New Mexico (BCBSNM) provider who is enrolled to receive Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) files from BCBSNM, you will now also receive EFTs and ERAs for government programs member claims, even if you are a non-contracted BCBSNM government programs provider. Specifically, this information applies to claims submitted for any of the following BCBSNM government programs members:

- Blue Cross Medicare Advantage (PPO)SM (MA PPO)
- Blue Cross Medicare Advantage (HMO)SM (MA HMO)

This notice provides an update to a March 2017 announcement that specified delivery of paper checks and provider claim summaries to non-contracted government programs providers. Please continue to watch *News and Updates* and *Blue Review* for additional information.

If you are not currently enrolled to receive EFT and ERA from BCBSNM, we encourage you to enroll online through the Availity™ Web Portal, which also permits users to make any necessary set-up changes online, at no cost. To learn more about EFT and ERA enrollment, visit the EFT and ERA page in the Claims and Eligibility section at *bcbsnm.com/provider*. If you have questions or need assistance with EFT and ERA enrollment through Availity, contact a BCBSNM Provider Education Consultant at ECommerceHotline@bcbsnm.com or 800-746-4614.

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Integration of Prime Therapeutics® and Walgreens® Specialty Pharmacy and Mail-Order Services

The Blue Cross and Blue Shield of New Mexico (BCBSNM) pharmacy benefit manager (PBM), Prime Therapeutics LLC (Prime), and Walgreens announced a strategic alliance in August 2016 to create a first-of-a-kind model for pharmacy benefit management. This new model aligns a national pharmacy chain, a leading PBM and health plans, and

includes a long-term retail pharmacy agreement. As part of this alliance, Prime and Walgreens have formed a yet to be named combined company for specialty pharmacy and mail-order services, headquartered in Orlando, FL. This new company is nationally accredited by the Accreditation Commission for Health Care (ACHC) and URAC.

Current prior authorization approvals on file for mail-order or specialty prescriptions will be transferred over to the new systems and will follow the standard BCBSNM process for renewals. Members with prescription history within the last 12-18 months were notified of the specialty pharmacy and/or mail-order service changes. All BCBSNM members whose pharmacy benefits are administered through Prime will be integrated into this new combined company's systems by mid-August, 2017.[1]

It is important to understand what changes will be occurring so providers will be ready as services change over:

Changes to Specialty Pharmacy Services

For prescriptions coming to your location, there may be changes in Prime Therapeutics' communications and packaging:

- The use of both Prime Therapeutics Specialty Pharmacy (Prime Specialty Pharmacy) and Walgreens names and logos may appear on packaging and informational materials.
- Shipping materials, coolers, and cooler packaging may change in appearance.
- Shipping labels may show a dispensing location other than Orlando, FL.

A vast selection of previously labeled limited-distribution products will also now be available through Prime Specialty Pharmacy. There are no changes to the way you submit a prescription, and the contact information for Prime Specialty Pharmacy remains the same.

Changes to Mail-Order Services

As of August 18, 2017, covered 90-day supply mail-order prescriptions will be filled by PrimeMail by Walgreens Mail Service home delivery program.

Providers will need to submit a new prescription for patients with expired or no remaining fill prescriptions. Providers will need to fax prescriptions to 800-332-9581 or send electronic prescriptions to Walgreens Mail Service in Tempe, AZ.

Please note: Existing PrimeMail, ePrescribing or fax methods may be used for the immediate future, but will be returned as "unable to fill" by the end of the year. Please

take this opportunity to update any pharmacy information that may be stored in your patient records.

If your patients have questions about their pharmacy benefits, please advise them to contact the Pharmacy Program number on their member ID card. Members may also visit bcbsnm.com and log in to Blue Access for Members℠ (BAM) for a variety of online resources.

[1] Members with Medicare Part D or Medicaid coverage transitioned to the new mail-order services as of February 1, 2017.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSNM contracts with Prime Therapeutics to provide pharmacy benefit management and other related services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSNM and contracting pharmacies is that of independent contractors. BCBSNM, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Prime has entered into an agreement with Walgreens, an independently contracted pharmacy, to form a combined specialty pharmacy and mail-order services company, owned by Prime and Walgreens.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are 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. This is only a brief summary of some plan benefits. For more complete details, including benefits, limitations and exclusions, members should refer to their certificate of coverage. Regardless of benefits, the final decision about any medication and pharmacy choice is between the member and their health care provider.

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Where Data Flows, Improvements are Bound to Follow

Payers and providers are increasingly collaborating to share clinical and claims data, with the shared goal of working to improve health outcomes and better manage the overall cost of care to consumers.

One of the main goals of Blue Cross and Blue Shield of New Mexico (BCBSNM) is to help our members, your patients, have access to quality, affordable health care. Access to data and analytics in a way that helps transforms data into actionable insights plays a role in meeting this goal and helps drive value-based outcomes. Secure and timely information exchange across health system stakeholders, without regard to geography, point of care or type of information system used, helps enable better care connections and more informed diagnostic and treatment decisions.

BCBSNM has launched a multi-pronged, multi-year effort to put quality, provider performance and members' clinical data within easy reach of providers, electronically, 24/7. Our endeavors are bringing technology experts, data scientists, health care quality professionals and select participating providers together to create and fine-tune new and sophisticated tools and systems.

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Three Synergistic Data Solutions to Help Improve Quality of Care

1. We are now in the pilot stage of offering new, strategic reporting of providers' own practice data, called **Provider and Network Decision Analytics℠.** This tool will provide a more comprehensive evaluation of providers' cost efficiency performance and treatment pattern differences compared to their peers within the network of independently contracted providers, using claims data from our members. We are currently evaluating the process and look to make adjustments before we deliver this insightful reporting in the near future. One goal of the tools is help you and other providers collectively learn from each other, leveraging each other's individual strengths while gaining new insights into successful practices of others to help drive improvements in care delivery. This tool will enable you to:

    - View how your relative cost performance derived from episodes of care, such as treatments for appendicitis or osteoarthritis, compares to the performance of similar providers in your area
    - See additional reporting to demonstrate provider-to-provider relationships through shared patient analysis (SPA) as teams of providers naturally form working relationships
    - Understand how care given by providers you share patients with as a team affects the total cost of care for your patients
    - Compare how services you provide your patients varies from some of your peers and how those peers may treat patients with similar conditions
    - Identify actions you can take that may have a positive impact on your patients' health and help reduce their out-of-pocket costs

We believe access to this type of data can drive both care value and quality enhancements.

2. For quality measurement and reporting, we are introducing **Electronic Quality Intelligence for Providers℠.** Our new care quality reporting tool is designed to help enable providers to view their quality performance against various standardized performance measures across their entire BCBSNM patient population. It seeks to deliver timely information to providers about patient care and risk gaps. Quality performance can be viewed at various levels: by organization, plan type and individual provider. Filters that are envisioned for this program will enable providers to view their quality performance by medical condition, patient gender and/or age range, or individual patient. These reports are meant to:

    - Enable providers to better monitor their quality performance and attend to potential gaps in care more quickly

- Support the development of scalable quality improvement programs that are more responsive to priority quality performance trends
- Better inform care teams and practice leadership decision making

This project is currently being reviewed with a select audience. The new tool is being rolled out in waves, with a broader implementation planned for in the near future with future plans to add physician specialist reporting. Ultimately, it will also be offered to facilities to aid in their accreditation and quality reporting requirements.

3. Our **Clinical Data Exchange** solution creates a bi-directional flow of information between BCBSNM and the independently contracted participating providers. We are advancing a series of services to exchange clinical information electronically 24/7. Special focus has been placed on developing secure data exchange capabilities that are readily accessible for providers and easily incorporated within their existing workflows.

   This effort builds channels and capabilities to enhance the exchange of key categories of clinical data that providers and BCBSNM rely on to make more informed decisions and better manage operations. Our data exchange solution will make it easier and quicker for providers to access members' health summary data at the site of care and submit what BCBSNM needs for health plan operations such as claims processing, precertification reviews, health care management, risk adjustment applications, and quality improvement initiatives.

   BCBSNM anticipates introducing its clinical data solution in the months ahead.

We are committed to becoming your payer of choice by making it easier to do business with us. We know that we can work together to enhance the care our members receive and help them better afford the care they need. Together, we can make the health system work better for all stakeholders.

Keep reading future issues of the *Blue Review* to find out what's new.

The initiatives discussed in this article rely upon claims information that BCBSNM receives from providers and therefore, may not represent a complete picture of a provider's practice or the medical services that a member may have received. The initiatives are designed with the goal to assist health care providers and members in better coordinating care and improving health outcomes. The programs are not a substitute for the independent medical judgment of a health care provider. Health care providers are instructed to use their own best medical judgment based upon all available information and the condition of the patient in determining a course of treatment.

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Medicaid only

Blue Cross Community Centennial℠ (Medicaid)

Not yet contracted?

Blue Cross and Blue Shield of New Mexico's (BCBSNM) Medicaid plan is Blue Cross Community Centennial.

Providers who are participating in commercial BCBSNM products are not automatically participating providers in Blue Cross Community Centennial. To become a Blue Cross Community Centennial provider, you **must** sign a Medicaid amendment to your Medical Services Entity Agreement (MSEA).

If you have any questions or if you are interested in becoming a Blue Cross Community Centennial provider, please call 505-837-8800 or 1-800-567-8540.

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Reminder: Update your Enrollment Information

Due to Centennial Care requirements, all enrollment information (changes to demographics, licensure or certification, provider status, etc.) must be updated on the NM Medicaid Provider Web Portal.

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Member Rights and Responsibilities

Blue Cross and Blue Shield of New Mexico (BCBSNM) is committed to ensuring that enrolled members are treated in a manner that respects their rights as individuals entitled to receive health care services. BCBSNM is committed to cultural, linguistic and ethnic needs of our members. BCBSNM policies help address the issues of members participating in decision making regarding their treatment; confidentiality of information; treatment of members with dignity, courtesy and a respect for privacy; and members' responsibilities in the practitioner-patient relationship and the health care delivery process.

BCBSNM also holds forth certain expectations of members with respect to their relationship to the managed care organization and the independently contracted providers participating in Blue Cross Community Centennial. These rights and responsibilities are reinforced in member and provider communications, including those on the Provider website.

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BCBSNM encourages all our independently contracted providers to become familiar with the following member rights and responsibilities, so you can assist us in serving our members in a manner that is beneficial to everyone.

MEMBER RIGHTS

1. **Our members have a right to know their rights.**
   a. Members have the right to receive information about their rights and responsibilities.
   b. Members have the right to make recommendations about these rights and responsibilities.

2. **Our members have the right to respect, dignity and privacy. That includes the right to:**
   a. Nondiscrimination.
   b. Know that their medical records and discussions with their providers will be kept private and confidential.
   c. Ask for and receive their medical records and if needed, have them corrected.

3. **Our members have the right to a fair opportunity to choose a health care plan and health care providers. They also have the right to change their plan or their provider without penalty at any time. That includes the right to:**
   a. Be told how to choose a health plan and Primary Care Physician (PCP) available in their area.
   b. Be told how to change their health plan or their PCP.
   c. Get information about providers and practitioners available to them.

4. **Our members have the right to ask questions and get answers about anything they do not understand. That includes the right to:**
   a. Have their provider explain their health care needs to them and talk to them about the different ways their health care problems can be treated, regardless of cost or benefit coverage.
   b. Be told why care or services were denied and not given.

5. Our members have the right to agree to or refuse treatment and have a say in treatment decisions. That includes the right to:
   a. Work as part of a team with their provider in deciding what health care is best for them.
   b. Say “yes” or “no” to the care recommended by their provider.

6. Our members have the right to use each complaint and appeal process available through the Managed Care Organization and through Medicaid. That includes the right to:

a. Make a complaint to their health plan or to the state Medicaid program about their health care, their provider or their health plan.
b. Get a timely answer to their complaint.
c. Use the Plan's appeal process and be informed on how to file a complaint.
d. Ask for a fair hearing from the State Medicaid program and get information about how that process works.

7. Our members have the right to quick and easy access to care. That includes the right to:

a. Have telephone access to a medical professional 24 hours a day/seven day a week for any emergency or urgent care they need.
b. Receive medical care in a timely manner.
c. Get in and out of a health care provider's office easily. There should not be any conditions that limit movement for people with disabilities according to the Americans with Disabilities Act.
d. Have interpreters, if needed, when getting covered services during appointments with their providers and when talking to their health plan. Interpreters are people who can speak their native language, help someone with a disability, or help them understand the information.
e. Be given information they can understand about their health plan rules, the services they can get and how to get them.

8. Our members have the right to refuse to be restrained or secluded for someone else's convenience or as a way of forcing them to do something they do not want to do, or as punishment.

9. Our members have the right to have open discussions with their doctors, hospitals and others who care for them regarding their health status, medical care and all options for treatment, even if the care or treatment is not a covered service.

10. Our members have the right to know that they are not responsible for paying for covered services in accordance with the terms in their evidence of coverage.

MEMBER RESPONSIBILITIES

Our members have the responsibility to:

1. Read and follow the Member Handbook.

2. Keep their scheduled appointments or call their provider to reschedule or cancel at least 24 hours before their appointment.

3. Show their Blue Cross Community Centennial ID card to each provider before getting covered services.

4. Call their PCP or the 24/7 Nurseline before going to an emergency room, except in situations that they believe are life threatening or that could permanently damage their health.

5. Follow plans and instructions for care that they have agreed to with their providers.

6. Call Member Services if they change their phone number or their address. They should also contact their Case Worker at the NM Human Services Department (HSD).

7. Share information about their health with their PCP and learn about service and treatment options. That includes the responsibility to:

a. Tell their PCP about their health.
b. Talk to their providers about their health care needs and ask questions about the different ways their health problems can be treated.
c. Help their providers get their medical records.
d. Treat their providers and other health care employees with respect and courtesy.

8. Be involved in service and treatment option decisions, and make personal choices to help keep themselves healthy. That includes the responsibility to:

a. Work as a team with their provider in deciding what health care is best for them.
b. Understand how the things they do can affect their health.
c. Do the best they can to stay healthy.
d. Treat providers and staff with respect.
e. Talk to their provider about all their medications.

If our members think they have been treated unfairly or discriminated against, they can call the U.S. Department of Health and Human Services (HHS) toll-free at 800-368-1019. They can also view information concerning the HHS Office for Civil Rights online at hhs.gov/ocr.

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Billing Medicaid Members

Appointment, interest and carrying charges: Medical Assistance Division (MAD) does not cover penalties on payments for broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts.

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A provider may not bill a Medical Assistance Program (MAP)-eligible recipient or his or her authorized representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of Children's Health Insurance Program (CHIP) or Working Disabled Individuals (WDI)who may be charged up to $5 for a missed appointment.

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Blue Cross Community Centennial Changes, Effective July 21, 2017

To reduce the number of Blue Cross Community Centennial claim rejections and denials related to billing and rendering provider taxonomy codes, Blue Cross and Blue Shield of New Mexico (BCBSNM) relaxed the following edits on July 21, 2017.

Availity™ Electronic Claim Submission Rejections for No Taxonomy Codes

As of July 21, 2017, the following electronic claim submission edits were removed for claims submitted for Blue Cross Community Centennial members (identified by alpha-prefix “YIF”). Providers that have received claims rejections for these edits between May 20, 2017, and July 21, 2017, should resubmit these claims for processing if the claims have not already been corrected and resubmitted. ***Please note that resubmission is required for only Availity electronic claim rejections for no taxonomy code.***

Blue Cross Community Centennial Claim Submission Edits Removed	Electronic Claim Loops and Segments
Billing Provider Taxonomy Code	2000A, PRV03
Rendering Provider Taxonomy Code	2310B, PRV03 (claim level) 2420A, PRV03 (service line level)

Claim Denials for No Billing Provider Taxonomy Code

Effective December 12, 2016, BCBSNM implemented Blue Cross Community Centennial claims processing edits requiring the billing provider taxonomy code to be populated for all claims submissions. Starting July 21, 2017, BCBSNM will no longer deny claims for no billing provider taxonomy code. BCBSNM does, however, encourage providers to submit the billing provider taxonomy code, when available. Providers with

claims denied for no billing provider taxonomy code between December 12, 2016, and July 21, 2017, that were **not** submitted through Availity are not required to resubmit claims. BCBSNM will re-adjudicate such claims previously denied for no billing provider taxonomy code.

If you have any questions or need additional information, please contact your Provider Network Representative. BCBSNM Provider Network Representatives are available to assist you Monday through Friday, 8 a.m. to 4 p.m. MST, locally (505) 837-8800 or toll-free (800) 567-8540.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

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Submitting Electronic Claims for Blue Cross Community Centennial Members

Our May 2017 *Blue Review* edition announced the implementation of **payer ID MC721**, which took effect May 20, 2017, for Blue Cross Community Centennial claims submitted electronically. Blue Cross Community Centennial members are identified by alpha-prefix YIF listed on their Blue Cross and Blue Shield of New Mexico (BCBSNM) identification card.

Health care providers who utilize a clearinghouse or practice management system vendor for electronic claim submissions are encouraged to share this new payer ID with their vendors to ensure Blue Cross Community Centennial claims are processed efficiently. If these claims are submitted via direct data entry through the Availity™ Web portal, providers should utilize the dropdown payer option of "Blue Cross Community Centennial."

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Pharmacy Change for Blue Cross Community Centennial Members Effective Sept. 1, 2017

As of Sept. 1, 2017, **TRUEplus®** and **TechLITE®** insulin pen needles will be the only covered insulin pen needles and **TRUEplus insulin** syringes will be the only covered insulin syringes on the Blue Cross and Blue Shield of New Mexico (BCBSNM) Medicaid formulary. Prescriptions for other brands will require prior authorization from BCBSNM. Plan members who are affected will be sent a letter in the mail letting them know of this change.

TRUEplus is the trademark of Trividia Health, Inc. a separate company that is a manufacturer and marketer of advanced performance products for people with diabetes. BCBSNM makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Trividia Health. If you have any questions about the products or services offered by such vendor, you should contact the vendor directly.

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Antidepressant Medication Management Initiative

Blue Cross and Blue Shield of New Mexico (BCBSNM) is committed to improving the rate at which Blue Cross Community Centennial members remain on antidepressant medications after newly diagnosed and treated depression.

Did you know?
According to the American Psychological Association (APA), major depressive disorder is a chronic condition that requires patients to participate actively in, and adhere to, treatment plans for long periods despite the fact that side effects or requirements of treatment may be burdensome. APA guidelines recommend antidepressants as the initial treatment for mild to moderate depression.

Our goal and who is eligible?
Our goal is to increase antidepressant medication adherence. The program is targeting Blue Cross Community Centennial members age 18 and older with at least one of the following:

- At least one principal diagnosis of major depression in an outpatient, ED,

intensive outpatient, or partial hospitalization setting

- At least two visits in an outpatient, emergency department, intensive outpatient, or partial hospitalization setting on different dates of service with any diagnosis of major depression
- At least one inpatient (acute or non-acute) claim

We measure adherence for both the acute and continuation phases as outlined in HEDIS® 2017 specifications.

- **Effective Acute Phase:** Percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective Continuation Phase:** Percentage of newly diagnosed and treated members who remained on an antidepressant for at least 180 days (6 months)

Comprehensive analysis of the results will be conducted quarterly and annually by Blue Cross and Blue Shield of New Mexico.

What you can do

- The physician should assess and acknowledge potential barriers to treatment adherence, including lack of motivation, side effects of treatment, and logistical, economic or cultural barriers to treatment.
- The physician should collaborate with the patient (and if possible the family) to minimize the impact of these potential barriers.
- Patients should be given realistic expectations during the different phases of treatment, including the time course of symptom response and the importance of adherence for successful treatment.
- Misperceptions, fears and concerns about antidepressants should be addressed with the patient.
- Education should be provided about major depression, the risk of relapse and the early recognition of recurrent symptoms, and the efficacy of Cognitive Behavioral Therapy in combination with medication.
- Patients should be informed about the need to taper antidepressants rather than discontinuing them prematurely.
- Common side effects of antidepressants should be discussed with the patient. The physician should encourage the patient to identify side effects they would consider reasonable and those they would consider unbearable.
- Physicians should offer to explain when and how to take the medication,

reminder systems, information about continuing the medication after symptoms of depression improve, strategies to incorporate medication into the daily routine, and minimizing the cost of antidepressant regimens to improve adherence.

You may reference the provider toolkit by clicking on this link: https://www.bcbsnm.com/provider/network/medicaid.html

"Practice Guideline for the Treatment of Patients with Major Depressive Disorder 3rd Edition" (2010) American Psychiatric Association

"HEDIS® 2017 Volume 2 Technical Specifications for Health Plans (the Healthcare Effectiveness Data and Information Set)

Such services are funded in part with the State of New Mexico.

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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Blue Cross Medicare Advantage℠

Member Rights and Responsibilities

Blue Cross Medicare Advantage members have the right to timely, high quality care and treatment with dignity and respect. Participating providers must respect the rights of all members. Blue Cross Medicare Advantage members have been informed that they have the following rights and responsibilities:

- Choice of a qualified participating provider and hospital.
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to their participating provider, and recommendations to specialty providers when medically necessary.
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive urgently needed services when traveling outside the Blue Cross Medicare Advantage service area or in the Blue Cross Medicare Advantage service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating provider.
- To request the aggregate number of grievances and appeals and dispositions.
- To request information regarding provider compensation.

- To request information regarding the financial condition of Blue Cross Medicare Advantage.
- To be treated with dignity and respect and to have their right to privacy recognized.
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To confidential treatment of all communications and records pertaining to the member's care.
- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA. To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care.
- To refuse treatment or leave a medical facility, even against the advice of providers (providing the member accepts the responsibility and consequences of the decision).
- To complete an Advance Directive, living will or other directive to the member's providers.

Blue Cross Medicare Advantage members have been informed that they have the following responsibilities:

- To become familiar with their coverage and the rules they must follow to receive care as a Blue Cross Medicare Advantage member;
- To give their providers the information they need to care for the member, and to follow the treatment plans and instructions that the member and his/her provider agree upon;
- To be sure to ask their provider if they have any questions;
- To act in a way that supports the care given to other patients and to help the smooth running of their provider's office, hospitals, and other offices;
- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities; and
- To let Blue Cross Medicare Advantage know if they have any questions, concerns, problems or suggestions.

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Prohibition on Billing Dually-Eligible Members Enrolled in the Qualified Medicare Beneficiary Program

Medicare providers may not bill, charge, collect a deposit, or seek reimbursement from any Medicare and Medicaid dually-eligible members enrolled in the Qualified Medicare

Beneficiary (QMB) program. The QMB program is a State Medicaid benefit that exempts Medicare beneficiaries from Medicare cost-sharing liability and covers premiums, deductibles, coinsurance and copayments for Medicaid and Medicare dually-eligible QMB members. Medicare providers must accept Medicare payments and any Medicaid payments provided as payment in full for services rendered to QMB members.

It is also against federal law (Section 1902(n)(3)(B) of the Social Security Act) for any Medicare provider, not only those that also accept Medicaid, to bill dually-eligible QMB members. Medicare providers that bill QMB members for Medicare cost-sharing are subject to sanctions per their Medicare Provider Agreement. To avoid billing QMB members for Medicare cost-sharing, Medicare providers should take the following precautions:

- Identify QMB-enrolled members by looking for "Blue Cross Medicare Advantage Dual Care" on member ID cards
- Check the New Mexico Medicaid portal to verify member QMB status
- Understand the Medicare cost-sharing billing process
- Ensure that billing software exempts QMB members from Medicare cost-sharing billing and related collections efforts

For more information regarding QMB billing, please see the following resources:

- Medicare Learning Network (MLN) MLN Matters® SE1128
- MLN Booklet: Dual Eligible Beneficiaries Under Medicare and Medicaid
- Medicaid.gov Dual Eligibles
- Medicaid.gov Seniors & Medicare and Medicaid Enrollees

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Federal Employee Program®

Federal Employee Program Member Rights and Responsibilities

BCBSNM Federal Employee Program 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, providers, appeals procedures 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.
- Receive from their physicians or providers, in terms that they understand, an explanation of their complete medical condition, recommended treatment, risks of the treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. 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 preauthorization.
- 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 preauthorization 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. 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.

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