BlueCross BlueShield of New Mexico

Blue Review℠

A Provider Publication

December 2017

In this month's *Blue Review*: Preauthorization updates, Pharmacy updates, HEDIS and CAHPS results, and more...

Please share this newsletter with others in your group or practice.

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2018 Additional Preauthorization Requirements

Beginning Jan.1, 2018, providers will be required to obtain preauthorization through Blue Cross and Blue Shield of New Mexico (BCBSNM) or eviCore for certain procedures as noted below. These new preauthorization requirements will apply to the fully insured members with PPO, Blue Advantage HMO℠, Blue Community HMO℠, Blue Preferred Plus℠, and HMO network plans. Additionally, these preauthorizations will also apply to fully insured membership with Blue Choice PPO℠ and Administrative Services Only (ASO) membership with Blue Choice PPO with the Health Advocacy Solutions (HAS)* option.

*Effective 1/1/2018, the Health Advocacy Solutions (HAS) program will require preauthorization for certain care categories. For more information, go to the Preauthorization page on bcbsnm.com/provider.

The new preauthorization requirement care categories are listed below:

- Radiation Therapy (eviCore)
- Genetic Testing (eviCore)
- Radiology (eviCore)
- Sleep Studies (eviCore)
- Advanced Radiology Imaging (eviCore) – Prenotification Only
- Maternity/Delivery (BCBSNM) – Prenotification Only
- Dialysis (BCBSNM) – Prenotification Only
- Musculoskeletal (BCBSNM)
- Neurology (BCBSNM)
- Specialty Pharmacy (BCBSNM)
- Ear, Nose and Throat (BCBSNM)
- Outpatient Surgery (BCBSNM)
  - Orthognathic Surgery
  - Mastopexy
  - Reduction Mammaplasty
- Gastroenterology (BCBSNM)
- Wound Care (BCBSNM)

Services performed without preauthorization may be denied for payment in whole or in part, and you may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft.

To obtain preauthorization through BCBSNM for the care categories noted above, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Network Management Consultant.

eviCore Web Orientation Schedule

eviCore will be hosting orientation sessions for the following care categories listed below. During these training sessions, BCBSNM will also provide a brief overview of the new Health Advocacy Solutions (HAS) product and Availity™ roles.

Anyone wishing to attend one of the sessions must register in advance. Sessions are free of charge and will last approximately one hour.

We hope you find one or more of the following session times convenient.

Web Orientation Sessions

Radiation Therapy	Dec. 5, 2017	Tuesday	11:00 a.m. Central
Genomic Lab	Dec. 5, 2017	Tuesday	1:00 p.m. Central
Radiology (CT/MR/PET)	Dec. 6, 2017	Wednesday	1:00 p.m. Central
Sleep Testing	Dec. 7, 2017	Thursday	10:00 a.m. Central
Sleep DME	Dec. 7, 2017	Thursday	1:00 p.m. Central

How to Register

Please read the following instructions carefully to register for and participate in a session:

1. Once you have chosen a date and time, please go to **http://evicore.webex.com**
2. Click on the “Training Center” tab at the top of the page.
3. Find the date and time of the orientation session you wish to attend by clicking the “Upcoming” tab. All of the orientation sessions will be named “Blue Cross and Blue Shield of New Mexico Provider [Program Name] Orientation Session.”
4. Click “Register.”
5. Enter the registration information.

After you have registered for the conference, you will receive an email containing:

1. The toll-free phone number and pass code you will need for the audio portion of the conference.
2. A link to the online portion of the conference.
3. The conference password.

Please keep the registration e-mail so you will have the link and dial-in information for the session in which you will be participating.

If you are unable to participate in a session at any of the times listed, you can find a copy of the presentation on the implementation site at https://www.evicore.com/healthplan/BCBSNM_c.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits 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 questions, contact the number on the member's ID card.

"Pulling It All Together" – Colon Cancer Screenings Goal: 80% Participation by 2018

The final article in a 4-part series regarding colorectal cancer screenings

The American Cancer Society and the National Colorectal Cancer Roundtable have pledged to have 80 percent of the population ages 50-75 screened for colon cancer by 2018.

We need your help to reach this goal!

Even though some screening methods are not appropriate or feasible for all patients, having a conversation with your patients to encourage colorectal cancer screenings is most likely to result in your patients getting screened regardless of the method chosen. Colorectal cancer screening is recommended for adults age 50 and older who are at average risk for colorectal cancer and who are asymptomatic. Some patients may need to be screened for colorectal cancer at an earlier age. It is also important to be aware that some screening methods may not be covered and an out-of-pocket cost may result.

What actions can you take to make a difference?

Have the conversation with your patients to discuss colorectal cancer risks and the best screening method for them. You are the biggest influence whether your patients receive colorectal cancer screening or not.

Colorectal cancer screening options:

- Colonoscopy – Screening interval every 10 years.[1]
- Flexible sigmoidoscopy – Screening interval every 5 years

- CT colonography – Screening interval every 5 years.[1]
- Stool-based tests[2] – This type of screening includes:
  - FIT or immunologic Fecal Occult Blood Test (iFOBT). FIT tests may be one or two sample tests. Screening interval every year.[1]
  - Guaiac-based stool tests or gFOBT – Screening interval every year.[1]
  - Stool DNA with FIT testing, also known as Cologuard: Screening interval every 3 years.[1]

Use a system within your practice to identify your patients age 50 and older who need colorectal cancer screening and start that conversation.

With your influence, we can raise the colorectal cancer screening rate and meet the 80% by 2018 goal.

Free Continuing Education

The Centers for Disease Control and Prevention provide **FREE continuing education** for PCPs, nurses, nurse practitioners and clinicians who perform colonoscopies. Access Screening for Colorectal Cancer: Optimizing Quality to download, print or watch the presentations on YouTube (expires March 10, 2019).

References

[1] (n.d.). Home - US Preventive Services Task Force. Final Recommendation Statement: Colorectal Cancer: Screening - US Preventive Services Task Force. Retrieved Dec. 6, 2016.

[2] Force, U. P. (2016). USPSTF Recommendation Statement: Screening for Colorectal Cancer. Retrieved Dec. 6, 2016.

[3] Levin, B., Lieberman, D. A., McFarland, B., Smith, R. A., Brooks, D., Andrews, K. S., Dash, C., Giardiello, F. M., Glick, S., Levin, T. R., Pickhardt, P., Rex, D. K., Thorson, A. and Winawer, S. J. (2008), Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology*†. CA: A Cancer Journal for Clinicians, 58: 130–160. doi:10.3322/CA.2007.0018

Reimbursement Policy Update Effective Jan. 1, 2018

Reimbursement Policy: Modifier 52 and Modifier 53
Effective Date: January 1, 2018

Purpose:
The purpose of this policy is to provide guidelines for the reimbursement of eligible services appropriately appended with Modifier 52 and Modifier 53 for professional providers.

Definition:
Modifier 52 is used to report a service or procedure that is partially reduced or eliminated at the physician's election when the procedure was terminated after the patient was prepped and was in the room where the service was to be performed.

Modifier 53 is used with surgical codes or medical diagnostic codes when the procedure is discontinued because of extenuating circumstances after anesthesia is administered to the patient.

Scope:
All products are included, except products where Blue Cross and Blue Shield of New Mexico (BCBSNM) is secondary to Medicare (i.e. Medigap). All other insured, ASO, and government programs products are included.

Policy:
BCBSNM will reimburse appropriately billed CPT codes appended with modifiers 52 and 53 at 50% of the applicable BCBSNM fee schedule amount. Please note Modifiers 52 and 53 do not convert a service that is otherwise ineligible for reimbursement to one that is eligible for reimbursement.

Limitations and Exclusions:
Reimbursement determinations remain subject to all applicable limitations and exclusions, including but not limited to:
•Member eligibility
•Plan benefit
•Medical necessity
•Provider participation agreement
•Routine claim editing logic, including but not limited to incidental or mutually exclusive logic.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2017

SELECT PRODUCTS EXCLUDED FROM RX COVERAGE

Effective Oct. 1, 2017, select prescription drugs that are available over-the-counter (OTC) were added to the OTC equivalent exclusion drug list. Because these equivalent products with the

same active ingredients in the same strength are available OTC without a prescription, the prescription versions of these medications are no longer covered under the prescription drug benefit.

Prescription Product Now Available OTC[1]	Condition Used For	OTC Equivalent Product Name[1]
Differin Gel 0.1%	Topical Acne	Differin Gel 0.1%
Rhinocort Aqua	Nasal Steroid	Rhinocort Allergy

MARKET WITHDRAWAL/PRODUCT RECALLS

On June 8, 2017, the U.S. Food and Drug Administration (FDA) requested Endo Pharmaceuticals remove its opioid pain medication, reformulated Opana ER (oxymorphone hydrochloride), from the market. Endo Pharmaceuticals voluntarily removed the product from the market and stopped all shipments to suppliers and pharmacies effective Sept. 1, 2017.* Members with a recent prescription claim for the medication, as well as their prescribing physician, were sent letters at the end of Aug. 2017 alerting them of this industry change. Effective Oct. 1, 2017, the product was removed from the Blue Cross and Blue Shield of New Mexico (BCBSNM) prescription drug lists.

On Aug. 20, 2017, Leader Brand, Major Pharmaceuticals and Rugby Laboratories voluntarily recalled all liquid medications manufactured by PharmaTech LLC due to the possibility of contamination. Members with a recent prescription claim for the affected medications, as well as their prescribing physicians, were sent letters in Sept. 2017 to alert them of the recall and advised to stop taking the medication.

** "News Release." Endo Provides Update On OPANA® ER. Endo Pharmaceuticals, 6 July 2017. Web. 28 July 2017. Lombardo, Cara. "Endo Says Shipments of Opana ER Will End Sept. 1." The Wall Street Journal. Dow Jones & Company, 21 July 2017. Web. 28 July 2017.*

DRUG LIST CHANGES

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions, revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were made to the BCBSNM drug lists. Changes that were effective Oct. 1, 2017 are outlined below.

Drug List Updates (Coverage Additions) – As of Oct. 1, 2017

Preferred Brand[1]	Drug Class/Condition Used For
Basic *(formerly known as Standard)*, Enhanced *(formerly known as Generics Plus)*, Performance and Performance Select Drug Lists	
Afstyla	Hemophilia
Fluticasone Propionate/Salmeterol 113-14, 232-14, 55-14 mcg/act (authorized generic for AirDuo)	Asthma/COPD
Isentress HD	Antivirals/HIV

Kisqali/Femara Dose Pack	Cancer
Rydapt	Cancer
Tymlos	Osteoporosis
Zytiga 500 mg tab	Cancer
Basic *(formerly known as Standard)* and Enhanced *(formerly known as Generics Plus)* Drug Lists	
Granix	Colony Stimulating Factors
Ixinity 250 units, 2000 units, 3000 units	Hemophilia
Sulfadiazine	Anti-Infectives
Viberzi	Irritable Bowel Syndrome
Performance and Performance Select Drug Lists	
Alunbrig	Cancer
atomoxetine hcl cap	ADHD
Austedo	Huntington's Disease
EPINEPHRINE (epinephrine solution auto-injector 0.15 mg/0.3 mL (1:2000) and 0.3 mg/0.3 mL (1:1000) mfg = Mylan	Anaphylaxis
Fluad, Fluarix Quadrivalent, Flublok, Flucelvax Quadrivalent, Flulaval Quadrivalent 2017-2018	Influenza Vaccine
Ingrezza	Tardive Dyskinesia
Jadenu Sprinkle	Iron Toxicity
melphalan tab 2 mg	Cancer
Menveo	Meningococcal Vaccine
mesalamine delayed release tab 1.2 gm	Ulcerative Colitis
Orencia 50 mg/0.4 mL, 87.5 mg/0.7 mL	Arthritis
Orenitram 5 mg	Pulmonary Hypertension
Rubraca 250 mg	Cancer
Selzentry 20 mg/mL	Antivirals/HIV
sevelamer carbonate	Hyperphosphatemia
Synjardy XR	Diabetes
testosterone td soln 30 mg/act	Low Testosterone
Xermelo	Cancer
Zejula	Cancer
Basic *(formerly known as Standard)* Drug List	
Synjardy XR	Diabetes
Enhanced *(formerly known as Generics Plus)* Drug List	
Zarxio	Colony Stimulating Factors
Performance Select Drug List	
doxycycline hyclate tab 75 mg, 150 mg	Antibiotics
moxifloxacin ophth soln 0.5%	Ophthalmic Anti-Infectives
oloptadine ophth soln 0.2%	Ophthalmic Anti-Infectives

Drug List Updates (Revisions/Exclusions) – As of Oct. 1, 2017

Non-Preferred Brand[1]	Drug Class/Condition Used For	Generic Preferred Alternative(s)[2]	Preferred Brand Alternative(s)[1,2]
Performance and Performance Select Drug List Revisions			
fluoxetine delayed release 90 mg	Depression	fluoxetine hcl cap 10 mg, 20 mg, 40 mg	N/A
levofloxacin oral soln 25 mg/mL	Antibiotic	ciprofloxacin oral susp, ciprofloxacin hcl tab, levofloxacin tab	N/A
potassium chloride oral soln 20% (40 mEq/15 mL)	Hypokalemia	potassium chloride microencapsulated crys cr tab, potassium chloride oral soln 10% (10 mEq/15 mL), potassium chloride powder packet 20 mEq	N/A
Performance and Performance Select Drug Lists Exclusions			
COREG CR	Hypertension	atenolol tab, carvedilol tab (immediate release), metoprolol tartrate tab, metoprolol succinate tab SR 24hr	N/A
DOXEPIN HYDROCHLORIDE	Dermatitis	betamethasone valerate cream, betamethasone valerate oint, tacrolimus oint, triamcinolone acetonide cream, triamcinolone acetonide oint	N/A
MILLIPRED (prednisolone sod phosphate oral soln 10 mg/ 5 mL)	Oral Steroid	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
MINASTRIN 24 FE (norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg	Oral Contraceptives	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
PRISTIQ (desvenlafaxine succinate tab SR 24hr)	Depression	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
PRUDOXIN (doxepin hcl cream 5%)	Dermatitis	betamethasone valerate cream, betamethasone valerate oint, tacrolimus oint, triamcinolone acetonide cream, triamcinolone acetonide oint	N/A
QUARTETTE (levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth	Oral Contraceptives	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	

est 0.01 mg			
TAZORAC (tazarotene cream 0.1%)	Acne	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
TRICOR (fenofibrate tab 145 mg)	High Cholesterol	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
VERIPRED 20 (prednisolone sod phosphate oral soln 20 mg/5 mL)	Oral Steroid	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
ZONALON (doxepin hcl cream 5%)	Dermatitis	betamethasone valerate cream, betamethasone valerate oint, tacrolimus oint, triamcinolone acetonide cream, triamcinolone acetonide oint	N/A
Performance Select Drug List Exclusions			
clindamycin phosphate-tretinoin gel 1.2-0.025%	Acne	clindamycin phosphate gel 1%, tretinoin gel	N/A

DISPENSING LIMIT CHANGES

The BCBSNM prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. Food and Drug Administration (FDA) approved dosage regimens and product labeling.

Effective Oct. 1, 2017:

Drug Class and Medication(s)[1]	Dispensing Limit(s)
Basic *(formerly known as Standard)*, Performance and Performance Select Drug List Changes	
Therapeutic Alternatives	
Azelex cream 20%	30 grams per 30 days
Noritate cream 1%	60 grams per 30 days
URAT1 Inhibitor	
Zurampic 200 mg tablet	30 tablets per 30 days

UTILIZATION MANAGEMENT PROGRAM CHANGES

- **Effective Oct. 1, 2017,** the following changes will be applied:
  - Several drug categories and/or targeted medications will be added to current prior authorization (PA) programs for standard pharmacy benefit plans, upon renewal for most members. *As a reminder,* please review your patient's drug list for the indicator

listed in the Prior Authorization or Step Therapy column, as not all programs may apply. Additionally, please be sure to submit the specific prior authorization form the medication being prescribed to your patient.

Drug categories added to current pharmacy PA standard programs, effective Oct. 1, 2017

Drug Category	Targeted Medication(s)[1]
Basic *(Standard,)* Performance and Performance Select Drug Lists	
URAT1 Inhibitor	Zurampic

Targeted drugs added to current pharmacy PA standard programs, effective Oct. 1, 2017

Drug Category	Targeted Medication(s)[1]
Basic *(Standard)* and Performance Drug Lists	
Therapeutic Alternatives	Azelex, Noritate

Per our usual process of member notification prior to implementation, targeted mailings were sent to members affected by drug list revisions and/or exclusions, dispensing limit and prior authorization program changes. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our Provider website.

[1]*Third party brand names are the property of their respective owners*

[2]*These lists are not all inclusive. Other medications may be available in this drug class.*

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Blue Cross Community Centennial℠ (Medicaid)

Not yet contracted?

Providers who are participating in commercial BCBSNM products are not automatically participating providers in Blue Cross Community Centennial. If you are interested in becoming a Blue Cross Community Centennial provider, please call 505-837-8800 or 1-800-567-8540.

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.

2018 Blue Cross Community Centennial Preauthorization Updates

Beginning Jan.1, 2018, providers will be required to obtain preauthorization through Blue Cross and Blue Shield of New Mexico (BCBSNM) or eviCore for certain procedures for Blue Cross Community Centennial members as noted below.

Services performed without benefit preauthorization may be denied for payment in whole or in part, and you may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly in accordance with NMAC 8.302.2.11(G).

To obtain benefit preauthorization through BCBSNM for the care categories noted above, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Network Management Consultant.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits 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 questions, contact the number on the member's ID card.

eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSNM.

Preauthorization Requirements through eviCore – Effective 01/01/2018	
1) Molecular Genetics **2) Radiation Therapy**	**Utilizing the eviCore Healthcare web portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations/eligibility and more: Visit https://www.evicore.com/healthplan/bcbs** **OR** **Call toll-free at 855-252-1117 between 8 a.m. to 8 p.m. (local time) Monday through Friday. Closed holidays.**

Preauthorization Requirements through BCBSNM – Effective 01/01/2018	
Covered Service	**Prior Authorization**
Allergy care, including tests and serum	Please refer to the procedure code list for authorization requirements
Bariatric surgery	Yes
Breast pumps and replacement supplies	No – subject to benefit and DME dollar amount
Chemotherapy and radiation therapy	Yes – please refer to the procedure code list for authorization requirements
Covered services provided in school-based health clinics	No
Durable Medical Equipment (DME) – Medical supplies (any single DME greater than $1,500)	Please refer to the procedure code list for authorization requirements and accumulated annual limits without authorization
Emergency dental care	Yes
Diabetes self-management services	Please refer to the procedure code list for authorization requirements
Dialysis services	Requires notification (effective 8/1/17)
Ground and air ambulance	Ground – No
	Air – Yes
Hearing services and devices	Yes
Home birthing	Notification is required
Home health care and intravenous services	Yes – please refer to the procedure code list for authorization requirements
Hospice	Yes
Hospital services (inpatient, outpatient, and skilled	Please refer to the procedure code list for

Preauthorization Requirements through BCBSNM – Effective 01/01/2018	
Covered Service	**Prior Authorization**
nursing)	authorization requirements. Skilled nursing facilities in IL are reviewed through eviCore. Inpatient stays with services that are managed by eviCore will be reviewed through eviCore.
Injections	Please refer to the procedure code list for authorization requirements
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	Please refer to the procedure code list for authorization requirements
Long-term support services	Long-term support services require pre-assessment, eligibility determination and service planning. This process is completed with the member's care/service coordinator and the treatment team. Once service planning is complete, the authorization process is completed according to State guidelines and requirements. Eligibility is limited to members qualified due to waiver status or eligibility established after evaluation.
Nursing facilities	Yes
Nutritional counseling services	Please refer to the procedure code list for authorization requirements
Minor surgeries	Please refer to the procedure code list for authorization requirements
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	No
Orthotics and prostheses	Please refer to the procedure code list for authorization requirements
Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program	Yes – If a member’s child is disabled, he or she may qualify for more services. Instruct member to call Member Services and ask to speak with a Care Coordinator/Case Manager for more information.
PET, MRA, MRI, and CT scans	Please refer to the procedure code list for authorization requirements
Podiatry (foot and ankle) services	Yes
Pregnancy-related and maternity services	No
Routine physicals, children’s preventive health programs, and Tot-to-Teen checkups	No
Second opinions (in network)	No

Preauthorization Requirements through BCBSNM – Effective 01/01/2018	
Covered Service	**Prior Authorization**
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	Please refer to the procedure code list for authorization requirements; all transplants and pre-transplant evaluation require prior authorization
Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Please refer to the procedure code list for authorization requirements

Summary of Behavioral Health Services	
Covered Service	**Prior Authorization**
Inpatient Psychiatric Services	Yes
Inpatient Substance Abuse Services	Yes
Mental Health Residential (up to age 21)	Yes
Sub Acute Residential	Yes *Only covered service for Centennial Care*
Substance Abuse Residential (up to age 21)	Yes *Only covered service for Centennial Care*
Community Mental Health Services	Please refer to the procedure code list for authorization requirements
Medication-Assisted Treatment for Opioid Dependence	No *Only covered service for Centennial Care*
Applied Behavioral Analysis (ABA) (up to age 21)	Yes, Stage 3 *Only covered service for Centennial Care*
Professional Outpatient Services	Please refer to the procedure code list for authorization requirements
Electroconvulsive Therapy	Yes
Developmental Testing	Please refer to the procedure code list for authorization requirements
Early, Periodic Screen, Diagnostic and Treatment Services	No
Group Home	Yes *Only covered service for Centennial Care*
Respite Care (up to age 21)	No *Only covered service for Centennial Care*
Telehealth Services	No
Value-Added Service – Infant Mental Health	Yes *Only a covered service for Centennial Care*
Value-Added Service – Transitional Living	Yes *Only a covered service for Centennial Care*

Service Spotlight: Special Beginnings® Maternity Program

Blue Cross Community Centennial℠ members can take advantage of our maternity care coordination program: Special Beginnings. Special Beginnings offers personal, confidential care coordination services to pregnant members during their entire pregnancy. Experienced in obstetrics, our care coordinators can assist members in understanding and managing their pregnancy to help achieve better health for themselves and their baby.

Members enrolled in the Special Beginnings program receive personal phone calls, educational materials and complete a risk assessment interview. Moderate to high-risk pregnant members will be followed by a registered nurse, and all members will have access to the care coordination staff.

Pregnant members also have opportunities to receive Centennial Rewards and Value-Added Services, such as an infant car seat and portable crib at no cost. Below are the steps the member must complete to get both items:

Infant Car Seat

- Enroll in the Special Beginnings Program
- Complete an initial prenatal visit occurring during the first trimester or within 42 days of enrollment in Blue Cross Community Centennial
- Complete at least eight prenatal visits during the pregnancy

Portable Crib

- Enroll in the Special Beginnings Program
- Complete an initial prenatal visit occurring during the first trimester or within 42 days of enrollment in Blue Cross Community Centennial
- Complete at least eight prenatal visits during the pregnancy
- Participate in the Safe Sleep Program provided by the Special Beginnings care coordinators

To review the most up-to-date Value-Added Services and Centennial Rewards, please visit our website at bcbsnm.com/community-centennial.

Please encourage your pregnant patients to join our Special Beginnings program. Joining the program early in pregnancy will help provide support during their pregnancy, delivery, and into the postpartum period.

For more information or to enroll in Special Beginnings, call (888) 421-7781.

Centennial Rewards points/credits are for qualifying catalog use only. Points/credits have no cash or monetary value and can never be exchanged or redeemed for cash. They are not transferable to other persons. They may not be combined with other members' points/credits or with other rewards or incentive programs offered by Centennial Care.

Updated Diagnosis Related Group Rates

Effective October 1, 2017, Blue Cross and Blue Shield of New Mexico (BCBSNM) updated the Diagnosis Related Group (DRG) rates for Blue Cross Community Centennial℠ based on the New Mexico Medicaid Fee Schedules.

Although there were very few updates to the weights from Version 34, providers may view the updated Version 35 DRG weights on the New Mexico Human Services Department (HSD) website by reading and agreeing to the terms and conditions as set forth by HSD.

The Medicaid DRG Weights Version 35 Grouper has been posted to the following HSD website: http://www.hsd.state.nm.us/providers/fee-schedules.aspx

If you have any questions regarding this revision, please contact your BCBSNM Provider Relations Representative.

New Dental Varnish Billing Code

Effective December 1, 2017, non-dental providers treating Blue Cross Community Centennial℠ members may begin to bill the CPT code 99188 for application of fluoride dental varnish. The use of code 99188 replaces D1206. To facilitate the transition, Blue Cross and Blue Shield of New Mexico (BCBSNM) will continue to accept claims using D1206 through December 31, 2017. Effective January 1, 2018, BCBSNM will deny claims submitted using the D1206 code.

There is no change to reimbursement associated with this change. Please contact your BCBSNM Provider Relations Representative if you have any questions regarding this notice.

Survey Shows Medicaid Members Give Their Providers High Ratings

Each spring, Blue Cross and Blue Shield of New Mexico (BCBSNM) surveys our members to find out how happy they are with us and with you, the providers. Using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), we give members the opportunity to rate the services we offer and the health care you provide.

Adults – percent who said they were "always" or "usually" satisfied with:	**2016**	**2017**	**Children and children with chronic conditions – percent who said they were "always" or "usually" satisfied with:**	**2016**	**2017**
Getting care quickly	77.82%	77.86%	Getting care quickly	90.29%	90.15%
Getting needed care	75.42%	76.70%	Getting needed care	86.50%	82.01%
Rating of health plan	78.99%	75.36%	Rating of health plan	84.13%	83.48%
How well doctors communicate	90.47%	91.48%	How well doctors communicate	93.57%	92.74%
Rating of all health care	78.16%	72.81%	Rating of all health care	84.52%	82.14%
Rating of personal doctor	79.44%	82.67%	Rating of personal doctor	88.02%	88.57%
Rating of specialist seen most often	N/A*	82.05%	Rating of specialist seen most often	N/A*	80.20%

*N/A – Insufficient responses for ranking

Adult members rated us higher this year than last in four categories and our care and services to children improved in one. We're proud of these achievements, and we thank you for the quality care and services you provide our members.

Can we do better? Yes. With contributions from all BCBSNM departments, our quality team is analyzing the drops in our plan and health care ratings for children and bringing focus to our adult members' health plan rating. Your contributions to these efforts are invaluable. Please consider sharing your ideas about our members' experiences and your thoughts on improvement with the BCBSNM Quality team by calling us at 855-699-0042. Together in 2018, we will continue to earn our members' confidence and improve their experience of our health care and services.

About CAHPS: CAHPS survey results are used in National Committee for Quality Assurance (NCQA) health plan performance reports, health plan accreditation decisions and to create national benchmarks for care. We encourage providers to learn more about CAHPS by visiting the NCQA CAHPS Web site.

Looking Back at HEDIS®: Results for HEDIS 2015, 2016, and 2017

With requests for medical records arriving by fax and phone for HEDIS 2018, we thought a look back at previous HEDIS seasons would show the progress Blue Cross and Blue Shield of New Mexico (BCBSNM) has made – and continues to make – in providing access to appropriate health care to our Medicaid members.

Children HEDIS Measures

Children HEDIS Measures	2015	2016	2017
Childhood Immunization Status:			
Diphtheria/Tetanus/Pertussis	80.57%	72.63%	76.16%
Polio	92.72%	86.31%	88.30%
Measles, mumps & rubella	90.51%	86.98%	87.20%
H influenza type b (flu)	92.94%	84.99%	87.42%
Hepatitis B	92.72%	87.20%	88.30%
Chicken pox	90.07%	86.98%	87.42%
Pneumonia	80.79%	73.95%	75.72%
Appropriate Testing for Sore Throats	68.09%	66.22%	63.78%
Medication Management for People with Asthma, 50% Compliance:			
5-11 years	43.88%	45.12%	52.28%
12-18 years	48.21%	35.75%	39.90%
Upper Respiratory Infection Treatment	88.33%	90.51%	88.26%
Annual Dental Visit (2-21 years)	57.46%	59.63%	61.78%
Well-Child Visits	44.34%	47.91%	58.35%

We have made a significant improvement in well-child visits with a 14 percentage point increase for the measure. Overall, the HEDIS results indicate that we are serving our children well, with many effectiveness measures holding steady or improving across the three-year look back period.

Adult HEDIS Measures

Adult HEDIS Measures	2015	2016	2017
Breast Cancer Mammograms	51.23%	54.57%	41.65%
Cervical Cancer Screening	28.35%	45.78%	52.55%
Prenatal/Postpartum Care:			
Timeliness of prenatal care	73.08%	72.61%	75.50%
Postpartum care	54.52%	57.91%	58.06%
Controlling High Blood Pressure	51.66%	56.99%	55.60%
Comprehensive Diabetes Care:			
A1c testing	83.42%	80.43%	82.56%
HbA1c poor control (>9.0%)	47.26%	52.90%	48.57%
HbA1c control (<8.0%)	43.12%	39.30%	41.94%
Retinal eye exam	54.23%	47.76%	51.21%
Attention for nephropathy	78.61%	85.07%	87.42%
Blood pressure control	57.38%	55.89%	55.41%

We have made great strides the area of comprehensive diabetes care. Given the prevalence of this complex disease in our adult population, these gains are significant indicators of our ability to improve care to meet our members' needs. Among our goals for 2017 and 2018 will be extending the practices employed in achieving these gains to achieving progress toward care goals for women's health.

Our efforts to ensure effective care for our members are ongoing and continuous. We thank you for your dedication to our members' health and wellbeing and to the continued improvement and effectiveness of health care services. We look forward to sharing the HEDIS 2018 results with you.

Our Medicaid Quality Improvement Program

The principle goal of the Blue Cross and Blue Shield of New Mexico (BCBSNM) Medicaid Quality Improvement (QI) Program is to improve our members' health. We strive to help them understand the importance of taking better care of themselves and their families. Every year, we develop a quality improvement plan in which we set specific quality goals, identifying the activities we will implement to achieve them and defining how we will measure our progress. All activities and goals lead back to the primary goal: improved health for our members, your patients.

The QI Program is a team effort that is built on contributions from our BCBSNM peers across all lines of business, departments and divisions. Program goals for health care and services are developed with input from you and from our members, brought into focus by our leadership, and

implemented by staff dedicated to the needs of our Medicaid membership. Quality committees, chaired by medical directors, keep our projects on target and focused through policies and procedures for day-to-day operations and annual measurements like HEDIS and CAHPS.

We continuously evaluate the effectiveness of our QI Program by measuring our success in terms of nationally applied and internally established standards and benchmarks. We are proud to have met the majority of our goals in 2017 and are especially pleased to report that we maintained National Committee for Quality Assurance (NCQA) accreditation for each of our product lines, including Medicaid. Our Medicaid product line was the only New Mexico Medicaid plan to achieve an NCQA Commendable Accreditation.

Several key points in the evaluation of our 2017 QI Program included:

- Member complaints and appeals
- Provider and practitioner safety and care practices
- Clinical practice guidelines
- Member and provider experience
- Clinical performance data
- Health care utilization and complex disease management

BCBSNM met the following 2017 QI Program achievements and goals:

- Achieved national percentile benchmarks for select New Mexico Health Services Department (HSD) performance measures
- Achieved Excellent standards for provider average scores on annual Medical Record Review
- Achieved Full Compliance with New Mexico External Quality Review Organization standards for annual audit of QI Performance Measure Program quality initiatives, interventions and process improvement projects
- Steadily improved compliance with HSD requirements for Critical Incidents processing and reporting; met and exceeded internal and external goals for timeliness and accuracy
- Exceeded audit requirements of the HEDIS annual medical records abstraction project

To learn more about the 2017 QI Program evaluation and providers' contributions to our QI efforts, please call the QI Department at 855-699-0042.

Electronic Visit Verification (EVV) Claim Entries Require Supporting Documentation

The Centennial Care managed care organizations (MCOs) are committed to ensuring providers have the tools and resources they need to provide Personal Care Services (PCS) to Centennial Care members. We would like to take this moment to inform PCS agencies of the appropriate use of manual Electronic Visit Verification (EVV) claim entries.

Effective Jan. 1, 2018, any claim that is manually entered (i.e., web-entered) into the EVV system, AuthentiCare, will require the agency to gather and maintain supporting documentation. For manually entered claims, the reviewing MCO may require this supporting documentation before payment is issued. It is the agency's responsibility to maintain this

documentation and establish records retention policies that are compliant with your individual contracts with the MCOs and your Medicaid Participation Agreement with the State of New Mexico Human Services Department. Providers should enter the supporting documentation in the notes field in the AuthentiCare system. The table below lists the exceptions and the appropriate documentation needed to issue payment for manual claim entries.

Exception	Required documentation
Tablet malfunction	The issue reference number and/or other documentation that demonstrates outreach to Mobility Exchange (ME) or AuthentiCare.
Smartphone malfunction	The issue reference number from the mobile network carrier, such as Verizon.
Interactive voice response (IVR) system is unavailable or landline is disconnected	The issue reference number that indicates outreach to either AuthentiCare for IVR issues or to the member's landline network carrier.
Tablet order was not delivered prior to services being rendered	The confirmation of the date the tablet was ordered and the date the tablet was delivered from ME. **Note:** Five to seven business days is the timeline provided for tablet delivery.
Inclement weather	Documentation from the PCS agency that supports the use of manual claim entries. Explain the reason for the manual entry.
Electrical outage unrelated to inclement weather	Documentation from the PCS agency that supports use of manual claim entries. Explain the reason for the manual entry.
Authorization issue	Documentation that supports outreach to the MCO for assistance in researching the issue. Include the date of discussion.
Substitute caretaker	Documentation from the agency that indicates a change in caretakers. **Note:** Manual claim entries should only be used if notification of substitution was not received in a timely manner and you are unable to reschedule the service in AuthentiCare.

If you have any questions or concerns regarding this communication, please use the information enclosed to contact your provider representative from any of the MCOs with whom you are contracted.

Thank you for your continued partnership.

MCO's Provider Representative Contact Information	
Blue Cross and Blue Shield of New Mexico	Felicity King Felicity_King@bcbsnm.com | 505-816-4207 Bernalillo County – Any agency with legal entity name starting with letters A – M and all counties north of Bernalillo Trish Eichwald Patricia_D_Eichwald@bcbsnm.com 505-816-4230 Bernalillo County – Any agency with legal entity name starting with letters N – Z and all counties south of Bernalillo
MOLINA HEALTHCARE	Leeann Kaminski Leeann.Kaminski@MolinaHealthCare.com | (505) 384-0352
PRESBYTERIAN	Adam Bailey abailey5@phs.org | (505) 923-5407
	Orlando Gonzalez ogonzalez3@phs.org | (505) 923-6205
UnitedHealthcare	Christina Salgado christina_c_salgado@uhc.com | (575) 589-1984 **Counties:** Catron, Chavez (south of Reserve), Grant, Hidalgo, Luna, Dona Ana, Chavez, Eddy, Lea Lincoln, Otero, Sierra
	Cynthia Cordova-Rivera cynthia_a_cordova-rivera@uhc.com | (505) 449-4328 **Counties:** Bernalillo, Tao, Rio Arriba, Los Alamos, Santa Fe, Valencia, Torrance, Socorro
	Jacque Daniels Jdani33@uhc.com | (505)632-4282 **Counties:** Bernalillo, San Juan, Sandoval, McKinley, Cibola, Catron (north of Reserve)

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

Medicare

2018 Blue Cross Medicare Advantage℠ Preauthorization Updates

Beginning Jan.1, 2018, providers will be required to obtain preauthorization through Blue Cross and Blue Shield of New Mexico (BCBSNM), DaVita Medical Group (DMG) or eviCore for certain procedures for Blue Cross Medicare Advantage members as noted below.

Services performed without benefit preauthorization may be denied for payment and in whole or in part, you may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

A referral to an out-of-plan or out-of-network provider which is necessary due to network inadequacy or continuity of care must be reviewed by the BCBSNM Utilization Management or DMG (if the member is attributed to DMG this information will be reflected on the ID card) prior to a BCBSNM patient receiving care.

To obtain benefit preauthorization through BCBSNM for the care categories noted above, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Network Management Consultant.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits 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 questions, contact the number on the member's ID card.

iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity and Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSNM

Blue Cross Medicare Advantage℠

Prior Authorization Rules - Medicare Medical/Surgical/Behavioral Health
Preauthorization Requirements through eviCore - Effective 01/01/2018

1. Cardiology **2. Radiology** **3. Medical Oncology** **4. Molecular Genetics** **5. Musculoskeletal - (PT/OT/ST; Spine/Joint/Pain/Chiro)** **6. Radiation Therapy** **7. Sleep** **8. Specialty Drug**	**Utilizing the eviCore Healthcare Web Portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations/eligibility and more url: https://www.evicore.com/healthplan/bcbs OR** **Call toll-free at 855-252-1117 between 7 am -7 pm local time Monday through Friday except holidays.**

Limitations Of Covered Benefits by Member Contract

This list is not exhaustive. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Consult the member benefit booklet, or contact a customer service representative to determine coverage for a specific medical service or supply.

Covered Service	Prior Authorization
Allergy care, including tests and serum	Please refer to the procedure code list for Authorization Requirements
Bariatric surgery	Yes
Blepharoplasty	Yes
Botox injections	Yes
Chemotherapy and radiation therapy	Yes
Dental care	Yes
DME - Medical supplies, Orthotics and Prosthesis (Any single durable medical equipment prosthetic and orthopedic device greater than $1500)	Please refer to the procedure code list for Authorization Requirements and Accumulated Annual Limits without authorization
Ground and air ambulance	Ground - No
	Air - Yes
Home health care and intravenous services	Please refer to the procedure code list for Authorization Requirements
Hospital services (inpatient, outpatient)	Please refer to the procedure code list for Authorization Requirements. Inpatient stays with services that are managed by eviCore will be reviewed through eviCore.
Hyperbaric oxygen	Yes
Injections	Please refer to the procedure code list for Authorization Requirements
Implantable devices	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	Please refer to the procedure code list for Authorization Requirements
Long-Term Acute Care (LTAC)	Yes
Minor surgeries	Please refer to the procedure code list for Authorization Requirements
Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy)	Please refer to the procedure code list for Authorization Requirements
Nutritional counseling services	Please refer to the procedure code list for Authorization Requirements

Nutritional products and special medical foods	Yes
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	No
Podiatry (foot and ankle) services	Yes
PET, MRA, MRI, and CT scans	Please refer to the procedure code list for Authorization Requirements
Routine physicals	No
Second opinions (in network)	No
Skilled Nursing Facilities	Yes
Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Yes, Please refer to the procedure code list for Authorization Requirements
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	Please refer to the procedure code list for Authorization Requirements; all transplants and pre-transplant evaluation require prior authorization
Intersex Reassignment Surgery 55970, 55980	Yes
Summary of Services and Behavioral Health UM requirements *Providers requesting services for Texas Medicare Advantage HMO Plans should contact Magellan for authorization requirements	
Covered Service	**Prior Authorization**
All inpatient stays facilities/hospitals	Yes
All network exceptions	Yes
Covered Service	**Prior Authorization**
Partial hospitalization	Yes
Psychological/neuropsychological testing	Please refer to the procedure code list for Authorization Requirements
Electroconvulsive therapy	Yes
Transcranial magnetic stimulation	Yes
Outpatient services	Please refer to the procedure code list for Authorization Requirements

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Federal Employee Program (FEP)

In-Home FOBT/FIT & HbA1c Test Kits for FEP Members

Beginning in November, some Blue Cross and Blue Shield FEP® members may receive the Fecal Immunochemical Test (FOBT/FIT) for colorectal cancer screening and/or hemoglobin A1c in-home test kits. Members were identified for possible participation if they have a diagnosis of diabetes and did not have a claim for hemoglobin A1c testing and/or had no claim history of colorectal cancer screening. Members can first expect to receive a communication from BCBS FEP about the tests, and within that communication, members will have the option to opt out of the program and decline the test kits.

The following two tests will be sent out to our members and processed by the Home Access Health Corporation and are offered at no additional cost to members:

- FIT tests for colorectal cancer screenings
- A1c tests for blood sugar control for diabetes

Home Access Health Corporation is an independent company that provides laboratory testing and will send results via mail to both the member and their primary care physician (PCP) on file. Our goal is to encourage members to close care gaps by making the process easier to complete the test(s) in the comfort of their own homes.

We are requesting that you do the following:

- Encourage your patients to take these test kits should they receive them and advise your patients that after taking the tests, they should return them in the prepaid postage envelope to the address listed.
- Reiterate to your patients that they should provide their PCP's name and mailing address, along with their sample, to receive the test results.
- Please be on the lookout for these test results so that you can place them into the member’s records and be prepared to follow up on any alert values received.

If you have any questions or if you need additional information, please contact your Blue Cross and Blue Shield of New Mexico Provider Network Representative. Members can use the Customer Service number listed on the back of their insurance card.

2018 FEP Utilization Management Clinical Guideline 002: Inpatient Skilled Nursing Facility Care

Effective Jan. 1, 2018, benefits will be available for Federal Employee Program (FEP) members for **up to 30 days** of inpatient skilled nursing facility (SNF) care **per benefit year** for Standard Option Members who are not enrolled in Medicare Part A. The provider and Blue Cross and Blue Shield of New Mexico (BCBSNM) staff must be proactive in identifying members for whom a SNF stay is an appropriate level of care in the continuum toward transition home. It may also be necessary to obtain the member's written consent for Case Management (CM). This may include identifying of the member's surrogate decision maker/proxy, assisting BCBSNM in delivering the case management consent to the member/proxy and/or having the signed consent returned to BCBSNM's case manager prior to BCBSNM rendering a benefit determination on the proposed SNF admission.

To utilize this benefit:

- The member must be enrolled in Case Management (CM) and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the discharge planning staff collaborate with the BCBSNM case manager, and in some cases, will necessitate the case manager/discharge planner's assistance in delivering the consent to the member and having it returned to BCBSNM after the member/proxy signs the document.
- The transferring facility must submit a detailed description of the patient's clinical status and the proposed treatment plan for BCBSNM's review of the proposed admission.

Once the member is admitted:

- The SNF representative must provide specific information regarding the patient's status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the member from achieving the goals.
- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the patient's admission. Patients admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the facility 24 hours/day
- Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 2 hours of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to BCBSNM to document therapy time).

The new FEP UM Guideline 002 Inpatient Skilled Nursing Facility Services will be added to the FEP Medical Policy Manual available at www.fepblue.org effective Jan. 1, 2018.

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Provider Resources

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 via our website, bcbsnm.com/provider, and our provider newsletter, *Blue Review*.

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*.

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

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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. These policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Claims inquiries?

Our Provider Service Unit (PSU) handles all provider inquiries about claims status, eligibility, benefits, and claims processing for BCBSNM members. **Call 888-349-3706** *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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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 for any changes to contact or practice information.

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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.

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.

Commercial, Exchange, and FEP
Blue Cross Community Centennial (Medicaid) (Page S97)
Medicare (Page S20)

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