BlueCross BlueShield of New Mexico

Blue Review℠

A Provider Publication

September 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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Adult BMI Assessment

Screening for health risk factors in adults ages 20 to 74 can begin with a brief discussion of the patient's current Body Mass Index (BMI). In young adult patients ages 18 to 20, a discussion of BMI percentile is warranted. The BMI, an indicator of body fat, can create an opportunity to assess and discuss activity, diet, alcohol, use of pain medications, smoking patterns and other lifestyle choices that may impact health.

In adults ages 20 to 74, documentation of a patient's weight and BMI value meet guidelines for the Healthcare Effectiveness Data and Information Set (HEDIS®) Adult BMI Assessment, or ABA, measure. In young adults ages 18 to 20, **the BMI percentile must be documented** as a value along with the patient's height and weight to meet documentation requirements for this measure.[1]

BMI calculation is based on a person's weight divided by their height squared.[2] Formulas and tools for determining BMI using the metric system or English unit system are readily available in English and Spanish from the National Institute of Health National Heart, Lung, and Blood Institute (NIH NHLBI)[3] if your practice does not have BMI calculation tools.

Many Electronic Health Record (EHR) systems will automatically calculate the BMI value and BMI percentile with documentation of the height and weight. Practices may not realize that their EHR can perform this function so be sure to check with your EHR system administrator or IT department. Online tools to calculate BMI[3,4] or BMI percentile[2] are an alternative if the EHR or practice does not calculate the BMI or BMI percentile.

The table below from the Centers for Disease Control and Prevention (CDC) shows the BMI range and weight status categories for adults ages 20 to 74:[4]

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal or Healthy Weight
25.0 - 29.9	Overweight
30.0 and above	Obese

The National Institute of Health National Institute of Diabetes and Digestive and Kidney Diseases (NIH NIDDK) classification of the BMI expands the weight status categories to include Extreme Obesity, a BMI > 40.0.[5] The NIH NHLBI further demonstrates BMI values up to 54.[6]

The **BMI percentile** compares the growth and development of a young adult to other young adults of the same age and sex in the U.S. and is used to screen for overweight and obesity.[2] When evaluating adolescents and young adults up to age 20, a BMI percentile at the 85th percentile up to the 94th percentile is classified as overweight. A BMI percentile at or above the 95th percentile is classified as obese.[2]

This table from the CDC shows the weight status category and corresponding BMI percentile for young adults 18 to 20 years old.[2]

BMI Percentile	Weight Status Category
Less than the 5th percentile	Underweight
5th percentile to less than the 85th percentile	Normal or Healthy Weight
85th to less than the 95th percentile	Overweight
Equal to or greater than the 95th percentile	Obese

The U.S. Preventive Services Task Force (USPSTF) recommends screening all adults for obesity. When the BMI is 30 or greater, their recommendation is for referral to "intensive, multicomponent behavioral interventions."[7]

While the USPSTF does not give a recommendation for the screening interval, the HEDIS® ABA measure **requires** BMI assessment in the current year or year before to meet criteria.[1]

The BMI and BMI percentile are important values to document and use in the assessment of your patient's health. Your discussion of the BMI result can help your patient identify opportunities for changes that will promote optimal health.

[1] HEDIS 2017, Volume 2

[2] https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

[3] https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

[4] https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

[5] https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity

[6] https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_tbl2.htm

[7] https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management

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Annual Well-Child Visit Important for Children and Caregivers

The Well-Child Visit offers an excellent opportunity to assess obesity risk. Attention to growth measurements, nutrition and physical activity offers our young members the best chance at a healthy lifestyle! The United States Preventive Services Task Force (USPSTF) recommends **screening children aged 6 years and older for obesity and offering or referring [them] for intensive counseling and behavioral interventions.[1]**

"Today, about one in three American kids and teens is overweight or obese. The prevalence of obesity in children more than tripled from 1971 to 2011. With good reason, childhood obesity is now the No. 1 health concern among parents in the United States, topping drug abuse and smoking."[2]

"Among children today, obesity is causing a broad range of health problems that previously weren't seen until adulthood. These include high blood pressure, type 2 diabetes and elevated blood cholesterol levels. There are also psychological effects:

Obese children are more prone to low self-esteem, negative body image and depression."[3]

The Well-Child Care Check or, per NCQA, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), for those 3–17 years of age consists of three components and their documentation:

1) Height, weight and BMI percentile (from the same data source) documentation
2) Counseling for nutrition
3) Counseling for physical activity

Body Mass Index (BMI) and BMI percentile are NOT the same

BMI is a person's weight in kilograms divided by the square of their height in meters. For children and teens, BMI is age- and sex-specific and is often referred to as BMI-for-age.[4] A high or low BMI can be an indicator of potential problems that may place a child at a higher risk for health issues.

BMI percentile shows how a BMI compares to other kids of the same age and sex. BMI percentile can be plotted on a chart or obtained from online calculators. The BMI-for-age percentile growth charts are the most commonly used indicator to measure the size and growth patterns of children and teens in the United States.[5]

Please refer to the following link for BMI-for-age growth charts and a BMI calculator.[6]
https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

Once height, weight and BMI percentile have been documented, a health care provider can discuss nutrition and physical activity **and** offer counseling.

Counseling for Nutrition

Environmental factors, lifestyle choices and food resources have changed the nutritional habits of our children. Recognizing these changes and identifying creative methods to meet the nutritional needs of this population may be a challenge.

- Explore what the child or adolescent is eating for meals as well as snacks. Ask about favorite foods, dislikes and allergies.
- Explain the importance of a well-balanced nutritional plan and offer recommendations.
- Have information available about fun recipes and/or meals that the child can assist in preparing.

- As teens bridge to adulthood, discuss how lifestyle choices may impact nutritional outcome.
- Provide and document referrals to nutritionists, weight management and obesity counselors.
- Assess whether financial assistance for meals is indicated and offer local resources.

NOTE:

- In your documentation, include checklists and anticipatory guidance for nutrition as well as any educational materials provided during the visit.
- Nutritional counseling specific to an acute or chronic condition **will not** satisfy the documentation requirement for this component.
- "Well-nourished" alone **does not** satisfy the nutritional counseling element.

Counseling for Physical Activity

Today, many children spend hours watching TV and/or playing video games. A sedentary lifestyle feels like the norm. Creating an open forum to discuss physical activity is beneficial for change.

- Assess and document participation in physical activity or lack thereof.
- Document the type(s) and frequency of the activities.
- Help the sedentary child or adolescent identify a sport or activity they may like to try.
- Implement motivational interviewing.

NOTE:

- Document checklists and anticipatory guidance for physical activity as well as any educational materials provided during the visit.
- Documentation of the hours of non-physical activity alone **is not** sufficient for physical activity counseling.
- "Clearance" for participation in a sport or gym class alone **does not** satisfy the requirement for physical activity counseling.
- Safety first! A discussion about safety alone such as "wears helmet" without mention of a specific physical activity **does not** satisfy the requirement for physical activity counseling.

Parents often seek health care providers only when their children are ill. Be sure to encourage a Well-Child Visit to address height, weight, BMI percentile and counseling for nutrition and physical activity!

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For more information, visit the Blue Cross and Blue Shield of New Mexico provider website for our Childhood Obesity Toolkit.
https://www.bcbsnm.com/provider/clinical/childhood_obesity.html

[1] *U.S Preventive Services Task Force Recommendations* https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/obesity-in-children-and-adolescents-screening, "Obesity in Children and Adolescents: Screening"

[2, 3] *American Heart Association© (Internet 06/12/2017)* http://www.heart.org/HEARTORG/HealthyLiving/HealthyKids/ChildhoodObesity/Overweight-in-Children_UCM_304054_Article.jsp, "Overweight in Children"

[4, 5, 6] *Centers for Disease Control and Prevention* https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html, "About Child & Teen BMI"

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Identifying and Prescribing Correct Glucose Meter Test Strips

When prescribing glucose meter test strips, it is important to verify the type of glucose meter the patient is using and which test strips it requires. Some glucose meters have similar names, but require different types of test strips. The CONTOUR® NEXT and CONTOUR line of glucose meters require different test strips. CONTOUR test strips **will not** work in the newer CONTOUR NEXT glucose meters **and vice versa**.

How to identify CONTOUR NEXT and CONTOUR glucose meters:

- **These meters require CONTOUR NEXT test strips:**
  - COUNTER NEXT EZ meters have "CONTOUR NEXT EZ" written on the front of the meter.
  - CONTOUR NEXT LINK meters have a gray front panel and will have "CONTOUR NEXT LINK" written on the sticker on the back of the meter.
  - CONTOUR NEXT USB meters have "CONTOUR NEXT USB" written on the sticker on the back of the meter and will have a model number of 7411 or 9636.
- **These meters require CONTOUR test strips:**
  - CONTOUR and CONTOUR LINK meters have "CONTOUR" written on the front of the meter.
  - DIDGET meters have "DIDGET" written on the front of the meter.

  - CONTOUR USB meters will have “CONTOUR USB” written on the sticker on the back of the meter and will have a model number of 7393A.
- **Check test strip compatibility for CONTOUR NEXT and CONTOUR glucose meters at:** https://www.contournext.com/our-products/test-strips-and-lancing/test-strip-compatibility/

It is imperative to use the **full name** of the correct test strips when writing prescriptions. Failure to do so will delay patients receiving the proper strips from their local or mail-order pharmacy.

Glucose Meters Available for Free to BCBSNM Commercial Members

Blue Cross and Blue Shield of New Mexico (BCBSNM) members may receive a free CONTOUR NEXT glucose meter by calling 800-401-8440 or by visiting www.contournextfreemeter.com. More information about these meters can be found on the BCBSNM member website at https://www.bcbsnm.com/pdf/rx/glucose-meter-offer-nm.pdf.

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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.

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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HSD No Longer Issuing Separate Medicaid Cards for MCO-Enrolled Members

Effective Oct. 1, 2017, the New Mexico Human Services Department, Medical Assistance Division (HSD/MAD) will no longer issue Medicaid identification cards to Medicaid recipients who are enrolled with a Managed Care Organization (MCO).

Please note that as of Oct. 1, 2017, Medicaid recipients who enroll with Blue Cross Community Centennial℠ will *only* receive a Blue Cross and Blue Shield of New Mexico-issued member ID card, which shall include the member's name, group number, and MCI ID number. Letters accompanying ID cards will explain that members will not receive a separate Medicaid card from HSD.

Providers should continue to ask for the ID card from Blue Cross and Blue Shield of New Mexico, but should no longer ask Blue Cross Community Centennial members to present an ID card from HSD. Be sure to verify eligibility before furnishing covered services.

If you have any questions regarding this change, please contact your regional network provider representative at 1-800-567-8540.

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Screening for Clinical Depression Initiative

Blue Cross and Blue Shield of New Mexico (BCBSNM) is committed to promoting annual screening and follow-up treatment for depression in the primary care setting for Blue Cross Community Centennial members. Although many patients may present to their primary care office with physical symptoms such as pain, poor sleep, or poor appetite, their comorbid diagnosis of depression often goes unrecognized. Primary care physicians may not have the tools or the time needed to screen or treat such patients. BCBSNM understands these challenges and wants to help.

Did you know?

- Major Depressive Disorder (MDD) remains a treatable cause of pain, suffering, disability, and death.[1]
- Primary Care Clinicians detect MDD in only one-third to one-half of their patients who meet diagnostic criteria for MDD and about one-half of those in which MDD is detected go untreated.[2]
- Additionally, more than 80% of patients with depression have a medical comorbidity.[3]

What will you need and how will we help?

- For Blue Cross Community Centennial members, BCBSNM reimburses providers for administering an annual depression screening tool using procedure code G0444 (administration). Results are reported simultaneously with either G8431 (positive screen with plan) or G8510 (negative screen) result code.
    - *For dates of service July 1, 2017, through December 31, 2018, (or an earlier end-date as may be determined by HSD or BCBSNM), additional reimbursement will be provided for G8431 and G8510.*
        - *Add the modifier, U8, in the modifier section on the CMS 1500 when submitting the claim that includes G0444 with the addition of either G8431 or G8510.*

[1] Williams Jr. JW, Noel PH, Cordes JA, et al. Is this patient clinically depressed? JAMA 2002;287:1160-70.
[2] Schonfeld WH, Verboncoeur CJ, Fifer SK, et al. The functioning and well-being of patients with unrecognized anxiety disorders and major depressive disorder. J Affect Disord 1997;43:105-19.
[3] Klinkman MS. The role of algorithms in the detection and treatment of depression in primary care. JClin Psychiatry 2003;64[suppl 2]:19-23.

  - *Any reimbursement will be made according to Blue Cross Community Centennial medical/reimbursement policies for services and other billing and reimbursement practices.*
- The PHQ-9 is completed by patients in your office and is easily accessible in multiple languages at www.phqscreeners.com. The purpose of the PHQ-9 is to screen for depression.

Who should I screen?

- Blue Cross Community Centennial patients who are 18 years of age and older
- Blue Cross Community Centennial patients without an active diagnosis of depression, bipolar disorder or other mood symptoms

Patients who are not eligible for depression screening:

- Patients who have had an annual depression screen or refuse to participate
- Patients who are in an urgent or emergent situation where a delay in treatment may jeopardize the patient's health status
- Patients whose functional capacity or motivation to improve may impact the accuracy of results (e.g., certain court-appointed cases or cases of delirium)
- Patients who already have an active diagnosis of depression or bipolar disorder

To request additional assistance, you may contact your Provider Representative at BCBSNM or email Behavioral Health Quality Improvement at BHQualityImprovement@bcbstx.com.

[1] Williams Jr. JW, Noel PH, Cordes JA, et al. Is this patient clinically depressed? JAMA 2002;287:1160-70.
[1] Schonfeld WH, Verboncoeur CJ, Fifer SK, et al. The functioning and well-being of patients with unrecognized anxiety disorders and major depressive disorder. J Affect Disord 1997;43:105-19.
[1] Klinkman MS. The role of algorithms in the detection and treatment of depression in primary care. JClin Psychiatry 2003;64[suppl 2]:19-23.

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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;

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- 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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Blue Cross Medicare Advantage: Electronic Claim Submission Edits

Beginning Sept. 16, 2017, Blue Cross and Blue Shield of New Mexico (BCBSNM) will implement new electronic claim submission validation edits for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Professional and Institutional claims (837P and 837I transactions). These claim edits will be applied to claims during the pre-adjudication process to help increase efficiencies and to comply with Medicare data reporting requirements.

Currently, these validation edits impact Blue Cross Medicare Advantage claims throughout the claim adjudication process, as well as in post-adjudication encounter data reporting, which can result in claim rejects or denials for missing data elements. Providers submitting these claims electronically on or after Sept. 16, 2017, may see new edit messages on the response files from their practice management system or clearinghouse vendor(s) before the claim is adjudicated. These responses will specify if additional data elements are necessary. If you receive claim rejections, the affected claims must be corrected and resubmitted with the needed information as specified in the rejection message.

As a reminder, Blue Cross Medicare Advantage electronic claims that are submitted through Availity™ or Experian Health must be submitted using Payer ID 66006. If these claims are submitted via direct data entry through the Availity Web portal, providers should select the drop-down payer option of "Blue Cross Medicare Advantage." Providers who are not registered with Availity or Experian Health should contact their clearinghouses to confirm the appropriate Payer IDs to be used when submitting Blue Cross Medicare Advantage claims, as other clearinghouses may assign their own unique numbers.

If you have questions regarding an electronic claim rejection message, contact your practice management system software vendor, billing service or clearinghouse for

assistance. For additional information on electronic options, refer to the Claims and Eligibility/Electronic Commerce section of our Provider website.

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Government Programs: Claims Rejecting as Duplicate Submissions

This notice applies to claims submitted by government programs providers for the following Blue Cross and Blue Shield of New Mexico (BCBSNM) members:

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

Providers submitting electronic claims for any of the above-referenced government programs members may experience duplicate claim rejections if claims are resubmitted within 90 days of a previously processed claim that includes the exact data for the same patient and date(s) of service. However, duplicate claim rejections should not occur if the following elements are different on the resubmitted claim:

- Patient Control Number (Loop 2300 – CLM01 Data Element)
- Clearinghouse Trace Number (Loop 2300 – REF02 where REF01=D9)
- Line Item Control Number (Loop 2400 – REF02 where REF01=6R)

On April 13, 2017, an issue was identified where duplicate claim rejections occurred inaccurately for some electronically resubmitted government programs claims. This issue was resolved as of June 14, 2017, allowing these claims to process appropriately based on the elements referenced above. If you experienced this issue, the impacted claims may now be resubmitted for processing.

We apologize for any inconvenience this issue may have caused. If you use a billing service or clearinghouse, please share the above information with your vendor. As a

reminder, providers should avoid submitting the same claim multiple times to avoid duplicate rejections.

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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 the 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

organization with a Medicare contract and a contract with the New Mexico Medicaid program. Enrollment in HCSC's plans depends on contract renewal.

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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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