

BlueSaludSM

A Section of the

Blues Provider Reference Manual

BlueSalud Section of the *Blues Provider Reference Manual*

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BlueSalud: Overview and Introduction

Introduction

HCSC Insurance Services Company (HISC), a wholly-owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, has contracted with the State of New Mexico, Human Services Department, Medical Assistance Division (HSD/MAD), to offer BlueSalud plans. Blue Cross and Blue Shield of New Mexico (BCBSNM), as an operating division of HCSC has contracted with HISC to administer these programs.

This Section applies to Physician/Professional Providers and Facility Providers who have agreed to participate as BlueSalud Providers and who have signed agreements in place. The *Blues Provider Reference Manual* plus this Section explain the policies and procedures of the BlueSalud network. We hope it provides you and your office staff with helpful information as you serve BlueSalud members. The information is intended to provide guidance in most situations your office will encounter while participating in these programs. This Section of the *Blues Provider Reference Manual* is applicable only to the operation of BlueSalud.

BlueSalud Network

BlueSalud is a Medicaid Managed Care Plan which focuses on breaking down the financial, cultural and linguistic barriers preventing low-income families and individuals from accessing healthcare. BlueSalud maintains and monitors a network of Participating Physicians/Professional Providers including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers through which members obtain covered services.

Program Overview

Primary Care Provider (PCP)	The primary care provider must be a Participating Physician/Professional Provider who has the responsibility for supervising, coordinating and providing primary health care to Members and maintaining the continuity of the member's care. Individuals with special health care needs may designate a specialist as their primary care provider as long as that specialist agrees to act in that role.
Member	Unless otherwise noted, Member refers to BlueSalud Members enrolled in HISC's programs.
24-Hour Coverage	Participating PCPs are expected to provide coverage for Members 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has arranged for coverage from another PCP. Hospital emergency rooms or urgent care centers are not substitutes for covering Participating Physicians/Professional Providers. Please refer to the BlueSalud Provider Directory on-line at www.bcbsnm.com to identify providers participating in the BlueSalud network. You may also contact the Provider Customer Service Department at the number listed on the back of the Member's ID card with questions regarding which providers participate in the BlueSalud network.
Emergency Services	<p>Emergency services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical conditions manifesting themselves by acute symptoms of sufficient severity (including severe pain), that would lead a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or the unborn child) in:</p> <ul style="list-style-type: none">• Serious jeopardy of the patient's health• Serious impairment to bodily functions• Serious dysfunction of any bodily organ or part• Serious disfigurement <p>Emergency Care services necessary to evaluate and stabilize an Emergency Medical Condition are covered by BlueSalud. Members with an Emergency Medical Condition should be instructed to go to the nearest Emergency Provider. Evaluation and stabilization of an Emergency Medical Condition in a hospital or comparable facility does not require preauthorization.</p>
Experimental Procedures and Items	Experimental or investigational procedures, technologies or therapies, as defined in 8.325.6 NMAC, "Experimental or Investigational Procedures, Technologies or Non-Drug Therapies" are not covered[8.305.7.12 NMAC - Rp 8.305.7.12 NMAC, 7-1-04; A, 7-1-05].

Program Overview

Experimental Procedures and Items, continued

In general, experimental, investigational, or unproven means the procedure, technology, or therapy meets any of the following conditions:

- Current authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of drug(s), biological product(s), other product(s) or device(s) for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis and/or treatment outside an investigational setting;
- The drug, biological product, other product, device, procedure or treatment (the “technology”) lacks final approval from the food and drug administration (FDA) or any other governmental body having authority to regulate the technology;
- The medical, surgical, other health care procedure or treatment, including the use of drug(s), biological product(s), other product(s) or device(s) is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis and/or treatment outside an investigational setting.
[2/1/95; 12/1/99; 8.325.6.12 NMAC - Rn, 8 NMAC 4.MAD.765.2 & A, 6-1-03]

Medically Necessary Services

Clinical and rehabilitative physical, mental or behavior health services that are essential to prevent, diagnose or treat medical conditions, and are essential to enable the Member to attain, maintain, or regain functional capacity. Those services are delivered in the amount, duration, and scope and setting that are clinically appropriate to the specific physical, mental and behavioral health care needs of the individual. The services are provided within professionally accepted standards of practice and national guidelines, are required to meet the physical, mental and behavioral needs of the individual, and are not primarily for the convenience of the individual, the provider, or the payer.

In interpreting medical necessity for the Salud program, BCBSNM follows MR:03-52, 8.302.1.7 NMAC – N, 12-1-03 where medically necessary services are defined as:

1. Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:
 - Are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

Program Overview

- Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;
 - Are provided within professionally accepted standards of practice and national guidelines;
 - Are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.
2. Application of the definition:
 - A determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit.
 - The department or its designee making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the Medicaid benefit package applicable to an eligible individual shall do so by:
 - a. Evaluating individual physical, mental and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
 - b. Considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views, and;
 - c. Considering the services being provided concurrently by other service delivery systems.
 3. Physical, mental and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness, or condition.
 4. Decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

Program Overview

Selected Benefits

Service	PCP Directed
Professional Services <ul style="list-style-type: none"> • PCP Office Visits • Inpatient Professional Services • Injections • Allergy Testing • Mammography Screening • Cytological Screening (pap smear) • Specialty Office Visits 	<ul style="list-style-type: none"> • Covered • Covered • Covered • Covered • Covered • Covered • Covered
Preventive Care <ul style="list-style-type: none"> • Physical Exams • Well Child Care • Immunizations 	<ul style="list-style-type: none"> • Covered • See EPSDT Program • Covered
Lab & X-Ray	<ul style="list-style-type: none"> • Covered at Contracted facility
Obstetrics/Gynecological (OB/GYN) <ul style="list-style-type: none"> • Maternity Care • Gynecological Office Visits 	<ul style="list-style-type: none"> • Notification Required • No referral required
Family Planning Services	<ul style="list-style-type: none"> • No referral required
Dental Services	<ul style="list-style-type: none"> • Doral Dental
Vision Services	<ul style="list-style-type: none"> • Davis Vision
Transportation Services (nonemergency transportation– prior authorization required)	<ul style="list-style-type: none"> • Logisticare

Behavioral Health

Contact **OptumHealth New Mexico** toll free at **1-866-660-7185** for ALL behavioral health services for BlueSalud Members. Services include, but are not limited to:

- Member services
- Provider services
- Claims
- Benefits
- Eligibility

Program Overview

Early & Periodic Screening, Diagnostic & Treatment (EPSDT)

The EPSDT Program is a federally mandated program ensuring comprehensive health care to Medicaid recipients from birth to 21 years of age. EPSDT visits include:

- Comprehensive health and development history*
- Comprehensive unclothed physical exam*
- Appropriate immunizations according to the most current Advisory Committee on Immunization Practices (ACIP) schedule*
- Laboratory tests, including an appropriate lead blood level assessment. An appropriate lead blood level assessment must be completed at 12 months and 24 months (filter paper test may be used).*
- Hematocrit/Hemoglobin at 9 months and 13 years
- Health education*
- Anticipatory guidance
- Nutrition screening
- Measurements – height, weights, and body mass index (BMI)
- Developmental/Behavioral assessment
- Any screenings necessary according to risk factors
- Dental screening
- Vision and hearing testing

*These bullets must be documented in order to fulfill the requirement of an EPSDT exam. Bullets 1-3 must be documented in order to meet HEDIS criteria. .

Centers for Medicare and Medicaid Services (CMS) has mandated that the following visit codes be used to capture all EPSDT visits:

- 99381 New Patient under one year
- 99382 New Patient (ages 1- 4 years)
- 99383 New Patient (ages 5 – 11 years)
- 99384 New Patient (ages 12 – 17 years)
- 99385 New Patient (ages 18 – 39 years)
- 99391 Established Patients under one year
- 99392 Established Patients (ages 1 – 4 years)
- 99393 Established Patients (ages 5 – 11 years)
- 99394 Established Patients (ages 12 – 17 years)
- 99395 Established Patients (ages 18 – 39 years)
- 99431 Newborn Care (history and examination)
- 99432 Normal Newborn Care

Program Overview

EPSDT,
continued

In addition, the above CPT-4 codes must be used in conjunction with V Codes V20 – V20.2 and/or V70.0 and V70.3 – V70.9. The V Code descriptions are as follows:

- V20 Health Supervision of infant or child
- V20.0 Foundling
- V20.1 Other healthy infant or child receiving care
- V20.2 Routine infant or child health check
- V70.0 Routine medical examination at a health care facility
- V70.3 Other medical examination for administrative purposes
- V70.4 Examination for medicolegal reasons
- V70.5 Health examination of defined populations
- V70.6 Health examination in populations surveys
- V70.7 Examination for normal comparison or control in clinical research
- V70.8 Other specified general medical examinations
- V70.9 Unspecified general medical examination

When a provider is seeing a child who is ill and a Tot To Teen health check is due, the provider may perform and bill for the health check as an additional service if the illness does not interfere with the health check.

For more information about EPSDT services, please refer to the [Keeping Kids Healthy](#) web page, and the [Program Policy Manual](#).

**Family
Planning**

Family Planning Services include but are not limited to:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated
- Screening, testing and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider/practitioner
- Provision of contraceptive pills
- Provision of devices/supplies
- Tubal ligations
- Vasectomies
- Pregnancy testing and counseling

Program Overview

Children With Special Health Care Needs (CSHCN)

The CSHCN program is defined as individuals less than 21 years of age, who have or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. Examples of common diagnosis include:

- Asthma
- Diabetes
- Congenital Anomalies
- Metabolic Disorders
- ADHD
- Behavioral Health Diagnosis
- Congenital Heart Disease

Individuals With Special Health Care Needs (ISHCN)

The ISHCN program is defined as individuals who have or are at an increased risk for a chronic physical, developmental, behavior, neurobiological or emotional condition, or have low to severe functional limitations and who also require health and related services of a type or amount beyond that required by individuals generally. Examples of common diagnosis include:

- Asthma
- Diabetes

Individuals With Special Health Care Needs (ISHCN),

continued

Medicaid Member Financial Responsibilities

- Congenital Anomalies
- Metabolic Disorders
- ADHD
- Behavioral Health Diagnosis
- Congenital Heart Disease

Providers who participate in Medicaid agree to accept the amount paid as payment in full per 42 CRF 447.15, with the exception of co-payment amounts required in certain Medicaid categories. Other than co-payments, a provider may not bill a Member for any unpaid portion of the bill or for a claim that is not paid because of a provider administrative error or failure of multiple providers to communicate eligibility information. Native Americans are exempt from co-payment requirement.

Aside from co-payments, a provider may not bill a Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- Failure to follow managed care policies: A Member must be aware of the providers, pharmacies, facilities, and hospitals that are contracted with BlueSalud.
- Denied emergency room claims: A Member is responsible for payment of a hospital outpatient emergency room visit if it is

Program Overview

determined that an emergency did not exist at the time the service was provided. The Member may only be billed for emergency room charges, but cannot be billed for the ancillary charges (e.g., laboratory and radiology services).

- Other Member responsibilities:
 - The Member has been advised by the provider that the service is not a covered benefit
 - The Member has been advised by the provider that he/she is not contracted with BlueSalud
 - The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment

Native Americans

Native Americans can choose to participate in BlueSalud or remain in fee-for-service (FFS) Medicaid (exempt). Native Americans who choose to participate in BlueSalud are subject to the same lock-in provisions as other BlueSalud Members.

Newborn Enrollment

Medicaid eligible and enrolled newborns of Salud! eligible enrolled mothers are eligible for a period of twelve (12) months starting with the month of birth. When a child is born to a mother enrolled with BlueSalud hospitals or other medical providers, a Notification of Birth ([MAD Form 313](#)) must be completed by the hospital or other Medicaid provider prior to, or at the time of discharge, to ensure that Medicaid eligible newborn infants are enrolled and medically covered as soon as possible following the birth. The child will be enrolled in the same MCO as the Salud! enrolled mother. Do not submit claims for a newborn with the mother's ID number.

Provider Satisfaction Survey

BCBSNM will conduct an annual Provider Satisfaction Survey for BlueSalud providers following NCQA guidelines and provide the results in report MAD #19 to the New Mexico Human Services Department (HSD) and the Medical Assistance Division (MAD). Summary results are also published in the provider newsletter, Blue Review, and on the provider web page on bcbsnm.com.

State Children Health Ins. Program (SCHIP)

Children eligible for category 071 with family income between 185-235% of poverty will have co-payment requirements. There are no co-payments required during presumptive eligibility or retroactive eligibility periods.

Working Disabled

Adults who qualify for Medicaid and are employed but not considered disabled will have a co-payment that is consistent with the SCHIP program under category 074.

- It is the responsibility of the provider to collect any and all applicable co-payments.
- It is the responsibility of the family to track and total the co-payments

Program Overview

paid. The family has to provide the Medical Assistance Division (MAD) verification that the co-payment maximum has been paid.

- Co-payment maximums are calculated at initial determination of eligibility by the Income Support Division (ISD).
- There is a co-payment requirement for a missed appointment. Based on standard provider practice, a member may be billed for cancellation of an appointment without adequate notice.

Claims

ID Cards & Verification of Coverage


Each Member will receive an identification (ID) card containing the Member's name, Member ID number, and information about their benefits.

At each office visit, your office staff should:

- Ask for the Member's ID card
- Copy both sides of the Member's ID card and keep the copy with the patient's file
- Determine if the Member is covered by another health plan and record information for coordination of benefits purposes. If the Member is covered by another health plan(s), the provider must submit to the other carrier(s) first. After the other carrier(s) pay, submit claim to BCBSNM.
- Refer to the Member's ID card for the appropriate telephone number to verify eligibility.

Sample of ID Card

Front of Card:

 BlueCross BlueShield of New Mexico An Independent licensee of the Blue Cross and Blue Shield Association	
Subscriber Name:	BlueSalud SM
PATIENT NAME	
Identification No.	
XXX999999999	
Group Number: 999999	OFFICE VISIT \$0
Plan:	EMERGENCY ROOM \$0
	URGENT CARE \$0
	HOSPITAL \$0
PCP: My Provider M.D.	
505-999-9999 03/01/09	
	RxBIN: 099999
	RxPCN: NMDR
	R_x

Back of Card:

www.bcbsnm.com	
 BlueCross BlueShield of New Mexico	
For care received in and outside of New Mexico: Blue Cross and Blue Shield of New Mexico Claims Dept. P.O. Box 27838 Albuquerque, NM 87125-7838 Some in-network services may need prior-authorization. Most out-of-network services will require prior-authorization. Special Beginnings Members must call within the first trimester of pregnancy to enroll in the mandatory maternity program.	Customer Service 1-866-689-1523 Medical/Pharmacy 1-866-689-1523 BH/OptumHealthNM* 1-866-660-7185 SpecialBeginnings* 1-800-395-2229 24/7 Nurseline 1-800-973-6329 Ride Assist* 1-866-418-9829 Reserve Transport* 1-866-913-4342 Davis Vision 1-877-393-2393 *Not a BCBS Product
	BlueCross BlueShield of New Mexico, a Division of Health Care Service Corporate, a Mutual Legal Reserve Company, an Independent Licensee of BlueCross BlueShield Association
	
	Pharmacy Benefits Manager

Claims

Claims Process Participating Physicians/Professional Providers and Facility Providers are strongly encouraged to submit claims within 90 days of the date of service, using the standard CMS-1500 or UB04 Claim Form or electronically as discussed below. Services billed beyond 180 days from the date of service are not eligible for reimbursement. Participating Physicians/Professional Providers and Facility Providers may not seek payment from the Member.

To expedite claims payment, the following items must be submitted on your claims:

- Member's name
- Member's date of birth and sex
- Member's ID number
- Individual Member's Group number, where applicable
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-9 Diagnosis Codes
- CPT Procedure Codes
- Date(s) of service(s)
- Charge for each service
- Provider's Tax Identification Number
- Provider NPI Number (Type 1 and Type 2 if applicable)
- Name/address of Participating Physician/Professional Provider
- Signature of Participating Physician/Professional Provider providing services.
- Place of Service Code
- Prior Authorization number if required

BCBSNM will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to BCSBNM should comply with those requirements.

Claims

Claims Submission Information

Claims should be submitted as follows:

- Claims should be submitted electronically through Availity Health Information Network for processing.
- The BlueSalud Electronic Payer ID # for Participating Physicians/Professional Providers and Participating Facilities is 00790.
- For information on electronic filing of claims, contact Availity at **1-800-282-4548**.
- Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. BlueSalud Physician/Professional and Facility Providers may not seek payment from the Member.
- **Paper claims** must be submitted on the Standard CMS-1500 (Physician/Professional Provider) or CMS-1450 (UB04 – Facility) claim form to:

**Medicaid
P.O. Box 27838
Albuquerque, NM 87125-7838**

- Claims (electronic and paper) must be filed with the Member's complete ID number exactly as it is shown on the member's ID card, including the following 3-digit alpha prefix: **YIF**.

Claims containing substantially all the required data elements necessary for accurate adjudication ("clean claim") without the need for additional information pay within thirty (30) calendar days of receipt.

Duplicate claims may not be submitted prior to the applicable 30-day claims payment period.

Claims

Coordination of Benefits

If a Member has coverage with another plan that is primary to Medicaid, you must submit a claim for payment to that plan first. The amount payable by BlueSalud will be governed by the amount paid by the primary plan and Medicaid secondary payer law and policies. As specified in New Mexico MAD guidelines, Medicaid Salud!, and conversely BlueSalud, is the payer of last resort for BlueSalud Members. Claims must be submitted within 180 days from the other insurance paid date.

Billing for Non-covered Services

You may not bill a Member for a non-covered service unless:

- You have informed the Member in advance that the service is not covered; and
- The Member is informed by a Participating Physician/Professional Provider of the necessity, options, and charges for the services, and the option of going to another Participating Physician/Professional Provider who is a Medicaid provider; and
- The Member has agreed in writing to pay for the services if they are not covered.

Hold Member Harmless

Participating Physicians/Professional Providers and any sub-contractors of Provider agree that in no event, including but not limited to nonpayment by the Corporation, insolvency of the Corporation, or breach of signed Agreement, shall Participating Physicians/Professional Providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member to whom health care services have been provided, or person acting on behalf of the Member for health care services provided. Participating Physicians/Professional Providers shall not be prohibited from collecting any outstanding deductible, coinsurance, or copayment, if applicable, or collection of payment for noncovered services from the Member. Remaining balances shall be treated as contractual adjustments by Participating Physicians/Professional Providers and shall not be billed to the Member. Members may not be charged for any unpaid portion of the bill or for a claim that is not paid because of a provider administrative error or failure.

Encounter Reporting

BCBSNM is required by New Mexico Human Services Department (HSD), to report ALL services rendered to BlueSalud Members. The reporting of these services, also known as encounter reporting, is an extremely critical element to the success of BlueSalud. HSD uses encounter reporting data to evaluate health plan compliance on many vital issues. Regardless of whether the service you provide is capitated or fee-for-service, claims should be submitted to BCBSNM within 90 days of the date of service to accommodate the State of New Mexico's request for timely encounter data. BlueSalud is required to submit encounter data to the State of New Mexico within 120 days. This would also include claims for which you expect no reimbursement from BCBSNM because another payer has already paid the claim in full.

Claims

**Provider
Claim
Summary
(PCS)**

Provider Claim Summaries (PCSs) for BlueSalud will be generated no differently than our other lines of business. The Member's share will be calculated based on the type of service, benefits, etc. The Explanation of Benefit (EOB) will not be sent to Members for the BlueSalud line of business.

Claim Disputes

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the BCBSNM Provider Customer Service Department at the number listed on the Key Contacts page. Claims returned as a dispute or with additional information must be returned to BCBSNM within 30 days of the receipt. If corrected claims are not resubmitted within 30 days, there is a risk of being denied for timely filing if the original date of service is greater than 180 days.

**Deficit
Reduction Act
(DRA)**

In an effort to deter and prevent fraud, waste, and abuse, health care entities who receive or pay out at least \$5 million in Medicaid funds per year must now comply with the DRA Section 6032, Employee Education about False Claims Recovery.

Participating Physicians/Professional Providers must establish written policies for all employees, including management, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. These written policies must include a specific discussion of the applicable laws and detailed information regarding Medical Services Entity's policies and procedures for detecting and preventing fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers. Medical Services Entity shall include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the Provider/Subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse.

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

Quality Improvement Program

Quality improvement is an essential element in the delivery of care and services to Members. To define and assist in monitoring quality improvement, the BlueSalud Quality Improvement Program focuses on measurement of clinical care and service delivered by Participating Physicians/Professional Providers and Facility Providers against established goals. The Quality Improvement Program is described in the Quality Management and Improvement section of the *BCBSNM Blues Provider Reference Manual*.

Utilization Management Program

The Utilization Management Program includes:

- Prospective review (referrals, prior authorization, and precertification)
- Concurrent review
- Discharge planning
- Retrospective review

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

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

BCBSNM clinical staff ensures appropriate utilization of medical services by:

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

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

Self-Referrals

PCP Referral Process

- PCPs do not have to notify BCBSNM for referrals to contracted specialists. Members may self refer to in-network specialists.
- Prior authorization is required from BCBSNM for services to non-contracted specialists before the services are rendered.
- Services rendered to Members by non-contracted providers without appropriate medical referrals or prior authorizations will not be considered for reimbursement, or will be processed at a lower benefit level for the patient.

In-Network Specialists

- Members may self-refer to in-network specialists. Authorizations must be obtained for services requested for non-contracted providers.

Referrals to Out-of-Network Providers

- Authorizations for referrals to out-of-network providers must be obtained through Health Services and are subject to the prior authorization process.
- Authorizations for referrals to out-of-network providers are valid for one (1) visit for six (6) months from the date the request is entered into the information system.

Behavioral Health

- Services for behavioral health and substance abuse are provided through OptumHealth New Mexico for BlueSalud.

Obstetrical/Gynecological Services

- Female Members can self-refer to in-network providers for routine OB/GYN services.

Family Planning Services

- Members can self-refer to in-network and out-of-network family planning providers in the State of New Mexico. Family planning providers include PCPs, OB/GYNs, Planned Parenthood clinics, and Department of Health clinics.

Prior Authorization

Unless otherwise prohibited by law, prior authorizations are necessary for certain services before they are rendered. Authorizations are based on benefits as well as medical necessity, which are supported through clinical information supplied by requesting physicians. Prior authorizations can be obtained by calling the BCBSNM Medicaid program number at **1-888-349-3706**.

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

BlueSalud Preauthorization Requirements	
Service	Preauthorization required?
Ambulance services <ul style="list-style-type: none"> • Nonemergency ground transportation • Air ambulance 	YES
Behavioral Health care	Call OptumHealth New Mexico, 866-660-7185
Bone mass measurement	NO
Case management	YES
Chemical Dependency care	Call OptumHealth New Mexico, 866-660-7185
Colorectal screening exams	NO
Devices (all devices except blood glucose monitors)	YES
Diabetes self-monitoring training and supplies	NO
Diabetic counseling	NO
Diabetic shoes, mycotic nails	YES – member must meet the criteria for routine foot care
Diagnostics <ul style="list-style-type: none"> • Elective MRI, MRA, CT, and PET scans (not through AIM) • Elective nuclear cardiology procedures 	YES
Dialysis	NO
Diapers and underpads	YES – this is a medical benefit, not a pharmacy benefit. After the initial preauthorization, the member receives automatic subsequent authorization.
Dietary and nutritional services	YES
DME, prosthetics, orthotics, and ostomy <ul style="list-style-type: none"> • DME • External prosthetic appliances • Hearing aids • Orthotics 	YES – if greater than \$1,000
Emergency care	NO
Home birth	YES – need release of liability form signed by member
Home health care	YES
Home infusion therapy (HIT)	YES
Hospice care – outpatient	NO
Hospital admissions – in patient <ul style="list-style-type: none"> • Acute hospital care • Acute rehabilitation facility • Inpatient hospice • Skilled nursing facilities (SNFs) • Subacute care similar to SNF 	YES
Immunizations	NO

Laboratory services (outpatient)	NO
Mammograms (annual screening for members over 40)	NO
Medications <ul style="list-style-type: none"> • Injectable medications provided in the physician's office when greater than \$200 on a single date of service, excluding chemotherapy • Home health care • Home infusion therapy 	YES – check for the latest list of medications requiring prior authorization on bcbsnm.com . Note: <ul style="list-style-type: none"> • Indian Health Service (IHS) is not restricted to formulary. • IHS prior authorization is required to assure use of injectible Specialty Pharmacy medications.
Out-of-network services	YES – not required for Native Americans using IHS facilities, for family planning, or for emergency care.
Outpatient services (outpatient facility-based services not included on this list)	NO
Pap smears and pelvic exams	NO
Personal care services/self-care	YES
Physician office visits	NO
Podiatry services	NO
Private-duty nursing	YES
Prostrate cancer screening exams	NO
Rehabilitation (outpatient)	YES
Temporomandibular joint (TMJ) (not a covered benefit)	NO
Therapies <ul style="list-style-type: none"> • Cardiac – prior to first visit (when provided by participating physician/professional provider) • Physical, speech, and occupational – prior to first visit (when provided by participating physician/professional provider) • Early Childhood Evaluation Program (ECEP) developmental evaluations • Family/infant/toddler (FIT) evaluations • Preschool Infant Evaluation (PIE) program evaluations 	YES YES YES YES NO – part of school-based program
Treatments and dental procedures <ul style="list-style-type: none"> • Anesthesia for dental work • Oral surgery • Treatment of injury to sound and natural tooth 	YES
Treatments and medical procedures <ul style="list-style-type: none"> • Carpal tunnel surgery • Cleft lip and palate repair • Infertility treatment (check with BCBSNM) • Pain management procedures • Reconstructive cosmetic procedures • Septoplasty • Transplants <ul style="list-style-type: none"> ○ Evaluation 	YES

<ul style="list-style-type: none">○ Listing○ Inpatient transplant● Treatment of varicose veins● Uvulopharyngopaletoplasty	
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NOTE: *Whether the services are Medically Necessary must be determined before an authorization number will be issued. **Claims received that do not have a preauthorization number will be denied.** Providers may not seek payment from the Member when a claim is denied for lack of a preauthorization number.*

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

Timeliness of Decisions & Notifications

Routine Precertification	<ul style="list-style-type: none"> • Decision – to be rendered < 14 calendar days from receipt of request for services • DME – new to be rendered within 7 working days, allow a longer period of time for DME repairs • Notification – provider shall be notified within one working day of making decision for authorization or denial of non-urgent (routine) care • Denial confirmation – For non-urgent (routine) care, the member and provider will be given written or electronic confirmation for the decision within 2 working days of making the decision.
Urgent Precertification	<ul style="list-style-type: none"> • Decision & notification – shall occur 72 hours of receipt of request. For denials of urgent care, the member and provider will be notified that an expedited appeal has already occurred. • Denial confirmation – The member and provider will be given written or electronic confirmation for the decision within 2 working days of making the decision.

Clinical Review Criteria

The Utilization Management/Case Management Committee will review and approve the utilization management processes and clinical review criteria used to determine medical necessity. BCBSNM currently uses Milliman CareGuide QI Guidelines[®] clinical protocols and screening criteria to screen preauthorization and concurrent review requests. For more information, please contact the UM Department at **1-888-349-3706**.

BCBSNM may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to Participating Physicians/Professional Providers via the BCBSNM Web site and *Blue Review* provider newsletter. Clinical Practice Guidelines are published in the *Blues Provider Reference Manual* and are also located on BCBSNM's Web site at www.bcbsnm.com.

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

Utilization Management Appeals Address

Member appeals regarding authorization or termination of coverage for a health care service should be mailed or faxed as follows:

- To file your grievance, call **1-866-689-1523**, or write to:
BlueSalud
ATTN: Grievance Coordinator
P.O. Box 27838
Albuquerque, NM 87125-7838
FAX: 1-888-240-3004
- To file your appeal, call **1-877-232-5520**, or write to:
BlueSalud
ATTN: Appeals Coordinator
P.O. Box 27838
Albuquerque, NM 87125-7838
FAX : 1-888-240-3004

For an Expedited Appeal Only, call: 1-877-232-5520

Health Risk Assessment

A health risk assessment (HRA) questionnaire will be sent to Members as a component of the enrollment materials. Medical Care Management staff will evaluate results and:

- Identify health care needs;
- Assist with access to health care services;
- Assist with coordination of care;
- Provide telephonic educational or written materials via mail as needed; and
- Refer Members to appropriate case and disease management programs as needed.

Disease Management Programs

The Disease Management Programs include but are not limited to:

- Asthma for adults and children
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Hypertension
- Obesity

Member participation is voluntary. Members receive telephonic health coaching, assessment of educational needs, gaps-in-care, psychosocial needs and assessment of readiness to change. Members are also provided with hard

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

Disease Management Programs, continued

copy educational information to enhance self-management of their condition.

In an effort to increase compliance with medications and other treatment regimens as ordered by their treating physician, Members are encouraged to track their own symptomology and vital signs. The treating Physician/Professional Provider is an integral part of the disease management program.

In addition, Special Beginnings[®] prenatal care management is included to reduce the risk of premature babies. Any member who is an expectant mother with maternity coverage may enroll in Special Beginnings at no cost. It includes a health risk assessment; educational materials; a 24-hour nurse line, **1-800-395-BABY (2229)**; and OB case management for high-risk pregnancies.

For additional information on Disease Management Programs, call the Disease Management Department at **1-888-349-3706**.

Disease Reporting

As required by the State of New Mexico, Human Services Department (HSD), all Participating Physicians/Professional Providers are required to report all applicable diseases as listed in the Notifiable Diseases/Conditions in New Mexico. Any confirmed or suspected diseases require immediate reporting by telephone to the Office of Epidemiology at **505-827-0006**.

All reports must include the following:

- The disease or problem being reported
- Patient's name, date of birth, age, gender, race/ethnicity, address and telephone number
- Physician's (or laboratory) name, NPI number and telephone number
- Other conditions of public health importance

Individual Case Management

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

Key points in case management include:

- Case management referrals are accepted and encouraged from physicians, members, facilities, and community providers.
- Early patient identification and intervention can support the member and improve coordination of care.

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

Individual Case Management, continued

- Flexibility of benefits may occur when the proposed service has a considerable positive impact on the recovery of the patient.
- Case managers work closely with physicians and ancillary providers and communicate with them by phone, onsite at the facility, and in team conferences. If notification is required, the nurses will contact the facility or provider's office prior to an onsite visit or attendance at a team conference. During any onsite activity, case managers will wear a photo ID with their full name and other company identification. Case Managers will check in with the appropriate area upon arrival.
- Case managers are available to attend provider visits with a member or make home visits.
- Case managers, in conjunction with the treatment team and family, are advocates for the member.
- All **transplants** must be performed within the BCBSNM transplant network or affiliated BCBSNM centers. The case manager will work with the provider to accomplish this. **Transplant services, including the evaluation, must be approved. The case manager will assist with this process.**

If you would like to refer a patient for case management, please call Health Services. See the phone directory on page S51. CM can also be contacted 24 hours a day, seven days a week, by leaving a voice mail at 1-888-349-3706. You will be contacted the next working day.

Care Coordination

Care coordination is a BCBSNM service to assist Members (and their families) with multiple, complex, cognitive, physical or special health care needs. The care is member-centered, family-focused (when appropriate), and culturally competent.

Care Coordination is a process that reviews, plans and helps Members find options and services to meet their health and/or social needs. BCBSNM has a team of medical case coordinators to provide these services. Care coordination works closely with Participating Physicians/Professional Providers to develop a Member care plan designed to meet the Member needs.

Care coordination helps ensure the Member's medical needs are fully identified and the necessary services are provided and coordinated by:

- Providing a designated person who is primarily responsible for coordinating the Member's health care services
- Ensuring access to providers who are experts for Members with

Care Management, Quality Improvement, Utilization Review and Disease Management Programs

- special needs
- Assisting with coordination of medical and behavioral health services
- Interface and collaborate with a Member's case manager if applicable. The care coordinator may also refer the Member to case management as needed.

For questions regarding the BCBSNM BlueSalud care coordination services, contact Case Management Programs at **1-888-349-3706**.

Cooperation

Participating Physicians/Professional Providers and Facility Providers must comply and cooperate with all BlueSalud Medical Management policies and procedures and the BlueSalud Quality Assurance and Performance Improvement Programs. In addition, Participating Physicians/Professional Providers and Facility Providers must cooperate with BCBSNM and requests from External Quality Review Organization (EQRO) retained by HSD/MAD, New Mexico Medical Review Association (NMMRA), as well as any medical review agencies authorized by the Human Services Department (HSD) to perform medical review or investigations.

Provider Performance Standards and Compliance Obligations

Provider Compliance with Standards of Care

BlueSalud Participating Physicians/Professional Providers (PP/PPs) must comply with all applicable laws and licensing requirements. In addition, covered services must be furnished in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. BlueSalud standards must be complied with, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity)
- All federal, state, and local laws regarding the conduct of their profession

BlueSalud policies and procedures must also be complied with regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Preauthorization requirements and timeframes
- Credentialing requirements
- Care Management and Disease Management Program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of Member medical record information to fulfill the business and clinical needs of BlueSalud
- Providing treatment to patients at the appropriate level of care
- Maintaining a collegial and professional relationship with BlueSalud personnel and fellow PP/PPs
- Providing equal access and treatment to all BlueSalud Members

PP/PPs acting within the lawful scope of practice are advised to inform Members about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered, and any abnormal medical or lab test results), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Such actions shall not be considered non-supportive of BlueSalud and BlueSalud will never adopt any policy or practice that prohibits PP/PPs from advising Members about their health status, medical care or treatment options.

PP/PPs shall provide an interpreter when the Member does not speak or understand the language that is being spoken.

Provider Performance Standards and Compliance Obligations

Primary Care Physician Responsibility

PCP responsibilities will include the following per MAD-MR:07-10, 8.305.6.12:

- 24-hour, seven day a week access to care
- Coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy
- Maintenance of current medical record for the Member, including documentation of services provided to the Member by the PCP and specialty or referred service
- Ensuring the provision of services under the EPSDT program is based on the periodicity schedule for Members under age 21
- Vaccinating Members in their office and not refer Members elsewhere for immunizations
- Ensuring the Member receives appropriate prevention services for his age group
- Ensuring that care is coordinated with other types of health and social program providers
- Governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed
- Governing how coordination with the PCP and hospitalists will occur when an individual with a special health care need is hospitalized

Laws Regarding Federal Funds

Payments that Participating Physicians/Professional Providers (PP/PPs) receive for furnishing services to Members are, in whole or part, from Federal funds. Therefore, PP/PPs and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination in Employment Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

Sanctions under Federal Health Programs and State Law

Participating Physicians/Professional Providers (PP/PPs) certify that to the best of their knowledge neither they or their employees or subcontractors have been: (a) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (federal, state or local) contract or subcontract; (b) listed by a federal governmental agency as debarred; (c) proposed for debarment or suspension or otherwise excluded from federal program participation; (d) been convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not

Provider Performance Standards and Compliance Obligations

Sanctions under Federal Health Programs and State Law, continued

limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; or (e) within a three (3) year period preceding the date of this Agreement, had one or more public transactions (federal, state or local) terminated for cause or default.; (f) have not been excluded from participation from Medicare, Medicaid, federal health care programs or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7 and other applicable federal statutes. PP/PP certifies that public sources of information are checked to confirm that its Vendors have not been (a) listed by a federal governmental agency as debarred; or (b) proposed for debarment or suspension or otherwise excluded from federal program participation.

Participating Physician/Professional Provider (PP/PPs) must disclose to BCBSNM whether the PP/PPs or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of New Mexico; the federal government; or any public insurer. BCBSNM must be notified immediately if any such sanction is imposed on a PP/PP, a staff member or subcontractor. Note: Federal Exclusion website: <http://oig.hhs.gov/fraud/exclusions.html>.

Cultural Competency & Diversity

Participating Physicians/Professional Providers (PP/PPs) must understand cultural competency as it pertains to their practice. Cultural competency refers to a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

PP/PPs are encouraged to respect and value human diversity and make a good faith, reasonable effort to utilize minority, women, and disabled owner business enterprises in the performance of services provided under the BlueSalud program.

PP/PPs are expected to provide an interpreter when the Member does not speak or understand the language that is being spoken.

Provider Performance Standards and Compliance Obligations

Employee Abuse Registry Act

All Participating Physicians/Professional Providers covered by the Employee Abuse Registry Act, NMSA 1978 Sections 27-7A-1 to 27-7A-8, are required to inquire of the Department of Health's Employee Abuse Registry ("Registry") as to whether an employee is included in the Registry before hiring or contracting with the employee.

Participating Physicians/Professional Providers covered by the law include, but are not limited to, intermediate care facilities for the mentally retarded, rehabilitation facilities, home health agencies, group homes, adult foster care homes, homes for the aged or disabled, a case management entity that provides services to elderly people or people with developmental disabilities.

Participating Physicians/Professional Providers must document that they have checked the Registry for each applicant before the applicant was considered for employment or contract.

Participating Physicians/Professional Providers cannot hire or contract with an employee in a direct care setting who is included in the Registry.

Marketing or Outreach Activities

Physician/Professional Providers cannot engage in any marketing or outreach activities without prior approval from BCBSNM. All marketing or outreach activities must comply with state and federal guidelines.

Selection and Retention of Participating Physicians/Professional Providers

Participation Requirements

To participate in BlueSalud, the Physician/Professional Provider or Facility Provider:

- Must be a Participating Physician/Professional Provider with BCBSNM
- Must have privileges at one of the BlueSalud participating hospitals (*unless inpatient admissions are uncommon or not required for the Physician's/Professional Provider's specialty*)
- Must have a valid National Provider Identifier (NPI)
- Must sign a Medicaid Amendment to his/her Medical Services Entity Agreement with BCBSNM
- Cannot have any sanctions or reprimands by any licensing authority or review organizations. Participating Physicians/Professional Providers cannot be named on the Office of the Inspector General (OIG) or Government Services Administration (GSA) lists which identify physicians/professional providers and facilities found guilty of fraudulent billing, misrepresentation of credentials, etc. Participating Physicians/Professional Providers cannot be sanctioned by the Office of Personnel Management or prohibited from participation in the Federal Employees Health Benefit Program (FEHBP)

Credentialing & Recredentialing of Participating Physician/Professional Providers

BCBSNM continuously reviews and evaluates information and recredentials Participating Physicians/Professional Providers every three years. The credentialing guidelines are subject to change based on industry requirements and BlueSalud standards.

Credentialing & Recredentialing of Participating Institution Providers

BCBSNM continuously reviews and evaluates Institution Provider information and recertifies Institution Providers every three years. The certification guidelines are subject to change based on industry requirements and BlueSalud standards.

Selection and Retention of Participating Physicians/Professional Providers

Appeal Process for Provider Participation Decisions

If BCBSNM decides to suspend, terminate or non-renew a Provider's participation status, BCBSNM will give the affected Provider written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the Provider and the numbers and mix of Providers needed for the BlueSalud network.

BCBSNM will allow the Provider to appeal the action to a hearing panel, and give the Provider written notice of his/her right to an appeal hearing and the process and timing for requesting a hearing. BCBSNM will ensure that the majority of the hearing panel members are peers of the affected Provider. A recommendation by the hearing panel is advisory and is not binding on BCBSNM.

When BCBSNM terminates a provider from the network, it notifies the provider in writing at least 90 calendar days in advance of the effective date of the termination, unless BCBSNM determines there is imminent risk to the health and safety of its Members. This is in accordance with the expedited termination process described in Section 11.4.6 of the BCBSNM Blues Provider Reference Manual.

If a reduction suspension or termination of a Participating Physician/Professional Provider's participation is final and is the result of quality of care deficiencies, BCBSNM will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician/professional provider groups must certify that these procedures apply equally to physicians/professional providers within those subcontracted groups. (Note: refer to the BCBSNM *Blues Provider Reference Manual*, Section 11.4.3. Provider Appeal Rights and Responsibilities for further instructions on the appeal process for provider terminations.)

Notification of Members of Provider Termination

BCBSNM will make a good faith effort to provide written notice of a termination of a Participating Physician/Professional Provider to all Members who are patients seen on a regular basis by that Provider at least 30 calendar days before the termination effective date regardless of the reason for the termination.

Medical Records

Medical Record Review	A BCBSNM representative may visit the Participating Physician/Professional Provider's office to review the medical records of BlueSalud Members as described in the <i>Blues Provider Reference Manual</i> .
Standards for Medical Records	Participating Physicians/Professional Providers must have a system in place for maintaining medical records for a period of not less than ten (10) years that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the Member's medical chart.
Medical Record Content	<ul style="list-style-type: none">• Allergy and adverse reactions - Each chart clearly identifies that the patient is either (a) not allergic to any drug or medication; or, (b) identifies what allergies or adverse reactions the patient does have.• Medications - Each chart contains current information about the medications the patient is taking, including dosages and dates. BlueSalud Member charts contain medication effectiveness information.• History of present illness - Each encounter documents history or other subjective data that are appropriate to the reason for the encounter.• Physical examination - Each encounter documents physical exam or other objective data that are appropriate to the reason for the encounter.• Important medical background data - The documentation used at the time of patient encounters contains sufficient background data relative to the patient's condition. Most commonly, this information will be categorized as past medical history, review of systems, social history, and risk factors. For BlueSalud Member charts, include a history of tobacco use, alcohol use, and substance abuse. The intent is met when the documentation includes sufficient information to identify conditions that would potentially affect the treatment plan or require coordination of care with other practitioners.• Working diagnosis - For each encounter, working diagnoses are either documented explicitly, or the records would make such a diagnosis implicitly clear. BlueSalud Member charts contain diagnostic information.• Follow-up - A follow-up plan of action including further diagnostics, treatment, and/or education is documented. If therapeutic or diagnostic procedures/services are furnished at the time of the visit, the indication for such services is clear from the documentation. For BlueSalud Member charts, include documentation of member notification of abnormal results and follow-up plan of action.

Medical Records

Additional Content Requirements

The following information must be filed in the Member's medical records.

- **Coordination of Care** - If the physician was sent information from another practitioner or provider, that information has been reviewed by the physician and placed into the record as appropriate. For BlueSalud Member charts, include reports of emergency care, to the extent possible.
- **Continuity of Care** - If laboratory, radiographic, or other studies have been ordered, there is evidence in the record as to the rationale for the study(ies), and evidence that the results have been tracked, reviewed, and acted upon as indicated.

Medical Record Organization

Medical records must be organized with the following elements:

- **Patient Identification** - Each chart contains demographic (biographic) and personal data sufficient to allow information transfer in case of emergencies.
- **Separate Records** - Each patient has a separate medical record.
- **Dated Records** - Each encounter between the physician and the patient is dated.
- **Treating practitioner identification** - Each encounter between the physician (or other licensed health care provider) and patient is documented so that the health care professional's identity is clear.
- **Data Integrity** - Each page of the medical record contains patient identification sufficient to allow it to be returned to the chart if lost.
- **Legibility** - Medical records must be sufficiently legible to allow transfer of critical patient care information when needed.

Retrieving Medical Records

Medical records must be easy to retrieve.

- **Identification** - Each record must be labeled or identified so that it can be retrieved by office staff and practitioners in a timely manner relative to the clinical needs of patients.
- **Systematic storage** - Records must be kept in a systematic file system. While not required, computerized medical records or retrieval systems are considered evidence of superior practice

Medical Records

Additional Standards - PCPs

Primary Care Physicians (PCPs) have these additional standards:

- **Vital Signs** - At every encounter, age appropriate vital signs are recorded.
- **Problem List** - There is a complete and current problem list including a patient's relevant and significant illnesses, medical, and psychological conditions.
- **Complete Medical Information** - There is documentation that the physician/practitioner obtained a past medical history and review of systems that, relative to the patient's clinical condition, is sufficiently comprehensive to identify all important problems that require follow-up.
- **Ongoing tracking** - Problems from previous visits are addressed or tracked for later consideration. Any systematized method for tracking and monitoring chronic disease conditions will be considered evidence of superior practice.
- **Consultation review** - The results of consultations (including lab tests, specialist consultations, hospital discharge reports, home health nursing reports, physical therapy reports, and behavioral health reports) are reviewed and integrated as appropriate into the care plan.
- **Immunization** - The medical record documents immunizations to identify if the patient's age-appropriate immunization status is up-to-date.
- **Preventive Health** - There is documentation of the provision of preventive health services, referral, or advice where appropriate, including preventive health counseling when rendered. For BlueSalud Member, the status of preventive services provided are to be documented in a single sheet form in the medical record within six months of enrollment.

Confidentiality of Member Information

Confidential patient information is subject to the following:

- **Treat as confidential** - Medical records are treated as confidential information.
- **Safeguards** - Appropriate safeguards are in place to protect the confidentiality of the medical record, in compliance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA).
- **Release** - Confidential information is released only in accordance with applicable state and federal laws.
- **Advance directives** - Advance Directives, or the documentation of discussion with the member about advance directives, are documented.

Initial Decisions, Appeals and Grievances

Initial Decisions

The “initial decision” is the first decision BCBSNM makes regarding coverage or payment for care. In some instances, a Participating Physician/Professional Provider, acting on behalf of a Member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a Member asks BCBSNM to pay for medical care the Member has already received, this is a request for an “initial decision” about payment for care.
- If a Member, or Participating Physician/Professional Provider acting on behalf of a Member, asks for preauthorization for treatment, this is a request for a Precertification routine request about whether the treatment is covered by BlueSalud.
- If a Member asks for a specific type of medical treatment from a Participating Physician/Professional Provider, this is a request for an “initial decision” about whether the treatment the Member wants is covered by BlueSalud.

BCBSNM will generally make decisions regarding payment for care that Members have already received within 30 calendar days.

A decision about whether BlueSalud will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 calendar days) or an expedited decision that is made more quickly (typically within 72 hours).

A Member can ask for an expedited decision **only** if the Member or any Physician/Professional Provider believes that waiting for a standard decision could jeopardize the life or health of the Member or the Member’s ability to regain maximum function. The Member or a Physician/Professional Provider can request an expedited decision. If an expedited decision is requested by the Member or Physician/Professional Provider, BCBSNM will automatically provide an expedited decision.

If BCBSNM does not make a decision within the timeframe and does not notify the Member regarding why the timeframe must be extended, the Member can treat the failure to respond as a denial and may appeal as set forth below.

Initial Decisions, Appeals and Grievances

Appeals and Grievances

Members have the right to submit a grievance if they have concerns or problems related to their coverage or care. All Participating Physicians/Professional Providers must cooperate in the BlueSalud Appeals and Grievances process.

- An “appeal” is a request for review by BCBSNM for services for a Member that are reduced, denied or limited. This includes requests for pharmacy, transportation or where BCBSNM did not complete an authorization on time.
- A “grievance” is any expression of dissatisfaction about any matter or aspect of BCBSNM, or its Salud! operation made by a Member or a Participating Physician/Professional Provider. For example, complaint concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the Participating Physician/Professional Providers’ facilities are grievances.

Appeals Address and Claim Inquiries Phone Number

Appeals regarding authorization for, or termination of coverage of, a health care service should be mailed or faxed as follows:

- Medical Care:
ATTN: BlueSalud Appeals
P.O. Box 27838
Albuquerque, NM 87125-7838
Fax #: 1-888-240-3004

For an Expedited Appeal Only, call: 1-877-232-5520

- For Claims Inquiries, contact:

BCBSNM
Provider Service Unit (PSU)
1-888-349-3706

Resolving Grievances/ Complaints

If a Member has a Grievance about BlueSalud, a Physician/Professional Provider or any other issue, Participating Physicians/Professional Providers should instruct the Member to contact the Customer Service Department at the number listed on the back of the Member’s ID card.

Resolving Appeals

A Member may appeal a notice of action concerning authorization for, or termination of coverage of, a health care service. A Member’s appeal of a notice of action must be resolved within 30 calendar days or sooner if the Member’s health condition requires. An appeal may be extended by 14 days if the member requests an extension.

If the normal time period for an appeal could jeopardize the life or health of

Initial Decisions, Appeals and Grievances

Resolving Appeals,
continued

the enrollee or the enrollee's ability to regain maximum function, the Member or the Member's Physician/Professional Provider can request an expedited appeal. Such appeal is generally resolved within 3 working days unless it is in the Member's interest to extend this time period.

Participating Physician/Professional Provider Obligations – Organization Determinations

At each patient encounter with a Member, the Participating Physician/Professional Provider must notify the Member of his or her right to receive, upon request, a detailed written notice from BCBSNM regarding the Member's services. The Participating Physician's/Professional Provider's notification must provide the Member with the information necessary to contact BCBSNM and must comply with any other requirements specified by HSD/MAD. If a Member requests BCBSNM to provide a detailed notice of a Participating Physician's/Professional Provider's decision to deny a service in whole or part, BCBSNM must give the Member a written notice of the determination.

Participating Physician/Professional Provider Obligations – Appeals

Participating Physicians/Professional Providers must also cooperate with BCBSNM and Members in providing necessary information to resolve the appeals within the required time frames. Participating Physicians/Professional Providers must provide the pertinent medical records and any other relevant information. In some instances, Participating Physicians/Professional Providers must provide the records and information in an expedited manner to allow BCBSNM to make an expedited decision.

Member Rights and Responsibilities

Member Rights

Members have the right to timely, high quality care, and treatment with dignity and respect. Participating Physicians/Professional Providers must respect the rights of all Members.

Timely, Quality Care

Members have been informed that they have the following rights and responsibilities, including, but not limited to:

- The right to health care when medically necessary as determined by their doctor and BCBSNM, 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined by the member handbook
- Choose a PCP or provider from the BCBSNM BlueSalud network and be able to refuse care of certain providers (a prior authorization may be necessary to see some providers)
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage; if the information is not clear, an explanation will be provided to next of kin, guardian, agent or surrogate, if able, and documented in Member's medical records
- To actively participate in decisions regarding their health and treatment options and give informed consent for medical services
- Members who have a disability have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act
- To file a complaint or appeal about BCBSNM or the care that the Member received and receive an answer within a reasonable time
- To be able to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands
- To have an interpreter when the Member does not speak or understand the language that is being spoken
- The right to talk to their provider about new uses of technology

Member Rights and Responsibilities

Treatment with Dignity and Respect

Members have the right:

- 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 Participating Physicians/Professional Providers (providing the Member accepts the responsibility and consequences of the decision)
- To complete an Advance Directive, living will or other directive and have it filed with their medical records
- To know the name and job title of people giving them care
- To be free from restraint or seclusion when used as a means of force, discipline, convenience, or retaliation

Member Responsibilities

Members have the following responsibilities:

- To become familiar with their coverage and the rules they must follow to receive care as a Member
- To give their Participating Physician/Professional Provider and other Providers the information they need to care for the Member, and to follow the treatment plans and instructions that the Member and his/her Participating Physician/Professional Provider agree upon
- To be sure to ask their Participating Physician/Professional Provider if they have any questions
- To keep, reschedule or cancel an appointment rather than to simply not show up
- To pay their plan premiums and any copayments they may owe for the Covered service they receive. They must also meet their financial responsibilities
- To let BCBSNM know if they have any questions, concerns, problems or suggestions

Member Rights and Responsibilities

Member Responsibilities, continued

- To report all information regarding other insurance coverage to the Income Support Division (ISD) case worker assigned to the Medicaid member
- To supply their Member ID card to their provider for insurance confirmation

Member Satisfaction

BCBSNM periodically surveys Members to measure overall customer satisfaction as well as satisfaction with the care received from Participating Physicians/Professional Providers. Survey information is reviewed by BCBSNM and results are shared with the Participating Physicians/Professional Providers.

Services Provided in a Culturally Competent Manner

BCBSNM is obligated to ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating Physicians/Professional Providers must cooperate with BlueSalud in meeting this obligation.

Customer Service (phone number is listed on the back of the member's ID card) has the following services available for Members:

- Teletypewriter (TTY) services
- Language services, and
- Spanish speaking Customer Service Representatives

Advance Directives

Members have the right to complete an "Advance Directive" statement. This statement indicates, in advance, the Member's choices for treatment to be followed in the event the Member becomes incapacitated or otherwise unable to make medical treatment decisions. BCBSNM suggests that Participating Physicians/Professional Providers have Advance Directive forms in their office and available to Members.

Note: A sample New Mexico Optional Advance Health Care Directive Form is included at the end of this Section.

Fair Hearing

Members have the right to request a Fair Hearing through the State of New Mexico at any time in the appeal process for Salud!. A Member's appeal request can be verbal or in writing. Members can have a fair hearing if their benefits have stopped, reduced or have been suspended. Fair Hearings are processed by the Fair Hearings Bureau at HSD/MAD, not BCBSNM. All requests for hearings must go to the State. If a Fair Hearing is held, the decision made by the State is the final decision. BCBSNM must follow the State's decision. If a benefit is denied, the Member will receive notice from BCBSNM. BCBSNM will not retaliate against a Member requesting a Fair Hearing.

Member Rights and Responsibilities

Member Complaints/ Grievances

BCBSNM tracks all complaints and grievances to identify areas of improvement for BlueSalud. This information is reviewed by the Quality Improvement Committee.

Obligation to Provide Access to Care

Member Access To Health Care Guidelines

The following appointment availability and access guidelines should be used to ensure timely access to medical, dental and behavioral health care:

- Routine, asymptomatic, member-initiated, outpatient appointments for primary medical care – within 30 days unless patient requests a later time
- Routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care – request-to-appointment time no greater than 14 days unless patient requests a later time
- Non-urgent behavioral health care – request-to-appointment time no greater than 14 days unless patient requests a later time
- Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours
- Emergency care – 24 hours/day, 7 days per week
- Specialty outpatient referral and consultation appointments, excluding behavioral health - request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless patient requests a later time
- Routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments – request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days unless patient requests a later time
- Outpatient diagnostic laboratory, diagnostic imaging and other testing, if a “walk-in” rather than an appointment system is used, the Member wait time shall be consistent with the severity of the clinical need
- Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours
- In-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes
- New durable medical equipment (DME) and repairs to existing DME owned or rented by the Member – approve or deny the request within seven (7) working days of the request date
 - All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.
 - All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.
 - All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

Obligation to Provide Access to Care

- All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.
- The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.
- The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:
 - members can access prescribed medical supplies within 24 hours when needed on an urgent basis;
 - members can access routine medical supplies within a time frame consistent with the clinical need;
 - subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly, and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.
- The MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the MCO/SE or its subcontractor.
- Sufficient transportation available to meet the needs of the Members

Adherence to Member access guidelines will be monitored through the office site visits and the tracking of complaints/grievances related to access and availability which are reviewed by the Clinical Quality Improvement Committee.

All Participating Physicians/Professional Providers and Hospitals will treat all Members with the same dignity and consideration as they do their non-BlueSalud patients.

Physician/ Professional Provider Availability

Participating Physicians/Professional Providers shall provide coverage 24 hours a day, 7 days a week. When a Participating Physician/Professional Provider is unavailable to provide services, he or she must ensure that another Participating Physician/Professional Provider is available. Hours of operation must not discriminate against BlueSalud Members relative to other members. Participating Physicians'/Professional Providers' standard hours of operation shall allow for appointment availability between the normal working hours of 9:00 a.m. - 5:00 p.m.

Obligation to Provide Access to Care

New Mexico Human Services Department (HSD) requires that the Member must be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g. Emergency cases) and be provided with an alternative appointment.

After hours access shall be provided to assure a response to after hour phone calls. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek emergency services.

Physician/ Professional Provider Office Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information. Participating Physicians/Professional Providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Patient Self- Determination Act (PSDA)

The PCP must comply with federal government regulations concerning the Patient Self-Determination Act (PSDA).

- PCPs must comply with all applicable state and federal laws regarding advance directives
- PCPs must ask if adult Members (18 and over) have advance directives, and include existing advance directives in the Member's medical record
- PCPs cannot require a Member to have an advance directive in order to receive medical care, nor can they prevent a Member from having an advance directive
- Minors should not be treated without the consent of a legal guardian or legally authorized surrogate decision-maker. **Note:** Medicaid Salud! does not require the consent of a legal guardian prior to services being provided for treating cases of sexually transmitted diseases, family planning, and behavioral health.

When treating BlueSalud Members that fall under the jurisdiction of the Children, Youth, and Family Department (CYFD), BlueSalud case managers work in conjunction with the CYFD case workers to meet care needs.

Obligation to Provide Access to Care

Prohibition Against Discrimination

Neither BCBSNM or Participating Physicians/Professional Providers may deny, limit, or condition the coverage or furnishing of services to Members on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Race, ethnicity, national origin
- Religion
- Sex, sexual orientation
- Age
- Mental or physical disability
- Source of payment

Participating Physicians/Professional Providers must have practice policies demonstrating that they accept for treatment any Member in need of health care services they provide.

Pharmacy Services

Introduction

The following policies apply to Members who have BCBSNM BlueSalud prescription benefits. Prime Therapeutics is the pharmacy benefit manager (PBM) that provides drug benefits through BCBSNM for BlueSalud Members. The PBM name is listed on the front of the Member's identification card.

BlueSalud Formulary

The BlueSalud Formulary is available on the BCBSNM web site at bcbsnm.com, in the *Providers* section under BlueSalud. Hard copies will be distributed to our Participating Physicians/Professional Providers and pharmacies upon request.

BCBSNM uses Prime Therapeutics National Pharmacy and Therapeutics (P&T) Committee, which is responsible for drug evaluation for BlueSalud Formulary. The P&T Committee consists of independent practicing physicians and pharmacists from throughout the country who are not employees or agents of Prime Therapeutics. BCBSNM will have one voting member on the committee. The P&T Committee meets quarterly to review new drugs and updated drug information based on the current available literature.

The HCSC Preferred Drug Committee includes clinical, marketing, and financial representation from HCSC. In conjunction with the P&T committee, the HSCS Preferred Drug Committee determines the additions of brand-name drug products to each plan's drug list/formulary.

BCBSNM remains responsible for the determination of benefit coverage and approvals for prior authorizations, quantity exceptions, and/or step therapy for BlueSalud Members. BCBSNM will handle all requests for prior authorization locally. To request a prior authorization, please call Health Services at **505-291-3585** or **1-800-325-8334, option 5**.

BCBSNM provides notification to BlueSalud Members and physicians of additions and changes made to the BCBSNM BlueSalud Formulary by direct mailings, newsletters, and on the BCBSNM-Web site. Additions to the BCBSNM BlueSalud Formulary are posted on the BCBSNM Web site in the *Providers* section. Select BlueSalud. Deletions and changes to the BCBSNM BlueSalud Formulary occur twice a year and are posted on www.bcbsnm.com, usually in April and October.

BlueSalud Members who are identified as taking a medication that has been deleted from the BCBSNM BlueSalud Formulary are sent a letter detailing the change at least 30 days prior to the effective deletion date. The Member's physician is also sent a letter at least 30 days prior to the effective deletion date. BCBSNM and Prime Therapeutics also provide pharmaceutical safety

Pharmacy Services

BlueSalud Formulary, continued

notification to dispensing providers for BlueSalud Members regarding point-of-dispensing drug-drug interaction, and FDA drug recalls.

The BlueSalud Formulary is provided as a guide to our Participating Physicians/Professional Providers to help them in selecting cost-effective drug therapy. Members have a closed pharmacy benefit. **Non Formulary drugs are generally considered not a covered benefit.** Most generics and listed brand name products are covered. A copay will apply for those Members in WDI and SCHIP benefits. Please refer to the BlueSalud Formulary when prescribing for our Members. The BlueSalud Formulary is available at www.bcbsnm.com in the *Providers* section under BlueSalud.

Generic Drugs

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

BCBSNM supports the FDA process for determining equivalency and strongly advises its Participating Physicians/Professional Providers to prescribe drugs that have generic alternatives available. **Brand name products with a generic equivalent noted to be “Dispense as written” are not covered for BlueSalud Members. Generic substitution is mandatory.**

Drug Utilization Review (DUR)

BCBSNM and Prime Therapeutics conduct prospective, concurrent, and retrospective drug utilization reviews for BlueSalud Members to ensure the most appropriate and cost-effective drugs are used safely. Prospective DUR entails provider education through the use of newsletters and personal contact by employees of the plan.

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

Retrospective DUR uses historical prescription claims data. The data is evaluated to determine compliance with the clinical practice guidelines approved by the P&T Committee. Individual letters are mailed to providers with Members identified as potential drug therapy concerns, together with a profile, listing the prescription medications filled during the study period and a response form to be mailed or faxed to the BCBSNM PBM. A provider’s

Pharmacy Services

Drug Utilization Review (DUR), continued

timely response is very important to BCBSNM.

Covered & Noncovered BlueSalud Pharmacy Services

Covered Pharmacy Services

- Glucagon and anaphylactic kits
- Insulin, syringes, lancets, and test strips
- The Member's applicable prescription copayment will apply for each prescription or refill for 30 days or 120 units, whichever is less
- Oral contraceptives
- Plan B (dispensing limits apply)
- Diaphragms and Condoms
- One applicable copay (depending upon benefit) will apply to most "packaged" items (e.g., inhalers)
- OTC

Noncovered Pharmacy Services

- Non Formulary medications (without prior authorization)
- Any charge for most therapeutic devices or appliances (e.g., support garments and other nonmedical substances), regardless of their intended use
- Investigational use of medication
- Medications specifically excluded from benefit (e.g., drugs used for cosmetic purposes and Infertility)
- Drugs used for treatment of obesity require prior authorization
- Certain Injectable drugs (other than insulin, glucagon, and anaphylactic kits) that are obtained at a pharmacy without prior authorization from the BCBSNM Health Services department. (Injectables received through a member's physician are covered if the drug meets all other criteria for coverage.)
- Nutritional supplements (coverage requires prior authorization)
- Prescriptions obtained at an out-of-network pharmacy, unless in an emergency
- Take Home drugs provided by a provider's office
- Lost, stolen, damaged or destroyed medications
- Drug Efficiency Study and Implementation (DESI) medications

Drugs Requiring Pre-authorization

Drugs with a high potential for experimental or off-label use may require preauthorization. When prescribing drugs on the BlueSalud *Formulary Limitations, Exclusions, and Prior Authorization Criteria* list (provided on bcbsnm.com), please contact the Health Services department at **505-291-3585** or **1-800-325-8334, option 5**. Changes to the list are published in our provider newsletter, *Blue Review*, and on our web site.

Pharmacy Services

Drugs Requiring Pre –authorization, continued

BCBSNM allows for certain off-label uses of drugs when the off-label uses meet the requirements of the BCBSNM policy. Please contact the Health Services department for more information on the BCBSNM off-label and investigational use policy.

Pharmacy Network

BCBSNM Members with a “pharmacy card” prescription drug benefit must use a pharmacy on the approved list of participating pharmacies. Please encourage your patients to use one pharmacy for all of their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

BCBSNM contracts with Prime for mail-order pharmacy services and retail pharmacies, and allows Members of BCBSNM **BlueSalud only** to receive up to a 90-day supply of maintenance medication (e.g., drugs for arthritis, depression, diabetes, or hypercholesteremia). If you believe that a BlueSalud Member will continue on the same drug and dose for an indefinite period of time, please consider writing the prescription for a 90-day supply with three refills. All new prescription therapy will be restricted to a 30 day supply on the initial fill to help assure the drug is tolerated.

Specialty Pharmacy Program

Specialty medications are used to treat serious or chronic conditions such as multiple sclerosis, pulmonary hypertension, hepatitis, certain cancer medications and rheumatoid arthritis. These medications are typically injectable and can be administered by the patient or a family member.

All specialty medications require prior authorization. BlueSalud Members must use contracted specialty network pharmacies to fill their prescription. The pharmacists, nurses, and care coordinators in our specialty network pharmacies are experts in supplying medications and services to patients with complex health conditions.

Covered Specialty drugs are listed along with the listing of contracted Specialty providers on our web site at www.bcbsnm.com in the *Providers* section under BlueSalud. The web site also provides an overview of the program, frequently asked questions, and the BlueSalud specialty drug list.

For more information, contact BCBSNM at **505-291-3585** or **1-800-325-8334, option 5**.

Glossary of Terms

Advance Directives	<p>Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the State of New Mexico and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.</p> <p>Note: A sample New Mexico Optional Advance Health Care Directive Form is included at the end of this Section.</p>
Appeal	<p>A request for review by BCBSNM for services for a Member that are reduced, denied or limited, or a request for review where BCBSNM did not complete an authorization on time.</p>
Code of Federal Regulations (CFR)	<p>The codified set of regulations published by the Office of the Federal Register, National Archives and Records Administration.</p>
Co-payment	<p>The portion of the claim or medical expense that Members must pay out of their pocket for the services.</p>
Covered Services	<p>Services covered by the Salud! insurance programs as defined in the BlueSalud Provider Reference Manual, the Medical Assistance Division Program Policy Manual, or other applicable rules, regulations or guidelines.</p>
Emergency Medical Condition	<p>Medical or behavioral health conditions manifesting themselves by acute symptoms of sufficient (including severe pain), that would lead a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in:</p> <ul style="list-style-type: none">• Serious jeopardy of the patient's health• Serious impairment to bodily functions• Serious dysfunction of any bodily organ or part• Serious disfigurement
External Quality Review Organization (EQRO)	<p>The External Quality Review Organization (EQRO) retained by HSD/MAD. New Mexico Medical Review Association (NMMRA) is the EQRO for BlueSalud.</p>

Glossary of Terms

Grievance	Any expression of dissatisfaction about any matter or aspect of BCBSNM or its Salud! operation.
HSD	New Mexico Human Services Department
HIPAA	Health Insurance Portability and Accountability Act and its implementing regulation, as amended
MAD	Medical Assistance Division
Member	A recipient who is currently enrolled in Corporation Salud! plan.
Participating Physician/ Professional Provider	Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State of New Mexico and Medicaid to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to BlueSalud Members pursuant to the terms of the Agreement.
Primary Care	All health and laboratory services customarily furnished by a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or certified nurse practitioner.
Primary Care Provider (PCP)	A provider who agrees to manage and coordinate the care provided to Members.
Salud!	The Medicaid managed care program administered by HSD/MAD.
State	Refers to the State of New Mexico
State Coverage Insurance (SCI)	A program that provides certain health care services to the low-income and uninsured and administered by HSD/MAD.

For additional procedures and information, please refer to the *BCBSNM Blues Provider Reference Manual*.

BlueSalud Key Contacts List	
Provider Customer Service	1-888-349-3706
Network Services Representative	1-505-837-8800 or toll free 1-800-567-8540
Contract Representative – Angela Sanchez-Caldwell	505-816-2038
Utilization Management (UM)	
• Preauthorization and Out-of-Network Referrals	1-888-349-3706
• Preauthorization Fax	1-505-816-3608
• Case Management Programs	1-888-349-3706
• Case Management Programs Fax	1-505-816-3608
• Disease Management Programs	1-888-349-3706
• Disease Management Programs Fax	1-505-816-3608
Utilization Management Member Appeals	1-877-232-5520
• Davis Vision	1-800-584-3140
• Doral Dental	1-800-417-7140
• Logisticare (Transportation services)	1-866-913-4342
Behavioral Health	
• OptumHealth New Mexico (BlueSalud)	1-866-660-7185
Electronic Claim Questions or Problems	
• The Availity Health Information Network	1-800-282-4548
• Web site Address	www.availity.com
BlueSalud Claims Address <i>(For submission of paper claims)</i>	Medicaid P.O. Box 27838 Albuquerque, NM 87125-7838
BlueSalud Rx	1-800-325-8334, option 5
Fraud Hotline (BCBSNM Special Investigations Department (SID))	1-877-272-9741 www.bcbsnm.com/sid/reporting

ATTACHMENT SECTION FOLLOWS

New Mexico Optional Advance Health Care Directive Form
EXPLANATION FOR MEMBERS

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
2. Select or discharge health care providers and institutions;
3. Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
4. Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I am unable to make my own health care decisions. If I initial this box [_____], my agent's authority to make health care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what

my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

(6) **END-OF-LIFE DECISIONS:** If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

I CHOOSE NOT To Prolong Life

I do not want my life to be prolonged.

I CHOOSE To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

I CHOOSE To Let My Agent Decide

My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) **ARTIFICIAL NUTRITION AND HYDRATION:** If I have chosen above NOT to prolong life, I also specify by marking my initials below:

I DO NOT want artificial nutrition OR

I DO want artificial nutrition.

I DO NOT want artificial hydration unless required for my comfort OR

I DO want artificial hydration.

(8) **RELIEF FROM PAIN:** Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

I REFUSE to make an anatomical gift of any of my organs or tissue.

I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

**PART 3
PRIMARY PHYSICIAN**

(11) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health care provider and any health care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health care provider.

(14) SIGNATURES: Sign and date the form here:

_____		_____
(date)		(sign your name)
_____		_____
(address)		(print your name)
_____		_____
(city)	(state)	(your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness:

Second witness:

_____		_____	
(print name)		(print name)	
_____		_____	
(address)		(address)	
_____		_____	
(city)	(state)	(city)	(state)
_____		_____	
(signature of witness)		(signature of witness)	
_____		_____	
(date)		(date)	