



A Section of the

Blues Provider Reference Manual

SM Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Blue Medicare PPO Section of the *Blues Provider Reference Manual*

Table of Contents	Page
Overview and Introduction	S3
Program Overview	S4 – S8
General Information	S9 – S13
Additional Benefits	S14
Care Management, Quality Improvement, Utilization Review and Disease Management Programs	S15 – S24
Provider Performance Standards and Compliance Obligations	S25 – S27
Selection and Retention of Participating Providers	S28 – S29
Medical Records	S30
Reporting Obligations	S31
Initial Decisions, Appeals and Grievances	S32 – S36
– Hospital Discharge Notification Requirements	S34
– Skilled Nursing Facility, Home Health Agency and Comprehensive Outpatient Rehabilitation Facility Discharge Notification Requirements	S35
Member Rights and Responsibilities	S37 – S39
Obligation to Provide Access to Care	S40 – S41
Glossary of Terms	S42 – S45
Blue Medicare PPO Key Contacts	S46
Attachments	
<ul style="list-style-type: none"> • New Mexico Optional Advance Health Care Directive Form • CMS 10095A/Notice of Medicare Non –Coverage Form 	

Blue Medicare PPO: Overview and Introduction

Our Name Blue Medicare PPO is a product of HCSC Insurance Services Company (HISC), which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Advantage products under HISC's contract H3208 with the Centers for Medicare and Medicaid Services (CMS).

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

The Blue Medicare PPO Network Blue Medicare PPO is a Medicare Advantage Plan which offers three different plan options (Blue Medicare PPO-Value, Blue Medicare PPO-Advantage, and Blue Medicare PPO-Premier). Blue Medicare PPO maintains and monitors a network of Participating Providers including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers through which Members obtain Covered Services. Although selection of a Primary Care Physician (PCP) is not required, Members are encouraged to have their PCP coordinate their care with specialty providers. Members may self-refer to participating Specialty Care Physicians/Professional Providers.

Blue Medicare PPO will market its Medicare Advantage Plan to individuals eligible for Medicare Parts A and B who live in its approved Service Area in the state of New Mexico. Blue Medicare PPO will furnish Members with a Member Handbook and Evidence of Coverage that will include a summary of the terms and conditions of its plan.

Program Overview

24-Hour Coverage

Participating Physicians/Professional Providers are expected to provide coverage for Blue Medicare PPO Members 24 hours a day, 7 days a week. When a Participating Physician/Professional Provider is unavailable to provide services, the Participating Physician/Professional Provider must ensure that he or she has arranged for coverage from another Participating Physician/Professional Provider. Hospital emergency rooms or urgent care centers are not substitutes for covering Participating Providers. Please refer to the Blue Medicare PPO Provider Directory on-line at www.bcbsnm.com to identify providers participating in the Blue Medicare PPO network. You may also contact the Blue Medicare PPO 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 Blue Medicare PPO network.

Emergency Care

Emergency Care services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Emergency Care services necessary to evaluate and stabilize an Emergency Medical Condition are covered by Blue Medicare PPO. 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. Emergency Care services will be covered at the in-network benefit level.

Program Overview, Continued

Out-of-Area Renal Dialysis Services

A Member may obtain Medically Necessary dialysis services from any qualified provider the Member selects when he/she is temporarily absent from the Blue Medicare PPO Service Area and cannot reasonably access Blue Medicare PPO dialysis Physicians/Professional Providers or other providers. No prior authorization or notification is required. However, a Member may voluntarily advise Blue Medicare PPO if he/she will temporarily be out of the Service Area. Blue Medicare PPO may assist the member in locating a qualified dialysis Physician/Professional Provider.

Preventive Services

Members may access the following services directly from any Participating Provider:

- Annual physical exams
- Annual routine vision exams
- Screening mammograms
- Routine and preventive women's health services (such as pap smears and pelvic exams)
- Bone mass measurements
- Colorectal screening exams
- Prostate cancer screening exams
- Cardiovascular disease screening
- Diabetes screening
- Diabetes self-management training
- Medical nutrition therapy
- Smoking cessation counseling
- Glaucoma screening
- Hearing screening
- Influenza or pneumococcal vaccinations (Members are not charged a copayment for influenza or pneumococcal vaccinations)
- Abdominal aortic aneurysm screening for high risk individuals

Please see www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp for detailed information on Medicare preventive services.

Program Overview, Continued

Hospital Services

All inpatient admissions require prior authorization from the Blue Medicare PPO Utilization Management (UM) Department. The prior authorization process for admissions is carried out by the admitting Physician/Professional Provider or hospital personnel.

Admitting Physicians/Professional Providers are responsible for contacting the UM Department to request authorization for additional days if an extension of the approved length of stay is required. The admitting Physician/Professional Provider will provide appropriate referrals for extended care. Blue Medicare PPO UM personnel will assist with coordinating all services identified as necessary in the discharge planning process.

Laboratory Services

The following labs are the **participating** labs for **outpatient** clinical reference laboratory services:

Quest	1-800-232-3766
SED	1-800-999-5227
Tricare	1-800-245-3296

Draw stations for Quest, SED, and Tricare are located throughout New Mexico. Please check our Web site, www.bcbsnm.com, for an up-to-date listing of all sites.

NOTE: If lab services are performed at the Participating Physician's/Professional Provider's office, the Physician/Professional Provider may bill for the lab services. However, if the Physician's/Professional Provider's office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Medicare PPO for the lab services.

Program Overview, Continued

Radiology Services

Outpatient, Non-Emergency Diagnostic High Tech Imaging Services

- American Imaging Management, Inc. (AIM) is responsible for managing outpatient, non-emergency diagnostic high tech imaging services for Blue Medicare PPO Members.
- Compliance with the Radiology Quality Initiative (RQI) Program through AIM is required for the outpatient, non-emergency diagnostic high tech imaging services listed below when performed in a Physician's/Professional Provider's office, outpatient department of a hospital or a freestanding imaging center. Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers), or 23-hour observation are excluded from this requirement.
- The ordering Physician/Professional Provider must contact AIM to obtain an RQI number for the following outpatient, non-emergency diagnostic high tech imaging services:
 - o CT Scans
 - o MRA Scans
 - o MRI Scans
 - o Nuclear Cardiology Studies
 - o PET Scans
- Ordering Physicians/Professional Providers must write the RQI number on the requisition for the imaging study.
- Hospitals and freestanding imaging centers that perform the imaging services listed above cannot obtain the RQI number.
- Hospitals and freestanding imaging centers may confirm that a preauthorization number was issued by accessing AIM's Interactive Web site at www.americanimaging.net.
- NOTE: Whether the services are Medically Necessary must be determined before an RQI number will be issued. Claims received that do not have an RQI number may be denied. Blue Medicare PPO Physicians/Professional Providers may not seek payment from the Member when a claim is denied for lack of an RQI number.

To obtain an RQI number, contact AIM as follows:

- Call Center: 1-866-745-1789
- Internet: www.americanimaging.net
- Fax: 1-800-610-0050

For a listing of imaging provider locations, contact AIM at 1-866-745-1789, or go to www.americanimaging.net

For routine radiology services that are not part of the preauthorization process above, refer to the BCBSNM Blues Provider Reference Manual.

Program Overview, Continued

Behavioral Health Services

Members requiring Behavioral Health Services (Mental Health and Substance Abuse) are required to call **Mesa Mental Health, at 1-800-583-6372**. Telephone access is available 24 hours a day, 7 days a week.

Customer Service Representatives and Care Managers at Mesa Mental Health will provide:

- Preauthorization for inpatient and outpatient care
- Referral services, if required
- Case management
- Assistance in the selection of a Participating Physician/Professional Provider
- Crisis interventions

The following referral procedures apply to behavioral health services only:

- All behavioral health services must be preauthorized by Mesa Mental Health (**NOTE:** Whether the services are Medically Necessary must be determined before an authorization number will be issued. **Claims that are received that do not have an authorization number will be denied.** Blue Medicare PPO Physicians/Professional Providers may not seek payment from the Member when a claim is denied for lack of a preauthorization number.)
- The call to preauthorize can be made by the Member's Participating Physician/Professional Provider.
- Participating Physicians/Professional Providers are encouraged to admit patients to a Participating Facility unless an emergency situation exists that precludes safe access to a Participating Facility or if the admission is approved for non-participating facility.
- The Member will only receive in-network benefits when services are performed at a participating Blue Medicare PPO Facility.

NOTE: To obtain benefits and eligibility information and/or claims processing status, call Blue Medicare PPO Provider Customer Service at 1-866-706-7745.

General Information

ID Cards & Verification of Coverage



Each Blue Medicare PPO Member will receive a Blue Medicare PPO 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 to record information for coordination of benefits purposes
- Refer to the Member's ID card for the appropriate telephone number to verify eligibility in the Blue Medicare PPO, deductibles, coinsurance amounts, copayments, and other benefit information

Blue Medicare PPO offers three different plan types (Value Plan, Advantage Plan and Premier Plan).

Sample of ID Card

 BlueCross BlueShield of New Mexico		Blue Medicare PPO*	
Member Name: <John Q. Public> Subscriber No.: <XXX123456789> Effective Date: <1/1/2008>		IN PCP OV: <\$10/\$5/\$0> IN Specialist OV: <\$40/\$20/\$15> Generic Drugs: <\$10/\$7/\$5> Emergency Care: <\$50>	
Issuer: <80840> Group No.: <NM3208>			
RxBIN: <011552> RxPCN: <MPDNM>			
BS Plan Code: <790> BC Plan Code: <290> Plan Name: <Value, Advantage, Premier>			
Medicare limiting charges apply			

 BlueCross BlueShield of New Mexico	
An Independent licensee of the Blue Cross Blue Shield Association	
Provider Service:	<www.bcbsnm.com> <1-866-706-7745>
Customer Service:	<1-800-718-2031>
	TTY: <1-888-844-5530>
To pre-authorize:	
Medical services:	<1-800-325-8334>
Behavioral health treatment:	<1-800-583-6372>
High-tech radiology:	<1-866-745-1789>
Pharmacy service:	<1-888-277-5507>
	TTY: <1-800-693-3816>
Send medical paper claim forms to: Blue Medicare PPO <P.O. Box 3567, Scranton, PA 18505> Electronically send claims via Availity using BAYER ID <NMPPO>. Call 1-877-334-8446.	
Send Rx claims to: Prime Therapeutics <P.O. Box 64813, St. Paul, MN 55164>	

General Information, continued

ID Card Copayment Information

The in-network office visit copayments for Blue Medicare PPO Members are:
Value Plan

- \$10 = Primary Care Physician
- \$40 = Specialty Care Physician/Professional Provider

Advantage Plan

- \$5 = Primary Care Physician
- \$20 = Specialty Care Physician/ Professional Provider

Premier Plan

- \$0 = Primary Care Physician
- \$15 = Specialty Care Physician/ Professional Provider

NOTE: The office visit copayment is determined by how a Physician/ Professional Provider is contracted with Blue Cross and Blue Shield of New Mexico (BCBSNM).

- If the physician is contracted as a Primary Care Physician, the physician should collect the Primary Care Physician copayment.
- If the physician/professional provider is contracted as a Specialty Care Physician/Professional Provider, the physician/professional provider should collect the Specialty Care Physician/Professional Provider copayment.
- If the physician is contracted as a Primary Care Physician and a Specialty Care Physician, then the physician should collect the Primary Care Physician copayment.

How will BlueCard work with Blue Medicare PPO?

BlueCard does not apply to Blue Medicare PPO. However, if a New Mexico Blue Medicare PPO Member sees a Texas Blue Medicare PPO Physician/Professional Provider, the claim will process at the in-network benefit level. Similarly, if a Texas Blue Medicare PPO Member sees a New Mexico Blue Medicare PPO Physician/Professional Provider, the claim will process at the in-network benefit level.

General Information, continued

Claims Process Participating Physicians/Professional Providers and Facility Providers must submit claims to Blue Medicare PPO within 180 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 for claims submitted after the 180 day filing deadline.

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 Blue Medicare PPO ID number
- Individual Member's Group number
- 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
- BCBSNM Provider Number
- Name/address of Participating Provider
- Signature of Participating Provider providing services.
- Place of Service Code

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

General Information, continued

Claims Submission Information

Blue Medicare PPO claims should be submitted as follows:

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

**Blue Medicare PPO
P.O. Box 3567
Scranton, PA 18505**

- Blue Medicare PPO 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: **YID**.

Blue Medicare PPO claims containing adequate information and submitted in accordance with these guidelines will be paid within 30 days.

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

General Information, continued

Coordination of Benefits	If a Member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by Blue Medicare PPO will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.
Claim Disputes	You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the Blue Medicare PPO Provider Customer Service Department at the number listed on the Key Contacts page.
Balance Billing	You <u>may not</u> bill a Member for a non-covered service unless: <ol style="list-style-type: none">1) You have informed the Member in advance that the service is not covered, and,2) The Member has agreed <u>in writing</u> to pay for the services if they are not covered.
Process Used to Recover Overpayments on Claims	If an overpayment occurs on a Blue Medicare PPO Physician's/Professional Provider's claims, the process that will be used to recover an overpayment will be an auto-recoupment. Should you have any questions about this process, please contact Blue Medicare PPO Provider Customer Service.

General Information, continued

**Additional
Benefits**

Routine Vision Care	Vision exams, annually (copay varies per plan). Eyewear, \$100 allowance every 2 years
Routine Hearing	Hearing exams, annually (copay varies per plan). Hearing aid, \$500 allowance every 3 years
Acupuncture	\$1500 annual maximum acupuncture benefit; 20% coinsurance for covered acupuncture services provided by in-network providers

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 by Blue Medicare PPO. To define and assist in monitoring quality improvement, the Blue Medicare PPO 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*.

Cooperation

Participating Physicians/Professional Providers and Facility Providers must comply and cooperate with all Blue Medicare PPO Medical Management policies and procedures and the Blue Medicare PPO Quality Assurance and Performance Improvement Programs. In addition, Participating Physicians/Professional Providers and Facility Providers must cooperate with the independent quality review and improvement organization (Quality Improvement Organization [QIO]) approved by CMS, New Mexico Medical Review Association (NMMRA) in its review of quality of care and investigation of quality complaints on behalf of the Medicare program.

Utilization Management Program

The Utilization Management program does not prohibit Physicians/Professional Providers from advocating on behalf of Members within the utilization management process.

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

Specialty Care Physician/ Professional Provider

A member may self-refer to any Blue Medicare PPO Participating Specialty Care Physician/Professional Provider. A referral is not required to access a Participating Specialty Care Physician/Professional Provider. If it is necessary to utilize a non-participating specialty care physician/professional provider due to network inadequacy or continuity of care concerns, the Physician/Professional Provider must obtain authorization from the UM Department for the in-network benefit level. If authorization is not obtained, claims will be paid at the out-of-network (OON) benefit level.

Members self-referring and Participating Physicians/Professional Providers making referrals to Participating Specialty Care Physicians/Professional Providers can check the Blue Medicare PPO Provider Directory to identify the Specialty Care Physicians/Professional Providers who are participating in the Blue Medicare PPO network. The Blue Medicare PPO Provider Directory is also available on-line via www.bcbsnm.com (select “Information for Providers,” then click on the link for “Blue Medicare PPO”).

The referring Physician/Professional Provider should provide the Specialty Care Physician/Professional Provider with the following clinical information:

- Member’s name
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the Specialty Care Physician/Professional Provider

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

Utilization Management Program – Specialty Care Physician/Professional Provider Responsibilities

Following an evaluation of a Blue Medicare PPO Member, the Specialty Care Physician/Professional Provider should:

- Contact the referring Physician/Professional Provider to discuss the Member's condition and any recommendation for treatment or follow up care, and
- Send the referring Physician/Professional Provider the consultation report including medical findings, test results, assessment, recommendations, treatment plan and any other pertinent information.

Utilization Management Program – Inpatient Preauthorization

The admitting Physician/Professional Provider or Facility should notify the UM Department if they are admitting a Blue Medicare PPO Member to a hospital or other inpatient facility.

The admitting Physician/Professional Provider or Facility should call the UM Department and provide the following information:

- Name of admitting Physician/Professional Provider
- Member's name, sex, date of birth and Blue Medicare PPO ID number
- Admitting Facility
- Primary diagnosis
- Reason for admission
- Date of admission
- Requested length of stay

The UM Department will review the initial hospitalization request to confirm that the hospitalization and/or procedures are Medically Necessary. If the UM Department concludes that certain services are not Medically Necessary, the physician reviewer will attempt to contact the admitting Physician/Professional Provider to discuss the treatment plan and treatment options prior to issuing the denial determination.

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

Utilization Management Program – Concurrent Hospital Review

If an extension of the initially approved length of stay is required, the admitting Physician/Professional Provider or Facility should contact the UM Department to request the extension.

Utilization Management Program – Discharge Planning

UM Department clinical staff will assist Participating Physicians/Professional Providers and Facilities in the inpatient discharge planning process. At the time of admission and during the hospitalization, the UM Department clinical staff will discuss discharge planning with the Participating Physician/ Professional Provider, the Member and the Member's family.

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

Blue Medicare PPO Preauthorization Requirements

Service	Preauthorization Requirements
Inpatient Hospital Admissions	YES – Refer to pages S6 & S16
Ambulance Services	YES – Air Ambulance only
Bone Mass Measurement	NO
Chiropractic Services	NO
Colorectal Screening Exams	NO
Diabetes Self Monitoring Training and Supplies	NO
Doctor Office Visits	NO
Durable Medical Equipment	YES > \$2500
Emergency Care	NO – Refer to page S4
Home Health Care/Home Infusion Therapy (HIT)	YES
Hospice Care	YES
Immunizations (Flu, Hepatitis B for At Risk and Pneumonia)	NO
Laboratory Services (Outpatient)	NO – Refer to page S6
Mammograms (Annual Screening 40+)	NO
Mental Health Care (Inpatient & Outpatient)	YES – All levels of care – Refer to page S8
Out-of-Network Services	YES – If In-Network Benefit Level is Requested
Outpatient Services (Outpatient Facility Based Services not included on this list)	NO
Pap Smears and Pelvic Exams	NO
Podiatry Services	NO
Prostate Cancer Screening Exams	NO
Prosthetic Devices	YES > \$2500
Radiology Services (Outpatient)	YES – High Tech Imaging Services only – Refer to page S7
Rehabilitation (Outpatient)	YES – Home Setting only
Skilled Nursing (In a Medicare Certified Nursing Facility)	YES
Substance Abuse Care (Inpatient & Outpatient)	YES – All levels of care – Refer to page S8

***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.** Blue Medicare PPO Physicians/Professional 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, Continued

Care Management

Blue Medicare PPO will assist in managing the care of Members with acute or chronic conditions who can benefit from care coordination and assistance. Blue Medicare PPO Participating Providers shall assist and cooperate with the Blue Medicare PPO Care Management Programs. Under its Care Management Program, and in coordination with Participating Providers, Blue Medicare PPO shall:

- Implement procedures to ensure that Members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.
- Make best efforts to conduct a health assessment of all new Members within 180 days of the effective date enrollment;
- Identify individuals with complex or serious medical conditions;
- Establish and implement case management plans that:
 - o Are appropriate;
 - o Facilitate direct access visits to Specialty Care Physicians/Professional Providers;
 - o Are time specific and updated periodically;
 - o Facilitate coordination among Physicians/Professional Providers; and
 - o Consider the Member's input.

The Participating Physician/Professional Provider will diagnose, assess, treat and monitor those conditions on an ongoing basis.

The Care Management Program includes, but is not limited to:

- Identification and monitoring of quality and performance indicators;
- Implementation of measures that contribute to improving quality of care and cost-effective management of targeted conditions;
- Promotion of preventive care strategies to keep Members healthy;
- Promotion of Member education and behavioral modification that improve outcomes; and
- Evaluation of outcomes and program effectiveness.

Members are informed of available programs through the enrollment process, marketing materials, and discussions with Participating Physicians/Professional Providers. Blue Medicare PPO will proactively identify Members who could benefit from Care Management and encourage enrollment in the Care Management Program, including the Disease Management Programs for certain chronic care conditions.

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

Second Medical or Surgical Opinion

A Member may request a second opinion if:

- the Member disputes the reasonableness of the treatment recommendation;
- the Member disputes necessity of the recommended procedure; or
- the Member does not respond to medical treatment after a reasonable amount of time.

Members may self-refer to a Participating Physician/Professional Provider within the Blue Medicare PPO network to obtain a second opinion. The Member will be responsible for the applicable copayments.

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

Medical Policy

Blue Medicare PPO Coverage Resources

Providers participating in the Blue Medicare PPO network should refer directly to Medicare coverage policies (located in the Medicare Coverage Database) when making coverage decisions. There are two types of Medicare coverage policies that apply:

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

As a Medicare Advantage plan, Blue Medicare PPO must cover all services and benefits covered by Medicare. Coverage information that you receive concerning original Medicare also applies to Blue Medicare PPO.

National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are found at <http://cms.hhs.gov/manuals/>. Key manuals for coverage include:

- Medicare National Coverage Determinations Manual
- Medicare Program Integrity Manual
- Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network. These articles can be found at www.cms.hhs.gov/MLNMArticles/.

Local Coverage Determinations (LCDs)

CMS contractors (e.g., Medicare Administrative Contractors or MACs) develop and issue local coverage determinations (LCDs) to provide guidance to the public and provider community within a specific geographical area. LCDs section an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

Providers may access our region's LCDs at the following website addresses:

Durable Medical Equipment (DMERC): www.cignagovernmentservices.com
Medicare Part B: www.trailblazerhealth.com
Medicare Part A: www.trailblazerhealth.com
Regional Home Health Intermediary (RHHI): www.palmettogba.com

Providers are encouraged to join mailing lists at the above Medicare contractors' websites for LCD policy publications and at CMS's website for NCD policy publications. This can be done by going to each contractor's web site (and CMS's web site) and subscribing to their mailing lists.

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

Medical Policy,
continued

The Medicare Coverage Database can be accessed at www.cms.hhs.gov/CoverageGenInfo/. The following areas may be searched:

- National Coverage Determinations (NCD)
- National Coverage Analyses (NCAs) – These documents support the NCD process.
- Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is updated on a monthly basis. Therefore, the most current information should be accessed through the local contractor web sites listed in the preceding box.

Clinical Review Criteria

The Clinical Quality Improvement Committee (CQIC) will review and approve the utilization management processes and clinical review criteria used to determine medical necessity. Blue Medicare PPO currently uses OPTIMED[®] Managed Care System clinical protocols and screening criteria to screen preauthorization and concurrent review requests. For more information or to receive a copy of these guidelines, please contact the UM Department at 1-800-325-8334.

Blue Medicare PPO 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 Providers via the BCBSNM Web site and bi-monthly *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.

Utilization Management Appeals Address

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

- Claims/Termination of Coverage:
Blue Medicare PPO
ATTN: Appeals
P.O. Box 833995
Richardson, TX 75083-3995
Fax #: 1-505-816-3608
- Medical Care:
ATTN: Appeals
P.O. Box 27630
Albuquerque, NM 87125-7630
Fax #: 1-505-816-3837

For an Expedited Appeal Only, call: 1-800-205-9926

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

Health Risk Assessment

A health risk assessment (HRA) questionnaire will be sent to Blue Medicare PPO 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 Blue Medicare PPO Members to appropriate case and disease management programs as needed.

Disease Management Programs

The Disease Management Programs include:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)

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 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.

For additional information on Disease Management Programs, call the Disease Management Department at the phone number listed on the Key Contacts page.

Provider Performance Standards and Compliance Obligations

Evaluating Performance of Participating Providers

When evaluating the performance of a Participating Physician/Professional Provider, Blue Medicare PPO will review at a minimum the following areas:

- **Quality of Care** – measured by clinical data related to the appropriateness of a Member’s care and Member outcomes.
- **Efficiency of Care** – measured by clinical and financial data related to a Member’s health care costs.
- **Member Satisfaction** – measured by the Members' reports regarding accessibility, quality of health care, Member-Participating Provider relations, and the comfort of the practice setting.
- **Administrative Requirements** – measured by the Participating Provider’s methods and systems for keeping records, transmitting information, hours of operation, appointment waiting time, and appointment availability.
- **Participation in Clinical Standards** – measured by the Participating Provider’s involvement with panels used to monitor quality of care standards.

Provider Compliance with Standards of Care

Blue Medicare PPO Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish covered services 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. Participating Providers must also comply with Blue Medicare PPO standards, which include but are not limited to:

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

Participating Physicians/Professional Providers must also comply with Blue Medicare PPO policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care;
 - Preauthorization requirements and timeframes;
 - Participating Provider 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 Blue Medicare PPO;
 - Providing treatment to patients at the appropriate level of care; and
-

Provider Performance Standards and Compliance Obligations, Continued

Provider Compliance with Standards of Care

- Maintaining a collegial and professional relationship with Blue Medicare PPO personnel and fellow Participating Providers.
- Providing equal access and treatment to all Blue Medicare PPO Members.

Participating Providers acting within the lawful scope of practice, are encouraged to advise patients who are Members of Blue Medicare PPO about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options;
2. The risks, benefits, and consequences of treatment or non-treatment; and
3. 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 Blue Medicare PPO.

Laws Regarding Federal Funds

Payments that Participating Providers receive for furnishing services to Blue Medicare PPO Members are, in whole or part, from Federal funds. Therefore, Participating Providers 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.

Marketing

Participating Providers may not develop and use any materials that market Blue Medicare PPO without the prior approval of Blue Medicare PPO in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are approved prior to use by CMS or are submitted to CMS and not disapproved within 45 days.

Provider Performance Standards and Compliance Obligations, Continued

Sanctions under Federal Health Programs and State Law

Participating Providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the Participating Provider.

Participating Providers must disclose to Blue Medicare PPO whether the Participating Provider 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. Participating Providers must notify Blue Medicare PPO immediately if any such sanction is imposed on a Participating Provider, a staff member or subcontractor.

Selection and Retention of Participating Providers

Participation Requirements

To participate in Blue Medicare PPO, the Physician/Professional Provider or Facility Provider:

- Must be a Participating Provider with BCBSNM
- Must have privileges at one of the Blue Medicare PPO 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 Medicare Advantage Amendment to his/her Medical Services Entity Agreement with BCBSNM
- Cannot have opted out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations. Blue Medicare PPO Participating 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. Blue Medicare PPO Participating 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 Providers

Blue Medicare PPO continuously reviews and evaluates Participating Provider information and recredentials Participating Providers every three years. The credentialing guidelines are subject to change based on industry requirements and Blue Medicare PPO standards.

Credentialing & Recredentialing of Participating Institution Providers

Blue Medicare PPO 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 Blue Medicare PPO standards.

Selection and Retention of Participating Providers, Continued

Appeal Process for Provider Participation Decisions

If Blue Medicare PPO decides to suspend, terminate or non-renew a Provider's participation status, Blue Medicare PPO 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 by Blue Medicare PPO.

Blue Medicare PPO 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. Blue Medicare PPO 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 Blue Medicare PPO.

When Blue Medicare PPO 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 Blue Medicare PPO 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 15.4.6 of the BCBCNM Blues Provider Reference Manual.

If a reduction suspension or termination of a Participating Provider's participation is final and is the result of quality of care deficiencies, Blue Medicare PPO 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: Please refer to the BCBSNM *Blues Provider Reference Manual*, Section 15.4.3. Provider Appeal Rights and Responsibilities for further instructions on the appeal process for provider terminations.

Notification of Members of Provider Termination

Blue Medicare PPO 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 Blue Medicare PPO representative may visit the Participating Provider's office to review the medical records of Blue Medicare PPO Members as described in Section 16 of the *Blues Provider Reference Manual*.

Standards for Medical Records

Participating Providers must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the Member's medical chart. Each medical record chart must include all of the elements specified in the *Blues Provider Reference Manual*. In addition, each medical record must also include the following:

- All Providers participating in the Member's care and information on services furnished by these Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Advance Directives – The Physician/Professional Provider must document whether or not the Member has executed an Advance Directive;
- Physical examinations, necessary treatments, possible risk factors for particular treatments; and
- Evidence of member input into the proposed treatment plan.

Advance Directive

Participating Providers must document in a prominent part of the Member's current medical record whether or not the Member has executed an Advance Directive.

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.

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

Confidentiality of Member Information

Participating Providers must comply with all state and Federal laws concerning confidentiality of health and other information about Members. Participating Providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Reporting Obligations

Cooperation in Meeting Centers for Medicare & Medicaid Services (CMS) Requirements	Blue Medicare PPO must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective Members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates; information on Member satisfaction; and information on health outcomes. Participating Providers must cooperate with Blue Medicare PPO in its data reporting obligations by providing to Blue Medicare PPO any information that it needs to meet its obligations.
Certification of Diagnostic Data	Blue Medicare PPO is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a Member and a Provider, supplier, or other practitioner (encounter data). Participating Providers that furnish diagnostic data to assist Blue Medicare PPO in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Initial Decisions, Appeals and Grievances

Initial Decisions

The “initial decision” (adverse determination) is the first decision Blue Medicare PPO makes regarding coverage or payment for care. In some instances, a Participating Provider, acting on behalf of a Blue Medicare PPO member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a Member asks Blue Medicare PPO 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 Provider acting on behalf of a Member, asks for preauthorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by Blue Medicare PPO.
- If a Member asks for a specific type of medical treatment from a Participating Provider, this is a request for an “initial decision” about whether the treatment the Member wants is covered by Blue Medicare PPO.

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

A decision about whether Blue Medicare PPO 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, Blue Medicare PPO will automatically provide an expedited decision.

If Blue Medicare PPO 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, Continued

Appeals and Grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints they can make. All Participating Providers must cooperate in the Blue Medicare PPO Appeals and Grievances process.

- An “appeal” is the type of complaint a Member makes when the Member wants Blue Medicare PPO to reconsider and change an initial decision (by Blue Medicare PPO or a Physician/Professional Provider) about what services are necessary or covered or what Blue Medicare PPO will pay for a service.
- A “grievance” is the type of complaint a Member makes regarding any other type of problem with Blue Medicare PPO or a Participating Provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the Participating 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:

- Claims/Termination of Coverage:
Blue Medicare PPO
ATTN: Appeals
P.O. Box 833995
Richardson, TX 75083-3995
Fax #: 1-505-816-3608
- Medical Care:
ATTN: Appeals
P.O. Box 27630
Albuquerque, NM 87125-7630
Fax #: 1-505-816-3837

For an Expedited Appeal Only, call: 1-800-205-9926

- For Claims Inquiries, contact:

Blue Medicare PPO
Provider Customer Services
1-866-706-7745

Initial Decisions, Appeals and Grievances, Continued

Resolving Grievances/Complaints

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

Resolving Appeals

A Member may appeal an initial adverse determination by Blue Medicare PPO concerning authorization for, or termination of coverage of, a health care service. A Member may also appeal an adverse initial decision by Blue Medicare PPO concerning payment for a health care service. A Member's appeal of an initial decision about authorizing health care or terminating coverage of a service must generally be resolved by Blue Medicare PPO within 30 calendar days or sooner if the Member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

If the normal time period for an appeal could jeopardize the life or health of 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 72 hours unless it is in the Member's interest to extend this time period. When a Member or Physician/Professional Provider requests an expedited appeal, Blue Medicare PPO will automatically expedite the appeal.

Hospital Discharge Notification Requirements

A special type of appeal applies only to Hospital discharges. Hospitals must notify (in person) a Medicare Advantage Member or representative about hospital discharge appeal rights using the revised version of the **Important Message from Medicare (IM)**. It must be delivered and signed by the Member or Member's representative within two days of admission and a copy must be given to the Member or representative at that time. Hospitals must also deliver a copy of the signed notice as far in advance as possible, but not more than two calendar days before discharge. If the Member thinks Blue Medicare PPO coverage of a Hospital stay is ending too soon, the Member can appeal directly and immediately to the Quality Improvement Organization (QIO). However, such an appeal must be requested no later than midnight of the day of discharge, but before the member leaves the hospital. If the Member misses this deadline, the Member can request an expedited appeal from Blue Medicare PPO.

Initial Decisions, Appeals and Grievances, Continued

SNF, HHA, and CORF Discharge Notification Requirements

Another special type of appeal applies only to a Member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs are responsible for providing Members with a written notice no later than *two days* before their services are scheduled to end. (An example of the required notice, CMS10095A/Notice of Medicare Non-Coverage, is provided in the attachment section.*) The Member must be able to understand that he or she may appeal the termination decision. If the Member thinks his or her coverage is ending too soon, the Member can appeal directly and immediately to the QIO. The Member must request an appeal to the QIO no later than noon of the day before the date services are to end. If the Member misses the deadline for appealing to the QIO, the Member can request an expedited appeal from Blue Medicare PPO.

*The CMS 10095A/Notice of Medicare Non-Coverage is available for download at www.bcbsnm.com/provider. Click on Blue Medicare PPO then Provider Resources. Providers can modify certain areas of this notice including name, address, and telephone number, as well as specific member information, dates and types of service.

Further Appeal Rights

If Blue Medicare PPO denies the Member's appeal in whole or part, Blue Medicare PPO will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of Blue Medicare PPO. This organization will review the appeal and, if the appeal involves authorization for health care, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the appeal involves an expedited reconsideration decision, the IRE will make the decision within 72 hours.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the Member may appeal to an Administrative Law Judge (ALJ). If the Member is not satisfied with the ALJ's decision and the amount in controversy meets the appropriate threshold, the Member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision and the amount in controversy meets the appropriate threshold, the Member may be able to request a judicial review.

NOTE: The Centers for Medicare and Medicaid Services (CMS) provides detailed information regarding appeals and grievances, and required Member notices, as well as required forms, at www.cms.hhs.gov/MMCAG/ and www.cms.hhs.gov/BNI/ .

Initial Decisions, Appeals and Grievances, Continued

**Participating
Physician/
Professional
Provider
Obligations –
Organization
Determina-
tions**

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

**Participating
Physician/
Professional
Provider
Obligations –
Appeals**

Participating Physicians/Professional Providers must also cooperate with Blue Medicare PPO 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 very quickly in order to allow Blue Medicare PPO, the IRE or QIO to make an expedited decision.

Members' Rights and Responsibilities

Member Rights

Blue Medicare PPO Members have the right to timely, high quality care, and treatment with dignity and respect. Participating Providers must respect the rights of all Blue Medicare PPO Members.

Blue Medicare PPO Members have been informed that they have the following rights and responsibilities:

Timely, Quality Care

- Choice of a qualified Participating Physician/Professional Provider and Participating Hospital.
- Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to their Participating Physician/Professional Provider, and recommendations to Specialty are Physicians/Professional Provides when Medically Necessary.
- To receive Emergency Services when the Member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive Urgently Needed Services when traveling outside the Blue Medicare PPO Service Area or in the Blue Medicare PPO Service Area when unusual or extenuating circumstances prevent the Member from obtaining care from a Participating Provider.
- To request the aggregate number of grievances and appeals and dispositions.
- To request information regarding Participating Physician/Professional Provider compensation.
- To request information regarding the financial condition of Blue Medicare PPO.

Members' Rights and Responsibilities, Continued

Treatment with Dignity and Respect

- 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 to the Member's Physicians/Professional Providers.

Member Responsibilities

Blue Medicare PPO Members have been informed that they have the following responsibilities:

- To become familiar with their coverage and the rules they must follow to receive care as a Blue Medicare PPO 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;
-

Members' Rights and Responsibilities, Continued

Member Responsibilities, continued

- To act in a way that supports the care given to other patients and to help the smooth running of their Physician's/Professional Provider's office, hospitals, and other offices;
- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities; and
- To let Blue Medicare PPO know if they have any questions, concerns, problems or suggestions.

Member Satisfaction

Blue Medicare PPO periodically surveys Members to measure overall customer satisfaction as well as satisfaction with the care received from Participating Providers. Survey information is reviewed by Blue Medicare PPO and results are shared with the Participating Providers.

Services Provided in a Culturally Competent Manner

Blue Medicare PPO 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 Providers must cooperate with Blue Medicare PPO in meeting this obligation.

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

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

Advance Directives

Blue Medicare PPO 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. Blue Medicare PPO suggests that Participating Physicians/Professional Providers have Advance Directive forms in their office and available to Members.

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

Member Complaints/ Grievances

Blue Medicare PPO tracks all complaints and grievances to identify areas of improvement for Blue Medicare PPO. 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 care and behavioral health care:

- Routine and preventive care – within 30 days
- Non-urgent care but in need of attention – within 7 days
- Urgent, but non-emergent care – within 24 hours
- Emergency care – 24 hours/day, 7 days per week

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 Blue Medicare PPO Members with equal dignity and consideration as their non-Blue Medicare PPO 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 Medicare 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.

The Member should normally 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

Blue Medicare PPO 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.

Obligation to Provide Access to Care, Continued

**Prohibition
Against
Discrimination**

Neither Blue Medicare PPO or Participating 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:

1. Medical condition, including mental as well as physical illness;
2. Claims experience;
3. Receipt of health care;
4. Medical history;
5. Genetic information;
6. Evidence of insurability, including conditions arising out of acts of domestic violence;
7. Disability;
8. Race, ethnicity, national origin;
9. Religion;
10. Sex, sexual orientation;
11. Age;
12. Mental or physical disability; or
13. Source of payment.

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

Glossary of Terms

Appeal	Any of the procedures that deal with the review of adverse organization determinations of the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service. These procedures include reconsiderations by Blue Medicare PPO, an independent review entity (IRE), hearings before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council, and judicial review.
Basic Benefits	All health care services that are covered under the Medicare Part A and Part B programs except Hospice services and additional benefits. All Members of Blue Medicare PPO receive all Basic Benefits.
Centers for Medicare & Medicaid Services (CMS)	The Centers for Medicare & Medicaid Services, the Federal Agency responsible for administering Medicare.
Covered Services	Those benefits, services or supplies which are: <ul style="list-style-type: none">• Provided or furnished at the in-network benefit level by Participating Providers or authorized by Blue Medicare PPO or its Participating Providers;• Provided or furnished by non-participating providers at the in-network benefit level when authorized by Blue Medicare PPO due to network inadequacy or continuity of care concerns;• Provided or furnished by non-participating providers at the out-of-network (OON) benefit level;• Emergency Services that are provided or furnished at the in-network benefit level, and may be provided by non-participating providers;• Renal dialysis services provided at the in-network benefit level while the Member is temporarily outside the Service Area; and• Basic and Sectional Benefits.
Emergency Medical Condition	Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in: <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; or• Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Glossary of Terms, Continued

Experimental Procedures and Items	Items and procedures determined by Blue Medicare PPO and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Blue Medicare PPO will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.
Grievance	Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process may include: waiting times in physician offices; and rudeness or unresponsiveness of Customer Service Staff.
Home Health Agency	A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in the Member's home when Medically Necessary, when Members are confined to their home and when authorized by their Participating Physician/Professional Provider.
Hospice	An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.
Hospital	A Medicare-certified institution licensed in the state of New Mexico, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.
Medically Necessary	Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of a Member or a Member's Physician/Professional Provider.
Medicare	The Federal Government health insurance program established by Title XVIII of the Social Security Act.
Medicare Part A	Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

Glossary of Terms, Continued

Medicare Part B	Sectional medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.
Medicare Advantage (MA) Plan	A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit Plan in the same Service Area. HISC is a Medicare Advantage organization and Blue Medicare PPO is a Medicare Advantage plan.
Member	The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in the Blue Medicare PPO and whose enrollment has been confirmed by CMS.
Non-Contracting Medical Physician/Professional Provider or Facility	Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of New Mexico or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract with Blue Medicare PPO to deliver Covered Services to Blue Medicare PPO Members.
Participating Physician/Professional Provider	<p>The Participating Physician/Professional Provider whom a Member chooses to coordinate their health care is responsible for providing covered services for Blue Medicare PPO Members and coordinating specialty care.</p> <p>Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of New Mexico and Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to Blue Medicare PPO Members pursuant to the terms of the Agreement.</p>
Quality Improvement Organization (QIO)	The independent quality review and improvement organization approved by CMS. New Mexico Medical Review Association (NMMRA) is the QIO for Blue Medicare PPO.

Glossary of Terms, Continued

Service Area A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. The geographic area for the Blue Medicare PPO includes all counties within the state of New Mexico.

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

NOTE: If you have any questions regarding the information in this Section, please contact the BCBSNM Network Services Department at (505) 837-8800, or 1-800-567-8540.

Blue Medicare PPO Key Contacts List	
Blue Medicare PPO Provider Customer Service <i>(To obtain Benefits, Eligibility or Claims Status)</i>	1-866-706-7745 M – F 8:00 a.m. – 5:00 p.m. (MST)
BCBSNM Network Services Government Programs Contract Representative : Cathie Rowland-Robert <i>(For Medicare Advantage Amendment information)</i>	1-505-816-2132
Utilization Management (UM)	
• Preauthorization and Out-of-Network Referrals	1-800-325-8334
• Preauthorization Fax	1-505-816-3608
• Case Management Programs	1-800-325-8334
• Case Management Programs Fax	1-505-816-3608
• Disease Management Programs	1-866-252-8106
• Disease Management Programs Fax	1-505-816-3608
American Imaging Management (AIM)	
• Call Center	1-866-745-1789
• Internet	www.americanimaging.net
• Fax	1-800-610-0050
Participating Labs	
• Quest	1-800-232-3766
• SED	1-800-999-5227
• Tricare	1-800-245-3296
Electronic/Paper Claim Questions or Problems	
• The Availity Health Information Network	1-800-282-4548
• Web site Address	www.availity.com
Blue Medicare PPO Claims Address <i>(For submission of paper claims)</i>	Blue Medicare PPO P.O. Box 3567 Scranton, PA 18505
Behavioral Health Services	
• Mesa Mental Health <i>(For Preauthorization Only)</i>	1-800-583-6372
• Blue Medicare PPO Provider Customer Service <i>(To obtain Benefits, Eligibility or Claims Status)</i>	1-866-706-7745
Blue Medicare Rx	
• MAPD Customer Service	1-888-277-5507
• MAPD Prior Authorization	1-888-277-5507
• MAPD Pharmacy Contact Center	1-800-693-7018
• PDP Customer Service	1-888-285-2254
• PDP Prior Authorization	1-888-285-2254
• PDP Pharmacy Contact Center	1-800-693-7018
CMS Web site Address	www.cms.hhs.gov

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)

(address)

(city) (state)

(signature of witness)

(date)

(print name)

(address)

(city) (state)

(signature of witness)

(date)

<Provider Name>
<Provider Street Address>
<City, State zip>
<Provider Telephone Number>

NOTICE OF MEDICARE NON-COVERAGE

Patient Name: <First Name> <Last Name>

Patient I.D. Number: <Patient I.D. Number>

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT <insert type>
SERVICES WILL END: <insert effective date>

-
- Your Medicare Health plan and/or provider have determined that Medicare probably will not pay for your current <insert type> services after the effective date indicated above.
 - You may have to pay for any <insert type> services you receive after the above date.
-

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
 - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
 - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
 - If you choose to appeal and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, neither Medicare nor your plan will pay for these services after that date.
 - If you stop services no later than the effective date indicated above, you will avoid financial liability.
-

See the back of this notice for more information.

HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than the effective date of this notice.
- Call your QIO at: New Mexico Medical Review Association (NMMRA) 1-800-663-6351, TTY users: dial "711" for the relay operator to appeal, or if you have questions.

OTHER APPEAL RIGHTS:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY:1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION: (OPTIONAL)

Contact information for your Medicare Advantage plan:

Blue Medicare PPOSM
Telephone: 1-800-205-9926
TTY: 1-800-659-8331
Fax: 1-800-773-1521

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative

Date

SMService Mark of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans

A Medicare Advantage plan offered by HCSC Insurance Services Company,
an Independent Licensee of the Blue Cross and Blue Shield Association under
contracts H4531 and H3208 with the Centers for Medicare and Medicaid Services

