4 – Professional Provider Responsibilities

Overview

Introduction

A provider is a duly licensed facility, physician or other professional authorized to furnish health care services within the scope of licensure.

A professional provider is any health professional such as a physician, dentist, nurse practitioner, registered nurse, licensed practical nurse, podiatrist, optometrist, chiropractor, physician’s assistant, behavioral health professionals and physicians, pharmacist, nutritionist, occupational therapist, physical therapist, practitioner of oriental medicine, or other professional engaged in the delivery of health care services who is licensed to practice in New Mexico or the state where services are rendered; is certified; and is practicing under the authority of a managed health care plan, medical group, hospital, independent practice association, or other authority authorized by applicable New Mexico law.

A facility provider is an alcohol or drug treatment center, day surgery center, home healthcare agency, skilled nursing facility, hospital, or other facility that is licensed or certified to perform designated, covered health care services by the state or jurisdiction where services are provided. See Section 6, Facility and Ancillary Providers, for further information.

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Overview, Continued

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4.1 Changes to Provider Information

4.1.1 Requests for Provider Information Changes

Requests for changes to provider information may be sent to Network Services via mail, email, or fax. Any change in your information must reach us in time to update the claims payment system, the provider directories, and our Credentialing Verification Organization (CVO), Hospital Services Corporation (HSC). This means that you must provide us with requests for changes a minimum of 60 working days prior to the effective date of change.

You may not be reimbursed properly if you do not report changes to the following provider information:

- National Provider Identifier (NPI) changes
- Office location(s)
- Mailing address
- Tax ID Number (TIN)*
- Name change of provider or practice
- Business phone number
- Email address
- Fax number
- Affiliations
- Covering physicians
- Hours of operation
- Practice limitations (e.g., HMO panel size, ability to see new patients, etc.)

*BCBSNM must be informed of all Tax ID changes. Not informing BCBSNM adversely affects claims payment as all monies paid must be tracked for IRS purposes. Your NPI does not replace your TIN.

Note: Click on the Update Your Provider Information link at bcbsnm.com to access a convenient email submission form that you can use to report any changes to your practice information.

Continued on next page
4.1 Changes to Provider Information, Continued

4.1.2 Voluntary Termination of Participation

Your provider contract requires that you provide a notice 90 working days prior to the effective date of your voluntary termination from our provider network. This advance notice ensures that we can notify our members of any provider terminations in order to address any continuity of care concerns, as required by the New Mexico Department of Insurance and Patient Protection Act.

For Primary Care Providers (PCPs) – BCBSNM will be responsible for notifying our members who have chosen you as their PCP regarding your termination status within 30 days of your notice to us to ensure that there will be no lapse in benefits to the member.

For Specialists – All referrals and preauthorizations made to you will be terminated on the effective date of the termination of your contract. BCBSNM will notify all members who have received services from you five times or more in the last year of your contracted status regarding the need to transfer their care to an in-network specialist.
4.2 Primary Care Providers (PCPs)

Overview

A PCP (M.D., D.O., or C.N.P.) may be a general practitioner, family practice physician, internal medicine physician, OB/GYN, geriatrician, or pediatrician. BCBSNM also contracts with Certified Nurse Practitioners who may also be designated as PCPs.

Health Maintenance Organization (HMO) members must choose a PCP who will be their primary contact with the medical care system. The PCP usually determines the nature and frequency of care that is necessary and appropriate.

4.2.1 PCP and PCP-Type Responsibilities

PCPs are responsible for the member’s timely access to appropriate services and care which include, but are not limited to, the following services as defined by the member’s benefits:

- Physician services
- Outpatient services
- Hospital services
- Home health services
- Diagnostic laboratory and/or radiology services and timely notification of results
- Family planning services
- Health education and medical social services, including mental health or drug dependency
- Vision and hearing examinations/screenings
- Emergency services
- Rehabilitation services, including physical, speech, and occupational therapies
- Skilled nursing services

4.2.2 PCP Administrative Responsibilities

For BCBSNM members, PCPs must:

- Use BCBSNM-contracted specialists, ancillary providers, hospitals, pharmacies, laboratories, radiologists, and behavioral health professionals and physicians. This means, for example, that a physician, professional provider, facility or ancillary provider who or which participates with BCBSNM is required to admit, transfer to, or refer BCBSNM Members to another professional provider, facility or ancillary provider who or which also participates with BCBSNM, except in emergencies or as may otherwise be required by applicable law.
4.2.2 PCP Administrative Responsibilities continued

- Comply with BCBSNM’s Quality Management and Improvement (QMI) and Utilization Management (UM) requirements.
- Collect only deductible, coinsurance (based on contract allowable), and specified copayments from BCBSNM members for office visits; and charges for non-covered services.
- Submit claims on CMS-1500 forms (see Section 8, Claims Submission).
- Follow referral and preauthorization procedures (see Section 10, Preauthorization).
- Submit claims information accurately and in a timely manner (see Section 8).
- Maintain confidentiality of all member records.
- Maintain medical records for members following regulatory guidelines (see Medical Record Documentation Standards at the end of Section 16, Credentialing).
- Follow all state regulations, such as Health Department reporting requirements.
- Notify BCBSNM of changes to provider information as defined in Section 4.1, Changes to Provider Information.
- Comply with BlueCard® requirements as set forth in the BlueCard Program Provider Manual.
- If participating as a Blue Cross Community CentennialSM (Medicaid) provider, comply with the requirements set forth in the Blue Cross Community Centennial Section.
- Notify the BCBSNM Credentialing Department of state or federal sanctions, restrictions to license, or other contractually reportable events within 30 days of occurrence.
- Comply with appropriate professional standards and licensure requirements.
- Comply with the BCBSNM member complaint and grievance procedure.

The PCP should ensure that patients are reminded of appointments to help them comply with treatment plans and preventive care. For example, the PCP should issue reminders of screenings needed, as appropriate for age and sex, including but not limited to mammograms, pap tests, and immunizations as listed in the “Preventive Health Guidelines” (at the end of Section 17, Quality Management and Improvement).

Other preventive health services should be made available to members only in those instances where the PCP, in consultation with BCBSNM, determines that such services are medically necessary and as outlined in the State of New Mexico Managed Health Care Rule.

Continued on next page
4.2 Primary Care Providers (PCPs), Continued

4.2.3 On-Call Coverage

The PCP will ensure the availability of services to members 24 hours per day, 7 days per week. The PCP will also:

- Maintain weekly appointment hours that are sufficient (at least four days per week)* and convenient to serve members.
- Maintain on-call service capability with other physicians who are contracted with BCBSNM to perform appropriate and cost-effective evaluation and treatment of members when the PCP is unavailable.
- Ensure that any covering physician is a participating provider and agrees to abide by all the procedures, requirements, and reimbursement policies described in the Participating Provider Agreement or other contract with BCBSNM and in this manual.

*You must notify Network Services if your regular office hours are less than four days per week. Providers with insufficient weekly appointment/office hours will not be listed as available to our members in our provider directories.

4.2.4 After-Hours Communication with Patients

The following information must be provided after normal office hours by either an answering service or answering machine message:

- How to make an appointment
- Hours of operation (when to call back)
- Emergency instructions including phone numbers
- How to reach the on-call provider

4.2.5 Interpreter Services

Contracted providers are expected to provide an interpreter for limited English proficient individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Providers need to arrange for the service using an interpreter service of their choice. Once the service is provided, the provider may submit an invoice for reimbursement to:

Provider Servicing
PO Box 23151
Waco, TX 76702

If you have any questions, call 817-826-8343.

Continued on next page
### 4.2 Primary Care Providers (PCPs), Continued

**4.2.6 PCP and PCP-Type Access Standards**

The following access standards define the minimum requirements of timely access to care. Individual cases will vary, and the standards represent the aggregate average of a provider’s practice for the condition and care required. Employer groups and regulatory agencies frequently ask us to provide access audits. Please be prepared to respond if asked for access information.

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<thead>
<tr>
<th>Condition</th>
<th>For</th>
<th>Time to Appointment</th>
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<tbody>
<tr>
<td>Routine, asymptomatic, recipient-initiated, outpatient appointments</td>
<td>Primary and preventive medical care</td>
<td>No greater than 30 days, unless member requests later date</td>
</tr>
<tr>
<td>Routine, symptomatic, recipient-initiated, outpatient appointments</td>
<td>Non-urgent primary medical care</td>
<td>No greater than 14 days, unless member requests later date</td>
</tr>
<tr>
<td>Urgent conditions</td>
<td>Primary medical care</td>
<td>Within 48 hours of notification; 7-days-a-week, 24-hour availability and 24-hour access to triage (PCP triage can be via telephone)</td>
</tr>
<tr>
<td>Emergency</td>
<td>Acute medical</td>
<td>Care for a non-life-threatening emergency within 6 hours; 7-days-a-week, 24-hour access to PCP triage or hospital emergency room</td>
</tr>
<tr>
<td>Routine outpatient</td>
<td>Diagnostic laboratory, diagnostic imaging, and other testing appointments</td>
<td>Time will be consistent with the clinical urgency but no greater than 10 days, unless member requests later date</td>
</tr>
<tr>
<td>Urgent outpatient</td>
<td>Diagnostic laboratory, diagnostic imaging, and other testing appointments</td>
<td>Time will be consistent with the clinical urgency but not greater than 48 hours</td>
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</table>

**Waiting time for outpatient scheduled appointments:** no more than 30 minutes after the scheduled time, unless there is an emergency or other urgent situation; in that case, the member will be given the opportunity to be seen by another provider in the office or to be rescheduled within 48 hours.

The timing of scheduled follow-up outpatient visits with providers will be consistent with the clinical need.
4.3 Specialists

4.3.1 Specialist Responsibilities

BCBSNM requires PCPs to refer members to in-network specialists, unless they have preauthorization from the Medical Director or his or her designee to refer the member to an out-of-network specialist. Follow the referral and preauthorization procedures (see Section 10, Preauthorization).

For BCBSNM members, specialists must:

- Notify the BCBSNM Credentialing Department of state or federal sanctions, restrictions to license, or other contractually reportable events within 30 days of occurrence (required by contract).
- Provide only those services requested by the PCP (exception: OB/GYN care).
- Contact the member’s PCP to discuss the indicated treatment.
- Work closely with the PCP to enhance continuity of health services.
- Communicate findings and recommended treatment plans to the PCP.
- Use BCBSNM-contracted ancillary providers, hospitals, pharmacies, laboratories, radiologists, and behavioral health professionals and physicians.
- Comply with BCBSNM QMI and UM requirements.
- Collect only deductible, coinsurance (based on contract allowable), and specified copayments from BCBSNM members for office visits; and also charges for non-covered services.
- Submit claims on CMS-1500 forms (see Section 8, Claims Submission).
- Obtain a referral from the PCP for any service that requires preauthorization before services are rendered (see Section 10, Preauthorization).
- Submit encounter and claims information accurately and in a timely manner (see Section 8).

Continued on next page
4.3 Specialists, Continued

4.3.1 Specialist Responsibilities (continued)

- Maintain confidentiality of all member records.
- Maintain medical records for members following regulatory guidelines (see Medical Record Documentation Standards at the end of Section 16).
- Follow all state regulations, such as Health Department reporting requirements.
- Notify BCBSNM of changes to provider information as defined in Changes to Provider Information in this section.
- Comply with BlueCard® requirements as set forth in the BlueCard Program Provider Manual.
- If participating as a Blue Cross Community CentennialSM (Medicaid) provider, comply with the requirements set forth in the Blue Cross Community Centennial Section.
- Comply with appropriate professional standards and licensure requirements.
- Comply with the BCBSNM member complaint and grievance procedure.

4.3.2 Interpreter Services

Contracted providers are expected to provide an interpreter for limited English proficient individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Providers need to arrange for the service using an interpreter service of their choice. Once the service is provided, the provider may submit an invoice for reimbursement to:

Provider Servicing
PO Box 23151
Waco, TX 76702

If you have any questions, call 817-826-8343.

Continued on next page
4.3 Specialists, Continued

4.3.3 Specialist and Behavioral Health Access Standards

The following access standards define the minimum requirements of timely access to care. Individual cases will vary and the standards represent the aggregate average of a provider’s practice for the condition and care required. Various groups, regulatory agencies, and clients ask us to provide access audits. Please be prepared to respond if asked for access information.

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<tr>
<td>Routine, symptomatic, recipient-initiated, outpatient appointments</td>
<td>Non-urgent primary medical care</td>
<td>No greater than 14 days, unless the member requests later date</td>
</tr>
<tr>
<td>Routine conditions</td>
<td>Behavioral health care</td>
<td>No greater than 10 days, unless the member requests later date</td>
</tr>
<tr>
<td>Urgent conditions</td>
<td>Primary medical care, including behavioral health care</td>
<td>Within 48 hours of notification; 7-days-a-week, 24-hour availability and 24-hour access to behavioral triage</td>
</tr>
<tr>
<td>Emergency</td>
<td>Acute medical and behavioral health care</td>
<td>Care for a non-life threatening emergency within 6 hours; 7-days-a-week, 24-hour access to triage or hospital emergency room</td>
</tr>
<tr>
<td>Routine outpatient</td>
<td>Diagnostic laboratory, diagnostic imaging, and other testing appointments</td>
<td>Time will be consistent with the clinical urgency, but no greater than 14 days, unless the member requests later date</td>
</tr>
</tbody>
</table>

Waiting time for outpatient scheduled appointments: no more than 30 minutes after the scheduled time, unless there is an emergency or other urgent situation; in that case, the member will be given the opportunity to be seen by another provider in the office or to reschedule within 48 hours.

The timing of scheduled follow-up outpatient visits with providers will be consistent with the clinical need.
4.4 Medical Records

Medical Record Requests

Providers will furnish medical, financial, and administrative information to BCBSNM that may be necessary for compliance with state and federal law and for QMI and UM purposes. Please send requested copies of medical records to BCBSNM within 30 days. BCBSNM does not pay for medical records.

Note: BCBSNM is compliant with the Health Insurance Portability & Accountability Act (HIPAA) regulations regarding required medical records.

Standards for Medical Records

Participating providers must have a system in place for maintaining medical records that conforms to regulatory standards. Each visit whether direct or indirect must be comprehensively documented in the member’s medical chart.

Refer to the Medical Records Documentation Standards in Section 16 of this manual, or in the Standards & Requirements section of our provider website.

Transfer of Medical Records

The physician or physician group practice is responsible for making appropriate arrangements for the disposition of medical records when a practice closes.

The recommended period for record retention is:

- Adult patients—10 years from the date the patient was last seen.
- Minor patients—28 years from the patient’s birth.
- Mammography patients—10 years from last mammography.
- Deceased patients—5 years from the date of death.

Continued on next page
4.4 Medical Records, Continued

For situations where a physician is turning over their practice to another physician:

- There should be a written agreement that stipulates the recommended retention time and access capability.
- If physicians choose to destroy clinical records after a set period of time, confidentiality must not be compromised. There are record destruction services that guarantee records are properly destroyed without releasing any information.
- When a practice closes and medical records are transferred, patients should be notified that they may designate a physician or other provider to receive their records.
- If a patient does not designate a physician, records may be transferred to a custodian (physician or commercial storage firm).

Custodians who agree to retain the records can be physicians, non-physicians, or commercial storage facilities. Custodial arrangements for retaining records are usually entered into for a fee and should be in writing. A written custodial agreement should guarantee future access to the records for both the physician and patients. A custodial agreement should include the following:

- Keep and maintain the medical records received for the same retention times as above.
- No right to access the information contained in the medical records without a signed release from the patient or a properly executed subpoena or court order.
- Notify the original physician or physician’s personal representative of any change of address or phone number.
- Terms apply to all persons in the custodian’s employment and facility.
- Release copies of the medical records to a person designated by the patient only with the patient’s written request.
- Comply with state and federal laws governing medical record confidentiality, access, disclosure, and charges for copies of the records.
- Agreed-upon fees for maintaining the records.
- Language that addresses any personal practice decisions made by a custodian (retirement, selling, or moving) to ensure the safety of and continued access to the records by the original physician or physician’s personal representative.
4.5 Medical Policy and Member Benefits

Overview

Providers are required to review BCBSNM medical policy information, as these policies may impact your reimbursement and your patients' benefits. Approved new or revised medical policies and their effective dates are posted on our website around the first and fifteenth of each month. To view Active Policies or Pending Policies, visit bcbsnm.com under Standards & Requirements. In addition, you may also click on Draft Policies to view policies that are under development or are being revised and submit your comments via email.

Medical policies are based on data from the peer-reviewed scientific literature, from criteria developed by specialty societies, and from guidelines adopted by other health care organizations. Medical policies are used to make benefit coverage determinations. In the event of conflict between a medical policy and any Plan document, the Plan document will govern.

Providers are responsible for being familiar with services that may not be covered by BCBSNM, such as procedures that may be considered experimental and/or investigational. If a procedure or diagnostic service is considered experimental and/or investigational, you must inform the member that they may incur financial responsibility.

Continued on next page
4.5 Medical Policy and Member Benefits, Continued

4.5.1 Experimental, Investigational or Unproven Services

Experimental, investigational, or unproven services include any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as defined below. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is considered experimental and will not be covered.

**Standard medical practice** means the use of services or supplies that are in general use in the medical community in the United States and that meet the following criteria:

- The services or supplies have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
- The services or supplies are appropriate for the hospital or other facility provider in which they were performed.
- The physician or other professional provider administering the services or supplies has had the appropriate training and experience to provide the treatment or procedure.

For a treatment, procedure, facility, piece of equipment, drug, device, or supply to be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

**Continued on next page**
4.5 Medical Policy and Member Benefits, Continued

4.5.1 Experimental, Investigational or Unproven Services (continued)

- The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.
- The service must be medically necessary and not excluded by any other contract exclusion.

Note: Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol(s) used by the treating facility; or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. Experimental, investigational, or unproven does not include cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

Note: For FEP members, any therapy that has been approved by the FDA is no longer considered to be experimental and/or investigational. In these cases, it must also be noted that medical necessity of the activity in question must also be considered before determining whether or not the treatment will be covered.

Continued on next page
4.5 Medical Policy and Member Benefits, Continued

4.5.2 Exclusions and Non-covered Services

BCBSNM does not cover services for which the member has no legal obligation* to pay or that are free, including:

- Charges made only because benefits are available under the health care plan
- Services for which the member has received a professional or courtesy discount
- Volunteer services
- Services provided by the member for him or herself
- Services provided by a BCBSNM provider to a family member or immediate relative, or services provided to persons ordinarily residing in a family member’s or immediate relative’s household (**See below for definitions and related information from the Medicare Benefit Policy Manual).
- Physician charges exceeding the amount specified by the Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

When BCBSNM receives claims that fall into the above categories, they will be denied as non-covered services.

*The “No Legal Payment Obligation” exclusion above does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services or Medicaid.

**The Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 16, Section 130, Charges Imposed by Immediate Relatives of the Patient or Members of the Patient’s Household, provides the following definitions of an immediate relative and members of the patient’s household:

An immediate relative includes the following degrees of relationship:

- Husband and wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild

Continued on next page
4.5 Medical Policy and Member Benefits, Continued

4.5.2 Exclusions and Non-covered Services (continued)

Note: A step-relationship and an in-law relationship continue to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties.

Members of the patient’s household are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included in this definition.

4.5.3 FEP Exclusions

Standby Physicians – The Federal Employee Program (FEP) Plans do not provide benefits for standby services.

- FEP benefits are available when a physician becomes actively involved in a patient’s care. In certain cases, such as neonatal intensive care, where the standby physician is in attendance because of a medically appropriate diagnosis, benefits may be available. The standby physician must be requested by the attending physician.
- Benefits are not provided for physicians who are on call at the hospital when the medical condition of the patient does not support the indication that additional physician assistance would be necessary.