BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

January 2022

News & Updates

COVID-19 Information for Providers

Please check the following Blue Cross and Blue Shield of New Mexico (BCBSNM) resources frequently for updates to important information related to COVID-19:

- Provider Information on COVID-19 Coverage
- BCBSNM News and Updates
- BCBSNM COVID-19 Member Website

Current Procedural Terminology (CPT®) Codes Updated for Prior Authorization, Jan. 1, 2022

BCBSNM is removing prior authorization requirements that may apply for some commercial and Medicaid Blue Cross Community Centennial℠ members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). Click "Read More" for a summary of changes.

Read More

Behavioral Health Cost Share Waiver for Some BCBSNM Members Begins Jan. 1, 2022

Beginning Jan. 1, 2022, fully-insured commercial, student health, retail, and Interagency Benefits Advisory Committee (IBAC) BCBSNM members will have no cost-sharing for certain behavioral

health services and medications. Click “Read More” for a list of applicable services and medications.

Read More

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan. 1, 2022 — Part 1

Based on the availability of new prescription medications and Prime’s National Pharmacy and Therapeutics Committee’s review of changes in the pharmaceuticals market, some additions or drugs moving to a lower out-of-pocket payment level, revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were made to the Blue Cross and Blue Shield of New Mexico (BCBSNM) drug lists. Your patient(s) may ask you about therapeutic or lower cost alternatives if their medication is affected by one of these changes.

View the Pharmacy Program Updates effective as of Jan. 1, 2022

Delivering Quality Care

Rural Health Clinics and Federally Qualified Health Centers May Meet Quality Measure

Starting Jan. 1, 2022, Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) may meet the requirements for the quality measure Follow-up After Hospitalization for Mental Illness (FUH). We track FUH as part of monitoring the quality of our members’ care. FUH requires a timely outpatient follow-up visit with a qualified mental health provider, including telehealth visits, or in certain outpatient settings. Timely follow-up care is important for members’ health and well-being after hospitalization for mental illness.

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Webinar on Avoiding Antibiotics Overuse

You’re invited to watch a recording of our free webinar on preventing antibiotics overuse. The webinar features Dr. Sharon Tsay, a medical officer from the Centers for Disease Control and Prevention (CDC) Office of Antibiotic Stewardship. It was recorded Nov. 16, 2021.

Watch the webinar online here

The webinar provides information on:

- Avoiding antibiotic treatment for acute bronchitis and other viral illnesses

- How antibiotics can do more harm than good when used and not needed
- Alternatives to antibiotics

About the Speaker

Sharon Tsay, MD, is an infectious diseases-trained physician who serves as a medical officer in CDC's Office of Antibiotic Stewardship, where she focuses on improving antibiotic use in outpatient settings. She trained in internal medicine at Columbia NY Presbyterian Hospital and completed an infectious diseases fellowship at University of Pennsylvania. She joined the CDC in 2016 as an Epidemic Intelligence Service officer, where she worked in fungal diseases. She maintains clinical practice and serves as an infectious diseases consultant in the Piedmont Healthcare System on weekends in Atlanta.

Coding and Claims

Claim Editing Enhancements Coming April 1, 2022

Effective April 1, 2022 BCBSNM will enhance our claims editing and review process with Cotiviti, INC. for some of our commercial members to help ensure accurate coding of services and that services are properly reimbursed. The enhancements require you to continue to follow generally accepted claim payment policies. With your help, the enhanced claims review process will help our members get the right care at the right time and in the right setting.

Read More

Federal Employee Program® (FEP®)

Summary of 2022 FEP Benefit Changes

Please click "Read More" below for a summary of changes to FEP member benefits including organ transplant, gender reassignment surgery, cardiovascular care, maternity programs, pharmacy, air ambulance and emergency medical services.

Read More

Blue Cross Medicare Advantage℠ (Medicare)

COVID-19 Vaccine Billing for Medicare Advantage Members

Starting Jan. 1, 2022, BCBSNM will cover the cost of COVID-19 vaccines and their administration for Blue Cross Medicare Advantage members instead of the Original Medicare program (also known as fee-for-service Medicare). Medicare Advantage members will continue to have no cost-sharing during their 2022 benefit year for COVID-19 vaccines and their administration, including approved booster doses.

For Medicare Advantage members you vaccinate on or after Jan. 1, follow your normal submission process to BCBSNM or refer to the member's ID card for billing instructions when submitting vaccine and administration claims.

Read More

New Flexible Medicare Advantage PPO Plan

We're offering certain Blue Cross Medicare Advantage members a new way to access care. The Blue Cross Medicare Advantage Flex (PPO)℠ Plan is an open access plan. It allows members to see any provider accepting Medicare, including Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO)℠ contracted providers. Members can see providers inside or outside the plan service area or plan network, at no additional cost.

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Patients in the Qualified Medicare Beneficiary Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage plans, you may not bill our members enrolled in the Qualified Medicare Beneficiary (QMB) program, a federal Medicare savings program. QMB patients are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a state Medicaid benefit, QMB covers the Medicare Advantage premiums, deductibles, coinsurance and copayments of QMB beneficiaries. QMB beneficiaries are not responsible for Medicare Advantage cost-sharing, or out-of-pocket costs.

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Hospitals Must Provide Medicare Outpatient Observation Notice (MOON)

Hospitals and Critical Access Hospitals (CAH) are required to give the standardized Medicare Outpatient Observation Notice (MOON) to our Blue Cross Medicare Advantage℠ membcare Advaners who are under outpatient observation for more than 24 hours. The notice explains why the members aren't inpatients and what their coverage and cost-sharing obligations will be.

Steps for providers to complete the MOON

- Download the notice from the Centers for Medicare and Medicaid Services (CMS) website
- Fill in the reason the member is outpatient rather than inpatient.
- Explain the notice verbally to the member if they are in observation more than 24 hours.
- Have the member sign to confirm they received and understand the notice. If the member declines, the staff member who provided the notice must certify that it was presented.
- Document all member communications regarding the MOON process in members' records.

The notice **must be completed no later than 36 hours after observation begins or sooner** if the patient is admitted, transferred or released.

Learn more from CMS' Notice Instructions.

The information provided here is only intended to be a summary of the law that have been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

CMS-Required Training for Dual-Special Needs Plans

Providers who treat dually-eligible Medicare and Medicaid members are required by the Centers for Medicare and Medicaid Services (CMS) to complete an annual Dual-Special Needs Plan (DSNP) training on DSNP plan benefits and requirements, including coordination of care and Model of Care elements.

Read More

Blue Cross Community Centennial℠ (Medicaid)

Required Cultural Competency Training Available Online

The New Mexico Human Services Department (HSD) requires all providers contracted within a New Mexico Medicaid Network, like Blue Cross Community Centennial, to take annual cultural competency training. This training is intended to include all cultures and not be limited to any particular group and is designed to address the needs of racial, ethnic, and linguistic populations that may experience unequal access to health services.

Read More

Not Yet Contracted?

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

Reminder: Update your Enrollment Information

Due to Centennial Care requirements, all enrollment information (changes to demographics, licensure or certification, provider status, etc.) must be updated on the NM Medicaid Provider Web Portal.

BCBSNM Website

It's important for you to stay informed about news that could affect your practice. BCBSNM offers many ways to stay informed via our website, bcbsnm.com/provider, and our provider newsletter, *Blue Review*. Signing up is easy.

Medical Policy Updates

Approved new or revised medical policies and their effective dates are usually posted on our website the 1st and 15th of each month. These policies may impact your reimbursement and your patients' benefits. These policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Clinical Payment and Coding Policies

BCBSNM has adopted additional clinical payment and coding policies. These policies are based on criteria developed by specialized professional societies, national guidelines (e.g. Milliman Care Guidelines (MCG) and the CMS Provider Reimbursement Manual and are not intended to provide billing or coding advice but to serve as a reference for facilities and providers. These policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Claims Inquiries

Our Provider Service Unit (PSU) handles all provider inquiries about claims status, eligibility, benefits and claims processing for BCBSNM members. For the BCBSNM BlueCard® PSU, call 800-222-7992. For out-of-area claims inquiries, call 888-349-3706.

Network Services Contacts and Related Service Areas

Do We Have Your Correct Information?

Maintaining up-to-date contact and practice information helps to ensure that you are receiving critical communications and efficient reimbursement processes. Please complete our quick and easy online form for any changes to your contact or practice information.

Member Rights and Responsibilities

BCBSNM policies help address the issues of members participating in decision making regarding their treatment; confidentiality of information; treatment of members with dignity, courtesy and a respect for privacy; and members' responsibilities in the practitioner-patient relationship and the health care delivery process.

bcbsnm.com/provider

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Current Procedural Terminology (CPT®) Codes Updated for Prior Authorization, Jan. 1, 2022

What's Changing: Blue Cross and Blue Shield of New Mexico (BCBSNM) is changing prior authorization requirements that may apply for some commercial and Medicaid Blue Cross Community Centennial℠ members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

Important Reminder: Always check eligibility and benefits first through Availity® or your preferred vendor, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable. Changes include:

- **Jan. 1, 2022** — Removal of Spinal Cord Stimulation codes previously reviewed by BCBSNM (Commercial)
- **Jan. 1, 2022** — Removal of Multiple Stimulation codes previously reviewed by BCBSNM (Commercial)
- **Jan. 1, 2022** — Removal of Radiation Oncology codes previously reviewed by AIM (Commercial and BCCC)
- **Jan. 1, 2022** — Removal of Advanced Imaging codes previously reviewed by AIM (Commercial and BCCC)
- **Jan. 1, 2022** — Removal of Medical Oncology codes previously reviewed by AIM (Commercial and BCCC)

More Information: Refer to the updated Preauthorization CPT Code Lists section in the Preauthorization area of the website. The code changes will be designated with dates of removal or addition.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Behavioral Health Cost Share Waiver for Some BCBSNM Members Begins Jan. 1, 2022

What's Changing

Beginning Jan. 1, 2022, fully-insured commercial, student health, retail, and Interagency Benefits Advisory Committee (IBAC)* Blue Cross and Blue Shield of New Mexico (BCBSNM) members will have no cost-sharing for certain behavioral health (BH) services and medications.

*IBAC inclusive of the following groups: Albuquerque Public Schools (APS), New Mexico Public Schools Insurance Authority (NMPSIA), New Mexico Retiree Health Care Authority (NMRHCA), and State of New Mexico Risk Management Division (SONM).

Remember to check patient eligibility and benefits prior to rendering services. Benefit exclusions, network requirements and utilization management policies, including prior authorization, remain applicable. Members with HSA-eligible High Deductible Health Plans must meet the deductible first before services and medications can be covered without cost-sharing.

The cost share waiver applies to the following services:

- Professional Services
    - Rendered by a BH provider
    - Rendered by a Primary Care Provider (PCP) when a BH diagnosis is the first or second code on the claim
- Outpatient Facility Services
    - Delivered in a BH facility, or in a non-BH facility with an attending BH provider
    - Non-emergency room/non-urgent care center outpatient services delivered in a non-BH facility by a non-BH provider when a BH diagnosis is the first or second code on the claim
- Inpatient Facility Services
    - Inpatient services, including professional services, delivered in a BH hospital, the BH department of a general acute care hospital or a residential treatment center

    - Inpatient services, including professional services, delivered in a general, acute care hospital when the attending provider is a BH provider
    - Detox services, including professional services, delivered in a BH hospital, a general, acute care hospital or a residential treatment center
- Ancillary Services
    - Clinical laboratory services, radiology services and other imaging services when the ordering provider is a BH provider
    - Clinical laboratory services, radiology services and other imaging services when a BH diagnosis is the first or second code on the claim
- Prescription Drugs
    - Certain BH medications are covered without cost-sharing, which will be listed on our Jan. 1, 2022, fully insured Performance and Health Insurance Marketplace drug lists
    - Providers or members can request a cost-sharing waiver for drugs not included on this list via a fax form that will be available on bcbsnm.com/provider on Jan. 1, 2022.

Check Patient Eligibility and Benefits

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit quotes include membership verification, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts.

Providers are strongly encouraged to use availity.com or their preferred vendor for eligibility and benefit verifications.
Please note that if BCBSNM must reimburse a member for cost sharing paid for a BH service or medication, BCBSNM may recoup the reimbursement amount from the network provider that accepted the cost sharing from the member.

Questions?

For more information about this communication please contact Provider Customer Service at 888-349-3706, or through our Email Us form at bcbsnm.com/provider.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

Rural Health Clinics and Federally Qualified Health Centers May Meet Quality Measure

Starting Jan. 1, 2022, Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) may meet the requirements for the quality measure **Follow-up After Hospitalization for Mental Illness (FUH)**. We track FUH as part of monitoring the quality of our members' care.

Meeting the Measure

For RHCs and FQHCs, Psychiatric Collaborative Care Model (CoCM) service may satisfy the measure. Psychiatric CoCM must meet all of the following criteria:

- Sixty minutes or more of clinical staff time for psychiatric CoCM services directed by an RHC or FQHC practitioner (physician, nurse practitioner, physician's assistant or certified nurse-midwife), and
- Include services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.

This guidance is for RHCs and FQHCs only. It applies to measurement year 2022.

Why FUH Matters

FUH is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). It requires a timely outpatient follow-up visit with a qualified mental health provider, including telehealth visits, or in certain outpatient settings. Timely follow-up care is important for members' health and well-being after hospitalization for mental illness, according to NCQA.

For FUH we capture the percentage of discharges for members ages 6 and older who were hospitalized for the treatment of selected mental illness or intentional self-harm and who had a follow-up visit with a mental health provider. The follow-up visit must be on a different date than the discharge date. Two percentages are measured and reported:

- Discharges for which members had a follow-up visit within 30 days after discharge

- Discharges for which members had a follow-up visit within seven days after discharge

If the first follow-up visit is within seven days after discharge, then both rates are counted for this measure.

Questions? Email BHQualityImprovement@bcbstx.com or contact your Provider Network Representative.

Claim Editing Enhancements Coming April 1, 2022

Effective April 1, 2022, Blue Cross and Blue Shield of New Mexico (BCBSNM) will enhance our claims editing and review process with Cotiviti, INC. for some of our commercial members to help ensure accurate coding of services and that services are properly reimbursed.

What this means for you: The enhancements will require you to follow generally accepted claim payment policies. With your help, the enhanced claims review process will help our members get the right care at the right time and in the right setting.

Note: Inaccurately coded claims will result in denied or delayed payment.
About the guidelines: BCBSNM will continue to follow claim payment policies that are global in scope, simple to understand and come from recognized sources, including:

- ICD-10 coding guidelines
- The Healthcare Common Procedure Coding System (HCPCS)
- Current Procedural Terminology (CPT) codes as documented by the American Medical Association (AMA)
- Correct Coding Initiatives (CCI)

- Post-Operative Period Guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS)

Using these guidelines will help ensure a more accurate review of all claims.

What's changing: Components of the editing and review enhancements include:

1. **Anatomical Modifiers** — This policy validates the area or part of the body on which a procedure is performed. Procedure codes that do not specify right or left require an anatomical modifier. This includes procedures on fingers, toes, eyelids and coronary arteries which have specific CMS-defined modifiers.
2. **Diagnosis Code Guidelines** — This policy enforces all ICD-10-clinical modification (CM) diagnosis coding guidelines, including reporting of inappropriate code pairs, as well as correct coding of secondary, manifestation, sequelae, chemotherapy administration, external causes and factors influencing health status diagnoses. These guidelines are contained in the ICD-10-CM Diagnosis Codes Manual.

More Information: These new enhancements follow a previous announcement for an edit that will go live Jan. 10, 2022.
View these supplemental guidelines for additional guidance. To edit or correct a denied claim, please follow the procedure outlined in Section 8 of the Provider Reference Manual on filing corrected claims. Watch News and Updates for future updates.

Summary of 2022 Federal Employee Program® (FEP®) Benefit Changes

The following is a summary of updates to FEP member benefits effective Jan. 1, 2022. For more information regarding member benefits, please call the telephone number on the back of the member ID card. Please confirm FEP member benefits with the 2022 benefit brochures, available at fepblue.org/brochure, prior to rendering services.

Organ Transplant:

Kidney transplants will now require Prior Approval and are now part of the Blue Distinction Centers for Transplants® (BDCT) Program. This means members may be eligible for BDCT travel and lodging benefits when criteria are met.
Pancreas transplants have been removed from the BDCT program but still require Prior Approval.

Gender Reassignment Surgery (GRS):

- Includes nipple reconstruction
- Top-only surgery
    - Hormone therapy no longer required
    - Only 1 referral letter needed
- Non-gender identity can be considered a form of gender dysphoria, and therefore can be covered if all other criteria are met

Electrocardiogram (EKG):

EKG will no longer be considered part of the preventive benefit with annual exams. EKG will be subject to post-service review for medical necessity.

Maternity:

FEP Maternity benefit now offers a breast pump and milk storage bags for members who are pregnant and/or nursing when ordered through our new fulfillment vendor. For more information, contact Customer Service.

Pharmacy:

Specialty drug pharmacy will now be administered by CVS Caremark. For information about the FEP specialty drug pharmacy program,
visit fepblue.org/specialtypharmacy or call us at 888-346-3731.
For FEP Blue Focus℠: AllianceRx Walgreens Prime and Duane Reade Pharmacies will no longer be in-network effective Jan. 1, 2022.

Air Ambulance:

Non-emergent air ambulance transport from one facility to another requires Prior Approval and like emergent air ambulance transport falls under the federal No Surprise Billing Act.

Emergency Medical Services:

For emergency medical services performed in the emergency department of a hospital or urgent care centers licensed for, and permitted to provide, emergency services, that does not contract with Blue Cross and Blue Shield of New Mexico, payment allowance

is determined in accordance with applicable law, such as the federal No Surprise Billing Act.

Questions?

Contact FEP Customer Service at 800-245-1609.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

COVID-19 Vaccine Billing for Medicare Advantage Members

Starting Jan. 1, 2022, Blue Cross and Blue Shield of New Mexico (BCBSNM) will cover the cost of COVID-19 vaccines and their administration for Blue Cross Medicare Advantage members instead of the Original Medicare program (also known as fee-for-service Medicare). Medicare Advantage members will continue to have no cost-sharing during their 2022 benefit year for COVID-19 vaccines and their administration, including approved booster doses.

What This Means for You

- **Through Dec. 31, 2021:** For Medicare Advantage members you vaccinate through Dec. 31, submit claims for the vaccine and its administration to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved. Payment for the vaccine and its administration is through the Original Medicare program until the end of the year.
- **Starting Jan. 1, 2022:** For Medicare Advantage members you vaccinate on or after Jan. 1, follow your normal submission process to BCBSNM or refer to the member's ID card for billing instructions when submitting vaccine and administration claims.

Reimbursement

- In-network providers will be reimbursed for the COVID-19 vaccine and administration fee based on contracted rates.
- Out-of-network providers will be reimbursed based on established out-of-network reimbursement policy that follows Medicare rates.

Resources

- Learn more about COVID-19 coverage.
- See CMS guidance on Medicare billing for the COVID-19 vaccine administration

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New Flexible Medicare Advantage PPO Plan

We're offering certain Blue Cross Medicare Advantage℠ members a new way to access care. The Blue Cross Medicare Advantage Flex (PPO)℠ Plan is an open access plan. **It allows members to see any provider accepting Medicare,** including Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ contracted providers. Members can see providers inside or outside the plan service area or plan network, at no additional cost.

What This Means for You

- Starting Jan. 1, 2022, you can identify Flex Plan members by their member ID card. Look for the Flex Plan name on the front.
- You can see Flex Plan members if you accept Medicare and bill Blue Cross and Blue Shield of New Mexico (BCBSNM). Follow the billing instructions on the member ID card.
- If you are a Medicare Advantage-contracted provider with BCBSNM, you will be paid at your contracted rate.
- If you are not a Medicare Advantage-contracted provider with BCBS, you will receive the Medicare allowed amount for covered services. You may not balance bill the member for any difference in your charge and the allowance.

Value for Members

Flex Plan members' coverage level is the same whether in or outside the plan service area nationwide. Services must meet medical necessity criteria to be covered. The Flex Plan includes:

- Prescription drug coverage
- MDLIVE® for telehealth and 24/7 Nurseline
- SilverSneakers® fitness program at no cost
- A traveler benefit for members leaving their service area for up to six months

Check Eligibility and Benefits First

Use the Availity® Provider Portal or your preferred vendor to verify members' eligibility and benefits before every appointment. Eligibility and benefit quotes include:

- Membership verification
- Coverage status

- Prior authorization requirements
- Provider's network status for the member's policy
- Applicable copayment, coinsurance and deductible amounts

Ask to see the member's ID card and a photo ID to help guard against medical identity theft. If services may not be covered, members should be notified that they may be billed directly.

Patients in the Qualified Medicare Beneficiary Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage℠ plans, you may not bill our members enrolled in the Qualified Medicare Beneficiary (QMB) program, a federal Medicare savings program.

QMB patients are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a state Medicaid benefit, QMB covers the Medicare Advantage premiums, deductibles, coinsurance and copayments of QMB beneficiaries. **QMB beneficiaries are not responsible for Medicare Advantage cost-sharing, or out-of-pocket costs.**
For services you provide to QMB patients, you must:

- Bill both Medicare Advantage and Medicaid
- Accept Medicare Advantage payments and any Medicaid payments as payment in full

Tips to Avoid Billing QMB Patients

Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare Advantage cost-sharing.

To avoid billing QMB patients, please take these precautions:

- Identify QMB patients by looking for **Blue Cross Medicare Advantage Dual Care**SM or **Blue Cross Medicare Advantage Dual Care Plus**SM on member ID cards
- Check the New Mexico Medicaid portal to confirm QMB beneficiary status
- Understand the Medicare Advantage cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare Advantage cost-sharing billing and related collections efforts

Questions?

Call Customer Service at 1-877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.