

2020

Medicare Advantage
Section of the
Blues Provider Reference Manual



**BlueCross BlueShield
of New Mexico**

Blue Cross Medicare Advantage and Blue Cross Medicare Advantage Dual Care plans are HMO, HMO-POS, PPO, and HMO Special Needs Plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract and a contract with the New Mexico Medicaid program. Enrollment in HCSC's plans depends on contract renewal.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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1 INTRODUCTION

1.1 Overview

1.1.1 Our Name

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, is a Medicare Advantage Organization contracted with the Centers for Medicare and Medicaid Services (CMS) under contracts H3822, H3251, and H8634.

1.1.2 This Section

This Medicare Section of the Provider Reference Manual applies to professional and facility providers who and which are contracted as Network Providers for Blue Cross Medicare Advantage. The Blues Provider Reference Manual plus this Medicare Section explains the policies and procedures of the Blue Cross Medicare Advantage network. Its terms are contractual and we hope it provides you and your office staff with helpful information as you serve Blue Cross Medicare Advantage members. The information is intended to cover most situations your office will encounter while participating with BCBSNM for Blue Cross Medicare Advantage.

This Medicare Section of the Blues Provider Reference Manual is applicable only to the operation of Blue Cross Medicare Advantage.

1.1.3 Our Plans

Blue Cross and Blue Shield of New Mexico offers a range of Medicare Advantage plans including:

- HMO H3822 – 006: Blue Cross Medicare Advantage Dual Care (HMO DSNP) special needs plan for beneficiaries who receive both Medicare and Medicaid. Premiums, copayments, coinsurance, and deductibles may vary based on the level of extra help a member receives
- HMO H3822-002: Blue Cross Medicare Advantage Basic HMO plan for Medicare beneficiaries who are not eligible for our Dual Care Special Needs plan
- HMO H3822-003: Blue Cross Medicare Advantage Premier HMO plan for Medicare beneficiaries who are not eligible for our Dual Care Special Needs plan
- PPO H8634-002: Blue Cross Medicare Advantage PPO plan for Medicare beneficiaries who are not eligible for our Dual Care Special Needs plan
- H3251: HMO HMO-POS Medicare Advantage plan for Medicare beneficiaries who are not eligible for BCBSNM Medicare Advantage Dual Care Special Needs plan

Blue Cross and Blue Shield of New Mexico maintains and monitors Network Providers including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers through which members obtain covered services.

Members who enroll in any of our HMO plans are required to select a Primary Care Physician (PCP) and must have their PCP coordinate any out-of-network care with specialty providers. Members who select our PPO plan are not required to designate a PCP, although we recommend that they do select a PCP to help coordinate their care.

Members of our PPO plans may self-refer to participating specialty care providers.

1.2 Hospital Services

All inpatient admissions require prior authorization. The prior authorization process for admissions is carried out by the admitting provider or hospital personnel.

Admitting providers are responsible for contacting the BCBSNM UM Department or delegated UM provider, as applicable, to request authorization for additional days if an extension of the approved length of stay is required. The admitting provider will provide appropriate referrals for extended care. UM personnel will assist with coordinating all services identified as necessary in the discharge planning process.

1.3 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 Cross Medicare Advantage. 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 including ambulance services dispatched through 911 will be covered at the in-network benefit level.

1.4 Laboratory Services

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

Quest – Phone: 866-697-8378

Lab Corp of America – Phone: 888-522-2677

TriCore – Phone: 800-245-3296

Note: If lab services are performed at the participating provider's office, the provider may bill for the lab services. However, if the provider's office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Cross Medicare Advantage for the lab services.

2 GENERAL INFORMATION

2.1 Eligibility and Benefits

2.1.1 Verification of Coverage

At each office visit, your office staff should:

- Ask for the member's ID card.
- Copy both sides of the 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, deductible, coinsurance, copayments and other benefit information.
- Medicare providers may not bill, charge, collect a deposit, or seek reimbursement from any Medicare and Medicaid dually-eligible members enrolled in the Qualified Medicare Beneficiary(QMB) program.
- Participating providers must 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 receive in-network benefits only when services are performed at a participating Blue Cross Medicare Advantage facility. (Applies to members in all of the BCBSNM Medicare Advantage plans, except for the Premier Plus HMO-POS plan.)

Note: To obtain benefits and eligibility information and/or claims processing status for Blue Cross Medicare Advantage Dual Care (HMO D SNP), call Provider Customer Service at 877-688-1813. For benefits and eligibility information or claims processing status for all other Blue Cross Medicare Advantage plans call 877-774-8592.

2.1.2 ID Cards

Each Blue Cross Medicare Advantage member will receive an identification (ID) card containing the member's name, ID number, and information about their benefits. The 3-digit prefix numbers for Blue Cross Medicare Advantage plans are:



- YIJ = all Blue Cross Medicare Advantage HMO plans
- YID = Blue Cross Medicare PPO plan

The specific Blue Cross Medicare Advantage plan name is located on the member's ID card.



For information on vision, dental, hearing, transportation, and fitness providers, members are advised to contact the Customer Service telephone number on the back of their ID cards.

Note: These additional benefits are not offered under all of the Blue Cross Medicare Advantage plans.

PPO sample ID card:

 Blue Cross Medicare Advantage (PPO)	
Name: Member Name ID: YID804xxxxxx Plan (80840): 9101000237 Plan: Choice (PPO)	Office Visit: \$ x Specialist: \$ xx Emergency Room: \$ xx
Rx Bin: 011552 Rx PCN: NMPARTD1 Rx Grp: 0002 Rx ID: 804xxxxxx	PCP: PCP Name / NO PCP Selected / Unassigned PCP Phone: 1-###-###-#### ABQ Health Partners BS Plan Code: 291 BC Plan Code: 291
HPID: TBD CMS H8634 002	 Prescription Drug Coverage
www.bcbsnm.com	
Submit Medical Claims to: Blue Cross Medicare Advantage PO Box 11968 Albuquerque, NM 87192 Send Prescription Drug Claims to: Blue Cross Medicare Advantage PO Box 14429 Lexington, KY 40512	Pharmacy Line: 1-877-277-7898 Customer Service: 1-877-774-8892 TTY/TDD: 711 Medicare Limiting Charges Apply
HMO, HMO-POS and PPO plans are provided by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	
(HCSC), an independent licensee of the Blue Cross and Blue Shield Association. HCSC is Medicare Advantage organization with a Medicare contract.	

HMO/SNP sample ID card:

 Blue Cross Medicare Advantage (HMO/SNP)	
Name: Member Name ID: YLJ804xxxxxx Plan (80840): 9101000237 Plan: Dual Care (HMO SNP)	Office Visit: \$ x Specialist: \$ xx Emergency Room: \$ xx
Rx Bin: 011552 Part D Rx PCN: NMSNP Part B Rx PCN: NMPARTB Rx Grp: 0006 Rx ID: 804xxxxxx	PCP: PCP Name / NO PCP Selected / Unassigned PCP Phone: 1-###-###-#### ABQ Health Partners BS Plan Code: 291 BC Plan Code: 291
HPID: TBD CMS H3822 006	 Prescription Drug Coverage
www.getbluenm.com/mapd	
Submit Medical Claims to: Electronic Payer ID: 00790 Blue Cross Medicare Advantage PO Box 11968 Albuquerque, NM 87192 Send Prescription Drug Claims to: Blue Cross Medicare Advantage PO Box 14429 Lexington, KY 40512	Pharmacy Line: 1-888-274-5246 Customer Service: 1-877-688-1813 TTY/TDD: 711 Medical Group: 1-855-793-9360
HMO Special Needs Plan provided by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the	
Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract and a contract with the New Mexico Medicaid program.	

HMO/POS sample ID card:

 Blue Cross Medicare Advantage (HMO-POS)	
Name: Member Name ID: YJXXXXXXXXXX Plan (XXXXXX): XXXXXXXXXX Plan: Premier Plus (HMO-POS)	Office Visit: \$ xx Specialist: \$ xx Emergency Room: \$ xx
Rx Bin: 011552 Rx PCN: MAPDNM Rx Grp: XXXX Rx ID: XXXXXXXXXX	PCP: PCP Name / NO PCP Selected / Unassigned PCP Phone: 1-###-###-#### Provider Group Name BS Plan Code: xxx BC Plan Code: xxx
HPID: TBD CMS H3822 005	 Prescription Drug Coverage
www.bcbsnm.com	
Submit Medical Claims to: Blue Cross Medicare Advantage PO Box 11968 Albuquerque, NM 87192 Send Prescription Drug Claims to: Blue Cross Medicare Advantage PO Box 14429 Lexington, KY 40512	Pharmacy Line: 1-877-277-7898 Customer Service: 1-877-774-8892 TTY/TDD: 711 Medical Group: 1-855-793-9360
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2.2 Medical Records

2.2.1 Medical Records Provision

For the purposes of CMS audits of risk adjustment data, upon which health status adjustments to CMS capitation payments to Medicare Advantage Plans are based, and for the purposes set forth below, Network Providers are required under their contracts to

provide medical records requested by BCBSNM. Purposes for which medical records from providers are used by the Medicare Advantage Plans include:

- Advance determinations of coverage
- Plan coverage
- Medical necessity
- Proper billing
- Quality reporting
- Fraud and abuse investigations
- Plan initiated internal risk adjustment validation

2.2.2 Medical Records Review

A Blue Cross Medicare Advantage representative may visit the provider's office Blue Cross Medicare Advantage members as described in Section 16 of the [Blues Provider Reference Manual](#).

2.2.3 Medical Records Standards

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 participating provider must document whether or not the member has executed an Advance Directive;
 - Physical examinations, necessary treatments, possible risk factors for particular treatments
 - Evidence of member input into the proposed treatment plan
-

3 CLAIMS

3.1 Claims Requirements

Participating professional and facility providers must submit claims to Blue Cross and Blue Shield of New Mexico within 180 days of the date of service, using the standard CMS-1500 or UB-04 claim form or electronically as discussed below. Services billed beyond 180 days from the date of service are not eligible for reimbursement. These providers may not seek payment from the member for claims submitted after the 180-day filing deadline (or otherwise).

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

- Member's name
- Member's date of birth and sex
- Member's ID number (as shown on the member's ID card, including the 3-digit alpha prefix **YIJ** or **YID**)
- 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 (or ICD-10 codes when mandated)
- CPT® procedure codes
- Date(s) of service(s)
- Charge for each service
- Provider's Tax Identification Number (TIN)
- Provider NPI Number
- Name and address of provider
- Signature of provider providing services
- Place of service code

Blue Cross and Blue Shield of New Mexico will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to BCBSNM should comply with those requirements.

3.2 Submitting Claims

Claims should be submitted electronically through the Availity™ Health Information Network or your preferred vendor portal for processing. For information on electronic filing of claims, contact [Availity](#) at 800-282-4548.

The Blue Cross Medicare Advantage Electronic Payor ID # for participating professional and facility providers is the same as for commercial electronic claims (66006).

Paper claims must be submitted on the standard CMS-1500 (physician/professional provider) or UB-04 (facility) claim form to:

BlueCross BlueShield of New Mexico Medicare Advantage

c/o TMG Provider Services
P. O. Box 3686
Scranton, PA 18505

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 3-digit alpha prefix **YIJ or YID**.

Clean claims, as defined by law, that are submitted in accordance with these guidelines will be paid within 30 days.

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

3.3 Coordination of Benefits

If a member has coverage with another plan that is primary to Medicare, submit a claim for payment to that plan first. The amount payable by BCBSNM will be governed by the amount paid by the primary plan and Medicare Secondary Payer law and policies.

3.4 Claim Disputes

Providers may dispute a claims payment decision by requesting a [claim review](#). If you have questions regarding claims appeals, contact the Blue Cross Medicare Advantage Provider Customer Service Department at the number listed on the Contacts page at the end of this Section.

3.5 Recovering Overpayments

If an overpayment occurs on a Blue Cross Medicare Advantage claim, the auto-recoupment process will be used. Should you have any questions about this process, please contact Blue Cross Medicare Advantage Provider Customer Service at 877-774-8592 or D SNP Customer Service at 877-688-1813.

3.6 Balance Billing

An important protection for members when they obtain plan-covered services in a Medicare Advantage Plan is that they do not pay more than plan allowed cost sharing.

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

- You have informed the member in advance that the service is not covered, and
- The member has agreed in writing to pay for the services if they are not covered.

3.7 Reimbursement

Blue Cross and Blue Shield of New Mexico generally employs standard Medicare pricing methodology when processing claims. However, for claims that are subject to the CMS Physician Fee Schedule (PF) our Medicare Advantage claims system calculates the payment rate by rounding the appropriate rate components to 2 digits past the decimal, while the PFS payment system rounds to the 4th digit past the decimal. This rounding difference may result in a pricing variance of a penny more or less than the PFS system.

4 BENEFITS AND MEMBER RIGHTS

4.1 Non-Discrimination

Neither Blue Cross Medicare Advantage or participating providers may deny, limit or condition enrollment to individuals eligible to enroll in the plan offered on the basis of any factor that is related to health status, including, but not limited to the following:

- Claims experience
- Receipt of health care
- Medical history and medical conditions arising out of acts of domestic violence
- Evidence of insurability including conditions arising out of acts of domestic violence and disability

Additionally, Blue Cross Medicare Advantage and its participating providers must:

- Comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008.
- Ensure that it has procedures in place to ensure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

4.2 Confidentiality

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

Blue Cross Medicare Advantage members have the right to privacy and confidentiality regarding their health care records and information. Providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

4.3 Plan Benefits

Blue Cross Medicare Advantage provides benefits for medically necessary Part A and Part B covered items and services. Plan benefits are offered uniformly to all members residing in the plan service area and are offered at a uniform premium, with uniform benefits and cost-sharing.

Blue Cross Medicare Advantage is required to continue to cover inpatient services of a non-plan enrollee if the individual was a member at the beginning of an inpatient stay.

Exceptions

The following circumstances are exceptions to the rule that Blue Cross Medicare Advantage plans must cover the costs of original Medicare benefits:

- Hospice – Original Medicare (rather than Blue Cross Medicare Advantage) will pay hospice services received by a Blue Cross Medicare Advantage member.
- Inpatient stay during which the member's enrollment ends - BlueCross Medicare Advantage is required to continue to cover inpatient services of the non-plan enrollee if the individual was a Blue Cross Medicare Advantage member at the beginning of an inpatient stay. Note that incurred non-inpatient services are paid by Original Medicare or the new Medicare Advantage Plan that the enrollee joined as of the effective date of the new coverage. Member cost-sharing for the inpatient hospital stay is based on the cost-sharing amounts as of the entry date into the hospital.
- In cases where the member may have enrolled or disenrolled from Blue Cross Medicare Advantage during the billing period, the skilled nursing facility (SNF) will split the bill and send the Blue Cross Medicare Advantage Plan's portion to it and the remaining portion to Original Medicare. If the member is in a SNF in December in a plan that does not require a prior qualifying 3-day hospital stay and then joined Original Medicare on January 1, the stay continues to be considered a covered stay (if medically required).
- Clinical Trials – Original Medicare (rather than Blue Cross Medicare Advantage) pays for the costs of routine services provided to a Blue Cross Medicare Advantage member who joins a qualifying clinical trial. Blue Cross Medicare Advantage pays the member the difference between original Medicare cost-sharing incurred for qualifying clinical trial items and services and Blue Cross Medicare Advantage's in-network cost sharing for the same category of items and services. The Clinical Trial National Coverage Determination (NCD) defines what routine costs mean and clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Refer to the Medicare Clinical Trial Policies web page at www.cms.gov/ClinicalTrialPolicies for more information.

4.4 24-Hour Coverage

Participating providers are expected to provide coverage for Blue Cross Medicare Advantage members 24 hours a day, 7 days a week. When a provider is unable to provide services, the provider must ensure that he or she has arranged for coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers.

Refer to the Blue Cross Medicare Advantage Provider Directory or Provider Finder online at bcbsnm.com to identify providers participating in the Blue Cross Medicare Advantage network. You may also contact the Provider Customer Service Department at the number listed on the back of the member's ID card with questions regarding which providers participate in the network.

4.5 Access and Availability

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 a day, 7 days per week

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

All providers and facilities will treat all Blue Cross Medicare Advantage members with equal dignity and consideration as their non- Blue Cross Medicare Advantage patients.

Blue Cross Medicare Advantage provides for necessary specialist care, and in particular gives female members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

4.6 Provider Availability

Participating providers shall provide coverage 24 hours a day, 7 days a week. When a provider is unavailable to provide services, he or she must ensure that another participating provider is available. Hours of operation must not discriminate against Medicare members relative to other members. Participating 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.

4.7 Member Rights

Blue Cross Medicare Advantage) members have the right to timely, high quality care and treatment with dignity and respect. Participating providers must respect the rights of all members.

Blue Cross Medicare Advantage members have been informed that they have the following rights and responsibilities:

- Choice of a qualified participating provider and hospital.
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to their participating provider, and recommendations to specialty providers when medically necessary.
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive urgently needed services when traveling outside the Blue Cross Medicare Advantage service area or in the Blue Cross Medicare Advantage service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating provider.
- To request the aggregate number of grievances and appeals and dispositions.
- To request information regarding provider compensation.
- To request information regarding the financial condition of BlueCross Medicare Advantage.
- To be treated with dignity and respect and to have their right to privacy recognized.
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To confidential treatment of all communications and records pertaining to the member's care.
- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA.
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care.
- To refuse treatment or leave a medical facility, even against the advice of providers (providing the member accepts the responsibility and consequences of the decision).
- To complete an Advance Directive, living will or other directive to the member's providers.

4.8 Member Responsibilities

Blue Cross Medicare Advantage members have been informed that they have the following responsibilities:

- To become familiar with their coverage and the rules they must follow to receive care as a Blue Cross Medicare Advantage member;
- To give their providers the information they need to care for the member, and to follow the treatment plans and instructions that the member and his/her provider agree upon;
- To be sure to ask their provider if they have any questions;
- To act in a way that supports the care given to other patients and to help the smooth running of their provider's office, hospitals, and other offices;
- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities; and

- To let Blue Cross Medicare Advantage know if they have any questions, concerns, problems or suggestions.

4.9 Member Satisfaction

Blue Cross Medicare Advantage 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 Cross Medicare Advantage and results are shared with the participating providers.

4.10 Cultural Competency

Blue Cross Medicare Advantage 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 Cross Medicare Advantage in meeting this obligation.

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

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

4.11 Preventive Services

Members may access certain preventive services from any participating provider. Blue Cross Medicare Advantage covers without cost sharing all in-network Medicare covered preventive services for which there is no cost sharing under original Medicare. Charges cannot be made for facility fees, professional services or physician office visits if the only service(s) provided during the visit is a preventive service that is covered at zero cost-sharing under original Medicare. However, if during the provision of the preventive service, additional non-preventive services are furnished, then Blue Cross Medicare Advantage cost-sharing standards apply.

Members may directly access (through self-referral to any participating provider) in-network screening mammography and influenza vaccine.

Refer to www.cms.gov/MLNProducts/35_PreventiveServices.asp for detailed information on Medicare preventive services.

4.12 Out of Area Renal Dialysis

A member may obtain medically necessary dialysis services from any qualified provider the member selects when he or she is temporarily absent from the Blue Cross Medicare

Advantage service area and cannot reasonably access Blue Cross Medicare Advantage dialysis participating providers. No prior authorization or notification is required. However, a member may voluntarily advise Blue Cross Medicare Advantage that he or she will temporarily be out of the service area. Blue Cross Medicare Advantage may assist the member in locating a qualified dialysis provider.

4.13 Drugs Covered Under Medicare Part B

Subject to coverage requirements and regulatory and statutory limitations, the following broad category of drugs may be covered under Medicare Part B:

- Injectable drugs that have been determined by Medicare Administrative Contractors (MAC) to be “not usually self-administered” and are administered incident to physician services
- Drugs that the Blue Cross Medicare Advantage member takes through durable medical equipment (i.e., nebulizers)
- Certain vaccines including pneumococcal, hepatitis B (high or intermediate risk), influenza, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition
- Certain oral anti-cancer drugs and anti-nausea drugs
- Hemophilia clotting factors
- Immunosuppressive drugs
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of End Stage Renal Disease

Some drugs are covered under either Part B or Part D depending on the circumstances.

4.14 Medical Supplies with Delivery of Insulin

Medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies, and needle-free syringes, can satisfy the definition of a Part D drug. However, test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D.

4.15 Advance Directives

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.

4.16 Additional Benefits

Some Blue Cross Medicare Advantage plans offer additional benefits such as vision, hearing, dental and medically necessary transportation services, and health/fitness programs. Members are advised to contact Customer Service for information regarding these services.

5 SELECTION AND RETENTION OF PROVIDERS

5.1 Participation Requirements

To participate in Blue Cross Medicare Advantage, the provider or facility:

- Must be a participating provider with BCBSNM
- Must have privileges at one of the Blue Cross Medicare Advantage participating hospitals (unless inpatient admissions are uncommon or not required for the 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 Cross Medicare Advantage participating providers cannot be named on the Office of the Inspector General (OIG) or Government Services Administration (GSA) lists which identify providers and facilities found guilty of fraudulent billing, misrepresentation of credentials, etc. Blue Cross Medicare Advantage participating providers cannot be sanctioned by the Office of Personnel Management or prohibited from participation in the Federal Employees Health Benefit Program (FEHBP).

5.2 Credentialing

Blue Cross Medicare Advantage continuously reviews and evaluates participating provider information and re-credentials providers every three years. The credentialing guidelines are subject to change based on industry requirements and Blue Cross Medicare Advantage standards.

5.3 Recertification

Blue Cross Medicare Advantage continuously reviews and evaluates facility provider information and recertifies providers every three years. The certification guidelines are subject to change based on industry requirements and Blue Cross Medicare Advantage standards.

5.4 Appeals Process

If Blue Cross Medicare Advantage decides to suspend, terminate or non-renew a physician's written participation status, the affected physician will be given a written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physician needed by Blue Cross Medicare Advantage.

The physician will be allowed to appeal the action to a hearing panel, given written notice of his/her right to an appeal hearing and the process and timing for requesting a hearing.

Blue Cross Medicare Advantage will ensure that the majority of the hearing panel members are peers of the affected physician. A recommendation by the hearing panel is advisory and is not binding on Blue Cross Medicare Advantage.

When a physician is terminated from the network, they will be notified in writing at least 90 calendar days in advance of the effective date of the termination, unless Blue Cross Medicare Advantage 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 of the BCBSNM [Blues Provider Reference Manual](#).

If a reduction, suspension or termination of a physician's participation is final and is the result of quality of care deficiencies, Blue Cross Medicare Advantage will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician groups must certify that these procedures apply equally to providers within those subcontracted groups.

(Note: Refer to the BCBSNM [Blues Provider Reference Manual](#), Section 15 - Provider Appeal Rights and Responsibilities for further instructions on the appeal process for provider terminations).

5.5 Notifying Members of Provider Termination

Blue Cross Medicare Advantage will make a good faith effort to provide written notice of a termination of a 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 termination.

5.6 Medicare Opt-Out Providers

Blue Cross Medicare Advantage is obligated to terminate from its network any provider who has formally opted out of Medicare, in accordance with the CMS Medicare Benefit Policy Manual, Chapter 15, Section 40.37, which states:

“Medicare Advantage plans must make no payment directly or indirectly for Medicare covered services furnished to a Medicare beneficiary by a physician or practitioner who has opted out of Medicare, except for emergency or urgent care services furnished to a beneficiary who has not previously entered into a private contract with the physician or practitioner.”

A provider who is contracted with Blue Cross Medicare Advantage and who decides to opt out of Medicare should notify his or her Blue Cross Medicare Advantage Contract Representative *immediately* so that the provider can be terminated from the Medicare Advantage network.

6 PERFORMANCE AND COMPLIANCE STANDARDS

6.1 Evaluating Performance

When evaluating the performance of a participating provider, Blue Cross Medicare Advantage 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-provider relations, and the comfort of the practice setting.
- **Administrative requirements** – measured by the 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 provider's involvement with panels used to monitor quality of care standards.

6.2 Compliance with Standards of Care

Blue Cross Medicare Advantage participating providers must comply with all applicable laws and licensing requirements. In addition, 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. Providers must also comply with Blue Cross Medicare Advantage 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 providers must comply with Blue Cross Medicare Advantage 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 Cross Medicare Advantage;
- Providing treatment to patients at the appropriate level of care
- Maintaining a collegial and professional relationship with BlueCross Medicare Advantage personnel and fellow participating providers

- Providing equal access and treatment to all Blue Cross Medicare Advantage members.

Participating providers acting within the lawful scope of practice, are encouraged to advise patients who are members of Blue Cross Medicare Advantage about:

- 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;
- The risks, benefits, and consequences of treatment or non-treatment; and
- 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 Cross Medicare Advantage.

6.3 Laws Regarding Federal Funds

Payments that providers receive for furnishing services to Blue Cross Medicare Advantage members are, in whole or part, from Federal funds. Therefore, 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.

Providers must also comply with Federal laws and regulations which include, but are not limited to: Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act).

6.4 Marketing

Providers may not develop and use any materials that market Blue Cross Medicare Advantage without prior approval of Blue Cross Medicare Advantage 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.

6.5 Sanctions

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

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

6.6 Reporting Obligations

Cooperation in meeting CMS services requirements

Blue Cross Medicare Advantage must provide CMS with 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. Providers must cooperate with Blue Cross Medicare Advantage in its data reporting obligations by providing to Blue Cross Medicare Advantage any information that it needs to meet its obligations.

Certification of diagnostic data

Blue Cross Medicare Advantage 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). Providers that furnish diagnostic data to assist Blue Cross Medicare Advantage in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

6.7 Annual Model of Care Training Requirements

DSNP (Dual Eligible Special Needs Plan) is a CMS recognized program in which enrollees are entitled to both Medicare and Medicaid benefits. Blue Cross Medicare Advantage aims to coordinate these benefits for its DSNP members in order to maximize each member's health.

In order to accomplish this goal, Blue Cross Medicare Advantage relies on the interdisciplinary care team (ICT). Each ICT is comprised of the individual member, Blue Cross Medicare Advantage staff (i.e., Care Coordinator, Care/Complex Case Manager, Community Health Worker, behavioral health clinicians) and the physicians, caregivers, facility staff members, community service agency staffs, pharmacists, counselors, advocates, and others involved in the member's care.

6.8 DSNP Training Requirements

Given the crucial role that members' physicians play in each member's care, Blue Cross Medicare Advantage provides a variety of training opportunities to enhance providers' ability to fully engage in the ICT. These opportunities include:

- Monthly *Blue Review* Provider Newsletter
- Face-to-face meetings
- Availity – web-based portal with capabilities for delivering information from Blue Cross Medicare Advantage to provider clinicians
- Cultural competency training
- The role of the care coordinator
- The role of the provider in the interdisciplinary care team

Blue Cross Medicare Advantage also provides specialized training to various providers on the Intensive Medical Home (IMH) model of care. This training program is customized to each IMH provider; Blue Cross Medicare Advantage representatives may:

- Participate in scheduled IMH provider staff meetings
- Host lunch and learn or dinner meetings
- Conduct webinars
- Meet with identified IMH providers individually

The IMH curriculum includes, but may not be limited to:

- IMH overview
- IMH as part of the patient-centered medical home (PCMH)
- IMH patient identification methodology by Blue Cross Medicare Advantage
- Roles of the ICT members, including the role of the clinic-based care coordinator in the PCMH setting
- Metrics and outcomes

Because it is important for providers to complete the training offered, Blue Cross Medicare Advantage will inform providers of their specific training expectations. Providers must provide written documentation/attestation of receipt and review of the Blue Cross Medicare Advantage Model of Care program materials, either in person during a visit by a Network Management provider representative, or by written attestation. Blue Cross Medicare Advantage will retain these attestations in each provider's file.

If provider completion of required training modules falls below performance goals, then Blue Cross Medicare Advantage will implement a Performance Improvement Plan (PIP) to improve provider awareness and engagement with the care model. The PIP may require additional work on the part of Blue Cross Medicare Advantage, the provider, or both. Blue Cross Medicare Advantage will partner with the provider to assure training completion.

Blue Cross Medicare Advantage is eager to assist providers who might have questions regarding the training expectations. Please call 877-774-8592 for more information.

7 UTILIZATION MANAGEMENT

7.1 Organization Determinations

7.1.1 Overview

An organization determination is any determination (i.e., an approval or denial) made by Blue Cross and Blue Shield of New Mexico (BCBSNM) or its designee with respect to any of the following:

- Payment for temporary out-of- -area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider that the member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by BCBSNM;
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the member believes should be furnished or arranged by the organization;
- Reduction, or premature discontinuation, or a previously authorized ongoing course of treatment; or
- Failure of BCBSNM to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay adversely affects the health of the member.

7.1.2 Standard Timeframes

When a Blue Cross Medicare Advantage member has made a request for a service, BCBSNM will notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date BCBSNM receives the request for a standard organization determination.

BCBSNM may extend the time frame up to 14 calendar days. This extension is allowed if the member requests the extension or if BCBSNM justifies a need for additional information and documents how the delay is in the interest of the member. When BCBSNM extends the deadline, the member is notified in writing of the reasons for the delay, and the member's right to file a grievance if he or she disagrees with BCBSNM's decision.

7.1.3 Expedited Determinations

A Blue Cross Medicare Advantage member, or any provider (regardless of whether the physician is Network Provider), may request that BCBSNM expedite an organization determination when the member or provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

When asking for an expedited organization determination, the member or provider must submit either an oral or written request directly to BCBSNM.

If BCBSNM decides to expedite the request, it will render a decision as expeditiously as the member's health condition might require, but no later than 72 hours after receiving the member's request. If BCBSNM denies the request for an expedited organization determination, it follows the requirements specified in the CMS Managed Care Manual, Chapter 13, Section 50.3.

7.1.4 Adverse Determinations

When BCBSNM decides not to provide or pay for a requested service, in whole or in part, this decision constitutes an adverse organization determination. In the event of any adverse organization determination of which BCBSNM is aware, BCBSNM will provide the member with a written denial notice with appeal rights.

7.2 Medical Necessity

Organization determinations are based on:

- The medical necessity of covered services – including emergency, urgent care and post-stabilization – based on Blue Cross Medicare Advantage coverage policies;
- Where appropriate, involvement of Blue Cross Medicare Advantage medical director; and
- The member's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes.

If BCBSNM approved the furnishing of a service through pre-service organization determination, coverage for that service may not be later denied for lack of medical necessity absent, to the fullest extent allowed by law, fraud or material misrepresentation (including by omission) in the pre-service request.

If BCBSNM expects to issue a partial or full adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before BCBSNM issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in the state.

7.3 Medical Policy

7.3.1 Overview

Providers participating in the Blue Cross Medicare Advantage network should refer directly to Medicare coverage policies when making coverage decisions. There are two types of Medicare coverage policies:

- National coverage determinations
- Local coverage determinations

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

7.3.2 National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are found at www.cms.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.gov/MLN MattersArticles.

7.3.3 Local Coverage Determinations (LCDs)

CMS contractors (e.g., Medicare Administrative Contractors or MACs) develop and issue LCDs to provide guidance to the public and provider community within a specific geographical area. LCDs supplement 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 LCD at the following websites:

- Durable Medicare Equipment (DMERC): www.cgsmedicare.com
- Medicare Part B: www.novitas-solutions.com
- Medicare Part A: www.novitas-solutions.com
- Regional Home Health Intermediary (RHHI): www.palmettogba.com/medicare

7.3.4 Medicare Coverage Database

CMS launched the Medicare Coverage Database in 2002, which can be accessed at www.cms.gov/CoverageGenInfo. The following areas may be searched:

- National Coverage Determinations (NCDs)

- 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 websites listed in the preceding box.
- Lab NCDs

In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare manuals, BCBSNM may adopt the coverage policies of other Medicare Advantage Organizations in its service area. BCBSNM may also make its own coverage determination and provide a rationale using an objective evidence-based process.

7.4 Preauthorization Requirements

7.4.1 Services Requiring Preauthorization

With the exception of emergency medical services, the services identified in this section 7.4 require preauthorization from BCBSNM or its designee, as indicated. Furnishing identified services without preauthorization may result in denial of payment and contracted providers shall not balance bill Members.

The contracted provider is responsible for requesting preauthorization for these services.

Services performed without preauthorization may be denied for payment, and the rendering provider may not seek reimbursement from our members. For any service that is not approved for payment, BCBSNM will offer all appropriate rights of appeal.

Blue Cross Medicare Advantage Preauthorization Requirements, Effective January 1, 2020

Prior Authorization rules - Medicare Medical / Surgical / Behavioral Health	
PREAUTHORIZATION REQUIREMENTS through eviCore - Effective 01/01/2018	
1. Cardiology 2. Radiology 3. Medical Oncology 4. Molecular Genetics 5. Musculoskeletal - (PT/OT/ST; Spine/Joint/Pain/Chiro) 6. Radiation Therapy 7. Sleep 8. Specialty Drug	For specific codes that apply, please access url: www.evicore.com/healthplan/bcbs *including Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy) for managed programs. Utilizing the eviCore Healthcare Web Portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations / eligibility and more url: www.evicore.com/healthplan/bcbs OR Call toll-free at 855-252-1117 between 7 am -7 pm local time Monday through Friday except holidays

PREAUTHORIZATION REQUIREMENTS through BCBSNM or DMG – Effective 1/1/2018	
Covered Service	Prior Authorization
Allergy care, including tests and serum	Please refer to the procedure code list for Authorization Requirements
Bariatric surgery	Yes
Blepharoplasty	Yes
Botox Injections	Yes
Chemotherapy and Radiation Therapy	Yes
Dental Care	Yes
DME - Medical supplies, Orthotics and Prosthesis (Any single durable medical equipment prosthetic and orthopedic device greater than \$1500)	Please refer to the procedure code list for Authorization Requirements and Accumulated Annual limits without authorization
Ground and air ambulance	Air - Yes Ground - No
Home health care and intravenous services	Please refer to the procedure code list for Authorization Requirements
Hospital services (inpatient, outpatient)	Please refer to the procedure code list for Authorization Requirements. Inpatient stays with services that are managed by eviCore will be reviewed through eviCore.
Hyperbaric Oxygen	Yes
Injections	Please refer to the procedure code list for Authorization Requirements
Implantable Devices	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	Please refer to the procedure code list for Authorization Requirements
Long Term Acute Care (LTAC)	Yes
Minor surgeries	Please refer to the procedure code list for Authorization Requirements
Network Exceptions including Out of Plan or Out of Network (due to Network Adequacy)	Please refer to the procedure code list for Authorization Requirements
Nutritional counseling services	Please refer to the procedure code list for Authorization Requirements
Nutritional products and special medical foods	Yes
Office visits to PCPs or specialists, including dietitians, nurse practitioners, and physician assistants	No
Podiatry (foot and ankle) services	Yes
PET, MRA, MRI, and CT scans	Please refer to the procedure code list for Authorization Requirements
Routine physicals	No
Second opinions (in network)	No
Skilled Nursing Facilities	Yes
Special rehabilitation services, such as: physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	Yes, Please refer to the procedure code list for Authorization Requirements
Surgery, including pre-and post-operative care: assistant surgeon, anesthesiologist, organ transplants	Please refer to the procedure code list for Authorization Requirements; all transplants and pre-transplant evaluation require prior authorization
Intersex Reassignment Surgery 55970, 55980	Yes
Please view the comprehensive preauthorization grid on bcbsnm.com/provider for a list of procedure codes that require review.	

PREAUTHORIZATION REQUIREMENTS through BCBSNM or DMG – Effective 1/1/2018 Summary of Services and Behavioral Health UM requirements	
Covered Service	Prior Authorization
All Inpatient Stays Facilities/Hospitals	Yes
All Network Exceptions	Yes
Partial Hospitalization	Yes
Psychological/Neuropsychological Testing	Please refer to the procedure code list for Authorization Requirements
Electroconvulsive Therapy	Yes
Transcranial Magnetic Stimulation	Yes
Outpatient Services	Please refer to the procedure code list for Authorization Requirements
Please view the comprehensive preauthorization grid on bcbsnm.com/provider for a list of procedure codes that require review.	

7.4.2 Out of Plan/Out of Network Referrals

A referral to an out-of-plan or out-of-network provider which is necessary due to network inadequacy or continuity of care must be reviewed by the BCBSNM Utilization Management or DaVita Medical Group (DMG) (if the member is attributed to DMG this information will be reflected on the ID card) prior to a BCBSNM patient receiving care.

The **Blue Cross Medicare Advantage** referring physician or professional provider must contact the Utilization Management Department or DaVita Medical Group at the number listed on the back of the members ID card to request an out-of-plan or out-of-network referral authorization. For requests that are approved, a letter will be forwarded with the approval to the out-of-plan or out-of-network physician or professional provider. If the out-of-network/plan provider determines that additional care is needed, the provider must obtain an additional approval.

7.5 Skilled Nursing Coverage – Termination of Services

Prior to termination of skilled nursing facility services, the provider must deliver a valid written notice to the member of BCBSNM's decision to terminate covered services no later than two days before the proposed end of the services (42 CFR 422.624(b)). BCBSNM is financially liable for continued services until two days after the member receives valid notice. If the member's services are expected to be fewer than two days in duration, the provider should notify the member at the time of admission to the provider.

8 CASE MANAGEMENT

8.1 Care Coordination

Blue Cross Medicare Advantage ensures continuity of services through arrangements that include, but are not limited to, the following:

- Offering to provide each Blue Cross Medicare Advantage member with an ongoing source of primary care and providing a primary care source to each member who accepts the offer
- Establishing coordination of plan services that integrate arrangements with community and social service programs
- Utilizing 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
- Employing systems to identify and address barriers to member compliance with prescribed treatments or regimens

To support the above requirements, Blue Cross Medicare Advantage has a robust case management program. Our suite of programs includes care transition support, condition management, longitudinal care and complex case management programs. Case managers identify members with complex needs so that timely interventions can be provided to increase positive health outcomes, lower costs, and decrease utilization. Case managers, who are telephonically based, coordinate, monitor and evaluate the options and services required to meet the member's needs, by ensuring care is provided in the right place and the right time.

8.2 Initial Health Risk Assessment

The **Centers for Medicare & Medicaid Services (CMS)** requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact a member.

8.3 Annual Health Assessment

The Blue Cross Medicare Advantage Annual Health Assessment (AHA) serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings, and chronic disease monitoring. These assessments can occur in the provider's office or member's home to remove barriers to completion.

9 APPEALS AND GRIEVANCES

9.1 Resolving Grievances

If a member has a grievance about Blue Cross Medicare Advantage a provider or any other issue, participating providers should instruct the member to contact the customer service department at the number listed on the back of the member's ID card.

9.2 Resolving Appeals

A member may appeal an adverse initial decision by Blue Cross Medicare Advantage 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 Cross Medicare Advantage within 30 days or sooner if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 days.

If the normal time period for an appeal could jeopardize the life or health of the member or the member's ability to regain maximum function, the member or the provider can request an expedited appeal. Such appeals are generally resolved within 72 hours unless it is in the member's interest to extend this time period. When a member or provider requests an expedited appeal, Blue Cross Medicare Advantage will automatically expedite the appeal.

9.3 Further Appeal Rights

If Blue Cross Medicare Advantage denies the member's appeal in whole or part, Blue Cross Medicare Advantage will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of Blue Cross Medicare Advantage. 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, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the member may be able to request Judicial Review.

9.4 Detailed Notice of Discharge

A special type of appeal applies only to hospital discharges. Hospitals must notify Medicare beneficiaries and Blue Cross Medicare Advantage members about their appeal rights and general liability. This will be accomplished by the hospital issuing the

CMS form Important Message from Medicare (IM) within two calendar days of admission and obtaining the signature of the patient or representative to indicate his or her understanding. The hospital will provide a copy to the patient/representative and keep a copy for the facility.

If the member or the member's representative does not agree with the hospital's discharge decision, the member or the representative may appeal the decision. The request for review must be made by midnight of the day of discharge. If the request is made after the deadline, the request will be accepted; however, the member is not protected from financial liability. Upon notification of the appeal, the hospital is required to complete the Detailed Notice of Discharge. The IM and Detailed Notice of Discharge forms and further guidance on this ruling can be found at the following internet address: www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp

9.5 SNF, HHA and CORF Discharge Notification Requirements

Blue Cross Medicare Advantage members will receive a Notice of Medicare Non-Coverage (NOMNC) prior to termination of Medicare covered skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation services (CORF). The NOMNC informs members of their right to an immediate, independent review of the proposed discontinuation of covered services. The SNFs, HHAs and CORFs are responsible for providing the member with a written notice no later than two days before their services are scheduled to end.

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 Quality Improvement Organization (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 Cross Medicare Advantage.

The CMS-10123 and instructions for use are available for download at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

9.6 Detailed Explanation of Non-coverage (DENC)

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 (CORF) services. The DENC is a standardized written notice that provides specific and detailed information to members concerning why their SNF, HHA, or CORF services are ending. Blue Cross Medicare Advantage will issue the DENC to the member whenever a member appeals a termination decision about their SNF, HHA or CORF services. The DENC will include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;

- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the member may obtain a copy of the Medicare policy from BlueCross Medicare Advantage;
- Any applicable Blue Cross Medicare Advantage plan policy, contract provision, or rationale upon which the termination decision was based; and
- Facts specific to the member and relevant to the termination decision that is sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.

Blue Cross Medicare Advantage will issue the DENC to members and provide a copy to the QIO no later than close of business of the day the QIO notifies Blue Cross Medicare Advantage that the member requested an appeal.

10 QUALITY IMPROVEMENT

10.1 Overview

Quality improvement is an essential element in the delivery of care and services by Blue Cross Medicare Advantage. To define and assist in monitoring quality improvement, the Blue Cross Medicare Advantage Quality Improvement Program focuses on measurement of clinical care and service against established goals.

10.2 Chronic Care Improvement Program (CCIP)

The CCIP is a set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

10.3 Quality Improvement Project (QIP)

The QIP is Blue Cross Medicare Advantage's initiative that focuses on specified clinical and non-clinical areas.

10.4 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

10.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS is a patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., Medicare Advantage organizations, prescription drug plans, private fee-for-service) are asked for their perspectives of care that

- Allow meaningful and objective comparisons between providers on domains that are important to consumers;
- Create incentives for providers to improve their quality of care through public reporting of survey results; and
- Enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

10.6 30-Day Readmissions

Consistent with CMS payment methodology and to help improve quality for our members, effective for admissions on and after March 1, 2020, BCBSNM will review readmissions to an acute care facility that occur within 30 days of discharge from the same facility. For participating providers, BCBSNM performs a clinical validation of acute care hospital claims to determine if such readmissions to the same facility within 30 days of discharge are related and may deny payment to the hospital for related readmissions.

Upon request, the hospital must forward any medical records and related documents involving the admissions. These documents will be clinically reviewed to determine if readmissions within 30-days were clinically related. If it is determined that the stays were clinically related, BCBSNM will not pay for the second or subsequent readmissions.

Exclusions: Readmissions under the following non-exhaustive circumstances are excluded from 30-day readmission review:

- Obstetrical readmissions
 - Transfers of patients to receive care that was unable to be provided at the initial facility
 - SNF and rehabilitation facility admissions
 - Planned readmissions for repetitive health care treatments, including but not limited to: chemotherapy, staged surgical procedures, procedures involving malignancies, burns procedures, cystic fibrosis procedures, and other treatments
 - Patient non-compliance, ONLY if this is adequately documented in medical records
-

CONTACT LISTS

Contact	Phone/Fax/Internet
Member/Provider Customer Service (excluding Blue Cross Medicare Advantage Dual Care (HMO D SNP)) <i>(To obtain benefits, eligibility or claims status)</i>	877-774-8592 Hours of operation: 8 a.m. - 8 p.m., MST, 7 days a week. From February 15 through September 30 alternate technologies (for example, voicemail) will be used on the weekends and holidays.
Blue Cross Medicare Advantage Dual Care HMO SNP (D SNP) Member/Provider Customer Service (To obtain benefits, eligibility or claims status)	877-688-1813 Hours of operation: 8 a.m. - 8 p.m., MST, 7 days a week. From February 15 through September 30 alternate technologies (for example, voicemail) will be used on the weekends and holidays.
Network Services Representative: (For Medicare Advantage Amendment information)	Refer to the Network Services Contacts and Related Service Areas at bcbsnm.com/provider/network
Care Management Programs (Medical & Behavioral Health)	855-390-6567
The Availity Health Information Network (For electronic claim questions)	800-282-4548 www.availity.com
Claims Address <i>(For submission of paper claims)</i>	Blue Cross Medicare Advantage P. O. Box 11968 Albuquerque, NM 87192
Appeals and Grievances P. O. Box 4288 Scranton, PA 18505	Medicare Coverage Determinations/Appeals Fax: 855-674-9185 Grievances Fax: 855-674-9189
Blue Medicare RX MAPD Pharmacy Help Desk	800-693-6704
CMS Website Address	www.cms.gov
Participating Labs	
Quest	866-MYQUEST (697-8378)
Lab Corp of America	888-522-2677
TriCore	800-245-3296
Utilization Management (UM) (For Medical & Behavioral Health)	
Preauthorization & Out-of-Network Referrals	877-774-8592
Preauthorization Fax	855-874-4711

GLOSSARY OF TERMS

Term	Description
Appeal	Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service (including prescription drugs). The procedures include reconsiderations by Blue Cross Medicare Advantage, an independent review entity (IRE), hearings before Administrative Law Judge (ALJ), review by the Medicare Appeals Council, and Federal 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 Cross Medicare Advantage receive all Basic Benefits.
Center for Health Dispute Resolution (CHDR)	An independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Cross Medicare Advantage.
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 by participating providers or authorized by Blue Cross Medicare Advantage or its participating providers. • Provided or furnished by non-participating providers at the in-network benefit level when authorized by BlueCross Medicare Advantage due to network inadequacy or continuity of care concerns. • Provided or furnished by non-participating providers at the out-of-network benefit level. • Emergency services and urgently needed services that may be provided by non-participating providers. • Renal dialysis services provided while the member is temporarily outside the service area. • Basic and supplemental benefits
Effectuation	Compliance with a reversal of Blue Medicare Advantage original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
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;

	<ul style="list-style-type: none"> • Serious impairment of 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 Services	<p>Covered inpatient or outpatient services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services; and • Needed to evaluate or stabilize an emergency medical condition.
Experimental Procedures and Items	<p>Items and procedures determined by Blue Cross Medicare Advantage) 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 Cross Medicare Advantage will follow CMS guidance if applicable or rely upon determinations already made by Medicare.</p>
Facility	<p>Hospital and ancillary providers which include but is not limited to: Durable Medical Equipment Supplier, Skilled Nursing Facility.</p>
Fee-for-Service Medicare	<p>A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare.</p>
Grievance	<p>Any complaint or dispute about Blue Cross Medicare Advantage or one of our network providers or pharmacies, 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.</p>
Home Health Agency	<p>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 provider.</p>
Hospice	<p>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.</p>
Hospital	<p>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.</p>
Independent Physicians Association (IPA)	<p>A group of physicians who function as a participating medical provider/group yet work out of their own independent medical offices.</p>
Medicare	<p>The Federal Government health insurance program established by Title XVIII of the Social Security Act.</p>
Medicare Part A	<p>Hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.</p>

Medicare Part A Premium	Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, members do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, they may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.
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 Part B Premium	A monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services whether members are covered by a Medicare Advantage plan or by original Medicare.
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. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage (MAPD). BCBSNM is a Medicare Advantage organization and Blue Cross Medicare Advantage is a MAPD Plan.
Member	The Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the Blue Cross Medicare Advantage 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 Cross Medicare Advantage to deliver covered services to Blue Cross Medicare Advantage members.
Organization Determination	Any determination made by Blue Cross Medicare Advantage with respect to any of the following: <ul style="list-style-type: none"> • Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services

	<ul style="list-style-type: none"> • Payment for any other health services furnished by a provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by BlueCross Medicare Advantage • Blue Cross Medicare Advantage’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by Blue Cross Medicare Advantage • Reduction, or premature discontinuation of a previously authorized ongoing course of treatment • Failure of Blue Cross Medicare Advantage to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member
Participating Hospital	A hospital that has a contract to provide services and/or supplies to Blue Cross Medicare Advantage members.
Participating Medical Group	Physicians organized as a legal entity for the purpose of providing medical care. The participating medical group has an agreement to provide medical services to Blue Cross Medicare Advantage members.
Participating Pharmacy	A pharmacy that has an agreement to provide Blue Cross Medicare Advantage members with medication(s) prescribed by the members’ provider in accordance with Blue Cross Medicare Advantage.
Participating Provider	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 Cross Medicare Advantage members pursuant to the terms of the Agreement.
Post-stabilization Care Services	Post-stabilization care services are covered services that are: <ul style="list-style-type: none"> • related to an emergency medical condition, • provided after a member is stabilized, and • provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the member’s condition.
Quality Improvement Organization (QIO)	Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs. New Mexico Medical Review Association (NMMRA) is the QIO for Blue Cross Medicare Advantage.

Quality of Care Issue	A quality of care complaint may be filed through Blue Cross Medicare Advantage’s grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.
Reconsideration	A Blue Cross Medicare Advantage member’s first step in the appeal process after an adverse organization determination. Blue Cross Medicare Advantage or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
Representative	An individual appointed by a Blue Cross Medicare Advantage member or other party, or authorized under State or other applicable law, to act on behalf of the member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.
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 Cross Medicare Advantage includes Bernalillo and Sandoval Counties within the State of New Mexico.
Urgently Needed Services	Covered services provided that are not emergency services as defined above but are medically necessary and immediately required as a result of an unforeseen illness, injury or condition.

For additional procedures and information, refer to the BCBSNM [Blues Provider Reference Manual](#).

If you have any questions regarding the information in this section, please contact the provider customer service at 877-774-8592 or DSNP customer service at 877-688-1813.

ATTACHMENTS SECTION FOLLOWS

New Mexico Optional Advance Health Care Directive Form EXPLANATION FOR MEMBERS

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

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

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

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

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

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

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

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

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

**PART 1
POWER OF ATTORNEY FOR HEALTH CARE**

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

(name of individual you choose as agent)

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

(home phone) (work phone)

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

(name of individual you choose as first alternate agent)

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

(home phone) (work phone)

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

(name of individual you choose as second alternate agent)

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

(home phone) (work phone)

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

(Add additional sheets if needed.)

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

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

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

PART 2 INSTRUCTIONS FOR HEALTH CARE

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

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

I CHOOSE NOT To Prolong Life

I do not want my life to be prolonged.

I CHOOSE To Prolong Life

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

I CHOOSE To Let My Agent Decide

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

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

I DO NOT want artificial nutrition OR

I DO want artificial nutrition.

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

I DO want artificial hydration.

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

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

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

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

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

I CHOOSE to let my agent decide.

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

(Add additional sheets if needed.)

**PART 3
PRIMARY PHYSICIAN**

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

(name of physician)

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

(phone)

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

(name of physician)

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

(phone)

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

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

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

(date) (sign your name)

(address) (print your name)

(city) (state) (your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness:

Second witness:

(print name)

(address)

(city) (state)

(signature of witness)

(date)

(print name)

(address)

(city) (state)

(signature of witness)

(date)