BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

November 2019

Education & Reference

Antibiotic Use in Outpatient Settings

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Collaborating to Reduce Opioid Abuse

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Are Utilization Management Decisions Financially Influenced?

Blue Cross and Blue Shield of New Mexico (BCBSNM) is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSNM prohibits utilization management decisions based on financial incentives — those decisions are based on appropriateness of care and service and existence of coverage.

BCBSNM does not specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective January 1, 2020 — Part 1

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

View the Pharmacy Program Updates effective as of January 1, 2020

NDC Fee Schedule Change for Fulphila (J5108) and Udenyca (J5111) Effective January 1, 2020

For commercial and retail lines of business, BCBSNM's fee schedule HNDCS1 for medications Fulphila (J5108) and Udenyca (J5111) will be updated effective January 1, 2020. The update

for these drugs/codes will be reflected in the BCBSNM professional NDC fee schedule. If you have any questions, please contact your local BCBSNM Provider Network Representative.

Updates Made to the Provider Reference Manual

The Provider Reference Manual (PRM) has been updated, effective Jan. 1, 2020. Changes to the PRM include, but are not limited to, the following sections:

- 10 – Preauthorization
- 11 – Utilization, Case, Population Health, and Condition & Lifestyle Management
- 12 – Behavioral Health Services
- 15 – Grievance Process for Participating Providers
- 16 – Credentialing
- 17 – Quality Improvement

The updated PRM will be available for review on the Provider Reference Manual webpage at bcbsnm.com/provider on or before Dec. 1, 2019. Blue Cross and Blue Shield of New Mexico reminds providers to review the PRM for all changes.

Blue Cross Medicare Advantage℠ (Medicare)

CMS-Required Training for Dual-Special Needs Plans

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

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Blue Cross Community Centennial℠ (Medicaid)

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Not Yet Contracted?

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

Reminder: Update your Enrollment Information

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

Such services are funded in part with the State of New Mexico.

BCBSNM Website

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

Medical Policy Updates

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

Clinical Payment and Coding Policies

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

Claims Inquiries

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

Network Services Contacts and Related Service Areas

Do We Have Your Correct Information?

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

Member Rights and Responsibilities

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

bcbsnm.com/provider

Antibiotic Use in Outpatient Settings

Over prescription of antibiotics has increased antibiotic resistance. We can work together to combat antibiotic resistance and appropriately prescribe these important medications. According to a Pew[1] Charitable Trust report regarding Antibiotic Use in Outpatient Settings, 30% of antibiotics prescribed are found to be unneeded for treating conditions like viral illnesses and asthma exacerbation.

Common Conditions That Don't Need Antibiotics

The Center for Disease Control and Prevention (CDC)[2] and other reliable sources have suggested antibiotics are most often inappropriately prescribed for conditions like:

- Asthma
- Flu
- Common cold
- Bronchitis

Using antibiotics when they are not needed can do more harm than good.

Alternatives to Antibiotics

You may consider other remedies when treating conditions that don't need antibiotics, like:

- Getting adequate rest
- Increasing oral fluids
- Using a humidifier or cool mist vaporizer and ensuring they have been properly cleaned
- Inhaling hot shower steam or other sources of hot vapor
- Taking throat lozenges for adults and children, ages five years and older
- Considering over-the-counter medications to treat symptoms

The CDC has a poster you can download and display in the exam room to inform patients of your commitment to their health.

If you have any questions about the appropriate use of antibiotics, please email the Federal Employee Program Quality Improvement Department at Blue Cross and Blue Shield of New Mexico.

1 https://www.pewtrusts.org/en/about/mission-and-values

2 CDC.gov (www.cdc.gov) (https://www.cdc.gov/index.htm) is the official website of the Centers for Disease Control and Prevention (CDC). It is a public domain website, which means you may link to CDC.gov at no cost and without specific permission.

Collaborating to Reduce Opioid Abuse

At Blue Cross and Blue Shield of New Mexico we pledge
To Do Everything In Our Power To Stand With Our Members In Sickness And In Health®.
We take that very seriously. That is why we have started a new program to help you care for members who may be at risk for an opioid-related adverse event. We hope that by collaborating with members and providers, we can find ways to reduce risk and promote patient safety.

BCBSNM now scans pharmacy and medical claims to identify members with a combination of the following risk factors:

- High morphine equivalent daily dosing (MED)[1]
- Dangerous drug combinations (i.e., opioids, benzodiazepines, muscle relaxers)
- Receiving controlled substance prescriptions from multiple providers.

When warranted, we reach out to members and providers to inform them of the potential risks. We also provide support to reduce that risk. Support can include ensuring members have access to Narcan (naloxone) and are aware of how to use it. We can also offer non-opioid alternatives such as physical therapy and cognitive behavioral therapy. This initiative is one of the enhancements we made this summer to our behavioral health offerings.

It is our hope that by identifying and sharing prescribing concerns, we can collaborate to increase patient safety and improve clinical care and outcomes.

“The number of opioid overdoses still occurring in this country requires a coordinated effort across the entire delivery system,” said Ben Kurian, MD, Executive Medical Director of Risk Identification & Outreach Program, Health Care Service Corporation. “We hope to use our data to partner with providers for the benefit of patients and their families.”

At Blue Cross and Blue Shield of New Mexico we are always working to improve health outcomes for all our members. Thank you for helping ensure the safety and wellbeing of your patients/our members.

1 Source: Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1-49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

2 The Behavioral Health program is available only to those members whose health plans include behavioral health benefits through Blue Cross and Blue Shield of New Mexico (BCBSNM). Some members may not have outpatient behavioral health care management. Members can check their benefit booklet, ask their group administrator or call Customer Service to verify that they have these services.

This is only a brief description of some member plan benefits. Not all benefits are offered by all plans. For more complete details, including benefits, limitations and exclusions, please refer patients to their certificate of coverage.

Be Covered — Increasing Coverage for the Uninsured and Underinsured

Around 208,000 people in New Mexico do not have health insurance. Approximately half qualify for Medicaid or a federal subsidy to help reduce the cost of coverage. Affordable care and better health outcomes start with health care coverage.

To help address this issue, we are promoting Be Covered, our grassroots campaign to educate, engage and enroll the uninsured and underinsured in our communities.
How can you help?

- If you have patients who are underinsured or uninsured, tell them about Be Covered and the available resources (like the subsidy calculator).
- Use Be Covered education tools so that members are better informed about their coverage options.

Our goal is to help people understand their coverage options and how to make the most of what is available to them – no matter their stage of life.

Through Be Covered, we are working with trusted community partners to reach areas with the highest concentration of uninsured people. Local events will offer resources in English and Spanish, and many will provide wellness screenings, family activities and healthy food giveaways.

Visit BeCovered.org for more information.

What You Need to Know About the 2019-2020 Flu Season

The Centers for Disease Control and Prevention (CDC) recommends yearly flu shots for all patients 6 months and older without vaccine contraindication. Providers may administer any U.S. Food and Drug Administration (FDA) approved, age-appropriate flu shot. Remember to review the current flu vaccine product table for the most recent updates on available products and their approved age ranges.[1]

What's different this flu season?[1]

- All standard adult and pediatric dose flu vaccines will be quadrivalent; no trivalent regular dose flu shots are available this season.
- Afluria Quadrivalent® is now licensed for children 6 months of age and older.
- Baloxavir (Xofluza™) is a new single-dose antiviral drug approved by the FDA for people 12 years and older who have had flu symptoms for less than 48 hours. Baloxavir (Xofluza) is not a substitute for early vaccination with the annual seasonal flu vaccine.

Reminders this Flu Season[2]

- Trivalent high dose or adjuvant containing flu vaccines for the elderly (65 and older) are made specifically to create a better or stronger immune response.
- Oseltamivir (Tamiflu®) is used for the treatment of influenza for patients 2 weeks or older who have had flu symptoms for less than 48 hours, as well as the prophylaxis of influenza in patients 1 year and older. Oseltamivir (Tamiflu) is not a substitute for early vaccination with the annual seasonal flu vaccine.
    - Oseltamivir (Tamiflu) is also available as a generic medication, which may have a lower cost to the member compared to a branded medication.

Coding Reminders

- Please file your claims with correct coding*
- The American Academy of Pediatrics (AAP) coding chart recommends which billing code to use based on the vaccine administered. (This chart is not a comprehensive list.)
- Code descriptions are specific to the vaccine product.
- Code descriptions may include:
    - Dosage amounts
    - Trivalent vs. quadrivalent formulations
    - Distinctive features (i.e., preservative-free, split virus, recombinant DNA, cell cultures or adjuvanted).

* *Correct coding requires services to be reported with the most specific code available that appropriately describes the service.*

1 CDC, Frequently Asked Influenza (Flu) Questions: 2019-2020 Season, Sept. 16, 2019.https://www.cdc.gov/flu/season/faq-flu-season-2019-2020.htm

2 CDC, Antiviral Drugs for Seasonal Influenza: Additional Links and Resources, Nov. 29, 2018. https://www.cdc.gov/flu/professionals/antivirals/links.htm

CMS-Required Training for Dual-Special Needs Plans

November 14, 2018

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

You may also recognize this program as Blue Cross Medicare Advantage Dual Care (HMO-SNP)℠.

Because it is important for providers to complete the required training, Blue Cross Medicare Advantage will inform providers of their specific DSNP Model of Care (MOC) training requirements and expectations. Providers can submit proof of completion by:

1. Completing a computer based training module issued to them and/or their provider group or,
2. Submitting an attestation after a live training provided by a Network Representative

Blue Cross Medicare Advantage will retain these attestations in each provider's file. The adherence of the required DSNP training is critical to our member's health and care.

If you have any questions about the training or would like a one-on-one training session, please reach out to your assigned Provider Network Representative at 1-800-567-8540.

New Names and ID Cards for Group Medicare Plans

Beginning Jan. 1, 2020, you may notice new names and ID cards for some of our group Medicare plans. In addition to Blue Cross Medicare Advantage℠ plans for individuals, you may see the following new names for group plans offered by our members' benefit administrators. While some plan names have changed, your experience as a provider will be the same. Members will have no change to benefits due to the plan name changes.

- **Blue Cross Group Medicare Advantage (HMO)℠** is the new name of Blue Cross Medicare Advantage (HMO)℠ for group Medicare members. This plan provides members access to providers within a defined network, with no out-of-network benefit.
- **Blue Cross Group Medicare Advantage (PPO)℠** is the new name of Blue Cross Medicare Advantage (PPO)℠ for group Medicare members. This traditional PPO allows members to seek care in network and out of network, typically providing cost savings for in-network care.
- **Blue Cross Group Medicare Advantage Open Access (PPO)℠** is the new name of Blue Cross Medicare Advantage (PPO) Employer Group℠. This plan offers members access to providers nationwide who accept assignments from Medicare and are willing to bill Blue Cross and Blue Shield of New Mexico (BCBSNM). Coverage levels are the same for in-network and out-of-network care.

- **Blue Cross Group MedicareRx℠** is the new name of Blue Cross MedicareRx (PDP)℠. It provides Medicare Part D prescription drug coverage.

The new member ID cards will include a Customer Service number for providers and the new plan names.

It is important to check eligibility and benefits for each patient before every scheduled appointment. Eligibility and benefit quotes include membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable benefit prior authorization/pre-renotification requirements. Ask to see the member's BCBSNM ID card and a driver's license or other photo ID to help guard against medical identity theft.

Checking eligibility and benefits and/or obtaining benefit prior authorization/pre-notification or predetermination of benefits is not a guarantee that benefits will be paid. Payment is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations and exclusions set forth in your patient's policy certificate and/or benefits booklet and/or summary plan description. Regardless of any benefit determination, the final decision regarding any treatment or service is between you and your patient. If you have any questions, please call the number on the member's ID card.

2020 Blue Cross Medicare Advantage℠ Preauthorization Updates

Beginning Jan.1, 2020, providers will be required to obtain preauthorization (or "prior authorization") through Blue Cross and Blue Shield of New Mexico (BCBSNM), DaVita Medical Group (DMG) or eviCore for certain procedures for Blue Cross Medicare Advantage members.

Claims for services for which preauthorization is required by BCBSNM and not obtained by Network Providers may be denied for payment and Network Providers may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.
A referral to an out-of-network provider which is necessary due to possible network inadequacy or for continuity of care must be reviewed by the BCBSNM Utilization Management department or DMG (if the member is attributed to DMG this information will be reflected on the ID card) prior to a BCBSNM member receiving care from the out-of-network provider.

To obtain preauthorization through BCBSNM for the care categories noted below, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Provider Network Representative.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity and Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSNM.

DaVita Medical Group (DMG) is an independent organization that provides health care services for Blue Cross and Blue Shield of New Mexico (BCBSNM). DMG is solely responsible for its provision of health care services. BCBSNM does not provide health care services.

Billing and Documentation Guidelines for Urine Drug Tests

Blue Cross and Blue Shield of New Mexico (BCBSNM) will continue to follow Medicare's lead and zero-price the CPT® drug testing codes (80300 — 80377, other than the presumptive codes listed below).

With a few exceptions, BCBSNM's billing guidelines for urine drug testing are intended to be consistent with those established by CMS for safety, accuracy and quality of diagnostic testing and will make use of CPT codes 80305, 80306 and 80307 for presumptive testing and HCPCS codes G0480, G0481, G0482, G0483 or G0659 for definitive testing that CMS published for 2018 drug testing.

Physician-owned/operated laboratories will use **G0659** *(Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen;* ***qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes)*** when performing urine drug testing using GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem).

CLIA Certification requirement

Facilities and private providers who perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

CPT Codes for Qualitative Drug Screen (Presumptive Drug Testing)

Use **80305** for testing capable of being read by direct optical observation only. Test includes validity testing when performed and may be performed only once per date of service.
Use **80306** when test is read by instrument- assisted direct optical observation. Test includes validity testing when performed and may be performed only once per date of service.

Use **80307** when test is performed by instrumented chemistry analyzers (e.g. Immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, CHPC, GC mass spectrometry). Test includes validity testing when performed and may be performed only once per date of service.
Qualitative or presumptive drug screening must meet medical policy criteria, including appropriate medical record documentation.

All of these codes include any number of drug classes, devices or procedures. Only one of the presumptive codes may be billed per date of service.

Confirmation Drug Testing

Consistent with HCSC Medical Policy MED207.154, Drug confirmation (definitive testing) is indicated when the result of the drug screen is different than that suggested by the patient's medical history, clinical presentation or patient's own statement.[1]
NOTE: Saliva or oral swabs do not meet the HCSC medical policy for drug testing.

Definitive Drug Testing

All of these codes are tests utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS, (any type, single, or tandem) and LC/MS (any type, single, or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., Alcohol dehydrogenase)); qualitative or quantitative, all sources, including specimen validity testing. Only one (1) of the definitive G codes may be billed per date of service.

- **G0480** — 1-7 drug class(es), including metabolites
- **G0482** — 15-21 drug class(es), including metabolites
- **G0481** — 8-14 drug class(es), including metabolites
- **G0483** — 22 or more drug class(es), including metabolites

REMINDER: Physician office laboratories will bill definitive testing using G0659, once per date of service.

Billing & Documentation Information & Requirements

BCBSNM does not allow Pass-Through Billing or Other Billing/Service Arrangements

- Pass-through billing occurs when a physician or other provider requests and bills for a service, but the service is not actually performed by that physician or provider
- "Under arrangement" billing and other similar billing or service arrangements are not permitted by BCBSNM. Physician or other provider is not permitted to allow another entity or individual to bill or submit claims for reimbursement to BCBSNM under its Agreement (contract) for services. "Under arrangement" billing occurs when a physician or other provider renders services and a hospital or other entity bills for the services under its agreement with The Plan. Physician or other provider is not permitted to bill for services that are provided by another entity or provider.

All testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

BCBSNM may monitor the manner in which test codes are billed, including frequency of testing. Abusive billing, poor or no documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

Documentation Requirements

The clinician's documentation must be patient-specific and accurately reflect the need for each test ordered. Each drug or drug class being tested for must be indicated by the ordering clinician in a written order and documented in the patient's medical record. As stated more fully in HCSC Medical Policy MED207.154:

> *Drugs or drug classes for which screening is performed should only reflect those likely to be present based on the patient's medical history or current clinical presentation, and without duplication. Each drug or drug class being tested for must be indicated by the referring clinician in a written order and so reflected in the patient's medical record. Additionally, the clinician's documentation must be patient specific and accurately reflect the need for each test.*

Orders

Orders for diagnostic tests, including laboratory tests, must be specific to both the patient and the need for the test requested. Panel testing is restricted to panels published in the current CPT manual. Orders must be signed and dated by the ordering health care professional. "Custom" panels are not specific to a particular patient and are not allowed. Further, the following are not reimbursable: **Routine screenings**, including quantitative (definitive) panels, performed as part of a clinician's protocol for treatment, **Standing orders** which may result in testing that is not individualized and/or not is used in the management of the patient's specific medical condition and **Validity testing**, an internal process to affirm that the reported results are accurate and valid.
For more information on laboratory orders/requisitions see *BCBSNM Blue Review Documentation Guidelines for Laboratory Audit/Review* published in the November 2017 Blue Review — Provider Newsletter.

Claims that are accompanied by medical records that do not meet documentation requirements will not be reimbursed.

Reimbursement is subject to:

- Medical record documentation, including appropriately documented Orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(ies)

1 BCBSNM Medical Policy MED207.154 states: Confirmatory testing is not appropriate for every specimen and should not be done routinely. This type of test should be performed in a setting of unexpected results and not on all specimens. The rationale for each confirmatory test must be supported by the ordering clinician's documentation. The record must show that an inconsistent positive finding was noted on the qualitative test testing or that there was not an available qualitative test to evaluate the presence of semi-synthetic or synthetic opioid in a patient.

2020 Blue Cross Community Centennial℠ Prior Authorization Updates

Beginning Jan.1, 2020, providers will be required to obtain prior authorization through Blue Cross and Blue Shield of New Mexico (BCBSNM) or eviCore for certain procedures for Blue Cross Community Centennial members.

Services performed without benefit prior authorization may be denied for payment in whole or in part, and you may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft.

To obtain benefit prior authorization through BCBSNM for the care categories noted below, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Provider Network Representative.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

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eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSNM.

Such services are funded in part with the State of New Mexico.