BlueCross BlueShield of New Mexico

Blue Review℠

A Provider Publication

**April 2017**

Please distribute this newsletter, which contains claims, billing, Medical Policy, reimbursement, and other important information, to all health care providers, administrative staff, and billing departments/entities that this email address represents.
You can find *Blue Review* online!

Ideas for articles and letters to the editor are welcome;
emailNM_Blue_Review_Editor@bcbsnm.com

### 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. Additionally, the Centers for Medicare & Medicaid Services require Blue Cross and Blue Shield of New Mexico (BCBSNM) to make sure that our online Provider Finder® and provider directory are kept current with our provider demographic information. Please complete our quick and easy online form if you have:

- Moved to another location
- Left a group practice
- Changed your phone number
- Changed your email address
- Retired
- Any other changes to your practice information

### Medical Policy Updates

Approved new or revised Medical Policies and their effective dates are usually posted on our website the first and fifteenth of each month. These policies may impact your reimbursement and your patients' benefits. On our website, you may view active, pending and updated policies and/or view draft policies and provide comments. The policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

## Office Staff

### Claims inquiries? Call the Provider Service Unit (PSU) at 888-349-3706

Our PSU handles all provider inquiries about claims status, eligibility, benefits, and claims processing for BCBSNM members. *For out-of-area claims inquiries, please call the BCBSNM BlueCard PSU at* ***800-222-7992***.

### Network Services Contacts and Related Service Areas

Network Services Regional Map

## BCBSNM Website

It's important for you to stay informed about news that could affect your practice. Blue Cross and Blue Shield of New Mexico (BCBSNM) offers many ways to stay informed. When you visit our website, **bcbsnm.com/provider**, and sign up to receive email updates and our provider newsletter, *Blue Review*, you get better access to timely information and topics. Read more

## Overcoming Barriers to Colorectal Cancer Screening

**Part 3 of a 3-part series regarding Colorectal Cancer (CRC) Screening**

Thank you for your continued support and interest in CRC screening. An article in the February 2017 *Blue Review*, **"Colorectal Cancer Screening: 80% by 2018, will you commit?"** discussed Blue Cross and Blue Shield of New Mexico's (BCBSNM) pledge, in cooperation with the American Cancer Society® and the National Colorectal Cancer Roundtable to have 80% of BCBSNM's members, age 50 to 75, screened for colorectal cancer by 2018. Read more

## The Importance of Care Coordination

Blue Cross and Blue Shield of New Mexico (BCBSNM) performs an annual Provider Satisfaction Survey. The survey includes items about continuity and coordination of care, the efficacy of which depends largely upon communication between specialists, hospitals, and primary care providers (PCP). Our goal is statistically significant increases in provider satisfaction with coordination of care. Read more

## Insurers Required by CMS to Conduct ACA Risk Adjustment Program Audit

In 2017, the Centers for Medicare & Medicaid Services (CMS) will conduct another Initial Validation Audit (IVA) to validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program. The provider's role is essential to the success of the IVA. Therefore, if any of your patients are selected to be included in the IVA, Blue Cross and Blue Shield of New Mexico (BCBSNM) is asking for your cooperation and commitment to fulfilling the requirements of the IVA. Read more

## *LifeTimes*® Member Newsletter Offers Tips on Preventing Heart Attacks and Strokes

Do you know the ABCs of preventing heart disease and stroke? The latest online *LifeTimes®*Member Newsletter embraces Heart Month and offers tips on preventing heart attacks and strokes.

*LifeTimes* is available online at lifetimes.bcbsnm.com. In this issue, we offer suggestions on how to change unhealthy habits that lead to heart disease and how those changes can significantly reduce the risk of heart disease.

## *Appointment Availability and Access Guidelines*

As a contracted BCBSNM provider the following appointment availability and access guidelines should be used to ensure timely access to medical and behavioral health care for our BCBSNM membership. Read more

## Provider Claim Summary Paper Mailing Discontinuance: Effective Date Delay

As a reminder, Provider Claim Summaries (PCS) are now accessible through the Reporting On-Demand application, located under our Blue Cross and Blue Shield of New Mexico (BCBSNM) branded *Payer Spaces* section on the Availity™ Web portal. Read more

**Receipt of Credentialing Application Notification**
Providers interested in becoming a contracted provider with Blue Cross and Blue Shield of New Mexico (BCBSNM) must complete the applicable BCBSNM Participating Provider Interest Form and CAQH Credentialing Application. Upon submission, BCBSNM will notify applicants by certified mail within 10 days of receipt that the credentialing request has been received and that:

- If the application is found to be complete, the credentialing process will begin according to the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC.
- If the application is found to be incomplete, the 45-day credentialing process **DOES NOT**commence until all requested information has been provided and application deemed complete by BCBSNM.

Additionally, providers can obtain the current status of their credentialing application by contacting the Provider Relations Representative assigned to the region.
A full list of Provider Relations Representatives is available in the Network Contact List under the Contact Us section of the BCBSNM provider website, bcbsnm.com/provider.

**Medicaid only**

## Blue Cross Community Centennial℠ (Medicaid)

**Not yet contracted?**

BCBSNM's Medicaid plan is Blue Cross Community Centennial.

Providers who are participating in commercial BCBSNM products are not automatically participating providers in Blue Cross Community Centennial. To become a Blue Cross Community Centennial provider, you **must** sign a Medicaid amendment to your Medical Services Entity Agreement (MSEA).
If you have any questions, please call 505-837-8800 or 1-800-567-8540 if you are interested in becoming a Blue Cross Community Centennial provider.

**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.

**Member Rights and Responsibilities**
BCBSNM is committed to ensuring that enrolled members are treated in a manner that respects their rights as individuals entitled to receive health care services. BCBSNM is committed to cultural, linguistic and ethnic needs of our members. 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. Read more

**Billing Medicaid Members**
**Appointment, interest and carrying charges:** MAD does not cover penalties on payments for

broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts. A provider may not bill a MAP-eligible recipient or his or her authorized representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of CHIP or WDI who may be charged up to $5 for a missed appointment.

Such services are funded in part with the State of New Mexico.
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a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

## Blue Cross Medicare Advantage℠

### New Medicare Preauthorization Requirements through eviCore

Blue Cross and Blue Shield of New Mexico (BCBSNM) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to provide Utilization Management services for new preauthorization requirements outlined below. Read more

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 .

Blue Cross and Blue Shield of New Mexico is committed to the highest standards of business ethics and integrity as well as strict observance and compliance with the laws and regulations governing its business operations.

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Part 3 of a 3-part series regarding Colorectal Cancer (CRC) Screening

Thank you for your continued support and interest in CRC screening. An article in the February 2017 *Blue Review*, **“Colorectal Cancer Screening: 80% by 2018, will you commit?”** discussed Blue Cross and Blue Shield of New Mexico’s (BCBSNM) pledge, in cooperation with the American Cancer Society® and the National Colorectal Cancer Roundtable to have 80% of BCBSNM’s members, age 50 to 75, screened for colorectal cancer by 2018. In March 2017, a News and Updates article titled **“Colorectal Cancer Screening Options”** discussed the various CRC screening methods available. The series continues here with article three, **“Overcoming Barriers to Colorectal Cancer Screening**.**”**

CRC screening can be a highly effective preventive measure that offers your patients improved outcomes. The USPSTF found convincing evidence that screening for CRC through a variety of different methods can accurately detect early-stage colorectal cancer and adenomatous polyps.[1]

The rates of new colorectal cancer cases and deaths among US adults aged 50 years or older are decreasing due to an increase in screening and changes in some risk factors (for example, a decline in smoking).[2]

Evidence is clear that CRC screening is beneficial. Still, overcoming the barriers may be challenging. This article will identify potential CRC screening barriers and some ideas to help overcome those barriers.

**Patient Concerns:**

A Health Care Service Corporation member survey, completed in January 2016, asked members why they chose NOT to complete CRC screening. The top three reasons were:

1) “I didn’t know that testing was covered by insurance.”
2) “I’m afraid of the test/discomfort.”
3) “I don’t have symptoms.”

Let’s take a closer look at patient concerns and sample approaches that you may choose to take.

1) **Embarrassment or awkwardness** about bowel functions and/or tests that involve stool collection.
Inform patients that there are several screening options available, including simple take home tests that can be done in the privacy of their own home.

2) **Misconceptions about cancer and cancer screening**
Some patients feel that being asymptomatic equates to an absence of cancer. A sensitivity to personal and cultural fears surrounding cancer itself is important. Let patients know that many people diagnosed with colon cancer do not have any symptoms or a family history, which is why screening is so important, even when they feel healthy.

3) **Lack of information** about available testing options and processes
Discuss the variety of CRC screening test options, as well as individual considerations that may impact CRC screening test selection. Offer a questionnaire at time of check-in to expedite CRC screening selection and to allow the patient time to formulate questions about CRC screening.

Once a CRC screening option is agreed upon, explain the expectations and process. Assure that medications for discomfort will be provided for CRC screening procedures. Patient brochures and information are available through your local American Cancer Society (ACS) office.[3]

4) **Concerns regarding costs and/or interruption of daily life responsibilities**
Although CRC screening is a preventive measure, there may be affiliated out-of-pocket costs. Loss of work and/or lack of transportation may be a concern with a flexible sigmoidoscopy or colonoscopy. Inform patients that preventing colorectal cancer or finding it early does not have to be expensive. There are simple, affordable tests available.

Encourage patients to contact their BCBSNM customer service advocates, using the phone number on the back of their ID cards, to discuss benefits and coverage.

**Provider Concerns:**

1) **Visit time constraints**
Addressing acute or chronic conditions may take precedence over preventive care during a visit. Train staff to identify patients with gaps in preventive care to allow for focused and efficient use of provider time. Office systems that "flag" patients needing a CRC screening are helpful. Printed materials available in waiting rooms also may encourage conversations.

2) **Familiarity with recommended CRC screening options**
Various factors will determine which option is best for each patient. March's *Blue Review* article, **"Colorectal Cancer Screening Options,"** addressed the CRC screening methods available such as direct visualization tests, stool-based tests, and serology.

3) **Office process**
Identify a CRC screening champion in your office to train staff in identifying patients who are due for screening. Standing orders will allow key staff to assess, implement, and follow up with patients regarding their selected CRC screening option. Stocking FIT kits in the office to dispense at the time of the patient's visit can be effective. **Should a patient agree to FIT testing, allow them to open the kit, handle the materials and complete the paperwork**. The mystery will be removed if the patient can see the test and ask questions. Patients will be more likely to complete the CRC screening if they feel confident in the process. Many useful resources have been developed to support providers in developing in-office screening practices and FIT programs.

4) **Resources to follow up on positive CRC screening**
Particularly in rural areas, providers may be concerned that patients with positive CRC screening results may not have ideal access to gastroenterologists or cancer treatment specialists. To alleviate this concern, stay current on the availability of reasonably accessible network providers and have patients contact BCBSNM customer advocates for assistance.

**Have the conversation with your patients to discuss CRC risks and the best screening method!**

**Overcome the barriers to CRC screening compliance!**

For a link to the Screening for Colorectal Cancer: Optimizing Quality (CME), go to http://www.cdc.gov/cancer/colorectal/quality/ to download, print or watch the presentations on YouTube! Expires March 10, 2019

*References*


1. *Final Recommendation Statement: Colorectal Cancer: Screening (n.d.). US Preventive Services Task Force, Release Date June 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2*
2. *Tests to Detect Colorectal Cancer and Polyps Retrieved from NIH National Cancer Institute https://www.cancer.gov/types/colorectal/screening-fact-sheet#q6*
3. *American Cancer Society, Find Local ACS: www.cancer.org*

### Insurers Required by CMS to Conduct ACA Risk Adjustment Program Audit

In 2017, the Centers for Medicare and Medicaid Services (CMS) will conduct another Initial Validation Audit (IVA) to validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program. The provider's role is essential to the success of the IVA. Therefore, if any of your patients are selected to be included in the IVA, Blue Cross and Blue Shield of (State) (BCBSXX) is asking for your cooperation and commitment to fulfilling the requirements of the IVA.

The IVA is expected to begin in June of 2017 and Blue Cross and Blue Shield of (State) (BCBSXX) will be working with Tactical Management Incorporated (TMI) to retrieve the requested medical records that we have to submit to our IVA auditor. Our IVA auditor requires medical records in order to validate the sampled member's risk score calculation which is based on the diagnosis codes submitted on a member's claims, as well as through supplemental diagnosis submissions based on medical record review. As (BCBSXX) providers, you may be asked to provide medical records directly to TMI in order to validate all of the diagnosis codes used in the ACA RA risk score calculation. It is of utmost importance that you respond to these requests in a timely manner.

The IVA will be performed on a sample of members enrolled in ACA-compliant individual and small group plans, both on and off-exchange. Our IVA auditor will validate medical claims of the sampled members from the previous calendar year. For example, this IVA will be conducted in 2017, but will review claims with dates of service in 2016. Please be aware some of these claims may have been paid in 2017 and are likely to be included in the IVA sample.

We understand that this is a very busy time; however, in an effort to comply with CMS' requirements, we appreciate your full support and cooperation as you receive requests from TMI and deliver the requested medical record(s) in a timely manner.

### Appointment Availability and Access Guidelines

As a contracted BCBSNM provider the following appointment availability and access guidelines should be used to ensure timely access to medical and behavioral health care for our BCBSNM membership:

□Routine, asymptomatic, member-initiated, outpatient appointments for primary medical care – within 30 days unless patient requests a later time.

□Routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and care – request-to-appointment time no greater than 14 days unless patient requests a later time

□Non-urgent behavioral health care – request-to-appointment time no greater than 10 days unless patient requests a later time

□Primary medical and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours

□Emergency care – 24 hours a day, 7 days per week

□Specialty outpatient referral and consultation appointments, excluding behavioral health – request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless patient requests a later time

**Other Appointment Availability and Access Guidelines for BCBSNM Medicaid membership.**

☐Routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments – request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days unless patient requests a later time

☐Outpatient diagnostic laboratory, diagnostic imaging and other testing – if a walk-in rather than an appointment system is used, the member wait time shall be consistent with the severity of the clinical need

☐Urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing – appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours

☐In-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes

☐For behavioral health crisis services, face-to-face appointments shall be available within two hours

☐Sufficient transportation is available to meet the needs of the member

☐New durable medical equipment (DME) and repairs to existing DME owned or rented by the member – approve or deny the request within seven working days of the request date.

o All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

o All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

o All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

o All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.

o The MCO shall have an emergency response plan for non- customized DME needed on an emergent basis

**After-Hours Care**

- PCP’s offices are to communicated after-hour care either via an answering system or answering service to the member who calls for information and/or instructions as to how to obtain health care when the practitioner's office is closed.
  - The following after-hour information is to be communicated to the member:
    - Current office hours (when to call back)
    - Instructions on calling for an office appointment
    - Information on how to access the on-call practitioner, as appropriate
    - Instructions to call “911" or to go to the emergency room if patient is experiencing a life-threatening condition

## Provider Claim Summary Paper Mailing Discontinuance: Effective Date Delay

As a reminder, Provider Claim Summaries (PCSs) are now accessible through the Reporting On-Demand application, located under our Blue Cross and Blue Shield of New Mexico (BCBSNM) branded *Payer Spaces* section on the Availity™ Web portal.

**A previous announcement indicated that distribution of paper PCSs via regular mail would be discontinued March 1, 2017. However, to ensure provider readiness, the effective date to discontinue mailing of paper PCSs has been delayed from March 1, 2017, to a future date within 2017. More information will be made available regarding the paper mailing end date in the upcoming months.**

Exception requests to receive paper PCS mailings will continue to be reviewed by emailing *PECS@bcbsnm.com*.

As a point of clarification, enrollment for Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) remains optional, and is not required to obtain your PCS from Reporting On-Demand. With Reporting On-Demand, the identical PCS received by mail from BCBSNM is readily available for you to view, download and/or print, at your convenience.

**Not yet registered with Availity?** Simply go to availity.com, select "Register" and complete the online registration process today at no additional cost. For more information on Availity registration or to request additional training, contact our Provider Education Consultants at *PECS@bcbsnm.com*.

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