BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

May 2018

Pharmacy Program

Quarterly Pharmacy Changes Effective Apr. 1, 2018

Based on availability of new prescription medications and review of the pharmaceuticals market, revisions and/or exclusions were made to the BCBSNM drug lists.

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Education & Reference

Services Rendered by Providers to Related Members and/or Self

BCBSNM benefit booklets exclude coverage for self-administered services and services provided by a member of your immediate family or a person normally residing in your home.

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Making the Health Care System Work Better Together

We're working with business and thought leaders, inside and outside of our organization, to explore ways we can all work together to make the health care system work better for everyone.

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Member Concerns About DME - Working Together to Improve the Member-Provider Experience

It may be difficult to understand why DME, when billed through insurance, may differ in cost from the same or similar product when purchased over-the-counter. Working together to assist members in understanding some of the factors that may impact the decision to provide DME through insurance vs over-the-counter may be helpful to reduce members' complaints about this issue.

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Blue Cross Community Centennial℠ (Meidcaid)

Critical Incident Reporting

Community agencies for Blue Cross Community Centennial (or NM Medicaid) are required to report any critical incidents of their patients/clients as outlined by the NM Human Services Department (HSD) in the following. Please reference the page linked below and the Helpful Documents at the bottom of that page.

Critical Incident Reporting

2018 Billing and Documentation guidelines for Urine Drug Tests

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.

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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 1-800-567-8540.

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.

Claims Inquiries

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

- Network Services Contacts and Related Service Areas
- Network Services Regional Map

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

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

5701 Balloon Fiesta Pkwy NE, Albuquerque, NM 87113

Quarterly Pharmacy Changes Effective April 1, 2018

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. Changes that became effective Apr. 1, 2018, are outlined below.

Please Note: If you have patients with an individual benefit plan offered on/off the New Mexico Health Insurance Exchange, they may be impacted by annual drug list changes. You can view a list of these changes on our Member Services website.

Services Rendered by Providers to Related Members and/or Self

Blue Cross and Blue Shield of New Mexico (BCBSNM) benefit booklets exclude coverage for self-administered services and services provided by a member of your immediate family or a person normally residing in your home. The BCBSNM Provider Reference Manual (PRM) excludes coverage for self-administered services, services rendered to a member of the household, and services provided to family members or any self-administered services. The PRM refers to Chapter 16, Section 130 of the Medicare Benefit Policy Manual for the definition of an "immediate relative," which includes the following:

1. husband and wife;
2. natural or adoptive parent, child, and sibling;
3. stepparent, stepchild, stepbrother, and stepsister;
4. father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
5. grandparent and grandchild; and (6) spouse of grandparent and grandchild.

For more information, please contact your Provider Network Representative or call the Toll-Free Customer Service phone number on the back of the member ID card for assistance. Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

Making the Health Care System Work Better Together

Blue Cross and Blue Shield of New Mexico has an insider's view of how health insurers, doctors, hospitals, employers and governments depend on one another to provide access to affordable, high-quality care and help people live healthy, productive lives. We're using this unique insight to work with business and thought leaders, inside and outside of our organization, to explore ways we can all work together to make the health care system work better for everyone.

View this video to learn more about the online magazine we created to tell these stories about how we're *Making the Health Care System Work*℠.
Join us and help grow the conversation by reading and sharing these articles and stories:

- **Subscribe:** Visit *Making the Health Care System Work* and subscribe to have new stories and videos delivered to your inbox.
- **Share:** Share information through Facebook, Twitter and LinkedIn with the hashtag #MHCSW, or email links directly from the site.
  Thank you for sharing our commitment to increasing access to affordable care through health, wellness and innovation.

Member Concerns About DME - Working Together to Improve the Member-Provider Experience

Blue Cross and Blue Shield of New Mexico (BCBSNM) is focused on improving our members' experience when they access care. On occasion, a member or their representative may call BCBSNM to voice concerns and/or dissatisfaction with a provider or care received. The BCBSNM Quality and Accreditation Department is responsible for processing complaints from commercial and marketplace members regarding the quality of care and/or the quality of service that they receive from their BCBSNM participating providers.

These quality of service and quality of care complaints are investigated and tracked to identify trends and best practices to improve the member-provider experience. The complaint investigation process involves reaching out to providers and may also involve collaboration with other BCBSNM departments such as Network Services, Provider Relations and/or claims processing.

BCBSNM will publish a series of articles throughout this year to address some of our members' most frequent concerns and remind providers of some of their related contractual obligations. We hope that we can work together with you and your staff to improve the care that you furnish to your patients (our members).

Last month we addressed the members' concerns about referring to appropriate providers/facilities. This month we will look at the following member concern: "Why am I billed more than the retail amount for Durable Medical Equipment (DME)?"

It may be difficult to understand why DME, when billed through insurance, may differ in cost from the same or similar product when purchased over-the-counter. Working together to assist members in understanding some of the factors that may impact the decision to provide DME through insurance vs over-the-counter may be helpful to reduce members' complaints about this issue.

Let's look at how DME is defined and then some considerations that may impact cost differences.

BCBSNM's commercial and retail benefit booklets define **Durable Medical Equipment (DME)** as any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured.[1]
How DME pricing is calculated may depend on various factors. The Durable Medical Equipment, Prosthetic/Orthotics, and Supplies (DMEPOS) Fee Schedule, published by the Centers for Medicare and Medicaid Services (CMS), is one of the resources that BCBSNM utilizes for DME pricing. The DMEPOS Fee Schedule provides Healthcare Common Procedure Coding System (HCPCS) codes. HCPCS is a standardized coding system that is used primarily to identify products, supplies and services not included in CPT (Current Procedural Terminology) codes. HCPCS codes, modifiers for the HCPCS codes as well as the DMEPOS Fee Schedule for each state, impact pricing for DME in this standardized coding system. Some DME items may be "grouped" with a specific price set, priced for a specific region, or have national "ceiling and floor" limits. Whether the DME can be rented vs purchased may also impact cost.

BCBSNM adopts the DMEPOS Fee Schedule and then applies specific considerations for each line of business and plan. Because of these differences, DME coverage and costs may vary. Below are some recommendations that may assist when members need covered DME and/or ask about covered DME costs.

<u>Recommendations:</u>

1. Encourage your patients to be aware of their coverage, benefits and networks. Provider Finder, located at bcbsnm.com, can assist providers and members in identifying contracted DME providers for each BCBSNM health plan. Contracted providers should confirm another provider's contracted status before referring a member to that other provider.
   Find a Doctor or Hospital link: https://www.bcbsnm.com/find-a-doctor-or-hospital

2. Encourage your patients to call a BCBSNM Customer Service Advocate (CSA) before services are furnished to verify whether a DME provider is in or out of the network for their health plan. Also encourage your patients to directly ask the DME provider about the DME provider's contracted status with BCBSNM.

   Numbers to reach BCBSNM customer service are found on the back of the member's BCBSNM ID card. If a member does not have their BCBSNM ID card, they may call:

Commercial members: 1-800-432-0750
Marketplace members: 1-866-236-1702

3. BCBSNM Provider Network Representatives are available to assist contracted providers:
   Monday - Friday, 8 a.m. to 4 p.m. Phone: (505) 837-8800 or toll free at 1-800-567-8540
   Fax: 1-866-290-7718
   Your Provider Network Representative can tell you if another provider is contracted with BCBSNM for your patient's particular BCBSNM health plan.

   By working ogether with BCBSNM, you can better refer your patients, our members, to appropriate DME providers for timely care and optimal use of their covered plan benefits.

[1]Not all DME is covered. The benefits, terms and conditions of each health plan determine coverage.

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]HCSC 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.*