BlueCross BlueShield of New Mexico

BLUE REVIEW℠

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Education & Reference

HHS-RADV/IVA — Frequently Asked Questions

Why am I receiving medical record requests from Blue Cross and Blue Shield of New Mexico (BCBSNM)?

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We are changing the way we review claims for implants performed at free-standing ambulatory surgery centers (ASCs). EquiClaim currently reviews implant claims submitted by hospitals and hospital outpatient departments for services provided to our members. As of Dec. 15, 2019, EquiClaim will also provide post-payment review for all ASC claims with implant charges.

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Pharmacy Program Updates: Quarterly Pharmacy Changes Effective October 1, 2019 — Part 2

This article is a continuation of the previously published Quarterly Pharmacy Changes Part 1 article. While that part 1 article included the drug list revisions/exclusions, dispensing limits, utilization management changes and general information on pharmacy benefit program updates, this part 2 version contains the more recent coverage additions, utilization management updates and any other updates to the pharmacy program.

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 October 1, 2019

Laboratory Benefit Level Change

Beginning Jan. 1, 2020, or upon a member's renewal date, non-preventive labs will no longer be covered at the no member cost-share level for some BCBSNM PPO and HMO members but will instead be treated as a standard medical benefit regardless of diagnosis code. Any

applicable cost sharing (copay, coinsurance and deductible) may apply, based on the member's health plan.

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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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Changes to Medicare Advantage Payment Models for Skilled Nursing Facility and Home Health Care Claims

The Centers for Medicare & Medicaid Services (CMS) is launching new payment models for skilled nursing facilities and home health care. Blue Cross and Blue Shield of New Mexico (BCBSNM) is aligning its payment models with CMS for Medicare Advantage claims.

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Medicare PTAN and Medicaid Numbers/Letters Required for Network Inclusion

Medicare PTAN and Medicaid numbers/letters are required for these networks to be added to a provider's record. Applications without Medicare PTAN and/or Medicaid numbers/letters will be processed normally but without Medicare and/or Blue Cross Community Centennial networks until information has been received. Failure to include this information may impact claims. Once you have received your Medicare PTAN and/or Medicaid numbers/letters, please send this documentation to NSD_RightFax@bcbsnm.com or fax to 866-290-7718 and reference the original case number you received with confirmation of receipt of your onboarding form submission.

Blue Cross Community Centennial℠ (Medicaid)

New Program Notification: Opioid Diagnosis Code Required at Pharmacy

Effective November 1, 2019: Each opioid prescription will be required to have a valid and appropriate diagnosis (defined below) in order for BCBSNM to provide coverage for the opioid

prescription. Excluded from this requirement, will be buprenorphine products used for treating opioid addiction.

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Screening for Clinical Depression Initiative

Blue Cross Community Centennial network providers may be paid for depression screening, when clinically appropriate, up to four times per year. Please review the Screening for Clinical Depression Initiative provider resource on bcbsnm.com/provider for information about billing codes and modifiers and a copy of the PHQ-9 screening tool.

Behavioral Health and Addiction TeleECHO Program

The Behavioral Health and Addiction (BHA) TeleECHO program from the University of New Mexico's ECHO Institute, with support from the Centennial Care Managed Care Organizations, helps providers in the assessment and management of substance use and mental health disorders. The TeleECHO series runs throughout 2019 and 2020. These sessions will feature case presentations and lectures on depression and anxiety, interventions, substance use disorders, motivational interviewing, ADHD, PTSD, and more. Please see the BHA TeleECHO webpage Learn more about third-party links for details, dates, and more information about TeleECHO. For a full listing of the 2019-2020 curriculum, see the BHA TeleECHO flier.

Medicare PTAN and Medicaid Numbers/Letters Required for Network Inclusion

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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

HHS-RADV/IVA -Frequently Asked Questions

Question: Why am I receiving medical record requests from Blue Cross and Blue Shield of New Mexico (BCBSNM)?
Answer: As an issuer participating in the Affordable Care Act's (ACA) Risk Adjustment (RA) program, BCBSNM needs your cooperation and participation in this required Initial Validation Audit (IVA). Therefore, we are requesting all medical records tied to applicable 2018 calendar year dates of service for the requested member(s).

Question: Who participates in this validation audit?
Answer: In addition to ACA/ RA participating insurers, participants include Hospitals, Physicians and Practitioners of health care services.

Question: Why am I required to provide medical records?
Answer: All BCBSNM contracted providers are required to provide medical records when requested for this and other audits. For this audit, CMS annually validates the accuracy of risk adjustment data submitted by a health insurance company for individuals on-and off-exchange as well as small groups. This is why your support and cooperation are so important.

Question: Whom do I contact with questions regarding the BCBSNM RADV/IVA audit?
Answer: BCBSNM has dedicated a phone number you can call to get answers regarding the RADV/IVA audit: (505) 816-5600. Additionally, you may email us at NMACAIVA@bcbsnm.com.

Addition of New Prior Authorization Requirements for New Mexico Members

There are important changes to the prior authorization requirements for some of your Blue Cross and Blue Shield of New Mexico (BCBSNM) commercial patients with PPO, HMO, EPO and POS benefit plans.

Beginning Jan. 1, 2020, the following services will require prior authorization:

- Outpatient provider-administered drug therapies including Cellular Immunotherapy, Gene Therapy, and other medical benefit drug therapies.

A list of the Drug Therapies Procedure Codes included are posted to the provider website.

It is important to use Availity®, or your preferred vendor, to check eligibility and benefits, determine if you are in-network for your patient, and whether any preauthorization or prenotification is required. Availity allows you to determine if preauthorization is required. Refer to the Eligibility and Benefits web page at bcbsnm.com/provider for more information on Availity. Providers can also refer to the Preauthorization web page for more information regarding preauthorizations.

For services requiring prior authorization through BCBSNM:

- Coming soon, there will be a new tool available in the Availity Provider Portal called Availity Authorizations, which will be used to submit prior authorizations. Watch the BCBSNM provider website for information on this new tool.
- At this time, providers, can continue to submit via iExchange®, our web-based automated tool. Refer to this web page for more information or to set up an iExchange account.

Preauthorization through BCBSNM may also be requested by calling the phone number listed on the member/participant's ID card.

As a reminder, it is important to check eligibility and benefits prior to rendering services. This step will help you determine if benefit prior authorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSNM's provider website.

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.

A Change in the Coding of Physical Medicine Service Units: Time-Based Measurement Standard to Follow AMA

As of July 22, 2019, we changed our time measurement standard for billing physical medicine services. We will now follow the American Medical Association (AMA) guidelines for time-based services. These are time-based codes within the Physical Medicine and Rehabilitation section of the Current Procedural Terminology (CPT) code book.

When billing for time-based services use the (CPT) codes in the AMA code book, except as required by federal law for Medicare and Medicaid patients. The AMA guidelines will apply to these physical medicine services:

97110, 97113, 97116, 97530, 97533, 97535, 97537, 97542, 97750, G0515

As always, it is critical to check eligibility and benefits first, prior to rendering care and services to confirm coverage, network status and other important details. When you check eligibility and benefits online by submitting an electronic 270 transaction through the Availity® Provider Portal or your preferred web vendor portal, you may determine if benefit prior authorization may be required based on the procedure code.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized/pre-notified 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.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM.

BCBSNM makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such Availity. The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor directly.

Measure and Document Body Mass Index (BMI)

Maintaining a healthy weight is key to reducing the risk of high blood pressure, high blood cholesterol and type 2 diabetes. Reducing the risk of these factors decreases the risk of heart disease and stroke. Measuring and documenting your patients' Body Mass Index (BMI) according to Healthcare Effectiveness Data and Information Set (HEDIS®) standards can help you care for their long-term health.

A healthy weight as determined by a person's BMI is one of 90 Healthcare HEDIS measurements. The National Committee for Quality Assurance (NCQA) collects HEDIS data. The goal is to provide information on the performance of our health care system. Blue Cross and Blue Shield of New Mexico collects HEDIS data from our providers to measure and improve the quality of care our members receive.

You can help us collect HEDIS data and better care for our members by measuring and documenting our members' BMI at least once every two years. BMI can help you identify patients who have an increased-risk of morbidity. To make this process easier, we have a HEDIS Tip Sheet available on our website with ICD-10 Z codes and charting tips.
You can help us collect HEDIS data and better care for our members by measuring and documenting our members' BMI at least once every two years. BMI can help you identify

patients who have an increased-risk of morbidity. To make this process easier, we have a HEDIS Tip Sheet available on our website with ICD-10 Z codes and charting tips.

The HEDIS Adult BMI Assessment measures the BMI of 18-to-74-year-olds. The member had to have seen their provider at an outpatient visit and had a documented BMI in the past two years.

NOTE: *The Z code must be used as a secondary code and is non-reimbursable.*

BCBSNM to Review Implant Claims from Stand-Alone ASCs

We are changing the way we review claims for implants performed at free-standing ambulatory surgery centers (ASCs). EquiClaim currently reviews implant claims submitted by hospitals and hospital outpatient departments for services provided to our members. As of Dec. 15, 2019, EquiClaim will also provide post-payment review for all ASC claims with implant charges.

Claims containing implant charges in any combination of revenue and procedure codes will be reviewed for:

- Consistency with the provider agreement
- Consistency with clinical payment and coding policies
- Accuracy of payment

EquiClaim will let you know if your claim for an implant was incorrectly paid. They will tell you how to repay the funds or appeal the decision.

As a reminder, we may recoup payment for any device that does not meet our requirements. For more information, refer to the requirements and provider manual on our provider site at **bcbsnm.com/providers**.
If you have any questions or concerns, call your Blue Cross and Blue Shield of New Mexico (BCBSNM) network management representative.

EquiClaim, a Change Healthcare Solution, an independent company, provides payment integrity solutions for Blue Cross and Blue Shield of New Mexico.

Laboratory Benefit Level Change

Currently, Blue Cross and Blue Shield of New Mexico (BCBSNM) covers many non-preventive lab services without any member cost sharing when billed with a preventive diagnosis.

Beginning Jan. 1, 2020, or upon a member's renewal date, non-preventive labs will no longer be covered at the no member cost-share level for some BCBSNM PPO and HMO members but will instead be treated as a standard medical benefit regardless of diagnosis code. Any applicable cost sharing (copay, coinsurance and deductible) may apply, based on the member's health plan.

What does this mean for you?

- You may have to seek payment from both BCBSNM and the member.
- You may want to alert members that they could have to pay any applicable cost share (copayment, coinsurance, deductible) for laboratory services.

Please refer to the Preventive Services Clinical Payment and Coding policy, which contains the list of lab procedures that are considered preventive and will now process at the no cost share benefit level when billed with a preventive diagnosis.

As a reminder, it is important to check member eligibility and benefits through Availity® Provider Portal or your preferred vendor web portal 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. Checking eligibility and benefits also helps providers confirm benefit preauthorization requirements. Providers must also ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly. Obtaining benefit preauthorization is not a substitute for checking member eligibility and benefits.

To confirm how a lab will process if it's not identified on the Preventive Clinical Payment and Coding Policy, please call the number on the member's ID card and ask about their non-ACA wellness benefit.

Note: This information does not apply to members who have Medicaid or Medicare plans.

Changes to Medicare Advantage Payment Models for Skilled Nursing Facility and Home Health Care Claims

The Centers for Medicare & Medicaid Services (CMS) is launching new payment models for skilled nursing facilities and home health care. Blue Cross and Blue Shield of New Mexico (BCBSNM) is aligning its payment models with CMS for Medicare Advantage claims.

These changes will help support patient-focused, streamlined claims processes for skilled nursing facilities and home health agencies that are contracted to provide care and services for our Blue Cross Medicare Advantage (PPO)℠ (MA PPO) and Blue Cross Medicare Advantage (HMO)℠ (MA HMO) members.

What Is Changing?

- Beginning **October 1, 2019**, BCBSNM will transition to CMS's Patient Driven Payment Model, which classifies skilled nursing facility claims into payment groups based on patient characteristics. This model replaces the Resource Utilization Group, Version IV (RUG-IV), which we will no longer support.
- Beginning **January 1, 2020**, BCBSNM will adopt CMS's Patient-Driven Groupings Model for home health patients, as part of the Home Health Prospective Payment System. Under this new model, payment is based on 30-day periods rather than 60 days, and therapy service thresholds are eliminated.

Medicare Advantage providers should use the new CMS classifications when submitting claims for skilled nursing facility and home health services.

Learn More

Visit the CMS website for more information, including answers to frequently asked questions about CMS's payment model for skilled nursing facilities. Also refer to the CMS website for access to an interactive grouper tool and other details on the home health patient-driven groupings model.

New Program Notification: Opioid Diagnosis Code Required at Pharmacy

Effective November 1, 2019: Each opioid prescription will be required to have a valid and appropriate diagnosis (defined below) in order for Blue Cross and Blue Shield of New Mexico to provide coverage for the opioid prescription. Excluded from this requirement, will be buprenorphine products used for treating opioid addiction.

- **Valid Code:** Current ICD10 diagnosis codes can be found in the CMS coding database https://www.cms.gov/medicare/coding/icd10/2019-icd-10-cm.html
- **Appropriate Code:** A Valid ICD10 Dx code that is an appropriate indication for the use of opioids. (i.e. G89.3 Neoplasm related pain)

The purpose of this update is to notify our valued medical providers about a new program that will be implemented in our work on the opioid epidemic in our communities. Our teams have implemented many standard opioid safety edits to limit the opioids available to the public to medically necessary purposes only and to prevent diversion and inappropriate use.

To further ensure proper utilization of opioids we have worked closely with our PBM, Prime Therapeutics to build and implement a Diagnosis (Dx) code requirement at the dispensing Pharmacy. The benefits of this will be to have faster and improved care management and disease management engagement with our members. This new process will ensure that all opioid prescriptions covered for our members are appropriate and that the dispensing pharmacists are aware of the patient's pain treatment needs.

For questions about drug coverage, plan members can call the Customer Service number on their member ID card.

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