BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

December 2021

Education & Reference

COVID-19 Information for Providers

Please check the following Blue Cross and Blue Shield of New Mexico (BCBSNM) resources frequently for updates to important information related to COVID-19:

- Provider Information on COVID-19 Coverage
- BCBSNM News and Updates
- BCBSNM COVID-19 Member Website

Catch Up on Vaccines for All Ages

The COVID-19 pandemic has significantly disrupted routine immunizations for children, adolescents and adults. You may hear from our members about catching up on delayed vaccinations. We've created resources for them about staying current on routine vaccines. In coordination with Merck & Co., we've also reached out to some members reminding them to discuss vaccines with their providers.

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Information About the 2021-2022 Flu Season and Vaccination

The Centers for Disease Control and Prevention (CDC) recommends yearly flu shots for all patients 6 months and older without vaccine contraindication. For the 2021-2022 flu season,

providers may choose to administer any licensed, age-appropriate flu vaccine (IIV, RIV4, or LAIV4) with no preference for any one vaccine over another. Patients may also get a COVID-19 vaccine and a flu vaccine at the same time.

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Single Sign-On Access to AIM Specialty Health® via Availity®

Checking patient eligibility and benefits is an imperative first step to confirm coverage and prior authorization requirements before rendering services. The Availity Eligibility and Benefits Inquiry allows you to quickly confirm prior authorization requirements, along with contact information for the utilization management vendor, if applicable. If the requested service(s) require prior authorization through AIM Specialty Health, providers can now utilize the new single sign-on access to AIM from the Availity portal.

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New Provider Designations and Services Forms for Provider Onboarding Applications

BCBSNM has implemented a new requirement for provider onboarding applications. Providers submitting onboarding applications will also need to attach a Provider Designations and Services Form to their application when submitting your application. This does not apply to currently contracted behavioral health rostered and/or delegated provider groups that are adding new providers.

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Watch for a Letter on Fighting Fraud, Waste and Abuse

Every year analysts and investigators for BCBSNM review claims data, industry trends and investigative results to identify potential areas of fraud and waste.

We share this information with you in letters mailed to your office. The current letters show instances of potential billing abuse around COVID-19 testing and vaccinations. The letters will remind you to comply with BCBSNM's policies and requirements.

For more information, please refer to the Provider Standards and Requirements on our website for additional information on policies.

If you encounter potential fraud, waste and/or abuse, please file a report online or call our Fraud Hotline at 800-543-0867. All online reports and calls are confidential, and you may remain anonymous. For more information, visit our Fraud and Abuse page.

Coding and Claims

Current Procedural Terminology (CPT®) Codes Updated for Prior Authorization (Commercial/Retail and Medicaid)

BCBSNM is changing prior authorization requirements that may apply for some retail/commercial and Medicaid Blue Cross Community Centennial℠ members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

Read More

Current Procedural Terminology (CPT®) Codes Updated for Prior Authorization (Medicare)

BCBSNM is changing prior authorization requirements that may apply for Medicare members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

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Claim Editing Enhancements Coming Jan. 10, 2022

Effective Jan. 10, 2022, BCBSNM will enhance our claims editing and review process with Cotiviti for some of our commercial members to help ensure accurate coding of services and that services are properly reimbursed. The enhancements will require you to follow generally accepted claim payment policies. With your help, the enhanced claims review process will help our members get the right care at the right time and in the right setting.

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Including Behavioral Health Diagnoses on Claims and Referring to Behavioral Health Providers

Providers are encouraged to include behavioral health diagnoses on claim forms as the primary or secondary diagnosis if applicable to the member being treated. Reporting behavioral health

diagnoses is important for BCBSNM and the New Mexico Medicaid program to accurately capture the prevalence of behavioral health needs across the state.

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View Withdrawn Claim Descriptions via the Availity® Claim Status Tool

There may be instances when you receive a withdrawn claim notification by mail explaining why the claim was withdrawn. As an alternative to the physical notification, you may also review why a claim was withdrawn via the Availity Claim Status tool response.

The Claim Status tool response includes the status for original, duplicate, adjusted, replacement, and withdrawn claims. Refer to the **Custom Status Description** field on the results page to review why the claim was withdrawn. After addressing the reason, the claim may be resubmitted electronically to Blue Cross and Blue Shield of New Mexico (BCBSNM) for processing.

For assistance with verifying claim status online, refer to the Claim Status User Guide.

This information is not applicable to Blue Cross Medicare Advantage℠ claims.

Reminder: Medicaid Providers Can Receive Payment for Project ECHO Consultations

Providers in the Blue Cross Community Centennial network may receive payment for presenting Blue Cross Community Centennial member patient cases as part of a Project ECHO consultation clinic. Providers should bill the appropriate CPT code listed below *with the modifier 32*.

CPT 99446-99449: Telephone or internet assessment and management service provided by consultative physician — minutes of medical consultative discussion and review		**Medicaid FFS Rate**
CPT 99446*	5–10 minutes	$16.34
CPT 99447*	11–20 minutes	$32.39
CPT 99448*	21–30 minutes	$48.74
CPT 99449*	31 minutes or more	$64.77

Federal Employee Program® (FEP®)

Health Benefits of Collaborating with Eye Care Professionals

Many primary care providers (PCPs) refer our diabetic FEP members to eye care specialists for annual eye examinations. PCPs need to know details about the care their patients receive and to

receive communications from their patients' eye care specialists. We want to encourage eye care specialists who do not routinely or promptly share results, to consider doing so.

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Hospital Discharge Summaries Are Important to Empower Members and Inform Specialists and Primary Care Providers

It is important for PCPs to know details about the care their patients receive during inpatient hospital stays. The hospital discharge summary is the key source for this information. BCBSNM 2021 Provider satisfaction survey results from PCPs and Specialists showed that while improvement was noted in receiving the hospital discharge summary there are still some providers not receiving them.

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Reminder to Encourage Early and Timely Intervention for Pre- and Post-Partum Care Even Now

Post-partum visits are recommended to be scheduled before discharge from the hospital. Written and/or electronic instruction is beneficial to the health of the member and the child. Coordination of care is best achieved when providers help members anticipate and follow through with transitions of care and between settings.

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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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Hospitals Must Provide Medicare Outpatient Observation Notice (MOON)

Hospitals and Critical Access Hospitals (CAH) are required to give the standardized MOON to our Blue Cross Medicare Advantage members in observation as outpatients for more than 24 hours. The notice explains why the members aren't inpatients and what their coverage and cost-sharing obligations will be.

Steps for providers to complete the MOON

- Download the notice from the Centers for Medicare and Medicaid Services (CMS) website
- Fill in the reason the member is outpatient rather than inpatient.
- Explain the notice verbally to the member.
- Have the member sign to confirm they received and understand the notice. If the member declines, the staff member who provided the notice must certify that it was presented.

The notice **must be completed no later than 36 hours after observation begins or sooner** if the patient is admitted, transferred or released.

Learn more from CMS' Notice Instructions.

Blue Cross Community Centennial℠ (Medicaid)

Our Medicaid Quality Improvement Program

The Quality Improvement Program's primary goal is to improve members' health status and outcomes through a variety of meaningful quality improvement activities and interventions that are implemented across all care settings that aims at improving the quality of care and services delivered to our members — your patients. BCBSNM has met most goals in 2021 and are especially pleased to report that BCBSNM maintained its accreditation through the National Committee for Quality Assurance (NCQA) for the Medicaid line of business.

Read More

Required Cultural Competency Training Available Online

The New Mexico Human Services Department (HSD) requires all providers contracted within a New Mexico Medicaid Network, like Blue Cross Community Centennial, to take annual cultural competency training. This training is intended to include all cultures and not be limited to any particular group and is designed to address the needs of racial, ethnic, and linguistic populations that may experience unequal access to health services.

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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.

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

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

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

5701 Balloon Fiesta Pkwy NE, Albuquerque, NM 87113

Catch Up on Vaccines for All Ages

The COVID-19 pandemic has significantly disrupted routine immunizations for children, adolescents and adults, according to the U.S. Department of Health and Human Services. You may hear from our members about catching up on delayed vaccinations. We've created resources for them about staying current on routine vaccines. In coordination with Merck & Co., we've also reached out to some members reminding them to discuss vaccines with their providers. Examples of routine vaccinations include:

- **Influenza (flu) vaccine** annually for ages 6 months and older
- **Human papillomavirus (HPV) vaccine** for ages 9 to 14, or for ages 15 to 26 if not received earlier, to protect against some cancers
- **Measles, mumps and rubella (MMR) vaccine** for ages 12 to 15 months; 4 to 6 years; and adults with no immunity or medical conditions
- **Pneumonia vaccine** for older adults and adults with health issues that weaken their immune system
- **Shingles vaccine** for adults ages 50 and older

See our preventive care guidelines on immunization schedules.

COVID-19 vaccine: The Centers for Disease Control and Prevention (CDC) recommends the **COVID-19 vaccine** for everyone ages 12 and older and booster shots in certain populations. The CDC says that other vaccines may be given with the COVID-19 vaccine. The Food and Drug Administration granted full approval of the Pfizer COVID-19 vaccine for ages 16 and older, and emergency use authorization (EUA) for ages 12 to 15. The Moderna and Johnson & Johnson vaccines have EUA for ages 18 and older. COVID-19 vaccines may be approved for younger children this fall. We will update vaccination information on our website when this occurs. Learn more about COVID-19 vaccines and coverage.

Closing Care Gaps

As part of monitoring and helping improve quality of care, we track two measures related to immunizations. Both are Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA).

- **Child Immunization Status**, which tracks the percentage of children who received by their 2nd birthday a total of four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one MMR; three haemophilus influenza type B (HiB); three hepatitis B (Hep B); one varicella (VZV); four pneumococcal (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two flu vaccines.
- **Immunizations for Adolescents**, which tracks the percentage of 13-year-olds who had one dose of meningococcal vaccine; one tetanus, diphtheria and pertussis (Tdap); and the complete HPV vaccine series by their 13th birthday.

Tips to Consider

- Identify members who have missed vaccinations and contact them or their caregivers to schedule appointments.

- Check at each visit for any missing immunizations and deliver vaccines that are due.
- Address common misconceptions about vaccines.

Information About the 2021-2022 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 flu vaccines are recommended this season?

For the 2021-2022 flu season, providers may choose to administer any licensed, age-appropriate flu vaccine (IIV, RIV4, or LAIV4) with no preference for any one vaccine over another.

Vaccine options this season include:

- Standard dose flu shots.
- High-dose shots for people 65 years and older.
- Shots made with adjuvant for people 65 years and older.
- Shots made with virus grown in cell culture. No eggs are involved in the production of this vaccine.
- Shots made using a vaccine production technology (recombinant vaccine) that do not require having a candidate vaccine virus (CVV) sample to produce.
- Live attenuated influenza vaccine (LAIV). — A vaccine made with attenuated (weakened) live virus that is given by nasal spray.
- Find additional information here: Influenza Vaccination: A Summary for Clinicians

What's different this flu season?[1]

- The composition of flu vaccines has been updated.

- All flu vaccines will be quadrivalent (four component), meaning designed to protect against four different flu viruses. For more information: Quadrivalent Influenza Vaccine | CDC.
- Licensure on one flu vaccine has changed. Flucelvax Quadrivalent is now approved for people 2 years and older.
- Flu vaccines and COVID-19 vaccines can be given at the same time.
- More detailed guidance about the recommended timing of flu vaccination for some groups of people is available.
- Guidance concerning contraindications and precautions for the use of two flu vaccines — Flucevax Quadrivalent and Flublok Quadrivalent — were updated.

Recommendations this Flu Season[2]

- Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.
- Vaccine should be ideally administered by the end of October but should continue to be offered as long as influenza viruses are circulating locally, and unexpired vaccine is available.
- Approved dose volumes vary by age and product. An age-appropriate vaccine should be used at an appropriate dose.
- Persons who are pregnant or who might be pregnant during the influenza season should receive influenza vaccine
- For more detailed recommendations visit the CDC website:
  Summary: 'Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP)-United States, 2021-22'

Can patients get a COVID-19 vaccine and a flu vaccine at the same time?

Yes, patients can get a COVID-19 vaccine and a flu vaccine at the same time.

Even though both vaccines can be given at the same visit, people should follow the recommended schedule for either vaccine: If you haven't gotten your currently recommended doses of COVID-19 vaccine, get a COVID-19 vaccine as soon as you can, and ideally get a flu vaccine by the end of October.

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
    - 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: 2021-2022 Season, Oct. 25, 2021. https://www.cdc.gov/flu/season/faq-flu-season-2021-2022.htm

2 CDC, Seasonal Influenza (Flu): Health Professionals, Oct 25th 2021. https://www.cdc.gov/flu/professionals/acip/summary/summary-recommendations.htm

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Single Sign-On Access to AIM Specialty Health® via Availity®

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If the requested service(s) require prior authorization through AIM Specialty Health, providers can now utilize the new single sign-on access to AIM from the Availity portal.

How to Access AIM from the Availity Portal®

- Select *Patient Registration* from the navigation menu and choose *Authorizations & Referrals*.
- On the Authorization page, select the *AIM (BCBSNM)* link in the Additional Authorizations and Referrals section.
- Select your provider organization and provider type (provider or facility), then click *Submit*.

- Users will be redirected to the AIM portal to start and submit the prior authorization request.

**** The above information applies only to prior authorization requests handled by AIM. The process of submitting prior authorization requests to Blue Cross and Blue Shield of New Mexico (BCBSNM) or through other vendors has not changed.***

Refer to the Eligibility and Benefits User Guide for assistance with determining prior authorization requirements in the Availity portal.

Checking 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, and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for BCBSNM. BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as AIM Specialty Health. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

New Provider Designations and Services Forms for Provider Onboarding Applications

Blue Cross and Blue Shield of New Mexico (BCBSNM) has implemented a new requirement for provider onboarding applications. Providers submitting onboarding applications will also need to attach a **Provider Designations and Services Form** to their application when submitting your application. This does not apply to currently contracted behavioral health rostered and/or delegated provider groups that are adding new providers.
Provider Designations and Services Forms are used to populate our provider directories to help our members find the care they need and provide data for required state and federal reporting.

The Provider Designations and Services Forms are available on our website, bcbsnm.com/provider, in the "How to Join BCBSNM Provider Networks" section under the "Network Participation" tab. There are different forms for each the following provider types:

- Groups, Clinics and Agencies
    - Physical Health
    - Behavioral Health
- Facilities
    - Physical Health

    - Behavioral Health
- Practitioners
    - Physical Health
    - Behavioral Health
- Long-Term Care

Please attach the appropriate completed form(s) with your Provider Onboarding application when submitting your application. Your application will be rejected if it is not accompanied by the appropriate Provider Designations and Services Form(s).

If you have any questions, or if you need additional information, please contact your local BCBSNM Provider Network Representative.

Current Procedural Terminology (CPT®) Codes Updated for Prior Authorization

What's Changing: Blue Cross and Blue Shield of New Mexico (BCBSNM) is changing prior authorization requirements that may apply for some commercial and Medicaid Blue Cross Community Centennial℠ members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

Important Reminder: Always check eligibility and benefits first through Availity® or your preferred vendor, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable. Changes include:

- **Jan. 1, 2022** — Addition of Genetic Testing codes to be reviewed by AIM (retail/commercial and BCCC)
- **Jan. 1, 2022** — Removal of Genetic Testing codes previously reviewed by AIM (retail/commercial and BCCC)
- **Jan. 1, 2022** — Removal of Musculoskeletal codes previously reviewed by AIM (retail/commercial and BCCC)
- **Jan. 1, 2022** — Removal of Physical Health codes previously reviewed by BCBSNM (BCCC only)

More Information: Refer to the updated Preauthorization CPT Code Lists section in the Preauthorization area of the website. The code changes will be designated with dates of removal or addition.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Current Procedural Terminology (CPT®) Codes Updated for Prior Authorization for Medicare Programs

What's Changing: Blue Cross and Blue Shield of New Mexico (BCBSNM) is changing prior authorization requirements for Medicare members, to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA).

Important Reminder: Always check eligibility and benefits first through Availity® or your preferred vendor, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable.
Changes include:

- **Jan. 1, 2022** — Removal of Radiation Therapy codes previously reviewed by eviCore
- **Jan. 1, 2022** — Removal of Genetic Lab codes previously reviewed by eviCore
- **Jan. 1, 2022** — Removal of Musculoskeletal codes previously reviewed by eviCore
- **Jan. 1, 2022** — Removal of Radiology codes previously reviewed by eviCore
- **Jan. 1, 2022** — Removal of Specialty Pharmacy codes previously reviewed by eviCore
- **Jan. 1, 2022** — Removal of Medical Oncology codes previously reviewed by eviCore
- **Jan. 1, 2022** — Addition of a Specialty Drug code to be reviewed by eviCore
- **Jan. 1, 2022** — Removal of a Specialty Drug code previously reviewed by eviCore
- **Jan. 1, 2022** — Removal of Physical Health codes previously reviewed by BCBSNM
- **Jan. 1, 2022** — Addition of Genetic Lab codes to be reviewed by eviCore
- **Jan. 1, 2022** — Addition of Radiology codes to be reviewed by eviCore

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Effective Jan. 10, 2022, Blue Cross and Blue Shield of New Mexico (BCBSNM) will enhance our claims editing and review process with Cotiviti for some of our commercial members to help ensure accurate coding of services and that services are properly reimbursed.

What this means for you: The enhancements will require you to follow generally accepted claim payment policies. With your help, the enhanced claims review process will help our members get the right care at the right time and in the right setting.
About the guidelines: BCBSNM will continue to follow claim payment policies that are global in scope, simple to understand and come from recognized sources, including the Centers for Medicare and Medicaid Services (CMS).
Using these guidelines will help ensure a more accurate review of all claims.

Note: Inaccurately coded claims will result in denied or delayed payment.
Coding for services within the global surgical period — The global surgery package payment policies include all necessary services normally provided by the surgeon before, during and after a surgical procedure, and applies only to primary surgeons and co-surgeons. The global surgery package applies only to surgical procedures that have post-operative periods of 0, 10 and 90 days, as defined by CMS.

More Detail from CMS:

The global surgery package includes:

- Review of preoperative evaluation and management visits after the decision is made to operate, where the visits occur one day prior to major surgery and on the same day a major or minor surgical procedure is performed.
- When a physician sees a patient within the global follow-up period of a surgical procedure that has a 10-, or a 90-day post-operative period, the physician should report the appropriate modifier(s), relevant to the circumstance, for the procedure performed.
- The physician should report the appropriate modifier for any surgical procedure performed within the follow-up period of the original surgical procedure, if applicable. The appropriate, applicable modifiers are as follows:
    - **58** – Staged or Related Procedure or Service by the Same Physician during the Postoperative Period
    - **78** – Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
    - **79** – Unrelated Procedure or Service by the Same Physician during the Postoperative Period

More Information: visit our provider web site for Clinical Payment and Coding Policies with more information on the global surgery package payment policies.

Including Behavioral Health Diagnoses on Claims and Referring to Behavioral Health Providers

Providers are encouraged to include behavioral health diagnoses on claim forms as the primary *or secondary* diagnosis if applicable to the member being treated. Reporting behavioral health diagnoses is important for Blue Cross and Blue Shield of New Mexico (BCBSNM) and the New Mexico Medicaid program to accurately capture the prevalence of behavioral health needs across the state.

In addition, BCBSNM encourages physical health providers to actively screen and identify behavioral health needs of members and refer them to behavioral health

professionals for ongoing treatment if appropriate. If you will be treating the member, please document your counseling or other interventions.

If you are interested in developing a referral relationship with a behavioral health provider and need assistance in identifying a behavioral health provider for this purpose, please contact Steve DeSaulniers at 505-816-2249 or Stephen_c_desaulniers@bcbsnm.com.

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

Health Benefits of Collaborating with Eye Care Professionals

We appreciate the care and services you provide to our Federal Employee Program® (FEP®) members. This article pertains to care/services provided to our FEP members and to encourage continuity and coordination of care.

For quick reference purposes, a recommendation summary and additional information are included below to assist you when you are providing annual eye exams to our diabetic FEP members. We acknowledge members may be hesitant or even have difficulty getting or adhering to their annual exam, especially given the barriers associated with COVID-19. However, diabetic annual eye exams remain an American Diabetes Association (ADA) recommended element in the treatment of patients with diabetes.

Many primary care providers (PCPs) refer our diabetic FEP members to eye care specialists for annual eye examinations. PCPs need to know details about the care their patients receive and to receive communications from their patients' eye care specialists. We want to encourage eye care specialists who do not routinely or promptly share results, to consider doing so.

For your reference, the following is a summary of the American Diabetes Association's (ADA) screening recommendations for patients with diabetes.[1]

Screening:	• Comprehensive evaluation by an eye care specialist should not be substituted by retinal photography. However, for screening purposes retinal photography with remote reading by a retinal specialist is acceptable where eye care professionals are not readily available.
Routine Exams:	• Every two years in the absence of retinopathy • Annually in the presence of retinopathy • At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression

Initial Exam:	• Within five years of diagnosis for adults who have Type 1 diabetes • At the time of diagnosis for adults with Type 2 diabetes
Pregnancy:	• Educate women who are planning to be or are pregnant and who also have diabetes about the risk of diabetic retinopathy developing or progressing • Perform an eye exam prior to or at the time of diagnosis of pregnancy, during every trimester, and one year after delivery in the presence of pre-existing Type 1 or Type 2 diabetes

To help improve patient outcomes, please consider the following:

- Incorporate ADA recommendations into practice
- Gather patient historical information
- Educate your patients
- Ensure diabetic eye exam results are made available to the members' Primary Care Provider (PCP)
- Remind your diabetic patients to contact the number on their member ID card if they have any questions about their health care coverage details.

We thank our primary care providers and eye care specialist for collaborating and supporting the ongoing health and wellness of our FEP members. Working together, we can help support improved continuity of care and health outcomes for people with diabetes.

1 Diabetic Retinopathy: A Position Statement by the American Diabetes Association, Sharon D. Solomon, Emily Chew, Elia J. Duh, Lucia Sobrin, Jennifer K. Sun, Brian L.VanderBeek, Charles

C. Wykoff, Thomas W. Gardner, Diabetes Care, Mar 2017, 40 (3) 412-418; DOI: 10.2337/dc16-2641. Additional information on diabetic retinopathy can be found on the ADA site at: http://care.diabetesjournals.org/content/40/3/412

Hospital Discharge Summaries Are Important to Empower Members and Inform Specialists and Primary Care Providers

It is important for primary care providers (PCPs) to know details about the care their patients receive during inpatient hospital stays. The hospital discharge summary is the key source for this information. Blue Cross Blue Shield of New Mexico (BCBSNM) 2021 Provider satisfaction survey results from PCPs and Specialists showed that while improvement was noted in receiving the hospital discharge summary there are still some providers not receiving them. It is important to communicate timely and ensure continuity of care for our Federal Employee Program® (FEP®) members, family, and the transition home or the next level of treatment. The discharge summary is not only used to improve coordination and quality of care, but ultimately to reduce the number of preventable readmissions. Additional guidance for discharge planning was published in 2019 by the Centers for Medicaid and Medicare Services (CMS).

We want to remind you about some important information to help you when discharging FEP members after inpatient hospital stays. Use of Electronic Health Records (EHRs), including wider acceptance of member portals, when available ensures smooth flow of information from hospital to the member's next level of care. Supporting the member's transition includes providing culturally appropriate member instructions, medication reconciliation and educating caregivers.

Studies have shown that providing timely, structured discharge summaries to PCPs helps reduce readmission rates, improves patient satisfaction, and supports continuity of care. One study found that, at discharge, approximately 40 percent of patients typically have test results pending and 10 percent of those results require action. PCPs and patients may be unaware of these results.[1, 3]

A prospective cohort study found that one in five patients discharged from the hospital to their homes experienced an adverse event (defined as an injury resulting from medical management rather than from the underlying disease) within three weeks of discharge. This study found 66 percent of these were drug-related adverse events.[2, 3]
As a reminder, please include the following information in every discharge summary:

- Course of treatment
- Diagnostic test results
- Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes/medication reconciliation

Communication between the inpatient medical team and the PCP helps ensure continuity and a smooth transition of the FEP patient to the next level of care. FEP Case

Management staff are available to work with members, providers and collaborate with medical team while inpatient and post discharge to facilitate discharge planning instruction. BCBSNM and FEP applaud PCPs who have adopted the best practice of utilizing written discharge summaries along with medication reconciliation from their inpatient admission.

1 Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143(2):121–8.

2 Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–7.

3 Snow, V., MD. (2009). Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. Journal of Hospital Medicine, 4(6), 364-370. doi:10.1002

Reminder to Encourage Early and Timely Intervention for Pre- and Post-Partum Care Even Now

The following information about communication between health care professionals during a patient's pre-pregnancy, pregnancy, and postpartum medical journey for Federal Employee Program® (FEP®) members is important. Establish regular appointments and immediate notification at time of discharge to facilitate the completion of the discharge summary to ensure continuity of care and to inform the member of next steps. This is an ongoing process, not a one-time follow-up encounter.

Post-partum visits are recommended to be scheduled before discharge from the hospital. Written and/or electronic instruction is beneficial to the health of the member and the child. Coordination of care is best achieved when providers help members anticipate and follow through with transitions of care and between settings. When providing care, please document the following information in the patient's chart to help ensure effective coordination and continuity of care:

- Prenatal Visit in First Trimester
    - Prenatal risk assessment, including the diagnosis of pregnancy, complete medical and obstetrical history, and physical exam as referenced in the American College of Obstetrics and Gynecology (ACOG) Form
    - Prenatal lab reports Ultrasound, estimated date of delivery (EDD)

    - Documentation of prenatal risk and education/counseling
- Post Postpartum
    - Documentation of a postpartum visit on or between 7 to 84 days after delivery. Postpartum office visit progress notation that documents comprehensive postpartum exam which may include an evaluation of weight, blood pressure, breast exam, abdominal exam, and pelvic exam.
    - **Best practice supports provider staff calling member within one week after delivery to schedule postpartum follow-up visit.**

Thank you for your help supporting continuity of care and improved quality outcomes for our FEP and other BCBSNM members.

Our Medicaid Quality Improvement Program

Goal

The Quality Improvement Program's primary goal is to improve members' health status and outcomes through a variety of meaningful quality improvement activities and interventions that are implemented across all care settings that aims at improving the quality of care and services delivered to our members — your patients.

Scope

The Quality Improvement/Quality Management (QI/QM) Program encompasses all clinical care and services furnished to our members, inclusive of medical, behavioral, and long-term care services. The scope of the quality improvement program includes the process and outcomes of medical, behavioral and long-term care and services; ancillary services; pharmacy services; dental, transportation and vendor services; member services and experience, patient safety and efficient use of resources. The QI/QM program is comprehensive and includes effective mechanisms of ongoing identification, monitoring, and evaluation, all of which rectifies identified issues that impact the safety, accessibility, availability, continuity and quality of care and services provided to our members.

BCBSNM continuously evaluates the effectiveness of the QI Program by measuring improvements against nationally applied and internally established standards and

benchmarks. BCBSNM has met most goals in 2021 and are especially pleased to report that BCBSNM maintained its accreditation through the National Committee for Quality Assurance (NCQA) for the Medicaid line of business.

Several key points in the evaluation of the 2021 QI Program includes:

- Member complaints and appeals
- Provider and practitioner safety and care practices
- Clinical practice guidelines
- Member and provider experience
- Clinical performance data
- Health care utilization and complex disease management

BCBSNM met the following 2021 QI Program achievements and goals:

- Achieved established benchmarks for select New Mexico Human Services Department (HSD) performance measures
- Achieved Full Compliance with New Mexico External Quality Review Organization standards for annual audit of QI Performance Measure Program quality initiatives, interventions, and performance improvement projects
- Steadily improved compliance with HSD requirements for Critical Incidents processing and reporting; met and exceeded internal and external goals for timeliness and accuracy
- Exceeded audit requirements of the HEDIS® annual medical records abstraction project

Participation in QI/QM

Blue Cross Community Centennial requires providers and practitioners to cooperate with all Quality Improvement activities, as well as allow the use of provider and/or practitioner performance data, to ensure the success of the QI/QM Program. If you are interested in learning more about Blue Cross Community Centennial QI/QM Program, please email qualityinquiry@bcbsnm.com.