BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

February 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

Documenting and Coding Guidance for Atrial Fibrillation

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Read More

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BCBSNM Federal Employee Program® Annual Medical Record Data Collection for Quality Reporting — HEDIS Measurement Year (MY) 2020 Begins Feb. 1, 2021

Blue Cross and Blue Shield Federal Employee Program® (FEP®) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS®). If you receive a request for medical records, we encourage you to reply within 5 business days. BCBS FEP may be contacting your office or facility in February or March 2021 to identify a key contact person and to ascertain which data collection method your office or facility prefers (fax, secure email, sFTP or onsite).

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New HEDIS® Tip Sheets* Behavioral Health HEDIS Measures: FUA and FUM

We've added two additional **behavioral health tip sheets** to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code claims appropriately:

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

These measures from the National Committee for Quality Assurance (NCQA) serve as a **quality improvement tool** to help ensure our members receive appropriate care.

Read More

Outpatient Provider Incentive Program for Behavioral Health Follow-up Visit

We invite you and your group to take part in our temporary **Outpatient Provider Incentive Program**. You may receive financial incentives for follow-up visits with our members after an acute mental health admission. The follow-up visit must be within thirty days of discharge.

Eligible visits

You will be eligible to earn $30 per claim if the visit is:

- Between March 4, 2020 and Dec. 31, 2021
- Within thirty days after discharge from an acute mental health admission
- Psychotherapy or pharmacologic management **(PLEASE NOTE THIS CAN BE A TELEHEALTH VISIT)**

- Member is NOT a Medicare or Medicare Supplement member

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Childhood Immunization Rates Fall Amidst Pandemic Fears

After the pandemic declaration in March, office visits for immunizations among BCBSNM members significantly dropped between March and May compared with the number of visits reported during the same period in 2019.

Parents nationwide have cancelled pediatric check-ups. Immunization levels for vaccine-preventable diseases have plummeted, according to the National Foundation for Infectious Diseases.

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Clinical Practice and Preventive Care Guidelines Updated for 2020-2021

Our medical directors and Quality Improvement Committee have updated our **Clinical Practice Guidelines** and **Preventive Care Guidelines** for 2020-2021. The guidelines are built on evidence-based standards of care and nationally recognized medical authorities to **direct our quality and health management programs** and improve member care. They can help **guide your decision-making** as you care for our members.

We **update** our guidelines at least **every two years** or when new significant findings or major advancements in evidence-based care are established. The **guidelines** are on our **website under Clinical Resources**.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan.1, 2021 — 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 Jan. 1, 2021

Coverage for Contraception Act

The New Mexico Office of Superintendent of Insurance drafted 13.10.32.1, et seq. NMAC (regulation) in order to implement the requirements of the Coverage for Contraception Act, HB 89 (2019). The regulation clarifies coverage requirements for various contraceptive methods. The regulation applies to all health insurers that provide a prescription drug benefit; excepted benefit, Medicare Supplement and other supplemental coverages are out of scope.

Blue Cross Medicare Advantage℠ (Medicare)

CMS-Required Training for Dual-Special Needs Plans

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

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Blue Cross Community Centennial℠ (Medicaid)

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. Failure to update information on the NM Medicaid Provider Web Portal may result in the denial of claims

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

Documentation and Coding Guidance for Atrial Fibrillation

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ICD-10-CM AF Codes	
Paroxysmal Atrial Fibrillation	I48.0
Persistent Atrial Fibrillation	I48.1_
Chronic Atrial Fibrillation	I48.2_
Typical Atrial Flutter	I48.3_
Atypical Atrial Flutter	I48.4_
Unspecified Atrial Fibrillation	I48.91_
Unspecified Atrial Flutter	I48.92_

Codes for AF Types

According to ICD-10-CM guidelines, these four unique codes describe the types of AF:

- **Persistent AF (I48.11)** describes AF that does not terminate within seven days, or that requires repeat pharmacological or electrical cardioversion.
- **Permanent AF (I48.21)** is persistent or longstanding persistent AF where cardioversion cannot or will not be performed, or is not indicated.
- **Chronic AF, unspecified (I48.20)** may refer to any persistent, longstanding persistent or permanent AF.
- **Chronic persistent AF** has no widely accepted clinical definition or meaning. Code **I48.19, Other persistent atrial fibrillation**, should be assigned.

Active AF vs. "History of" AF

- In coding, "history of" indicates a condition is no longer active.
- Document in the note any current associated physical exam findings (such as irregular heart rhythm or increased heart rate) and related diagnostic testing results.
- Only one code may be assigned for a specific type of AF. The type of AF (paroxysmal, persistent, permanent or history of) should be documented consistently throughout the note to avoid unspecified codes that don't fully define the member's condition.

Best Practices

- Include patient demographics, such as name and date of birth, and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure documents are signed and dated by a credentialed provider.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Take advantage of the Annual Health Assessment (AHA) or other yearly preventative exam as an opportunity to capture all conditions impacting member care.

Coding Example

Progress Note: Assessment: Atrial fibrillation, stable and controlled with digoxin.
Plan: Continue digoxin for AF and follow up in three months.
ICD-10: I48.91 (If supported by documentation, a more specific code than 148.91 should be used.)

For more details, see:

- 2021 ICD-10-CM (Chapter 9: Diseases of the Circulatory System)
- AHA Coding Clinic, Q2, Q4 2019
- Centers for Medicare & Medicaid Services Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance
- BCBSNM Medicare Advantage Annual Wellness Visit Guide

Questions? Contact your BCBSNM Network Representative.

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Sammple ICD-10-CM DM Codes	
Type 1 DM without complications	E10.9
Type 2 DM without complications	E11.9
Type 1 DM with diabetic chronic kidney disease (CKD) Use additional code to identify CKD stage (N18.1–N18.6)	E10.22
Type 2 DM with CKD Use additional code to identify CKD stage (N18.1–N18.6)	E11.22

Codes for DF Types

DM types are divided into five categories:

- **E08** DM due to
- **E09** Drug or chemical induced DM
- **E10** Type 1 DM
- **E11** Type 2 DM
- **E13** Other specified DM

ICD-10-CM requires **documentation to specify DM with hyper- or hypoglycemia**, instead of controlled or uncontrolled. Without this documentation, **DM unspecified** will be coded.

Specificity Matters

These categories are further divided into subcategories of four, five or six characters. They include the DM type, the body system affected and the complications affecting that body system.

A relationship is assumed for conditions listed under "with" in the ICD-10 Alphabetic Index. The **DM combination code** will be appended unless documentation specifically states a relationship doesn't exist. For example, the combination code E11.65 is appropriate for Type 2 DM with hyperglycemia, rather than two separate codes for these conditions.

Best Practices

- Include patient demographics, such as name and date of birth, and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure documents are signed and dated by a credentialed provider.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Assign as many codes as needed to describe all disease complications. This includes combination codes (such as E11.621 Type 2 DM with foot ulcer) and additional codes (such as CKD stage and ulcer site).
- For patients who routinely use insulin, assign code Z79.4, Long term (current) use of insulin. Note: Z79.4 shouldn't be assigned if insulin is given to bring a patient's blood sugar temporarily under control during an encounter.
- Take advantage of the Annual Health Assessment (AHA) or other yearly preventative exam to capture all conditions impacting member care.

Coding Example

Progress Note: A/P Mrs. Garcia presents today with multiple issues. Her Type 2 diabetes is controlled with current Metformin regimen; continue dose. No changes to CKD III. Lab work performed to confirm. Back pain has not improved since last visit. Suggested chiropractor as next step since over-the-counter medications and yoga have not provided adequate relief. Renewed bouts of depressed mood due to inability to find relief from back pain. Mrs. Garcia has a long-standing relationship with a mental health provider for her recurrent depression (see BH consult note 6/2020). Will initiate contact with BH provider for a follow-up visit.
DM codes: E11.22, N18.30

For more details, see:

- 2020 ICD-10-CM Official Guidelines for Coding and Reporting, Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E08–E13)
- Centers for Medicare & Medicaid Services Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance
- BCBSNM Medicare Advantage Annual Wellness Visit Guide

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Patient authorization for release of medical record data is not required. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations (45 C.F.R. Parts 160 and164), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as incorporated in the American Recovery and Reinvestment Act (ARRA) of 2009, and its implementing regulations, each as issued and amended.
We appreciate your time and continued collaboration. If you have any questions about medical record requests, please contact the BCBS FEP QI (HEDIS) Department at (888) 907-7918.