BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

December 2020

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

BCBSNM Moving Preauthorization Duties from eviCore to AIM Effective Jan. 1, 2021, for Some Members

Our vendor who processes preauthorizations for certain Blue Cross and Blue Shield of New Mexico (BCBSNM) group and individual members and Blue Cross Community Centennial℠ members is changing. Starting Jan. 1, 2021, AIM Specialty Health® (AIM) will handle our preauthorizations for these members. eviCore healthcare will no longer handle our preauthorizations for these members effective Jan. 1, 2021. We are also adding preauthorization requirements for our Blue Cross Community Centennial members.

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BCBSNM Preauthorization Changes Beginning Jan. 1, 2021

Effective Jan. 1, 2021, BCBSNM will be updating preauthorization requirements for certain group and individual members. These updated requirements are expected to include the application of preauthorization to more services. This may reduce post-service denials for lack of medical necessity.

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Revision to Specialty Medication Administration Site of Care Policy, Effective Jan. 1, 2021

The Specialty Medication Administration Site of Care Policy, effective March 15, 2020, will be updated to add these HCPCS codes: J0791, Q5121, J0584, J3060, J0223, J0638, J3245, J3397, J0222, J3241, J1746, J1303, J3032 and J1558.

An updated RX501.096 Medical Policy will be posted prior to Jan. 1, 2021 to assist providers in determining when to apply benefit preauthorization requirements for these codes. The Specialty Pharmacy Infusion Site of Care Benefit Preauthorization Drug List can be found on the Preauthorization page of the BCBSNM provider website.

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.

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. Regardless of benefits, the final decision about any medication is between the member and their health care provider. If you have questions, contact the number on the member's ID card.

Updates Made to the Provider Reference Manual

The Provider Reference Manual (PRM) has been updated, effective Jan. 1, 2021. Changes to the PRM include, but are not limited to, the following sections:

- 10 — Preauthorization
- 12 — Behavioral Health Services
- 14 — Pharmacy Services
- 15 — Grievance Process for Participating Providers

The updated PRM will be available for review on the Provider Reference Manual webpage at bcbsnm.com/provider on or before Dec. 1, 2020. Blue Cross and Blue Shield of New Mexico reminds providers to review the PRM for all changes.

Billing Reminders for Psychological and Neuropsychological Testing

Below are billing reminders for psychological and neuropsychological testing. Proper coding of the specific services provided can help expedite claim processing and support accurate claim payment. BCBSNM may reach out to you by phone or email when we note incorrect coding patterns.

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New HEDIS® Tip Sheets for Behavioral Health HEDIS Measures: APM and UOP

Two new behavioral health tip sheets have been added to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code claims appropriately:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Opioids from Multiple Providers (UOP)

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New Electronic Duplicate Claim Rejections for Commercial Claims Effective Nov. 14, 2020

Starting Nov. 14, 2020, duplicate claim validation edits will be implemented for commercial 837P and 837I transactions when submitted to BCBSNM. As of this date, you may see new duplicate claim rejection messages on the response files from your practice management system or clearinghouse vendor(s).

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Verify Multiple Patient's Eligibility and Benefits Coverage via Availity®

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View, Download and Print the BCBSNM Member's ID Card Online via the Availity Provider Portal

BCBSNM is excited to offer providers the ability to view, download and print the member's medical ID card online via the Availity Eligibility and Benefit Inquiry results (271 transaction). This new and more convenient option will be available for medical ID cards issued to BCBSNM members in Dec. 2020, making it easier to obtain the member's ID card for your records.

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Are Utilization Management Decisions Financially Influenced?

Blue Cross and Blue Shield of New Mexico (BCBSNM) is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSNM prohibits utilization management decisions based on financial incentives — those decisions are based on appropriateness of care and service and existence of coverage.

BCBSNM does not specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2021, Part 1

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

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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Importance of Hospital Discharge Summaries Both Empowers the Members and Informs 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 and used to improve coordination and quality of care ultimately reducing the number of preventable readmissions.

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2020 Reminder to Encourage Regular Pre- and Post-Natal Care

The following information is important to help provide pre- and post-natal care and services to Federal Employee Program® (FEP®) members. Communication between health care professionals during a patient's pre-pregnancy, pregnancy and postpartum medical journey is important.

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2021 Blue Cross Medicare Advantage Preauthorization Updates

Beginning Jan.1, 2021, providers will be required to obtain preauthorization through Blue Cross and Blue Shield of New Mexico (BCBSNM), Optum, or eviCore for certain procedures for Blue Cross Medicare Advantage members as noted below. Claims for services for which preauthorization is required by BCBSNM and not obtained by Network Providers may be denied for payment and Network Providers may not seek reimbursement from members.

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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.

Read More

2021 Blue Cross Community Centennial Prior Authorization Updates

Beginning Jan.1, 2021, providers will be required to obtain prior authorization through Blue Cross and Blue Shield of New Mexico (BCBSNM) or AIM Specialty Health® (AIM) for certain procedures for Blue Cross Community Centennial members.

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Our Medicaid Quality Improvement Program

The principle goal of the BCBSNM Medicaid Quality Improvement (QI) Program is to improve our members' health and wellness. BCBSNM strives to help our members understand the importance of taking better care of themselves and their families. Every year, we develop a quality improvement plan in which specific quality goals are identified along with the activities that will be implemented to achieve them and define how progress is measured. All activities and goals lead back to the primary goal: improve the health and wellness of our members, your patients.

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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

BCBSNM Moving Preauthorization Duties from eviCore to AIM

Change happens Jan. 1, 2021, for some members

What's changing?

Our **vendor** who **processes preauthorizations** for certain Blue Cross and Blue Shield of New Mexico (BCBSNM) group and individual members and Blue Cross Community Centennial℠ members is changing. **Starting Jan. 1, 2021, AIM Specialty Health®** (AIM) will handle our preauthorizations for these members. eviCore healthcare will no longer handle our preauthorizations for these members effective Jan. 1, 2021. We are also **adding preauthorization** requirements for our **Blue Cross Community Centennial℠** members.

What is not changing?

The **care categories** that require preauthorization for group and individual members will stay the same:

- Advanced imaging
- Cardiology
- Genetic testing
- Joint and spine surgery
- Pain management
- Radiation therapy
- Sleep medicine

What's new for Blue Cross Community Centennial members?

Starting on **Jan. 1, 2021**, the following care categories will be delegated to AIM for preauthorization requests for Blue Cross Community Centennial members:

- Acute rehabilitation therapy* (physical, occupational, speech)
- Advanced imaging*
- Joint and spine surgery*
- Molecular and genomic testing
- Outpatient radiation therapy
- Pain management*
- Sleep medicine*

* New care categories requiring preauthorization

Learn more about preauthorization in BCBSNM, including code lists for the services that require preauthorization on our website. Remember code lists are periodically updated. Check eligibility and benefits first to confirm membership, check coverage, determine if you are in-network for the member's policy and determine whether **preauthorization** is required through Availity® or your preferred vendor. This step will help you confirm coverage and other important details, such as preauthorization requirements and vendors, if applicable.

How can you prepare?

Make sure you have an **account** with **AIM**. To **create** an account:

- Access AIM ProviderPortal, or
- **By Phone** — Call the **AIM Contact Center at 800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a,m. to noon, CT on weekends and holidays.

If you are already registered with AIM you do not need to register again.

How to submit a preauthorization request through AIM starting Jan. 1, 2021

Submit preauthorization requests to AIM in one of the following ways:

- **Online** — Submit requests **via the AIM ProviderPortal** 24/7.
- **By Phone** — Call the **AIM Contact Center at 800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a,m. to noon, CT on weekends and holidays.

Why it matters

If benefit preauthorization is required, services performed without benefit preauthorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Which members and services need preauthorization?

Use Availity® or your preferred vendor to:

- Check eligibility and benefits
- Determine if you're in-network for your patient
- Find out if the patient and service(s) require preauthorization

Look for future News and Updates on upcoming training and FAQs that will provide all of the important information you need to successfully transition to AIM.

BCBSNM Preauthorization Changes Beginning Jan. 1, 2021

Effective Jan. 1, 2021, Blue Cross and Blue Shield of New Mexico (BCBSNM) will be updating preauthorization requirements for certain group and individual members. These updated requirements are expected to include the application of preauthorization to more services. This may reduce post-service denials for lack of medical necessity.

Patient eligibility and benefits sho/uld be verified prior to every scheduled appointment. Eligibility and benefit information includes membership verification, coverage status and, preauthorization requirements. To obtain fast, efficient, detailed information for BCBSNM members, please access the Availity® Eligibility and Benefits tool. Please note that you must be registered with Availity to gain access to this free online tool. Additional tip sheets are available on the BCBSNM Provider website under Claims and Eligibility. Watch for future updates to the preauthorization requirements list reflecting the 2021 changes on the preauthorizations page at bcbsnm.com/provider.
For additional information, please contact your Provider Network Representative.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized 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.

Billing Reminders for Psychological and Neuropsychological Testing

Below are billing reminders for psychological and neuropsychological testing. Proper coding of the specific services provided can help **expedite claim processing and support accurate claim payment**. Blue Cross and Blue Shield of New Mexico (BCBSNM) may reach out to you by phone or email when we note incorrect coding patterns.

The following are common Current Procedural Terminology (CPT®) codes for billing psychological and neuropsychological testing services:

Code	Service
96127	BRIEF EMOTIONAL/BEHAV ASSMT
96130 **+96131**	PSYCL TST EVAL PHYS/QHP 1ST +PSYCL TST EVAL PHYS/QHP EA
96132 **+96133**	NRPSYC TST EVAL PHYS/QHP 1ST +NRPSYC TST EVAL PHYS/QHP EA
96136 **+96137**	PSYCL/NRPSYC TST PHY/QHP 1ST +PSYCL/NRPSYC TST PHY/QHP EA

96138 **+96139**	PSYCL/NRPSYC TECH 1ST +PSYCL/NRPSYC TST TECH EA
96146	PSYCL/NRPSYC TST AUTO RESULT

Billing Reminders

- According to CPT guidelines, codes **96130-96133** and **96136-96139** are for a **psychological or neuropsychological assessment**. BCBSNM doesn't recognize these codes for brief screenings or assessments to monitor patient progress during routine therapy sessions or psychiatric follow-up visits unless followed by a comprehensive assessment. CPT guidelines provide specific brief screening codes for these purposes.
- **Base codes** (96130, 96132, 96136, 96138) may be used only **once per testing episode**. If testing occurs across multiple days, the base code may be used one time at the start of testing.
- Determine whether the testing is **mainly psychological or neuropsychological**. Psychological and neuropsychological evaluation codes shouldn't be applied to the same episode of service.
- **Time-based CPT codes** billed by one servicing provider **shouldn't overlap**. For example, if a Beck Depression Inventory is administered during a 60-minute therapy session, a 60-minute therapy code and a brief behavioral assessment code may be billed. An additional half-hour or one hour of testing shouldn't be billed since only 60 minutes was spent with the member.

To learn more about Psychological and Neuropsychological Testing, refer to the Clinical Payment and Coding Policy on our provider website.

This material is for informational/educational purposes only and is not intended to be a substitute for the independent medical judgment of a physician or a definitive source for coding claims. The reference to any particular brand, type or method of testing is solely for informational purposes and is not, and should not be, construed as an endorsement, representation or recommendation for any particular test. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment. Health care providers are instructed to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials.

New HEDIS® Tip Sheets for Behavioral Health HEDIS Measures: APM and UOP

Two new **behavioral health tip sheets*** have been added to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code claims appropriately:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Opioids from Multiple Providers (UOP)

These measures from the National Committee for Quality Assurance (NCQA) serve as **quality improvement tools** to help ensure our members receive appropriate care. The tip sheets include **measurement requirements, best practices and billing codes**.

APM Measure

Document **metabolic testing** for members ages **1 to 17** who were dispensed **two or more antipsychotic medications** within a year. If the medications are dispensed on different dates, even if it's the same medication, test **both** blood glucose **and** cholesterol levels.

UOP Measure

This measure evaluates members **18 years and older** who were dispensed an **opioid for 15 days or more** from multiple prescribers and/or pharmacies. Three rates are reported. The proportion of members dispensed opioids from **four or more different prescribers, four or more different pharmacies** and from a **combination** of four or more different prescribers ***and*** four or more different pharmacies.

New Electronic Duplicate Claim Rejections for Commercial Claims Effective Nov. 14, 2020

In the March 2020 News and Updates, we announced that as of April 1, 2020, Blue Cross and Blue Shield of New Mexico (BCBSNM) would start implementing new electronic claim submission validation edits for commercial Professional and Institutional claims (837P and 837I transactions).* Starting Nov. 14, 2020, duplicate claim validation edits will be implemented for commercial 837P and 837I transactions when submitted to BCBSNM. As of this date, you may see new duplicate claim rejection messages on the response files from your practice management system or clearinghouse vendor(s).

If you receive a duplicate claim rejection, the affected claim would not be found in our system, as BCBSNM does not create claim numbers (document control numbers) for rejected claims. Providers can verify real-time status of the original claim number, at no cost, by using the Search by Member option in the Availity® Claim Status tool. For navigational assistance, refer to the Availity Claim Status user guide found on our Provider website.
If you have questions regarding an electronic claim rejection message, contact your practice management/hospital information system software vendor, billing service or clearinghouse for assistance.

**** This new duplicate rejection edit does not apply to Medicare Advantage or Blue Cross Community Centennial electronic claim submissions.***

Verify Multiple Patient's Eligibility and Benefits Coverage via Availity®

Patient eligibility and benefits should be verified before every scheduled appointment. Providers are encouraged to use the Availity Provider Portal or their preferred vendor for eligibility and benefits verification. The Availity Eligibility and Benefits Inquiry offers an Add Multiple Patients feature for providers to check real-time eligibility and coverage details for 2 to 50 patients in the same request. In the Availity Eligibility and Benefits response a Patient Card will appear in the left-side Patient History list, for each patient requested. Patient Cards will be available for interpretation for 24 hours at which time they will auto delete from the Patient History list.

Tips for Using the Add Multiple Patients Option:

- Enter each patient's information on a separate line.
- Press Enter on your keyboard to start a new line.
- Separate each piece of information on each line with a comma.
- Make sure to enter the information that matches the search option you selected in the Patient Search Option field.

This feature is available for Blue Cross and Blue Shield of New Mexico (BCBSNM) commercial, Federal Employee Program® (FEP®) and on and off-exchange members. Start saving time and streamlining your eligibility and benefits inquiries by utilizing the Add Multiple Patients option. Refer to the Availity Eligibility and Benefits User Guide for step&8209;by-step instructions.

Please note that the Add Multiple Patients feature is currently unavailable for Medicare Advantage members.

View, Download and Print the BCBSNM Member's ID Card Online via the Availity® Provider Portal

Blue Cross and Blue Shield of New Mexico (BCBSNM) is excited to offer providers the ability to view, download and print the member's medical ID card online via the Availity Eligibility and Benefit Inquiry results (271 transaction). This new and more convenient option will be available for medical ID cards issued to BCBSNM members in Dec. 2020, making it easier to obtain the member's ID card for your records.

Please note that Federal Employee Program® (FEP®) member ID cards are not currently available in the Availity eligibility and benefits results.

How do you view the member ID card via Availity?

Viewing and printing the member ID card online is easy and consists of only five steps:

1. Log into Availity
2. Select Patient Registration from the navigation menu
3. Select Eligibility and Benefit Inquiry, then complete and submit request
4. Select the View Member ID Card from the top of the results screen, if available*
5. View, download and print the BCBSNM ID card

** The online ID card is a courtesy feature offered to assist you. There may be instances when the BCBSNM member ID card is not readily available online. The eligibility and benefits response provides sufficient details to determine patient coverage and benefits in absence of an ID card.*

Providers not yet registered with Availity can sign up today at Availity, at no charge. For registration assistance call Availity Client Services at 800-282-4548.

For More Information

Refer to the Availity Eligibility & Benefits User Guide for navigational online assistance. If you need further assistance or customized training, contact our Provider Education Consultants.

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.
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 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 to be in such close contact with doctors due to COVID-19, however, diabetic annual eye exams remain an American Diabetes Association (ADA) recommended element in the treatment of patients with diabetes.

In 2017, the American Diabetes Association (ADA) updated its position statement on diabetic retinopathy and screening recommendations.[1] A summary of ADA screening recommendations for patients with diabetes is included here for your reference.

Screening:	Comprehensive evaluation by an eye care specialist should not be substituted by retinal photography. However, 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.** Following the above screening recommendations can help ensure best practice for patients.
- **Gather patient information.** Ask the patient about their diabetes history, medications they are taking, symptoms they are experiencing and if they have any questions.
- **Educate your patients.** Help them understand why a retinal exam for patients with diabetes is different than an eye exam for glasses and why it is essential to help prevent future problems.
- **Remind your diabetic patients to contact the number on their member ID card if they have any questions about their health care coverage details.** A yearly retinal exam may be a covered benefit for patients with diabetes.
- **Submit claims accurately.** When submitting a claim for a diabetic patient eye exam, be sure to include “diabetes” as a diagnosis to help ensure proper application of benefits.

We thank you for collaborating with us to support the health and wellness of our FEP members. Working together, we can help support improved 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

Importance of Hospital Discharge Summaries Both Empowers the Members and Informs 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 and used to improve coordination and quality of care ultimately reducing the number of preventable readmissions.

We want to remind you about some important information to help you when discharging Federal Employee Program® (FEP®) members after inpatient hospital stays. Use of Electronic Health Records (EHRs) when available ensures smooth flow of information from hospital to the member's extended healthcare network. Providing culturally appropriate member instructions, medication reconciliation and educating caregivers supports the member's transition.

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 a smooth transition of the patient to the next level of care. FEP Case Management staff are available to work with members, collaborate with medical team while inpatient and post discharge to facilitate discharge planning instruction. Blue Cross and Blue Shield of New Mexico and FEP applaud PCPs who have adopted the best practice of utilizing discharge summaries along with medication reconciliation from their patients' 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

2020 Reminder to Encourage Regular Pre- and Post-Natal Care

The following information is important to help provide pre- and post-natal care and services to Federal Employee Program® (FEP®) members. A practice advisory from the American College of Obstetricians and Gynecologists (ACOG) reported that pregnant women with COVID-19 may be at increased risk for more severe illness compared with nonpregnant peers although still substantially lower than that of pandemic H1N1 influenza infection during pregnancy.

Even though there are community efforts underway to mitigate the spread of COVID-19, these efforts should not inhibit the medically necessary prenatal care, referrals, and consultations that are necessary for members (ACOG, *Practice Advisory Novel Coronavirus 2019*, September 2020).[1]

Communication between health care professionals during a patient's pre-pregnancy, pregnancy and postpartum medical journey is important. 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 (e.g., obstetric (OB) panel/toxoplasmosis, rubella, cytomegalovirus, herpes simplex, and HIV antibody (TORCH) panel/Rubella antibody test/ABO (O, A, B, or AB blood group testing)/Rh factor testing)
  - Ultrasound, estimated due date (EDD)
  - Patient 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 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 positive outcomes for our FEP and other Blue Cross and Blue Shield of New Mexico members.

1 ACOG reference: https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019

2021 Blue Cross Medicare Advantage℠ Preauthorization Updates

Beginning Jan.1, 2021, providers will be required to obtain preauthorization through Blue Cross and Blue Shield of New Mexico (BCBSNM), Optum, or eviCore for **certain procedures** for Blue Cross Medicare Advantage members as noted below. Claims for services for which preauthorization is required by BCBSNM and not obtained by Network Providers may be denied for payment and Network Providers may not seek reimbursement from members.

Member eligibility and benefits should be checked 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. It is strongly recommended that providers **ask to see the member's ID card for current**

information and a photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

A referral to an out-of-network provider which is necessary due to possible network inadequacy or for continuity of care must be reviewed by the BCBSNM Utilization Management department or Optum (if the member is attributed to Optum this information will be reflected on the ID card) prior to a BCBSNM member receiving care from the out-of-network provider.

Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Provider Network Representative.

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.

eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSNM.

2021 Blue Cross Community Centennial℠ Prior Authorization Updates

Beginning Jan.1, 2021, providers will be required to obtain prior authorization through Blue Cross and Blue Shield of New Mexico (BCBSNM) or AIM Specialty Health® (AIM) for certain procedures for Blue Cross Community Centennial members.

Services performed without benefit prior authorization may be denied for payment in whole or in part, and you may not seek reimbursement from members.

Member eligibility and benefits should be checked 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. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft.

To obtain benefit prior authorization through BCBSNM for the care categories noted below, you may continue to use Availity®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the Availity page in the Provider Tools section of our Provider website. Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Provider Network Representative.

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.

AIM Specialty Health (AIM) is an operating subsidiary of Anthem, Inc., an independent specialty medical benefits management company that provides utilization management services for BCBSNM.

Availity is a trademark of Availity, LLC, 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 provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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

Our Medicaid Quality Improvement Program

The principle goal of the Blue Cross and Blue Shield of New Mexico (BCBSNM) Medicaid Quality Improvement (QI) Program is to improve our members' health and wellness. BCBSNM strives to help our members understand the importance of taking better care of themselves and their families. Every year, we develop a quality improvement plan in which specific quality goals are identified along with the activities that will be implemented to achieve them and define how progress is measured. All activities and goals lead back to the primary goal: improve the health and wellness of our members, your patients.

The QI Program is a team effort that is built on contributions from our BCBSNM-contracted providers and internal departments. Program goals for health care and services are developed with input from you and from our members, brought into focus by our leadership, and implemented by staff dedicated to the needs of our Medicaid membership. Quality committees, chaired by medical directors, keep projects on target and focused through policies and procedures for day-to-day operations and annual measurements like Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). BCBSNM continuously evaluates the effectiveness of our QI Program by measuring improvements against nationally applied and internally established standards and benchmarks. BCBSNM is proud to have met most of our goals in 2020 and are especially pleased to report that BCBSNM maintained National Committee for Quality Assurance (NCQA) accreditation for our Medicaid line of business.

Several key points in the evaluation of our 2020 QI Program included:

- 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 2020 QI Program achievements and goals:

- Achieved regional percentile 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 process 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

To learn more about the 2020 QI Program evaluation and providers' contributions to our QI efforts, please call the QI Department at 855-699-0042 or email us at: qualityinquiry@bcbsnm.com.

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