BLUE REVIEW℠

A Provider Publication

January 2020

Education & Reference

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New HEDIS® Behavioral Health Measures Tip Sheets

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Reminder that Laboratory Benefit Level Changes for Some Members this Month

As we shared in October, beginning Jan. 1, 2020, or upon a member's renewal date, non-preventive labs are no longer covered at the no member cost-share level for some Blue Cross and Blue Shield of New Mexico (BCBSNM) PPO and HMO members. Non-preventive labs will be treated as a standard medical benefit regardless of diagnosis code. Any applicable cost sharing (copay, coinsurance and deductible) may apply, based on the member's health plan.

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Blue Cross Medicare Advantage℠ (Medicare)

CMS-Required Training for Dual-Special Needs Plans

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

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Reminder: Medicare Providers May Not Bill Participants in the Qualified Medicare Beneficiary Program

As a Medicare provider, you may not bill individuals enrolled in the Qualified Medicare Beneficiary Program (QMB), a federal Medicare Savings Program. Individuals enrolled in QMB are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a State Medicaid benefit, QMB covers the Medicare premiums, deductibles, coinsurance and copayments of QMB beneficiaries. QMB beneficiaries are not responsible for Medicare cost-sharing, or out-of-pocket costs.

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Medicare Advantage 30-Day Facility Readmissions Review

Consistent with CMS guidelines, beginning March 1, 2020, Blue Cross and Blue Shield of New Mexico (BCBSNM) will review acute hospital readmissions of Medicare Subscribers to determine if such readmissions to the same facility within 30 days of discharge are related. BCBSNM may deny payment to the facility for related admissions.

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National Coordination of Care℠ Program to Serve Group Blue Cross Medicare Advantage (PPO)℠ Members

Beginning Jan. 1, 2020, we will participate in a new Blue Cross and Blue Shield Association (BCBSA) National Coordination of Care program to help improve care and services for Blue Cross Group Medicare Advantage (PPO) (MA PPO) members nationwide. This program also will help streamline administrative processes for providers.

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Annual Reminder: Medicare Outpatient Observation Notice Required

As of March 8, 2017, hospitals and Critical Access Hospitals (CAH) must give the standardized Medicare Outpatient Observation Notice (MOON) to people who receive Medicare benefits and are observed as outpatients for more than 24 hours. This includes people with Blue Cross Medicare Advantage (PPO)SM, Blue Cross Medicare Advantage (HMO)SM, Blue Cross Group Medicare Advantage (HMO)SM, Blue Cross Group Medicare Advantage (PPO)SM and Blue Cross Group Medicare Advantage Open Access (PPO)SM health plans.

This notice lets people know why they are not considered to be inpatient and what their cost sharing and hospital coverage will be. It must be explained verbally and completed no later than 36 hours after observation begins or sooner if patients are admitted, transferred or released. Patients must sign to confirm they received and understand the notice. If they say no, the staff member who gave the patient the notice must certify that it was presented.

The MOON and what to do with it can be found on the CMS website.

The information provided here is only intended to be a summary of the law that have been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

Updates Made to the Medicare Advantage Section of the Blues Provider Reference Manual

The Medicare Advantage section of the Blues Provider Reference Manual (PRM) has been updated, effective Feb. 20, 2020.

Changes to the PRM include, but are not limited to, the following sections:

- 10 — Quality Improvement

The updated PRM is available for review on the Provider Reference Manual webpage at bcbsnm.com/provider. Blue Cross and Blue Shield of New Mexico reminds providers to review the PRM for all changes.

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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Changes to the HEDIS 2020 Prenatal and Postpartum Care Measure

In line with the American College of Obstetrics & Gynecology's (ACOG) Committee Opinion 736, released in May 2018, the National Committee of Quality Assurance (NCQA) has changed the HEDIS Timeliness of Prenatal and Postpartum Care measure for HEDIS 2020.

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Survey Shows Medicaid Members Give Their Providers High Ratings

Each spring, BCBSNM surveys Blue Cross Community Centennial℠ members to find out how happy they are with us and with you, their providers. Using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), we give members the opportunity to rate the services we offer and the health care you provide. The following table shows the results of this survey from 2018 to 2019.

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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. We strive to help them understand the importance of taking better care of themselves and their families. Every year, we develop a quality improvement plan in which we set specific quality goals, identifying the activities we will implement to achieve them and defining how we will measure our progress. We are proud to have met most of our goals in 2019 and are especially pleased to report that we maintained National Committee for Quality Assurance (NCQA) accreditation for each of our product lines, including Medicaid.

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Not Yet Contracted?

Providers who are participating in commercial BCBSNM products are not automatically participating providers in Blue Cross Community Centennial. If you are interested in becoming a Blue Cross Community Centennial provider, please call 505-837-8800 or 800-567-8540.

Reminder: Update your Enrollment Information
Due to Centennial Care requirements, all enrollment information (changes to demographics, licensure or certification, provider status, etc.) must be updated on the NM Medicaid Provider Web Portal.

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

BCBSNM Website

It's important for you to stay informed about news that could affect your practice. BCBSNM offers many ways to stay informed via our website, bcbsnm.com/provider, and our provider newsletter, *Blue Review*. Signing up is easy.

Medical Policy Updates

Approved new or revised medical policies and their effective dates are usually posted on our website the 1st and 15th of each month. These policies may impact your reimbursement and your patients' benefits. These policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Clinical Payment and Coding Policies

BCBSNM has adopted additional clinical payment and coding policies. These policies are based on criteria developed by specialized professional societies, national guidelines (e.g. Milliman Care Guidelines (MCG)) and the CMS Provider Reimbursement Manual and are not intended to provide billing or coding advice but to serve as a reference for facilities and providers. These policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Claims Inquiries

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

Network Services Contacts and Related Service Areas

Do We Have Your Correct Information?

Maintaining up-to-date contact and practice information helps to ensure that you are receiving critical communications and efficient reimbursement processes. Please complete our quick and easy online form for any changes to your contact or practice information.

Member Rights and Responsibilities

BCBSNM policies help address the issues of members participating in decision making regarding their treatment; confidentiality of information; treatment of members with dignity, courtesy and a respect for privacy; and members' responsibilities in the practitioner-patient relationship and the health care delivery process.

bcbsnm.com/provider

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Two New ClaimsXten™ Rules to be Implemented in 2020

We will soon update our ClaimsXten software database to better align coding with the reimbursement of claim submissions.

Update Schedule

On April 20, 2020, we will update two rules:

- Bilateral Services for Professional Claims
- Modifier to Procedure Validation Filter — Non-Payment Modifiers

Update Details

Bilateral Services for Professional Claims	This rule identifies claim lines where the submitted procedure code was already billed with a modifier — 50 for the same date of service. The same service performed bilaterally should not be billed twice when reimbursement guidelines require the code to be billed once with a bilateral modifier. The rule denies the second submission.

Modifier to Procedure Validation Filter — Non-Payment Modifiers	For non-payment modifiers, this rule identifies claim lines with an invalid modifier to procedure code combination. It recommends the denial of procedure codes when billed with any non-payment affecting modifier that is not likely or appropriate for the procedure code billed. When multiple modifiers are submitted on a line, all are evaluated and if at least one is found invalid with the procedure code, the line is recommended for denial.

To determine how coding combinations may be evaluated during claim adjudication, use Clear Claim Connection™ (C3). Refer to the [Clear Claim Connection page] for answers to [frequently asked questions] about ClaimsXten and details on how to gain access to C3.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSNM. Change Healthcare is solely responsible for the software and all the contents. BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Change Healthcare. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

New HEIDS® Behavioral Health Measures Tip Sheets

We've created behavioral health tip sheets to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code appropriately. These measures from the National Committee for Quality Assurance (NCQA) help ensure our members receive appropriate care.

The tip sheets include measurement requirements, medical record best practices and billing codes. Compliance with HEDIS measures reduces the need for you to send medical records later for review.

Follow-Up Care for Children Prescribed ADHD Medication (ADD) Tip Sheet

- Children ages 6 to 12
- Newly[1] filled attention-deficit hyperactivity disorder (ADHD) medication
- Prescribed in the ambulatory setting

Antidepressant Medication Management (AMM) Tip Sheet

- Members ages 18 and older
- Diagnosed with major depression
- Newly[2] filled antidepressant medication

Diabetes Screening for Members Taking Antipsychotics (SSD) Tip Sheet

- Members ages 18 to 64
- Diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder
- Received an antipsychotic medication at any time during the year

1 Defined as no ADHD medication filled in past 120 days

2 Defined as no antidepressant medication filled in past 105 days

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The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. 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.

Laboratory Benefit Level Change

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

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

What does this mean for you?

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

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

As a reminder, it is important to check member eligibility and benefits through Availity® Provider Portal or your preferred vendor web portal prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. Checking eligibility and benefits also helps providers confirm benefit preauthorization requirements. Providers must also ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

Obtaining benefit preauthorization is not a substitute for checking member eligibility and benefits.

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

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

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.

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.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Medicare Advantage 30-Day Facility Readmissions Review

Consistent with the Centers for Medicare & Medicaid Services (CMS) guidelines, **beginning March 1, 2020**, Blue Cross and Blue Shield of New Mexico (BCBSNM) will review acute hospital readmissions of Medicare Subscribers to determine if such readmissions to the same facility within 30 days of discharge are related. BCBSNM may deny payment to the facility for related admissions. These changes help support quality of care improvement efforts by linking payment to the quality of facility care for our Medicare Subscribers with Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM (or other) Medicare Advantage Plans.

As a provider what should I expect?

- **Beginning March 1, 2020**, BCBSNM will perform a clinical review of acute care facility readmissions that occur within 30 days of discharge from the same facility
- If BCBSNM determines that a provider has submitted a second claim after a patient has been discharged from an acute in patient stay, BCBSNM may request medical records from the provider.

As a provider what should I do?

- Upon request of medical records, the facility must forward related medical records and any documents involving the admissions.
- If it is determined that the acute stays were clinically related, BCBSNM may deny payment to the facility for the readmission.
- Providers may dispute determinations through existing processes, which can be found in the provider manual located on our website.

To learn more, please visit the CMS website and search for Hospital Readmissions Reduction Program (HRRP). If you have additional questions, please contact your Provider Relations Representative.

National Coordination of Care℠ Program to Serve Blue Cross Group Medicare Advantage (PPO)℠ Members

Beginning **Jan. 1, 2020**, we will participate in a new Blue Cross and Blue Shield Association (BCBSA) National Coordination of Care program to help improve care and services for Blue Cross Group Medicare Advantage (PPO) (MA PPO) members nationwide. This program also will help streamline administrative processes for providers.

As we announced in November, Blue Cross Group Medicare Advantage (PPO) is the new name of Blue Cross Medicare Advantage (PPO)℠ for Blue Cross and Blue Shield of New Mexico (BCBSNM) members who purchase MA PPO coverage through their employers or other groups. While the name has changed, the program retains its traditional PPO network that allows members to seek care in-network and out-of-network, typically providing cost savings for in-network care.

Through the National Coordination of Care program, BCBSNM will collaborate with you to identify gaps in care and retrieve medical records for claims you submit to BCBSNM for Group MA PPO members living in New Mexico. This includes BCBSNM members with Group MA PPO coverage, as well as Group MA PPO members enrolled in other BCBS Plans who are living in New Mexico.

You will receive requests only from BCBSNM or our vendor when medical records are needed, or when potential gaps in care or risk adjustment gaps are identified related to claims submitted to BCBSNM for these members. You will no longer receive these requests from multiple BCBS plans or their vendors.

This program is part of our ongoing initiative to support our members in receiving the right care at the right time and place. As a result of concerns about gaps in care, this program may help encourage members to come into your practice more frequently, allowing for greater continuity of care. For out-of-area members with Group MA PPO coverage, this program will help BCBSNM give these members' BCBS Plans a fuller understanding of their members' health status.

Questions? Call the Customer Service number on the member's ID card.

Important Reminders

- As outlined in your contract with us, you are required to respond to requests in support of risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®) and other government-required activities within the requested timeframe. This includes requests related to this program.
- It is important that you use Availity® or your preferred vendor to check eligibility and benefits for all BCBSNM patients before every scheduled appointment, including for Group MA PPO members in this program. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable benefit prior authorization requirements. Ask to see the member's BCBSNM ID card and a driver's license or other photo ID to help guard against medical identity theft. See our Eligibility and Benefits page for more details.
- Consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any other applicable laws and regulations, BCBSNM or BCBSNM's vendor is contractually bound to preserve the confidentiality of members' protected health information (PHI) obtained from medical records and provider engagement on Stars and/or risk adjustment gaps. You will only receive requests from BCBSNM or BCBSNM's vendor that are permissible under applicable law. Consistent with your current practices, patient-authorized information releases are not required in order for you to fulfill medical records requests and support closure of Stars and/or risk adjustment gaps received through this care coordination program.

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 the vendor, you should contact the vendor directly.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized 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, call the number on the member's ID card.

HEDIS® is a registered trademark of NCQA.

Changes to the HEDIS® 2020 Prenatal and Postpartum Care Measure

Summary of Changes for HEDIS 2020 (Measurement Year 2019)

In line with the American College of Obstetrics & Gynecology's (ACOG) Committee Opinion 736, released in May 2018, the National Committee of Quality Assurance (NCQA) has changed the HEDIS Timeliness of Prenatal and Postpartum Care measure for HEDIS 2020. Currently, as many as 40% of women do not attend a postpartum visit, which impedes the management of chronic health conditions and access to contraception to promote healthy birth spacing.[1] As such, rather than a single traditional "6-week" checkup, ACOG recommends that the timing of a postpartum visit should be individualized and woman-centered, noting, "To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs."

The Timeliness of Postpartum Care timeframe will be expanded to 7-84 days from the original 21-56 days. This is hoped to be a great benefit to both providers and members now as the timing of the visit can be better tailored to meet individual member needs while continuing to satisfy the HEDIS measure.

Current qualifying services* for Timeliness of Postpartum Care include:

- Pelvic exam
- Evaluation of weight, BP, breasts, and abdomen
- Notation of postpartum care

Additional Timeliness of Postpartum Care measures now include:

- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
- Glucose screening for women with gestational diabetes
- Documentation of infant care, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity and attainment of healthy weight

We thank the contracted providers in the Blue Cross Community Centennial℠ network for the care they give our members. Perinatal visits represent important opportunities to provide evidence-based care, and conformance to the Timeliness of Prenatal and Postpartum Care measure helps women access obstetrical health care in a timely way. If you have any questions or concerns as to how this measure works, please reach out to the BCBSNM Quality Improvement Department at 855-699-0042 or qualityinquiry@bcbsnm.com.

* Qualifying services must be provided in an outpatient setting.

The health information provided above is not intended as medical advice or meant to be a substitute for the independent judgment of a medical provider.

1 ACOG Committee Opinion No. 736. (2018). American College of Obstetrics & Gynecology, 131(5). doi: 10.1097/aog.0000000000002633

Survey Shows Medicaid Members Give Their Providers High Ratings

Each spring, Blue Cross and Blue Shield of New Mexico (BCBSNM) surveys Blue Cross Community Centennial℠ members to find out how happy they are with us and with you, their providers. Using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), we give members the opportunity to rate the services we offer and the health care you provide. The following table shows the results of this survey from 2018 to 2019.

Adults — percent who said they were "always" or "usually" satisfied with:	2018	2019	Children and children with chronic conditions — percent who said they were "always" or "usually" satisfied with:	2018	2019
Getting care quickly	84%	80%	Getting care quickly	91%	90%
Getting needed care	82%	82%	Getting needed care	82%	81%
Rating of health plan	75%	75%	Rating of health plan	88%	84%
How well doctors communicate	96%	93%	How well doctors communicate	97%	97%
Rating of all health care	78%	74%	Rating of all health care	87%	85%
Rating of personal doctor	81%	84%	Rating of personal doctor	91%	91%
Rating of specialist seen most often	88%	84%	Rating of specialist seen most often	88%	84%

From the results of these seven areas, adult members indicate satisfaction increased in *rating of personal doctor*. We're proud of these achievements, and we thank you for the quality care and services you provide our members.

Can we do better? Yes. With contributions from all BCBSNM departments, our Quality team is analyzing the drops in our plan and health care ratings for children and bringing focus to our adult members' health plan rating. Your contributions to these efforts are invaluable.

Please consider sharing your ideas about our members' experiences and your thoughts on improvement with the BCBSNM Quality team by calling us at 855-699-0042 or emailing us at: qualityinquiry@bcbsnm.com. We will continue to earn our members' confidence and improve their experience of our health care and services together in 2020.

About CAHPS: CAHPS survey results are used in National Committee for Quality Assurance (NCQA) health plan performance reports, health plan accreditation decisions and to create national benchmarks for care. We encourage providers to learn more about CAHPS by visiting the NCQA CAHPS Web site.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

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. We strive to help them understand the importance of taking better care of themselves and their families. Every year, we develop a quality improvement plan in which we set specific quality goals, identifying the activities we will implement to achieve them and defining how we will measure our progress. All activities and goals lead back to the primary goal: improved health for our members, your patients.

The QI Program is a team effort that is built on contributions from our BCBSNM peers across all lines of business, departments and divisions. 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 our projects on target and focused through policies and procedures for day-to-day operations and annual measurements like HEDIS and CAHPS.

We continuously evaluate the effectiveness of our QI Program by measuring our success in terms of nationally applied and internally established standards and benchmarks. We are proud to have met most of our goals in 2019 and are especially pleased to report that we maintained National Committee for Quality Assurance (NCQA) accreditation for each of our product lines, including Medicaid.

Several key points in the evaluation of our 2019 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 2019 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
- Improved NCQA Accreditation to “Commendable” rating

To learn more about the 2019 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.

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