BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

August 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

Federal Agencies Extend Timely Filing and Appeals Deadlines

As a result of the National Emergency declared on March 1, 2020, the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service and the Department of the Treasury extended certain timeframes to ease the burden of maintaining benefits and compliance with notice obligations.

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Colorectal Cancer Screening at Home

Members in our Blue Community (metal) HMO networks who have not been screened may qualify for a Fecal Immunochemical Test (FIT) Kit at no extra charge. We are working with Home Access Health Corporation to provide in-home kits to encourage screening for our at-risk members. Screening with a FIT Kit may be a good option to close care gaps.

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Overpayment Recovery Process for Contracted Providers — Changes as of Jan. 1, 2020

Blue Cross and Blue Shield of New Mexico (BCBSNM) payment processes were updated on Jan. 1, 2020. You may have noticed changes in the number of payments you receive from us and in our overpayment recovery process.

What has changed?

Multiple payments: You may be used to receiving a consolidated payment from BCBSNM that addresses multiple claims for members who belong to different employer groups. Now our employer groups have the choice to not participate in this type of reimbursement. This means that you may now be receiving reimbursements from us in multiple payments.

Overpayment recovery: Employer groups may also choose not to participate in offsetting overpayments from consolidated payments that address multiple claims from members who belong to different employer groups. This means that when we attempt to recover overpayments, you may have to send in a check for certain overpayments. Instructions for submitting a refund will be in the request letter we send you.

More information

If you have any questions, please call our Financial Operations at (844) 866-BLUE.

BCBSNM will update CPT® codes for some preauthorization services

On Sept. 1, 2020, Blue Cross and Blue Shield of New Mexico (BCBSNM) will update its list of Current Procedural Terminology (CPT) codes to comply with changes from the American Medical Association (AMA). These changes are the result of new, replaced or removed codes implemented by the AMA since Jan. 1, 2020.

What's New: On Sept. 1, 2020 we will update the procedure code list for services that require preauthorization.

More Information: View a revised list of codes (effective Jan. 1, 2020) on the preauthorization page of our provider website, bcbsnm.com/provider. Check the AMA website for more information on CPT codes.

Check Eligibility and Benefits: To identify which members require preauthorization for services on the code list, check eligibility and benefits through Availity® or your preferred vendor.

COVID-19 Coverage Updates for Medicare Providers

As the COVID-19 crisis continues to evolve, Blue Cross and Blue Shield of New Mexico (BCBSNM) is making changes to serve our Medicare members. We are following Centers for Medicare & Medicaid Services (CMS) guidelines as appropriate. You can find updates in our COVID-19 FAQs for Medicare Providers, including on testing, treatment, telehealth and claims.

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CMS Payment Adjustments for Medicare Providers

During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) has adjusted certain payments to Medicare providers. Blue Cross and Blue Shield of New

Mexico (BCBSNM) is applying these temporary adjustments to claims reimbursements, as appropriate and where consistent with network contracts, for Medicare Advantage providers.

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Blue Cross Medicare Advantage Prior Authorization Updates effective Sept. 1, 2020

On Sept. 1, 2020, Blue Cross and Blue Shield of New Mexico (BCBSNM) will update its list of Blue Cross Medicare Advantage Prior Authorization Procedure Codes to comply with the American Medical Association (AMA). These changes are the result of new, replaced or removed codes implemented by the AMA.

What's New: Providers will need to utilize the new list of procedure codes on the Blue Cross Medicare Advantage℠ Plans web page under the Prior Authorizations Requirement section when determining if a service requires prior authorization **Sept. 1, 2020**, and after. You can also use Availity® or your preferred vendor for prior authorization requirements.

Check Eligibility and Benefits: Prior to rendering services, providers should use Availity or your preferred vendor to check eligibility and benefits to confirm membership, check coverage, determine if you are in-network for the member's policy and determine whether prior authorization is required. Availity allows prior authorization determination by procedure code and providers can submit requests on Availity using the Authorization & Referral tool. Refer to the BCBSNM Eligibility and Benefits page for more information on Availity. Payment may be denied if you perform procedures without authorization. If this happens, you may not bill your patients.

More Information: Check the AMA website for more information on CPT codes. If you have questions, contact Provider Customer Service.

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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Addition of New Prior Authorization Requirements for Blue Cross Community Centennial℠ Members

There are important changes to the prior authorization requirements for Blue Cross Community Centennial Members. Beginning September 1, 2020, the following changes will be made to the Blue Cross Community Centennial Prior Authorization Grid:

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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

Federal Agencies Extend Timely Filing and Appeals Deadlines

As a result of the National Emergency declared on March 1, 2020, the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service and the Department of the Treasury extended certain timeframes to ease the burden of maintaining benefits and compliance with notice obligations. Blue Cross and Blue Shield of New Mexico (BCBSNM) will follow these guidelines.
This is for members of all fully insured and self-funded groups that are regulated by the Employee Retirement Income Security Act.

What's New?

In compliance with the guidelines, **between March 1, 2020, and 60 days after the announced end of the National Emergency**, the following periods and dates are suspended:

- The date within which individuals may file a claim
- The date within which claimants may file an appeal of adverse benefit determination
- The date within which claimants may file a request for external review after receiving an adverse determination

We appreciate your cooperation as we update our systems and processes to comply with the latest rules. Call the number on our members' ID card or your BCBSNM representative with questions.

Timely Filing Rule

To help providers and individuals meet timely filing rules, **the period from March 1, 2020, to 60 days after the announced end of the National Emergency** will not count towards timely filing requirements. Timely filing limits may vary by state, product and employer groups.

Example 1
Situation (assume 180-day timely filing rule) — The time for a claim to fulfil the timely file rule expired on Feb. 29, 2020
Outcome — The rules to suspend timely filing do not apply. If we receive the claim after Feb. 29, the claim is subject to denial.

Example 2
Situation (assume 180-day timely filing rule) — Service was rendered on Sept. 2, 2019. The claim entered day 179 of the 180-day timeline on Feb. 29, 2020.
Outcome — The time to file this claim is suspended starting on March 1, 2020, until 60 days after the National Emergency is declared over. If the National Emergency were over on June 1, 2020, 60 days later is July 31, 2020. On July 31, one day remains to file the claim.

Example 3
Situation (assume 180-day timely filing rule) — The date of service was March 1, 2020
Outcome — If the National Emergency were over on June 1, 2020, the 180-day timeline to

file this claim would start 60 days later, on July 31. The claim would be due before Jan. 27, 2021.

Appeals of Adverse Benefit Determination

The 180-day timeline for appealing an adverse benefit determination on a claim has been suspended as well. In compliance with the guidelines, **the period from March 1, 2020, to 60 days after the announced end of the National Emergency** will not count towards the deadline to submit an appeal. Until further notice, we will accept as timely all valid appeals of adverse benefit notifications dated on or after Sept. 3, 2019.

Example 1
Situation — The adverse decision is received by the claimant on June 1, 2019. The claimant files an appeal on March 24, 2020. Outcome — The rules to suspend the timeline for appealing a decision do not apply because the appeal should have been filed by Nov. 28, 2019. Because the timeline for appealing expired before the effective date of these DOL guidelines, the normal timeframes apply and the appeal submitted on March 24, 2020 is not timely.

Example 2
Situation — The adverse decision is received by the claimant on Sept. 3, 2019. The end of the 180-day timeline is March 1, 2020.
Outcome — The claimant has until the end of the National Emergency, plus 60 days to file the appeal.

Request for External Review

The timeline to file a request for an external review will be suspended. In compliance with the guidelines, **the period from March 1, 2020, to 60 days after the announced end of the National Emergency** will not count towards the deadline to request an external review. External review application timelines may vary by state, product and employer groups. Members should follow the instructions received in the appeal decision notification to initiate an external review.

More information

- The Final Rule from DOL and IRS
- Disaster Relief Notice 2020-01 from EBSA
- FAQs issued by DOL

Colorectal Cancer Screening at Home

Consider screening our members who are 50 to 75 years old for colorectal cancer. Members in our Blue Community (metal) HMO networks who have not been screened may qualify for a **Fecal Immunochemical Test (FIT) Kit** at no extra charge. We are working with Home Access Health Corporation to provide **in-home** kits to encourage screening for our at-risk members. Screening with a FIT Kit may be a good option to close care gaps.

Why emphasize screening?

Colorectal cancer is the second leading cause of cancer deaths in the United States.[1] About one-third of adults 50 years and older have not received the recommended screening.[2]

How it Works

- We notify members that they will receive the test kit and that using it is voluntary
- The member submits the test for processing to Home Access Health Corporation by Nov. 30, 2020
- Home Access Health Corporation sends the results in three to four weeks to the member and the provider they specify

How You Can Help

- Discuss the importance of screening and healthy lifestyle choices with our member
- If our member receives a FIT Kit and calls your office with questions, discuss which screening test would be the best option for them
- Document any test results in the patient's medical record and discuss the results with our member

Other Benefits of the FIT Kit

- No need for anesthesia or prep
- Screen members at home who may be at risk during the COVID-19 pandemic
- **The U.S. Multi-Society Task Force of Colorectal Cancer**[3] considers annual FIT testing and colonoscopy every 10 years the **two cornerstones** of screening for those of average risk.

If you have any questions, please contact your Blue Cross and Blue Shield of New Mexico Provider Network Representative.

1 Basic Information About Colorectal Cancer

2 Screen for Life: National Colorectal Cancer Action Campaign

3 Colorectal Cancer Screening: Recommendations for Physicians and Patients From the U.S. Multi-Society Task Force on Colorectal Cancer

Home Access Health Corporation is an independent company that provides laboratory testing services for Blue Cross and Blue Shield of New Mexico.

COVID-19 Coverage Updates for Medicare Providers

June 8, 2020
Updated on July 24, 2020

As the COVID-19 crisis continues to evolve, Blue Cross and Blue Shield of New Mexico (BCBSNM) is making changes to serve our Medicare members. We are following Centers for Medicare & Medicaid Services (CMS) guidelines as appropriate. You can find updates in our **COVID-19 FAQs for Medicare Providers**, including on testing, treatment, telehealth and claims.

Unless otherwise noted, the FAQs refer to our members in these individual and group Medicare Advantage and Medicare Supplement plans:

- **Blue Cross Group Medicare Advantage (HMO)℠**
- **Blue Cross Group Medicare Advantage (PPO)℠**
- **Blue Cross Group Medicare Advantage Open Access (PPO)℠**
- **Blue Cross Medicare Advantage HMO**
- **Blue Cross Medicare Advantage Dual Care (HMO SNP)℠**
- **Blue Cross Medicare Advantage (PPO)℠**
- **Blue Cross Medicare Supplement℠**

The FAQs include details on:

Coverage for testing, testing-related visits and treatment

Medicare Advantage and Medicare Supplement members won't pay copays, deductibles or coinsurance for:

- Medically necessary lab tests to diagnose COVID-19 that are consistent with CDC guidance
- Testing-related visits related to COVID-19 with in-network* providers, including at a provider's office, urgent care clinic, emergency room and by telehealth
- Treatment for COVID-19 with providers or at facilities from April 1 through Aug. 31, 2020 (previously June 30, 2020). Members should confirm whether their benefit plan covers services received from out-of-network providers. For questions about benefits, members may call the number on their ID card.

Expanded access to telehealth at no cost-share

Medicare Advantage and Medicare Supplement members can access in-network telehealth services at no cost-share for medically necessary, covered services and treatments consistent with the terms of the member's benefit plan. Medicare Advantage PPO members have access to telehealth services with out-of-network providers but will be responsible for member cost-share for these services consistent with the terms of their plans. This cost-share waiver for telehealth services applies to claims beginning March 1, 2020.

Telehealth for annual health assessments

Initial and subsequent Annual Wellness Visits (G0438 and G0439) may be conducted by telehealth. Submit claims for wellness visits with Modifier 95 and Place of Service (POS) 11. BCBSNM covers one wellness visit every calendar year.

- Note: CMS has not approved Initial Preventive Physical Examinations (IPPE) (G0402) for telehealth. Members are eligible for the IPPE during their first 12 months of enrollment in Medicare.

To confirm Medicare members' coverage and benefits, you may use the Availity® Provider Portal or your preferred vendor. To verify telehealth coverage, please call Provider Services at **1-877-774-8592** for individual and **1-877-299-1008** for group members.

Resources

- CMS Current Emergencies and News Alerts
- CMS Covered Telehealth Services and Telehealth Codes

*Blue Cross Medicare Supplement members do not have network restrictions unless otherwise noted in their plan terms.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized/pre-notified 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.

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.

CMS Payment Adjustments for Medicare Providers

During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) has adjusted certain payments to Medicare providers. Blue Cross and Blue Shield of New Mexico (BCBSNM) is applying these temporary adjustments to claims reimbursements, as appropriate and where consistent with network contracts, for Medicare Advantage providers.

What has changed?

Diagnosis Related Group (DRG) add-on payment: For discharges of members diagnosed with COVID-19, the weight of the assigned DRG has temporarily increased 20 percent. Providers should use the appropriate diagnosis code and date of discharge to identify members:

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after Jan. 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the emergency period.

Medicare sequestration suspended: The Medicare sequester has been suspended between May 1, 2020, and Dec. 31, 2020. During this time, BCBSNM is suspending the 2% sequestration reduction in Medicare claims payments. This applies to Medicare providers who service Medicare Advantage members.

Questions?

Please call the number on members' ID cards.

CMS resources

- CMS Current Emergencies and News Alerts

Addition of New Prior Authorization Requirements for Blue Cross Community Centennial℠ Members

There are important changes to the prior authorization requirements for Blue Cross Community Centennial Members.

Beginning September 1, 2020, the following changes will be made to the Blue Cross Community Centennial Prior Authorization Grid:

Code	Prior Authorization Source	Change	Effective Date
63688	BCBSNM	remove	9/1/2020
C9024	BCBSNM	remove	9/1/2020
C9028	BCBSNM	remove	9/1/2020
C9030	BCBSNM	remove	9/1/2020
C9032	BCBSNM	remove	9/1/2020
C9467	BCBSNM	remove	9/1/2020
C9492	BCBSNM	remove	9/1/2020
C9493	BCBSNM	remove	9/1/2020
C9016	BCBSNM	remove	9/1/2020
C9466	BCBSNM	remove	9/1/2020
97124	BCBSNM	remove	9/1/2020

Code	Prior Authorization Source	Change	Effective Date
0153U	eviCore	add	9/1/2020
0156U	eviCore	add	9/1/2020
0157U	eviCore	add	9/1/2020
0158U	eviCore	add	9/1/2020
0159U	eviCore	add	9/1/2020
0160U	eviCore	add	9/1/2020
0161U	eviCore	add	9/1/2020
0162U	eviCore	add	9/1/2020
0169U	eviCore	add	9/1/2020
0170U	eviCore	add	9/1/2020
0171U	eviCore	add	9/1/2020
81277	eviCore	add	9/1/2020
81307	eviCore	add	9/1/2020
81308	eviCore	add	9/1/2020
81522	eviCore	add	9/1/2020

81542	eviCore	add	9/1/2020
81552	eviCore	add	9/1/2020
77399	eviCore	remove	9/1/2020
76873	eviCore	remove	9/1/2020
76965	eviCore	remove	9/1/2020
77261	eviCore	remove	9/1/2020
77262	eviCore	remove	9/1/2020
77263	eviCore	remove	9/1/2020
77280	eviCore	remove	9/1/2020
77285	eviCore	remove	9/1/2020
77290	eviCore	remove	9/1/2020
77293	eviCore	remove	9/1/2020
77295	eviCore	remove	9/1/2020
77299	eviCore	remove	9/1/2020
77300	eviCore	remove	9/1/2020
77301	eviCore	remove	9/1/2020

77306	eviCore	remove	9/1/2020
77307	eviCore	remove	9/1/2020
77316	eviCore	remove	9/1/2020
77317	eviCore	remove	9/1/2020
77318	eviCore	remove	9/1/2020
77321	eviCore	remove	9/1/2020
77331	eviCore	remove	9/1/2020
77332	eviCore	remove	9/1/2020
77333	eviCore	remove	9/1/2020
77334	eviCore	remove	9/1/2020
77336	eviCore	remove	9/1/2020
77338	eviCore	remove	9/1/2020
77370	eviCore	remove	9/1/2020
77417	eviCore	remove	9/1/2020
77427	eviCore	remove	9/1/2020
77431	eviCore	remove	9/1/2020

77432	eviCore	remove	9/1/2020
77435	eviCore	remove	9/1/2020
77469	eviCore	remove	9/1/2020
77470	eviCore	remove	9/1/2020
77499	eviCore	remove	9/1/2020
77789	eviCore	remove	9/1/2020
77790	eviCore	remove	9/1/2020
77799	eviCore	remove	9/1/2020
81200	eviCore	remove	9/1/2020
81205	eviCore	remove	9/1/2020
81507	eviCore	remove	9/1/2020
C9408	eviCore	remove	9/1/2020
0104U	eviCore	add	9/1/2020
0036U	eviCore	add	9/1/2020
81362	eviCore	add	9/1/2020
81322	eviCore	add	9/1/2020

81293	eviCore	add	9/1/2020
81289	eviCore	add	9/1/2020
A9590	eviCore	add	9/1/2020
0172U	eviCore	add	9/1/2020
0173U	eviCore	add	9/1/2020
0175U	eviCore	add	9/1/2020
0179U	eviCore	add	9/1/2020

It is important to use Availity®, or your preferred vendor, to check eligibility and benefits, determine if you are in-network for your patient, and whether any preauthorization or prenotification is required. Availity allows you to determine if preauthorization is required. Refer to the Eligibility and Benefits web page for more information on Availity. Providers can also refer to the Prior Authorization section Blue Cross Community Centennial web page for more information regarding prior authorizations.

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

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

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

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. eviCore is an independent specialty 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 Availity or eviCore. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly

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