BlueCross BlueShield of New Mexico

BLUE REVIEW℠

A Provider Publication

November 2021

Education & Reference

COVID-19 Information for Providers

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

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

New Laboratory Policies Coming Jan. 1, 2022

Beginning Jan. 1, 2022, BCBSNM will implement new policies and a new program for claims for certain outpatient laboratory services provided to our Fully Insured commercial members. Our New Laboratory Management Program will help ensure our members get the right care at the right time and in the right setting. It will also help you better prepare and submit claims that support and reflect high quality, affordable care delivery to our members.

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2022 Telemedicine Services

In support of our members and employer groups, in 2022 BCBSNM will continue to cover the expanded telemedicine services that we've covered in 2021.

We are still evaluating our members' needs and may add services to our coverage. We'll provide a final code list in the coming months.

This applies to our fully insured and self-funded employer group members. Benefit coverage will be consistent with the member's benefit plan, including copays, coinsurance and deductibles. Medicare members' telemedicine coverage is consistent with CMS requirements. Our Medicaid members' telemedicine benefits are defined by state Medicaid requirements.

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct.1, 2021 — Part 2

This article is a continuation of the previously published Quarterly Pharmacy Changes Part 1 article. While that part 1 article included the drug list revisions/exclusions, dispensing limits, utilization management changes and general information on pharmacy benefit program updates, this part 2 version contains the more recent coverage additions, utilization management updates and any other updates to the pharmacy program.

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions or drugs moving to a lower out-of-pocket payment level, revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were made to the 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 Oct 1, 2021

Delivering Quality Care

Avoiding Antibiotics for Acute Bronchitis

Antibiotics only treat certain bacterial infections and don't work against viruses, which are often the cause of acute bronchitis, colds and flu. According to the Centers for Disease Control and Prevention (CDC), at least 28% of antibiotics prescribed each year in doctor's offices and emergency departments aren't needed. We encourage providers to talk with our members about taking antibiotics only when necessary.

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Managing Diabetes

More than 34 million Americans — just over one in 10 — have diabetes, according to the Centers for Disease Control and Prevention (CDC). Because symptoms can develop slowly, one in five don't know they have it. If left unmanaged, diabetes can lead to serious complications. As part of

monitoring and helping improve quality of care, we track Comprehensive Diabetes Care (CDC). CDC is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA).

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BCBSNM Moves to Streamline Coordination of Benefits for Members with Secondary Coverage

In October, BCBSNM began working with CAQH to help identify some commercial and Blue Cross Community Centennial℠ members who have more than one health insurance policy. By leveraging CAQH's COB Smart® database, we are collaborating with other health insurers to streamline benefit coordination.

Read More

Coding and Claims

Introducing Electronic Clinical Claim Appeal Requests via Availity® Provider Portal

The following information is ONLY applicable to Federal Employee Program® (FEP®) and Blue Cross Community Centennial claims.

BCBSNM is excited to announce a new and convenient electronic capability to submit appeal requests for specific clinical claim denials through the Availity Portal. This electronic option allows you to submit the clinical appeal request, upload supporting documentation, and monitor the status.

Read More

Initiation of Substance Use Disorder Provider Enhanced Payment Program — Blue Cross Community Centennial

Providers participating in the BCBSNM Blue Cross Community Centennial network may receive an enhanced payment for a follow-up visit for Blue Cross Community Centennial members with a newly diagnosed substance use disorder. The follow-up visit regarding the substance use disorder must be within 14 days of the initial diagnosis.

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Provider Incentive Program for Weight Assessment and Counseling for Children and Adolescents — Blue Cross Community Centennial

We invite providers that participate in the BCBSNM Blue Cross Community Centennial network to take part in our temporary provider incentive program for outpatient visits documenting weight assessment and counseling for nutrition and physical activity for children and adolescents (Service). You may receive an increase in reimbursement of $50 for these visits with some of our Blue Cross Community Centennial members.

Read More

Transparency in Care — Consolidated Appropriations Act

Surprise Billing Provisions of No Surprises Act

The No Surprises Act (NSA) is part of the Consolidated Appropriations Act (CAA). Under NSA, most out-of-network providers will no longer be allowed to balance bill patients for:

- Emergency services
- Out-of-network care during a visit to an in-network facility
- Out-of-network air ambulance services, if patients' benefit plan covers in-network air ambulance services

For items and services subject to NSA requirements, member cost-share will be calculated based on the lesser of a new qualified payment amount or the provider's billed charge. The qualified payment amount is a new median contract rate calculation set forth by the NSA and related interim rules.

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Provider Directory Information Verification

The Consolidated Appropriations Act (CAA) requires provider directory information to be verified every 90 days. Providers and insurers have roles in fulfilling this requirement to maintain an accurate directory. Under CAA, **we are required to remove providers from our directory** whose data we are unable to verify within 90 days. We recommend using the Availity® Provider Data Management feature to quickly verify and update your information with us and other insurers.

Read More

Continuity of Care Changes

Most of our group and fully insured plans currently include a time period for continuity of care at in-network reimbursement rates when a provider leaves our networks. The new legislation also requires continuity of care for affected members when:

- A provider's network status changes
- A group health plan changes health insurance issuer, resulting in the member no longer having access to a participating provider in our network.

For items and services subject to NSA requirements, member cost-share will be calculated based on the lesser of a new qualified payment amount or the provider's billed charge. The qualified payment amount is a new median contract rate calculation set forth by the NSA and related interim rules.

Read More

New Information on Member ID Cards

The Consolidated Appropriations Act requires that member ID cards include **deductible information** and **out-of-pocket maximums**. We will provide all members with updated **electronic ID cards** that include this information.

How to access ID cards

- **You** can view, download and print most members' electronic cards by completing an eligibility and benefits inquiry through Availity.
- **Members** can access their card several ways:
  - Through the BCBSNM app
  - By printing a copy of their updated electronic ID card, including deductible and out-of-pocket information from Blue Access for Members℠ (BAM℠)
  - By requesting a physical card from customer service

We will mail new cards that include deductible and out-of-pocket information to current members whose benefit plan changes in 2022. We'll also send cards with updated information to new members whose plans go into effect in 2022.

Machine-Readable Files

Health insurers are required to publicly display certain health care price information via machine-readable files on their websites beginning in 2022. These machine-readable files will include negotiated rates with in-network providers, allowed amounts for out-of-network providers and may include prescription-drug pricing. The Departments of Health and Human Services (HHS), Labor and Treasury have issued guidance indicating they will delay their enforcement of the machine-readable file requirements until July 1, 2022.

What this means for you

- These files will include your federal Taxpayer Identification Number (TIN), in addition to your National Provider Identifier.
- If you are using your Social Security number as your TIN, we encourage you to register for a new TIN and update us through Availity or submit a Demographic Change Form.

For items and services subject to NSA requirements, member cost-share will be calculated based on the lesser of a new qualified payment amount or the provider's billed charge. The qualified payment amount is a new median contract rate calculation set forth by the NSA and related interim rules.

More on the CAA and Transparency in Coverage Final Rule.

Blue Cross Medicare Advantage℠ (Medicare)

CMS-Required Training for Dual-Special Needs Plans

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

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Blue Cross Community Centennial℠ (Medicaid)

Required Cultural Competency Training Available Online

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

Read More

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

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

5701 Balloon Fiesta Pkwy NE, Albuquerque, NM 87113

New Laboratory Policies Coming Jan. 1, 2022

Beginning **Jan. 1, 2022**, Blue Cross and Blue Shield of New Mexico (BCBSNM) will implement new policies and a new program for claims for certain outpatient laboratory services provided to our Fully Insured **commercial** members. Our New Laboratory Management Program will help ensure our members get the right care at the right time and in the right setting. It will also help you better prepare and submit claims that support and reflect high quality, affordable care delivery to our members.
See below for key points to help you prepare.

Medical Policy Updates:
Watch for new and revised BCBSNM Medical Policies and reimbursement policies effective **Jan. 1, 2022**, related to certain laboratory, services, tests, and procedures. Also refer to our Clinical Payment and Coding Policies.
Affected claims: our new program will include the following outpatient laboratory claims:

- Dates-of-service on or after Jan. 1, 2022
- Performed in an outpatient setting (typically office, hospital outpatient, or independent laboratory)

Note: Laboratory services provided in emergency room, hospital observation and hospital inpatient settings are **excluded** from this program. Member contract benefits and clinical criteria still apply.

New Claim Simulation Tool:

Effective **Jan. 1, 2022**, you can get free access to the program's **Trial Claim Advice Tool**, which allows you to input codes and diagnoses to see, before submitting a claim, the potential outcome of your claim. The Trial Claim Advice Tool is a free simulation tool and does not guarantee approval, coverage, or reimbursement of services. Responses consider information entered through the tool for the date of service entered and historical claims finalized through the previous business day. Claims not yet finalized won't be considered.

What you need to do:

- To access the Trial Claim Advice Tool, log on to the Availity® Provider Portal.
- To get to the Trial Claim Advice Tool, use the single sign-on feature via the BCBSNM-branded Payer Spaces section within the Availity portal.
- If you're not a registered Availity user, we encourage you to sign up before the January 2022 program activation, to gain access to the Trial Claim Advice

Tool. Register on the Availity website today, at no charge. For registration help, call Availity Client Services at 800-282-4548.

Provider Training:

Attend free webinars on how to use the Trial Claim Advice Tool and learn more about the Laboratory Management Program. To register, select your preferred date and time from the list below:

- Nov. 4, 2021 from noon to 1 pm CST
- Nov. 9, 2021 from 10 to 11am CST
- Nov. 11, 2021 from 11 to 12 pm CST
- Nov. 17, 2021 from 11 to Noon CST
- Nov. 23, 2021 from 10 to 11 am CST
- Dec. 1, 2021 from 11 to Noon CST
- Dec. 7, 2021 from 2 to 3 pm CST
- Dec. 15, 2021 from 11 to Noon CST
- Dec. 28, 2021 from 11 to Noon CST
- Jan. 5, 2022 from 11 to Noon CST

For More Information:

Continue to watch News and Updates for more information.

Delivering Quality Care

Avoiding Antibiotics for Acute Bronchitis

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in News and Updates.

Antibiotics only treat certain bacterial infections and **don't work against viruses, which are often the cause of acute bronchitis, colds and flu**. According to the Centers for Disease Control and Prevention (CDC) at least 28% of antibiotics prescribed each year in doctor's offices and emergency departments aren't needed. We

encourage providers to talk with our members about taking antibiotics only when necessary.

Why It Matters

Antibiotics can cause side effects ranging from minor to severe, according to the CDC. These include rash, diarrhea, yeast infections and allergic reactions. Antibiotics also give bacteria a chance to become more resistant to them, making future infections harder to treat. More than 35,000 people die each year in the U.S. because of antibiotic-resistant infections, according to the CDC.

Closing Care Gaps

We track Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) as part of monitoring and helping improve quality of care. AAB is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). The measure tracks the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in the member receiving an antibiotic prescription. A higher ratio indicates appropriate treatment for acute bronchitis/bronchiolitis, meaning antibiotics weren't prescribed.

Tips to Consider

The CDC suggests alternatives to antibiotics for acute bronchitis and other conditions, including:

- Adequate rest and increased fluids
- Using a clean humidifier or cool mist vaporizer
- Inhaling hot shower steam or other sources of hot vapor
- Throat lozenges for adults and children age 5 years and older
- Over-the-counter medications to treat symptoms

Consider providing our members handouts, such as these from the CDC, explaining that viruses, not bacteria, cause colds and flu.

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.

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.

Delivering Quality Care

Managing Diabetes

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in News and Updates.

More than 34 million Americans — just over one in 10 — have diabetes, according to the Centers for Disease Control and Prevention (CDC). Because symptoms can develop slowly, one in five don't know they have it. We encourage providers to talk with our members about diabetes, including:

- Type 1 and Type 2 symptoms
- Regular eye exams to avoid vision loss, or diabetic retinopathy
- Screenings for kidney disease, or diabetic nephropathy

Why Diabetes Care Is Important

If left unmanaged, diabetes can lead to serious complications. These may include heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Providers play an important role in supporting our members through regular screenings, tests and office visits. See our preventive care and clinical practice guidelines on diabetes, and tools from the CDC.

Closing Care Gaps

As part of monitoring and helping improve quality of care, we track Comprehensive Diabetes Care (CDC). aCDC is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). It applies to our members ages 18 to 75 with diabetes (type 1 or type 2) who had the following during the measurement year:

- Hemoglobin A1c (HbA1c) testing

- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Retinal eye exam
- Medical attention for nephropathy
- Blood pressure control (<140/90 mm Hg)

In addition to CDC, we track Kidney Health Evaluation for Patients with Diabetes (KED) . This is a HEDIS measure developed by NCQA with input from the National Kidney Foundation. It applies to our members ages 18 to 85 with diabetes (type 1 or type 2) who received a kidney health evaluation. An evaluation is defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year.

Tips to Consider

- Identify care gaps and schedule lab tests before office visits to review results and adjust treatment plans if needed.
- Complete urine protein testing for attention to nephropathy at any office visit. Testing includes basic urinalysis by dip stick or tablet reagent.
- Document medication adherence to angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB) when applicable.
- Repeat abnormal lab tests later in the year to document improvement.
- Monitor blood pressure status at each visit and adjust medications as needed for control.
- Encourage members with diabetes to have annual retinal eye exams by an eye care specialist.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.

BCBSNM Moves to Streamline Coordination of Benefits for Members with Secondary Coverage

In October, Blue Cross and Blue Shield of New Mexico (BCBSNM) began working with the Council for Affordable Quality Healthcare (CAQH) to help identify some commercial and Blue Cross Community Centennial℠ members who have more than one health insurance policy. By leveraging CAQH's **COB Smart® database**, we are collaborating with other health insurers to streamline benefit coordination.

Background: Historically, coordinating payments for members who have multiple policies has been a lengthy, manual process. This challenge has been costly for everyone across the health care industry. Tracking down multiple policies for members resulted in delayed and inaccurate payments, stakeholder abrasion, significant recovery activities and unnecessary administrative costs.

How it works: CAQH is a non-profit alliance of health plans and trade associations that creates shared industry initiatives to streamline the business of health care. Its COB Smart database contains records for approximately 180 million insured members, over half of the insured population in the U.S. We will use the database to identify members with overlaps in health coverage and facilitate more efficient claim adjudication.

No action needed: You don't need to do anything to benefit from this program. By collaborating with CAQH, BCBSNM is working to reduce the administrative burden and timelines required to coordinate these claims, resulting in faster and more accurate claims payments to you.

References to other third-party sources or organizations, such as CAQH, are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.

Initiation of Substance Use Disorder Provider Enhanced Payment Program Blue Cross Community Centennial℠

Providers participating in Blue Cross and Blue Shield of New Mexico's (BCBSNM's) Blue Cross Community Centennial network may receive an enhanced payment for a follow-up visit for Blue Cross Community Centennial members with a newly diagnosed substance use disorder. The follow-up visit regarding the substance use disorder must be within 14 days of the initial diagnosis.

Eligible visit

You will be eligible to earn an additional $75 per claim if:

- You diagnose a new substance use disorder and provide an initial follow-up visit related to substance use disorder previously diagnosed.
- The follow-up service is within 14 days of the initial appointment in which the diagnosis of a new substance use disorder is made.
- Member is a Blue Cross Community Centennial (Medicaid) member.
- This enhanced payment program began September 1, 2021.

How to submit a claim for an eligible follow-up visit using CMS 1500

- Add **procedure code H0006** to your standard code(s) for the visit.
- Use the **modifier U9** in the modifier section.
- Use the code and modifier only once for the same member annually.
- Only one provider may use the code and modifier for the same member annually.
- **VISITS CAN BE A TELEHEALTH VISIT.**

Program limitations

BCBSNM may extend, discontinue or change this program at any time. We will publish notice if we do.

Program rules

By submitting procedure code H006 with modifier U9 on the claim, your organization is representing to BCBSNM that the terms and conditions of this letter for use of the procedure code and modifier are agreeable and have been met. Your organization is also consenting to possible selection for a random audit to confirm the members for whom claims with the procedure code and modifier were eligible, along with general medical record quality elements to include, without cost to BCBSNM for any copies, signed consent, biographical data, documented diagnosis, service dates, medication information, treatment plan, and confidentiality safeguards.

More information

For questions and comments, please email BHQualityImprovement@bcbstx.com or contact your assigned BCBSNM Provider Network Representative.

Introducing Electronic Clinical Claim Appeal Requests via Availity® Provider Portal

The following information is ONLY applicable to Federal Employee Program® (FEP®) and Blue Cross Community Centennial℠ claims.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is excited to announce a new and convenient electronic capability to submit appeal requests for specific clinical claim denials through the Availity Portal. This electronic option allows you to submit the clinical appeal request, upload supporting documentation, and monitor the status.

A Clinical Appeal is a request to change an adverse determination for care or services when a claim is denied based on lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic.
Using this new online offering allows the following:

- status management
- upload clinical medical records with submission
- view and print confirmation and decision letter
- generates Dashboard view of appeal-related activity

Steps to submit appeal requests for clinical claim denials online:

1. Log into Availity
2. Select *Claims & Payments* from the navigation menu, then choose *Claim Status*
3. Search and locate the claim by using the Member ID or Claim Number
4. On the Claim Status results page, select *Dispute Claim (if applicable offered and applicable)*
5. Complete the *Dispute Request Form*
6. Upload supporting documentation
7. Review and submit your appeal request

For assistance with obtaining claim status online, refer to the Claim Status Tool user guide.

Training
BCBSNM is hosting complimentary webinars for providers to learn how to use this new electronic appeals tool. To register for a training session, select your preferred date and time below.

- Nov. 8, 2021 – 12 to 1 p.m.
- Nov. 10, 2021 – 9 to 10 a.m.
- Nov. 12, 2021 – 9 to 10 a.m.
- Nov. 15, 2021 – 12 to 1 p.m.
- Nov. 17, 2021 – 9 to 10 a.m.
- Nov. 19, 2021 – 9 to 10 a.m.

- Nov. 22, 2021 – 12 to 1 p.m.
- Nov. 24, 2021 – 9 to 10 a.m.
- Nov. 29, 2021 – 12 to 1 p.m.

Availity Administrators need to assign their users the **Claim Status role** in Availity to ensure users can access and submit electronic appeals online. If your provider organization is not yet registered with Availity, you can sign up today at Availity, at no charge. For registration assistance contact Availity Client Services at 800-282-4548.

For More Information
Watch for the **Electronic Appeals User Guide** coming soon to the Provider Tools section of our website. Refer to upcoming *Blue Review* publication. Visit the Training page for additional webinar sessions that will be hosted in December. If you need further assistance, contact our Provider Education Consultant.

Provider Incentive Program for Weight Assessment and Counseling for Children and Adolescents — Blue Cross Community Centennial℠

We invite providers that participate in Blue Cross and Blue Shield of New Mexico's (BCBSNM's) Blue Cross Community Centennial network to take part in our temporary provider incentive program for outpatient visits documenting weight assessment and counseling for nutrition and physical activity for children and adolescents (Service). You may receive an increase in reimbursement of $50 for these visits with some of our Blue Cross Community Centennial members.

How to submit a claim for an eligible visit

Any outpatient encounter with a primary care provider may be eligible for this incentive. To qualify for the increase in reimbursement, providers must:

- furnish and document the service between July 1, 2021 and December 31, 2021, and
- submit a CMS-1500 clean claim with HCPCS code G0447, or

- submit a UB-04 clean claim with code G0447 for outpatient encounters, if the provider is an FQHC.

The incentive will be automatically applied to claims that meet the program criteria. Any reimbursement will be made according to BCBSNM medical and reimbursement policies.

Program limitations

BCBSNM may extend, discontinue or change this program at any time. We will publish notice if we do.

Program rules

By submitting procedure code G0447 on the claim, your organization is representing to BCBSNM that the terms and conditions of this letter for use of the code are agreeable and have been met. Your organization is also consenting to possible selection for a random audit to confirm the members for whom claims with the procedure code and modifier were eligible, along with general medical record quality elements to include, without cost to BCBSNM for any copies, signed consent, biographical data, documented diagnosis, service dates, medication information, treatment plan, and confidentiality safeguards.

More information

For questions regarding this communication, please contact Quality Improvement at qualityinquiry_SG_Full@bcbsnm.com.

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

Surprise Billing Provisions of No Surprises Act

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

The No Surprises Act (NSA) is part of the Consolidated Appropriations Act (CAA). Under NSA, most out-of-network providers will no longer be allowed to balance bill patients for:

- Emergency services
- Out-of-network care during a visit to an in-network facility

- Out-of-network air ambulance services, if patients' benefit plan covers in-network air ambulance services

For items and services subject to NSA requirements, member cost-share will be calculated based on the lesser of a new **qualified payment amount** or the provider's billed charge. The qualified payment amount is a new median contract rate calculation set forth by the NSA and related interim rules.

Generally, if an out-of-network provider isn't satisfied with a payment on items or services subject to NSA, they can first initiate a negotiation with the plan and, failing that, pursue binding **independent dispute resolution (IDR)**. Through this process, the parties submit their respective offers and other required information, and the IDR entity selects one of the parties' offers as the outcome, which determines whether any additional amount will be paid to the provider.

The NSA and related interim rules state that some of its provisions such as member cost-share requirements, claim payment deadlines and availability of the federal IDR process, do not apply if a state law provides a method for determining the total amount payable to the provider for that item or service.

CAA expands the current definition of emergency services. Emergency services continue to be defined by the prudent layperson standard. If a plan covers services in an emergency department or independent freestanding emergency room, the following services will be included as emergency services under NSA:

- Screening and ancillary services necessary to evaluate the emergency condition (participating and non-participating)
- Services to stabilize the patient (participating and non-participating)
- Post-stabilization outpatient observation or an inpatient or outpatient stay, if the plan would cover the services (non-participating only)

More on the CAA and Transparency in Coverage Final Rule.

Provider Directory Information Verification

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

The Consolidated Appropriations Act (CAA) requires provider directory information to be verified **every 90 days**. Providers and insurers have roles in fulfilling this requirement to maintain an accurate directory.

What this means for you:
Starting Jan. 1, 2022, you must:

- Verify your directory information every 90 days
- Update your information when it changes, including if you come in or go out of a network

We recommend using the Availity® Provider Data Management feature to quickly verify and update your information with us **and other insurers** every 90 days. If you are unable to use Availity, you may submit a Demographic Change Form or, if you are new to our networks, the Provider Onboarding Form. We won't accept changes by email, phone or fax. Updates will be reflected in our Provider Finder®.

Under CAA, **we are required to remove providers from our directory** whose data we are unable to verify within 90 days. If you don't verify your details every 90 days, we will reach out to you by **email** and ask that you **quickly respond** by following the unique link in the email. It will take you to a secure landing page where you can update your information.

If you leave a network, please update your directory information immediately. If you are incorrectly identified as an in-network provider, it may limit member cost-sharing to in-network levels.

More on the CAA and Transparency in Coverage Final Rule.

Continuity of Care Changes

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

Most of our group and fully insured plans currently include a time period for continuity of care at in-network reimbursement rates when a provider leaves our networks. The new legislation also requires continuity of care for affected members when:

- A provider's network status changes
- A group health plan changes health insurance issuer, resulting in the member no longer having access to a participating provider in our network.

What this means for you:
If you leave our network, we will notify members and allow them to request continuity of care for the following conditions or care:

- Treatment of a serious and complex condition
- Institutional or inpatient care
- Schedule a nonelective surgery
- Pregnancy or course of treatment for pregnancy
- Terminal illness

Members can choose to continue services with the same in-network coverage for either (the earlier date):

- 90 days after the notice
- The date they're no longer a continuing care patient

State laws, which may require a longer continuity of care period for certain conditions, will continue to apply.

You (or your facility) must accept payment from us plus member cost share as payment in full during the continuity of care period.

More on the CAA and Transparency in Coverage Final Rule.
