New York Provider News

June 2020 Empire Provider News

Medicaid:

Medicare:

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Prior authorization updates for specialty pharmacy effective September 1, 2020

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

Prior authorization updates

Effective for dates of service on and after September 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

Please note, inclusion of NDC code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

To access the Clinical Criteria information please click here.

Empire BlueCross BlueShield's ("Empire") prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team.

Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company and are shown in italics in the table below.

Clinical Criteria	HCPCS or CPT Code(s)	Drug
ING-CC-0161	*C9399* *J3490* *J3590* *J9999*	*Sarclisa*
**ING-CC-0058*	*J2354*	*Bynfezia*

***** Non-oncology use is managed by Empire's medical specialty drug review team. O*ncology use is managed by AIM.*

Step therapy updates

Effective for dates of service on and after September 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process.

To access the step therapy drug list, please click here.

Empire's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team.

Clinical Criteria	Status	Drug(s)	HCPCS Code(s)
ING-CC-0003	Non-preferred	Panzyga	J1599
ING-CC-0003	Non-preferred	Xembify	J3490

458-0620-PN-NY

URL: https://providernews.empireblue.com/article/prior-authorization-updates-for-specialty-pharmacy-effective-september-1-2020

Clinical Criteria updates for specialty pharmacy are available

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

Empire BlueCross BlueShield's ("Empire") pre-service clinical review of non-oncology specialty pharmacy drugs will be managed by Empire's medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health (AIM), a separate company.

The following Clinical Criteria documents were endorsed at the March 26, 2020 Clinical Criteria meeting. To access the clinical criteria information please click here.

Revised Clinical Criteria effective April 1, 2020
The following clinical criteria were updated with CPT/HCPCS procedure code updates.
ING-CC-0153 Adakveo (crizanlizumab)
ING-CC-0154 Givlaari (givosiran)

Revised Clinical Criteria effective April 27, 2020
The following current clinical criteria were revised to expand medical necessity indications or criteria.

- ING-CC-0119 Yervoy (ipilimumab)
- ING-CC-0125 Opdivo (nivolumab)

Revised Clinical Criteria effective April 27, 2020

The following clinical criteria were reviewed with no significant change to the medical necessity indications or criteria.

- ING-CC-0037 Kanuma (sebelipase alfa)
- ING-CC-0070 Jetrea (ocriplasmin)
- ING-CC-0087 Gamifant

Revised Clinical Criteria effective September 1, 2020
The following current clinical criteria were revised and might result in services that were previously covered but may now be found to be not medically necessary.

- ING-CC-0002 Colony Stimulating Factor Agents
- ING-CC-0058 Octreotide Agents

New Clinical Criteria effective September 1, 2020
The following clinical criteria are new.

- ING-CC-0161 Sarclisa (isatuximab-irfc)

461-0620-PN-NY

URL: https://providernews.empireblue.com/article/clinical-criteria-updates-for-specialty-pharmacy-are-available-6

Pharmacy information available on empireblue.com

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit empireblue.com/pharmacyinformation. The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate Marketplace scroll down to “Select Drug Lists.” This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

463-0620-PN-NY

URL: https://providernews.empireblue.com/article/pharmacy-information-available-on-empirebluecom-13

Empire Enhances Process for Submitting Behavioral Health Authorizations - Now Available

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Empire BlueCross BlueShield (“Empire”) is excited to announce an enhanced process for submitting behavioral health authorizations. We have enhanced the Interactive Care Reviewer (ICR) tool on the Availity Portal to provide the opportunity for quicker resolutions.

The ICR tool on the Availity Portal will now utilize sophisticated clinical analytics in order to provide an immediate decision on an authorization for higher levels of care such as inpatient, intensive outpatient (IOP) and partial hospitalization (PHP). Here are a few of the many reasons behavioral health providers will benefit from using ICR with the newly enhanced functionality:

- Reduction of administrative burden
- Quicker access to care for some services deemed eligible for our immediate decisions
- Increased member focus
- Prioritizes more complex cases
- Reduced possibility of errors such as illegible faxes
- Maximize the amount time spent with members

Follow these instructions to access ICR through the Availity Portal (www.Availity.com)
First, ask your Availity administrator to grant you the appropriate role assignment.

Do you create and submit prior authorization requests?
Required role assignment: *Authorization and Referral Request*

Do you check the status of the case or results of the authorization request?
Required role assignment: *Authorization and Referral Inquiry*

Once you have the authorization role assignment, log onto Availity with your unique user ID and password follow these steps.

1. Select Patient Registration from Availity's home page
2. Select Authorizations & Referrals
3. Select Authorizations *(for requests)* | Select Auth/Referral Inquiry *(for inquiries)*

Training:
Follow these instructions to access ICR on demand training through the Availity Custom Learning Center:

- From Availity's home page, select Payer Spaces > Empire BlueCross BlueShield tile > Applications > Custom Learning Center tile.
- From the Courses screen use the filter catalog, and select Interactive Care Reviewer – Online Authorizations from the menu and click Apply.

You will find two pages of online courses consisting of on demand videos and reference documents illustrating navigation and features of ICR. Enroll for the course(s) you want to take immediately or save for later.

468-0620-PN-NY

URL: https://providernews.empireblue.com/article/empire-enhances-process-for-submitting-behavioral-health-authorizations-now-available

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Follow-Up after Hospitalization for Mental Illness

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

As a provider, we understand you are committed to providing the best care for our members, including follow up appointments with members after a behavioral health (BH) inpatient stay. Since regular monitoring, follow up appointments and making necessary treatment recommendations or changes are all part of excellent care, we'd like to provide an overview of the related HEDIS measure.

The Follow-Up after Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members [6 years and older] who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of behavioral health inpatient discharges for which the member received follow-up within 7 days after discharge.
- The percentage of behavioral health inpatient discharges for which the member received follow-up within 30 days after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are being recommended and scheduled during the inpatient stay as part of discharge planning by the eligible behavioral health facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as practicing behavioral health providers.

Please consider the following for improving member outcomes for this measure:

- Earliest follow up with a BH provider can help with continuing treatment after leaving the hospital.
- With greater emphasis on care coordination, primary care providers can help facilitate the BH follow up appointments.
- Weekend member discharges have shown to have very inconsistent follow up after discharge. Start discharge planning as soon as possible while members are inpatient so those who are discharged on weekends have scheduled follow up appointments.
- In addition, other social determinants of health pertinent to the member such as housing, food, living in a rural area, transportation, job schedules, family and social support, child care, etc., can impact follow-up opportunities. Please address these needs and issues; refer to resources that can help support the member.
- Social workers at the facilities can contact [brand] member services to learn if additional sources of assistance are available through [brand] such as case management

and other referrals.

- Telehealth services has been identified as part of follow up for this HEDIS measure available in certain parts of the country. Telehealth follow up may not be the best choice for everyone; however, not having a BH follow up for several weeks can be detrimental to the member can be a reason for relapse.

440-0620-PN-NY

URL: https://providernews.empireblue.com/article/follow-up-after-hospitalization-for-mental-illness-1

A special thank you to Care Providers

Published: Jun 1, 2020 - **Administrative**

We want to express our most sincere thanks for your dedication to serving the patients in your care. Please take a moment to watch this brief thank you message from Empire BlueCross BlueShield.

524-0620-PN-NY

URL: https://providernews.empireblue.com/article/a-special-thank-you-to-care-providers-3

Be sure to notify Empire of changes to your demographic data

Published: Jun 1, 2020 - **Administrative**

Although Empire BlueCross BlueShield does verify your demographic data each year, contractually you (or a representative from your organization) is obligated to inform the health plan within 45 days of any changes. Failure to comply with this requirement can result in late or incorrect claim payments.

You can make these changes electronically by accessing the demographic change form on Availity.com > Payer Spaces > Resources/Empire BlueCross BlueShield Provider Maintenance Form, or by faxing your changes to 1-877-281-6713.

443-0620-PN-NY

URL: https://providernews.empireblue.com/article/be-sure-to-notify-empire-of-changes-to-your-demographic-data

Empire to change ID numbers for City of New York members

Published: Jun 1, 2020 - **Administrative**

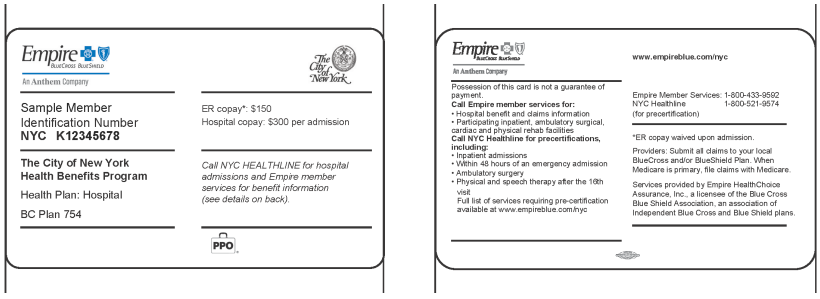
Article Attachments

Starting July 1st 2020, Empire BlueCross BlueShield (“Empire”) City of New York members will begin using a new 9-digit HCID. The new 9-digit member ID number begins with the letter “K” + 8 numeral digits (e.g. K12345678).

New Empire HCID numbers will be required for all City of New York member hospital claims and inquiries. Provider transactions that are submitted using Emblem 11-digit member HCIDs to Empire’s systems of engagement (web and EDI) portals will not be recognized.

The new Empire BlueCross BlueShield ID cards for City of New York members with the new 9-digit HCID should not be used prior to July 1st 2020.

9-digit HCIDs will be on Empire Hospital-Only ID Cards:



516-0620-PN-NY

URL: https://providernews.empireblue.com/article/empire-to-change-id-numbers-for-city-of-new-york-members

Empire Covers HIV PrEP Medications at 100% for prevention

Published: Jun 1, 2020 - **Administrative**

In recognition of the evidence that the prescription medication PrEP (Truvada) is of substantial benefit for decreasing the risk of HIV infection in persons at high risk of HIV infection and in accordance with the NYS Insurance Law, beginning January 1, 2020, for New York Fully Insured and Minimum Premium non-grandfathered members. Empire BlueCross BlueShield ("Empire") began to cover PrEP medication at 100% when used for prevention of HIV and dispensed at an in-network pharmacy. Since PrEP can also be used *to treat* HIV, Empire will review medical and pharmacy claims data to determine if a member has been diagnosed and prescribed treatment for HIV or prescribed PrEP for preventive purposes. When prescribed for prevention of HIV, this drug is covered with no member cost share. When prescribed for treatment of HIV, member cost share applies pursuant to the terms of the member's benefit plan. This coverage includes Truvada and its components. When medically necessary, a prior authorization process is available for Descovy to be covered with no member cost share when used for prevention of HIV.

447-0620-PN-NY

URL: https://providernews.empireblue.com/article/empire-covers-hiv-prep-medications-at-100-for-prevention

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Empire CRA Program Update: Retrospective Program Begins; Prospective Program Continues

Published: Jun 1, 2020 - **Administrative**

Empire BlueCross BlueShield ("Empire") is committed to collaborating with the provider community and offering flexible options to meet the needs of both the retrospective program and the prospective program. The retrospective program focuses on medical chart collection. The prospective program focuses on member health assessments for patients with undocumented Hierarchical Condition Categories (HCC's), in order to help close patients' gaps in care.

Retrospective Chart Requests

We appreciate that care providers across the country on the front line are committed to providing care during these challenging times, and as such, that care results in a visit where we may need the medical chart. Medical chart collection must be done to obtain undocumented HCC's on your patients in order to be compliant with the provisions of the Affordable Care Act, (ACA), that require our company to collect and report diagnosis code data for ACA membership. This process will begin in June. In order to make these chart requests the most efficient for your office, we have electronic options available:

- EMR Interoperability
- Allscripts (Opt in -- signature required)
- NextGen
- Athenahealth
- MEDENT
- Remote/Direct Empire access
- Vendor virtual or onsite visit (if the offices are opened back up from COVID-19 closures)
- Secure FTP

The goal of these electronic options is to both improve the medical record data extraction and the experience for Empire's providers. If you are interested in this type of set up or any other remote access options, please contact the Commercial Risk Adjustment Network Education Representative listed below.

Prospective Patient Outreach (Incentive opportunity for properly completed health assessments: Physicians are eligible to receive $150 for electronic submissions or $50 for paper in addition to the office visit reimbursement.)
We encourage members to form a relationship with their Primary Care Physician to complete a clinical assessment to ensure you have a clearer picture of your patients' health. Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. Previous *Provider News* updates have given telehealth reimbursement guidance to follow when submitting the claim.

As a reminder, the May newsletter mentioned incentives for prospective program participation ($150 or $50). We would be happy to meet and review incentive opportunities along with other flexible options for program participation and chart collection. Please contact Alicia.Estrada@Empire.com to set up a meeting.

Thank you for your continued efforts with the CRA Program.

454-0620-PN-NY

URL: https://providernews.empireblue.com/article/empire-cra-program-update-retrospective-program-begins-prospective-program-continues

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Availity Portal Notification Center

Published: Jun 1, 2020 - **Administrative**

Empire BlueCross BlueShield (“Empire”) is now using the Notification Center on the Availity Portal home page to communicate vital, time sensitive information. A Take Action call out and a red flag in front of the message will make it easy to see that there is something new requiring your attention.

The Notification Center is currently being used to notify you if there are payment integrity requests for medical records or recommended training in the Custom Learning Center. Select the Take Action icon to instantly access the custom learning recommended course.

For membership where the disputes tool is available, Availity will also post a message in the notification center when a dispute request you have submitted is finalized. Selecting the Take Action icon will allow easy access to your appeals worklist for details.

Viewing the Notification Center updates should be included as part of your regular workflow so you are always aware of any outstanding action items and can respond timely.

457-0620-PN-NY

URL: https://providernews.empireblue.com/article/availity-portal-notification-center-2

Quality Corner: CPT Category II Codes - Collaborating for enhanced patient care

Published: Jun 1, 2020 - **Administrative**

The American Medical Association has an alphabetical listing of clinical conditions with which measures and CPT Category II codes are associated. The use of CPT Category II Codes and ICD-10-CM codes can reduce the number of medical records that we request during the HEDIS® medical record review season (January – May each year), thus reducing the administrative burden on physician offices.

Article Attachments

CPT Category II Codes.pdf
application/pdf - 89.42 KB

See the attachment for some commonly used codes.

460-0620-PN-NY

URL: https://providernews.empireblue.com/article/quality-corner-cpt-category-ii-codes-collaborating-for-enhanced-patient-care-2

Medical Policy Updates

Published: Jun 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

These updates list the new and/or revised Empire BlueCross BlueShield (“Empire”) medical policies, clinical guidelines and reimbursement policies*. The implementation date for each policy or guideline is noted for each section. Implementation of the new or revised medical policy, clinical guideline or reimbursement policy is effective for all claims processed on and after the specified implementation date, regardless of date of service. Previously processed claims will not be reprocessed as a result of the changes. If there is any inconsistency or conflict between the brief description provided below and the actual policy or guideline, the policy or guideline will govern.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and clinical guidelines (and medical policy takes precedence over clinical guidelines) and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that the services are rendered must be used. This document supplements any previous medical policy and clinical guideline updates that may have been issued by Empire. Please include this update with your Provider Manual for future reference.

Please note that medical policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Empire's medical policies and clinical guidelines can be found at empireblue.com.

*Note: These updates may not apply to all ASO Accounts as some accounts may have non-standard benefits that apply.

Medical Policy Updates

New Medical Policies Effective 09-01-2020
(The policies below were created and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

- DME.00041 - Low Intensity Therapeutic Ultrasound for the Treatment of Pain
- GENE.00053 - Metagenomic Sequencing for Infectious Disease in the Outpatient Setting
- GENE.00054 - Paired DNA and Messenger RNA (mRNA) Genetic Testing to Detect, Diagnose and Manage Cancer
- SURG.00154 - Microsurgical Procedures for the Treatment of Lymphedema
- SURG.00155 - Cryoneurolysis for Treatment of Peripheral Nerve Pain

Revised Medical Policies Effective 09-01-2020
(The policies below were revised and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

- DME.00011 - Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices
- SURG.00032 - Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention

- SURG.00150 - Leadless Pacemaker

Revised Medical Policies Effective 09-19-2020
(The policies below were revised and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

- RAD.00038 - Use of 3-D, 4-D or 5-D Ultrasound in Maternity Care
- SURG.00096 - Surgical and Ablative Treatments for Chronic Headaches

462-0620-PN-NY

URL: https://providernews.empireblue.com/article/medical-policy-updates-5

Transition to AIM Rehabilitative Services Clinical Appropriateness Guidelines

Published: Jun 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

Effective October 1, 2020, Empire BlueCross BlueShield (“Empire”) will transition the clinical criteria for medical necessity review of certain rehabilitative services to AIM Rehabilitative Service Clinical Appropriateness Guidelines as part of the AIM Rehabilitation Program. Reviewed services will include certain physical therapy, occupational therapy and speech therapy services.

As part of this transition of clinical criteria, the following procedures will be subject to prior authorization as part of the AIM Rehabilitation program:

CPT code	Description
90912	Biofeedback training for bowel or bladder control, initial 15 minutes
90913	Biofeedback training for bowel or bladder control, additional 15 minutes
96001	Three-dimensional, video-taped, computer-based gait analysis during walking
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
S8940	Therapeutic horseback riding, per session
S8948	Treatment with low level laser (phototherapy) each 15 minutes
S9090	Vertebral axial decompression (lumbar traction), per session
20560	Needle insertion(s) without injection(s), 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s), 3 or more muscle(s)
90901	Biofeedback training by any modality (when done for medically necessary indications)
97129	One-on-one therapeutic interventions focused on thought processing and strategies to manage activities
97130	each additional 15 minutes (list separately in addition to code for primary procedure)
92630	Hearing training and therapy for hearing loss prior to learning to speak
92633	Hearing training and therapy for hearing loss after speech

The following procedure will be removed from the program:

S9117	back school, per visit

- Access AIM's ***Provider****Portal*$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way

to request authorization.

- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number at 1- 877-430-2288, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

467-0620-PN-NY

URL: https://providernews.empireblue.com/article/transition-to-aim-rehabilitative-services-clinical-appropriateness-guidelines-2

New Reimbursement Policy: Nurse Practitioner and Physician Assistant Services - Professional

Published: Jun 1, 2020 - **Policy Updates** / Reimbursement Policies

A new professional reimbursement policy for Nurse Practitioner, and Physician Assistant services, will be implemented beginning with dates of service on, or after September 1, 2020.

Empire BlueCross BlueShield (“Empire”) will allow reimbursement for services provided by Nurse Practitioner (NP) and Physician Assistant (PA) providers. Unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- The service is considered a physicians’ service.
- The service is within the NP or PA provider’s scope of practice.
- A payment reduction consistent with CMS reimbursement.

Services furnished by the NP or PA should be submitted with their own NPI.

For more information on the Nurse Practitioner and Physician Assistant Services Professional policy, visit the Reimbursement Policy page at empireblue.com/provider.

470-0620-PN-NY

URL: https://providernews.empireblue.com/article/new-reimbursement-policy-nurse-practitioner-and-physician-assistant-services-professional

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Updates to AIM Sleep Disorder Management Clinical Appropriateness Guideline

Published: Jun 1, 2020 - **State & Federal** / Medicaid

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health®* (AIM) *Sleep Disorder Management Clinical Appropriateness Guideline*.

***Sleep Disorder Management Clinical Appropriateness Guideline* updates by section:**

- Bi-Level Positive Airway Pressure (BPAP) Devices:
  - Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and alignment with Medicare requirements for use of BPAP
- Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing:
  - Style change for clarity
  - Code changes: none

As a reminder, ordering and servicing providers may submit prior authorization (PA) requests to AIM by:

- Accessing AIM's ***Provider****Portal*SM directly at **com**. Online access is available 24/7 to process orders in real time, and is the fastest and most convenient way to request PA.
- Accessing AIM via the **Availity Portal**.*
- Calling the AIM Contact Center at **1-800-714-0040** from 7 a.m. to 7 p.m. ET.

What if I need assistance?
If you have questions related to AIM guidelines, email AIM at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

NYE-NU-0222-20 April 2020
509517MUPENMUB

URL: https://providernews.empireblue.com/article/updates-to-aim-sleep-disorder-management-clinical-appropriateness-guideline-15

2020 affirmative statement concerning utilization management decisions

Published: Jun 1, 2020 - **State & Federal** / Medicaid

All associates who make utilization management (UM) decisions are required to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

NYE-NU-0209-20 April 2020

URL: https://providernews.empireblue.com/article/2020-affirmative-statement-concerning-utilization-management-decisions

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Modifier use reminders

Published: Jun 1, 2020 - **State & Federal** / Medicaid

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Empire reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is "above and beyond" or "separate and significant" from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Empire will publish additional articles on correct coding in provider communications.

NYE-NU-0202-20 April 2020
509409MUPENMUB

URL: https://providernews.empireblue.com/article/modifier-use-reminders-8

Coding spotlight - provider's guide to code social determinants of health

Published: Jun 1, 2020 - **State & Federal** / Medicaid

What are social determinants of health (SDOH)?

The World Health Organization (WHO) defines SDOH as "conditions in which people are born, grow, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequalities." Capturing SDOH is becoming a necessary element of documentation.

Official coding guidelines for SDOH — new update

For 2019, the *ICD-10-CM Official Guidelines for Coding and Reporting* has been updated to allow reporting SDOH using the documentation of clinicians other than the patient's provider. Most of the patient-specific SDOH information is captured by ancillary staff supporting the physicians.

Do SDOH affect everyone?

The SDOH codes are very powerful tools in capturing the complexity of patient populations and allowing application of more accurate care. These conditions affect patient care. This publicly reported data will also improve capture of conditions that impact readmission reduction and mortality metrics.

SDOH diagnosis codes are one of the few tools that are shared collectively to measure and evaluate SDOH on a national scale.

How can providers address SDOH issues for the members?

- Using the CMS Screening Tool, which can be found at:
- **https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf**
- Submitting ICD-10-CM codes from *Chapter 21 (Z00 to Z99)* to identify issues that may impact member health via claims

Coding SDOH

SDOH codes are represented in ICD-10-CM code categories Z55 to Z65 — persons with potential health hazards related to socioeconomic and psychosocial circumstances. Codes in the Z55 to Z65 groupings include the following:

Code grouping	Examples
Z55 — Problems related to education and literacy	Illiteracy/low level of literacy, schooling unavailable
Z56 — Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, military deployment status, sexual harassment on the job
Z57 — Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, tobacco, toxic agents in agriculture, extreme temperature
Z59 — Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, extreme poverty, low income
Z60 — Problems related to social environment	Adjustment to lifestyle transition, problems living alone, acculturation difficulty, social exclusion and rejection
Z62 — Problems related to upbringing	Inadequate parental supervisions and control, parental overprotection, institutional upbringing
Z63 — Other problems related to primary support group, including family circumstances	Problems with spousal or other relationship, absence of a family member, alcoholism or drug addiction in family
Z64 — Problems related to certain psychosocial circumstances	Problems with unwanted pregnancy, problems related to multiparity, discord with counselors
Z65 — Problems related to other psychosocial circumstances	Conviction, imprisonment, victim of crime or terrorism

See attached for SDOH diagnosis code reference.

Resources

World Health Organization, About social determinants of health, found online at: **https://www.who.int/social_determinants/sdh_definition/en**.

ICD-10-CM Expert for Physicians, the complete official code set, Optum360, LLC. 2020.

NYE-NU-0210-20 April 2020

Article Attachments

SDOH diagnosis code reference.pdf
application/pdf - 91.12 KB

URL: https://providernews.empireblue.com/article/coding-spotlight-providers-guide-to-code-social-determinants-of-health

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Follow-Up After Hospitalization for Mental Illness

Published: Jun 1, 2020 - **State & Federal** / Medicaid

We understand providers are committed to providing our members with quality care, including follow-up appointments after a behavioral health (BH) inpatient stay. Since regular monitoring, follow-up appointments and making necessary treatment recommendations or changes are all part of quality care, we would like to provide an overview of the related HEDIS®/QARR measure.

The Follow-Up after Hospitalization for Mental Illness (FUH) HEDIS/QARR measure evaluates members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

This HEDIS/QARR measure looks at the percentage of BH inpatient discharges for which the member received follow-up within seven days days after discharge. The follow-up visit cannot occur on the day of discharge or it will not count.

On a regular basis, we continue to monitor if follow-up appointments are recommended and scheduled during the inpatient stay as part of discharge planning by the eligible BH facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as by practicing BH providers.

Please consider the following for improving member outcomes for this measure:

- Earliest follow-up with a BH provider can help with continuing treatment after leaving the hospital.
- With greater emphasis on care coordination, PCPs can help facilitate the BH follow-up appointments.

- Weekend discharges have shown to have very inconsistent follow-up appointments after discharge. Start discharge planning as soon as possible during inpatient stay so those who are discharged on weekends have already scheduled follow-up appointments.
- In addition, facilitate discussion of other social determinants of health (such as housing, food, living in a rural area, transportation, job schedules, family and social support, child care, etc.) which can influence follow-up opportunities. Please address these needs and issues during the behavior health inpatient stay.
- Social workers at the facilities can contact Member Services for Empire BlueCross BlueShield HealthPlus to learn if additional sources of assistance are available through case management or other referrals.
- Telehealth services may be considered as part of follow-up for this HEDIS/QARR measure if permitted in your state for BH follow-up and must be based on your clinical evaluation since this may not be the best choice of follow up for everyone.
    - However, it is also extremely important to note that telehealth services are subject to state and federal policies, coding and other requirements.
    - Please follow required guidelines and policies related to telehealth services specific to this measure.
- Our goal is continuity of care and treatment within seven days of inpatient BH discharge, followed by another visit within 30 days.

Please note this bulletin is for informational purposes only, as a resource for BH HEDIS/QARR follow up guidelines.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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URL: https://providernews.empireblue.com/article/follow-up-after-hospitalization-for-mental-illness-2

Complex Case Management program

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Managing illness can be a daunting task for our members. It is not always easy to

understand test results, how to obtain essential resources for treatment, or whom to contact with questions and concerns.

Empire BlueCross BlueShield HealthPlus (Empire) is available to offer assistance in these difficult moments with our **Complex Care Management program**. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals there to support members, families, primary care physicians and caregivers. The complex care management process uses the experience and expertise of the care coordination team to educate and empower our members by increasing self-management skills. The complex care management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Member Services number located on their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means at **www.empireblue.com/nymedicaiddoc**. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can contact us by phone at **1-800-450-8753**. Case Management business hours are Monday to Friday from 8:30 a.m. to 5:30 p.m.

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Members' Rights and Responsibilities Statement

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The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment participating practitioners and members in our system, Empire has adopted a *Members' Rights and Responsibilities Statement*, which is located within the provider manual.

If you need a physical copy of the statement, call Provider Services at 1-800-450-8753.

Important information about utilization management

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Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Our medical policies are available on our provider website at **https://www11.empireblue.com/ny_search.html.**

You can request a free copy of our UM criteria from Provider Services at **1-800-450-8753**. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the number listed below. To access UM criteria online, go to **https://www11.empireblue.com/ny_search.html.**

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 days a week to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests by:

- Faxing to **1-800-964-3627**
- Calling us at **1-800-450-8753**
- The Availity Portal at **https://www.availity.com***

Have questions about utilization decisions or the UM process?

Call our clinical team at **1-410-981-4050** Monday to Friday from 8:30 a.m. to 5:30 p.m. Eastern time.

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URL: https://providernews.empireblue.com/article/important-information-about-utilization-management-28

Keep up with Medicaid news

Published: Jun 1, 2020 - **State & Federal** / Medicaid

Please continue to check Medicaid Provider Communications & updates at www.empireblue.com/nymedicaiddoc for the latest Medicaid information, including:

- MCG care guidelines — 24th edition
- Medical Policies and Clinical Utilization Management Guidelines update

URL: https://providernews.empireblue.com/article/keep-up-with-medicaid-news-29

Introducing Interactive Care Reviewer - an online prior authorization tool

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On March 27, we introduced the Interactive Care Reviewer (ICR) — a self-service prior authorization (PA) tool that will improve the efficiency of your authorization process for Empire BlueCross members. ICR offers a streamlined process to request and check the status of medical and behavioral health inpatient and outpatient procedures. You can easily access ICR through the Availity Portal.*

What benefits/efficiencies does the ICR provide?

- You can determine if PA is needed. For most requests, when you enter patient, service and provider details, you will receive a message indicating whether review is required.

- You receive a comprehensive view of all your prior authorization requests. You have a complete view of all the utilization management requests you submitted online, including the status of your requests and specific views that provide case updates and a copy of associated letters.
- You will have inquiry capability. Ordering and servicing physicians and facilities can locate information on preauthorization requests for those with which they are affiliated; this includes requests previously submitted via phone, fax and ICR.
- You have the ability to request and check the status of clinical appeals. You can use ICR to request a clinical appeal for denied authorizations and access letters associated with the appeal.
- ICR reduces the need to fax. ICR allows text detail as well as images to be submitted along with the request.
- There is no additional cost to you. ICR is a no-cost solution that's easy to learn and even easier to use.

Follow these instructions to access ICR through the Availity Portal

First, ask your Availity administrator to grant you the appropriate role assignment.

Do you create and submit PA requests?
Required role assignment: *Authorization and Referral Request*

Do you check the status of the case or results of the authorization request?
Required role assignment: *Authorization and Referral Inquiry*

Once you have the authorization role assignment, log in to Availity with your unique user ID and password follow these steps.

1. Select **Patient Registration** from Availity's home page
2. Select **Authorizations & Referrals**
3. Select **Authorizations** (for requests) | Select **Auth/Referral Inquiry** (for inquiries)

Monthly ICR training

Register for one of our free webinars created to familiarize new users with ICR features and navigation. Registration link: **https://anthemincub.webex.com/anthemincub/onstage/g.php?PRID=aa5396352099172976c26a64eacbad6f**

***Availity is an independent company that provides a secure provider portal on behalf of Empire BlueCross.

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URL: https://providernews.empireblue.com/article/introducing-interactive-care-reviewer-an-online-prior-authorization-tool

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Empire working with Optum to collect medical records for risk adjustment

Published: Jun 1, 2020 - **State & Federal** / Medicare

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Empire will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Additional information, including an FAQ, will be available on the provider website under Important Medicare Advantage Updates.

* Optum and Ciox Health are independent companies providing medical record review services on behalf of Empire BlueCross BlueShield.

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URL: https://providernews.empireblue.com/article/empire-working-with-optum-to-collect-medical-records-for-risk-adjustment

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Diabetes HbA1c < 8 HEDIS guidance

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Diabetes is a complex chronic illness requiring ongoing patient monitoring. The National Committee for Quality Assurance (NCQA) includes diabetes in its HEDIS® measures on which providers are rating annually.

Since diabetes HbA1c testing is a key measure to assess for future medical conditions related to complications of undiagnosed diabetes, NCQA requires that health plans review claims for diabetes in patient health records. The findings contribute to health plan Star Ratings for commercial and Medicare plans and the Quality Rating System measurement for marketplace plans. A systematic sample of patient records is pulled annually as part of the HEDIS medical record review to assess for documentation.

Which HEDIS measures are diabetes measures?

The diabetes measures focus on members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following assessments:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (> 9%)
- HbA1c control (< 8%)
- Dilated retinal exam
- Medical attention for nephropathy

The American College of Physicians' guidelines for people with type 2 diabetes recommend the desired A1c blood sugar control levels remain between 7% to 8%.[1]

In order to meet the HEDIS measure *HbA1c control < 8*, providers must document the date the test was performed and the corresponding result. For this reason, report one of the four Category II codes and use the date of service as the date of the test, not the date of the reporting of the Category II code.

To report most recent hemoglobin A1c level greater than or equal to 8% and less than 9%, use 3052F. To report most recent A1c level less than or equal to 9%, use codes 3044F, 3051F and 3052F:[2]

1. If the most recent hemoglobin A1c (HbA1c) level is less than 7%, use 3044F.

2. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 7% and less than 8%, use 3051F.

3. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 8% and less than or equal to 9%, use 3052F.

Continued management and diverse pathways to care are essential in controlling blood glucose and reducing the risk of complications. While it is extremely beneficial for the patient to have continuous management, it also benefits our providers. As HEDIS rates increase, there is potential for the provider to earn maximum or additional revenue through Pay for Quality, Value-Based Services and other pay-for-performance models.[3]

Racial and ethnic disparities with diabetes

It is also important for providers to be aware of critical diabetes disparities that exist for diverse populations.

Compared to non-Hispanic whites:[4]

- African Americans, Hispanics, and American Indian/Alaska Natives have higher mortality rates from diabetes.
- African Americans and Hispanics have higher rates of complications from uncontrolled diabetes, including lower limb amputation and end-stage renal disease.
- More than half of Asian Americans and nearly half of Hispanic Americans with diabetes are undiagnosed.[5]
- Asian Americans are at risk for type 2 diabetes at a lower body mass index (BMI); therefore, diabetes screening at a BMI of 23 is recommended.[6]

Sources include:

- **Diabetes prevalence:**
  - 2015 State Diagnosed Diabetes Prevalence, **https://www.cdc.gov/diabetes/data**.
  - 2012 State Undiagnosed Diabetes Prevalence, Dall et al., “The Economic Burden of Elevated Blood Glucose Levels in 2012”, *Diabetes Care*, December 2014, vol. 37.
- **Diabetes incidence:**
  - 2015 State Diabetes Incidence Rates, **https://www.cdc.gov/diabetes/data**.

- **Cost:**
  - American Diabetes Association, “Economic Costs of Diabetes in the U.S. in 2017”, Diabetes Care, May 2018.
- **Research expenditures:**
  - 2017 National Institute of Diabetes and Digestive and Kidney Diseases funding, **https://projectreporter.nih.gov**.
  - 2017 CDC diabetes funding, **https://www.cdc.gov/fundingprofiles**.

[1] **https://www.medicalnewstoday.com/articles/321123#An-A1C-of-7-to-8-percent-is-recommended**
[2] **https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf**
[3] **https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html**
[4] Office of Minority Health. Minority Population Profiles: **https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlID=26**
[5] U.S. Department of Health and Human Services, National Institutes of Health. (2015, September 8), *More than half of Asian Americans with diabetes are undiagnosed*. Retrieved from **https://www.nih.gov/news-events/news-releases/more-half-asian-americans-diabetes-are-undiagnosed**.
[6] ADA; NCAPIP; AANHPI DC; Joslin Diabetes Center Asian American Diabetes Initiative. (2015, September). Screen at 23. Retrieved from **http://screenat23.org/wp-content/uploads/2015/10/Screenat23package-1.pdf**.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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URL: https://providernews.empireblue.com/article/diabetes-hba1c-8-hedis-guidance-1

2020 Medicare risk adjustment provider trainings

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The Medicare Risk Adjustment Regulatory Compliance team at Empire BlueCross BlueShield offers two provider training programs regarding Medicare risk adjustment and documentation guidelines. Information for each training is outlined below.

Medicare Risk Adjustment and Documentation Guidance (General)

When: Offered the first Wednesday of each month from 1 to 2 pm ET

Learning objective: This onboarding training will provide an overview of Medicare Risk Adjustment, including the Risk Adjustment Factor and the Hierarchical Condition Category (HCC) Model, with guidance on medical record documentation and coding.

Credits: This live activity, Medicare Risk Adjustment and Documentation Guidance, from January 8, 2020, to December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at **https://bit.ly/2z4A81e**.
**Note: Dates may be modified due to holiday scheduling.*

Medicare Risk Adjustment, Documentation and Coding Guidance (Condition specific)

Series: Offered on the third Wednesday of every other month at 12 to 1 pm ET

Learning objective: This is a collaborative learning event with Enhanced Personal Health Care (EPHC) to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.

Credits: This live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from January 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:

- Red Flag HCCs, part one: Training will cover HCCs most commonly reported in error as identified by CMS (chronic kidney disease stage 5, ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, end-stage liver disease) *{Recording will play upon registration.}*

- **https://bit.ly/3ae9znc**

- Red Flag HCCs, part two: Training will cover HCCs most commonly reported in error as identified by CMS (atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation) *{Recording will play upon registration.}*

- **https://bit.ly/3abKg52**

- Neoplasms (*recording link will be available later 2020.)*
- Acute, Chronic and Status Conditions (July 15, 2020)

- **https://bit.ly/2ygZfNR**

- Diabetes Mellitus and Other Metabolic Disorders (September 16, 2020)

- **https://bit.ly/2XQ9hjZ**

- TBD - This Medicare Risk Adjustment webinar will cover the critical topics and updates that surface during the year (November 18, 2020)

- **https://bit.ly/2xxjhUj**

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URL: https://providernews.empireblue.com/article/2020-medicare-risk-adjustment-provider-trainings-10

Keep up with Medicare news

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Please continue to check Important Medicare Advantage Updates at empireblue.com/medicareprovider for the latest Medicare Advantage information, including:

- MCG care guidelines — 24th edition

URL: https://providernews.empireblue.com/article/keep-up-with-medicare-news-134
