Provider Newsletter

https://providers.healthybluela.com

Healthy Blue

Medicaid Managed Care
Dual Advantage

June 2020

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COVID-19 information from Healthy Blue

Healthy Blue is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) and the Louisiana Department of Health (LDH) to help us determine what action is necessary on our part. Healthy Blue will continue to follow LDH guidance policies.

For additional information, reference the *COVID-19 News and Updates* section of our **website**.

BLAPEC-1682-20/BLACARE-0163-20

Medicaid

Members' Rights and Responsibilities Statement

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 to involve the health plan, participating practitioners and members in our system, Healthy Blue has adopted a *Members' Rights and Responsibilities Statement*, which you can locate within the provider manual.

If you need a physical copy of the statement, call us at **1-844-521-6942**.

BLA-NL-0210-20

MCG Care Guidelines — 24th edition

Effective August 1, 2020, Healthy Blue will upgrade to the 24th edition of MCG Care Guidelines for the following modules: Inpatient Surgical Care (ISC), General Recovery Care (GRC), Chronic Care (CC), Recovery Facility Care (RFC) and Behavioral Health Care (BHC). The tables highlight new guidelines and changes that may be considered more restrictive.

Read more online.

BLA-NL-0201-20

Healthy Blue

Acquisition of Beacon Health Options

We have completed acquisition of Beacon Health Options (Beacon),* a large behavioral health organization that serves more than 36 million people across the country. Bringing together our existing solid behavioral health business with Beacon's successful model and support services creates one of the most comprehensive behavioral health networks in the country. It's also an opportunity to offer best-in-class behavioral health capabilities and whole-person care solutions in new and meaningful ways to help people live their best lives.

From the standpoint of our customers and providers at this time, it's business as usual:

- Members should continue to call the customer service number on the back of their membership card or access their health plan's website for online self-service.
- Providers should continue to use the provider service contact information, websites and online self-service websites as part of their agreement with either Healthy Blue or Beacon.
- There will be no immediate changes to the way Healthy Blue or Beacon manage their respective provider networks, contracts and fee arrangements. Healthy Blue and Beacon provider networks, contracts and fee arrangements will remain separate at this time.

We know our providers continue to expect more of their health care partner, and at Healthy Blue, we aim to deliver more in return.

For more details, please see the press release (**https://ir.antheminc.com/news-releases/news-release-details/anthem-inc-completes-acquisition-beacon-health-options**); additional details will be shared in future communications.

** Anthem, Inc. completed its acquisition of Beacon Health Options (Beacon). Beacon will operate as a wholly owned subsidiary of Anthem. Healthy Blue is a partnership with a subsidiary of Anthem, Inc. to provide administrative services on behalf of Medicaid and Dual Advantage members.*

BLA-NL-0200-20

Healthy Blue

Modifier use reminders

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Healthy Blue 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.

Healthy Blue will publish additional articles on correct coding in provider communications.

BLA-NL-0199-20

New behavioral health discharge call-in line

We value the strong and collaborative relationships we have with the providers in our network. As we continuously work to improve our process, we have a new option for providers to communicate with us. Effective April 1, 2020, behavioral health providers have a new discharge call-in line.

What is the impact of this change?

If a member is discharging from inpatient or residential treatment, providers may send the discharge information via the call-in line at **1-833-385-9055**. The call-in line is staffed from 8 a.m. to 8 p.m. ET, Monday through Friday. If all representatives are on calls, or if it's a weekend, the confidential voicemail will be initiated, allowing providers to leave discharge information.

Providers can also continue to submit the information via fax or the **Availity Portal**.*

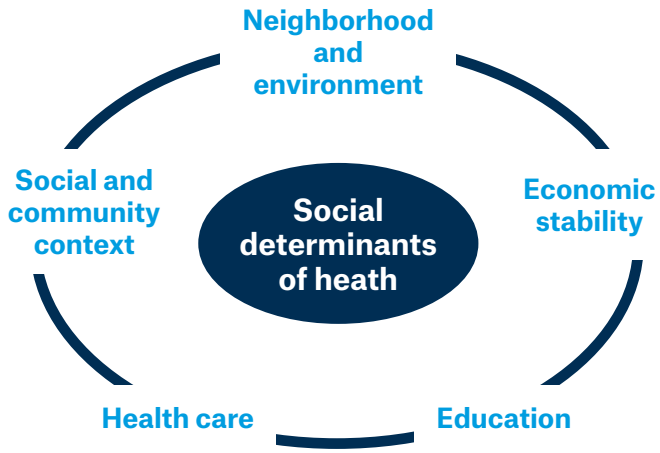
** Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.*

BLA-NL-0211-20

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

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.



Read more online.

BLA-NL-0205-20

Healthy Blue

Complex Case Management program

Managing illness can be a daunting task for our members. It is not always easy to understand test results, know how to obtain essential resources for treatment, or know whom to contact with questions and concerns.

Healthy Blue is available to offer assistance in these difficult moments with our Complex Case Management program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals here to support members, families, primary care physicians and caregivers. The complex case management process uses the experience and expertise of the Case Coordination team to educate and empower our members by increasing self-management skills. The complex case 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. 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 email at la1casemgmt@healthybluela.com or by phone at **1-844-521-6942,** available 24/7. Case Management business hours are Monday through Friday from 8 a.m. to 5 p.m.

BLA-NL-0208-20

Follow-Up After Hospitalization for Mental Illness

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® 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 BH inpatient discharges for which the member received follow-up within seven days after discharge.
- The percentage of BH inpatient discharges for which the member received follow-up within 30 days after discharge.

Read more online.

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

BLA-NL-0207-20

Healthy Blue

Important information about utilization management

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://providers.healthybluela.com/la/pages/medical-policies.aspx**.

You can request a free copy of our UM criteria from our Medical Management department. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the numbers listed below. To access UM criteria online, go to **https://providers.healthybluela.com/la/pages/medical-policies.aspx**.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 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:

- Calling us at **1-844-521-6942**.
- Faxing to **1-800-964-3627**.
- Visiting **https://www.availity.com**.*

Have questions about utilization decisions or the UM process?

Our clinical team is available 24/7 at **1-844-521-6942**.

Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

BLA-NL-0209-20

2020 affirmative statement concerning utilization management decisions

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.

BLA-NL-0204-20

Healthy Blue

Acquisition of Beacon Health Options

View the **article** in the Medicaid section.

BLA-NL-0200-20

Modifier use reminders

View the **article** in the Medicaid section.

BLA-NL-0199-20

New behavioral health discharge call-in line

View the **article** in the Medicaid section.

BLA-NL-0211-20

Medical drug *Clinical Criteria* updates

February 2020 update

On November 15, 2019, and February 21, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the Healthy Blue Dual Advantage (HMO D-SNP) medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the ***Clinical Criteria* web posting**.

BLACRNL-0015-20

The *Clinical Criteria* is publicly available on the provider website. Visit the ***Clinical Criteria* website** to search for specific policies.

For questions or additional information, use this **email**.

MCG Care Guidelines — 24th edition

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Read more online.

BLACRNL-0008-20

Healthy Blue

Multi-dose packaging

Healthy Blue wants to make multi-dose packaging available to your patients to help support medication adherence. It's a simpler, safer way for your patients to manage their medications. Multi-dose packaging is a free service available to members at select network pharmacies.

What is multi-dose packaging?

Multi-dose packaging (MDP) involves organizing prescription and over-the-counter products to provide ease to patients when taking their routine medications. Each MDP dispenser provides patients with a personalized roll of pre-sorted medication packs, labeled with the date and time of the patient's next scheduled dose. MDP helps reduce the stress of determining which medications to take, when to take them and how much of them to take.

Who provides these services?

MDPs can be shipped to the CVS* retail pharmacy of choice or directly to a patient's home at no additional charge. The MDP Care team is available 24/7 to address patient questions and concerns. The team also coordinates mid-month prescription changes with local CVS pharmacies. CVS MDP is licensed in all states and the District of Columbia.

If CVS isn't the right fit based on geography, PillPack* can provide MDP services for your patients. Packages can include prescription medication, over-the-counter medication and vitamins, and will include a date and time stamp on each packet to help your patients remember to take their medications. Patient copays should be the same; in some cases, it may be cheaper.

How do I refer my patients to MDP providers?

For CVS:

Patients can enroll online at **https://www.CVS.com/multidose** or call **1-800-753-0596**. Patients residing in the District of Columbia, Georgia or South Carolina should call **1-844-650-1637** (due to remote practice restrictions). Members may also enroll at their local CVS pharmacy.

For PillPack:

Patients interested in PillPack can enroll online at **https://www.pillpack.com/blue** or via phone by calling **1-866-282-9462.**

** CVS and PillPack are independent companies providing pharmacy services on behalf of Healthy Blue.*

BLACRNL-0010-20

Healthy Blue working with Optum to collect medical records for risk adjustment

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, Healthy Blue 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, is available by visiting the **provider website**, selecting **Healthy Blue Dual Advantage D-SNP**, scroll down to the *D-SNP News and Announcements* and select **2020**.

** Optum and Ciox Health are independent companies providing medical record review services on behalf of Healthy Blue.*

BLACRNL-0011-20

New specialty benefits program effective September 1, 2020

Healthy Blue Dual Advantage (HMO D-SNP) is always looking for ways to create value for all our stakeholders. With that in mind, we are pleased to announce a multisolution program beginning September 1, 2020. Effective August 15, 2020, Healthy Blue Dual Advantage will transition review of radiology, cardiology, sleep, musculoskeletal, rehabilitation, genetic testing, medical oncology and radiation oncology services for Healthy Blue Dual Advantage members to AIM Specialty Health® (AIM),* specialty benefits management company.

This relationship with AIM enables Healthy Blue Dual Advantage to ensure that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Healthy Blue Dual Advantage for medical necessity determination. Healthy Blue Dual Advantage makes coverage determinations based on guidance from CMS, including national coverage determinations, local coverage determinations, other coverage guidelines and instructions issued by CMS and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Healthy Blue Dual Advantage clinical guidelines *CG.REHAB.04, CG.REHAB.05 and CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed online at **https://bit.ly/3ca4yx5**.

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue.*

BLACRNL-0014-20

Healthy Blue

2020 Medicare risk adjustment provider trainings

The Medicare Risk Adjustment Regulatory Compliance team at Healthy Blue 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 p.m. to 2 p.m. 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, 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 **ttps://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 noon to 1 p.m. 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, 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, see the list of topics and 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**

BLACRNL-0012-20

Diabetes HbA1c < 8 HEDIS guidance

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.

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**

BLACRNL-0016-20

Policy Update — Medicaid

Present on Admission Indicator for Health Care Acquired Conditions

(Policy 12-001, effective 09/01/20)

In accordance with the *Deficit Reduction Act of 2005*, present on admission (POA) indicators are required for all inpatient discharges on or after October 1, 2007. The POA indicator is required for all primary and secondary diagnosis codes but is not required on the admitting diagnosis. Failure to include the POA indicator with the primary and secondary diagnosis codes may result in the claim being denied or rejected.

Currently under *Exhibit C: HealthCare-Acquired Condition Categories*, Healthy Blue has identified the following as part of the falls and trauma category:

- Fractures
- Dislocations
- Intracranial injuries
- Crushing injuries
- Burns

Effective 09/01/20, in addition to the POA indicator requirements, Healthy Blue requires additional days added to the length of an inpatient stay due to health-care acquired conditions to be reflected on *Type of Bill 0110* (no-pay claim).

Additionally, the falls and traumas category in *Exhibit C: HealthCare-Acquired Condition Categories* is defined as all injuries related to falls and trauma.

For additional information, please review the Present on Admission Indicator for Health Care Acquired Conditions reimbursement policy at **https://providers.healthybluela.com.**

BLA-NL-0177-19

Healthy Blue