Update

JANUARY 2018

BlueCross BlueShield Nebraska

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PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

The Update is a bimonthly provider newsletter that contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers. It also offers important details about BlueCard providers and the Federal Employee Program. It is published by the Health Network Services (HNS) Department and the Marketing Department.

If you are a contracting BCBSNE health care provider, this newsletter serves as an amendment to your agreement and affects your contractual relationship with us. You are encouraged to file every issue of the Update within your BCBSNE Policies and Procedures manual and reference it often. You may also view the current manual in the Provider section at **nebraskablue.com/providers**.

As a service for Blue Cross and Blue Shield members, we also make this newsletter available to nonparticipating Nebraska providers.

We also publish each issue online in the Provider section at: **nebraskablue.com/providers.**

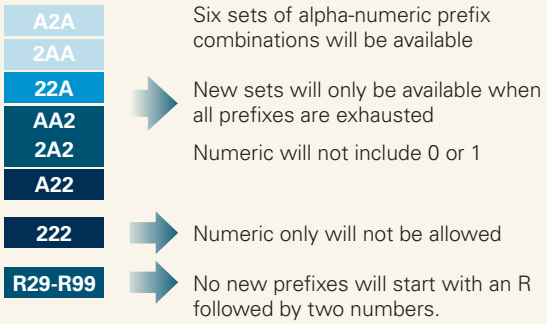
You may print a copy of this Update to file within your BCBSNE Policies and Procedures Manual. To request permission to reprint the material published in this Update for any other purpose, you must e-mail the editor, Brooke Ossenkop, at: **brooke.ossenkop@nebraskablue.com**

If you would like to receive an e-mail each time a new issue of this newsletter is posted on the website, go to **bit.ly/updatenewslettersignup**. You can view the newsletter and request online notifications of special announcements about workshops, resources and other information.

Alpha-Numeric Prefixes Coming in 2018

BCBSNE member ID numbers currently begin with a three-character alpha prefix. Beginning in 2018, we will introduce alpha-numeric prefixes to our member ID cards. The graphic is showing prefix combination options and guidelines.

Prefix Combinations



Please review all software programs you use and work with your vendors to ensure they all can facilitate ID numbers containing alpha-numeric prefixes. If you are confident your systems can process alpha-numeric prefixes, no further action is needed. If you have questions about the ability of your software or that of your vendors to process ID numbers which contain alpha-numeric prefixes, please work with your IT team and your vendors for resolution. If you have questions about a rejected claim, contact EDIsupport@nebraskablue.com

Diagnosing and treating testicular hypofunction:

When patients initially present for decreased libido or other sexual dysfunction concerns, the symptoms should be billed as the initial diagnosis until after testicular hypofunction and/or hypogonadism (ICD-10: E29.1) is verified utilizing the community standard testing processes. When testing testosterone levels, Serum Testosterone should be measured in the morning, ideally between 7-11 a.m. in the fasting state. If a single 7-1 a.m. value is low or borderline low, or does not fit with the clinical findings, the measurement should be repeated once or twice before making the diagnosis of testicular hypofunction. If the results are equivocal, measurement of free testosterone can be considered. In addition, the testosterone levels must be <300 ng/dl for replacement pursuant to Medical Policy x.66.

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NaviNet – What you need to know

When you access Clear Coverage through NaviNet, the Clear Coverage dropdowns are based on clinic/facility address. NaviNet only displays providers for the location(s) that a user has linked to their account. To add a location to the drop-down, you must contact NaviNet and request to add location. You will need to provide the Tax ID, NPI and address.

You can also use NaviNet to check eligibility for all members, including Bluecard members.

Contact NaviNet
888-482-8057

Mark your calendar!

BCBSNE is hosting our next Regional Provider Meeting in Omaha.

Wednesday, March 14, 2018

- Morning session 8-11 a.m.
- Afternoon session 1-4 p.m.

Register at **bcbsneprovidermeeting.eventbrite.com**

The topics that will be covered are:

- Networks overview (NEtwork Blue, Premier Select, BluePrint, Medicare Advantage)
- Subrogation / workers comp
- Medical policy, preauthorization, precertification
- NaviNet / EDI
- Credentialing
- Customer Service
- Refunds
- Billing 101 (self-service options – nebraskablue.com, NaviNet, IVR, etc., timely filing, corrected claims, reconsideration versus appeal, claim filing edits)*

Get your free ticket at **bcbsneprovidermeeting.eventbrite.com**. Additional Regional meetings will be offered in other locations throughout 2018.

*Topics are subject to change

Teleservices Policy

Effective January 1, 2018 BCBSNE has an updated policy for services covered and how to bill for Tele services. Please see the provider Policies and Procedures Manual for details. https://www.nebraskablue.com/providers/policies-and-procedures/manual

When submitting the Reconsideration/ Appeal form, do you know which box to check?

Please remember when submitting the Appeal/Reconsideration Request form that checking the wrong box or checking both boxes **will** result in a delay in the handling of your request.

RECONSIDERATIONS
Check this box to request BCBSNE review a claim with additional information/documentation that was not previously provided.

A RECONSIDERATION request is most commonly submitted for:

- Timely filing denials
- Coordination of Benefits denials or conflicts
- Worker's Compensation denials
- Medical documentation to support coding denial, such as the use of modifiers -25 or -59
- Pricing issues

APPEAL
To request that BCBSNE review a claim with a disposition that the member or provider disagrees with based on the information already provided.

An APPEAL request is submitted for:

- Medical necessity denials
- Investigational denials
- Experimental denials
- Medical policy denials

Additional information on filing the Appeal/Reconsideration Request form can be found in the **Policies and Procedures Manual**.

FEP benefit change

Effective Jan. 1, 2018, benefits are available for up to 30 days of inpatient skilled nursing facility (SNF) care per benefit year. This benefit is available for FEP Standard Option members who are not enrolled in Medicare part A.

The following criteria must be met:

- Precertification must be obtained prior to admission (including overseas).
- The member must be enrolled in case management (CM) and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the hospital discharge planning staff collaborate with the Plan case manager. It will also necessitate the hospital case manager/discharge planner's assistance in delivering the consent to the member and having it returned to the Plan after the member/proxy signs the document.
- The transferring facility must submit a detailed description of the patient's clinical status and the proposed treatment plan for the Plan's review of the proposed admission.
- Once the member is admitted and within the timeframes established by the Plan, the SNF representative must provide specific information regarding the patient's status, progress toward goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the member from achieving the goals.
- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the patient's admission. Patients admitted on a ventilator must be seen by a pulmonologist within 12 hours of admission, and respiratory therapy must be available in the facility 24 hours/day.
- Members admitted for rehabilitation must receive an evaluation by a physical therapist, and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least two hours of physical and occupational therapy combined at least five days per week (logs must be provided to the Plan to document therapy time).

The new FEP UM Guideline 002 Inpatient Skilled Nursing Facility Services will be added to the FEP Medical Policy Manual. You can access the new coverage information at **www.fepblue.org**. Click on Benefit Plans, Brochures and Forms, Plan Brochures and then the PDF document to the right of the page.

If you have further questions you can contact FEP Member Services at 800-223-5584.

Please don't bill CPT D0290 for Dental Procedures

Dental code D0290 was termed effective 12-31-16. We did not terminate the code in our processing systems prior to the creation of the 2017/2018 fee schedule. Therefore, when the fee schedules were created, a rate was published for this code. It should not have been on the schedule as it is termed and was not reinstated.

Mobile Enhanced Maternity Care Program

At Blue Cross and Blue Shield of Nebraska (BCBSNE), helping patients achieve healthier outcomes is our number one goal. To achieve this goal, we have collaborated with Wellframe to offer a maternity mobile app as part of our free maternity care program

The program and the app give your patients extra pregnancy support, access to education, ability to track important reminders and chat with a nurse. The app is designed to help guide your patients through potential challenges between office visits and adhere to prescribed regimens. The app is designed to:

- Help foster a better maternal health experience and the likelihood of a healthy, term delivery
- Educate expectant mothers from the first trimester through postpartum in order to keep expectant mothers healthy and decrease pregnancy and neonatal risks
- Encourage healthier outcomes for mothers and babies through customized support, tools and educational content

The Maternity Care program is offered to BCBSNE members at no cost. To learn more about the Maternity Care program and mobile app or request a demo, call 844-201-1546 or download the brochure at **nebraskablue.com/providers/care-management/maternity-management.**

Have you heard about our Gold Card Provider Program?

The Gold Card Provider program was implemented in early 2016 and was designed to help remove some of the administrative responsibility around the prior authorization process. BCBSNE offers this program to physicians and mid-level providers who meet pre-determined denial metrics when submitting prior authorizations. This program applies to the designated procedures listed below.

Benefits of being a Gold Card provider are:

- no requirement to go through medical review for pre-designated procedures
- provider receives automatic approval once the Gold Card Authorization form is submitted with the patient demographic information
- dramatic decrease to the administrative burden when providing care to our members
- proven to have high provider satisfaction

Designated procedures include:

- Sinus surgeries
- Hysterectomies
- Pain management
- Spinal surgeries

BCBSNE is reviewing additional procedures to expand the scope and provider pool.

How to Qualify:

To qualify as a Gold Card Provider, you must maintain an overall preauthorization denial rate of less than 6%. There is no application needed for this program. Our medical review team will review prior authorizations for the services listed left for the previous 9-12 months. Once it is determined you qualify for the program you will be notified and advised how to move forward with the program.

Gold Card Provider status is re-evaluated every 9 to 12 months with an audit of the provider's medical records for the designated procedures. To maintain their status in the program the provider must maintain a denial rate of less than 6%.

We have established a process through a secure electronic portal that allows us to notify any qualifying provider of the periodic audit. The notification will also include a list of records being requested and instructions of how to submit them through the secure portal. This process safeguards the security of the medical records and eliminates the need for our staff to conduct the audit in your office.

We have had great success with the program so far. All audited physician have requalified for the Gold Card Program and have been approved for an additional 12 months.

If you would like more information about the Gold Card Program, please reach out to your Provider Relationship Manager. To find who your Provider Relationship Manager is view the PRM map at nebraskablue.com/providers/contacts-for-providers.

Changes to prior authorization requirements for Medicare Advantage beginning 4/1/18

Effective 4/1/18, prior authorizations for Medicare Advantage members will be required for the following services:

- Durable Medical Equipment (DME) >$500
- Genetic Testing
- Services deemed investigational
- Spinal Fusion and Pain Management Injections
- High Tech Radiology (MRI, CT, PET etc.)
- Intensity-Modulated Radiation Therapy and Stereotactic Body Radiation Therapy

This is in addition to the prior authorization requirements that are already in place for Acute Hospital Admissions, 14–Day Bundling for Readmissions, Post–Acute Admissions and Part B Medication.

Note: This is for Medicare Advantage only. Medical policy details will be provided at a later date.

For additional benefit information please contact 1-888-505-2022, or for pre-notifications contact 1-877-399-1671.

REMINDER

Medicare Advantage has its own Update newsletter, published on opposite months of this Update.

View newsletter - **https://www.nebraskablue.com/providers/alerts-and-newsletters/medicare-advantage-newsletter**