Update

MARCH 2018

BlueCross BlueShield Nebraska

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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 email the editor, Brooke Ossenkop, at: **brooke.ossenkop@nebraskablue.com**

If you would like to receive an email 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 from BCBSNE.

Steve Grandfield selected as the next President and CEO of Blue Cross and Blue Shield of Nebraska

Blue Cross and Blue Shield of Nebraska's (BCBSNE) board of directors announced in January that Steven H. Grandfield will replace Steven S. Martin as the company's president and chief executive officer in late March of this year. Martin will be retiring at the end of 2018 after a 16-year tenure leading the company.

Grandfield currently serves as executive vice president of strategy, innovation, talent, sales and marketing, and is also president of Genesys Innovations LLC, the company's growth subsidiary.

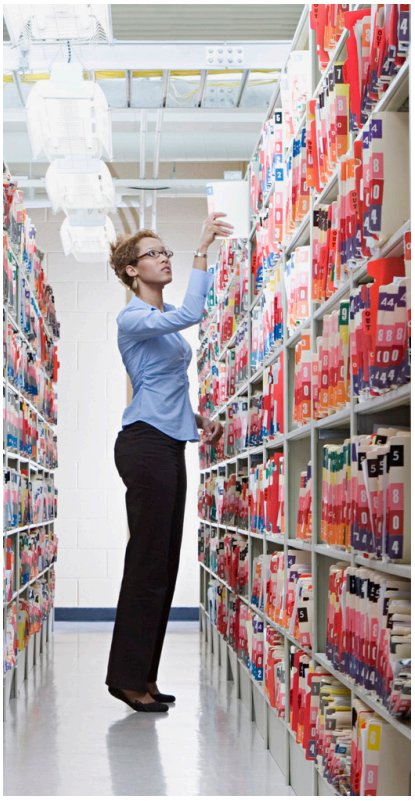
To view the full news release, please visit our online newsroom.

12th annual National Walk at Lunch Day with BCBSNE

Each year, BCBSNE promotes National Walk at Lunch Day, encouraging Nebraskans to walk over their lunch hour for just thirty minutes. For every group registration, $20 is donated to the Special Olympics and for every individual registration, $1 is donated.

Join us to celebrate National Walk at Lunch Day on Wednesday, April 25. Please share with your patients and staff to promote health and wellness. You can register at nebraskablue.com/walk.

In this issue ➜ Click on the headline to jump to the article.



Risk adjustment medical record retrieval

BSBSNE is working with CIOX Health to support our efforts in retrieving medical records related to a risk adjustment chart review. Risk adjustment is the payment methodology used by the Centers for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS) for Medicare Advantage policies.

The goal of the retrieval and review is to ensure proper documentation and coding of medical conditions. CIOX Health, the single largest release of information partner, is a HIPAA-compliant company and will begin requesting these records shortly. In order to ensure complete documentation of our members' health conditions and to improve coordination of care, it is necessary to perform ongoing risk adjustment chart reviews. Per your contract with BCBSNE, health care professionals and facilities agree to submit medical records requested in a timely manner at no cost to the covered person or to BCBSNE.

Covered persons have consented to release medical records to us. An additional release is not required. All information resulting from the review is confidential.

For questions, please contact Provider Solutions at **ProviderSolutions@nebraskablue.com** or call **402-392-4131**

Provider Relationship Manager (PRM) at **800-821-1487**

Blue Distinction program for 2019 includes fertility care

The Blue Distinction Specialty Care program is expanding to include fertility care in 2019.

In vitro fertilization (IVF) is the most common assisted reproductive technology (ART) treatment and is widely becoming the preferred option for fertility treatment. The fertility care program is a voluntary program that will designate individual physicians, practices and clinics performing IVF that meet national quality and cost criteria. Similar to the other Blue Distinction Specialty Care programs, program selection criteria for the fertility care program will be based on quality, business (network status, other criteria specified by local plan) and cost of care components and will offer two levels of designation:

- **Blue Distinction Center:** Health care providers recognized for their expertise in delivering specialty care.
- **Blue Distinction Center+:** Health care providers recognized for their expertise and cost efficiency in delivering specialty care.

Additional information, including eligible physicians, practices and clinics, will be available in fourth quarter of 2018.

NOTE: This does not mean fertility benefits are a covered service. Please verify member benefits prior to providing services.

Retraction from January 2018 newsletter

In the last newsletter edition, we provided information about preauthorization requirements for Medicare Advantage beginning 4/1/18. Since the time the January edition was posted we have made a decision **NOT** to move forward with the listed requirements, at this time. The changes in the article **will not go into effect 4/1/18**. Should we decide to add these, or other preauthorization requirements, all Medicare Advantage providers will be notified.

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

2016 RADV audit results

CMS conducts the Risk Adjustment Data Validation audit annually to verify that diagnoses submitted on members' claims are accurate and supported by medical record documentation. For the 2016 RADV audit, we had achieved a 93% medical record documentation retrieval rate. Thank you for your timely response and attention to this important matter.

To make the 2017 audit go even more smoothly, we have compiled a list of tips for you to consider:

1. Entries require a provider's signature, credentials and the date of service. This prevents the need for an attestation to be completed.
2. Common errors found on the CMS audit:
   a. For diagnoses that are no longer active and, "History of" diagnoses should be used for the following:
      i. Myocardial Infarction
      ii. CVA/ Stroke
      iii. Deep Vein Thrombosis or Pulmonary Emboli
      iv. Cancer
   b. Diagnoses that are active, but not submitted on the claim:
      i. Asthma or COPD
      ii. Diabetes
3. Ensure medical records support all diagnoses coded for the date of service submitted.

Our goal is to have consistent and complete medical record documentation. Without it, accurate coding cannot be achieved and audit findings cannot be validated. Accurate documentation and coding will limit the number of medical record requests, saving your staff time.

Submitting late charges and replacement claims; voiding or canceling a claim

When you are submitting a replacement or corrected claim, or need to void a claim, please make sure that you are also submitting the correct type of bill.

Claims Status	Bill Type	
Late Charges Only	XX5	Use this code for submitting charges to the payer, which were received by the provider after the Admit Through Discharge, or the Last Interim Claim has been submitted.
Replacement of Prior Claim	XX7	The original claim has errors such as missing charges, or incorrect diagnosis or CPT codes. This indicates something that has changed on the claim that needs to be taken into consideration.
Void/Cancel of Prior Claim	XX8	The claim was submitted in error and needs to be removed. This should be used when a claim was submitted with the incorrect patient or ID #. A new claim (bill type XX1) will need to be submitted with the correct information.

Note: Claims submitted with a corrected type of bill with no identifiable changes to the original claim indicated will be returned with an accompanying return letter.

If you want to dispute how the original claim processed, but no changes are needed to the claim, please submit a Reconsideration or Appeal request.

FEP Skilled Nursing Facility benefit clarification

On Jan 1, 2018, FEP Skilled Nursing Facility (SNF) benefits were expanded to include all Standard Option members. FEP has recently clarified SNF benefits for members with Medicare secondary coverage, as described below.

• When Medicare Part A is not the primary payor

When Medicare Part A is not a member's primary payor (including members with Medicare secondary coverage), FEP covers SNF inpatient care for a maximum of 30 days annually; when the member can be expected to benefit from short-term SNF services with a goal of returning home.

The following criteria must be met:

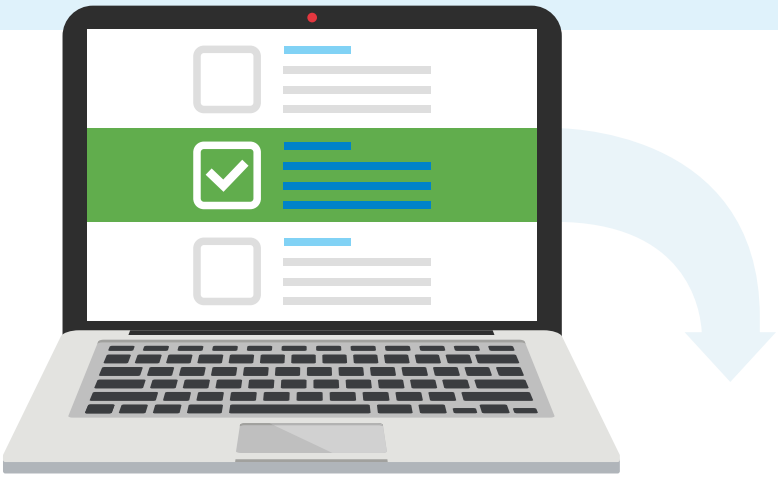
- Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF.
- Precertification is obtained prior to admission (including overseas care).
- The payor must approve the preliminary treatment plan prior to admission (the treatment plan must include proposed therapies and document the need for inpatient care).
- Member participates in all treatment and care planning activities, including discharge planning/transition to home.

• When Medicare Part A is the primary payor

FEP Standard Option provides limited secondary benefits when Medicare Part A has made a payment as the primary payor. When Medicare Part A is the primary payor, the above-stated criteria (for case management, precertification, etc.) do not apply.

Change of address reminder!

Remember that if you are planning to transition to a new practicing location or change your billing information, you are required to notify BCBSNE. Help us get any information we may need to mail to you correctly and in a timely manner. More information can be found in the provider manual under "Changes of address, telephone number, tax identification number or adding practice locations."



Best practices for reconsiderations/ appeal requests, preauthorizations and benefit return letters

Requesting a reconsideration or appeal:

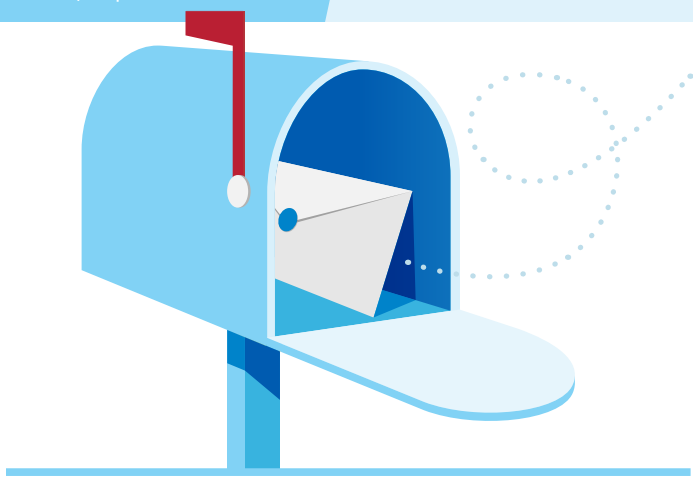
- It is important to include the reconsideration/appeal form and either check the recon box or appeal box—do **NOT** check both

Preauthorizations:

- We have a new online Preauthorization Request Form, under Utilization Management, that now includes a definition of "Urgent" and a box to indicate that.
- Prioritization:
  - Preauthorizations are **NOT** prioritized based on the anticipated date of service
  - Non-urgent requests have a review allowance of 15 calendar days, so please take this into consideration when scheduling your patient's appointment.
  - If the patient meets urgent criteria our review allowance is up to 72 hours.

Benefit Return letters:

- The Benefits Return letter (from the Claims Department) has an "action requested" box that will indicate what information is missing or incorrect in order to process the claim.
- When you receive a benefit return letter, you **MUST** submit the claim again, as a **NEW** claim (bill type XX1).
  - You cannot just submit the return letter with the missing or corrected information noted on it.
  - If you only submit back the return letter without the actual claim form, these will not be accepted and will be returned back to their office and delay the processing of the claim.
- If you have additional medical information or additional attachments that you want to provide, place those attachments behind the actual claim form, and send back to BCBSNE.



Best practices when submitting medical records

By following these guidelines, you will avoid any unnecessary delays for your request:

- When faxing or mailing in medical records to BCBSNE, you **MUST** include the BCBSNE letter that we sent to you requesting these records, or the records will be returned back to you for that information.
- Please do not submit unsolicited/non-requested medical records to BCBSNE.
- When faxing medical records to BCBSNE, please send medical records for one patient per fax. Do not include multiple patients on the faxes.

Mid-level reimbursement REMINDER

All mid-level providers must bill under their own NPI for services rendered. BCBSNE applies a 15% differential to the applicable physician fee schedule for covered services performed or provided by physician assistants (PAs), nurse practitioners (NPs), advanced practice registered nurses (APRNs) and certified nurse midwives (CNMWs).

All mid-level providers are expected to bill under their own NPI for services rendered and not under the physician NPI.

Note: In certain situations, health care services performed by a duly licensed APRN may be submitted as a professional claim. For more information about submitting claims for health care services performed by a duly licensed APRN, please check "Mid-level Providers" in the Policy and Procedures manual.

Reimbursement for medical records REMINDER

We have been receiving an increasing number of invoices billing us for medical records. Your agreement with BCBSNE states that you must submit requested medical records and at no charge to BCBSNE or our member. It is also stated in the Policies and Procedures manual that all information resulting from the review of the medical records is kept confidential.

We understand that many providers use billing companies, so please take this opportunity to remind them of this requirement as well.