Update
SEPTEMBER 2018

BlueCross BlueShield Nebraska

PARTNERING WITH YOU FOR A HEALTHIER 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) and Communications Departments.

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.**

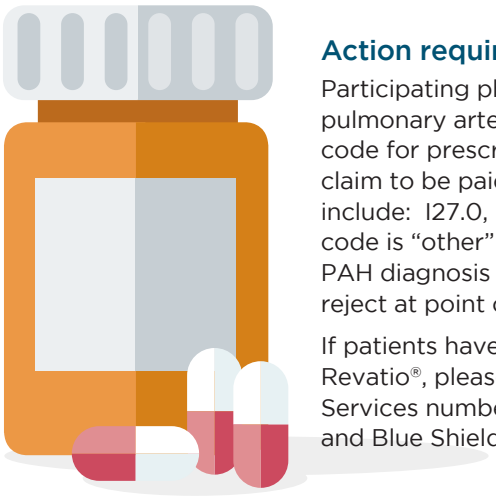
You may print a copy of this Update to file within your BCBSNE Policies and Procedures Manual. To request permission to reprint the material published in this Update for any other purpose, you must email the editor, Michelle Tanga, at: **michelle.tanga@nebraskablue.com**

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.

What's New

Pharmacy — Sildenafil

Beginning Oct. 1, 2018, a diagnosis code will be required for prescriptions for Revatio® (Sildenafil 20mg) to document appropriate use.



Action required:

Participating pharmacies must submit an acceptable pulmonary arterial hypertension (PAH) diagnosis code for prescriptions for Revatio in order for the claim to be paid. Acceptable PAH diagnosis codes include: I27.0, I27.20, I27.21, I27.29. If the diagnosis code is "other" and/or does not match a covered PAH diagnosis code for the drug, the claim with reject at point of sale (POS).

If patients have questions regarding coverage of Revatio®, please instruct them to call the Member Services number on the back of their Blue Cross and Blue Shield of Nebraska (BCBSNE) ID card.

Reimbursement policies

The Billing and Reimbursement policies and procedures manual was updated to reflect two new reimbursement policies, Section 5, Drug Reimbursement Policy and Section 6, Inclusive Billing Policy. The updated version of the manual was posted Aug. 10, 2018. Both policies are effective Oct. 15, 2018. Please make sure to review these policies prior to the effective date.

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

Pharmacy – Sildenafil	1
Reimbursement policies	1
Colorectal cancer screenings	2
Mark your calendars – Fall provider conference	2
Preauthorization requests	3
Chiropractors and physical therapy – maintenance therapy	3
Medical record submissions	4
Risk adjustment medical record retrieval	4

Colorectal cancer screenings

With medical advancements in prevention, early detection and treatment, more patients can count themselves as survivors of colorectal cancer every year. Despite the decline in mortality from colorectal cancer, it is estimated that only about one-third of the eligible population in the United States receives colorectal cancer screening. Blue Cross and Blue Shield of Nebraska is challenging our providers to help close this gap in colorectal cancer screening and save more patient lives through evaluation of the clinic's current policy, procedures and management of the patients eligible for the preventive intervention.

HEDIS® measure description

The colorectal cancer screening quality measure evaluates the percentage of adults age 50-75 years who get the appropriate screening for colorectal cancer. It excludes patients with a history of colorectal cancer, a total colectomy or those in hospice.

HELPING PATIENTS GET PROTECTED FROM THE UNEXPECTED

Improving quality of care

- Develop a colorectal cancer screening policy
- Implement a protocol for colorectal cancer screening
- Use patient and provider reminders for due and overdue colorectal cancer screenings
- Track test results and follow up on positive results or missed appointments
- Identify and manage the population through a colorectal cancer screening patient registry
- Offer all acceptable colorectal cancer screening options to enable a shared and individualized decision on the appropriate screening for each patient (COL conversation cards)

Appropriate screening for colorectal cancer

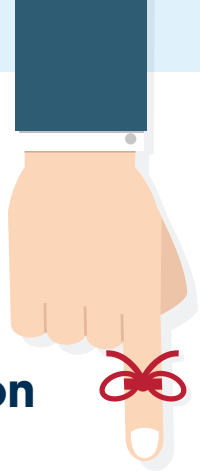
TEST	INTERVAL
Screening colonoscopy	Every 10 years
Screening flexible sigmoidoscopy	Every 5 years
Screening CT colonography	Every 5 years
FIT DNA (i.e. Cologuard®)	Every 3 years
Fecal occult blood test (FOBT)	Every year

Mark your calendars

BCBSNE is hosting the last provider conference of the year

Wednesday, October 10, 2018
8:30 a.m. - 12:30 p.m.
Embassy Suites, Omaha/LaVista
12520 Westport Parkway
La Vista, NE 68128

REGISTER HERE!



Reminders

Preauthorization requests

We typically see an increase in the number of claims we receive in the last three months of the year. Many members who have met their calendar year deductible want to get needed procedures performed before the end of the year so they have lower out-of-pocket costs. Some of those procedures will require you to submit preauthorizations. Here are a few tips for submitting preauthorizations to streamline the process during this high volume time of year:

- Verify if there is a medical policy for the procedure/service by going to: **medicalpolicy.nebraskablue.com**
  - If there is a medical policy for the procedure, it will indicate if a preauthorization is needed
  - The preauthorization may be submitted to us directly from the medical policy tool
  - When using the medical policy tool, make sure you are registered and log in to ensure we have your most updated contact information
- Verify if the procedure/service requires preauthorization through the "Prior Authorization List" on nebraskablue.com
- Verify eligibility and benefits using your online tools (Contact Us/NaviNet), or by calling the number on the back of the member's ID card
- Attach supporting documentation of medical necessity to the preauthorization
- Submit the preauthorization at least 15 days prior to the scheduled procedure
  - Preauthorizations are NOT prioritized based on the anticipated date of service.
  - Only mark a preauthorization as urgent if it meets urgent criteria as defined by the Department of Labor and Insurance, summarized below.
  - Urgent criteria is defined as: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations:
    - Could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function OR
    - In the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care of treatment that is the subject of the case.
    - If waiting up to 15 days for the preauthorization review to be completed could cause either of the above situations, it would be considered urgent.

Chiropractors and physical therapy — maintenance therapy

BCBSNE and SecureCare wish to remind Chiropractors and Physical Therapists that preventative and maintenance therapies are considered not medically necessary and are also non-covered services in several member contracts. (Note: FEP member's contracts may have different benefit elections from other plans.)

In accordance with BCBSNE's General Policies and Procedures Manual, Section 6: Member Benefits/ Responsibility and Cost-Share Information, subsection Therapy, "maintenance therapy conducted by Chiropractors or Physical Therapists is not considered to be medically necessary, and is therefore not payable," even if the member has not reached their maximum number of covered therapy sessions per calendar year.

BCBSNE and SecureCare urge Chiropractors and Physical Therapists to request that members sign an Advanced Beneficiary Notice (ABN) for preventative/maintenance therapy. In addition, providers can use Healthcare Common Procedure Coding System (HCPCS) code A9270 to bill for non-covered items and items that do not meet the definition of a medical benefit. If the claim is not filed in a timely manner, then it will be provider liability (even when an ABN has been signed).

Please note, providers are still to file claims on behalf of BCBSNE members; however, the members should not expect BCBSNE to pay for these services. Per the BCBSNE General Policies and Procedures Manual, if a BCBSNE member requests a claim be filed for a non-covered service, the provider must file the claim, whether it is for a covered benefit or not.

For additional education, please refer to BCBSNE's Library for Policies and Procedures, Medical Policy, newsletters and other provider resources at **nebraskablue.com/providers**

Medical record submissions

When you receive a letter from BCBSNE requesting medical records, please include a copy of that letter along with the information we requested. This is critical to ensure the medical records get to the appropriate team. Medical records sent to us without the original request will be returned to you.

If you are faxing or mailing the medical records, please make sure our initial letter is **attached to the front** of the request.

Make sure you only submit one patient per fax.

Risk adjustment medical record retrieval

BCBSNE 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 and Affordable Care Act (ACA) policies based on the health status of the member. 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 the NEtwork BLUE contract, health care professionals and facilities agree to submit medical records requested by BCBSNE in a timely manner at no cost to the covered person or to BCBSNE.

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

Please contact Provider Solutions at:

- providersolutions@nebraskablue.com
- call **800-821-4787** for your Provider Relationship Manager
- or fax Provider Solutions at **402-392-4131**

To find your PRM, please click here:

- nebraskablue.com/providers/contacts-for-providers and click "provider relationship manager map."

REMINDER

Medicare Advantage has it's own Update newsletter published on opposite months of this Update.
To access the Medicare Advantage newsletter CLICK HERE.