Update

MAY 2019

BlueCross BlueShield Nebraska

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

nebraskablue.com/providers

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, Loraine Miller, at: **loraine.miller@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 nebraskablue.com/update. You can view the newsletter and request online notifications of special announcements about workshops, resources and other information from BCBSNE.

What's New

A special announcement to our providers

BCBSNE values you and your staff. We also appreciate your ongoing efforts to provide care and answers to your patients, who are also our customers. We recognize the need to improve your service experience with us.

That's why we are pleased to announce our Customer Service team began taking provider calls once again on Wednesday, April 3, 2019. You may contact us for any claim, reconsideration or appeal items you have not been able to resolve via self-service. We understand your need for interaction with our team and the value this brings. We look forward to helping you.

Provider Customer Service hours

7:30 a.m. - 5 p.m. CT
Monday - Friday
800-635-0579

In order to give the best service possible to all our providers and minimize wait times, up to 20 ID numbers may be taken per call.

Self-service information, including the Interactive Voice Response (IVR) and other provider resources, are available at www.nebraskablue.com/providers. In addition to the above, online inquiries to Customer Service may be submitted any time at www.nebraskablue.com/Providers/Eligibility-and-Claims under 'Check Claims Status'. Our standard response time is three business days.

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Provider service improvements

In response to your feedback, we have made the following enhancements to improve your service experience with us:

Online inquiries to Customer Service

- **Faster response time**
  Beginning in mid-December 2018, we implemented an improved response time, from five business days to three business days.
- **Ability to reply to our email**
  When we send an email response to your inquiry, you may now reply to our email with any follow-up questions.

  Email replies from us now come from provider-inquiry@nebraskablue.com; the replies previously came from web.csc@nebraskablue.com. To ensure you receive our emails, please add providerinquiry@nebraskablue.com to your address book or safe sender list.

Appeal and reconsideration status

- **Status of appeals and reconsiderations received after July 1, 2018, are now available by calling our interactive voice response (IVR) phone system**
  To check the status, call 800-635-0579, choose the medical claims option and enter the date of service in question. The resulting claim detail will include any appeals or reconsiderations in process.

  Note: Appeal status information is only available on our IVR system for BCBSNE members. BCBSNE does not make decisions on appeals related to medical policy, preauthorization guidelines, benefit maximums or noncovered services for patients who are members of other Blue Cross and Blue Shield plans. For this information, please submit an online inquiry by selecting "Inquire About a Claim" at www.nebraskablue.com/contact.
- **Check on the status 30 days sooner**
  Beginning 30 days after submission of an appeal or reconsideration, you may submit questions to our Customer Service department by selecting "Inquire About a Claim" at https://www.nebraskablue.com/Providers/Eligibility-and-Claims. You no longer need to wait 60 days after submission to check the status of an appeal or reconsideration; this matches our regular claim inquiry timeframe, which is 30 days from submission.

Returned claims

- **Details now available on our IVR system**
  Previously, information regarding when and why a claim was returned was only provided via a letter from us. You may now also access this information by calling our IVR phone system at 800-635-0579. Returned claim information will continue to be mailed to you, and you may ask, through IVR, that a duplicate letter be mailed to you.

MORE INFORMATION ON HOW TO CHECK ON THE STATUS OF A CLAIM

- **For more information, please review our NEW! Provider Caller Guide at www.nebraskablue.com/providers/check-claim-status**

COMING SUMMER 2019

NICU Levels of Care

BCBSNE will begin issuing levels of care for NICU admissions in the summer of 2019. We want to ensure we are reimbursing for the appropriate levels of care based on information from concurrent utilization review. This will bring BCBSNE in line with industry standards for NICU management. Utilization review will be done locally by BCBSNE utilization review nurses, case managers and medical directors using standard utilization review. The exact date of the start of the NICU leveling program will be announced in a future provider newsletter.

We know you share our goal of providing high quality care that improves patient outcomes. As we get closer to the start date, we will provide more details and contact information.

$25 cost differential required to adjust/reconsider claims

Effective June 1, 2019, when providers incur a supply cost above the contracted amount, there must be at least a $25 differential per claim in order for us to adjust/reconsider it.

We will reprocess any claim that is overpaid or underpaid according to the contract. There is no charge for submitting reconsiderations.

FOR EXAMPLE:

If the difference in supply cost is $25 or more per claim, please send us the invoice showing the cost difference.

If the difference in supply cost is less than $25 per claim, the threshold would apply, and a reconsideration would not be made.

Change in appeal and reconsideration forms

You asked for it and we listened! To help lessen confusion about our appeal and reconsideration form, we have replaced it with two separate forms – one for appeals only and one for reconsiderations only.

Please note: Appeal requests must be sent to us within six months from the initial denial of benefits.

Please start using the new forms now. They are located at www.nebraskablue.com/Providers/Find-a-Form. Continuing to use the previous forms could result in a delay in handling your request.

Please note that there are no fees associated with using the old forms. We apologize for any confusion this may have caused.

Featured

Taxonomy code requirement

Did you know?

When submitting a HCFA, it is important to have the correct provider taxonomy on the claim in order for it to process. Please see Claims FAQs on our website.

What is provider taxonomy?

Provider taxonomy is a set of 10 alphanumeric characters that define specific specialty categories for providers (individual, group or institution). There are different levels defined in the code set, including Provider Grouping, Classification and Area of Specialization. Providers may identify under more than one code set.

How does this affect you?

Please ensure you are submitting the correct taxonomy associated with providers. This information is needed for credentialing, delegated updates and claims processing. It is important that the taxonomy matches the Board Certification and Subspecialty (if applicable). If the appropriate information is not submitted, there will be a delay in validating providers and adding them to our system, as well as in processing claims.

Board Certification	Subspecialty	Taxonomy
Internal Medicine	Sports Medicine	207RS0010X

Taxonomy resource

An excellent source for more information on taxonomy is www.nucc.org.

Patient engagement: The catalyst to better patient outcomes

Patient-centered care is a powerful means to achieve better patient experience, improve health outcomes, and reduce the cost of care. By identifying and integrating patient engagement strategies within your clinical practice you can improve patient participation and satisfaction. Two techniques that can be used to facilitate patient engagement are shared decision making and motivational interviewing.

Consideration of the patient's preferences, perceptions and readiness is a core element when providing patient-centered care[1]. Integrating shared decision making and motivational interviewing within clinical practice can improve patient participation and satisfaction with their health care needs and outcomes.

Please consider using some of these online resources to help with implementation of patient engagement initiatives within your clinical practice:

Shared Decision Making:

- Blue Cross and Blue Shield of Nebraska: Colorectal Cancer Screening Decision Aid
- The Ottawa Hospital Research Institute: Decision Aids
- Mayo Clinic: Decision Aids

Motivational Interviewing:

Strategies to understanding MI

- Center for Integrated Healthcare: Motivational Interviewing for Health Behavior Change
- Center for Evidenced Based Practices: Motivational Interviewing tip card

Action plans to supplement MI strategies

- Blue Cross and Blue Shield of Nebraska: Diabetic Patient Action Plan
- The Center for Excellence in Primary Care (CEPC): Action Plan Example

[1] Source: Elwyn, G., Deblendorf, C., Epstein, R., Marrin, K., James, W., & Frosch, D. (2014). Shared decision making and motivational interviewing: Achieving patient-centered care across the spectrum of health care problems. Annals of Family Medicine, 270-275.

Reminders

Anesthesia billing – professional services

Charges for anesthesia must be billed under the name and NPI number of the CRNA or anesthesiologist who administers the anesthesia.

The claim will be denied if the anesthesia charge is submitted under the surgeon's name and NPI number.

Autism education

As a reminder, per the CPT manual, code 97153 should only be used if a technician, under the direction of a physician or other qualified health care professional, provides treatment to one patient. Code 97154 should be used if treatment is provided to two or more patients by a technician under the direction of a physician or other qualified health care professional.

Clear coverage

When using Clear Coverage and you see "Criteria Met", please do not assume the request has been approved. You need to go to "Finish" and "Submit" so that you can see if the request is "pended", "authorized" or "denied".

Preauthorization Forms

We will be updating the preauthorization form to include required fields that must be present on the form. If these fields are missing, the preauthorization form will be faxed back to the sender as incomplete.

Iontophoresis

Effective Jan. 1, 2019, iontophoresis (97033) is no longer a covered benefit unless the employer group has specified that this service is covered. BCBSNE encourages all providers to check eligibility and benefits prior to rendering services.

Reminders

Medical records – faxing documents

When faxing us medical records, please remember:

- Be sure to include a copy of our letter requesting the records immediately following your fax cover sheet.
- If you are faxing us a preauthorization request, please make sure all the required fields are completed; the form should immediately follow your fax cover sheet.
- We do not accept unsolicited medical records and will fax them back to you if we receive them.
- If you receive a "failed fax" response from our server and you resend, please send us all the pages from the original fax, including the cover letter.

Place of Service (POS) codes

Please be sure to choose the correct POS code for professional claims. The codes and descriptions may be found at www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

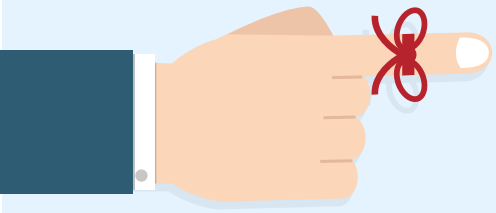
In the future, our new payer system will deny claims if the correct POS code is missing. Getting into the habit now of including the correct POS code will reduce the risk of denials when we move to our new system.

Fee schedules effective July 1, 2019

Providers who receive their fee schedule directly from BCBSNE must log into NaviNet to obtain it.

Dental and PHO providers will receive their updated fee schedules via the usual communication method.

For questions on how to access your fee schedules on Navinet, please email ProviderExecs@nebraskablue.com or call 800-821-4787, option 4.



REMINDER

Medicare Advantage has its own Update newsletter, published on opposite months of this Update.
To access the Medicare Advantage newsletter, **CLICK HERE.**