Update

NOVEMBER 2019

BlueCross BlueShield Nebraska

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Update is a provider newsletter that contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers that is published online every other month. 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.

Find 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

Armor Health

On Jan. 1, 2020, Blue Cross and Blue Shield of Nebraska (BCBSNE) will launch Armor Health, a new individual health plan. Armor Health claims and eligibility will be administered on the HealthRules platform. Armor Health is an alternative to Affordable Care Act (ACA) coverage for individuals who are under 65 and can pass medical underwriting. The effective date of the policy may begin the first day of any month, which means Armor Health ID cards will be issued throughout the year. Coverage lasts for 12 months and may be renewed by reapplying. Coverage can be declined during the reapplication process.

Armor Health is a major medical health plan modeled after ACA products, meaning it covers many of the same health care services standard ACA plans cover. Armor Health differs from standard ACA plans in that it has a lifetime benefit maximum of $1 million and does not cover maternity*, inpatient mental illness, inpatient substance abuse, pediatric dental or pediatric vision services. Armor Health has a 12-month waiting period for pre-existing conditions on new sold business, but pre-ACA members will not have waiting periods for pre-existing conditions. Armor Health offers coverage for preventive services at 100%, as defined by the ACA.

Members covered under Armor Health will have a unique member ID prefix. For new business, the prefix is YDB. Members who transition from an individual pre-ACA plan to Armor Health can be identified by the YXN prefix.

*Benefits for pregnancy and maternity care are extended to covered persons who were 1) enrolled as of Dec. 31, 2019, in a pre-ACA individual policy issued by BCBSNE that covered benefits for pregnancy and maternity care; and 2) diagnosed as pregnant in 2019 while enrolled in the pre-ACA individual policy and continuing to receive treatment in 2020 for the same pregnancy.

In this issue

Therapy Payment Policy, Effective Feb. 1, 2020

BCBSNE reimburses contracted therapists for all covered, medically-necessary physical, occupational and speech therapy services provided in a non-facility setting, according to the member's contract/benefit plan. We cover short-term rehabilitation services to meet the functional needs of patients suffering from physical impairment due to disease, trauma or prior therapeutic intervention. We will only cover physical therapy and occupational therapy for one-on-one services. We do not provide coverage for group therapy sessions. General benefit information and subsequent payment are based on the member's benefit plan and provider agreement.

- A therapist/clinician must apply their skills by actively participating in (not merely supervising) the treatment of a patient during each progress report period.
- In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next complex or difficult task. Beneficiary's diagnosis is not the sole factor in determining coverage; the key is that the skills of the therapist are needed to treat the illness or injury.
- Amount, frequency and duration must be reasonable under accepted standards of practice.

Consistent with The Centers for Medicare and Medicaid Services (CMS):

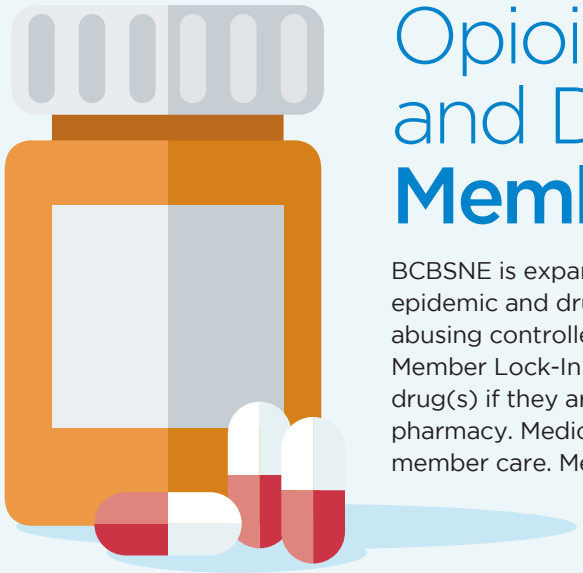
- Unattended electrical stimulation will not be considered for reimbursement; the appropriate codes should be used for wound healing of stage III and IV pressure wounds.
- Electrical stimulation for all other conditions is considered inclusive.

Hot or cold packs:

This service does not require the provider to have one-to-one patient contact. The application of this modality is an integral part of a service or visit by CMS. Therefore, the service for the application of hot or cold packs is a status B (bundled) code on the Medicare Fee Schedule Data Base (MFSDB). Separate payment is not allowed for this service.

BCBSNE does not reimburse for the following:

- Dry hydrotherapy
- More than four modalities on a single date of service
- More than three modalities in addition to a physical therapy or occupational therapy re-evaluation service
- Application of hot or cold packs
- Iontophoresis
- Whirlpool
- Electrical stimulation



Opioid Epidemic and Drug Abuse: **Member Lock-in Program**

BCBSNE is expanding its Member Lock-In Program to stay vigilant against the opioid epidemic and drug abuse. Beginning in 2020, BCBSNE members who are found to be abusing controlled substances or muscle relaxers may be asked to participate in the Member Lock-In Program. BCBSNE will only pay claims for the abused prescription drug(s) if they are prescribed by an approved prescriber and filled at an approved pharmacy. Medical providers may be contacted by BCBSNE and asked to coordinate member care. Medical provider and member participation is voluntary.

Patient-Driven Payment Model (PDPM) – Skilled Nursing Facility

The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System.

Effective Oct. 1, 2019, providers should follow CMS guidelines with respect to PDPM billing for SNF patients. Medicare Advantage claims will be priced according to the CMS PDPM fee schedule.

If you have additional questions, please reach out to your provider executive.

Clarification to Sept. 2019 Update: Initial Evaluation and Management During an Inpatient Stay

The initial hospital codes, 99221-99223, should only be billed by the admitting physician and will be reimbursed to the first claim processed, according to CMS and industry standards.

For initial encounters by physicians other than the admitting physician, providers should bill with the subsequent hospital care codes as appropriate. This information can be found in the beginning of the Initial Hospital Care section of the CPT Manual.

It is important to note that BCBSNE follows CMS guidelines with regard to not accepting consultation codes, these have not been accepted since Jan. 1, 2011.

Benefit Changes Regarding Growth Hormone Products, Effective Jan. 1, 2020

Beginning Jan. 1, 2020, Norditropin® will become the preferred growth hormone product for BCBSNE. Patients currently treated with Omnitrope® will transition to Norditropin, and their authorization will be extended for 12 months.

Benefit Changes Regarding Brand-name Medications That Have a Generic Equivalent, Effective Jan. 1, 2020

Beginning Jan. 1, 2020, a patient cost-share penalty may be assessed if prescribed brand name medications have a generic equivalent available. If providers prescribe a brand name medication and denote that no generic substitution is allowed, supporting documentation must be provided to avoid a cost-share penalty. BCBSNE will require a copy of a prescriber completed/submitted Food & Drug Administration (FDA) MedWatch Adverse Event Reporting Form outlining reasons the generic equivalent cannot be used. The FDA MedWatch form can be found at fda.gov.

FEATURED:

Consumer Assessment of Health Care Providers and Systems (CAHPS)

Patient experience and a patient's perception of health care quality are vital to understanding and identifying strategies to improve care quality. The Consumer Assessment of Health Care Providers and Systems (CAHPS) survey gathers clinically meaningful patient-reported outcomes and health status data, which can help payors and providers improve any uncovered deficiencies. BCBSNE contracts with an external company, DSS Research, to conduct the survey every year. DSS Research mailed 1,100 surveys to randomly selected Adult Commercial Members.

We received scores greater than the national average for:

- How members rate their health plan
- How members rate the health care they receive from their primary care provider
- How well the members' health care is coordinated throughout the health care system
- How member claims are processed
- How members get needed care and appointments
- How well adults are vaccinated against influenza

Sample questions in these areas:

- In the last 12 months, did you and a doctor or another health provider talk about specific things you could do to prevent illness?
- In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

CAHPS – Continued

Areas where we can improve include:

- How to better provide members with information they need regarding costs of service or equipment
- How members rate their specialist visits
- How members rate their personal doctor

Sample questions in these areas:

- In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?
- We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from zero to 10, where zero is the worst specialist possible, what number would you use to rate that specialist?
- In the last 12 months, how often did your personal doctor show respect for what you had to say?

Reasons to improve CAHPS scores:

- Improved patient experiences and quality outcomes lead to healthier and happier patients.
- Patients make more informed health care decisions and rely on these publicly available survey results when deciding where to receive care.

Please encourage your patients to complete these surveys if they receive them. Together, we can work toward ensuring members receive the care they need when they need it.

HEDIS RESULTS FOR 2019

HEDIS, the Health Care Effectiveness Data and Information Set, is a set of standardized performance measures updated and published annually by the National Committee for Quality Assurance (NCQA). HEDIS is a tool used by most U.S. health plans to measure performance on important aspects of care and service. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. The Centers for Medicare & Medicaid Services (CMS) uses HEDIS data to monitor health plan performance in multiple areas, including quality of care and service.

HEDIS results guide effective and efficient management of patient care by allowing us to continually monitor patient health, prevent complications and identify any additional issues that may develop.

Through HEDIS, BCBSNE is accountable for the timeliness and quality of health care services delivered to our members. **The chart below provides our HEDIS results for 2019**.

MEASURE	Commercial PPO 2017	Commercial PPO 2018	Commercial PPO 2019
Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis (AAB)	22.36%	27.7%	31.3%
Breast Cancer Screening (BCS)	68.09%	73.6%	74.7%
Childhood Immunization Status - Combo 10 (CIS)	44.3%	55.96%	61.31%
Colorectal Cancer Screening (COL)	49.6%	59.8%	56.5%
Comprehensive Diabetes Care - Eye Exam Performed (CDC)	42.1%	50.4%	47.5%
Comprehensive Diabetes Care - Medical Attention for Nephropathy (CDC)	85.2%	89.8%	88.6%
*Comprehensive Diabetes Care - Poor Control >9.0% (CDC)	No Data	43.6%	44%

*Lower is better

REMINDERS:

Medicare Advantage Provider Appeals

The address to send provider appeals for BCBSNE Medicare Advantage is different from the address for commercial. Providers may appeal decisions on Medicare Advantage denied claims, such as denial of a service related to medical necessity and appropriateness, by submitting an appeal in writing to:

Blue Cross and Blue Shield of Nebraska
Medicare Advantage
Attn: First Level Appeals
P.O. Box 261273
Plano, TX 75026

For more information, call **888-505-2022**

Appeals must be submitted within 60 days of the denial from the date the provider received the initial denial notice. Be sure to include appropriate documentation to support your appeal. We will review your appeal and respond to you in writing within 60 days from the time we receive notice of your appeal.

Visit NebraskaBlue.com for details on the appeal process. If you have questions, please call customer service at 888-505-2022 between 8 a.m. and 8 p.m., CT, Monday through Sunday. You may receive a messaging service on weekends and holidays from April 1 through Sept. 30. Please leave a message, and your call will be returned the next business day.

Change of Address Forms

It is important we have the most up-to-date information for our providers.

If you have a change in practicing address or mailing/billing address, please complete the "Change of Address" form located on NebraskaBlue.com. This information needs to be sent to HealthNetworkRequests@NebraskaBlue.com

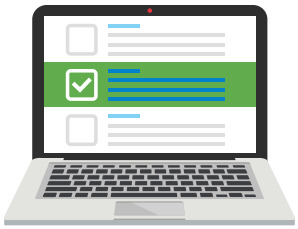
Impacts of not updating your address:

- Mail going to the wrong location
- Delay in authorization approvals
- Location displaying incorrectly in directory for members
- Remits/payments not getting to providers
- Submitted claims with new information not matching existing information in our system, causing claim return

If you have any questions about this process, please reach out to ProviderExecs@NebraskaBlue.com

Social Security Numbers

Social security numbers **should not be used** as patient account numbers on claim forms.



Precertification and Preauthorization Reminders

Precertifications:

When calling into BCBSNE's precertification line (402-390-1870/800-247-1103), please make sure you have all the appropriate information you need to request a precertification, including:

- Anticipated dates of admission
- Diagnosis codes and CPT codes
- Facility's full name and address
- Patient's full name, date of birth, BCBSNE member identification number and phone number

This will ensure we can help you immediately, and you can avoid having your office call back with any missing information.

Preauthorizations:

As we are in full swing of the fourth quarter, please take note of our service-level agreements:

- Urgent preauthorizations may take up to 72 hours to finalize.
- Non-urgent preauthorizations may take up to 15 calendar days to finalize.

Please plan your preauthorizations and anticipated dates of service accordingly.

When filling out your preauthorization form to be faxed in, please include your provider practicing office location on the form. Do not include any provider office address changes since those should be handled using our change of address form.

Precert/Preauth Reminders – Continued

If you are trying to determine whether or not you need to submit a preauthorization, please check the code at NebraskaBlue.com. If the code does not require a preauthorization, you do not need to fax us a request.

Once you fax your preauthorization, you will receive a fax confirmation indicating if the fax was successful or failed. If it was successful, allow us 72 hours for a response on urgent requests and up to 15 calendar days on non-urgent requests. There is no need to call to make sure we received your fax. Please use your fax confirmation as acknowledgment.

If your fax was missing required information (as indicated on the fax form), we will return the fax back to your fax number for you to complete the missing data.

If your fax confirmation indicated that it was unsuccessful or failed, please try again until you receive a successfully transmitted fax acknowledgement.

Please do not send in multiple faxes after successfully receiving a fax acknowledgement as this can result in delays in handling your request.

When submitting photographs with preauthorization requests via Clear Coverage or MedPolicy Blue, the following information must be included on all photographs:

- Patient name
- Patient date of birth
- Patient's BCBS member ID number

Get to Know Your **Provider Executive Team**

Meet Debby Synowicki, Provider Executive II.

Debby has 25 years of experience working as a provider relationship manager and provider executive. March will mark her third year at BCBSNE

In her role, Debby most enjoys the variety of tasks she completes.

"Every day is exciting and challenging," Debby said. "It gives me great pleasure to assist my providers with their issues and concerns."

Debby loves country music, traveling, crocheting and spending time with her family. She has two beautiful grandchildren from her daughter and son-in-law and eagerly awaits the arrival of her son and daughter-in-law's first child in March.

You can reach Debby at Deborah.Synowicki@NebraskaBlue.com.

PROVIDER SITE VISITS: Your provider executive is available to come to your office to address your concerns. If you are interested in having your provider executive make a site visit, please call or email them for scheduling. To find your provider executive, reference the provider contact directory.

REMINDER

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