Update

NOVEMBER 2020

BlueCross BlueShield Nebraska

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA | NebraskaBlue.com/Providers

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 for BlueCard® providers and about the Federal Employee Program (FEP). 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.**

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

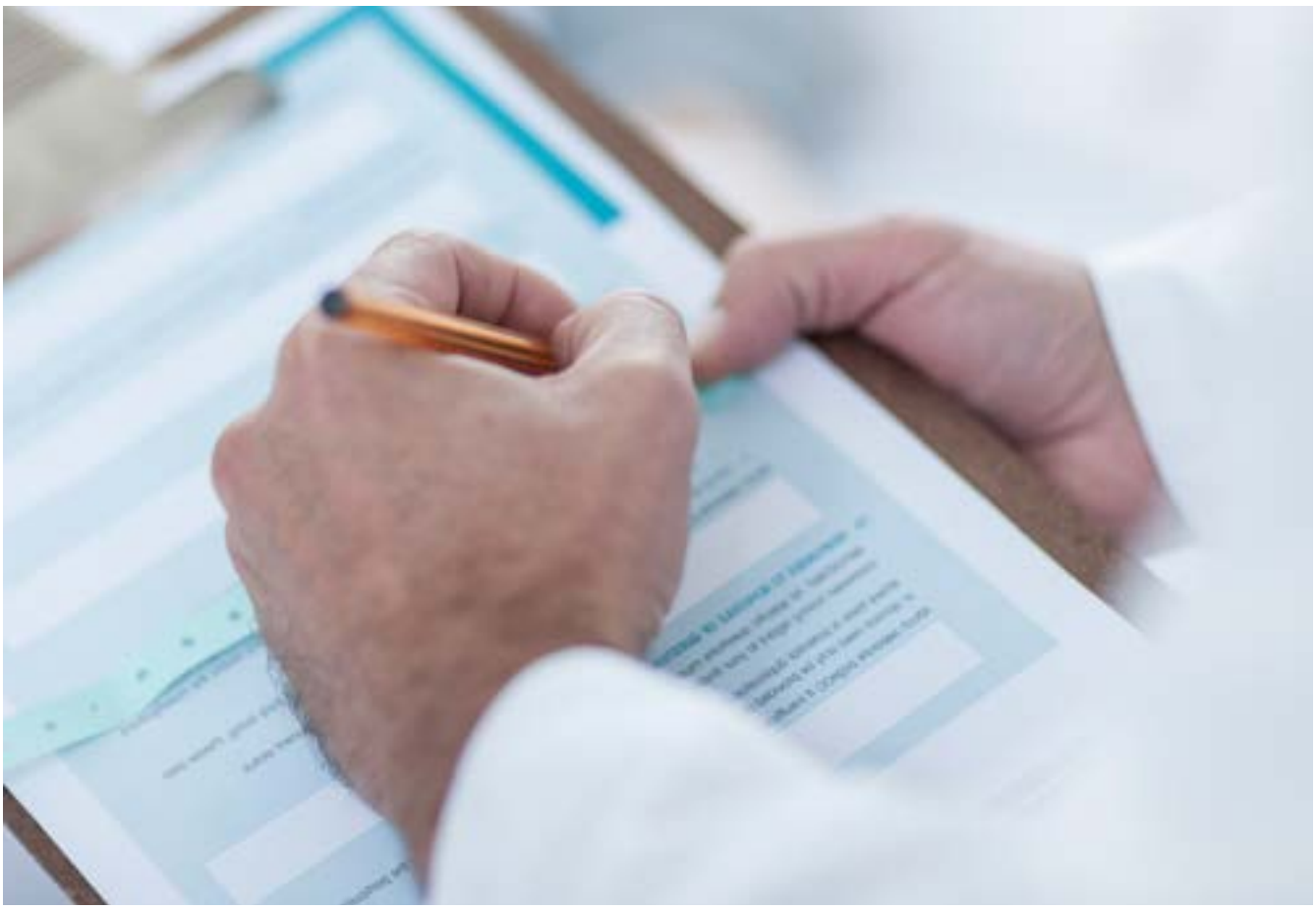
Happening Now

Please continue to check our Happening Now page for current information and updates.

COVID 19

For up-to-date information on our COVID-19 policies, check our COVID-19 page.

In this Issue



Timely Filing – Effective Jan. 1, 2021

In response to COVID-19, BCBSNE extended the timely filing deadline for providers to Dec. 31, 2020 or to your current contract filing deadline, whichever is later.

Enforcement of timely filing deadlines will resume for all claims received on and after Jan. 1, 2021, meaning claims with a 2020 date of service that are received in 2021 will be subject to contractual timely filing limits.

Evaluation and Management Codes – Effective Jan. 1, 2021

BCBSNE will support the American Medical Association's (AMA) and Centers for Medicare & Medicaid Services' (CMS) changes to evaluation and management codes. Effective Jan. 1, 2021, providers must submit appropriate level of care codes on claims.

For more information, please refer to this AMA document.

COVID-19 and VEKLURY (remdesivir)

The following COVID-19 treatment recommendations are from the National Institute of Health (NIH). BCBSNE recommends following NIH's guidelines for treatment with Veklury (remdesivir).

Figure 1. Recommendations for Pharmacologic Management of Patients with COVID-19 Based on Disease Severity

DISEASE SEVERITY	PANEL'S RECOMMENDATIONS *(Recommendations are listed in order of preference in each category below; however, all options are considered acceptable.)*
Not Hospitalized *or* **Hospitalized but Does Not Require Supplemental Oxygen**	No specific antiviral or immunomodulatory therapy recommended The Panel **recommends against** the use of **dexamethasone (AI)** See the Remdesivir section for a discussion of the data on using this drug in hospitalized patients with moderate COVID-19.[a]
Hospitalized and Requires Supplemental Oxygen **(but Does Not Require Oxygen Delivery Through a High-Flow Device, Noninvasive Ventilation, Invasive Mechanical Ventilation, or ECMO)**	**Remdesivir** 200 mg IV for one day, followed by remdesivir 100 mg IV once daily for 4 days or until hospital discharge, whichever comes first **(AI)**[b,c,d] *or* **Remdesivir** (dose and duration as above) plus **dexamethasone**[e] 6 mg IV or PO for up to 10 days or until hospital discharge, whichever comes first **(BIII)**[f] If **remdesivir** cannot be used, **dexamethasone**[e] may be used instead **(BIII)**
Hospitalized and Requires Oxygen Delivery Through a High-Flow Device or Noninvasive Ventilation	**Dexamethasone**[e] plus **remdesivir** at the doses and durations discussed above **(AIII)**[f] *or* **Dexamethasone**[d,e] at the dose and duration discussed above **(AI)**
Hospitalized and Requires Invasive Mechanical Ventilation or ECMO	**Dexamethasone**[d,e] at the dose and duration discussed above **(AI)** *or* **Dexamethasone**[e] plus **remdesivir** for patients who have recently been intubated at the doses and durations discussed above **(CIII)**[f]

Rating of Recommendations: A = Strong; B = Moderate; C = Optional
Rating of Evidence: I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies; III = Expert opinion

[a] The Panel recognizes that there may be situations in which a clinician judges that remdesivir is an appropriate treatment for a hospitalized patient with moderate COVID-19 (e.g., a patient who is at a particularly high risk for clinical deterioration). However, the Panel finds the data insufficient to recommend either for or against using remdesivir as routine treatment for all hospitalized patients with moderate COVID-19.
[b] Treatment duration may be extended to up to 10 days if there is no substantial clinical improvement by Day 5.
[c] The Panel recognizes there is a theoretical rationale for initiating remdesivir plus dexamethasone in patients with rapidly progressing COVID-19.
[d] For patients who are receiving remdesivir but progress to requiring oxygen through a high-flow device, noninvasive ventilation, invasive mechanical ventilation, or ECMO, remdesivir should be continued until the treatment course is completed.
[e] If dexamethasone is not available, equivalent doses of other corticosteroids, such as prednisone, methylprednisolone, or hydrocortisone, may be used. See Corticosteroids for more information.
[f] The combination of dexamethasone and remdesivir has not been studied in clinical trials; see text for the rationale for using this combination.

Key: ECMO = extracorporeal membrane oxygenation; IV = intravenously; PO = orally

In Figure 1, the panel refers to NIH. BCBSNE recommends following NIH's guidelines for treatment with Veklury (remdesivir).

Billing Excessive Labs and Referring to Out-of-Network Labs

BCBSNE examined providers' claims and has concerns with many providers increasingly referring members to out-of-network laboratories and ordering a high volume of labs.

In accordance with BCBSNE's General Policies and Procedures Manual, Section 2 – Provider Responsibilities and Considerations, subsection Referrals, you should make your best efforts to refer patients to other in-network providers unless they cannot or do not render the services needed.

Excessive or increased referrals to out-of-network labs

BCBSNE has identified several providers who have excessive or increased referrals to out-of-network laboratories compared to their peers. By referring a BCBSNE member to an out-of-network provider, you are placing the member at risk of being liable for dollar amounts in excess of the out-of-network allowances set by BCBSNE. BCBSNE urges providers to stop ordering laboratory services from out-of-network laboratories and begin using in-network providers for all laboratory services needed. BCBSNE strives to provide in-network access for all services our members may need. If you find a network inadequate, please contact your Provider Executive.

Ordering a high number of labs

BCBSNE has identified several providers who are outliers among their peers in ordering a high number of labs. BCBSNE recognizes the nature of a provider's service varies by specialty and the patient's condition. In BCBSNE's General Policies and Procedures Manual, Section 6 – Member Benefits/Responsibility and Cost Share Information, subsection Medical Necessity, services are not automatically considered medically necessary because a provider ordered or provided them. BCBSNE's concern is the value of the high number of labs in caring for patients. Providers should only order tests needed for proper patient care.

BCBSNE is providing this information to ensure providers are aware of our expectations and to deter any improper billing, fraud, waste or abuse. We appreciate your help on behalf of our members.

Billing

High-Dollar Pre-Payment Review (HDPR) Audit Process Changes – Effective Jan. 1, 2021

Beginning Jan. 1, 2021, the HDPR audit process will apply to claims with allowable charges ≥ $100,000.

All claims, including diagnostic related group claims with outliers, with allowable charges ≥ $100,000 will require itemized statements to be submitted via secure email to HDPR@NebraskaBlue.com. The member ID must be included in the body of the email and must match the member ID on the submitted claim. Each itemized billing must be submitted in a spreadsheet. Claims received without an itemized statement will be returned.

For more information, please refer to the letter on HDPR that was mailed to providers in early November.

Split-Claim Billing

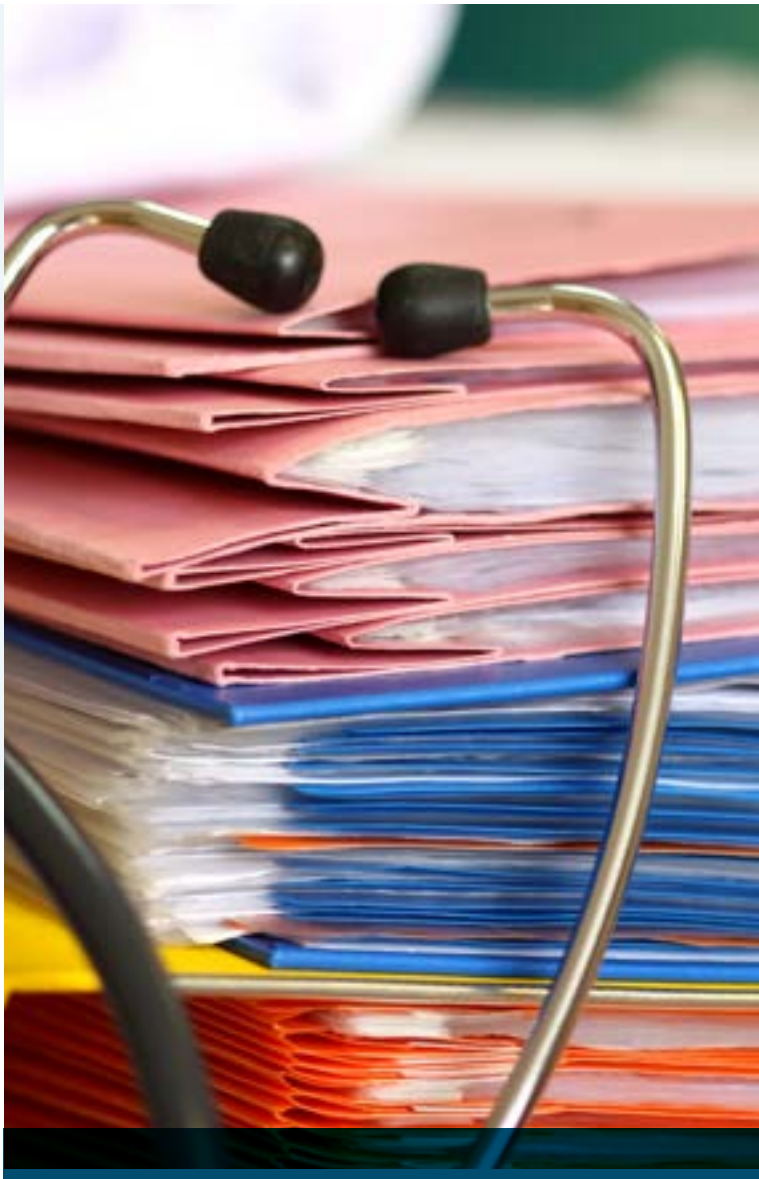
All in-patient* and professional claims that occur at the end of one year and continue into the next year must have charges submitted on separate claims. This requirement takes effect with claims that span from 2020-2021.

For example:

If dates of service are from Dec. 15, 2020, to Jan. 15, 2021:

- Submit charges incurred from Dec. 15, 2020, to Dec. 31, 2020, on one claim
- Submit charges incurred from Jan. 1, 2021, to Jan. 15, 2021, on a separate claim

Claims submitted with charges incurred during both years on the same claim will result in processing delays. BCBSNE recommends split billing of charges on claims that span from one year to the next since split billing can result in auto-adjudication and faster processing times.



Reminder: Correcting Claims

When submitting a corrected claim via paper, please do not include a reconsideration request form with the corrected claim.

*Inpatient includes acute care hospital, psychiatric hospital, rehabilitation hospital, skilled nursing and swing-bed.

Clinical

Readmissions

BCBSNE is changing its readmissions program, effective Nov. 1, 2020. We will now look at readmissions within 14 days of the index admission instead of the current 30 days.

Preauthorizations: Duplicate Requests

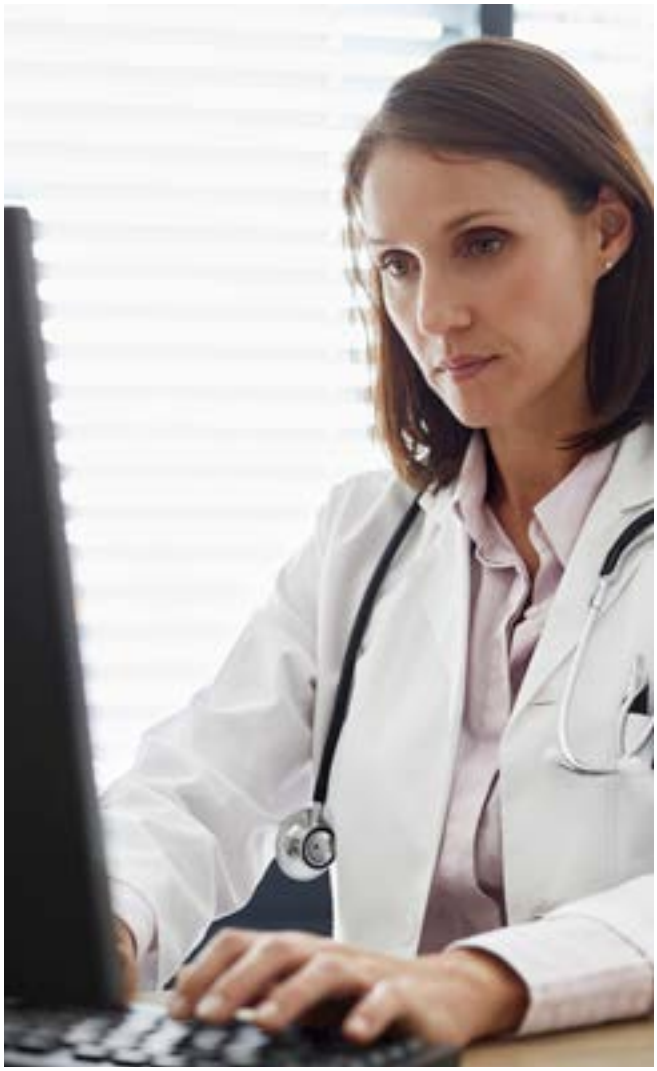
To determine the status of a preauthorization request, please check our online resources before resubmitting the request. Submitting duplicate requests can delay handling, so please check our online resources first.

Preauthorizations: Faxes

BCBSNE always acknowledges faxed preauthorization requests with a confirmation of either "successful" or "ok," which means BCBSNE successfully received the fax and will work it in the received date and time stamp order.

If the requester receives a response of "error in transmission," "failed" or "interrupted," the fax was not successful and will be purged and not worked. If your fax failed, the entire document should be faxed to us until a successful acknowledgment is received.

Be sure to submit preauthorizations using our online tools, where you can attach documents.



Credentialing

Genetic Counselors

Beginning Feb. 1, 2021, genetic counselors will be accepted for credentialing.

Genetic counselors are required to be board certified and licensed by the State of Nebraska.

Learn more about the credentialing process.

News

Out-of-Network Emergency Medical Care Act (LB997)

Out-of-network providers in Nebraska may no longer balance bill patients for medical care received from facilities in emergency situations. The recently-passed Legislative Bill 997 (LB997), also known as the Out-of-Network Emergency Medical Care Act, keeps consumers from receiving surprise bills from out-of-network providers or facilities for medical emergencies.

Pharmacy

Diabetic Products

New benefit changes for DPP-4 diabetic products, effective Jan. 1, 2021

Beginning Jan. 1, 2021, Janumet®, Janumet XR® and Januvia® will be the preferred DPP-4 inhibitor products for BCBSNE. All other DPP-4 inhibitor products (e.g. Kombiglyze XR®, Onglyza®and Tradjenta®) will require a trial/failure of a preferred product prior to being approved. Continued benefits for patients currently treated with non-formulary DPP-4 inhibitor products will require that patients have previously tried/failed a preferred product.

Changes for GLP-1 agonist diabetic products, effective Jan. 1, 2021

Beginning Jan. 1, 2021, GLP-1 agonist medications (e.g. Ozempic®, Trulicity® and Victoza®) will require documentation of an FDA-approved diagnosis and failure of a first-line agent (e.g. Metformin®) for benefits to be available. Patients currently receiving GLP-1 agonist products can continue therapy without interruption. This change will apply only to patients new to therapy.

Risk Adjustment and Risk Management

Medical Records Reminder

When submitting medical records, only submit medical records specific to the member on the request.

When submitting multiple requests, please fax each request separately to avoid the blending of PHI.

Ensuring medical record request compliance

When your office receives a medical record request from BCBSNE, please follow the steps listed below to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the protection of Private Health Information (PHI).

Please use the following guidelines when returning medical record requests to BCBSNE:

- Include BCBSNE's original letter requesting medical records with correspondence to ensure the record is routed to the proper BCBSNE department for processing.
- Submit each medical record request separately by member; please avoid grouping multiple members together when returning a record request by fax. This will ensure protection of PHI.
- Mail or fax medical records to BCBSNE; faxing is the easiest and quickest method for returning medical records.
- Face documents in the same direction when faxing, rather than backwards or upside down, as this would cause BCBSNE to send a second request for the records.

Thank you for remembering these tips to avoid duplicate requests and remain HIPAA compliant.

Sharing Our Commercial HEDIS Results for 2020

HEDIS®, the Healthcare 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 and is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans.

HEDIS® results can help us 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.

Due to the COVID-19 pandemic, which impacted the retrieval of records for hybrid measures, NCQA released guidance in March allowing plans to suspend medical record retrieval and report 2019 results for 2020.

The chart below provides our HEDIS® results for 2019 and 2020:

Measure	Commercial 2019	Commercial 2020
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	31.30%	31.10%
Breast Cancer Screening (BCS)	74.70%	75.58%
Childhood Immunization Status (CIS) - Combo 10	61.31%	61.31%
Colorectal Cancer Screening (COL)	56.50%	56.50%
Comprehensive Diabetes Care (CDC) - Eye Exam Performed	47.50%	47.50%
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	88.60%	88.60%
*Comprehensive Diabetes Care (CDC) - Poor Control > 9.0%	44.00%	44.00%

*Lower is better

2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Commercial Member Survey

Understanding a patient's experience and perception of their health care quality is vital when forming strategies to improve quality of care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey collects data on patient experience and satisfaction. This survey gathers clinically-meaningful patient-reported outcomes and health status data, which can help payors and providers improve on any uncovered deficiencies. BCBSNE contracts with an external company, SPH Analytics (SPH), to conduct the survey every year. SPH mailed 1,100 surveys to randomly selected adult commercial members.

We received scores greater than the national average for:

Survey Measure	National Average	BCBSNE 2020
Care received from personal doctor	71.8%	76.7%
Care received from specialist	70.0%	70.4%
Care coordination throughout the health care system	84.7%	88.5%
Getting needed care and appointments	87.8%	91.9%
Vaccination against influenza	55.8%	68.7%

Sample questions in these areas:

- In the last 12 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?
- In the last 12months, 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?

Areas where we can improve:

Survey Measure	National Average	BCBSNE 2020
Advising smokers and tobacco users to quit	73.6%	73.7%
Discussing cessation medications	49.3%	39.5%
Getting care quickly	86.4%	82.9%

Sample questions in these areas:

- In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? Never, Sometimes, Usually, Always
- In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are nicotine gum, patch, nasal spray, inhaler or prescription medication.

Improved patient experiences and quality outcomes lead to healthier and happier patients.

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.

Documenting Lifelong Conditions in Risk Adjustment

When documenting lifelong conditions for risk adjustment, it is important to indicate how the condition is being monitored or managed throughout the member's life. This applies to lifelong conditions, such as sickle cell anemia, cystic fibrosis, multiple sclerosis, Parkinson's disease, autism, cerebral palsy and congenital heart conditions, to name a few.

As a health care professional, think of yourself as the storyteller. It is imperative that each condition discussed with the member during a visit is completely and accurately documented. A diagnosis code is risk adjustable only if it is explicitly stated by the health care professional through narrative description of the disease documented during the visit.

A good example of a lifelong condition once diagnosed is autism:

A simple statement, such as the example below, indicates several aspects of monitoring a condition. Including just one of these statements in a chart note provides the coder enough data to abstract the diagnosis and include on a claim specifically for risk adjustment.

Example

"The member was diagnosed with autism two years ago, follows Dr. James with psychiatry and has seen improvement with behavior therapy."

When discussing a member's ongoing chronic or lifelong condition, it is best to refrain from using statements such as "history of autism," as this would indicate the condition occurred in the past and is part of the member's overall medical history but not a current issue. In this circumstance, autism would technically not be reportable under risk adjustment guidelines.

Autism is a lifelong and incurable condition. A brief narrative to support how the condition is currently being managed or monitored is required in the chart note to abstract the diagnosis for risk adjustment.

Telling the story of the member's health consists of more than including the condition on a problem list within the note. Diagnoses that appear in a problem or past medical history list in a chart note need to have supportive documentation to submit that diagnosis for risk adjustment. Diagnosis listed in a chart note are best used as a reference guide at the member's visit to start a discussion about existing lifelong conditions, thus creating the opportunity to document and expand the story of the member's overall condition.

Lifelong or chronic condition diagnosis are reportable on a claim used for risk adjustment if a member is being seen for an acute condition and:

- Medical decision making is made during the visit
- Consideration is made regarding the member's overall picture of health to prescribe a medication, test or treatment

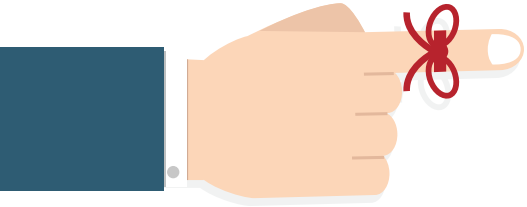
Follow these documentation tips for lifelong conditions. The example below discusses a patient with autism.

1. Note the status of each chronic or lifelong condition

   Example: The member's autism is improving, stable or worsening.

2. Note any medication(s) used in treating chronic or lifelong conditions

Very simply, for a diagnosis to be reported in risk adjustment, it should have at least one reason documented in the narrative of the note saying that the condition is current and sharing what is being done to manage it, even if another health care professional is responsible for treating the actual condition.



REMINDER

Medicare Advantage has its own Update newsletter from BCBSNE, published on opposite months of this Update. Read the **Medicare Advantage newsletter.**