Update

MARCH 2021

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 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

New Features

Save Feature Added to New Preauthorization Tool

The preauthorization tool BCBSNE released in the fourth quarter of 2020 has a new save feature that allows nonclinical staff to save a preauthorization as a draft. Once clinical information has been added as an attachment, the preauthorization can be submitted. When submitting the authorization, remember to add your facility's contact name, fax number and phone number for BCBSNE staff to follow up if needed.

Training on the new save feature is coming soon. Watch for updates on the NaviNet News and Announcement page.

Key details to know:

- The draft authorization will have its own list with drafts for both inpatient and outpatient, similar to the existing inpatient and outpatient authorization list
- The draft authorization will have its own ID number starting with the letter 'D'
- BCBSNE will not see this draft ID number in our system until the authorization has been completed and submitted
- The draft authorization will expire after seven calendar days. On the eighth day, you will no longer see this draft in your list

Questions?

Email ProviderPortalAuthQuestions@NebraskaBlue.com or call 800-247-1103, option 6.

Reminders

Preauthorizations

- For questions on the new preauthorization tool, please call 800-247-1103, option 6. Questions can also be emailed to ProviderPortalAuthQuestions@NebraskaBlue.com.
- When submitting your authorization, it is important to put your name, phone number and fax number in the NOTES section to help expedite communication with your office on the authorization.
- If your authorization is for services, you must fill in the ordering provider information. This should automatically populate for your office when using NaviNet. If the provider is different than what is automatically populating, you can change it to the correct ordering provider by searching for the provider's name.
- For inpatient care authorizations, you must fill in the facility provider information. This should automatically populate for your office when using NaviNet. If the facility is different than what is automatically populating, you can change it to the correct facility by searching for the facility name.
- It is important that the ordering and rendering providers are listed as names of providers and not as facility names. When filling out information for the facility, the name of the facility should be entered instead of a provider.
- Authorizations are not prioritized by the date or service. Urgent authorizations are handled within 72 hours of receipt in our system while nonurgent authorizations are handled within 15 calendar days.

Reminders

Peer-to-Peer

- Peer-to-peer scheduling requests must be made within 14 calendar days of the denial date on the denial letter. Authorizations that are denied as "not medically necessary" are the only authorization denials that qualify for a peer-to-peer appointment. All other denials have the appeals option. Please see your specific denial letter for options and instructions.
- Peer-to-peer appointments cannot be made if services have already been performed. If the services have already been performed, you will need to file a claim and submit an appeal.
- If you have a peer-to-peer appointment and there is a medical emergency that causes you to miss that scheduled appointment, please have your office call us immediately. Our medical director will attempt to make two phone calls to the phone number listed for the appointment. If contact is not made, the appointment is considered missed and the next option would be to appeal the denial. It is important to call our schedulers as soon as possible, preferably before the appointment time, if an appointment needs to be rescheduled due to an emergency.
- If you are faxing in additional medical records for your peer-to-peer review, it is important to have the full patient name, full BCBSNE ID number, date of birth and authorization number on the faxed cover page.

Medical Records

- When faxing in medical records, it is important to include the original letter requesting the medical records and for that letter to immediately follow the fax cover letter. You must have the patient's full name, date of birth and BCBSNE ID number on each page of the medical records. If you are sending in photographs, the patient's name, date of birth and BCBSNE ID number must be on the photographs to ensure they stay with the medical records of the patient.
- Please make sure you are only sending in the specific medical records BCBSNE requests to ensure the minimal records as requested are received. It is not necessary to include the patient's complete medical records unless you have specifically been requested to provide that information.

Faxed Preauthorization Forms

When submitting faxes to BCBSNE, it is imperative to provide all of the following information to avoid any delays or having the item returned to your office as incomplete:

- Full BCBSNE ID number, including the alpha prefix (this should match what is listed on the patient's BCBSNE member ID card)
- Full patient name (this should match what is listed on the patient's member ID card)
- Patient's full date of birth
- Patient's full address
- Provider's first and last name
- Provider's full address
- Facility full name
- Facility full address

These fields must match what is in BCBSNE's membership system. If the above items are not filled out completely or are filled out incorrectly, it may delay the processing of these requests.

Out-of-state providers are allowed to send faxes rather than submit preauthorizations online.

Out-of-State Members and Preauthorizations

Clarification to article published in the January 2021 Update

Effective April 18, 2021, participating providers and providers that accept Medicare assignment will be held responsible for claim charges in which preauthorization was not obtained. Currently, when an out-of-state member's plan does a retro review, the member is held liable during the review process.

Starting April 18, once the retro review is complete, the out-of-state member's plan will initiate an adjustment and process the claim according to medical policy/medical necessity, just as they do today. The only change is that during the review process, the liability falls to the provider instead of the member.

Colorectal Cancer

March is National Colorectal Cancer Awareness Month – Make Screening a Priority

The American Cancer Society anticipates that decreased resources and access to care due to the pandemic will make it more difficult for providers to diagnose and treat cancer, resulting in lower incidence, higher mortality and decreased survival. Nebraska ranks 33rd in the nation in prevalence of colorectal cancer screenings (CRC) among adults age 50 and over, with only 68% of Nebraskans getting screened. Our already low rate of screening coupled with the impact of COVID-19 gives many in health care cause for concern. Despite the challenges we face during the pandemic, colorectal cancer remains a public health priority, and we must provide the public with safe opportunities to prevent and detect colorectal polyps and cancer.

Providers have a unique opportunity to regain momentum in CRC screening with the availability of multiple screening test options. Studies have stated that the single most important influence on a patient's decision to get screened for CRC is having their provider recommend screening. During National Colorectal Cancer Awareness Month and all year long, we encourage our providers to help close this gap in CRC and save more patient lives.

Improving Quality

- Implement a CRC protocol
- Identify and manage the population through a CRC patient registry
- Review and/or confirm all preventive health screening at each visit
- Make a recommendation for your patients to get screened. Recommendation from a doctor is the single most powerful factor in a patient's decision to be screened for cancer
- Consider scheduling screening before the patient's next appointment, so you have results at the appointment
- Encourage shared decision making when determining the most appropriate CRC test for the individual patient
- Be persistent with reminders, track test results and follow up with patients

HEDIS® Measure Description

The Healthcare Effectiveness Data and Information Set (HEDIS) 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.

Appropriate screening for colorectal cancer

Test	Interval
Screening colonoscopy	Every 10 Years
Screening flexible sigmoidoscopy	Every five years
Screening CT colonography	Every five years
FIT DNA (i.e. Cologuard®)	Every three years
Fecal occult blood test (FOBT)	Every year

To help providers encourage colorectal cancer screening, the National Colorectal Cancer Roundtable developed a playbook for reigniting colorectal cancer screening as communities respond to COVID-19. You can also find resources for National Colorectal Cancer Screening Month at www.FightBackNE.org.

2020 HEDIS® Medical Record Review

Each year from February through May, BCBSNE performs medical record reviews to collect HEDIS measurement quality data. BCBSNE uses the vendor Centauri Health Solutions to collect data for commercial members. Centauri looks for clinical details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results and colorectal cancer screenings. Centauri may contact your clinic to schedule a HEDIS review or request that you fax necessary records to them. We appreciate your assistance with these important reviews. Your cooperation helps us meet our quality goals as we seek to improve the overall health of our members – your patients.

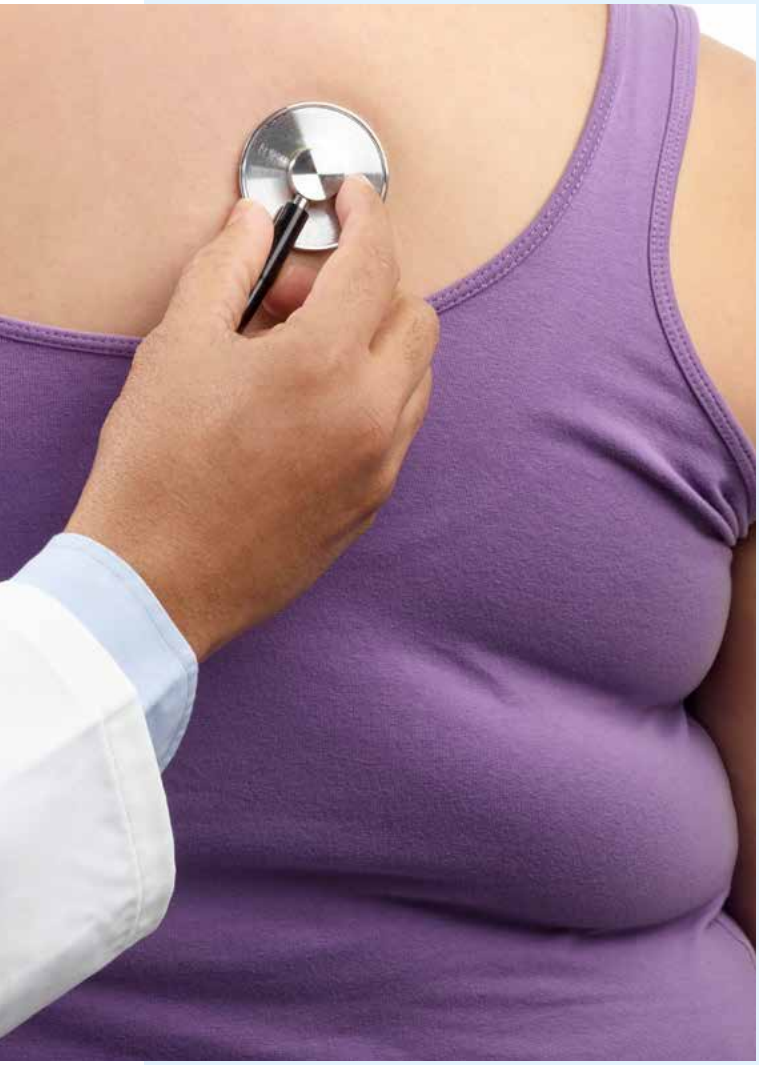
HEDIS medical record reviews reflect the quality of care patients receive that cannot be captured via the claims process. We appreciate your commitment to providing high-quality care to our members and look forward to working with you to complete this process.

As a reminder, your contract as a participating provider contains language around the provision of providing requested records to BCBSNE, at no charge, to capture the content of clinical encounters with our members.

We don't want to disrupt your office workflow any more than necessary, so the faster we obtain the requested records, the fewer follow-up contacts will be needed. Thank you in advance for your prompt response to our requests and for helping us successfully complete our HEDIS reporting.

For more information on HEDIS visit NCQA.org/HEDIS/.

Weight-Related Diagnosis Coding and Documentation



Diagnosis codes for overweight, obesity or morbid obesity are assigned based on the health care provider's documentation and statement that the condition exists.

Excess weight, obesity and morbid obesity are always going to affect the health of a member and should be documented and reported for any encounter in which the condition is observed, as well as any comorbidities that exist. Obesity can cause serious medical complications, such as metabolic syndrome, high blood pressure, heart disease, diabetes, high blood cholesterol and sleep disorders, just to name a few.

Body mass index (BMI) is a quality measure used as a screening tool for weight and nutrition, calculated based on height and weight. When selecting a code for assignment, BMI cannot be reported without an accompanying weight-related diagnosis that is documented or stated during an encounter by the health care provider.

When only the BMI is listed in the encounter and there is no mention of obesity, coders are unable to select a weight-related diagnosis code. The BMI noted in a record should never be converted into a weight diagnosis. The provider must document a specific weight-related diagnosis for the BMI to be abstracted and coded.

If there is conflicting medical record documentation, remember to code from the provider statement, regardless of documented BMI. Since BMI is a screening tool, if a patient's BMI level falls into the morbid obesity range but the provider only documents obesity, the coder should abstract obesity. This would be a good time to ask the provider for more clarity and specificity.

The care of an obese or morbidly obese patient may require extra work and extra cost. It may also require coordination of care between providers, especially if the condition exists with other acute or chronic conditions that may require treatment.

Coders need to encourage their physicians to document this important medical information as part of the physical exam findings.

Smoking Cessation

Smoking cessation reduces the risk of poor reproductive health outcomes, heart disease, chronic obstructive pulmonary disease and cancer, among other health conditions, according to the 2020 Surgeon General's report on smoking cessation. This report highlights that one of the most critical actions a person can take to improve their health is to quit smoking. It encourages health care providers to advise patients to quit, offer brief counselling, prescribe cessation medications, connect them to resources, like a quit line, and follow up to prevent relapse.

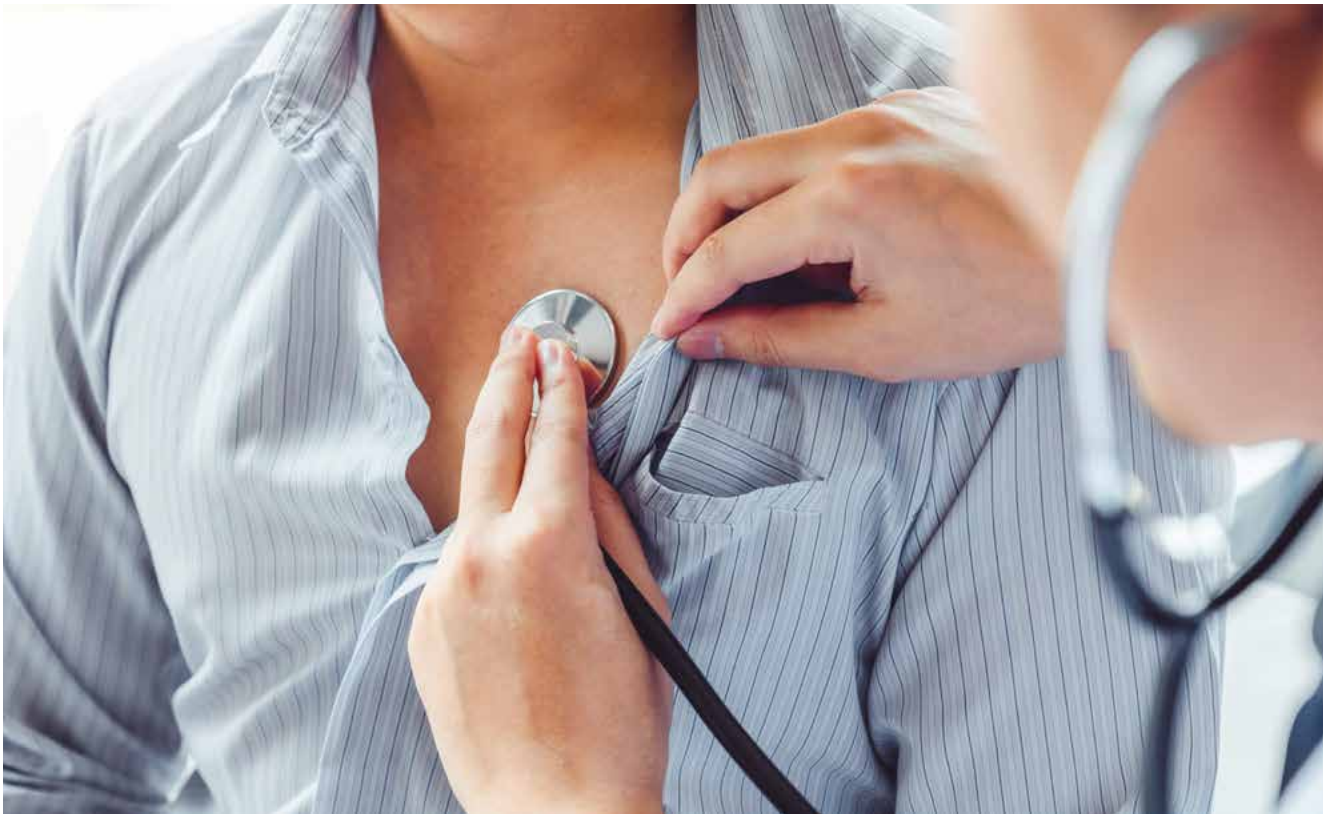
In an effort to promote high use of comprehensive, barrier-free, evidence-based cessation treatments, we want to make you aware of our commitment to support and monitor the use of these interventions. In addition to providing coverage of all FDA-approved prescribed cessation medications approved for the purpose of tobacco cessation, we also support tobacco cessation counseling in your offices.

The following CPT codes can be used up to eight times in a 12-month period:

CPT 99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes.

CPT 99407: Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.

Documentation in the medical record must include that tobacco cessation was discussed. We will continue to track the use of these tobacco cessation benefits and promote their use in light of their proven effectiveness in helping people quit successfully.



Changes to Oncology Medication Reimbursement Tiers

BCBSNE is making a reimbursement change for certain oncology medications. Effective April 1, 2021, some brand name and biosimilar oncology products will have a different reimbursement tier placement. The impacted medications are bevacizumab, pegfilgrastim, rituximab and trastuzumab. We encourage oncology providers to access their NaviNet account to view the tier placement updates.

Welcome to BCBSNE!

We are happy to announce the addition of two people to the Provider Executive team: Leigh Ann Ingraldi and Kara Urkoski.

Leigh Ann Ingraldi

Leigh Ann Ingraldi previously served as a medical staff coordinator and brings with her tremendous knowledge in the front- and back-end medical environment. Leigh Ann has an extensive background in health care and has served in a variety of positions throughout Nebraska. Leigh Ann's experience has provided her the expertise needed to serve our provider community. BCBSNE is thrilled to offer Leigh Ann's collaborative approach in the provider executive role, and we are excited for the providers she will work with.

Kara Urkoski

Kara Urkoski comes to BCBSNE with a wealth of experience, including serving as director of patient access for a local health care partner and Trinity Health, where she partnered with providers throughout the East Coast to maximize efficiency and process improvement as the senior performance management consultant. Kara has an extensive background in health care and has served in a variety of positions throughout Nebraska. As a market director for a local large health care system, Kara was key in building and maintaining client relationships. We are excited to have Kara on our team and have her as your partner.

Share your story with BCBSNE

From the birth of a child to the healing of a broken bone, everyone's health journey has unique moments of joy and times of hardship. We're grateful for the care you provide our members, and we want to hear from you and your patients.

Please consider sharing your health journey at **NebraskaBlue.com/YourStory**. We will amplify many stories to inspire others – like that of Joanna, nursing director of the Intensive Care and Progressive Care Units at Mary Lanning Healthcare.

Thank you for the role you play in our members' stories and letting us be part of yours.

Provider Executive Assignments

Our Provider Executives are available to assist you

John Larson

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Phone: 402-982-6455
Email: John.Larson@NebraskaBlue.com

Kara Urkoski

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Tawny Archer

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Loraine Miller

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Leigh Ingraldi

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Jessica Medura

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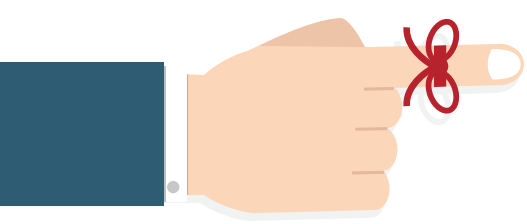

REMINDER

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