Update

MAY 2022

BlueCross BlueShield Nebraska

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Update is an online newsletter containing up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers. 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 every other month.

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 review every issue of the Update and reference it often. In addition, you may view the Policies and Procedures 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 at **NebraskaBlue.com/Providers**.

To request permission to reprint the material published in this Update for any 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 about workshops, resources and other information from BCBSNE.

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association

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Happening Now

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

COVID-19 Policies

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

In this Issue

New Features

NaviNet

Professional fee schedule now available

The July 2022 professional fee schedule is currently available in NaviNet. Providers affiliated with a physician hospital organization (PHO) will need to contact their PHO to obtain the July 2022 fee schedule.

Update on claim status attachments and return letters

Blue Cross and Blue Shield of Nebraska (BCBSNE) is excited to announce the release of claim status inquiry attachments and claim return letters available through NaviNet!

- **Attachments:** Send supporting documentation electronically to BCBSNE for certain claim statuses via Claim Status Inquiry. Learn more about sending attachments.
- **Return letters:** Review claim return letters from BCBSNE through Patient Clinical Documents under your Workflow menu. Please view the user guide for more information.

NOTE: BCBSNE will continue to mail return letters, in addition to having them available in NaviNet. Return letters in NaviNet will be available for a 12-month period.

If you do not have access to the Patient Clinical Documents workflow, please speak with your NaviNet Security Officer.

› For more information on all BCBSNE transactions available in NaviNet, please visit the NaviNet Help Center.

Throughout 2022, we will continue to enhance eligibility, benefit and claim status information, as well as add new streamlined claim management processes.

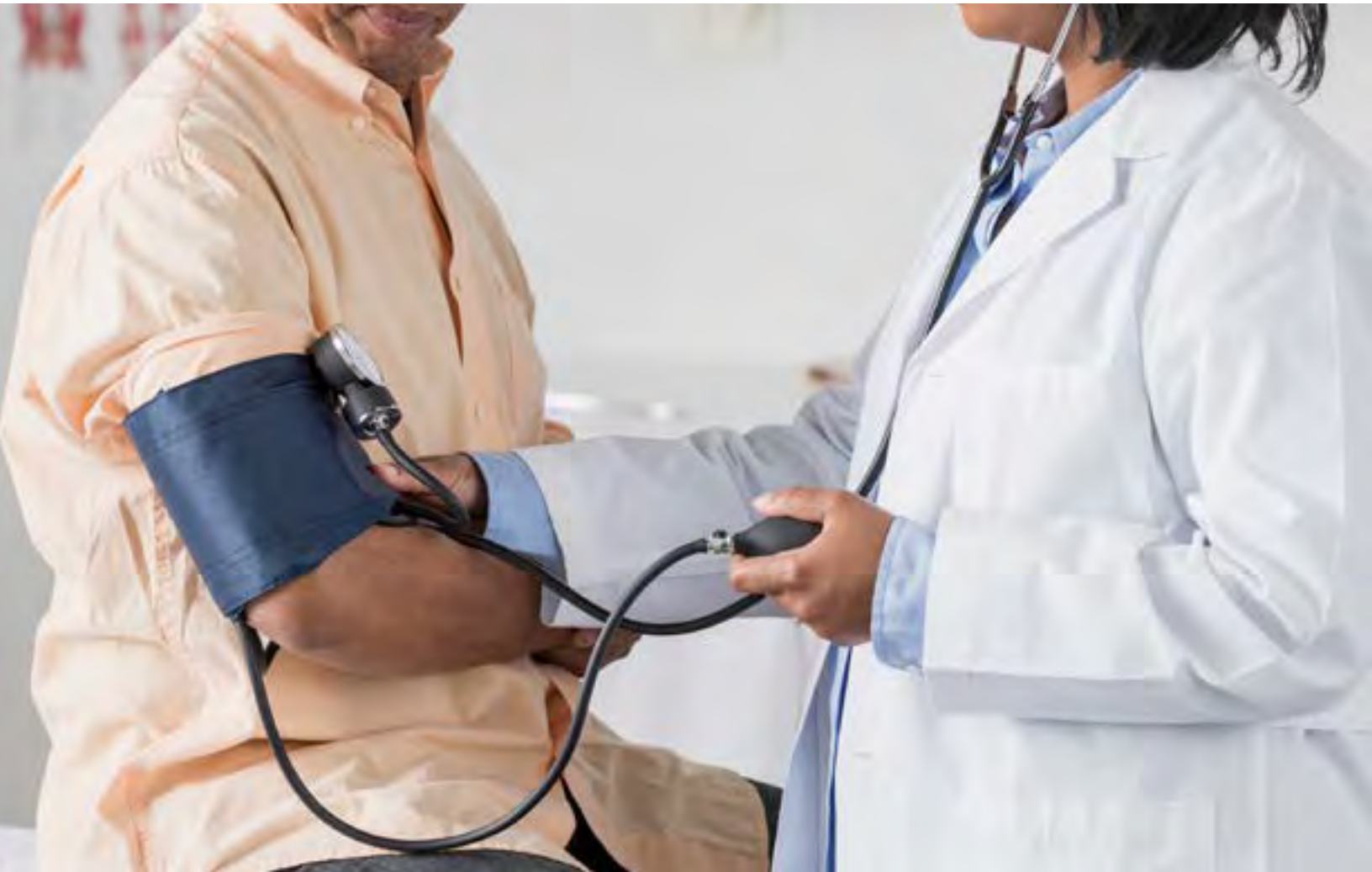
New patient visits

BCBSNE previously followed the American Medical Association's (AMA) guidelines in the determination of a new patient visit. Based on feedback we received from our providers, we began to follow the Centers for Medicare & Medicaid Services' (CMS) guidelines instead in late April.

For claims returned or denied for new patient E&M prior to May 1, 2022, please resubmit those claims as a new claim using an established patient E&M code.

The difference between the AMA's and CMS' guidelines are outlined below:

- **AMA guidelines:** In 2012, the AMA revised the definition of new patient to: "A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years."
- **CMS guidelines:** Medicare did not accept the new AMA definition with the inclusion of "subspecialty" and does not recognize subspecialty designations in their system. Medicare only recognizes specialty by the provider's primary specialty when they enrolled in Medicare.



Colorectal cancer screening changes

Beginning June 1, 2022, we will cover colonoscopies once every five years at 100% for members starting at age 45, regardless of diagnosis billed when submitted by an in-network provider.

Most colonoscopies billed for members younger than 45 or conducted more often than five years, regardless of the diagnosis code billed, will be covered at the plan's cost shares. Please check the member's benefits to determine the amount to bill them.

Educators Health Alliance members

Prescription drug list change to PDL 40

In an effort to keep medications affordable, effective Sept. 1, 2022, Educators Health Alliance (EHA) members will move to a new prescription drug list. Communications to all members whose ID number begins with EHN started in March; impacted members will receive formal letters from BCBSNE starting July 1.

New ID cards

All EHA members will receive new ID cards with a QR code, effective Sept. 1, 2022, so providers can easily access their benefits. ID numbers will not change.

Blue Distinction Centers and Nebraska Preferred Centers

BCBSNE offers two programs that recognize high quality specialty care at select facilities. They are the national Blue Distinction Centers (BDC) designation and the local Nebraska Preferred Centers.

BDC – national designation program

BDC and BDC+ designations are awarded to facilities based on a thorough, objective evaluation of their performance in the areas that matter most—quality care and treatment expertise.

BDC+ demonstrates more affordable care, in addition to quality care and treatment expertise.

Quality is key. Only those facilities that first meet nationally-established, objective quality measures for BDC will be considered for designation as a BDC+

In Nebraska, there are BDC/BDC+ specialty providers for:

- Bariatric surgery
- Cardiac care
- Knee and hip replacement
- Maternity care
- Spine surgery
- Substance use treatment and recovery
- Transplants

Locate BDC-designated facilities.

BDC: Recognition among employers

Employers adopt many tactics to help improve the quality of health care for their employees, while also managing cost. Some of these tactics may include offering richer benefits to employees who use designated Blue Distinction providers and adopting narrow networks that feature these higher-quality, lower cost providers.

Although other plans may offer richer benefits to their members who receive care at a BDC designated facility, BCBSNE employer groups do not offer this incentive.

Nebraska Preferred Centers – local designation program

BCBSNE established Nebraska Preferred Centers to recognize local surgical facilities that have demonstrated high-quality care through low readmission and infection rates, high patient satisfaction and lower costs for spine surgeries, total knee and hip replacements.

BCBSNE members may be able to take advantage of having their deductible and coinsurance waived for inpatient or outpatient surgical facility charges for spine surgeries, total knee or hip replacement performed at one of the Nebraska Preferred Centers below.

NEBRASKA PREFERRED CENTERS

Facility	Spine	Knee & Hip
Columbus Community Hospital, Columbus		✓
Kearney Regional Medical Center, Kearney	✓	✓
Lincoln Surgical Hospital, Lincoln	✓	✓
Midwest Surgical Hospital, Omaha	✓	✓
Nebraska Spine Hospital, Omaha	✓	
OrthoNebraska Hospital, Omaha	✓	✓

To have the deductible and coinsurance waived, the surgery and health plan must meet the following requirements:

- Nebraska Preferred Centers must be in network for the member's plan
- Surgeries that are covered:
  - Dorsal and lumbar fusion (except for curvature of the back)
  - Cervical spinal fusion and other back/neck procedures
  - Total hip replacement
  - Total knee replacement
- Facility approves your surgery (higher risk patients may be referred to another facility)

For BCBSNE members with a qualified high-deductible health plan, only coinsurance will be waived if all other requirements are met.

Only the surgical facility charges will be waived for deductible and coinsurance amounts. Deductible and coinsurance for all other services (lab work, surgeon and anesthesiologist fees, etc.) related to the surgery will be member liability.

For more information, visit NebraskaBlue.com.

Ancillary billing – DME

When submitting DME claims with POS 12 (Home) for members who live out of state, submit the claim to:

- The plan in the state where the member resides if you are billing at the location level with a DME specialty.
- BCBSNE if you are billing with a rendering practitioner (not a DME specialty).

If the DME claim is billed with POS 11 (office), the supply or equipment will deny as content of service.

If the DME claim is billed with POS 17 (retail store), you must submit claims to BCBSNE.

Ancillary billing – home infusion

When submitting a POS 12 (Home) home infusion therapy claim, the claim must be submitted to the plan in the state where the member resides.

Medical policy updates

Great news! You can find medical policy updates online as of March 1, 2022. BCBSNE no longer mails medical policy updates to providers.

To view medical policy updates, visit NebraskaBlue.com/Provider-Update.

Inclusive item denials – A9279

Effective with dates of service beginning July 1, 2022, BCBSNE will deny A9279 as inclusive.

High volume claim adjustments

If your office plans to submit a high volume of adjusted claims (50 or more) to BCBSNE, please notify your Provider Executive prior to sending in the claims. This notification ensures our claims teams are prepared for the high volume of adjustments.

Gold Card program

We implemented the Gold Card provider program in 2016 to help remove some of the administrative responsibility for the prior authorization process. BCBSNE offers this program to physicians and mid-level providers who meet pre-determined denial metrics when submitting prior authorizations.

This program applies to the designated procedures below:

✓ Sinus surgeries ✓ Hysterectomies ✓ Pain management ✓ Spinal surgeries

BCBSNE is reviewing additional procedures to expand the scope and provider pool.

Benefits of being a Gold Card provider include:

- No requirement to go through medical review for pre-designated procedures
- Provider receives automatic authorization for the pre-designated procedures when submitted through NaviNet
- Dramatic decrease to the administrative burden of providing care to our members
- A proven increase in provider satisfaction

How to qualify:

Providers must maintain an overall preauthorization denial rate of less than 6%. Our Medical Review team will review prior authorizations for the services listed above for the past nine to 12 months.

No application is needed for this program. BCBSNE will notify providers who qualify for the program and advise them on how to move forward.

Gold Card provider status is re-evaluated every nine to 12 months with an audit of the provider's medical records for the designated procedures. To maintain status in the program, the provider must maintain a denial rate of less than 6%.

We have established a process through a secure electronic portal that allows us to notify any qualifying provider of the periodic audit. The notification will also include a list of records requested and instructions on how to submit them through the secure portal. This process safeguards the security of the medical records and eliminates the need for our staff to conduct the audit in your office.

Substance use, abuse and dependence

There is a difference between drug use, abuse and dependence, and health care provider documentation should reflect the status of the patient, as outlined below:

- **Drug use** - A pattern of using a psychoactive substance that causes damage to a person's health.
- **Drug abuse** - The desire to have the drug and continuous use of a drug, even though it may have an adverse effect on health or well-being.
- **Drug dependence** - The physiological need to have a drug and losing control over the substance itself. Tolerance may be built up, and the member may have withdrawal if they stop taking the drug.

Health care provider documentation:

Health care provider documentation should specifically indicate if a member has drug use, abuse or dependence; these terms are not interchangeable. Document the recurring nature of the disorder in each encounter. The medical record for each encounter or date of service should stand on its own.

Specific elements to document in the medical record:

- What is the name of the drug being used and how long has the patient used it?
- Is it use, abuse or dependence?
- Is the patient in current remission, current withdrawal or have a history of withdrawal?
- What is the alcohol level if intoxicated?
- What are the complications or side effects associated with the drug?
- Is it impacting the patient's lifestyle?

Professional coding staff:

Diagnoses that are listed in the patient's problem list or past medical history list should not be abstracted and used on a claim unless the condition is addressed in the current encounter and supported with documentation.

When health care provider documentation refers to use, abuse and dependence of the same substance (e.g., alcohol, opioid, cannabis), only one code should be assigned to identify the pattern of use, based on the following hierarchy:

- If both use and abuse are documented, assign only the code for **abuse**.
- If both abuse and dependence are documented, assign only the code for **dependence**.
- If use, abuse and dependence are all documented, assign only the code for **dependence**.
- If both use and dependence are documented, assign only the code for **dependence**.
- If a member presents with abuse in remission and dependence in remission, code for **dependence in remission**. Ask the health care provider when there is question whether to abstract a diagnosis, as these conditions are particularly sensitive and should be coded to the highest level of severity that exists.

Improve diabetic patient eye health while reducing medical record reviews

BCBSNE collects data from our providers to measure and improve the quality of care our members receive. The HEDIS® Comprehensive Diabetes Care (CDC) – Eye Exam metric is one aspect of care we measure in our quality programs.

The CDC Eye Exam measure intends to ensure that members with evidence of any type of retinopathy have an annual eye exam, while members who remain free of retinopathy receive a screening at least every other year.

How to meet the HEDIS requirements:

- Medical records should include the date of service, diabetic eye exam results, the eye care professional's name, credentials and signature.
- If a copy of the eye exam report is not available, document in the patient's medical history the date of the eye exam, the results and the name and credentials of the eye care professional who conducted the eye exam.
- Patients with positive retinopathy results need an annual exam with their eye care provider.
- Patients with negative results can be examined every two years. However, negative eye results must be reviewed, and CPTII® codes or the results must be submitted yearly.

Submitting retinal eye exam results

When results are received from an eye care professional, add the results to the EMR and submit the results on a $0.01 claim with the appropriate CPT II code.

CPT II code	Retinal eye exam findings
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
3072F	Low risk for retinopathy; no evidence of retinopathy in the prior year (use only if the eye exam was completed in the prior measurement year)

Talking to your patients about preventive services

As preventive services do not generally include services intended to treat an existing illness, injury or condition, please remind your BCBSNE patients that if they receive these services during their preventive visit, they may be required to pay a copay, deductible and/or coinsurance for those covered services.

REMINDER

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

For questions on Medicare Advantage claims, please call **888-505-2022** for assistance.

Questions?

Please contact your Provider Executive.