Update

JULY 2022

BlueCross BlueShield Nebraska

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

NebraskaBlue.com/Providers

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.

60-117 (06-30-22)

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

Medical Policy Updates

Medical policy updates are now available online on the Alerts and Updates page.

Multiple Procedure Adjustments for Payment: Therapy and Radiology – Coming fourth quarter of 2022

Medicare's National Physician Fee Schedule (PFS) is a listing of CPT procedure codes sorted and ranked by their relative weight, meaning the average time a provider would take to perform the procedure, along with the expense involved in performing it. This ranking provides a recommended payment based on the relative value unit (RVU) of work. Procedures valid for Multiple Procedure Payment Reduction (MPPR) can be identified under Column S, Mult Proc, of the PFS Relative Value File.

Centers for Medicare & Medicaid Services (CMS) created guidelines under the MPPR to handle scenarios where multiple procedures are performed on the same patient on the same date of service. Per MPPR guidelines, multiple procedures are ranked according to RVU and paid in descending order of highest to lowest RVU. The highest-ranked procedure receives 100% payment, with the second and subsequent lower-ranked procedures receiving a reduced payment.

Chapter 1 of the National Correct Coding Initiative (NCCI) Policy Manual explains, "Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often an overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work."

Blue Cross and Blue Shield of Nebraska (BCBSNE) has decided to align with CMS's MPPR guidelines and apply the MPPR for therapy and radiology procedures. These changes will take place in the fourth quarter of 2022. Please continue to review future issues of the Update newsletter for more information.

Resources:

CMS transmittal R11940TN
National Physician Fee Schedule Relative Value File

Modifier 52: When to Use and How it Pays

Modifier 52 is used to identify reduced or eliminated services for surgical or diagnostic CPT procedure codes. As defined by CPT Appendix A, “Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.”

The use of modifier 52 applies when the procedure performed is less than what is defined by CPT for that procedure, and there is no other CPT code that reflects the reduced services performed. Clear, concise provider documentation is necessary to support application of this modifier.

Modifier 52 is considered a payment modifier, meaning payment is reduced when this modifier is applied. BCBSNE has recently reviewed our payment policy for Modifier 52. The decision was made to apply a 50% reduction in payment to procedures with Modifier 52 attached. This change more accurately reflects the reduction in services based on average provider work and practice expenses involved.

These changes will take place in the fourth quarter of 2022. Please continue to review future issues of the Update newsletter for more information.

Professional fee schedule now available

A revised copy of the July 2022 professional fee schedule will be posted to NaviNet by the end of July. Please be sure that you are accessing the most current fee schedule in NaviNet. Providers affiliated with a physician-hospital organization (PHO) will need to contact their PHO to obtain the July 2022 fee schedule.

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) will be changing to PDL 40. This change will also impact these diabetic supplies: Autosoft Infusion Set, Minimed Infusion Set and Paradigm Infusion Set.

Beginning Sept. 1, 2022, these supplies will be covered under the medical benefit versus the pharmacy benefit. All EHA members (member ID beginning with EHN) have been notified of the change. Members directly impacted started receiving letters from BCBSNE 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.

Provider Directory: Make Sure that Your Information is Correct

The Consolidated Appropriations Act (CAA), effective Jan. 1, 2022, requires that online provider directory information be reviewed and updated (if needed) at least every 90 days.

We ask that you take a few minutes to review your online provider directory information to help ensure BCBSNE members can locate your most current information.

If changes are needed, please take the time to update your information by submitting updates and corrections via one of our provider forms on NebraskaBlue.com/Providers/Find-a-Form.

Facility credentialing and re-credentialing

As part of an ongoing commitment to both our subscribers and our network practitioners, BCBSNE has a credentialing program that has been established in compliance with Nebraska law and modeled after URAC and NCQA standards. Initial credentialing must be completed prior to participation and re-credentialing must be completed every three years. The credentialing standards can be found on the BCBSNE credentialing page.

As a reminder, Medicare certification is a mandatory credentialing requirement for some Facility/Institution types. This information can be found in the Facility/Institution Initial and Recredentialing Standards Matrix. During the credentialing process, we will require documentation of Medicare certification.

Online form update options include:

- Change an address
- NPI notification
- Add a provider to a current or new location
- Transferring providers' locations
- Tax ID changes
- Phone/fax number changes

In the 4th quarter of 2022, we are implementing a new process using NaviNet that will allow you to review your provider directory information to ensure we have the most current information available to our members. For those providers not enrolled in NaviNet, we strongly encourage you to register as soon as possible. Go to Connect.NaviNet.Net/Enroll to register. All participating medical and dental providers can register for a NaviNet account. NaviNet is a secure self-service provider portal for verifying benefit and eligibility information, checking on claim status and submitting prior authorizations.

More information to come on the process of reviewing your directory information in NaviNet.

For PHO groups handling their own credentialing processes, we will be requesting submission of a full roster every 90-days. Additional communications will be sent on the timeline for this request, and your Provider Executive will be reaching out with more information.

We appreciate your help ensuring our members have the most up-to-date information.

Credentialing

As part of an ongoing commitment to both our subscribers and network practitioners, BCBSNE has a credentialing program that has been established in compliance with Nebraska law and modeled after URAC and NCQA standards:

- Initial credentialing must be completed prior to participation.
- Re-credentialing must be completed every 3 years.
- Credentialing standards can be found at NebraskaBlue.com/Providers/Credentialing.
- As a reminder, Medicare certification is mandatory credentialing requirement for some facility/institution types.
- This information can be found in the Facility/Institution Initial and Recredentialing Standards Matrix.
- During the credentialing process, we will require documentation of Medicare certification.

Changes to 835 Files and Provider Level Adjustments

To help our providers better understand provider-level adjustments on 835 files, changes have been made to how the 835 files display the claim that has been adjusted.

Previously, the 835 displayed the claim the offset was FROM, rather than the claim the offset was FOR.

For more information, please refer to the Provider-Level Adjustments document.

Preauthorization Form Changes

The medical and pharmacy preauthorization forms for BCBSNE members with commercial policies have been updated.

When faxing a preauthorization request and medical records, please make sure the preauthorization form is the first page of the fax, followed by medical records. Medical records should have the patient's full name on each page of the record. Please only fax one patient request at a time. Multiple patients should be separated and faxed individually.

If you receive a failed fax confirmation sheet, you will need to re-fax the entire fax, not just the pages that failed.

On all preauthorization requests, it is important to make sure that the member's ID number is the most current and that the full ID number, including the prefix, is submitted.

Nebraska providers should continue to submit through NaviNet for prompt handling of preauthorization requests.

MEDICARE ADVANTAGE MEMBERS: Prior authorization requests must be submitted on the appropriate Medicare Advantage form:

- Medical Prior Authorization Form
- Medicare Advantage Part B Drug Request Form

Preauthorization for high-tech radiology and cardiac imaging, radiation therapy and interventional pain management can be submitted via AIM* or by calling 866-745 -3265.

*BCBSNE does not control this website or endorse its content.

Documentation and Coding Best Practices:
Inflammatory Bowel Disease

Inflammatory bowel disease includes various levels of severity commonly found in members ages 15-35. However, it may be diagnosed in anyone at any age, including young children.

When documenting regarding inflammatory bowel disease in the medical records it is imperative to indicate:

- Severity of the condition (Colitis, ulcerative colitis or Crohn's disease)
- Status of the condition as being stable, worsening or improving.
- Current treatment plan, medication, planned or historical surgical procedures, referral to specialists and follow-up plan of care.

Specificity in documentation can make a big difference in reporting diagnosis codes for risk adjustment. Colitis (ICD-10 code K52.9) does not fit into a risk-adjustable HCC category, while Ulcerative Colitis (ICD-10 code K51.90) and Crohn's disease (K50.90) risk adjust to HCC 48.

Often, unspecified colitis can be reported on a medical claim for a member who has a condition that is much more severe. Health care providers work diligently and may try numerous treatments to control the symptoms of inflammatory bowel disease. They deserve credit for the extensive work they perform; thus, the importance of documenting the highest level of severity.

Professional medical coders should review documentation and query the health care professional when possible if the specificity of diagnosis is not clear.

It is important for health care professionals to educate members on additional risk factors associated with this family of inflammatory bowel diseases, such as immunosuppression, depression, tobacco use, osteoporosis, eye and oral complications, blood pressure screening, cancer screening and the frequency of having a colonoscopy.

Both ulcerative colitis and Crohn's disease are long-term, chronic, incurable conditions. Some individuals may go for years without having symptoms while others have more frequent flare-ups. Although there is no cure for these conditions, they can often be managed or controlled with proper treatment.

HEDIS Measures for Patients with Diabetes: What's new for Measurement Year 2022

Every year, the NCQA reviews, updates (if needed) and releases the Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. HEDIS® measures development and updates follow a rigorous process that includes a public comment period and input from advisory panels. This process ensures that HEDIS® measures remain relevant and feasible for implementation.

The diabetes measure was previously a combined:

- Comprehensive Diabetes Care: Hemoglobin A1C Control for Patients with Diabetes
- Comprehensive Diabetes Care: Eye Exam Performed for Patients with Diabetes measure

For the 2022 measure year, NCQA separated the indicators into standalone measures: Hemoglobin A1C Control for Patients with Diabetes (HBD), and Eye Exam Performed for Patients with Diabetes (EED). Kidney Evaluation for Patients with Diabetes (KED) remains a standalone measure as in the previous measure year.

For more information, please refer to HEDIS Measurement Year 2022.

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.