BlueCross BlueShield Nebraska

Provider Updates
March 2023

No Surprises Act and Qualifying Payment Amount (QPA)

The No Surprises Act requires Blue Cross and Blue Shield of Nebraska (BCBSNE) to disclose the qualifying payment amount (QPA) to out-of-network providers at the time of initial claim payment or denial of payment when BCBSNE uses the QPA to calculate the member's cost share.

Please note, the QPA does not impact the amount you are reimbursed for out-of-network services, as your office receives its NEtwork Blue contracted rate for out-of-network services subject to the No Surprises Act.

For offices that currently receive electronic remittance advice (ERA), BCBSNE ERAs are not formatted to include the QPA; however, our paper remittance advice (PRA) is formatted to include this amount. We recognize that opting in to receive PRA may not be the best option for your office, as PRA can increase the administrative burden on your staff.

Since the QPA does not alter the amount of reimbursement you receive, we will assume that you prefer to continue to opt out of receiving PRA and will further assume that you waive receipt of the required QPA disclosures at the time of initial payment or denial of payment.

For each claim covered under the No Surprises Act, you may request the QPA and additional information about how it was determined using the service code on these types of claims.

If your office prefers to receive the PRA, please send an email to ProviderExecs@NebraskaBlue.com. Please include your tax ID and NPI numbers in the request. Note: If you choose to opt into receiving PRAs, your office will receive paper remits for all claims in addition to the ERA that your office receives.

Provider Directory: Make Sure 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.

All providers (including dentists) can now review directory information in NaviNet. Directory information for your office can be located under Practice Documents.

For PHO groups handling their own credentialing processes, we will be requesting the submission of a full roster every 90 days.

Please 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.

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Provider Access and Availability Standards

BCBSNE has established access and availability standards to ensure timely services are available to all members. These standards were updated December 2022 to comply with regulatory and accreditation requirements. BCBSNE is utilizing Press Ganey to conduct phone surveys to ensure our network of providers are complying with the availability standards. Press Ganey will be announcing themselves, advising they are calling on behalf of BCBSNE, and asking questions to confirm if your office can schedule appointments according to the availability standards. Phone calls will be made during March and April 2023. For more information on Appointment Availability/Access standards, go to NebraskaBlue.com/Providers/Credentialing.

Remicade changes effective July 1, 2023

At BCBSNE, we are working to help our members with complex medical conditions get the care they need in the most cost-effective way.

The biologic medication Remicade (infliximab) has multiple cost-effective biosimilar alternatives available. Biosimilar products can be utilized in place of reference drugs in most clinical circumstances. Prior to 2022, our only preferred infliximab product was Remicade. Starting Jan. 1, 2022, we added the biosimilar products Avsola and Inflectra to our preferred product list. Current requests for Avsola and Inflectra that meet medical policy criteria will be approved and reimbursed accordingly.

Beginning July 1, 2023, patients who are on Remicade will need to switch to a preferred biosimilar alternative for treatment. Patients that are new to therapy will also be required to use a preferred biosimilar agent prior to the use of Remicade. The preferred infliximab products will be Avsola and Inflectra.

For questions regarding coverage of infliximab, please refer BCBSNE members to call the Member Services department at the number on the back of their member ID card.

Growth Hormone Therapy

In response to the Norditropin shortages in the market, our formulary and medical policy now include another growth hormone product, Genotropin.

BCBSNE will not require another preauthorization from providers for Genotropin.

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ASCs and Implants

For ASCs that bill implants, each implant should only be billed with one unit per line.

If an implant line is billed with multiple units and the billed charges exceed $100, the line will be denied as content to services, and a provider write-off. In this scenario, a corrected claim would need to be submitted changing the number of units to one per implant line.

Nebraska HeartlandBlue

Nebraska HeartlandBlue, BCBSNE's ACA product, allows us to offer more coverage options to Nebraska. These plans, offered in all 93 counties, use our existing networks; however, there will be no coverage for services received outside the state of Nebraska or outside the member's network except for emergency services.

Because of this difference, you will see "HB" behind each of the networks offered with Nebraska HeartlandBlue.

These plans can be identified by their alpha prefix YST or YNQ.

If your office is contracting with….	**Your office is also in-network with…**
NEtwork BLUE	NEtwork BLUE HB
Premier Select BlueChoice	Premier Select BlueChoice HB
Blueprint Health	Blueprint Health HB

Please share this information with your staff to make sure that they are aware of the above networks and inform Nebraska HeartlandBlue members appropriately.

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CommonSpirit Direct Primary Care (DPC)

The Nebraska division of CommonSpirit Health/CHI Health has BCBSNE medical coverage for 2023.

Providers may see two different ID cards issued by BCBSNE:

PREFIX	COVERAGE	NETWORK
CSE	Medical coverage	Blueprint Health
YNX	ACA medical contraceptive coverage	NEtwork BLUE

Under the CSE prefix, members will have three plan options: HSA option, PPO option and a new plan type – DPC.

The DPC plan has no copays, deductibles or coinsurance for DPC services, as long as the DPC member uses their CHI Health DPC provider. If the DPC member sees a non-DPC provider, there will be no coverage for these services and the DPC member will pay full billed charges. Covered services by specialists will be allowed.

When DPC members visit their CHI Health DPC provider, all of their encounters are covered, whether they are for preventive services, illness, injury or management of ongoing medical conditions. This includes:

- All in-office X-rays
- In-office procedures such as stitches for cuts or mole/lesion removal done by the direct primary provider
- In-office labs such as urinalysis, blood count, strep, mono and influenza testing
- The common/usual labs direct primary care providers request and manage are also covered
- No-cost or low-cost generic medications filled at a CHI Health pharmacy

Submitting Medical Records

When responding to medical records request letters, please make sure that the medical records submitted are only for the patient identified in the letter.

Each of these letters contains a QR code. When letters and medical records are returned, an automated process scans the QR code and directs the medical records to the appropriate area for review. Multiple patient medical records included under one letter creates a delay in the review and could possibly result in another request.

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Mental Health Providers and Telehealth – Effective May 1, 2023

For mental health providers to provide remote services (telehealth), the provider must live in Nebraska. Providers must also meet the credentialing criteria available at NebraskaBlue.com/Credentialing.

This change is effective May 1, 2023.

Medicare Advantage: Annual visit phone scheduling outreach begins in April

From April to June 2023, members who are due for an annual visit will receive calls from a BCBSNE third-party vendor. These calls will review the importance of annual visits with their primary care provider, and the key role preventative care plays in improving or maintaining their health.

The third-party vendor will also offer to help schedule an annual wellness visit or an annual physical exam with the member's primary care provider. A "Welcome to Medicare" visit will be offered to members who are within their first 12 months of Part B coverage.

Note the following codes should be used when billing:

- Physical exam codes: 99381–99387, 99391–99397
- Wellness exams (Annual Wellness Visits): G0438, G0439
- Welcome to Medicare exam: G0402

Members are eligible for a gift card reward for completing one annual visit by Dec. 31, 2023. If members have any questions about the reward, direct them to call the Customer Service phone number on their BCBSNE member ID card.

Medicare Advantage: HEDIS® measure: Follow-up after an emergency department visit is important patient care

Many patients discharged from the emergency department (ED) require urgent follow-up care with their providers due to their high-risk chronic conditions. Often, an ED discharge is based on the presumption of continued care.

The Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) focuses on the percentage of members age 18 and older who have multiple high-risk chronic conditions and who had a follow-up visit within seven days of an emergency department visit.

There are many ways to conduct a follow-up visit, including outpatient, telephone, Transitional Care Management (TCM), case management, complex care management, outpatient or telehealth behavioral health, intensive outpatient encounter or partial hospitalization, community mental health center, electroconvulsive therapy, telehealth, observation, e-visit, virtual check-in or domiciliary/rest home visits.

Read the tip sheet to learn more about this measure, including information about eligible chronic conditions, exclusions, best practices, documentation requirements and more.

Healthcare Effectiveness Data Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medicare Advantage: Transitions of Care HEDIS® measure focuses on medication management and care coordination for Medicare beneficiaries

According to the *American Journal of Managed Care*, the ineffective transferring of a patient from one care setting (e.g., a hospital, nursing facility, primary care physician, long-term care, home health care, specialist care) to another often leads to confusion about treatment plans, missed follow-up appointments, patient dissatisfaction, medication nonadherence and, most importantly, unnecessary readmissions.

The Transitions of Care (TRC) HEDIS® measure for star ratings focuses on the percentage of members who had an acute or non-acute inpatient discharge during the measurement year and who had each of the following:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge

Documentation of all four components must be in any outpatient record, as well as accessible by the PCP or ongoing care provider.

We encourage you to establish an office practice that explains to patients why it's critical they inform your office about their hospital admissions and discharges. Let them know this is important because it can improve their care coordination and maintain their safety.

Read the tip sheet to learn more about the measure, including exclusions, best practices, and documentation requirements.

Healthcare Effectiveness Data Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Source: American Journal of Managed Care

Contributor: Why Medicare Advantage Plans Must Transform Post Discharge to Medication-Focused Transitions of Care (ajmc.com)

Medicare Advantage and Commercial: Advanced illness and frailty exclusions allowed for HEDIS® measures

The National Committee for Quality Assurance (NCQA) allows patients to be excluded from select HEDIS® quality measures due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

You can submit claims with advanced illness and frailty codes to exclude patients from select measures. Using these codes also reduces medical record requests for HEDIS data collection purposes.

Read the **Advanced Illness and Frailty Exclusions for HEDIS Measures Guide** for a description of the advanced illness and frailty exclusion criteria and a list with some of the appropriate HEDIS-approved billing codes.

Source: http://blog.ncqa.org/improving-care-advanced-illness-frailty/

Medicare Advantage and Commercial: Encourage eligible patients to get screened for colorectal cancer

According to the American Cancer Society, colorectal cancer (CRC) is the fourth leading cause of cancer death for both men and women combined in the United States. However, more than one-half of all cases and deaths are attributable to modifiable risk factors, such as smoking, an unhealthy diet, high alcohol consumption, physical inactivity and excess body weight, and thus potentially preventable.[1] CRC morbidity and mortality can also be mitigated through appropriate screening and surveillance.[2]

The Colorectal Cancer Screening (COL) HEDIS® measure assesses patients ages 45–75 who had appropriate screenings for colorectal cancer.

Colonoscopy is the gold standard for colorectal cancer screening. There are alternative options for patients who are hesitant to have one.

Read the **Colorectal Cancer Screening tip sheet** to learn about this measure including what information to include in medical records, codes for patient claims and tips for talking with patients.

Source: Colorectal cancer statistics, 2020 - Siegel - 2020 - CA: A Cancer Journal for Clinicians - Wiley Online Library

[1]Islami F, Goding Sauer A, Miller KD, et al. Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States. CA Cancer J Clin. 2018;68:31-54.

[2]Winawer SJ, Zauber AG. The advanced adenoma as the primary target of screening. Gastrointest Endosc Clin N Am. 2002;12:1-9, v.

Security Corner: Responding to a Cybersecurity Incident

Be ready to respond to incidents that put data privacy and security at risk. This includes cybersecurity incidents, but also inadvertent events such as weather emergencies.

Create a **response plan** that includes:

- Notifying those affected
- Keeping business operations up and running
- Reporting the incident to the required authorities
- Investigating and containing the incident

After an incident, remember to update your response plan with any lessons learned.