BlueCross BlueShield Nebraska

The Update Newsletter
May 2023

COVID-19 national emergency and public health emergency ending May 11, 2023

The federal government will end the COVID-19 national emergency and public health emergency on May 11, 2023. **This means starting May 12, 2023, standard health plan provisions will apply with cost shares as applicable for COVID-19 testing, related services and vaccine administration.**

For more information, please read the BCBSNE response to the end of the national emergency and public health emergency at NebraskaBlue.com.

NaviNet® Enhancement: Claim Investigation – coming in June!

New functionality is coming soon to NaviNet!

This new investigation functionality is designed to replace our current online claim inquiry process on our provider website and allows providers to have an ongoing conversation with us about claims. Providers will have a record of what was asked and be able to keep the history of that request for future reference.

To submit an inquiry to Blue Cross and Blue Shield of Nebraska (BCBSNE) regarding a claim, simply log into NaviNet, perform a Claim Status Search, and look for the new “Investigate” button at the top of your Claim Status Results page:

An inquiry can be submitted by clicking the “Investigate” button and filling out the fields. When you receive a response from our Customer Service team, that button will be flagged with an exclamation point (shown above). Clicking on the “Investigate” button will open your Investigation List.

This application will keep a running history on any inquiries made on this claim and responses to and from that inquiry. If our Customer Service team has sent documentation in support of the inquiry, there will be a new document table where the attachment can be accessed. The document table will be located on the bottom of the Claim Status Details screen, below “Claim and Service Line Details” section.

NaviNet is a healthcare provider portal providing services for Blue Cross and Blue Shield of Nebraska

NaviNet Enhancement: Claim Appeal – Coming Soon!

A new Claim Appeal application is coming soon to NaviNet! This application will replace the current attachment process for submitting Appeals, Reconsiderations and Claim Timely Filing Disputes, and no longer requires forms to be downloaded and submitted.

For finalized claims found in Claim Status Results, you will be able to click on the “Appeal” button, select the type of request, reason for submitting, add comments and attach any supporting documentation. Requests will keep a history on the claim and will indicate that the status is “open” until a response has

been made to that request. The Document Table mentioned above will contain an electronic copy of any Appeal Outcome Letter that will be mailed to you if your request is denied. This table will also include Claim Return Letters that were previously only available within your "Patient Clinical Documents" workflow. Now you can easily access those documents directly from the claim status without navigating away from the claim details. This will make the process of submitting a dispute on a particular claim even easier! This new functionality is planned to be available mid-June, and additional information will be provided soon.

If you are currently not registered to use the NaviNet Provider Portal, please go to Connect.NaviNet.net/Enroll and you will be set up with access to use these new enhancements!

Risk Adjustment Data Validation Audit: Annual medical record retrieval process begins in June 2023

The Centers for Medicare and Medicaid Services (CMS) conducts an annual Risk Adjustment Data Validation (RADV) audit. The RADV audit verifies diagnosis codes submitted for payment, along with the corresponding medical records. BCBSNE will begin the process to retrieve medical records in June. Under the terms of your contract with us, health care professionals and facilities agree to submit medical records requested by BCBSNE in a timely manner at no cost to the patient or BCBSNE. Patients have consented to release medical records to us. An additional release is not required for this audit. All information resulting from the review is confidential.

Mental Health Providers and Telehealth – Effective May 1, 2023

The article in the March 2023 Update newsletter advised that in order for mental health providers to provide remote services (telehealth), the provider must live in Nebraska.

That article has been amended as follows:

Effective May 1, 2023, providers exclusively delivering telehealth services must either:

- Live in the State of Nebraska;
- Be a member of a credentialed Nebraska-based PHO; or
- Be employed by a licensed or credentialed Nebraska facility/practice.

Providers will also still need to meet the credentialing criteria that is available at Credentialing Information for Providers.

BlueCross BlueShield Nebraska

The Update Newsletter
May 2023

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.

CMS Rate Letters

To minimize financial impact of the settlement and to ensure proper reimbursement throughout the year, hospitals are expected to retrieve their current year rates from the Fiscal Intermediary/MAC and submit their rate letter (or system equivalent) to ProviderExecs@NebraskaBlue.com.

Rate letters must include the facility NPI numbers and indicate if the facility is a Method I or II biller.

Modifier FB change – effective July 1, 2023

Modifier FB should be appended to all devices, supplies, or drugs obtained at no cost to the provider.

Effective July 1, 2023, services appended with modifier FB are not eligible for reimbursement.

Preauthorization Requests

Preauthorization requests are reviewed in a timely manner, based on priority ordered by the provider. The timeline for review is from the receipt of the request to communicating the decision. The timeline is based on accreditation standards and regulatory requirements. Preauthorization requests include pharmacy, medical and radiology.

Priority:

- **Non-urgent:** includes up to 15 calendar days to communicate the review decision.

- **Urgent:** includes requests ordered by the provider as urgent, meaning the 15-day timeline could seriously jeopardize the life or health of a patient or subject the patient to severe pain that cannot be adequately managed without the requested treatment. When the ordering provider indicates urgent, we communicate the review decision within 72 hours of receipt of the request.
- **Step-therapy:** Except in the case of an urgent care request and upon receipt of complete, clinically relevant written documentation a review decision is provided within five calendar days.

To ensure most efficient review of the request:

- Use the online preauthorization portal through NaviNet for the Medical and Radiology preauthorizations. The review turnaround time is quicker since it eliminates time setting up the request. The link to the online preauthorization portal is NebraskaBlue.com/Providers/Preauthorization
- Always indicate the correct priority ordered by the provider, per their orders and/or medical records when the preauthorization request is submitted through the online tool or via a faxed request.
- Always include medical records for clinical review by attaching a pdf document or add a note in the online tool, or when you fax in the request. If not included, clinical staff will need to request medical records which delays the clinical review until the records are received.
- Always include the contact person's name, phone number and fax number in the notes of the online portal preauthorization request. This is helpful if additional medical records are needed to review your request. If there is no fax number, this will delay the request for medical records getting to your offices.
- **Always include the following on all faxed requests:**
    - The complete BCBSNE ID number, including the alpha prefix (this should match what is listed on the patient's BCBSNE member ID card)
    - The complete patient's name (this should match what is listed on the patient's member ID card)
    - Patient's date of birth
    - Patient's address, city, and state
    - Ordering provider's first and last name (NPI alone is not sufficient)
    - Ordering provider's full address
    - Facility/rendering provider's full name
    - Facility/rendering provider's address
    - Contact name, phone number and fax number who submits the request.
    - Procedure and diagnosis information

BlueCross BlueShield Nebraska

The Update Newsletter
May 2023

Medicare Advantage: Codes removed from Prior Authorization

Effective May 1, 2023, the following codes were removed from the prior authorization list:

CODE	DESCRIPTION
88271	MOLECULAR CYTOGENETICS DNA PROBE EACH
88273	MOLECULAR CYTOGENETICS CHRMOML ISH 10-30 CLL
88275	MOLEC CYTG INTERPHASE ISH ANALYZE 100-300 CLL
88291	CYTOGENETICS&MOLEC CYTOGENETICS INTERP&REP
93241	EXTERNAL ECG REC>48HR<7D SCAN ALYS REPORT R&I
93242	EXTERNAL ECG REC>48HR<7D RECORDING
93243	EXTERNAL ECG REC>48HR<7D SCANNING ALYS W/REPORT
93244	EXTERNAL ECG REC>48HR<7D REVIEW & INTERPRETATION
93245	EXTERNAL ECG REC>7D<15D SCAN ALYS REPORT R&I
93246	EXTERNAL ECG REC>7D<15D RECORDING
93247	EXTERNAL ECG REC>7D<15D SCANNING ALYS W/REPORT
93248	EXTERNAL ECG REC>7D<15D REVIEW & INTERPRETATION
J0897	XGEVA® (DENOSUMAB)
S9960	AMB SERVICE AIR NONEMERGENCY 1 WAY FIXED WING
S9961	AMB SERVICE AIR NONEMERGENCY 1 WAY ROTARY WING

HEDIS® measure focuses on helping prevent unnecessary hospital readmissions

Readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse patient outcomes and higher costs.

The Plan All-Cause Readmissions (PCR) HEDIS® measure assesses the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Coordinating care from the hospital to home and ensuring a follow-up visit with the primary care physician can help your patients avoid a readmission.

Read the PCR tip sheet to learn more about this measure, including information about exclusions, best practices and tips for success while talking with patients.

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The Update Newsletter
May 2023

HEDIS® measures for diabetic patient health

In 2022, the HEDIS® Comprehensive Diabetes Care measure was separated into three standalone measures. All diabetes care measures are used for HEDIS reporting, to drive improvements in patient health.

The standalone measures include:

- Hemoglobin A1C Control for Patients with Diabetes (HBD)
- Eye Exam for Patients with Diabetes (EED)
- Kidney Health Evaluation for Patients with Diabetes (KED)

Patients with diabetes require consistent medical care and monitoring to reduce the risk of severe complications and improve health outcomes. Interventions to improve diabetes outcomes go beyond glycemic control. That is why the comprehensive diabetes care composite measure has been split to enable more focus of the components of diabetes care.

View the tip sheets to learn more about what is included in the measures and ways you can close gaps in care for patients with diabetes. The tip sheets also cover required medical record documentation and claims coding to reduce the need for medical record reviews.

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

Security Corner: Recovering After a Cybersecurity Incident

Recovering after a cybersecurity incident means more than just ensuring that affected equipment and networks are repaired and restored. A recovery plan should also include an effective **communication strategy** that:

- Ensures appropriate information is shared with your various stakeholders—so that all affected parties get the information they need, but no inappropriate information is released.
- Manages public relations and company reputation. This is best done by ensuring that your information sharing is accurate, complete, and timely—and not reactionary.