Dear Health Care Provider:

This manual is dedicated to keeping you and your staff informed about Blue Cross and Blue Shield of Nebraska’s (BCBSNE) operational policies and procedures.

The contents of this manual are contractually binding for compliance, based on your provider agreement with BCBSNE. Providers must follow all applicable BCBSNE policies and procedures, as well as those applicable to the covered person. Contracting providers agree to provide appropriate information to their employees, agents and representatives consistent with this commitment.

It is important to familiarize yourself with the information provided in this manual and have it readily available as a reference. For your convenience, the manual is available online at NebraskaBlue.com/Providers the clicking “Policies and Procedures.” The online version of the manual contains the most current and updated information.

If you have any suggestions on how we can improve this manual as a comprehensive resource for you, please let us know.

Sincerely,

Dwayne M. Asche, Vice President, Health Network Services
# Current Edition Updates

**August 31, 2022**
- Section 1 – Participation Requirements updated
- Section 3 – Split Year Claims updated
- Section 6 – Telehealth updated
- Section 8 – Refund Offseting updated

**July 29, 2022**
- No updates

**June 30, 2022**
- Section 8 – Timely Filing updated
- Section 16 – Removed – moved to individual document

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Preface

Many “Blue” terms are used throughout this manual to describe the different BCBSNE programs and products designed to meet the needs of both our contracting providers and our members.

Each program/product is unique in its focus and because it carries the term “Blue,” you can be assured that it is supported by our mission to deliver the health and wellness solutions people value most.

Please note that your subcontractors are subject to the terms of your contract with us, and you are responsible for ensuring their compliance with it, as well as this manual and all applicable federal and state statutes, laws and regulations.

When there is a discrepancy between the terminology in this manual and the provider contract, the specific contract language will prevail.

The information in this manual is subject to change. Deletions and additions are published periodically. Some will have an effective date. Those with no effective date are effective as of the date the manual is published. We encourage you to utilize the most current version of the manual by visiting NebraskaBlue.com/Providers by clicking “Providers” then “Policies and Procedures.”

Revisions are often published in our Provider UPDATE newsletter and in direct mailings to your office. View newsletters by going to NebraskaBlue.com/Providers and click on “Alerts and Updates.” To receive an e-mail each time we post a new issue of the Provider UPDATE newsletter on the website, fill out the information in Contract Update Signup. In addition, we encourage you to view our comprehensive online provider library of past issues.

The information in this manual should not be considered all-inclusive. It contains general information that applies to many - but not all – employer group health plans. Employers can and do request variations of endorsements.

Health care providers should take advantage of our online provider portal through NaviNet to verify member eligibility and benefits, verify claim status or access a remittance advice. Go to NebraskaBlue.com/Providers and click on NaviNet go directly to the NaviNet sign in page to register or log-in. This information is available for you free of charge by BCBSNE and should be your primary source of verification.

Call our toll-free voice response system at 800-635-0579 to get answers to claim or benefit questions that may not be available on NaviNet.
About Blue Cross and Blue Shield of Nebraska

Who we are

Blue Cross and Blue Shield of Nebraska (BCBSNE) is a member of the national Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. BCBSNE is an independent mutual health insurance company licensed by the State of Nebraska.

BCBSNE has done business in Nebraska for nearly 80 years. We work with network health care professionals statewide to provide the best health care possible to our customers.

Financial stability

Although the Blue Cross and Blue Shield Association does not act as a guarantor of each Plan’s financial obligations, all Plans are subject to uniform financial standards established by the Association. These standards are intended to foster a system in which each Plan maintains adequate resources to meet its obligations to its customers. We have an A- financial rating with A.M. Best, which reflects a stable outlook.

BCBSNE monitors financial and operational performance through strict customer service and claims processing standards, performance guarantees and other methods of measurement.

Our Board of Directors

Business leaders, consumers and health care professionals across the state comprise our board of directors. The Board sets standards for operations and financial performance. Such standards include the amount of operating reserves we maintain. Reserves are funds that are set aside over and above dollars needed to pay claims and run the business.

The board also establishes and monitors all policies governing the conduct of our employees, officers and directors. These policies ensure the corporation operates ethically and within the laws and regulations prescribed for us.

Our mission, vision and values

BCBSNE’s mission is to deliver the health and wellness solutions people value most. Our vision is a health care world without confusion that adds more good years to peoples’ lives.

Our values include:

- Innovate to differentiate.
- Invite change to create opportunity.
- Enable customer passion.
• Openly embrace our communities.
• Be open, honest, and respectful to inspire trust.
• Collaborate to create excellence.

Advertising Policy

With prior approval from BCBSNE, as a contracting health care provider, you are permitted to mention your Blue Cross and Blue Shield of Nebraska (BCBSNE) network affiliation(s) in any electronic or print advertising or promotional materials, such as telephone directories, websites and brochures.

You are NOT permitted to use the Blue Cross and Blue Shield symbols at any time.

You are required to submit your camera-ready copy for review and approval to:

Blue Cross and Blue Shield of Nebraska
Marketing Department
P.O. Box 3248
Omaha, NE 68180-0001
Section 1: Becoming an In-network Provider

Participation Requirements
To become a contracting BCBSNE provider all applicants must complete the credentialing process and have a signed agreement on file, prior to be accepted into the network. New practitioners wishing to join BCBSNE can complete the CAQH application at CAQH.org. For more information regarding credentialing requirements and/or to request a provider agreement, please visit NebraskaBlue.com/Providers/Credentialing.

Effective November 7, 2022, BCBSNE requires all providers that are not sole proprietors to have a Type 2 NPI. This is required to align with Blue Cross Blue Shield Association standards.

If you do not currently have a Type 2 on file, you can apply at https://nppes.cms.hhs.gov/. Providers without a Type 2 NPI on file will be subject to contract termination. Please ensure you are keeping all your data current in NPPES. The Blue Cross Blue Shield Association does verify all BCBSNE provider data against NPPES to confirm taxonomy and NPI information is valid and accurate.

For more information regarding credentialing and/or to request a provider agreement, please visit NebraskaBlue.com/Providers/Credentialing.

Participation Acceptance Notification
BCBSNE will notify health care providers /facilities whose applications have been approved for participation in writing.

For information on adding/changing practice locations or submitting a facility/clinic name change, please see Administrative Updates for Providers | BCBSNE (nebraskablue.com).
Section 2: Provider Responsibilities and Considerations

This Section outlines the responsibilities of all providers (both professional and facility) that are accepted into our PPO network.

Following the terms below ensures the least amount of “out-of-pocket” expense to the patient. In-network health care professionals must:

- Providers must bill using in-network/contracted credentials (NPI, EIN, etc) associated with where the services are performed. Providers may not bill using sister/parent company credentials.
- Refer/admit covered persons only to hospitals that are in network with the member’s benefit plan. *
- Refer covered persons only to medical specialists and other health care providers that are in network with the member’s benefit plan. *
- Arrange vacation and call coverage to be provided by a provider that is in network with the member’s benefit plan.

*Except under circumstances identified in the agreement.

Access, Use, and Transfer of Interplan Data

As a participating provider with BCBSNE, you agree to comply with all Blue Cross Blue Shield Association (BCBSA) policies regarding the access, use, and transfer of BCBSA and/or another Blue Cross Blue Shield Licensee’s confidential information, including data. These restrictions include the following:

- You must limit the use of confidential information strictly for the purpose for which it was disclosed, and you must limit the disclosure of confidential information to the minimum necessary to fulfill the purpose for which it was disclosed.
- You may not use, distribute, exploit or re-sell confidential information in whole, or in part, for your own benefit, or that of any third party.
- You must destroy, or return, confidential information to BCBSNE upon conclusion of the purpose for which the confidential information was disclosed.
- You must notify BCBSNE if your ownership changes.
- You may not co-mingle the released confidential information with other employer or third-party information.
- You may not de-aggregate confidential information to identify the disclosing party, or a licensee of BCBSA.

BCBSNE may request a limited audit solely for the purpose of ensuring compliance with the above limitations. Such audit shall be undertaken not more than annually.
Cash discounts
If you offer a cash discount, that discount needs to extend to BCBS patients. The discounted amount must be the amount billed on the claim. If a BCBS member requests a claim be filed for a non-covered service, the provider must file the claim. See “Sliding Fee Schedules”

Changes of address, telephone number and/or tax identification number, or adding practice locations
Contracting providers are required to notify BCBSNE of any changes of address, telephone number, NPI or tax identification number.

An in-network health care provider must complete the appropriate form if he/she wants to:
- add a location with the same tax ID – keeping current location active
- add a location with a different tax ID - keeping current location/tax ID
- transfer to a new location under a new tax ID – inactivate current location/tax ID

Instructions on how to return the form are located at the bottom of the form.

All forms require the affected provider’s signature or the signature of the individual with signing authority for the tax ID.

Tips for completing the Provider Extend/Transfer form
The tax ID number that should be listed at the top of the form is the one tied to the current practice location and existing BCBSNE provider agreement. All required fields must be completed prior to submitting the form to BCBSNE.

Closing practice to new patients
A provider may refuse to take new BCBS patients but only if their practice is closed to all new patients regardless of insurance coverage

Confidentiality of Substance Use Disorder Patient Records Rule (42 CFR Part 2)
Provider agrees to comply with the Confidentiality of Substance Use Disorder Patient Records Rule (42 CFR Part 2) to the extent that provider is subject to 42 CFR Part 2.

Provider agrees to obtain appropriate patient consent prior to disclosing patient information that is subject to 42 CFR Part 2 to BCBSNE. The patient consent must: identify the appropriate third-party as the permitted recipient, allow the third-party to use the information for payment and health care operations activities, specify that the third-party payer may disclose information back to the provider for the provider’s payment and health care operations activities, and otherwise comply with the requirements of 42 CFR Part 2. For BCBSNE members, the consent should name the patient’s self-funded health plan (if applicable) and should always name BCBSNE. For other Blue Plan members, the consent should name the self-funded health plan (if applicable) and should always name BCBSNE and the Blue Plan through which the patient receives health coverage. For information on if the patient is
covered under a fully insured or self-funded plan and the name of the employer group, please contact Customer Service using the number on the back of the patient’s identification card or call the BlueCard Eligibility Locator line at 800-676-2583.

In addition, provider must include a Part 2 Disclaimer with any claim (or other record) that contains Patient Identifying Information (subject to 42 CFR Part 2) when submitting the claim (or other records) to BCBSNE. The Part 2 Disclaimer is: “42 CFR part 2 prohibits unauthorized disclosure of these records.” BCBSNE reserves the right to deny payment of any claim, and/or to refuse to process other information, if the provider fails to obtain the required consent and/or fails to include the required notification.

**Continuity of care**

If a provider’s in-network status is terminated (either by BCBSNE or at the provider’s request), BCBSNE will continue to provide benefits for a specified period after that termination to members who are actively receiving certain types of care (see chart below). The provider is contractually responsible to continue to render covered services and will be reimbursed at the previously contracted rates. The provider should not balance bill the member for these services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Time covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Covered Services</td>
<td>Up to 30 days following discharge date</td>
</tr>
<tr>
<td>Non-surgical Cancer Treatment</td>
<td>Up to 90 days or a complete cycle of radiation or chemotherapy, whichever is greater</td>
</tr>
<tr>
<td>Surgical Cancer Treatment</td>
<td>Up to 90 days post-surgery date</td>
</tr>
<tr>
<td>End Stage Kidney Disease and Dialysis</td>
<td>Up to 90 days after initiation of COC</td>
</tr>
<tr>
<td>Symptomatic AIDS undergoing active treatment</td>
<td>No specific time frame for limitation of care</td>
</tr>
<tr>
<td>Recent bone marrow or organ transplant (or on the waiting list)</td>
<td>Up to 1 year after initiation of COC</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Up to 6 weeks post deliver date (after 1st trimester)</td>
</tr>
<tr>
<td>High Risk Pregnancy</td>
<td>Up to 6 weeks post deliver date</td>
</tr>
<tr>
<td>Mental Illness and/or Substance Abuse (inpatient or outpatient)</td>
<td>No time frame for limitation of care due to availability of timely care</td>
</tr>
<tr>
<td>Circumstances where BCBSNE is required by applicable law to provide transition coverage of services being rendered by a provider after the provider leaves the network accessed by the member’s benefit plan</td>
<td></td>
</tr>
</tbody>
</table>

When BCBSNE becomes aware of one of these situations, we will send a Continuity of Care (COC) form to the member. To continue to receive in-network benefits for the conditions/time frames listed above, the form must be completed and returned to us.
BCBSNE will make a good faith effort to arrange for the expedient transfer of all patients to another qualified provider upon termination of the provider’s agreement.

**Coordination of Benefits**

The Coordination of Benefits (COB) provision is designed to prevent duplicate benefit payments when a patient is covered by two or more health and/or dental insurance plans. If BCBSNE is the secondary plan we will need the primary insurance’s EOB/remit to process the claim, even if you do not contract with other insurance payer(s).

See chart below.

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
<th>Include</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSNE or another Blue Plan</td>
<td>Non-Blue plan</td>
<td>Other carrier’s name and address on the claim filed to BCBSNE</td>
<td>To avoid claim processing and payment delays, include the other insurance information. This will also avoid post payment adjustments, which can increase your administrative costs.</td>
</tr>
<tr>
<td>Non-Blue Plan</td>
<td>BCBSNE or another Blue Plan</td>
<td>Copy of the Explanation of Benefits (EOB) from the primary carrier - submit the claim &amp; EOB to BCBSNE</td>
<td>Please include the primary carrier’s EOB to avoid claim denial and post payment adjustment.</td>
</tr>
<tr>
<td>Two different Blue Plans</td>
<td></td>
<td>File a claim for the primary plan first. Once the primary Blue plan claim is processed, file a claim for the secondary Blue plan with a copy of the primary EOB</td>
<td>Filing to the incorrect Blue plan as primary and/or not including the primary EOB for the secondary claim will result in delay of claim processing and post-payment adjustment.</td>
</tr>
</tbody>
</table>

COB rules dictate which payer is primary. When BCBSNE is the primary payer, benefits are determined as if no other plan provided coverage. When BCBSNE is the secondary payer, benefits are determined after the primary plan has decided its benefit amount. As the secondary payer, BCBSNE may reduce benefits due to the primary plan benefit responsibility.

Payment will not be made for any amount for which the covered person is contractually held harmless by either the primary or secondary plan. Payment shall not exceed the amount paid under the BCBSNE Plan had it been primary.

BCBSNE, along with most group health plans, follows the most current National Association Insurance Commissioners (NAIC) COB model regulations when determining the order of benefits. The NAIC Coordination of Benefits model regulations dealing with “Order of Benefits Determination” sets forth six rules for determining the order of benefits between plans.
Most plans follow the “birthday rule” to determine which parent’s plan is primary for children. The plan covering the parent whose birthday falls earlier in the year is considered the primary payer.

“Birthday” refers only to the month and day in the calendar year – not the year of birth. If the parents share the same birthday, the primary plan is the plan that has been in effect for the longest time.

There are exceptions in the case of separated/divorced parent. Unless specifically stated in the decree the primary plan is determined in the following order:
1. The plan covering the custodial parent;
2. The plan covering the custodial parent’s spouse;
3. The plan covering the non-custodial parent; and then
4. The plan covering the non-custodial parent’s spouse.

However, if we are informed that a divorce decree or a child support order requires one parent to be responsible for health care expenses, that parent’s plan will be primary.

A universal Coordination of Benefits (COB) questionnaire is available to you on our website. Please ensure the form is completed and signed by the member.

For questions regarding other COB rules, please contact the Coordination of Benefits department at 402-390-1840 or 800-462-2924.

COB and Medicare
For questions about coordinating benefits with Medicare please visit the Medicare website.

**Documentation**

**BCBSNE Documentation Policy for E & M Services**
Your office should submit CPT codes in compliance with CMS CPT and NCCI coding rules for reimbursement. When CPT codes are not addressed by CMS, then AMA CCI rules will be followed. For more specific information please check the Billing and Reimbursements Manual.

**Risk Adjustment**
Under the Affordable Care Act, everyone will have access to health insurance irrespective of their health status. To try and create a system in which some payers and their networks of providers are compensated for the risk associated with the members they treat (known as risk adjusted payments), a complete and accurate capture of each individual patient’s health status through claims and encounter data is critical.

Providers need to code any chronic conditions from the patient’s medical record whether it had anything to do with that day’s visit or not.
**HITECH Act**

BCBSNE encourages our network providers to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the [HITECH Act](https://www.gpo.gov/fdsys/pkg/PLAW-111publ5/pdf/PLAW-111publ5.pdf) (Public Law 111-5, The Health Information Technology for Economic and Clinical Health Act).

**Hold Harmless and Balance Billing**

In-network providers are not permitted to “balance bill” a member for amounts more than the BCBSNE allowance for covered services. Providers are also responsible for the cost of billing claims and any collection service activities they may engage.

Provider, their associated billing services and/or collection agencies that improperly balance bill BCBSNE members will be in violation of the provider contract. Once notified, the provider must promptly take necessary steps to halt any such activity. If balance billing is not stopped, the provider may be terminated from participating in any BCBSNE networks.

A provider may bill the covered person for services, procedures, drugs, supplies and medical equipment when BCBSNE has applied amounts to deductible, coinsurance or co-pay, and where services are denied as not covered by the member’s benefit plan.

For a provider to be allowed to bill the member for services that are denied as not scientifically validated, investigative or not medically necessary two conditions must be met:

1. The provider must have advised the member in writing that the member is likely to be financially liable for the services provided. Documentation must show the provider informed the member of the total out of pocket cost or which the member could be liable.
2. The Advanced Beneficiary Notice (ABN) or waiver documentation must have been presented and signed by the member prior to the service being rendered.

If written agreement cannot be obtained, verbal notification may be given by the provider, but it must be documented in the patient’s medical records at the time the notification is given. For all other balances, the provider agrees not to bill or collect any amount from the member.

**NOTE:** For patients who are covered under a Federal Employee Program (FEP) plan, the ABN or waiver must be presented and signed by the member. Medical records will not be accepted as proof of ABN.

**Immediate Family**

In-network providers may not bill, or cause BCBSNE to be billed, BCBSNE for health care services rendered to, or ordered for, themselves or their immediate family members. In-network providers also may not designate themselves as a primary care physician, for any purpose, for themselves or their immediate family members.

"Immediate family member" is defined as:

- current spouse
• eligible domestic partner
• parents and stepparents of the provider or the provider’s spouse or domestic partner
• children and grandchildren (biological, adopted, or other legally placed children) of the provider and/or the provider’s spouse or domestic partner
• siblings (including biological, adopted, step, half, or other legally placed children) of the provider or the provider’s spouse or domestic partner

BCBSNE will not process or make payment for any claims for services rendered by an in-network provider to him or herself or to his or her immediate family members. Additionally, BCBSNE will not process or make payment for any claims for services ordered by an in-network provider for him or herself or for his or her immediate family members. If BCBSNE determines that a benefit was paid in error, BCBSNE has the right to request and receive a refund of the payment from the in-network provider.

**Locum Tenens**

Locum tenens is a person who is temporarily fulfilling the duties and responsibilities of an office in the absence of the appointed holder of that office. Often used for a physician who substitutes for another physician.

When locum tenens is used, bill services under the physician who is temporarily gone. Likewise, if a physician is serving as locum tenens for a midlevel practitioner, bill the services under the midlevel practitioner who is temporarily absent.

**The contracting status of the physician/practitioner under whose name the services are being billed will be used for claim payment. Payment for locum tenens will only be made if there is an actual substitution for an in-network provider.**

If the substitution lasts for more than ninety days, the physician filling in needs to be credentialed. Locum tenens is not a new permanent physician or a physician going through credentialing.

**Midlevel Providers**

Physician Assistants (PA), Advanced Practice Registered Nurses (APRN) and Certified Nurse Midwives (CNMW) need to contract individually with Blue Cross and Blue Shield of Nebraska.

For Billing information - see the “Midlevel Providers” section of the *Billing and Reimbursements Manual.*

**Multiple “Pay-to” Locations**

BCBSNE does not separate out payments for multiple office locations that share the same tax identification number.
Name Change - Facility/Clinic
BCBSNE must be notified by letter or email, whenever a facility/clinic changes its name but keeps the same tax ID, ownership, location, and providers. The request must include all the follow:

• Previous (current) name
• New name
• NPI(s) – multiple NPIs all must be listed
• Updated copy of NE license showing the name has been updated with NE Department of Health and Human Services (DHHS)
• If the facility/clinic has multiple lines of business (skilled nursing, home health, hospice, HME, etc.), those entities must also be listed in the request

For questions on how to submit or status of an update, contact the HealthNetworkRequests@NebraskaBlue.com.

Non-Covered Services
If a BCBS member requests a claim be filed for a noncovered service, the provider must file the claim.

Non-Discrimination
In-network providers must not discriminate, treating all members with dignity, respect and courtesy regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status.

In-network providers must provide services to all BCBSNE members without regard to the member’s enrollment in a managed care plan, either as a private purchaser or as a participant in a publicly financed health care program, unless limitations are due to lack of training, skill, experience, or licensing restrictions.

Onsite Review
There are times when BCBSNE may request an onsite review with a provider’s practice or institution. Some reason we may request on onsite review include, but are not limited to:

• A general visit following a member complaint
• Suspected fraud, waste and/or abuse of service
• Review best practices for billing
• General review of all provider practices to maintain and continue our partnership
• When credentialing is delegated

An assessment will be made by a BCBSNE designated individual attending the onsite visit, and a summary of the findings will be given to the provider. The outcome of the onsite visit will determine if a corrective action plan will be initiated. Should a corrective action plan be required, that information will be included in the summary.
Physical Presence

Contracting providers must have a physical presence in the state of Nebraska. Physical presence means you have an office with a street address. A P.O. Box is not enough. The physical office location must be used to provide services to patients.

Exceptions to this requirement are the following providers when they have obtained prior approval from the BCBSNE Network Oversight Committee:

- Air ambulance
- Independent lab
- Home medical equipment/durable medical equipment
- Specialty pharmacy
- Non-Nebraska providers located in contiguous counties

Preauthorization and Certification

Preauthorization

Preauthorization is based on the terms of the covered person’s contract and information submitted to BCBSNE. Preauthorization guidelines apply when BCBSNE is the primary payer; no preauthorization is required when BCBSNE is secondary to any other insurance (including Medicare or another Blue Plan). When BCBSNE is secondary, our medical policy will still apply.

Payment for services requiring preauthorization requires the preauthorization approval to be in the BCBSNE system. A provider’s submission of a preauthorization request acts as a provider attestation that all information included is accurate. If no approval is obtained prior to the service being rendered, the claim will be denied as “no preauthorization obtained.” Medical necessity review upon appeal will not be done except for FEP or if the service was rendered under emergent circumstances. Using the medical policy tool, we have made available, you will have real-time access to the most current information, and can search for a medical policy by keyword, policy number, or procedure code.

Providers may submit online preauthorization’s directly from MedPolicy Blue. Provider’s will then be asked to log in to Navinet to complete the submission of the preauthorization.

If a policy is not listed for a procedure or if the provider is not certain the member’s condition meets coverage guidelines, the care should be preauthorized.

Preauthorization requests are processed in the order they are received. If the procedure will not be scheduled until the preauthorization has been completed, use the date the doctor would like to perform the service as the scheduled procedure date.

Preauthorization’s that are not urgent will be processed within 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If information is requested, providers are given
not less than 21 calendar days to submit additional information. The patient is given not less than 45 calendar days to submit additional information.

A preauthorization determination will be made within 15 calendar days of receipt of the information or the end of the extension period.

If a rush request is received, the request will not be placed in a rush status unless it meets the status for an urgent preauthorization. The requestor will be notified that the anticipated decision date will be 15 days from the date of submission.

In the case of an urgent preauthorization, the claimant/provider will be notified of the decision within 72 hours of receipt, unless further information is needed. If additional information is necessary, the claimant/provider will be given at least 48 hours from the date of the request to provide the specified information. We will communicate our decision within 48 hours of receiving the additional requested information, or the end of the period allowed to provide the information.

An authorization is generally effective for six months, unless otherwise specified. All authorizations are based on the terms of the member benefit plan as of the date the authorization is done. Benefits are based on the member’s plan as of the date services are received.

Changes in the patient’s coverage for any reason, including eligibility, benefit revisions, or contractual maximums, may affect the approval.

Any time there is a question whether a procedure or service is covered by BCBSNE, the provider should try to determine if a preauthorization is needed by checking MedPolicy Blue.

**Note:** All medical policy criteria and preauthorization requirements applicable to out-of-state Blue Cross and/or Blue Shield patients are dictated by the Blue Plan that insures the member. Refer to “Medical Policy and Pre-cert Lists for all Blue Plans” for preauthorization requirements for the member’s plan.

**Radiology Preauthorization Program**

BCBSNE has implemented a Radiology Quality program to promote the most appropriate use of advanced imaging services. The program aligns with the goals of the Nebraska Health Care Reform Task Force: To promote high quality, affordable health care coverage and utilize the best practices and practice guidelines to help reduce unnecessary medical expense.

The ordering provider/office should complete the preauthorization. Radiology providers/free standing imaging centers should confirm from the ordering provider that a preauthorization has been obtained. Authorizations are valid for 60 days from the date of submission of the authorization.
To submit a preauthorization for a radiology service, you will need a NaviNet account. Once logged into NaviNet, click on the preauthorization tool link on the left side of the screen.

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<td></td>
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</table>

**How the program works**

- If the information provided meets InterQual criteria, the user will be issued an auto authorization.
- If all criteria are not met and additional information or review is needed, the authorization will be pended. Additional information will be requested for review by our nurses or medical staff.

**NIA Magellan Spine Pain Management Program**

BCBSNE’s spine pain management program is part of our commitment to member safety and promoting continuous quality improvement for services. We work with National Imaging Associates, Inc. (NIA), a Magellan Health Services company, for administration of this program.

This program includes prior authorization for two components of non-emergent spine care: (1) outpatient interventional pain management (IPM) services, and (2) inpatient and outpatient cervical and lumbar spine surgeries:
<table>
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<tr>
<td>Cervical artificial disc replacement</td>
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<td></td>
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<tr>
<td>Cervical anterior decompression (without fusion)</td>
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</table>

BCBSNE oversees the program and is responsible for claims adjudication and medical policies. NIA manages non-emergent outpatient IPM services, along with inpatient and outpatient cervical and lumbar spine surgeries, through the specialist contractual relationship with BCBSNE.

**Important information to note:**

- It is the responsibility of the ordering physician to obtain prior authorization for all interventional spine pain management procedures and spine surgeries outlined above.
- NIA does not manage prior authorization for emergency spine surgery cases that are admitted through the emergency room or for spine surgery procedures outside of those procedures listed above.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of the claim.
- Facilities must continue to follow BCBSNE’s prior-authorization requirements for hospital admissions and elective surgery based on the member’s benefit and coverage requirements.
Any BCBSNE prior authorization requirements for the facility or hospital admission must be obtained separately and should only be initiated after the surgery has met NIA’s medical necessity criteria.

NIA Magellan’s clinical guidelines can be found on NIA Magellan’s website at www.RadMD.com.

Certification

BCBSNE requires precertification for all acute inpatient (medical and surgical) and inpatient observation admissions for BCBSNE members and their dependents on day one.

Planned admissions may be certified on or before admission date.

- Precertification notification for unplanned admissions should occur on the first business day following admission.

- **This requirement does not apply to:**
  - Members with Medicare Supplement coverage
  - Members for whom BCBSNE is secondary to another payer
  - Hospital stays for labor and delivery (48- or 96-hour admissions)
  - Preauthorization is required if the patient is transferred to a lower level of care, such as skilled nursing or home health facility, on the first day. All other hospitals and residential treatment centers must call us on the first inpatient day.

Federal Employee Program (FEP) Members

Precertification requirements apply to FEP members. If precertification is not obtained when required for FEP members, a $500 precertification penalty will be applied to the provider’s reimbursement, if care is determined to be medically necessary.

***Please note: ALL inpatient admissions for gastric restrictive procedures require precertification to confirm the member has met requirements for medical necessity. If precertification is not done and care is determined to be medical necessary, the $500 penalty will be applied. If the precertification is not done and the care is determined NOT medically necessary, all charges will be denied.

Adhering to these requirements will prevent the above precertification penalties from being passed to providers and/or members. Outpatient surgery does not require precertification. If the patient subsequently needs to be admitted as an inpatient, then precertification is required on the first day.

NICU Inpatient Level of Care

All Neonatal Intensive Care Unit (NICU) admissions require precertification for the appropriate NICU level of care throughout the inpatient stay, and until the newborn is discharged.

- Based on medical necessity, a NICU admission can potentially be certified for more than one NICU level of care.
- The 4 NICU levels of care are represented by a unique revenue code and should be billed with the level of care that was approved during the utilization review process.
• If the claim is billed at a higher level of care than the level approved in the authorization, the claim will be denied.
• If provider disagrees, please follow the appeal or resubmission process.

Note: All certification requirements for out-of-state Blue Cross and/or Blue Shield patients are dictated by the Blue Plan that insures the member. Refer to the BlueCard® Program section of this manual for more information.

Peer-to-peer discussion
When a BCBSNE physician reviewer denies a certification request for medical necessity, the attending physician has the right to discuss the decision with him or her prior to requesting an appeal. (If the BCBSNE physician who made the denial is not available, the attending physician will be given the opportunity to discuss the case with a different physician reviewer.)

Peer-to-peer discussion appointments may be made by calling 800-424-7079. We will need the reference number and patient’s ID number.

Requests for peer-to-peer reconsiderations of not medically necessary denials on prospective and concurrent reviews must be requested within 14 calendar days of the denial. If a peer-to-peer request is not received within 14 calendar days of the denial, the provider will need to submit a request for an appeal.

The BCBSNE physician reviewer discusses a case only with the attending physician, not with the patient. The peer-to-peer discussion will occur within 24 hours of the attending physician’s request.

If the attending physician disagrees with our decision, he or she is encouraged to discuss the case with our physician reviewer. It is important to include any additional information that we did not have when the original denial was issued.

If the attending physician declines the peer-to-peer discussion or if the peer-to-peer discussion does not resolve a difference of opinion, the attending physician has the right to request an appeal.

Appeals
All BCBSNE member contracts offer two levels of appeal. Appeals are performed by physicians who were not previously involved in the original review.

When requesting an appeal, it is important to submit all relevant information that may assist in conducting the appeal. Refer to Section 16 of this manual for additional information.
**Provision of Services**

When a BCBSNE member is accepted as a patient, the provider is contractually responsible to provide services that fall within the Provider’s normal scope of practice and expertise and as set forth by state law.

Providers are responsible for the creation and maintenance of the patient relationship and shall be solely responsible for all aspects of the delivery of treatment and medical care. No provision of the provider contract requires the provider to enter or continue a patient relationship with any member.

No provision of the provider contract expands the scope of the provider’s responsibility for the medical care provided beyond the usual provider-patient responsibility.

**Referrals**

If the provider determines that a covered person requires services not customarily rendered by the provider, including the services of physicians, hospitals, or other health care providers, the provider shall use best efforts to refer patients to providers that participate in BCBSNE’s provider networks or in the BlueCard Program.

Providers shall be guided by reasonableness and the covered person’s best medical interests in referring, admitting, or directing him or her for such services and providing information about all known referral choices.

**Scope of Practice**

If a provider has questions regarding services within their scope of practice, they should check with the Nebraska Department of Health and Human Services, Professional and Occupational Licensure Regulations.

**Sleep Lab**

The sleep lab is a facility where patients are referred by their physicians to evaluate or diagnose sleep disorders. This includes neurological disorders, movement disorders and breathing disorders during the hours of sleeping. A lab can be hospital-based or independent.

**Independent Sleep Lab**

Independent sleep labs are required to be licensed as a “clinic” with the State of Nebraska to be eligible to participate with BCBSNE and must be approved by the BCBSNE Network Oversight Committee to be considered for network status.

For billing guidelines - see “Sleep Lab” in the *Billing and Reimbursements Manual*. 
Sliding Fee Schedules
BCBSNE providers must be consistent in the amount they charge for their services. If you utilize a sliding fee scale for your disadvantaged clients, you must also apply this sliding fee scale to your BCBS patients and bill that amount to us. See – “Cash discounts”

Submission of Claims
Providers are responsible for submitting clean claims for all services. Claims submission should be prompt and, in the format, requested by BCBSNE, regardless of whether there are other sources of payment or reimbursement.

The provider agrees that charges for covered services provided to their BCBS patients will be at the same rate as is charged to their other patients.

The provider also agrees to provide BCBSNE with any additional information which is reasonably necessary to determine benefits and to verify performance under their agreement. Such information will be provided without charge and in a timely manner.

The provider agrees to follow all policies on authorization, verification, precertification and preauthorization of benefits where required by member’s Blue Plan. This includes working with vendors utilized by the Blue Plan to perform this service.

Nothing in the agreement shall convey to BCBSNE the right to release or obtain information which is declared to be confidential or privileged communication, or otherwise restricted, by federal or state statutes or regulations. We require strict compliance with the statutory/regulations disclosure requirements.

Subrogation
The health plans underwritten and/or administered by BCBSNE have a contractual right to recover amounts paid because of an injury/illness caused by a third party. This priority lien of the health plan on proceeds paid by a third party applies whether the covered person has been fully compensated. The health plans also may have a contractual right of reimbursement from other proceeds to the extent benefits were also paid under the health plan for the same illness or injury.

Before sending in an accident claim
As a network provider, you have agreed to file all claims to BCBSNE for any covered benefit provided to our members and to accept our allowance as payment in full. All claims should be submitted to BCBSNE, even if the member request they only be filed to third party insurance.

If a covered benefit involves claims that are a result of an accident or illness caused by a third party, you must file a claim including accident information to BCBSNE. We will provide benefits according to the member’s contract and supply payment to the provider of service pursuant to our agreement with them. If the claim is submitted past the applicable limit, no payment will be available.
Our Subrogation Department will begin the necessary procedures to recover paid amounts from the covered person or third-party payer, which will not exceed the amount we paid in benefits.

If you are notified of an injury or accident after filing claims to BCBSNE and have not included the accident information on the claim, you should notify our Subrogation Department immediately at 402390-1847 or 800-662-3554.

**Subrogation or right of reimbursement term in a member contract**
Subrogation is the right of a person to assume a legal claim of another or the right of a person who has paid a liability or obligation of another to be indemnified by that person. A right of reimbursement is a contractual term granting one party to a contract the right to obtain reimbursement from the other party to the contract under certain circumstances. All member contracts of insurance with BCBSNE and all health plans administered by BCBSNE contain subrogation and right of reimbursement provisions.

**How BCBSNE members are affected by subrogation and right of reimbursement**
Member contracts receive include an obligation to reimburse BCBSNE or the health plan if another party is responsible for payment or if the member is pursuing payment from another source and, in some circumstances, when certain conditions are met.

BCBSNE enforces the terms of the contract and pursues recoveries through our Subrogation Department. The contract or health plan language in place at the time of the accident will determine the rights and obligations of the parties.

**How BCBSNE providers are affected by subrogation and right of reimbursement**
In general, providers are not affected by subrogation or right of reimbursement. In certain circumstances, two insurers may potentially be responsible for payment (usually BCBSNE and the member’s/third party auto insurer). Some BCBSNE member contracts have Coordination of Benefits language in them, and BCBSNE must coordinate benefits with the individual auto carriers.

In some cases, an insurer other than BCBSNE another third party will make payment directly to the provider. The provider may have received payment from BCBSNE, as well. If you receive a payment from two sources, your BCBSNE provider agreements states that you should return the overpayment to BCBSNE, even if the payment received from the third party is less than the BCBSNE payment.

In all cases, BCBSNE will follow the member contract or health plan when processing claims and payments from other sources. In no circumstance should providers send an overpayment to the other insurer or the member without direction from our Subrogation Department.

For questions, please call the BCBSNE Subrogation Department 800-662-3554 or 402-390-1847.
Tax Identification Number - Multiple Locations
As a network provider, you have agreed to file all claims to BCBSNE for any covered benefit provided to our members and to accept our payment as payment in full. If an office has multiple locations with multiple billing addresses, the provider will need to designate one payee location.

Tax Levy and Garnishment
When BCBSNE received a tax levy or garnishment for a participating provider we are required to comply with the levy or garnishment request.

Once the levy/garnishment is received the provider’s method of payment is changed to paper check, whether they were receiving payment by EFT. BCBSNE will hold all payments scheduled to pay to the provider and will send these payments (with required documentation) to the IRS/State of NE. This process will continue until we receive an updated tax levy or documentation releasing or completing the tax levy from the IRS or State of Nebraska.

The provider receives documentation showing that we made payment to the IRS/State of NE due to a levy. We will send a copy of the voided check, a copy of the check remitted to the IRS/State of Nebraska, a copy of the EOB and a letter stating payment was issued but was remitted to the IRS/State of Nebraska due to a tax levy.

We keep copies of all documents that are mailed for future reference.

Utilization Review/Management
In-network providers are contractually responsible to participate in programs to effectively manage the cost of health care services. Such programs are identified and described within the contents of the Policies and Procedures manuals.

Verification of Enrollment
As an in-network provider it is expected that you will use all reasonable efforts to obtain the patient’s eligibility status. There are several ways to obtain a patient’s eligibility information, including online or by phone.

The preferred method of checking eligibility and benefits is through NaviNet. Once logged into NaviNet, you can verify eligibility and benefits for all BCBSNE and BlueCard members, as well as FEP members.

You can also check eligibility status by an online inquiry at NebraskaBlue.com/Providers/Eligibility-and-Claims. Click on “Verify Benefits” and complete the form.

You may also check eligibility and benefits by calling:
- 800-635-0579 (GABBI system to check eligibility and benefits for BCBSNE members). Must provide:
NPI (National Provider ID) o Tax ID o Member ID number

Patient date of birth

- 800-676-BLUE (2583) (BlueCard Eligibility Line to check eligibility and benefits for members insured by an out-of-state Blue Plan) – must provide the three-character prefix
- 402-390-1879 or 800-223-5584 (FEP Program Service to check eligibility and benefits for members enrolled under the Federal Employee Program)

**Waiver of Deductible/Coinsurance/Copayment**

BCBSNE strongly recommends collection of copayments at the time of service. BCBSNE does not permit the waiver of cost sharing, apart from demonstrated financial hardship. The routine waiver of deductible/coinsurance/copayment may represent a breach of contract with BCBSNE.

Routine waiver of deductible/coinsurance/copayment is unlawful because it results in false claims, violations of the anti-kickback statute and excessive utilization of items and services. In addition to being unlawful, the waiver discourages patients from using health care services responsibly by removing the economic obligation of receiving care, which in turn indirectly raises the cost of health care to other covered persons.

**Workers’ Compensation**

The health plans underwritten and/or administered by BCBSNE exclude benefits for services received because of injuries or illnesses related to employment. These provisions apply whether the covered person asserts rights to or waives workers’ compensation coverage. Please send a copy of the First Injury Report, as this enables us to process claims accurately and reduces the likelihood that future refunds or adjustments will have to be made. For questions, please call 402-398-3615 or 800-821-4786.

**Section 3: What is the BlueCard® Program?**

**Definition and Advantages**

BlueCard® is a national Blue Cross and Blue Shield program that enables members of one Blue Plan to obtain health care services while traveling or living in another Blue Plan’s service area. The program links health care providers participating with independent Blue Plans nationwide and around the world through a single electronic network for claims processing and reimbursement.

The program allows you to submit claims for patients who are covered by another Blue Plans to your local Blue Plan.
As your local Blue Plan, BCBSNE is your sole contact for claims payment, problem resolution and adjustments.

**Products Included in BlueCard**

Claims for members covered under most group and individual health care plans are eligible for processing through the BlueCard Program.

**Note:** Stand-alone vision and self-administered prescription drug policies that are issued directly by a BCBS plan should be submitted to your local plan. These policies can be processed through Blue Card. Policies that are administered through a third-party vendor such as VSP®, Avesis, EyeMed Vision Care, etc. should not be submitted to your local plan but submitted to the appropriate third-party vendor.

**Products Excluded from the BlueCard Program**

The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- The Federal Employee Program (FEP)

**How the BlueCard® Program Works**

**How to Identify Members**

When a member of a Blue Plan arrives at your office or facility, be sure to ask for his/her current Blue Plan membership identification (ID) card.
The main identifier for out-of-area members is the prefix (first three positions of the ID number).

Important facts concerning member IDs:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total.
- The prefix on a member’s ID must be three characters.
- Some member ID numbers may include alphabetic characters in other positions following the prefix. Others may be fewer than 17 positions.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

**ID Number Prefix**

The three-character prefix, at the beginning of the member’s ID number, is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient’s membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card and pass this key information to your billing staff.

**Sample ID Cards**

The PPO suitcase logo indicates that the member is enrolled in either a preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan. In either case, you will be reimbursed according to your network provider agreement. Please note, however, that EPO products may have limited out-of-area benefits. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.
The empty suitcase logo 📦 indicates the member is enrolled in one of the following types of plan: Traditional, health maintenance organization (HMO) or point of service (POS). For members with these types of coverage, you will be reimbursed for covered services according to your provider agreement.

The following ID cards do not feature either suitcase logo:

• Medicaid
• State Children’s Health Insurance Programs (SCHIP)
• Medicare Supplement

Government-determined reimbursement levels apply to these products. While BCBSNE routes all these claims for out-of-area members to the member’s Blue Plan, most of the Medicare Supplement or Medigap claims are sent directly from the Medicare intermediary to the member’s Plan via the established electronic crossover process.

**How to identify international members**

Occasionally, you may see ID cards from members of international Blue Plans, which include the following:

• BlueCross BlueShield of Costa Rica
• Blue Cross and Blue Shield of Uruguay
• Blue Cross and Blue Shield of Panama
• BlueCross BlueShield of the U.S. Virgin Islands

These Plans’ ID cards will also contain three-character prefixes. Please treat these members the same as domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost sharing amounts, such as deductible, coinsurance and copayment).

Submit all claims for international Blue members to [Blue Cross and Blue Shield Global](http://www.bcbs.com) (GeoBlue).

The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the United States.
Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. For claim filing instructions, please refer to these Plans’ ID cards.

Plans in the Canadian Association of Blue Cross Plans are as follows:
- Alberta Blue Cross
- Manitoba Blue
- Atlantic Blue Cross Care
- Quebec Blue Cross
- Saskatchewan Blue Cross
- Pacific Blue Cross

Limited Benefits Products
Some Blue plans offer benefit plans with limited benefits, so verifying Blue patients’ benefits and eligibility is extremely important. Currently, Blue Cross and Blue Shield of Nebraska does not offer such limited benefit plans to our members; however, you may see patients with limited benefits who are covered by another Blue Plan.

How do I recognize members with limited benefits products?
Patients are covered under a Blue Plan’s limited benefits coverage carry ID cards that have:
- One of two product names - InReach or MyBasic,
- A tagline in a green stripe at the bottom of the card, and
- A black cross and/or shield to help differentiate it from other identification cards.

These ID cards may look like this:

Coverage and Eligibility Verification
To verify eligibility and benefits for other Blue Plan members, submit an eligibility and benefits request through NaviNet. You may also call the BlueCard Eligibility® line at 800-676-BLUE (2583). English and Spanish speaking phone operators are available to assist you.

Note: The BlueCard Eligibility® line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status.
Utilization Management
You should remind patients that they are responsible for obtaining precertification/preauthorization when required by their Blue Plan. You may also request precertification/preauthorization on the member’s behalf. You can do so by one of two ways:

• Call the utilization management / pre-certification number on the back of the member’s ID card.
• If the utilization management number is not listed on the back of the member’s ID card, call 800-676-BLUE (2583) and ask to be transferred to the utilization Management area.

The member’s Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

Medical Policy and Pre-certification list for all Blue Plans
You can look up medical policy and precertification/preauthorization requirements for out-of-are Blue members at NebraskaBlue.com/Providers/Policies-and-Procedures.

Once on the page, click “Find a member’s Blue Plan by Prefix.” Then enter the member’s three-character prefix. Click “Submit.” You will be taken to the member’s Blue Plan website.

This is an excellent resource for the verification of medical policy applicable to a member’s benefit contract and required precertification/preauthorization requirements.

Claim Filing
Whenever a member of another Blue Plan receives services from you, file the claim with the local Blue Plan. Typically, your local Blue Plan is BCBSNE. However, the determination of “local” Blue Plan can differ for contiguous county providers, and ancillary providers. Refer to the subsections related to these topics for more information.

When we are the local Plan, we work with the member’s Blue Plan to process the claim. Once the claim is processed, the member’s Blue Plan will send the member an explanation of benefits (EOB). BCBSNE will send you the remittance advice (RA) and claim payment for covered services.

NOTE:
• Benefits are determined by the member’s Blue Plan.
• Payment for covered services is made to the provider according to the terms of the provider agreement.

Below is an example of how claims flow through BlueCard®:
For claim filing tips, see the helpful tips in the Member ID Card section.

**Contiguous Area Claim Filing**

A contiguous area is generally defined as a county bordering another Blue Plan’s service area. For example, Council Bluffs, Iowa in Pottawattamie County is in Wellmark Blue Cross and Blue Shield’s service area. Pottawattamie County is contiguous with the border of BCBSNE’s service area. Contiguous County guidelines do not apply to FEP claims, FEP claims should be filed to the state the provider is located, the only exception is Medicare Crossover.

If you are in a non-Nebraska county that is contiguous with BCBSNE’s service area AND have a PPO contract with both plans, file claims for BCBSNE patients with the Blue Plan in the state in which the member lives or works. Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract.

- Provider Location (i.e., In which Plan service area is the provider’s office located?)
- Provider contract with the two contiguous counties (i.e., does the provider have a PPO contract with only one or both service areas?)
- The member’s Home plan and where the member lives (i.e., Is the member’s Home Plan with one of the contiguous county’s Plans?)
- The location of where the services were received (i.e., Does the member work and reside in one contiguous county and see a provider in another contiguous county?)

**EXAMPLE:**

- If the BCBSNE member lives **AND** works in the state services were provided, not in Nebraska, BCBSNE’s contiguous county contract with that state would not apply and the claim should be filed to the state in which the member lives **AND** works.
- If the BCBSNE member lives **OR** works in Nebraska, but services were provided in the contiguous county, BCBSNE’s contiguous county contract would apply and claims should be submitted to Nebraska.

**NOTE:** Contiguous Counties guidelines only apply to a PPO product and do not apply to Ancillary Claim Filing. Contiguous County guidelines do not apply to the FEP product.
Ancillary Claim Filing (for BCBSNE and other Blue Plan members but excluding FEP members) see “Ancillary Billing Guidelines.”

Coding your BlueCard Claims
Code your claims based on the patient’s medical record, using BCBSNE billing/coding guidelines. If there are differences between BCBSNE’s coding/billing guidelines and the Blue Plan that insures the member, ALWAYS follow BCBSNE guidelines.

Medical Records - Reference Medical Record Standards
There are circumstances when the provider may get requests for medical records for out-of-area members.
• As part of the preauthorization process
• As part of claim review and adjudication

BlueCard Medical Record Process for Claim Review
• Your office will receive an initial communication, generally in the form of a letter, requesting the needed information.
• It may happen that you submit requested medical records and subsequently receive a remittance indicating the claim is being denied pending receipt and review of records.
• Upon receipt of the information, the claim will be reviewed to determine the benefits.

Adjustments
Claim adjustments must be submitted to BCBSNE. We will work with the member’s Blue Plan for adjustments; however, your workflow should not be different.

Appeals
Appeals for all claims are handled through BCBSNE. Submit the appeal using an Appeal Form and attach all supporting documentation. BCBSNE will forward the appeal electronically to the member’s Blue Plan for review. The member’s Blue Plan will send out the appeal decision.

Coordination of Benefits (COB) for BlueCard
When a member has health coverage through another insurance company in addition to BCBSNE, we coordinate our benefit payment with that of the other carrier to help prevent duplicate payment for the same services.

If you discover your patient is covered by more than one health plan you may need to file two separate claims.
Claim Payment

1. BlueCard® claims are priced and processed based on the provider agreement you have with BCBSNE. As a contracted provider, you may collect deductible, copays and/or coinsurance directly from the patient or responsible party, as well as billed charges for noncovered services.

2. BlueCard® Program claim processing times may vary. If you have not received payment for a claim, do not resubmit unless you have verified it was not received. The quickest and most efficient way to check claim status is by submitting a claim status inquiry through NaviNet.

3. In some cases, a member’s Blue Plan may pend a claim because medical review or additional information is needed. When resolution of a pended claim requires additional information from you, BCBSNE may either ask you for the information or give the member’s Plan permission to contact you directly.

Claim Status/Inquiries

BCBSNE is your single point of contact for all claim inquiries. You can verify claim status through NaviNet or by calling GABBI at 800-635-0579.

If an out-of-area member asks you about a claim, instruct him or her to call the customer service phone number listed on the back of their ID card. Please do not refer members covered by other Blue Plans to BCBSNE Customer Service.

The member’s Plan should not contact you directly regarding claim issues. If the member’s Plan requests that you submit the claim to them, refer them to BCBSNE.

Split Year Claims

Professional and Institutional Outpatient Claims
Non-Nebraska outpatient and professional claims, with charges incurred during different years, must be submitted on separate claims.

This requirement will be the same each year end for split year claims. Claims for non-Nebraska members that are not split will reject back to the provider upon submission.

For example:
If dates of service are from 12/15/2022 to 1/15/2023:
- Submit charges incurred from 12/15/2022 – 12/31/2022 on one claim
- Submit charges incurred from 1/1/2023 – 1/15/2023 on a separate claim
Claims that are submitted with charges incurred during both years on the same claim will be rejected back to the provider to split the claim.
Institutional Inpatient Claims

For inpatient* institutional claims, it is no longer required to split the entire claim for non-Nebraska members, however, it will be required to split the R&B charges per calendar year. Claims for non-Nebraska members where the R&B charges are not split per line by calendar year, will reject back to the provider upon submission.

For example:
If dates of service are from 12/15/2022 to 1/15/2023:
• Submit R&B line for 2022 dates of service on another line
• Submit R&B line for 2023 dates of service on another line

Claims that are submitted with the R&B on one line for multiple years, will be rejected back to the provider to split the R&B lines.

*Inpatient includes acute care hospital, psychiatric hospital, rehabilitation hospital, skilled nursing and swing-bed

Section 4: Federal Employee Health Benefits Program®

BCBSNE administers the Federal Employee Health Benefits Program (FEP).

Under the FEP Service Benefit Plan, members may select between the Basic and Standard Option. Both options cover most of the same services and supplies; however, different benefits and out-of-pocket costs may apply. Notable differences between the options include:

• Under **Standard Option**, FEP members receive the highest level of benefits when in-network PPO providers are used. When out-of-network providers are used, members still receive benefits for covered services, but at a higher out-of-pocket cost.

• Under **Basic Option**, FEP members must use contracting providers to receive benefits. In-network benefits are not subject to a deductible. **IMPORTANT:** If out-of-network providers are used, no benefits are available.

The entire FEP Service Benefit Plan brochure may be viewed at [www.fepblue.org](http://www.fepblue.org).

The ID number for FEP members always begins with an “R.” Below is a sample ID card:
**The Federal Employee Program® and Medicare**

A provision of the Omnibus Budget Reconciliations Act (OBRA) of 1993 applies the Medicare participation and physician payment rules and requirements to all retired individuals covered under FEP. These payment rules include CMS-approved demonstration projects.

OBRA affects FEP reimbursement when the patient:

- is 65 years of age or older;
- does not have Medicare Part A, Part B, or both;
- is a former spouse (or family member of a former spouse) who is entitled to receive benefits; and
- is not employed in a position that offers FEP coverage

Federal Employee Plan (FEP) policies are not a Medicare supplemental policy. Be sure to submit claims directly to BCBSNE as they may not cross over directly from Medicare.

**Professional Reimbursement**

OBRA bases physician services reimbursement on the lesser of the Medicare approved amount or the actual charge. Member liability is dependent on the physician’s participating status with Medicare and/or the physician’s NEtwork BLUE contracting status.

<table>
<thead>
<tr>
<th>Provider Medicare Status</th>
<th>Provider BCBSNE Status</th>
<th>Member Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating/accepts Medicare assignment</td>
<td>Participating</td>
<td>Deductibles, coinsurance, and copayments</td>
</tr>
<tr>
<td>Participating/accepts Medicare assignment</td>
<td>Non-participating</td>
<td>Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount</td>
</tr>
</tbody>
</table>
### Institutional

When a patient is age 65 or over and does not have Medicare Part A, Part B or both:

Under the FEHB law, payments for inpatient hospital care and physician care are limited to those benefits the patient would have received if they had Medicare. The physician and hospital must follow Medicare rules and cannot bill the patient for more than they would bill if the patient had Medicare. Outpatient hospital care is not covered by this law.

OBRA bases inpatient care reimbursement on an amount that is equivalent to Medicare’s payment amount unless the charge is less than the Medicare equivalent amount. FEP members are NOT responsible for any charges greater than the Medicare equivalent amount. The law prohibits a hospital from collecting more than the Medicare equivalent amount. FEP members who have Standard Option coverage are responsible for deductibles, coinsurance, and/or co-payments.

### Waiver Copy Required for Denial Review

If a FEP member has signed a waiver and files an appeal on a claim denied as not medically necessary, the Office of Personnel Management (OPM) requires the provider to send us a copy of the waiver for final review. If the provider cannot present the signed waiver, the member must be held harmless. OPM will not allow the submission of medical record documentation.

For requirements of an Advanced Beneficiary Notice (ABN) or waiver see “Hold Harmless and Balance Billing” in Provider Responsibilities.

For billing and claim guidelines and other information for FEP members, please see the appropriate section throughout this document.

<table>
<thead>
<tr>
<th>Non-participating</th>
<th>Participating</th>
<th>Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount</th>
<th>Copayments, coinsurance, and any balance up to 115% of the Medicare approved amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-participating</td>
<td>Non-participating</td>
<td>Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount</td>
<td>All charges</td>
</tr>
</tbody>
</table>
Section 5: Member ID Card Information

Identification
The back of the patient’s ID card gives instructions on where to file claims, as well as customer service and precertification phone numbers.

It is recommended that you photocopy the patient’s member ID card at every visit to ensure you have the most up-to-date coverage information.

ID Number and the Prefix
Blue Plan ID card numbers feature a three-character prefix that MUST be included in your records and claims.

Note: The names of covered family members are not listed on the ID card. Some cards may feature an employer name or logo. Additionally, copay amounts are not shown on the card. You can determine if copays apply when checking the member’s eligibility and benefits.

Helpful tips:
- Photocopy the front and back of the member’s ID card at every visit. This will enable you to submit claims accurately and avoid unnecessary payment delays.
- Use NaviNet to check eligibility and benefits. For BlueCard claims, you may also call the BlueCard Eligibility line at 800-676-BLUE (2583).
- Applicable deductible and coinsurance amounts are determined at the time of claim processing, not when the service is received. Please note that these amounts can change between the time of service and when the claim is processed. Therefore, we ask that at the time of service, the member is only charged for copayments or noncovered services.
- If the member presents a health care debit card, be sure to verify the copayment amounts before processing payment. (For more information about health care debit cards, refer to the next section, “Consumer-Directed Health Care and Health Care Debit Cards.”)
- Please do not use the debit card to process full payment upfront.
- For questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator’s number on the back of the card.
Consumer-Directed Health Care and Health Care Debit Cards

Consumer-directed health care (CDHC) plans provide the member with additional information to make informed and appropriate health care decisions, using support tools, provider and network information and financial incentives.

Members covered by CDHC plans often are issued health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Some cards are “stand-alone” debit cards that cover eligible out-of-pocket costs, while others also serve as the member’s ID card. These debit cards can help you simplify your administration process.

Blue Plan debit cards will feature the nationally recognized cross and shield logos, along with the logo from a major debit card vendor, such as MasterCard® or Visa®.

Sample Combined Health Care Debit Card and Member ID Card

The cards include a magnetic strip allowing providers to swipe the card at the point of service and collect the member cost sharing amount.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

See the previous section, “ID Number and the Prefix” for tips on handling health care debit cards.

Note: All services, whether you’ve collected the member’s out-of-pocket responsibility at the time of service, must be billed to BCBSNE for proper benefit determination and to update the member’s claim history.

Electronic Health ID Cards

Some Blue Plans have implemented electronic health ID cards to facilitate seamless coverage and eligibility verification process.
Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider’s system.

- A Blue electronic health ID card has a magnetic strip on the back of the ID card, like what you can find on the back of a credit or debit card.

- Subscriber/member electronic data is embedded on the third track of the three-track magnetic strip, and includes name, ID number, date of birth and Plan ID.

- The Plan ID data element identifies the health plan that issued the ID card. Plan ID will help providers facilitate health transactions among various payers in the marketplace.

- Providers will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read.

### Section 6: Member Benefits/Responsibility and Cost Share Information

#### Audiology Testing

BCBSNE member contracts exclude audiological function tests except for limited circumstances. **Note:** Dispensing fees are considered content to the hearing aid purchase and if billed, BCBSNE will deny as provider contractual write off.

#### Biofeedback

Biofeedback training is a therapeutic technique and training experience by which the patient is taught to exercise control over a physiologic process occurring within the body.

Biofeedback is considered acceptable medical practice with payable benefits when used as adjunctive therapy with a diagnosis of mental illness.
Birth Doula Services
BCBSNE does not contract with birth doula providers. Birth doula providers may bill their services with 59899 (unlisted maternity care) and the charges will deny as non-covered.

Cardiac Rehabilitation
Cardiac Rehabilitation is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

Cardiac rehab does not require preauthorization.

Professional
Cardiac rehabilitation is scientifically validated if started within four (4) months of:

- An acute myocardial infarction;
- Coronary artery angioplasty, with or without stent placement, or other scientifically validated procedure to clear blocked coronary vessels;
- Heart or coronary artery surgery;
- Heart transplant; or
- Heart-lung transplant.

Cardiac rehabilitation is scientifically validated for treatment of congestive heart failure and stable angina initially and after significant changes in clinical status. All other uses of cardiac rehabilitation are investigative.

Note: The diagnosis and time frame may vary based on the member’s contract. If the member has benefits for Cardiac Rehabilitation but does not meet the contract criteria, then it is denied as a contract exclusion and not investigative.

To be considered for reimbursement, providers must be JCAHO accredited for cardiac rehabilitation.

Institutional
The cardiac or pulmonary rehabilitation program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or as otherwise approved by BCBSNE.

Benefit Provisions
Benefits are provided for medically necessary outpatient facility rehabilitation programs, according to the terms of the subscriber’s contract. In addition, the following services are covered when provided as part of the approved rehabilitation program:

- Initial rehabilitation evaluation
• Exercise sessions
• Concurrent monitoring during the exercise session for high risk patients.

The patient’s condition must be such that rehabilitation can only be carried out safely under the direct, continuing supervision of a physician and in a controlled hospital environment. Services are provided at any therapeutic level, limited to the number of sessions listed in the subscriber’s contract, for the following diagnoses occurring during the four months prior to the start date of a cardiac program:
  • An acute myocardial infarction
  • Coronary bypass surgery
  • Coronary artery angioplasty or other procedure to clear blocked vessels
  • Heart transplant
  • Heart-lung transplant
  • Heart valve surgery
All other uses of cardiac rehabilitation are investigative.

**Cataracts**
Splitting of the 90-day post-operative period is not permitted. If an Ophthalmologist and Optometrist share post-operative care, only one should bill for the service.

**Clinical Trials**
Clinic trials require preauthorization. Submit a preauthorization online from the [Medical Policy](#). Approved clinical trials include a Phase I, Phase II, Phase III or Phase IV clinic trial that is conducted in relation to; the prevention, detection or treatment of cancer or other life-threatening diseases or conditions and is one of the following:
  1. A federally funded or approved trial
  2. A clinic trial conducted under an FDA investigational new drug application
  3. A drug trial that is exempt from the requirement of FDA investigation new drug application

**Fertility Testing/Treatment**
Benefits for pregnancy assistance treatment, including but not limited to infertility treatment are excluded under most BCBSNE contracts. Diagnostic testing done to determine the diagnosis of infertility, treatment of polycystic ovary disease and treatment of endometriosis are not considered to be infertility treatments.

**Jail or Prison Benefits**
BCBSNE will allow for covered services provided to a member incarcerated in a correctional facility if the services are not a result of the member’s engagement in an illegal occupation or his/her commission of or attempt to commit a felony.
Jaundice (Neonatal)

Jaundice is a medical condition common in newborns. The diagnosis of jaundice billed with medical procedures codes will be processed as medical. If the claim is received with a routine diagnosis for services that would normally be considered medical, the claim will be returned for verification of routine vs. medical.

Language Interpreter or Translation Services

Charges for an interpreter or translator are considered content of service and not payable, nor are they billable to the patient.

Medical Necessity

BCBSNE, or the applicable Blue Plan, will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Provider.

Medically Necessary or Medical Necessity is defined as health care services ordered by a treating physician exercising prudent clinical judgment, provided to a covered person for the purposes of prevention, evaluation, diagnosis or treatment of that person’s Illness, injury or pregnancy that are:

1. Consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and

2. Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person’s Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person’s medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and

3. Not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient’s Illness, Injury or Pregnancy, without adversely affecting the Covered Person’s medical condition; and

4. Not provided primarily for the convenience of the following;
   a. The Covered Person;
   b. The Physician.
   c. The Covered Person’s family
   d. Any other person or health care provider; and
5. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses, or treatment procedures.

**Member Responsibility — Cost Sharing**

BCBSNE members are responsible for paying a portion of the cost of covered services. The member's cost sharing responsibility includes applicable deductible, coinsurance, and copayments. In limited circumstances, the member also may be responsible for the balance of the provider's charges not reimbursed by BCBSNE. Cost sharing amounts vary by benefit plan.

*Please note: If the information in this section differs from the member's actual benefit plan, the terms of the member’s coverage will apply.*

**Allowable Charge**

The amount we use to calculate our payment of covered services. For an in-network provider, the allowable charge is based on the lesser of the contracted amount or the billed amount; for out-of-network providers the allowable charge is the lesser of the out-of-network allowance or the billed amount.

**Balance bill**

"Balance bill" refers to the dollar difference between a provider's billed charges and the BCBSNE allowed amount. Under the terms of their contract with us, in-network providers must accept the allowed amount as payment in full for covered services and may not balance bill the member for the remainder.

Out-of-network providers have no obligation to accept the allowed amount as payment in full and can balance bill the member. Balance bill amounts paid by the member do not count toward the deductible, coinsurance, or coinsurance limit.

**Deductible**

The amount the member must pay for covered services each calendar or plan year before the benefit plan begins to pay for covered services. The deductible applies to all covered services, unless otherwise specified by the member’s plan.

<table>
<thead>
<tr>
<th>Calculation of deductible</th>
<th>The deductible is calculated based on the BCBSNE allowed amount for covered services or the billed charge, whichever is less.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of deductible</td>
<td>A contracted provider must file all claims for members, including those that may require payment of deductibles. Application of the deductible is determined in the order in which claims are processed by BCBSNE, not the date services were provided within the calendar or plan year.</td>
</tr>
<tr>
<td>What does not apply</td>
<td>Member copay amounts do not apply toward satisfaction of the deductible</td>
</tr>
</tbody>
</table>
Deductible limits
A deductible can be either embedded or aggregate. In general, PPO plans feature embedded family deductibles. Most qualified high deductible health plans have aggregate family deductibles. This will vary based on the plan.

- **Aggregate family deductible**
The entire family deductible must be met prior to any benefits becoming available. Once member on the plan may satisfy the entire family deductible, or family members may combine their covered expenses to satisfy the required family deductible.

- **Embedded family deductible**
Family members may combine their covered expenses to satisfy the required calendar year family deductible. No one family member contributes more than the individual deductible amount to satisfy the family’s deductible.

Deductible carry over
Any amounts applied to the annual deductible for services provided in October, November or December will be carried over and applied to the next calendar or plan year’s deductible. Applicable based on the member’s plan.

Coinsurance
The percentage of covered charges the member pays once the deductible has been satisfied. Coinsurance applies to every covered service unless the member’s benefit plan states otherwise. Typically, coinsurance percentages differ for in-network and out-of-network providers.

Calculation of coinsurance
Coinsurance is calculated based on the contracted amount or the billed amount, whichever is less. Members pay more in coinsurance when they use out-of-network providers.

What does not apply to the coinsurance limit
Deductible and copay amounts do not apply toward satisfaction of the member’s coinsurance limit.

Coinsurance limits
The amount the member must pay each calendar or plan year in coinsurance before BCBSNE begins paying 100% of the allowed amount for most covered services. The member is still responsible for paying applicable copay amounts.

Family coinsurance limit
In general, PPO plans feature embedded family coinsurance limits. Most qualified high deductible health plans have an aggregate family coinsurance limit. This will vary based on the plan.

- **Aggregate**
The entire family coinsurance limit must be met before covered services are paid at 100%. Family members may combine their covered expenses to satisfy the required coinsurance limit.

- **Embedded**
means that while family members may combine their covered expenses to satisfy the required family out-of-pocket limit, no one member contributes more than the individual out-of-pocket limit to satisfy the family amount.
Copayments
Copayments are fixed dollar amounts a member must pay to the provider for specific covered services. If a copay applies, the member must pay it at the time of service. Some copayment information is also displayed on the front of the member's ID card.

<table>
<thead>
<tr>
<th>Copay amounts greater than BCBSNE allowed amount</th>
<th>The provider may only collect the allowed amount. If the provider knows the allowed amount at the time of service, that amount may be collected at time of service instead of the copay. If the provider later determines that the allowed amount is less than the copay, the difference must be refunded to the member.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays related to deductible</td>
<td>Even after the member’s deductible and/or coinsurance limit have been reached (except for qualified high deductible health plans).</td>
</tr>
<tr>
<td>Copays related to out-of-pocket limit</td>
<td>Once the out-of-pocket limit has been met – copays no longer apply</td>
</tr>
<tr>
<td>Common services covered under a copay</td>
<td>Office visits/office services, urgent care facility visits and emergency room visits. Under some plans, copays apply to allergy injections and serum, ambulance services, inpatient admissions and preventive services (those not required to be paid at 100% by the ACA).</td>
</tr>
<tr>
<td>• Office visit copays</td>
<td>Typically, includes office visits, the initial visit to diagnose pregnancy, consultations, medication checks and psychological therapy and/or substance dependence and abuse counseling/rehabilitation.</td>
</tr>
<tr>
<td>• Office services copays</td>
<td>Typically, includes x-rays, laboratory and pathology services performed in the physician’s office, supplies used to treat the patient in the office, drugs administered by the physician in the office, hearing and vision examinations due to illness, (excluding vision refractions) and allergy testing.</td>
</tr>
<tr>
<td>• Emergency room (ER) copays</td>
<td>Typically, ER copays are waived if admitted to the hospital within 24 hours of the same diagnosis.</td>
</tr>
</tbody>
</table>

Note: Verify member benefits to confirm what services are subject to copays under the patient’s plan, and how covered services are reimbursed after payment of the copay.

* Please note: If the information in this section differs from the member’s actual benefit plan, the terms of the member’s coverage will apply.

Out-of-pocket Limit
The maximum amount the member must pay in a calendar or plan year before all services are paid at 100% of the allowable charge. All amounts applied to deductible, coinsurance and copays are applied to the out-of-pocket limit. Once the out-of-pocket limit is met copays no longer apply.
Nutritional Therapist
Most BCBSNE member contracts do not cover services by Medical Nutritional Therapists. Benefits should be verified prior to providing services.

Physical Rehabilitation (Acute Inpatient Programs)
Physical rehabilitation is defined as the restoration of a person who was totally disabled as the result of an injury or an acute physical impairment to a level of function which allows that person to live as independently as possible.

A person is totally disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position. Patients requiring a single modality are not considered totally disabled and therefore do not qualify (examples: fractured extremity, total hip/knee replacement, cervical strain).

For benefits to be available for a physical rehabilitation program, the provider must be accredited for comprehensive inpatient rehabilitation by the Commission on the Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Benefit Provisions
Benefits will be provided for medically necessary covered services according to the subscriber’s contract. In addition to all services defined as covered services for inpatient care, the following will be covered services when provided as part of the physical rehabilitation program:

- Recreational therapy
- Social service counseling
- Prosthetic devices
- Psychological testing

Benefits are not available under Physical Rehabilitation Benefits for the treatment of chronic medical conditions or a disabling disease.

Benefits for further rehabilitation will stop under any of the following circumstances:

- Further progress toward the established rehabilitation goal is minimal or unlikely
- Such progress can be achieved in a less intensive setting
- Treatment can be continued on an outpatient basis
- The patient no longer meets criteria for eligibility

Services will be provided for patients who are totally disabled and who meet specifications for coverage as set forth by the BCBSNE Physical Rehabilitation Program Guidelines. The covered person must require intense daily involvement in two or more of the following treatment modalities for not less than three hours daily:

- Physical therapy
• Occupational therapy
• Speech therapy

Inpatient rehabilitation must follow within 90 days of discharge from the acute hospitalization of the injury, illness or condition causing the disability.

**Postoperative Pain Control**
Continuous infusion of anesthetic agents to operative wound sites using an elastomeric pump is scientifically validated as a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics for pain relief.

Trade names of elastomeric pump and associate catheters that have received approval for marketing from the U.S. Food and Drug Administration (FDA), include, but are not limited to, Infusor System™, On-Q® Post Op Pain Relief System, On-Q Soaker™ catheter delivery system, and the Pain Buster™ Pain Management System.

While the charge for the elastomeric pump may be covered, the insertion will be denied as global to the surgery.

**Preventive Care Benefits**
Our group health plans are compliant with the Affordable Care Act (ACA) requirements regarding preventive care benefits.

Benefits will be payable for preventive services provided by a physician, an oral surgeon, a certified nurse midwife, a certified nurse practitioner or a certified physician's assistant, within the provider's scope of practice.

For additional information, see [NebraskaBlue.com/PreventiveCare](http://NebraskaBlue.com/PreventiveCare).

For specific member preventive care benefits, please use NaviNet or contact BCBS Customer Service at the number on the ID card.

**Pulmonary Rehabilitation**
Benefits vary according to various member/group contracts. Please verify member benefits prior to providing services.

The pulmonary rehabilitation program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations, or as otherwise approved by BCBSNE.
Services are provided at any therapeutic level, limited to the number of sessions listed in the subscriber’s contract under the following circumstances:

- lung transplant during the preceding four months
- heart-lung transplant during the preceding four months
- preoperative and postoperative care for lung volume reduction surgery

Benefits are not available for pulmonary rehabilitation if cardiac rehabilitation is provided for a heart/lung transplant.

For instructions on billing these services, see “Pulmonary Rehabilitation” in the Billing Policies & Procedures for Providers | BCBSNE (nebraskablue.com)

Vision Supplies
All vision supplies are reviewed to determine if they are needed because of an intraocular surgery or ocular injury. BCBSNE allows payment for eyeglasses or contact lenses (or their replacement) because of a change in prescription of at least one diopter as a direct result of intraocular surgery or ocular injury. Covered services must be provided within 12 months of the date of the surgery or injury and must be ordered by a physician.

Skilled Nursing Benefit Provisions
Benefits may be payable according to the member’s benefits for skilled nursing facility care. If benefits are available, the following requirements must be met:

- Services are provided in a semiprivate room
- Facility is licensed as a Skilled Nursing facility to provide:
  - medically necessary room and board 24-hours per day
  - skilled nursing care and other related non-custodial
  - services are for the care and rehabilitation of injured, disabled or sick persons
- confinement must have been ordered by a Physician
- must be medically necessary
- skilled nursing care is for an unstable health condition and must meet all the following criteria:
  - Daily skilled observation of the patient’s medical status
  - Daily therapeutic treatment by a skilled professional
  - The condition must interfere with the patient’s ability to perform the activities of daily living unassisted.

Exclusions and Limitations
A skilled nursing facility does not include a place that is primarily used for rest, care and treatment of mental illness, alcoholism or drug abuse; or for custodial care or educational or non-medical personal services.
Note: To have custodial care charges auto-deny, place “Custodial Care” in the comments section on the UB claim. Medical records and review of charges will not be required.

Skilled Nursing Facility/Swing Bed (Inpatient)
Provider must preauthorize services with case management.

BCBSNE considers coverage if the following criteria is met:
• Patient is an inpatient and treatment is appropriate to the illness
• Patient is receiving skilled nursing services daily (PT, OT, ST, Medication Adjustment).
• Coverage for the following conditions is conditional (TPN, Wound Care, Teaching, Trach Care, G-Tube Care, IV Therapy).

Subrogation
If a covered benefit involves claims that are a result of an accident or illness caused by a third party, you must file a claim including accident information to BCBSNE. We will provide benefits according to the member’s contract and supply payment to the provider of service pursuant to our agreement with them.

Our Subrogation Department will begin the necessary procedures to recover paid amounts from the covered person or third-party payer, which will not exceed the amount we paid in benefits. If you are notified of an injury or accident after filing claims to BCBSNE and have not included the accident information on the claim, you should notify our Subrogation Department immediately.

Policies for Teleservices
This benefit policy applies to BCBSNE members only and excludes any FEP or out-of-state Blue Cross and Blue Shield members. BCBSNE will consider reimbursement for Nebraska network providers for telemedicine when all the following conditions are met:
1. All services provided are medically appropriate and necessary
2. Services are within the provider’s scope of practice as defined by state law
3. The service takes place via an interactive audio and video telecommunications system. Interactive telecommunications systems must be multi-media communication that, at a minimum, includes audio and video equipment permitting real-time consultation among the patient, consulting provider, and referring provider (as appropriate) unless prohibited by state law
4. A service provided to a member located in Nebraska is rendered by a provider licensed to practice independently in the state of Nebraska
5. A permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient’s medical record
6. BCBS providers must deliver services via a secure and private data connection. All transactions and data communication must follow the Health Insurance Portability and Accountability Act (HIPAA).
7. Providers performing, and billing teleservices must be eligible to independently perform and bill the equivalent face to face service

Exclusions for teleservices:

1. Services that occur the same day as a face-to-face visit, when performed by the same provider and for the same condition.
2. Triage to assess the appropriate place of service and/or appropriate provider type.
3. Patient communications incidental to E/M, counseling, or medical services covered by this policy, including, but not limited to:
   a. Reporting of test results.
   b. Provision of educational materials.
4. Administrative matters, including but not limited to; scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
5. Medical interpretation or translation services
6. There will be no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.
7. Costs associated with enabling or maintaining contracted providers’ telemedicine technologies
8. Interprofessional telephone or internet consultations

BCBSNE reserves the right to audit these procedures at any time. This includes but not limited to demos of technology, onsite visits, and review of medical records.

**Telehealth**

**COVID-19 and Telehealth**

Blue Cross and Blue Shield of Nebraska’s (BCBSNE) telehealth services policy includes the following providers:

- Medical doctors
- Doctors of osteopathy
- Physician assistants
- Nurse practitioners
- Behavioral health providers
- Occupational, physical and speech therapists

Effective April 1, 2022, BCBSNE will update its telehealth services policy to add the following providers:

- Certified Diabetic Educators
- Licensed Medical Nutritional Therapist

**Legislative mandate:** Out-of-network telehealth services will be covered at no cost to the member if related to COVID-19 diagnostic testing.
Telehealth Codes
The codes below are the only applicable telehealth codes that should be billed. Additionally, the below codes are the only applicable telehealth codes that should be billed with POS 02 or POS 10*** and modifier 95. All other procedure codes are not medically appropriate to be performed via telehealth.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
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</thead>
<tbody>
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<td>96158</td>
<td>97161</td>
<td>99406-99407</td>
</tr>
<tr>
<td>90961</td>
<td>96159-96161</td>
<td>97162</td>
<td>99451*</td>
</tr>
</tbody>
</table>

*Can be submitted with GQ or 95 modifier
**Q3014 - See additional information below
***POS 10 - See additional information below
****Effective 04/1/2022

Institutional/facility Telehealth
Institutional/facility telehealth claims will no longer be allowed, except as follows:

- OT/PT/ST (effective 11/1/2020)
- G0108 Diabetic Self-Management Training (effective 4/1/2022)
- Q3014 Originating Site Fee (effective 4/1/2022)
  - Appropriate billing of Q3014:
    - Facility:
      - Claim form: UB04
      - Type of Bill: 12X (Medicare Part B only), 13X, 22X (Medicare Part B only), 23X, 71X, 72X, 73X, 76X, and 85X
      - Revenue Code: 078X | Procedure Code: Q3014
    - Professional:
      - Claim form: HCFA 1500
      - Procedure code: Q3014
      - Place of service: 11 (must be billed by a rural health clinic - RHC)
Provider at the distant site who is performing the telehealth visit with the member, may bill their services on a HCFA 1500 form
  ▪ Must use an approved telehealth code with POS 02 and modifier 95
  ▪ POS 10 is not applicable

The below will not be considered for telehealth:
  • Quick Care
  • Urgent Care
  • Retail Clinic
  • ASC
  • Minute Clinic
  • Pharmacy

These changes are specific to BCBSNE members; please check benefits for FEP or out-of-state Blue Cross and Blue Shield (BCBS) members.

For coverage information on other BCBS Plans, as well as the BCBS Federal Employee Program (FEP), related to COVID-19 treatment go to BCBS.com.

For Medicare Advantage members, we will continue to cover telehealth services for non-COVID-related services after July 1, 2020, for the remainder of the year, however, the applicable cost-shares/copays will apply.

Providers performing and billing teleservices must be eligible to independently perform and bill the equivalent face-to-face service.

Our members may seek telehealth services through their current physician/provider, or they can receive services through Amwell®. This information has been communicated separately to our members.

Amwell® is an independent company that provides telehealth services for Blue Cross and Blue Shield of Nebraska.

**Telemedicine**

This benefit policy applies to BCBSNE members only and excludes any FEP or out-of-state Blue Cross and Blue Shield members. BCBSNE will consider reimbursement for Nebraska network providers for telemedicine when all the following conditions are met:

1. All services provided are medically appropriate and necessary
2. Services are within the provider’s scope of practice as defined by state law
3. The service takes place via an interactive audio and video telecommunications system. Interactive telecommunications systems must be multi-media communication that, at a minimum, includes audio and video equipment permitting real-time consultation among the patient, consulting provider, and referring provider (as appropriate)
4. A service provided to a member located in Nebraska is rendered by a provider licensed to practice independently in the state of Nebraska.

5. A permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient’s medical record.

6. BCBS providers must deliver services via a secure and private data connection. All transactions and data communication must follow the Health Insurance Portability and Accountability Act (HIPAA).

7. Providers performing, and billing teleservices must be eligible to independently perform and bill the equivalent face to face service.

**Exclusions for teleservices:**

1. Services that occur the same day as a face-to-face visit, when performed by the same provider and for the same condition.

2. Triage to assess the appropriate place of service and/or appropriate provider type.

3. Patient communications incidental to E/M, counseling, or medical services covered by this policy, including, but not limited to:
   a. Reporting of test results
   b. Provision of educational materials

4. Administrative matters, including but not limited to; scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

5. Medical interpretation or translation services.

6. There will be no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

7. Costs associated with enabling or maintaining contracted providers’ telemedicine technologies.

8. Interprofessional telephone or internet consultations.

BCBSNE reserves the right to audit these procedures at any time. This includes but not limited to demos of technology, onsite visits, and review of medicals records.

**Telemonitoring**

Telemonitoring services are considered investigational and not covered. Currently there is insufficient evidence in the clinical literature to substantiate the health outcomes of telemonitoring.

**Section 7: Pharmacy Benefits Overview**

**Prime Therapeutics**

Promoting Quality Drug Therapy while Containing Costs

402-970-2600

800-821-4795
Prime Therapeutics LLC (Prime) is a leader in pharmacy benefit management strategies. Prime’s mission is to provide the highest quality care and service for members while focusing on delivering the lowest cost of care and empowering clients to make informed decisions in health care management.

Together with Blue Cross and Blue Shield of Nebraska (BCBSNE), Prime proves that the best outcomes are achieved by a different kind of business model - one that supports low net cost with client-aligned incentives, focused clinical programs including integration of pharmacy and medical management, and superior service that promotes collaboration, flexibility, and a positive member experience. Prime, privately owned by not-for-profit Blue Cross and Blue Shield plans including BCBSNE; works side by side with groups to manage overall health care benefits. Flexible benefit designs, sophisticated trend forecasting, comprehensive reporting, focused clinical strategies and administrative ease add up to a program that delivers outstanding service.

**Pharmacy and Medical Data Integration**

Only with Prime can BCBSNE realize the benefit of true medical and pharmacy data integration. Using medical and pharmacy data together in our analyses allows us to better identify opportunities for improved care and cost savings. It also means we can more effectively target members and physician populations for interventions based on diagnosis information, rather than just pharmacy or medical data alone. Prime measures the impact pharmacy decisions have on overall medical outcomes. Prime will not decrease pharmacy costs at the expense of medical costs or quality outcomes.

**Focused Clinical Strategies**

BCBSNE, through our partnership with Prime, has developed numerous programs that focus on driving appropriate drug therapy and educating members. We incorporate a strong emphasis on member education as a part of our program development, rather than simply creating limitations that drive cost savings. Pharmacy cost savings is one goal in program development; however, our partnership also provides our clients with the added value that comes from an ability to combine and analyze both pharmacy and medical data.

BCBSNE and Prime believe the value of drug therapy is directly correlated with our ability to enhance health and/or disease-specific outcomes, not solely with attention to pricing and costs. Drug expense is important, and BCBSNE and Prime offer a variety of opportunities to manage drug costs. However, the optimal value we offer is a partnership with the real disease managers: individual patients, physicians and other health care providers within the managed health care setting.

We understand that to optimize pharmaceutical care value, drug considerations must be integrated into a comprehensive medical care plan. We offer several solutions designed to maximize the cost effectiveness of our programs. These include:

- Concurrent Drug Utilization Review
- Utilization Management Programs
  - Quantity Limitation Programs
  - Pre-authorization Programs
To elaborate on one of the above, BCBSNE and Prime’s retrospective DUR programs analyze pharmacy claims history and identify opportunities to improve the cost and quality of pharmaceutical care. Retrospective DUR programs are designed to identify real problems that impact members, physicians and drug trend. Built on rigorous clinical rationale and sound methodology, the targeted interventions provide physicians with actionable information, and members with key educational materials. Changes in therapy are measured at defined intervals, and initiatives can be repeated to address persistent medication use problems. Retrospective DUR initiatives target both overuse and under use of drugs.

Flexible Pharmacy Benefit Designs
Prime supports a variety of benefit designs that are customized to meet the needs of participating employer groups. We provide a spectrum of benefit design options, program management tools, and customized modeling assessments to facilitate the decision-making process. Benefit designs offered include those with a copay differential for brand/generic medications, coinsurance or flat copays. We work closely with groups to design a benefit strategy based on specific needs.

The majority of the BCBSNE book of business is enrolled in formulary-based, three-tiered benefit plans that assign copays/coinsurance according to a drug’s status of generic, brand, or non-formulary brand.

Formulary Focused on Safety and Low Net Cost
Benefit designs are complemented by use of the BCBSNE formulary which provides members with broad access to safe, medically necessary products. The formulary is a list of medications which represent the current clinical judgment of physicians and other experts in the health care arena.

The Prime Pharmacy and Therapeutics Committee, comprised of actively practicing, independent physicians and pharmacists, make formulary decisions driven by four criteria considered in this order:

- Safety
- Efficacy
- Unique properties of the drug
- Lastly net cost

The Nebraska marketplace is represented on the Prime Pharmacy and Therapeutics committee. In addition to that representation, BCBSNE utilizes a local Formulary Business Committee to review decisions made by Prime’s committee. Use of formulary agents and generic products enhance our members’ pharmacy benefit.

Contact Information
Jeffrey R. Huether, Pharm.D., MBA
Director of Pharmacy and HCDW Strategic Partnerships
How to Precert/Certify
Blue Cross and Blue Shield of Nebraska’s Pharmacy Services Department, in collaboration with our pharmacy benefit manager Prime Therapeutics, LLC., develops programs and resources to inform both physicians and their patients, our members, about the appropriate, cost-effective use of pharmaceuticals. Given the rising cost of health care, some groups have chosen to implement programs that promote appropriate therapy through pharmacy preauthorization programs.

The preauthorization request forms for these pharmacy preauthorization programs are available at NebraskaBlue.com/Providers/Pharmacy-Management. The forms are located below the subheading of Preauthorization Forms.

A listing of medications that require preauthorization is also located on the same webpage as listed above. BCBSNE will NOT accept other preauthorization forms from sources such as www.CoverMyMeds.com.

FEP follows the same set of medical policies and requires prior approval (PA) regardless of where the drug/prescription is obtained. These medical policies are maintained by Caremark, the FEP pharmacy benefit administrator.

Note the following:
• Drugs administered by a pharmacy that require prior approval must be submitted to Caremark.
• Drugs administered by a physician or facility that require prior approval must be submitted to BCBSNE

Outpatient Prescription Drugs
Under some BCBSNE plans, benefits for certain prescription drugs and covered services administered in an outpatient setting will only be available for in-network benefits if they are obtained from a participating pharmacy and processed under the member’s BCBSNE prescription drug plan. The list of medications that are no longer covered under the medical plan is available at NebraskaBlue.com/Providers/Pharmacy-Management.

An outpatient setting includes a home, physician’s office, outpatient hospital or other outpatient facilities. It does not include a hospital emergency room.
Medical providers who administer the drug(s) in the outpatient setting will be reimbursed only for the administration under the member’s medical plan.

**Step Therapy Reform Act**

**Overview**
The Step Therapy Reform Act is in effect starting on January 1, 2022, for health benefit plans as defined in the Act.

The Step Therapy Reform Act allows health care providers to request a step therapy override exception, provides certain circumstances when a health care provider can override the step therapy protocol, and establishes timelines for which an insurance company or pharmacy benefit manager must respond when a step therapy override exception request is submitted. The override exception process is in addition to any current appeals process.

**Review Process**
Except in the case of an urgent care request, a health carrier or utilization review organization shall decide to approve or deny a request for a step-therapy override exception within five (5) calendar days after receipt of complete, clinically relevant written documentation supporting a step-therapy override exception.

In the case of an urgent care request, a health carrier or utilization review organization shall approve or deny a request for a step-therapy override exception within seventy-two (72) hours after receipt of such documentation. If a request for a step-therapy override exception is incomplete or additional clinically relevant information is required, the health carrier or utilization review organization may request such information within the applicable time provided in this section. Once the information is submitted, the applicable time for approval or denial shall begin again. Per the Act, completed requests for a step-therapy override exception outside the indicated timeframe will be granted.

Rationale will be provided, and the current appeals processes will be followed, if an adverse benefit determination for a step-therapy override exception is determined. Please note, a prior authorization request is a separate process and review from a step therapy override exception request.

**Section 8: Claims Submission, Payments and Refund Guidelines**

Note: For specific billing and reimbursement guidelines - see the Billing and Reimbursement Manual.

**You File, So They Do Not Have To**
We encourage you to remind your patients that YOU file the claims for the services they receive. If the patient is given a copy of the charges, please annotate the copy: “For your records only. We file your Blue Cross and Blue Shield of Nebraska insurance claim.”
The advantage of submitting claims for your services directly to us is that it is not only a benefit to your patient, but also a benefit to you because:

• You have all the required information in the patient’s file to complete a valid claim.
• Your expertise in completing insurance claims means you complete claims correctly at the time of submission.
• You control the accuracy of the information used to calculate benefits for your services.
• Patient submitted claims are often the cause of overpayments and payments to the wrong office.

A verbal reminder may also help the patient to understand that this is one of the services you provide as part of your agreement with us.

**Ancillary Claim Submission (Billing) Guidelines**

The Blue Cross and Blue Shield Association Mandates Plan compliance with the handling and processing of the following ancillary claims:

- Independent Clinical Laboratory
- Durable Medical Equipment and Supplies
- Specialty Pharmacy

**Independent Labs**

Independent Labs are required to file the claim to the Blue plan in whose state the specimen was drawn. Where the specimen is drawn is determined by what state the ordering (referring) provider is located. If the referring provider in Box 17 is not a Nebraska provider, BCBSNE will reject the claim and direct the lab to file to the Blues plan where the referring provider is located. To prevent physician offices from being impacted by the ancillary claim filing guidelines when submitting charges for laboratory services, it is important to use POS 11 (office) when filing your claim. Only a laboratory referring services to another laboratory should use Modifier -90.

POS 81 is to be used only by independent laboratory providers, which are defined as “a laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician’s office.” Physician offices who bill for laboratory services sent to an independent clinical laboratory should NOT assign POS 81 to the service line(s) in which the laboratory is reported on the claim.

**Note:** This applies to freestanding, independent clinical laboratories only. Claims for laboratory services provided in a hospital setting or billed by a physician office should be sent to the Blue Plan in the state where the laboratory services were performed.

**Durable Medical Equipment (DME)**

DME claims must be filed to the plan in the state the equipment was shipped to or purchased in a retail store.
Note: When submitting a POS 12 (Home), the claim should always be filed to the plan in the state where the patient resides. Equipment and/or supplies purchased in a retail store should be submitted with a POS 17 and filed to the plan in the state where the store is located.

**Specialty Pharmacies**

Specialty Pharmacies must file to the Plan in whose state the referring provider is located.

Required fields as noted in the following chart must be populated on the claim. Claims that are missing required information will be returned to the provider.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Required Fields</th>
<th>Where to file</th>
</tr>
</thead>
</table>
| Independent Clinical Laboratory (any type of non-hospital based laboratory) | Ordering Provider Name and Type I NPI Number | File the claim to the Plan in whose state the **specimen was drawn***  
* Where the **specimen was drawn** will be determined by which state the ORDERING provider is located. |
| Durable/Home Medical Equipment and Supplies (DME/HME) | Patient’s Address  
Ordering Provider Name and Type I NPI Number  
Place of Service  
Service Facility Location Information | File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.  
**Note:** Items shipped to the patient should be submitted with a POS 12 (Home). Items purchased in the retail store should be submitted with a POS 17 (Retail Clinic) |

Examples:

1. Wheelchair is purchased at a retail store in Nebraska.  
*File claim to: Blue Cross and Blue Shield of Nebraska. The physical location of the retail store must be populated in field 32 (Loop 2310C).*
2. Wheelchair is purchased on the internet from an online retail supplier in Nebraska and shipped to Minnesota.  
*File claim to: Blue Cross and Blue Shield of Minnesota. Field 32 (Loop 2310C) should be blank.*
3. Wheelchair is purchased at a retail store in Nebraska and shipped to Minnesota.  
*File claim to: Blue Cross and Blue Shield of Minnesota.*
Specialty Pharmacy
Ordering Provider Name and Type I NPI Number
File the claim to the Plan whose state the ordering provider is located.

**Example:**
- Patient is seen by a physician in Nebraska who orders a specialty pharmacy injectable for this patient
- Patient will receive the injections in Florida where the member lives for 6 months of the year

*File claim to:* **Blue Cross and Blue Shield of Nebraska**

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**Assignment of Benefits**

BCBSNE does not recognize “Assignment of Benefits.” All covered services provided by non-participating providers will be paid to the member.

**Billing – Claim Submission**

The only exception to a provider’s requirement to submit claims is HIPAA rule 164.522(a)(1)(vi). If a member requests that a provider restrict disclosure of PHI to the health plan **AND** pays the provider in full, the request must be honored. The request is only applicable for those services/items specifically directed by the member and paid in full.

This does not apply to PHI required to be disclosed due to federal or state mandates and laws. For more information see the following: Federal Register January 25, 2013 – Final Rule.

**Corrected Claims**

If the information on an already processed (paid or denied - **not returned**) claim is incorrect or charges need to be added or voided, you must submit a corrected claim electronically.

**Some examples of when you would submit a corrected claim could include (not limited to):**

- Changing CPT code
- Changing diagnosis
- Changing place of service
- Adding a modifier
- Changing date of service
- Adding or removing charges, etc.

*Do not submit with a reconsideration*

Steps to submit a corrected claim electronically:

1. Place a value of ‘7’ (replacement of prior claim) or ‘8’ (void/cancel of prior claim) in the 2300 CLM 05-3 element in the 837P file.
2. Enter the original claim number assigned by BCBSNE in the 2300 REF*8 segment of the 2300 loop.
   a. These two element/segment values on the electronic claim form correspond to Box 22, Resubmission Code and Original Reference Number, on the CMS claim form.
3. Type of Bill (TOB) 7 indicates you are replacing a previously submitted claim so do not change or remove data that needs to process again - submit the complete claim with the changes made.

Claims submitted and processed under an incorrect patient and/or member Identification (ID) number will need to be voided before a new claim is submitted.
1. Resubmit the claim as it was originally submitted, but with a claim frequency code 8 to void the inaccurate claim record
2. Submit a new claim with correct patient and/or ID information using claim frequency code 1
3. Claims with frequency code 1 do not need a claim number submitted in the original reference number field

If you are not able to file your corrected claim electronically because your claim will include attachments, you must file your corrected paper claim to Blue Cross and Blue Shield of Nebraska with the attachments. **Do not submit corrected claims using a reconsideration form.**

Do not send only the claim with “corrected claim” or “replacement claim” written or typed on the claim itself, as it will be returned and should follow the steps above. Corrected claims submitted as reconsiderations will be returned and should be submitted electronically following the steps above.

Submitting a new claim to replace one that has already been filed may result in a duplicate denial.

**Returned Claim**
If a claim submission is rejected or returned due to incorrect or invalid information, it is the provider’s responsibility to make the necessary corrections and resubmit the claim within the timely filing period. When submitting a new claim do NOT place a 7 or 8 in box in the 2300 CLM 05-3 element in the 837P file or in Box 22 of the paper form. The new claim is not considered a correct or replacement claim since the original was never processed. It is a NEW claim and will be processed as such.

**Electronic Claims Submission**
Electronic submission is the preferred method of filing claims for professional services. Benefits of electronic claim submission include:

- Lower operating costs. You will spend fewer dollars for clerical work and postage. Most electronic claims are submitted in less than 60 seconds.
- Greater control over claim data. Electronic claim submission is a more efficient way to submit claims. Submitting claims electronically will lead to a faster, more accurate payment.
When all necessary information is submitted electronically, fewer claims will be returned for missing or incorrect information.

- No limit on the maximum number of lines that can be submitted on one claim. (No HIPAA mandate for line limitations)

**Note:** When submitting a UB-04, Field Locator (FL) 3b (Medical/health Record Number) is a required field. If FL 3b is left blank, the claim will be returned.

**Filing Secondary Claims Electronically**

If you can send institutional or professional primary claims electronically, you can send secondary claims electronically as well. Please follow these billing guidelines found in the 837 Companion Guide for Health Care Claim (Coordination of Benefits) at to file secondary claims to BCBSNE.

Our NEBLUEconnect Account Managers can tell you about the hardware and software that make electronic claim submission possible and can show you how electronic claims processing has helped offices like yours. If you would like to speak with an Account Manager, please call 800-821-4787, Option 3.

For more information, go to [NebraskaBlue.com/Providers/Eligibility-and-Claims](https://www.nebraskaBlue.com/Providers/Eligibility-and-Claims).

**Faxed Claims**

BCBSNE does not accept faxed claims. Claims can only be accepted by electronic submission or by mail.

**Electronic Funds Transfer**

If you are interested in having your claim payments electronically deposited into your bank account, please call or send an email to: Phone: 800-821-4787 (option 3) E-mail: [ProviderOperationsSupport@NebraskaBlue.com](mailto:ProviderOperationsSupport@NebraskaBlue.com)

**NOTE:** If you are changing EFT from one bank or account to another, you will receive paper checks until the effective date of the new bank account.

**Payment**

In-network providers agree to accept our reimbursement as payment in full, except for the following amounts when applicable:

- **Deductible**
- **Coinsurance**
- **Copayment**
- **Charges for services and supplies which are not covered in the member’s contract and are not provider liability**
The reimbursement amount received by the billing provider may differ slightly from the contractual reimbursement amount due to system rounding.

**Note:** The member is not responsible for noncovered charges for services and supplies that are deemed not medically necessary by BCBSNE. However, on an exception basis, if prior to the services being provided, you have advised the member of this fact, in writing, and the member has agreed, in writing, to be responsible for payment, you may bill the patient. This may not be done as standard practice.

**Note:** Charges for noncovered services as well as any copay, deductible and coinsurance on covered services may be collected at the time of service. BCBSNE does not restrict providers from reducing charges to members on non-covered services.

Contracting institutional and professional claims are finalized on Tuesday night. Payments and remittance advices (checks and 835’s) are distributed weekly on Wednesdays.

**Remittance Advice**
Contracting providers receive direct payment from BCBSNE. They will also receive remittance advice (remit) to advise on the amounts of Provider liability, BCBSNE liability/payment and member liability. Tips about remits:

- Remits are generated the same day the claim is processed.
  - Most providers receive remits electronically
  - Paper remits are mailed the next working day
  - Once a provider has converted to an electronic remit; paper remits will discontinue and will no longer be available

- The subscriber EOB and participating provider’s remit are sent at the same time.
- Payment information is detailed for each claim on the remittance advice.
- Deductible, co-insurance, co-pay, and noncovered charges are identified.
- Amounts considered provider responsibility/write off are identified.
- If a patient account number is submitted on a claim, that number is included on the remittance advice.

Information on our new system offsetting information can be found at NebraskaBlue.com/Providers/Alerts-and-Updates/Happening-Now.

**Replacement Claims**
List the appropriate bill type when submitting a replacement claim (xx7) or a late charge claim (xx5).

- The replacement claim bill type indicates the previously submitted claim should be voided and the replacement claim should be substituted.
- A late charge claim bill type indicates the charges should be appended to the previously submitted claim.
Both late charge and replacement claims will be monitored, and any abnormalities will be brought to the attention of the facility.

**Note:** Do not use bill type xx7 if your original claim submission was not adjudicated by BCBSNE. If your original claim was rejected/returned due to a billing or coding error, do not submit your corrected claim as a replacement claim.

**Refund Offsetting**

BCBSNE requires a refund offsetting process for in-network providers.

Effective October 1, 2022, when a claim overpayment occurs, the provider will be offset immediately on the same payment cycle. If the offset is greater than the current payment in the payment cycle, continued offsets will occur until the overpayment is satisfied.

If an overpayment is identified by the provider, please follow the claims adjustment process.

Direct all questions concerning refunds and offsetting to our Refunds Department at 800-562-3381.

**Note:** If the offset is due to an overpayment of an FEP claim, offsetting will only occur on other FEP claims. We will not offset over payments on FEP claims with claims that are non-FEP.

**Refund Requests**

BCBSNE will not initiate refund requests beyond the time specified in the applicable Provider Agreement except in specific situations. No refund time limit will apply when the refund initiation is based on a reasonable belief of fraud, abuse or other intentional misconduct; if required by a state or federal government program or if another payor is involved (e.g. coordination of benefits, subrogation or right of reimbursement, and workers’ compensation coverage).

Beginning June 1, 2021, internal initiated adjustments will have an overpayment threshold of $40.00. Adjustments will not be made unless they exceed the $40.00 threshold. This applies to dental, Medicare supplement, local and FEP claims.

**Timely Filing Limit**

Providers are contractually responsible for filing clean claims, within 120 days or the timeframe specified in the applicable provider agreement.

If a claim submission is rejected or returned (unprocessed) due to incorrect or invalid information, it is the provider’s responsibility to make the necessary corrections and resubmit the claim within 120 days or the timeframe specified in the applicable provider agreement.

For adjustments or revisions, providers will be held to the post service adjustment timely filing of 12 months from the latest payment, or the specific language specified in their contract.
When BCBS is the secondary payor, claims must be received 120 days after the date the Provider receives the EOB from the primary payor. Claims denied due to exceeding the timely filing limit are the provider’s liability and cannot be billed to the member. The Federal Employee Program (FEP) follows the same timely filing limits. Non-Nebraska BCBS member claims are subject to timely filing limits of the member’s plan.

Exceptions to the timely filing rule can apply to:

• Coordination of benefits (timely filing is 120 days from the date on the primary payer’s EOB which must be included)
• Subrogation – timely filing limit in the provider’s contract applies. The exception is to the adjustments/revision rule (above). Timely filing requirement starts on the date of care.
• Workers’ compensation (timely filing is 120 days from the date on the workers’ compensation carrier letter which must be included)
• Obstetrical (OB) claim, total OB care
• Fraud Waste Abuse Intentional Misconduct
• Not obtaining member identification card – for exception consideration, providers must produce written documentation, obtained at the time of service and signed by the member, indicating the member does not have insurance. Proof of attempts to obtain insurance information from the member within the timely filing period will be considered at the discretion of BCBSNE. Effective 2-1-21: Documentation must be submitted to BCBSNE within 12 months of the date of service.

BCBSNE does not consider a rejected or returned claim as proof of timely filing.

If a claim is listed on a BCBSNE accepted claim report and shows no errors but was not processed or returned, we will reconsider the timely filing rejection and process the claim.

• Please include the page from the clearinghouse report showing both the clearinghouse and BCBSNE accepted the claim without errors (this must be included, or the request will not be considered)
• Returned claims cannot be used as proof of timely filing of a clean claim
• BCBSNE does not consider provider internal delays as a reason to override timely filing
• These requests will not be considered

Please use the Timely Filing Override Request (nebraskablue.com) to submit your request for an override.

Claims submitted and processed under an incorrect patient and/or member ID number will need to be voided and a new claim submitted before the timely filing deadline.

If a claim is denied as timely and you collected any payment from the member at the time of service (deductible, coinsurance, copay) you will need to refund the money collected.
**1500 Paper Claim Submission**

Paper claims are entered into our claim processing system by transforming information on paper claims to an electronic format. If the claim cannot be entered electronically, it is delayed for research and entered manually by an auditor. When submitting paper claims with multiple pages, please label pages as “1 of 2,” “2 of 2,” and total the final page as the total billed charge to ensure the claim is loaded as one claim and not split into multiple claims per page.

A HIPAA mandate designates that on paper claims there is a limit on the number of lines that can be submitted on one claim.

Claims can be mailed to:
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

To expedite paper claim processing:
- The text must be printed clearly.
- Keep all text inside the lines.
- Text must be dark.
- Dates must be numeric and six positions (mmddyy).
- Do not use nicknames or “Baby Girl,” “Baby Boy” as the patient’s name.
- Print - do not write in script.
- Print the entire ID number in Box 1a - including the prefix.
- Current CPT codes (Box 24D) and current diagnosis (Box 21) codes are needed, but nomenclature is not needed unless you are billing an unlisted or miscellaneous CPT code.

The provider’s name and identification numbers on CMS 1500 forms must correspond with information we have on our provider data file.

**Section 9: Home Medical Equipment, Home Infusion, Home Health, and Hospice**

**BlueCard**
Coverage for Home Medical Equipment (HME) items provided to a member covered by another state’s BCBS Plan need to be verified and/or preauthorized through that member’s Blue Plan.

**Certificate of Medical Necessity**
If your item requires an order of medical necessity, it is required for you to keep it on file but not required to be submitted with the claim.
Medicare-Related Issues

Medicare and Oxygen Concentrators
Medicare’s rental policy does not match BCBSNE’s rental policy. Medicare allows rental of the concentrator for 36 months, but BCBSNE’s rental period is 10 months. Medicare requires the Oxygen Concentrator to be a rental to pay for the supplies. Once the purchase price is met (with BCBSNE), you can continue to bill Medicare for rental if it is appropriate according to Medicare guidelines. The benefit as a secondary payer, however, are limited to the purchase price.

Coinsurance liability once Purchase Price Met
When the customer has Medicare as primary and according to BCBSNE the purchase price of an item has been met, the provider can bill the member for the coinsurance that is left over from Medicare.

Ostomy Supplies
Coverage for Ostomy Supplies can vary based on the member’s benefit plan. Please be sure to check member benefits to determine if these supplies are covered under the medical plan or the drug plan. Generally, for fully insured groups the supplies are covered under medical. An exception is to our Individual and Small group “keep your plan” members. Self-Insured groups have the option to cover the benefits under the medical or drug plan.

Prescriptions
Many items require an order from a physician indicating the item ordered is medically necessary. This needs to be on file but is not required to be submitted with the claim.

Physician Assistants (PA) can prescribe drugs and devices as delegated by their supervising physician. If an HME provider has concerns with a script written by a PA, they should ask for clarification from the PA and/or supervising physician prior to filling the script. Supplies for an original scripted HME item (e.g. prosthetic device) do not require additional or ongoing scripts.

Replacement of Existing Equipment
A second or subsequent purchase of an item of Home Medical Equipment may be preauthorized under the following conditions:

• There is a significant change in the covered Person’s condition;
• Growth of a Covered Person;
• The item is irreparable, and/or the cost of repairs exceeds the expense of purchasing a second piece of equipment;
• The item is five or more years old (unless replacement is Medically Necessary prior to that time); or
• As otherwise determined to be reasonable and necessary.
Note: Even if an item is five or more years old, preauthorization is still strongly recommended if replacement is being considered.

**Section 10: Mental Health**

Categorization of Mental Health providers occurs based on their level of training/education. BCBSNE recognizes three levels of Mental Health Providers, auxiliary, level II and level III. See the below:

<table>
<thead>
<tr>
<th>Provider Level</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level I</strong></td>
<td>Psychiatrist</td>
</tr>
<tr>
<td></td>
<td>Licensed Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td>Advanced Practice Registered Nurse</td>
</tr>
<tr>
<td></td>
<td>Physician Assistant</td>
</tr>
<tr>
<td><strong>Level II</strong></td>
<td>Special Licensed Psychologist</td>
</tr>
<tr>
<td></td>
<td>Licensed Mental Health Practitioner</td>
</tr>
<tr>
<td></td>
<td>Licensed Alcohol and Drug Counselor</td>
</tr>
<tr>
<td></td>
<td>Licensed Independent Mental Health Practitioner</td>
</tr>
<tr>
<td><strong>Level III</strong></td>
<td><strong>Auxiliary Providers</strong></td>
</tr>
<tr>
<td></td>
<td>Provisionally Licensed Mental Health Practitioners</td>
</tr>
<tr>
<td></td>
<td>Provisionally Licensed Drug and Alcoholism Counselors</td>
</tr>
<tr>
<td></td>
<td>Certified Social Workers</td>
</tr>
<tr>
<td></td>
<td>Certified Masters Social Workers (without an LMHP license)</td>
</tr>
</tbody>
</table>

**Auxiliary Provider**

All Auxiliary (provisional) Providers must be supervised by an in-network, qualified Physician or Licensed Clinical Psychologist or as otherwise permitted by state law. The **provisional provider’s network status is directly tied to the participating status of the supervising provider**. Certified Master Social Workers or Certified Professional Counselors performing Mental Health Services who are not Licensed Mental Health Practitioners are included in this definition. Auxiliary providers need to provide BCBSNE with their professional information, so they can submit claims for services they are providing. See “**Becoming an In-network Provider**” for more information.

Once the provisional provider receives their full/active LMHP, LADC, LCSW, CMSW, PhD, or PsyD their provisional license becomes void, and BCBSNE will terminate the provisional status. The provisional provider will then need to be credentialed as a new provider.

**Note**: If a Provisionally Licenses Psychologist is also an LMHP, we will continue to list the provider as a LMHP until they are fully licensed as an LP. This is beneficial to the practitioner since the reimbursement for an LMHP is a Level II versus a Level III for a PLP. If a fully licensed provider wants to be listed as a provisional provider with BCBSNE, they must inactivate their current license with the state.
As a provisional provider – if your supervisor terminates their agreement with BCBSNE you must provide us with your new supervisor’s information.

**Dual License**
If you are already an LMHP and add your LADC license or vice versa, you do not have to credential again. Simply notify BCBSNE of your additional credentials and license.

**Dual Therapists**
If there are two therapists present in either an individual session or a group session, only one therapist can bill for their services.

**Free-Standing Intensive Outpatient/Day Treatment/Partial Care Programs**
For a qualified free-standing program to receive in-network benefits, they must have signed an “Outpatient Mental Illness or Alcoholism and Drug Abuse Treatment Program” Agreement.

Depending on the services provided, two numbers may be issued: one for mental health and one for drug/alcohol rehab. See the *Billing and Reimbursement Manual* for billing guidelines.

**Inpatient Psychiatric Sessions**
Only Physicians, PAs, Dos and APRNs may bill for psychiatric sessions while patient is inpatient. PhD’s cannot bill inpatient psychiatric sessions.

**Marital Counseling**
Only covered under certain contracts.

**Mental Health Parity and Substance Use Disorders**
According to federal Mental Health Parity Act mandates, financial obligations (deductible, coinsurance, copays) and treatment limitations (including visit and/or day limits) imposed on mental health and substance abuse benefits *cannot* be more restrictive than the financial requirements and treatment limitations applying to all other medical and surgical benefits under the plan. The law does not require that a plan provide mental health and substance abuse benefits, but if included in the coverage, the benefits must be provided in parity with medical and surgical benefits.

Additionally, non-quantitative treatment limits (medial management, step-therapy, utilization review, etc.) for MH/SUD benefits must be comparable to and applied no more stringently than nonquantitative treatments limits for medical/surgical benefits. MHPAEA does not require that a plan/insurer provide MH/SUD benefits, but if such benefits are provided, they must be provided in parity with medical/surgical benefits.
Services received in residential treatment centers under the final Mental Health Parity regulations must follow these guidelines:

- The residential treatment program/facility must be licensed, accredited or certified by the appropriate state agency or accredited by Commission on Accreditation of Rehabilitation Facilities CARF International or The Joint Commission.
- Benefits for covered services will be subject to all terms of the contract and the endorsement, including limitations, exclusions, certification, medical necessity criteria and Utilization Management Program requirements.

BCBSNE implemented MHPAEA in conjunction with the IFR (and subsequent amendments thereto) and complies with all mental health parity requirements for all lines of business.

**Pharmacologic Management (CPT Code: 90863)**

Pharmacologic management includes prescription, use, and review of medication with no more than minimal medical psychotherapy. When payable according to a patient’s coverage, BCBSNE allows benefits for this procedure once per day. This code is billed by an MD, DO, PA, APRN only.

**Provider Levels**

Verify benefits for members covered by other Blue Cross and/or Blue Shield Plans by calling BlueCard Eligibility® at 800-676-BLUE (2583).

<table>
<thead>
<tr>
<th>Provider Level</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>Psychiatrist, Licensed Clinical Psychologist, Advanced Practice Registered Nurse, Physician Assistant</td>
<td></td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>Special Licensed Psychologist, Licensed Mental Health Practitioner, Licensed Alcohol and Drug Counselor, Licensed Independent Mental Health Practitioner</td>
<td></td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>Auxiliary Providers: Provisionally Licensed Mental Health Practitioners, Provisionally Licensed LPs, Provisionally Licensed Drug and Alcoholism Counselors, Certified Social Workers, Certified Masters Social Workers (without an LMHP license), Psychiatric Registered Nurse</td>
<td></td>
</tr>
</tbody>
</table>

**Psychiatric**

Psychiatric benefits and the certification of the health care professional who can provide them vary from one member/group contract to contract. Please contact Provider Service Department for information about a specific patient’s benefits.

When verifying benefits with BCBSNE or any other BCBS Plan, you should ask about the member’s coverage and about any restrictions on the type of provider covered under the contract for these services.
Psychologist (PhD) Inpatient Psychiatric Billing

Only Physicians, PAs, DOs and APRNs may bill for psychiatric sessions while patient is inpatient. PhD’s cannot bill inpatient psychiatric sessions.

Risk Factor Reduction Intervention and/or Counseling

Coverage for these services vary by member benefit plan. Please verify the member’s benefits prior to providing services.

Section 11: Quality Management

BCBSNE maintains a Quality Management (QM) Program to support corporate objectives and strategies. Activities undertaken in support of the BCBSNE vision (“A healthcare world without confusion that add more good years to peoples’ lives.”), and in compliance with regulatory requirements, are evaluated on a regular basis and reported annually to the Board of Directors. The Quality Management Program is an ongoing effort that may focus on a variety of opportunities for improvement as they become apparent through analysis. Communication and collaboration with providers in the BCBSNE networks, as well as professional and community organizations in Nebraska and nationally, contributes to the success of our program and demonstrates our commitment to high quality care and service in Nebraska and beyond.

The Clinical Quality Improvement (CQI) Department coordinates and facilitates the QM program including but not limited to:

- URAC accreditation
- Accountable care organizations and patient–centered medical homes
- Preventive Health and Wellness
- Consumer Safety and Transparency
- Clinical quality improvement activities
- Health care safety and quality
- Provider office standards for:
  - Practitioner offices
  - Urgent Care Centers
  - Appointment Availability and Access to care

Programs are initiated and facilitated by the Quality Improvement Department to enhance care delivery, contribute to a positive member experience, and create a collaborative atmosphere with the provider community with a goal of improving the care and services your patients, our members, receive.
Accreditation
BCBSNE is fully accredited by URAC under the Health Plan Standards, which ensures we are conducting business in a manner consistent with national standards. For more information on URAC and to view our approval status, see Ratings and Accreditations at NebraskaBlue.com/About-Us/Our-Company/Ratings-and-Accreditation

Appointment Availability and Access Standards
BCBSNE has established standards for access to care for in-network providers. Performance against these standards is assessed on a practice-specific and an organization-wide basis. Compliance to Appointment Availability/Access to Care Standards is monitored as part the Quality Management Program. Member complaints and applicable member satisfaction survey results are also used by the plan to evaluate performance.
For more information on Appointment Availability/Access Standards, go to the Credentialing page of NebraskaBlue.com.

Blue Distinction Centers (BDC)
Blue Distinction is a national designation program which recognizes those facilities that demonstrate expertise in delivering quality specialty care safely, efficiently, and cost effectively. True to its original commitment as a quality-based program for specialty care, Blue Distinction has evolved to include a value-based designation awarded to facilities that meet stringent quality measures, focused on patient safety and outcomes, as well as cost of care criteria. Nebraska currently has facilities in the following BDC specialty care categories: Substance Use Treatment and Recovery, Maternity Care, Cardiac Care, Bariatric Surgery, Transplants, Spine Surgery and Knee/Hip Replacement.

The Blue Distinction Specialty Care Program includes two levels of designation:
• Blue Distinction Centers: Healthcare providers recognized for their expertise in delivering specialty care.
• Blue Distinction Centers+: Healthcare providers recognized for their expertise and cost-efficiency in delivering specialty care. Quality remains key: only those providers that first meet nationally established, objective quality measures for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+.

Complaint Investigation and Process
The Quality Improvement (QI) Department tracks, trends, analyzes, investigates, and facilitates resolution of complaints from members, providers, employer groups and brokers as well as internal sources. Investigation of these potential issues may involve:
• Obtaining medical record documentation related to the concern.
• Contacting the provider’s office directly to discuss service or access issues.
• Soliciting additional information directly from the practitioner to supplement medical record findings.
Complaints related to the quality of care rendered to a member are reviewed by the BCBSNE Medical Director or designee to determine if a quality-of-care issue exists and its severity. Significant quality of care issues are presented for peer review at the BCBSNE Quality Management Committee comprised of practicing network physicians not employed by BCBSNE. Recommendations for further action, if appropriate, are determined by the committee. The QI complaint process enables tracking and trending of issues of concern and serves as a valuable tool for maintaining high quality provider networks as well as improving processes and services our members expect from their health plan.

**Consumer Safety and Transparency**

BCBSNE supports the focus on clinical performance and cost transparency for services and products provided to our members. This initiative is designed to enable members to actively participate in their health care decision making. The following tools have been developed and are displayed online as part of our customer transparency initiative.

*National Consumer Cost Tool*

An interactive tool that helps consumers evaluate the cost of health care services and make informed decisions regarding their health care and related expenses.

*Physician Quality Measurement*

The Physician Quality Measurement initiative provides details on a physician’s performance on selected Health Care Effectiveness Data Information Set (HEDIS) measures and helps consumers select a doctor or facility that best meets their needs.

*Patient Review of Physicians*

The Patient Review of Physicians is a resource for member feedback regarding overall experience with a physician following an encounter with the practitioner. This resource also helps other consumers select a physician that’s right for them.

*Facility Standards for Practitioner Offices, Urgent Care Facility Standards, Medical Record Documentation Standards*

Each provider office/facility shall maintain compliance with standards to provide a safe and confidential environment that is conducive to the delivery of effective patient care for members as well as the protection of the office staff. Facilities are reviewed when necessary, against each applicable standard. Medical records may also be reviewed when necessary, against the Medical Record Documentation Standards. For more information on these standards – see the Credentialing page of NebraskaBlue.com.

**Preventive Health and Wellness**

Blue Cross and Blue Shield of Nebraska’s BlueHealth Advantage consultative program helps employer groups with the tools and resources needed to implement a worksite wellness program that can improve employee’s health and productivity. All members have access to a health and wellness
website (www.bluehealthadvantagene.com) that provides information to free and high quality health resources; such as the wellness newsletters, a health library, monthly health challenges and a variety of other tools and resources.

**Readmission Quality Program**

When a claim is received which indicates it is for a readmission for a patient to the same facility, with the same or similar diagnosis, within 14 days for the original admission discharge date, both the original and readmission claims will be reviewed by BCBSNE Medical Staff. If it is determined that the readmission is for the same or similar diagnosis or a complication of the initial admission, we will reimburse either the initial admission OR the subsequent readmission, whichever is the greater amount. The claim that is determined to be reimbursable will be reimbursed according to the terms of the patient’s contract. Decisions can be appealed through the normal appeal channels.

Readmissions related to the following diagnoses will NOT be part of the Readmission Quality Program:

- Maternity
- Cancer
- Transplants
- Behavioral health

This policy is intended to increase the quality of care for our members though encouraging a greater emphasis on care coordination and discharge planning. With a decrease in repeat admissions the patient’s risk for complications and poor outcomes decreases.

**Medical Records Standards**

You may receive requests from us or one of our vendors to review medical charts for one or several of your patients. We appreciate your cooperation in helping us meet our quality goals as we seek to improve the overall health of our members—your patients. We know it's not an easy task to prepare charts for medical review, but we believe you are as committed to improving patients' health outcomes as we are. That's why we are asking you to help us by complying with our requests for records. We would also like you to talk with your vendors and encourage them to cooperate with requests they may receive on your behalf. As a participating provider, your contract states you agree to permit Blue Cross and Blue Shield of Nebraska or one of our business partners to inspect, review and obtain copies of such records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment. If there is anything we can do to make this process easier for you, please let us know. We will do all we can to accommodate you.

Reference [Medical Record Standards](#).
Section 12: Member Benefit Appeal and Reconsideration

All BCBSNE contracts adhere to the applicable state and/or federal guidelines governing appeals. Appeals are performed by nurses and/or physicians who were not previously involved in the review or appeal process. When requesting an appeal, it is important to submit all relevant information that may assist in conducting the appeal.

**Expedited Appeal**

BCBSNE offers an expedited appeal to the attending/ordering provider, patient/enrollee and facility when a determination is made not to certify services and the situation meets the requirements for an expedited appeal as defined by BCBSNE.

The appeal is expedited if the appeal pertains to a “claim involving urgent care.” All other appeals are standard appeals.

A “claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**First Level of Appeal**

The first level of appeal may be expedited or non-expedited and should be submitted in writing. Providers are encouraged to use the Appeal form.

For most groups covered by BCBSNE, the time frame for requesting a first level appeal is six (6) months from the initial denial of benefits. The following information will assist the attending provider in requesting an appeal. A written request for an appeal can be faxed to 402-392-4111 or 800-991-7389; or it can be mailed to:

Appeals Department
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

The laws and regulations governing appeals do not allow the plan to delay or postpone an appeal decision if additional information is requested but not received. For an expedited first level appeal, a determination will be made within 72 hours of the request for the appeal. An expedited appeal is offered to the attending/ordering provider, patient/enrollee, and facility when a determination is made not to certify services and the situation meets the requirements for an expedited appeal as defined by BCBSNE.
An expedited appeal may be submitted in writing or verbally by calling us at 402-982-8314 or toll free 1-877-448-3339.” If additional information was requested but not received, the appeal decision will be made based on the information available. For a non-expedited first level appeal, a decision will be made on either the 15th working day or 30th calendar day (depends upon the group’s contract) from receipt of the appeal request.

The attending provider will be notified of the appeal determination within 72 hours of the request for the appeal when care is expedited. Written notification of the appeal determination will be sent for expedited and non-expedited appeal determinations.

**Second Level of Appeal (if applicable)**
A second level of appeal is available when the first level of appeal results in a denial of benefits. The denial of benefits letter following the first level of appeal will provide the necessary information and the process to use to request a second level of appeal, when the second level appeal is available.

If the second level appeal results in a denial of benefits, then the appeal process at BCBSNE has been exhausted and no further appeals are available.

**Denial Upheld on Appeal**
When a denial is upheld on appeal, the attending provider has the right to request in writing:

- A copy of the rule, guideline, protocol, or other similar criterion that was relied upon in making the decision (if applicable); and
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances (if the denial is based on medical necessity or experimental treatment or similar exclusion or limit).

**Reconsideration Requests**
Providers may ask for a reconsideration of the reimbursement level of submitted charge(s) and must supply all information necessary for BCBSNE to decide regarding appropriate reimbursement. Providers are encouraged to use the Reconsideration form.

Reconsideration requests are only applicable if a claim has been processed and a remittance advise has been issued.

Please use the following guidelines when submitting a claim for a reconsideration request: The correct, most recent version of the reconsideration form must be used. Please make sure the form is filled out in its entirety, including the BCBSNE claim number and member ID.

In the reason section of the form, please check the applicable box. In the comments section, please provide a brief but concise description of the issue, including the code(s) in question.
If submitting documentation, please include all relevant documentation for the reconsideration request reason, but do not include information that does not pertain to the issue.

Reasons for a reconsideration request are:

- An Invoice for Pricing Review
- Worker’s Compensation or Subrogation
- Provider Contract Pricing (include the relevant fee schedule information being referenced)
- Review of Medical Records for CPT/HCPCS/IDC10 code edits/denials
- Other Insurance Information
- Issues Regarding Modifier Submission

Please note if the issue is regarding a preauthorization, medical necessity denial, investigative denial or no assistant surgeon allowed, these should be sent as Appeals, not as a reconsideration.

Please review the instructions on submitting an Appeal in the General Policies and Procedures Manual. BCBSNE reserves the right to determine a cost threshold for any reconsiderations requested to be cost efficient for providers and members. The threshold for reimbursements is $25.00 based on current costs of claims handling.

If the denial of a reconsideration is upheld, the provider may not submit another reconsideration request unless the necessary documentation was not sent initially. Otherwise, the provider will be required to submit an appeal.

In all cases, BCBSNE will make a final determination of reimbursement level based upon the criteria detailed above. The covered person is not responsible for payment of disputed charges during the appeal/reconsideration process. The provider may not bill the covered person for any payment under dispute.

**Please Note**

Appeals and/or reconsiderations received on the INCORRECT Appeal/Reconsideration form it will be returned requiring the provider to be submit on the correct Appeal OR Reconsideration form.
Section 13: Network Termination and Non-Payable Status, Appeal and Reinstatement, Administrative Disputes and Provider Corrective Actions

Network Termination and Non-Payable Status
BCBSNE may terminate a contracted physician, facility, or other health care provider (provider) from plan networks and/or place them in a non-payable status, with or without cause, based on contract provisions of the Provider Agreement.

In addition, BCBSNE may require termination of a provider if the provider:

• Submits a pattern of claims which willfully and intentionally misrepresent the services provided or the charge for such service, or demonstrates a pattern of fraud, waste, or abuse (FWA).
• No longer maintains the applicable unrestricted state or federal license.
• No longer provides services to patients within the State of Nebraska; or has not submitted claims to BCBSNE in the past 18 months.
• Is convicted of a felony or is expelled or suspended from the Medicare or Medicaid programs (Title XVIII or XIX of the Social Security Act).

Subject to applicable laws, such provider may be given an opportunity to enter and complete a corrective action plan (CAP) prior to termination. Participation in a CAP exhausts one level of appeal. No corrective action is available in cases of fraud, imminent harm to patient health, or when the provider’s ability to provide services has been restricted by action, including probation or any compliance agreement, by the Nebraska Department of Health or other governmental agency. When the provider’s attempt to correct the situation is insufficient, the provider’s participation with BCBSNE will be terminated. Since participation in a CAP exhausts one appeal right, only one appeal remains following the completion of a CAP.

Network Termination Appeal
BCBSNE offers providers with an appeal and fair hearing process. This process is to be used in instances when BCBSNE makes the decision to decline participation in plan networks, places a provider in a nonpayable status or terminates a provider’s participation for cause based on quality issues, utilization issues, FWA, or non-compliance with credentialing criteria or contractual and policy requirements, except as identified below in the Non-Appealable Decisions section.

First Level of Appeal
The notification of declined participation, non-payable status or termination will contain the applicable reason(s) for the adverse action, the grounds upon which the adverse action is based, and any other relevant subject matter that was considered. The notification will also inform the provider they have
thirty (30) business days from the date of the notification to submit a written appeal request when the reason for the declined participation, non-payable status or termination is appealable.

Within thirty (30) business days of receiving an appeal request, BCBSNE will furnish the provider written notice of the date and time of the hearing. The hearing will be held at BCBSNE’s offices in Omaha, Nebraska as soon as reasonable arrangement can be made. The hearing will be conducted not more than forty-five (45) business days from the date the appeal request was received, unless the provider or Hearing Committee is unable to participate within that time frame. In that case, the hearing will be held within ninety (90) business days of the request unless otherwise agreed upon by both parties.

The Chief Medical Officer (CMO) or designee shall determine the Hearing Committee members. At least one member of the Hearing Committee must be of the same profession as the provider who is appealing. At least one member of the Hearing Committee must be a participating provider who is not otherwise involved in network management.

The CMO or designee may request the appearance of up to two individuals at the hearing to answer questions and/or to make a statement on BCBSNE’s behalf. The individuals shall not vote in the decision of the Hearing Committee.

The provider may have up to two people attend the hearing on the provider’s behalf to answer questions and/or to make a statement on the provider’s behalf.

Each person appearing at the hearing is limited to 15 minutes of speaking time. Both the provider and the Hearing Committee have the right to question the individuals appearing on behalf of either side.

The CMO or designee shall serve as chairperson for the hearing but shall not vote in the decision of the Hearing Committee. The chairperson shall preside over the hearing and determine the order of procedure to ensure all participants in the hearing have a reasonable opportunity to present relevant verbal and documentary evidence, and to maintain decorum. Upon conclusion of the presentation of verbal and written evidence, the hearing shall be closed. The provider may submit a written statement at the close of the hearing before deliberations.

Minutes of the hearing will be recorded and made available to the provider upon written request.

Hearings are not open to the public and are not subject to formal rules of evidence. Either party may present material evidence or testimony as may be necessary to resolve the dispute. The applicable Nebraska statute does not provide for immunity of the proceedings.

Within fifteen (15) business days of the final adjournment of the hearing, the Hearing Committee shall decide. A majority vote is required to overturn the original adverse recommendation. The provider will be notified of the Hearing Committee’s decision via letter.
Second Level of Appeal

A second level appeal is available only to participating providers whose participation or payable status in the plan networks is being terminated for cause.

**Note:** Providers that leave a delegated credentialing arrangement will be treated as new applicants and therefore will only be eligible to receive one level of appeal if network participation is denied.

The second level appeal request must be made in writing and submitted to BCBSNE within thirty (30) business days of the date of the Hearing Committee’s decision letter. BCBSNE will furnish written notice of the date and time of the hearing within thirty (30) business days of receiving of the appeal request. The hearing will be held at BCBSNE’s offices in Omaha, Nebraska as soon as reasonable arrangement can be made. The hearing will be conducted not more than forty-five (45) business days from the date the appeal request was received unless the provider or Hearing Committee is unable to participate within that time frame. In this case, the hearing will be held within ninety (90) business days of the request unless otherwise agreed upon by both parties.

The second level Hearing Committee members will consist of one person selected by each party to the appeal and one individual mutually agreeable to both parties. At least one member of the committee shall be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. The first level Hearing Committee panel members may not participate in the second level appeal hearing. The CMO or designee will serve as chairperson for the second level hearing but shall not vote in the decision of the Hearing Committee. Each party pays costs for the person it selected and shares the costs of the third. Costs are not recoverable.

If the parties cannot mutually agree on the third Hearing Committee member, the two Hearing Committee members (selected by each party to the appeal) will choose the third Hearing Committee Member. The parties may stipulate that the committee members select a candidate that practices in the same specialty as the participating provider.

Minutes of the hearing are recorded and made available to the provider upon written request.

Within fifteen (15) business days of the final adjournment of the hearing, the Hearing Committee shall decide. A majority vote is required to overturn the original adverse recommendation.

**Note:** The provider’s right to a hearing will be forfeited if the provider fails, without good cause, to appear at the scheduled hearing of either the first or second level appeal or if the provider fails to participate in good faith in the appeal and fair hearing process. In such cases, the original adverse recommendation will stand as the final decision.

Non-Appealable Decisions

Non-appealable issues include, but are not limited to:

- Contracting requirements for networks:
- Lack of privileges at a contracting facility
- Lack of covering contracting practitioners
- Not participating in the organized delivery system or group model
- No geographic need
- No need for specialty
- Change in practice affiliation or location
  
  • If the provider’s license to practice is currently revoked, terminated, or suspended.
  • If the practitioner’s Federal DEA or CDC issued number is currently revoked or suspended (if it is required for practitioner’s profession).
  • If the provider is convicted of a felony or is expelled or suspended from the Medicare or Medicaid programs (Title XVIII or XIX of the Social Security Act).
  • If the provider’s professional liability insurance coverage does not meet the coverage requirements of BCBSNE.
  • Any material misrepresentation made by the provider during network participation.
  • Primary office location is not in Nebraska or contiguous county.
  • Lack of office facility, cessation of business or insolvency of the provider.

**Application for Reinstatement following Network Termination or Non-Payable Status**

Providers may reapply for reinstatement in instances where BCBSNE terminated their plan network participation or placed them in a non-payable status.

**Network Termination Reinstatement**

Providers who have been terminated from participation with plan networks can reapply for participation twelve (12) months following the termination effective date. The provider must meet all credentialing requirements, provide evidence that the deficiency(ies) that resulted in plan network termination have been remedied and submit a Reinstatement Plan detailing how compliance with BCBSNE policies will be maintained. BCBSNE will review the submitted Reinstatement Plan to ensure the provider adequately addressed all deficiency(ies). BCBSNE will amend the Reinstatement Plan, if adjustments are deemed necessary. The provider can accept the terms outlined in the amended Reinstatement Plan or remain terminated from participation with plan networks.

**Payable Status Reinstatement**

Providers who have had their status changed to non-payable can request a review of the non-payable status thirty-six (36) months following the status change effective date. The provider must meet all credentialing requirements, provide evidence that the deficiency(ies) that resulted in the payment status change have been remedied and submit a Reinstatement Plan detailing how compliance with BCBSNE policies will be maintained. BCBSNE will review the submitted Reinstatement Plan to ensure the provider adequately addressed all deficiency(ies). BCBSNE will amend the Reinstatement Plan, if adjustments are deemed necessary. The provider can accept the terms outlined in the amended Reinstatement Plan or in a non-payable status with BCBSNE.
Note: As a condition of reinstatement, BCBSNE reserves the right to require that a provider contract with an independent, third-party entity approved by BCBSNE to monitor for compliance with BCBSNE policies. The provider bears the full financial responsibility of contracting with the auditing entity. The auditing entity and BCBSNE may monitor for compliance with the Reinstatement Plan by conducting on-site office or facility visits, medical record reviews or any other actions deemed appropriate by BCBSNE. The provider may also be held financially responsible by BCBSNE for costs associated with increased claim, medical record, and preauthorization review time necessary to ensure compliance with the Reinstatement Plan. The review period and expected costs will be added to the Reinstatement Plan, if deemed necessary by BCBSNE.

Administrative Disputes
All administrative disputes are received and tracked by the Provider Relations department. Administrative disputes with participating providers include, but are not limited to, issues with the timely filing of claims, network accessibility and not submitting requested medical records. Providers have a right to consideration by an authorized representative of the organization, not involved in the initial decision that is the subject of the dispute. The authorized representative will notify the provider of any decisions or recommendations of follow up activities. Providers can contact Provider Executives via email at ProviderExecs@NebraskaBlue.com or directly by locating your specific Provider Executive here → Provider Contacts

Provider Corrective Actions (CAP)
BCBSNE may grant providers the opportunity to correct situations when administrative disputes, quality issues, utilization issues, FWA or noncompliance with credentialing criteria or contractual and policy requirements are identified. No corrective action is available in cases of fraud, imminent harm to patient health, or when the provider’s ability to provide services has been restricted by action, including probation or any compliance agreement, by the Nebraska Department of Health or other governmental agency. The opportunity to complete a CAP exhausts one level of appeal.

The provider will be notified in writing if BCBSNE opts to offer an opportunity to enter a CAP. The CAP shall:

- Identify the provider’s deficiency(ies) related to administration, quality, utilization, FWA or compliance with credentialing criteria or contractual and policy requirements.
- Notify the provider that a response outlining an action plan to correct the identified deficiency(ies) must be submitted to BCBSNE within specified timeframe.
- Specify when the deficiency(ies) must be corrected to be compliant with the CAP.
- Notify the provider that BCBSNE and an independent, third-party entity may monitor for CAP compliance following the date BCBSNE specified the deficiency(ies) must be corrected and at varying intervals after the CAP’s conclusion.
• Identify any action deemed appropriate by BCBSNE to resolve or correct the deficiency(ies), including but not limited to requiring a continuing education course related to the deficiency(ies) or establishing a repayment plan for identified overpayments.

• Notify the provider that failure to correct the identified deficiency(ies) may result in the provider being terminated from plan networks or placed in a non-payable status.

BCBSNE may terminate and/or place the provider in a non-payable status if a response is not submitted to BCBSNE within timeframe specified in the CAP, the third-party monitoring entity is not contacted within 15 calendar days of submitting the CAP response (when required in the CAP), or the third-party monitoring entity does not have a signed agreement to monitor for CAP compliance within 45 calendar days of submitting the CAP response (when required in the CAP).

BCBSNE will review the submitted response to ensure the provider adequately addressed the deficiency(ies) identified in the CAP. BCBSNE will contact the provider if adjustments are necessary and will provide a timeline for resubmission. The provider may be terminated and/or placed in a nonpayable status if a corrected CAP is not submitted to BCBSNE within the specified timeline or if the provider fails to make a good faith effort to address the deficiency(ies).

BCBSNE will determine the next course of action, if any, that must be taken if BCBSNE approves the CAP response submitted by the provider.

The provider may be held financially responsible by BCBSNE for costs associated with increased claim, medical record, and preauthorization review time necessary to ensure compliance with the CAP. The review period and expected costs will be added to the CAP, if deemed necessary by BCBSNE.

As a condition of the CAP, BCBSNE also reserves the right to require that a provider contract with an independent, third-party entity approved by BCBSNE to monitor for compliance with BCBSNE policies. The provider bears the full financial responsibility of contracting with the auditing entity. The auditing entity and BCBSNE may monitor for compliance with the CAP by conducting on-site office or facility visits, medical record reviews or any other actions deemed appropriate by BCBSNE.

The auditing entity’s findings will be reported to BCBSNE. All findings identified by BCBSNE and the auditing entity will also be reported to the provider. Based on the monitoring results, BCBSNE may:

• Determine that acceptable improvement has been made and not further action or review is needed.

• Continue monitoring the provider through audits or special studies.

• Recommend additional continuing education.

• Extend the monitoring period or initiate a new CAP.

• Recommend the provider be terminated from plan network participation and placed in a nonpayable status.
BCBSNE will notify the provider of the decisions or recommendations for follow-up activities. When a
determination is made to terminate participation with BCBSNE and/or place the provider in a
nonpayable status, the provider will be given the right to appeal the decision as identified above in the

Network Termination Appeal section. Since the opportunity to complete a corrective action plan
exhausts one appeal right, only one appeal remains following the participation in a corrective action
plan.

Section 14: Provider Audit and Special Investigations Unit (SIU)

Standard Review Policy
BCBSNE reserves the right to perform a review or audit of any item or service provided to covered
persons to ensure medical record completeness, appropriate coding and billing, and that the items or
services were medically necessary and provided in accordance with the member’s benefit plan,
accepted medical practice standards, and BCBSNE medical and provider policies and contracts.

Reviews may also be conducted as a part of BCBSNE’s Utilization Review Program. For example, a
review may be part of a continued stay review, case management review, medical necessity review,
DRG validation review or other review of items and services provided to members. These reviews may
be conducted onsite, or BCBSNE may request documents to review at the BCBSNE site.

Health care providers agree to cooperate and assist with these efforts. BCBSNE agrees to make every
attempt to abide by reasonable and non-obstructive practices. Reviews and audits will be conducted
by BCBSNE staff or designated vendors acting on behalf of BCBSNE.

The review may include inspection and duplication of all medical and other records applicable to
treatment of a covered person necessary to determine liability, medical appropriateness and/or to
verify that items or services were rendered. Only medical records, itemized statements, or other
necessary items of BCBSNE covered persons will be reviewed.

BCBSNE reserves the right to require a physician, facility or other health care provider (provider) to
comply with recommendations resulting from reviews or audits when noncompliance is identified.

Provider Audit Program
Prepayment/Post-Payment Review
BCBSNE or designated vendors acting on behalf of BCBSNE can conduct prepayment and post-payment
reviews to monitor and assess the accuracy of the diagnosis and procedure coding as well as to
determine the medical necessity and appropriateness of the items or services provided.
Claims subject to prepayment and post-payment reviews include, but are not limited to:

- All claims with allowable charges amount ≥ $200,000 received prior to January 1st, 2021.
- All claims with allowable charges ≥ $100,000 received on or after January 1, 2021.
- All inpatient claims indicating a readmission within seven (7) calendar days. Each readmission is reviewed in conjunction with the previous admission.
- All inpatient claims indicating a transfer to an inpatient facility from a lower level of care.
- All outlier claims as identified by the BCBSNE Provider Audit Department.
- All inpatient interim claims.
- Randomly selected outpatient claims.
- Randomly selected inpatient claims.
- Randomly selected professional claims.

BCBSNE reserves the right to require a provider submit medical records and itemizations supporting billed items and services with the claim.

**Prepayment Audit**

**High Dollar Prepayment Review Audit Process**

The audit process for claims with allowed charges at $100,000 and above can include a review of the itemized billing and a desk review of selected medical records, if received on or after January 1, 2021. The audit criteria is dollar based, therefore, the itemized billing and selected medical records need to be submitted regardless of BCBSNE primacy.

All claims, including DRG claims with outliers, that have allowable charges at $100,000 and above will require itemized statements. Itemized statements need to be submitted via secure email to HDPR@NebraskaBlue.com. Claims will not be processed until itemized statements are received. The billed charges total within the itemized statements must match the submitted claims. Failure to submit required itemized statements as requested and within the specified requested timeframe will significantly delay processing. The member ID must be included in the body of email and must match the member ID on the submitted claim. Each itemized billing should be sent in a separate email.

Medical records must be submitted within 21 calendar days of BCBSNE’s request. BCBSNE reserves the right to deny the claim, if the provider fails to provide the medical records in a timely manner.

Itemized billings should be submitted in a pivotable Microsoft Excel format and include the following information:

- Patient Name
- Hospital Account Number
- Date of Service
- Revenue Code
- Description of Item Billed
The information provided in the Excel spreadsheet should only reflect the charged amounts. Any overcharges or reversed charges should be removed.

Itemized statements for interim bills must include all charges for the dates of service in which the allowable amount is at $100,000 and above. Each interim itemized statement should be numbered at top to identify which interim claim the itemized statement is for.

Final claims, not including interim claims, should not be submitted until all charges are accounted for to avoid rework on both sides. Please ensure that correct or replacement claims do not contain any of the items or charges removed in a Summary of Adjustments. The appeal process outlined in Section 12, Member Benefit Appeal and Reconsideration should be followed if a payment dispute arises. The continuous resubmission of removed items or charges may result in corrective action including termination from the network in accordance with the terms of the provider contract.

BCBSNE is under no obligation to provide DRG and Severity of Illness (SOI) information to the provider for approval to audit. BCBSNE is also under no obligation to provide a letter of intent to audit to the provider.

**Standard Prepayment Audit Process**
The audit process can include a review of the itemized billing and a desk review of selected medical records.

Itemized billings and medical records must be submitted within 21 calendar days of BCBSNE’s request. BCBSNE reserves the right to deny the claim, if the provider fails to provide the itemized billing or medical records in a timely manner.

Itemized billings should be submitted as noted above under the High Dollar Prepayment Review Audit Process.

**Post-Payment Audit Audit Process**
The audit process can be a review of the itemized billing itself, a desk review at BCBSNE of selected medical records, or an onsite audit of the medical records at the facility or office. The provider will be notified if a desk audit will be performed. If an onsite audit is performed, BCBSNE will contact the provider to schedule an appropriate audit date as soon as possible. BCBSNE will verify the mutually agreed upon audit date and time for an onsite audit. An itemized billing and any applicable provider audit work papers are generally requested prior to scheduling the audit.
Itemized billings must be submitted within 30 calendar days of BCBSNE’s request, unless BCBSNE agrees to extend the due date. BCBSNE reserves the right to reverse the claim to deny, if the provider fails to provide the itemized billing or initiate contact with BCBSNE to extend the due date.

Itemized billings should be submitted in a Microsoft Excel format and include the following information:

- Patient Name
- Hospital Account Number
- Date of Service
- Revenue Code
- Description of Item Billed
- Units
- Unit Charge
- Total Amount Billed

The information provided in the Excel spreadsheet should only reflect the charged amounts. Any overcharges or reversed charges should be removed.

BCBSNE is under no obligation to provide DRG and Severity of Illness (SOI) information to the provider for approval to audit. BCBSNE is also under no obligation to provide a letter of intent to audit to the provider.

**Preliminary Report Sheet and the Final Summary of Adjustments**

When an audit has been completed, a Preliminary Report Sheet is provided to the provider outlining the audit findings. The provider will then have up to thirty (30) days to complete an exit interview and/or submit supporting documentation to defend any charges noted in the Preliminary Report Sheet. If no response is received at the end of thirty (30) days, then the audit findings will stand as final. Either BCBSNE or the provider may request an onsite exit interview, if desired.

**Onsite Exit Interview**

If an onsite exit interview is requested, audit results will be reviewed with the provider within thirty (30) days of completion of the audit findings.

Upon completion of the exit interview, BCBSNE has fourteen (14) calendar days to return the Final Summary of Adjustments to the provider.

After the receipt date of the Final Summary of Adjustments, the provider has fourteen (14) calendar days to file a written appeal. If an appeal is not received by close of business on the 14th calendar day, then the Final Summary of Adjustment will stand as final.
Process to Appeal Prepayment Provider Audit Findings
The provider is required to follow the process outlined in Section 12, Member Benefit Appeal and Reconsideration.

Process to Appeal Post-Payment Provider Audit Findings
Level I Appeal Process
The provider is required to submit a written appeal to BCBSNE. The appeal must state the specific reason for the dispute. Send the appeal and all required supporting documentation to the following address:

Blue Cross and Blue Shield of Nebraska
ATTN: Provider Audit/Corporate Audit
P.O. Box 3248
Omaha, NE 68180-0001

Required supportive documentation:
1) The appeal must be accompanied by any new or additional documentation from provider records to substantiate the provider’s position. This additional information must meet the following criteria:
   a. The information must be relevant to the disputed issue(s).
   b. The information must have existed during the dates of service for the record(s) in question.
   c. The information must provide evidence based supporting documentation.
2) If the appeal contests the case review decision of the BCBSNE Medical Director or other BCBSNE physician consultant, the provider must provide its medical staff member or medical consultant written reply to BCBSNE for case review.
3) Peer-reviewed medical literature and other expert opinion may be included.

Level II Appeal Process
Upon communication of the level I appeal results, the provider has an additional fourteen (14) calendar days to submit a written notice of second appeal with additional supporting documentation. The Provider Audit staff will review the additional documentation. If the dispute is still unresolved, Provider Audit staff will forward the documentation to the BCBSNE Medical Director or other BCBSNE physician consultant. Once the BCBSNE physician/Medical Director decision is made, documentation for that decision will be returned to the Provider Audit Department to communicate the appeal results back to the provider.

Provider Audit Provisions
1) All BCBSNE policies and procedures, medical policy, and Provider Agreements are considered while reviewing medical records. BCBSNE medical policy includes but is not limited to: medical necessity policy and investigative policy.
2) In no case will an audit be scheduled beyond the refund time limit specified in the
Refund/Offsetting section of the applicable Provider Agreement, unless there is a reasonable belief of fraud, waste or abuse (FWA).

3) **Once a claim has been selected for audit review, the provider should not submit a replacement or corrected electronic or paper claim, nor should one be submitted at any time during or after the review process.**

4) Standing orders or care protocols must be available for review.

5) Charges for nursing and/or ancillary personnel care that do not include supplies are not considered billable services and will be removed from the charges prior to calculation of negotiated reimbursement methodology. These services are not billable to the member.

6) Issues identifying lack of appropriate documentation to support billed charges may result in recommendations by our staff to address a corrective action plan or disallowance of the charges billed. These recommendations are noted in the Final Report Letter.

7) When BCBSNE medical policy determines an item or service to be investigative, experimental or not medically necessary, the item(s) or service(s) considered noncovered services will be deemed provider liability.

**Examples of Nonbillable Facility Charges**
The list below contains examples of nonbillable facility component charges. This list is NOT an all-inclusive list of nonbillable charges. Nonbillable charges are removed from the total charges before calculating reimbursement. Nonbillable services may not be billed to the member.

**Nonbillable Services**
- Administration of blood products or medications
- After-hours, On-call, stand-by, emergency call or stat charges - e.g., Lab, EKG/EEGs, X-ray, CT Scan, U/S, Nuc. Med., O.R.
- Blood service charges
- Bone marrow collection or aspiration
- Bronchoscopy assists
- Catheterization technical services
- Charges for nursing and/or ancillary personnel care that do not include supplies
- Code 99, CPR, or unscheduled cardioversion
- E.R. patient assist or transport
- Extubating/intubation
- Insertion of catheters, i.e., arterial, Groschong, central line, PICC, IV, foley, nasogastric
- Incentive spirometry or MDI treatment
- Kinetic consult or monitoring
- Manual ventilation
- Medication mixing fees
- Nasal tracheal, tracheal tube suction or aspiration, cough induction, suctioning, secretion induction
- Obtaining blood specimen, any method, for inpatient lab testing
- Patient assessment
• Patient assistance
• Patient education or teaching
• Patient transportation
• Pathology tech assist or slide preparation
• Peritoneal lavage procedure
• Set-up charges e.g., ventilators, arterial lines, oximetry, etc.
• Swab specimen collection
• Therapist assist; PT/OT/Speech, Respiratory Therapist
• Vital sign monitoring including oximetry and/or CO2 monitoring/capnography
• Duplication of Therapeutic Services

**Provider Audit** will refer to Section 6, Inpatient Inclusive Billing Policy of the BCBSNE Billing and Reimbursement Manual to identify the nonbillable charges for claims with dates of services November 1, 2018 and after.

**Special Investigations Unit**

*Audit and Investigation Process*

BCBSNE utilizes software, data analytics, medical record reviews and other techniques, including patient and provider interviews and site inspections, to identify FWA and/or overutilization and misutilization on a prepayment and post-payment basis.

**Patient and Provider Interviews**

Patient interviews may be conducted to assist in verifying that items and services were provided as billed. BCBSNE staff will identify themselves to members as BCBSNE employees and present their contact as a routine verification of services or a random provider satisfaction survey.

Provider interviews may be requested to clarify claims review findings and/or provide education. Provider interviews will be recorded to ensure the communication is accurately captured as a protection to both parties.

**Site Inspections**

Site inspections may be performed as part of a random provider audit or when evidence suggests FWA may be occurring. BCBSNE will contact the provider to schedule an appropriate date and time for the site inspection. The provider will be notified by certified letter of the mutually agreed upon date and time as well as the medical records and/or other information needed to validate billing accuracy and appropriateness. Advance notification of a site inspection may not be provided to the provider in certain circumstances, including if there is concern of fraud or member harm.

BCBSNE may coordinate a secure file transfer protocol (SFTP) prior to the site inspection for electronic records. Paper records will be scanned onsite. BCBSNE staff will observe the records being pulled or copied to the SFTP to ensure the complete record is provided. BCBSNE reserves the right to request additional records while onsite.
Any interviews conducted during the site inspection will be recorded to ensure the communication is accurately captured as a protection to both parties.

**Prepayment/Post-Payment Review**

BCBSNE can conduct prepayment and post-payment reviews to monitor and assess the accuracy of the diagnosis and procedure coding as well as to determine the medical necessity and appropriateness of the items or services provided.

As part of a SIU prepayment review, BCBSNE reserves the right to require a provider submit medical records and other documentation supporting billed items and services with the claim. The provider may be required to submit paper claims, medical records and other supporting documentation via mail. Failure to provide the requested information with the claim will result in the claim being returned.

Claims subject to prepayment and post-payment reviews include, but are not limited to:

- Professional claims
- Outpatient claims
- Inpatient claims
- Pharmacy claims
- Dental claims

**Statistical Sampling to Identify Overpayments**

A full claims audit or a sample audit may be conducted to identify aberrant patterns of utilization or charges and to calculate improper payment amounts. If statistical sampling is conducted, BCBSNE will utilize RAT-STATS, a software package created and used by the U.S. Department of Health & Human Services’ Office of Inspector General (HHS OIG), to select a random sample of claims to review. The confidence level of the sample size calculation shall not be less than ninety percent (90%). BCBSNE may elect to perform a Probe Sample Audit or Statistical Sample Audit.

**Probe Sample Audit**

In a Probe Sample Audit, BCBSNE will select 20-40 of the claims identified via RAT-STATS and request medical records or other supporting documentation. If the requested documentation is not submitted or made available, then the associated claim(s) will be applied to the error rate used to calculate the improper payment amount. BCBSNE also reserves the right to conduct an unannounced on-site audit, if records are not received.

The improper payment amount is calculated as follows:

- Calculate the total dollar overpayment in the probe sample.
- Divide the total dollar overpayment by the total paid dollars of audited services to determine the error rate. Any underpayments found during the Probe Sample Audit will be subtracted from any overpayments and factored into the calculated error rate.
• Multiply the error rate by the total paid dollars within the universe to determine the extrapolated overpayment.

• Multiply the extrapolated overpayment by 80% to determine the settlement offer.

The SIU will send a Settlement Letter to the provider for review. The provider will have 30 business days to respond to the settlement offer or BCBSNE will consider the settlement offer agreed upon and pursue repayment.

The provider can request that a Statistical Sample Audit be performed, if they do not wish to settle based on the Probe Sample Audit findings within 30 business days; however, BCBSNE will seek full recoupment of the extrapolated overpayment following the Statistical Sample Audit.

**Statistical Sample Audit**

In a Statistical Sample Audit, BCBSNE will request medical records or other supporting documentation for all claims identified via RAT-STATS. If the requested documentation is not submitted or made available, then the associated claim(s) will be applied to the error rate used to calculate the improper payment amount. BCBSNE also reserves the right to conduct an unannounced on-site audit, if records are not received.

The improper payment amount is calculated as follows:

• Calculate the total dollar overpayment in the statistical sample.

• Divide the total dollar overpayment by the total paid dollars of audited services to determine the error rate. Any underpayments found during the Statistical Sample Audit will be subtracted from any overpayments and factored into the calculated error rate.

• Calculate the statistical margin of error using RAT-STATS.

• Multiply the lower limit error rate by the total paid dollars within the universe to determine the extrapolated overpayment.

The SIU will send a Demand Letter to the provider for review. If the provider disagrees with the Statistical Sample Audit findings, the provider can appeal any of the individual claims identified via RAT-STATS within 30 business days, in accordance with the appeal process outlined below, or BCBSNE will consider the overpayment demand agreed upon and pursue repayment. The audit and extrapolation methodologies are not appealable.

The provider can request that a full audit be performed, if they do not agree with the Statistical Sample Audit findings; however, BCBSNE may hold the provider financially responsible for all costs associated with the increased claim and record review time. Additionally, BCBSNE will adjust all claims that contain errors.

**Process to Appeal SIU Non-Sample Audit Findings**

The provider is required to follow the process outlined in Section 12, Member Benefit Appeal and Reconsideration.
Process to Appeal SIU Sample Audit Findings

Level I Appeal Process
The provider is required to submit a written appeal to BCBSNE. The appeal must state the specific reason for the dispute. Send the appeal and all required supporting documentation to the following address:

Blue Cross and Blue Shield of Nebraska  
ATTN: Manager SIU and Provider Audit/Corporate Audit  
P.O. Box 3248  
Omaha, NE 68180-0001

Required supportive documentation:

1) The appeal must be accompanied by any new or additional documentation to substantiate the provider’s position. This additional information must meet the following criteria:
   a. The information must be relevant to the disputed issue(s).
   b. The information must have existed during the dates of service for the record(s) in question.
   c. The information must provide evidence based supporting documentation.

2) If the appeal contests the case review decision of the BCBSNE Medical Director or other BCBSNE physician consultant, the provider must provide its medical staff member or medical consultant’s written reply to BCBSNE for case review.

3) Peer-reviewed medical literature and other expert opinion may be included.

Level II Appeal Process
Upon communication of the level I appeal results, the provider has an additional fourteen (14) calendar days to submit a written notice of second appeal with additional supporting documentation. The SIU staff will review the additional documentation. If the dispute is still unresolved, SIU staff will forward the documentation to the BCBSNE Medical Director or other BCBSNE physician consultant. Once the BCBSNE physician/Medical Director decision is made, documentation for that decision will be returned to the SIU to communicate the appeal results back to the provider.

Corrective Action Plans and Repayment Requests
BCBSNE will initiate a repayment request for identified overpayments. The provider will either be asked to return a check to BCBSNE for the identified repayment amount or allow BCBSNE to take an offset of the overpayment amount. BCBSNE will not initiate repayment requests beyond the time specified in the applicable Provider Agreement; however, no time limit will apply to the initiation of repayment requests based on a reasonable belief of FWA or other misconduct, or if required by a state or federal government program.

When a health care provider fails to comply with BCBSNE billing guidelines or performance standards, the provider may be required to complete a corrective action plan, to remain in-network with BCBSNE.
The terms of the corrective action plan may require the provider to reimburse BCBSNE for identified overpayments.

**Audit and Investigation Outcomes**

In addition to the above, when FWA or improper billing are identified during an audit or investigation, BCBSNE reserves the right to take any action necessary to address the identified issues, including but not limited to, the following:

1. Contact the provider to discuss the findings
2. Seek recovery of identified overpayments
3. Provide education
4. Place the provider under a Corrective Action Plan (CAP), in accordance with Section 13.
5. Require periodic self-audits, in accordance with Section 13.
6. Terminate the provider’s BCBSNE participation, in accordance with Section 13.
7. Convert the provider’s status to non-payable, in accordance with Section 13.
8. Refer the investigation findings to law enforcement, medical licensure board, and/or Federal, State, or Local government agency.
9. Conduct a full claims audit.
10. Offset the identified overpayment from future claim payments.
11. Require that the provider submit future claims on paper with the medical records supporting the billed item(s) or service(s) prior to adjudication.
12. File a lawsuit to collect the identified overpayment.

**Reporting Fraud, Waste and/or Abuse (FWA)**

Concerns regarding FWA can be reported confidentially to BCBSNE by phone or online at any time. The BCBSNE Fraud Hotline telephone number is 1-877-632-2583.
Section 15: Non-Covered Services

BCBSNE member contracts do not provide benefits for the following Non-Covered Services or for amounts above Allowable Charges for Covered Services.

BCBSNE does not restrict providers from reducing charges to members on non-covered services.

**BCBSNE member contracts’ non-covered services include but are not limited to any service for, or related to:**

1) Services not covered by the member benefit contract.
2) Services determined by BCBSNE to be not medically necessary.
3) Services considered by BCBSNE to be Investigative, or for any directly related Services.
4) Voluntary, Investigative Test or Research
5) Screening audiological examinations and testing (except infant hearing exams); external and surgically implantable devices and combination external/implantable devices to improve hearing, including audient bone conductors or hearing aids and their fitting.
6) Preventive vision examinations or care and screening eye examinations, including eye refractions, except as specifically covered in the member benefit contract.
7) Eyeglasses or contact lenses, eye exercises or visual training (orthoptic), except as specifically covered in the member benefit contract.
8) Services for or related to any surgical, laser or nonsurgical procedure or alteration of the refractive character of the cornea including, but not limited to, correction of myopia, hyperopia or astigmatism. Benefits for eyeglasses and contact lenses are not available after this surgery.
9) Hospital or Physician charges for standby availability.
10) Personal expenses while hospitalized, such as guest meals, television rental and barber services.
11) Services, supplies, equipment, procedures, drugs or programs for the treatment of nicotine addiction, except as mandated by the Affordable Care Act.
12) Dietary counseling (i.e., eating disorder, nutrition therapy), except as defined in our practitioner initial and recredentialing standards matrix on the credentialing page of NebraskaBlue.com
13) Except as mandated by the Affordable Care Act, treatment and monitoring for obesity or weight reduction, regardless of diagnosis, including but not limited to surgical operations, weight loss programs, health and athletic club memberships, physical conditioning programs such as athletic training, body-building exercise, fitness, flexibility and diversion or general motivation.
14) Services, except as otherwise covered in the member benefit contract, including related diagnostic testing, which are primarily:
   a) Recreational, such as music or art therapy.
   b) Educational.
   c) Work-hardening therapy; vocational training.
   d) Medical and nonmedical self-care.
   e) Self-help training.
15) Alternative therapies, including, but not limited to:
a) Massage therapy, including Rolfing;
b) Acupuncture/Dry Needling;
c) Aromatherapy;
d) Light therapy;
e) Naturopathy;
f) Vax-D therapy (vertebral axial decompression)

16) Treatment or removal of corns, callosities, or the cutting or trimming of nails.

17) Infertility treatment and related services, which includes, but is not limited to:
   a) Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization;
   b) Embryo transfer procedures;
   c) Drug and/or hormonal therapy for fertility enhancement;
   d) Ultrasounds, lab work and other testing in conjunction with infertility treatment;
   e) Reversal of voluntary sterilization;
   f) Surrogate parenting, donor eggs, donor sperm and host uterus; and
   g) Storage and retrieval of all reproductive materials.
      (Diagnostic testing done to determine the diagnosis of infertility, treatment of polycystic ovary disease, and treatment of endometriosis are not considered to be infertility treatment.)

18) Services provided for, or related to, sex transformation surgery.

19) Interest and sales or other taxes or surcharges on Covered Services, drugs, supplies or Durable Medical Equipment, other than those surcharges or assessments made directly upon employers or third-party payers.

20) Repairs, maintenance or adjustment of Durable Medical Equipment provided other than by a Durable Medical Equipment or a medical supply company. Repair or replacement of an item of Durable Medical Equipment will not be covered if damage occurred due to misuse, malicious damage, gross neglect or to replace lost or stolen items.

21) The following items of Durable Medical Equipment, even if prescribed by a Physician: a) Enuresis alarm;
   b) Non-wearable external defibrillator;
   c) Mouth guards.

22) Genetic Treatment or Engineering. Any service performed to alter or create changes in genetic structure.

23) Genetic testing, unless scientifically validated by BCBSNE medical policy.

24) Lodging or travel, even though prescribed by a Physician for obtaining medical treatment.

25) Charges for any office or facility overhead expenses including, but not limited to, staff charges, copying fees, facsimile fees and office supplies.

26) Custodial care, domiciliary care, rest cures, or services provided by personal care attendants.

27) Charges for failure to cancel a scheduled appointment.
28) Nutrition care, nutritional supplements, FDA-Exempt infant formulas, supplies or other nutritional substances, including but not limited to Neocate, Vivonex and other over-the-counter nutritional substances.

29) Enteral feedings, even if the sole source of nutrition.

30) Equipment for purifying, heating, cooling or otherwise treating air or water.

31) The building, remodeling or alteration of a residence; the purchasing or customizing of vans or other vehicles.

32) Exercise equipment.

33) Orthopedic shoes; orthotics for the feet; except when such podiatric appliances are necessary for the prevention of complications associated with diabetes, or when necessary to treat a congenital anomaly, as determined by BCBSNE.

34) Food antigens and/or sublingual therapy.

35) Services, drugs, medical supplies, devices or equipment which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of the Covered Person.

36) The reduction or elimination of snoring, when that is the primary purpose of treatment.

37) Automated external defibrillator.

38) Calls or consults by telephone or other electronic means, video or Internet transmissions and telemedicine, except in conformance with BCBSNE policies and procedures.

39) Blood, blood plasma or blood derivatives or fractionates, or Services by or for blood donors, except administrative and processing charges for blood used for a Covered Person furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood.

40) Cosmetic Services, or any routine complications thereof, except for Covered Services:
   a) Required because of a traumatic Injury;
   b) To correct a congenital abnormality of a Covered Person, only when the defect severely impairs or impedes normal essential functions;
   c) To correct a scar or deformity resulting from cancer or from non-cosmetic surgery.
   d) Reconstructive surgery is available only when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged because of Injury or Illness.

Except as stated above, this exclusion applies regardless of the underlying cause of the condition or any expectation that the cosmetic procedure may be psychologically or developmentally beneficial to the patient.

Procedures for liposuction, telangiectasias, dermabrasion, protruding ears and spider veins are examples of excluded Services.

Benefits for treatment of complications are payable, only if such treatment is normally covered under this Contract.

41) Services considered to be obsolete or for any related Services. Procedures will be obsolete when such procedures have been superseded by more efficacious treatment procedures and are generally no longer considered effective in clinical medicine.
42) Wigs, hair prostheses and hair transplants, regardless of the reason for the hair loss.
43) Hair analysis, including evaluation of alopecia or age-related hair loss.
44) Massage therapy provided by a massage therapist.
45) Acupuncture/Dry Needling.
46) Electron beam computed tomography for vascular screening, including but not limited to screening for cardiovascular, cerebrovascular and peripheral vascular disease.
47) Autopsies are non-covered. No charges after the person dies are covered.
48) Private Duty Nursing.
49) Respite care when not provided as part of a covered Hospice benefit.
50) The following Services related to home health aide, Skilled Nursing Care, or Hospice Services:
   • Services performed by volunteers;
   • Pastoral Services, or legal or financial counseling services;
   • Services primarily for the convenience of the patient, or a person other than the patient; • Home delivered meals.
51) Shipping and Handling charges.
52) Services provided at the following places of service:
   • Daycare
   • School (except for mental health services billed with place of service as school)
   • Library
   • Church
   • Health Fair (unless specifically listed in member benefit plan)
53) Supplies, equipment and similar incidental Services for personal comfort, including, but not limited to:
   • Batteries and battery chargers, unless the device is covered by BCBSNE
   • Hot tubs
   • Humidifiers
   • Jacuzzis
   • Medical alert systems
   • Music devices
   • Personal computers
   • Pillows
   • Radios
   • Saunas
   • Strollers
   • Safety equipment
   • Video players
   • Whirlpools
54) Services otherwise covered under the member benefit contract, when:
   • Required solely for camp, travel, career, employment, insurance, marriage or adoption
   • Related to judicial or administrative proceedings or orders
   • Conducted for medical research
   • Required to obtain or maintain a license of any type
Foreign language and sign language services
Driving tests or exams

In addition, the following are not covered under the Rx Nebraska:
1) Diet or appetite suppressant drugs.
2) Nutrition care, nutritional supplements, FDA-Exempt infant formulas, supplies or other nutritional substances, including but not limited to Neocate, Vivonex and other over-the-counter nutritional substances.
3) Drugs or medicinal for treatment of fertility/infertility.
4) Cosmetic alteration drugs, including but not limited to health and beauty aids such as Vaniqa, Propecia and Renova.
5) Home infusion therapy. (Covered under Other Covered Services only.)
6) Home Medical Equipment or devices of any type, including, but not limited to: contraceptive devices; therapeutic devices; or artificial appliances.
7) Investigative drugs or drugs classified by the FDA as experimental.
8) Prescription medications used to treat nicotine addiction.
9) Non-prescription medications.
10) Over-the-counter medications.
11) Prescription medications determined to be “less than effective” by the Drug Efficacy Study Implementation Program (DESI).
12) Supplies other than ostomy designated injectable, diabetic and insulin pump supplies.
13) Services, drugs and medical supplies which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of the Covered Person.
14) Prescription medications purchased in a foreign country. Exception: If the covered person is living in another country or has an emergency medical condition while traveling in that country, evidence of residency or an emergency medical condition must be provided with the claim, or the claim will be denied. This evidence may be reviewed by BCBSNE. Foreign drug policy is subject to change with changes in federal legislation regarding importation.

Mental Health Benefit Exclusions
1) Mental health services, psychological or substance abuse counseling services which are not within the scope of practice of the provider or services provided by one of the following:
   • Qualified Physician or Licensed Psychologist.
   • Licensed Special Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor or Licensed Mental Health Practitioner.
   • Auxiliary Providers who are supervised and billed for by a professional provider listed at a), or as otherwise permitted by state law.
     All Licensing or Certification shall be by the appropriate state authority. Supervision and consultation requirements shall be governed by state law.
2) Programs for co-dependency; employee assistance; probation; prevention; educational or self-help.
3) Programs that treat obesity, gambling, or nicotine addiction, except as mandated by the Affordable Care Act.
4) Residential Treatment Programs for Mental Illness.
5) Residential Treatment Programs, halfway house or methadone maintenance programs that treat Substance Abuse.
6) Programs ordered by the Court determined by BCBSNE to be not Medically Necessary.

**Services Provided**

1) Services provided to or for:
   - Any dependent of a Subscriber who has a Single Membership, except as specified in this Contract for newborn or adopted children.
   - Any person who does not qualify as an Eligible Dependent.
   - Any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of coverage.
   - Any Covered Person for any Pre-existing Condition for which coverage is not available because of any Contract Waiting Periods.
2) Services for Illness or Injury related to military service.
3) Non-approved Facility: A health care facility that does not meet the Licensing or Accreditation Standards required by BCBSNE.
4) Services provided in or by:
   - A Veterans Administration Hospital where the care is for a condition related to military service; or
   - Any non-Participating Hospital or other institution which is owned, operated or controlled by any federal government agency, except where care is provided to non-active duty Covered Persons in medical facilities.
5) Services required by an Employer as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests.
6) Services for any Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplants.

**Charges for Services**

1) Interest and sales or other taxes or surcharges on Covered Services, drugs, supplies or Home Medical Equipment, other than those surcharges or assessments made directly upon employers or third-party payors.
2) Charges made while the patient is temporarily out of the Hospital.
3) Charges made for filling out claim forms or furnishing any records or information or special charges such as dispensing fees, admission charges, Physician’s charge for Hospital discharge services, after-hours charges over and above the routine charge, administrative fees, technical support or utilization review charges which are normally considered to be within the charge for a service.
4) Charges received when there is inadequate documentation that a service was provided.
5) Services available at government expense, except as follows: If payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments a Covered Person is eligible for under such program (except Medicaid).

With respect to persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the Covered Person is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected this Contract as primary, unless otherwise provided by federal law. Services provided for renal dialysis and kidney transplant Services also will be provided pursuant to federal law.

6) Services for which there is no legal obligation to pay, include:
   • Recreational, such as music or art therapy.
   • Educational.
   • Work-hardening therapy; vocational training.
   • Medical and nonmedical self-care.
   • Self-help training.
   • Services for which no charge would be made if this coverage did not exist.
   • Any charge above the charge that would have been made if no coverage existed.
   • Any service which is primarily furnished without charge.

7) Services arising out of or during employment, whether the Covered Person fails to assert or waives his or her rights to Workers’ Compensation or Employers’ Liability Law. This includes Services determined to be work-related under Workers’ Compensation laws, or under a Workers’ Compensation Managed Care Plan, but which are not payable because of noncompliance with such law or Plan.

8) Charges for Services provided by a person who is a member of the Covered Person’s immediate family by blood, marriage or adoption.

9) Charges for Services by a health care provider which are not within the scope of practice of such provider; or charges by a non-Approved Provider.

10) Charges more than the Contracted Amount or the Reasonable Allowance.

11) Charges made separately for Services when they are included within the charge for a total Service payable under this Contract or if the charge is payable to another provider.

   **EXCEPTION:** If such charges are made separately when they are included within the charge for a total service performed by a BCBSNE NETwork BLUE provider, then this amount is not the Covered Person’s liability.

12) Charges made pursuant to a Covered Person’s engagement in an illegal occupation or his or her commission of or attempt to commit a felony.
Section 16: How to Contact Us

Send an Inquiry
Locate your specific Provider Executive on our website under Provider Contacts or email us at ProviderExecs@NebraskaBlue.com