2024

For use by Nebraska providers only. Many of the provisions don't apply to providers in other states.

BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Make the most of Medicare

Blue Cross and Blue Shield of Nebraska Medicare Advantage Provider Manual

This provider manual is subject to change by Blue Cross and Blue Shield of Nebraska on an ongoing basis. To ensure providers review the most current version, Blue Cross and Blue Shield of Nebraska strongly discourages providers from relying upon printed versions.

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Provider Manual for Blue Cross and Blue Shield of Nebraska Medicare Advantage

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Many of the provisions do not apply to providers in other states.
If you are an out-of-state provider, for more information, please visit:
Medicare.NebraskaBlue.com.

Plan overview

Blue Cross and Blue Shield of Nebraska is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare & Medicaid Services to offer Medicare Advantage plans in the senior market. Blue Cross and Blue Shield of Nebraska offers HMO and PPO Medicare Advantage plans to Medicare-eligible Nebraska residents.

Blue Cross and Blue Shield of Nebraska Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare Part A and Part B and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross and Blue Shield of Nebraska to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit. You can find these benefit policies on our website at **Medicare.NebraskaBlue.com**.

ID card

Overview

Our member identification cards contain basic information you will need when providing covered services to our members. The Blue Cross and Blue Shield of Nebraska (BCBSNE) Medicare Advantage ID card indicates the member is enrolled in a BCBSNE Medicare Advantage plan. Our Blue Cross and Blue Shield of Nebraska Medicare Advantage members only need to show our ID card to receive services. A member doesn't need to show their Original Medicare ID card to obtain services.

All Blue Cross and Blue Shield Association (the national organization for all Blue plans) cards have a similar look and feel, which promotes nationwide ease of use. The cards include a magnetic stripe on the back to provide easier access to eligibility and benefit information.

Providers must include the three-character alpha prefix found on the member's ID card when submitting paper and electronic claims. The alpha prefix helps facilitate prompt payment and is used to identify and correctly route claims and confirm member coverage. It is critical for the electronic routing of specific transactions to the appropriate Blue Cross and Blue Shield of Nebraska plan.

Below is a sample of the members' ID card.

The Medicare Advantage plans all have coverage outside of the service area for providers that accept Medicare Advantage (does not require Blue Card providers). As with other Blue Cross and Blue Shield of Nebraska products, members should provide their ID cards when requesting services from you.

The front of the card may include:

- The Enrollee name, also called the subscriber or member, who is the contract holder.
- The Enrollee ID also called the contract number, which is made up of randomly chosen characters, either alpha-numeric or all numeric.
- The issuer ID number just below the member information. This number identifies which Blue plan issued the card (Blue Cross and Blue Shield of Nebraska or another plan.)
- A logo in the lower right corner of many cards identifies the member's prescription drug claims processor (for use by pharmacists).

The back of the card may include:

- Our website address
- A magnetic stripe at the top
- Phone numbers
- An address showing where to send claim

Eligibility and Coverage

Each time your patient receives care, check to see if there have been any coverage changes.

- Ask to see the patient's Blue Cross and Blue Shield of Nebraska Medicare Advantage ID card or acknowledgement letter at every encounter
- Verify eligibility and coverage
    - Call 888-505-2022
    - Nebraska–affiliated Blue providers can verify eligibility and claims status online through NaviNet

NaviNet®

NaviNet is a Blue Cross and Blue Shield of Nebraska web-based information system for providers. NaviNet provides up to date Medicare Advantage Eligibility information and claim status

- **Fast** — giving you the information you need quickly
    - Available 24 hours a day, seven days a week
    - User-friendly

If you need access to NaviNet, we can help you get the information you need to use the system. NaviNet login and other information are available at NaviNet.net.

Billing members

Collect coinsurance and or copayments at time of service

Providers should collect the applicable coinsurance and/or copayments, also known as the members cost-share, from the member at the time of the service when possible. After collecting these amounts, bill your local Blue plan for covered services.

Balance billing is not allowed

You may only collect applicable cost–sharing from BCBSNE Medicare Advantage members for covered services and may not otherwise charge or bill them.

Refund over–billed members

If you collect more from a member than the applicable cost–sharing, you must refund the difference. Medicare Advantage members are to be reimbursed within 30 days of recognizing the error.

Coordination of benefits

If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we will pay depends on the amount paid by the primary plan. We follow all Medicare secondary–payer laws.

Non–covered services and referrals for non–covered services - provider responsibilities

Sometimes you and your patient may decide that a service, treatment, or item is the best course of care, even though it isn't covered by BCBSNE Medicare Advantage plans or may be supplied by another provider or practitioner.

You are responsible for determining which items, services or treatments are covered. If you believe that a service, item or treatment won't be covered, you must tell the member before the service or treatment is performed or item obtained. If the member acknowledges that the item, service or treatment won't be covered by BCBSNE and agrees that they will be solely responsible for paying you, you may perform and bill the member for the non–covered service, treatment or item. When the member covers an expense for an item, service or treatment, the rendering provider will submit a claim to the plan for a post service organization determination, using the appropriate modifier when applicable.

If you provide an item, treatment or service that is not covered and have not provided the patient with prior notice that the item, treatment or service is not (or may not be) covered by the plan, you may not bill the patient for such non–covered items, treatments or services.

If you believe that an item, service or treatment won't be covered and the provider supplying the service, treatment or item is not contracted with BCBSNE, you must tell the member before you refer them. If the member acknowledges that the item, service and/or treatment won't be covered and understands that you're referring them to a non–contracted provider and agrees that they will be solely responsible for paying for the service, then you may refer the member to the non–contracted provider for the non–covered service.

DME/P&O, medical suppliers, and pharmacists

DME Benefit Management

BCBSNE Medicare Advantage plans include medically necessary durable medical equipment, prosthetics and orthotics, medical supplies, and pharmacy; including Part B drugs that are all covered under Original Medicare. For additional details, reference the Evidence of Coverage at Medicare.NebraskaBlue.com/Medicare Advantage/PlanDetails2024.

Lab services

BCBSNE Medicare Advantage plans also include lab services and test specimens provided by participating hospitals and providers. Refer to the Evidence of Coverage at Medicare.NebraskaBlue.com/MedicareAdvantage/PlanDetails2024.

Benefits

For basic Medicare benefits, refer to cms.gov*.

Medicare Advantage benefits are available in most areas both in and out-of-network as long as the provider accepts Medicare Advantage.

BCBSNE Medicare Advantage plans offer coverage for the following with minimal or no member cost-share:

- Welcome to Medicare Visit
- Annual Wellness visit (AWV)
- Annual physical exam
- Diagnostic testing, annual hearing exam, annual vision exam, routine dental, fitness program
- World-Wide Emergency or Urgent Care services.

Benefits are plan specific. Refer to the Evidence of Coverage for details.

Vision

Vision coverage services are administered by Vision Service Plan (VSP). When members obtain covered services from a VSP network provider, they receive the maximum level of coverage available under their plan. Information about VSP®, is available at 800-877-7195 and on their website at vsp.com/*.

Fitness Program

BCBSNE Medicare Advantage plans offer a fitness benefit known as the Silver Sneakers® Fitness Program. BCBSNE supports physical fitness at any age and hopes that you will encourage your BCBSNE Medicare Advantage patients to enroll in the program, which offers a complimentary membership to any participating location. Silver Sneakers also includes a self-directed program for members who are unable to leave the home. More information about this fitness benefit is available at 866-678-0828 and online at tools.silversneakers.com/*.

Prior Authorization

Some benefits require medical management, and a prior authorization is required prior to scheduling or performing the service. Authorization requests for Medicare Advantage plans can be submitted via Fax at 866-422-5120 or by calling 877-399-1671, Monday through Friday 8:00 a.m. CST to 4:30 p.m. CST. For a complete list of services requiring prior authorization go to NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

For High Tech Radiology and Cardiac Imaging, Radiation Therapy and Interventional Pain Management submit prior authorizations via the AIM portal at providerportal.com/* or by calling 866-745-3265.

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

Primary Care Physicians

Blue Cross and Blue Shield of Nebraska Medicare Advantage recognizes the following practitioner specialties as personal or primary care physicians:

Family Practice	Pediatric Medicine	Physician Assistant – Primary Care Focus
General Practice	Internal Medicine	
Geriatrician	Certified Nurse Practitioner	Obstetrics and Gynecology

Hospice Services

Federal regulations require that Medicare fee-for-service contractors (Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier) maintain payment responsibility for Medicare Advantage members who elect hospice care. Claims for services provided to a Medicare Advantage member who has elected hospice care should be billed to the appropriate Medicare contractor.

- If the member elects hospice care and the service is related to the member's terminal condition, submit the claim to the regional home health intermediary.
- If the member elects hospice care and the service is not related to the member's terminal condition, submit the claim to the Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier as appropriate.
- If the service is provided during a lapse in hospice coverage, submit the claim to the local Blue plan.

  Note: Original Medicare is responsible for the entire month that the member is discharged from hospice.
- If the service is not covered under Original Medicare but offered as an enhanced benefit under the member's Medicare Advantage (for example, vision), submit the claim to the local Blue plan.

Medicare Advantage member cost-share for hospice services

As provided in 42 CFR § 422.320, an MA organization must inform each enrollee eligible to select hospice care about the availability of hospice care if: (1) a Medicare hospice program is located within the plan's service area; or (2) It is common practice to refer patients to hospice programs outside the MAO's service area.

An MA enrollee who elects hospice care but chooses not to disenroll from the plan is entitled to continue to receive (through the MA plan) any MA benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the enrollee and the MAO, providers, and suppliers for other Medicare–covered services furnished to the enrollee.

The table below summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

Type of Services	Enrollee Coverage Choice	Enrollee Cost-sharing	Payments to Providers
Hospice program	Hospice program	Original Medicare cost-sharing	Original Medicare
Non-hospice[1], Parts A & B	MA plan or Original Medicare	MA plan cost-sharing, if enrollee follows MA plan rules[3]	Original Medicare[2]
		Original Medicare cost-sharing if enrollee does not follow MA plan rules[3]	Original Medicare
Non-hospice[1], Part D	MA plan (if applicable)	MA plan cost-sharing	MAO
Supplemental	MA plan	MA plan cost-sharing	MAO

Notes:

1) The term “hospice care” refers to Original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term “non-hospice care” refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.
2) If the enrollee chooses to go to Original Medicare for non-hospice, Original Medicare services, and also follows plan requirements, then, as indicated, the enrollee pays plan cost–sharing and Original Medicare pays the provider. The MA plan must pay the provider the difference between Original Medicare cost–sharing and plan cost–sharing, if applicable.

Access to Care

After-Hours Access

CMS requires that the hours of operation of its practitioners are convenient for and do not discriminate against members.

Practitioners must provide coverage for their practice 24 hours a day, seven days a week with a published after-hours telephone number (to a practitioner’s home or other relevant location), pager or answering service, or a recorded message directing members to a physician for after-hours care instruction. **Note:** Recorded messages instructing members to obtain treatment via emergency room for conditions that are not life threatening is not acceptable.

In addition, primary care physicians must provide appropriate backup for absences.

Appointment Access

Primary Care and Behavioral Health practitioners must meet the following appointment standards for all BCBSNE Medicare Advantage members.

Appointment accessibility will be measured and monitored using the following standards:

Appointment Type	Service is provided within…
Routine and Preventive Care	30 business days.
Non-Urgent that requires medical attention	7 business days.
Emergent Care for urgently needed services	Immediately

Compliance with Access Standards

BCBSNE has delegated the responsibility to assess and monitor compliance with the standards to its HMO Network. If it is determined that a practitioner does not meet access to care standards, the non-compliant practitioner must submit a corrective action plan within 30 days of notification.

If…	Then…
The practitioner’s corrective action plan is approved	The practitioner is notified, and the provider’s office will be called approximately 14 days after receipt of the corrective action plan to reassess compliance with the corrective action plan.
The corrective action plan is not approved	A request will be made that the practitioner submits an acceptable corrective action plan within 14 days.
A reply is not received within 14 days	The practitioner will be sent a second letter, signed by the appropriate medical director. Copies of the letter will be forwarded to the Blue Cross and Blue Shield of Nebraska Medicare Advantage Quality Improvement Department.
A reply to the second letter is not received within 14 days	A third letter, signed by an appropriate medical director, will be sent to inform the practitioner that termination will occur within 60 days.

BCBSNE encourages Medicare Advantage plan practitioners (or their office staff) to assist members whenever possible in finding an in-network practitioner who can provide necessary services. If assistance is needed in arranging for specialty care (in– or out-of-network), please call our Provider Inquiry department at 888-505-2022.

BCBSNE network providers must ensure that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. Providers and their office staff are not allowed to discriminate against members in the delivery of health care services consistent with benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as end stage renal disease, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. It is necessary that a provider's office can demonstrate they accept for treatment any member in need of health care services they provide.

Reimbursement

BCBSNE reimburses network providers at the reimbursement level stated in the provider's Medicare Advantage agreements minus any member required cost sharing; for all medically necessary services covered by Medicare plan. Providers should collect any applicable cost-share from their members at the time of service or when possible. Cost–share refers to a flat-dollar copayment and/or percent coinsurance. Providers will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost–share. This represents payment in full and providers are not allowed to balance bill members for differences between the allowed amount and charges.

We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest in accordance with the applicable CMS guidelines.

BCBSNE provides an *Evidence of Coverage* to all members following enrollment. This document provides general benefit information for members by plan option. It also describes member cost–sharing requirements that can be used by the provider to collect payment at the time the service is provided, rather than waiting for the claim to be processed and the member billed.

Original Medicare benefit coverage rules apply, except where noted. BCBSNE will not reimburse providers for services that are not covered under Original Medicare unless such services are specifically listed as covered services under the member's Medicare Advantage Plan.

BCBSNE must also comply with CMS' national coverage determinations, general coverage guidelines included in Original Medicare manuals and instructions, and written coverage decisions of the local Medicare Administrative Contractor.

Follow all Original Medicare billing guidelines and be sure to include the following on all claims:

- Diagnosis code to the highest level of specificity. When a sixth or seventh digit exists for a code, you must supply all applicable digits.
- Medicare Part B supplier number, national provider identifier and federal tax identification number
- The member's BCBSNE Medicare Advantage numbers, including the alpha prefix, found on the member's ID card.
- For paper claims, the provider's name should be provided in Box 31 of the CMS-1500 (02/12) claim form.

Providers affiliated with the Medicare Advantage network agree to BCBSNE reimbursement policies outlined in the Medicare Advantage agreement. These include:

- Accepting the applicable Medicare Advantage plans agreement as payment in full for covered services, except for cost-sharing, which is the member's responsibility.
- Billing BCBSNE, not the patient, for covered services
- Not billing patients for covered services that:
    - Required but did not receive preapproval.
    - Were not eligible for payments as determined by BCBSNE based upon our credentialing or privileging policy for the particular service rendered.

Claim Filing

Claims, including revisions or adjustments that are not filed by a provider prior to the claim filing limit of one calendar year from date of service or discharge will be the provider's liability.

The National Uniform Claim Committee approved a new version of the CMS–1500 Health Insurance Claim Form. Blue Cross and Blue Shield of Nebraska accepts the revised CMS–1500 claim form (version 02/12) and all claims must be submitted using this form. Use BCBSNE Medicare Advantage billing requirements, use CPT/HCPCS codes and diagnosis codes to the highest level of specificity, include National Provider Identifier numbers on all claims, and send claims to your local BCBS plan (see address below).

When submitting a corrected claim, providers are required to complete field 22 of the CMS-1500 claim form. The provider must enter 7 for Replacement of a prior claim or 8 for Void/Cancel of a prior claim in the Resubmission portion of the field (found on the left-hand side of the claim form). The original claim number must be supplied in the Original Reference Number portion of the field (found on the right-hand side of the claim form).

For more information on how to properly complete the new CMS–1500 (02/12) claim form contact your provider consultant or visit nucc.org/*.

Where to Submit a Claim

- For electronic claim submission, send claims to your local Blue plan.
  - Medical Electronic Claim IDs: Professional – 77780 and Institutional - 00260
- For electronic claim submission, please call the Electronic Data Interchange help desk at 888-233-8351. Option 3. An EDI user guide is also available at NebraskaBlue.com/Providers/Eligibility-and-Claims/Electronic-Data-Interchange.
- For Medical paper claim submission, send claims to:
  Blue Cross and Blue Shield of Nebraska
  P.O. Box 3248
  Omaha, NE 68180-0001
- For Pharmacy paper claims, send claims to:
  Prime Therapeutics
  P.O. Box 20970
  Lehigh Valley, PA 18002-0970

UB-04 Facility Claims

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their website at nubc.org/*.

Advance Directives

BCBSNE Medicare Advantage plans provide its members information on their right to complete an advance directive. Advance directive means a written instruction, recognized under state law, relating to how to provide health care when an individual is incapacitated. As part of the medical record content requirements for BCBSNE, physicians must document in the medical record of whether a member has or does not have an advance directive. If a member has completed and presents an advance directive, then the provider must include it in the member's medical record.

Overview of Care Management

The BCBSNE Care Management program promotes cost-effective and medically appropriate care and services. Components include clinical review of selected services, care transition, and case management.

This comprehensive approach employs key interactive Medical Management activities across the care continuum so that BCBSNE can achieve its goal for Medicare Advantage members.

Care Management Services

Care Management provides the following services:

- Clinical review of inpatient and select Part B medications
- Provider appeal process
- Analysis of utilization data for trends in over and underutilization
- Inter-rater reliability testing
- 24/7 On-Call nurse availability for urgent after-hour requests
- Provide coordination of care after a member is discharged from an inpatient acute care facility
- Identification of members for case manager program referrals
- Quality Management Program Development

Contacting Care Management (Normal Business Hours)

Providers can contact Care Management representatives as specified below.

Utilization Management

Normal business hours:

8:00 a.m. to 4:30 p.m. CST Monday through Thursday

8:30 a.m. to 4:30 p.m. CST Friday

The department is closed for lunch for phone calls only from 11:00 a.m. - 12:00p.m. CST daily

Toll-free telephone for service requests (Inbound call center available for providers for servicing requests that require authorization) **877-399-1671**.

Providers may also submit requests for authorization via Fax 24/7- *Note, Faxed requests will only be processed during normal business hours:

866-422-5120 All authorization requests except Part B and Radiology

855-342-9648 Part B Medications

Care Transition and Case Management

Telephonic Nurses will provide outreach to members.

Case Managers (CM) and Care Transition (CT) nurses are available during normal business hours:

8:00 a.m. to 4:30 p.m. CST Monday through Thursday

8:30 a.m. to 4:30 p.m. CST Friday

Phone: **877-399-1675** (CM, CT)

Fax: **866-588-9145** (CM)

Contacting Care Management (After Hours)

An after-hours program is available Monday-Friday to respond to urgent utilization management related issues after normal business hours on weekdays and 24 hours/day on weekends and holidays.

Care managers available after normal business hours and on weekends and holidays, with 24-hour service to assist physicians and other providers.

Providers should call 877-399-1674 and follow the prompts to reach a care manager for any of the following needs:

- Determining alternatives to inpatient admissions and triaging members to alternate care settings
- Arranging for emergent home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Coordinating and obtaining authorization for emergent discharge plans
- Expedited appeals of utilization management decisions

Note: Precertification for admission to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergent placement.

Utilization Management Program

The Medicare Advantage Utilization Management Program is designed to promote quality, cost effective and medically appropriate services. The UM program uses a comprehensive approach by integrating key medical utilization management activities. BCBSNE annually reviews and updates the UM program.

The primary goals of the Medicare Advantage UM Program Description are to:

- Achieve effective, high-quality outcomes that meet the expectations of members, purchasers and clinical health care professionals, by ensuring that medically necessary care is delivered in the appropriate setting at the time such service is needed.
- Monitor effective and efficient medical and behavioral health utilization of services.
- Provide a comprehensive UM Program to monitor member progress toward expected outcomes, resource use, and efficient and effective transitions across the continuum of care.

Medical Records

Patient medical records and health information shall be maintained in accordance with current federal and state regulations (including prior consent when releasing any information contained in the medical record).

BCBSNE Medicare Advantage providers must maintain timely and accurate medical, financial, and administrative records related to services they render to Medicare Advantage members, unless a longer time period is required by applicable statutes or regulations. The provider shall maintain such records and any related contracts for 10 years from date of service.

The provider shall give without limitation, BCBSNE, U.S. Department of Health and Human Services, U.S. General Accounting Office, or their designees, the right to audit, evaluate, and inspect all books, contracts, medical records, and patient care documentation, maintained by the provider, which will be consistent with all federal, state, and local laws. Such records will be used by CMS and BCBSNE to assess compliance with standards which includes, but not limited to:

1. Complaints from members and/or providers;
2. Conduct HEDIS® reviews, quality studies/audits or medical record review audits;
3. CMS and Medicare Advantage reviews of risk adjustment data;
4. BCBSNE Medicare Advantage determinations of whether services are covered under the plan are reasonable and medically necessary and whether the plan was billed correctly for the service;
5. Making advance coverage determinations;
6. Medical Management specific medical record reviews;
7. Suspicion of fraud, waste and/or abuse;
8. Periodic office visits for contracting purposes; and
9. Other reviews deemed appropriate and/or necessary.

Medical record content and requirements for all practitioners (for behavioral health practitioners see below) include, but may not be limited to:

- Clinical record
  - Patient name, identification number (name and ID number must be on each page), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.
- Medical documentation

- History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services, and other risk screening.
- Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
    - Past medical, surgical, and behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age and sex specific risk screening exam, relevant review of systems including depression and alcohol screening.
- Documentation of patient education (age and condition specific), if applicable: injury prevention, appropriate dietary instructions, lifestyle factors and self-exams.

- Clinical record — progress notes
    - Identification of all providers participating in the member's care and information on services furnished by these providers.
    - Reason for visit, or chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, follow-up plans from previous visits have been addressed and follow-up report to referring practitioner (if applicable).
- Clinical record — reports content (all reviewed, signed, and dated within 30 days of service or event)
    - Lab, X-ray, referrals, consultations, discharge summaries, consultations and summary reports from health care delivery organizations, such as skilled nursing facilities, home health care, free-standing surgical centers, and urgent care centers.

For behavioral health practitioners:

- Chief complaint, review of systems and complete history of present illness
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history
- Past medical history
- A medication list including dosages of each prescription, the dates of the initial prescription and refills.
- At least one complete mental status examination, usually done at the time of initial evaluation and containing each of the items below:
    - Description of speech
    - Description of thought processes
    - Description of associations (such as loose, tangential, circumstantial, or intact)
    - Description of abnormal or psychotic thoughts
    - Description of the patient's judgment
- Complete mental status examination
- Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content (including any thoughts of harm), mood, affect and other information relevant to the case.
- A DSM-IV diagnosis, consistent with the prese.

Clinical Review of Inpatient Services and Select Part B Medications

For the most current list of Medical and Part B services requiring clinical review visit NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

Providers are advised to submit clinical information via fax or phone for elective acute care admissions, skilled nursing facility, long term acute care facilities, inpatient rehabilitation facilities and Part B medication requests prior to the start date. Providers are advised to submit clinical documentation via NaviNet or phone on the next business day for all urgent acute care admissions.

Providers will have access to form templates, which identify the specific information required to process a service request via NaviNet.

*Note- BCBSNE does not impose any administrative denials for failure to comply with the notification timeframes. Post service requests will be processed, and decisions are based on medical necessity and the member's benefit coverage only.

If the nursing clinical review staff is unable to approve the request for inpatient services, the request is referred to a plan medical director for review.

When the plan medical director is unable to approve the service a denial notification is sent to the member, provider, and practitioner. The denial notification includes:

- Description of the criteria utilized to render the determination
- Reason for the denial
- Right to request the criteria used to render the decision
- Right to request the diagnosis and procedure codes related to the request
- Description of how to file an appeal
- Availability of a plan medical director to discuss the individual merits of the case

Pharmacists review and make final determinations on all requests for Part B Medications that require prior authorization.

The clinical staff also reviews requests that require a benefit determination. If the service is not a covered benefit, the clinical staff denies the request. The denial notification includes the specific location in the Evidence of Coverage that describes the exclusion as well as the member appeal rights.

All decisions are made and notifications are provided in compliance with state and federal laws, regulations and accreditation standards. A plan medical director makes all denial determinations based on medical necessity.

Application of Medical Necessity Criteria

Clinical staff applies objective and evidence-based criteria for medical services that require medical necessity review. All clinical staff must retain a current unrestricted license. Clinical managers provide oversight of the clinical staff who reviews services that require the application of medical necessity criteria. The member's individual circumstances and the local delivery system are considered when determining appropriateness of services. Written policies and procedures provide the staff with direction for appropriately applying the criteria. Clinicians base utilization decisions about care and service solely on the appropriateness related to each member's specific condition. Clinical review staff has no compensatory arrangements that encourage denial of coverage. Plan medical directors and/or Pharmacists render all denial determinations based on medical necessity.

Monitoring Utilization

BCBSNE uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure that Medicare Advantage members receive the medical services required for health promotion, including acute and post-acute care management. Some examples of these mechanisms include:

- Results of member satisfaction surveys

- Rate of inpatient admissions
- Rate of emergency services
- Review of alternative levels of care such as observation

Process for Approvals and Decisions

BCBSNE continues to demonstrate its commitment to a fair and thorough utilization decision process by working collaboratively with its participating physicians. A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by BCBSNE Care Management nurses. It may be necessary for the plan medical director to contact physicians for additional information about their patients to assist in making a determination.

Clinical Review Requirements

Blue Cross and Blue Shield of Nebraska clinical review process is established to do the following:

- Ensure uniformity in the provision of medical care
- Ensure the medical appropriateness and cost effectiveness of certain services
- Improve the overall quality of care BCBSNE members receive
- Lower the cost of coverage for BCBSNE members

Inter-Rater Reliability

The UM department ensures the consistency with which the clinical staff applies medical necessity criteria by performing inter-rater audits at least annually. Consistent application of medical necessity criteria reduces the potential for waste of health care services. The goal for staff in their role for one year or greater is an aggregate annual score of at least 90 percent. The goal for staff functioning in their role for less than one year is an aggregate annual score of at least 85 percent. Staff who do not achieve the required aggregate score are provided improvement plans and re-audited after the interventions are completed.

Utilization Management Decision and Notification Timeliness

The UM department is committed to performing decision and notification activities in a consistent and timely manner to minimize disruption in the provision of health care for its members. BCBSNE makes timely UM decisions and provides notification to the member, practitioner, and provider according to the clinical urgency of the service request. UM decisions are made in compliance with state, federal, and accrediting agency regulations. Leadership performs ongoing monitoring of adherence to established time frames. Opportunities for improvement are conducted at the individual staff level and department wide.

Clinical Review Required Specifics

BCBSNE must review and approve select services before they are provided. The primary reason for clinical review is to determine whether the service is medically necessary, whether it is performed in the appropriate setting and whether it is a benefit.

Criteria and Guidelines for Decisions

InterQual criteria adopted by the plan are updated annually and include CMS Medicare Guidelines and also the following:

Criteria	Application
InterQual® Acute – Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care – Subacute and Skilled Nursing Facility	• Subacute and skilled nursing facility admissions

InterQual Rehabilitation – Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care – Long Term Acute Care	• Long-term acute care facility admissions
InterQual Procedures – Adult	• Surgery and invasive procedures
Medical policies	• Part B Medications and 30-Day Bundling Criteria
CMS Inpatient Procedure List	• CMS list of procedures that can be performed in the inpatient setting

Clinical Review Determination

Clinical information is necessary for all services that require clinical review to determine medical necessity. In addition to reviewing clinical information, BCBSNE Care Management evaluates:

- The member's eligibility coverage and benefits
- The medical need for the service
- The appropriateness of the service and setting

If additional clinical information is required to approve the service, a BCBSNE Care Management representative telephones the provider to ensure that all needed information is received in a timely manner, a written request may also be sent to the member or provider receiving the authorization.

Submit the Required Clinical Information with the Initial Review Request

Providers are encouraged to submit the required clinical information with the initial request for clinical review sent via Fax.

Clinical Information for Part B Medication Prior Authorization can be submitted by faxing it to 855-342-9648.

Clinical information for Acute and Post Acute Hospital Admissions can be submitted by faxing it to Care Management at 866-422-5120.

BCBSNE is required by Medicare to notify members as to what clinical information is needed to process a request for clinical review when not provided at the time of request. When providers submit the clinical information with the initial request, it decreases the number of letters BCBSNE is required to send to members.

Standard Time Frames for All Requests for Service

BCBSNE conducts timely reviews of all requests for service, according to the type of service requested. Decisions are made:

Type of Request	Decision	Initial Notification	Written Notification	Type of Service
Pre-service urgent/ concurrent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification	Acute and Post Acute Admissions
Pre-service non-urgent	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request	Part B Medications and members already admitted
Post-service	Within 30 days of receipt of request	N/A	Within 30 days of receipt of request	Services already provided

Notification of Decisions:

If…	Then...
The service is approved	For all service requests, the members and providers receive written notification. Providers will also receive verbal notification for inpatient and post-acute services.
The service is denied	BCBSNE Care Management sends the member, practitioner, and facility a letter within the time frames stated above. The letter includes the reason(s) for the denial, informs the member and practitioner of their right to appeal and explains the process. BCBSNE Care Management also notifies the provider verbally of all denied determinations.

Medications Covered Under the Medical Benefit (Part B Medications)

Certain medications covered under the medical benefit (Part B medications) require clinical review (Prior Authorization). These medications are not self-administered and are typically administered in a specialty clinic or physician office. These drugs are managed by BCBSNE through the Pharmacy department.

Drugs that are subject to clinical review and the clinical information required for a decision are listed on NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

For these drugs, providers may submit the clinical review request in one of the following ways:

- By calling 877-399-1671 or the After Hours 877-399-1674
- By faxing a completed Medical Benefit Drug Request Form along with supporting documentation to the fax number, 855-342-9648. This form can be accessed via NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

Note: For medications covered under the pharmacy benefit (Part D medications), providers must contact the Medicare Advantage Clinical Pharmacy Help desk at: 855-457-1351.

NOC Codes Related to Part B Medication Require Clinical Information

Certain medications with "not otherwise classified" codes do not require a prior authorization and will be reviewed as a post-service request.

- The NOC codes included are J3490 and J3590

Note: NOC codes are also referred to as "unclassified codes," "unlisted codes" and "unspecified codes."

Clinical Review for Part B Medications

The pharmacist reviews the clinical information, using established criteria, and the member's benefits. Clinical information includes relevant information regarding the member's:

- Health history
- Physical assessment
- Test results
- Consultations
- Previous treatment

Note: Reference the Medical Benefit Drug Request form via the Blue Cross and Blue Shield of Nebraska Website: NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

Clinical information should be provided at least 14 days prior to the service. The provider is responsible for ensuring authorization. BCBSNE provides a reference number on all authorizations.

If clinical information is not received with the request, BCBSNE contacts the physician or facility verbally to request the necessary documentation. In addition, follow-up letters are sent to the member and the provider requesting the required information. If documentation is not submitted within the designated time frame, the service is denied.

Guidelines for Observations and Acute Inpatient Hospital Admissions

Contracted facilities must notify BCBSNE Care Management of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that Medicare Advantage members receive care in the most appropriate setting, that BCBSNE Care Management is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing complex and chronic disease processes, demonstrating high use of health resources, and who are at high risk for health complications.

BCBSNE Care Management nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Care Management nurses also speak to attending physicians when necessary to obtain information.

Clinical information includes relevant information about the member regarding the following:

- Health history
- Physical assessment
- Test and laboratory results
- Consultations
- Emergency room treatment and response
- Admitting orders

NOTE: A copy of the form used to submit clinical information for Inpatient acute can be found on Blue Cross and Blue Shield of Nebraska website: NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies. This form also includes required documentation for **readmissions within 30 days** of discharge from the initial admission with the same or a similar diagnosis.

Once authorization is attained, the facility will be provided with an authorization number that is valid for the entire length of stay for the acute care admission.

Elective Admissions

Primary care and specialist physicians are required to notify BCBSNE at least 14 days before arranging elective inpatient, whenever possible.

BCBSNE Care Management reviews the request to determine whether the setting is appropriate and, if required, meets criteria. Notification is made to the member, primary care physician, attending physician, and facility of the determination.

Facilities must provide clinical information to BCBSNE within one business day of the elective admission.

Note: BCBSNE does not impose any administrative denials for failure to comply with the notification timeframes. Post service requests will be processed and decisions are based on medical necessity and the member's benefit coverage only.

Obstetrical Admissions

BCBSNE requires facilities provide both admission and discharge information on deliveries via fax or phone. For all deliveries, the facility should notify BCBSNE one day after discharge. The following information must be provided:

- Admission date, delivery date and discharge date
- Type of delivery
- Whether the baby was born alive
- Whether both mother and baby were discharged alive

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services that are described as follows:

- The services include ongoing short-term treatment, assessment, and reassessment.

- The services are furnished while a decision is being made regarding whether a member requires further treatment as a hospital inpatient or is able to be discharged from the observation bed.

Observation stays of up to 48 hours for Medicare Advantage members may be eligible for reimbursement when providers need more time to evaluate and assess a member's needs in order to determine the appropriate level of care. Examples (not all-inclusive) of diagnoses that may be treated in an observation setting include:

- Chest pain
- Syncope
- Cellulitis
- Pneumonia
- Bronchitis
- Pain or back pain
- Abdominal pain
- Pyelonephritis
- Dehydration (gastroenteritis)
- Overdose or alcohol intoxication
- Close head injury without loss of consciousness

Requirements for Observation Stays

Observation stays do not require any pre-authorization or pre-notification requirements for Medicare Advantage Members.

Providing Medicare Outpatient Observation Notice (MOON)

Blue Cross follows CMS guidance for the Medicare Outpatient Observation Notice (MOON). Hospitals and Critical Access Hospitals (CAHs) are required to furnish the MOON to any Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. The MOON is a standardized notice developed to inform beneficiaries (including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH). The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release.

The MOON notice informs beneficiaries of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost-sharing and coverage for post-hospitalization skilled nursing facility (SNF) services. Provider compliance with this notification requirement is mandatory.

The standard language for the MOON notice and instructions can be accessed at the following link: cms.gov/medicare/forms-notices/beneficiary-notices-initiative*.

Options Available Beyond the Observation Period

For members who require care beyond the observation period, the following options are available:

- Contact BCBSNE clinical staff to discuss alternate treatment options such as home care or home infusion therapy
- Request an inpatient admission

Note: If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should re-evaluate the member's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.

Medical Necessity Considerations: Inpatient vs. Observation Stays

When Medicare Advantage members are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses.

Here are some guidelines that clarify how BCBSNE determines medical necessity:

- BCBSNE uses InterQual criteria to make determinations of medical necessity for all Medicare Advantage members.
- BCBSNE does not require physician certification of inpatient status to ensure that a member's inpatient admission is reasonable and necessary. For Original Medicare patients, however, this certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B and 42 CFR 412.3.
- When the application of InterQual criteria results in a Medicare Advantage member's inpatient admission being changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- BCBSNE clinical review process takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures.

Review of Readmissions that Occur Within 30 Days of Discharge

BCBSNE reviews inpatient readmissions that occur within 30 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member has the same or a similar diagnosis. BCBSNE reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of, or inadequate, discharge planning
- A planned readmission
- Surgical complications

In some instances, BCBSNE combines the two admissions into one for purposes of the DRG reimbursement. Medical Advantage guidelines for bundling a readmission with the initial admission are available: NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

Guidelines for submitting Skilled Nursing, Long-Term Acute Care and Inpatient Rehabilitation Facilities

Facilities must notify BCBSNE of all post-acute admissions and provide clinical information prior to the admission for initial requests and prior to the expiration of approved days for continued stay review requests. Timely notification helps ensure that Medicare Advantage members receive care in the most appropriate setting, that BCBSNE Care Management is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

BCBSNE Care Management nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Care Management nurses also speak to attending physicians when necessary to obtain information.

Clinical information includes relevant information about the member regarding the following:

- Health history
- Prior level of functioning
- Clinical assessment
- Therapy evaluations
- Admitting orders

- Discharge plans

A copy of the form used to submit clinical information for *p*ost-acute admissions can be found: NebraskaBlue.com/Providers/Policies-and-Procedures/Medicare-Advantage-Policies.

For post-acute admissions, if authorization is obtained, it will be valid for a defined length of time. If additional days are needed, a continued stay review will be required prior to the expiration of the initial approved days.

Patient Driven Payment Model (PDPM)

The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility patients into payment groups under the SNF Prospective Payment System. Effective October 1, 2019, PDPM replaced Resource Utilization Group, Version IV (RUG-IV). For more information on this program, visit cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model.

Decision Criteria and Guidelines

BCBSNE criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan or a combination of both. Individual circumstances of a member are taken into consideration when applying the criteria, as are characteristics of the local delivery system such as:

- Availability of skilled nursing facilities, subacute care facilities or home care in the network to support the member after discharge
- Member's coverage of benefits for skilled nursing facilities, subacute care facilities or home care, where needed
- Ability of network hospital(s) to provide all recommended services within the established length of stay

Discharge Planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member
- Family members
- Primary care physician
- Specialist
- Hospital discharge planning staff
- Ancillary providers, as necessary

BCBSNE monitors all hospitalized members to assess their readiness for discharge and assist with post-hospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. BCBSNE nurses work in conjunction with members' primary care physicians to authorize and coordinate post-hospital needs, such as home health care, durable medical equipment, and skilled nursing placement. For these members, providers should follow the processes described in the "Guidelines for care transition" section of this chapter.

Note: Only Acute Care, Skilled Nursing Long Term Acute Care and Inpatient rehabilitation facilities require pre- authorization.

Requesting an Expedited Decision

Either the physician or the Medicare Advantage member may request an expedited decision if they believe that waiting for a standard decision could or would do one of the following:

- Seriously harm the life or health of the member
- Seriously compromise the ability of the member to regain maximum function
- Subject the member to severe pain that cannot be adequately managed with the care or treatment that is being requested

BCBSNE relies on the physician to determine conditions that warrant expedited decisions.

- If the physician requests an expedited decision, the decision is made according to preservice urgent time frames.
- If the member requests an expedited decision, BCBSNE calls the physician to determine whether the member's medical condition requires a fast decision.
  - o If the physician agrees, BCBSNE makes a decision to approve or deny the request according to preservice urgent time frames (see table found under the subheading "Standard time frames Medicare Advantage members").
  - o If the physician disagrees, BCBSNE makes a decision according to standard time frames (see table above) and notifies the member of a decision not to make an expedited decision.
  - o BCBSNE will not make an expedited decision about payment for care the member has already received.

Expedited requests must be submitted by telephone during normal business hours to 877-399-1675

Expedited requests may be submitted after hours by calling 877-399-1674

Medical Necessity Considerations: General

As a Medicare Advantage organization, BCBSNE is required by CMS to provide coverage to enrollees for all Part A and Part B Original Medicare covered services. However, CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes as Original Medicare does for providers.

While BCBSNE does apply medical necessity criteria to determine coverage; the criteria does not have to be applied in the same manner as is required under Original Medicare. Specifically:

- Benefits: Medicare Advantage plans must provide or pay for medically necessary covered items and services under Part A (for those entitled) and Part B.
- Access: Medicare Advantage enrollees must have access to all medically necessary Part A and Part B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under Original Medicare.
- Billing and payment: Medicare Advantage plans need not follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures as long as providers, whether contracted or not, are paid accurately, in a timely manner and with an audit trail.

When determining medical necessity, both BCBSNE and Original Medicare coverage and payment are contingent upon a determination that all three of the following conditions are met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member or is a covered preventive service.

Members Held Harmless

In accordance with their affiliation agreement, providers may not seek payment from members for elective services that have not been approved by BCBSNE unless the member is informed in advance regarding their payment responsibility.

Some of the circumstances in which members are held harmless for denied covered services include:

- Urgent/emergent admission denials
- Partial denial of a hospital stay
- Requests for elective services provided by contracted providers that require clinical review

but were not forwarded to BCBSNE prior to the service being rendered

- Denials issued for post-service requests for services provided by contracted providers when the information submitted is not substantiated in the medical record

Members at Risk

In certain instances, members are held at financial risk for denied services. These instances occur when:

- The member's contract was not in effect on the date of service.
- The member refuses to leave an inpatient setting after the attending physician has discharged the member.
- A denial has been issued for pre-certified services.
- Services are rendered that are not a covered benefit under the member's certificate.

Medical Records Requests

Medical records may be requested to render a decision or to investigate potential quality concerns. The member's contract allows BCBSNE to review all medical records. BCBSNE must receive all records within 10 days of the request.

Appealing Care Management Decisions

Providers and practitioners who provide services for Medicare Advantage members have the right to appeal any denial decision made by BCBSNE. The provider appeals process for Medicare Advantage members, however, is governed by Medicare regulations.

Provider appeals for care management decisions should follow the outlined below. For all other appeals, please refer to the grievance and appeal section of the manual.

Appeal type	Description of appeal process
Preservice appeal request (contracted or non-contracted physician): For standard non-urgent appeal requests prior to the service being rendered	A physician who is providing treatment to a member, upon providing notice to the member, may request a standard first level appeal on the member's behalf without submitting an Appointment of Representative form or Waiver of Liability form. In any case, the member can choose to appeal without involving the physician. BCBSNE Appeals and Grievances P.O. Box 21831 Eagan, MN 55121 Fax: 210-579-6930
Post-service request (contracted physician or other contracted provider): For denials of post-service requests for urgent/emergent inpatient admissions or bundled admissions only	The appeal is conducted according to the two-level appeal provider process described later in this document. **Note:** BCBSNE assumes that the physician or other provider is acting on their own behalf. Submission of an Appointment of Representative form is not required for these appeals. BCBSNE Provider Correspondence P.O. Box 21501 Eagan, MN 55121 Fax: 210-579-6930

Appealing BCBSNE decision- Two Level Provider Appeal Process-Post Service Denials for Urgent/Emergent Inpatient Admissions or Bundled Admissions

Denials of care related to medical necessity or medical appropriateness are made by plan medical directors and are based on:

- Review of pertinent medical information
- Consideration of the member's benefit coverage

- Information from the attending physician and primary care physician
- Clinical judgment of the medical director

All contracted providers have the right to appeal an adverse decision rendered by the BCBSNE Care Management staff. The two-step appeal process is designed to be objective, thorough, fair and timely.

At any step in the appeal process, a plan medical director may obtain the opinion of a same-specialty, board- certified physician or an external review board.

When a provider appeal request is received and a member grievance is in process, the member grievance takes precedence. When the member appeal process is complete, the member appeal decision is considered to be final and the provider appeal request is not processed.

Filing Deadlines for Provider Appeal Requests at Contracted Acute Care Hospitals

The table that follows outlines the filing deadlines for provider appeal requests.

Two Level Appeal process for post service request for urgent/emergent inpatient or bundled admissions for contracted providers	
Level One appeals	Must be submitted to BCBSNE within 60 calendar days of the date noted on the written denial notification. Requests are to be in writing and must include additional clarifying clinical information to support the request. BCBSNE notifies the provider of the decision within 30 calendar days of receiving all necessary information. Mail appeal requests to: BCBSNE Provider Correspondence P.O. Box 21501 Eagan, MN 55121 Fax: 210-579-6930
Level Two appeals	Must be submitted to BCBSNE within 21 calendar days of the date noted on the Level One appeal decision notification. Level Two appeal requests must be submitted in writing and must contain at least one of the following: • New or clarifying clinical information or • A clear statement that the provider is requesting a BCBSNE physician reviewer different from the one who reviewed the Level One appeal If neither the clinical information nor the request for a different physician reviewer is included, BCBSNE is not obligated to review the Level Two appeal request. BCBSNE Appeals and Grievances P.O. Box 21831 Eagan, MN 55121 Fax: 877-482-9749 BCBSNE notifies the provider of the decision within 45 calendar days of receiving all the necessary information. This decision is final.

Note: If an appeal request is received outside the designated time frame, BCBSNE is not obligated to review the case. A letter is sent to the requesting provider either advising that the appeal was not reviewed or notifying the physician of the outcome of the request if the plan has chosen to review the case.

Administrative Denials

The administrative determination appeal process affords providers and practitioners one level of appeal for coverage determinations related to administrative denials.

Administrative denials are determinations made by BCBSNE in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness.

Administrative denials can be issued by BCBSNE with or without review by a plan medical director. An administrative denial is applied when there is provider noncompliance with providing clinical information needed to render a decision for inpatient admission.

Appealing Administrative Denials

Administrative appeal requests must be submitted to BCBSNE within 45 calendar days of the provider's receipt of the denial decision. Documentation submitted must include a written appeal request along with the rationale and supporting documentation, if applicable, related to the denial and any other information pertinent to the request. BCBSNE notifies the provider of the decision within 30 calendar days of receiving all necessary information.

Providers should mail appeal requests related to Administrative denials, inpatient to the following address: Blue Cross and Blue Shield of Nebraska Medical Management
Attention: Provider Appeals, Mail
Code C336 20500 Civic Center Dr
Southfield, MI 48076

The decision regarding the administrative determination appeal process is final. If the administrative denial is overturned but a denial determination is subsequently rendered in accordance with Medicare Advantage criteria, the provider is eligible to appeal through the clinical determination appeal process described on the previous page.

Quality Improvement Organization – Livanta

A Quality Improvement Organization consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan like Medicare Advantage. The QIO for Nebraska is Livanta.

Contacting the QIO

Members may request a QIO review from Livanta if they disagree with the decision of an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency to discharge them.

To appeal, members may contact Livanta at:

- Address:

  Livanta BFCC-QIO Program

  10820 Guilford Road Suite 202

  Annapolis Junction, MD 20701

- Toll-free number: 888-755-5580 (TTY: 888-985-9295)

  Hours: 9 a.m. to 5 p.m. Monday through Friday (Eastern, Central, Mountain Time)

  11 a.m. to 3 p.m. weekends and holidays (Eastern, Central, Mountain Time)

- Toll-free fax: 833-868-4061
- Website: livantaqio.com*

Member Appeal Rights for Hospital Discharge

Members who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe that coverage of their hospital stay is ending too soon.

Hospitals are required to notify all Medicare Advantage members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the standard CMS form *An Important Message from Medicare About Your Rights* twice — the first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the member or of their representative and provide a copy.

Note: A link to the form An Important Message from Medicare About Your Rights is found at: cms.gov > Covering more Americans > Medicare > Medicare Program – General Information > Beneficiary Notices Initiative > Hospital Discharge Appeal Notices > Important Message from Medicare - English

and Spanish. *

Medicare Advantage members have the right to appeal to the QIO for immediate review when a hospital and BCBSNE, with physician concurrence, determine that inpatient care is no longer necessary.

Hospital Discharge Appeal Process

If the Medicare Advantage member is dissatisfied with the discharge plan:

1. A member who chooses to exercise their right to an immediate review must submit a request to the QIO, following the instructions on the *An Important Message from Medicare About Your Rights* notice.
2. If BCBSNE is driving the discharge, the QIO notifies the health plan that the member has requested an immediate review.
3. BCBSNE or the facility is responsible for delivering to the member a *Detailed Notice of Discharge* as soon as possible, but no later than noon of the day after the QIO's notification. The standardized notice includes a detailed explanation of the reason that services are either no longer reasonable or necessary or are otherwise no longer covered. The *Detailed Notice of Discharge* must be completed and submitted by the entity that determines that covered services are ending, whether it is BCBNE or the facility.
4. BCBSNE or the facility must supply any other information that the QIO needs to make its determination as soon as possible but no later than the close of business on the day that BCBSNE notifies the facility of the request for information. This includes copies of both the *An Important Message from Medicare About Your Rights* notice and the *Detailed Notice of Discharge* and written records of any information provided by phone.
5. The QIO makes a determination and notifies BCBSNE, the member, the hospital, and the physician of its determination within one calendar day after it receives the requested information.
6. BCBSNE continues to be responsible for paying the costs of the member's stay until noon of the next calendar day following the day that the QIO notifies the member of their coverage decision.
7. If the member is late or misses the noon deadline to file for an immediate review by the QIO, they may still request an expedited appeal from BCBSNE.

Member Responsibilities Related to Hospital Discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to hospital discharges.

If...	Then...
The QIO agrees with the doctor's decision to end covered services	The member is financially responsible for services on the date indicated on the *Notice of Medicare Non Coverage*.
The QIO disagrees with the doctor's decision to end covered services	BCBSNE will continue to cover the services.

QIO Immediate Review of SNF, CORF and HHA Discharges

Special expedited appeal rights for members being discharged from SNF, CORF or HHA services.

BCBSNE members receiving skilled nursing facility care, home health agency services or services at a comprehensive outpatient rehabilitation facility, have special appeal rights that allow an expedited review if they disagree with the decision to end covered services.

The Medicare form Notice of Medicare Non-Coverage (NOMNC) is delivered to BCBSNE members by the providers of SNF, HHA or CORF services in one of the following situations:

- When medical necessity criteria are no longer met and no additional days are authorized by BCBSNE or the facility/provider
- At least two days prior to a scheduled discharge date
- The NOMNC contains detailed instructions about how members may request an immediate appeal directly to the QIO if they disagree with the decision to end services.

The NOMNC Appeal Process

Medicare regulations require the provider to deliver the standard *NOMNC* to all members when covered services are ending, whether or not the member agrees with the plan to end services. Here's how:

- The provider delivers the *NOMNC* to members at least two calendar days before coverage ends. If the member is receiving home health agency services and the span of time between services exceeds two days, the provider may deliver the *NOMNC* at the next-to-last time that services are furnished. The form must be delivered whether or not the member agrees with the plan to end services.

Special considerations related to delivery of the *NOMNC*:

- BCBSNE encourages providers to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.
- If services are expected to be less than two days in duration, the provider may deliver the *NOMNC* at the start of service. A member who receives the *NOMNC* and agrees with the termination of services before the end of the two days may waive the right to request the continuation of services.
- If the member is not mentally competent to receive the notice, the provider must deliver it to the member's authorized representative.
- The provider requests that the member sign and date the *NOMNC*, acknowledging receipt of their appeal rights. If the member refuses to sign the form, the facility must record the date and time it was delivered to the member.

The provider must fax the signed *NOMNC for Skilled Nursing Facilities* back to BCBSNE at 866-422-5120, Attention: Medical Records.

The provider is expected to retain a signed copy of the *NOMNC* form with the member's medical record. The member is responsible for contacting the QIO by noon of the day before services end if they wishes to initiate an expedited review by following the detailed instructions on the form.

When the member initiates an expedited review, the *Detailed Explanation of Non-Coverage (DENC)* is delivered to the member by the close of business on the same day that the QIO is notified of the member's request for appeal. The *DENC* provides specific and detailed information as to why the member's SNF, HHA or CORF services are ending.

Note: The *DENC* must be completed and submitted by the entity that determines that covered services are ending, whether it is BCBSNE or the SNF, HHA or CORF provider.

BCBSNE may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.

A copy of the *DENC* is also sent to the QIO

The expedited review process conducted by the QIO is usually completed within 48 hours. The provider, the member and BCBSNE are notified of the decision by the QIO.

If the member is late or misses the noon deadline to file for an immediate review by the QIO, they may still request an expedited appeal from BCBSNE.

Member Responsibilities when Appealing SNF, CORF or HHA Discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to discharges from SNF, CORF or HHA services.

If...	Then...
The QIO agrees with the doctor's decision to end covered services	The member is financially responsible for services on the date indicated on the *NOMNC*.
The QIO disagrees with the doctor's decision to end covered services	BCBSNE will continue to cover the services.

Other Considerations in the Notice of Medicare Non-Coverage Process

Providers should also be aware of the following when notifying a member that their services are ending:

- Contracted facilities should be using the appropriate NOMNC forms. Providers should insert their name, address and phone number in the spaces provided at the top of the form.
- BCBSNE may issue a next review date when authorizing SNF services. The next review date does not mean BCBSNE is denying further coverage.
- Providers should submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, BCBSNE will allow for two additional days for the provider to supply
- The member with the NOMNC. The form should only be given to members when SNF criteria are no longer met and no further days are authorized by BCBSNE or two days prior to a scheduled discharge date.
- If there is a change in the member's condition after the NOMNC is issued, both BCBSNE and providers should consider the new clinical information. If there is a change in the effective date that coverage ends, the provider should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.

Medicare Advantage Care Transition

The Medicare Advantage Care Transition Program is the coordination of care after a member is discharged from an inpatient acute care facility. Proactive interventions begin when the member is directly contacted by telephone prior to discharge and continues post discharge during a 34-day period. BCBSNE annually reviews and updates the CT program.

The primary goals of the Medicare Advantage Care Transition Program are:

- Increase member adherence to treatment plan through education
- Affect healthy outcomes and member experience
- Encourage member communication with their practitioner about their health conditions and treatment
- Assist in coordinating care after discharge including follow up visits following discharge
- Provide information about community resources that may be helpful
- Decrease inappropriate inpatient admissions and emergency room visits

Care Transition Process

1. The Care Transition (CT) nurse will receive a notification from the UM nurse when a member is admitted to the hospital for acute care.
2. In order to be proactive, and to ensure a safe and effective discharge, the CT nurse will attempt to contact the member during the inpatient admission to discuss discharge needs and will also work with their discharge planner.
3. Once the member is discharged, the CT nurse will contact the member to provide education, address gaps in care and medication adherence issues, and coordinate services as needed.
4. The nurse will also assess the member's risk for readmission and apply appropriate follow up interventions.

Care Transition Program Outcomes

Care Transition Program trends are analyzed and opportunities for improvement are identified through Care Transition and UM reports. The program will used targeted interventions to drive positive and healthy member outcomes, monitor ongoing progress and refer members to the Case Management program as appropriate.

Medicare Advantage Case Management Program

The Medicare Advantage Case Management Program is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet member's health needs and to promote quality and cost-effective interventions and outcomes across the continuum of care. A nurse will work with members, their families, their doctor and other health professionals to facilitate appropriate utilization of health care services, and to help members reach their optimum level of wellness through education, support and coordination of care.
BSBSNE annually reviews and updates the CM program.

The primary goals of the Medicare Advantage Case Management Program are to:

- Reduce costs related to unplanned readmissions, optimize resource utilization, affect healthy outcomes and member experience, and support efforts for measures and STARS rating.
- Help members manage complex and chronic health conditions.
- Decrease the burden of disease complications through referrals to improve member self-management, increase member compliance with treatment plans to maximize quality of life and reduce risk of unnecessary utilization.

The Case Manager Role

A Medical Management case manager facilitates the physician's plan of treatment and the provision of health care services as outlined in evidence-based clinical practice guidelines. The case manager contacts members by phone to perform an assessment of the member's health care status. Goals are identified and interventions are implemented to support the physician's treatment plan. The case manager provides personalized support and education on disease, nutrition, medication and managed care processes and also identifies and facilitates access to benefits and resources available to prevent complications and progression of disease.

The case manager coordinates care with the treating physician and offers suggestions to practitioners for member management. Timely communication with the treating practitioner is essential in the performance of case management activities. Ongoing communication occurs based on changes in the member's condition or identified needs.

The case manager may contact the treating practitioner, and talk with the plan medical director, as necessary, in the following circumstances:

- When there are significant changes in the member's health status
- When intervention on the part of the treating practitioner is thought to be necessary
- When the member uses emergency room services or is admitted for inpatient care
- To review the member's progress at various intervals in the case management process
- To notify the treating practitioner that:
  - A member who was participating in the case management program but who refuses further intervention even though goals are unmet
  - A member has not complied with the recommended plan of care
  - A potential urgent or emergent situation has been identified related to a member (for example, safety issues such as a member self-reporting that they took an unusually large dose of medication or the case manager identifying a potential case of abuse or neglect)
- To obtain the health information necessary to ensure the highest quality of care

Member Identification

The Medical Management program provides patient-focused, individualized case management for members who meet trigger criteria, including but not limited to the following:

- Are dealing with chronic or complex disease process

- Are at high risk for health complications
- Demonstrate high use of health care resources
- Experience admissions and readmissions to an inpatient care setting
- Have gaps in medical care
- Have medication compliance issues

Case Management Direct Referral Sources

Typical referral sources may include (but are not limited to):

- Customer Service
- Care Transition program
- Primary Care Physician
- Completion of health assessments
- UM inpatient admissions
- Members and caregivers

Conditions Addressed by Case Management Services

Case management services are available for members with the following conditions (but are not limited to):

- Chronic obstructive pulmonary disease
- Complex conditions
- Diabetes
- Heart failure
- High-risk pregnancy
- Ischemic heart disease
- Kidney health management
- Oncology

What Physicians can Expect from Case Management

Case managers recognize the provider's right to:

- Obtain information about case management programs and staff, including staff qualifications, with which the provider's members are involved
- Be informed about coordination of case management activities, interventions and treatment plans through reports from the case manager throughout the course of case management
- Be supported by the case manager in making decisions interactively with members regarding member health care needs
- Receive courteous and respectful treatment from the case management staff
- Know how to contact the person responsible for managing and communicating with the provider's patients

Note: Case managers may receive requests for services specifically excluded from the member's benefit package and will not make exceptions to member benefits, which are defined by the limits and exclusions outlined by the individual member's certificate and riders. In these situations, case managers inform the member about alternative resources for continuing care and how to obtain care, as appropriate, when a service is not covered or when coverage ends.

Health Risk Assessments

Note: A health assessment completed by the member is encouraged as part of an annual wellness visit for Medicare Advantage members, according to the Patient Protection and Affordable Care Act and CMS.

BCBSNE mails the form to the member and asks that the member complete it and return it to Scantron®, the Medical Management vendor, for processing. Members receive a response letter from BCBSNE outlining topics they should discuss with their physician.

Practitioners should also remind patients to bring a copy of their member health assessment or the response letter to their annual wellness visit. The results of the member's health assessment need to be available during the wellness visit so they can be considered when a care plan is created.

Quality Management

All Medicare Advantage organizations are required to have a quality improvement (QI) program as described in the federal regulations at 42 CFR §422.152, Quality improvement program. The requirements for the PDP Quality Assurance program are based in regulation as per 42 Code of the Federal Regulations § 423.153(c).

The primary goal of the Medicare Advantage organization's QI program is to effect sustained improvement in patient health outcomes. As provided under 42 CFR §422.152(c) and §422.152(d), Medicare Advantage's QI program must include at least one chronic care improvement program (CCIP) for one chronic condition that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

Payment Disputes for Contracted and Non-contracted Providers

(not related to claim denials or retrospective audits)

Provider payment disputes include any decisions where there is a dispute that the payment amount made by the BCBSNE Medicare Advantage plan to providers is less than the payment amount that would have been paid under the Medicare fee schedule.

If you believe that the payment amount you received for a service is less than the amount paid by Medicare, you have the right to dispute the payment amount by following our payment dispute process.

First Level Appeals

Provide appropriate documentation to support your payment dispute, such as a remittance advice from a Medicare carrier. Claims must be disputed within **120 days** from the date payment is initially received.

We will review your dispute and respond to you within **60 days** from the time we receive notice of your dispute. If we agree with your position, then we will pay you the correct amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

To file a payment dispute with BCBSNE, submit your dispute in writing or by telephone as shown below:

Nebraska providers	**Write to:** Blue Cross and Blue Shield of Nebraska Medicare Advantage Attn: BCBSNE Provider Correspondence P.O. Box 21501 Eagan, MN 55121 Fax: 210-579-6930	**Call:** 888-505-2022
Non-Nebraska providers	Your local Blue plan	

Second Level Appeals

After completing the first level payment dispute process as described above, if you still believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for a

secondary review of this determination within **60 days** of receiving written notice of our first level decision.

We will review your dispute and respond within **60 days** of the date on which we received your request for a secondary review. Please provide appropriate documentation to support your payment dispute and a copy of the first level decision letter. **Decisions from this secondary review will be final and binding**.

You may file a request for a secondary review of this determination in writing to:

Nebraska providers	**Write to:** Blue Cross and Blue Shield of Nebraska Medicare Advantage PRS - Appeals Attn: BCBSNE Appeals and Grievances P.O. Box 21831 Eagan, MN 55121
Non-Nebraska providers	Your local Blue plan

Be sure to include the following information with your request for a payment dispute:

- Provider or supplier contact information including name and address
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Reason for dispute- a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original pricing determination
- Documentation and any correspondence that supports your position that the plan's reimbursement was incorrect (including interim rate letters when appropriate)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

Contracted Provider Appeals

Appeals of Claim Denials and/or Medical Necessity Denials

(not related to retrospective audits)

Contracted providers with BCBSNE Medicare Advantage plans have their own appeals rights. Providers may appeal decisions on denied claims, such as denial of a service related to medical necessity and appropriateness. Instead of following the member appeals process, BCBSNE Medicare Advantage providers should follow these guidelines when submitting an appeal.

Calling Provider Inquiry Services is the first step in addressing a concern. If you are still unhappy with the decision after speaking with a representative, you may submit an appeal in writing to:

Nebraska providers	**Write to:** Blue Cross and Blue Shield of Nebraska Medicare Advantage Attn: BCBSNE Provider Correspondence P.O. Box 21501 Eagan, MN 55121 Fax: 210-579-6930	**Call:** 888-505-2022
Non-Nebraska providers	Your local Blue plan	

Appeals must be submitted within **60 days** of the denial from the date the provider receives the initial denial notice. Be sure to include appropriate documentation to support your appeal. We will review your appeal and respond to you in writing within **60 days** from the time we receive notice of your appeal.

If you believe that we have reached an incorrect decision regarding your appeal, you may file a request for a secondary review of this determination by mailing it to:

Nebraska providers	**Write to:** Blue Cross and Blue Shield of Nebraska Medicare Advantage PRS - Appeals Attn: BCBSNE Appeals and Grievances P.O. Box 21831 Eagan, MN 55121
Non-Nebraska providers	Your local Blue plan

A request for secondary review must be submitted in writing within **60 days** of written notice of the first level decision from BCBSNE Medicare Advantage. We will review your appeal and respond to you within **60 days** from the time we receive notice of your secondary review. Please provide appropriate documentation to support your appeal and a copy of the first level decision letter. **Decisions from this secondary review will be final and binding**.

Appropriate documentation needed for a medical necessity appeal review:

- Provider or supplier contact information including name and address
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Reason for dispute- a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Documentation and any correspondence that supports your position that the plan's denial was incorrect (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

Non-Contracted Provider Appeals

Appeals of Claim Denials and/or Medical Necessity Denials

(not related to retrospective audits)

Calling Provider Inquiry Services is the first step in addressing a concern. If you are still unhappy with the decision after speaking with a representative, you may appeal decisions on denied claims, such as denial of a service related to medical necessity and appropriateness by following the member appeals process.

Non-contracted providers may submit an appeal in writing to:

Nebraska providers	**Write to:** BCBSNE Appeals and Grievances P.O. Box 21831 Eagan, MN 55121	**Call:** 888-505-2022

Non-contracted providers appealing claim/medical necessity denials must sign a waiver of liability. The waiver of liability indicates that you formally agree to waive any right to payment from the member for the service in question regardless of the outcome of your appeal.

Appeals must be submitted within **60 days** of the denial from the date the of the initial denial notice. Be sure to include appropriate documentation to support your appeal. We will review your appeal and respond to you in writing within **60 days** from the date we receive your appeal request.

Appropriate documentation needed for a medical necessity appeal review:

- Provider or supplier contact information including name and address
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Reason for dispute- a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Documentation and any correspondence that supports your position that the plan's denial was incorrect (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

Provider Request for an Advance Coverage Determination

Getting an Advance Coverage Determination

(not related to services or items requiring pre-authorization/certification)

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before providing a service or item.

All BCBSNE Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets Original Medicare medical necessity criteria, it will be covered by the plan.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To request an advance coverage determination, submit your request in writing by mail or fax to:

Nebraska providers	**Write to:** BCBSNE Care Management P.O. Box 21501 Eagan, MN 55121	**Fax:** 877-399-1671

BCBSNE will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or BCBSNE justification that the delay is in the member's best interest.

In cases where you believe that waiting for a decision under this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, fax your request indicating "Urgent" or "Expedite" on the first page of the request. We will notify you of our decision within 72 hours; unless a 14-day extension is requested by the member or the plan justifies a 14-day extension is in the best interest of the member.

Be sure to include the following information with your request for an advance coverage determination:

- Provider or supplier contact information including name and address
- Anticipated date of service, if applicable
- Procedure/HCPCS and Diagnosis codes
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Documentation and any correspondence that supports your position that the plan should cover the service or item (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)
- Name and signature of the provider or provider's representative

Network Exception

In most cases, BCBSNE Medicare Advantage HMO members do not have coverage for services or items received from an out-of-network providers within the service area. Providers have the option of requesting a network exception for specialized services when there is limited or no access to BCBSNE Medicare Advantage network providers.

To request a network exception, submit your request in writing by mail or fax to:

Nebraska providers	**Write to:** BCBSNE Care Management P.O. Box 21501 Eagan, MN 55121	**Fax:** 877-399-1671

* Exceptions: Emergency care, urgently needed services when the network is not available and out-of-area dialysis services.

Blue Cross and Blue Shield of Nebraska HEDIS & Stars

Quality Improvement Program

BCBSNE is committed to improving the quality of health care for our Medicare Advantage members. Medicare Advantage maintains a quality improvement program that continuously reviews and identifies the quality of clinical care and services members receive and routinely measure the results to ensure members are satisfied and expectations are met.

The Medicare Advantage Quality Improvement (QI) unit develops an annual quality improvement program that includes specific quality improvement initiatives and measurable objectives. Activities that are monitored for QI opportunities include:

- Appointment and after-hours access monitoring
- Quality of care concerns
- Member satisfaction
- Chronic care management
- Utilization management
- Health outcomes
- Medical record documentation compliance
- Quality improvement projects
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Provider and Systems Survey and Health Outcomes Survey
- Regulatory compliance

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. Medicare Advantage follows HEDIS reporting requirements established by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services. Audited HEDIS reports are used to identify quality improvement opportunities and develop quality related initiatives.

The HEDIS measures that Medicare Advantage focuses on include (but are not limited to):

- Acute hospital utilization
- Adults access to preventive/ambulatory health services
- Adult Immunizations
- Antidepressant medication management
  - Effective acute phase treatment
  - Effective continuation phase treatment

- Breast cancer screening (women 50–74 years of age)
- Colorectal cancer screening (members 50–75 years of age)
- Controlling high blood pressure (members 18-85 years of age)
- Emergency department utilization
- Eye exam for patients with diabetes (members 18-75 years of age)
- Fall risk management
- Follow-up after emergency department visit for substance abuse
- Follow-up after emergency department visit for mental illness (within seven and 30 days)
- Follow-up after emergency department visit for people with high-risk chronic conditions (within seven and 30 days)
- Follow-up after hospitalization for mental illness (within seven and 30 days)
- Frequency of selected procedures
- Hemoglobin a1c control for patients with diabetes (members 18-75 years of age)
- Hospitalization for potentially preventable complications
- Inpatient utilization – general hospital/acute care
- Medication reconciliation post-discharge
- Non-recommended prostate-specific-antigen based screening in older men
- Osteoporosis management in women who had a fracture (women age 67–85)
- Pharmacotherapy management of chronic obstructive pulmonary disease exacerbation
  - Systemic corticosteroid
  - Bronchodilator
- Plan all-cause readmissions
- Potentially harmful drug-disease interactions in the elderly
- Statin therapy for patients with cardiovascular disease
- Statin therapy for patients with diabetes
- Tobacco cessation – medical assistance
- Transitions of care
- Use of high-risk medications in older adults (at least two dispensing events)
- Use of opioids at high dosage
- Use of opioids from multiple providers
- Use of spirometry testing in the assessment and diagnosis of COPD

What is the CMS Quality Star Ratings Program?

CMS evaluates Medicare Advantage health insurance plans and issues Star ratings each year; these ratings may change from year to year. The methodology used by CMS is subject to change and final guidelines are released each spring after the measurement year. The CMS plan rating uses quality measurements widely recognized within the health care and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services that the BCBSNE Medicare Advantage plans offer. CMS compiles its overall score for quality of services based on measures such as:

- How BCBSNE helps members stay healthy through preventive screenings, tests, and vaccines and how often they receive preventive services to help them stay healthy
- How BCBSNE helps members manage chronic conditions
- Member satisfaction with BCBSNE and their experience with their provider
- How often members filed a complaint against BCBSNE
- How well BCBSNE handles calls from members

In addition, because BCBSNE Medicare Advantage plans offer prescription drug coverage, CMS also evaluates these prescription drug plans for the quality of services covered such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings

- Member experience with drug plan
- Drug pricing and patient safety

How are star ratings derived?

Star measurement is comprised of approximately 40 measures and is assessed across clinical, member perception and operational measures.

Clinical - HEDIS and Pharmacy

- Staying healthy, including screenings, tests, and vaccines
- Managing chronic (long-term) conditions
- Member Perception Surveys
  - The Consumer Assessment of Healthcare Providers and Systems (CAHPS), survey measures how members feel about their health plan, its network providers, and the care they receive.
  - The Health Outcome Survey(HOS), assesses the physical and mental health of members.

Operations

- Member complaints, handling of member appeals and members choosing to leave the plan
- Plan performance improvement

Performance is converted to star ratings, based on CMS specifications, as one through five stars, where five stars indicate higher performance. This rating system applies to all Medicare Advantage lines of business: health maintenance organizations, preferred provider organizations and prescription drug plans. In addition, the ratings are posted on the CMS consumer website, medicare.gov* to help beneficiaries choose a Medicare Advantage plan offered in their area.

Star Clinical Performance

Star clinical performance is determined by who in the eligible population received appropriate services/care as defined by the measure.

Numerator: Eligible population that met the criteria

Denominator: Eligible population for the measure

= % Compliant

CMS determines the thresholds of performance required to achieve a star rating.

Classification of Clinical Measures

Administrative: Transaction data or other administrative data is used to identify the eligible population and the numerator. The reported rate is based on all members who meet the eligible population and who are found through administrative data to have received the service required.

Hybrid: Administrative data is used to identify the eligible population. A combination of administrative data and medical record review data is used to calculate the numerator. Exception to this is Controlling Blood Pressure in which the numerator is completely collected from medical record review data.

2024 CMS Quality Star Measures

Area	Measure	Description
Clinical	Breast cancer screening	Percent of plan members aged 52-74 who had a mammogram to screen for breast cancer.
Clinical	Colorectal cancer screening	Percent of plan members aged 50-75 who had appropriate screenings for colorectal cancer.
Clinical	Controlling blood	Percent of plan members aged 18-85 with high blood pressure who received treatment and were able to maintain a healthy pressure

	pressure	• <140/90 mm Hg
Clinical	Diabetes care – eye exam	• Percent of plan members aged 18-75 with diabetes who had an eye exam to check for damage from diabetes during the year.
Clinical	Diabetes care – blood sugar controlled	Percent of plan members aged 18-75 with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control (<9%).
Clinical	Hospitalization for Preventable Complication	The rate of hospitalization for plan members aged 67 years and older related to complications of chronic and acute ambulatory care sensitive conditions.
Clinical	Medication Reconciliation Post Discharge	Percent of plan members aged 66 years and older who were discharged from an acute or non–acute inpatient facilities and had medications reconciled within 30 days of discharge.
Clinical	Osteoporosis management in women who had a fracture	Percent of female plan members aged 67-85 who broke a bone and received screening or treatment for osteoporosis within six months.
Clinical	Plan all–cause readmissions	Percent of senior plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.
Clinical	Statin therapy for patients With cardiovascular disease	Percent of male plan members aged 275 and female plan members aged 40-75 who were identified as having clinical atherosclerotic cardiovascular disease and dispensed at least one high or moderate- intensity statin medication and remained on a high or moderate- intensity statin medication for at least 80% of the treatment period.
Clinical	Pharmacy Part D medication adherence for diabetes medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Clinical	Pharmacy Part D medication adherence for hypertension (RAS antagonists))	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Clinical	Pharmacy Part D medication adherence for cholesterol (statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Clinical	Pharmacy Statin use in persons with diabetes	Percent of members aged 40 to 75 years who were dispensed a medication for diabetes that receive a statin medication.
Clinical	Operations Part D Medication Therapy Management	Percent of plan members 18 and older who were enrolled in the MTM program for at least 60 days during the reporting period.

Member survey	Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.
Member survey	Improving or maintaining physical health	Percent of all plan members whose physical health was the same or better than expected after two years.
Member survey	Improving or maintaining mental health	Percent of all plan members whose mental health was the same or better than expected after two years.
Member survey	Monitoring physical activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
Member survey	Improving Bladder Control	Percent of plan members experiencing urinary incontinence and talked to their doctor about treatment approaches.
Member survey	Getting needed care	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Member survey	Getting appointments and care quickly	This case-mix adjusted composite measure is used to assess how quickly the member is able to get appointments and care.
Member survey	Rating of health care quality	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Member survey	Getting needed prescription drugs	Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.
Member survey	Care coordination	Percent of the best possible score the plan earned on how well the plan coordinates members‘ care.

Please note that the methodology used by CMS is subject to change and final guidelines are released each spring after the measurement year.

Blue Cross and Blue Shield of Nebraska’s Goals for the Five-Star Rating System

BCBSNE is strongly committed to providing high-quality Medicare Advantage health plans to meet or exceed CMS quality benchmarks, operational, and marketing requirements. BCBSNE works with providers and members to ensure appropriate and timely care was received, chronic conditions are well-managed, and satisfaction with the level of service obtained from BCBSNE and in-network providers.

BCBSNE uses mailings and personal and automated phone calls to remind members about needed care and to help maintain optimal health.

BCBSNE partners with our MA providers by identifying their Medicare Advantage patients who need specific medical services to encourage providers to contact those patients and schedule necessary services:

Provider Tips for Improving Star Ratings and Quality Care

- Continue to encourage patients to obtain preventive screenings annually or when recommended
- Create office practices to identify noncompliant patients at the time of their appointment
- Submit complete and correct encounters/claims with appropriate codes
- Understand the metrics included in the CMS rating system
- Review the gap in care files listing members with open gaps
- Ensure documentation includes assessment of cognitive and functional status
- Identify opportunities for you or your office to have an impact

HEDIS Medical Record Reviews

BCBSNE records medical data for HEDIS at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archived medical records/data may be required to complete data collection.

For the HEDIS reviews, we look for details that may not have been captured in claims data such as blood pressure readings, HbA1c lab results, and colorectal cancer screenings. This information helps us enhance our member quality improvement initiatives.

A BCBSNE employee or designated vendor(s) will perform the HEDIS reviews. Provider offices are responsible for responding to the medical record request and providing the documentation requested in a timely manner. BCBSNE or its designated vendor(s) will contact your office to establish a date for an onsite visit or the option to fax or mail the data requested. A patient list will be sent including the name and information being requested. If your office is selected for an onsite visit, please have the medical records available ahead of time. If a chart for a patient is being requested and not available at your practice location, you should notify the BCBSNE employee or the designated vendor immediately.

We request that providers allow BCBSNE employees or its designated vendor(s) to scan the medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record. BCBSNE will not reimburse for copy house services. If a provider or an accountable care organization contract with a copy house vendor they will be responsible for reimbursing that vendor.

Medicare Part D Prescriber Prerequisite

Health care professionals who write prescriptions for Medicare Part D members were required to enroll in Medicare for an approved prescriber status. This is required of health care professionals who write prescriptions to ensure continued prescription coverage under Medicare Part D. Those who have previously applied to meet this requirement and have received confirmation of their registration from CMS are not required to take additional action to fulfill this requirement.

Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. Part D plans will only cover up to one 3–month provisional supply of a drug, if prescribed by a provider who has not enrolled in or validly opted out of Medicare. If you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

In addition, in order for Part D claims to adjudicate appropriately, eligible prescribers must ensure their taxonomy information is accurate in the CMS National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) registry. You can search npiregistry.cms.hhs.gov/search* to verify the taxonomy code(s) associated with your NPI. The taxonomy code is an element Prime Therapeutics uses to determine whether or not a claim may be paid based on eligibility to prescribe.

Enrolling in Medicare Part D

You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System located at pecos.cms.hhs.gov/* or by completing the paper CMS-855I or CMS-855O application, which is available at cms.gov/medicare/forms-notices/cms-forms-list*. Note that an application fee is not required as part of your application submission.

Medication Therapy Management Program

According to CMS, to be eligible for participation in a Medication Therapy Management program, a candidate must:

- Meet all the following criteria:
  - Have at least three of these chronic medical conditions: Osteoporosis, CHF, Diabetes, Dyslipidemia, and COPD
  - Be on at least eight Part D medications
  - Be reasonably expected to incur a set dollar amount worth of drug expenses in one calendar year. The set dollar amount is revised annually by CMS.

- Be an at-risk beneficiary (ARB) for prescription drug abuse as determined under BCBSNE's drug management program (DMP).

Prime Therapeutics, the Medicare Advantage Pharmacy Benefit Manager, is committed to optimizing therapeutic outcomes by improving the use of drugs to avoid adverse drug events. Prime does this through both an internal MTM department and external MTM vendors that provide annual Comprehensive Medication Review (CMR) services for MTM-enrolled Covered Persons. Prime also provides quarterly, criteria-based Targeted Medication Review (TMR) services to MTM-enrolled Covered Persons.

Pharmacy Treatment Improvement Opportunities

In addition to our formularies, prescribing limits, and restrictions, we promote quality of care by monitoring claims to improve outcomes and patient safety. CMS requires us to identify certain treatment opportunities and proactively address them with providers and members. Some of these medication issues factor into our Star rating scores.

High Risk Medications

Certain medications pose a high-risk of serious side effects in older patients, as described in the *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*. BCBSNE and CMS endorse the Beers Criteria and, when a routine claim review identifies an instance when a high-risk medication (HRM) is prescribed, we alert the prescriber of the risk and offer safer alternatives.

Medication Adherence

We pay close attention to medication adherence for disease states such as diabetes, hypertension, and hypercholesterolemia. We monitor medication adherence rates by reviewing pharmacy claims data, and if a member is non-adherent to their medications, we will address this with the member to see why the member is not taking their medication as prescribed.

Statin Use in Diabetes

The guidelines of several medical societies state that diabetics should be on a statin, regardless of whether they have high cholesterol or not, to prevent cardiac events such as heart attacks. We will alert prescribers when they have members with diabetes that are not on a statin.

Opioid Overutilization

Because of the risks involved with opioid and acetaminophen use, both BCBSNE and CMS urge physicians to prescribe opioids with caution and carefully monitor patients using these medications. CMS requires BCBSNE to actively monitor claims data for potential opioid and/or acetaminophen overuse. If our analysis suggests potential overuse, we send a letter to the prescriber detailing our concerns and ask them to complete and return a questionnaire about the patient's condition and treatments. If the physicians verify that the current opioid therapy is medically necessary, safe, and appropriate for their patient, we'll follow up with a letter of confirmation and report our findings to CMS.

If the physicians fail to respond to our request for information or agree that the current opioid therapy is not appropriate, BCBSNE may stop or limit coverage for the patient's opioid medication and notify the member, prescribers, and report our findings to CMS.

Our analysis looks at:

- Safety risks, such as instances when a patient receives a daily dosage of opioids — either from a single prescription, or multiple prescriptions – that's higher than established safety levels.
- High utilization patterns, where a patient may have opioid prescriptions from multiple physicians within the same time period.
- Potential fraud, waste, or abuse, when a patient visits multiple physicians to expand their access to these painkillers, a practice known as "doctor shopping."

Immunization

Medicare Part B and Part D both cover certain immunizations. Although the delineation of coverage is clear, there are some exceptions where a vaccine could be covered under either plan.

When billing for prophylactic immunizations, the following always applies:

- **Influenza and pneumonia immunizations are always paid under Part B.** (These are never covered under Part D.)
- **Shingles immunizations are always paid under Part D.** (These are never covered under Part B.)

Part B covers two categories of immunizations (prophylactic and injury/disease-related) and the benefit pays everything associated with the vaccination in a single claim, including ingredient cost, dispensing fee, and injection or administration fee. Medicare will pay for immunizations in various venues: at a pharmacy, a clinic or a physician's office.

Activity associated with administering Part D vaccinations are also bundled into a single claim. However, incidental activity, such as an office visit, may involve additional cost-share to the patient.

Type of immunization	Part A covers	Part B covers	Part D covers
Prophylactic immunizations associated with a senior population: • Seasonal influenza • Pneumococcal pneumonia • Hepatitis B		Covers influenza, pneumonia, and hepatitis B for patients at high- or intermediate risk of contracting the disease.	Hepatitis B vaccine may be covered if the patient does not meet Medicare's Part B criteria.
Vaccines administered by a health care provider for treatment of an injury, or because of direct exposure to a disease or condition.	Covers vaccines administered during an inpatient stay.	Covers limited vaccines administered on an outpatient basis. Some vaccines subject to review of clinical criteria to determine Part B or Part D coverage.	Covers shingles vaccination, and other Part D vaccines. Some vaccines (other than shingles) subject to review of clinical criteria to determine Part B or Part D coverage.

Medicare Part B covers influenza immunizations in full and some organizations provide the influenza immunizations free of charge while others may charge for an influenza immunizations. Because not all venues will file the Part B claim on the patient's behalf, the patient may have to pay cash for the influenza immunizations, and then seek reimbursement from Medicare Part B.

It's important to remind these patients that Medicare Part B covers annual influenza immunizations at 100 percent (no copay or deductible) and that they must submit a completed claim form and receipt to their Medicare Part B insurance plan to obtain reimbursement. The claim must be submitted under Part B because influenza immunizations and pneumonia vaccinations are never paid under Part D.

Although shingles vaccinations are a prophylactic measure, these vaccinations are always covered under Part D. There is no coverage for this vaccination under Part B.

Billing Guidelines for Roster Bills

Providers who are mass immunizers, and/or providers who chose to bill using the roster billing method, must submit immunization claims on a roster bill and accept assignment under Original Medicare on both the administration and vaccine. Physicians and other health care providers enrolled in the Medicare program should follow the billing guidelines below when submitting roster bills to BCBSNE:

- At this time, BCBSNE can only accommodate roster billing on paper claims.
- Providers may submit up to three rosters on a single CMS-1500 claim form for each type of vaccination.
- Rosters may include information regarding multiple patients.
- Typed rosters are preferred. If it is not typed, the roster information must be in blue or black ink and legible.
- Do not fold your claim or roster forms.

Mail your CMS-1500 claims and attached roster bills to the following

address: Prime Therapeutics

P.O. Box 20970

Lehigh Valley, PA 18002-0970

Other Requirements

Additional requirements pertaining to BCBSNE Medicare Advantage programs are described below.

Settlements

Hospital Settlement

Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted which are at least partially reimbursed based on their reasonable costs rather than a fee schedule. The Medicare Fiscal Intermediary/ Administrative Contractor will attempt to make the interim payments as accurate as possible.

After the hospital's fiscal year end, the fiscal intermediary settles with the providers for the difference between interim payments and actual reasonable costs.

CMS policy does not require plans to agree to settle with providers. BCBSNE conducts settlements on hospital claims for BCBSNE Medicare Advantage members, when requested, where certain provisions of the Original Medicare reimbursement system are not accounted for through the normal claims vouchering system (for example, disproportionate share, bad debt, capital for a new hospital for first two years, etc.) Bad debt and critical access hospital settlements include both inpatient and outpatient claims for BCBSNE Medicare Advantage members. All other outpatient reimbursement issues should be referred to your BCBSNE provider consultant.

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

BCBSNE conducts settlements on a hospital's full fiscal year at the appropriate Medicare rate based on discharge date. BCBSNE reviews the Medicare Cost Report, the specific claims submitted for review, and the interim rate letters to determine the cost settlement.

The hospital must request a settlement from BCBSNE in writing within 180 days of the hospital's fiscal year-end, and must include all of the following information:

- A description of the issue
- An estimate of the impact
- Supporting documentation including (as appropriate)
  - The filed Medicare Cost Report for the year in question
  - The Medicare interim rate letter (or system equivalent) for the applicable time period
  - A detailed BCBSNE claims list (a template will be provided)
  - Calculations showing how the impact amount was determined

BCBSNE reviews the information and gives a written determination of funds owed the provider from BCBSNE or funds owed BCBSNE from the provider. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

BCBSNE reimburses Bad Debt claims for only uncollected BCBSNE Medicare Advantage member liability. Charges for non–covered services are not included. The hospital must provide a signed attestation that it defines and calculates its bad debt numbers in accordance with the CMS rules and guidelines. The BCBSNE bad debt claims template, along with the attestation, are provided upon receipt of the request for settlement.

BCBSNE pays Critical Access Hospital claims on an interim basis using the per diems and percentage of charges stipulated in the Fiscal Intermediary/MAC interim rate letter applicable to the date on which services are rendered. The cost-based reimbursement rate and elected payment method used for the year under review are compared to the rate calculated on the Medicare Cost Report and a settlement is made based on the difference. Once a hospital elects to engage in the settlement process, all

subsequent years will need to be settled.

BCBSNE reviews the information and gives a written determination of funds owed the provider from BCBSNE or funds owed BCBSNE from the provider. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

Serious Adverse Events and Present on Admission

BCBSNE Medicare Advantage plans do not pay for medically unnecessary services, regardless of the cause. The main provisions of the policy are as follows:

- BCBSNE will not reimburse a hospital or physician whose direct actions result in a serious adverse event.
- Serious adverse events affected by this policy will be updated as needed to remain consistent with changes made by the Centers for Medicare & Medicaid Services.
- BCBSNE Medicare Advantage participating hospitals are required to report present on admission indicators on all claims.
- BCBSNE Medicare Advantage participating hospitals are not to balance bill members for any incremental costs associated with the treatment of a serious adverse event that BCBSNE has paid.
- BCBSNE Medicare Advantage members who have been billed in error should report incidents to BCBSNE as appropriate.
- The policy on serious adverse events applies to all acute care hospitals, exempt hospital units and critical access hospitals that have signed a BCBSNE Medicare Advantage participating hospital agreement.
- BCBSNE developed the following list of events and conditions:
    - Object left in the body after surgery
    - Air embolism as a result of surgery
    - Blood incompatibility
    - Catheter-associated urinary tract infections
    - Pressure sores (decubitus ulcers) — Stage 3 or 4
    - Vascular catheter-associated infections
    - Surgical site infections
        - Mediastinitis following a coronary artery bypass graft surgery
        - Gastric bypass
        - Orthopedic procedures
        - Cardiac Implantable Electronic Device
    - Hospital-acquired injuries
        - Falls and fractures
        - Dislocations
        - Intracranial and crushing injury
        - Burns
    - Deep vein thrombosis or pulmonary embolism following:
        - Total knee replacement
        - Total hip replacement
    - Manifestations of poor glycemic control
    - Diabetic ketoacidosis
        - Non-ketotic Hyperosmolar coma
        - Hypoglycemic coma
        - Secondary diabetes with ketoacidosis

- Secondary diabetes with hyperosmolarity
- Iantrogenic pneumothorax with venous catheterization

Additionally, CMS further defined the following events for easier identification:

- Performance of procedure on patient not scheduled for operation (procedure) — formerly known as surgery on wrong patient
- Performance of correct procedure on wrong side or body part — formerly known as surgery on wrong body part
- Performance of wrong procedure on correct patient — formerly known as wrong surgery

Hospitals participating with BCBSNE Medicare Advantage are required to submit present-on-admission (POA) indicator information for all primary and secondary diagnoses, for both paper and electronic claims.

The POA indicator is used to identify conditions present at the time the admission occurs, including those that develop during an outpatient encounter in settings that include the emergency department, observation or outpatient surgery. The POA indicator is not required on secondary claims.

Certain code categories are exempt from POA indicator reporting requirements because either they are always present on admission or they represent circumstances related to the health care encounter or factors influencing health status that do not represent a current disease or injury.

The following values should be used to indicate POA when submitting data:

Value	Definition
Y	Diagnosis was present at the time of inpatient admission
N	Diagnosis was not present at the time of inpatient admission
U	Documentation is insufficient to determine whether the condition was present at the time of inpatient admission
W	Provider is unable to determine clinically whether the condition was present at the time of inpatient admission
1	Exempt from POA reporting
Blanks	Exempt from POA reporting Note: Blanks are valid only on paper claims.

*Note: These values were established by CMS.

On electronic claims, the POA data element must contain the letters POA followed by a single POA indicator for every diagnosis reported, as follows:

- The POA indicator for the principal diagnosis should be the first indicator after the POA letters, followed by the POA indicators for the secondary diagnoses as applicable.
- The final POA indicator must be followed by either the letter Z or the letter X, to indicate the end of the data element.

For paper claims, the POA indicator is the eighth digit of the principal diagnosis field in Form Locator 67 on the UB-04 claim and the eighth digit of each of the secondary diagnoses in Form Locator 67, A-Q.

The policy on serious adverse events is administered as follows:

- **For DRG-reimbursed hospitals** — BCBSNE uses the Medicare severity diagnosis-related groups (MS-DRG).
- **When the member is readmitted to the same hospital and the admissions are combined** — Hospitals should follow the current process for combining admissions:
  - If the POA indicator is correctly reported as Y (indicating the condition was present on admission), there is no financial reduction.
  - In cases in which the POA for the serious adverse event was N (indicating that the condition was not present on admission and that, therefore, the readmission was a direct result of the serious adverse event), the two cases are combined and only the first admission is

reimbursed.

- **When the member is readmitted to the same hospital and the admissions are not combined** — Any readmission with diagnosis associated with a serious adverse event during the initial admission may be selected for audit review to validate its presence on admission.
- **When the member is admitted to a different hospital** — When an admission to a second hospital carries a POA indicator of Y but the treatment is that which is medically necessary to treat the adverse event, the second hospital is held harmless and is reimbursed for the admission.
- **When claims are submitted with an invalid POA** — Claims submitted with an invalid POA indicator are returned to the hospital for correction and are not entered into the BCBSNE claims system.
- **When treatment to correct the adverse event is rendered by a hospital or physician not responsible for the adverse event** — In all cases, the second hospital and the second physician correcting the adverse event are held harmless. Because the treatment is medically necessary, they are reimbursed.

Clinical Research Study

If a member with BCBSNE Medicare Advantage coverage participates in a Medicare-qualified clinical research study, Original Medicare will pay the provider on behalf of the BCBSNE plan. BCBSNE will pay for Medicare-covered services that are not affiliated with the clinical trial. **Therefore, providers must submit claims for Medicare-covered services related to the clinical trial to carriers and fiscal intermediaries, not to** BCBSNE, using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to BCBSNE, and BCBSNE will reimburse providers accordingly.

Swing Beds

Swing beds in a critical access hospital are paid according to the critical access hospital methodology.

Swing beds located in non-critical access hospitals are paid using the Medicare skilled nursing facility prospective payment system, which is a per diem payment.

Network Participation

Overview

BCBSNE will give select provider types an opportunity to apply for participation in the Medicare Advantage network. Network providers provide care to BCBSNE Medicare Advantage members, and we reimburse them for covered services at the agreed upon payment rate. Network providers must sign formal agreements with BCBSNE, to participate in the Medicare Advantage networks. By signing the agreement, the provider agrees to bill us for covered services provided to BCBSNE Medicare Advantage members, accept our reimbursement as full payment minus any member required cost sharing, and receive payment directly from BCBSNE.

Qualifications and Requirements

To be included in BCBSNE Medicare Advantage network, providers must:

- Have a national provider identifier used to identify the provider when submitting electronic transactions to BCBSNE (in accordance with HIPAA requirements) or to submit paper claims to BCBSNE
- Meet all applicable licensure requirements in the state of Nebraska and meet BCBSNE credentialing requirements pertaining to licensure
- Provide services to a BCBSNE member within the scope of their licensure or certification and in a manner consistent with professionally recognized standards of care
- Provide services that are covered by our plan and that are medically necessary by Medicare definitions
- Meet applicable Medicare approval or certification requirements
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services

- Sign formal agreements with BCBSNE
- Agree to bill us for covered services provided to BCBSNE Medicare Advantage members
- Accept our reimbursement as full payment less any member cost sharing
- Receive payment directly from BCBSNE
- Not be on the U.S. Department of Health and Human Services Office of Inspector General excluded and sanctioned provider lists
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members
- Agree to cooperate with BCBSNE to resolve any BCBSNE Medicare Advantage member grievance involving the provider within the time frame required under federal law
- For providers who are hospitals, home health agencies, skilled nursing facilities, long-term acute care hospitals or comprehensive outpatient rehabilitation facilities, provide applicable member appeal notices
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy
- Provide certain special services to members only if approved by Medicare to provide such services (e.g., transplants, VAD distribution therapy, carotid stinting, bariatric surgery, PET scans for oncology, or lung volume reduction). The list of special services will be automatically updated as determined by CMS.
- Be in good standing with BCBSNE and meet and maintain all BCBSNE credentialing requirements for network inclusion. Examples of being in good standing are:
  - Unrestricted license to practice
  - No license limitations
  - Not on prepayment utilization review, not in the performance monitoring program or not de-participated from the Traditional program
  - Not denied or disaffiliated from the TRUST program within a two-year period of application to BCBSNE Medicare Advantage
  - No Medicare or Medicaid exclusion, sanction, or debarment
  - Not opting out of Medicare
- Agree to accept all BCBSNE Medicare Advantage members unless practice is closed to all new patients (commercial or Medicare)

Network Information and Affiliation

Overview

BCBSNE Medicare Advantage includes a network of health care providers consisting of primary care physicians, specialists, hospitals and other health care providers who have agreed to provide services to BCBSNE Medicare Advantage members. The BCBSNE Medicare Advantage plan focuses on delivering cost-effective and quality patient care. Network providers agree to accept BCBSNE reimbursement as payment in full for covered services (minus any member required cost sharing). Members with BCBSNE Medicare Advantage coverage receive services from a select network of providers.

Network Sharing

For the HMO and PPO plans the provider just needs to accept the Medicare Advantage plan (Blue Card participation is not required).

If you are a contracted Medicare Advantage provider for BCBSNE and you see Medicare Advantage members from other Blue plans, these members will be extended the same contractual access to care and you will be reimbursed in accordance with the rate for your Medicare Advantage contract. These members will receive in-network benefits in accordance with their member contract.

Effective July 1, 2014, the Blue Cross Blue Shield Association issued a mandate to all Association members, which requires all participating providers to be responsible for obtaining pre-service reviews for inpatient facility services provided to Medicare Advantage members from other states. Keep the following guidelines in mind:

- Obtain pre-service reviews prior to admission for inpatient facility services when such a review is required under the member's plan.
- Out-of-state members will be held harmless if a pre-service review is required and not performed prior to admission for inpatient facility services. You cannot bill or collect from a member for covered services where you failed to perform pre-service review as required.
- Specified timeframes for pre-service review may apply. These include: 48 hours to notify the host plan of a change in the pre-service review and 72 hours in the case of an emergency or urgent care notification.

Affiliation

Professional and Facility Enrollment

Information on how to enroll in the Medicare Advantage Network is available in the Credentialing section of NebraskaBlue.com/providers/credentialing.

Eligible Practitioners

Practitioners eligible for affiliation in the BCBSNE Medicare Advantage are:

- Medical Doctors
- Doctors of Osteopathy
- Doctors of Podiatric Medicine
- Doctors of Dental Surgery (oral surgeons only)
- Doctors of Chiropractic Medicine
- Anesthesia Assistants
- Audiologists
- Certified Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Independent Physical Therapists
- Occupational Therapists
- Optometrists
- Hearing aid dealers
- Fully licensed psychologists
- Clinical licensed master's social worker
- Ambulance providers
- Independent speech language pathologists
- Clinical nurse specialist
- Physician assistant
- Licensed Mental Health Practitioner
- Licensed Independent Mental Health Practitioner

Facility Affiliation

Facilities eligible for affiliation in the BCBSNE Medicare Advantage network are:

- Ambulatory surgical facilities (freestanding only)
- End stage renal disease facilities (hemodialysis centers)

- Federally qualified health centers
- Home health care facilities
- Hospitals
- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Rural health clinics
- Skilled nursing facilities

Affiliation requirements include:

Facility
Facilities must meet certain requirements to participate in the BCBSNE Medicare Advantage network. These requirements are available in the applications which can be found in the provider enrollment section of NebraskaBlue.com/Credentialing.

Practitioner
Practitioners (except ambulance) who request affiliation in the BCBSNE Medicare Advantage Network must meet specific network requirements and complete an online application on the Council for Affordable Quality Health Care ProView Datasource (CAQH) website. Typically, up to five years of history are reviewed during the initial credentialing process. We use the same review process to credential new applicants and to recredential network practitioners.

- BCBSNE registered — must be or become registered with BCBSNE and have an active provider record. To become registered, go to NebraskaBlue.com/Credentialing.
- Fully licensed — must be fully licensed and free of any current disciplinary actions of suspension, revocation, surrender, limitation or probation. A provider who has any of these disciplinary actions imposed because of a criminal conviction related to payment or provision of health care will be restricted from applying to the network for a period of two years following the date the license restriction is lifted.
- Malpractice coverage — must have and maintain current malpractice coverage of $100,000 per occurrence, and $300,000 annual aggregate. The coverage must protect the provider from all liability, whether a claim is filed against the individual provider or jointly with a hospital. Liability insurance must cover all practice locations unless the provider is directly employed by a hospital and practices exclusively at that hospital.
- Professional certification bodies — Non-physician providers must be in good standing with designated professional certification bodies applicable to their area of expertise.
- Government sanctions — must be free of any exclusions or sanctions from Medicare and Medicaid.
- Opt out — must not have opted out of participation in the Medicare program under §1802 (b) of the Social Security Act, unless providing emergency or urgently needed services.
- Prepayment utilization review — An applicant who is currently in or has a significant history in the BCBSNE prepayment utilization review program will be denied affiliation with the BCBSNE Medicare Advantage network.
- BCBSNE departicipation — an applicant with a current or significant history of formal departicipation action by BCBSNE will not be accepted in the BCBSNE Medicare Advantage.
- Malpractice case history — must be reported with supporting details. These include the number of malpractice cases against the applicant that have been filed, adjudicated or settled within the five years prior to the application date. We review all cases against established screening criteria and may deny the application.
- Substance abuse or chemical dependency — Current use or recent history of illegal drug use or substance abuse or dependence will result in a denied application. New applicants with history of chemical dependence or substance abuse must:
  - Provide proof of treatment
  - Be substance-free during the 24-month period before application

- Attest that they have no current chemical dependence and are currently free of all illegal chemicals

- Additional considerations — We may use other information in credentialing and recredentialing review and decision-making, such as:
  - Data Bank (National Practitioner – Healthcare Integrity and Protection) findings
  - No history of conduct that threatens patient safety or adversely affects BCBSNE's business interests

Affiliated Provider Agreement

As an affiliated provider, you agree to (but not limited to):

- Meet our re-credentialing requirements every three years (includes facilities)
- Meet and maintain board certification requirements (when applicable)
- Abide by the BCBSNE Medicare Advantage Network agreement, policies and procedures (includes facilities)
- Bill only for professional services personally provided by the BCBSNE Medicare Advantage Network provider. (This specifically prohibits billing for services provided by any subcontractor, or other provider, including a partner in a group practice.)

  Note: The only exception is when a physician personally supervises a provider who cannot bill BCBSNE directly. Provide complete care within the BCBSNE Medicare Advantage provider's specialty and do not systematically refer or "share" the care of patients
- Provide safe, medically necessary, and cost-effective care (includes facilities)
- Maintain a current and accurate CAQH ProView record — Update the CAQH ProView minimally once every 120 days and re-attest to the completeness and accuracy of the information.

Disaffiliation

The BCBSNE Medicare Advantage Provider Agreement can be terminated by BCBSNE or an affiliated provider, in accordance with the terms of the Agreement. When the agreement is terminated, the provider is no longer affiliated with the BCBSNE Medicare Advantage network. We call this activity "disaffiliation."

There are two types of disaffiliations:

- **Voluntary** — Initiated by the provider at any time, except during the initial term of the Agreement, with 60 days written notice to BCBSNE or as otherwise provided in the Agreement
- **Involuntary** — Initiated by BCBSNE in accordance with the terms of the Agreement and applicable internal policies. Depending on the reason(s) for this type of disaffiliation, you may be able to re-apply for affiliation two years after the disaffiliation date.

Obligations of Recipients of Federal Funds

Providers participating in BCBSNE Medicare Advantage are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act (32 USC 3729, et seq.) and the Anti-kickback Statute (section 128B(b) of the Social Security Act).

BCBSNE is prohibited from issuing payment to a provider or entity that appears on the List of Excluded Individuals/ Entities as published by the U.S. Department of Health and Human Service Office of Inspector General or on the list of debarred contractors as published by the U.S. General Services Administration (apart from payment for emergency services under certain circumstances). Providers can access additional information as follows:

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/ Entities can be found at oig.hhs.gov* **> Exclusions > Online Searchable Database**.
- The General Services Administration list of debarred contractors can be found at sam.gov*. In the System for Award Management.

Fraud, Waste, and Abuse

Detecting and Preventing Fraud, Waste, and Abuse

BCBSNE is committed to detecting, mitigating, and preventing fraud, waste, and abuse. Providers are also responsible for exercising due diligence in the detection and prevention of fraud, waste, and abuse, in accordance with the Blue Cross and Blue Shield of Nebraska Detection of Fraud, Waste and Abuse policy. BCBSNE encourages providers to report any suspected fraud, waste and/or abuse to the Blue Cross and Blue Shield of Nebraska Corporate and Financial Investigations department, the Corporate Compliance Officer, the Medicare Compliance officer, or through the anti-fraud hotline, 877-632-2583. The reports may be made anonymously.

What is Fraud?

Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor (such as BCBSNE) to get money or a benefit.

Examples of Fraud

Examples of fraud include:

- Billing for services not rendered
- Billing for services provided to a member at no cost
- Upcoding services
- Falsifying certificates of medical necessity
- Knowingly double billing
- Unbundling services for additional payment

Providers and Vendors are Required to Take CMS Training on Medicare Fraud

Providers must understand fraud, waste, and abuse in Medicare and participate in required compliance programs per Centers for Medicare & Medicaid Services (CMS) regulations. Review these resources for more information:

- Combatting Medicare Fraud, Waste, & Abuse cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html
- Medicare Compliance

Providers and vendors should make sure that governing body members and any employees (including volunteers and contractors) providing health or administrative services in connection with the BCBSNE Medicare Advantage program complete the training within 90 days of being hired and annually thereafter. Be sure to keep the certificate generated by the website as proof that you took the training and retain evidence of training for 10 years from the end date of your contract with BCBSNE. You need to be able to provide proof to BCBSNE or CMS if requested.

What is Waste?

Waste includes activities involving payment or an attempt to receive payment for items or services where there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods cause unnecessary costs.

Examples of Waste

Example of waste include:

- Inaccurate claims data submission resulting in unnecessary rebilling or claims
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed
- Overuse, underuse, and ineffective use of services

What is Abuse?

Abuse includes practices that result in unnecessary costs or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of Abuse

Examples of abuse include:

- Providing and billing for excessive or unnecessary services
- Routinely waiving member coinsurance, copayments or deductibles
- Billing Medicare patients at a higher rate than non-Medicare patients

Medicare Part D Program

As part of an ongoing effort to combat fraud, waste, and abuse in the Medicare Part D program, CMS' program integrity contractor, the NBI MEDIC (Health Integrity, LLC), requests prescriber prescription verifications. The NBI MEDIC routinely mails prescriber prescription verification forms containing the beneficiary's name, the name of the medication, the date prescribed, and the quantity given. The form also asks the prescriber to check yes or no to indicate whether the prescriber wrote the prescription. The prescriber is asked to respond within two weeks. If no response is received, then the investigator follows up with a second request.

A timely and complete response to prescription verification is important as it is likely to result in the elimination of an allegation of wrongdoing and/or prevent the payment of fraudulent prescriptions without need for further investigation.

Providers who are involved in the administration or delivery of the Medicare Part D prescription drug benefit are strongly encouraged to respond in a timely manner to prescription verifications when contacted by the NBI MEDIC.

Additionally, beginning Jan. 1, 2016, if you want to participate in Part D to cover a prescription, not only must you have a valid NPI number, but you must also be either: (1) enrolled in Medicare or (2) validly opted-out of the program. BCBSNE will reject an otherwise valid prescription, if it was written by a prescriber who is neither enrolled in Medicare nor validly opted-out of the program.

Repayment Rule

Under the Patient Protection and Affordable Care Act, effective March 23, 2010, providers are required to report and repay overpayments to the appropriate Medicare administrative or other contractor (Fiscal Intermediary or Carrier) within the later of (a) 60 days after the overpayment is identified, or (b) the date of the corresponding cost report is due, if applicable.

Under the Affordable Care Act, a provider is obligated to report and return an overpayment by the later of (1) 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due (if applicable). Failure to do so may render the provider subject to liability and penalties under the False Claims Act.

Offsets

BCBSNE will withhold funds from future claim payment(s) to providers up to the amount of any identified overpayment.

Questions, Additional Information, and Contacts

BCBSNE does not prohibit network health care professionals from advising or advocating on behalf of patients. If you have general questions about BCBSNE Medicare Advantage, call Provider Inquiry at 888-505-2022 (8 a.m. to 4:30 p.m.) or write to:

BCBSNE Provider Correspondence
P.O. Box 21501
Eagan, MN 55121
Fax: 210-579-6930

What if I suspect fraud? If you suspect fraud, please contact BCBSNE Anti-Fraud Hotline at 877-632-2583 (24 hours a day/seven days a week).

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