BlueCross BlueShield Nebraska

BCBSNE Western Nebraska Provider Summit

Agenda

01 Communication and Engagement

02 Claims and Reimbursement

03 Appeals and Medical Management

04 Risk and Quality/VBC

05 Medicare Advantage

06 Open Q&A

We are **a champion for the health and well-being of our members and the communities we serve.**

Redefining Partnership:
A Shared Commitment to Better Care

Collaborating with providers, not just contracting with them

Improving processes to reduce administrative burden

Listening and evolving based on your feedback

Focusing on what matters most — better outcomes for patients

Together, we're not just navigating the system — we're reimagining it.

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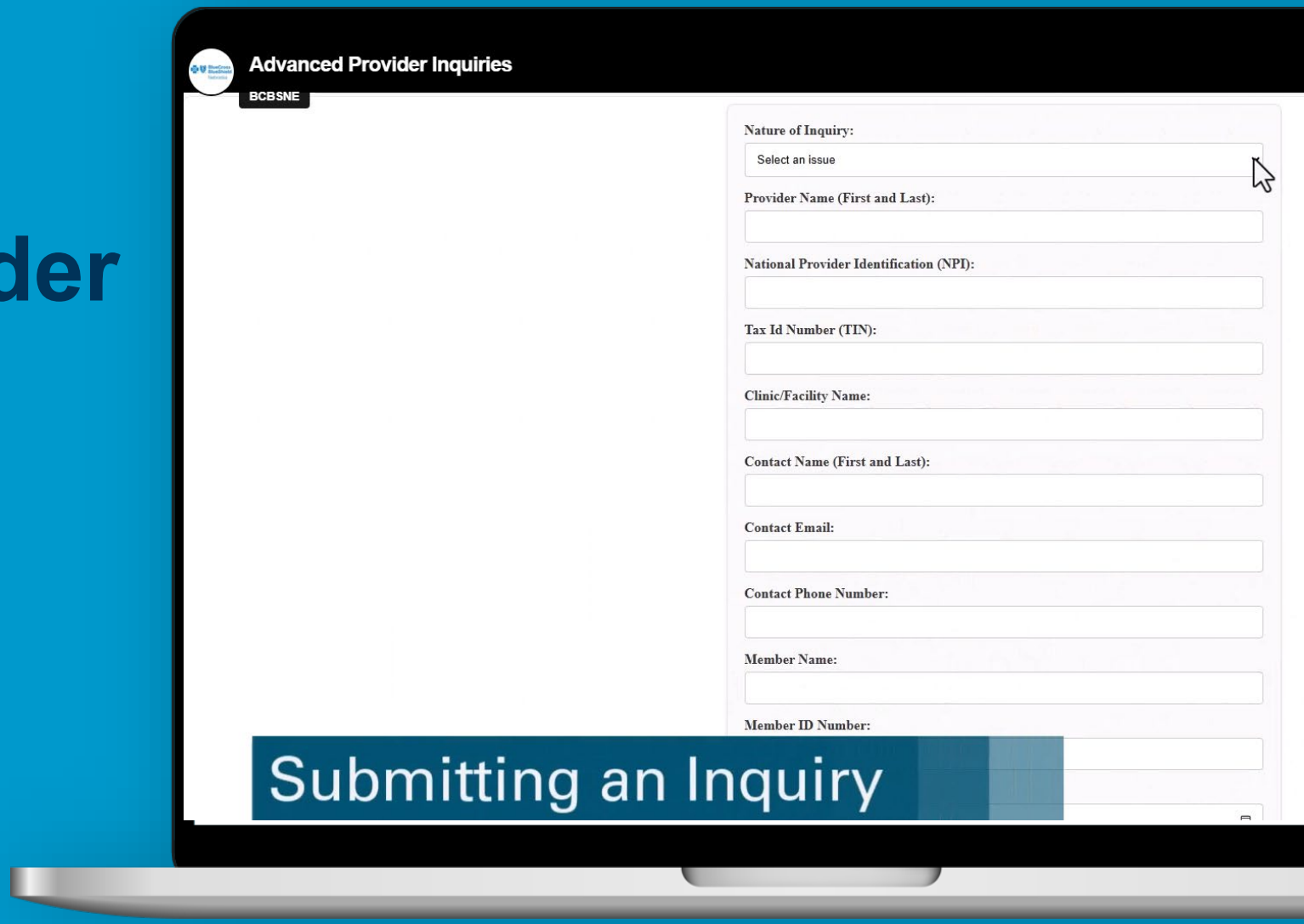
Communication and Engagement

PRESENTERS: LORAINE MILLER, JENNIFER DREW AND KATRINA WULF

Advanced Provider Inquiry Tool

ENHANCING PROVIDER COMMUNICATION

This form via NaviNet® is designed to streamline the submission process by collecting all necessary information upfront, enabling the appropriate support team to address the inquiry efficiently and reducing the number of communications required.



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

Partnering for Wellness: Free Member Well-Being Programs

As trusted partners in care, we're proud to offer a variety of **no-cost well-being programs** to support the health of our members. These resources are designed to complement the care you provide and help address physical, emotional and social health needs.

By staying informed about these offerings, providers can:

- **Enhance patient outcomes** through holistic support
- **Connect members** to valuable tools and services
- **Strengthen our shared mission** to improve the health of the communities we serve

Together, we are champions for member well-being — **in the exam room and beyond.**

Disclaimer: *Please note that not all employer groups have opted into these well-being programs. Availability may vary based on the member's specific benefit plan. We encourage providers to verify eligibility before recommending services..*

VIRTA PROGRAM BENEFITS

- Program managing type 2 diabetes
- Root-Cause Approach
- Physician-Led Remote Care
- Sustainable Behavior Change
- Collaborative Care
- Proven Outcomes
- Time-Saving Support

Disclaimer:

Virta is an independent company that provides diabetes management services to Blue Cross and Blue Shield of Nebraska. Availability may vary by plan

TELESCOPE HEALTH

- Enhancing the telehealth experience for both patients and providers.
- Seamless Care Coordination
- Reduced Workload
- Improved Patient Outcomes
- Access to Specialized Expertise
- Efficient Resource Use
- Higher Patient Satisfaction

Disclaimer:

Telescope Health is an independent company providing telehealth services to BCBSNE members. Availability may vary by plan

STAY INFORMED

Keep an eye on the **Happening Now** section on NebraskaBlue.com for the latest updates on our free member well-being programs. New resources and opportunities are added regularly to support your patients and practice.

Provider Partnerships

PARTNERSHIPS ADVOCATE

Serve as a liaison between the health plan and providers

Understanding of value-based care initiatives and quality improvement programs

Support providers with tools, data and resources to enhance patient care

Offer educational opportunities (such as webinars and seminars) to support process improvement and guide accuracy

Promote mutual goals such as reducing costs and improving quality and member satisfaction

PARTNERSHIPS NETWORK EXECUTIVE

Support contract negotiations by fostering alignment of goals among hospitals, physicians and health care partners

Stay aligned to market trends, community needs and provider strengths to support a resilient, high-performing network

Support strategic initiatives to achieve alignment whenever possible

Foster open, transparent communication with hospital leadership to build trust and foster collaboration

Monitor evolving conditions and partner priorities to maintain strong, collaborative relationships

Provider Communications

Content Development and Communication
Support creation of website content, bulletins and newsletters
Tailored messaging for both Commercial and Medicare Advantage (MA) audiences

Content Accuracy and Timeliness
Collaborate with content owners to review and update provider procedures
Ensure timely updates are reflected across platforms

Website Management
Maintain NebraskaBlue.com
Manage real-time updates to the Happening Now section

Provider Education & Outreach
Facilitate training sessions and educational events
Strengthen engagement with the provider community

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Claims and Reimbursement

PRESENTERS: PROVIDER ADVOCATES – JESSICA BAILEY, KATHERINE VRBKA & TAWNY ARCHER

OB/Maternity Reimbursement

Global vs. Non-Global Service

Global maternity services include antepartum care, delivery and postpartum care. The total global service is submitted after delivery with the delivery date as the date of service.

Non-global maternity services are payable as separate services outside of the total global service.

Transfer of care

Billing requirements vary based on the type of transfer:

- Permanent Transfer Between Practitioners (Different TINs)
  - Initial physician bills partial OB care for services prior to delivery.
  - **Paper Claims:** Note transfer below the last item charge.
  - **Electronic Claims:** Note the transfer in the available narrative field.

  Please indicate the name of the physician who will be assuming care for the patient.
- TOC between practitioners under the same TIN
  - Only **one global OB claim** is accepted.
  - If another provider under a **different TIN** renders services (e.g., delivery only), they must bill **partial OB care** separately.
- OB provider changes TIN
  - If the same provider continues care under a **new TIN**, treat as a **TOC**.
  - Follow **partial OB billing** guidelines.
- Member changes insurance carriers
  - Bill **partial OB** or **global OB care** based on services rendered during each coverage period.

Online Procedure

You can access the OB/Maternity Service Guidelines procedure at any time on NebraskaBlue.com

Anesthesia Reimbursement

Billing Time-Based Anesthesia Services

Anesthesia time begins with the administration of anesthesia and ends when the patient is released to recovery

Bill total minutes only in the units field (e.g., 45 minutes = 45 units).

Do not include calculated time units or start/stop times on the claim.

Time units are calculated by BCBSNE's system using:

Base units (assigned per CPT code via ASA guidelines)

+ Time units (1 unit = every 15 minutes)

Important Reminders

OB anesthesia and some other codes are reimbursed at a **flat rate** (no time units)

Duplicate billing: Only one anesthesia code reimbursed per patient per day unless MD and CRNA bill together with appropriate modifiers

Standby anesthesia is not covered

Physical status and qualifying circumstance modifiers do **not** affect reimbursement

Online Procedure

You can access the Anesthesia Guidelines procedure at any time on NebraskaBlue.com

Common MA Claims Denial Trends

Modifier Usage – Know the Indicators

WHAT WE'RE SEEING:

Claims denied due to **invalid use of LT, RT or 50 modifiers**

These modifiers are being applied to codes where **bilateral indicators** do not support them

HELPFUL TIPS:

Refer to the **CMS Physician Fee Schedule**

If the bilateral indicator is **0, 2 or 9, do not append** a bilateral modifier

Incorrect use prevents our system from applying correct pricing

DME Billing – Use the Right Taxonomy

WHAT WE'RE SEEING:

Denials when DME items are billed under a non-DME taxonomy

HELPFUL TIPS:

Bill DME items using a **DME-specific taxonomy**

This ensures correct **MUEs and rates** are applied

DME should be billed as **Provider Type: Supplier**

WHY THIS MATTERS?

These issues are leading to high volumes of reconsiderations

Addressing them proactively can:

- Reduce administrative work
- Improve claim accuracy
- Speed up resolution times

FUTURE UPDATES

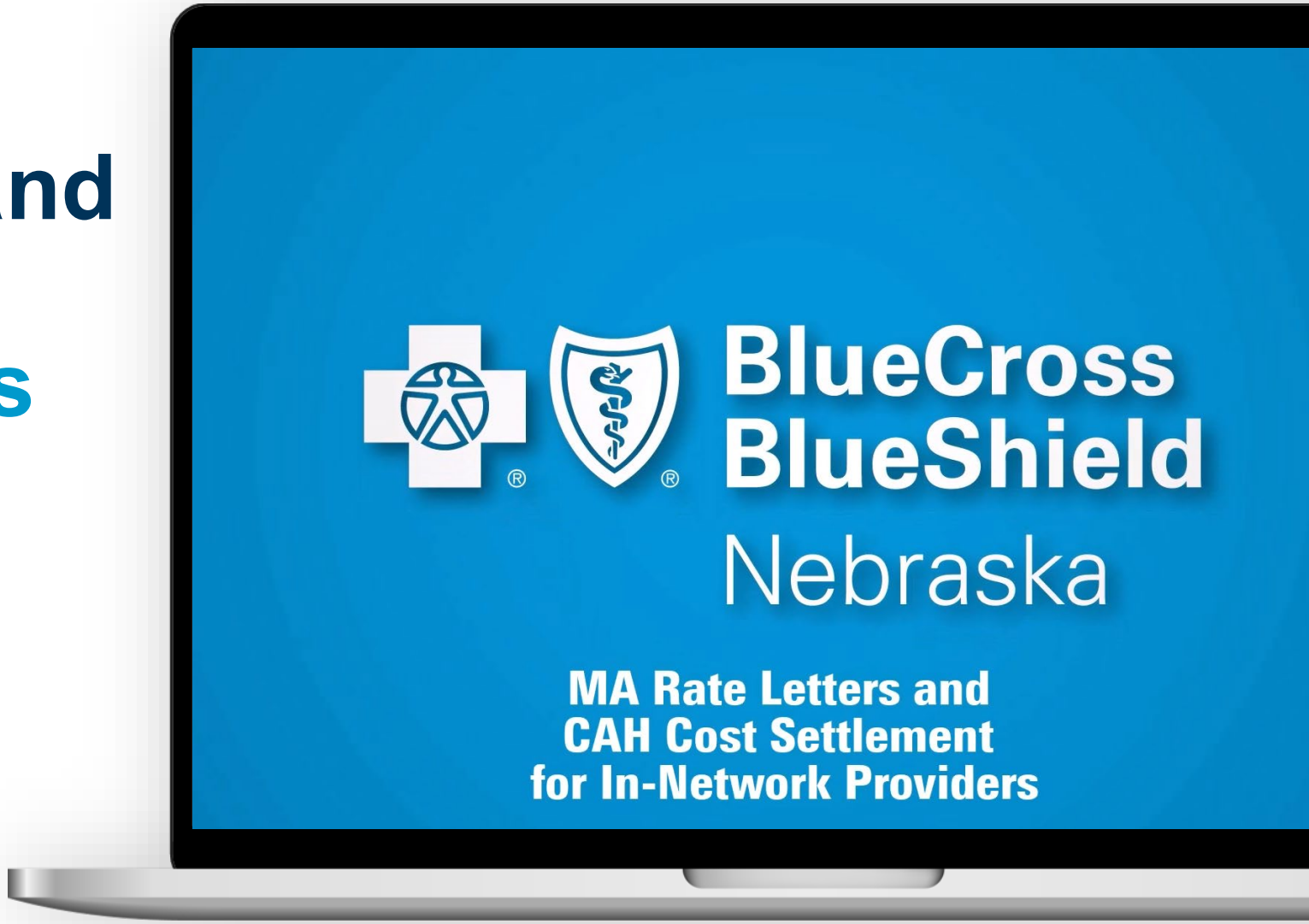
Check Happening Now often to stay informed on any future denial trends

Disclaimer: Please note that this summit is intended for educational and informational purposes only. We will not be discussing individual provider rates or contract terms during this event.

MA Rate Letters and Cost Settlements for Critical Access Hospitals

ACCESS TO TRAININGS

You can access this eLearning and the Provider Procedure anytime on NebraskaBlue.com, whenever it's most convenient for you



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Appeals and Medical Management

PRESENTER: RENEE BEACOM

Differences of Appeal and Reconsideration

WHY IS IT IMPORTANT?
Understanding the difference between submitting an appeal versus a reconsideration is key to ensuring your requests are handled efficiently and accurately. Using the correct process from the start can help:

- **Faster resolution times**
- **Reduce unnecessary administrative follow-up**
- **Preserve your limited appeal opportunities by avoiding misdirected submissions**

By choosing the right path the first time, you support smoother workflows, reduce delays and help ensure better outcomes for both your organization and your patients.

Appeal

What is an Appeal?
A formal request to review a denied claim/service due to medical reasons (e.g., medical necessity, preauthorization).

How to submit?
Via NaviNet the process is now streamlined — just select the appropriate Type, and the system will handle the rest

Common Reasons
- Medical necessity denials
- Investigational denials
- Experimental denials
- Medical Policy denials

FYI: Timely Filing denials should be disputed using the Timely Filing Override Request via NaviNet

VS

Reconsideration

What is a Recon?
A request to review a processed claim with new or corrected information not previously submitted.

How to submit?
Via NaviNet the process is now streamlined—just select the appropriate Type, and the system will handle the rest

Common Reasons
- Copy of Medical Records
- Coordination of Benefits denials Worker's Compensation denials
- Pricing issues
- Billing/coding Dispute

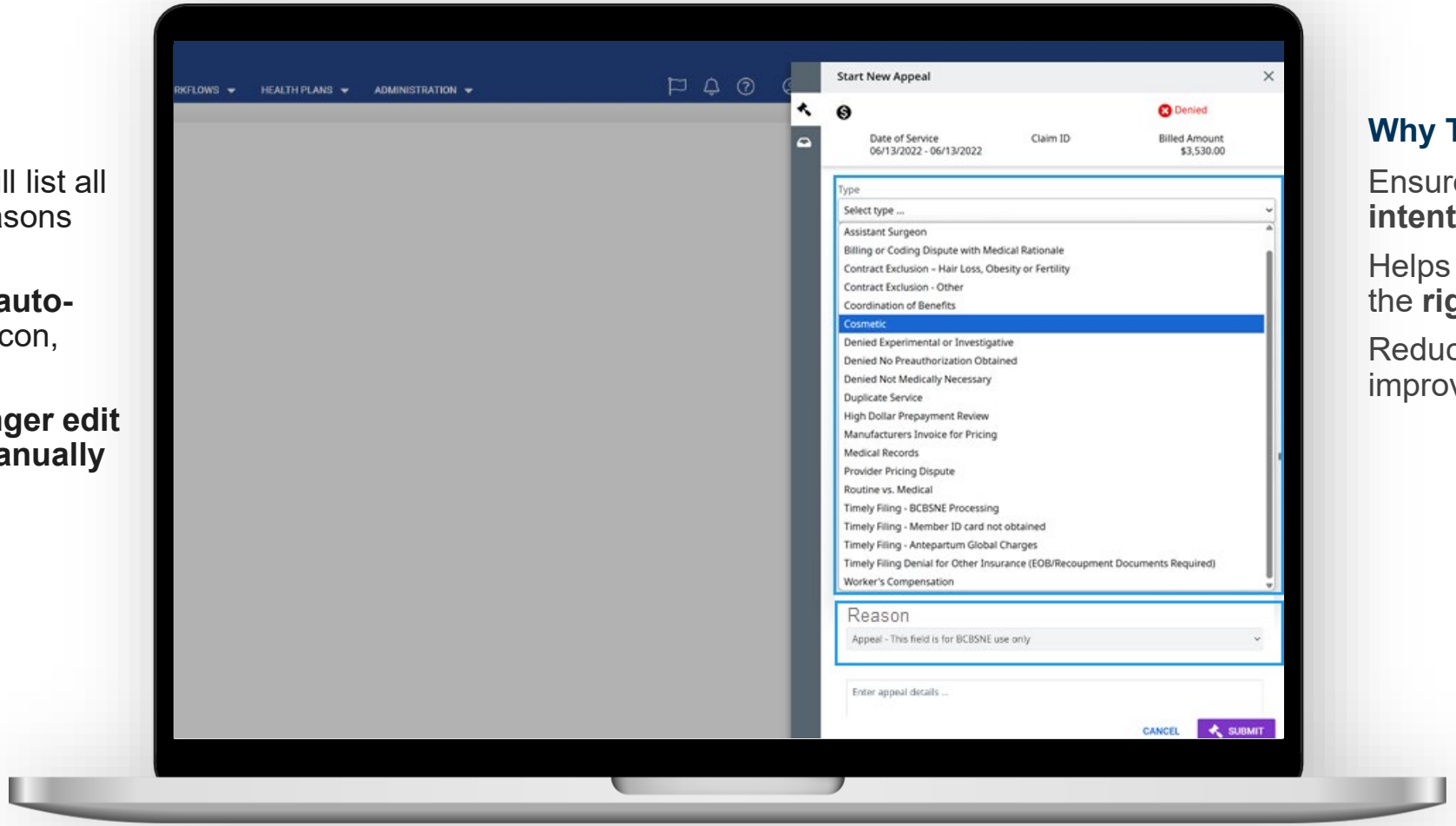
Simplifying NaviNet
Claims Appeal/Recon Submissions

What Changed?

New "Type" field will list all available dispute reasons

Once selected, the **"Reason" field auto-fills** (e.g., appeal, recon, timely filing)

Providers will **no longer edit the Reason field manually**



Why This Matters?

Ensures **clearer intent** behind each dispute

Helps route appeals to the **right team faster**

Reduces errors and improves processing time

Reimagining Preauthorization

November 2024 – Provider Feedback

We engaged providers statewide — from metro hospitals to rural clinics — to gather input on our preauthorization process.

- Strengths acknowledged
- Key areas for improvement identified

January 2025 – Statewide Collaboration on LB77

- Nebraska Hospital Association
- Nebraska Medical Association
- Senator Eliot Bostar

PROCEDURE UPDATES

ENHANCING EFFICIENCY

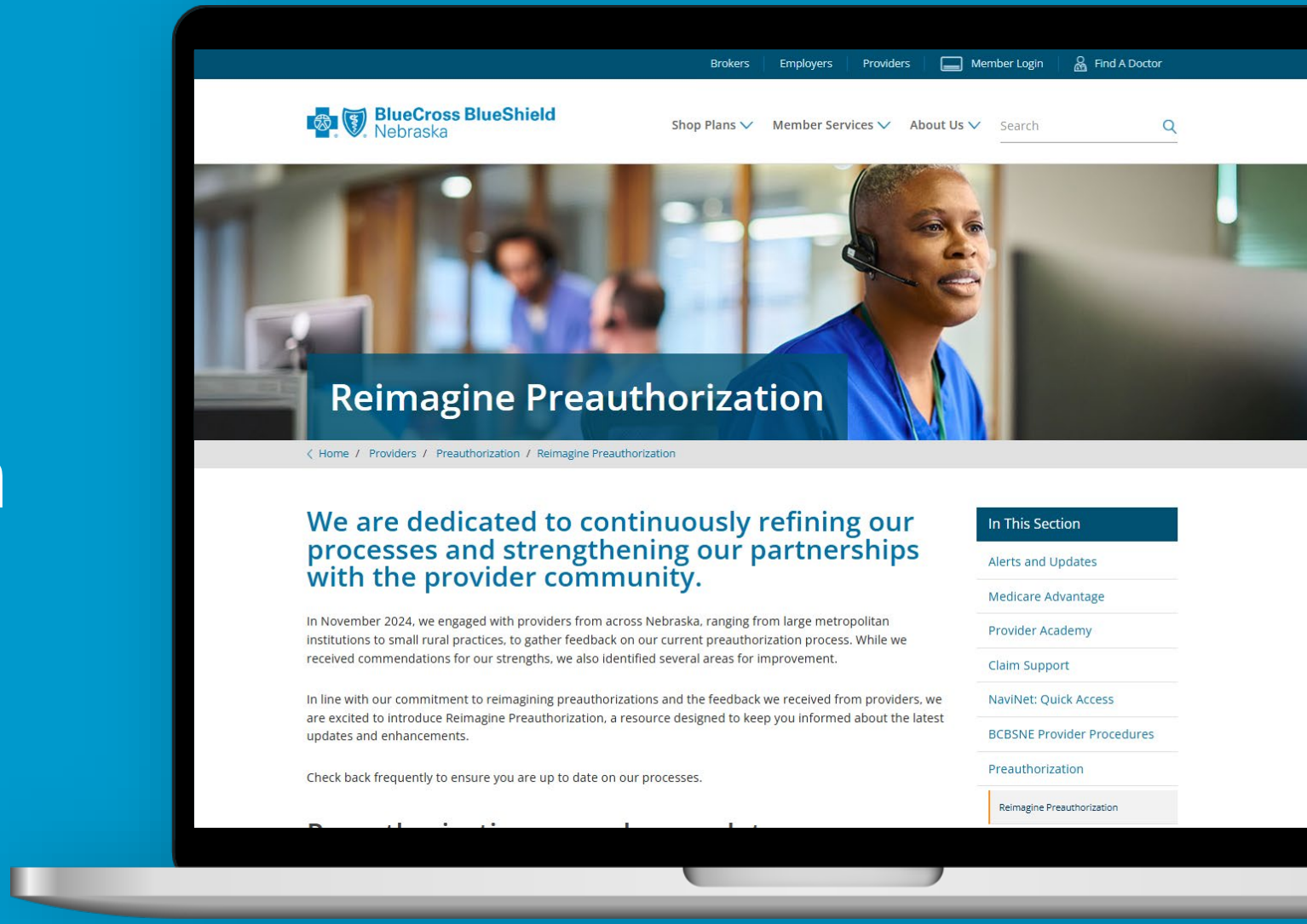
STATEWIDE COLLABORATION

FAX LINE RETIREMENT

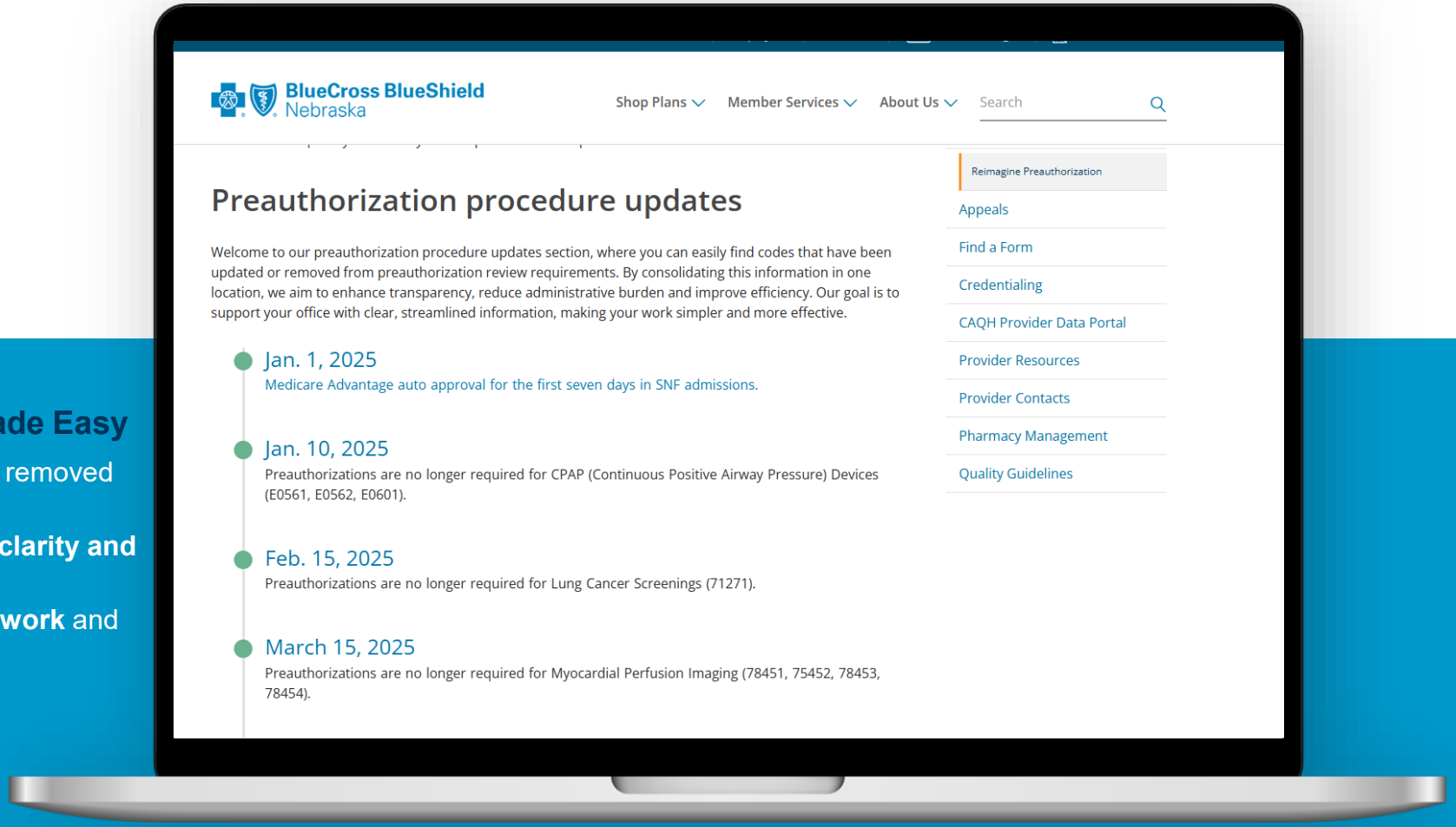
Reimagining Preauthorization

ONE CENTRALIZED LOCATION

Our new Reimagine Preauthorization page will keep you updated on how we're improving our preauthorization processes. Check back often to stay informed on the changes that matter most to you.



Preauthorization procedure updates



Procedure Updates Made Easy

Quickly find codes added or removed from review

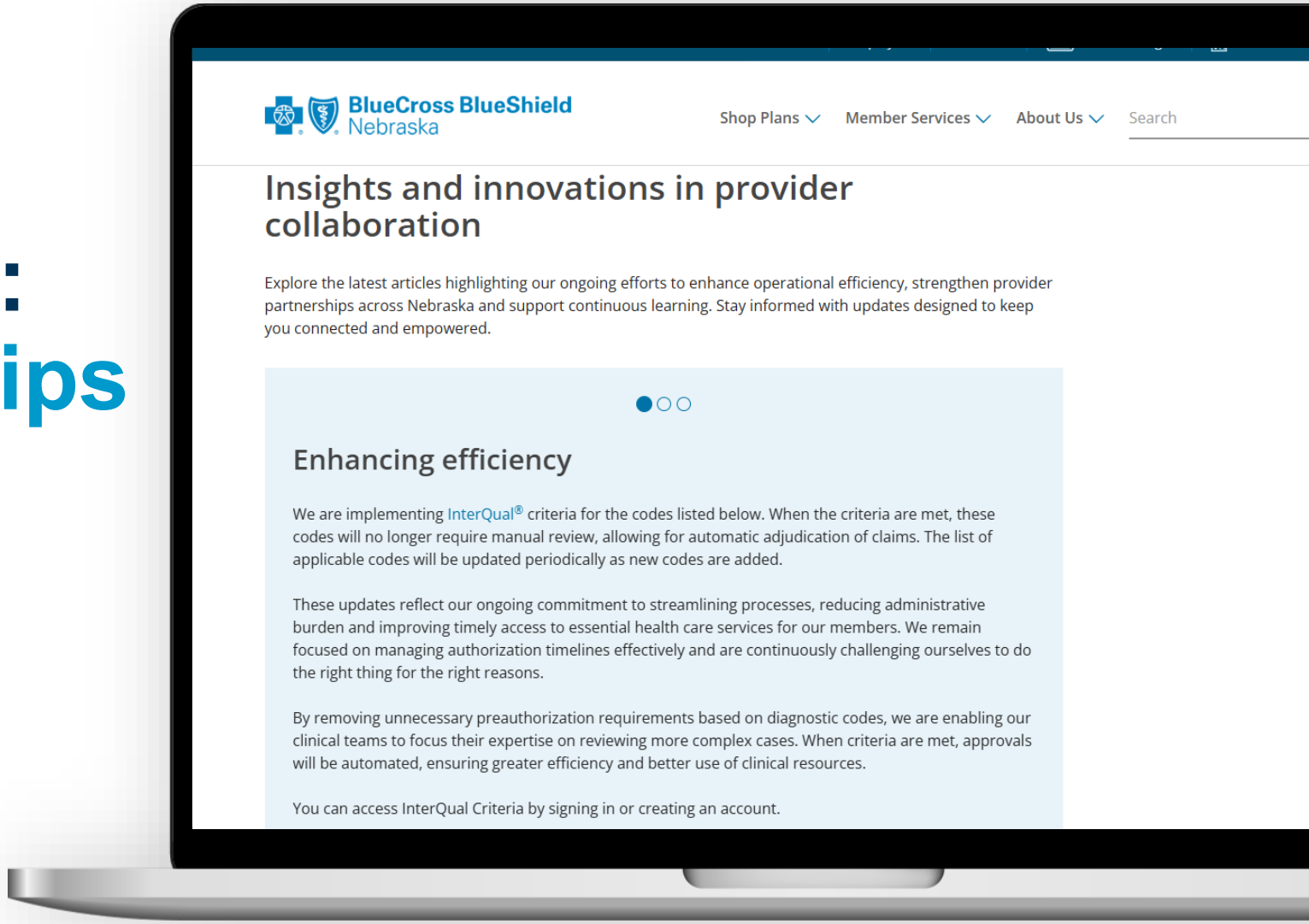
All updates in one place for **clarity and efficiency**

Designed to **reduce admin work** and support your office

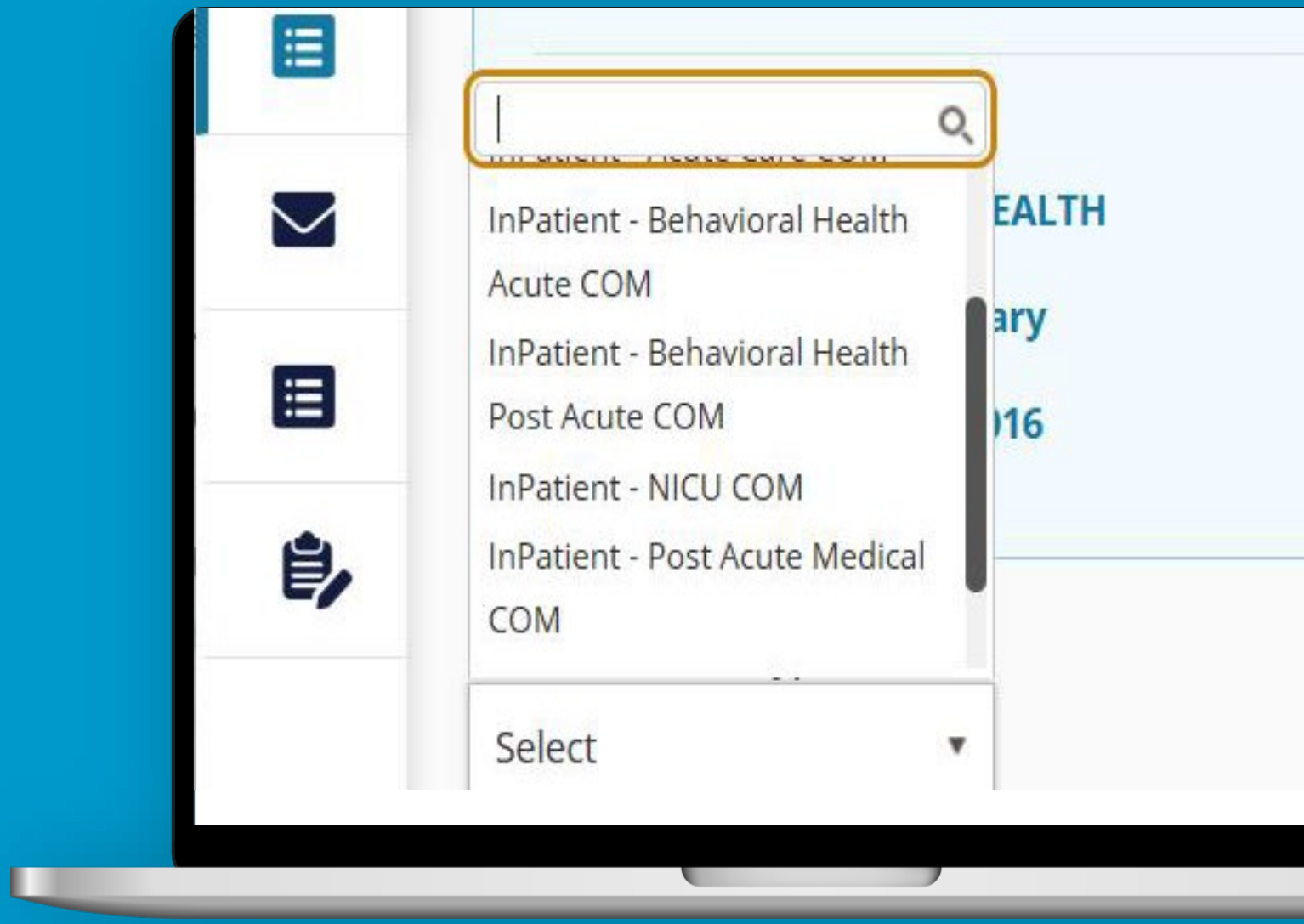
Staying Connected: Insights, Partnerships and Progress

LATEST ARTICLES

Enhancing efficiency with InterQual



Coming This Fall: Enhanced Preauthorization Experience on NaviNet



WHAT'S NEW?

More Options, Less Hassle: Submit preauthorizations with expanded authorization types, including lower levels of care and behavioral health settings

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Risk and Quality/VBC

PRESENTER: ERIN KUHR AND CHRISTY COLLIERS

Value-Based Care

Our value-based programs emphasize quality and efficiency, which leads to better health outcomes and member experiences. We **partner** locally with **primary care physicians** to help coordinate care, keep quality high and costs low.

- Shift from **volume-based** care model to **value-based** care model
- Aligns provider **incentives** with **patient outcomes**
- **Promotes** innovation in care delivery

- Encourages **integrated care**, addressing physical, mental, behavioral and social needs.
- Considers an individual's **personal health goals**.

Working Together in Value-Based Care

SHARED GOALS AND OUTCOMES

- ✓ Focus on preventive care and management of chronic conditions
- ✓ Better access to care and member experience
- ✓ Shared financial responsibility to ensuring affordability for our members

TRANSPARENCY AND COLLABORATION

- ✓ **Share Data and Analytics of Attributed Members**
- ✓ Provide support with case management and care coordination activities with **BCBSNE** teams
- ✓ Meet Frequently to review program performance
- ✓ Share best practices and provide education

SHARED ACCOUNTABILITY

- ✓ Provide options to meet providers at different levels of readiness to effectively manage risk
- ✓ Incentivize care transformation, efficiency and high-quality care

Improve Health Outcomes

Use predictive analytics for earlier intervention and treatment

Reduce Healthcare Costs

Eliminate waste, inefficiencies and conflicting medications

Improve Member and Provider Experiences

Cohesive approach ensuring patient care is coordinated to eliminate unnecessary treatments, duplicative exams or procedures and focus on continuity of care

Value-Based Care Focus Areas

PREVENTIVE MEASURES	GAP CLOSURE	CARE MANAGEMENT	COST AND UTILIZATION MANAGEMENT
Annual Wellness Visits	Avoidance of Antibiotic treatment for Acute Bronchitis	Asthma	Acute Hospital Utilization
Breast Cancer Screening	Controlling High Blood Pressure	Cancer Diagnosis	Discharge Follow-up
Cervical Cancer Screening	Eye Exam for Patients with Diabetes	Chronic Obstructive Pulmonary Disease (COPD)	Emergency Department Utilization
Colorectal Cancer Screening	Hemoglobin A1C Control for Patients with Diabetes	Congestive Heart Failure (CHF)	Financial Trend
Immunizations	Kidney Health Evaluation for Patients with Diabetes	Depression	Hospital-Wide, 30-day, All-Cause Unplanned Readmission*
		Diabetes	

Value-Based Care Program Offerings

PROGRAM	ELIGIBLE POPULATION	INCENTIVE LEVEL	FOCUS AREAS
Accountable Care Organization (ACO)	Commercial and ACA	Upside/Shared Savings Downside/Shared Savings & Loss	Healthcare Cost Trends Utilization Management Preventive Measures Chronic Condition Management Care Gap Closure (Quality Measures)
Patient Centered Medicare Home (PCMH)	Commercial and ACA	Quality Bonus	Utilization Management Preventive Measures Chronic Condition Management Care Gap Closure (Quality Measures)
Provider Excellence Program	Medicare Advantage	Quality Bonus	Utilization Management Preventive Measures Chronic Condition Management Care Gap Closure (Quality Measures)
Chronic Condition Revalidation Incentive	Medicare Advantage	Quality Bonus	Chronic Condition Management

For further inquiries regarding our VBC program, please contact us at
VBPQuestions@NebraskaBlue.com

Accountable Care Organization (ACO)

To improve the health of BCBSNE members by partnering with providers to align the ACO's high-quality, cost-effective care with BCBSNE's health plan expertise — working together through a shared accountability model.

PROGRAM STRUCTURE

BCBSNE offers flexible shared savings and risk arrangements tailored to each providers readiness to manage financial risk.

ACOs can earn shared savings by meeting financial and quality targets – or share in losses if targets are not met, promoting accountability for both cost and high-quality care.

MEMBER ATTRIBUTION

Members are attributed to providers based on their claim utilization patterns. This approach establishes clear provider accountability for care delivery, efficiency and total cost of care.

TARGET GOALS

The incentive structure is designed to incentivize care transformation, promote efficiency and support long-term delivery of safe, high-quality care with strong patient outcomes.

CARE COORDINATION SUPPORT

To support enhanced care delivery — particularly for patients with chronic conditions — ACOs receive quarterly care coordination payments to invest in the infrastructure and systems needed for effective care management.

Patient Centered Medical Home (PCMH)

The goal of this program is to transform how primary care is delivered by placing patients at the center of care — emphasizing coordinated, comprehensive, and accessible services that improve outcomes and enhance the patient experience.

PROGRAM STRUCTURE

Providers who prioritize high-quality care and clinical engagement are eligible to earn a quality bonus by meeting established performance targets.

MEMBER ATTRIBUTION

Members are attributed to providers based on their claim utilization patterns. This approach establishes clear provider accountability for care delivery, efficiency and total cost of care.

TARGET GOALS

The incentive structure reinforces a shared commitment to delivering high-value, patient-centered care.

CARE COORDINATION SUPPORT

BCBSNE supports primary care practices with care coordination payments to help invest in the infrastructure and systems needed to enhance care delivery.

Provider Excellence Program

By closely collaborating with our provider partners, we aim to achieve better outcomes — driving positive clinical results and improving performance on key quality measures, including HEDIS® and CMS STAR ratings.

PROGRAM STRUCTURE

Rewards participating providers for managing their attributed members by encouraging preventive care and closing quality care gaps.

POPULATION – QUALIFYING MEMBERS

The incentive is based on attributed Medicare Advantage population, who have open care gaps.

TARGET GOALS

The incentive structure allows for increased financial opportunity based on overall care gap closures.

A FOCUS ON MEMBER OUTCOMES

An additional incentive is rewarded if an entity's final measure rate meets or exceeds the High-Performing Provider rate in any measure.

INCENTIVE TIMING

Incentive payments will be distributed in the 2nd quarter of the subsequent year.

Chronic Condition Revalidation

The goal of this program is to ensure all chronic conditions are assessed and accurately documented annually.

PROGRAM STRUCTURE

BCBSNE will award a per member per year (PMPY) incentive for improvement in the revalidation rate from an providers 2024 benchmark year to the 2025 measurement year for qualifying members.

POPULATION – QUALIFYING MEMBERS

The incentive is based on attributed Medicare Advantage population, who have a qualifying chronic condition in previous years.

TARGET GOALS

The incentive structure allows for increased financial opportunity based on your overall revalidation rate.

INCENTIVE TIMING

Incentive payments will be distributed in the 2nd quarter of the subsequent year.

A FOCUS ON MEMBER OUTCOMES

This Revalidation Program Incentive is in addition to our Provider Excellence Program (PEP).

Closing the Gaps: Recapture Chronic Conditions

- Documentation and coding **must** be updated at **least** annually to maintain accurate representation of each patient's true burden of illness.
- Every year on **Jan. 1** each patient's risk score is reset to the **base** risk score **omitting** the disease factors and reflecting **only** the demographic factors.
- All existing conditions **must** be reported again in the current calendar year to count towards the risk score.

Risk Adjustment Provider Education

RISK ADJUSTMENT

- Risk Adjustment 101
- Documentation Overview
- Coding Overview

ANNUAL WELLNESS VISITS AND EXAMS

- Workflow packet
  - Types of visits
  - Appt. scheduling
  - Scheduling scripts
  - Team roles
  - Exam checklists
  - Coding and billing guides

CONDITION SPECIFIC

- Acute MI
- Asthma
- Atrial Flutter
- Cancer
- CVAs
- COPD
- CKD
- CHF
- DVT/PE
- Diabetes
- Eating Disorders
- Hypoglycemia
- Obesity
- SUD
- Schizophrenia
- Seizure Disorders

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Medicare Advantage

PRESENTER: ERIN KUHR AND JACOB NYSSON

Medicare Advantage RADV Changes

- Accelerated audit time-frame
- PY 2018 – PY 2024*
- Completed by early 2026

*DOS 2017-2023

ENHANCED TECHNOLOGY

- CMS will deploy advanced systems to efficiently review medical records and flag unsupported diagnoses

WORKFORCE EXPANSION

- CMS will increase its team of medical coders from 60 to approximately 2,000 by Sept. 1, 2025
- These coders will manually verify flagged diagnoses to ensure accuracy

INCREASE AUDIT VOLUME

- CMS will increase from ~ 60 MA plans to ALL eligible MA plans each year
- Increase from auditing 35 record per plan to 35-200 records per plan
- Condensed time to gather audit materials

Medicare Advantage RADV Changes

Impact on Providers

Medical Record Retrieval

- Potential increase in medical record requests
- Condensed time frame for medical record submission
- More persistent follow – up for records

Documentation and Coding Oversight

- Increase in BCBSNE led audits
- Increase in provider education and guidance

How To Help…

Medical Record Retrieval

- Review requests for deadlines
- Prioritize URGENT requests

Documentation and Coding Oversight

- Encourage patient to participate in annual visits and exams
- Assess and treat all conditions impacting the patient's health status concurrently
- Document and code to the highest supported specificity

Behind the Benefits:
Medicare Advantage 101

- Extra Benefits Included
  - Vision, dental, hearing and wellness programs
- Cost Savings
  - Lower out-of-pocket costs
  - $0 premium options available
  - Prescription Drug Coverage
- Often includes Part D
  - More cost-effective than separate Part D plans
- Coordinated Care
  - Nurse case management
  - Better healthcare service management and outcomes
- Simplified Coverage
  - Bundles Part A, B, and often D
  - Easier for members to manage
- High Standards of Coverage
  - Must meet or exceed Original Medicare standards
  - Copays replace 20% coinsurance
- Whole-Person Approach
  - Integrated view of member's health (Part C + Part D)

FYI: Due to time constraints, we may not be able to address every question or comment during the live session.

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Thank You for Your Partnership

We sincerely appreciate the opportunity to work alongside you.
Your **dedication, collaboration, and commitment** to quality care make a meaningful difference — for us, for our shared processes and, most importantly, for the patients we serve together.

Here's to continued partnership and progress.