The update provider newsletter contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for healthcare providers throughout Nebraska to continually communicate with those who contract with us.

If you are a BCBSNE Participating, BlueClassic and/or BluePreferred healthcare provider, this newsletter serves as an amendment to your agreement with us. Therefore, it is your responsibility to comprehend and act upon all information that affects your contractual relationship with BCBSNE.

You are encouraged to file every issue of the update within your BCBSNE Policies and Procedures manual.

As a service for BCBS members we also send this newsletter to non-participating Nebraska providers.

We also publish each issue online at:

www.bcbsne.com/update

For permission to reprint material published in the update, e-mail the editor Marian Gramlich at:

marian.gramlich@bcbsne.com

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**PAs/APRN/CNMWs – Be Advised!**

In the February 2006 Update newsletter, Blue Cross and Blue Shield of Nebraska (BCBSNE) announced June 1, 2006 as the deadline for mid-level practitioners (Physician Assistants, Advanced Practice Registered Nurses and Certified Nurse Midwives) to be credentialed and begin billing under their individual BCBSNE provider ID number.

**Please pay special attention to the following guidelines:**

- If you have submitted your application and have received a letter advising you of your acceptance in the BCBSNE provider network(s), you should already be filing your claims under your name and ID number.

- If your application has been received and is in process, continue billing your services under your supervising physician until you receive written notification from BCBSNE of your acceptance as a network provider.

- If you have been notified by our credentialing staff that your application is incomplete, it is your responsibility to provide the necessary information within a timely manner. Be aware that the credentialing process cannot continue when required information is missing. Failure to submit a complete application or respond to our inquiries will result in your application being withdrawn from processing and returned to your office.

- Mid-level providers who have not been credentialed because their application has been returned or has not been submitted should not provide services to BCBS members unless they have informed the member in advance of their non-network status. Should the member choose to proceed with receiving care from the out-of-network midlevel practitioner, the claim must be submitted under the mid-level as the provider of service. Do not submit the services under the supervising physician.

If you are in need of an application packet, please contact Jill Nolan at 1-800-821-4787 (option 2,2). Should you have any questions, please contact your Health Network Consultant. HNS
**TriCare Staff Changes**

Ruth Gahan, RN, BSN, CMAS was named TriCare Regional Consultant and replaced Norma Sterba, who retired from Blue Cross and Blue Shield of Nebraska (BCBSNE) on December 31, 2005. For the last nine years Ruth has been employed at BCBSNE as a Hospital Bill Audit Specialist and for the last 18 years she has been active in the local and national Bill Audit associations. In addition Ruth previously worked at local hospitals as a registered nurse and as a nurse auditor. Currently Ruth serves as President of the American Association of Medical Audit Specialists.

Ruth is looking forward to working with each of you and may be contacted by telephone at 343-3517 in Omaha or 800-821-4787 (option 1,5) outside of Omaha, by fax at 402-343-3451, or by email at ruth.gahan@bcbsne.com. **HNS**

**Sliding Fee Scale**

BCBSNE providers must be consistent in the amount they charge for their services. If you utilize a sliding fee scale for your disadvantaged clients, you must also apply this sliding fee scale to your BCBS covered members and bill that amount to BCBSNE. **HNS**

**Trauma Code Edits**

BCBSNE has identified specific ICD-9 diagnosis codes as trauma codes. When submitting a claim with a diagnosis from the codes below, additional information is needed to properly process the claim.

**UB-92:** Form locators 32 (Occurrence Code and Date) and 77 (E-code) must be completed. Because of space limitation, you may not have an E code for every trauma code, but there should be at least one E code on the claim if there are trauma codes listed on the UB-92.

**CMS (HCFA) 1500:** Box 10 must be completed. Please keep in mind when the claim contains an accident date and indicator, the primary diagnosis code must be from the list below.

**Trauma Codes**

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**FEP Risk Alert Pharmacy Program**

BCBS Federal Employee Program (FEP) will implement a program called Pharmacy Risk Alert Program for FEP members in Nebraska. Utilization Review Pharmacy Management is an ongoing computer-based review of prescription drug claims that identifies patients whose drug therapy may be sub-optimal, because of inappropriate drug, possible drug interactions, poor adherence, etc. When patients are identified, a drug history profile is printed out for review by a clinical pharmacist.

Cases that are validated by a clinical pharmacist will result in an advisory letter to the prescribing physician. This letter will describe the clinical issue and offer alternative drug suggestions to the physician. The letter clearly states that FEP is not fully aware of the patient’s condition and that the suggestion is purely advisory.

The letter requests physicians to either send a written response to or call the sender of the letter. BCBSNE would appreciate physician’s responses to the letter; however, physicians are not required to take any action in response to the letter. **HNS**

**Get With The Guidelines**

On April 5, 2006, Blue Cross and Blue Shield of Nebraska continued its partnership with the American Heart Association’s “Get With The Guidelines” (GWTG) program at the “Getting Started” Workshop in Grand Island. This professional education was offered to assist hospital providers with increasing compliance with AHA’s guidelines, and impacting care provided in sites across the state. Approximately 60 people attended this event. To date, GWTG has eight Nebraska hospitals implementing 12 modules (sites may implement improvements in HF, CAD, Stroke, or any combination of these). **HNS**
TriCare News:

Adding Areas of Interest
TriCare is in the process of adding Areas of Interest to the provider file. The Areas of Interest information provides an opportunity for the provider to indicate a particular practice interest or sub specialty within their scope of practice. This information is designed to guide the TriCare beneficiary to the appropriate practitioners. Currently we are collecting data for Ophthalmology, Dermatology, Orthopedics and Behavioral Health.

Expanding Network
TriCare has requested that we expand our network to provide services for the families of our Reservists and Guardsman while they are deployed, as well as coverage for the serviceman and family members upon return from their tour of duty. We will be contacting providers to ask if they would consider becoming a contracted TriCare Network Provider. If you are interested or would like additional information please contact Ruth Gahan at 343-3517 or 800-821-4787 (option 1,5) and she will assist you in this process. HNS

Don’t forget!
TriCare Provider Seminars
Omaha
Tuesday, June 6
Wednesday, June 7
Lincoln
Thursday, June 8
Register via the web at TriWest.com

NACO Drug Benefit Changes
The Nebraska Association of County Officials (NACO) will implement a number of changes to its current drug benefit, effective July 1, 2006. The Proton Pump Inhibitor PA program is designed to promote cost-effective care for NACO members in the PPI class.

Pre-authorization programs typically target drugs that may be unnecessary and costly for the vast majority of patients. Pre-authorization of drugs is a tool that helps ensure patients have coverage for the most effective and safest drugs, while managing the cost of more expensive agents with no additional benefit.

BCBSNE uses a clinical team of physicians and pharmacists to identify those medications appropriate for pre-authorization programs. Patients medical and pharmacy claims are reviewed for clinical evidence of appropriate use. Additionally, physicians may submit a PA form for patients who may be eligible based on medical necessity.

Criteria that are used for all pre-authorization programs, as well as further instructions, are available as downloadable forms by clicking on Electronic Forms on our provider website: www.bcbsneprovider.com. HNS

Don’t Forget to Apply for Your NPI!!
Beginning May 23, 2007, Providers must use their National Provider Identifier (“NPI”) for all electronic HIPAA transactions as the sole means to identify a provider of service. Providers can apply for their NPI now! This includes individual providers that are assigned one NPI (e.g., Physicians, nurse practitioners, chiropractors), as well as Organizations (e.g., Hospitals, clinics, labs) who may have multiple NPIs for each subpart (e.g., urgent care, lab, pharmacy). BCBSNE cannot apply for an NPI for you! BCBSNE is dedicated to implement NPI successfully. This includes processing your transactions, responding to your inquiries, and appropriately paying your claims in an efficient, quality manner. In order to achieve this, you must apply for an NPI and communicate with us. In the coming months, we will be reaching out to gather your NPI information.

NPIs will be assigned by the National Plan and Provider Enumeration System (“NPPES”) used by CMS. NPPES will validate your application data to ensure accuracy and authorization. The following is how you can apply for an NPI number:

Please see “Apply for Your NPI” on page 5.
Is Your Provider Data Current?

Our ability to successfully direct Blue Plan members to you depends on the accuracy of the information that you provide us about you and your office/facility.

To keep information about our network providers up-to-date and accurate, a vendor will contact a randomly selected list of providers each quarter to verify some of the following information:

- Provider’s name
- Provider’s specialty
- Provider’s address
- Telephone number for scheduling an appointment

The company will verify this information with your front office staff, and will notify us of any differences in what you tell them and what we report in our Provider Directories.

Please do not wait until you receive a call to update your provider data! Be sure to report any changes to Jill Nolan via e-mail (jill.nolan@bcbsne.com) or fax (402-343-3455).

When reporting changes, please include your tax identification number and/or BCBSNE assigned provider number.

Don’t forget to let us know if a provider is no longer scheduling patients at a published location, i.e., changed locations, retired, covering only, etc.

We appreciate your help in making sure that the information we publish about you and your practice is accurate. Go to http://www.bcbsne.com/Providerdirectory/default.asp to review your information on a regular basis.

Medical Record Project: Reduce Your BlueCard Claim Denials

In an effort to improve the efficiency and timeliness of BlueCard claims adjudication, Blue Cross Blue Shield of Nebraska has entered into a pilot project with Blue Plans in Minnesota, Iowa, North Dakota and South Dakota to test a new streamlined, standardized workflow process.

Ultimately, our goal is to:

- Reduce medical record requests by standardizing medical review processes between Blue Plans, whenever possible.
- Improve claims processing time when medical records are required by using fax communication as the primary mode of transmission between the provider and the Blue Plan.
- Reduce the number of claim denials and subsequent claim adjustments that occur because the requested medical rationale was not received in a timely manner.

Be sure to read the BlueCard Bulletin in the August 2006 update issue for more details about this effort!

Did you know?

- The Blue Brands are the most recognized in the health insurance industry, with a total of 38 Blue Cross and/or Blue Shield Plans in 50 states, including Puerto Rico and District of Columbia, and registered in 174 countries.
- Nearly one-in-three Americans (94.4 million) receive their health insurance through a Blue Cross and/or Blue Shield Plan. This marks an increase of 28.8 million customers in the last 10 years.
- 86.9% of Blue System customers are enrolled in a managed care product (PPO, POS, HMO).
- Blue Cross Blue Shield of Nebraska has over 123,000 enrolled members receiving services outside of Nebraska, and there are over 164,000 members who are enrolled with an out-of-state Blue Plan receiving services in Nebraska.
- 88% of all doctors and hospitals throughout the U.S. contract with Blue Cross Blue Shield Plans. Outside of the U.S., Blue System customers have access to 5000+ credentialed international providers in more than 200 countries.

HNS
Special Provisions for Retired FEP Members without Medicare

A provision of the Omnibus Budget Reconciliation Acts (OBRA) of 1990 and 1993 applies the Medicare participation and payment rules and requirements to all retired individuals without Medicare who are covered under the BCBS Federal Employee Program (FEP). These payment rules include CMS-approved demonstration projects.

**OBRA affects FEP reimbursement when the patient:**
- is 65 years of age or older;
- does not have Medicare Part A, Part B, or both;
- has FEP as an annuitant or as a former spouse, OR is a family member of an annuitant or former spouse; and
- is not employed in a position that offers FEP coverage.

**Inpatient Reimbursement**
OBRA bases inpatient care reimbursement on an amount that is equivalent to Medicare’s payment amount. FEP members are NOT responsible for any charges greater than the Medicare equivalent amount. The law prohibits a hospital from collecting more than the Medicare equivalent amount. FEP members are responsible for applicable deductibles, coinsurance, and/or copayments.

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

If the physician participates with Medicare or accepts Medicare assignment and is in the BluePreferred network, the FEP member is responsible for:
- **Standard Option** – deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If the physician participates with Medicare or accepts Medicare assignment and is NOT in the BluePreferred network, the FEP member is responsible for:
- **Basic Option** – copayments and coinsurance.

If the physician does not participate with Medicare and is in the BluePreferred network, the FEP member is responsible for:
- **Standard Option** – deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If the physician does not participate with Medicare and is NOT in the BluePreferred network, the FEP member is responsible for:
- **Basic Option** – all charges.

If the physician does not participate with Medicare and is NOT in the BluePreferred network, the FEP member is responsible for:
- **Basic Option** – all charges.

More information can be found at http://new.cms.hhs.gov/NationalProvIdentStand. Again, BCBSNE cannot do this for you.

**“Apply for Your NPI” continued from page 3.**
- Call (800) 465-3203 or (800) 692-2326 (TTY) for a paper application
- Email customerservice@npienumerator.com to obtain a paper application
- Write to NPI Enumerator, P.O. Box 6059, Fargo, N.D. 58108-6059
- Apply through the web address https://nppes.cms.hhs.gov

Again, BCBSNE cannot do this for you.
Please contact your consultant for any questions you may have.
Notes from Provider Service:

Remember the Boy Scout Motto: “Be Prepared”

The scout motto is good advice and a good motto for everyone to follow, especially in business. In Provider Service at BCBSNE we continually evaluate how to prepare for your questions.

We realize you want accurate information from a person who can react quickly to your question – not a recorded voice and automated options. During the last year we added staff to our Provider Service line. To assist our representatives in answering your questions, we enhanced our technology and more technological improvements are on the horizon.

Yet the best tool to assist us in helping you remains our communication with you. The knowledge you bring to a call is essential. Before you call, have the following information at your fingertips:

- The member’s name and ID number.
- Your BCBSNE Provider ID number (rather than the tax ID number). Your Provider ID number allows for tracking your call history, and is vital if any claim follow-up needs to be done.
- The reason for your call.
- The claim (case) number, when applicable to your call.
- The date(s) of service.
- The specific code in question, i.e., procedures code, diagnosis code, etc.
- The dollar amount billed.

If you are doing follow-up on an issue we are researching for you, please let us know:

1. The date you previously called.
2. The name of the representative you spoke with previously.
3. The nature of your inquiry.

So remember the scout motto of “Be Prepared” and have this information ready before you call! HNS

Provider Service Phone Numbers

402-390-1890
Local direct

800-642-8516
Toll free direct

800-635-0579
GABBI
Policy: Medical and Surgical Supplies

As a reminder, charges for medical and surgical supplies when used in the physician’s office are considered to be included as “total service charges” (content of service) for all BCBSNE lines of business. Charges denied as content of service are not separately reimbursed and are not billable to the patient.

Please refer to the list below of the medical and surgical supplies that are not payable. **HNS**

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June 1, 2006 Cutoff Date for PAs, APRNs and Midwives to be Credentialed.
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