BlueCross BlueShield of Nebraska
An Independent Licensee of the Blue Cross and Blue Shield Association.

APRIL 2010

Update

bcbsne.com

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

The Update is a bimonthly provider newsletter that contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers. It is published by the Health Network Management Services Department (HNS).

If you are a contracting BCBSNE health care provider, this newsletter serves as an amendment to your agreement and affects your contractual relationship with us. You are encouraged to file every issue of the Update within your BCBSNE Policies and Procedures manual and reference it often. You may also view the current manual in the Provider section at bcbsne.com.

As a service for Blue Cross and Blue Shield members, we also send this newsletter to non-participating Nebraska providers.

We also publish each issue online in the Provider section at:

bcbsne.com

For permission to reprint material published in the Update, e-mail the editor, Kimberly Vavra, at:

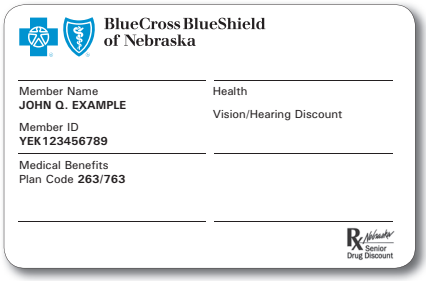
kimberly.vavra@bcbsne.com

Time Limit Change for Medical Records Requests Effective July 1

If a request for medical records is submitted to a provider office by Blue Cross and Blue Shield of Nebraska, the information must be provided in a timely manner.

Effective July 1, 2010, BCBSNE will reduce the number of wait days to 21 calendar days (from an average of 41-45 days) before we will deny the claim for patient liability. Once we receive the requested medical records, the claim will be promptly reopened and processed.

Medicare Supplemental Member Migration


BlueCross BlueShield of Nebraska

Member Name
JOHN Q. EXAMPLE

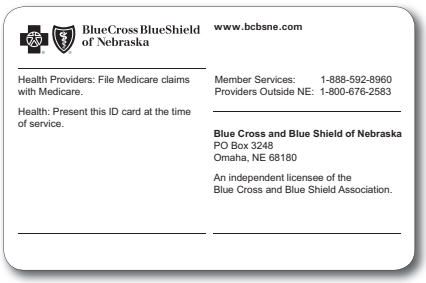
Member ID
YEK123456789

Medical Benefits
Plan Code 263/763

Health

Vision/Hearing Discount

Senior Drug Discount


BlueCross BlueShield of Nebraska

www.bcbsne.com

Health Providers: File Medicare claims with Medicare.

Health: Present this ID card at the time of service.

Member Services: 1-888-592-8960
Providers Outside NE: 1-800-676-2583

Blue Cross and Blue Shield of Nebraska
PO Box 3248
Omaha, NE 68180

An independent licensee of the Blue Cross and Blue Shield Association.

A large portion of BCBSNE's Medicare Supplemental coverage members migrated to our new network and claims processing system on April 1, 2010. These members have been assigned an entirely new I.D. number with a YEK alpha prefix. Non-migrated members will retain their existing I.D. number with the YET alpha prefix.

If you receive a termination notice of March 31, 2010 for one of these members, please ask for their new I.D. card to complete the eligibility for dates of service April 1, 2010 and after. The new I.D. card information is needed for claim submission to avoid unnecessary denial on a migrated member.

The BlueBoard

Neurofeedback Not The Same As Biofeedback

Neurofeedback (also called EEG biofeedback, neurotherapy or EEG neurotherapy,) is a form of biofeedback, linked to aspects of the electrical activity of the brain such as frequency, location or amplitude of specific EEG activity. It has been utilized for the treatment of a number of disorders, ranging from attention deficit hyperactivity disorder to seizure disorders, as well as many other applications.

Neurofeedback is considered to be investigative by BCBSNE and will be denied as member liability.

Neurofeedback is not the same as biofeedback and should not be billed under the biofeedback codes.

If the member requests you bill for neurofeedback, it should be billed under 90899 with "Neurofeedback" in the narrative/remarks field.

One-Year Claim Billing Reminder

Remember that claims that span over the end of a calendar year into the next will need to be split to reflect charges and dates of service separately.

Discontinued Procedures

For BCBSNE members covered by NEtwork BLUE, a 20 percent discount off allowed amounts will be taken on discontinued surgical procedures.

BlueCard® Bulletin

Easier Access to Precertification/Preauthorization Information for Out-of-Area Blue Members as of April 1, 2010

Enhancements have been made to the BlueCard Eligibility Line at **(800) 676-BLUE (2583).** These changes will improve your experience in verifying eligibility and obtaining precertification/ preauthorization information for your out-of-area Blue patients. Please note the following :

When calling the BlueCard Eligibility® Line to obtain precertification/preauthorization only:

Effective April 1, 2010, when precertifications/preauthorizations for a specific member are handled separately from eligibility verifications, your call will be routed directly to the area that handles pre-certifications/preauthorizations. You will be asked to choose from four options regarding type of service:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment (DME)

Upon making your selection, you will be transferred to the appropriate area.

When calling the BlueCard Eligibility® Line to obtain eligibility only or if you need both eligibility and precertification/preauthorization:

Your call will be handled as it is today. You will select the option to obtain eligibility and pre-certification/preauthorization information. First, your eligibility inquiry will be addressed. Then you will be transferred, as appropriate, to the precertification/preauthorization area.

If you have any questions about the BlueCard Eligibility line at **(800) 676-BLUE (2583)**, please contact your Health Network Consultant.

FEP Updates 2010 FEP Benefit Changes Recap

In the last "Update," we notified you that as of January 1, 2010, all Federal Employee Program (FEP) business is a part of the NEtwork BLUE provider network. Please be aware of the following changes:

- Claims processing will be based on the date the claim was received rather than date of service.
- The FEP I.D. card has not changed. FEP members can be identified by their I.D. number, which consists of a single "R" followed by eight numerals (e.g. R12345678).
- You will receive a separate remittance advice and check for your FEP patients.
- Reimbursement will be on the same schedule as your other NEtwork BLUE business.
- Any provider who is BlueClassic participating only will be considered out-of-network for Federal Employee Program (FEP) members. As an out-of-network provider, you will no longer receive remittance advices or direct payment.
- FEP members with Basic Option coverage must seek care from NEtwork BLUE providers in order to receive benefits. FEP members with Standard Option coverage must seek care from NEtworkBLUE providers in order to receive in-network benefits. Services provided by non-NEtwork BLUE providers will be processed at the out-of network level. Payments for out-of-network services will be sent to the members.

Note that this transition is slowing some claim adjudication processes, so please do NOT resubmit previously submitted claims as this will increase our backlog.

FEP changed their policy for verifying COB information from every two years to every year. This policy change may slow down our ability to adjudicate claims.

We apologize for the inconvenience and appreciate your patience during this transitional period.

The Difference Between FEP Primary Care and Specialist Copays

FEP primary care and specialist copayment differentials may be confusing at times.

Primary care copays apply to the following:

- Family Practice
- General Practitioners
- Internal Medicine
- Pediatricians
- OB/GYN
- Physician Assistants

A specialist copay will apply to all others. However, when a physician's credentialing status includes two specialties and one specialty is equivalent to one of the primary care types listed above, a primary care copay will be applied.

BCBSNE Medical Policy Update

Updates were finalized and posted online at **bcbsne.com/providers** on the following policies:

I.129 Virtual colonoscopy
I.170 Manipulation of spine/pelvis under anesthesia
I.133 Epithelial cell cytology (ductal lavage)
I.97 Human growth hormone changed policy number to X.6 and retired the policy
II.18 Donor leukocyte infusion
III.145 Cryoablation of solid tumors
IV.78 Bone mineral density measurements
VII.51 Continuous glucose monitoring
X.7 Botox

The following policies were retired:

III.152 Endoluminal radiofrequency and laser ablation of varicose veins
VII.8 External infusion pumps
VII.64 Home testing for HbA1c
VII.66 Dry hydrotherapy

Comments on these or other medical policies are welcomed. Please direct those comments or other inquiries to BCBSNE's Health Policy and Research Lead, Heather Scholting, at **heather.scholting@bcbsne.com**.

Bone Density Policy - Questions and Answers

Q. This policy went into effect on March 1, 2010. Does this apply moving forward only or is BCBSNE going to look back to see when the last DXA was done and start the two-year rule from that date?

A. The claims will be reviewed against the member's BCBSNE history since the last time a DXA was performed.

Q. Regarding your bone density policy for women under 60 and men under 70, it does not list estrogen deficiency or early menopause as a valid reason to screen. Medicare guidelines consider this to be a reason for early screening. Is this something that can be considered?

A. The recommendation for a woman who has undergone early menopause is to take calcium and vitamin D supplements unless there is another indication of osteoporosis.

Q. The policy states that DXA is covered only every two years. If a person is on Fosamax® or a similar drug for osteoporosis, can this scan be done more frequently?

A. If a person is on Fosamax or a similar drug, the research does not show that any measurable difference is seen for two to three years. For that reason, the two-year frequency was put in place.

Q. Is the policy for screening only? Does a previous diagnosis of osteoporosis or osteopenia exclude a DXA from the terms of this policy?

A. This policy is to address any use of DXA, not just screening.

TRICARE Provider Seminars Coming Soon

TriWest Healthcare Alliance Corp. is presenting the latest TRICARE provider education seminars throughout the 21-state TRICARE West Region. In 2010, seminars will be held through June.

For those new to TRICARE, these seminars provide basic TRICARE information and are a great opportunity to learn about the program. They can also serve as a good refresher for those who have previously attended a TRICARE seminar. If you have recently attended a seminar and feel comfortable with the TRICARE program, you may wish to send another team member from your office or bring a less experienced person with you.

The easiest way for you to check online and register for a upcoming seminar is to do so online at **triwest.com/provider.** When you provide your e-mail address during the online seminar registration, you will:

- Receive an immediate e-mail confirmation of your registration
- Receive a reminder e-mail notice prior to your scheduled seminar
- Be eligible to participate in a drawing for a prize at the seminar

Please note that confirmations are e-mailed to you only when your e-mail address has been provided with your registration. If you register online, please add **pseminar@triwest.com** to your safe sender's list to ensure that you receive your confirmation from TriWest.

If you have questions regarding provider seminars, you may contact your local network representative, e-mail **pseminar@triwest.com** or call **1-888-TRIWEST (888-874-9378).**

If you are unable to attend a seminar, please consider participating in a TriWest webinar. Webinars are training sessions from your own computer with a live instructor. You can ask questions and also hear questions asked by other providers attending the training via conference call. For more information, please visit **triwest.com/provider.**

* The seminar will run approximately 2½ hours; however, the end time may vary based on the level of audience participation.

Blue Cross and Blue Shield Association Expands Blue Distinction® Designation To Include Spine Surgery, Knee and Hip Replacement

The following Nebraska facilities were recently designated as Blue Distinction Centers for Spine Surgery℠ and Blue Distinction Centers for Knee and Hip Replacement℠:

- Alegent Health Bergan Mercy Medical Center, Omaha
- Alegent Health Immanuel Medical Center, Omaha
- Alegent Health Lakeside Hospital, Omaha
- The Nebraska Medical Center, Omaha
- Nebraska Methodist Hospital, Omaha

The following Nebraska facilities were designated as Blue Distinction Centers for Knee and Hip Replacement℠:

- Creighton University Medical Center, Omaha
- Saint Elizabeth Regional Medical Center, Lincoln
- Saint Francis Medical Center, Grand Island

Blue Distinction® is a designation awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians and medical organizations. Its goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of care nationwide.

At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care®, facilities that we recognize for their distinguished clinical care and processes in the areas of:

- Bariatric Surgery
- Cardiac Care
- Complex and Rare Cancers
- Knee and Hip Replacement
- Spine Surgery
- Transplants

The criteria used to select Blue Distinction Centers®, determined with input from leading medical organizations and expert physicians and based on medical evidence, are made available to the public. This allows both consumers and providers to understand what's behind this quality designation. Our goals are:

- to encourage providers to improve the overall quality and delivery of healthcare, resulting in better overall outcomes for patients
- to support consumers in their search for medical facilities that best meet their needs

To be eligible for a Blue Distinction designation, a facility must meet all required selection criteria and a certain number of optional selection criteria, plus the local Blue Cross and Blue Shield Plan's more stringent selection criteria (if any). The facility must be also be a Blue Cross and Blue Shield contracting provider.

To view the national listing of Blue Distinction Centers, please go to:
Spine Surgery: **bcbs.com/innovations/bluedistinction/blue-distinction-centers-spine-surgery/**

Knee and Hip Replacement:
bcbs.com/innovations/bluedistinction/blue-distinction-centers-knee-hip-replacement/

Blue Distinction Facts

Blue Distinction is national in scope with more than 1,600 designations* awarded to over 800 facilities nationwide, across 46 states and the District of Columbia. Our most recent count of Blue Distinction Centers® includes:

- 268 Blue Distinction Centers for Bariatric Surgery®
- 417 Blue Distinction Centers for Cardiac Care®
- 90 Blue Distinction Centers for Complex and Rare Cancers®
- 87 Blue Distinction Centers for Transplants® representing 330 transplant programs
- 449 Blue Distinction Centers for Knee and Hip Replacement℠
- 250 Blue Distinction Centers for Spine Surgery℠

* expected by end of Q2 2010
Source: Blue Distinction® Update, March 2010

UB04 Billers - Claims for Routine vs. Medical Services

When submitting claims for routine vs. medical services, the primary diagnosis code must represent the majority of time spent with the patient/the primary reason for the visit. Blue*Preferred* claims will always be processed according to the primary diagnosis code on the claim. NEtwork BLUE claims will also be processed according to the member's routine benefit UNLESS there is also a medical diagnosis code on the claim. In that case, the entire claim will be processed under the member's medical benefits. If a member is treated for routine and medical services during the same visit, the facility must file separate claims (UB04) for each service.

When or if a NEtwork BLUE claim is processed under a member's medical benefit and the primary diagnosis code is routine, your office may call our Provider Service line at **(800) 635-0579** to request an adjustment without sending an appeal or reconsideration form.

Let the Provider Service Representative know the primary diagnosis code on the claim. The representative should also be informed that the claim should have been processed according to the primary diagnosis code. Ask that an internal inquiry be set up requesting an adjustment of the claim.

Sometimes a claim is submitted with a medical diagnosis code listed as primary and includes a routine diagnosis, when it should have been processed according to the member's routine benefits.

If this is the case, an appeal and medical records are required for an adjustment to be considered.

When a patient receives both routine and medical services, the claim should be split into two separate bills. By separating the bill, the routine benefits can be correctly calculated for the routine services and the medical benefits can be correctly calculated for the medical services. This will help the claim to be paid promptly.

Highlights from Recent Issues Online:

Click on the green Provider tab at www.bcbsne.com, then Library and then Newsletters for current and archived newsletters.

General Coding Reminders to note
October 2009

Prioritization of Preauthorization Requests
August 2009

Submit Exact Member I.D. Number to Prevent Claim Rejection
June 2009

Before you Submit, Check the Card
April 2009

Inside update

Time Limit Change for Medical Records Requests Effective July 1	1
Medicare Supplemental Member Migration	1
BlueBoard: Neurofeedback Not the Same as Biofeedback	2
BlueBoard: One-Year Claim Billing Reminder	2
BlueCard Bulletin: Easier Access to Precertification/Preauthorization Information for Out-of-Area	2
FEP Updates: 2010 FEP Benefit Changes Recap	3
The Difference between FEP Primary Care and Specialist Copays	3
Medical Policy Update	4
Bone Density Policy – Questions and Answers	4
TRICARE Update: TRICARE Provider Seminars Coming Soon	5
BCBSNE Expands BlueDistinction Designation	6
BlueDistinction Center Facts	7
UB04 Billers - Claims for Routine vs. Medical Services	7