Update

FALL 2013

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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 **www.nebraskablue.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: **www.nebraskablue.com**

For permission to reprint material published in the Update, e-mail the editor, Kimberly Vavra, at: **kimberly.vavra@nebraskablue.com**

If you would like to receive an e-mail each time a new issue of this newsletter is posted on the website, click **here**. You can view the newsletter and request online notifications of special announcements about workshops, resources, and other information from BCBSNE.

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Pre-Service Review Program Expansion for Total Hip, Total Knee, Lumbar Spinal Fusions

As a reminder, BCBSNE expanded the pre-service review program for total hip, total knee, and lumbar spinal fusions to include the Educators Health Alliance (alpha prefix EHA) and BCBSNE (alpha prefix YED) employees and their covered dependents, effective September 1, 2013. Employees and dependents of the Metropolitan Utilities District (MUD) have had this program in place since January 2013.

IMPORTANT NOTE: The YED alpha prefix is not exclusive to the BCBSNE employee group policy. Please do not submit a pre-service authorization request for a BCBSNE member whose ID number begins with alpha prefix YED unless they are a BCBSNE employee or covered dependent. Be sure to verify the group name prior to determining if a pre-service review is required.

Preauthorization is required for coverage. If a pre-service authorization is not completed, the claims for services will be denied as provider liability without the opportunity to balance bill the impacted member for the services. However, the claim will be held for review against the criteria to determine if post-discharge services may be eligible for coverage.

Services will not be covered if criteria are not met. If a pre-service authorization request is submitted for these three services and BCBSNE determines that criteria are not met, the claim will deny as member liability. The service may be performed but there will be no coverage as a result of this program. In addition, post-discharge services necessitated by the procedure will not be covered and denied as member liability.

In this issue

Click on one of the headlines below to go directly to the article you wish to view.

Pre-Service Review Program Expansion for Total Hip, Total Knee, Lumbar Spinal Fusions	1
BlueBoard: Go Green with Blue: Update Newsletter Goes Digital	2
BlueBoard: Changes for Type of Bill for Home Health Services	2
BlueBoard: BluePreferred Claims System to Decommission	2
BlueBoard: Specialty Lenses and Pre-Testing Services	2
BlueBoard: Did You Know?	2
BlueBoard: ASCs and Cataract Removal	3
BlueBoard: Electronic Submission of Corrected Claims	3
BlueBoard: Timely Filing Limit Reminder	3
BlueCard Bulletin: Imaging Management Program for Sprint Members	4
Medical Policy Update: Genetic Testing for Cancer Susceptibility	5
What to Do When Additional Information is Needed to Process a Claim	5
Updates to AIM Clinical Appropriateness Guidelines	5
URAC Brings Changes to BCBSNE Credentialing Requirements	6
How to Become a Participating Provider: First Steps	7
Pricing Claims for Medicare Statutorily Excluded Services	8
Health Care Reform Update: Health Insurance Marketplaces	9
2013 Blue Distinction Centers	10
At Your Service: The Provider Solutions Team	10

BlueBoard

Go Green with Blue

Update Newsletter Goes Digital

In an effort to provide you with important provider information in an efficient and cost-effective manner, the "Update" newsletter will now be published in digital format. Starting with this issue going forward, you will receive a postcard to inform you when the newest issue of "Update" is available online.

Current and past issues of "Update" are online under "Newsletters" at **www.nebraskablue.com/providers**.

Tip: For easier newsletter navigation, click on the bolded links to take you to the specific webpage mentioned in the article you're reading.

Changes for Type of Bill for Home Health Services

Type of Bill 033X will be discontinued on October 1, 2013. New claims received on and after October 1, 2013, regardless of date of service, will require Type of Bill 032X or 034X. If you have a replacement claim in need of submission for service dates prior to October 1, 2013, BCBSNE will accept the claim provided the Type of Bill submitted is 0337.

BCBSNE-required revenue codes and Healthcare Common Procedure Coding System (HCPCS) codes remain unchanged.

BluePreferred Claims System to Decommission

With the transition to our new claims systems and network completed in July 2012, the Blue*Preferred* claims system will be shut down in December 2013. As a result, we encourage providers to submit any remaining Blue*Preferred* claims (including any adjustments) prior to December 2013.

If a Blue*Preferred* claim must be submitted for payment or adjustment purposes after December 2013, the claim can still be submitted electronically. However, all HIPAA transactions (i.e. 271, 277, 835) will NOT be created.

Specialty Lenses and Pre-Testing Services

For dates of service beginning October 1, 2013, pre-testing for specialty lenses only should be billed under CPT 92136 with the Place of Service (POS) of 11 (office). Billing for pre-testing services with a surgical CPT code in the range of 66982-66984 with a modifier 22 is no longer recommended.

Did You Know?

- ✔ Revenue Code 762 is billable per day.
- ✔ PC-ACE is written for Microsoft and uses high speed internet service.
- ✔ When searching PDF documents, including the NEtwork BLUE Policy and Procedure manual, hold down both the "Ctrl" and "F" keys. Once you do that, a search box will appear. Enter your search term and click "Next."

ASCs and Cataract Removal

Ambulatory Surgery Centers (ASC) that offer cataract removal in their facility should bill for accommodating intraocular lenses (when applicable), using the appropriate Level II HCPCS code from the list provided below.

Code	Description
V2787	Astigmatism correcting function of intraocular lens (Toric Lens)
V2788	Presbyopia correcting function of intraocular lens (Crystalens, Crystalens HD, ReZoom, Restor)
Q1004	New technology, intraocular lens, category 4 as defined in Federal Register notice
Q1005	New technology, intraocular lens, category 5 as defined in Federal Register notice

The ASC facility fee for the surgery includes $200 for all lenses when billed with a surgical Current Procedural Terminology (CPT) in the range of 66982-66984. The cost invoice for the lens must be attached. When covered by the member's benefit contract, BCBSNE will calculate the reimbursement of the lesser of billed charge or 100 percent of the acquisition cost minus the $200 already included in the facility fee allowance.

If 100 percent of the acquisition cost of the lens is less than $200, it is not necessary for the lens to be billed separately.

Electronic Submission of Corrected Claims

Please note that electronic claim submitters must file corrected (replacement) claims electronically. We will no longer accept a corrected claim accompanied by a Reconsideration Form.

Also, if BCBSNE determines that medical records are needed, we will request medical records from your office. Do not send medical records with paper-submitted corrected claims.

If you have any questions on how to submit a replacement claim electronically, please refer to the HIPAA ANSI X12N 837P or HIPAA ANSI X12N837I implementation guide for detailed instructions.

To resubmit a professional claim in PC-ACE Pro32 as a replacement or void/cancel claim, you will need to do the following:

- Locate the claim in the "TR - transmitted" location and reactivate it
- Change the "Frequency" field as desired (located near the bottom of the Patient Info and General tab) Enter the Original Claim Number in the "Payer/Insured Reference IDs/Types" field set on the Ext. Payer/Insured tab using the "F8 - Original Reference Number" type code
- Save/prepare/transmit the replacement/voided claim

If you want to keep the original claim in the "TR" location, you can copy the original claim instead of reactivating it.

ICD-10 questions? Contact us.
ICD10@nebraskablue.com

Timely Filing Limit Reminder

In order to comply with timely filing limits, all claims must be submitted by the provider or covered person within 180 days of the date of service. If a claim for a covered person is not filed originally within 180 days of the date of service (or the time limit set forth in the applicable Master Group Application) and in compliance with BCBSNE's Policies and Procedures, no benefits will be paid, and NEtwork BLUE providers agree that no payment will be pursued from the covered person.

If a copay is collected from our member at the time of service and the claim is denied for timely filing, the copay does not need to be refunded to the member. Conversely, if monies for deductible or coinsurance are collected at the time of service from our member and the claim is denied for timely filing, either or both must be refunded to our member as they are calculated on allowed amounts and subject to the timely filing denial. Adjustments or revisions to timely filed claims may be made within 12 months from the date of service. No adjust¬ments or revisions to timely filed claims will be accepted more than 12 months from the date of service.

If a claim submission is rejected due to incorrect or invalid information, it is the provider's responsibility to make the necessary corrections and resubmit the claim within the timely filing period. BCBSNE does not consider a rejected claim as proof of timely filing but will reconsider a claim listed on a BCBSNE accepted claim report if the claim shows no errors but was not processed.

BlueCard Bulletin

Imaging Management Program for *Sprint* Members

Effective **August 1, 2013**, **Sprint**, in partnership with Blue Cross and Blue Shield of Illinois and AIM Specialty Health[SM] is offering the Radiology Quality Initiative (RQI) program in all states. This makes AIM effective for all Sprint employees. RQI is a prospective clinical review program for outpatient advanced diagnostic imaging services. Participating members can be identified by the alpha prefixes ***(SKL, SXX, SKP, SHM, SPW, SMT)*** that appear on their Blue Cross and Blue Shield (BCBS) member ID cards.

The diagnostic imaging studies covered under this program include the following:

- Computed Tomography (CT/ CTA)
- Magnetic Resonance Imaging (MRI/MRA)
- Nuclear Cardiology
- Positron Emission Tomography (PET)

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and free standing surgery centers), urgent care centers, or 23-hour observations are excluded from this requirement.

How the Process Works

Similar to your existing imaging management program, all providers are required to contact AIM for an order number before scheduling one of the outpatient advanced diagnostic imaging procedures listed above for a Sprint member. Imaging providers are strongly encouraged to verify that an order number has been obtained before scheduling and performing diagnostic imaging exams.

You may contact AIM to request or verify an order number one of two ways: online through AIM's ***Provider****Portal*[SM] at **www.aimspecialtyhealth.com/goweb** or via telephone at **(866) 455-8415**. If you are already registered for AIM's ***Provider****Portal*, you do not need to register again.

If you have any questions or require any additional information, please contact the number on the back of the member's ID card.

Required Information for Imaging Requests

The checklist below is a guideline to help ensure you have all the information necessary when submitting a request for an imaging exam:

- ✔ Member's identification number, name, date of birth, and health plan
- ✔ Ordering physician information (name, location)
- ✔ Imaging provider information (name, location)
- ✔ Imaging exam(s) being requested (body part, right, left, or bilateral)
- ✔ Patient diagnosis (suspected or confirmed)
- ✔ Clinical symptoms/indications (intensity/duration)

For most situations, the above information will suffice. For complex cases, more information may be necessary, including:

- ✔ Results of past treatment history (previous tests, duration of previous therapy, relevant clinical medical history)

Medical Policy Update: Genetic Testing for Cancer Susceptibility

Effective December 26, 2013, BRCA testing criteria will be added to Policy V.16 (Genetic Testing for Cancer Susceptibility). Currently, BRCA testing will be reviewed for medical necessity.

Genetic testing for inherited BRCA1 or BRCA2 mutations is Scientifically Validated in:

- Individuals who have breast or ovarian cancer; **OR**
- Individuals who have first degree relatives with breast or ovarian cancer; **OR**
- Individuals who have family members with known BRCA1 or BRCA2 mutations; **OR**
- Unaffected individuals from families with a high risk of BRCA1 or BRCA2 mutation based on a family history, where it is not possible to test an affected family member for a mutation.

If you have any questions regarding this policy, please contact Rhonda Schulte, Health Policy Research Administrator, at **rhonda.schulte@nebraskablue.com**.

What to Do When Additional Information is Needed to Process a Claim

Occasionally, additional information is needed to consider benefits on a claim. When this occurs, the denial explanation noted on your remittance advice will begin with the following, "Claim/service lacks information that is needed for adjudication." This explanation does not necessarily mean medical records are needed; it could be that the member's Blue Plan is waiting for their member to return other insurance information, or respond to a worker's compensation or subrogation questionnaire, for example.

Be sure to read the complete denial explanation for additional details. Remember, if medical records are needed from your office to process a claim on a Blue member, BCBSNE will send a letter outlining what is specifically needed for review. Sending unsolicited medical records is an administrative inefficiency you will want to avoid.

AIM Update

Updates to AIM Clinical Appropriateness Guidelines

Effective November 4, 2013, the following updates to the AIM Specialty Health (AIM) Clinical Appropriateness Guidelines are scheduled for release.

Imaging Guideline General Updates

Please note that AIM does not adjudicate requests for ultrasound studies.

AIM has incorporated the recommendations below into its Clinical Appropriateness Guidelines.

Enhanced Ultrasound Recommendations

Ultrasound – General

- Identifies instances where ultrasound is the preferred initial modality prior to advanced imaging (CT and CTA/MRA abdomen and pelvis, CT of chest, and CT of neck)

Ultrasound – Pediatric

- Identifies instances where ultrasound is the preferred initial modality prior to advanced imaging

Clarified Guideline Intent

- Additional changes that clarify intent of the indication or improve the usability of the Guidelines. (CT/MRI upper/lower extremity, CT/MRI spine)

Strengthened Evidence-based Guideline Process

AIM has expanded its evidence-based review process to include the consideration of specialty society recommendations associated with the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely Campaign (CT abdomen and pelvis, CT/CTA/MRI of the neck, CT/MRI of the head)

"Safe Choices in Imaging" Program (Formerly AIM Patient Safety Program)

- Ultrasound enhancements will encourage ordering providers to avoid studies associated with ionizing radiation when appropriate
- AIM has expanded its evidence-based review process to include the consideration of specialty society recommendations associated with the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely Campaign (CT abdomen and pelvis, CT/CTA/MRI of the neck, CT/MRI of the head)

To access the document that outlines the updates, go to **bit.ly/19M5wrV**.

For any questions, comments or additional information, please contact your BCBSNE health network consultant.

URAC Brings Changes to BCBSNE Credentialing Requirements

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) expands consumer choices of health insurance through Health Insurance Marketplaces, also known as Exchanges. Health insurance coverage can be purchased online through comparison shopping of insurance carriers.

The law also requires every Marketplace to be composed of health plan issuers accredited by a Health and Human Services (HHS)-approved accrediting entity. The Utilization Review Accreditation Commission, or URAC, earned HHS approval to accredit issuers participating on Marketplaces in all 50 states and the District of Columbia.

URAC's accreditation signifies an issuer has undergone and passed every aspect of its operation, including the quality of care and level of service they provide their enrollees. As BCBSNE will participate in the Marketplace next year, our provider credentialing process began using URAC compliance measures for accreditation in June 2013.

As a result, two major changes affect the credentialing process. First, URAC requires that BCBSNE verify the highest level of education via a Primary Source Verification (PSV) for all non-board certified providers. This means we must receive a letter of education verification, or a copy of the transcripts from the school (or the school's clearinghouse, in the case of transcripts).

If the verification letter option is used, the letter must contain the provider's name, degree earned, dates attended, type of program and a statement that the provider successfully completed this training. Per URAC, in order to be a primary source, this information must come to BCBSNE from the school's administration, registrar's office or the school's clearing house in the case of a transcript. A diploma does not count as verification of highest level of education.

While BCBSNE can request the PSV, we recommend that providers request it directly from their school to avoid unnecessary delays. Any fees associated with acquiring the letter from the school will be the provider's responsibility.

Secondly, URAC requires all providers (physicians, mid-levels and therapists) to be named on malpractice insurance policies. BCBSNE can no longer accept a policy with just a provider roster. If the provider is not listed on the policy by name, then we must have a new policy with their name on it or a letter from the liability carrier (on the carrier's letterhead) listing the individual provider, policy number effective dates and a statement that the specific provider is covered under the listed policy.

For any specific questions concerning URAC credentialing requirements, please visit **www.urac.org** or email **credentialingrequests@nebraskablue.com**.

Additional Credentialing Details to Note

The "Universal Provider Application" is no longer valid for credentialing and has been removed from our website.

Provisionally licensed providers should not complete the "Request to Participate" form. These providers must complete the "Provisional Provider Form" located online at **www.nebraskablue.com/providers** under "Forms for Providers".

Please make sure that the provider's contact email address and outreach address in CAQH is current. Not having a current email address and outreach address could result in delays of the provider's application processing.

How to Become a Participating Provider: First Steps

In the **Spring 2012** issue of the Update newsletter, we introduced you to the new credentialing process for professional providers – an arrangement with the Council of Affordable Quality Healthcare (CAQH).

In the first of a series of articles on CAQH, we will address our most commonly received questions.

Who should use the Request to Participate form?

Any professional provider (non-facility) who wishes to participate in a BCBSNE network must complete the credentialing process, starting with the completion of the Request to Participate form. The completed form is then submitted to CAQH.

To access the credentialing timeline for an estimate on how long you can expect the credentialing process to take, go to the Credentialing section at **www.nebraskablue.com/providers**.

Will I be notified when BCBSNE has received the Request to Participate form?

Yes. You will receive an email confirmation upon successful submission. If you do not receive an email confirmation, please resubmit the Request to Participate form.

I received the email confirmation that BCBSNE has received the Request to Participate form, but I haven't heard from CAQH as to the next steps. What should I do?

Please contact the CAQH Provider Help Desk at 888-599-1771 and inform them that you have been rostered by BCBSNE.

I don't know where I am at in the credentialing process. Who do I contact?

If you have been issued a CAQH Provider ID number, you may check your application status at **www.caqh.org/oas**. Once you have logged in, navigate to "Your Activity Log." For additional information on the application status types found in Your Activity Log, go to the Credentialing section at **www.nebraskablue.com/providers** and click on the "How to Check Application Status" link.

If you have not been issued a CAQH Provider ID number, please email the Provider Solutions Team at **providersolutions@nebraskablue.com**.

I am already a contracting provider under another tax ID number but I am changing locations or employers. Do I need to go through the credentialing process again?

Chances are that you will not have to. If you are already contracting with BCBSNE and are simply changing employers or tax IDs, you will just need to complete the Extend-Transfer Existing Agreements form. This form requests that we "extend" or "transfer" your existing BCBSNE contract to a new employer or tax ID.

If you are currently practicing as part of a Physician-Hospital Organization (PHO), please send an email to the Provider Solutions Team at **providersolutions@nebraskablue.com** for more information.

Pricing Claims for Medicare Statutorily Excluded Services

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare claims to the Blue secondary payer, eliminating the need for the provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, this has also allowed Medicare crossover claims to be processed in the same manner nationwide.

Effective October 13, 2013, the following Medicare crossover servicing updates are in place for all Blue Plans to more accurately price and process these claims:

➜ For services that are statutorily excluded by Medicare (i.e., home infusion therapy and hearing aids) providers should submit only those statutorily excluded services to BCBSNE with a GY modifier on each line for the service that is excluded or not covered by Medicare. The GY modifier should be used to indicate that the item or service is statutorily excluded. This will allow BCBSNE to apply the contracted rate with the provider to accurately process the claim according to the member's benefits. Also, by submitting statutorily excluded services with a GY modifier directly to BCBSNE, you will receive payment for these services in a more timely manner.

➜ When a provider submits a claim to Medicare for statutorily excluded services that are covered under the member's Blue policy, providers will receive notification from the member's Blue Plan to submit those statutorily excluded services directly to BCBSNE. Instructions will be communicated in either a paper or electronic remittance advice or in a letter from the Blue Plan.

- Paper Remittance Advices and Letters:
  - When receiving paper remittance advices or letters, you will receive instructions similar to the message below:
    - This service is excluded or not covered under Medicare. However, the service may be eligible for benefits under other coverage. Please submit this service to your local Plan.
- Electronic Remittance Advices (835):
  - The following HIPAA claim adjustment reason codes and remark codes will be included on the 835 responses:
    - Claim Adjustment Reason Code (CARC) 109: "Claim not covered by this payor/contractor. You must send the claim/service to the correct payer/contractor."
    - Remittance Advice Remark Code (RARC) N418: "Misrouted claim. See the payer's claim submission instructions."
    - Group Code: CO

Commonly Asked Questions:

How do I know if a service is statutorily excluded or not covered by Medicare?

Providers rendering services to Medicare beneficiaries are responsible for knowing when a service is statutorily excluded by Medicare. Visit **www.cms.gov** for further information regarding statutorily excluded services.

Where on the claim do I put the GY modifier?

The GY modifier should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a "not otherwise classified code" (NOC) must be used with the GY modifier.

The GY modifier is located in the line level procedure code modifier field(s) and the modifier can be:

- Present position 1, 2, 3 or 4.
- On the paper 1500 form, the GY modifier can be found in field 24D.
- On the paper UB04 form, the GY modifier can be found in field 44.
- On the 837P the GY modifier is found at level 2400, Service Line Loop in SV101-3, SV101-4, SV101-5 or SV101-6.
- On the 837I the GY modifier is found at level 2400, Service Line Loop in SV202-3, SV202-4, SV202-5 or SV202-6.

Health Care Reform Update: Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (PPACA) of 2010 provides for the establishment of Health Insurance Marketplaces (also known as Exchanges), in each state, where individuals and small businesses will be able to purchase qualified coverage beginning October 1, 2013 for an effective date of January 1, 2014. These Marketplaces will be internet websites through which eligible consumers may purchase insurance. These Marketplaces are intended to create a more organized and competitive marketplace for health insurance by offering members a choice of health insurance plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. The Marketplaces will enhance competition in the health insurance market, improve choice of affordable health insurance, and give individuals and small businesses purchasing power comparable to that of large businesses.

Health insurance Marketplaces are expected to offer consumers a variety of health insurance plans. Product and plan information, such as covered services and cost sharing (i.e. deductibles, coinsurance or copayments, and out-of pocket limits) will be organized in a matter that will make comparisons across health insurance plans easier for consumers. In conjunction with offering a choice of health insurance plans, the Marketplace is intended to provide consumers with transparent information about health insurance plan provisions such as premium costs and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Each state was given the option to set-up its own "state-run" Marketplace approved by HHS for marketing products to individual consumers and small employers. If the state did not set up a state-run Exchange, the Department of Health and Human Services (HHS) has established either a federally-facilitated Marketplace or a Federal-partnership Marketplace in the state. Blue Plans that offer products on the Marketplaces will collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and employer sponsored health insurance products.

Exchange Individual Grace Period - Background

PPACA also mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period. Consequently if a member is within the last two months of the federally mandated individual grace period, you will receive the following notification from BCBSNE:

Exchange Individual Grace Period – Notification Letter to Provider

<Provider Name>
<Provider Address>
<Provider Address> Member Name:________________
<Provider Address> Member ID:__________________
Date of Service:________________
Total Charge:__________________
Member Acct #:________________
Claim #:_______________________

Dear <Practitioner Name>:

Under the Patient Protection and Affordable Care Act (PPACA), there is a three-month grace period for Exchange-purchased individual insurance policies when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.

If you have any questions regarding this claim, please feel free to contact Blue Cross and Blue Shield of Nebraska at 800-635-0679.

Sincerely,
Blue Cross and Blue Shield of Nebraska

What Else Do I Need to Know?

The new products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Blue Cross and Blue Shield of Nebraska (BCBSNE) for claims processing and handling, as outlined below.

- Eligibility and Benefits
- Care Management
  - Pre-Service Review
  - Medical Policy
- Claim Pricing and Processing
  - Contracting
  - Claim Filing
  - Pricing
  - Claim Processing
  - Medical Records
  - Payment
  - Customer Service

2013 Blue Distinction Centers

BCBSNE has recognized the following Nebraska hospitals as Blue Distinction Centers in the areas of knee and hip replacements, spine surgery and cardiac care.

Blue Distinction Centers are part of a national designation program recognizing hospitals that meet quality-focused criteria surrounding patient safety and outcomes. For those hospitals that meet these quality standards and demonstrate cost-efficiency, they are recognized as a Blue Distinction Centers+.

Knee and Hip Replacement

Blue Distinction Centers+ (Total Value)

- Alegent Creighton Health Immanuel Medical Center, Omaha
- Saint Elizabeth Regional Medical Center, Lincoln
- The Nebraska Medical Center, Omaha

Blue Distinction Centers (Quality Only)

- Alegent Creighton Health Bergan Mercy Medical Center, Omaha
- Alegent Creighton Health Lakeside Hospital, Omaha
- BryanLGH Medical Center East (Bryan Medical Center), Lincoln
- BryanLGH Medical Center West (Bryan Medical Center), Lincoln
- Fremont Area Medical Center, Fremont
- Nebraska Methodist Hospital, Omaha
- Saint Francis Medical Center, Grand Island

Spine Surgery

Blue Distinction Centers+ (Total Value)

- Nebraska Spine Hospital, Omaha
- Saint Elizabeth Regional Medical Center, Lincoln
- The Nebraska Medical Center, Omaha

Blue Distinction Centers (Quality Only)

- Alegent Creighton Health Bergan Mercy Medical Center, Omaha
- Alegent Creighton Health Immanuel Medical Center, Omaha
- Alegent Creighton Health Lakeside Hospital, Omaha
- BryanLGH Medical Center West (Bryan Medical Center), Lincoln
- Nebraska Methodist Hospital, Omaha

Cardiac Care

Blue Distinction Centers+ (Total Value)

- BryanLGH Medical Center East (Bryan Medical Center), Lincoln
- The Nebraska Medical Center

Blue Distinction Centers (Quality Only)

- Alegent Creighton Health Bergan Mercy Medical Center, Omaha
- Creighton University Medical Center, Omaha
- Nebraska Methodist Hospital, Omaha

If you are a physician or hospital administrator interested in learning more or applying for the Blue Distinction Center or Blue Distinction Center+ designation for your medical facility, please contact Gail Brondum at **gail.brondum@nebraskablue.com**. Additional information is also available online at **www.bcbs.com/why-bcbs/blue-distinction**.

At Your Service: The Provider Solutions Team

As announced in the Spring/Summer 2013 Update newsletter, the Provider Solutions Team is available to assist you with the service and management of inquires that cannot be otherwise resolved with Customer Service.

Together with the Health Network Consultants, Credentialing and Electronic Data Interchange (EDI), the team handles the following inquiries:

- Credentialing and application status
- Provider agreement inquiries
- Reimbursements and fee schedules
- Billing and coding
- Navinet
- EDI
- Request Electronic Funds Transfer (EFT)/ Electronic Remittance Advice (ERA)
- Escalated claim issues
- Change of name, location, tax identification number, NPI, etc.

The team can be reached via phone or email at **(800) 821-4787 (option 4), (402) 982-7711** or **ProviderSolutions@nebraskablue.com**.

As a reminder, the credentialing process with CAQH will remain the same. Providers are still required to fill out the "Request to Participate" form located online at **www.nebraskablue.com/providers** on the Credentialing a page.

The Health Network Consultants will still be available to assist you with provider agreement education and contract negotiations.

The Customer Service team will continue to assist all members and providers with customer service-related issues including, but not limited to, all claims issues including coding, BCBSNE member benefits and eligibility, help with navigation on NaviNet, questions regarding medical policy, precertification/preauthorization and/or appeals and plan-to-plan calls to resolve BlueCard claims issues.