Blue Cross and Blue Shield of Nebraska (BCBSNE)
Claims Administration
for

City of Omaha
Service-Connected Disabilities

1. For purposes of the Service-Connected Disabilities Claims Administration, a Covered Person shall be defined as a former employee, designated by the City of Omaha Police and Fire Retirement System (COPFRS) as having a service connected disability, who is eligible for service-connected disability benefits. Omaha Municipal Code Section 22-78 provides that for those individuals who have received a service-connected disability pension, that the individual shall be paid for any Medically Necessary Covered Services which may be incurred as a result of such sickness or injury, and the Section requires reference to the health insurance in effect for current employees.

2. Medical claims directly resulting from a service-connected disability will be processed by BCBSNE based on the allowable charge for In-network/Contracting Providers and at 100% of billed charges for Out-of-network/non-Contracting Providers. Claims for services provided outside the state of Nebraska, may be processed pursuant to Blue Cross and Blue Shield BlueCard Inter-Plan Arrangements (see Administrative Services Agreement), however claims for non-Contracting Providers outside the BCBSNE service area will be processed at 100% of the billed charges.

All services are subject to utilization review by BCBSNE to determine whether the services are Medically Necessary or Scientifically Validated under the terms of this service-connected disability benefit. Benefit payment is not available for services determined to be not Medically Necessary, or Investigative (not Scientifically Validated). See Definitions.

All hospital stays, certain surgical procedures and other specialized or designated services, as shown on the Client Profile, must be certified or preauthorized.

If there is a question as to whether a service is the result of, or related to, a service-connected disability that would qualify for payment according to the City of Omaha service-connected disability provision(s), the City of Omaha will make the final determination.

3. Payment issued by BCBSNE for covered services provided to Covered Persons for service-connected disabilities will not be subject to:

a. deductible, coinsurance, or other cost-sharing by the Covered Person
b. a maximum (total) dollar limit, and/or annual dollar maximums, except as otherwise stated
c. coordination of benefits provisions, including coordination with Medicare

Payment for covered services <u>will be</u> subject to the following limits:

a. outpatient physical therapy, occupational therapy, speech therapy sessions, osteopathic and chiropractic physiotherapy, osteopathic and chiropractic manipulative treatments – 75 sessions per calendar year (combined)
b. outpatient cardiac rehabilitation – 18 sessions per calendar year
c. outpatient pulmonary rehabilitation – 36 sessions per calendar year
d. hospice services – 180 days
e. treatment of temporomandibular or craniomandibular disorders

Services provided in excess of the above limits will be subject to review for Medical Necessity, as determined by BCBSNE.

4. Appeal Procedure: A Covered Person may appeal a claim or benefit determination or certification (preauthorization) decision pursuant to the following appeal process:

a. First Level Appeal: A request for a first level internal appeal must be submitted to BCBSNE. BCBSNE will review the request and applicable claim information, and make a decision to uphold or overturn the initial determination. If overturned, BCBSNE will notify the Covered Person (retiree) of the decision and reprocess claims or update an authorization if applicable. If the initial determination is upheld, BCBSNE will notify the Covered Person of the decision and the right to request a second level internal appeal.

b. Second Level Appeal: A request for a second level internal appeal must be submitted to BCBSNE. BCBSNE will review the request and applicable claim information. The appeal will be reviewed by individuals who were not involved in the prior decision(s). BCBSNE shall forward the second level appeal to the City of Omaha Human Resources Department, which will forward to the Disability Committee of the City of Omaha Police and Fire Retirement System (COPFRS) to make the final determination on the second level appeal. If the prior decision is overturned by COPFRS, BCBSNE will notify the Covered Person of the decision and reprocess the claims, or update an authorization if applicable. If the prior decision is upheld by COPFRS, BCBSNE will notify the Covered Person and provide the option to request a final appeal through an External Review.

c. External Review (IRO): Following exhaustion of the internal appeal process, a request for an external review by an Independent Review Organization (IRO) may be submitted. The request should be submitted to BCBSNE, who will forward the documentation to an IRO for review and final determination. If the IRO overturns the prior decision(s), BCBSNE will notify the Covered Person and have the claims reprocessed or authorization updated if applicable. If the IRO upholds the prior decision, the IRO will notify the Covered Person of this determination. Notification of the decision will also be provided to the City of Omaha. The Covered Person has a final option of having the matter reviewed directly by COPFRS.

d. City of Omaha Police and Fire Retirement System: This is the last option for review of the Covered Person's matter. The Covered Person must submit his/her request for review to the City of Omaha Human Resources Department, for review by COPFRS. COPFRS will notify the Covered Person of the decision to overturn or uphold the prior decision(s). If the decision is to overturn, COPFRS will notify BCBSNE to have claims reprocessed or authorization updated if applicable. If the Covered Person is not satisfied with the final decision of COPFRS, the last course of action is filing a lawsuit, however all appeal options above should be exhausted.

5. The City of Omaha shall provide BCBSNE with the applicable names and service-connected conditions of Covered Persons, and other specific information necessary to process medical claims for a Covered Person's service-connected disability. This specific information may include but is not limited to, drug names and dosages, diagnosis codes and ICD-10 codes.

6. BCBSNE does not underwrite or insure the liability of the City of Omaha under this document. BCBSNE provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

7. **Compensation to BCBSNE** for claims paid on behalf of Covered Persons under the service-connected disability benefits shall be made on a monthly basis. Claims data which is, for any reason, omitted from a particular month's billing, shall be added to the billing for a subsequent month.

BCBSNE will provide the SCD billing invoice to the City of Omaha on behalf of COPFRS by the 8th business day of the month. The Disability Pension Board Committee meeting is held on the third Thursday of each month; payment shall be made to BCBSNE within 15 days of the Disability Pension Board Committee meeting unless some dispute as to the appropriateness or amount of the payment arises.

8. The Administrative Service Fee and Out-of-Area Service Fees stated in the Administrative Services Agreement includes BCBSNE's services as described herein for service-connected disabilities.

9. The service-connected disability benefit is administered by BCBSNE pursuant to the Client Profile, and the terms of the Administrative Services Agreement for the City of Omaha group health plan, except as noted otherwise. However, the service-connected disability benefit is distinct from the group health plan coverage for the City of Omaha, and is not considered part of the ”Plan” as that term is used in the ASA.

The following “Guarantees” as stated in the ASA are not applicable to the service connected disability benefit: Medical Performance Guarantee, Medical Provider Discount Guarantee and Medical Claims Projection Guarantees.

A Summary Plan Description is not produced or distributed for the service-connected disability benefit.

***Effective 12/27/2020**, COPFRS is no longer responsible for any medical expenses that might be incurred by a member of the **Omaha Police Officers Association** who receives a service-connected disability pension. The City of Omaha shall be responsible for work related medical expenses, if it has accepted compensability or has been deemed to have liability for the work related injury and remains obligated to pay the medical expenses pursuant to its statutory obligations under the Nebraska Workers Compensation Act.*

DEFINITIONS

Administrative Services Agreement (ASA): The agreement entered into between the City of Omaha and BCBSNE for administration of the Group’s self-insured, or partially self-insured, health care programs for eligible employees.

Client Profile: A document prepared by BCBSNE in collaboration with the Group (City of Omaha), which sets forth specific benefit plan terms and requirements, including covered and non-covered services,

Independent Review Organization: An entity that conducts independent reviews of adverse claim determinations, independent of BCBSNE or COPFRS.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

Medically Necessary (or used as "Medical Necessity"): Health care services ordered by a treating physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's illness or injury, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and

2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's illness, or injury. The most appropriate setting and the most appropriate level of Service is that setting and that level of service, considering the potential benefits and harms to the Covered Person. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and

3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment

of the Covered Person's Illness or Injury, without adversely affecting the Covered Person's medical condition; and

4. not provided primarily for the convenience of any of the following:

   a. the Covered Person;
   b. the physician;
   c. the Covered Person's family;
   d. any other person or health care provider; and

5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

Scientifically Validated: A technology, drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated that meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the net health outcome.

4. The technology must improve the net health outcome as much as or more than established alternatives.

5. The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Scientifically Validated.

CITY OF OMAHA – SERVICE CONNECTED DISABILITY
CLAIM SUBMISSION AND REVIEW PROCESS

PROFESSIONAL
On HCFA 1500 claim forms, each procedure code specifically indicates (on that line) the diagnosis code(s) that apply.

Professional claims will be reviewed line by line. If the diagnosis code(s) in the primary position on the line is one of the diagnosis codes approved by City of Omaha for the Covered Person's approved Service Connected Disability (SCD), BCBSNE will pay that line. If there are no approved SCD diagnosis codes in the primary position on a line, BCBSNE will deny that line.

INSTITUTIONAL
On UB04 claim forms, the diagnosis codes do not point to certain lines on the claim. The primary diagnosis on the claim should indicate the primary reason the Covered Person was being treated.

Institutional claims will be paid by BCBSNE when the primary diagnosis on the claim is one of the diagnosis codes approved by City of Omaha for the Covered Person's approved Service Connected Disability. If the primary diagnosis code is not an approved SCD diagnosis code, BCBSNE will deny the claim.

CLAIM ID SUBMISSION WITH MULTIPLE CONTRACT NUMBERS
If provider submits the claim with the Service Connected Disability ID Number and the service is not approved, BCBSNE will deny non-approved services, set up claim, and process charges on the non-Service Connected Disability ID Number per the Covered Person's group health plan benefits.

If provider submits the claim with the non-Service Connected Disability ID Number, the claim will be processed per the Covered Person's group health plan benefits, regardless of the diagnosis code. The claim will not be considered under the Service Connected Disability guidelines.

SERVICE CONNECTED DISABILITY – CONFIRMATION OF DIAGNOSIS CODES
If BCBSNE receives a claim which includes codes that are not approved SCD diagnosis codes, the BCBSNE Account Service Representative will request verification via email from the City of Omaha. The City will respond via email if denied, or send an updated approval form if approved. If codes are denied, the claim will be denied and may be reprocessed under the Covered Person's group health plan benefits, if applicable.

DENIED CLAIMS/DENIED LINES
If a Covered Person feels a denied claim/denied lines were related to an approved SCD diagnosis, he/she has the following options:

- Talk to the provider and ask if they can submit a Reconsideration Request to BCBSNE with a corrected diagnosis. (This is the quickest solution).
- Send an appeal in writing.
    - It is best to have Covered Person obtain supporting documentation from the provider to submit with the appeal. It will make the process go quicker.
    - If the Covered Person cannot obtain supporting documentation from the provider, BCBSNE will order medical records from the physician. The process is on hold until the provider sends in the medical records. (This would be the slowest solution).

BILLING REPORT
The report the City of Omaha receives with their monthly invoice (from BCBSNE), will only show the primary diagnosis for all claims (professional & institutional) paid by BCBSNE. If the diagnosis code and diagnosis description is not an approved SCD diagnosis code, the City of Omaha should contact the BCBSNE Account Service Representative. The ASR will research the claim/line and confirm via email which approved SCD diagnosis prompted BCBSNE to pay the claim/line.