



**BlueCross
BlueShield
of Kansas**

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Web site: www.bcbsks.com

In Topeka – (785) 291-7000
In Kansas – (800) 432-0216

July 2007

CAP

Competitive Allowance Program

2008 CONTRACT

The mission at Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) is to excel at meeting our customers' health and benefit needs. The cost and affordability of health insurance remains a major concern of our members. Health care continues to be impacted by a number of factors: escalating medical use, increasing trends, demand for services, aging population, technological advances and shrinking population in the BCBSKS service area, just to name a few.

Our administrative expenses remain low at 8.03 percent of premium income, as of April 30, 2007. We know of no other insurance company that rivals this low percentage. Our company continues to focus on controlling our corporate administrative costs while maintaining prompt service to our members and providers.

Local enrollment totals 699,965 members, as of June 30, 2007. In the last twelve months we have had a significant gain in membership adding 21,005 local members. Taking all business including BlueCard into consideration, BCBSKS addresses the health care needs of 893,882 Kansans. Financially, BCBSKS is in a solid position with positive contribution to reserves. Strong policyholder reserves allow us to make available valuable Web-based services, meet the health care coverage needs of our members, adhere to state and federal regulations, and meet the requirements of the Blue Cross and Blue Shield Association.

As a contracting provider, you continue to receive excellent business services which bridge the gap between the delivery of health care services and the financing of prepaid health care benefits for your patients. Business services provided by BCBSKS creating the most significant value to you as a contracting provider include:

- Local member contracts structured to allow 100 percent of the maximum allowable payment (MAP) for participating CAP providers (subject to deductible and coinsurance).
- Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow.
- Web site (www.bcbsks.com) available at your convenience, which improves your office efficiencies and maximizes your employee resources.
 - Secured services to include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
 - Other services including training modules, newsletters, manuals, policy memos, and medical policies/guidelines.
- Detailed claims payment information provided to both you and the member explaining their financial responsibilities.
- Contracting providers' names made available to BCBSKS members through a number of sources, including the Internet, employer groups, and other contracting providers for referral purposes, increasing the potential for new patients.
- A dedicated field staff available to visit your office to address any operational issues.
- Periodic workshops held by professional relations staff, which deliver continuous training for new and experienced medical assistant staff to help update them on new administrative procedures to ensure timely claim payments.
- Providers and their staffs having access to professional relations hotline personnel to answer policy questions or obtain assistance with claim coding questions.

NOTE: Non-contracting providers receive 80 percent of the MAP (subject to deductible, coinsurance, and non-network reductions). In addition, they do not receive direct payment, nor is assignment of benefits allowed.

Please review all materials immediately, as the 2008 contracting deadline of **September 4, 2007** is fast approaching. If you have questions regarding any information contained in this mailing, please contact your professional relations representative or the hotline at the numbers listed below:

<u>Professional Relations Staff</u>	<u>Location</u>	<u>Phone Numbers</u>
Fred Boston, Director	Topeka	800-432-0216 ext. 8831 (785) 291-8831
Rusty Doty, Manager	Topeka	800-432-0216 ext. 8206 (785) 291-8206
Sue Dunaway	Topeka	800-432-0216 ext. 8207 (785) 291-8207
Diana Evans	Topeka	800-432-0216 ext. 8716 (785) 291-8716
Cheri Iarossi	Topeka	800-432-0216 ext. 8651 (785) 291-8651
Vikki Lindemuth	Topeka	800-432-0216 ext. 7724 (785) 291-7724
Professional Relations Hotline	Topeka	800-432-3587, opt. 1 (785) 291-4135, opt. 1
Debra Meisenheimer	Hutchinson	(620) 663-1313
Velda Fresquez-Gray	Wichita	800-432-0216 ext. 1674 (316) 269-1674
Denny Hartman	Wichita	800-432-0216 ext. 1674 (316) 269-1674
Gwen Nelson	Dodge City	(620) 225-0884

Your continued contracting status is important to our members and many of your patients. If for any reason you feel unable to continue your contract, please phone me (Fred Boston, 785-291-8831) to discuss. Then, if you still feel you cannot accept this contract offering and choose to terminate your provider contract, you must send signed correspondence postmarked no later than midnight, **September 4, 2007**, to Fred Boston, Director of Professional Relations, cc480E1, 1133 SW Topeka Blvd., Topeka, KS 66629.

Additional Important Information

Trends



- Wellness programs are becoming more important to members and our company.
- Providers continue to establish electronic connectivity to BCBSKS to efficiently complete daily health care administration.
- There is increased use of Health Information Technology at the point of patient care to improve quality of care and enhance patient safety.

Blue Ribbon News

- Blue Choice enrollment has gained 33,893 members, with enrollment totaling 440,214 members as of May 31, 2007. This program does not utilize referrals and members may seek care from the CAP providers of their choice.
- BCBSKS offers our members wellness information and services which can be accessed through our Web site in the Resource Blue Section.
- 98 percent of physicians and 93 percent of all professional providers are CAP contracting in our Kansas Plan area.
- BCBSKS remains a financially strong company. The CMS decision not to award our Wheatlands Administrative Services subsidiary the Jurisdiction 5 Medicare contract will not affect the products and services you are accustomed to seeing from us.



Reimbursement and Policy Memo Changes

On June 28, 2007, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2008.

A charge comparison report reflecting reimbursement changes for 2008 is available by contacting your professional relations representative or the professional relations hotline. **The charge comparison is based on services billed by you during the first five months of 2007.**

Below is a brief overview of the reimbursement changes for 2008:

- The MAPs for most covered CPT codes will increase.
- The administration of an injection will be allowed in addition to an office visit, home visit, or nursing home visit.
- MAPs for evaluation and management services will increase.
- The anesthesia conversion factor will increase to \$51.76.
- Reimbursement for the professional component of specialized imaging (CT, MRI/MRA, PET) will increase, while reimbursement for the technical component will remain the same as 2007.
- Reimbursement for clinical lab and venipuncture will remain the same as 2007.
- Ambulance and HME reimbursement will increase.

Following is a summary of the changes to Blue Shield policies and procedures for 2008. A complete set of policy memos for 2008 will be available in December 2007 in the provider publications section of www.bcbsks.com.

Policy Memo No. 1

Section II. Denied Claims Appeals Procedure

A note was added to clarify that content of service issues described in Policy Memos 1-12 are contractual obligations and are not considered eligible for claims appeals.

NOTE: Medical policies including Content of Service (COS) as described in BCBSKS Policy Memos 1-12 or provider's obligations specified in their provider contracts are not considered eligible claims appeals as outlined in Section II. DENIED CLAIMS APPEALS PROCEDURE. Annually, BCBSKS outlines any changes to the Policy Memos and forwards them to providers for their review. Once providers accept these changes, they are part of the provider's contract and therefore not considered for claims appeals. Providers disagreeing with any policies should submit their position and supportive documentation to BCBSKS staff for future consideration.

Section III. Post-Payment Audit Appeals

Language was added clarifying the time frame for audited claims and refunds.

III. POST-PAYMENT AUDIT APPEALS

BCBSKS conducts periodic post-payment audits of patient records to substantiate the medical necessity of services billed on the provider claim. The BCBSKS audit time frame will be no greater than 15 months following the date of claims adjudication. Due to additional time allowed for provider appeals, as outlined in this policy memo, refunds would be applicable after the provider appeals have been exhausted, regardless of the time frame involved. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, and on-site visits.

If medical necessity is not documented, BCBSKS will request refunds.

Section V. Content of Service

The administration of an injection on the same day as an office visit, home visit, or nursing home visit will no longer be considered content of service. BCBSKS will begin reimbursing separately for the administration of the injection effective January 1, 2008. This section has been revised accordingly.

Section X. Documentation

Language was added outlining the flexibility to grant additional time, on a case-by-case basis, for providers to submit medical records.

X. DOCUMENTATION

Appropriate documentation of services is an integral part of the payment and/or review process. The contracting provider agrees to keep sufficient records to support claims for reimbursement, documents the medical need for the service, and agrees to make available all information necessary to carry out the terms of his/her contracting provider agreement at no charge. Information, when requested, should be submitted to BCBSKS within 30 days of the request. Time extensions may be granted on a case-by-case basis; however, any extension must be approved by BCBSKS and will allow BCBSKS additional time for review activities. Certain unusual circumstances require the immediate submission of medical records. In these cases, BCBSKS will have a representative visit the office and secure requested records. The provider agrees to provide these records at the time of request. The member's contract gives us the ability to obtain this information without a signed patient release. If there is insufficient information to determine medical necessity, claims will ultimately be a provider write-off or refund. Failure to send the requested documentation within the time frame will also result in claim denials for lack of medical necessity.

Section XV. Refund Policy

This section was modified to indicate that duplicate claims, including other party liability claims are not subject to the 15-month time frame limit for requesting refunds.

XV. REFUND POLICY

BCBSKS must request refunds from providers within 15 months from the date of adjudication. Failure to do so will result in the provider being held harmless. Refund requests for fraudulent claim payments and duplicate claim payments, including other party liability claims, are not subject to the 15-month limitation.

Refunds as a result of an audit are due within 30 days from the date the audit is presented before exercising the right of offset.

Section XXIX. Charge Comparison Reports

Since BCBSKS does not use pure Relative Value Units to establish reimbursement, language regarding such was removed from this section.

XXIX. CHARGE COMPARISON REPORTS

The provider may request one annual charge comparison report for procedures billed to BCBSKS on behalf of our members. Information included in the annual charge comparison will include services billed and allowed from January 1 to May 31 each year.

Policy Memo No. 2

Section II. Content of Service

The administration of an injection on the same day as an office visit, home visit, or nursing home visit will no longer be considered content of service. BCBSKS will begin reimbursing separately for the administration of the injection, effective January 1, 2008. This section has been revised accordingly.

Policy Memo No. 11

Section I. Multiple Procedures When Performed by One Physician

Wording was added throughout the section to clarify that this policy applies to arthroscopic and other scope procedures as well as endoscopic procedures.

I. MULTIPLE PROCEDURES WHEN PERFORMED BY ONE PHYSICIAN

BASIC PREMISE

The policy, in respect to multiple procedures performed by the same provider, is based upon the premise that usual charges for multiple procedures will normally not equal the sum of the charges for each procedure, if these were done independently. This is because there would be a common episode of preparation and follow-up. The procedure of greater value or of more clinical significance will be paid at 100 percent of the usual professional allowed charge up to the maximum allowable payment (MAP). For other procedures performed at the same setting, 50 percent of the usual professional allowed charge, up to the MAP, will be paid.

Services for procedures that are considered to be an integral part of previous or concomitant services or procedures are not recognized for separate reimbursement. Procedures that accomplish the same result are also considered content of service.

Contracting providers agree to accept the review process policy.

A. ENDOSCOPIES, ARTHROSCOPIES, AND OTHER SCOPE PROCEDURES

- A diagnostic scope is incidental to another diagnostic scope or a surgical scope (including biopsy).
- A diagnostic scope “with” or “without” biopsy is incidental to an open surgical procedure in the same anatomical area.
- A diagnostic scope is incidental to a diagnostic scope with biopsy unless the verbiage distinguishes the procedure as “with biopsy” versus “without biopsy.”
- Incidental relationships are applied to endoscopic, arthroscopic, and other scope procedures based on the following:
 - complete versus partial
 - with versus without
 - extensive versus limited

- For procedures that can be performed through the same scope, the more complex procedure will be reimbursed and the clinically less intense procedure is denied as incidental.
- If two procedures accomplish the same result, but it is unlikely that it would be clinically appropriate for both to be performed at the same time, the more intense procedure will be reimbursed.
- There are some situations in which multiple endoscopic, arthroscopic, or other scope procedures are necessary, each with sufficient clinical intensity to warrant separate reimbursement.

B. SCOPE VERSUS OPEN PROCEDURES

- An endoscopic, arthroscopic, or other scope procedure and open surgical procedure in the same anatomic area will not both be reimbursed.
- If an open surgical procedure and an endoscopic, arthroscopic, or other scope procedure accomplish the same result, the clinically more intense procedure is recommended for reimbursement. The comparable procedure is found incidental.
- For some endoscopic, arthroscopic, or other scope procedure assisted, open surgical procedures performed on the same anatomic area during the same operative session, separate reimbursement will be allowed based on additional time, skill and physician resources.

Policy Memo No. 12

Section IV. Nerve Blocks

This section was moved under OB Epidural Guidelines paragraph B. 4., page 4. The language was not changed.

Section VI. Related Policies, A. Unusual Cases

Language was added to include the use of Modifier 22 when sending medical information.

A. UNUSUAL CASES

When the condition of the patient relative to the surgical procedure to be performed is such as to imply an unusual risk, consideration of an unusual fee may be provided. In such cases, it is necessary to use Modifier 22 and send medical information that will substantiate the case and document direct attendance. It is acknowledged that unusual detention with the patient is eligible for additional time charges. Contracting providers agree to accept the review process determination in such cases.

Section VI. Related Policies, B. Regional Block Anesthesia

The heading was modified removing the word BLOCK; it now reads REGIONAL ANESTHESIA.

Section VI. Related Policies, C. OB Anesthesia

The heading was changed to OB Epidural Guidelines and the paragraph itself was relocated under B. REGIONAL ANESTHESIA.

Section VI. Related Policies, D. Unusual Anesthesia

This is a new section explaining our change in policy to recognize payment for anesthesia for upper gastrointestinal and lower intestinal endoscopic procedures.

D. UNUSUAL ANESTHESIA

Unusual anesthesia is applicable only to anesthesia for upper gastrointestinal or lower intestinal endoscopic procedures.

1. Claims for this level should be billed with modifier 23 describing unusual anesthesia.
2. Reimbursement to a CRNA or physician capable of starting anesthesia will be the lesser of your charge up to the MAP.

Section VI. Related Policies, E. Moderate (Conscious) Sedation

Language was added clarifying moderate sedation is content of service of the office procedure.

E. MODERATE (CONSCIOUS) SEDATION

CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider who is capable of initiating general anesthesia. However, when done in an office setting moderate sedation will be considered content of service to the office procedure.

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.