



**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 2008

CAP

Competitive Allowance Program

2009 CONTRACT

We appreciate your continued participation in serving our members as a contracting provider in the Competitive Allowance Program (CAP) and invite you to maintain your contracting status for 2009. Since your contract is perpetual, no action is necessary on your part for renewal.

The mission at Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) is to be recognized as the most trusted insurer operating in Kansas. 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 population in the BCBSKS service area, just to name a few.

Our administrative expenses remain low at 8.2 percent of premium income, as of May 31, 2008. 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 699,182 members, as of May 31, 2008. Taking all business including BlueCard into consideration, BCBSKS addresses the health care needs of 898,341 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 member benefits).
- 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 claim 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 conducted by professional relations staff who 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: Noncontracting providers' services are paid direct to the member at 80 percent of the MAP (subject to member benefits). In addition, assignment of benefits to noncontracting providers is not permissible.

Please review all materials immediately, as the 2009 contracting deadline of **September 3, 2008**, 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:

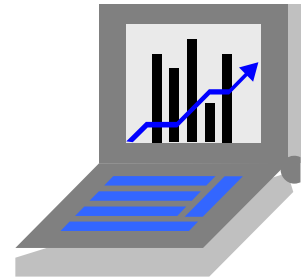
<u>Professional Relations Staff</u>	<u>Location</u>	<u>Phone Numbers</u>	
Doug Scott, Director	Topeka	800-432-0216 ext. 8831	(785) 291-8831
Robyne Goates, Manager	Topeka	800-432-0216 ext. 8206	(785) 291-8206
Sue Dunaway	Topeka	800-432-0216 ext. 8207	(785) 291-8207
Diana Evans	Topeka	800-432-0216 ext. 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
Velda Fresquez-Gray	Wichita	800-432-0216 ext. 1674	(316) 269-1674
Debra Meisenheimer	Hutchinson	(620) 663-1313	
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 (Doug Scott, 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 3, 2008**, to Doug Scott, Director of Professional Relations, cc480D2, 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 50,133 members, with enrollment totaling 490,347 members as of May 31, 2008. 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 88 percent of all professional providers are CAP contracting in our Kansas Plan area.
- BCBSKS remains a financially strong company.

Reimbursement and Policy Memo Changes

On June 26, 2008, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2009.

A charge comparison report reflecting reimbursement changes for 2009 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 2008.**

Below is a brief overview of reimbursement for 2009:

Increasing:

- Most covered CPT codes
- Evaluation and management services
- The anesthesia conversion factor to \$53.57
- The professional component of specialized imaging (CT, MRI/MRA, PET)
- The technical component of MRIs
- The technical component of PET scans (when a local community oncologist is engaged in the treatment)
- Ambulance
- HME

No change:

- The technical component of CTs
- The technical component of PET scans (when no local community oncologist is engaged in the treatment)
- Clinical lab
- Sleep medicine

Following is a summary of the changes to Blue Shield policies and procedures for 2009. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2008.

Policy Memo No. 1 POLICIES AND PROCEDURES

Preface

The second sentence of the third paragraph was modified, as shown below, to state that arbitration proceedings are conducted in Topeka unless both parties agree otherwise.

The arbitrator shall have the right to determine his or her own jurisdiction. The arbitration proceeding shall be conducted in Topeka, Kansas, unless both parties agree otherwise. The arbitrator may construe and interpret, but shall not delete from, add to, or modify the terms of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement. The arbitrator shall have no authority to award extracontractual damages of any kind, including but not limited to consequential, punitive or exemplary damages, and shall be bound by controlling law. The arbitrator shall apply the substantive law of Kansas, without giving effect to any conflict-of-laws principles.

The following paragraph was added explaining that the arbitration process is available to a provider only after all applicable review and/or appeal processes have been exhausted.

The arbitration process described above shall be available to providers only after exhaustion of all applicable review and/or appeal processes described within these policies and procedures. This exhaustion requirement shall apply to each claim or service in dispute.

Medical Review Processes

The following language was added to the fourth paragraph to more clearly explain the elements required in medical records to support medical necessity of services:

Complete medical records are expected to contain all the elements required by Section X. below and by K.A.R. 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.

Section I. Retrospective Claim Reviews

Wording was added to paragraph A. allowing providers to contact customer service by telephone, in addition to writing, to request retrospective claim reviews. Language was also modified stating that requests for retrospective review be submitted within 120 days from the date of the remittance advice, rather than within 120 days of adjudication.

- A. All requests for retrospective review, including corrected claims, must be submitted (in writing or by phone) to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice.

Section II. Denied Claims Appeals Procedure, Second Level

The title vice president of medical affairs was changed to chief medical officer. Language regarding final determination was modified for clarity.

Second Level: Forward a written request to customer service with your letter addressed to the Chief Medical Officer. The second and final appeal determination shall be made by the Chief Medical Officer. The contracting provider agrees to abide by the second level appeal determination.

Section III. Post-Payment Audit Appeals

The title of this section changed to Post-Payment Audits and language was modified throughout to clarify both post-payment audits and post-payment audit appeals. The title vice president of medical affairs was changed to chief medical officer.

The entire section, as modified, appears below:

III. POST-PAYMENT AUDITS

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity. Post-payment audits can range from a basic encounter audit to determine if the level of care is accurately billed, to a complete audit which thoroughly examines all aspects of the medical record and medical practice. Post-payment audits are performed after the service(s) is billed to BCBSKS and payments have been received by the provider. BCBSKS cannot go back further than 15 months following the date of claim adjudication to initiate an audit. 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 supported by the medical record, BCBSKS will deny as not medically necessary and request refunds. If no documentation is received, BCBSKS will deny for no documentation and request refunds. Denials will be a provider write-off.

Post-payment Audit Appeals:

A. First Level Appeal

Claims denied not medically necessary as a part of the post-pay audit process may be appealed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided with the appeal. The BCBSKS determination will be made within 30 days of receipt of the appeal.

B. Second Level Appeal

A provider may request a second and final appeal in writing within 30 days of notification of the first level appeal determination. The second and final appeal is to be submitted to the BCBSKS Chief Medical Officer. The second and final appeal determination will be made by the BCBSKS Chief Medical Officer within 30 days of receipt of the appeal.

When findings reveal issues, which are presently specified in BCBSKS policy memos, billing guidelines or newsletters relating to content of service, multiple surgery guidelines, and other billing and/or reimbursement guidelines, the terms of this appeal are not available.

Section X. Documentation

A statement was added requiring typed or electronic medical records be signed by the provider at the time of submission. Wording was modified to remove "for lack of medical necessity" and clarify provider write-off. These changes were necessary because without receiving documentation from the provider, BCBSKS is unable to determine medical necessity.

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 necessity 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. In the case of typed or electronic medical records, the entry must be authenticated (signed) by the provider at the time of submission.

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 contract gives us the ability to obtain this information without a signed patient release.

Failure to send the requested documentation within the time frame above or providing insufficient or no documentation to determine medical necessity will result in claim denial, and accordingly a provider write-off.

Section XIV. Claims Filing

The following language was added explaining add-on codes as defined by CPT, must never be reported as stand-alone procedures. Language was also added to reinforce that BCBSKS has the discretion to determine the applicability of codes/modifiers.

BCBSKS requires providers to report procedures according to CPT and HCPCS guidelines. However, the proper submission of codes and/or modifiers according to these guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modified or add-on codes for additional reimbursement.

For primary procedures, providers should submit the code that most accurately describes the service provided. Add-on codes (as defined by CPT) should not be reported as stand-alone procedures and must be submitted with the primary service in order to be considered for reimbursement. A list of additive codes BCBSKS recognizes for reimbursement is available from your provider representative or the BCBSKS Web site.

Section XVIII. Locum Tenens Providers

This section was added to outline appropriate billing for services provided by a LOCUM TENENS.

XVIII. LOCUM TENENS PROVIDERS

In situations in which the regular physician is unavailable, a locum tenens can be used to provide a visit/service. The locum tenens must not provide services over a continuous period

of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.

In billing for services provided by a locum tenens, the claim must be filed with the provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used. In addition, the medical record must indicate the services were provided by a locum tenens.

Section XXIV. Reimbursement for Pharmaceuticals

This section was revised in its entirety to reflect that reimbursement for pharmaceuticals will be based on a formula utilizing the published average sales price or the average wholesale price.

Covered pharmaceuticals are reimbursed based on a formula as determined by BCBSKS that utilizes the published average sales price (ASP) or the average wholesale price (AWP). Reimbursement for pharmaceuticals will be reviewed periodically and may be adjusted during the year to reflect changes in the ASP or AWP. A charge comparison report is available upon request.

Section XXVI. Adverse Events

This is a new section outlining the policy of BCBSKS to not reimburse for certain adverse events.

XXVI. ADVERSE EVENTS

Adverse events A, B, and C are not billable to BCBSKS.

- A. Surgery performed on the wrong body part
- B. Surgery performed on the wrong patient
- C. Wrong surgical procedure on a patient

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

- D. Retention of foreign object in surgical patient

In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object then no payment for the correcting surgery will be made and the patient will be held harmless.
2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.

Section I. Credentialing

This section was revised throughout to reflect that a new credentialing department has been established and credentialing activities are no longer part of the quality improvement department.

In paragraph F., #2., the title vice president of medical affairs was changed to vice president of provider relations and medical affairs.

Section II. Medical Record Review

The following paragraphs were added further explaining the quality improvement plan (QIP) process.

A QIP is developed for all providers identified as having a pattern of quality issues. Problem codes assigned to these cases are reviewed to tailor the QIP according to specified problems identified during the initial review process. Therefore, QIPs may be developed for facility, physician, or ancillary providers depending upon the problem focus.

Evaluation of the effectiveness of the QIP will be performed at intervals appropriate to the identified problem or deficiencies, but not to exceed one (1) year.

Section III. Adverse Quality of Care Determinations and Quality Improvement Plan (QIP) Appeal Process

Throughout this section the title vice president of medical affairs was changed to vice president of provider relations and medical affairs. On page 9, corporate medical director was changed to corporate medical director/CMO.

Section X. Provider Satisfaction

This section was eliminated because provider satisfaction surveys are no longer a function of the quality improvement department.

Section X. Disease Management (Care Management)

This section was renumbered and wording was modified to better describe the services offered by the care management area.

This HIPAA compliant program is physician directed and nurse managed via telephone. Through periodic telephone calls, the nurse case managers can assist in identifying risk factors and offer tools and resources to assist members in managing their chronic health condition.

Members will be contacted by phone or letter and invited to participate in the program. Education material is free of charge, and mailed on an individual basis.

Section IV. Providers Furnishing Less Than The Full Global Package

Paragraph A was modified to clarify payment between two or more physicians and use of the modifier with the corresponding surgical code.

- A. Except for physicians in group practice, there may be occasions when more than one physician provides services included in the global package. The physician who performs the procedure may not furnish the follow-up care. Payment for the postoperative, post-discharge care shall be split proportionately between two or more physicians in those instances in which those physicians agree on transfer of care. When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services. Where physicians agree on the transfer of care during the global period, the appropriate modifier should be reported with the corresponding surgical code.
 - 1. 54 for surgery only
 - 2. 55 for postoperative management only
 - 3. 56 for preoperative management only

Section X. Adverse Events

This is a new section outlining the policy of BCBSKS to not reimburse for certain adverse events.

X. ADVERSE EVENTS

Adverse events A, B, and C are not billable to BCBSKS.

- A. Surgery performed on the wrong body part
- B. Surgery performed on the wrong patient
- C. Wrong surgical procedure on a patient

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

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- 2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.