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Web site: [www.bcbsks.com](http://www.bcbsks.com)

July 2010

# CAP

## Competitive Allowance Program

### 2011 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 2011. 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 the best at providing health insurance 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, and technological advances in the BCBSKS service area, just to name a few.

The health care industry is challenged this year and going forward with the implementation of the Patient Protection and Affordable Care Act (PPACA) (Health Care Reform). We continually strive to improve the affordability of health insurance, the wellness of Kansans, and access to needed medical care. We appreciate your role in our partnership to achieve these objectives as you serve our members, your patients.

Our administrative expenses remain low at 8.7 percent of premium income, as of May 31, 2010. This puts us comfortably in compliance with the new minimum loss ratio standards (80-85 percent based on group size) mandated in PPACA. We know of no other Kansas insurance company that rivals this low administrative expense percentage. Our company continues to focus on controlling our corporate administrative costs while maintaining prompt service to our members and providers.

Local enrollment totals 686,362 members, as of May 31, 2010. Taking all business including BlueCard into consideration, BCBSKS addresses the health care needs of 939,947 Kansans. Financially, BCBSKS is in a solid position with positive contribution to reserves. Strong policyholder reserves allow us to 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.

We continue to strive toward providing you, our contracting provider, with 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.
- Electronic remittance advice and payment capabilities.
- Web site ([www.bcbsks.com](http://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, podcasts, 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 staff 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 charge up to 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 2011 contracting deadline of **September 3, 2010**, 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
Diana Evans	Topeka	800-432-0216 ext. 8716	(785) 291-8716
Darin Fieger	Topeka	800-432-0216 ext. 8207	(785) 291-8207
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 or 3	(785) 291-4135, opt. 1 or 3

<u>Professional Relations Staff</u>	<u>Location</u>	<u>Phone Numbers</u>	
Kyle Abbott	Wichita	800-432-0216 ext. 1674	(316) 269-1674
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 your concerns. 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, 2010**, to Doug Scott, Director of Professional Relations, cc480D2, 1133 SW Topeka Blvd., Topeka, KS 66629.

Thank you for your continued willingness to partner with Blue Cross and Blue Shield of Kansas to bring the highest quality health care to our members at the lowest possible cost.

Sincerely,



Douglas R. Scott  
Director, Professional Relations

## Additional Important Information

### Trends

- Wellness programs continue to be 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 continues to be the flagship product with enrollment totaling 550,666 members as of May 31, 2010. 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.
- 99 percent of physicians and 95 percent of all professional providers are CAP contracting in our Kansas Plan area.
- BCBSKS remains a financially strong company.
- BCBSKS is ranked number one of all Blue Plans in the Blue Brand Excellence award for Provider Satisfaction.
- BCBSKS continues to receive the prestige designation for World Class Customer Service.

# Reimbursement and Policy Memo Changes

On June 25, 2010, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2011. Highlights of the 2011 reimbursement are noted below.

A charge comparison report reflecting reimbursement changes for 2011 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 2010.**

## Below is a brief overview of reimbursement for 2011:

### Increasing: ↑

- Most covered CPT codes
- Evaluation and management services (except preventive medicine codes which are being held to current levels)
- The anesthesia conversion factor to \$55.04
- Ambulance
- Some home medical equipment items

### No change: ↔

- The professional and technical components of specialized imaging and nuclear medicine (CT, MRI/MRA, PET)
- Ultrasound
- Most clinical lab
- Sleep medicine
- Anesthesia pain management
- E/M preventive medicine codes

### Decreasing: ↓

- Some physical medicine
- Pharmaceuticals

**Tiered Reimbursement** – The allowances for the following specialties have been set at the identified percentages of the MAP:

85 Percent	70 Percent	50 Percent
<ul style="list-style-type: none"> <li>Advanced Registered Nurse Practitioners (ARNPs) [not including Certified Registered Nurse Anesthetists (CRNAs)]</li> </ul>	<ul style="list-style-type: none"> <li>Community Mental Health Centers</li> </ul>	<ul style="list-style-type: none"> <li>Certified Occupational Therapy Assistants (COTAs)</li> </ul>
<ul style="list-style-type: none"> <li>Chiropractors</li> </ul>	<ul style="list-style-type: none"> <li>Licensed Clinical Marriage and Family Therapists</li> </ul>	<ul style="list-style-type: none"> <li>Certified Physical Therapist Assistants (CPTAs)</li> </ul>
<ul style="list-style-type: none"> <li>Clinical Psychologists</li> </ul>	<ul style="list-style-type: none"> <li>Licensed Clinical Professional Counselors</li> </ul>	
<ul style="list-style-type: none"> <li>Occupational Therapists</li> </ul>	<ul style="list-style-type: none"> <li>Licensed Clinical Psychotherapists</li> </ul>	
<ul style="list-style-type: none"> <li>Physical Therapists</li> </ul>	<ul style="list-style-type: none"> <li>Licensed Specialist Clinical Social Workers (LSCSWs)</li> </ul>	
<ul style="list-style-type: none"> <li>Physician Assistants</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient Substance Abuse Facilities</li> </ul>	
<ul style="list-style-type: none"> <li>Speech Language Pathologists</li> </ul>		

# BLUE CROSS AND BLUE SHIELD OF KANSAS

## PROVIDER POLICIES AND PROCEDURES

### CHANGES FOR 2011

Following is a summary of the changes to Blue Shield Policies and Procedures for 2011. The policy memos in their entirety will be available in the provider publications section of [www.bcbsks.com](http://www.bcbsks.com) in December 2010.

NOTE: Changes in numbering due to insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2011 Policy Memos. Deleted wording is noted in brackets [ ]. New verbiage is identified in **bold**.

## Policy Memo No. 1

### MEDICAL REVIEW PROCESSES

- **Page 2:** Wording in the third paragraph was changed and a sentence added to make the process more clear: in sentence 2 "information" was changed to "documentation," and the phrases, "or information" and "after the review has been completed," were deleted. A sentence was added at the end of the paragraph.

**NOTE:** All pertinent and complete medical records must be provided by the contracting provider when records are needed for the initial review of a claim or when records are requested for an audit. Additional [information] **documentation** that is not a part of the medical record [or information] **and** that was not provided at the time of the initial request will not be accepted [after the review has been completed]. Only records created contemporaneous with treatment will be considered pertinent. **Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off.**

- **Page 2:** In paragraph 4, added wording to identify the initials, K.A.R.

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

- **Page 2:** In paragraph 5, added the words "ordered or" to signify the ordering physician is responsible for documenting the medical necessity of any services ordered.

Each patient record must contain adequate documentation to justify the course of treatment **ordered or** provided, and reflect the patient's current status and progress during the course of treatment.

## Policy Memo No. 1

### SECTION I. CORRECTED CLAIM

- **Page 2:** Added Section I. CORRECTED CLAIM to define the difference between a corrected claim and retrospective claim reviews.

#### I. CORRECTED CLAIM

A request made from a contracting provider to change a claim, (e.g., changing information on the service line, modifier addition, diagnosis correction, etc.) that has previously processed is considered a corrected claim. This excludes claims denied for additional information. The submission of a corrected claim must be received by BCBSKS within the 15-month timely filing deadline.

## Policy Memo No. 1

### SECTION II. RETROSPECTIVE CLAIM REVIEWS

(Previously Section I.)

- **Page 3:** In Section A., deleted the phrase "including corrected claims" since that is now addressed in Section I. CORRECTED CLAIM.

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.

- **Page 3:** In Section B., the word "written" was added before "request" for greater clarification.

B. The provider will be given a written response to the **written** request for a retrospective review as soon as possible, but no later than 60 days from receipt date. In cases where claims are adjusted, the remittance advice will serve as the written response.

## Policy Memo No. 1

### SECTION III. DENIED CLAIMS APPEALS PROCEDURE

(Previously Section II.)

- **Page 3:** In paragraph 5, First Level, wording was added to the last sentence to clarify the process.

This decision will be binding unless the provider [re-appeals the decision] **files a second level appeal** within 60 days of notification of **such decision**.

- **Page 3:** In paragraph 6, Second Level, wording was added to clarify the process.

Forward a written request to customer service with your letter addressed to the Chief Medical Officer **within 60 days following the first level appeal denial notification**.

## Policy Memo No. 1

### SECTION IV. POST-PAYMENT AUDITS

(Previously Section III.)

- **Page 4:** Additional wording clarifies audit verification factors in sentence 1 of paragraph 1. In the last sentence of the same paragraph, another avenue of education is identified.

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity **and established standards of care.**

BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, **peer consultant medical opinion**, and on-site visits.

## Policy Memo No. 1

### SECTION V. UTILIZATION REVIEW AND MEDICAL NECESSITY

(Previously Section IV.)

- **Page 5:** Under B. PRE-ADMISSION CERTIFICATION & CONCURRENT REVIEW, Paragraph 1. After sentence 2, a sentence was inserted to define concurrent review.

**Concurrent review is the process of obtaining current medical information to review for the medical necessity of a requested extension to the length of stay or course of treatment.**

- **Page 7:** On the first line of the page (under H. MEDICAL NECESSITY/UTILIZATION REVIEW DENIALS—section begins on page 6), a phrase was inserted to call attention to a documentation requirement.

Failure to discuss the above with the patient in advance, **document this in the medical record**, and obtain the waiver will result in a provider write-off.

## Policy Memo No. 1

### SECTION VI. CONTENT OF SERVICE

(Previously Section V.)

- **Page 7:** Under the last bullet, verbiage was added to make the statement a complete sentence.

**Such services are not covered if billed separately and the only service rendered on that day.**

## Policy Memo No. 1

### SECTION VII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

(Previously Section VI.)

- **Page 8:** In the last paragraph, second sentence, after section D., verbiage was added to outline documentation requirements for use of the waiver form.

. . . must have a signed waiver in his/her file. The provider must **discuss this with the patient in advance, document this in the medical record, and** include the GA modifier (waiver on file) on the claim form (electronic or paper). (See Section X. WAIVER FORM) **Failure to discuss and obtain a signed waiver in advance of the service will result in provider write-off. Denied experimental or investigational services are not eligible for appeal.**

## Policy Memo No. 1

### SECTION VIII. NON-COVERED SERVICES

(Previously Section VII.)

**Page 8:** Removed "Please note:" on the first line.

[Please note:] Providers are not reimbursed . . .

## Policy Memo No. 1

### SECTION X. WAIVER FORM

(Previously Section IX.)

- **Page 10:** Under Section C., removed the word "SAMPLE."  
C. [SAMPLE] WAIVER FORM (see last page of Policy Memo No. 1)

## Policy Memo No. 1

### SECTION XI. DOCUMENTATION

(Previously Section X.)

- **Page 10:** After the third paragraph, two paragraphs were added defining requirements of medical records.

**Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Complete medical records are also expected to contain all the elements required herein and by K.A.R. 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.**

Medical records are expected to support the medical necessity for all aspects of patient care, including ancillary services provided on the date of service for which a claim is filed. Each patient record must contain adequate documentation to justify the course of treatment provided and reflect the patient's current status and progress during the course of treatment. The intensity of the service billed must be supported by the diagnosis code. Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

## Policy Memo No. 1

### SECTION XV: CLAIMS FILING

(Previously Section XIV.)

- **Page 11:** The exclusion defined by HITECH was added to the first sentence of the first paragraph.

The contracting provider agrees to submit claims to BCBSKS for covered services (**excluding "self pay" requests made by the patient as defined within the Health Information Technology for Economic and Clinical Health (HITECH) Act, Section 13405(a)**) rendered to members at the usual charge (normal retail charge for HME suppliers) in the BCBSKS designated format, and to look to BCBSKS for payment except for amounts identified as patient responsibility:

- **Page 12:** A sentence was inserted at the beginning of the second paragraph stating that contracting providers shall submit claims using their NPI or specific performing provider number, if applicable.

All contracting providers (except as provided in Section XXV.), who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific performing provider number, except when exempt by law) must appear on every claim.

## Policy Memo No. 1

### SECTION XVI. REFUND POLICY

(Previously Section XV.)

- **Page 12:** In the first paragraph, a final sentence was added to state that providers should notify BCBSKS upon discovery of an overpayment.

Providers shall promptly notify BCBSKS upon becoming aware of an overpayment to initiate the refund process.

## Policy Memo No. 1

### SECTION XVII. RIGHT OF OFFSET

(Previously Section XVI.)

- **Page 13:** A sentence was inserted after sentence 1 to further clarify the right of offset.

BCBSKS will, through auto deduction processes, exercise the right of offset for claims previously paid. **This right includes offset against any subsequent claim(s) submitted by the provider, including those involving other members.** To accomplish this, BCBSKS will supply [the] providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently.

## Policy Memo No. 1

### SECTION XVIII. SERVICES PROVIDED BY NON-PHYSICIANS AND RESIDENT PHYSICIANS

(Previously Section XVII.)

- **Page 13:** Sections A., C., D., and E.: References to "UPIN" were removed and replaced with "National Provider Identifier" and "NPI;" and wording was rearranged for clarity. A sentence was added to Section B. to clarify that eligible services must be an integral part of the physician's professional service.

- A. All non-physicians, who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, [should] **shall** bill their charges to BCBSKS under their own National Provider **Identifier** (NPI) **or specific performing provider number**, if applicable. The name of the ordering provider, when applicable, (including [UPIN or] NPI, except when exempt by law) must appear on every claim.
- B. A physician may bill for the services of a nurse, other than an ARNP, if there is an employer/employee relationship and the services are supervised by the physician (supervision means the patient recognizes the supervising physician as his/her physician and there is a periodic review of the records by the physician). **These services must be an integral part of the physician's professional service, included in the physician's bill, and be of the type that are commonly furnished in the physician's office or clinic.**
- C. Independently practicing Advanced Registered Nurse Practitioners (ARNPs) who are providing services as defined in their Kansas licensure or certification, [should] **shall** bill their charges to BCBSKS under their own **NPI or specific performing** provider number. The name of the ordering provider, when applicable, (including [UPIN or] NPI, except when exempt by law) must appear on every claim.
- D. Services of a Resident Physician are billed under the attending Faculty Physician's **NPI or specific performing** provider number if done in connection with the Residency Program.
- E. If the Resident Physician is providing services outside of the Residency Program, all Blue Shield Policy Memos apply and [a separate provider number is required] **services shall be billed under his/her own NPI or specific performing provider number.**

## Policy Memo No. 1

### SECTION XIX. LOCUM TENENS PROVIDER

(Previously Section XVIII.)

- **Page 14:** Wording was changed in the second paragraph to comply with NPI usage.

In billing for services provided by a locum tenens, the claim must be filed [with] **using** the **NPI or specific performing** provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used.

## Policy Memo No. 1

### SECTION XX. CONTRACTING STATUS DETERMINATION

(Previously Section XIX.)

- **Page 14:** In the third paragraph of Section C., the section number identified for TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS is changed.

C. If such eligible provider is among those identified in Section [XXIV] **XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS . . .**

- **Page 15:** Section D. was added stating it is the responsibility of the provider to notify BCBSKS of status changes.

D. **It is the responsibility of the contracting provider or a representative to notify BCBSKS of any changes in practice information, e.g., license status, address, tax ID number, NPI, ownership, individual provider leaving/joining group practice, death of provider, closure of office, etc.**

## Policy Memo No. 1

### SECTION XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS

(Previously Section XXIV.)

- **Pages 16-17:** Three new categories of Behavioral Health providers were added to the list of eligible providers, as well as certified physical therapist assistants and certified occupational therapy assistants.

BCBSKS has established different MAPs for the same service for the following specialties: Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, Outpatient Substance Abuse Facilities, Chiropractors, Physical Therapists, **Certified Physical Therapist Assistants**, Occupational Therapists, **Certified Occupational Therapy Assistants**, [and] Speech Language Pathologists, **Licensed Clinical Marriage and Family Therapists**, **Licensed Clinical Professional Counselors**, and **Licensed Clinical Psychotherapists**.

- **Page 17:** A reference to charge comparison reports was added (end of first paragraph), and verbiage was changed to comply with NPI usage (first full paragraph on page).

Please review your charge comparison (refer to Section XXXV. CHARGE COMPARISON REPORTS) to determine any write-off amounts.

Eligible providers listed above must obtain an NPI [provider number from BCBSKS] and assure [that] it is included as the performing provider **number** on all claims submitted before any payment for such claims will be made by BCBSKS. Members may not be billed for services when a claim has not been paid because of the lack of the performing provider [number] NPI.

## Policy Memo No. 1

### SECTION XXVIII. REIMBURSEMENT FOR SLEEP STUDY TESTING

(Previously Section XXVII.)

- **Page 17:** Verbiage was added to identify additional accreditation allowed, and to define where sleep study testing must occur for reimbursement, as well as defining the reimbursement allowed. For purposes of clarity, the sentences were divided into paragraphs, with the first paragraph referring to professional providers, and the second paragraph referring to facilities. Thus, the word "providers" was changed to "facilities" in the second paragraph.

The allowance for sleep testing procedures as outlined by CPT is 100 percent of the MAP for providers board certified in sleep medicine. All other eligible providers receive 60 percent of the MAP.

The allowance for sleep testing procedures [for] **performed in** Freestanding Sleep Laboratories or Centers is 100 percent of the MAP for those [providers] **facilities** [who are] accredited by the American Academy of Sleep Medicine (AASM) **and/or the Accreditation Commission for Health Care, Inc. (ACHC)**. All other eligible [providers] **facilities** receive 60 percent of the MAP **when services are provided in a Freestanding Sleep Laboratory or Center. Services provided in a setting other than a Freestanding Sleep Laboratory or Center will be limited to 50 percent of the applicable MAP for facilities.**

## Policy Memo No. 1

### SECTION XXXII. ACKNOWLEDGMENT OF INDEPENDENT STATUS OF PLAN

(Previously Section XXXI.)

- **Page 19:** The acronym "BCBSA" was added for any future reference to the Association.

The provider hereby expressly acknowledges its understanding that the agreement to which these policies and procedures apply constitutes a contract between the provider and BCBSKS that the Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (**BCBSA**), an association of independent Blue Cross and Blue Shield Plans, the Association permitting the Plan to use the Blue Cross and Blue Shield Service Mark, and that the Plan is not contracting as the agent of the Association.

## Policy Memo No. 1

### SECTION XXXIX. CAP PROVIDER DIRECTORIES

(Previously Section XXXVIII.)

- **Page 20:** Wording was added to send provider information for national doctor locator directories.

BCBSKS makes CAP provider information, including contracting providers' names, available to members on our Web site: [www.bcbsks.com](http://www.bcbsks.com), and to BCBSA for national doctor locator directories.

## Policy Memo No. 4

### PREFACE

- **Page 1:** The sentence was replaced to better introduce the topic, "Quality of Care."

[The quality of care and peer review programs described in this policy memo may apply to providers delivering services to Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) members.]

**An integral component of the BCBSKS quality improvement program is the evaluation of the health care services rendered to members by contracting providers through medical peer review. Potential quality of care concerns, including adverse events, may be identified and referred by members, providers or other persons who have such information. All such quality of care concerns shall be referred to the manager of the Quality Improvement/Care Management department, who serves as the designated peer review officer for BCBSKS as defined in K.S.A. 65-4915.**

## Policy Memo No. 4

### SECTION I. QUALITY IMPROVEMENT PROGRAM

- **Page 2:** Sentence was removed from the first paragraph.

[Problem codes assigned to these cases are reviewed to tailor the QIP according to specified problems identified during the initial review process. Therefore,]

- **Page 2:** In paragraph 3, verbiage "for greater than 30 days" was removed from the first sentence where the [\*] appears.

If, as a result of an adverse quality of care determination by BCBSKS, a QIP is assigned which restricts or suspends a provider's clinical privileges [\*], the provider will be notified of the appeal rights set forth herein.

## Policy Memo No. 9

### SECTION I. GLOBAL FEE CONCEPT

- **Page 2:** Under A.3., the first full paragraph on the page was removed as it did not apply to the Global Fee Concept.

[Medically necessary moderate sedation when performed by a trained observer and directed by the surgeon will be allowed when performed in an office setting, except when the surgery procedure code is on CPT Appendix G or a corresponding HCPCS code. (Anesthesia for procedures on Appendix G and corresponding HCPCS codes is included in the MAP for the surgery and not separately payable.)]

- **Page 3:** Section B. MODERATE (CONSCIOUS) SEDATION was added to define when and how payment is allowed.

#### B. MODERATE (CONSCIOUS) SEDATION

**When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider, other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the performing provider and will be denied as a provider write-off. (Dental providers please refer to Dental Policy Memo, Section XXXIV.)**

## Policy Memo No. 12

### SECTION VI. RELATED POLICIES

- **Page 4:** Under Section E. MODERATE (CONSCIOUS) SEDATION, second paragraph, verbiage clarifies that payment will be allowed for medically necessary moderate sedation in an inpatient or outpatient facility to an authorized provider other than the provider of the primary service. However, moderate sedation in an office setting will be considered content of service and will deny as a provider write-off.

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider, **other than the provider of the primary service**, who is authorized under state law to administer general anesthesia. [Medically necessary] Moderate sedation, [when performed by a trained observer and directed by the anesthesia provider will be allowed] when performed in an office setting, [except when the surgery procedure code is on CPT Appendix G or a corresponding HCPCS code. (Anesthesia for procedures on Appendix G and corresponding HCPCS codes is included in the MAP) for the surgery and not separately payable.)] **is considered content of service to the office procedure rendered by the performing provider and will be denied as a provider write-off.**