1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Web site: www.bcbsks.com

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

July 2011

CAP

Competitive Allowance Program

2012 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 2012. 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 affordability of health insurance remains a major concern for all of us. 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 Federal Health Care Reform (Affordable Care Act (ACA)) legislation. 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 7.67 percent of premium income, as of May 31, 2011. This puts us comfortably in compliance with the new minimum loss ratio standards (80-85 percent based on group size) mandated in ACA. 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 659,761 members, as of May 31, 2011. Taking all business including BlueCard into consideration, BCBSKS addresses the health care needs of 911,274 members. 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.

*An Independent Licensee of the Blue Cross and Blue Shield Association.

We continue to strive to provide 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) 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 delivers 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 (i.e., there is a 20 percent penalty for members receiving services from a noncontracting provider) (subject to member benefits). In addition, assignment of benefits to noncontracting providers is not permissible.

Please review all materials immediately, as the 2012 contracting deadline of **September 3, 2011,** 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:

Professional Relations Staff	Location	Phone Numbers	
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

Professional Relations Staff	Location	Phone Numbers	
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, 2011**, 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

Blue Ribbon News

- Blue Choice continues to be the flagship product with enrollment totaling 529,071 members as of May 31, 2011. 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 96 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 July 1, 2011, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2012. Highlights of the 2012 reimbursement are noted below. It is noteworthy to expand on the 2012 reimbursement considerations and decisions. As referenced on page one of this communication, Health Care Reform is shaping the way health plans, providers and patients will work collaboratively to promote better health, demonstrated outcomes, and reduced costs. In order to be designated a qualified health plan that is eligible to be offered on the Health Insurance Exchange, health insurance companies must have a quality-based reimbursement program. While the specific details of Health and Human Services' (HHS) vision of a quality-based reimbursement program is yet to be defined, we wholeheartedly believe that we need to move in this direction, gain some experience, and demonstrate our compliance between now and 2014. As such, the premise for the 2012 reimbursement is primarily built on the opportunity for providers to earn increased reimbursement by meeting the criteria as outlined in the 2012 Quality-Based Reimbursement Program (QBRP) as described below.

There are a few categorical increases, decreases, and areas of neutrality that specifically address some provider specialties and/or services. Reimbursement is tailored for those areas which will not be included in the QBRP. There is also a concentrated focus on enhancing reimbursement opportunities for primary care services, including the administration for immunizations. In addition, we have observed market trends toward aggressive pricing for reference lab. As BCBSKS competes for enrollment we must remain sensitive to market influences and the impact they have on our ability to offer a competitive premium. While other carriers and large employers may require reference lab to be channeled through a lab vendor, we want to continue to allow lab to be performed by our

network providers at competitive allowances. Finally, there will be a change in the reimbursement administration when using modifier 25 to bill an additional service. Services billed using the modifier 25 will be treated like multiple surgery (full and half) where reimbursement is allowed for the primary service and the second service is allowed at 50 percent. As in the multiple surgery guidelines, overhead costs associated with providing an additional service in the same setting are not doubled.

A charge comparison report reflecting reimbursement changes for 2012 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 2011.**

Below is a brief overview of reimbursement for 2012:

Increasing: ⇧

- Evaluation and management (E/M) code 99213 (eligible for QBRP)
- Immunization administration (eligible for QBRP)
- Physical, Occupational, and Speech therapy (not eligible for QBRP)
- The anesthesia conversion factor to $55.59 (not eligible for QBRP)
- Ambulance (ground and air) (not eligible for QBRP)
- Some home medical equipment, prosthetics, and orthotics (not eligible for QBRP)

No change: ⇔

- The professional and technical components of specialized imaging and nuclear medicine (CT, MRI/MRA, PET) (not eligible for QBRP)
- Sleep medicine (not eligible for QBRP)
- Most CPT codes (increases available in accordance to the QBRP)

Decreasing: ⇩

- Pharmaceuticals (not eligible for QBRP)
- Clinical lab (not eligible for QBRP)
- Modifier 25 services

Tiered Reimbursement – The allowances for the following specialties have been set at the identified percentages of the MAP (no change for 2012):

85 Percent	70 Percent	50 Percent
• Advanced Registered Nurse Practitioners (ARNPs) [not including Certified Registered Nurse Anesthetists (CRNAs)]	• Community Mental Health Centers	• Certified Occupational Therapy Assistants (COTAs)
• Chiropractors	• Licensed Clinical Marriage and Family Therapists	• Certified Physical Therapist Assistants (CPTAs)
• Clinical Psychologists	• Licensed Clinical Professional Counselors	
• Occupational Therapists	• Licensed Clinical Psychotherapists	
• Physical Therapists	• Licensed Specialist Clinical Social Workers (LSCSWs)	
• Physician Assistants	• Outpatient Substance Abuse Facilities	
• Speech Language Pathologists		

2012 Professional Providers Quality-Based Reimbursement Program

Background

Section 1311(c)/(g) of the Health Care Reform Act requires health plans to have a reimbursement arrangement with providers that incents quality in order to be designated a qualified health plan that is eligible to be offered on the Health Insurance Exchange. The Exchange takes effect in 2014, and it is envisioned that the health plan review and approval process will occur in 2013. Thus, it is imperative for BCBSKS to take steps to implement a Quality-Based Reimbursement Program (QBRP) for 2012 to gain experience and make any appropriate modifications in 2013 to become qualified.

Criteria for 2012

In accordance to the 2012 Policy Memo No. 1, Section XXX. Reimbursement for Quality, this document describes the components of the quality-based reimbursement program effective January 1, 2012 through December 31, 2012. This program applies to all CAP professional providers and services except for clinical lab, sleep lab, PT/OT/SLP, anesthesia, ambulance, pharmaceuticals, HME, dentists, and specialized imaging. This program will offer an opportunity for eligible providers to earn increased reimbursement based on a two-tiered approach. This reimbursement will be in addition to the established Maximum Allowable Payments (MAPs) for 2012. **Tier I** will apply to all eligible contracting professional providers. **Tier II** will only apply to providers represented in the category of office-based "primary care physicians (PCPs)" (family practice, general practice, general internal medicine, and pediatrics). The components of the QBRP are largely process-based metrics rather than clinical measures. Clinical measures as well as an expansion of other quality components will be considered for inclusion for 2013.

There are two pre-requisites to earning the opportunity to participate in the QBRP. The professional provider must be fully compliant with transacting business with BCBSKS in an electronic fashion (i.e., turn off paper), and the provider must agree to participate in a Health Information Exchange approved by the Kansas Health Information Exchange, Inc. (KHIE), when such exchange becomes generally available. As for going paperless, this includes submitting all eligible claims electronically, accepting electronic remittance advice documents (ERA's; either through receiving the ANSI 835 transaction or by downloading the RA from the BCBSKS Web site), and receiving all communications (newsletters, etc.) electronically.

Qualifications for any quality-based reimbursement will be on an individual provider basis, rather than a clinic basis. There will be three components to the program and an eligible provider will independently qualify for each component. The attached sample Attestation Form will be available in the secured provider section of the BCBSKS Web site by mid-September. Providers will be notified when the Attestation Form is available to complete and submit to BCBSKS to attest to meeting the pre-requisite requirements and the applicable Tier 1 and/or Tier II components.

Tier I (Applies to all eligible CAP contracting professional providers) (1.50%)

1. Electronic Medical Records (EMR) System: The provider must either have an operating EMR system or be working towards selecting and implementing an EMR system. For the purpose of this metric, "working towards" means have a signed contract with an EMR

system vendor to implement a system or attest to the intent to sign such a contract sometime during the course of 2012. Providers who meet the EMR criteria will receive an additional 1.50 percent increase to the 2012 MAPs for all CPT/HCPCS codes except CPT codes for Clinical Lab, Sleep Lab, PT/OT/SLP, Ambulance, Anesthesia, HME, Dentists, Pharmaceuticals, and Specialized Imaging.

Tier II (Applies only to office-based Primary Care Physicians in the specialties of family practice, general practice, general internal medicine, and pediatrics).

2. Use of Electronic Prescriptions: (a.) Electronically access member benefit information for eligibility, formulary, and medication history a minimum of 15 times per quarter and (b.) Minimum generic use of 70 percent (for all BCBSKS members with a prescription drug benefit) **(.50%)**

   BCBSKS will obtain reports from Prime Therapeutics to validate this metric.

3. Attest to meeting any three of the following: **(.50%)**
   a. Establish and maintain a patient registry of BCBSKS patients by date of birth (DOB) and BCBSKS ID number, and share that registry with BCBSKS upon request.
   b. Process to evaluate 100 percent of re-admissions that occur within 30 days with the goal of reducing the number of re-admissions.
   c. Provide an open appointment scheduling process to allow for same day appointments.
   d. Establish an internal patient care committee to meet regularly to discuss specific patient medical and access issues, and to support quality improvement activities.
   e. Implement a follow up process to ensure all patient diagnostic test information is communicated to the patient in a timely fashion and documented in the medical record.
   f. Implement a referral tracking and follow up process to ensure all patient care is coordinated, appropriate records are shared with and received from referral specialists, duplicate tests are minimized, and a comprehensive patient record is maintained by the PCP.

Providers who meet the criteria for items 2. and/or 3. above will receive an additional .50 percent increase (for each item, 2. and 3.) to the 2012 MAPS for all E/M codes.

If you have any questions regarding QBRP, please contact your professional provider relations representative.

Please read before completing: Provider types not eligible for the Quality-Based Reimbursement Program (QBRP) that should not submit this form are: Ambulance, Anesthesia, Clinical Lab, Sleep Lab, Dentists, PT/OT/SLP, Specialized Imaging, Pharmaceuticals, and HME.

This information will be auto-populated when the form is opened. An e-mail address will be required to send a confirmation to the provider on the QBRP elements submitted, and the effective date of the incentive.

Date ______________ NPI ____________ Provider Name ____________________________
Billing NPI _______________ ____________ Group Name _____________________________

Web user ID and corresponding name of person attesting to compliance with the Quality-Based Reimbursement Program requirements as the provider or provider legal designee.

Web user ID:__________________________ User ID Name:_____________________________

E-mail address to confirm the QBRP elements submitted along with the QBRP effective date:____________(Required)

2012 Professional Provider Quality-Based Reimbursement Program Attestation

Providers may enroll in the Quality-Based Reimbursement Program at any time by completing and submitting an attestation. The QBRP effective date will be the first day of the month following receipt of the completed QBRP attestation. The QBRP effective date and QBRP elements attested to will be confirmed by e-mail to the e-mail address provided above.

Pre-requisites - Validate your compliance to the pre-requisites for the QBRP by completing the following:

- The professional provider must be fully compliant with transacting business with BCBSKS in an electronic fashion (i.e., turn off paper).

  _____File Claims Electronically _____Do not file claims electronically and request assistance from BCBSKS.

  _____BlueShield Report Newsletter – Newsletters are sent via list serve at least quarterly.
  Qualifying e-mail address____

  _____Accepting electronic remittance advice documents (ERAs; either receiving the ANSI 835 transaction or retrieving your remittance advice from the BCBSKS Web site. Remittance advices are posted to the BCBSKS secured provider portal Tuesday of each week.
  Qualifying e-mail address ____

- The professional provider must participate in a KHIE-approved Health Information Exchange.

  _____ I intend to participate in a KHIE, Inc.-approved Health Information Exchange (HIE) when one is generally available.

Tier I (Applicable to all eligible CAP contracting professional providers)

1) Use of Electronic Medical Records System (EMR): Provider must either have an operating EMR system or be working towards selecting and implementing an EMR system. "Working towards" means have a signed contract with an EMR system vendor to implement a system or the intent to sign such a contract sometime during 2012. Providers meeting the EMR system criteria receive an additional 1.50% increase to the 2012 MAPs for all **CPT** codes billed except CPT codes for Clinical Lab, Sleep Lab, PT/OT/SLP, Pharmaceuticals, Anesthesia, Ambulance, Dental, HME, and Specialized Imaging. (Please check and complete as appropriate.)

   _____EMR system in practice today and used by provider. (Meets requirement.)
   Name of EMR system vendor:____

SAMPLE

_____Have signed a contract with an EMR system vendor with implementation planned in 2012. (Meets requirement.)
Name of EMR system vendor:____

_____EMR system is being evaluated with the intent to sign contract with a vendor to implement an EMR system sometime in 2012. (Meets requirement.)

_____Have no current plans for adding an EMR system. (Does not meet requirement.)

Tier II (Applicable to office-based Primary Care Physicians in the specialties of family practice, general practice, general internal medicine, and pediatrics)

Providers who meet the criteria for items 2) and/or 3) below will receive an additional .50% increase (for each item 2. and/or 3.) which will be applied to the 2012 MAPS for all **E/M** codes billed.

2) Use of Electronic Prescriptions: (a.) Electronically access member benefit information for eligibility, formulary, and medication history a minimum of 15 times per quarter and (b.) Minimum generic use of 70 percent (for all BCBSKS members with a prescription drug benefit) **(.50%)**

BCBSKS will obtain reports from Prime Therapeutics to validate these metrics and include in the QBRP confirmation e-mail your performance in this category. Periodic reports will be run throughout 2012 to verify additional providers who qualify for this metric. Providers may also request a compliance status at their convenience.

3) Have at least three of the following processes ongoing in the practice (Please mark three that apply):
   a. ____Establish and maintain a patient registry of BCBSKS patients by DOB and BCBSKS ID number, and share that registry with BCBSKS upon request.
   b. ____Process to evaluate 100 percent of re-admissions that occur within 30 days with the goal of reducing the number of re-admissions.
   c. ____Provide an open appointment scheduling process to allow for same day appointments.
   d. ____Establish an internal patient care committee to meet regularly to discuss specific patient medical and access issues, and to support quality improvement activities.
   e. ____Implement a follow up process to ensure all patient diagnostic test information is communicated to the patient in a timely fashion and documented in the medical record.
   f. ____Implement a referral tracking and follow up process to ensure all patient care is coordinated, appropriate records are shared with and received from referral specialists, duplicate tests are minimized, and a comprehensive patient record is maintained by the PCP.

Form Revision: July 2011

SAMPLE

BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
CHANGES FOR 2012

Following is a summary of the changes to Blue Shield Policies and Procedures for 2012. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2011.

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
INTRODUCTION

- **Page 1:** Changed inclusion of Blue Cross and Blue Shield of Kansas (BCBSKS) publications into only Policy Memo No. 1 to the applicable Policy Memo. Language was also added to establish hierarchy of the most recent document in the event of conflict.

  All existing and future policies and procedures published within BCBSKS publications that are available via the BCBSKS Web site are considered part of [this Policy Memo No. 1] **the applicable Policy Memo**. These publications include newsletters, provider manuals, workshop materials, and periodic update communications. **In the event provisions of such BCBSKS publications, policy memos, and/or the provider agreement conflict, the most recently published provision controls.**

Policy Memo No. 1
MEDICAL REVIEW PROCESSES

- **Page 2:** Wording was changed in the first and second paragraphs to identify the practice of BCBSKS to utilize qualified, clinical professionals who are typically currently practicing.

  The medical review processes are conducted by the staff of BCBSKS who seek the advice of qualified and**, typically,** practicing professionals [related to medical necessity] **when necessary**. A contracting provider agrees to accept review process decisions and to follow the established appeals procedures.

  The entire review process itself includes the development of guidelines that relate to specific provisions of members' contracts; the processing of claims based on guidelines and medical records when indicated; the retrospective review of claim determinations; and the appeal process. BCBSKS seeks the advice of [practicing] **clinical** professionals at appropriate points throughout the entire review process.

- **Page 2:** In paragraph 3, a 30-day time frame was added for submission of records requested for a review or audit. Language was also added to identify the responsibility of the ordering/referring provider to provide medical records to the performing provider when requested for review. This paragraph is a NOTE, and will be indented to clarify it as such.

> **NOTE:** All pertinent and complete medical records must be provided by the contracting provider **within 30 days upon request** when records are needed for the initial review of a claim or when records are requested for an audit. **The ordering/referring provider shall also provide medical records to the performing provider when requested for the purpose of medical necessity review.** Additional documentation that is not a part of the medical record and that was not provided at the time of the initial request will not be accepted. 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.

Policy Memo No. 1
SECTION IV. POST PAYMENT AUDITS

- **Page 4:** The word "claims" in the first line of paragraph A was changed to "services" to more accurately identify what is being denied.

A. First Level Appeal

[Claims] **Services** 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.

Policy Memo No. 1
SECTION X. WAIVER FORM

- **Page 9:** In paragraph B. 2, the words "and reason" were added to clarify that the reason for the waiver must be included on the waiver form.

B. THE WAIVER FORM MUST BE

1. Signed prior to receipt of service.
2. Patient**,** [and] service**, and reason** specific.

Policy Memo No. 1
SECTION XI. DOCUMENTATION

- **Page 10:** Wording was added in the second paragraph to more clearly outline the process for procuring medical records in certain unusual circumstances.

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. Rubber stamp signatures are not permissible; however, electronic signatures are. The signature must be legible and contain at least the first initial and full last name. This provision does not affect stamped signatures on claims, which remain permissible. 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 **as determined solely by BCBSKS** require **contracting providers to submit [**the immediate submission of] medical records **to BCBSKS upon request and without advance notice**. In these cases, **a** BCBSKS [will have a] representative **will** visit the **provider's** office **during business hours** and secure **the** requested records **immediately and without giving prior notice to the provider**. 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.

Policy Memo No. 1
SECTION XV. CLAIMS FILING

- **Page 12:** A new fifth paragraph was inserted to provide notice that non-specific diagnosis codes will not be accepted upon implementation of ICD-10-CM.

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.

Upon implementation of ICD-10-CM, non-specific diagnosis codes (including, but not limited to, Not Otherwise Classified (NOC) and Not Otherwise Specified (NOS) codes) will not be accepted.

- **Page 12:** In paragraph 5 (will be paragraph 6 after the above addition), the number of days allowed for refunding a member's credit balance was expanded, and wording was changed to clarify when the timeframe begins.

[The provider may contact BCBSKS to verify the status of a patient's deductible.] If after BCBSKS makes its payment to the provider and a credit balance results from having collected payment from the member**,** [prior to filing with BCBSKS]then the provider must refund the credit balance to the member within [thirty (30)] **sixty (60)** days from the [time the member requests the refund of the credit balance. Otherwise, the provider will make the refund within 60 days from notice from BCBSKS] **date the overpayment is identified,** unless directed by the member to apply the credit balance to their account for future services.

Policy Memo No. 1
SECTION XVI. REFUND POLICY

- **Page 12:** Deleted the second paragraph.

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

[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.]

Policy Memo No. 1
SECTION XVIII. SERVICES PROVIDED BY NON-PHYSICIANS AND RESIDENT PHYSICIANS

- **Page 13:** Under paragraph G, added the newly recognized term of "APRN" in addition to "ARNP." The three specialty categories of eligible providers that became effective 10/1/2010 have also been added to the list of eligible providers.

G. BCBSKS will not pay for outpatient services connected with a nervous and mental diagnosis when provided by an unlicensed provider, or a licensed provider with a licensure other than designated in the member's contract as eligible to provide nervous and mental benefits. Supervision of an unlicensed provider, a licensed counselor, or one not designated as eligible in the member's contract does not constitute a service being rendered by an eligible provider. The exception to this would be if the service was rendered through a state licensed alcohol or drug abuse treatment facility, a hospital, psychiatric hospital, or a community mental health center. Eligible non-physician psychiatric providers include **APRNs/**ARNPs, certified psychologists, [and] licensed specialist clinical social workers**, licensed clinical marriage and family therapists, licensed clinical professional counselors, and licensed clinical psychotherapists**.

Policy Memo No. 1
SECTION XXVI. REIMBURSEMENT FOR NEW PROCEDURE CODES

- **Page 17:** A third sentence was inserted to address the instance of a newly introduced code which combines two existing codes; a new MAP will be established for such new code.

Periodically new American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes are published and finalized, usually each December with a January 1 effective date; however, new codes can be added at any time. For those new codes that replace existing codes, BCBSKS will crosswalk the existing MAP to the new code. **In the event a new code is established which combines two existing codes, a new maximum allowable payment (MAP) will be established for such new code.** For those brand new codes or codes without a Relative Value Unit (RVU), BCBSKS will consider a number of sources, for example: the RVU when applicable, consultants, and input from providers to establish the MAP.

Policy Memo No. 1
SECTION XXX. REIMBURSEMENT FOR QUALITY (New Section)

- **Page 17:** A new section was added to provide for an alternative reimbursement based on quality.

XXX. REIMBURSEMENT FOR QUALITY

In addition to, or in lieu of, the maximum allowable payment (MAP) as referenced elsewhere in any BCBSKS Policy Memo, BCBSKS may establish reimbursement criteria based on quality components to reward providers for meeting specified performance levels. Such criteria and corresponding reimbursement changes will be communicated in advance of the effective date.

Policy Memo No. 2
SECTION II. CONTENT OF SERVICE

Page 1: Added one bullet to the list of included fees: examination and/or treatment room.

- Examination of patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Any entries into the patient's record.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- **Examination and/or treatment room**
- Items of office overhead such as malpractice insurance, telephones, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls and Web-based correspondence are content of service when billed with another service on the same day. Not covered if billed separately and the only service rendered on that day.

Policy Memo No. 2
SECTION VI. ADDITIONAL POLICY CLARIFICATION

- **Page 3:** In paragraph E, a correction is needed: it should read “Paragraph C. 2,” not “Paragraph B.” The word “surgical” was also inserted after the word “new.”

E. For new **surgical** patient visits, see Policy Memo No. 9, Section I., Paragraph [B] **C. 2.**

- **Page 3:** A new paragraph F was added to clarify that routine rounds in a hospice setting are not separately billable.

  F. **If a physician service is routinely provided to hospice patients, it is not separately billable.**

Policy Memo No. 4
SECTION IV: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- **Page 3:** A Health Information Exchange (HIE) was added to the list of entities to which a health care provider may disclose protected health information (PHI).

  According to the HIPAA Privacy Rule, health care providers can disclose protected health information (PHI) to health plans pertaining to credentialing, retrospective review, office record reviews, **a Health Information Exchange (HIE),** and HEDIS (Healthcare Effectiveness Data and Information Set) data collection for the following types of health care operations:

Policy Memo No. 4
SECTION V. STATE HEALTH INFORMATION EXCHANGE (HIE) (New Section)

- **Page 3:** A new section was added to address the requirement of providing data to an approved Health Information Exchange (HIE).

  V. STATE HEALTH INFORMATION EXCHANGE (HIE)

  In the event a Health Information Exchange (HIE) is approved by Kansas Health Information Exchange, Inc., providers are required to provide data to any such health information exchange as requested by BCBSKS.

Policy Memo No. 4
SECTION VI. QUALITY REPORTING AND TRANSPARENCY (New Section)

- **Page 3:** This new section addresses any quality initiatives and programs that could be established by BCBSKS.

  VI. QUALITY REPORTING AND TRANSPARENCY

  BCBSKS may establish quality initiatives and programs to monitor and report performance results of participating providers, and make available such results in web based and/or written form to the general public, enrolled employer groups, and members.

Policy Memo No. 5
SECTION II. IN-HOSPITAL CONSULTATIONS

- **Page 2:** A new paragraph D was added to clarify that routine rounds in a hospice setting are not separately billable.

D. **If a physician service is routinely provided to hospice patients, it is not separately billable.**

Policy Memo No. 9
SECTION I. GLOBAL FEE CONCEPT

- **Page 1:** Verbiage was added to the sixth paragraph to clarify the intent of the global fee concept.

The **global** maximum allowable payment **(MAP)** for [these] **a surgical** procedure[s] includes **all** services **listed in Section A below** related to [the] **that** procedure [when furnished by the physician who performs the procedure]. **These services will not be separately reimbursed.** The services included in the global surgical package may be furnished in any setting (e.g., hospitals, ASCs, physicians' offices). Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon.

- **Page 1:** Added wording to further clarify intraoperative services.

2. Intraoperative Services

Intraoperative services **(including intraoperative monitoring)** are **[**normally a] **all** usual and necessary [part] **aspects** of a procedure.

Policy Memo No. 12
SECTION III. CONTENT OF SERVICES WITHIN USUAL ANESTHESIA FEE

- **Page 1:** In paragraph D, wording was added to clarify that intraoperative monitoring will be contented into the all-inclusive surgical MAP.

D. Monitoring of sedation for cardiac catheterizations and PTCAs is done by the cardiologist and facility personnel, therefore, separate reimbursement is not provided. **If intraoperative monitoring is required and performed during a surgery, BCBSKS will content the service into the all-inclusive surgical MAP.**