

July 2006

CAP

Competitive Allowance Program

2007 AMBULATORY SURGERY CENTER CONTRACT

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

Our administrative expenses are 7.82 percent of premium income, as of April 30, 2006. We know of no other insurance company that rivals this low percentage. Our company continues to focus on maintaining low corporate administrative costs with prompt service to our members and providers.

Local enrollment now stands at 678,960 members. BCBSKS addresses the health care needs of 875,628 Kansans, including BlueCard. In the last twelve months we have added 64,412 members, which is a significant gain in membership. 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, make available valuable Web-based services, prepare for contingencies/disasters, and adhere to state regulations and requirements of the Blue Cross and Blue Shield Association, while controlling administrative costs.

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:

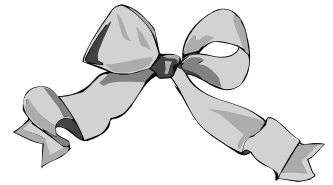
- Local member contracts structured to allow 100 percent of the maximum allowable payment (MAP) for participating CAP providers and 80 percent of the MAP to non-contracting providers.
- Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow. (Please note: Non-contracting providers do not receive direct payment, nor is assignment of benefits allowed.)
- Web site (www.bcbsks.com) available at your convenience, which improves your office efficiencies and maximizes your employee resources.
 - Secured services to include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
 - Other services including training modules, newsletters, manuals, policy memos, and medical policies/guidelines.
- Detailed claims payment information provided to both you and the member explaining their financial responsibilities.
- Contracting providers' names made available to BCBSKS members through a number of sources, including the Internet, employer groups, and other contracting providers for referral purposes, which increases the potential for new patients.
- A dedicated field staff available to visit your office to address any operational issues.
- Periodic workshops held by professional relations staff, which deliver continuous training for new and experienced medical assistant staff to help update them on new administrative procedures to ensure timely claim payments.
- Providers and their staffs having access to professional relations hotline personnel to answer policy questions or obtain assistance with claim coding questions.

If you have questions regarding any information contained in this letter, please contact your professional relations representative or the hotline at 1-800-432-3587 (in Topeka, 785-291-4135).

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 contact me directly (Fred Boston, 785-291-8831). If you feel you cannot accept this contract offering and choose to terminate your provider contract, you must forward your written correspondence postmarked no later than midnight, **September 1, 2006**. Please mail it to: Fred Boston, Director, Professional Relations, CC 480E1, 1133 S.W. Topeka Blvd., Topeka, KS 66629.

Blue Ribbon News

- Blue Choice enrollment gains 57,479 members, with enrollment totaling 446,321 members as of May 31, 2006. This program does not utilize referrals and members may seek care from the CAP providers of their choice.
- 98 percent of Kansas physicians are CAP contracting.
- 93 percent of all professional providers are CAP contracting.



Trends

- Consumer-directed health options are available from BCBSKS.
- Technology costs and prescription medication continue to contribute significantly to increasing premiums.
- Some employers are continuing to carve out benefits and evaluate high deductible programs.
- More providers are electronically connected to BCBSKS to effectively complete daily operational health care administration.
- Wellness programs and healthy lifestyles are of interest to consumers.



REIMBURSEMENT CHANGES

We have recently completed an extensive review of our Ambulatory Surgery Center (ASC) reimbursement policies. It is our corporate position that we reimburse a facility a set fee for the primary procedure being completed on the day of service and that in most cases when multiple procedures are being done, the facility does not incur much additional cost for doing additional procedures. Although some payors follow CCI editing and allow for multiple procedures, we have found that our level of reimbursement is appropriate. When we compare our level of reimbursement to Medicare, which does follow CCI editing, we find that in most cases our level of reimbursement is still above Medicare by about 50 percent.

On June 22, 2006, the BCBSKS Board of Directors met and approved 2007 reimbursement and policy memo changes. Charge comparisons reflecting reimbursement changes are available by contacting your professional relations representative or the professional relations hotline at 1-800-432-3587 (in Topeka 291-4135).

Please review all materials immediately, as the September 1, 2006 deadline is fast approaching. The following is a brief overview of reimbursement changes reflected in your ASC charge comparison and a summary of policy memo changes for ASCs.

- ASC MAPs for scope procedures will be reduced by \$25.00. MAPs for the remaining procedures will be increased by 1.5 percent.
- The above changes are reflected in your charge comparison for services billed during the first five months of 2006.

Contact Information

Professional Relations Staff	Location	Phone Number	
Fred Boston, Director	Topeka	1-800-432-0216 ext. 8831	(785) 291-8831
Rusty Doty, Manager	Topeka	1-800-432-0216 ext. 8206	(785) 291-8206
Vikki Lindemuth	Topeka	1-800-432-0216 ext. 7724	(785) 291-7724
Professional Relations Hotline	Topeka	1-800-432-3587	(785) 291-4135

Important Information

Following is the summary of changes to Blue Shield policies and procedure for 2007 that apply to ASCs. A complete set of policy memos will be available December 2006 in the provider publications section of www.bcbsks.com.



Policy Memo No. 1

Page 2, Medical Review Processes

The third paragraph was reworded to include record requests for audits. The fifth paragraph was reworded specifying "complete" medical record. The last paragraph was reworded for clarity.

The medical review processes are conducted by the staff of BCBSKS who seek the advice of qualified and practicing professionals related to medical necessity. 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 professionals at appropriate points throughout the entire review process.

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 that is not a part of the medical record or information 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.

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).

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 need 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.

If it is determined that the patient services provided by the contracting provider and documented as outlined above, are not medically necessary, the claim is denied and is a write-off to the provider. If the services are requested by the patient after being advised by the provider of the lack of medical necessity and the daily record or patient chart has been documented to that effect and a written waiver is obtained by the provider prior to the service being rendered, charges for the services will be the patient's responsibility.

Sections I. & II. Retrospective Claim Reviews & Denied Claim Appeal Procedure

Using existing time frames, the entire review process can take up to one year and three months. Medical review staff felt this was too lengthy and shortened the time frames for BCBSKS to respond and for providers to initiate a retrospective claim review and claims being appealed.

I. RETROSPECTIVE CLAIM REVIEWS

The contracting provider shall have the right to a retrospective review of any claim denied in whole or in part. The purpose of a retrospective review is for customer service to determine whether the original adjudication was correct.

- A. All requests for retrospective review, including corrected claims, must be submitted in writing to and received by BCBSKS Customer Service within 120 days of the adjudication.
- B. The provider will be given a written response to the 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.

II. DENIED CLAIMS APPEALS PROCEDURE

Contracting providers may appeal certain pre and post-service claim denials. Only claims denied as not medically necessary may be appealed on the provider's own behalf as set forth in the policies and procedures. The provider may be designated as the member's authorized representative for appeal purposes according to the terms of the member's contract.

NOTE: Medical policies described in BCBSKS Policy Memos 1-12 or provider's obligations specified in their provider contracts are not considered eligible claims appeals as outlined in Section II. DENIED CLAIMS APPEALS PROCEDURES. Annually, BCBSKS outlines any changes to the Policy Memos and forwards them to providers for their review. Once providers accept these

changes, they are part of the provider's contract and therefore not considered for claims appeals. Providers disagreeing with any policies should submit their position and supportive documentation to BCBSKS staff for future consideration.

Appeals as the Member's Authorized Representative: Appeals that you can make as the member's authorized representative according to the terms of the member's contract are claims for which the member is financially responsible. When you act as the member's authorized representative you are not separately entitled to any appeals pursuant to this Contracting Provider Agreement.

Appeals Pursuant to Contracting Provider Agreement: Before initiating the appeal procedures, verify through I. Retrospective Claim Reviews inquiry procedures that the claim was correctly adjudicated. After verifying the claim adjudication you may appeal as follows:

First Level: Written notification of disagreement highlighting specific points for reconsideration of a claim denied not medically necessary shall be provided to BCBSKS within 180 days from the original claim adjudication date. This notice shall be considered an initial appeal and be forwarded with all pertinent medical records to BCBSKS Customer Service. Medical records submitted with the request for initial appeal will be referred to the appropriate consultant and a determination will be rendered. This decision will be binding unless the provider re-appeals the decision within 60 days of notification.

Second Level: Forward a written request to customer service, with your letter addressed to the vice president of medical affairs. The final appeal determination shall be provided by the vice president of medical affairs. The contracting provider agrees to abide by the final determination in the appeals process.

All appeal decisions under this agreement must be provided within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider and claim payments will be adjusted accordingly.

Cases may only be appealed once at each step in the first or second levels. A contracting provider agrees to accept the determination made at each level or to appeal the claim at the next step of the appeals process. If throughout the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. If, however, the decision reverses a previous determination (either partially or totally), a refund will be requested.

The result of the appeals process shall be binding on the provider and BCBSKS subject only to the provision for binding arbitration previously stated herein.

Section V. Content of Service

The reference to content of service for venipuncture to an E&M was removed since we now allow separate reimbursement for venipuncture.

Section IX. Waiver Form

Wording was added clarifying deluxe waivers are applicable to deluxe orthopedic and prosthetic appliances as specified in the member contract.

IX. WAIVER FORM

NOTE: The waiver cannot be utilized for services considered to be content of another service provided.

A. SITUATIONS REQUIRING A WAIVER

3. Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract.)

Section X. Documentation

Language was added clarifying that failure to send requested records to determine medical necessity will result in claim denials.

X. DOCUMENTATION

Appropriate documentation of services is an integral part of the payment and/or review process. The contracting provider agrees to keep sufficient records to support claims for reimbursement, documents the medical need for the service, and agrees to make available all information necessary to carry out the terms of his/her contracting provider agreement at no charge. Information, when requested, should be submitted to BCBSKS within 30 days of the request. The member's contract gives us the ability to obtain this information without a signed patient release. If there is insufficient information to determine medical necessity, claims will ultimately be a provider write-off or refund. Failure to send the requested documentation within the time frame will also result in claim denials for lack of medical necessity.

Section XVII. Services Provided by Non-Physicians and Resident Physicians

Wording was added to paragraphs A. & C. to include the National Provider Identifier number.

XVII. SERVICES PROVIDED BY NON-PHYSICIANS AND RESIDENT PHYSICIANS

- 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 bill their charges to BCBSKS under their own specific performing provider number or National Provider Identifier (NPI) if applicable. The name of the ordering provider, when applicable, (including UPIN or NPI, except when exempt by law) must appear on every claim.

- C. Independently practicing Advanced Registered Nurse Practitioners (ARNPs) who are providing services as defined in their Kansas licensure or certification, should bill their charges to BCBSKS under their own specific provider number. The name of the ordering provider, when applicable, (including UPIN or NPI, except when exempt by law) must appear on every claim.

Section XXIV. Reimbursement for Sleep Study Testing

Wording was removed referring to specific CPT codes for sleep testing. Also, BCBSKS no longer reimburses those providers who have only applied for AASM certification at 100 percent of MAP. All providers are required to attain AASM certification to receive 100 percent of the MAP.

XXIV. REIMBURSEMENT FOR SLEEP STUDY TESTING

The allowance for sleep testing procedures as outlined by CPT is 100 percent of the MAP for providers who are board certified in sleep medicine. All other eligible providers receive 60 percent of the MAP. The allowance for sleep testing procedures for Freestanding Sleep Laboratories or Centers is 100 percent of the MAP for those providers who are accredited by the American Academy of Sleep Medicine (AASM). All other eligible providers receive 60 percent of the MAP.

Section XXXVII. Medicare Advantage Claims

Language was added clarifying Medicare Advantage programs offered by other Blue Plans.

XXXVII. MEDICARE ADVANTAGE CLAIMS

Medicare Advantage (MA) claims should be submitted directly to BCBSKS, who will report the status of such claims on its remittance advices. However, MA claims cannot and will not be processed or appealed pursuant to BCBSKS policies and procedures. For MA claims occurring under a form of coverage offered by a Blue Cross and Blue Shield Plan other than BCBSKS, such other Blue Plan is solely responsible for determining pricing and medical policy (as required by the Centers for Medicare & Medicaid Services [CMS]). A provider's contracting status with CMS determines MA payment allowances. The provider may appeal MA claims only to the Blue Plan providing the MA coverage regardless of whether BCBSKS or another Blue Cross and Blue Shield Plan issued payment. The provider agrees to abide by the final determination resulting from the MA appeals process, which is established by CMS. The appeals policies and procedures of such other Blue Plans should be obtained from those Blue Plans directly.

Last Page, Waiver Form

Wording was added clarifying deluxe waivers are applicable to deluxe orthopedic and prosthetic appliances as specified in the member contract.

Policy Memo No. 4

Section VI. Member Concern and Complaint

Wording was modified specifying only written inquiries and removing the ability for a member to request a formal grievance hearing.

VI. MEMBER CONCERN AND COMPLAINT

BCBSKS recognizes that from time to time members may encounter situations where the performance of BCBSKS or their PCP does not meet their expectations. When this occurs, the member has the right to direct an inquiry to the attention of BCBSKS management. An inquiry must be received in writing. It is the policy of BCBSKS to promptly and fairly consider all inquiries of its members. BCBSKS monitors the number and type of complaints made by members, and monitors trends and patterns.

Complaints are reviewed on an ongoing basis. The member's PCP may be contacted by their professional relations representative for additional information, such as medical records, to assist in resolving the matter. Following receipt of all the necessary information, a thorough review is conducted and a determination made. When the outcome of the case affects the PCP, a representative will contact the PCP to apprise him/her of the determination.

If a member requests information on filing an inquiry, it should be forwarded to the respective customer service area: Blue Cross and Blue Shield of Kansas, Customer Service Center, 1133 SW Topeka Boulevard, Topeka, Kansas, 66629-1622. Phone: 785-232-4054 or 1-800-521-0117.

ASC Policy Memo

Section III. Approved Procedures

Language in this section was rewritten because predeterminations are no longer allowed. The approved procedures list is reviewed annually for additions/deletions.

III. APPROVED PROCEDURES

BCBSKS will review annually additions and deletions to the list of approved ASC procedures (available on the Web at www.bcbsks.com). Procedures contained in this list will be reimbursed by BCBSKS.



**BlueCross
BlueShield
of Kansas**

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

LIMITED PATIENT WAIVER

Patient's Name: _____

Provider Name: _____

Identification Number: _____

Provider Address: _____

Provider Number: _____

The provider must document in the patient record the discussion with the patient regarding the following service(s).

**NOTICE OF PERSONAL FINANCIAL OBLIGATION
Read Before Signing**

I have been informed and do understand that the charge(s) for _____
(nomenclature/procedure code/appliance)
provided to me on _____ (date) will not be covered because Blue Cross and Blue
Shield of Kansas (BCBSKS) or Premier Blue considers this service(s) to be:

- Not medically necessary
- Utilization Denials
- Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract). The allowance for a standard item(s) will be applied to the deluxe item(s).
- Patient Demanded Services
- Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS or Premier Blue.

I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR APPROXIMATELY \$ _____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Patient/Parent/Guardian Signature

Date

I, _____(witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Witness Signature

Date