



**BlueCross
BlueShield
of Kansas**

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Web site: www.bcbsks.com

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

July 2009

CAP

Competitive Allowance Program

2010 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 2010. 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, technological advances and population in the BCBSKS service area, just to name a few.

The health care industry has been challenged this year by the economic downturn. 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 this objective as you serve our members, your patients.

Our administrative expenses remain low at 8.3 percent of premium income, as of May 31, 2009. We know of no other insurance company that rivals this low percentage. Our company continues to focus on controlling our corporate administrative costs while maintaining prompt service to our members and providers.

Local enrollment totals 686,682 members, as of May 31, 2009. Taking all business including BlueCard into consideration, BCBSKS addresses the health care needs of 908,916 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.

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

- Local member contracts structured to allow 100 percent of the maximum allowable payment (MAP) for participating CAP providers (subject to member benefits).
- Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow.
- 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 deliver continuous training for new and experienced medical assistant staff to help update them on new administrative procedures to ensure timely claim payments.
- Providers and their staffs having access to professional relations hotline personnel to answer policy questions or obtain assistance with claim coding questions.

NOTE: Noncontracting providers' services are paid direct to the member at 80 percent of the MAP (subject to member benefits). In addition, assignment of benefits to noncontracting providers is not permissible.

Please review all materials immediately, as the 2010 contracting deadline of **September 3, 2009**, 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	(785) 291-4135, opt. 1

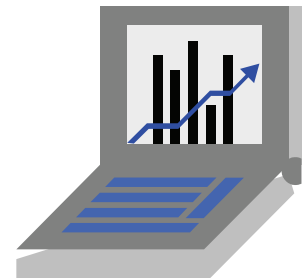
<u>Professional Relations Staff</u>	<u>Location</u>	<u>Phone Numbers</u>	
Kyle Abbott	Wichita	800-432-0216 ext. 1674	(316) 269-1674
Velda Fresquez-Gray	Wichita	800-432-0216 ext. 1674	(316) 269-1674
Debra Meisenheimer	Hutchinson	(620) 663-1313	
Gwen Nelson	Dodge City	(620) 225-0884	

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. 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, 2009**, to Doug Scott, Director of Professional Relations, cc480D2, 1133 SW Topeka Blvd., Topeka, KS 66629.

Additional Important Information

Trends

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



Blue Ribbon News



- Blue Choice continues to be the flag ship product with enrollment totaling 495,666 members as of May 31, 2009. This program does not utilize referrals and members may seek care from the CAP providers of their choice.
- BCBSKS offers our members wellness information and services which can be accessed through our Web site in the Resource Blue Section.
- 98 percent of physicians and 88 percent of all professional providers are CAP contracting in our Kansas Plan area.
- BCBSKS remains a financially strong company.

Reimbursement and Policy Memo Changes

On June 26, 2009, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2010.

A charge comparison report reflecting reimbursement changes for 2010 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 2009.**

Below is a brief overview of reimbursement for 2010:

Increasing:

- Most covered CPT codes
- Evaluation and management services
- The anesthesia conversion factor to \$54.50
- The professional and technical components of specialized imaging (CT, MRI/MRA, PET)
- The technical component of MRIs
- The technical component of PET scans (when a local community oncologist is engaged in the treatment)
- Ambulance
- HME

No change:

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

Decreasing:

- Some clinical lab
- Some physical medicine
 - ✓ MAPS
 - ✓ Units
 - ✓ Content of service/bundling

BLUE CROSS AND BLUE SHIELD OF KANSAS

PROVIDER POLICIES AND PROCEDURES

CHANGES FOR 2010

Following is a summary of the changes to Blue Shield policies and procedures for 2010. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2009.

Policy Memo No. 1

PREFACE

- **Page 1:** Wording was added at the end of the first paragraph to state that all existing and future policies and procedures published within BCBSKS publications which are available on the BCBSKS Web site are considered part of Policy Memo No. 1.

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. These publications include newsletters, provider manuals, workshop materials, and periodic update communications.

Policy Memo No. 1

SECTION II. DENIED CLAIMS APPEALS PROCEDURE

- **Page 3:** Under **First Level** changed the reference date to "of the remittance advice."

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 date of the remittance advice. 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 reappeals the decision within 60 days of notification.

Policy Memo No. 1

SECTION IV. UTILIZATION REVIEW AND MEDICAL NECESSITY

- **Page 5, Outpatient Pre-Certification:** Added wording to state that BCBSKS will provide notification 60 days in advance of the effective date when outpatient pre-certification requirements change.

Contracting providers will be notified 60 days in advance of criteria to identify those situations falling within the scope of this provision.

Policy Memo No. 1

SECTION V. CONTENT OF SERVICE

- **Page 7:** Tenth bullet point, removed specific procedure code 90772 due to ongoing updates to CPT. Codes become obsolete.
 - Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.
- **Page 7:** The last bullet point was condensed to remove references to Blue Select/Premier Blue and managed care.
 - Telephone calls **and** Web-based correspondence **are** content of service when billed with another service on the same day, and are not covered if billed separately and the only service rendered on that day.

Policy Memo No. 1

SECTION VI. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

- **Page 7-8:** Added verbiage to "experimental" to align with the member contract, changed "reliable" to "credible," and added a definition of "Research-Urgent."

Any drug, device or medical treatment or procedure and related services that are Experimental or Investigational as defined by BCBSKS are non-covered services.

Experimental or Investigational refers to the status of a drug, device or medical treatment or procedure

- A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished **and**

the drug or device is not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

- B. if **Credible Evidence** shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis **and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or**
- C. if **Credible Evidence** shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis **and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or**
- D. if there is no **Credible Evidence** available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis **except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.**

Credible evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Research-Urgent shall mean a drug, device, medical treatment or procedure that may be covered (even though otherwise excluded by the member's contract as experimental or investigational) providing the specified criteria outlined in the member's contract is met.

Contracting providers shall notify the patient when services to be rendered are considered experimental or investigational and may not be covered under the member's contract. Any patient being billed for services considered experimental or investigational must have a signed waiver in his/her file and the provider must include the GA modifier (waiver on file) on the claim form (electronic or paper). (See Section IX. WAIVER FORM)

Policy Memo No. 1

SECTION X. DOCUMENTATION

- **Page 10:** Clarified that rubber stamp signatures are not permissible, but electronic signatures are.

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 require the immediate submission of medical records. In these cases, BCBSKS will have a representative visit the office and secure requested records. The provider

agrees to provide these records at the time of request. The member contract gives us the ability to obtain this information without a signed patient release.

Policy Memo No. 1

SECTION XXIII. ESTABLISHING AND AMENDING MEDICAL POLICY

- **Page 15:** Inserted a new section outlining the resolution authorized by BCBSKS Board of Directors regarding establishing and amending medical policy changes and staff's authority.

XXIII. ESTABLISHING AND AMENDING MEDICAL POLICY

The BCBSKS Board of Directors authorized the following resolution regarding establishing and amending medical policy changes and staff's authority.

WHEREAS, the Provider Relations and Medical Affairs Division has identified a need for the ability to establish and amend corporate medical policy in a more expeditious and efficient manner, and

WHEREAS, this division has developed new procedures to establish and amend medical policies more efficiently to better serve Blue Cross and Blue Shield of Kansas members and providers,

BE IT RESOLVED, that the Blue Cross and Blue Shield of Kansas Board of Directors hereby affirms as policy, that when a proposed medical policy does not originate in a Liaison Committee or does not rise to a level of concern requiring review by Liaison, Medical or Dental Advisory Committees, the Provider Relations and Medical Affairs Division is authorized to establish or amend corporate medical policy; and

BE IT FURTHER RESOLVED, that except for non-substantive operational changes, Blue Cross and Blue Shield of Kansas staff shall report all such new policies or amendments to the Board of Directors in a timely fashion. However, failure to do so shall not invalidate any new or amended medical policy.

Policy Memo No. 1

SECTION XXVIII. REIMBURSEMENT FOR LESSER SERVICES

- **Page 16:** Explanation that reimbursement may be reduced when a lesser service is performed. Requires a "52" modifier.

XXVIII. REIMBURSEMENT FOR LESSER SERVICES

When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

Policy Memo No. 1

SECTION XXIX. ADVERSE EVENTS

- **Page 16:** Added language to state that Adverse Events shall automatically include all future CMS adopted "Never Events." Updates are effective immediately, and do not constitute a change in policy.

XXIX. ADVERSE EVENTS

The Blue Cross and Blue Shield list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBS shall pay for the medical errors.

Policy Memo No. 1

PREVIOUS SECTION XXXV. MANAGED CARE

- **Page 19:** Deleted previous Section XXXV. MANAGED CARE. which appears after the current Section XXXVII. LIMITED PROVIDER NETWORKS. Managed Care, Premier Blue and Blue Select are no longer products offered by BCBSKS.

Policy Memo No. 2

SECTION II: CONTENT OF SERVICE (See also Policy Memo No. 1)

- **Page 2:** Sixth bullet point was condensed to remove references to Blue Select/Premier Blue and managed care.
 - Telephone calls **and** Web-based correspondence **are** content of service when billed with another service on the same day, and are not covered if billed separately and the only service rendered on that day.

Policy Memo No. 4

INTRODUCTION

- **Page 1:** In the first paragraph the word "may" was added with reference to programs described in this policy. "Blue Select" was replaced with "BCBSKS."

The quality of care and peer review programs described in this policy memo **may** apply to providers delivering services to **BCBSKS** members.

Policy Memo No. 4

SECTION I. CREDENTIALING

- **Pages 1-6:** Deleted Section I. CREDENTIALING.

Policy Memo No. 4

SECTION I. QUALITY IMPROVEMENT PROGRAM

- **Pages 6-9:** Re-numbered as Section I, and renamed "Quality Improvement Program." Incorporated the previous "Section III. Adverse Quality of Care Determination and Quality Improvement Plan (QIP) Appeal Process" into the new Section I as well. Outlined the appeal process with request directed to the BCBSKS Chief Medical Officer whose determination is final.

I. QUALITY IMPROVEMENT PROGRAM

An integral component of the quality improvement program is the evaluation of the health care rendered to members by contracting providers through medical record review. The initial step in improving health care is identification of areas for improvement. Medical record documentation merits special consideration in evaluating the appropriateness and effectiveness of health care.

Pertinent data collected from the medical record is analyzed according to established criteria and implicit medical knowledge by quality improvement staff and peer reviewers. Providers are encouraged to take an active role in the review process, providing additional information and clarification when appropriate.

The second step is to work cooperatively with providers in the development of solutions to the identified problems.

The third step requires recommendations be evaluated to ensure provider's performance meets established standards.

The final step in quality improvement through medical record review is to revise or enhance recommendations which are not improving or maintaining the quality of care as planned.

Emerging patterns of confirmed inappropriate or inadequate care provided by contracting providers are monitored within the quality improvement department. Once a problem or pattern of problems is identified, a Quality Improvement Plan (QIP) may be developed as an educational effort to correct a specific problem relating to the care rendered by contracting providers. **All cases in which the quality of care is either questionable or**

substandard are referred to a physician advisor for evaluation and implementation of a QIP if necessary. If the QIP limits the provider's practice/privileges and the provider does not agree with the determination, the provider may appeal.

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

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

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 for greater than 30 days, the provider will be notified of the appeal rights set forth herein. No action will be taken until the provider either exhausts his/her appeals rights or voluntarily waives his/her appeal rights, unless imminent risk of member's health is at stake. If this risk is present, then a temporary action will be implemented awaiting completion of the appeals process.

Prior to institution of any legal proceedings or suit, the appealing provider will utilize the appeal process as outlined.

The appealing provider must submit a letter to the **BCBSKS Chief Medical Officer** within 30 days of the initial notification of the QIP requesting an appeal. The request should outline why he/she disagrees with the QIP and supply additional information or highlight specific points for reconsideration.

Upon receipt of the outcome of the appeal from the **BCBSKS Chief Medical Officer**, a letter shall be sent to the appealing provider relaying the **final** determination. If the determination does not concur with the initial QIP, the plan will be modified or canceled and the provider so notified. If the determination results in continued upholding of the QIP, the appealing provider will be notified of the decision and informed that he/she **has exhausted the appeal process**.

If the provider continues to disagree with the corrective action plan, he/she may pursue normal remedies of law, if any.

Policy Memo No. 4

SECTION IV. HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

- **Page 9:** Deleted Section IV as it relates to managed care which no longer exists.

Policy Memo No. 4

SECTION VI. MEMBER CONCERN AND COMPLAINT

SECTION VII. PATIENT DISMISSAL/EDUCATION – APPLICABLE TO PCPS ONLY

SECTION VIII. MEMBER'S RIGHTS AND RESPONSIBILITIES

SECTION IX. PROVIDER ACCESS

- **Pages 9-14:** Deleted these sections as they relate to managed care and primary care physicians.

Policy Memo No. 4

SECTION III. CARE MANAGEMENT

- **Page 14:** Previously numbered Section X. Deleted "Disease Management." Added wording to include other chronic medical conditions.

III. CARE MANAGEMENT

BCBSKS has care management initiatives available for our members with diabetes, coronary artery disease, asthma, congestive heart failure, **and other chronic medical conditions**. The intent of these initiatives is to improve the overall health of our members with chronic health conditions by providing the education, tools, and one-on-one support that may assist members in having a positive impact on their health.

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

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

Members will be selected for these initiatives by utilizing the health conditions risk identification tool.

Policy Memo No. 9

SECTION I. GLOBAL FEE CONCEPT

- **Page 4:** Under B. a new item, numbered "7," was inserted to explain the use of modifier "78," denoting that a new postoperative period begins when a second related procedure is performed.

7. "78" modifier is used to identify a separate but related procedure being rendered during a postoperative period of another procedure. When appending modifier "78," the original postoperative period ends and a new postoperative period begins, (e.g., major surgery is performed, on day 35 a second related procedure is performed).

- **Page 4:** Under B. a new item, number "9," was added to explain that when appending modifier "52," denoting a lesser service, reimbursement may be reduced to an allowance reflective of the service performed.

9. When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

Policy Memo No. 9

SECTION X. ADVERSE EVENTS

- **Page 6-7:** Added language to state that Adverse Events shall automatically include all future CMS adopted "Never Events." Updates are effective immediately, and do not constitute a change in policy.

X. ADVERSE EVENTS

The Blue Cross and Blue Shield list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBS shall pay for the medical errors.

Policy Memo No. 12

SECTION VI. RELATED POLICIES

- **Page 5:** Wording was changed under E. to more accurately define an anesthesia provider as one who is "authorized under state law to administer" general anesthesia. Wording was also added to clarify that reimbursement will be allowed when a trained observer, under the direction of the anesthesia provider, performs the administration of moderate sedation preceding surgery in an office setting, except when the surgery procedure code is on the CPT Appendix G or a corresponding HCPCS code.

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider 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.)