July 2014

CAP

Competitive Allowance Program

2015 HOME MEDICAL EQUIPMENT SUPPLIER 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 2015. 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 being the insurer Kansans trust with their health. 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 costs, demand for services, aging population, and technological advances, just to name a few.

2014 marked the implementation of key components of the federal health care reform law (Affordable Care Act (ACA)). BCBSKS has been working during the past four years to implement the requirements of the law. Although there were some initial challenges with enrollment through the Federally Facilitated Marketplace, BCBSKS was able to successfully implement all requirements of the law. While we view the first cycle of Marketplace-based enrollment as a success, the majority of our business remains grandfathered and thus not subject to the ACA requirements. In any event, BCBSKS will continue to focus on improving 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. As an example, we worked together as part of our pursuit of URAC Health Plan accreditation in 2013 and 2014, to get you and our entire network of contracting providers credentialed. Successfully completing that project was critical for us to obtain "qualified health plan" status and the ability to offer our products in the Marketplace. Thank you for your efforts in that regard. BCBSKS is proud to report full accreditation was achieved in April 2014.
This fall, Kansans will have the opportunity to purchase health insurance from a new not-for-profit health maintenance organization (HMO) called BlueCross BlueShield Kansas Solutions, Inc. (Solutions). This new HMO is a wholly owned subsidiary of BCBSKS and will offer health insurance to individuals and small groups in our 103-county service area. All administrative services such as claims, customer service, and marketing will be handled by BCBSKS. Therefore, Solutions will have the benefit of the BCBSKS name recognition along with its superior operational performance.

Solutions is not an HMO in the traditional sense and it is not a new version of Premier Health, our former successful HMO that was dissolved a few years ago. Members will not have to choose a primary care provider (PCP) or obtain a referral to visit a specialist. Solutions’ products will have a point of service (POS) network to allow members open access to care. Members also will have access to the SolutionsCAP or SolutionsChoice provider networks, which are similar to the BCBSKS Blue Choice provider network that includes 97 percent of professional providers (including 99 percent of all physicians) and 100 percent of the hospitals in our service area. Furthermore, providers will not experience any challenges with HMO-style reimbursement models such as capitation or new contracts. Solutions will reimburse providers using the same maximum allowable payments (MAPs) that our current BCBSKS products use. Policy Memo No. 1 for 2015 includes a reference to the CAP network applying to subsidiary companies of BCBSKS.

Solutions received its certificate of authority (COA) April 1, 2014 to sell HMO insurance in the state. BCBSKS staff spent several months preparing the applications for the insurance commissioner’s review and working with URAC for Solutions to achieve its “provisional status” accreditation. The goal is to make sure Solutions can sell products both on and off the Marketplace during the fall open enrollment period for members seeking coverage effective January 1, 2015.

Our administrative expense remains low at 11.32 percent of premium income, as of May 31, 2014. Although our administrative expenses have increased due in large part to fees associated with the ACA, we are still comfortably in compliance with the minimum medical loss ratio standards (80-85 percent based on line of business) mandated in the ACA. We are confident we continue to have the lowest administrative expense ratio of any health insurance company operating in Kansas. We will continue to focus on controlling our corporate administrative costs while maintaining prompt service to our members and providers.

Local enrollment totals 661,412 members, as of May 31, 2014. Taking all of our lines of business into consideration including BlueCard, BCBSKS addresses the health care needs of 927,580 members. Financially, BCBSKS has strong policyholder reserves that allows us to meet the health care coverage needs of our members, comply to state and federal regulations, and meet the requirements of the Blue Cross and Blue Shield Association.

We continue to strive to provide you, our contracting provider, with excellent business services that 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 MAP for participating CAP providers (subject to member benefits).
• Opportunity to earn additional revenue through the Quality-Based Reimbursement Program (QBRP).

• Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow.

• Electronic remittance advice and payment capabilities.

• Website (www.bcbsks.com) and self-service access through Availity available at your convenience, which improves your office efficiencies and maximizes your employee resources.
  o Secured services include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
  o 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, which increases 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 that delivers continuous training for new and experienced medical assistant staff, helping update your staff on new administrative procedures to ensure timely claim payments.

• Access to professional relations provider network services personnel to answer policy questions or obtain assistance with claim coding questions.

**NOTE:** In 2015, for the majority of our business, non-contracting providers’ services will be paid direct to the member at a charge up to 80 percent of the MAP (i.e., there is a 20-percent penalty for members receiving services from a non-contracting provider; subject to member benefits). In addition, BCBSKS does not recognize assignment of benefits to non-contracting providers.
Please review all materials immediately, as the 2015 contracting deadline of September 3, 2014, is fast approaching. If you have questions regarding any information contained in this mailing, please contact your professional relations representative or provider network services at the numbers listed in the following table:

<table>
<thead>
<tr>
<th>Professional Relations Staff</th>
<th>Location</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doug Scott, Director</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8831</td>
</tr>
<tr>
<td>Robyne Goates, Manager</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8206</td>
</tr>
<tr>
<td>Diana Evans</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8716</td>
</tr>
<tr>
<td>Darin Fieger</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8207</td>
</tr>
<tr>
<td>Christie Blenden</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8651</td>
</tr>
<tr>
<td>Vikki Lindemuth</td>
<td>Topeka</td>
<td>800-432-0216 ext. 7724</td>
</tr>
<tr>
<td>Professional Relations Provider Network Services</td>
<td>Topeka</td>
<td>800-432-3587, opt. 1 or 3 ({785) 291-4135, opt. 1 or 3}</td>
</tr>
<tr>
<td>Kyle Abbott</td>
<td>Wichita</td>
<td>800-432-0216 ext. 1674</td>
</tr>
<tr>
<td>Velda Fresquez-Gray</td>
<td>Wichita</td>
<td>800-432-0216 ext. 1674</td>
</tr>
<tr>
<td>Debra Meisenheimer</td>
<td>Hutchinson</td>
<td>(620) 663-1313</td>
</tr>
<tr>
<td>Gwen Nelson</td>
<td>Dodge City</td>
<td>(620) 225-0884</td>
</tr>
</tbody>
</table>

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, 2014, 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
Blue Ribbon News

- Blue Choice continues to be the flagship product with enrollment totaling 538,080 members as of May 31, 2014. This program does not utilize referrals and members may seek care from the CAP providers of their choice.

- BCBSKS offers its members wellness information and services that can be accessed through its website in the Resource Blue Section.

- 99 percent of physicians and 97 percent of all professional providers are CAP contracting in our Kansas Plan area.

- BCBSKS remains a financially strong company.

- For several years in a row, BCBSKS has ranked No. 1 of all Blue Plans in the Blue Brand Excellence award for Provider Satisfaction.

- BCBSKS continues to receive the prestigious designation for World Class Customer Service.

- BCBSKS is URAC accredited for Health Plan, Case Management, and Disease Management. BCBSKS has received its URAC provisional accreditation for Solutions and should receive full accreditation in 2015.

- BCBSKS is the sole commercial health insurance carrier supporting the Patient Centered Medical Home concept in Kansas and has expanded to include numerous primary care practices throughout Kansas.

Reimbursement and Policy Memo Changes

On June 26, 2014, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2015. Highlights of the 2015 reimbursement are noted below. As referenced on Page 1 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 offer its products on the health insurance Marketplace, health insurance companies must have a quality-based reimbursement program. We continue to build on the program started in 2012 to gain experience, demonstrate our compliance with the law, and encourage higher quality and lower health care costs. As such, our provider reimbursement program for 2015 will continue to create opportunities for providers to earn reimbursement by meeting the criteria as outlined in the 2015 Quality-Based Reimbursement Program (QBRP) as described below.
Aside from the opportunity to earn increased income through the QBRP, we continue to adjust our fee schedule in specific areas to achieve better correlation between our MAPs for different services using relative values units. As such, we are working to increase undervalued CPT codes while reducing overvalued CPT codes. To minimize the extent of any negative impact, we are pursuing this fee schedule compression during a period of several years. We also are introducing for the first time, a new 5 percent revenue opportunity for primary care providers with practices located in counties with a population of 13,000 or less.

We continue to observe aggressive pricing for reference labs in our market. As BCBSKS competes for enrollment, particularly in the new health insurance Marketplace, we must remain diligent in reacting 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 labs to be channeled through a lab vendor, we have again chosen not to pursue this model, instead allowing lab service to be performed by our network providers at competitive allowances.

A charge comparison report reflecting reimbursement changes for 2015 is available by contacting your professional relations representative or professional relations provider network services. The charge comparison is based on services billed by you during the first five months of 2014. Please note that the format of the charge comparison report has changed. The new format will actually provide the maximum allowable payment (the lesser of your charge or the MAP) for each procedure code. In addition, the new report will show whether each procedure code qualifies for QBRP.

Below is a brief overview of reimbursement for 2015:
Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted. (See QBRP section, Page 9.)

Increasing: ↑ (QBRP incentive available where noted)
- Evaluation and management (E/M) codes (eligible for QBRP)
- Undervalued CPT codes (eligible for QBRP)
- Ambulance base rates for fixed wing and rotary wing and codes A0433 and A0434 (eligible for QBRP)
- Some DME (eligible for QBRP)
- (New) Services billed by primary care providers located in counties with a population of 13,000 or less. (Providers meeting this requirement will receive a 5 percent add-on to the MAP on all eligible CPT codes.) (not eligible for QBRP)

No change: ↔ (QBRP incentive available where noted)
- Clinical lab codes (not eligible for QBRP)
- Sleep medicine (eligible for QBRP)
- Anesthesia conversion factor at $58.37 (eligible for QBRP)
- Pharmaceuticals (not eligible for QBRP)
Decreasing: ↓ (QBRP incentive available)
- Professional consult codes (eligible for QBRP)
- Most overvalued CPT codes (eligible for QBRP)
- DME oxygen and oxygen-related supplies (eligible for QBRP)
- Mileage rates for fixed wing and rotary wing (eligible for QBRP)
- Some DME (eligible for QBRP)
**Tiered Reimbursement** – The allowances for the following specialties have been set at the identified percentages of the MAP (no change for 2015). In addition, Licensed Dieticians and Athletic Trainers were added to the table:

<table>
<thead>
<tr>
<th>85 Percent</th>
<th>70 Percent</th>
<th>50 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advanced Practice Registered Nurses (APRNs)</td>
<td>• Community Mental Health Centers</td>
<td>• Certified Occupational Therapy Assistants (COTAs)</td>
</tr>
<tr>
<td>(APRNs) [not including Certified Registered Nurse Anesthetists (CRNAs)]</td>
<td></td>
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<tr>
<td>• Chiropractors</td>
<td>• Licensed Clinical Marriage and Family Therapists</td>
<td>• Certified Physical Therapist Assistants (CPTAs)</td>
</tr>
<tr>
<td>• Clinical Psychologists</td>
<td>• Licensed Clinical Professional Counselors</td>
<td>• Athletic Trainers</td>
</tr>
<tr>
<td>• Occupational Therapists</td>
<td>• Licensed Clinical Psychotherapists</td>
<td></td>
</tr>
<tr>
<td>• Physical Therapists</td>
<td>• Licensed Specialist Clinical Social Workers (LSCSWs)</td>
<td></td>
</tr>
<tr>
<td>• Physician Assistants</td>
<td>• Outpatient Substance Abuse Facilities</td>
<td></td>
</tr>
<tr>
<td>• Speech Language Pathologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Licensed Dieticians</td>
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**2015 Professional Providers Quality-Based Reimbursement Program**

**Overview**
The BCBSKS Quality-Based Reimbursement Program (QBRP) is designed to promote improved quality, patient care, and outcomes. Contracting BCBSKS providers have an opportunity to earn additional revenue through add-ons to allowances for meeting the defined quality metrics.

**IMPORTANT REMINDER**
The 2015 QBRP program is effective for services performed January 1, 2015 through December 31, 2015. Since the 2015 CAP letter is sent out in July 2014, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2015. Please read the requirements and metrics for the 2015 QBRP program so you are prepared to maximize the available incentives.

**Criteria for 2015**

In accordance with the 2015 Policy Memo No. 1, Section XXX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2015 through December 31, 2015. This program applies to all CAP and Solutions professional providers and services except for clinical lab, pharmacies and pharmaceuticals, and dentists. This program will offer an opportunity for eligible providers to earn increased reimbursement based on a three-group approach (Groups A, B and C). This reimbursement will be in addition to the established base MAPs for 2015. Overall, the QBRP program has been expanded for 2015 to include some new quality metrics and altered incentive opportunities. **Group A** will apply to all eligible contracting professional providers and the incentives are applicable to all covered services billed by those providers. **Group B** will only apply to prescribing providers (MD, DO, DPM, PA, APRN, OD) and the incentives are applicable to all covered services billed by those providers, and **Group C** 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). Physician extenders (Physician Assistants (PA) and/or Advanced Practice Registered Nurses (APRN)) working under supervision or collaboration with a primary care provider also are considered eligible for Group C increased reimbursement. The incentives are applicable only to E&M (office visit) services.

While our goal is to eventually incorporate more outcomes-based metrics, many of our metrics continue to be process-based, although we have begun to include minimum standards (benchmarks) to enhance the value of the measures. Where possible, we also have included some clinical measures such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, including cancer screening for breasts (mammogram) as well as an immunization metric (Measles, Mumps and Rubella (MMR and Tdap)), LDL screening for diabetic patients, and becoming National Committee for Quality Assurance (NCQA) certified for the Heart Stroke program for **Group C**.

In order to pay incentives on these clinical-based targets, we developed a doctor/patient registry. BCBSKS will review claims for the preceding 12 to 24 months and attribute patients to primary care physicians based on the frequency of office visit encounters with a given physician. In the event multiple primary care physicians have the same number of encounters for the same patient, the patient will be attributed to the physician with the
most recent encounter.

The prerequisites to participate in the QBRP require each provider to be fully compliant with transacting business with BCBSKS in an electronic fashion (i.e., turn off paper). This includes submitting all eligible claims electronically, accepting electronic remittance advice documents (ERAs: either through receiving the ANSI 835 transaction or by downloading the RA from the BCBSKS website), and receiving all communications (newsletters, etc.) electronically.

The quality-based incentives will be earned at the individual provider level (except as administration of metric #1 and #2 are outlined here) and paid to the entity to which non-quality based payments are made.

In the case of metric #1 below, all providers billed for under a single tax ID number will have their contacts with BCBSKS combined for the purpose of determining whether the 60 percent benchmark for self service is met.

In the case of metric #2, administration will be at the individual provider level when the provider's electronic medical record system supports that process. Otherwise compliance will be determined by multiplying the number of providers billed for under a single tax ID number by 60, to determine compliance with the minimum number of queries necessary.

There will be a total of 12 components to the program, and an eligible provider may independently qualify for each component, except as outlined above. The sum of all incentive percentages earned will be multiplied by the applicable MAPs for payment purposes. The 5 percent rural access payment is separate and distinct from QBRP.

In order for incentive payments to begin January 1, 2015, BCBSKS will use information on file or available from outside sources to determine which incentives providers qualify for based on unique provider billing NPI numbers. Confirmation notices with the qualifying incentive category, amount, and effective date will be generated for each individual provider and sent by email to the address on file. Email delivery of the confirmation notices for QBRP 2015 incentives effective January 1, 2015 will begin November 2014.

We will continue monthly reviews throughout 2015 to identify providers who did not qualify for incentive beginning January 1, 2015, but may subsequently qualify for incentive. When a provider newly qualifies for an incentive(s), the incentive(s) will be effective the first of the following month or quarter, whichever is applicable. An updated confirmation notice will be emailed to the provider to include the new incentive category and effective date.

We will conduct a QBRP refresh in July 2015 to determine if providers are continuing to earn the incentive payments effective earlier in the year. If the refreshed data indicates a provider is no longer earning an incentive(s), then the associated QBRP incentive will cease until such time the provider again earns the incentive as determined through monthly monitoring. If a provider ceases to meet the metric(s), he/she will receive a new communication advising of the change in their QBRP incentive qualifications. Likewise, if a provider no longer meets the metric(s) and later re-qualifies to meet the metric(s), he/she will receive a new communication to inform them of the new effective date for receiving the associated QBRP incentive.
Group A (Applies to all eligible CAP contracting professional providers)

1. (Revised) Electronic Self-Service: The provider must use the Availity portal or the ANSI 270/271 transaction to electronically obtain BCBSKS patient eligibility and benefit information and will obtain BCBSKS claims status information through the Availity portal or the ANSI 276/277 transaction at least 60 percent of the time when compared to the provider's total number of queries to BCBSKS regardless of the mode of inquiry. BCBSKS will rely on internal data to determine which providers qualify. All providers billed under a single tax ID number will have their inquiries to BCBSKS combined for the purpose of determining whether the 60 percent benchmark for self service is met. Providers that qualify for this incentive will receive an additional 2.5 percent add-on to the 2015 MAPs for all services except for clinical lab, pharmacies and pharmaceuticals, and dental services. (2.5 percent, applies to all eligible CPT codes)

Group B (Applies to the following prescribing providers only: (MD, DO, DPM, PA, APRN, OD)

2. (Revised) Use the Kansas Health Information Exchange (KHIE) through a Kansas Department of Health and Environment approved Health Information Network. Each provider must inquire (search for patient medical information) to the approved KHIE network at least 60 times per quarter to earn this incentive. Provider groups with EMR systems that only report by Tax ID must meet the aggregate of 60 inquiries multiplied by the number of prescribing providers in the group. (2.5 percent, applies to all eligible CPT codes)

3. Use of Electronic Prescriptions: (a. & b. are separate, independent measures)
   a. Electronically access member benefit information for eligibility, formulary, and medication history a minimum of 90 times per quarter. ((Revised) .75 percent, applies to all eligible CPT codes)
   b. Minimum generic prescribing of 75 percent (for all BCBSKS members with a prescription drug benefit). ((Revised) .75 percent, applies to all eligible CPT codes)

BCBSKS will obtain reports from Prime Therapeutics to validate these metrics quarterly.

4. (New) Specialty Pharmacy Prescriber: Must have at least five specialty pharmacy prescriptions per quarter and at least 50 percent of all specialty pharmacy prescriptions must be filled through Prime Specialty Pharmacy. (.75 percent, applies to all eligible CPT codes)

Group C (Applies only to office-based Primary Care Physicians and associated PAs and APRNs in the specialties of family practice, general practice, general internal medicine, and pediatrics)

5. Receive recognition from NCQA for the Diabetes Recognition Program. (.75 percent, applies to E/M CPT codes only)

6. Achieve NCQA and/or URAC Patient Centered Medical Home recognition.
   (a.) Level 1 or Level 2 (.75 percent, applies to E/M CPT codes only)
   or
   (b.) (New) Level 3 (1.75 percent, applies to E/M CPT codes only)
7. MMR percentage of children who had one measles, mumps and rubella vaccine by their second birthday (turned age 2 in 2013). MMR percentage must be equal to or greater than 60 percent to meet metric. (.75 percent, applies to E/M CPT codes only)

8. (New) Immunization Outcome Measure for Tdap: The percentage of adolescents 13 years of age (turned age 13 in 2013) who had a Tdap vaccine by their 13th birthday. Must be equal to or greater than 70 percent to meet metric. (.75 percent, applies to E/M codes only)

9. Breast cancer screening – The percentage of women 50-74 years of age (52-74 as of December 31, 2013) who had a mammogram anytime on or between October 1, 2011 and December 31, 2013. Adult mammography percentage must be equal to or greater than 60 percent to meet metric. (.75 percent, applies to E/M CPT codes only)

10. (New) NCQA Heart Stroke Recognition Program – Receive recognition from NCQA for the heart stroke program. (.75 percent, applies to E/M CPT codes only)

11. (New) LDL Screening: Diabetes – The percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had an LDL-C screening performed during the measurement year (calendar year 2013). Must be equal to or greater than 70 percent to meet metric. (.75 percent, applies to E/M CPT codes only)

BCBSKS will review the NCQA and/or URAC websites to identify those providers qualifying for incentives available in items five, six, and 10. Providers who meet one or more of the criteria for items five through 11 above will receive the additional increase (for each item, five, six, seven, eight, nine, 10, and/or 11) to the 2015 MAPS for all E/M CPT codes.

If you have any questions regarding QBRP, please contact your professional relations representative.
Following is a summary of the changes to Blue Shield Home Medical Equipment Supplier Policies and Procedures for 2015. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2014.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2014 Policy Memos. Deleted wording is noted in brackets italicized. New verbiage is identified in bold.

Home Medical Equipment Supplier Policy Memo

No changes for 2015.

Policy Memo No. 1

SECTION II. RETROSPECTIVE CLAIM REVIEWS

- Page 2: Removed verbiage to clarify.

  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

- Page 3: Added verbiage to clarify and help fix delays.

  Second Level: Forward a written request for the second-level appeal to BCBSKS customer service [with your letter addressed to the Chief Medical Officer] within 60 days following the first-level appeal denial notification. The second and final appeal determination shall be made by [the Chief Medical Officer] a physician or clinical peer. The contracting provider agrees to abide by the second-level appeal determination.

- Page 3: Added verbiage to clarify and fix misleading text.

  [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] determination 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. However, a refund will be requested if the decision reverses a previous determination (either partially or totally). a refund will be requested.

Policy Memo No. 1
SECTION IV. POST-PAYMENT AUDITS

- Page 4: Removed verbiage to clarify and help fix delays.

  B. Second-Level Appeal

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

Policy Memo No. 1
SECTION V. UTILIZATION REVIEW AND MEDICAL NECESSITY

- Page 5: Added "Prior authorization" behind "pre-certification," changed 60 days to 30 days for notification to be consistent with other BCBSKS notification processes, then added/subtracted verbiage for clarity.

  C. OUTPATIENT PRE-CERTIFICATION/PRIOR AUTHORIZATION

  Under certain circumstances and upon specific notification, pre-certification/prior authorization may be required for outpatient services/procedures. BCBSKS will notify contracting providers will be notified at least 60 days in advance of such requirement. [criteria to identify those situations for BCBSKS members falling within the scope of this provision.]

  Pre-certification/prior authorization may also be required for other outpatient services such as home medical equipment and case management, including those services specified by employers, and outpatient procedures which necessitate a greater level of facility care than is usually needed.

  Following provider notification, continued failure to complete pre-certification/prior authorization activities will result in a 50 percent Maximum Allowable Payment (MAP) reduction up to $200 with the member held harmless. Compliance audits will take place on a post-payment basis, which may result in refunds.
Policy Memo No. 1
SECTION XI. [DOCUMENTATION] MEDICAL RECORDS

- Pages 10-13: Removed, replaced and rewrote section on Medical Records to Section XI. Renamed Documentation to Medical Records. Changes made to improve policy language and better address medical review processes.

A. Form of documentation in medical records

Documentation in the medical record must accurately reflect the healthcare services rendered to the patient and is an integral part of the reimbursement, audit, and review processes. [All pertinent and complete medical records must be provided or made available at no charge by the contracting provider upon request by BCBSKS or an entity acting on behalf of BCBSKS. Certain unusual circumstances as determined solely by BCBSKS require contracting providers to submit medical records to BCBSKS upon request and without advance notice. In these cases, a BCBSKS 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.]

1. Documentation of Medical Services

   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). Each diagnosis submitted on the claim must be supported by the documentation in the patient’s medical record. The contracting provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s) which shall be made available for audit and review at no charge. 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.

2. [Blue Cross and Blue Shield of Kansas] BCBSKS has adopted the following standards for documentation of medical services.

   Each patient’s health record shall meet these requirements:
   a. Be legible in both readability and content.
   b. Contain only those terms and abbreviations that are or should be comprehensible to similar providers/peers.
   c. Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
   d. Indicate the dates any professional service was provided and date of each entry.
   e. Contain pertinent information concerning the patient’s condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
   f. Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed, and the results of each.
   g. List start and stop times on all timed codes per CPT nomenclature.
   h. Document the initial diagnosis and the patient’s initial reason for seeking the provider’s care.
   i. Document the patient’s current status and progress during the course of treatment provided.
   j. Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each.
   k. Include all patient records received from other health care providers if those records formed the basis for treatment decision by the provider.
   l. Each entry shall be authenticated by the person making the entry (see Signature Requirements) unless the entire patient record is maintained in the provider’s own handwriting.
m. Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.

3. **Signature Requirements**

In the context of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.

a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.

b. An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author’s first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: “Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M.”

c. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.

d. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

4. **Corrections in the Medical Record**

If the original entry in the medical record is incomplete, [please] contracting providers shall follow the guidelines below for making a correction, addendum, or amendment. Signature requirements as defined above apply to all corrections in the medical record.

a. Errors in paper-based records:

To add an [A]ddendum or [A]mendment to paper-based records, draw a single line in ink through the incorrect entry, print the word "error" at the top of the entry, the reason for the change, the correct information, and authenticate the error by signing (including credentials) the notation with the date and time. Entries should not be antedated (assigned a date earlier than the current date). Errors must never be blocked out or erased.

b. **Electronic medical records/Electronic health records:**

   i. **Addendum**

   An addendum is new documentation used to add information to an original entry that has already been signed. Addenda should be timely with date and time of the addendum. Write “addendum” and state the reason for the addendum referring back to the original entry. Complete the addendum as soon after the original note as possible. Identify any sources of information used to support the addendum. Entries should not be antedated (assigned a date earlier than the current date).
ii. Amendment
An amendment is documentation meant to clarify or provide additional information within the medical record in conjunction with a previous entry. An amendment is made after the original documentation has been completed \([\text{and signed}]\) by the provider. All amendments should be timely with the date and time of the amended documentation. Write “amendment” and document the clarifying information referring back to the original entry. Complete the amendment as soon after the original note as possible. Entries should not be antedated (assigned a date earlier than the current date).

5. Use of Medical Scribes
Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. BCBSKS expects the signing and dating of all entries made by a scribe to be identifiable and distinguishable from that of a physician or licensed independent practitioner. All entries made by a scribe are ultimately the practitioner’s responsibility; therefore, review of the documentation and verification of its accuracy, including authentication by the practitioner, is required.

B. [MEDICAL REVIEW PROCESSES] BCBSKS requests for medical records

1. BCBSKS staff members conduct medical review of claims and seek the advice of qualified and, typically, practicing professionals when necessary. Contracting providers agree to accept the decisions made as a result of those reviews and to follow the appeals procedures established by this Policy Memo.

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

2. 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 clinical professionals at appropriate points throughout the entire review process.

3. Contracting providers must submit [A]ll pertinent and complete medical records [must be provided by the contracting provider] to BCBSKS within [30 days] the time frame specified by BCBSKS [upon request] when records are needed for the initial review of a claim or when records are requested for an audit. In most instances, BCBSKS will allow 30 calendar days for the production of the requested records. In certain unusual circumstances as determined solely by BCBSKS, BCBSKS will require providers to submit medical records without advance notice. In such cases, a BCBSKS representative will visit the provider's office during business hours and secure the requested records immediately. The provider agrees to provide the requested records immediately. Members' contracts permit BCBSKS to obtain medical records without a signed patient release.

4. 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.
5. If [it is] BCBSKS determines that the patient services provided by the contracting provider 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 before the service being rendered, charges for the services will be the patient's responsibility.

Policy Memo No. 1
SECTION XIV. PROFESSIONAL SERVICES COORDINATED WITH A NON-CONTRACTING PROVIDER

- Page 14: Verbiage added to clarify non-contracting referrals.

However, in the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.

Policy Memo No. 1
SECTION XIX. LOCUM TENENS PROVIDER

- Page 16: Inserted verbiage to include parallel substitutions.

In situations in which the regular [physician] provider is unavailable, a locum tenens can be used to provide a visit/service. The locum tenens must be the same type of provider as for whom the locum is substituting (for example, a physician can only authorize another physician as a locum tenens, an APRN/PA can only authorize another APRN/PA, etc.) and the locum tenens must be licensed in Kansas and only perform within his/her scope of license. The locum tenens must not provide services [over] during a continuous period of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.

Policy Memo No. 1
SECTION XXXIII. APPLICATION OF CONTRACT

- Page 21: Included verbiage to include BCBSKS subsidiaries.

The conditions of these policies and procedures and the contracting provider agreement apply to all benefit programs, indemnity and to self-insured plans administered by Blue Cross and Blue Shield of Kansas, Inc. or its subsidiaries, including those with deductibles, coinsurance and shared payments. For indemnity plans the difference between payment and the MAP allowance can be billed to the patient.

The conditions of these policies and procedures and the contracting provider agreement also apply to other entities when services (including services covered by workers compensation) are received within the company service area and Blue Cross and Blue Shield of Kansas, Inc., or its subsidiaries, is involved in the pricing and/or processing of the claim and payment is issued either by Blue Cross and Blue Shield of Kansas, Inc., its subsidiaries, other Blue Cross and Blue Shield companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers...
compensation plans. In the event there is need for substantive differences between the terms and conditions of these Policies and Procedures and those applicable to a subsidiary of BCBSKS, a separate contract would govern the subsidiary network.

The conditions of these policies and procedures and the contracting provider agreement DO NOT apply to the programs insured and/or administered by Blue Cross and Blue Shield companies/plans when such programs rely upon providers who contract with an entity other than Blue Cross and Blue Shield of Kansas, Inc. for the purpose of establishing reimbursement levels in the company service area. And, in the event the provider is required to submit claims direct to a Blue Cross and Blue Shield company/plan outside the company service area that is adjudicating the claim, the provisions of these policies and procedures do not apply.

Policy Memo No. 1
SECTION XLI. CAP PROVIDER DIRECTORIES

- Page 23: Added verbiage regarding suppressing providers when current information is not provided.

BCBSKS makes CAP provider information, including contracting providers’ names, available to members on our website: www.bcbsks.com, and to BCBSA for national doctor locator directories. BCBSKS reserves the right to suppress a provider from the directory when current information is not provided upon request.

Policy Memo No. 1
SECTION XLVI. CONTRACT AMENDMENT

- Page 24-25: Added verbiage to amend Contracting Provider Agreement.

The Contracting Provider Agreement is hereby amended to delete Section IV.B, paragraphs 1 through 5 (see below), which references certain circumstances under which BCBSKS could make adjustments to the maximum allowable payment (MAP) for services.

SECTION IV. MAXIMUM ALLOWABLE PAYMENT SYSTEM
B. The physician agrees to fully and promptly inform BCBSKS of the existence of agreements under which such physician agrees to accept an amount for any and or all services as payment in full which is less than the amount such physician accepts from BCBSKS as payment in full for such services. BCBSKS staff is authorized to adjust maximum allowable payments for the physician in light of such agreements, under the following terms:

1. The BCBSKS staff may adjust the maximum allowable payment only in circumstances in which the staff becomes aware through independent investigation or as a result of information provided by a contracting provider, that a contracting provider has a payment agreement with another payor or offers a discount or other financial arrangement, the effect of which is that such contracting provider accepts from another payor as payment in full an amount less than such contracting provider would accept from this corporation as payment in full.

2. Such adjustment shall be approved in writing by the executive vice president or by the president of this corporation.

3. Such adjustment shall be communicated in writing to the contracting provider. Such communication shall be considered a change in policy adopted by the board of directors, and the contracting provider shall have such advance notice of the change and such rights to cancel the Contracting Provider Agreement rather than abide by the change as are afforded for other amendments to policies and procedures under Section III.A.2.
of this agreement.

4. The board of directors or executive committee of BCBSKS shall be informed by the staff of any such adjustments to MAPs so made, at the next meeting of the board of directors or executive committee immediately following such adjustment.

5. The board of directors or executive committee of this corporation shall have the ability to make subsequent changes in adjustments to MAPs so made, which changes shall be prospective only and shall be effective as any other amendment to policies and procedures after communication. If a change in such adjustments would have the effect of inducing a party which terminated its Contracting Provider Agreement as a result of the staff adjustment to MAPs to wish to contract anew with BCBSKS, a contract shall be tendered to such party and shall become effective on the date of execution by such party.

Policy Memo No. 1
SECTION XLVII. GLOSSARY

- Page 25: Added glossary link to Policy Memo.

A list of definitions for some of the language used in these Policy Memos can be found at the Blue Cross and Blue Shield of Kansas website.

http://bcbsks.com/help/glossary.htm

Policy Memo No. 3

No changes for 2015.

Policy Memo No. 4
SECTION VII. CREDENTIALING

- Page 3: Changed verbiage to better address the credentialing process.

BCBSKS has a credentialing program that consists of the initial full review of the provider's credentialing application and recredentialled at a minimum of every 36 months. Monitoring of all network providers for continual compliance with established criteria will occur as needed, but not less than monthly.

If a provider ceases to comply with criteria or has actions taken by the licensing board (e.g. any agreement entered into with the appropriate licensing board), credentialing staff will review all adverse actions and report to the Corporate Credentials Committee. If a provider's license has been suspended or revoked, action will be taken immediately to cancel their contract.

[This process consists of an initial full review of the provider's credentials at the time of application and at the time of recredentialing which occurs at least every 36 months.] Credentialing criteria are available on the BCBSKS website at:

http://www.bcbsks.com/CustomerService/Providers/Publications/professional/PolicyMemos/credentialing-criteria.htm

- Page 4: Added verbiage to address member safety and timeframes for appeals.

C. Suspension for Member Safety

BCBSKS will review any action taken against a contracting provider where there is unacceptable conduct, competency concerns or where there is concern for the safety of BCBSKS members. The contracting provider will be offered appeal rights if his/her contracting status is suspended.
D. First-Level Appeal Panel
All appealed disputes are referred to a first-level appeal panel consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. **BCBSKS will have 60 days from the receipt of the first-level appeal request to organize a first-level appeal panel.**

E. Second-Level Appeal Panel
If the first-level appeal panel upholds the denial or restriction, the provider may submit a written request for a second-level appeal. This provides consideration to a second-level appeal panel consisting of at least three individuals as defined in the first-level appeal panel and that were not involved with the first-level appeal panel. **BCBSKS will have 60 days from the receipt of the second-level appeal request to organize a second-level appeal panel.**