2018 Contracting

Professional Relations

CAP REPORT

INTRODUCTION

Blue Cross and Blue Shield of Kansas (BCBSKS) is the insurer Kansans trust with their health. Much of that status can be attributed to the high-quality care delivered by our network providers. This document outlines the details related to our Competitive Allowance Program (CAP) offer, and includes the specifics of our Quality-Based Reimbursement Program (QBRP), which has been designed to reward your efforts toward maintaining high-quality standards.

BCBSKS continues to offer contracting providers top-notch services, including Professional Provider Representatives and provider network services.

If you need clarification or additional information related to any information included herein, contact your Professional Relations Representative or Provider Network Services.

Professional Relations Staff	Location	Phone Numbers	
Doug Scott, Director	Topeka	(800) 432-0216 ext. 8831	(785) 291-8831
Robyne Goates, Manager	Topeka	(800) 432-0216 ext. 8206	(785) 291-8206
Gwen Nelson	Topeka	(800) 432-0216 ext. 8716	(785) 291-8716
Darin Fieger	Topeka	(800) 432-0216 ext. 8207	(785) 291-8207
Christie Mugler	Topeka	(800) 432-0216 ext. 8651	(785) 291-8651
Vikki Lindemuth	Topeka	(800) 432-0216 ext. 7724	(785) 291-7724
Provider Network Services	Topeka	(800) 432-3587 option 1 or 3	(785) 291-4135 option 1 or 3
Kyle Abbott	Wichita	(800) 432-0216 ext. 1674	(316) 269-1674
Vickie Kloxin	Wichita	(800) 432-0216 ext. 1674	(316) 269-1674
Debra Meisenheimer	Hutchinson	(620) 663-1313	
Jennie Fellers-Morgan	Dodge City	(620) 225-0884	

BY THE NUMBERS

Blue Cross and Blue Shield of Kansas provides the best service in the industry and strives to be the health insurance company of choice for our members and providers.

#1

BCBSKS is top-ranked for Provider Satisfaction.

BCBSKS is projecting $78 million in QBRP incentives in 2017 (professional and institutional).

$78 Million

987,957

BCBSKS and its subsidiaries serve 987,957 members across all lines of business, including BlueCard, as of May 31, 2017.

BCBSKS serves 680,569 members locally, as of May 31, 2017.

680,569

9.60%

BCBSKS spent 9.60 percent of annual premium income on administrative expenses for the year 2016.

BCBSKS is 100 percent URAC accredited in health plan, case management and disease management.

100%

99%

BCBSKS contracts with 99 percent of all physicians in the Plan area.

BCBSKS contracts with 97 percent of all professional providers in the Plan area.

97%

PCMH/ACO

BCBSKS continues to support and expand Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) arrangements.

THE VALUE IN CONTRACTING

BCBSKS provides business services that bridge the gap between the delivery and financing of health care. Services creating significant value for contracting providers include:

► **Local member contracts** structured to allow charges up to 100 percent of the MAP for participating CAP providers (subject to member benefits).

► **Detailed claim-payment information** provided to both you and the member explaining their financial responsibilities.

► **A dedicated field staff** available to visit your office to address any operational issues.

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

► **Website (bcbsks.com) and self-service** access through Availity, which improves your office efficiencies and maximizes your employee resources.

- Secured services include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
- Other services include training modules, podcasts, newsletters, manuals, policy memos, and medical policies/ guidelines.

► **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.

► **Opportunity to participate on specialty liaison committees** and provide direct input in the development of medical policies and emerging issues.

► **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.

► **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.

NOTE — In 2018, 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, assignment of benefits to non-contracting providers is not allowed.

2018 REIMBURSEMENT AND POLICY MEMO CHANGES

On June 30, 2017, the BCBSKS Board of Directors met and approved reimbursement and Policy Memo changes for 2018. A summary of the Policy Memo changes is enclosed for your review. Highlights of the 2018 reimbursement are noted below. We continue to build on the Quality-Based Reimbursement Program (QBRP) started in 2012 to encourage higher quality care and better control of health care costs. Our reimbursement program for 2018 will continue to create opportunities for providers to earn incentives by meeting the criteria as outlined in the 2018 QBRP as described on pages 7-13.

A charge comparison report reflecting reimbursement changes for 2018 is available by contacting your Professional Relations Representative or our Provider Network Services area. The charge comparison is based on services billed by you during the first five months of 2017. As a reminder, the format of the charge comparison report changed in 2016. The new format provides the lesser of your charge or the MAP for each procedure code you performed thus far in 2017. In addition, the new report shows whether each procedure code qualifies for QBRP.

OVERVIEW OF 2018 REIMBURSEMENT

Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted. (See QBRP section, pages 7-13.)

Increasing ▲	No change —	Decreasing ▼
Evaluation and Management (E&M) codes 99213 and 99214 (eligible for QBRP)	Professional consultation codes (eligible for QBRP)	Overvalued CPT codes (eligible for QBRP)
Undervalued CPT codes (eligible for QBRP)	Administration for injectable drugs (eligible for QBRP)	Clinical lab codes (not eligible for QBRP)
Ambulance base rates for fixed wing (eligible for QBRP)	Physical therapy, occupational therapy, and speech pathology services (eligible for QBRP)	Mileage rates for fixed wing and rotary wing (eligible for QBRP)
Ambulance base rates for rotary wing (eligible for QBRP)	Services billed by primary care providers located in counties with a population of 13,000 or less will continue to receive a 5 percent add-on to the MAP on all eligible CPT codes (not eligible for QBRP). See county listing on page 14.	
Anesthesia conversion factor at $59.84 (eligible for QBRP)		Durable Medical Equipment (DME) services (eligible for QBRP)
Some Durable Medical Equipment (DME) services (eligible for QBRP)	Evaluation and Management (E&M) codes other than 99213 and 99214 (eligible for QBRP)	
	Sleep medicine (eligible for QBRP)	

TIERED REIMBURSEMENT

The allowances for professional services associated with the following specialties have been set at the identified percentages of the MAP (no reimbursement changes for 2018).

85 percent*	70 percent*	50 percent*
Advanced Practice Registered Nurses (APRNs) [not including Certified Registered Nurse Anesthetists (CRNAs)]	Community Mental Health Centers	Certified Occupational Therapy Assistants (COTAs)
Chiropractors	Licensed Clinical Marriage and Family Therapists	Certified Physical Therapist Assistants (CPTAs)
Clinical Psychologists	Licensed Clinical Professional Counselors	Licensed Athletic Trainers (LATs)
Occupational Therapists	Licensed Clinical Psychotherapists	
Physical Therapists	Licensed Specialist Clinical Social Workers (LSCSWs)	
Physician Assistants		Individual Intensive Support (IIS) providers
Speech Language Pathologists	Outpatient Substance Abuse Facilities	
Licensed Dieticians/ Certified Diabetic Educators	Autism Specialists (AS)	

*Amounts are rounded to the nearest $0.01 per line item.

2018 PROFESSIONAL PROVIDERS QBRP

The BCBSKS Quality-Based Reimbursement Program (QBRP) is designed to promote efficient administration, improved quality, and better 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. BCBSKS claims data is used to determine qualification for any applicable metric requiring data.

IMPORTANT REMINDER — The 2018 QBRP program is effective for services performed January 1, 2018 through December 31, 2018. Since the 2018 CAP letter is sent out in July 2017, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2018, in accordance with the metric review schedule (see pages 9-10). Please read the requirements and metrics for the 2018 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2018

In accordance with the 2018 Policy Memo No. 1, Section XXX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2018 through December 31, 2018. This program applies to all BCBSKS CAP and BlueCross BlueShield of Kansas Solutions, Inc. (a wholly owned subsidiary of BCBSKS) professional providers and services except for clinical lab (using codes on the Medicare clinical lab fee schedule), pharmacies and pharmaceuticals, and dental services. This program will offer an opportunity for eligible providers to earn increased reimbursement based on a four-group approach (Groups A, B, C, and D). This reimbursement will be in addition to the established base MAPs for 2018. **Please note —** Changes in CPT codes (added/deleted) will be effective prospectively, including QBRP.

In order to pay incentives on the metrics in Groups B, C, and D, we developed a doctor/patient registry. BCBSKS will review claims from the preceding 12 to 24 months and attribute patients to the applicable physicians based on the frequency of office visit encounters with a given physician. In the event multiple 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 quality-based incentives will be earned at the individual provider level unless otherwise specified.

Qualification to participate in the incentives made available in the program will vary depending on provider type. An eligible provider may independently qualify for each metric, except when measured on a group basis. The QBRP metrics are multiplied individually by the MAP, then totaled with the MAP to determine the total reimbursement “QBRP MAP.” BCBSKS will allow the lesser of the provider’s charge or the “QBRP MAP.”

In order for incentive payments to begin January 1, 2018, BCBSKS will use information on file or available from outside sources to determine which incentives providers qualify for based on unique provider individual NPI numbers, billing NPI numbers or tax ID, whichever is applicable. 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 2018 incentives effective January 1, 2018 will be sent mid-December 2017.
Please note — BCBSKS is working on enhancements to the provider information portal to include self-service QBRP information. Once this portal is available, it may replace the email confirmation process. More information and instructions will be communicated when the QBRP portal is available.

2018 PROFESSIONAL PROVIDER QBRP

(NEW) All metrics will be reviewed on a semi-annual basis and any incentives earned will be effective either January 1, 2018 or July 1, 2018 as applicable. We will continue monthly reviews for 2018 to identify providers who did not qualify for incentive(s) beginning January 1, 2018 because of not meeting prerequisites, or new providers/groups after January 1, 2018, but may subsequently qualify for incentive(s). If/when one of these two situations occur, the incentive(s) will be effective the first of the following month. A confirmation notice will be emailed to the provider to include the new incentive category and effective date. Any corrections will be effective the first of the following month unless otherwise specified.

We will conduct a QBRP refresh in the first and second quarters (depending on the metric) of 2018 for an effective date of July 1, 2018 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2018. If the refreshed data indicates a provider is no longer meeting the performance standards for the metric(s), then the associated QBRP incentive(s) will cease beginning July 1, 2018 for the remainder of the year. If a provider no longer meets the performance standards for the metric(s), a new communication advising of the change in QBRP incentive(s) qualifications will be sent.

QBRP PREREQUISITES AND GROUPS FOR PROVIDERS	
QBRP Participation Prerequisites	Providers must conduct business with BCBSKS electronically (i.e. turn off paper). Providers must submit all eligible claims electronically, accept electronic remittance advice documents (ERAs: either through receiving the ANSI 835 transaction or by downloading the RA from the BCBSKS secured website (and turn off printed RAs), and receive all communications (newsletters, etc.) electronically.
Group A	Applies to all eligible contracting professional providers and to all eligible/covered CPT and HCPCS codes (excludes Clinical Lab [using codes on Medicare clinical lab fee schedule], Pharmacy and Pharmaceuticals, and Dental services).
Group B	Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and to all eligible/covered CPT codes (excludes Clinical Lab [using codes on the Medicare clinical lab fee schedule], Pharmacy and Pharmaceuticals, and Dental services).
Group C	Applies to primary care professionals including supervised mid-levels (FP, GP, Peds, IM, PA, APRN) unless otherwise noted and only to covered E&M codes. Group C incentives are earned at the group level (for physicians with attributed members) with the exception of Level 3 PCMH Recognition, which is incentivized at the individual level. New providers joining a group or changing tax IDs will not be eligible for the HEDIS metrics under the new arrangement until the refresh period.
Group D	Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and only to covered E&M codes.

2018 PROFESSIONAL PROVIDERS QBRP

Metric	%	Group	Description	Qualifying Period
Electronic Self-Service (ES3, ES2)	**2.5 (ES3)** *(96% or >)* **1.5 (ES2)** *(86-95%)*	A	Must use Availity portal or ANSI 270/271 & 276/277 transactions to electronically obtain BCBSKS patient eligibility, benefit, and claims status information. Electronic access must meet one of the percentages at left compared to the provider's total number of queries to BCBSKS, regardless of the mode of inquiry to receive the corresponding incentive. Providers billing under a single tax ID number will have their inquiries combined for determining the applicable percent.	Semi-annual
Provider Information Portal (PRT)	2.0	A	Must verify provider information twice a year according to the qualifying schedule below. Each individual provider's information within a group must be verified. Verification must be completed within the BCBSKS provider information portal.	Semi-annual

QUALIFYING FOR ELECTRONIC SELF-SERVICE INCENTIVE (ES3, ES2)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period:	Incentive begins:
August 1 - October 31, 2017	January 1, 2018
February 1 - April 30, 2018	July 1, 2018

QUALIFYING FOR PROVIDER INFORMATION PORTAL (PRT) AND REGISTRY DATA (REG) INCENTIVES

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period:	Incentive begins:
June 1 - November 30, 2017	January 1, 2018
December 1, 2017 - May 31, 2018	July 1, 2018

Metric	%	Group	Description	Qualifying Period
Registry Data (REG) (applies only to anesthesia, pathology, radiology, urology, and chiropractors)	1.5	B	Must send sufficient patient information to meet CMS quality measures to a CMS-approved registry. Electronic submission is preferred. Providers under a group qualify as a group. Must send report to BCBSKS demonstrating acceptance of submitting data and meeting registry requirements. **Note —** Although not prescribing providers, chiropractors will be eligible for this Group B measure only.	Semi-annual
Well-Child visits (W15) **(New)** 6-plus visits in first 15 months	.25	B	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual

2018 PROFESSIONAL PROVIDERS QBRP

Metric	%	Group	Description	Qualifying Period
Well-Child visits (W34) **(New)** 1 or more visits for 3-6 year olds	.25	B	The percentage of members 3 to 6 years of age who had at least one well-child visit with a PCP during the measurement year. Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
KHIE HL7 use — Each provider must have a user ID and real-time connectivity to qualify for:				
a-KHIE HL7 (ADT) Demographics, admissions, discharges, transfers	1.0	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.	Semi-annual
b-KHIE HL7 (OPN) Progress notes	1.0	B	Must send progress notes on all patient encounters.	Semi-annual
c-KHIE HL7 (ABS) Diagnosis, Procedure coding	1.0	B	Must send diagnosis and/or procedure coding on all patient encounters.	Semi-annual
d-KHIE HL7 (LAB) Lab reporting	1.0	B	Must send all lab reports on all patient lab tests.	Semi-annual
e-KHIE HL7 (MED) Medication records	1.0	B	Must send medication history on all patient encounters.	Semi-annual
Access Formulary Electronically (EEX)	1.0	B	Must electronically access member benefit information for eligibility, formulary, and medication history a minimum of 120 times per quarter.	Semi-annual
Generic Utilization Rate (GUR)	1.0	B	Minimum generic prescribing of 80 percent (for all BCBSKS members with a prescription drug benefit).	Semi-annual

QUALIFYING FOR KHIE INCENTIVES (ADT, OPN, ABS, LAB, MED)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period:	Incentive begins:
August 1 - October 31, 2017	January 1, 2018
February 1 - April 30, 2018	July 1, 2018

QUALIFYING FOR ACCESS FORMULARY ELECTRONICALLY, GENERIC UTILIZATION RATE INCENTIVES (EEX, GUR)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period:	Incentive begins:
September 1 - November 30, 2017	January 1, 2018
March 1 - May 31, 2018	July 1, 2018

2018 PROFESSIONAL PROVIDERS QBRP

Metric	%	Group	Description	Qualifying Period
PCMH Recognition (BST) Level 3	2.0	C	Provider must achieve Level 3 NCQA and/or URAC Patient Centered Medical Home recognition.	Semi-annual
Breast Cancer Screening (BCS)	1.0	C	The percentage of women 50 to 74 years of age (52 to 74 as of the end of the measurement period) who had a mammogram anytime in the past two years. Must be greater than or equal to 70 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients for breast cancer screening. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** OB-GYN and Geriatrician providers can qualify as well.	Semi-annual
Appropriate Testing for Children with Pharyngitis (CWP)	1.0	C	The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e. appropriate testing). Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	1.0	C	The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. Must be greater than or equal to 85 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual

2018 PROFESSIONAL PROVIDERS QBRP

Metric	%	Group	Description	Qualifying Period
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	1.0	D	The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. Must be greater than or equal to 30 percent to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Monitoring Patients on Persistent Medications (MPM)	1.0	D	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (ACE Inhibitors or ARB's, Digoxin, Diuretics) and also had at least one applicable lab test in the measurement period. Must be greater than or equal to 85 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual

2018 PROFESSIONAL PROVIDERS QBRP

QBRP CHANGES FOR 2018		
Metric	**Change**	**Reason**
Electronic Self-Service	Changed from three to two incentive categories, raised thresholds, and changed incentive weighting.	To increase self-service.
Provider Information Portal	Increased incentive from 1.5 to 2.0 percent.	To increase provider data validation adherence.
Registry Data	Added other specialties.	To increase quality registry data participation, submission.
KHIE Inquiries	Deleted	Provider adoption of querying is commonplace.
KHIE HL7 Lab Reporting	Increased incentive from .5 to 1.0 percent.	To be consistent with other HL7 metrics.
Access Formulary Electronically	Changed name of metric. Raised threshold from 90 to 120 times per quarter. Increased incentive from .75 to 1.0 percent.	Overall average use has increased and need to strive for improvement.
Generic Utilization Rate	Raised from threshold from 75 to 80. Also increased incentive from .75 to 1.0 percent.	Overall average has increased to 86 percent and need to strive for improvement.
Cover My Meds	Deleted	Challenge to administer.
Specialty Pharmacy	Deleted	Most benefit plans now require use of Prime Specialty.
Diabetes Recognition Program	Deleted	Very low adoption.
PCMH Recognition	Deleted Level 1 or 2. Must be Level 3 to earn incentive. Also raised incentive for Level 3 from 1.75 to 2.0 percent.	Recognize higher achievement.
NCQA Heart Stroke Program	Deleted	Very low adoption.
Immunization for Adolescents Tdap	Deleted	Performing at national average, low impact on STARS rating.
Childhood Immunization MMR	Deleted	Performing at national average, low impact on STARS rating.
Well-child visits in first 15 months	New	Greater impact on FEP and STARS rating.
Well-child visits 3-6 years old	New	Greater impact on FEP and STARS rating.
Breast Cancer Screening	Increased incentive from .75 to 1.0 percent.	To be consistent with other HEDIS measures.
Appropriate Testing for Children with Pharyngitis	Raised threshold from 70 to 80 percent.	Align with national average.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Decreased threshold from 50 to 30 percent.	Align with national average.

RURAL ACCESS COUNTIES ...

The following is a list of counties with a population of 13,000 or less that qualify for a Rural Access incentive. (Source: U.S. County 2012 Estimated Census)

County	Population
Anderson	7,917
Barber	4,861
Brown	9,881
Chase	2,757
Chautauqua	3,571
Cheyenne	2,678
Clark	2,181
Clay	8,531
Cloud	9,397
Coffey	8,502
Comanche	1,913
Decatur	2,871
Doniphan	7,864
Edwards	2,979
Elk	2,720
Ellsworth	6,494
Gove	2,729
Graham	2,578
Grant	7,923
Gray	6,030
Greeley	1,298
Greenwood	6,454
Hamilton	2,639
Harper	5,911
Haskell	4,256
Hodgeman	1,963
Jewell	3,046
Kearny	3,968
Kingman	7,863
Kiowa	2,496
Lane	1,704
Lincoln	3,174
Linn	9,441
Logan	2,784

County	Population
Marion	12,347
Marshall	10,022
Meade	4,396
Mitchell	6,355
Morris	5,854
Morton	3,169
Nemaha	10,132
Ness	3,068
Norton	5,612
Osborne	3,806
Ottawa	6,072
Pawnee	6,928
Phillips	5,519
Pratt	9,728
Rawlins	2,560
Republic	4,858
Rice	9,985
Rooks	5,223
Rush	3,220
Russell	6,946
Scott	4,937
Sheridan	2,538
Sherman	6,113
Smith	3,765
Stafford	4,358
Stanton	2,175
Stevens	5,756
Thomas	7,941
Trego	2,986
Wabaunsee	7,039
Wallace	1,517
Washington	5,758
Wichita	2,256
Wilson	9,105
Woodson	3,278

BlueCross
BlueShield
of Kansas

BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2018

Following is a summary of the changes to Blue Shield Policies and Procedures for 2018. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2017.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2017 Policy Memos. Deleted wording is noted in brackets [*italicized*]. New verbiage is identified in **bold.**

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

- **Page 8:** Changed verbiage for clarity.

V. POST-PAYMENT AUDITS

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity and established standards of care. Post-payment audits can range from a basic encounter audit to determine if the level of care is accurately billed, to a complete audit which thoroughly examines all aspects of the medical record and medical practice. Post-payment audits are performed after the service(s) is billed to BCBSKS and payments have been received by the provider. [*BCBSKS cannot go back further than 15 months following the date of claim adjudication to initiate an audit.*] **BCBSKS will not initiate audits more than 15 months following the date of claim adjudication.** Post-payment audits being performed to resolve an allegation of fraud or abuse are not subject to the 15-month limitation. Due to additional time allowed for provider appeals, as outlined in this policy memo, refunds would be applicable after the provider appeals have been exhausted, regardless of the time frame involved. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, peer consultant medical opinion, and on-site visits.

Policy Memo No. 1
SECTION VI. CONTENT OF SERVICE

- **Page 9:** Added verbiage for clarity.
  - **For services that include assessment and evaluation of that assessment, the date of the assessment shall be the date of service.**

Policy Memo No. 1
SECTION XI. MEDICAL RECORDS

- **Page 14:** Updated verbiage for clarity.

B. 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.
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 all pertinent and complete medical records to BCBSKS within the time frame specified by BCBSKS when records are needed for the initial review of a claim or when records are requested for an audit. Medical records shall include all versions, whether handwritten or EMR/EHR-generated. Any applicable audit log documentation must be provided. In most instances, BCBSKS will allow 30 calendar days for the production of the requested records. **Failure to send the requested documentation or providing insufficient documentation to determine medical necessity may result in a claim denial and accordingly a provider write-off.** 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.*]

Policy Memo No. 1
SECTION XV. CLAIMS FILING

- **Page 15:** Added verbiage as notification that employee groups may impose alternate timely filing requirements.

XV. CLAIMS FILING

The contracting provider agrees to submit claims to BCBSKS for covered services (excluding "self pay" requests made by the patient as defined within the Health Information Technology for Economic and Clinical Health (HITECH) Act, Section 13405(a)) rendered to members at the usual charge (normal retail charge for HME suppliers) in the BCBSKS designated format, and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, indemnified payment balances and non-covered amounts. The contracting provider agrees to accept payment allowances in all cases once notified of payment determination. Claims must be filed within 15 months of the service date or discharge from the hospital. Failure to do so will result in claims being rejected with members held harmless. **When BCBSKS becomes aware, BCBSKS will notify contracting providers when employee groups impose alternate timely filing requirements.**

Policy Memo No. 1
SECTION XIX. LOCUM TENENS PROVIDER

- **Page 18:** Added verbiage for clarity.

In billing for services provided by a locum tenens, the claim must be filed using the NPI or specific performing provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used. In addition, the medical record must indicate the services were provided by a locum tenens. **Locum tenens can be utilized in certain situations. However, covering for a deceased provider and billing under that deceased provider's NPI does not meet the criteria for locum tenens and is not permissible.**

Policy Memo No. 1
SECTION XX. CONTRACTING STATUS DETERMINATION

- **Page 18:** Updated verbiage for clarity.

XX. CONTRACTING STATUS DETERMINATION

A. Any entity which provides and/or bills members and/or BCBSKS for health care services which advertises or represents itself to the general public as being owned**/owning**, controlled**/controlling**, managed**/managing**, affiliated with, or operated by a contracting provider must also be contracting with BCBSKS unless otherwise permitted by BCBSKS. Failure of such providers to contract with BCBSKS shall be considered cause for termination of the Contracting Provider Agreement in accordance with the Contracting Provider Agreement. This provision is applicable to entities serving members in the BCBSKS operating area. **Contracting providers shall not subcontract other providers using their BCBSKS contracting agreement without the written consent of BCBSKS.**

Policy Memo No. 1
SECTION XLIII. ACKNOWLEDGEMENT OF K.S.A. 44-1030

- **Page 25:** Updated verbiage to reflect current laws.

XLIII. ACKNOWLEDGMENT OF [*K.S.A. 44-1030*]NON-DISCRIMINATION LAWS

As a provider of services to the State of Kansas and to counties, municipalities and other state governmental units, BCBSKS is required by K.S.A. 44-1030 to observe the provisions of the Kansas Act Against Discrimination, not to discriminate against any person in the performance of work because of race, religion, color, sex, disability, national origin or ancestry, to include the phrase "equal opportunity employer" or a similar phrase in advertisements for employees, and to require in any contracts BCBSKS has with others that such others shall also abide by such provisions, and that if such contractors are found guilty of a violation of the Kansas Act Against Discrimination, such contractors shall be deemed to have breached their contracts with BCBSKS and the contract may be canceled, terminated or suspended in whole or in part. The contracting provider agrees that it shall abide by the foregoing provisions.

As a provider of services for qualified health plans, any entity that operates a health program or activity, any part that receives Federal financial assistance is required by Section 1557 of the Patient Protection and Affordable Care Act, and its implementing regulations published by the Office of Civil Rights, to not discriminate against any person on the basis of race, color, national origin, sex, gender identity, age, or disability, to accommodate individuals with limited English proficiency. Any entities that are found to have discriminated in violation of section 1557, and its implementing regulations, can be subject to a private right of action. The contracting provider agrees that it shall abide by the foregoing provisions.

Policy Memo No. 1
LIMITED PATIENT WAIVER

- **End of Policy Memo No. 1:** Updated Limited Patient Waiver to match other BCBSKS forms (esthetic only).

*Please see page 7 of this summary for updated form.

Policy Memo No. 2
SECTION III. SERVICE QUALIFYING FOR A SEPARATE PROFESSIONAL FEE IN ADDITION TO AN OFFICE/OUTPATIENT VISIT

- **Page 4:** Removed reference to modifier.
    - Administration of chemotherapy when a separate and identifiable E&M is justified[*25 modifier required*].

Policy Memo No. 7
SECTION I. DIAGNOSTIC RADIOLOGY POLICY

- **Page 4:** Verbiage added to reflect current practice.

D. DOCUMENTATION FOR INTERPRETATIONS OF DIAGNOSTIC IMAGING PROCEDURES

Interpretations of diagnostic imaging procedures reported separately for payment must include the following minimum information, either as a separate document or within the main body of the patient's record:

- **Patient's name and other appropriate identifier (date of birth, Social Security number, record number, etc.)**
- **Referring physician name**
- **Name or type of procedure performed**
- **Date and time procedure was performed**
- **Name of interpreting physician**
- **Date and time interpretation was performed**
- **Body of the report, including**
    - **Procedures and materials**

- **Findings**
- **Limitations**
- **Complications**
- **Clinical issues**
- **Comparisons, when indicated and available**
- **Clinical impression and diagnosis, including differential diagnosis when appropriate**

- **Legible signature (holographic or electronic)**

Records containing only documentation of diagnostic impressions, such as "Chest x-ray normal," "Chest x-ray shows CHF," and even more cryptic notations such as "CXR reviewed," are insufficient to support payment and must not be billed as a separately reported diagnostic imaging or interpretation.

Policy Memo No. 12
SECTION VI. RELATED POLICIES

- **Page 4:** Added verbiage for clarity.

3. OB Epidural Guidelines
   a. Epidural placement should be billed separately and reimbursed under the appropriate placement CPT code. The time for the placement of the epidural should NOT be included in total time of the monitoring/delivery anesthesia.
   b. Monitoring and delivery anesthesia will be reimbursed under the appropriate CPT neuraxial labor analgesia/anesthesia codes for vaginal and cesarean deliveries. BCBSKS will reimburse one unit for every hour of documented monitoring.
   c. Anesthesia time should be reported as total minutes.
   d. Anesthesia monitoring concludes at time of delivery.

Limited Patient Waiver

BlueCross BlueShield of Kansas

Section 1 – Patient Information

First Name | MI | Provider Name

Last Name | Suffix | Provider Address

Identification Number | City

Provider NPI | State | ZIP Code | +4

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

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance

provided to me on ____ ____ _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- ☐ Not medically necessary
- ☐ Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s)
- ☐ Patient demanded services
- ☐ Utilization denials
- ☐ Experimental or investigational

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

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.

Options: Check only one box. We cannot choose for you.

- ☐ **Option 1:** I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier.
- ☐ **Option 2:** I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance.

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.

Your signature required

Patient (Signature of parent/guardian if other than patient) | Date Signed

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.

Your signature required

Witness | Date Signed