BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2019

Following is a summary of the changes to Blue Shield Policies and Procedures for 2019. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2018.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2018 Policy Memos. Deleted wording is noted in brackets [*italicized*]. New verbiage is identified in **bold.**

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 9:** Updated verbiage to accurately reflect current practices.
  - Items of office overhead such as malpractice insurance, telephones, **computer equipment, software**, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
  - Telephone calls and web-based correspondence are content of service when billed with another service on the same day. **Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 and the GT modifier.** *[Such services are not covered if billed separately and the only service rendered on that day.]*

Policy Memo No. 1
SECTION XI. Medical Records

- **Page 12:** Added language regarding cloning of medical records.

A. Form of documentation in medical records – Documentation in the medical record must accurately reflect the health care services rendered to the patient and is an integral part of the reimbursement, audit, and review processes.

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. **Cloned Medical Record Documentation – BCBSKS expects providers to submit documentation specific to the patient and specific to the individual encounter. Documentation should support the individualized care each BCBSKS member received.**

   Documentation identified as cloned, copied and pasted, pulled forward, or inserted via template without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining services provided for that visit.

Policy Memo No. 1
SECTION XI. Medical Records

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

B. BCBSKS requests for medical records

1. **Contracting providers must provide or make available complete medical records at no charge in a format that can be utilized by BCBSKS or an entity acting on behalf of BCBSKS.**

Policy Memo No. 1
SECTION XV. Claims Filing

- **Page 15:** Added verbiage for clarity.

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. **Provider may not charge a Blue Cross and Blue Shield (BCBS) member or employer policy holder any enrollment and/or maintenance fees associated with membership into a concierge, direct primary care, or any other similar model practice**. 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 XXVIII. Reimbursement for Sleep Study Testing

- **Page 22:** Changed verbiage to align with current practices.
  [The allowance for sleep testing procedures as outlined by CPT is 100 percent of the MAP for providers' board certified in sleep medicine. All other eligible providers receive 60 percent of the MAP.]

  The allowance for sleep testing procedures performed in Freestanding Sleep Laboratories or Centers is 100 percent of the MAP for those facilities accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC). All other eligible *[facilities}* **providers** receive *[60 percent of the]* **a reduced** MAP**.** *[when services are provided in a Freestanding Sleep Laboratory or Center. Services provided in a setting other than a Freestanding Sleep Laboratory or Center will be limited to 50 percent of the applicable MAP for facilities.]*

  Unattended sleep studies will be allowed at the MAP without regard to accreditation.

Policy Memo No. 1
SECTION XLVI. Provider Dispute Resolution

- **Page 27:** Updated verbiage for clarity.
  A. Providers may dispute issues of concern through their Professional or Institutional Relations Representative. **A provider representative will respond to the provider in writing within 30 days of the request to advise of the status of the dispute or the outcome.** The representative will work with the provider to address the dispute. If the provider remains dissatisfied the dispute may be escalated to BCBSKS management. Disputes referred to BCBSKS management must be in writing and include the supporting documentation used to initially resolve the dispute and any additional information submitted by the provider that supports the issue. BCBSKS will provide a written response to the provider within 60 days of BCBSKS management receiving the written request.

Policy Memo No. 2
SECTION II. Content of Service

- **Page 3:** Updated verbiage to accurately reflect current practices.
  - Items of office overhead such as malpractice insurance, telephones, **computer equipment, software**, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
  - Telephone calls and web-based correspondence are content of service when billed with another service on the same day. **Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 and the GT modifier.** *[Not covered if billed separately and the only service rendered on that day.]*

Policy Memo No. 2
SECTION VI. Telemedicine (new section)

- **Pages 4-5:** Added new section to accurately reflect current practices.

VI. Telemedicine

Telemedicine, including telehealth, is a covered service as per Kansas Telemedicine Act.

Telemedicine, including telehealth, means the delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine shall be provided by means of real-time, two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telemedicine does not include communication between:

A. Health care providers that consist solely of a telephone voice-only conversation, email/eVisits, text, or facsimile transmission; or
B. A physician and a patient that consists solely of an email/eVisit, text, or facsimile transmission.

Physical therapy, speech therapy, occupational therapy, and audiology services are not covered as telehealth services.

"Distant site" means a site at which a health care provider is located while providing health care services by means of telemedicine.

"Health care provider" means a physician, licensed physician assistant, licensed advanced practice registered nurse, or person licensed, registered, certified, or otherwise authorized to practice by the behavioral sciences regulatory board (BSRB).

"Licensed mental health care professional" means an individual licensed by the BSRB who is acting within the scope of the individual's professional licensure act and held to the standards of professional conduct as set forth by the BSRB.

"Originating site" means a site at which a patient is located at the time health care services are provided by means of telemedicine.

"Physician" means a person licensed to practice medicine and surgery by the state board of healing arts.

Benefit coverage for health care services that are medically necessary – subject to the terms and conditions of the covered individual's health benefits plan – provided through telemedicine, rather than in-person contact or based upon the lack of a commercial office for the practice of medicine, will be the same when such services are delivered by a health care provider.

Policy Memo No. 4
SECTION III. Disease Management

- **Page 4:** Updated verbiage to accurately reflect current programs.

III. Disease Management**/Wellness**

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

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

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

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

BCBSKS has telephone-based Disease Management and Wellness programs designed to help members improve quality of life and overall health by understanding health risks and possible complications, making healthy lifestyle choices, improving gaps in

care/preventive care, and communicating with the health care team to make informed decisions in care. Disease Management programs offered include diabetes, coronary artery disease, asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and hyperlipidemia. Wellness programs offered include weight loss, tobacco cessation, and stress management. Through these programs, registered nurses provide one-on-one support, coaching, and educational tools to assist members in self-management skills to improve overall health.

The Disease Management Program is URAC accredited. Both the Disease Management and Wellness programs are HIPAA compliant.

Members are identified for participation in one or more of the Disease Management programs by diagnoses codes on claims and will be invited to participate by letter or telephone. Additionally, members can self-enroll for any Disease Management or Wellness program, and providers may refer members for participation. Participation in the programs is voluntary. Members may choose to discontinue participation in the programs at any time. Participation in the programs will not affect any health insurance benefits. For additional information, go to bcbsks.com/BeHealthy/DiseaseMgmt or bcbsks.com/BeHealthy/Wellness-Management.

Policy Memo No. 4
SECTION V. State Health Information Exchange (HIE)

- **Page 5:** Updated verbiage to accurately reflect current practices.

V. *[State]* **Health Information Exchange (HIE)**
BCBSKS *[supports the efforts of the Kansas Health Information Exchange, Inc. (KHIE) to establish a health insurance exchange in Kansas. When a provider has connected to a KHIE-approved Health Information Organization (HIO),]* **believes in the value of health information exchange to support delivery of high-quality and cost-effective health care. BCBSKS is committed to supporting electronic sharing of clinical information that is HIPAA compliant and designed to achieve the goals of improving member experience, quality of care, and the health of our member population.** BCBSKS may require electronic submission when requesting clinical information.

Policy Memo No. 10
SECTION IV. Non-Physician Assistants

- **Page 3:** Changed verbiage to reflect name change.
A list of those procedures for which an assistant surgeon is not normally reimbursed is found in your BCBSKS *[Business Procedure]* **Professional Provider** Manual.

Policy Memo No. 12
SECTION VI. Related Policies

- **Page 5:** 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 monitoring for vaginal deliveries and one unit for every 15 minutes for cesarean deliveries.
     c. Anesthesia time should be reported as total minutes.
     d. Anesthesia monitoring concludes at time of delivery **for vaginal deliveries**.
     e. For cesarean deliveries, anesthesia monitoring concludes when patient is transferred to the post-anesthesia care unit/recovery room.