What's New in 2022

Insurance Billing Workshop

BlueCross BlueShield of Kansas

bcbsks.com

Agenda

- Review of 2022 Annual CAP Report
- Review of Quality-Based Reimbursement (QBRP)
- Review of 2022 Policy Memo Changes

2022 Competitive Allowance Program (CAP) Contract

- Being the insurer Kansans trust with their health.
- Implementation of Affordable Care Act requirements.
- Low administrative expenses.
- BCBSKS addresses the health care needs of 983,362 Kansans.
- BCBSKS contracts with 99 percent of physicians and 97 percent of all professional providers in our Kansas Plan area.
- BCBSKS is 100 percent URAC accredited in health plan, case management, and disease management.
- BCBSKS continues to support and expand Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) arrangements.

2022 Reimbursement – Increasing

- Undervalued CPT codes
- Air Ambulance base rates

2022 Reimbursement – No Change

- Professional consultation codes
- Anesthesia conversion factor at $63.34
- PT, OT, and speech pathology services
- Rural County Incentive – Services billed by primary care and behavioral health providers located in counties with a population of 13,000 or less.
- Evaluation and Management codes
- Ground Ambulance base rates

2022 Reimbursement – Decreasing

- Overvalued CPT codes
- Clinical lab codes
- Durable Medical Equipment (DME)

Tiered Reimbursement

Definition – The allowances for professional services has been designated as a percentage of MAP based on the provider specialty. Refer to the table on page seven of CAP mailing for a list of specialty providers.

If services are rendered by an eligible provider, you are required to file the claim under that provider's individual NPI.

Quality-Based Reimbursement Program (QBRP)

- Incentive plan designed to promote efficient administration and improved quality with better patient care and outcomes.
- Prerequisite – Turn off paper (claims, remittance advice, newsletters).
- Excluded – Clinical lab (using codes on the Medicare clinical lab fee schedule), pharmacies/pharmaceuticals, and dental services.

Quality-Based Reimbursement Program (QBRP)

- Metrics are categorized into three groups – A, B, and C.
- Achievement of a metric can be measured at different intervals, depending upon the metric.
- Refer to CAP mailing for defined time frames.
- Incentives will be earned at the individual level unless otherwise specified.
- Provider must be in good standing with BCBSKS to qualify for and receive QBRP.

QBRP – Group A Components

- Applies to all eligible CAP professional providers.
- Incentive – Applies to all eligible CPT/HCPCS codes except for clinical lab (using codes on Medicare clinical lab fee schedule), pharmaceuticals and dental services.

QBRP – Group A

Electronic Self-Service

(ES3) – 3.0% (96% - 100%) or

(ES2) – 1.5% (86-95%)

(**prior to** EPM implementation Jan. 1 – April 30, 2022)

- Metric is broken down into two tiers and is reimbursed at a greater level as the percentage of self-service increases.
- Evaluated at the group level on a semi-annual basis.
- Calls made in January do not impact this incentive. Eligibility files could be delayed. The member will be issued a letter showing eligibility.

QBRP – Group A

Electronic Self-Service

(ES3) – 2.0% (96% - 100%) or

(ES2) – 1.0% (86-95%)

(**after** EPM implementation May 1- Dec. 31, 2022)

- Metric is broken down into two tiers and is reimbursed at a greater level as the percentage of self-service increases.
- Evaluated at the group level on a semi-annual basis.

QBRP – Group A

Provider Information Portal (PRT) – 3.0

Percent incentive

Must verify provider information every 90 days for each provider tied to your contract.

The first attestation date sets the start date for the new rolling 90 day attestation contractual requirement.

- Completion is done through BCBSKS secure website (Blue Access) found on Availity.

QBRP – Group A

Provider Information Portal (PRT)

Qualifying Period	Incentive
September 2021 - November 2021	January 1, 2022
December 2021 - February 2022	April 1, 2022
March 2022 - May 2022	July 1, 2022
June 2022 - August 2022	October 1, 2022

QBRP – Group A

Electronic Provider Message Board (EPM) – 1.0 Percent Incentive

Provider Messaging Portal:

A unique electronic communication interface by which providers can address and upload requested claim information for the purposes of supporting final claim adjudication.

- Provider should submit claims for reimbursement as described in the Contracting Provider Agreement.
- BCBSKS will notify Provider through the Provider Messaging Portal if additional documentation is required to substantiate a claim.
- Provider will have fifteen (15) calendar days to upload requested medical records to the Provider Messaging Portal.
- If Provider fails to substantiate the claim within 15 calendar days, the claim will be denied. Provider is responsible for resubmitting the claim if denied for lack of medical records substantiation.

QBRP – Group A

Electronic Provider Message Board (EPM)

Qualifying for Electronic Provider Message Board (EPM)

The onboarding process for this QBRP will be available April 1, 2022 through Availity.

Qualifying Period	Incentive
1st - 15th of any given month	1st of the following month
16th - 31st of any given month	1st of 2 month after receipt
If the electronic provider message board (EPM) is used as outlined in the EPM agreement, one-time authorization allows for continuation of qualifying period without interruption.	

QBRP – Group A

CPT II Codes (CAT2) - .50 Percent Incentive

- Add Supplemental Procedure Codes to claims
- Decreases need for medical record requests
- Produces a more accurate HEIDIS score
- During the measurement period must be greater than or equal to 30 encounters
- Calculated at the individual provider level

Qualifying Period	Incentive begins
August 1 - October 31, 2021	January 1, 2022
February 1 - April 30, 2022	July 1, 2022

QBRP – Group A

ICD-10 SDoH Codes (ZZZ) - .75 Percent Incentive

SDoH – Social Determinants of Health

- Supplemental diagnosis codes used to identify SDoH,'history of' procedures, or 'acquired absence of' codes used to support HEIDIS
- During the measurement period must be greater than or equal to 30 encounters
- Calculated at the individual provider level

Qualifying Period	Incentive begins
August 1 - October 31, 2021	January 1, 2022
February 1 - April 30, 2022	July 1, 2022

QBRP – Group B-Components

- Applies to prescribing providers (MD, DO, DPM, OD, APRN, PA, CRNA).
- Incentive – Applies to all eligible CPT codes except for clinical lab (using codes on the Medicare clinical lab fee schedule), pharmaceuticals, and dental services.

QBRP – Group B

Kansas Health Exchange - 1.25 percent incentive

- All 5 metrics must be met to qualify in 2022
- HIE HL7 V2, Demographic, admissions, discharges, transfers.
- HIE HL7 V2, Progress Notes
- HIE HL7 V2, Diagnosis, Procedure coding
- HIE HL7 V2, Lab Reporting
- HIE HL7 V2, Medication Records OR
- CCD Complete Continuity of Care Document AND
- HL7 V2, ADT
- HL7 V2, Lab

QBRP – Group B

Verinovum Clinical Data Repository – 3.75 percent incentive

- » All 5 metrics must be met to qualify in 2022
- » CDR HL7 V2, Demographic, admissions, discharges, transfers.
- » CDR HL7 V2, Progress Notes
- » CDR HL7 V2 Diagnosis, Procedure coding
- » CDR HL7 V2, Lab Reporting
- » CDR HL7 V2, Medication Records OR
- » CCD Complete Continuity of Care Document AND
- » CDR V2, ADT
- » CDR V2, Lab

QBRP – Group B

CMS-approved Registry Data (REG) – 2.5 percent Incentive

Must send patient information to meet CMS quality measurement.

- Measured at the group level.
- Applies only to:
  - Anesthesia
  - Pathology
  - Radiology
  - Urology
  - Chiropractors
  - Optometrists
  - Ophthalmologists
  - Arthritis and Rheumatology
  - Pulmonary - New

QBRP – Group B

- **Access Formulary Electronically** (EEX) – .75 percent incentive
  - Access benefit information 120 times per quarter.
- **Generic Utilization Rate** (GUR) – .75 percent incentive
  - Minimum generic prescribing is 85 percent (for all BCBSKS members with a prescription drug benefit).

QBRP – Group B

Anesthesia Performed in a Level 1 Trauma Center (ATC) – 7.5 percent.

Must be a dedicated onsite 24 hours a day, seven days a week, 365 days a year to be a level 1 trauma center facility with a PICU and NICU involved with teaching anesthesia residents.

QBRP – Group B

HEIDIS Measures

Incentives are calculated at the group level, the group must have at least five attributable members. Individual providers in the group must have at least one attributable member to receive incentive.

QBRP – Group B

Group B –Breast Cancer Screening (BCS) – 1.0 percent incentive.

Mammography for women ages 50 to 74 (52 to 74 as of the end of the measurement period) who had a mammogram anytime in the past two years. Percentage must be greater to or equal to 75 percent to meet the metric.

QBRP – Group B

Cervical Cancer Screening (CCS) –1.0 percent incentive.

The percentage of women 21-64 years of age who were screened for cervical cancer. Must be greater than or equal to 75 percent to meet the metric.

QBRP – Group B

Colorectal Cancer Screening (COL) –1.0 percent incentive.

The percentage of adults 50-75 years of age (51-75 as of Dec. 31 of the measurement year) who had appropriate screening for colorectal cancer. Must be greater than or equal to 60 percent to meet the metric.

QBRP – Group B

Low-Back Pain (LBP) –1.0 percent incentive.

The percentage of members with a primary diagnosis of low-back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

Must be greater than or equal to 85 percent to meet the metric. This percentage is reported as an inverted rate. A higher reported rate indicates appropriate treatment of low-back pain.

The member is attributed to the provider associated with the earliest date of service for an eligible encounter with the low-back pain.

QBRP – Group B

- **Well-Child visits (W30A)** –1.0 percent incentive

Six-plus visits in first 15 months of life

- **Well-Child visits (W30B)** –1.0 percent incentive

Two or more visits between15-30 months of life

- Must be with a PCP
- Must be greater than 80 percent to meet the metric

QBRP – Group B

- **Well-Child visits (WCV)** –1.0 percent incentive. The percentage of members who were 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.
- Must be greater than 50 percent to meet the metric

QBRP- Group B

Statin Therapy for Patients with Cardiovascular Disease (SPC) – 1.25 percent incentive.

Percentage of males 21-75 years of age and females 40-75 years of age during measurement year identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high intensity or moderate intensity statin medication during the measurement year.

Must be greater than or equal to 85 percent to meet the metric.

QBRP– Group B

Statin Therapy for Persons with Diabetes (SPD) – 1.25 percent incentive.

Percentage of members 40-75 years of age during measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year.

Must be greater than or equal to 65 percent to meet the metric.

QBRP – Group B

Comprehensive Diabetes Care (CDC) –1.0 percent incentive.

The percentage of members 18-75 years of age with diabetes (type 1 or 2) who had a Hemoglobin A1c test during the measurement year. Must be greater than or equal to 90 percent to meet the metric.

QBRP – Group B

Diabetes Care (CDCE) – 1.0 percent incentive.

Percentage of members 18-75 years of age at the end of the measurement year with diabetes (type 1 or 2) who had an eligible screening or monitoring for diabetic retinal disease as identified by administrative data.

Must be equal greater than or equal to 55 percent to meet the metric.

QBRP – Group C

- Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, and CRNA).
- Incentive applies to E&M CPT codes only.

Incentives are earned at the group level, if the group has at least five attributable members (for physicians with at least one attributed member).

QBRP – Group C

Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB) – 2.0 percent incentive.

Measures percentage of members 3 months of age and older with diagnosis of acute bronchitis/bronchiolitis who were NOT dispensed an antibiotic prescription. Must be equal to or greater than 30 percent to meet the metric.

QBRP – Group C

Appropriate Testing for Children with Pharyngitis (CWP) –1.5 percent incentive.

Measures percentage of members 3 years of age and older diagnosed with pharyngitis, dispensed and antibiotic and received a group A Streptococcus (strep) test for the episode.

Must be greater than or equal to 80 percent to meet the metric.

QBRP – Group C

Appropriate Treatment for Members with Upper Respiratory Infection (URI) –2.0 percent incentive.

The percentage of members 3 months of age and older who were given a diagnosis of URI and were NOT dispensed an antibiotic prescription. Must be greater than or equal to 85 percent to meet the metric.

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1, Section II – Retrospective Claim Reviews/Corrected Claim

Page 4: Updated the link to the on-line Provider Claim Enrollment Inquiry form

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1, Section V – Post-Payment Audits

Page 8: Clarified who would be handling the first level appeal determination

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1, Section X – Waiver Form

Page 12: Added link to the waiver form

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1 – Section XII: Uniform Charging Practices

Page 16: Added language to clarify no claim should be filed if there is not a patient charge

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1 - Section XIV – Professional Services Coordinated with a Non-Contracting Provider

Page 16: Added Verbiage clarifying BCBSKS policy regarding services ordered through a non-contracting entity

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1 – Section XX: Contracting Status Determination

Page 20: Added verbiage regarding assignment in the event of sale, consolidation, or merger of a contracting provider.

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 1 – Section XXVII: Reimbursement for Pharmaceuticals

Page 23: Update verbiage to reflect all published and publicly available pricing that is used

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 2 – Section VI: Telemedicine

Page 5: Added note to clarify billing requirements and billing ineligible telehealth services

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 3 – Section V: Additional Policy Clarification

Page 4: Updated to provide link to on-line CMS 1500 tutorial

Provider Policies and Procedures Summary of Changes for 2022

Policy Memo No. 7 – Section I: Diagnostic Radiology Policy

Page 4: Updated verbiage to include ordering providers

Telehealth Do's and Don'ts

- **DO:**
- Service must be rendered by an eligible provider type: MD, DO, PA, APRN, Behavioral Health providers
- File with Place of Service 02 and GT modifier
- Provider must be licensed in state where patient is located at time of visit
- Service must be provided by means of real-time, two-way interactive communication (audio, visual, or audio-visual)
- Patient is responsible for co-pay/deductible amounts

Telehealth Do's and Don'ts

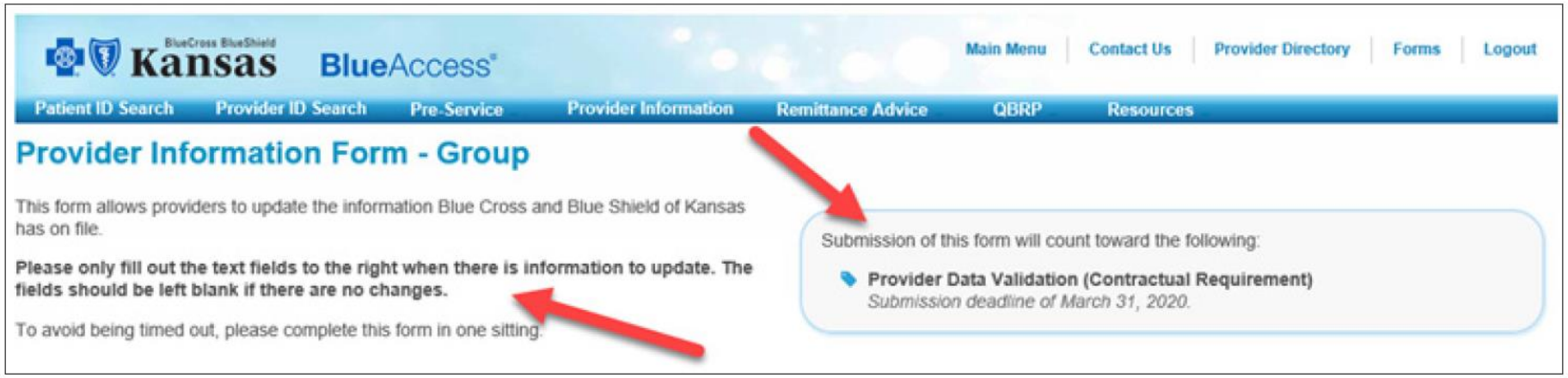
- **DON'T :**
- File services that require the patient be present, example: lab, venipuncture, injections, and x-rays
- Q3014 (Telehealth originating site). The same provider cannot bill the distant site and originating site. The Q code is only appropriate to bill when there is an eligible provider at the originating site coordinating care.

Provider Information Attesting

Located on BCBSKS Blue Access/Availity

- Medicare Advantage and QBRP - Review and attest business and provider information every 90 days.

BCBSKS Blue Access/Availity



BCBSKS Blue Access/Availity

Performing Provider List

☑ Show only performing providers requiring attention

Provider Name	Provider NPI	QBRP Qualification Last Met	Provider Data Validation Last Met
Ima Provider	1234567890	10/09/2019 ⚠	10/09/2019 ⚠
John D Chiropractor	2345678901	10/09/2019 ⚠	10/09/2019 ⚠
Medical Doctor	3456789012	10/09/2019 ⚠	10/09/2019 ⚠
Carry A Lot	4567890123	10/09/2019 ⚠	10/09/2019 ⚠

QBRP Reporting
Located on BCBSKS Blue Access/Availity

QBRP Reporting
Located on BCBSKS Blue Access/Availity

Performing NPI

Expand All | Collapse All

	NPI	Name	Total Charge	Total Allowed	QBRP Earned	% Total Allowed
⊕	1234567890	Performing Provider 1	$43,321.00	$29,600.49	$2,550.28	8.56%
⊕	2345678901	Performing Provider 2	$41,826.00	$30,867.46	$2,611.14	8.46%
⊕	3456789012	Performing Provider 3	$36,615.00	$27,224.04	$1,845.69	6.78%
⊕	4567891023	Performing Provider 4	$90,107.00	$58,777.83	$5,003.25	8.51%
⊕	5678901234	Performing Provider 5	$17,652.00	$12,204.71	$1,015.60	8.32%
⊕	6789012345	Performing Provider 6	$33,663.00	$21,614.53	$1,698.32	7.86%
⊕	7890123456	Performing Provider 7	$51,280.00	$34,189.62	$2,825.92	8.27%
⊕	8901234567	Performing Provider 8	$36,327.00	$19,464.64	$1,343.10	6.89%
		Grand Total	$352,787.00	$234,163.82	$18,853.70	

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QBRP Earned/ Total Allowed = % of Total Allowed

QBRP Reporting
Located on BCBSKS Blue Access/Availity

- Click the arrow to display the components for individual performing providers.
- Click the "Expand All" button to see components for all performing providers.
- Click the "Collapse All" button to hide components for all performing providers.

Business Associate Agreements – BAA

Located on BCBSKS Blue Access/Availity

Provider Business Arrangements

Providing BCBSKS with information on the business arrangements your practice has in place helps us to serve your practice better while also assisting us in safeguarding your patient and our member's Personal Health Information (PHI) and Personal Identifying Information (PII).

Each billing NPI on file for a provider practice's tax identification number must provide a *yes* or *no* response, indicating whether the practice employs a business partner that may contact BCBSKS on behalf of the practice. Providers will be asked annually to confirm their existing business arrangements or to attest to not having any business arrangements where an entity is permitted to represent their practice and call BCBSKS on their behalf.

Active business partners that have been submitted by your practice are listed below. You can update a business partner's information by clicking the Manage button, which will take you to a screen showing the detailed information on the partner. You can then update or delete the business partner using the buttons at the bottom of the screen.

Once you have finished adding partners and making changes, please click the Submit button at the bottom of this page to send us the changes.

What is a Business Arrangement?

Any arrangement where another entity, defined here as a *business partner*, is performing services on your (the contracting provider's) behalf that involves the use, transmission, or disclosure of protected health information (PHI) or personal identifying information (PII).

Why does BCBSKS need this information?

Protecting PHI is a top priority at BCBSKS. By providing us with the names of your business partners, BCBSKS can validate the caller when an inquiry is received. This allows us to safely respond to the inquiry without delaying service to your practice.

Business Associate Agreements – BAA

Located on BCBSKS Blue Access/Availity

Add a New Business Partner

To add a new business to the list of business partners and arrangements that Blue Cross Blue Shield of Kansas has on file for you, please complete the following form. The type of business partner arrangement will be determined based upon your responses to the questions below.

Business Arrangement Type

Are you currently sharing protected health information (PHI) as part of this business arrangement?

Yes No

Is this business partner an offshore subcontractor (i.e., are its employees outside the borders of the United States of America)?

Yes No

RETURN TO ARRANGEMENTS

ADD BUSINESS PARTNER

Business Arrangement Type

Are you currently sharing protected health information (PHI) as part of this business arrangement?

(•) Yes ( ) No

Is this business partner an offshore subcontractor (i.e., are its employees outside the borders of the United States of America)?

( ) Yes (•) No

Business Partner Information

Legal Business Name (as reported to the IRS)

Tax ID (e.g., EIN)

Doing Business As Name (if applicable)

Business Associate Agreements – BAA

Located on BCBSKS Blue Access/Availity

Business Arrangement Type

Are you currently sharing protected health information (PHI) as part of this business arrangement?

(•) Yes ( ) No

Is this business partner an offshore subcontractor (i.e., are its employees outside the borders of the United States of America)?

(•) Yes ( ) No

Offshore Business Partner Information

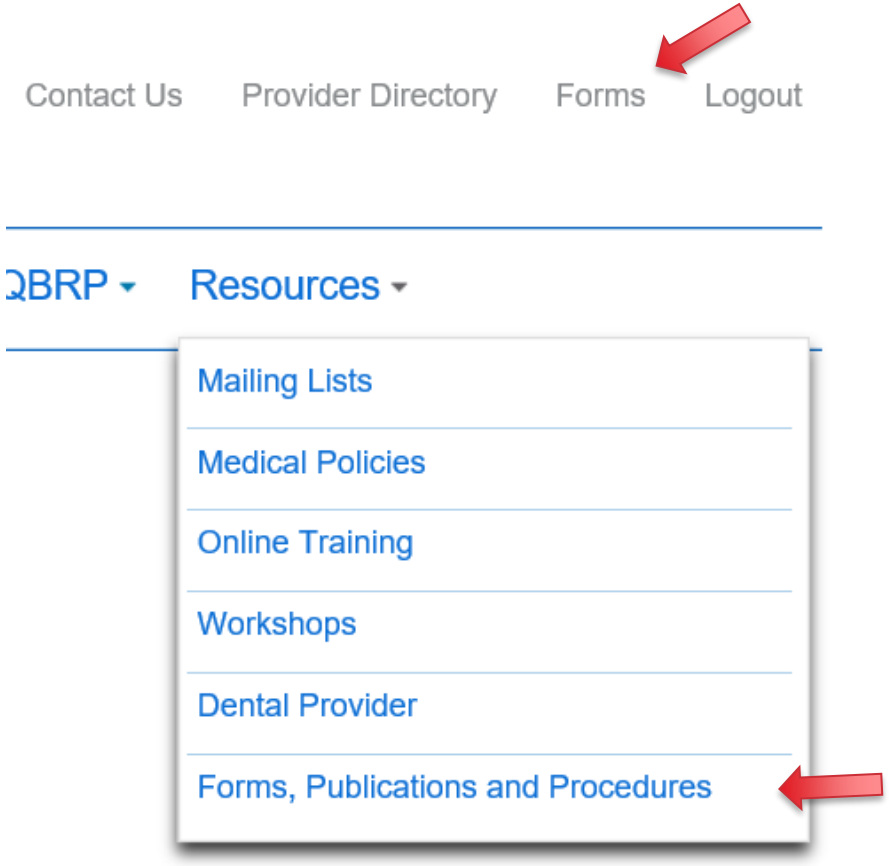
Legal Business Name

Tax ID (if applicable)

Doing Business As Name (if applicable)

Electronic Funds Transfer – EFTs

Located on BCBSKS Blue Access/Availity



Electronic Funds Transfer – EFTs

Located on BCBSKS Blue Access/Availity

EFT Enrollment Form

This e-form may be used to initiate, modify or terminate EFT enrollment. Please complete a separate form for each TIN/EIN your request pertains to and include all applicable billing NPIs. (NOTE: NPIs can only be edited in the Provider Identifiers section of this e-form.) This Plan does not require submission of hand-written signatures; typed entries in this e-form will be considered sufficient authorization to comply with your request. Please allow two weeks for the EFT process to complete. If you do not begin receiving payments after two weeks, or if you have any questions about the EFT enrollment process, please call Provider Network Services at 1-800-432-3587 or (785) 291-4135, option 1.

Provider Information - Please fill out completely

Provider Name

Provider Address

Street

City

State/Province

ZIP Code/Postal Code

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider.

Street – The number and street name where a person or organization can be found.

City – City associated with provider address field.

State/Province – ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.

ZIP Code/Postal Code – System of postal-zone codes (ZIP stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.

SOS Differential (Site of Service)

- Site of Service differential will continue in 2022. BCBSKS recognizes the additional cost of supplies, personnel, and cost of the office space itself for selected procedures done in the office setting.
- The allowed charge is reduced when those services are rendered outside of the office setting.
- Reflected on your charge comparison report.

Preventive Health Benefits

The Preventive Services Guide is based on published literature by nationally recognized authorities in health care and the expressed opinions of participating network physicians. If a recommended diagnosis is listed next to the benefit within the guide, please be sure to **list it as the primary diagnosis** in order for benefits to be administered correctly.

To access the guide, go to: https://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/preventive-services-guide.pdf

MiResource – Behavioral Health Providers

- BCBSKS is partnering with MiResource, an online behavioral health company that uses patient responses to connect patients to the right mental health provider via an online directory portal.
- Participation is Free to BCBSKS Behavioral Health Providers.
- The platform has many searchable fields, including options to match patients with providers who specialize in the care they are seeking.

No Surprises Act

- Consolidated Appropriations Act (CAA)
  - Passed by Congress in December 2020
  - Contains COVID – 19 relief measures
  - Legislative items impacting healthcare and health insurance industries
  - Changes will impact individual and group health plans (grandfathered and non-grandfathered)
  - Regulators working on final details
- Implementation January 1 2022

No Surprises Act

- Key Points:
  - *Balance Billing: Surprise Bills, from out of network providers, must be covered at in-network rates*
    - Emergency Services
    - Air Ambulance Services
    - Services by out of network providers at in-network hospitals or facilities

No Surprises Act

- Key Points:
  - *Directories must be updated every 90 days*
    - New QBRP measure
  - *Price comparison tools for consumers*
    - Available by phone and internet
    - Allows covered individuals and in-network providers to compare expected cost-sharing amounts for covered services.

No Surprises Act

- Key Points:
  - *Advanced Explanation of Benefits*
    - Explains benefits and estimates of cost-sharing.
    - Provided within 3 business days when services are scheduled more than 10 days in advance
    - Provided within 1 business day when services are scheduled within 10 days
  - *Providers will furnish good-faith estimates*
    - Must include related billing and diagnostics codes.

No Surprises Act

- Key Points:
  - *In-network negotiated rates and out-of-pocket costs available*
    - *Negotiated rates available on bcbsks.com*
    - *Personalized OOP cost information provided upon request*
      - *OOP cost information available in two waves – negotiated rates will be available in regularly updated, machine-readable files located on bcbsks.com.*

No Surprises Act

- Key Points:
  - *Notification to members when a provider leaves the network*
    - Up to 90 days of transitional coverage provided at contracting rates
    - Available for serious/complex health conditions, inpatient care, non-elective surgery, pregnancy and terminal illness

No Surprises Act

- Key Points:
  - *Updated physical and digital ID cards*
    - Must list deductibles and out-of-pocket maximums
  - *Updated pharmacy reporting procedures*
  - *Parity strengthened in mental health and substance use disorder benefits*

Additional Training Opportunities
How Can We Help You?

- Literature/documentation (newsletters, etc.)
- Workshops
- Office/staff training
- Webinars

Questions?

Thank you for being a contracting provider

BlueCross BlueShield of Kansas

An independent licensee of the Blue Cross Blue Shield Association