All Payers

Blue Cross and Blue Shield of Kansas

December 17, 2010
Cindy Garrison, CPC

- Staff Changes
- Misc Updates
Angie Strecker, Director.
Many of you already know Angie Strecker as she has served as the Manager of Institutional Relations for the past 10 years. Angie assumed the role of Director of Institutional Relations effective with the retirement of Steve Dean on Friday, October 1, 2010. Angie has been at Blue Cross and Blue Shield of Kansas since December 2, 1985 and brings 18 years of experience working with contracting providers to her new role. She started her career in Customer Service where she held many positions from correspondent to trainer. During this time, Angie earned a bachelor's degree in business administration from Washburn University in 1991. In January 1992 she became the Education Coordinator for Institutional Relations. Then in the summer of 1998 she accepted the position of Internal Operations Manager for Professional Relations on the Shield side. In the summer of 2000, she became the Manager of Institutional Relations. Health Care Reform is one of the challenges Angie is looking forward to in her new position as Director of Institutional Relations. She will continue to work with facilities as we move forward in a changing health care environment. We are excited for her in this new role and look forward to working with her in the upcoming challenges we will face in a changing health care environment.

Teresa Van Becelaere, Manager.
Just like Angie, some of you already know Teresa as she was our Contract/Provider Consultant. Teresa Van Becelaere became the Manager of Institutional Relations effective October 4, 2010. She brings 15 years of experience in the health care industry to her new role. Teresa started her career at Blue Cross and Blue Shield of Kansas in October 1995 as a customer service center representative. Teresa spent a few years in Marketing before accepting a promotion as Education Coordinator in September 1998. In June 2001, Teresa became the Contract Consultant in Institutional Relations. Teresa is pleased with the opportunity to continue to serve the institutional providers in her new role. She looks forward to expanding her outreach in the institutional provider community and enhancing the relationships that have been developed over the previous 12 years.

Christie Blenden, Contract/Provider Consultant. Christie is the newest addition to the IR staff in that she took Teresa's position. Christie responsibilities will include contract development as well as being the provider consultant for these provider types:

- Statewide ESRD,
- Home Health,
- Skilled Nursing Facilities
- Substance Abuse Facilities
- Hospice,
- Ambulatory Surgery Centers
<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Phone#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>Angie Strecker</td>
<td>(785) 291-8227</td>
</tr>
<tr>
<td>Manager</td>
<td>Teresa Van Becelaere</td>
<td>(785) 291-2129</td>
</tr>
<tr>
<td>Provider Consultant</td>
<td>Vicki Haverkamp</td>
<td>(785) 291-8862</td>
</tr>
<tr>
<td>Provider Consultant</td>
<td>Denny Hartman, CPC</td>
<td>(316) 269-1602</td>
</tr>
<tr>
<td>Provider/Contract Consultant</td>
<td>Christie Blenden</td>
<td>(785) 291-8813</td>
</tr>
<tr>
<td>Education/Communication</td>
<td>Cindy Garrison, CPC</td>
<td>(785) 291-7236</td>
</tr>
<tr>
<td>Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Analyst</td>
<td>Nicole Dodds</td>
<td>(785) 291-8849</td>
</tr>
<tr>
<td>Support Staff – Topeka</td>
<td>Dona Rhoads</td>
<td>(785) 291-7213</td>
</tr>
<tr>
<td>Support Staff – Topeka</td>
<td>Melanie Moriarty</td>
<td>(785) 291-7838</td>
</tr>
<tr>
<td>Support Staff – Wichita</td>
<td>Cheryl Carner</td>
<td>(316) 269-1609</td>
</tr>
</tbody>
</table>

| FAX – Topeka                 | (785) 290-0734              |
| FAX – Wichita                | (316) 269-1695              |
HEALTH INFORMATION TECHNOLOGY (HIT)

Software users that utilize an Electronic Health Record (EHR) component are encouraged to make sure they are using a product that meets the definition of "Meaningful Use" as outlined by the Health Information Technology for Economic and Clinical Health (HITECH) Act. BCBSKS has set up a link called "Health Information Technology (HIT)," for our providers to visit in order to see if their vendor meets the "Meaningful Use" guidelines. The HIT link provides a way for providers to visit multiple sites that help educate on "Meaningful Use," as well as determine the compatibility of their EHR product. Providers should contact their software vendor to see what their plans are to meet the "Meaningful Use" specifications for the HER component.

New Web page
UB-04 CHANGES

Effective Jan 1, 2012 with the implementation of HIPAA* version 5010, Blue Cross and Blue Shield of Kansas will require the presence of a diagnosis code describing the patient's reason for visit on ALL outpatient claims. This will effect the information you provide in loop "2300 HI – Patient Reason for Visit" in the 837I electronic transaction or form locator 70 on the UB-04 claim form.

<table>
<thead>
<tr>
<th>70 PATIENT REASON DX</th>
<th>a</th>
<th>b</th>
<th>c</th>
</tr>
</thead>
</table>

PATIENT'S REASON FOR VISIT - REQUIRED FOR ALL OUTPATIENT VISIT

Enter the appropriate diagnosis code describing the patient's reason for the visit at the time of the outpatient encounter.

Providers may need to share this information with their vendor to insure that claims are submitted with this information. Outpatient claims that do not include a patient's reason for visit once version 5010 is implemented will be rejected and returned to the provider.

Watch for a newsletter regarding this change.
LIMITED PATIENT WAIVER

Blue Cross and Blue Shield of Kansas (BCBSKS) has defined Limited Patient Waiver to mean a form that a contracting provider must have the member sign prior to rendering services in order to transfer financial responsibility to the member for certain services not covered by a payer - commonly because the services are not medically necessary, experimental or investigational, patient demanded, or considered deluxe features.

As a result of this definition, Blue Cross will transition the Notice of Personal Financial Obligation (NOPFO) waiver to the Limited Patient Waiver (LPW) during 2011. You can start using this new form immediately or you can continue to use the NOPFO through 2011. Both waivers will be on the Web site at [http://www.bcbsks.com/CustomerService/Providers/forms.htm](http://www.bcbsks.com/CustomerService/Providers/forms.htm) through 2011. You will need to scroll down on the Web page to the forms under INSTITUTIONAL and select the waiver you want to use.

As a reminder, contracting providers shall notify BCBSKS members when services are determined medically unnecessary or experimental/investigational. Providers cannot bill the member for these services unless the member has been given written notification in advance of receiving the service that they will be responsible.

If you obtain a waiver you do not need to drop the claim to paper. You can still file the claim electronically by appending modifier GA to the applicable CPT/HCPCS code(s). Modifiers should immediately follow the procedure code, with no space between. By obtaining a signed waiver, the charges will be denied as the patient’s responsibility. If a waiver is not obtained, the services will be a provider write-off.

Remember to retain the waiver in the patient's file.

MEDICAL RECORDS REQUEST

Before some claims can be processed, Blue Cross and Blue Shield of Kansas will request medical records in order to determine if medical necessity and/or criteria has been met.

Sometimes the information being requested is not in any of the records at the facility. When this happens, it is up to the facility to obtain the essential documentation from the referring physician. Should the facility have difficulty obtaining the requested records from the ordering physician, the facility can contact their provider consultant for assistance.

If the ordering physician decides to send in the requested records directly to BCBSKS, they will need to include a copy of the medical request letter that was sent to the facility. This way, BCBSKS can match the records with the claim needing the information for
processing. If BCBSKS cannot identify which claim needs the records, the records will be returned to the ordering physician.

BCBSKS will only request the necessary documentation once. We will make a decision on how to process the claim based on what records are received as a result of the request. If the records received do not support the medical necessity and/or criteria for the service, the claim will be denied.

If the provider feels the denial is incorrect and they have obtained the essential documents, they may file a written inquiry. The inquiry to verify the original determination should be made within 180 days of the date of the remittance advice (RA) if done in 2010 and 120 days of the date of the RA if done in 2011. It is vital that you do not use the word appeal in your written notice when you send the required documentation to support the medical necessity and/or approved criteria of the service. It is helpful if providers include a copy of the RA showing the denied claim.

The inquiry step is optional. Providers can skip this step and proceed straight to the appeal process. However, if the provider does the inquiry review step and disagrees with the inquiry review decision, the provider may send a written appeal notification of the disagreement to BCBSKS. This initial appeal must be submitted within 180 days of the date of the RA. Providers should include the word appeal in this written notification. See your Policies and Procedures for complete details regarding the appeal process. All requested medical records must be provided at the initial appeal.

As indicated in Section II of the Policies and Procedures, the Contracting Provider shall not bill BCBSKS members for medically unnecessary services unless the members have been notified in advance that specific services, which they are going to receive, will be their responsibility.

Providers wishing to send a written inquiry review or appeal should send their request, along with the necessary documentation, to:

Attn: Customer Service Center
Blue Cross and Blue Shield of Kansas
1133 Topeka Blvd
Topeka, KS  66629-0001
MEDICAL POLICY ROUTER

Blue Cross and Blue Shield of Kansas is excited to offer providers a new tool: Medical Policy and Pre-certification/Pre-Authorization Router. This new tool will:

- Improve access to information
- Improve your overall pre-claim experience with out-of-area patients
- Provide "one-stop-shop" for medical policy and pre-certification information
- Provide administrative ease for providers
- Eliminate some out-of-area claim issues

The Medical Policy and Pre-certification/Pre-authorization Router became available October 1, 2010.

Access to the out-of-area Plan's requirements is an easy process. Providers are not required to log-in or be authenticated to access this information. Providers simply:

For Medical Policy Information

2. Click "For Providers"
3. Click on Medical Policies in the left hand column.
4. Click Medical Policies under Institutional Relations
5. Enter the first three alpha characters of the member's identification number in the space provided and Click GO.

The provider is taken directly to that member's Home Plan medical policies. If the Home Plan's medical policies are located in their secure area, the provider will not be allowed to navigate to other areas of that Web site.

The Home Plan will present providers with the following information regarding their medical policies:

- Policy title/name
- Policy statement and/or coverage criteria
- Policy guidelines
- Effective date of policy
- Benefit application
- Procedure/diagnosis code or billing codes when applicable
- Ability to search policies
For **Pre-certification/Prior-authorization** Information

2. Click "For Providers".
3. Click on Pre-certification/Prior-authorization in the left hand column.
4. Enter the first three alpha characters of the member's identification number in the space provided and Click GO.

The provider is taken directly to that member's Home Plan pre-certification/prior-authorization page. If the Home Plan's information is located in their secure area, the provider will not be allowed to navigate to other areas of that Web site.

The Home Plan will offer providers the following information regarding pre-certification/pre-authorization:

- Disclaimer letting providers know of any limitation
- General list of services that require pre-certification/pre-authorization
- Phone number to connect the provider directly to the appropriate area

**Podcast**

A Provider Podcast on this same topic can be viewed at [http://www.bcbsks.com/CustomerService/Providers/podcast.htm](http://www.bcbsks.com/CustomerService/Providers/podcast.htm).

**PRE-CERTIFICATION – WHEN REQUIRED**

Contracting providers shall provide notice for all BCBSKS members admitted for inpatient care. *This notification will be required either:*

- Prior to the admission;
- The day of admission; or
- The first working day following a weekend or holiday

*NOTE: There are some exceptions*

- FEP – if an emergency admission, then precert needs to be done within 2 business days
- Not required when Medicare is primary
Pre-certifications remain in the Pre-certification in Process until a discharge date has been entered (i.e. the pre-certification has been completed).

Pre-certifications In Process include pre-certifications that are available for:

- Completing the initial pre-certification process by adding clinical information
- Requesting additional days for extension
- Submitting a date of discharge (ending the continued stay review process)

Once the patient is discharged, the discharge date needs to be entered to the pre-certification within two (2) business days. This will complete the pre-certification. Failure to add the discharge date within two business days will result in an INCOMPLETE PRE-CERTIFICATION. After the two business days the provider will receive a letter stating that the pre-certification is incomplete and medical records may be requested. Additional information cannot be added online by the provider. The provider needs to call the precertification department (1-800-782-4437).

IT’S UP TO YOU
TO KEEP YOUR PRE-CERTIFICATION IN PROCESS SEARCH LIST CURRENT
Health Care Reform
State of Kansas 2011 Changes
Federal Employee Program 2011 Changes
BCBSKS continues to post information affecting providers with regard to changes in member benefits. FAQs are available on our Web site regarding "Dependent to Age 26" and "Grandfathered Plans," as well as other topics. Details about continuing legislative health care changes and their affect on coverage will continue to be updated on our Web site, www.bcbsks.com, as they become available. Remember to check the Web site and sign up to receive Health Care Reform Updates via e-mail.

Preventive Health Benefits

Patient Protection and Affordable Care Act (PPACA)
- The PPACA portion of the law created a category of preventive services to be paid without cost sharing on behalf of the member.
- Website for a complete listing of preventive services: www.healthcare.gov/law/about/provisions/services/lists.html
- Our newsletter of Nov 19, 2010 (BC-10-16) links to this.

BCBSKS
- Applied to all non-grandfathered insured's
- Applied to some grandfathered insured's

Grandfathered Health Plans
- Allows individuals and employers to maintain existing insurance coverage if enrolled on the date of the law's enactment on March 23, 2010
- Employers must provide notice to employees of the Health Plan's "grandfathered" status
- PPACA does not require 100% of preventive benefits be added to grandfathered plans. Must comply with some but not all of the requirements under the PPACA

Non-grandfathered Health Plans
- All non-grandfathered plans must provide PPACA's recommended Preventive Health Services without cost share to the insured.
- For plans beginning on or after Sept 23, 2010, all deductibles, coinsurances or co-payments are to be waived and the health plan will pay 100% of the plan allowance (subject to medical necessity and medical management guidelines) to the BCBSKS contracting provider.
Annual Wellness/Preventive Services
- May be provided in an out-patient setting
- CPT defines preventive medicine services and when it is appropriate to use the counseling risk factor reduction and behavior change intervention set of codes
- Periodic comprehensive preventive CPT codes for an annual exam for members older than 3 years of age will be allowed once per benefit period with no cost sharing
- SOK – non-grandfathered – will have all of these benefits
- FEP – non-grandfathered – will have all of these benefits

Coding for Preventive Health Benefits
- Diagnosis code is very important!
- Quick reference guide on bcbsks.com (see newsletter BC-10-16)
- If not Well Person ICD-9 codes, then it is cost shared!
- Diagnosis codes drive cost sharing and in some cases, actual coverage!

State of Kansas 2011 Changes

Patient Protection and Affordable Care Act (PPACA)
- Non-grandfathered – SOK will not be exempt from the PPACA's provisions
- Preventive Care – Will be provided with no cost sharing for members when performed by a Network Provider
- Coverage for children up to age 26 – Extension of coverage for adult children up to age 26 under the parent's health insurance enrollment

Autism Services
- Must be pre-approved by BCBSKS
- May include Applied Behavioral Therapy, Developmental Speech Therapy, Developmental Occupational Therapy or Developmental Physical Therapy
- Periodic re-evaluations and assessments required
- Continuous improvement must be shown in order to qualify for continued treatment
  - Call New Directions for prior approval at 1-800-952-5906

Intravenous & Injectable Anti-cancer Drug Rider
- Separate coinsurance and coinsurance maximum for anti-cancer medication
- Medical deductible and coinsurance does not apply to this rider
- 25% coinsurance to maximum of $750 per member/per year
• After $750 max is met, coverage is 100% of the MAP for the remainder of the calendar year
• Non-network provider – Benefits are the same except the $ amount over the MAP is member's responsibility

Exclusions:
  ▪ Charges to administer or inject any drug
  ▪ Compound drugs not containing at least (1) ingredient with a valid NDC number and requiring a physician's order to dispense
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<th>CPT Code</th>
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<td>J0594</td>
<td>Injection, busulfan, 1 mg</td>
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<tr>
<td>J9001</td>
<td>Injection, doxorubicin hydrochloride, all lipid formulations, 10 mg</td>
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<tr>
<td>J9010</td>
<td>Injection, alemtuzumab, 10 mg</td>
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<tr>
<td>J9015</td>
<td>Injection, aldesleukin, per single use vial</td>
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<td>J9017</td>
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<td>J9020</td>
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<td>J9027</td>
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<tr>
<td>J9031</td>
<td>Bac (intravesical) per instillation</td>
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<td>J9033</td>
<td>Injection, bendamustine hcl, 1 mg</td>
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<td>J9035</td>
<td>Injection, bevacizumab, 10 mg</td>
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<td>Injection, bortezomib, 0.1 mg</td>
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<td>J9207</td>
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<td>J9208</td>
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<td>J9211</td>
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<td>J9214</td>
<td>Injection, interferon, alfa-2b, recombinant, 1 million units</td>
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<td>J9215</td>
<td>Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 iu</td>
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<td>J9216</td>
<td>Injection, interferon, gamma 1-b, 3 million units</td>
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<td>J9217</td>
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<td>J9218</td>
<td>Leuprolide acetate, per 1 mg</td>
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<td>J9219</td>
<td>Leuprolide acetate implant, 65 mg</td>
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<td>J9225</td>
<td>Histrelin implant (vantas), 50 mg</td>
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<td>J9226</td>
<td>Histrelin implant (supprelin la), 50 mg</td>
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<td>Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg</td>
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<td>J9250</td>
<td>Methotrexate sodium, 5 mg</td>
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<td>J9266</td>
<td>Injection, pegaspargase, per single dose vial</td>
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<td>J9270</td>
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<tr>
<td>J9355</td>
<td>Injection, trastuzumab, 10 mg</td>
</tr>
<tr>
<td>J9357</td>
<td>Injection, valrubcin, intravesical, 200 mg</td>
</tr>
<tr>
<td>J9360</td>
<td>Injection, vinblastine sulfate, 1 mg</td>
</tr>
<tr>
<td>J9370</td>
<td>Vincristine sulfate, 1 mg</td>
</tr>
<tr>
<td>J9375</td>
<td>Vincristine sulfate, 2 mg</td>
</tr>
<tr>
<td>J9380</td>
<td>Vincristine sulfate, 5 mg</td>
</tr>
<tr>
<td>J9390</td>
<td>Injection, vinorelbine tartrate, 10 mg</td>
</tr>
<tr>
<td>J9395</td>
<td>Injection, fulvestrant, 25 mg</td>
</tr>
</tbody>
</table>
• Benefits not available to the extent an anti-cancer medication has been covered under another SOK health plan

General Information
• Requests for additional information – Must be received within one (1) year and 90 days from the date of service. If the request for more information is close to the end of the 1 year and 90 days from the date of service, then the provider has 90 days from the date this information is requested to furnish this additional information. If not received within 90 days, the claim will be denied.
• Adjustment of Claim – Requests to adjust a claim must be received with one (1) year and 90 days from the date of service. After 1 year and 90 days from the date of service, only claims that require adjustments due to legal finding or audit will be adjusted if the request is received with 180 days of the completion of the legal find or audit. Fraudulent billing has no time limits.

Exclusions (not a complete list):
• Blood, Blood Products, Blood Storage
• Surgical treatment or other related services for surgical treatment of obesity
• Sleep studies provided within the home
• Supplies and prescription products for tobacco cessation programs and treatment of nicotine addiction.

Kansas Senior Choice Plan C Summary
• Covers the Medicare Part A & B deductible and coinsurance
• The 1st three pints of blood are covered
• Hospice care is available effective January 1, 2011.
• There is no coverage for charges in excess of Medicare's approved amounts
• Skilled nursing – The Member must meet Medicare's requirements including having been in the hospital for at least 3 days and entered a Medicare-approved facility within 30 days of leaving the hospital. Medicare provides benefits for all approved amounts for the first 20 days; subsequently no coverage is needed under Plan C. For the 21st through 100th day Medicare pays all but the amounts in the Chart; therefore, Plan C will pay those amounts. For the 101st day or after Medicare provides no coverage, subsequently Plan C provides no coverage.
Basic or Standard Option
Non-grandfathered under Patient Protection and Affordable Care Act (PPACA)

- Preventive care with no cost sharing for members when performed by a Preferred Provider
- Coverage for children up to age 26

Standard Option

- Uses CAP Blue Cross contracting provider contract as provider network
- ID cards use:
  104 = Standard Option / Single
  105 = Standard Option / Family

Basic Option

- Uses the Blue Choice provider network except for emergency care
- **NO BENEFITS** are available for service provided by institutional providers who are not part of Blue Choice provider network
- Non-hospital institutional providers who are in the CAP provider network are considered to be Blue Choice providers
- ID cards will have the work "BASIC" written on outline of the United States and the following:
  111 = Basic Option / Single
  112 = Basic Option / Family

Miscellaneous

- Prior approval required for out-patient surgery for morbid obesity
- Prior approval required for all out-patient IMRT services except IMRT related to the treatment of head, neck, breast or prostate cancer. **Prior approval is required** for IMRT of brain cancer
- Pre-certification is required for partial day, home health, hospice, in-patient skilled nursing facilities and in-patient services
Marie Burdiek

HIPAA 5010

Turn Off Paper Remit
HIPAA 5010

Although 5010 gets much less notoriety than ICD-10 it is just as important and practices should already be working with vendors on the transition to 5010.

History - Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- **Purpose:**
  - Provide greater access to health care insurance (portability)
  - Protect health care data (privacy and security)
  - Promote more standardization and efficiency (transactions, code sets and identifiers)
- Required covered entities who exchange information electronically to do so in a standard format
- Covered entity includes:
  - Health Plan
  - Health Care Clearinghouses
  - Health Care Provider – any provider of medical or other health services, or supplies, who transmits health information electronically

What is in the final rule?

- Covered entities must move to version 5010 for the existing transactions required under HIPAA
  - Professional Claims– 837P
  - Institutional Claims– 837I
  - Dental Claims– 837D
  - Remittance Advices– 835
  - Request for Review and Response - 278
  - Claim Status Inquiry and Response – 276/277
  - Eligibility Inquiry and Response – 270/271
  - Payroll Deducted and other Group Premium Payments for Insurance Products - 820
  - Benefit enrollment and maintenance – 834

Why change? **Current version of the transactions were:**

- Published more than 7 years ago and implemented more than 5 years ago
- Doesn't meet current business needs
  - Ex. NPI
- Ambiguous Language
  - Ex. Should vs. Must

What are the changes?

- Field length changes
- Data added and deleted
Includes new or deleted loops, segments or data elements
- Ex. Some Coordination of Benefits (COB) information deleted
- Ex. Added fields for ambulance pick-up or drop-off information

- Code values eliminated or added
  - Ex. Remittance advice (835) – The claim adjustment group code of CR (Corrections and Reversals) is eliminated

- New business functionality
  - Ex. Eligibility (270/271) 45 new service types available to report benefit information
  - Ex. Remittance advice (835) Ability to return healthcare policy information

Timelines
- December 2010 – Covered entities achieve Level 1 Compliance
  - Level 1 Compliance – covered entities have completed internal testing and can send and receive compliant transaction.
- January 2011 – Begin Level 2 testing period
  - Level 2 testing – Trading Partners can begin testing. Trading Partners may move to production with payer approval.
- January 2012 – Achieve Level 2 Compliance
  - Everyone in production with 5010

HIPAA Resources
These offsite links may be helpful as you gather information about HIPAA.
- U.S. Department of Health and Human Services Administrative Simplification Page - Source for Final Rules, HIPAA FAQs and links to other HIPAA-related sites
- HIPAA Transaction Implementation Guides from the Washington Publishing Company
- Web site for Workgroup for Electronic Data Interchange - Provides information and advisory papers regarding HIPAA
- HIPA Alert - Provides free monthly subscription providing up-to-date e-mail notification of HIPAA information
- CMS - (Centers for Medicare & Medicaid Services) Advisory body to HHS and the source of legal updates
- CMS site with links to other Web sites regarding Administrative Simplification
Questions to Ask Your Vendor, Billing Service or Clearinghouse
1. Will software upgrades or changes accommodate both HIPAA 5010 and ICD-10?
2. What if any costs are involved?
3. When will the upgrades or changes be available for implementation?
4. Will I be required to test with ASK?
5. Will my software support and convert the 277CA into a readable format?
6. What customer support and training is provided?
7. How will the software changes handle both ICD-9 and ICD-10 before and after the deadline for code sets?

HIPAA FAQ
Q1. What is the purpose of the Health Insurance Portability and Accountability Act of (HIPAA) of 1996?
   • Provide greater access to health care insurance (portability)
   • Protect health care data
   • Privacy and Security
   • Standardization of Transactions, Code Sets, and Identifiers

Q2. Who is a covered entity?
   • Health Plan
   • Health Care Clearinghouse
   • Health Care Provider – any provider of medical or other health services, or supplies, who transmits health information electronically.

Q3. Why is it important to change to HIPAA Version 5010?
   • The current HIPAA Version 4010/4010A1 does not meet upcoming business needs
   • To support use of ICD-10
   • Technical and Data content improvements

Q4. What are standard electronic transactions?
   • Professional Claims - 837P
   • Institutional Claims - 837I
   • Dental Claims - 837D
   • Remittance Advice - 835
   • Request for Review and Response - 278
   • Claim Status Inquiry and Response – 276/277
   • Eligibility Inquiry and Response – 270/271
   • Payroll Deducted and other Group Premium Payments for Insurance Products - 820
   • Benefit enrollment and maintenance - 834

Q5. What are some of the updates with HIPAA Version 5010?
   • Some field length changes
   • Data is added and deleted
• Includes new or deleted loops, segments or data elements. A couple examples of this would be:
  • Some Coordination of Benefits (COB) information deleted
  • Added fields for ambulance pick-up or drop-off information
• Code values eliminated or added. Example: Remittance advice (835) – The claim adjustment group code of CR (Corrections and Reversals) is eliminated
• New Business functionality. Example: Eligibility (270/271)
• Ability to return healthcare policy information on the 835

Q6. Who within your organization needs education on HIPAA Version 5010?
  • Virtually everyone
    • Information technology health information management
    • Quality utilization management
    • Claims, billing, auditing, accounting, financial management, corporate compliance and clinicians.

Q7. Does HIPAA Version 5010 affect all providers, regardless of contracting status?
  • Yes. HIPAA Version 5010 affects any covered entity utilizing electronic transactions.

Q8. Dates to Remember:
  • December 2010 – Covered entities achieve Level 1 Compliance.
    o This means payers must have completed internal testing and can send and receive compliant transactions.
  • January 2011 – Begin Level 2 testing period
    o This means Trading Partners (TPs) can begin testing. We will move TP to production once testing is complete.
  • January 2012 – Achieve Level 2 Compliance.
    o This means everyone must be in production with HIPAA Version 5010.

Q9. What should I do?
  • Contact your vendor. Ask, what are your plans?
  • If you are using a Clearinghouse contact them. Ask, what are your plans?
  • Educate yourself. Attend workshops and sign up for email list:
    o www.ask-edi.com and www.bcbsks.com
Remittance advices can be accessed via the BCBSKS Web site; in fact, we encourage providers to discontinue receiving RAs by mail and rely on the online RA for their payment information. Some providers have more than one NPI. For example a hospital could have a NPI for the hospital, swing bed unit, emergency room physicians, home health agency, etc. If you have multiple numbers, please be sure to shut off ALL the paper RA.

Following are a few of the many advantages to turning off your paper RA:

- Gets to you faster. Electronic RAs are posted to the Web by noon on Tuesday.
- Multiple people can access the online RA at the same time. No longer do you have to copy the RA so each person has his or her own copy to work from.
- The information is stored securely protecting PHI.
- The online RA looks exactly like the paper copies.
- If you need a copy of the RA, you can print it off or if you only need one or two pages, you can print only those.
- You can search the online RA by any field including patient name, ID number, patient account number, etc.
- If you need to see it better, the online screen image can be made bigger. The paper copy only comes in one size.

RA information is confidential and requires the user to establish a provider profile. Information about using secured services including how to establish a provider profile is available at our Web site at

https://clyde.bcbsks.com/bcbsks/allUsers/ProviderGettingStarted.
It is simple to turn off your paper RA. You just need to:

1. Sign-in under each NPI
2. Select Remittance Advice under Services
3. Select "Stop receiving mailed remittance advice documents"

Remember to do this for each NPI.
Vicki Haverkamp

- MSP
- National Consumer Cost Tool
- Off Site Services
- Policy & Procedures 2011 Update
- TRICARE
Year 2011 will be upon us soon and now is a good time to remind staff members that new deductibles will be applied during claims processing for patients. This creates some problems for those that are expecting Medicare Primary claims to crossover to Blue Cross and Blue Shield of Kansas and be paid automatically.

Although our crossover problems have for the most part, gone away………..we are still experiencing those problems with certain claims that have been processed by Medicare but included a

- third party payor on the claim, or
- BCBSKS does not have the patient loaded as Medicare primary
- BCBSKS has the wrong Medicare information loaded
- there was a negative paid amount on the claim.

The last scenario can occur in the RHC offices as it is possible that the total charge on the claim will be less than the payment rate established by Medicare. This creates a negative payment amount on the claim.

If you are experiencing secondary payment problems such as the ones mentioned above or any other problems for that matter, please let us know. We will research to determine why the claim didn't cross from Medicare initially or if the claim is one that will always need to be submitted electronically to Blue Cross and Blue Shield.

Paper claims including RA should be submitted only as a last resort as all secondary claims can be billed electronically. Please be sure when submitting Blue Cross secondary claims electronically that ALL MEDICARE PROCESSING INFORMATION FOUND ON THE EOB IS INCLUDED IN THE SUBMISSION OF THE CLAIM. This would include

- the total amount billed,
- the amount paid by Medicare,
- the contractual write-off,
- the coinsurance and deductibles and
- non-covered portion if applicable.

Without all the pertinent information we cannot "balance" the claim and assure that correct reimbursement is made. You are likely to receive a letter from us indicating a copy of the Medicare RA is needed to properly pay the claim. This only delays processing and adds additional costs to your office and ours as well.

If you are having difficulties in submitting secondary claims SUCCESSFULLY to Blue Cross and Blue Shield please contact the ASK Help Desk @ 1-800-472-6481. It is our desire to make sure all claims can be submitted electronically and handled quickly and efficiently.
The Blue Cross and Blue Shield Association (BCBSA) has developed a National Consumer Cost Tool (NCCT) capability to be implemented January 1, 2011. The purpose is to enable members to obtain information on estimated costs for common health care services. The consumer-facing cost tool is designed to provide the data transparency essential to engaging consumers in their healthcare decision making.

The NCCT will not be available to Blue Cross and Blue Shield of Kansas members at this time. However, other Blue Plans will have this information available to their members and thus their members could view Kansas provider information.

Member's access will be through the member’s Blue online customer service Web site. The member will enter their member Identification number, select the treatment category, and select the geographic area desired for service. Members can choose from 54 of the most common, elective procedures for inpatient, outpatient and diagnostic services. The Blue Distinction Center designations will display as appropriate to any specific facility for a relevant procedure. Also, average cost estimates for five types of Office Visit are available without provider-specific designation.

The estimates are developed using twelve months of claims data from contracting facilities. Medicare and secondary claims are excluded. For the inpatient treatment, categories episodes are built by summing all claims created at the facility from admission to discharge. Outpatient episodes sum all claims created on that day of service at that facility and also may include ‘pre-work’ diagnostics done beforehand. The diagnostic episodes isolate just the claims specific to that procedure. A set of exclusions are used to filter out outliers and episodes with complications. As appropriate, refinements are applied to the historical claims to present the reasonable ranges based on current arrangements. Market ranges or ‘cost bands’ based on a fixed percentage of the market average are then assigned to a facility for each treatment category. Cost estimates are updated approximately every six months.

The information presented to the member will contain, the approximate costs for the selected treatment category, for hospital/facility-based services, the approximate costs with the name and practice location of the hospital/facility, the approximate out of pocket liability calculated by the member’s Plan, and links to supplemental information such as health/wellness, care management, quality, etc.
Off Site Payments

BLUE CROSS AND BLUE SHIELD OF KANSAS PAYMENT ATTACHMENT FOR ACUTE HOSPITALS FOR CALENDAR YEAR 2011 PAYMENT ATTACHMENT provides the following information concerning off-site services:

Off-site Services
Services provided off-site of the physical presence of the main hospital campus must be billed on the CMS-1500 claim form, except in those cases where that off-site location is the sole place of service for an outpatient ancillary service or as determined by BCBSKS. When hospitals provide multiple services off-site of the main hospital campus, an addendum agreement to peer group pricing may be offered.

Facilities throughout the State are looking for ways to keep medical care in their communities and be more accommodating to their patients. Thus we are seeing many satellite offices established. We have received a number of inquiries regarding the possibility of including such off-site services...physical therapy, occupational therapy, imaging, lab and other diagnostic services on a hospital UB04 claim form. As is discussed in the Policies and Procedures above, we expect such services to be submitted to Blue Cross and Blue Shield on a 1500 claim form. Reimbursement will be based on the Blue Shield fee schedules and Blue Shield guidelines will be applicable. If your facility is providing ancillary services off-site the main hospital campus, please let us know so that we can assure that claims are being billed accurately. If you have questions, please contact either Denny Hartman or Vicki Haverkamp.
On July 26, 2010, a letter was sent to all chief executive officers and administrators. The letter outlined reimbursement and policy changes.

The changes for 2011 were minor.

<table>
<thead>
<tr>
<th>PAGE and SECTION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaced 'substance abuse' with 'substance use' and/or 'substance use disorder' throughout the document. This is the terminology used in federal/state laws.</td>
<td></td>
</tr>
<tr>
<td>Page 5, Section I. Definitions, Corrected Claim</td>
<td>Added the following definition.</td>
</tr>
<tr>
<td></td>
<td>&quot;A request made from a contracting provider to change a claim (e.g., changing information on the service line, diagnosis correction, etc.) that has previously processed.&quot;</td>
</tr>
<tr>
<td>Page 6, Section I. Definitions, Member</td>
<td>Revised the definition of &quot;Member&quot; to fulfill the requirements of the Patient Protection and Affordable Care Act (PPACT).</td>
</tr>
<tr>
<td></td>
<td>Removed:</td>
</tr>
<tr>
<td></td>
<td>&quot;Means the person named on the Identification Card. Member also means the following persons under family coverage.</td>
</tr>
<tr>
<td></td>
<td>1. The husband or wife of the person named on the Identification Card; and</td>
</tr>
</tbody>
</table>
| | 2. Each unmarried dependent child by birth or adoption who is under the limiting age as specified by the contract."
<p>| | Added: |
| | &quot;A term used by BCBSKS to define any person who is enrolled with benefits. A Member may include an insured, a policyholder, a subscriber, or a dependent.&quot; |</p>
<table>
<thead>
<tr>
<th>Page &amp; Section</th>
<th>General Conditions, Claim Submission</th>
<th>Added language as outlined by the Health Information Technology for Economic and Clinical Health (HITECH) Act. Replaced the word &quot;billings&quot; with 'claims'.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 10 &amp; 11, Section II. General Conditions, Timely Filing</td>
<td>Clarified that payments involving other Members would be used to offset refund recoupments. Additionally, outlined the Contracting Providers requirement to notify BCBSKS of overpayments.</td>
<td></td>
</tr>
</tbody>
</table>
| Page 12, Section II. General Conditions, Partial-Day Services | Removed the following requirement which became null and void due to Mental Health Parity.  
"Providers of partial-day psychiatric or substance abuse services must provide to the patient or patient representative a Partial-Day Treatment Release Form prior to admission. The form allows the patient to designate how benefits for partial-day treatment will be applied. If the patient elects to exchange inpatient benefits, each day of partial-day psychiatric or substance abuse service will reduce the number of inpatient psychiatric or substance abuse days available. If the patient elects to apply outpatient benefits, only those services provided through the partial-day program, which are eligible under the outpatient program, will be considered for reimbursement, and inpatient days will not be reduced. Other outpatient services are patient responsibility if they are not covered by the member contract." |
<p>| Page 12, Section II. General Conditions, Audit Requirements, Post-Pay Audits | Added language relating to the standard of care. |
| Page 15, Section II. General Conditions, Acknowledgement of Independent Status of Company | Added the acronym for the Blue Cross and Blue Shield Association. |</p>
<table>
<thead>
<tr>
<th>Page &amp; Section</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 17 &amp; 18, Section III. Medical and Utilization Review, Medical Necessity</td>
<td>Clarified that the Notice of Personal Financial Obligation (NOPFO) should be given to the patient in advance of services being provided. Removed the word 'sample' in describing the NOPFO form found in the Institutional Provider Manual.</td>
</tr>
<tr>
<td>Page 22, Section IV. Requests for Information, Abstract Information</td>
<td>Reworded for clarity.</td>
</tr>
<tr>
<td>Page 23, Section IV. Requests for Information, Quality of Care</td>
<td>Removed the word 'Reviews' from the heading. Added the following language. &quot;Potential quality of care concerns, including preventable adverse events, may be identified and referred by members, providers or other persons who have such information. All such quality of care concerns shall be referred to the manager of Quality Improvement/Care Management department, who serves as the designated peer review officer for BCBSKS as defined in K.S.A. 65-4915.&quot;</td>
</tr>
<tr>
<td>Page 23 &amp; 24, Section V. Appeals, Right of Appeal</td>
<td>Reworded for clarity.</td>
</tr>
<tr>
<td>Page 25, Section V. Appeals, Provider Appeals For Experimental / Investigational or Not Medically Necessary Services</td>
<td>Clarified that the provider inquiry to verify original payment determination should be made within 120 days of the date of the remittance advice.</td>
</tr>
</tbody>
</table>