BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2020

Following is a summary of the changes to Blue Shield Policies and Procedures for 2020. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2019.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2019 Policy Memos. Deleted wording is noted in brackets [*italicized*]. New verbiage is identified in **bold.**

Policy Memo No. 1
NEW SECTION. Confidentiality

- **Page 4:** Added new section that includes new verbiage and existing language from introduction to reflect current practices.

I. Confidentiality

The effective delivery of health care requires communication and collaboration among providers, patients and payors. BCBSKS requires that all proprietary information be kept confidential. BCBSKS agrees to hold any and all information released to it in confidence unless otherwise instructed by the Contracting Provider or as otherwise required or permitted by law. The Contracting Provider may not disclose any terms of the Agreement to the third party except upon written consent of BCBSKS and as required by state or federal law, financial audits or quality of care investigations allowed by business arrangements and those additions are bound by confidentiality agreements. Failure to comply may result in penalties up to and including termination of the provider agreement. *[This requirement shall survive any termination or expiration of the Agreement and BCBSKS may seek injunctive relief or specific performance in order to enforce its terms.]*

Use of Confidential Information by Provider must be strictly for the purpose for which it was disclosed, and may not be sold to any third party. Confidential Information, including claims data, obtained by provider may neither be de-aggregated in any manner to identify BCBSKS, other BCBS entities, and/or Member information, nor may it be comingled in any manner. Any disclosure of Confidential Information shall be limited to the minimum necessary to fulfill the purpose for which it was disclosed. Confidential Information must be returned or securely destroyed by the Provider upon conclusion of the purposes for which it was disclosed. In the event Provider cannot immediately return or destroy Confidential Information due to legal, license, or other requirements, Provider agrees to maintain the confidentiality

of such information until the expiration of said requirements. BCBSKS maintains the right to audit Provider to ensure compliance with these provisions.

These requirements shall survive any termination or expiration of the Agreement and BCBSKS may seek injunctive relief or specific performance in order to enforce its terms.

Policy Memo No. 1
SECTIONS I&II. Corrected Claim & Retrospective Claim Reviews

- **Page 4:** Merged Sections I and II to accurately reflect current practices, as Corrected Claim falls under the Retrospective Review Process.

[I. Corrected Claim

A request made from a contracting provider to change a claim, (e.g., changing information on the service line, modifier addition, diagnosis correction, etc.) that has previously processed is considered a corrected claim. The submission of a corrected claim must be received by BCBSKS within the 15-month timely filing deadline. Claims denied requesting additional information (e.g. by letter or adjustment reason code) should never be marked "corrected claim" when resubmitted. Instead, providers should submit a new claim with the requested information.

When a claim denial or adjustment is made as a result of a BCBSKS audit, the provider may not submit a corrected claim to reverse the decision. The provider's next course of action is to enter into the appeal process.]

II. Retrospective Claim Reviews**/Corrected Claim**

The contracting provider shall have the right to a retrospective review of any claim denied in whole or in part. The purpose of a retrospective review is to allow the provider to contact customer service to determine whether the original adjudication was correct.

A. All requests for retrospective review must be submitted (in writing or by phone) to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice. To submit review online, go to: https://clyde.bcbsks.com/WebCom/Secure/forms/bcbsks_provider_claiminquiry.htm

B. The provider will be given a response to the request for a retrospective review as soon as possible, but no later than 60 days from receipt date. In cases where claims are adjusted, the remittance advice will serve as the response.

C. When a claim denial or adjustment is made as a result of a BCBSKS audit, the provider may not submit a corrected claim to reverse the decision. The provider's next course of action is to enter into the appeal process.

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 9:** Inserted verbiage to accurately reflect current practices.

    - Examination of the patient.
    - History of illness and/or review of patient records.
    - Evaluation of tests or studies (i.e., radiology or pathology).
    - **Hearing and vision screenings.**

Policy Memo No. 1
SECTION IX. Patient-Demanded Services

- **Page 11:** Changed verbiage to reflect current practices.

    IX. Patient-*[Demanded]***Requested** Services

Policy Memo No. 1
SECTION X. Waiver Form

- **Page 11:** Changed verbiage to reflect current practices

    4. Patient *[demanded]***-requested** services

Policy Memo No. 1
SECTION XI. Medical Records

- **Page 13:** Separated item 4.a. into two items to clarify signature requirements.

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

    a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date.

    b. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.

Policy Memo No. 1
SECTION XII. Uniform Provider Charging Practices

- **Pages 15-16:** Moved verbiage from section XV to XII to better reflect practices.

XII. Uniform Provider Charging Practices

D. 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.

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. *[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 XV. Claims Filing

- **Page 16:** Updated verbiage to accurately reflect current practices.

All contracting providers who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own **billing** National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific performing provider number, except when exempt by law) must appear on every claim. *[When applicable,]* The contracting provider agrees to conduct claim transactions with BCBSKS as standard transactions in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Policy Memo No. 1
SECTION XXVIII. Reimbursement for Sleep Study Testing

- **Page 22:** CMS has revised their credentialing process for sleep studies providers and they now require providers to be accredited to perform these services. As such, we are removing the language in this section since sleep studies will be performed by CMS compliant providers and to be consistent with the member contract.

[XXVIII. Reimbursement for Sleep Study Testing

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 providers receive a reduced MAP.

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

Policy Memo No. 1
SECTION XLI. CAP Provider Directories

- **Page 26:** Updated verbiage to accurately reflect current practices.

Providers must notify BCBSKS of changes to provider data (including, but not limited to, **change in ownership,** EIN, TIN, NPI, legal name, address, adding or removing a provider) within 10 business days.

Policy Memo No. 1
SECTION XLII. Acknowledgement of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations

- **Page 26:** Added paragraph to address vendor offshore outsourcing.

Although BCBSKS does not guarantee the availability of a website, if and when a website may be made available to contracting providers, the contracting provider shall access such website and the information available through it only for the purpose of payment, treatment, and operations as these terms are defined in HIPAA at 42CFR, part 164.

The Contracting Provider shall not, in connection with any functions, activities, or services directly or indirectly contract with any person or entity that undertakes any functions, activities, or services, including without limitation storage of member information outside of the United States of America or its territories without prior written consent from BCBSKS.

Policy Memo No. 1
SECTION XLIV. Medicare Advantage Claims

- **Pages 26-27:** Language adjusted to reflect introduction of BCBSKS Medicare Advantage network in 2020.

  Medicare Advantage (MA) claims should be submitted directly to BCBSKS, which will report the status of such claims on its remittance advices. *[However,]* MA claims *[cannot and]* will *[not]* be processed *[or appealed]* pursuant to BCBSKS policies and procedures **specific to MA and are subject to applicable MA appeal rights**. For MA claims occurring under a form of coverage offered by a BCBS Plan other than BCBSKS, **the provider in the BCBSKS MA provider network will be reimbursed for covered services at the BCBSKS MA reimbursement rate.** *[, such]* **The** other **BCBS** *[Blue]* Plan is solely responsible for determining *[pricing and]* medical policy**. BCBSKS providers not participating in the BCBSKS MA provider network who provide services to an MA member of either BCBSKS or another BCBS Plan will be reimbursed at the amount applicable in Original Medicare** (as required by the Centers for Medicare & Medicaid Services (CMS)).

  BCBSKS contracting MA providers, see the Medicare Advantage Manual for MA-specific policies, procedures, and guidelines. *[A provider's contracting status with CMS determines MA payment allowances. The provider may appeal MA claims only to the Blue Plan providing the MA coverage regardless of whether BCBSKS or another BCBS Plan issued payment. The provider agrees to abide by the final determination resulting from the MA appeals process, which is established by CMS. The appeals policies and procedures of such other Blue Plans should be obtained from those Blue Plans directly.]*

Policy Memo No. 1
Limited Patient Waiver

- **Last page of Policy Memo No. 1:** Updated verbiage to accurately reflect current practice.

  - Patient *[demanded]*-**requested** services

Policy Memo Nos. 1, 7, 9 & 12
MULTIPLE SECTIONS. Rendering Provider

- **PM 1 pages 15, 16, 18,19, 22, 23; PM 7 page 3; PM 9 page 4; PM 12 page 5:** Updated instances of outdated verbiage to accurately reflect current practices.

  [performing] **rendering** provider

Policy Memo No. 2
SECTION II. Content of Service

- **Page 3:** Inserted verbiage to accurately reflect current practices.

  Usual fees for the professional services for new and established patients are considered to include the following:
  - Examination of the patient.
  - History of illness and/or review of patient records.
  - Evaluation of tests or studies (i.e., radiology or pathology).
  - **Hearing and vision screenings.**

Policy Memo No. 4
Introduction

- **Page 3:** Updated title to accurately reflect current position.

  An integral component of the Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) quality improvement program is the evaluation of the health care services rendered to members by contracting providers through medical peer review. Potential quality of care concerns, including 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 Nurse Coordinator *[for Care Coordination]* **of** Quality Improvement *[and Accreditation]*, who serves as the designated peer review officer for BCBSKS as defined in K.S.A. 65-4915.

Policy Memo No. 4
SECTION I. Quality Improvement Process

- **Page 3:** Updated verbiage to accurately reflect current practices.

  Emerging patterns of confirmed inappropriate or substandard care provided by contracting providers are monitored within the quality improvement department. Once a problem or pattern of problems is identified, a corrective action plan may be requested as an educational effort to correct a specific problem relating to the care rendered by contracting providers. All cases in which the quality of care is either questionable or may be substandard are referred for external review by a contracted quality improvement and peer review organization for a final determination. **BCBSKS may report providers to the appropriate licensing authority based on peer review organization's final determination. BCBSKS may also take further action up to and including termination of the provider's participation agreement.**