Professional Provider
# Report

A newsletter for professional providers and their staff members

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## What's Inside



The *Professional Provider Report* is published by the Professional Relations department of Blue Cross and Blue Shield of Kansas.

Dustin Kimmel,
Communications Coordinator

# K-TRACS Valuable in Fight Against Opioid Epidemic

When prescribing and dispensing opioid medications, Blue Cross and Blue Shield of Kansas (BCBSKS) encourages all prescribing providers to use Kansas Tracking and Reporting of Controlled Substances, or K-TRACS.

## What is K-TRACS?

K-TRACS is the prescription monitoring program that tracks the use of controlled substances and allows a provider to access a controlled substance report for patients. Through the K-TRACS portal, providers can access what controlled substances a patient has filled, as well as see the quantities, prescribing providers, and pharmacies associated with each prescription.

Issues can be easily identified in-office and addressed at the point of discovery.

The Kansas State Board of Pharmacy, the Kansas Department of Health and Environment, and Appriss Health have partnered to provide all prescribers and pharmacists in Kansas with access to K-TRACS directly in electronic health records and pharmacy management systems. The project is funded by a grant from the Centers for Disease Control and Prevention.

See page 2 for integration steps.

*Please see* **K-TRACS**, *page* ***2***

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# K-TRACS: Data Collection Helps Identify, Treat Abuse

*Continued from page **1***

## K-TRACS in use?

Data from K-TRACS shows that more and more providers are registering and using K-TRACS to access the valuable data. Imagine looking up a patient only to find they have visited 15 physicians and filled 15 controlled substance prescriptions in the past 90 days. Would you think twice before providing a controlled substance for a patient who was visiting eight different pharmacies for their 15 controlled substance prescriptions?

K-TRACS helps prescribing providers identify patients who may be misusing or diverting opioids and can help prevent unnecessary opioids from entering these patients' hands.

K-TRACS also helps providers identify patients who may need a referral to a pain management specialist. More importantly, K-TRACS helps identify patients with an unknown opioid-use disorder so these patients can begin receiving help for their addiction. You can access more information about K-TRACS or register for K-TRACS at the Kansas Board of Pharmacy website: http://pharmacy.ks.gov/k-tracs

By integrating this tool into practices, providers can help ensure the appropriate use of opioid medications for patients and BCBSKS members.

Addiction or misuse of opioids often starts innocently — after a knee replacement, tooth extraction, or accident — and is not discriminatory in nature.

Opioid addiction can happen to anyone. It is important to keep in mind that each person struggling with opioid use has a unique story, and it is going to take a multi-disciplinary approach to help them.

## The Integration Process

1. Complete the Integration Interest Form. Make sure to identify the primary contact as the person who is leading the integration project on behalf of your organization.
2. Review, sign, and return the Terms and Conditions Agreement.
3. Notify your software vendor that your entity is pursuing integration.
4. Wait for your software vendor to be approved for integration by the Kansas Board of Pharmacy.
5. Have your software vendor review the Application Programming Interface (API) guidelines to determine the level of effort necessary for organization to integrate and the approximate timeline for implementation.
6. Appriss, the K-TRACS software vendor, will set up an initial technical meeting with your software vendor.
7. Check on the status with your software vendor to ensure timely responses and encourage progress.

# Predetermination for Cologuard Testing

Blue Cross and Blue Shield of Kansas (BCBSKS) highly recommends a predetermination be made prior to ordering Cologuard™ testing. As a reminder, the laboratory that conducts the testing is non-contracting with BCBSKS and therefore, without medical necessity being met, your patient will be held liable for the total cost of the Cologuard™ testing. Medical necessity criteria is outlined in the Medical Policy. See below:

**POLICY**

A. DNA analysis of stool samples using Cologuard™ may be considered medically necessary as a screening technique for colorectal cancer in average risk, asymptomatic individuals between the ages of 50 and 75 years when no other Colorectal cancer screening has been performed during the recommended screening interval:
   1. Guaiac-based fecal occult blood test in the past year, or
   2. Fecal immunochemical test in the past year, or
   3. Multitargeted stool DNA test in the past 3 years, or
   4. Colonoscopy in the past 10 years, or
   5. CT colonography in the past 5 years, or
   6. Flexible sigmoidoscopy in the past 5 years.

B. In individuals who are considered candidates for Cologuard™ screening, repeat testing at intervals of every 3 years may be considered medically necessary.

C. DNA analysis of stool samples is considered experimental / investigational when the criteria above are not met and for all other indications including post colorectal cancer diagnosis surveillance.

D. All other screening stool DNA tests are considered experimental / investigational.

Should you have questions regarding the predetermination process, please contact your Professional Relations representative.

## Pharmaceutical Formulary Update

Prime Therapeutics updates the Blue Cross and Blue Shield of Kansas formulary (preferred medication list) on a quarterly basis. Please refer to the links below when prescribing or dispensing medications for your BCBSKS patients. Coverage is subject to the limitations of the member's individual plan.

For commercial members, go to: https://www.myprime.com/content/dam/prime/memberportal/forms/2018/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSPREFDRUG/KS_Alpha_Drug_List.pdf

For BlueCare/BCBSKS Solutions/EPO members, go to: https://www.myprime.com/content/dam/prime/memberportal/forms/2018/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSBLCREPO/KS_Complete_Formulary_2018.pdf

For BlueEdge/ResultsRx medication list, go to: https://www.myprime.com/content/dam/prime/memberportal/forms/2018/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSRXDRUG/KS_BlueEdge_MedicationList.pdf

# Coding Accidental Injuries Correctly can help Avoid Delays, Errors

## FEP has Separate Guidelines for Coverage, Claim Filing of Accidents

"Accidental injury" is defined as an injury caused solely through external, violent, and accidental means.

Accidental injury does not include disease or infection — unless it's a pus-producing infection that occurred from an accidental cut or wound — hernia, or injuries caused by biting or chewing.

Sprains and strains are accidental injuries.

Some Blue Cross and Blue Shield of Kansas (BCBSKS) policies offer a benefit that allows 100 percent of the Maximum Allowable Payment (MAP) for covered services associated with accidental injuries that are incurred per member per benefit period and up to the contract maximum.

The Federal Employee Program (FEP) has separate guidelines for accident coverage.

When an accident claim is submitted it must have:

- Accident diagnosis code
- Accident date
- Related cause (accident type)

When an accident diagnosis is submitted on claims, there is an expectation that the corresponding information will be identified in box 10 of the CMS 1500 claim form or loop and segment 2300 CLM11 along with the accident date in box 15 or loop and segment 2300 DTP.

The following boxes/loops and segments must be completed for accidents:

Box 10 or loop and segment 2300 CLM11 — Mark YES in the appropriate box.

Box 15 or loop and segment 2300 DTP, Qualifier 439 must be used — If box 10 a, b, or c is marked "yes," another date related to the patient's condition or treatment is needed. Enter the date in a 6-digit (MM/DD/YY) or an 8-digit (MM/DD/YYYY) format.

Box 19 or loop and segment 2300 NTE — Complete description of the accident and exactly where it happened.

Box 21 or loop and segment 2300 HI01 — Accident diagnosis must be used as the primary diagnosis. (This is a BCBSKS payer-specific edit.)

## Helpful Hints

- When rendering a combination of accident vs. non-accident services, please separate the services on separate claims. (This should eliminate non-accident claims from being delayed in processing.)
- If you routinely treat diagnosis which are considered "potentially" accident related, you are strongly encouraged to have the patient complete an OPL questionnaire, which is located in the Forms tabs in the Provider section of the BCBSKS website.
- Additional training for completing the CMS-1500 Claim Form can be found under the Education & Workshops tab in the Provider section at www.bcbsks.com. (Contains special instructions and the common errors that cause claims to be rejected.)

# When to Submit 'Corrected' Claim vs. New Claim

Recently, Blue Cross and Blue Shield of Kansas has seen an increase in claims being submitted as "corrected" claims in error.

Per Policy Memo No. 1, "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."

Claims denied requesting additional information (e.g. by letter or denial code MA130) never should be marked "corrected claim" when resubmitted. Instead, providers should submit a new claim with the requested information.

The key element is a corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional changes, different procedure code or diagnosis codes, or any information that would change the way the claim originally processed.

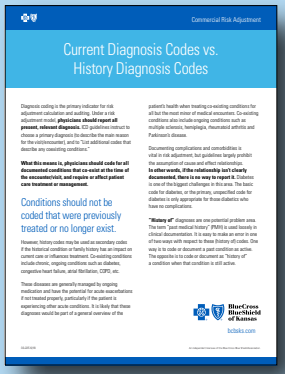
In addition, if a claim comes into us with a cover letter or medical records, it will be considered a retrospective review and not a "corrected claim."

## Corrected Claims Need Code 7, Original Control Number

When submitting a corrected claim, resubmission code 7 must be used with the original claim control number listed under original reference number in box 22 of the CMS 1500 claim form.

| 22. RESUBMISSION CODE | ORIGINAL REF. NO. |
|---|---|
| 7 | 2528XXXXXXXX |

For electronic resubmission, use loop and segment 2300 CLM05-3 for the claim frequency code 7, and submit the original claim control number in loop and segment 2300 REF02.


Commercial Risk Adjustment

Current Diagnosis Codes vs. History Diagnosis Codes

Diagnosis coding is the primary indicator for risk adjustment calculation and auditing. Under a risk adjustment model, **physicians should report all present, relevant diagnosis.** ICD guidelines instruct to choose a primary diagnosis (to describe the main reason for the visit/encounter), and to "List additional codes that describe any coexisting conditions."

**What this means is, physicians should code for all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management.**

Conditions should not be coded that were previously treated or no longer exist.

However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. Co-existing conditions include chronic, ongoing conditions such as diabetes, congestive heart failure, atrial fibrillation, COPD, etc.

These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters. Co-existing conditions also include ongoing conditions such as multiple sclerosis, hemiplegia, rheumatoid arthritis and Parkinson's disease.

Documenting complications and comorbidities is vital in risk adjustment, but guidelines largely prohibit the assumption of cause and effect relationships. **In other words, if the relationship isn't clearly documented, there is no way to report it.** Diabetes is one of the biggest challenges in this area. The basic code for diabetes, or the primary, unspecified code for diabetes is only appropriate for those diabetics who have no complications.

**"History of"** diagnoses are one potential problem area. The term "past medical history" (PMH) is used loosely in clinical documentation. It is easy to make an error in one of two ways with respect to these thistory ofl codes. One way is to code or document a past condition as active. The opposite is to code or document as "history of" a condition when that condition is still active.

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## New Coding Corner Page Dedicated to Best Practices

Coding Corner is a new page on the Blue Cross and Blue Shield of Kansas (BCBSKS) website dedicated to helping providers use the best coding practices. The page can be accessed at: https://www.bcbsks.com/CustomerService/Providers/icd-10/

The articles on the page are specifically designed for BCBSKS providers and/or their support staff as a way of providing the best and most-current practices in ICD-10 coding.

For more information or assistance, contact Your Professional Relations representative or Provider Network Services in Topeka at (785) 291-4135 or (800) 432-3587.

# Inovalon Continues to Collect Medical Records

Inovalon has been collecting medical records on behalf of Blue Cross and Blue Shield of Kansas since Jan. 1.

The Centers for Medicare and Medicaid Services (CMS) and Department of Health and Human Services (HHS) require Medicare Advantage and commercial plans to submit detailed documentation to support patient conditions.

As outlined in the contract, providers are required to respond within a requested time frame to requests in support of Risk Adjustment and Healthcare Effectiveness Data and Information Set (HEDIS), risk adjustment, and government-required programs related to the Affordable Care Act.

Inovalon is contractually bound to preserve the confidentiality of health plan members' protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations. Providers are permitted to disclose protected health information (PHI) to health plans and the contracted partners without authorization from the patient when both the provider and the health plan had a relationship with the patient.

For more information or questions about this request and process, contact Inovalon at (800) 390-3180.

# Avoiding Donor Claim Denials

When filing claims for donors or potential donors, follow the following steps to avoid denial or delays in payment.

1. Providers should submit claims filed under the recipient name and indicate "Donor" or "Potential Donor" and the name of the donor in the 2300 Loop NTE Segment for electronic claims or box 19 of the CMS 1500 claim form.
2. File with an ICD-10 donor or potential donor code. These diagnosis codes will have a diagnosis category of DON.
3. On potential donor claims, the testing procedure code should be submitted with modifier 76 to avoid denying as a duplicate claim.

## Billing for Prep of Vials of Non-Venom Antigens

When billing CPT code 95165 for preparation of single- or multiple-dose vials of non-venom antigens, a provider should not bill the code for more than 10 doses per vial. Reimbursement is for preparation of a 10cc vial, despite the number of doses removed from the vial.

For example, if a physician uses .5cc doses for a 10cc multiple-dose vial for a total of 20 doses, the provider should bill for no more than 10 units. If the provider prepares two 10cc multiple-dose vials and uses .5cc from one vial and 1cc from the other, the provider should bill for no more than 20 units.

## Be Certain to Include Dates when Submitting Claims for POS 21

When a patient is listed as an in-patient within a hospital facility (Place of Service 21), the in-patient stay dates need to be included in box 18 of a CMS 1500 claim form or loop and segment 2300 DTP and use Qualifier 435 for electronic submission.

# Data Updates can be Sent Anytime Via Provider Portal

## Making Changes to Information on File with BCBSKS Can Be Done Whenever the Need Arises Throughout the Year

Provider data updates may be sent at any time via the Provider Portal and doesn't have to be related to one of two bi-annual Provider Data Attestations (PDA).

The section of the provider information display has three options to choose from when submitting a change and/or completing a PDA. Below is a brief explanation of the options to choose when reviewing or submitting and change.

- **I am only submitting the changes above** — This option is available when submitting updates at any time via the portal. This option may be used most often when updating group level information.
- **I have reviewed and attest that the Group/Practice information above is accurate** — When selected demonstrates the provider has reviewed the data and is confirming the data is accurate as presented. Applied toward the applicable bi-annual PDA.
- **I have reviewed and attest that the Group/Practice information above (with my stated changes) is accurate** — When selected demonstrates the provider has reviewed the data, identified errors and provided the necessary updates in the blank fields. Applied toward the applicable bi-annual PDA.

For more information regarding PDA, contact your Professional Relations Representative or Provider Network Services in Topeka at (785) 291-4135 or (800) 432-3587.

### Availity Registration reminder

Providers who have not registered through Availity will not be able to access the Provider Portal to complete the data review and attestation. For instructions on how to set up an account, see Professional Provider Report S-7-13.

## What's New in 2019 Workshops still Have Space Available

Blue Cross and Blue Shield of Kansas is offering What's New in 2019 workshops for professional providers and their office staff. Remaing workshops in 2018 begin at 9 a.m. and include:

Oct. 4 — Wichita

Oct. 9 — Ottawa

Oct. 25 — Great Bend

Oct. 26 — Hays

Nov. 2 — Colby

Nov. 8 — Hutchinson

Nov. 8 — Liberal

Nov. 8 — Wichita

Nov. 9 — Scott City

Dec. 7 — Topeka

Dec. 12 — Atchison

To register, click the desired date above or go to https://www.bcbsks.com/CustomerService/Providers/Training/workshops/pro_billing.shtml. Space is limited for each workshop.

# Web Changes — Medical Policy

Since the publication of Professional Provider Report S-3-18, the following policies have been posted at: https://www.bcbsks.com/CustomerService/Providers/MedicalPolicies/policies.shtml

- Accelerated Breast Irradiation and Brachytherapy Boost After Breast-Conserving Surgery for Early Stage Breast Cancer
- Actigraphy
- Actimmune (interferon gamma-1b)
- Alcohol Injection Therapy for Morton's Neuroma
- Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry
- Antidepressant Agents
- Antihypertensive Medications
- Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer
- Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions
- Automated Ambulatory Blood Pressure Monitoring for the Diagnosis of Hypertension in Patients With Elevated Office Blood Pressure
- Axial Lumbosacral Interbody Fusion
- Benlysta® (belimumab)
- Bio-Engineered Skin and Soft Tissue Substitutes
- Biologic Immunomodulators Therapy (Pharmacy Benefit Only)
- Bronchial Thermoplasty
- Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
- Catheter Ablation as Treatment for Atrial Fibrillation
- CGRP (calcitonin gene-related peptide)
- Charged-Particle (Proton or Helium Ion) Radiotherapy for Neoplastic Conditions
- Circadian Rhythm Disorder
- Corneal Collagen Cross-Linking
- Coronary Computed Tomography Angiography with Selective Noninvasive Fractional Flow Reserve
- Cryosurgical Ablation of Primary or Metastatic Liver Tumors
- Cystic Fibrosis Transmembrane Conductance Regulator (CFTR)
- Diagnosis and Treatment of Sacroiliac Joint Pain
- Drug Testing in Pain Management and Substance Use Disorder Treatment
- Electronic Brachytherapy for Nonmelanoma Skin Cancer
- Endari™ (L-glutamine)
- Enhanced External Counterpulsation (EECP)
- Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies
- Extracorporeal Shock Wave Therapy (ESWT) for Plantar Fasciitis and Other Musculoskeletal Conditions
- Extracranial Carotid Artery Stenting
- Gene Expression Profiling and Protein Biomarkers for Prostate Cancer Management
- Gene Expression Profiling for Cutaneous Melanoma
- Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
- Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- Genotype-Guided Tamoxifen Treatment
- Hemlibra® (emicizumab-kxwh)
- Implantable Cardioverter Defibrillators
- Insomnia Agents (Sherwood Employer Group)
- Interspinous Fixation (Fusion) Devices
- In Vitro Chemoresistance and Chemosensitivity Assays
- KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy
- KRAS, NRAS, and BRAF Variant Analysis in Metastatic Colorectal Cancer
- Laboratory Tests for Heart Transplant Rejection
- Lumbar Spinal Fusion
- Lysosomal Storage Disorders
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders
- Miscellaneous Genetic and Molecular Diagnostic Tests
- Molecular Analysis for Targeted Therapy of Non-Small-Cell Lung Cancer
- Molecular Markers in Fine Needle Aspirates of the Thyroid
- Multiple Sclerosis Agents
- Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease
- Open and Thoracoscopic Approaches to Treat Atrial Fibrillation and Atrial Flutter (Maze and Related Procedures)
- Opioid Immediate Release
- Opioids, Extended Release (ER)
- Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders
- Otezla (apremilast)
- Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
- Percutaneous Vertebroplasty and Sacroplasty
- Posterior Tibial Nerve Stimulation
- Proprotein Convertase Subtilisin/kexin type 9 (PCSK9) Inhibitors
- Proton Pump Inhibitors (PPIs) (Sherwood Employer Group)
- Risk-Reducing Mastectomy
- Scanning Computerized Ophthalmic Diagnostic Imaging Devices
- Selective Serotonin Inverse Agonist (SSIA)
- Self Administered Oncology Agents
- Spinal Cord and Dorsal Root Ganglion Stimulation
- Spinraza™ (nusinersen)
- Substrate Reduction Therapy
- Surgical Treatment of Femoroacetabular Impingement
- Synagis (palivizumab)
- Topical Doxepin
- Transcatheter Aortic Valve Implantation for Aortic Stenosis
- Tumor Treating Fields Therapy
- Tysabri® (natalizumab), Lemtrada™ (alemtuzumab), and Ocrevus® (ocrelizumab) (IV Multiple Sclerosis Agents)
- Ultrafiltration in Heart Failure
- Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis
- Wearable Cardioverter Defibrillators

**Questions?** Contact your professional relations representative or provider network services in Topeka at (785) 291-4135 or (800) 432-3587.



Sent to: CAP excluding dentists and pharmacies. Contains public information.

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