What's New in 2025

BlueCross BlueShield Kansas

Agenda

Virginia Barnes, Director of Blue Health Initiatives
Review of 2025 annual CAP report
Review of Quality-Based Reimbursement (QBRP)
Review of 2025 policy memo changes
TriWest Updates
Health Blue Updates
Lucky Strikes
- Availity
- Vitamin D reminder
- MA Workshops
- Fall Workshop on Documentation Integrity

Virginia Barnes, Director of Blue Health Initiatives

Virginia has been with Blue Cross Blue Shield of Kansas since October 2015, serving as the director of Blue Health Initiatives. Blue Health Initiatives strives to improve the health and quality of life for all Kansans, and Kansas communities.

Pathways to a Healthy Kansas is the signature initiative and is the largest grant program ever administered by Blue Cross and Blue Shield of Kansas. This initiative combines community-wide, evidence-based solutions and practices to help Kansas communities improve active living, healthy eating, and tobacco prevention as well as providing community coalitions with tools and resources needed to engage communities and remove barriers to healthy living.

Virginia currently serves on the Topeka Community Foundation and Kansas Public Health Association Boards, along with numerous advisory committees focused on improving health in Kansas.

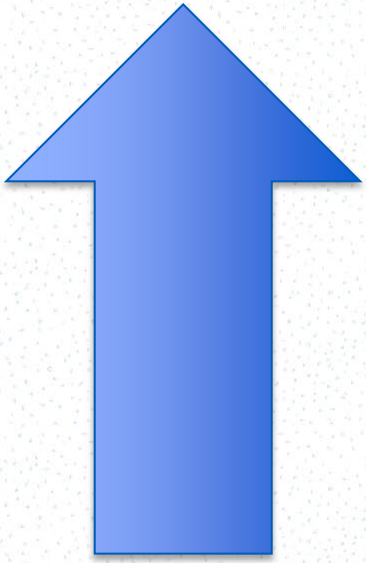
2025 Competitive Allowance Program (CAP) contract

- Being the insurer Kansas trust with their health.
- Implementation of Affordable Care Act requirements.
- BCBSKS address the health care needs of 903,356 Kansans
- BCBSKS contracts with 99% of physicians and 98% of all professional providers in our Kansas Plan area.
- BCBSKS is 100% 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.

2025 Reimbursement

Increasing

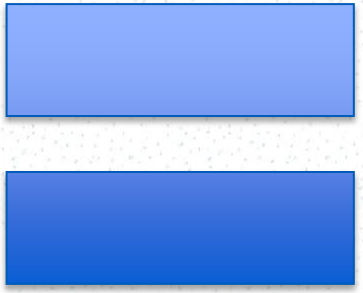
- Anesthesia conversion factor
- Undervalued CPT codes
- Durable Medical Equipment (DME) services



2025 Reimbursement

No change

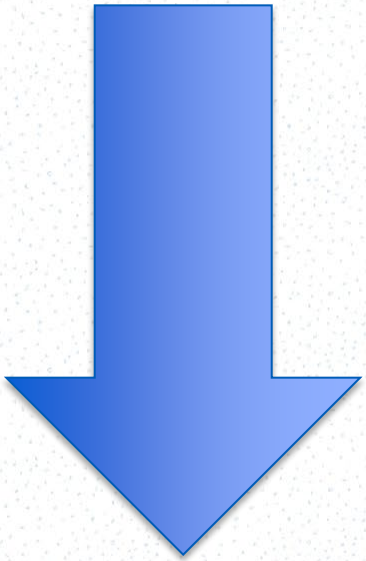
- Rural county incentive – services billed by primary care and behavioral health providers located in counties with a population of 13,000 or less
- Ground ambulance base rates
- Air ambulance base rates
- Air ambulance – fixed wing mileage
- Ground ambulance mileage
- Specialty care transport
- Telehealth services paying at parity allowing same as in office
- Physical therapy, occupational therapy, speech pathology services



2025 Reimbursement

Decreasing

- Overvalued CPT codes
- Lab codes



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 7 of the CAP annual report.

- 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, newsletter) and be a provider in good standing with BCBSKS.
- Excluded – clinical lab (using codes on 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 annual report for defined time frames.
- Incentives will be earned at the individual level unless otherwise specified.

Quality-Based Reimbursement Program (QBRP)

Page 8:

- Please note – Changes in CPT codes (added/deleted) will be effective prospectively, including QBRP. In addition, any adjustments to QBRP payments will also be made prospectively. Any corrections will be effective the first of the following month, unless otherwise specified.

Page 9:

- All metrics, with the exception of the Provider Information Portal, will be reviewed on a semi-annual basis and any incentives earned will be effective either January 1, 2025 or July 1, 2025 as applicable.

Page 10:

- Confirmation of QBRP measure can be obtained real time on the provider portal. The portal will reflect real time effective and termination dates of all applicable QBRP measures.

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) – 2.0% (96%-100%)

- Evaluated at the group level on a semi-annual basis.

Qualifying for Electronic Self-Service Incentive (ES3)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
August 1 - October 31, 2024	January 1, 2025
February 1 - April 30, 2025	July 1, 2025

QBRP – group A

Provider Information Portal (PRT) – 2.5%

- Must verify provider information every 90 days for each individual provider within your group, and for the group itself.
- 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.
- Providers who do not attest every 90 days will be suppressed from the provider directory

Qualifying for Provider Information Portal (PRT)

The following is a list of incentive effective dates and the corresponding qualifying periods.

Qualifying Period	Incentive
September 2024 - November 2024	January 1, 2025
December 2024 - February 2025	April 1, 2025
March 2025 - May 2025	July 1, 2025
June 2025 - August 2025	October 1, 2025

QBRP – group A

Electronic Provider Message Board (EPM) – 1.0% 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 load the request on 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.

Qualifying for Electronic Provider Message Board (EPM)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive
June 2024 - November 2024	January 1, 2025
December 2024 - May 2025	July 1, 2025
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

MiResource (MiR) – 0.5% incentive

Metric	%	Group	Description	Qualifying Period
MiResource (MiR) (Applies to Behavior Health Providers only)	0.5	A	Must enroll in MiResource provider directory in order to be eligible.	Monthly

Qualifying for MiResource Incentive (MiR)

The following is a list of incentive effective dates and the corresponding qualifying periods:

NOTE: Existing providers that have already signed up with MiResource will be allowed for continuation of qualifying period without interruption for this QBRP incentive.

Qualifying Period	Incentive begins
June 2024 - November 2024	January 1, 2025
December 2024 - May 2025	July 1, 2025

QBRP – group A

CPT II Codes (CAT2) – .50% incentive

- Add Supplemental Procedure Codes to claims
- Decreases need for medical record requests
- Produces a more accurate HEDIS score
- The provider must have 30 or more qualifying encounters during the measurement year
- Calculated at the individual provider level

Qualifying for CPT II Codes (CAT2)/ ICD-10 SDoH Codes (ZZZ) Incentives

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
July 1, 2023 - June 30, 2024 (as paid through September 30, 2024)	January 1, 2025
January 1, 2024 - December 30, 2024 (as paid through March 31, 2025)	July 1, 2025

QBRP – group A

ICD-10 SDoH Codes (ZZZ) – .75% incentive

- SDoH – Social Determinants of Health
- Supplemental diagnosis codes used to identify SDoH, 'history of' procedures, or 'acquired absence of' codes used to support HEDIS
- The provider must have 30 or more qualifying encounters during the measurement year
- Calculated at the individual provider level

Qualifying for CPT II Codes (CAT2)/ ICD-10 SDoH Codes (ZZZ) Incentives

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
July 1, 2023 - June 30, 2024 (as paid through September 30, 2024)	January 1, 2025
January 1, 2024 - December 30, 2024 (as paid through March 31, 2025)	July 1, 2025

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

BCBSKS will award QBRP incentive for HIE if the provider either transmits all five HL7 feeds or transmits a CCD, ADT and ORU (lab). We are working to establish a comprehensive clinical data repository and anything short of complete and comprehensive data will prevent us from reaching our goal, therefore, providers must meet the requirements to earn the HIE incentive.

QBRP – group B

Kansas Health Exchange – 3.0% incentive

All five metrics must be met to qualify

- HIE HL7 V2, Demographic, admissions, discharges, and transfers.
- HIE HL7 V2, Progress Notes
- HIE HL7 V2, Vitals, Diagnosis, Procedure coding
- HIE HL7 V2, Lab Reporting
- HIE HL7 V2, Medication administration

OR

- CCD Complete Continuity of Care Document (CCD HL7 V3)
- HL7 V2, ADT
- HL7 V2, Lab (ORU)

QBRP – group B

KHIN Clinical Data Repository – Qualifying periods:

Qualifying for HIE Incentives (ADT, OPN, ABS, LAB, MED, CCD)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
May 1 - October 31, 2024	January 1, 2025
November 1 - April 30, 2025	July 1, 2025

QBRP – group B

CMS-approved Registry Data (REG) – 3.0% 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
  - Gastroenterology
  - Otolaryngology

QBRP – group B

CMS-approved Registry Data (REG) – Qualifying periods:

Qualifying for Registry Data (REG) Incentives

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
June 1 - November 30, 2024	January 1, 2025
December 1, 2024 - May 31, 2025	July 1, 2025

QBRP – group B

Access formulary Electronically (EEX) – 0.75% incentive

- Access benefit information 120 times per quarter.

Generic Utilization Rate (GUR) – 0.75% incentive

- Minimum generic prescribing is 85 percent (for all BCBSKS members with a prescription drug benefit).

Qualifying for Access Formulary Electronically, Generic Utilization Rate Incentives (EEX, GUR)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
September 1 - November 30, 2024	January 1, 2025
March 1 - May 31, 2025	July 1, 2025

QBRP – group B

Anesthesia performed in a Level 1 Trauma Center (ATC) – 8.5% incentive

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

HEDIS 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% 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) – 1.5% 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% incentive

- The percentage of adults 45-75 years of age (46-75 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% 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 90 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% incentive

- Six-plus visits in first 15 months of life.

Well-Child visits (W30B) – 1.0% 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% 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) – 1.0% 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 80 percent to meet the metric.

QBRP – group B

Statin Therapy for Persons with Diabetes (SPD) – 1.0% 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

Eye Exams for Patients with Diabetes (EED) – 1.0% 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 50 percent to meet the metric.

QBRP – group C components

- Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, and CRNA).
- Incentive applies to E&M CPT codes only.
- Incentives are calculated at the group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive the incentive.

QBRP – group C

Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB) – 1.5% 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 50 percent to meet the metric.

QBRP – group C

Appropriate Testing for Children with Pharyngitis (CWP) – 1.5% 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 70 percent to meet the metric.

QBRP – group C

Appropriate Treatment for Members with Upper Respiratory Infection (URI) – 1.5% 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 80 percent to meet the metric.

QBRP – group C

Follow-up After Hospitalization for Mental Illness (FUH) – 0.5% incentive

- The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider within 7 days after discharge. Must be greater than or equal to 70 percent to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.
- Note — The member is attributed to the provider associated with the earliest date of service of an eligible encounter with a principal diagnosis of mental illness or intentional self-harm, regardless of the specialty.

Provider Policies and Procedures:

Summary of changes for 2025

Summary of Changes for 2025

Policy Memo No. 1 SECTION I. Confidentiality
• **Page 4:** Added verbiage to cover complying with the gag clause prohibition. 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. Nothing in this section shall be construed to limit the disclosure of confidential information to the extent required by law.

Summary of Changes for 2025

Policy Memo No. 1
SECTION V. Post-Payment Audits

- **Page 9:** Updated verbiage for clarity regarding timeframe related to post-payment audits.

  If medical necessity is not supported by the medical record, BCBSKS will deny as not medically necessary. When BCBSKS requests medical records for an audit and no documentation is received within the 30 ~~business~~ day time limit, BCBSKS will deny for no documentation.

Summary of Changes for 2025

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 10:** Updated verbiage to reflect accurate examples of content of service.
  - Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
  - Examination and/or treatment room.
  - Items of office overhead such as malpractice insurance, telephones, computer equipment, software, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
  - Telephone calls and web-based correspondence are content of service when billed with another service on the same day. ~~Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 or 10 and the GT modifier.~~
  - Anesthesia provided in an office setting is considered content of service and not reimbursed separately. The provider cannot require the patient to sign a waiver or bill the patient for this service.
  - For services that include assessment and evaluation of that assessment, the date of the assessment shall be the date of service.
  - Mileage (except for ambulance)

Summary of Changes for 2025

Policy Memo No. 1
SECTION XV. Claims Filing

- **Page 17:** Updated verbiage to add clarity on what information is needed to file a claim.

  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 rendering provider number,~~ if applicable. The name of the ordering provider, when applicable, (including NPI or specific rendering provider number, except when exempt by law) must appear on ~~every~~ the claim.

Summary of Changes for 2025

Policy Memo No. 1
SECTION XVIII. Services Provided by Non-Physicians and Resident Physicians

- **Page 19:** Updated verbiage to reflect current eligible providers.

G. BCBSKS will not pay for outpatient services connected with a nervous and mental diagnosis when provided by an unlicensed provider, or a licensed provider with a licensure other than designated in the member's contract as eligible to provide nervous and mental benefits. Supervision of an unlicensed provider, a licensed counselor, or one not designated as eligible in the member's contract does not constitute a service being rendered by an eligible provider. The exception to this would be if the service was rendered through a state licensed alcohol or drug abuse treatment facility, a hospital, or a psychiatric hospital~~, or a community mental health center~~. Eligible non-physician psychiatric providers include APRNs, certified psychologists, licensed specialist clinical social workers, licensed clinical marriage and family therapists, licensed clinical professional counselors, and licensed clinical psychotherapists.

Policy Memo No. 1
SECTION XXXIII. Acknowledgment of Independent Status of Plan

Summary of Changes for 2025

Policy Memo No. 1
SECTION XXXIII. Acknowledgment of Independent Status of Plan

- **Page 25:** Updated verbiage to clarify BCBSKS jurisdiction.

The provider hereby expressly acknowledges its understanding that the agreement to which these policies and procedures apply constitutes a contract between the provider and BCBSKS that the Plan is an independent corporation operating under a license with the Blue Cross Blue Shield Association (Association), an association of independent BCBS Plans, the Association permitting the Plan to use the BCBS Service Marks, and that the Plan is not contracting as the agent of the Association. BCBSKS serves an operating are of 103 counties in Kansas (all counties except Johnson and Wyandotte).

Summary of Changes for 2025

Policy Memo No. 1
SECTION XLII. Acknowledgment of Non-Discrimination Laws

- **Page 27:** Updated verbiage and section title to include equitable access along with non-discrimination laws.

Acknowledgement of Non-Discrimination Laws and Equitable Access Requirements

As a provider of services to the State of Kansas and to counties, municipalities and other state governmental units, BCBSKS is required by K.S.A. 44-1030 to observe the provisions of the Kansas Act Against Discrimination, not to discriminate against any person in the performance of work because of race, religion, color, sex, disability, national origin or ancestry, to include the phrase "equal opportunity employer" or a similar phrase in advertisements for employees, and to require in any contracts BCBSKS has with others that such others shall also abide by such provisions, and that if such contractors are found guilty of a violation of the Kansas Act Against Discrimination, such contractors shall be deemed to have breached their contracts with BCBSKS and the contract may be canceled, terminated or suspended in whole or in part. The contracting provider agrees that it shall abide by the foregoing provisions.

As a provider of services for qualified health plans, any entity that operates a health program or activity, any part that receives Federal financial assistance is required by Section 1557 of the Patient Protection and Affordable Care Act, and its implementing regulations published by the Office of Civil Rights, to not discriminate against any person on the basis of race, color, national origin, sex, gender identity, age, or disability, to accommodate individuals with limited English proficiency. Any entities that are found to have discriminated in violation of section 1557, and its implementing regulations, can be subject to a private right of action. The contracting provider agrees that it shall abide by the foregoing provisions.

Providers agree to ensure that all services are provided in a culturally competent manner to all enrollees and to promote equitable access to all enrollees, including but not limited to the following:

- People with limited English proficiency or reading skills.
- People of ethnic, cultural, racial, or religious minorities.
- People with disabilities.
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
- People living in rural areas and other areas with high levels of deprivation.
- People otherwise adversely affected by persistent poverty or inequality.

Summary of Changes for 2025

Policy Memo No. 2
SECTION II. Content of Service (See also Policy Memo No. 1)

- **Page 3:** Updated verbiage to reflect accurate examples of content of service and to match Policy Memo No. 1.
  - The application or the re-application of any standard dressing during a visit.
  - Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.
  - Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
  - Examination and/or treatment room.
  - Items of office overhead such as malpractice insurance, telephones, computer equipment, software, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
  - Telephone calls and web-based correspondence are content of service when billed with another service on the same day. ~~Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 or 10 and the GT modifier.~~
  - Anesthesia provided in an office setting is considered content of service and not reimbursed separately. The provider cannot require the patient to sign a waiver or bill the patient for this service.
  - For services that include assessment and evaluation of that assessment, the date of the assessment shall be the date of service.
  - Mileage (except for ambulance)

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

Summary of Changes for 2025

Policy Memo No. 2 SECTION VII. Additional Policy Clarification
• **Page 5:** Removed inaccurate reference to Policy Memo No. 5. A. Office/outpatient visits provided on the same day as a hospital admission are considered content of the admission. ~~(See In-Hospital Medical [Non-Surgical] Care Policy Memo No. 5.)~~

Summary of Changes for 2025

Policy Memo No. 8
SECTION V. Additional Obstetrical Procedures

- **Page 4:** Removing reference of a labor management fee to reflect current billing practices.

~~D. LABOR MANAGEMENT FEE~~

~~Physicians are eligible for a separate labor management fee when the outcome of a pregnancy results in an emergency cesarean section that is performed by another physician. The physician who provided the antepartum and labor care may bill a separate labor management fee.~~

Summary of Changes for 2025

Policy Memo No. 12
SECTION II. Time of Administration

- **Page 3:** Updated verbiage to clarify on how anesthesia units should be billed.

  Anesthesia time begins with the initial administration of anesthetic agents by the anesthetist/anesthesiologist and ends when the anesthetist/anesthesiologist is no longer in personal attendance. The time of anesthesia administration and the CPT anesthesia codes are required on all claims to ensure proper payment. Anesthesia units should reflect total minutes.

Summary of Changes for 2025

Policy Memo No. 1
SECTION XIX. Locum Tenens Provider

- **Page 19:** Updated verbiage for clarity and better flow.

  In billing for services provided by a locum tenens, the claim must be filed using the NPI or specific rendering provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used. In addition, the medical record must indicate the services were provided by a locum tenens. ~~Locum tenens can be utilized in certain situations. However, covering for a deceased provider and billing under that deceased provider's NPI does not meet the criteria for locum tenens and is not permissible.~~ Situations when Locum Tenens is not permitted:

  A. Deceased provider
  B. Replace a provider who has permanently left the practice/group
  C. Locum tenens provider has a temporary license
  D. Provider is pending completion of credentialing

Summary of Changes for 2025

Policy Memo No. 1
SECTION XXIII. Amendments to Policies and Procedures; Right to Terminate Contract

- **Page 21:** Updated verbiage to follow current practices of notifications sent to providers.

  A. Annual Contract Renewal – As part of its annual provider contract renewal process, BCBSKS notifies providers via ~~U.S Mail~~, hand delivery or electronically of all changes to its Policies and Procedures and Maximum Allowable Payment schedules at least 150 days before the amendments' effective date, which shall be January 1 of the following year.

BREAK

Medicare Advantage

2024 Workshop

October 29, 2024

9-12:30

Patrick Artzer, MA Professional Relations Representative

Patrick.Artzer@bcbsks.com

785-291-6289

Joseph Scherr, MA Professional Relations Support

Joseph.scherr@bcbsks.com

785-291-4187

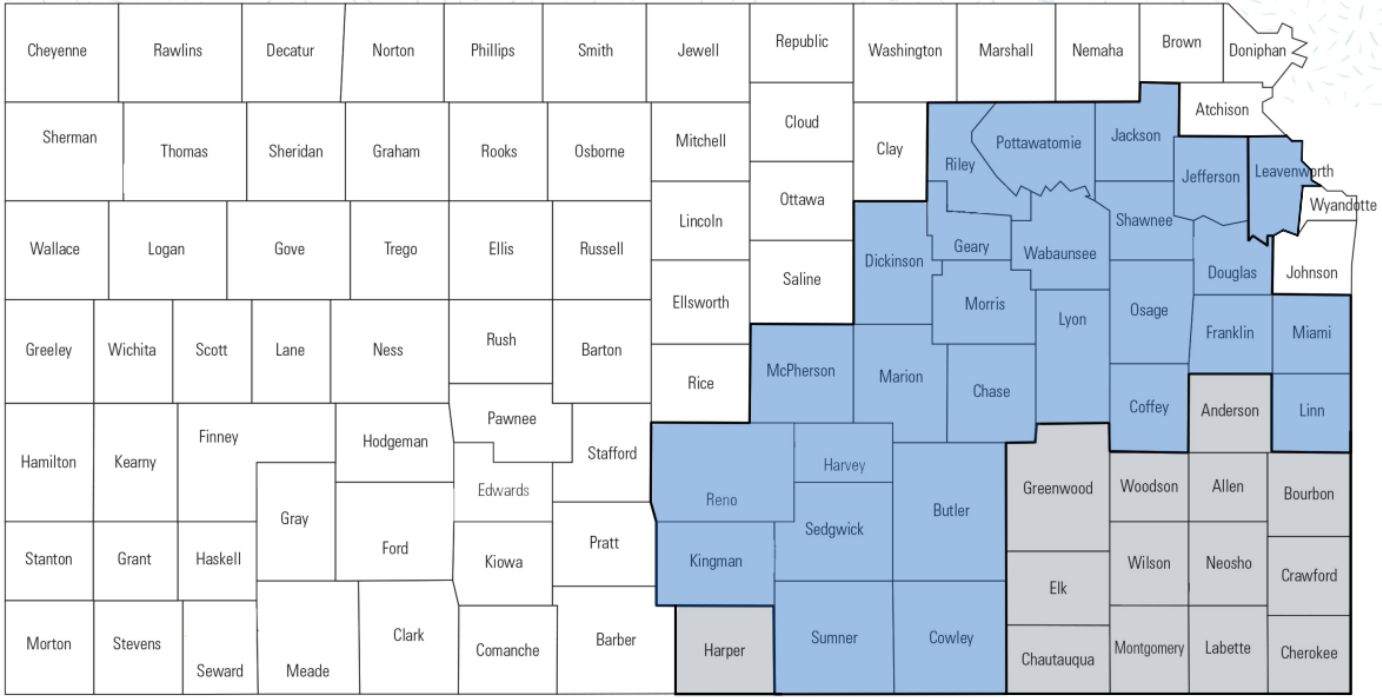
Workshops

CMS Ruling for provider locations

CMS has assigned a new guideline for the number of physical locations a provider can be listed at within a group status. The group status is identified by organization NPI under a tax ID number.

- Providers are allowed to be listed at a maximum of 10 physical locations
- The provider must practice at their listed locations at least once weekly to have that location listed in the directory
- Providers not practicing at least once weekly at a location, having over the max of 10 locations will be suppressed from the BCBSKS directory

Medicare Advantage Possible Expansion for 2025



TRICARE

- BCBSKS has partnered with TriWest to serve our military families utilizing our provider network.
- Contracts were sent to our CAP providers (excluding dentists and chiropractors) over the last few months.
- Contracts will go live and be in effect beginning January 1, 2025.
- If you are a current TriWest provider, you will need to sign a new contract with BCBSKS to stay in the TriWest network.

TRICARE FAQ'S

ID Cards

Prior Authorizations

Availity

CMAC (CHAMPUS Maximum Allowable Charge)
https://www.health.mil/CPT-Agreement?content=/sitecore/content/MHSHome/Military%20Health%20Topics/Access%20Cost%20Quality%20and%20Safety/TRICARE%20Health%20Plan/Rates%20and%20Reimbursement/CMAC%20Rates/Procedure%20Pricing#resultsPanel

TRICARE Contact Information

If you have any questions regarding TriWest, please feel free to reach out.
Professional TRICARE Representative – Emily Emmot

Emily.Emmot@bcbsks.com
785-291-8819

Healthy Blue

A collaboration with BCBSKS, BCBSKC, and Elevance Health.

Marcie Eckhart
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For more information, please visit https://www.healthybluekansas.com or contact us at ksproviderinquiry@healthybluekansas.com.

Lucky Strikes

Availity Reminders

Vitamin D Policy

Documentation Integrity Workshop
Oct 17, 2024
8:30-12:30
Jaci Kipreos, CPC, CPMA, CDEO, CEMC, CRC, COC
Approved Instructor, AAPC

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!