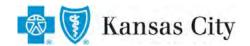


# Provider Office Guide

A Reference Manual for Blue KC Practitioners



# Blue KC Provider Office Guide

Away From Home Care Module

### **Provider Office Guide**

The Blue KC Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue Cross and Blue Shield of Kansas City (Blue KC). The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)
- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and

Procedures of the Physician Network Agreement/Physician

Participation Agreement including any incorporated

Amendments you agree to comply with all rules, regulations,

procedures and administrative policies and programs

outlined in the Provider Office Guide.

# Away From Home Care



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## Away From Home Care



## What is AFHC?

Away From Home Care (AFHC) is an out-of-area program sponsored by the Blue Cross and Blue Shield Association (BCBSA) that is available to select HMO members. AFHC enables members to receive Guest Membership coverage and benefits from other participating Blues Plan HMOs, while temporarily residing outside of the home Plan HMO service area. The member must contact his or her home Plan to confirm the out of area location participates in the AFHC program.

Members must complete a guest application with their home Plan to be considered for a Guest membership. Coordination of the AFHC guest enrollment, PCP assignment and Blues Plan billing is tracked by AFHC coordinators. Blues Plan AFHC coordinators from each Blues Plan work together throughout the duration of a guest enrollment period to ensure all aspects of the program run smoothly.

### **Guest Membership**

This service provides courtesy enrollment in a Blues Plan HMO outside the member's home Plan service area. Members have access to a comprehensive range of benefits, including routine and preventive services. HMO members may obtain a Guest Membership if they plan to stay in the other Blues Plan HMO location for 90 or more consecutive days. Guest Membership types include:

#### **Families Apart**

Available to spouses and dependents living away from the member's home Plan HMO service area and residing in another Blues Plan service area.

#### Long-term traveler

Available to members with dual residence or long-term work assignments. Membership is limited to six months.

#### **Students**

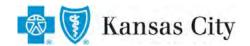
Available to dependents who enroll in an out-of-area school.

## **Coverage and Benefits**

Guest members enjoy the full range of benefits/services offered by another Blues Plan HMO. Covered benefits include in and outpatient services and other medical care, including routine and preventive care.

When Blue KC functions as a host Blues Plan for a guest, members access Blue-Care. There is a high and low benefit option available to members. The main

## Away From Home Care

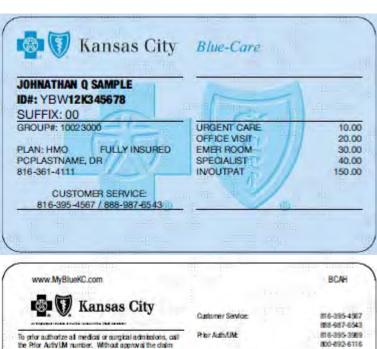


difference between these options is member copayment amounts. Copayment information is on the member identification (ID) card.

Guest members must select a PCP, but are free to self-refer within the Blue-Care specialist physician network.

## **Provider Information**

- Blue KC will advise you of any AFHC/Guest members assigned to you.
- Claims should be filed to Blue KC and payment is directed to the physician.
- If you have questions about a patient's eligibility as a Guest member, call our Away From Home Care number (see Contact | Resource Directory).
- The PCP's name and phone number is on the member's ID Card.
- A special prefix, preceding the policy number, is assigned to Blue-Care guest (see sample member ID card below).





# Blue KC Provider Office Guide

Blue KC Basics Module

## **Provider Office Guide**

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If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.



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## **Overview of Blue KC Basics**

This document is a collection of general information that is of value to providers in the Blue KC networks.

## Blue KC - Provider Portal

Providers with Internet access can quickly find answers to questions about members, providers, and benefit plans by visiting Blue KC's provider portal at Providers.BlueKC.com.

Blue KC's provider portal gives you 24/7/365 access to:

- Member information such as the status of a claim, eligibility of a member, benefits or coverage of a member's plan, remittance advices, explanation of benefits (EOB) and medical policies.
- A provider directory, which enables members and providers to find addresses and telephone numbers for network providers affiliated with Blue KC.
   Physicians can use this site to verify the accuracy of their own contact information.

Note: Providers must login to the provider portal to access claims and eligibility information, forms, benefits or coverage of a member's plan, remittance advices and medical policies. Login is not necessary to use Find a Doctor.



## To request access to the provider portal

Follow these steps.

- 1. From <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> click <a href="Register Now.">Register Now.</a>
- 2. Complete the form.
- 3. Click Submit.

You will receive an email with login information.

## To log in to the provider portal

Once you have login information (user ID and password), follow these steps to login.

- 1. Go to Providers.BlueKC.com.
- 2. In the **Log in** area type your **User name** and **Password**, then click **LOG IN**.

Note: All alphabetic characters in your user ID and initial password are lower case.

After logging on, the Home page will be displayed. From the Home page, use the navigation menu across the top or left side of the page. Menu items include: Claims/Eligibility, Communications, Resources, Forms, Medical Policies and Account Administration. In the upper right you'll see Find a Doctor, Contact and the Log Off links.

Call your Provider Relations Representative with any questions about the Blue KC provider portal.



## PPO, HMO and EPO Defined

### **Definition**

Blue KC offers the region's premier preferred provider (PPO), health maintenance organizations (HMO) and exclusive provider organizations (EPO), better known as PPOs, HMOs and EPO:

Blue-Care HMO, Preferred-Care PPO, Preferred-Care Blue PPO, Blue Access PPO, BlueSelect PPO and BlueSelect Plus PPO.

### **PCP Requirements**

All members participating in an HMO product must select a Primary Care Physician (PCP). PCP referrals are not required within the commercial HMO network. (For Blue Medicare Advantage HMO information see, Contact | Resource Directory.)

A physician and his/her office staff may not use the Blue Cross and Blue Shield name, publication, symbol or trademark without first obtaining Blue KC's prior written consent, and shall cease any such usage or publication upon receipt of written notice from Blue KC staff withdrawing such consent or upon contract termination by either the provider or Blue KC, whichever comes first.

## Consumer Driven Health Plan (CDHP) Components

A CDHP is typically represented by a high-deductible health plan and a tax advantaged account such as a Health Savings Account (HSA) or a Health Reimbursement Account (HRA). These tax-advantaged accounts work to the advantage of both the employer and the employee.

A Health Savings Account (HSA) is an account owned by an individual, which is used to pay for current or future medical expenses. Both individuals and employers can make contributions to an HSA account up to federally defined limits. These accounts are portable and can be carried over year to year. A Health Reimbursement Account (HRA) is similar in concept to an HSA, but unlike HSAs, HRAs must be funded solely by the employer and are typically not portable. While not required, most HRAs are linked to high deductible plans. HRAs are typically funded on receipt of claims.



## **High-Deductible Health Plans**

A high-deductible health plan compatible with HSAs is a medical plan that has specified minimum and maximum limits on deductible and out-of-pocket amounts that are updated annually. Blue KC offers BlueSaver, our high-deductible health plan, to all market segments (i.e. direct pay, small group and large group).

To qualify as an HSA compliant plan, federal legislation requires that BlueSaver plans cannot have embedded (or stacked) deductible where the individual deductible falls below \$2,600 in 2017. Therefore, plans with individual deductibles lower than this amount have aggregate deductibles. With an aggregate deductible, the entire family deductible must be satisfied before benefits for any covered person under the policy will be paid. This method of accumulating a deductible only applies to plan designs with an individual deductible lower than the deductible amounts previously specified.



## **Member Rights and Responsibilities**

Note: This information is written from the member as reader perspective.

Blue KC members have certain rights and responsibilities, as outlined below. Blue KC members have the right to:

- Receive considerate and courteous care with respect and recognition of personal privacy, dignity and confidentiality.
- Have a candid discussion of medically necessary and appropriate treatment options or services for your condition from any participating physician, regardless of cost or benefit.
- Receive medically necessary and appropriate care or services from any participating physician or other participating healthcare provider from those available as listed in your managed care plan directory or from any nonparticipating physician or other healthcare provider.
- Receive information and diagnosis in clear and understandable terms, and ask questions to ensure you understand what you are told by your physician and other medical personnel.
- Participate with providers and practitioners in making decisions about your healthcare, including accepting and refusing medical or surgical treatments.

- Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event you cannot participate in decision making.
- Discuss your medical records with your physician and have health records kept confidential, except when disclosure is required by law or to further your treatment.
- Be provided with information about your managed healthcare plan, its services and the practitioners and providers providing care, as well as have the opportunity to make recommendations about your rights and responsibilities.
- Communicate any concerns with your managed healthcare plan, regarding care or services you received, receive an answer to those concerns within a reasonable time, and initiate the complaint and grievance procedure if you are not satisfied.



Blue KC members have the responsibility to:

- Respect the dignity of other members and those who provide care and services through your managed healthcare plan.
- Ask questions of your treatment physician or treatment provider until you fully understand the care you are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the mutually agreed upon plans and instructions for care that you have discussed with your healthcare practitioner, including those regarding medications.
   Comply with all treatment follow-up plans, and be aware of the medical consequences of not following instructions.

- Communicate openly and honestly with your treatment provider regarding your medical history, health conditions, and the care you receive.
- Keep all scheduled healthcare appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.
- Know how to use the services of your managed healthcare properly.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.



## **Privacy and Security**

## **Our Pledge to Our Members**

Blue Cross and Blue Shield of Kansas City (Blue KC) provides each member with a Notice of Privacy Practices (NOPP) which indicates how we will use and disclose their health information. The NOPP is available on our website.

We do not limit the amount or type of data we will provide you in treatment of our members (your patients) and similarly expect the exchange of accurate information to facilitate claims processing. We accept only HIPAA compliant transactions or paper claims.

## **Our Expectation of Our Providers**

Protecting PHI is everyone's business. Each of, us as a covered entity under HIPAA, has specific responsibilities for protecting and securing PHI.

If, in the course of your business operations, you receive PHI from us that is not for your patient(s) we want to know. While we may not consider it a breach because we are both covered entities and you have a responsibility for protecting PHI just as Blue KC does, it does mean that we have a potential process breakdown or opportunity for coaching. Notification of privacy issues and concerns should be sent to the Blue KC Privacy Office. See Contact | Resource Directory, HIPAA Privacy and Security for details.

If you notice inappropriately displayed or transmitted member information or receive unexpected or erroneous data, it may be an indicator that there is a problem with the Blue KC information systems environment. Quick reporting of what you see could help us in early detection of problems. Please contact us immediately. See Contact | Resource Directory, HIPAA Privacy and Security for details.

Providers calling customer service must be able to verify their identity and the patients by providing the following:

- Inquirer's name
- Inquirer's telephone number
- Provider number or Tax ID number
- Provider name
- Member's Blue KC ID number or Social Security number

Provider Hotline: 816-395-3929



# Member Identification and Verification of Eligibility

An individual's possession of a membership ID card is not a guarantee of eligibility or benefits. Always verify eligibility and benefits in advance of providing (non-urgent or non-emergent) services. Always verify another form of legal photo identification, such as a driver's license, passport or other government issued ID, to help prevent identity theft.

Member eligibility and benefits can be verified

- Online on the Provider Portal (see Contact | Resources Directory).
- By calling our Provider Hotline (see Contact | Resources Directory).

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## Fraud, Waste and Abuse

### What Constitutes Fraud, Waste and Abuse?

Fraud, Waste and Abuse (FWA) encompasses a wide range of improper billing practices. Blue KC is committed to identifying, investigating, correcting; and if necessary, referring to law enforcement officials, cases of suspected fraud, waste and abuse by either providers, pharmacies or members.

Note: The definitions of Fraud, Waste and Abuse herein are for reference only and may be subject to change depending upon applicable contract requirements and/or law, including without limitation, case law, statutes, regulations or administrative determinations.

### **Definitions of Fraud, Waste and Abuse**

- Fraud: In general, means knowing and willful deception, misrepresentation, or a reckless disregard of the facts with the intent to receive an unauthorized benefit.
- Waste: The expenditure, consumption, mismanagement, use of resources, practice of inefficient or ineffective procedures, systems, and/or controls to the detriment or potential detriment of entities.
- Abuse: Practices, which, while not necessarily meeting the legal definition of "fraud," conflicted with or take advantage of legally sanctioned standards or contract provisions.

Fraud generally involves a willful act. Waste is generally not considered criminally negligent action but rather a misuse of resources. Abuse involves actions that are inconsistent with acceptable fiscal, business or medical practices. Fraudulent or abusive practices include, but are not limited to, the following:



- Billing for services not actually performed.
- Falsifying a patient's diagnosis to justify tests, surgeries or procedures that aren't medically necessary.
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery.
- Upcoding billing for a more expensive service than the one actually performed.
- Unbundling billing separately for services that are typically billed together.
- Accepting kickbacks for patient referrals.
- Waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan.
- Billing a patient more than the deductible, co-pay and coinsurance amounts for services.

- Some examples of consumer healthcare fraud are:
  - Visiting numerous doctors ("doctor shopping") to get multiple prescriptions for the same drug is illegal in most states, including Missouri and Kansas.
  - Filing claims for services or medications not received.
  - o Forging or altering bills or receipts.
  - Using someone else's coverage or insurance card.
  - Allowing someone else to use your insurance card.

Blue KC is committed to identifying, investigating, correcting and referring to law enforcement officials' cases of suspected fraud or abuse by either providers, pharmacies or members.



## **Applicable Laws**

The following information provides an overview of certain laws that apply to providers.

#### The Civil False Claims Act

Prohibits the following:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer;
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

#### **Penalties**

The damages may be tripled. Civil Money Penalty between \$10,781 and \$21,563 for each claim.

#### The Anti-Kickback Statute

Prohibits: Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

#### **Penalties**

Fine of up to \$25,000, imprisonment up to five (5) years, or both fine and imprisonment.

### The Stark Statue (Physician Self-Referral Law)

Prohibits: A physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

#### **Penalties**

Up to a \$15,000 fine for each service provided. Up to a \$100,000 fine for entering into an arrangement or scheme.

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Provider Hotline: 816-395-3929



#### The Whistleblower Protection Act

- Allows employees to stop, report, or testify about employer actions that are illegal, unhealthy, or violate specific public policies.
- Protects those who report illegal activity from retaliation.
- The Whistleblower Protection Enhancement Act of 2012 protects federal employees who disclose evidence of waste, fraud, or abuse.
- Awards for whistleblowers range between 15 and 25 percent of the funds recovered.

## **Blue KC Right to Audit**

Blue KC may conduct audits and/or reviews of services in accordance with your Physician Participation Agreement/Physician Network Agreement including any incorporated Amendments, Article 5.13 *Blue KC Right to Audit*. These audits may consist of, but shall not necessarily be limited to, verification of services reported to Blue KC and medical necessity of services and quality of care provided. Blue KC may recover or offset any amount related to billing code errors. There is no time limitation on recovery or offset in instances of fraud and the right to recover or offset shall not be affected by termination of this agreement.



## **Surveillance and Audit Procedures**

Procedures and mechanisms employed in the detection of possible fraud and abuse include, but are not limited to:

- Review of member profiles of use of services and payment made for such, including pharmacy utilization.
- Review of provider claims and payment history for patterns indicating need for closer scrutiny.
- Computer-generated listing of duplication of payments.
- Field auditing activities.
- The use of third party audit vendors for claim overpayment recovery.

- Computer-generated listing of conflicting dates of services.
- Computer-generated overutilization listing.
- Internal checks on such items as claims pricing, procedures, quantity, duration, deductibles, coinsurance, provider eligibility, member eligibility, etc.
- Medical staff review and application for established medical service parameters.
- Pre-pay and post-pay audits to identify FWA and for overpayment recovery.

See Contact | Resource Directory for information on reporting suspected fraud. Providers may also use these contact options to report suspicions or allegations of Fraud or Abuse anonymously.



## **Post-Payment Audits**

Blue KC conducts post-payment audits of patient records and adjudicated claims to verify compliance with Blue KC medical and payment policies, CMS regulations, including medical necessity, established standards of care and appropriate coding. Post-payment audits can range from a basic encounter audit to determine if the level of care is accurately billed, to a complete audit which thoroughly examines all aspects of the medical record and medical practice to determine if the services billed are supported. Post-payment audits are performed after the service(s) is billed and payments have been received by the provider. If medical necessity is not supported by the medical record, Blue KC will deny as not medically necessary.

Documentation in the medical record must reflect the healthcare services rendered to the patient. The provider shall maintain medical, financial, accounting and other records and will:

- Provide complete records upon request in accordance with your Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments, which includes but is not necessarily limited to Article 2.10 Maintenance of Records; BCBSKC Access to Records (records to be provided upon request).
- Utilize the Blue KC standards for documentation of medical services. These standards are documented in the Health Services module of the Provider Office Guide.

If the records are not received within the timeline indicated in the request letter (typically 30-60 days):

- A technical denial of the claim may be issued and the overpayment recovery process initiated.
- The provider may be placed on pre-payment review status.
- The provider may be considered in breach of our agreement and may result in termination of participation (in accordance with Article 2.12 Effect of Refusal to Grant Access to Records of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments).

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Providers.BlueKC.com

Provider Hotline: 816-395-3929



#### **Medical Records for Post-Payment Audits**

The provider shall maintain, in accordance with standard and accepted practices and Blue KC standards, such medical, financial, accounting and other records, in an organized record-keeping system.

The first copy of any records requested by Blue KC, its authorized representatives or agents or any governmental agency shall be provided by the provider at no cost to the requesting party. Records or copies of records requested by Blue KC the shall be provided within the timeframe outlined from the date such request is made; however, records shall be provided on an expedited basis where necessary for Blue KC to conduct a medical records review on an expedited basis, or in the case of an audit or site visit by Blue KC, such records or copies of records shall be provided at the time of the audit or site visit. Site visits, audits, or any other inspection of books and records shall occur during regular business hours.

If you are unable to provide the requested documentation within thirty (30) calendar days from the date of the letter, please contact your provider relations representative for assistance.

#### **Documentation of Medical Services for Post-Payment Audits**

Medical records are expected to contain all elements required in order to file and substantiate a claim for services as well as the appropriate level of care, i.e. evaluation and management services.

Letters/checklist are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be untestable to the reviewer.

#### **Post-payment Audit Dispute Process**

#### 1. First-Level Dispute

Services denied as a part of the post-pay audit process may be disputed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided with the dispute. The dispute determination will be made by a clinical peer within 30 days of receipt of the appeal. Submit the appeal as instructed in the findings letter containing the determination or outcome of the Post-Payment Audit.

#### 2. Second-Level Dispute

A provider may request a second and final dispute in writing within 30 days of notification of the first-level appeal determination. Submit the dispute as instructed in the letter containing the determination of the First-Level Dispute.

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Providers.BlueKC.com
Provider Hotline: 816-395-3929



## **Provider Directory Information Changes**

To keep your data up to date and as appropriate, available in the Provider directory, follow these steps.

To submit rosters or change files alone,

1. Email the roster and/or change file to Provider\_Data@BlueKC.com.

To submit changes impacting provider directory information (not rosters or change files)

- 1. Download the Provider Demographic Changes form from the provider portal (Login to <u>Providers.BlueKC.com</u>, click Forms).
- 2. Complete the form.
- 3. Email the completed form with any required supporting documents to Provider\_Data@BlueKC.com.

Once a completed submission—including supporting documents—is submitted, changes to your provider information will go into effect within 30 days from the date of your submission.

If your changes impact information in any or all of Blue KC's provider directories, those changes will be visible in those directories within 30 days from the date of your submission.

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Providers.BlueKC.com
Provider Hotline: 816-395-3929



## **Risk Adjustment Process**

Risk adjustment, a component of the Affordable Care Act (ACA), helps align payments to health plans with the risk characteristics of people enrolled in each plan.

Accurate risk adjustment relies on comprehensive, face-to-face health assessments of patients. These assessments result in appropriate medical record documentation and diagnosis coding. The diagnosis codes are then submitted to the health plan on a claim and used to determine the level of risk associated with the patient.

Blue KC has risk adjustment programs in place that align with our commitment to ensuring that quality of care is maintained through the physician-patient relationship. These programs help identify care and coding opportunities that can help prevent and/or detect conditions and encourage members to schedule health screenings, tests and vaccines.



## **HEDIS**

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS® is administered by the National Committee for Quality Assurance (NCQA). The accuracy of our reporting contributes directly to our success in the marketplace and ultimately to the success of your physicians. NCQA has expanded the size and scope of HEDIS to include measures for physicians, PPOs and other organizations. HEDIS 2017 will include 91 measures across 7 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare performance on an "apples-to-apples" basis.

The quality piece of our HEDIS® measurement requires that we access and copy information from member medical records. As defined by the Health Insurance Portability and Accountability Act (HIPAA), Blue KC is a "covered entity" and therefore we are legally bound to protect, preserve, and maintain the confidentiality of any protected health information (PHI) obtained from your office. You can be confident we will treat your patients' PHI with total protection and confidentiality.

The HEDIS® medical record data abstraction process begins in late January and finishes in late April.

Prior to conducting an on-site review, our abstractors will contact your office to determine who will be coordinating your HEDIS record requests, location of medical records and information regarding EMR (Electronic Medical Record) vendor, if applicable.

To minimize office disruption, we ask providers with 15 or less records to pull their records and submit to Blue KC via our secure Accellion system, fax-mail or U.S. mail. See HEDIS in Contact | Resource Directory for details.

As a reminder, Article 2.10 Maintenance of Records; BCBSKC Access to Records of the Physician Network Agreement and the Physician Arrangement Agreement (as amended by Amendment One) states that the first copy of any records requested by Payor, its' authorized representatives or agents or any governmental agency or its' representatives or agents shall be provided by the physician at no cost to the requesting party. This includes records provided by a copy service. Please make the data available within 30 days or sooner. The use of a copy service often involves delays in obtaining necessary information. Please be sure these requests are forwarded promptly and followed-up on to ensure timely delivery. If you have questions or concerns about payment, please contact your Provider Relations representative.

We are committed to working with you to obtain the necessary information with minimal disruption to your workflow. Thank you for partnering with us to improve the health of our members.



# Blue Distinction Center and Blue Distinction Center+

The Blue Distinction Specialty Care Program is a national designation program that recognizes healthcare facilities that demonstrate expertise in delivering quality specialty care—safely, effectively, and cost efficiently—through two levels of designation across seven areas of specialty care.

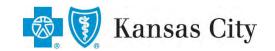
2 Levels		7 Areas of Care			
Blue Distinction® Center	Healthcare facilities recognized for their <b>expertise</b> in delivering specialty care	Bariatric Surgery Cardiac Care Complex and Rare Cancers* Knee and Hip Replacement			
Blue Distinction® Center+	Healthcare facilities recognized for their expertise and efficiency in delivering specialty care	Maternity Care Spine Surgery Transplants *Blue Distinction Center designation only			

Only those facilities that first meet nationally established, objective quality measures for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+. See Contact | Resource Directory.

## **Blue Distinction Total Care**

Blue Distinction Total Care (BDTC) is a delivery model designed to improve specific aspects of the healthcare delivery system. The Primary Care Physicians (PCP) engaged in this delivery model will play a key role in the transformation of the delivery system. Blue KC has designed compensation methodologies that reward physicians for managing the care of their patients giving attention to cost, quality, and patient satisfaction. For further information see the Blue Distinction Total Care provider manual on the provider portal. See Contact | Resource Directory.

Blue KC Provider Office Guide Effective: December 2017



Abbro	eviations				
ABN	Advanced Benefit Notification	HEDIS	Healthcare Effectiveness Data and Information Set		
ACA	Affordable Care Act	ННА	Home Health Agency		
AFHC	Away From Home Care	HIPAA	Health Insurance Portability and Accountability Act		
ASK	Administrative Services of Kansas	HIT	Home Infusion Therapy		
ASO	Administrative Services Only	НМО	Health Maintenance Organization		
Blue KC	Blue Cross and Blue Shield of Kansas	HRA	Health Reimbursement Account		
BDTC	Blue Distinction Total Care	HSA	Health Savings Account		
BNDD	Bureau of Narcotics and Dangerous Drugs	IVR	Interactive Voice Response		
BQCT	Blue Quality Center for Transplant	MA	Medicare Advantage		
CAD	Coronary Artery Disease	MM	Medical Management		
CAQH	Council for Affordable Quality Healthcare	MPMC	Medical and Pharmacy Management Committee		
CDHC	Consumer Directed Health Care	MSA	Medical Savings Account		
CDHP	Consumer Directed Health Plan	MSN	Medicare Summary Notice		
CMN	Certification of Medical Necessity	NCQA	National Committee for Quality Assurance		
CMS	Centers for Medicare & Medicaid Services	NDC	National Drug Code		
COB	Coordination Of Benefits	NOC	Not Otherwise Classified		
COBRA	Consolidated Omnibus Budget Reconciliation Act	NPI	National Provider Identifier		
COPD	Chronic Obstructive Pulmonary Diseases	OB/GYN	Obstetrics/Gynecology		
CPT	Current Procedural Terminology	OPL	Other Party Liability		
CRNA	Certified Registered Nurse Anesthetist	OPM	Office of Personnel Management		
DEA	Drug Enforcement Administration	PCP	Primary Care Physician		
DM	Disease Management	PDL	Prescription Drug List		
DME	Durable Medical Equipment	PFFS	Private Fee For Service		
EFT	Electronic Funds Transfer	RVU	Relative Value Units		
EMS	Electronic Media Services	POS	Point of Service		
EOB	Explanation of Benefits	PPO	Preferred Provider Organization		
EPO	Exclusive Provider Organization	QI	Quality Improvement		
ESI	Express Scripts Inc.	RA	Remittance Advice		
ESRD	End Stage Renal Disease	RBRVS	Resource Based Relative Value System		
FEHB	Federal Employee Health Benefits	SCHIP	State Children's Health Insurance Plan		
FEP	Federal Employee Program	SNP	Special Needs Plan		
FSA	Flexible Spending Account	TPN	Total Parenteral Nutrition		

Blue KC Provider Office Guide Effective: December 2017

Provider Hotline: 816-395-3929



FWA	Fraud, Waste and Abuse	UM	Utilization Management
HCFA	Health Care Financing Administration (now CMS)	URAC	Utilization Review Accreditation Commission
HCPCS	Healthcare Common Procedure Coding System		



# Blue KC Provider Office Guide

Blue KC Network Descriptions Module

## **Provider Office Guide**

The Blue Cross and Blue Shield of Kansas City (Blue KC) Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue KC. The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)
- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.



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Note: It is extremely important that contracted providers know which of these networks they participate in.

Note: Please verify that you are a participating provider in the specific network prior to rendering services. If you have questions about our networks, please contact your Provider Relations Representative.

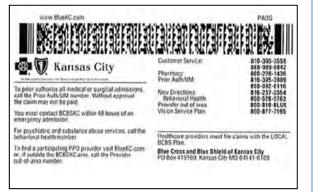
A local member's Blue Cross and Blue Shield of Kansas City (Blue KC) ID card is imprinted with the plan/network name and the Blue KC name and logo.



## **BlueAccess**

BlueAccess is a limited PPO network available for the Blue4U PPO product in the Individual market only. See <u>Plans Service Areas</u> below.

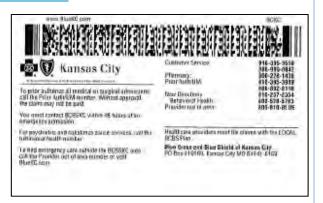




## **Blue-Care**

Blue-Care, HMO network. See Plans Service Areas below.







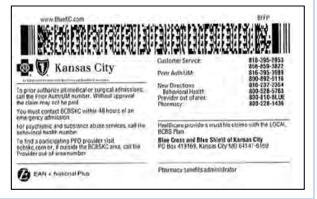
## **Blue Medicare Advantage (HMO)**

Blue Medicare Advantage (HMO) is a local Blue KC plan and network. See the Blue Medicare Advantage Provider Admin Manual located at provider.bluekcma.com.

## **BlueSelect**

BlueSelect, limited PPO network. See Plans Service Areas below.



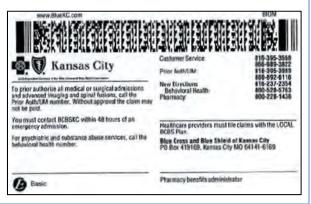




## BlueSelect for Basic Individual

BlueSelect for Basic Individual, limited provider network. BlueSelect for Basic Individual does not include the national Blue Cross and Blue Shield BlueCard® network of participating providers who are outside of the 5-county metro KC area. See Plans Service Areas below.





## **BlueSelect Plus**

BlueSelect Plus, limited PPO network. See Plans Service Areas below.



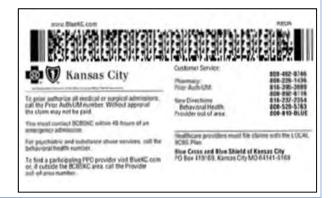




## **Preferred-Care**

Preferred-Care, PPO network. See Plans Service Areas below.

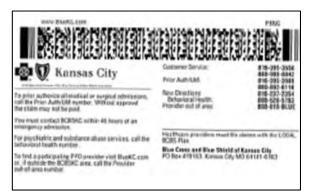




## **Preferred-Care Blue**

Preferred-Care Blue® PPO. See Plans Service Areas below.







## **Blue KC Network's Service Areas**

Kansas counties: Johnson and Wyandotte

Missouri counties: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth

If you have questions about our networks, please contact your Provider Relations Representative. Network design is based on business and member needs.

Note: BlueAccess is a limited network that may or may not have any providers in the Blue KC counties listed below.

State	County	Blue- Care	BlueSelect	BlueSelect Basic Ind.	BlueSelect Plus	Preferred- Care	Preferred- Care Blue
KS	Johnson	х	Х	х	Х	Х	х
	Wyandotte	х	х	х	х	Х	х
	Andrew	Х				Х	Х
	Atchison					Х	Х
	Bates					Х	Х
	Benton					Х	Х
	Buchanan	Х				Х	Х
	Caldwell					Х	Х
	Carroll					Х	Х
	Cass	Х				Х	Х
	Clay	Х	Х	Х	Х	Х	Х
	Clinton					Х	Х
	Daviess					Х	х
	DeKalb					Х	Х
	Gentry					Х	Х
	Grundy					Х	Х
MO	Harrison					Х	Х
Σ	Henry					Х	Х
	Holt					Х	Х
	Jackson	Х	Х	Х	Х	Х	Х
	Johnson	Х				Х	Х
	Lafayette	Х				Х	Х
	Livingston					Х	Х
	Mercer					Х	Х
	Nodaway					Х	Х
	Pettis					Х	Х
	Platte	Х	Х	Х	Х	Х	Х
	Ray	Х				Х	Х
	St. Clair					Х	Х
	Saline					Х	Х
	Vernon					Х	Х
	Worth					Х	Х



# Blue KC Provider Office Guide

BlueCard Module

# **Provider Office Guide**

The Blue KC Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue Cross and Blue Shield of Kansas City (Blue KC). The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

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# Introduction: BlueCard Program Makes Filing Claims Easy

As a participating provider of Blue KC you may render services to patients who are National Account members of other Blue Plans, and who travel or live in the Blue KC service area.

This manual describes the advantages of the program, and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

# What is the BlueCard Program?

#### **Definition**

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution.



# **BlueCard Program Advantages to Providers**

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Blue KC. Blue KC will be your only point of contact for all of your claims-related questions.

More than 325,000 other Blue Plans' members are currently residing in Blue KC's service area.

Blue KC continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. Working together, we can ensure your patients will have a positive experience at each visit.

### Products included in BlueCard

A variety of products and claim types may be eligible to be delivered via BlueCard, however not all Blue Plans offer all of these products to their members. Currently Blue KC offers products indicated by the asterisk below, however you may see members from other Blue Plans who are enrolled in the other products:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)\*
- EPO (Exclusive Provider Organization)\*
- POS (Point of Service)
- HMO (Health Maintenance Organization)\*
  - HMO claims are eligible to be processed under the BlueCard
     Program or through the Away From Home Care Program.
- BlueCard Worldwide Program claims
- GeoBlue Expat claims
- Medigap Medicare Complementary/Supplemental\*
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards will not have a suitcase logo.
- Stand-alone SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These member ID cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo.
- Standalone vision
- Standalone prescription drugs



Note: Standalone vision and standalone self-administered

prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back

of the ID cards.

Note: Definitions of the above products are available in the

Glossary of Terms section of this Manual.

## **Products Excluded from the BlueCard Program**

The following claims are excluded from the BlueCard Program:

- Standalone dental
- Vision delivered through an intermediary model (using a vendor)
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Medicaid and SCHIP that is part of the Medicaid program
- Medicare Advantage\*
- The Federal Employee Program (FEP)

Please follow Blue KC billing guidelines.

\*Medicare Advantage is a separate program from BlueCard, and delivered through its own centrally-administered platform. See our Medicare for Other Blue Plans module for details.

Note: Blue KC offers the Blue Medicare Advantage HMO product. See the Contact | Resource Directory for information on reaching the local Blue Medicare Advantage provider support.



# **How the BlueCard Program Works**



In the example above, suppose a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another Plan's service area, in this example, Illinois:

- 1) If the member was traveling in Illinois or
- 2) If the member resided in Illinois and had employer-provided coverage through BlueCross BlueShield of Tennessee.

Note: Members are not obligated to identify participating providers through either of these methods but it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits



When the member makes an appointment and/or sees a Kansas City BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility Line at 1-800-676-BLUE (2583). The provider also may obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue KC.

After rendering services, the provider in Kansas City files a claim locally with Blue KC. Blue KC forwards the claim to BlueCross BlueShield of Tennessee that adjudicates the claim according to the member's benefits and the provider's arrangement with the Kansas City Plan. When the claim is finalized, the Tennessee Plan issues an explanation of benefit or EOB to the member and the Illinois Plan issues the explanation of payment or remittance advice to its provider and pays the provider.



# **How to Identify Members**

#### Member ID Cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

The main identifier for out-of-area members is the alpha prefix. The ID cards also may have:

- PPO in a suitcase logo, for eligible PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank suitcase logo

Important facts concerning member IDs:

- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the alpha prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

Examples of ID numbers:

ABC1234567

ABC1234H567

ABC12345678901234

Alpha

Alpha

Prefix

Prefix

ABC12345678901234

Prefix



As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 1-800-676-BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.

Remember: Member ID numbers must be reported exactly as

shown on the ID card and must not be altered. Do not add or omit any characters from the member ID

numbers.

#### Alpha Prefix

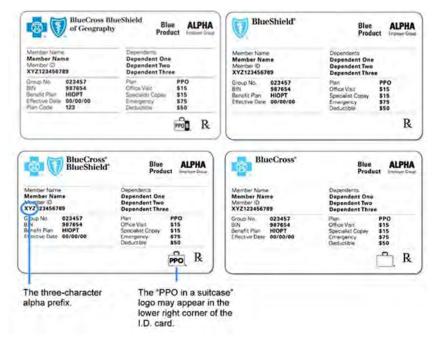
The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff.

- Do not make up alpha prefixes.
- Do not assume that the member's ID number is the social security number.
   All Blue Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.



#### Sample ID Cards



BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to Blue KC Preferred-Care PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Providers will be reimbursed for covered services in accordance with your Preferred-Care Blue PPO contract with Blue KC.

The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional or HMO coverage, you will be reimbursed according to Blue KC traditional provider contract.



Some Blue Plans ID cards don't have any suitcase logo on them. The ID cards for Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While Blue KC routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Plan via the established electronic crossover process.

Tip: While Blue KC routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic Medicare crossover process.

# **Summary: BlueCard Host Products Accessing Blue KC Networks**

Product	ID Card logo	Blue KC Network
Standard PPO/EPO	PPO suitcase logo	Preferred-Care
HMO/Traditional	Empty suitcase logo	Participating
*Alternative PPO	Preferred-Care Blue logo	Preferred-Care Blue
PPO Basic	PPOB suitcase logo	Preferred-Care Blue

<sup>\*</sup> Alternative PPO ID cards will also have a PPO suitcase logo which is used when services are rendered outside the Blue KC service area.

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Providers.BlueKC.com

Provider Hotline: 816-395-3929



# **BlueCard HMO Product**

The BlueCard Program offers HMO members access to local provider networks while traveling outside of their Plan area. These members have an empty suitcase logo on their ID card and have access to the participating network. As with the BlueCard PPO Program, the providers should call **800-676-BLUE (2583)** to obtain HMO member eligibility, benefits and precertification information. All claims are submitted to Blue KC.

#### **Benefits**

The HMO benefit delivery as determined by the member's Blues Plan may vary for non-emergent services. However, the BlueCard Program supports Urgent and Follow-Up care as follows:

- Urgent Care is available to HMO members who become ill or injured while traveling and cannot reasonably wait until returning home. They will call the National Call Center 800-810-BLUE (2583) to locate a Participating BCBS provider.
- Follow-Up Care is a pre-arranged treatment for an illness or injury that
  originates before the member leaves home. The member's Blues Plan and
  PCP have approved certain services by where a written acknowledgement
  should be available from the member prior to receiving care outside the area.

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Providers.BlueKC.com

Provider Hotline: 816-395-3929



# How to Handle Claims for Blue HMO Members Affiliated with other Blue Plans

You may see Blue HMO members affiliated with other Blue Plans who will be seeking care at your office or facility.

You should handle claims for these members the same way as you do Blue Cross and Blue KC Traditional or PPO members by submitting them to Blue KC through the BlueCard Program®.

You can identify Blue HMO members from other Blue Plans by the three-character alpha prefix preceding the member's identification number on their ID card.

You may also see the empty suitcase identifier, which indicates that the claim should be filed through the BlueCard Program.

Here's how to handle claims for Blue HMO members affiliated with other Blue Plans:

- 1. With the member's ID card in hand, call BlueCard Eligibility at **800-676-BLUE (2583)**.
  - a. Quick Tip: for faster processing, use electronic capabilities.
- 2. When prompted, provide the first three characters of the member's ID number (alpha prefix).
- 3. Once the member receives care, please do not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, coinsurance, and non-covered services).
- 4. Submit the member's claim with the member's complete identification number, which includes the alpha prefix, to Blue Cross and Blue Shield of Kansas City. Blue KC will send you a Remittance Advice.

# BlueCard Accounts Using the Preferred-Care Blue Network (PCB)

Blue KC has entered into an agreement with a few BCBS Plans for the use of the PCB network in the Kansas City area. The Preferred-Care Blue network logo is on the ID cards along with the PPO suitcase logo. The members receiving services in the 32-county service area must utilize the PCB network to obtain a higher benefit level. The PPO suitcase applies to services rendered outside of our service area.



## **How to Identify International Members**

Occasionally, you may see identification cards from members of International Licensees. Currently those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross and BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, Blue Cross Blue Shield of Costa Rica and GeoBlue, but if in doubt, always check with Blue KC as the list of International Licensees may change. ID cards from these Licensees will also contain three-character alpha prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to Blue KC.

Example of an ID card from an International Licensee:





#### Canadian ID Cards

Note: The Canadian Association of Blue Cross Plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.



Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

Alberta Blue Cross Ontario Blue Cross Quebec Blue Cross

Manitoba Blue Cross Pacific Blue Cross Saskatchewan Blue

Medavie Blue Cross Cross

Source: <a href="http://www.bluecross.ca/en/contact.html">http://www.bluecross.ca/en/contact.html</a>



# Consumer Directed Healthcare and Healthcare Debit Cards

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

Members who have Consumer-Directed Healthcare (CDHC) plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "stand-alone" debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard $^{\circ}$  or Visa $^{\circ}$ .



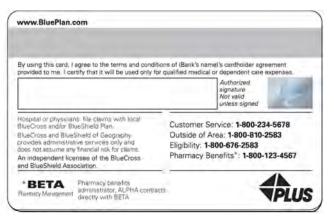
Below is a sample stand-alone healthcare debit card:





Below is a sample combined healthcare debit card and member ID card:





The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e. copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.



#### Helpful Tips:

- Using the member's current member ID number, including alpha prefix, carefully determine the member's financial responsibility before processing payment. Check eligibility and benefits electronically through **Blue KC** or by calling 1-800-676-BLUE (2583).
- All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to **Blue KC** for proper benefit determination, and to update the member's claim history.
- Please do not use the card to process full payment up front. If you have any
  questions about the member's benefits, please contact 1-800-676-BLUE
  (2583) or, for questions about the healthcare debit card processing
  instructions or payment issues, please contact the toll-free debit card
  administrator's number on the back of the card.

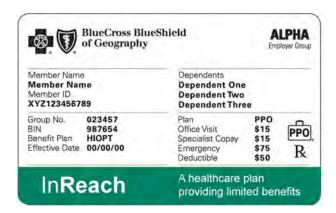


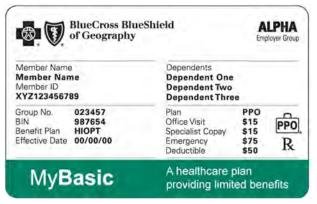
# How to recognize members with limited benefits products?

Members with Blue limited benefits coverage (that is, annual benefits limited to \$50,000 or less) carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as InReach or MyBasic
- A green stripe at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A black cross and/or shield to help differentiate it from other identification cards

These ID cards may look like this:







#### How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility.

You may do so electronically by submitting HIPAA 270 eligibility inquiry to Blue KC at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> or via an Electronic Data Interchange (EDI) transaction or may call 1-800-676-BLUE (2583) eligibility line for out-of-area members.

Both electronically and via phone, you will receive patient's accumulated benefits to help you understand the remaining benefits left for the member.

#### Tips

- In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, always verify eligibility and benefits electronically with **Blue KC** or by calling 1-800-676-BLUE (2583). You will receive the member's accumulated benefits to help you understand his/her remaining benefits.
- If the cost of service extends beyond the member's benefit coverage limit, please inform your patient of any additional liability he/she might have.
- If you have questions regarding a Blue Plan's limited benefits ID card/product, please contact **Blue KC**.

If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

# What should I do if the patient's benefits are exhausted before the end of their treatment?

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment are the member's liability.

We recommend that you inform the patient of any potential liability they might have as soon as possible.



### **Reference Based Benefits**

With healthcare costs increasing, employers are placing a greater emphasis on employee accountability by encouraging members to take a more active role while making healthcare decisions. Plans have begun to introduce Reference Based Benefits, which limit allowables for certain (or specific) benefits to a dollar amount that incents members to actively shop for healthcare for those services.

The goal of Reference Based Benefits is to have members engage in their health choices by giving them an incentive to shop for cost effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated "reference cost" ceiling for a single episode of service. Due to the possibility of increased member cost sharing, Reference Based Benefits will incent members to use Plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost effective providers and/or facilities that charge at or below the reference cost ceiling.

#### How does Reference Based Benefits work?

Reference Based Benefits are a new benefit feature where the Plan will pay up to a pre-determined amount for specific procedures called a "Reference Cost." If the allowed amount exceeds the reference cost, that excess amount becomes the members' responsibility.

#### How are Reference Costs Established?

The reference costs are established for an episode of care based on claims data received by Blue KC from providers in your area.

#### How will I get paid?

Reference Based Benefits will not modify the current contracting amount agreed on between you and Blue KC. Providers can expect to receive their contract rate on all procedures where Reference Based Benefits apply.

Example 1: If a member has a reference cost of \$500 for an MRI of the spine and the allowable amount is \$700, then Blue KC will pay up to the \$500 for the procedure and the member is responsible for the \$200.

Example 2: If a member has a reference cost ceiling of \$600 for a CT scan of the Head/Brain and allowable amount is \$400, then Blue KC will pay up to the \$400 for the procedure.



#### How much will the member be responsible for out-of-pocket?

When Reference Based Benefits are applied and the cost of the services rendered is less than the reference cost ceiling, then Blue KC will pay eligible benefits as it has in the past; while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, co-pay, or deductible as normal.

If the cost of the services rendered exceeds the reference cost ceiling, then Blue KC will pay benefits up to that reference cost ceiling, while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, co-pay or deductible; as well as any amount above the reference cost ceiling up to the contractual amount.

# How will I be able to identify if a member is covered under Reference Based Benefits?

When you receive a response from a benefits and eligibility inquiry, you will be notified if a member is covered under Reference Based Benefits.

Additionally, you can call the Blue Eligibility number (800-676-2583) to verify if a member is covered under Reference Based Benefits.

# Do I need to do anything different if a member is covered under Reference Based Benefits?

While there are no additional steps that you need to take, you may want to verify the reference cost maximum prior to performing a procedure covered under Reference Based Benefits. You can check if Reference Based Benefits apply to professional and facility charges for the member, by submitting an electronic benefits and eligibility inquiry to your local Blue Plan. Alternatively, you can contact the member's Plan by calling the Blue Eligibility number (800-676-2583).

#### Do Reference Based Benefits apply to emergency services?

No. Reference Based Benefits are not applicable to any service that is urgent or emergent.

# Do Reference Based Benefits apply to benefits under the Affordable Care Act essential health benefits?

Yes. Reference Based Benefits are permitted under the ACA.

#### How does the member identify services at or below the reference cost?

Members with Reference-Based Benefits use consumer transparency tools to determine if a provider will deliver the service for less than the reference cost.



# How will the Reference Based Benefits cost apply to professional and facility charges?

For more information on how Reference Based Benefits will apply costs to the professional and facility charges please submit an electronic benefits and eligibility inquiry to the members local Blue Plan. If you have additional questions, you can contact the Blue Eligibility number (800-676-2583) for the member you are seeing. For Electronic Provider Access, see section 3.8.

# What if a member covered under Reference Based Benefits asks for additional information about their benefits?

Since members are subject to any charges above the reference cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost.

Also, you can direct members to view their Blue Plans transparency tools to learn more about the cost established for an episode of care.

#### What procedures are covered under Reference Based Benefits?

The following procedures will be covered under Reference Based Benefits:

\* Applicable services may vary by employer group.

#### Where do I submit the claim?

You should submit the claim to Blue KC under your current billing practices.

#### How will Reference Based Benefits be shown on a payment remittance?

When you receive payment for services the claim will pay per the member's benefits with any amount over the reference cost being applied to the Benefit Maximum.

#### Is there anything different that I need to submit with member claims?

No. You should continue to submit your claims as you previously have to Blue KC.



# **Coverage and Eligibility Verification**

For other Blue Plans' members, submit an electronic inquiry to Blue KC or call BlueCard Eligibility 1-800-676-BLUE (2583) to verify the patient's eligibility and coverage:

Electronic—Submit a HIPAA 270 transaction (eligibility) to Blue KC.

• You can receive real-time responses to your eligibility requests for out-ofarea members between 6 a.m. and Midnight, Central Time, Monday through Saturday.

Phone—Call BlueCard Eligibility 1-800-676-BLUE (2583)

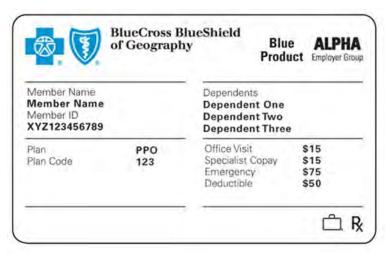
- English and Spanish speaking phone operators are available to assist you.
- Blue Plans are located throughout the country and may operate on a different time schedule than Blue KC. You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
- The BlueCard Eligibility line is for eligibility, benefit and precertification/referral authorization inquiries only. It should not be used for claim status. See the Claim Filing section for claim filing information.

#### Electronic Health ID Cards

- Some local BCBS Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.
- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
- A Blue electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.
- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and PlanID.
- The PlanID data element identifies the health plan that issued the ID card.
   PlanID will help providers facilitate health transactions among various payers in the market place.
- Providers will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 and 2 of the magnetic stripe; tracks 1 and 2 are proprietary to the financial industry).

Sample of electronic health ID card:







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# **Utilization Review**

You should remind patients that they are responsible for obtaining precertification/preauthorization for out-patient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see Provider Financial Responsibility). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

- 48 hours to notify the member's Plan of change in pre-service review; and
- 72 hours for emergency/urgent pre-service review notification.

General information on pre-certification/preauthorization information can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> (login, click Medical Policies, click BlueCard Medical Policies, click "click here") then use the three letter alpha prefix found on the member ID card to complete the search.

You may also contact the member's Plan on the member's behalf. You can do so by:

For other Blue Plans members:

- Call BlueCard Eligibility 1-800-676-BLUE (2583)—ask to be transferred to the utilization review area.
  - o When pre-certification/preauthorization for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles precertification/pre-authorization. You will choose from four options depending on the type of service for which you are calling:
    - Medical/Surgical
    - Behavioral Health
    - Diagnostic Imaging/Radiology
    - Durable/Home Medical Equipment (D/HME)

If you are inquiring about <u>both</u>, eligibility and pre-certification/pre-authorization, through 1-800-676-BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.



- Submit an electronic HIPAA 278 transaction (referral/authorization) to Blue KC.
- The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

# **Electronic Provider Access**

Electronic Provider Access gives providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The availability of EPA varies depending on the capabilities of each Home Plan. Some Home Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact Home Plans.



#### **Using the EPA Tool**

The first step for providers is to go to <u>Providers.BlueKC.com</u> and log in. Next, you will be asked to enter the alpha prefix from the member's ID card. The alpha prefix is the first three alpha characters that precede the member ID.

You can first check whether pre-certification is required by the Home Plan by either:

- 1. Sending a service-specific request through BlueExchange.
- 2. Accessing the Home Plan's pre-certification requirements via Medical Policies on the Provider Portal.

Entering the member's alpha prefix from the ID card automatically routes you to the Home Plan EPA landing page. This page welcomes you to the Home Plan portal and indicates that you have left Blue KC's portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The Home Plan landing page looks similar across Home Plans, but will be customized to the particular Home Plan based on the electronic pre-service review services they offer.



# Provider Financial Responsibility for Pre-Service Review for BlueCard® Members

Blue KC participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard® members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's Blue Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue Plan for pre-service review or for a change or modification of the pre-service review will result in claims being denied and/or sanctioned for inpatient facility services. The BlueCard® member must be held harmless and cannot be balance-billed if pre-service review has not occurred\*.

\*Unless the member signed a written consent to be billed prior to rendering the service.

Pre-service review contact information for a member's Blue Plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at Blue KC provider portal at <u>Providers.BlueKC.com</u>. Note: The availability of EPA will vary depending on the capabilities of each member's Blue Plan
- Submitting an ANSI 278 electronic transaction to Blue KC or calling 1-800-676-BLUE (2583).

Services that deny as not medically necessary remain member liability.

# Who do I contact if I have additional questions about Provider Financial Responsibility for Pre-Service Review?

If you have any questions on Provider Financial Responsibility or general questions, please call your Blue KC provider representative.

# Who do I contact if I have additional questions about Electronic Provider Access?

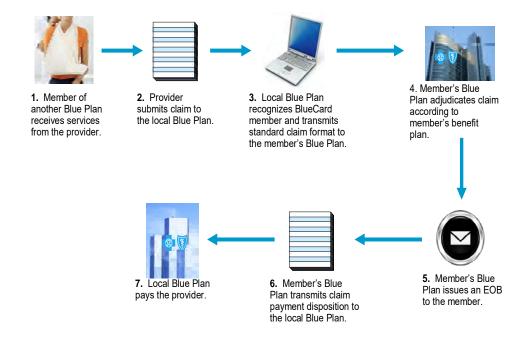
If you have any questions on how to use the EPA tool, please contact your Blue KC provider representative.



# **Claim Filing**

## How Claims Flow through BlueCard

Below is an example of how claims flow through BlueCard.



After the member of another Blue Plan receives services from you, you should file the claim with Blue KC. We will work with the member's Plan to process the claim and the member's Plan will send an explanation of benefit or EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the members benefits and coverage.

You should always submit claims to Blue KC.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically on the provider portal or by calling 1-800-676-BLUE (2583). Be sure to provide the member's alpha prefix.



- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=**F5** patient paid amount; on the CMS1500 locator **29** amount paid; on UB92 locator **54** prior payment; on UB04 locator **53** prior payment.)
- Submit all Blue claims to Blue KC. Be sure to include the member's complete
  identification number when you submit the claim. This includes the threecharacter alpha prefix. Submit claims with only valid alpha-prefixes; claims
  with incorrect or missing alpha prefixes and member identification numbers
  cannot be processed.
- In cases where there is more than one payer and a Blue Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue claim.
   Upon receipt, Blue KC will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment; Blue KC will reimburse you for services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claims status by contacting Blue KC or submitting an electronic HIPAA 276 transaction (claim status request) to Blue KC.

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Provider Hotline: 816-395-3929



# Health Insurance Marketplaces (a.k.a Exchanges)

# **Health Insurance Marketplaces Overview**

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (i.e. Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage through internet websites.



# **Exchange Individual Grace Period**

The Patient Protection and Affordable Care Act (PPACA) mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue KC indicating that the member is in the grace period.



# Exchange Individual Grace Period – Post Service Notification Letter to Provider

Communication to providers will include the following information:

	Claim #:	
2.	Name of the QHP and affiliated issuer (Home Plan name)	
3.	3. Explanation of the three month grace period:	
	Under the Patient Protection and Affordable Care Act (PPACA), there is a	
	three month grace period under Exchange-purchased individual insurance	

1. Notice-unique identification number (claim includes member information):

- Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.
- 4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period and individuals affected under the policy and possibly under care of the provider:
  Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.
- 5. Consequences: If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.
- 6. QHP customer service telephone number:
  Please contact Blue KC Monday through Friday, at 800-320-9550 if you have any questions regarding this claim.



## **Health Insurance Marketplaces Claims**

#### What else do I need to know?

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Blue KC for claims processing and handling such as outlined below

- Eligibility and Benefits
- Care Management
  - o Pre-Service Review
  - o Medical Policy
- · Claim Pricing and Processing
  - o Contracting
  - o Claim Filing
  - o Pricing
  - o Claim Processing
  - Medical Records
  - o Payment
  - o Customer Service



# **International Members**

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to Blue KC. See section for servicing international members and the note regarding members of the Canadian Blue Cross Plans.

# **Claims Coding**

Code claims as you would for Blue KC claims.



# **Ancillary Claims**

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  - o The Plan in whose state the specimen was drawn based on the location of the referring provider.
  - Durable/Home Medical Equipment and Supplies (D/HME)
    - o The Plan in whose state the equipment was shipped to or purchased at a retail store.
  - Specialty Pharmacy
    - o The Plan in whose state the Ordering Physician is located.
- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Providers are encouraged to verify member Eligibility and Benefits by contacting the phone number on the back of the member ID card or call 1-800-676-BLUE (2583), prior to providing any ancillary service.
- Providers who use outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should use in-network participating Ancillary Providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained on the Blue KC website (see Contact | Resource Directory).
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- If you have any questions about where to file your claim, please contact the BlueCard Provider Hotline (See Contact | Resource Directory).



Providor Typo	How to file (required	Where to file	Evample
Provider Type	How to file (required fields)	where to me	Example
Independent Clinical Laboratory (any type of non- hospital based laboratory) Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.	Referring Provider:  • Field 17B on CMS 1500 Health Insurance Claim Form or  • Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose state the <i>specimen was drawn*</i> * Where the <i>specimen was drawn</i> will be determined by which state the referring provider is located.	Blood is drawn* in a lab or office setting located in the Blue KC servicing area. Blood analysis is done in Nebraska (BCBSNE).  File to: Blue KC.  *Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn.
Durable/Home Medical Equipment and Supplies (D/HME)  Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc.	<ul> <li>Patient's Address:</li> <li>Field 5 on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2010CA on the 837 Professional Electronic Submission.</li> <li>Ordering Provider:</li> <li>Field 17B on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2420E (line level) on the 837 Professional Electronic Submission.</li> <li>Place of Service:</li> <li>Field 24B on the CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions.</li> <li>Service Facility Location Information:</li> <li>Field 32 on CMS 1500 Health Insurance Form or</li> <li>Loop 2310C (claim level) on the 837 Professional Electronic Submission.</li> </ul>	File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.	<ul> <li>A. Wheelchair is purchased at a retail store in Blue KC.</li> <li>File to: Blue KC</li> <li>B. Wheelchair is purchased on the internet from an online retail supplier in BCBSNE and shipped to Blue KC.</li> <li>File to: Blue KC</li> <li>C. Wheelchair is purchased at a retail store in Blue KC and shipped to BCBSNE.</li> <li>File to: BCBSNE</li> </ul>
Specialty	Referring Provider:	File the claim to the	Patient is seen by a physician
Pharmacy  Types of Service:  Non-routine, biological therapeutics ordered	<ul> <li>Field 17B on CMS 1500         Health Insurance Claim         Form or</li> <li>Loop 2310A (claim level)         on the 837 Professional</li> </ul>	Plan whose state the <i>Ordering</i> <i>Physician is</i> <i>located</i> .	in <b>Blue KC</b> service area who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in <b>BCBSNE</b> where

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Provider Type	How to file (required	Where to file	Example
	fields)		
by a healthcare professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited	Electronic Submission.		the member lives for 6 months of the year.  File to: Blue KC
to: injectable, infusion therapies, etc.			



# **Contiguous Counties**

Blue KC has elected to contract with providers in the following contiguous Kansas counties: Atchison, Douglas, Franklin, Leavenworth and Miami. Contracted providers will file claims for <u>Blue KC members</u> directly to Blue KC (rather than as BlueCard claims to Blue Cross and Blue Shield of Kansas). All other Blue member claims should be filed to Blue Cross and Blue Shield of Kansas.



# **Medical Records**

#### **Medical Records**

Blue Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

# Under what circumstances may the provider get requests for medical records for out-of-area members?

- As part of the pre-authorization process If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Plan that requested them.
  - This is the only circumstance where you would not submit them to Blue KC.
- 2. As part of claim review and adjudication These requests will come from Blue KC in the form of a letter, fax, email, or electronic communication requesting specific medical records and including instructions for submission.

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#### **BlueCard Medical Record Process for Claim Review**

- 1. An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
- 2. A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact BlueCard Provider Hotline (see Contact | Resource Directory) to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
- 3. If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Blue KC to determine if the records are needed from your office.
- 4. Upon receipt of the information, the claim will be reviewed to determine the benefits.



#### Ways You Can Assist in Timely Processing of Medical Records

- 1. If the records are requested following submission of the claim, forward all requested medical records to Blue KC.
- 2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- 3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue KC.
- 4. Please submit the information to Blue KC as soon as possible to avoid further delay.
- 5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
- 6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

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# **Adjustments**

Contact Blue KC if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

# **Appeals**

Appeals for all claims are handled through Blue KC. If the initial denial is upheld following the submission of a claim inquiry form, a formal appeal can be submitted by sending a second claim inquiry form with a formal appeal letter attached and any additional medical records or documentation. Blue KC will coordinate the appeal process with the member's Blue Plan, if needed.



# Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more than one health plan, and:

- Blue KC or any other Blue Plan is the primary payer, submit the other carrier's name and address with the claim to Blue KC. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.
- Other non-Blue health plan is primary and Blue KC or any other Blue Plan is secondary, submit the claim to Blue KC only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden. Note: We can accept secondary claims electronically.
- Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Blue KC remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with Blue KC.
- For professional claims, if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, either "YES" or "NO" be checked. Leaving the box unmarked can cause the member's Plan to stop the claim to investigate for COB.

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# **Claim Payment**

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple Explanations of Benefits (EOBs). Blue KC standard time for claims processing is 30 days. However, claim processing times at various Blue Plans vary.
- If you do not receive your payment or a response regarding your payment, please call Blue KC's BlueCard Provider hotline or check the provider portal (see Contact Details) to check the status of your claim.
- In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, Blue KC may either ask you for the information or give the member's Plan permission to contact you directly.

# **Claim Status Inquiry**

Blue KC is your single point of contact for all claim inquiries.

Claim status inquires can be done by:

- Electronically—send a HIPAA transaction 276 (claim status inquiry) to Blue KC.
- Phone—call Provider Hotline (see Contact | Resource Directory)



# Calls from Members and Others with Claim Questions

If other Blue Plan members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to Blue KC.

# **Key Contacts**

• See the Contact | Resource Directory for information on reaching BlueCard Customer Service or contact your Blue KC provider service representative (see Contact | Resource Directory).



# **Frequently Asked Questions**

### **BlueCard Basics**

#### What Is the BlueCard Program?

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you conveniently submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution.



#### What products are included in the BlueCard Program?

The following products/claims may be included in the BlueCard Program:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
- Medigap
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo.
- SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo.
   Standalone SCHIP programs will have a suitcase logo.
- Standalone vision
- Standalone prescription drugs

Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed thru BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

#### What products are excluded from the BlueCard Program?

The following products/claims are excluded from the BlueCard Program:

- Stand-alone dental
- Medicare Advantage\*
- The Federal Employee Program (FEP)

Please follow Blue KC billing guidelines.

#### What is the BlueCard Traditional Program?

It is a national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

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Providers.BlueKC.com

Provider Hotline: 816-395-3929



#### What is the BlueCard PPO Program?

It is a national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

#### Are HMO patients serviced through the BlueCard Program?

Yes, occasionally, Blue HMO members affiliated with other Blue Plans will seek care at your office or facility. You should handle claims for these members the same way as you do for Blue KC members and Blue traditional, PPO, and POS patients from other Blue Plans by submitting them to the Blue KC. Please be sure to always check the member's benefits. Some HMO members only have access to urgent/emergent care when they are outside of their home plan's servicing area.



## Identifying members and ID Cards

#### How do I identify members?

When members from Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out-of-area members is the alpha prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank suitcase logo

#### What is an "alpha prefix?"

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

### What do I do if a member has an identification card without an alpha prefix?

Some members may carry outdated identification cards that may not have an alpha prefix. Please request a current ID card from the member.

#### How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign Blue Plan members. These ID cards will contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.

#### What do I do if a member does not have an ID card?

Call the BlueCard Provider Hotline (see Contact | Resource Directory).



## **Verifying Eligibility and Coverage**

### How do I verify membership and coverage?

For other Blue Plan members, contact Blue KC electronically or BlueCard Eligibility by phone to verify the patient's eligibility and coverage:

- Electronic—Submit a HIPAA 270 transaction (eligibility) to Blue KC.
- Phone—Call BlueCard Eligibility (see Contact | Resource Directory).



### **Utilization Review**

#### How do I obtain utilization review?

You should remind patients that they are responsible for obtaining precertification/authorization for outpatient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility). See Utilization Review section.

You may also contact the member's Plan on the member's behalf. You can do so by:

For other Blue Plans members,

- Phone—Call the utilization management/pre-certification number on the back of the member's card. If the utilization management number is not listed on the back of the member's card, call BlueCard Eligibility 1-800-676-BLUE (2583) and ask to be transferred to the utilization review area.
- Electronic—Submit a HIPAA 278 transaction (referral/authorization) to Blue KC.

See Electronic Provider Access section.

### **Claims**

#### Where and how do I submit claims?

You should always submit claims to Blue KC electronically via Administrative Services of Kansas (ASK) or if necessary on paper. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. Do not make up alpha prefixes. Claims with incorrect or missing alpha prefixes and/or member identification numbers cannot be processed. See Claims document for details.

#### How do I submit claims for international Blue members?

The claim submission process for international Blue Plan members is the same for domestic Blue Plan members. You should submit the claim directly to Blue KC.



#### How do I handle COB claims?

If after calling 1-800-676-BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan and Blue KC is the primary payer, submit the claim with information regarding COB to Blue KC.

If you do not include the COB information with the claim, the member's Blue Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

#### How do I submit Medicare primary / Blue Plan secondary claims?

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification.

Be certain to include the alpha prefix as part of the member identification number. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. **DO NOT** resubmit that claim to Blue KC; duplicate claims will result in processing and payment delays.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue KC with the Medicare remittance advice. Blue KC also accepts electronic claims submissions.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, check <u>Providers.BlueKC.com</u> or call BlueCard Provider Hotline. See Contact | Resource Directory for details.



#### When will I get paid for claims?

If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs). Blue KC processes claims as quickly as possible, but claim processing times at various Blue Plans can vary.

If you do not receive your payment or a response regarding your payment, please call BlueCard Provider Hotline or visit our provider portal to check the status of your claim (see Contact | Resource Directory)

In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, Blue KC may either ask you for the information or give the member's Plan permission to contact you directly.

#### **Contacts**

#### Who do I contact with claims questions?

Check <u>Providers.BlueKC.com</u> or call BlueCard Provider Hotline. See Contact | Resource Directory for details.

#### How do I handle calls from members and others with claims questions?

If members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.

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# **Glossary of BlueCard Program Terms**

#### **Administrative Services Only (ASO)**

ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, coordination of benefits or timely filing limitations.

Blue KC receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

#### **Affordable Care Act**

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

#### **Alpha Prefix**

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The alpha prefix identifies the member's Blue Plan or National Account and is required for routing claims.

#### BlueCard Access® 1-800-810-BLUE (2583)

A toll-free 800 number for you and members to use to locate healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

#### BlueCard Eligibility® 1-800-676-BLUE (2583)

A toll-free 800 number for you to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans.

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Providers.BlueKC.com

Provider Hotline: 816-395-3929



#### **BlueCard PPO**

A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

#### **BlueCard PPO member**

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.



#### **Doctor and Hospital Finder Web Site**

www.bluekc.com/providerfinder

#### BlueCard Doctor and Hospital Finder Web Site

A Web site you can use to locate healthcare providers in another Blue Plan's area <a href="https://www.bluekc.com/providerfinder">www.bluekc.com/providerfinder</a>. This is useful when you need to refer the patient to a physician or healthcare facility in another location.

#### BlueCard Worldwide®

A medical assistance program that provides Blue members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

#### Consumer Directed Healthcare/Health Plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

#### Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

#### Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

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#### Co-payment

A specified charge that a member incurs for a specified service at the time the service is rendered.

#### **Deductible**

A flat amount the member incurs before the insurer will make any benefit payments.

#### **EPO**

An Exclusive Provider Organization or EPO is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

#### **FEP**

The Federal Employee Program.

#### **Hold Harmless**

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with a Blue Plan as full payment for these services.

#### Marketplace/Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA).

#### Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age six and low-income pregnant women, Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

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#### **Medicare Advantage**

"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

#### **Medicare Crossover**

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

#### Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn't cover.

Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

#### **National Account**

An employer group with employee and/or retiree locations in more than one Blue Plan's Service Area.



#### Other Party Liability (OPL)

Cost containment programs that ensure that Blue Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

#### **Plan**

Refers to any Blue Plan.

#### **POS**

Point of Service or POS is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

#### **PPO**

Preferred Provider Organization or PPO is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

#### **PPOB**

A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

#### Qualified Health Plan (QHP)

Under the Affordable Care Act, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

#### Small Business Health Options Program (SHOP)

A Health Insurance Marketplace that allows employers to choose the level of coverage and offer choices among health insurance plans.



#### State Children's Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

#### **Traditional Coverage**

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.



# **BlueCard Program Quick Tips**

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Plans with your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 1-800-676-BLUE (2583) to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to the local Plan.
- Submit the claim to Blue KC electronically via Administrative Services of Kansas (ASK) or if necessary on paper. Always include the patient's complete identification number, which includes the three-character alpha prefix. See Claims document for details.

For claims inquiries, check <u>Providers.BlueKC.com</u> or call BlueCard Provider Hotline. See Contact | Resource Directory for details.



# Blue KC Provider Office Guide

Claims, Remittance and Billing Module

## **Provider Office Guide**

The Blue KC Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue Cross and Blue Shield of Kansas City (Blue KC). The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)
- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.



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# **Claims Filing**

### **Submission of Claims**

To ensure payment is issued to the correct provider of service, here are claims submission tips:

For Electronic Claim Submission	For Paper Claims Submission
Send your Type I and/or Type II NPI(s) depending how you are set up with Blue KC.	Send your Blue KC eight-digit provider number(s). (The rendering Blue KC assigned eight- digit provider number goes in box 24J, and the group number goes in box 33B.)
Blue KC Payor ID Number: 47171	Blue KC Payor ID Number: 47171

- A local member's Blue Cross and Blue Shield of Kansas City (Blue KC) ID card will be imprinted with the plan/network name (examples: Preferred-Care, Preferred-Care Blue, Blue-Care, or etc.) and the Blue KC name and logos. See the Blue KC Networks Descriptions document for member ID card examples.
- Use Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes. Please ensure your office is using the current codes reflective of the date of service of the claim.
- Submit itemized bills for all physician services.
- Do not send a duplicate bill to Blue KC sooner than 30 days after submitting the original bill.
- If it is determined by Blue KC that the covered individual is not entitled to benefits, then such claims may be denied.
- The physician may be required to repay amounts erroneously paid, or amounts previously paid may be deducted from subsequent amounts due. Any additional amounts due to the physician shall be paid promptly.

### Who Must File Claims?

Participating physicians must file claims for all Blue KC members, as well as for members who have BCBS coverage through other Plans, for all practitioner services. PPO physicians, and at times HMO physicians, must also file claims for members who are part of self-funded groups who lease specific Blue KC networks. Physicians must always remember to include the alpha-prefix portion of the member identification number on all claim forms.

## Where to File

Claims filing information is printed on the back of a member's identification card. If a physician is unsure where to mail a claim, please call the Provider Hotline (see Contact | Resource Directory for details).



## **Timely Filing**

A regular follow-up approach is essential to ensure that a claim has been received for processing at Blue KC. In the Blue KC Physician Network Agreement Article 5.3, we ask that claims be filed within 30 days of the date of service but no later than 180 days in order to be considered for payment. For claims in which Blue KC is the secondary payer, we ask that claims be filed within 180 days of the date of service or 90 days from the Primary Carrier's payment.

We emphasize that the key step in the claims payment process is for your accounts receivable department to do complete remit reconciliation and then perform any necessary follow-up. A remit reconciliation confirms that the claim has been received. The majority of "clean" claims received by Blue KC are processed rapidly and, therefore, payment or a denial can be anticipated within 30 days. Claim status is available through the Blue KC provider portal, or by calling the Provider Hotline.

Claims Filing Requirements		
Primary	Claims should be filed within 30 days of the date of service but no later than 180 days to be considered for payment.	
Secondary	Claims should be filed within 180 days of the date of service or 90 days from the primary carrier's payment date with the Primary payer remittance. Please note: Blue KC accepts secondary claims electronically.	
Paper Claims	Note: CMS 1500 (paper claims only) still require Blue Cross and Blue Shield of Kansas City 8-digit provider numbers in both box 24J and in box 33B. The NPI is not necessary, but if your claims processing system is not able to separate out the NPI number, it may be included along with the provider numbers.	
	Next Step	
Claim	(Follow-Up at 30 days if no remittance)	
Verification	Visit the provider portal or call the Provider Hotline. See the Contact   Resource Directory for claims related information.	
	Next Step	
Written Inquiry	(Claim Inquiry Form)	
	Submit within 12 months of last processing date.	
Medical Policy Issues	Check medical policy on the provider portal.	
Clinical Editing Modifier	Check medical policy on the provider portal.	



Incorrect
<b>Allowable</b>

Request a copy of the current fee schedule from your Provider Relations Representative if your office does not have one.

### **Provider Electronic Claim Submissions**

- All Electronic Claims must be submitted to Administrative Services of Kansas (ASK).
- ASK accepts electronic claims directly or through a clearinghouse.
- After a claim file has been submitted to ASK a Claims Acknowledgement (277CA) is produced which indicates the status of each claim: rejected, or accepted. ASK will provide a 277CA to whomever submits the claim(s).
- If claim was rejected, it must be corrected and resubmitted.
- Accepted claims are transmitted to Blue KC for processing.
- If no payment or response is received within 30 days, check the provider portal or call Provider Hotline for status.
- Electronic Claim Submissions is the preferred method and saves providers time and money.

## **Timely filing**

File within 30 days, but no later than 180 days, from date of service.

Note: If you have any questions related to electronic claim submission, please contact ASK (see Contact | Resource Directory for details).



## Administrative Services of Kansas (ASK) - Claims Acknowledgement (277CA)

The Claims Acknowledgement (277CA) provides detailed information on all electronic claims that have been accepted or rejected. This information is vital to your office since it represents the actual accepted claims that will be forwarded to Blue KC for processing as well as rejected claims that must be corrected and resubmitted. ASK delivers a 277CA back to the original submitter (trading partner) of the electronic claim file. Some trading partners, such as clearinghouses, may reformat, repackage, or bundle the information in the 277CA into other various printed and electronic reports.

Important: It is your responsibility to become familiar with the processes and procedures of your clearinghouse in regards to their handling and distribution of the 277CA, so please initiate this discussion whenever you change software vendors and/or clearinghouses. Failure to reconcile the 277CA can result in Blue KC not receiving all the initial electronic claims that you intended to submit to us.

See the ASK website: for more information about

- electronic claim processes and the 277CA with training examples
- upcoming workshops
- register for ASK email notifications

See Contact | Resource Directory for ASK details.



## **Paper Claims**

#### Use this procedure to file a paper claim:

- 1. The Blue KC eight-digit provider number is required in box 24J and 33B on all paper claims. A claim with only the NPI number is unacceptable and will be returned.
- 2. Mail the completed claim form to the address indicated on the member's ID card.
- 3. If the claim does not appear on a remittance advice within 30 days, check the provider portal or call the Provider Hotline to make sure the claim was received.
- 4. If it is determined that the claim has not been received and processed, re-file the claim immediately.
  - a. **Timely filing** File within 30 days, but no later than 180 days, from date of service.
  - b. **Proof of timely filing** A certified mail return receipt.

Note: It is imperative to do a timely follow-up (please allow 30 days) on a first submission paper claim.



## **Member Billing**

Participating providers may collect the following payments from a member after Blue KC has processed the claim and issued a remittance advice:

- **Deductible:** A specific amount the member pays toward covered services before Blue KC begins to make payments.
- **Coinsurance:** A percentage of the Blue KC reimbursement allowable for a covered service that the member is required to pay.

Participating providers may collect the following payments from a member at the time of a visit:

- **Copayment:** A specified dollar amount which the member is responsible for paying at the time of an office visit. The amount of the copayment (if it is required) is typically specified on the member's ID card.
- **Non-covered service amounts**: Services that are not eligible for payment under the member's policy or benefit plan.

Participating providers may not collect from a member any amount above the established Blue KC allowable for a corresponding covered service. The Blue KC remittance advice shows the amount a provider may bill the member and the amount the provider agrees to write-off, pursuant to contract terms.



## Completing the CMS 1500 Claim Form

All paper claims filed to Blue KC must be filed on the current CMS 1500 claim form.

Note: Blue KC encourages using the electronic format rather than typing/printing the CMS 1500 claim form as described in this section.

## **Guidelines for Completing CMS 1500**

- CMS 1500 Use the current version of the CMS 1500 form which is printed with special red ink designed for scanning. Detailed instruction for completing the CMS 1500 can be found at the National Uniform Claim Committee (NUCC) website (see Contact | Resource Directory).
- Type Use black ink, typed or computer printed. Avoid handwritten information. Use of quality, dark-printing typewriter or computer printer ribbons is mandatory.
- Avoid italic or script print.
- Avoid extraneous printed, handwritten or stamped information.
- Dot matrix print does not make a complete character. Try a double pass or a new printer ribbon. Dark print is mandatory.
- A claim with more than six lines will require more than one CMS 1500. On all but the final CMS 1500, boxes 28 and 29 should be filled with 'CONTINUED.'

- **Punctuation -** Avoid punctuation (dollar signs or decimals) in money fields, or apostrophes in names.
- Dates Submit all dates as month, day and year without dashes or slashes. All dates should have six numbers (for example, September 30, 2017 is written as 093017).
- **Corrections Make corrections** with correction tape or white out. Do not hand-write corrections.
- **Not Otherwise Classified** (NOC) - Submit the description for Not Otherwise Classified (NOC) procedure codes in box 19 (Additional Claim Information) or if it will not fit, on a separate attachment.
- Anesthesia claims must be submitted in minutes, not units.

Providers.BlueKC.com



## **Billing for Routine Examinations and Screenings**

As more emphasis is being placed on preventive and wellness care, it is increasingly important that providers be familiar with how to bill correctly for services that may be part of routine physical examinations. It is critical that these services be reported with the appropriate type of service, procedure and diagnosis codes.

While Blue KC provides wellness benefits that are mandated by Kansas and Missouri state and Federal laws, most Blue KC benefit plans provide coverage for routine preventive screenings, based on recommendations from the Blue Cross and Blue Shield Association and guidelines set forth by the American College of Physicians.

## Member eligibility

To determine if a member is eligible for preventive care benefits under his/her contract, a provider may check the provider portal or call the Provider Hotline (see Contact | Resource Directory for details).

### **Preventive/Routine Care Guidelines**

The guidelines set forth to determine what services are considered preventive are updated periodically. Refer to cdc.gov/vaccines to access the most up-to-date immunization schedules. Blue KC's current Preventive Healthcare Guide is located at <a href="BlueKC.com">BlueKC.com</a>; click Living Healthy then select Preventive Guidelines.

## **Coordination of Benefits (COB)**

Coordination of benefits (COB) is a cost-containment provision of group contracts which helps to avoid duplicate payment of covered services. COB is applied when a member is enrolled with Blue KC and another insurance plan. COB assures that services are not reimbursed at more than 100 percent of total charges.

### **Questions about payors**

For questions about which insurance company or payor has primary liability for claims payment, please call the Provider Hotline (see Contact | Resource Directory for details).

### **Coordination with Medicare**

Employer group insurance is frequently primary to Medicare benefits for the working aged, and beneficiaries with renal and other disabling conditions. Blue KC may pay secondary for members enrolled in an individual plan who are eligible for or enrolled in Medicare.



## Filing claims for members with more than one insurance plan

Physicians can help in the coordination of benefits process by asking members if they have other insurance in addition to Blue KC. If members have more than one insurance plan, always include the following information in the appropriate box on the claim form:

- Name of other insurance company
- Policyholder's name
- Identification number

It is possible for Blue KC to be the insurer of both spouses under different contracts.

### No-fault automobile insurance

State insurance commissions regulate whether insurance companies can coordinate benefits with no-fault automobile insurance coverage.

Kansas	Missouri
Benefits are coordinated with the no-fault insurer. Please check the Auto Accident box on the CMS 1500 claim form.	There is no coordination of benefits with no-fault carriers for Missouri residents.



### **Worker's Compensation**

Work-related accidents are not covered under most Blue KC contracts. If services provided by the provider's office are the result of a member's on-the-job injury, specific information regarding the accident or condition is always needed on the claim. Please include:

- An indication that the injury was work-related (CMS 1500 Employment box)
- Related diagnoses in appropriate fields on the claim form

### **Overpayments**

If a provider receives an aggregate overpayment due to excess reimbursement from multiple group insurance carriers, please do not refund the overpayment to the member. Call the Provider Hotline (see Contact | Resource Directory) for information on where the overpayment should be sent.

## **Secondary Coverage Guidelines**

The determination of which insurance carrier's allowable applies and which Plan pays primary is determined in accordance with the member's health Plan and the National Association of Insurance Commissioners (NAIC) guidelines. The Blue KC provider agreement does not govern these determinations.

The following guidelines apply when Blue KC is a member's secondary health plan, except when the application of such guidelines could cause either party to violate any federal or state law.

When an individual is covered by two or more health plans, Blue KC's secondary payment will vary based on the rules governing a member's health plan. The provider must "write off" any amount that exceeds the applicable allowable described below. Once the appropriate allowable is determined, the provider should expect to receive payment from multiple health plans and/or the member that equals the allowable.

Note: For purposes of Secondary Coverage Guidelines, allowable means the amount the provider has agreed to accept as payment for the service or supply.



### Missouri Group Insured Health Plans

When determining the secondary payment under these programs, Blue KC applies the primary carrier's allowable. However, Blue KC's secondary payment will never exceed the amount of the member's responsibility determined by the primary program.

Note: The group purchaser is located in Missouri.

### **Kansas Group Insured Health Plans**

When determining the secondary payment under these programs, Blue KC applies the highest of the allowables between the two or more programs.

Note: The group purchaser is located in Kansas.

### **Self-Insured or ASO Plans**

When determining the secondary payment under these programs, Blue KC applies the allowable as required in the plan sponsor's plan documents.

### Federal Employee Plan

When determining the secondary payment under this program, FEP applies the lower of the allowables between the two or more programs.

## BlueCard (Other Blue Cross and Blue Shield Plans)

When determining the secondary payment under these plans, the home Plan determines what allowable applies in accordance with state law and Plan documents.

Due to the variety of ways that an allowable may be determined, you should not expect that your claims will be processed under the same rule on each claim that is processed. Your allowable may be determined in several ways and thus the amount of your secondary payment will differ.

Provider Hotline: 816-395-3929



### Medicare

Within Medicare Part A refers to inpatient institutional services, and Part B refers to outpatient and professional services. When Blue KC is secondary to Medicare, the following guidelines apply:

### **Provider Filing with Medicare**

Please **<u>DO NOT</u>** file with Blue KC and Medicare simultaneously. The provider must wait until receipt of the Medicare remittance advice. After receipt of the Medicare remittance advice, please determine if the claim was automatically crossed-over to the member's supplemental insurance.

### **Crossed-over claims**

If the claim was crossed-over, the paper and electronic (835) remittance advice should have Remark Code MA 18, which states, "The claim information is also being forwarded to the member's supplemental insurer. Send any questions regarding supplemental benefits to them."

Note: If the claim was crossed-over, please DO<u>NOT</u> file the claim with Blue KC unless it has been 30 days and the cross-over claim has not been received.

### Claims not crossed-over

If the remittance advice does not indicate the claim was crossed-over please file the claim to Blue KC.

If you have questions regarding COB or Medicare supplemental reimbursement, please go to the provider portal or call the Provider Hotline (see Contact | Resource Directory for details).

### **Resubmitting Claims**

Before resubmitting a claim, please:

- Allow at least 30 days from the date of claim submission before following up on a claim. This allows adequate time for processing.
- To verify claim status please check the provider portal or call the Provider Hotline (see Contact | Resource Directory for details).



## **Claims Inquiries**

## Ways to get Claims Information

**Provider Portal:** claims status or to review paid claims (plus eligibility and benefits) and view BlueCard responses and inquiries; click Claims/Eligibility

**ASK:** real-time eligibility request and response (270/271) and claim status and response (276/277)

**Written:** corrected claims, overpayments, questioning allowable and "other" (see below for more detailed information)

### Written Claim Inquiry Form

For efficient handling of a written request, please complete a Claim Inquiry form. There is an interactive PDF copy of the form in the Forms section on our provider portal (see Contact | Resource Directory).

#### Completing the Written Form

Include all necessary information on the form in order for the claim to be properly researched. Be certain to include the following:

- Claim number
- Date of service
- The Blue KC 8-digit provider/group number
- The policy holder's/insured's name (if different from the member) and identification number

The information specific to the claim may differ depending on the question or problem. For example, if the provider is:

- Questioning a denied service, or is changing or submitting an additional diagnosis, always submit a copy of the provider's office records or required supporting documentation.
- Questioning the allowed amount on a surgery, include a copy of the operative report.

## **Faxing the Written Form**

We offer the option of sending Claim Inquiry forms by fax. This process allows Blue KC to fax responses back to the person generating the inquiry.

#### To complete the form:

- 1. Check the **FAX** box and complete the To Attn: and provider Fax # sections.
- 2. Insert a blank sheet between multiple inquiry forms.

The FAX numbers are listed by line of business at the bottom of the Claim Inquiry form.



Note: To avoid duplication, please do not mail any Claim Inquiry forms that have already been faxed to us. Please allow 30 days to process your claim inquiry form request.

### **Blue KC Written Claims Inquiry**

For Local, FEP-Federal Employee Program and BlueCard claims inquiries can be mailed to the Claims Inquiry department. See Contact | Resource Directory for details.

### **BlueCard members**

The main identifier for out-of-area members is the alpha prefix, which identifies the Blue Plan or national account to which the member belongs. A BlueCard member's ID card may indicate the Home Plan's name. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo, for comprehensive Major Medical or HMO members

The claim inquiry fax number is on the bottom of the Claim Inquiry form.

## **Federal Employee Program members**

The Federal Employee Program (FEP) member ID cards will have an ID number that begins with "R." The claim inquiry fax number is on the bottom of the Claim Inquiry form.



## **Overpayment and Underpayment Policy**

## **Blue KC overpayments**

To the extent you receive an overpayment from Blue KC for insured local business, Blue KC may initiate recovery from you or offset against other claims Blue KC received from you. Blue KC will not pursue recovery of an overpayment if the recovery is not initiated within 12 months of Blue KC's payment of the claim except in the case of fraud or misrepresentation by you.

For all other lines of business, Blue KC will not pursue recovery of an overpayment if the recovery is not initiated within 24 months of Blue KC's paid date except in the case of fraud or misrepresentation by you. To the extent Blue KC receives a recovery, you may dispute such recovery by submitting a Claim Inquiry form within 12 months of the date of the recovery.

## Member overpayments

Upon receipt of a remittance advice for insured Blue KC local business, if you collected more than the amount indicated as member responsibility on the remittance advice, you must refund such amount to the member no later than 30 days after receipt of the remittance advice. A refund is not required if the member owes you for previous services rendered and the overpayment is applied to the outstanding balance.

## **Provider underpayment**

If the provider seeks additional payment for a claim previously paid by Blue KC, Blue KC shall not consider such a request if the request is made more than 12 months after Blue KC has paid the claim.

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Provider Hotline: 816-395-3929



## **Fifty Percent Copay Rule**

### MO Regulation: 20 CSR 400-7.100

This Missouri regulation states that a health maintenance organization (HMO) may require copayments of its enrollees as a condition for the receipt of health care services. This rule is promulgated pursuant to sections 354.430 and 354.485, RSMo.

A health maintenance organization (HMO) may require copayments of its enrollees as a condition of the receipt of specific health care services. An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services.

An HMO may not impose copayment charges for basic health care services on any enrollee in any calendar year after the copayments made by the enrollee in that calendar year for basic health care services total two hundred percent (200%) of the total annual premium which is required to be paid by, or on behalf of, that enrollee and shall be stated as a dollar amount in the group contracts.

Copayments shall be the only allowable charge, other than premiums, assessed to enrollees for basic and supplemental health care services. Single service copayment amounts shall be disclosed either as a percentage or as a stated dollar amount in the evidence of coverage. For group contracts the copayment amount may be changed only on the anniversary date of the group contract except by mutual agreement of the parties to the contract.

Compliance with this regulation includes the requirement that providers refund to members any copayments collected that were in excess of fifty percent (50%) within 30 days of receipt of the remittance advice.

If Blue KC receives information that a provider may not be compliant with this regulation, Blue KC is required to perform a provider audit. This provider audit will include but is not necessarily limited to a review of the provider's process for member copayment refunds, access to any records required to research and validate compliance/non-compliance with this regulation and when necessary may result in a plan for provider corrective action. If uncorrected, provider contract renewal may be jeopardized.



## **Chiropractic**

## MO Statute: 376.391 - Copayments for chiropractic services, cap 376.391

A health benefit plan or health carrier, as defined in section 376.1350, including but not limited to preferred provider organizations (PPO), independent physicians associations, third-party administrators, or any entity that contracts with licensed health care providers shall not impose any copayment that exceeds fifty percent of the total cost of providing any single chiropractic service to its enrollees. (L. 2009 H.B. 577)



## Payment errors or remittance advice problems

Use the following procedure if you encounter payment errors or remittance advice problems

- 1. If you receive an incorrect payment (e.g. duplicate payment, payment to incorrect physician), or a remittance advice does not balance to the payment received, please deposit the check. Do not return Blue KC's check.
- 2. You may report the error one of the following ways:
  - a. Submit your question via Contact Us on the Provider Portal. Choose "Claims" as the type of inquiry in the dropdown box.
  - b. Through the Written Correspondence Unit or FAX on a Claim Inquiry form.
  - c. Call the Provider Hotline (see Contact | Resource Directory).

The problem will be routed to the appropriate area for correction, and every effort will be made to resolve the problem quickly.

An adjustment will be made to a future remittance advice to account for (or balance) the reported problem. If appropriate, incorrect payments will be deducted at that time.

### Interest on claims

If a claim received by Blue KC is not paid within the guidelines established by the states of Missouri or Kansas, Blue KC will pay interest to the provider. If additional information is required by Blue KC to process the claim, the claim must be paid within a specified period from the receipt of this new information to avoid interest charges.

## **Reporting interest**

Interest is reported on the remittance advice in two areas:

- At the claim level
- At the summary level by line of business

### No interest paid

Claims related to Administrative Services Only (ASO) business, certain rental business, and FEP groups are exempt from state interest statutes. No interest will be paid on these claims.



## Refunds to Covered Individuals (Physician Network Agreement Article 5.12)

Physician agrees to remit to Covered Individuals within thirty (30) days after receiving payment from Payor any credit balances due Covered Individuals from Physician for Covered Services. On those claims for which Physician is required to remit part of the payment to a Covered Individual with a credit balance, if Blue KC has been required by statute to pay Physician any interest as a part of its claims payment process, Physician is required to reimburse a pro rata share of that interest payment to the Covered Individual.

## Blue KC Right to Audit (Physician Network Agreement Article 5.13)

BCBSKC may conduct reasonably scheduled audits and/or reviews during Physician's regular business hours. These audits and/or reviews may consist of, but shall not necessarily be limited to, verification of services reported to Payor, and Medical Necessity of services and quality of care provided. Payor may recover or offset any amount related to billing code errors and other matters not involving Medical Necessity. Payor has the right to initiate recovery or offset of amounts paid in error up to two (2) years from date of payment. There is no time limitation on recovery or offset in instances of fraud, and the right to recover or offset shall not be affected by termination of this Agreement.



## **Claims Payments and Remittance**

## Resource Based Relative Value System (RBRVS)

#### What is RBRVS?

Most Blue KC provider claims are paid based on the Plan's RBRVS-based fee schedule. RBRVS is a payment methodology featuring a variety of published relative value units (corresponding to a specific CPT code) comprised of components for intensity of service, overhead costs, malpractice components and geographical constants. These values, along with appropriate adjustment factors, are multiplied by a Blue KC conversion factor to produce an allowable.

### Member responsibility

Participating physicians agree to accept the Blue KC fee schedule allowable as payment in full and to not bill the member for any amount over this allowable. The member is responsible for any deductible, coinsurance, copayments and non-covered amounts.

Note: The Blue KC fee schedule is proprietary and confidential information. Under the terms of the Physician Participating Agreement, a physician is prohibited from disclosing this information to anyone outside the provider's organization.

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## Health Insurance Marketplaces 101 (a.k.a. Exchanges)

The Patient Protection and Affordable Care Act of 2010 (ACA) calls for the establishment of Health Insurance Marketplaces (Exchanges) where individuals can purchase health insurance coverage for effective dates beginning January 1, 2014. For individuals who qualify, there are advance premium tax credits (subsidies) available to assist in payment of monthly health insurance premiums.

## **Exchange Individual Grace Period**

The ACA mandates a three-month grace period for individuals who enroll for coverage on the Exchange and receive an advance premium subsidy but are delinquent in paying their portion of the premium. This grace period applies as long as the individual has previously paid at least one month's premium. During the grace period, the health insurance plan is required to pay claims for services rendered during the first month of the grace period.

## How Will I Know If the Member Is Within a Delinquency Period?

You can also verify a member's delinquency status by checking member eligibility on the provider portal, by calling the Customer Service phone number listed on the back of the member ID card or by calling the Blue KC Provider Hotline (see Contact | Resource Directory).

## How Will Claims Be Processed During the Grace Period?

Blue KC will process the claim and render no decision on payment responsibility on claims for dates of service within the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue KC indicating the member is in the grace period and we are unable to assign financial responsibility for the claim until the member either pays his or her premium or the grace period expires. If the member does not make payment by the end of the three-month grace period, the member's coverage will be terminated retroactive to the last day of the first month of the grace period. Claims will be adjusted upon payment of premium or termination of coverage.



## **Third Party Payments**

The Department of Health and Human Services (HHS) has expressed concerns regarding providers and hospitals, as well as other third party entities, making individual's premium payments for qualified health plans (QHPs) purchased in the Health Insurance Marketplaces. As a result, HHS expressly discourages this practice and encourages Blue KC and other issuers to reject such third party payments.

As referenced in section 2.17 of your Provider Agreement, premiums to Blue KC are owed by the Subscriber and may not be paid by third parties. As a result, Blue KC will not accept premium payments by you, a hospital, or other third party entities, unless required to do so by law. Even though Blue KC may have previously accepted premium payments from you does not mean we will accept premiums from you in the future.

## Contraceptive Non-Profit Religious Organization Accommodation

A non-profit religious Contraceptive Accommodation is available to certain non-profit religious organizations with objections to contraceptives. In general, qualifying religious organizations will be permitted to exclude contraceptive services, which would otherwise be covered as required by the ACA's preventive care rules, from their group health coverage. Instead, health insurance issuers will be required to make separate payments for these accommodated items and services directly without cost-sharing or other charges when prescribed or performed by an innetwork provider.

Note: The Religious Accommodation is different than the Permanent Religious Exemption in which Blue KC would not be responsible for separate payments.

In the event a member of an accommodated religious organization obtains contraceptive items or services in-network from you, which would otherwise be covered but for the Accommodation, Blue KC will make separate payments for the items or services according to your current fee schedule.

As a result, reimbursement will be consistently applied for ACA mandated contraceptives, whether covered by the employer or not, and no action will be required on your part to obtain reimbursement.



### **Out-of-Pocket Maximum**

The Affordable Care Act has a direct impact on the rules regarding how the member's out-of-pocket maximums are calculated. Except as described below, the rules require that all in-network member cost-sharing, including deductibles, coinsurance and copayment (including pharmacy) apply to the limit. Patients now have a greater possibility of meeting the max, as defined by their plan, and may not have balances for you to collect in your office. All services with a member cost-share will now be accumulated toward an in-network or out-of-network maximum, including copayments. This is a big change, so you may want to review your provider remits much closer so that you are not collecting copayments unnecessarily. In the event you unnecessarily collect a copayment, you are responsible for returning the overpayment to the member.



## **Remittance Advice**

#### What is a remittance advice?

Blue KC sends a weekly remittance advice statement to participating providers. This statement provides detailed information for any claim processed (paid or denied) during that week.

### Electronic remittance advice (835)

The 835 will allow automatic posting of your office's accounts receivable and is one of the major cost savings of the HIPAA implementation. If you are interested in implementing the benefits of an electronic remittance advice, please contact your practice management system vendor or clearinghouse for availability.

Next, your vendor, clearinghouse or you will need to contact Administrative Services of Kansas (ASK) (see Contact | Resource Directory) for set up.

For those receiving an 835, you will still get a paper remittance as well, unless you contact your Provider Relations Representative to opt out.

### **Electronic Funds Transfer (EFT)**

If you are not already set up for EFT, please complete the Provider Electronic Funds Transfer Application in the Forms section on the provider portal. This option will allow you to receive your payments faster by having them deposited directly into your bank account.

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Provider Hotline: 816-395-3929



## Payment checks

Providers may receive up to five checks with each weekly remittance advice. One check is issued for each of the following five Blue KC lines of business:

- BlueCard
- Blue-Care
- Blue Cross and Blue Shield
- Federal Employee Program (FEP)-Standard
- Federal Employee Program (FEP)-Basic

Each line of business may include several products. For example, Blue Cross and Blue Shield may include Preferred-Care Blue, Preferred-Care, Medicare Supplemental or Traditional.

## **Remittance Advice Format and Examples**

The format of the remittance advice is divided into three parts for every check or payment made to a provider. The parts are as follows:

- 1. Original Claims (Example 1)
- 2. Adjusted Claims (Examples 2 void, 3 supplemental and 4 overpayment)
- 3. Payment Summary (Example 5)

A summary line is presented for each provider of service per product.

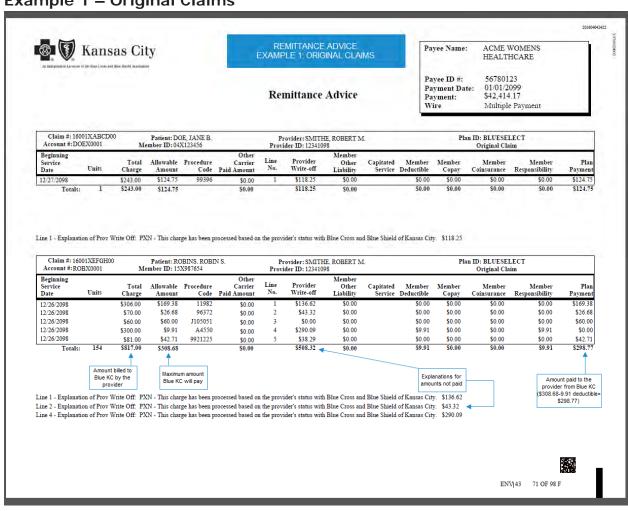
The examples on the pages that follow represent the format of the Professional Provider Remittance Advice. The Facility Remittance Advice is slightly different.

Blue KC Provider Office Guide Effective: December 2017



### **Remittance Advice Examples**

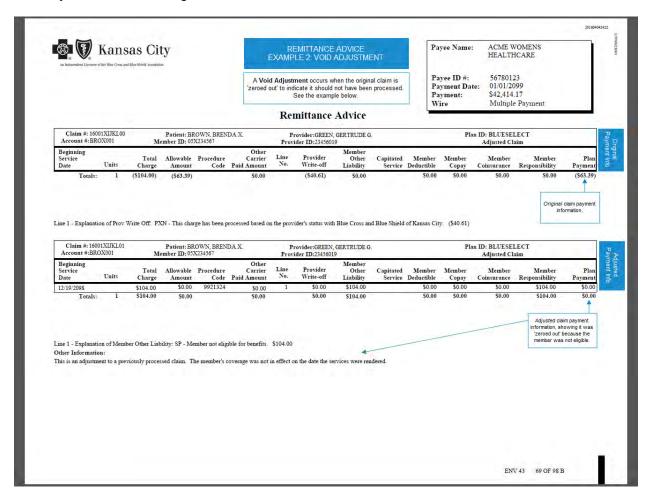
### Example 1 - Original Claims



Provider Hotline: 816-395-3929

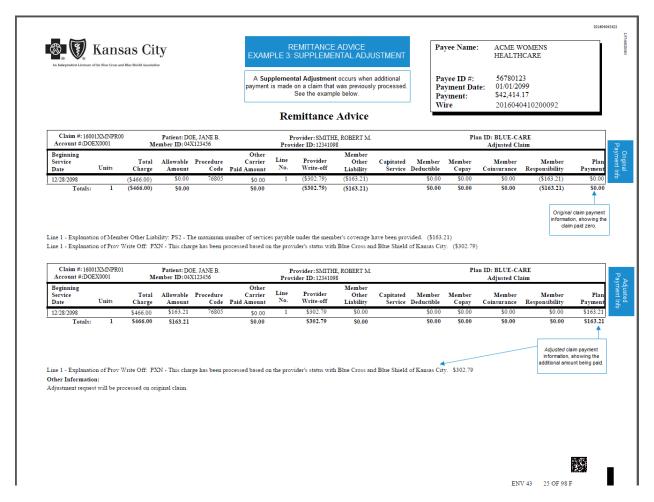


### Example 2 - Void Adjustment





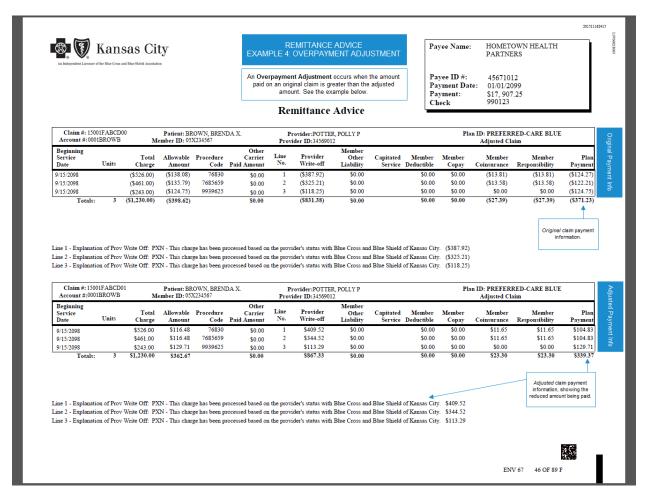
### Example 3 - Supplemental Adjustment



Provider Hotline: 816-395-3929

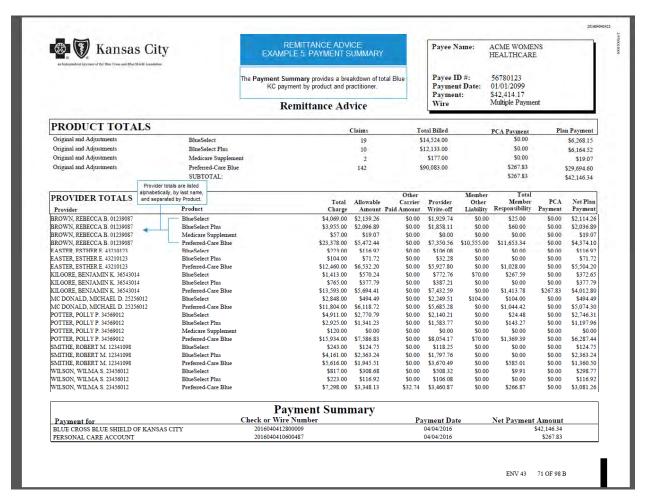


### Example 4 - Overpayment Adjustment





### **Example 5 – Payment Summary**



Provider Hotline: 816-395-3929



## Blue KC Provider Office Guide

**Contact Resource Directory** 

## **Provider Office Guide**

The Blue KC Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue Cross and Blue Shield of Kansas City (Blue KC). The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)
- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.



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### **Main Contacts and Resources**

#### PROVIDER PORTAL

WEB ADDRESS: Providers.BlueKC.com

**Notes:** The Provider Portal supplies you with claims and eligibility search/information, forms, medical policies, archived issues of Blue KC's BlueSpeak and reference documentation/resources.

PROVIDER HOTLINE						
<b>TOLL FREE NUMBER</b> 800-456-3759	PHONE NUMBER 816-395-3929 TDDY: 816-842-5607	<b>FAX NUMBER</b> 816-395-3959	WEB ADDRESS	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS						
Notes: Available Monday	/ - Friday 8 a.m. to 8	3 p.m. Central Tin	ne			

Provider Relations Representatives						
	PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS			
Adrienne Lambeth	816-395-3049	816-395-3959	Adrienne.Lambeth@BlueKC.com			
Carla Jensen	816-395-3944	816-995-1558	Carla.Jensen@BlueKC.com			
Deb Armenta	816-395-3963	816-995-1572	Deb.Armenta@BlueKC.com			
Dena Roberts	816-395-3210	816-995-1555	Dena.Roberts@BlueKC.com			
Jennifer Reese	816-395-3902	816-995-1569	Jennifer.Reese@BlueKC.com			
Katrina Taggart	816-395-3946	816-995-1559	Katrina.Taggart@BlueKC.com			
Laura Griffin	816-395-3548	816-995-1596	Laura.Griffin2@BlueKC.com			
LeAnn Banks	816-395-3904	816-995-1576	Leann.Banks@BlueKC.com			
Marsha Yarnell	816-395-3909	816-995-1563	Marsha.Yarnell@BlueKC.com			
Regina Carlson	816-395-3552	816-995-1513	Regina.Carlson@BlueKC.com			
CORRESPONDENCE Blue KC, Attn: Provider Relations, 2301 Main St, A6B1, Kansas City, MO 64108						
<b>Notes:</b> A list of reproportal.	resentative by ZIP	code, County and	State is available on the provider			



### **Blue KC**

Blue Cross and Blue Shield of Kansas City (Blue KC)						
TOLL FREE NUMBER	PHONE FAX WEB ADDRESS EMAIL					
800-822-2583 (BLUE)	NUMBER BlueKC.com Address					
888-989-8842	816-395-2222		Providers.BlueKC.com			
CORRESPONDENCE	Blue KC, PO Box	419169, I	Kansas City, MO 64141			
ADDRESS						
LOCATION ADDRESS	RESS 2301 Main, Kansas City, MO 64108					
Notes: Available Monda	y - Friday 8 a.m.	to 6 p.m.	Central Time			

Appeals (regarding Medical Necessity)							
TOLL FREE NUMBER 800-892-6116 ext. 2214 (expedited)	(standard) (standard) 816-395-2214 816-395-2073 (expedited) (expedited)						
CORRESPONDENCE (standard) Blue KC, Appeals Department, PO Box 417005, Kansas City, MO 64141-7005 (expedited) Blue KC, Attn: Medical Director, PO Box 419169, Kansas City, MO, 64141-6169							
_	Notes: For continued stay denials and expedited appeals call the Blue KC Medical Director at 816-395-2214 or toll-free at 800-892-6116 ext. 2214.						

AWAY FROM HOME CARE					
<b>TOLL FREE NUMBER</b> 800-348-2421	<b>PHONE NUMBER</b> 816-395-3791	FAX Number	WEB ADDRESS	EMAIL ADDRESS	
CORRESPONDENCE ADDRESS					
<b>Notes:</b> Away From Home Care is an out-of-area program sponsored by the BCBS Association that is available to select HMO members.					

BLUE DISTINCTION					
TOLL FREE NUMBER	PH	IONE <b>N</b> UMBER	FAX NUMBER	WEB ADDRESS	EMAIL ADDRESS
CORRESPONDENCE ADDRESS				'	

#### NOTES:

- The Blue Distinction Specialty Care Program is a national designation program that recognizes healthcare facilities that demonstrate expertise in delivering quality specialty care safely, effectively and cost efficiently through two levels of designation Blue Distinction Center and Blue Distinction Center+. For more information, please click <a href="here">here</a> to visit this web site.
- Blue Distinction Total Care (BDTC) is a delivery model designed to improve specific aspects of the healthcare delivery system. Blue KC has designed compensation methodologies that reward physicians for managing the care of their patients giving attention to cost, quality, and patient satisfaction. For information about BDTC, see the Provider Manual on the Provider Portal.



Blue Medicare Advantage - (Blue-Advantage Plus of Kansas City, Inc.)						
TOLL FREE NUMBER	PHONE NUMBER	FAX Number	WEB ADDRESS Provider.BlueKCMA.com	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS						

**Notes:** Blue-Advantage Plus of Kansas City, Inc. is a wholly owned subsidiary of Blue Cross and Blue Shield of Kansas City offering Medicare Advantage (HMO) plans. See the separate Provider Administrative Manual located at the web address above.

Management Referral Line						
TOLL FREE NUMBER		PHONE	FAX	WEB	EMAIL	
800-822-2583 ext. 20	60	NUMBER	NUMBER	ADDRESS	Address	
866-859-3811		816-395-2060				
CORRESPONDENCE						
Address						
<b>Notes:</b> Members with chronic, catastrophic, high-risk, or high cost conditions are referred to the Case Management Program for assistance. This program goes beyond short term						
discharge planning.	ziil F	riogram for assist	ance. This prog	graffi goes beyor	id Short term	

CLAIMS INQUIRY						
TOLL FREE NUMBER	PHONE NUMBER	FAX NUMBER 816-395-395 (Local) 816-395-381 (FEP) 816-817-338 (BlueCard)	59 I 1	WEB ADDR Provider.B		EMAIL ADDRESS
CORRESPONDENCE ADDRESS	For Loca Blue KC Attn: Writ Correspor PO Box 47 Kansas Ci 64141-61	ten ndence 19169 ty, MO	Corres PO Bo	C Written spondence x 419071 s City, MO	For Blue C Blue KC Attn: Writ Correspon PO Box 41 Kansas Cit 64141-60	ten dence 9016 sy, MO

**NOTES:** ALL PROVIDERS SHOULD SUBMIT EFORMS, ELECTRONIC CLAIMS INQUIRY FORM, AS OF MARCH 17, 2017. However, the following fax numbers may be used with PDFs after MARCH 17 2017, IF NECESSARY:

816-395-3959 (LOCAL), 816-395-3811 (FEP), 816-817-3381 (BLUECARD)



CLINICAL OPERATIONS						
TOLL FREE NUMBER	PHONE	FAX NUMBER	WEB ADDRESS	EMAIL		
	NUMBER	816-395-		ADDRESS		
	816-395-	2073				
	2214					
CORRESPONDENCE	Blue KC, Attent	ion: Medical Dir	rector, PO Box 4	19169, Kansas		
ADDRESS	<b>ADDRESS</b> City, MO 64141-6169					
<b>Notes:</b> For policy information go to <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> , access Medical Policies then						
search for the policy nan	ne, number, CPT	code, keyword c	or phrase.			

CUSTOMER SERVICE						
<b>TOLL FREE NUMBER</b> 888-989-8842	PHONE NUMBER 816-395-3558 TDDY: 816-842-5607	FAX Number	WEB ADDRESS	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS						
NOTES: AVAILABLE MONDAY	- FRIDAY 8 A.M. TO	8 P.M. CENTRA	al Time			
CREDENTIALING						
<b>TOLL FREE NUMBER</b> 800-822-2583 ext. 3949	<b>PHONE NUMBER</b> 816-395-3949	FAX NUMBER 816-395- 3185	WEB ADDRESS	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS			·			
Notes:						

EDI HELP DESK				
<b>TOLL FREE NUMBER</b> 800-472-6481	PHONE NUMBER	FAX Number	WEB ADDRESS	EMAIL ADDRESS
CORRESPONDENCE ADDRESS				
Notes:				

FEP - FEDERAL EMPLOYEE PROGRAM							
TOLL FREE	<b>PHONE NUMBER</b> 816-395-3678	<b>FAX NUMBER</b> 816-395-3811	WEB ADDRESS	EMAIL ADDRESS			
800-221-2362	610-393-3076	010-393-3011	FEPBlue.org	ADDRESS			
CORRESPONDENCE	Blue KC, PO Box 419071, Kansas City, MO 64179-0288						
Address							
Notes: A summary of benefits is found on the website, click Benefit Plans, then							
Brochures and Forms.							



FIND BLUE KC DOCTORS, HOSPITALS AND PHARMACIES						
TOLL FREE NUMBER	PHONE NUMBER	FAX Number	WEB ADDRESS Providerfinder.BlueKC.com	EMAIL ADDRESS		
CORRESPONDENCE		'				
Address						
NOTES: In addition to looking up any provider, a provider may use this site to verify the						
accuracy of their own contact information.						

FRAUD, WASTE	FRAUD, WASTE AND ABUSE HOTLINE - BLUE KC FEP							
TOLL FREE	PHONE NUMBER	FAX NUMBER	WEB ADDRESS	EMAIL ADDRESS				
NUMBER	816-395-2870	816-502-0182	BlueKC.com	_SIU@BlueKC.com				
800-337-8440			(in lower right,					
(National FEP			click Anti-					
Anti-Fraud			Fraud)					
Hotline)			or at					
			FEPBlue.org					
CORRESPONDE	Blue KC, PO Box 419169, Kansas City, MO 64141							
NCE ADDRESS			-					

**Notes:** Providers may also use these contact options to report suspicions or allegations of Fraud or Abuse anonymously.

FRAUD, WASTE AND ABUSE HOTLINE - BLUE KC LOCAL						
TOLL FREE	PHONE	FAX NUMBER	WEB ADDRESS	EMAIL ADDRESS		
Number	NUMBER	816-502-0182	BlueKC.com	_SIU@BlueKC.com		
800-340-0119	816-395-3151		(in lower right,			
			click Anti-Fraud)			
CORRESPONDE	Blue KC, PO Box 419169, Kansas City, MO 64141					
NCE ADDRESS						

**NOTES:** Providers may also use these contact options to report suspicions or allegations of Fraud or Abuse anonymously.

FRAUD, WASTE AND ABUSE HOTLINE - BLUE KC PHARMACY						
TOLL FREE	PHON	E	FAX NUMBER	WEB ADDRESS	EMAIL ADDRESS	
NUMBER	NUMBER		816-502-0182	BlueKC.com	_SIU@BlueKC.co	
	816-395-3778			(in lower right,	<u>m</u>	
				click Anti-Fraud)		
CORRESPONDENCE Blue KC, PO Box 419169, Kansas City, MO 64141						

**Notes:** Providers may also use these contact options to report suspicions or allegations of Fraud or Abuse anonymously.

HEALTHY COMPANION™ PROGRAM (DISEASE MANAGEMENT)						
TOLL FREE	PHONE	FAX	WEB	EMAIL ADDRESS:		
Number	NUMBER	NUMBER	ADDRESS	HealthyCompanion@BlueKC.com		
866-859-3813	816-395-2076					
CORRESPONDEN	CORRESPONDENCE ADDRESS					
Notes: Disease Management Program benefit to Blue KC members. Physicians may refer						
members via phone or confidential email for nurse outreach.						



HEDIS					
TOLL FREE NUMBER	PHONE NUMBER	<b>FAX NUMBER</b> 816-995-1593	WEB ADDRESS	EMAIL ADDRESS:	
CORRESPONDENCE ADDRESS	Blue KC, Attention: Curtisi Cross, Quality Management Department, 2301 Main, Mail Stop A6F1, Kansas City, MO 64108				

**Notes:** The HEDIS® medical record data abstraction process begins in late January and finishes in late April. To minimize office disruption, we ask providers with 15 or less records to pull their records and submit to Blue KC via our secure Accellion system, faxmail or U.S. mail. Accellion is at <u>Blue KC Secure File Sharing</u>. If you need assistance accessing Accellion, contact Bradford Mitchell at 816-395-3134. If you have questions or concerns regarding the medical record abstraction process, please contact Stephanie Findley R.N., Clinical Quality Nurse, at 816-395-2653.

HIPAA PRIVACY AND SECURITY						
TOLL FREE NUMBER 800-932-1114	PHONE NUMBER 816-395-3784 (privacy)	FAX Number	WEB ADDRESS	EMAIL ADDRESS: Privacy@BlueKC.com IS Security@BlueKC.com		
CORRESPONDENCE ADDRESS NOTES:	Blue KC, PO Box 417012, Kansas City, MO 64141-7012					

LITTLE STARS PRENATAL PROGRAM						
<b>TOLL FREE NUMBER</b> 800-822-2583 ext. 3964	PHONE NUMBER 816-395-3964	<b>FAX NUMBER</b> 816-395-2363 816-395-2287	WEB ADDRESS	EMAIL ADDRESS LittleStars@BlueKC.com		
CORRESPONDENCE ADDRESS NOTES:						

MEDICAL RECORDS (WHERE TO SEND MEDICAL RECORDS)						
TOLL FREE NUMBER	PHONE NUMBER	FAX NUMBER Per request letter	WEB ADDRESS	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS	For HMO/PPO/BA+/Federal Employees Program Motors members Blue KC		For ITS Host members (BlueCard) Blue KC PO Box 419016			
Notes: Medical rec	PO Box 411878 Kansas City, MO 64141- Kansas City, MO 64141-1878 6016  Fall records may be mailed to the address above or can be faved to the					
<b>Notes:</b> Medical records may be mailed to the address above or can be faxed to the number indicated on the request letter.						



Pharmacy Services						
TOLL FREE	P⊦	IONE <b>N</b> UMBER	FAX	WEB ADDRESS	EMAIL	
NUMBER	81	6-395-2176	NUMBER	Providers.BlueKC.com	Address	
800-228-1436						
CORRESPONDENCE Blue KC Pharr			nacy Servi	ces, PO Box 419169, Ka	nsas City, MC	
<b>ADDRESS</b> 64141-273						

**Notes:** A list of medications or classes of medications requiring prior authorization, step therapy, specialty pharmacy and/or having dose optimization/quantity limits are listed at <a href="BlueKC.com">BlueKC.com</a> (Contact, FAQs, Medical Policies, Review our Medical Policy, Prescription Drugs or search by drug name) or at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> (Log on, Medical Policy, Review our Medical Policy, agree to terms, Prescription Drugs or search by drug name). Calls are answered 24/7 (outside of Mon-Fri 8 a.m. to 5 p.m. calls are answered by Express Scripts)

IN AN EFFORT TO MAKE SURE THE NEW-TO-MARKET PRESCRIPTION DRUGS COVERED ARE SAFE, EFFECTIVE AND AFFORDABLE, COVERAGE OF MANY NEW DRUG PRODUCTS WILL BE DELAYED UNTIL THE PLAN'S MEDICAL AND PHARMACY MANAGEMENT COMMITTEE (MPMC) HAS REVIEWED THEM. THIS REVIEW PROCESS IS USUALLY COMPLETED WITHIN SIX MONTHS AFTER A DRUG BECOMES AVAILABLE.

PRIOR AUTHORIZATION/PRE-DETERMINATION (UTILIZATION MANAGEMENT)						
<b>TOLL FREE NUMBER</b> 800-892-6116 ext. 3989	PHONE NUMBER 816-395-3989 TDDY: 816-842-5607	FAX NUMBER 816-926-4253	WEB ADDRESS Providers.BlueKC.com	EMAIL ADDRESS		
CORRESPONDE NCE ADDRESS						

**Notes:** A list of services or medications requiring prior authorization, step therapy, specialty pharmacy and/or having dose optimization/quantity limits are listed at <a href="BlueKC.com">BlueKC.com</a> (Contact, FAQs, Medications) or (Contact, Find a Form).

PROVIDER DATA				
TOLL FREE NUMBER 800-822-2583 ext. 3929	PHONE NUMBER 816-395-3929	FAX Number 816-395-3387	WEB ADDRESS Providers.BlueK C.com	EMAIL ADDRESS Provider_Data@ BlueKC.com
<b>^</b>				

#### CORRESPONDENCE ADDRESS

**Notes:** To update your provider data, please download a <u>Provider Demographic Change Request Form</u> from the web address above, complete and email the form, with any required supporting documents, to the email address above.



PROVIDER PORTAL SUPPORT (PROVIDERS.BLUEKC.COM)							
<b>TOLL FREE NUMBER</b> 800-822-2583 ext. 3700	<b>PHONE NUMBER</b> 816-395-3700	FAX NUMBER	WEB ADDRESS Providers.BlueK C.com	EMAIL ADDRESS			
CORRESPONDENCE ADDRESS							
Notes: To get a login ID, register from <a href="Providers.BlueKC.com">Providers.BlueKC.com</a>							

UTILIZATION MANAGEMENT/CONCURRENT REVIEW						
TOLL FREE	PHONE NUMBER	FAX NUMBER	WEB ADDRESS	EMAIL		
NUMBER	816-395-2388	816-995-1556	Providers.BlueKC.com	ADDRESS		
800-892-6116	TDDY:					
ext. 2388	816-842-5607					
CORRESPONDENCE						
Address						
Notes: Clinical Information can be faxed to the number above.						



Providers.BlueKC.com

## **BlueCard**

BLUECARD ACCESS				
<b>TOLL FREE NUMBER</b> 800-810-2583	PHONE NUMBER	FAX Number	WEB ADDRESS	EMAIL ADDRESS
CORRESPONDENCE ADDRESS				
Notes: 365/24/7; Use to find providers in another Blue Plan's area				

BLUECARD ELIGIBILITY					
TOLL FREE NUMBER	PHONE	FAX	WEB	EMAIL	
800-676-2583	NUMBER	NUMBER	ADDRESS	ADDRESS	
CORRESPONDENCE					
Address					
Notes: 365/24/7; Eligibility, benefits and pre-certification/referral authorization from the					
Provider Portal					

BlueCard Provider Hotline (Customer Service)							
TOLL FREE	PHONE	FAX NUMBER	WEB ADDRESS	EMAIL			
NUMBER	NUMBER	816-527-0432	Providers.BlueKC.com	ADDRESS			
800-320-9550	816-395-3686						
CORRESPONDENCE ADDRESS	, , , , , , , , , , , , , , , , , , , ,						
Notes: Toll free and local phone numbers are staffed 8 a.m. to 8 p.m. CT Monday -							

Friday.

# Contact Resource Directory



## **Vendors/Delegates**

HOUREDO OI LUIALII	Accredo Specialty Pharmacy (Formerly Curascript)					
TOLL FREE NUMBER 877-259-2295	PHONE Number	<b>FAX NUMBER</b> 877-773-7386	WEB ADDRESS Accredo.com/healthcare- professionals	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS NOTES:						

ASK - ADMINISTRATIVE SERVICES OF KANSAS (EDI HELP DESK)						
TOLL FREE	PHONE	FAX NUMBER	WEB	EMAIL ADDRESS		
NUMBER	NUMBER	785-290-0720	ADDRESS	askedi@ask-edi.com		
800-472-6481			ask-edi.com			
CORRESPONDENCE						
Address						
Notes: Electronic c	Notes: Electronic claim assistance					

CAQH SOLUTIONS - COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE				
TOLL FREE NUMBER	PHONE NUMBER	FAX Number	WEB ADDRESS proview.caqh.org/pr	EMAIL ADDRESS
CORRESPONDENCE ADDRESS				
Notes: Used to obtain a	CAQH number	and maintain	your credentialing infor	mation.

EVICORE (FORMERLY MEDSOLUTIONS IMAGING)				
<b>TOLL FREE NUMBER</b> 888-693-3211	PHONE NUMBER 888-693- 3210	FAX Number	WEB ADDRESS evicore.com	EMAIL ADDRESS
CORRESPONDENCE ADDRESS				
Notes: Radiology Prior Authorization				

NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)					
TOLL FREE NUMBER 800-528-5763 (member)	PHONE NUMBER 816-237-2323 (provider) 816-237-2354 (members)	FAX Number	WEB ADDRESS nucc.org	EMAIL ADDRESS nuccinfo@nucc.org	
CORRESPONDENCE ADDRESS					

# Contact Resource Directory



New Directions Behavioral Health						
Toll Free Number Physician HelpLine: 800-528-5763 (member & provider) 888-611-6285 (provider relations)	PHONE NUMBER 816-237-2354 (member & provider)	FAX NUMBER	WEB ADDRESS ndbh.com	EMAIL ADDRESS		
CORRESPONDENCE ADDRESS	FOR LOCAL Blue KC Attn: NDBH Written Correspondence PO Box 419169 Kansas City, MO 64141-6169	FOR FEP Blue KC Attn: NDBH Written Correspondence PO Box 419071 Kansas City, MO 64179-0288	For BlueCa Blue KC Attn: NDBH Corresponde PO Box 4190 Kansas City, 64141-6016	Written ence 016 MO		

**Notes:** Blue KC contracts with New Directions Behavioral Health for coordination of all behavioral health, psychiatric and/or substance abuse services for members. To prior authorize mental health or substance abuse services, call the number above. Staff can call the Physician Help Line for immediate assistance if your patient has an urgent need or you need to discuss a case with a clinician.

PREFERRED HEALTH PROFESSIONALS- PHP					
<b>TOLL FREE NUMBER</b> 800-544-3014	PHONE NUMBER 816-823-6700 EDI support: 816-823-6706	<b>FAX NUMBER</b> 800-874-9179	WEB ADDRESS	EMAIL ADDRESS	
CORRESPONDENCE ADDRESS NOTES:					

Walgreens Specialty Pharmacy					
<b>TOLL FREE NUMBER</b> 800-424-9002	PHONE NUMBER	<b>FAX NUMBER</b> 800-874-9179	WEB ADDRESS	EMAIL ADDRESS	
CORRESPONDENCE ADDRESS					
Notes:					

# Contact Resource Directory



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## Blue KC Provider Office Guide

Federal Employee Program (FEP) Module

### **Provider Office Guide**

The Blue KC Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue Cross and Blue Shield of Kansas City (Blue KC). The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)
- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.

Provider Hotline: 816-395-3929



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## What is FEP/Service Benefit Plan?

Through the Federal Employees Health Benefits (FEHB) Program, the federal government contracts with health plans to provide health care benefits coverage for its employees and retirees. The Blue KC Plan offered to the FEHB program is termed Service Benefit Plan. More federal employees and annuitants subscribe to the Service Benefit Plan than any other FEHB Plan. (The Service Benefit Plan is also referred to as the Federal Employee Program or FEP.)

## **Federal Employee Program members**

The Federal Employee Program (FEP) member ID cards will have an ID number that begins with "R" followed by 8-digits.

# Membership—Standard Option vs. Basic Option

Membership records for federal employees are maintained in Washington, D.C. Although FEP members are enrolled in Preferred-Care Blue, they may choose standard option or basic option.

#### How they differ

For the most part, Standard and Basic Options cover the same services and supplies. However, under the Basic Option Plan, benefits are not available for services performed by an out-of-network physician or facility.

#### Identifying members

Identification numbers for FEP members begin with "R," followed by eight digits. The type of coverage is identified on the member's ID card as an enrollment code, as defined below:

Code	Option	Coverage
104	Standard	Individual
105	Standard	Family
106	Standard	Self Plus One
111	Basic	Individual
112	Basic	Family
113	Basic	Self Plus One



# Federal Employee (FEP) Member Rights and Responsibilities

Blue KC provides services for the Federal Employee Health Benefits Program (FEHB) members. These members have specific rights and responsibilities which are posted on fepblue.org. They are provided to you below.

#### As our valued member:

- 1. We ask that you give us and your healthcare providers' accurate information regarding your health and wellness (including any allergies you have, medications you take or over-the-counter (OTC) products you use), so that collectively we can better work with you to help you reach your health goals. Together, you and your healthcare team should develop a mutually agreed upon care plan. You should work with your team to better understand these agreed upon goals, and follow the plan to the best of your ability. If you have any information that could affect your care such as a living will or power of attorney you should provide this information to your providers.
- 2. Your healthcare providers must allow you, and/or someone you choose, to actively participate in your healthcare decisions. You can ask your providers to provide you, and/or your representative, any information related to a diagnosis, evaluation, treatment or prognosis you receive. You should discuss any medical treatment options related to your health with your providers, regardless of the treatment cost or whether or not we cover it. If you choose to receive treatment that is not a covered benefit, you agree to accept any of the charges as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.
- 3. We respect your right to privacy; so do the providers who participate in our network. You can approve or refuse the release of any of your personal information. We hold all our member records confidential, and will only release them to the appropriate entities if required to do so by law.
- 4. Above all, we will always treat you with dignity and respect. The same treatment you expect from us, we ask you to provide to us and anyone else involved in your healthcare. If you have any comments, concerns or complaints, we want you to voice those to us by calling the number on the back of your member ID card or on the Contact Us page. Also, if you ever feel the need to change providers for any reason, you can do so easily by searching our provider directory.
- 5. You or your providers can always ask us for more information about what we expect from you as our member, and what you should expect from your healthcare team. You also have the right to ask for more information about our



organization, the providers who participate in our network, and your rights and responsibilities. If you have any recommendations on this rights and responsibilities statement, please let us know. Please print this page for a copy of this statement, or you can request a copy by calling the number on the back of your member ID card during regular business.



# Blue KC Service Benefit Plan – Summary of Benefits

All benefits are subject to the definitions, limitations, and exclusions stated in the member's policy. The summary of benefits for the Standard and Basic options for the current year can be found on the FEP Blue website on the Brochures and Forms page (see Contact | Resource Directory).

## **Cost-Containment Measures**

Like all FEHB plans, FEP has cost containment measures in place. In addition, all fee-for-service plans, like the Service Benefit Plan (FEP), must include two specific provisions in the benefit package: (1) precertification of inpatient admissions and (2) flexible benefits option.

#### **Precertification**

The member is responsible for ensuring that precertification is obtained for all inpatient admissions except routine maternity. Either the member or the member's physician must contact the Local Plan prior to the admission to obtain the certification and length of stay assignment.

#### Without precertification

A \$500 per admission benefit reduction occurs if precertification is not obtained. Precertification is not required for hospital admissions when Medicare Part A or another group health insurance is primary, or when confined in a hospital outside the United States or Puerto Rico.

#### Flexible benefits option

Under this Flexible Benefits Option, Blue KC has the authority to determine the most effective way to provide services. Blue KC may identify medically appropriate alternatives to traditional care and coordinate Plan benefits as a less costly alternative benefit.

These alternative benefits are subject to ongoing review and Blue KC may elect to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of future alternative benefits. The decision to offer an alternative benefit is solely Blue KC's and may be withdrawn at any time, and is not subject to Office of Personnel Management (OPM) review under the disputed claims process.



## **Prior Authorization**

The services listed in the table below require prior authorization before they may be rendered. Additional information can be found in the Service Benefit Plan Brochure under Section 3 "How you receive benefits."

Other Services Requ	iiring Prior Approval	
Outpatient Sleep	Prior approval is required for sleep studies performed in a	
Studies	provider's office, sleep center, clinic, outpatient center,	
	hospital, skilled nursing facility, residential treatment	
	center and any other location that is not your home.	
Applied Behavior	Prior approval is required for ABA and all related services,	
Analysis (ABA)	including assessments, evaluations, and treatments.	
Gender	Prior to surgical treatment of gender dysphoria, your	
Reassignment	provider must submit a treatment plan including all	
Surgery	surgeries planned and the estimated date each will be	
	performed. A new prior approval must be obtained if the	
	treatment plan is approved and your provider later	
	modifies the plan.	
BRCA Testing	Prior approval is required for BRCA testing and testing for	
	large genomic rearrangements in the BRCA 1 and BRCA 2	
	genes whether performed for preventative or diagnostic	
	reasons. The medical information necessary to make a	
	coverage decision will be requested by Blue KC for these	
	services.	
Home Hospice Care	Prior approval is required for home hospice, continuous	
	home hospice, or inpatient hospice care services. We will	
	advise you which home hospice care agencies we have	
	approved. The medical information necessary to make a	
	coverage decision should be requested by Blue KC for	
	these services.	
Organ and Tissue	Blue KC should request the necessary medical information	
Transplants	to make the appropriate medical decision Both the facility	
	and the procedure require Prior Approval. Blue KC will also	
	make sure the member meets the criteria or transplant	
	established by the facility. Members also have enhanced	
	benefits if they receive the transplant services from a Blue	
Clinical Trials for	Quality Center for Transplant (BQCT).	
Clinical Trials for	Contact us at the customer service number listed on the	
Certain Organ and	back of the member's ID card for information or to request	
Tissue Transplants	prior approval before obtaining services. We will request	
	the medical evidence we need to make our coverage determination.	
	determination.	



_	Other Services Requiring Prior Approval			
Prescription Drugs and Supplies	Certain prescription drugs and supplies require prior approval. Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain a list of drugs and supplies that require prior approval. The Retail Pharmacy Program will request the medical evidence necessary to make a coverage determination.			
Outpatient intensity- modulated radiation therapy (IMRT)	Prior approval is required for all outpatient IMRT services except IMRT related to treatment of head, neck, breast, or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required. The medical information necessary to make a coverage decision will be requested by Blue KC for these services.			
Outpatient surgery for morbid obesity, outpatient surgical correction of congenital anomalies and outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.	These surgical services require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers. The medical information necessary to make a coverage decision should be requested by Blue KC for these services.			

#### **Deductibles**

Deductible information for the current year, can be found in the Service Benefit Plan Brochure in Section 5 "Standard and Basic Option Benefits"

#### Carryover

When the effective date of an Open Season enrollment change for an enrollee is after January 1, any covered expenses incurred from January 1 to the effective date of the change count toward the prior year deductible of the prior Plan or option.

If the prior year deductible has been met, the prior Plan or option will pay for the covered services rendered from January 1 to the effective date of the change at the new year's level of payment. If the deductible has been partially met, the prior Plan or option will first apply the covered expenses to meet the rest of the deductible and then provide reimbursement for covered expenses at the new level of payment.



#### Change in ID Number

When an enrollee is assigned a new FEP identification number for any reason, the amount applied to the deductible and the benefit maximums under the old FEP identification number will be transferred to the new identification number. This provision applies when a terminated or canceled member, including spouses eligible under the Spouse Equity Act, re-enrolls in the same option under a new identification number with or without a break in coverage during the same year in which the previous FEP coverage terminated or canceled. ID cards are issued only in the Policyholder's name.

#### Coinsurance

Coinsurance is the percentage of covered charges the member must pay once the applicable deductible is satisfied and Blue KC has paid benefits. The Plan will base this percentage on either the billed charge or the allowable charge, whichever is less. For example when Blue KC pays 65 percent of the allowable charge for a covered service, the member is responsible for the coinsurance which is the remaining 35 percent of the allowable charge.

## Using Preferred and Member/Participating Physicians

Basic Option members may only use preferred providers. Standard option members may use Preferred or Member/Participating physicians. The member's share of covered charges (after meeting any applicable deductible) is limited to the stated coinsurance amounts based on the allowable charge.

For physician services, coinsurance will be based on the lesser of the billed charge or the negotiated amount that physicians have agreed to accept, including any savings Blue KC realizes through discounts that are known and that can be accurately calculated at the time the claim is processed.

#### **Using Non-Participating Physicians**

Under the standard option, members who use a non-participating physician may have significantly more patient responsibility. Under Basic Option, no benefit is available when a non-participating physician is used.

#### Copayments

A copayment is the stated amount the member must pay for certain covered services before the FEP program makes its payment.



For outpatient facility care, inpatient and outpatient mental conditions, and substance abuse care at in-network hospitals, the members are responsible for the lesser of the sum of the applicable per day copayments, the billed charge, or the Preferred or Member rate, after they have met any applicable deductibles.

## **Prescription Drug Benefits**

The pharmacy carrier for retail and mail order is Caremark. See the Service Benefit Plan Brochure for the current year benefit as well as the cost per tier.

## **Claims and Payments**

When FEP is the secondary payer, Blue KC determines the allowance. After the primary plan pays, FEP pays what is left of the Blue KC allowance, up to the FEP regular benefit. Blue KC does not pay more than the Blue KC allowance up to the FEP regular benefit. In certain circumstances when FEP is the secondary payer and there is no adverse effect on the member, Blue KC may use physician discount arrangements coordinated by the primary plan.

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## Coordinating Benefits — Medicare

The FEP program covers many of the same kinds of expenses as Medicare, as outlined below. Medicare has two parts: Part A and Part B.

#### Part A - Hospital Insurance

Covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care.

#### Part B - Medical Insurance

Covers physician services, outpatient hospital services, and equipment and supplies. Part B also provides benefits for home health care if the subscriber does not have Part A.

Under the Basic Option, members are required to use in-network physicians in order to receive covered benefits. Outpatient prescription drugs are not covered under either Medicare Part A or Part B.

FEP will never pay primary benefits for qualified skilled nursing facility care.

Any member who is eligible for Medicare may enroll in a Medicare+Choice plan and also remain enrolled with FEP. An annuitant or former spouse can suspend their FEHB coverage and enroll in a Medicare+Choice plan if one is available in their area.



#### Who is the Primary Payer?

#### Who is the Primary Payer?

FEP is the primary payer in these situations:

- If the member is employed by the federal government, age 65 or older and has Medicare Part A or Medicare Parts A and B.
- If the spouse covered under the FEP contract is 65 years of age or older, has Medicare Part A or Parts A and B, and the contract holder or the spouse is employed by the Federal government.
- When the member is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) (when Medicare was not already primary for the member due to age or disability).
- If the member is employed by the federal government and the member is under age 65 and eligible for Medicare benefits solely on the basis of disability.



#### Who is the Primary Payer?

# Medicare is the primary payer if:

- 1. The member is an annuitant age 65 or over, covered by Medicare Part A or Parts A and B, and is not employed by the Federal government.
- 2. The covered spouse is age 65 or over, has Medicare Part A or Parts A and B, and neither the member nor the spouse is employed by the Federal government.
- 3. The member is age 65 or over and is: (A) a Federal judge who retired under Title 28 of U.S. Code, or (B) a Tax Court judge who retired under Section 7447 of Title 26 of U.S. Code. Medicare is also primary for the covered spouse of a retired judge described in (A) and (B).
- 4. The member is an annuitant, not employed by the Federal government, and either the contract holder or a covered family member (who may or may not be employed by the Federal government) is under the age of 65 and eligible for Medicare on the basis of disability.
- 5. The member is enrolled in Medicare Part B only, regardless of his/her employment status.
- 6. The member is age 65 or over, employed by the Federal government in an appointment that excludes similarly appointed non-retired employees from FEHB coverage, and has Medicare Part A or Parts A and B.
- 7. The member is a former Federal employee receiving workers compensation and the Office of Worker's Compensation has determined that the member is unable to return to work.
  - The member has completed the 30-month End Stage Renal Disease (ESRD) coordination period and is still eligible for Medicare due to ESRD.
  - The member becomes eligible for Medicare due to ESRD after Medicare has assumed primary payer status for the member under rules 1) through 7) above.

FEP benefits in coordination with Medicare are not paid like Medicare complementary coverage. If FEP members have Medicare A or B, most FEP deductibles and coinsurances are waived if Medicare is the primary payer. This applies to both Standard and Basic Options. Any visit limitations that apply to member's care under the FEP are still in effect when Blue KC/FEP is the secondary payer.

#### When Medicare is Primary

The benefit limits and lifetime maximums are not waived when Medicare is primary.



#### **Medicare Part A**

#### **Under Standard Option**

When the member has Medicare Part A as his/her primary coverage, he/she does not have to meet the FEP inpatient per admission deductible for care in a member or non-member hospital. All of the covered inpatient care expenses in a Preferred Member, or non-member hospital are paid in full when Medicare is primary. The requirement for precertification for hospital admissions is waived.

#### **Under Basic Option**

Only services in a network facility are paid in full when Medicare is primary.

#### Mental Conditions and Substance Abuse

Under Standard Option, when a member with Medicare Part A as the primary payer is hospitalized for the treatment of mental conditions or substance abuse in a Preferred Member, or non-member hospital, the per day copayment is waived.

Under Basic Option, only services rendered in an in-network facility are covered.

#### **Home Hospice Care**

Under home hospice care benefits, any per admission deductible on inpatient hospital care in a member and non-member hospital and freestanding inpatient hospice facility is waived for Standard Option. Under Basic Option, only services rendered by in-network physicians are payable.

#### **Skilled Nursing Facility Care**

Effective January 1, 2018, inpatient skilled nursing facility (SNF) benefits are available to Blue Cross and Blue Shield FEP Standard Option members. This benefit enhancement now covers SNF services up to thirty (30) days per benefit year for members not enrolled in Medicare Part A.

For FEP Standard Option members to be eligible for this benefit, they must give their consent and be enrolled in case management. A signed consent for case management must be on file before the member is transferred to the admitting facility. Prior authorization of the SNF stay <u>cannot</u> be initiated if the letter of consent is not on file. Plan staff will work collaboratively with case managers/discharge planners to ensure that the consent is completed for FEP Standard Option members who can benefit from this service.

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## **Medicare Part B**

When the member has Medicare Part B and Medicare is the primary payer, he/she does not have to meet any applicable FEP calendar year deductible. The coinsurance amounts under Surgical, Maternity, Mental Conditions and Substance Abuse, and Other Medical benefits are waived. In addition, the copayment for each home and office visit, outpatient consultation, and outpatient second surgical opinion will be waived. Copayments for physical examinations provided by network physicians are waived. Under Basic Option only services rendered by in-network physicians are payable.

#### **Medicare Part B Payments and FEP**

All Medicare Participating physicians must accept the Medicare assignment of benefits. Non-Medicare Participating physicians can choose this on a claim-by-claim basis. However, all eligible physicians must file the Medicare claim.

#### **Limiting Charge**

Federal law prohibits non-Medicare Participating physicians from charging more than a certain percentage in excess of Medicare's prevailing charge. This limit on non-participating Medicare physician's charges for covered Medicare services is called the "limiting charge." The limiting charge must be accepted as payment in full by the physician. The limiting charge only applies to members that are age 65 or older that do not have Medicare.



## Tips to avoid claim processing delays:

- Lab charges need to be filed with a medical diagnosis. A diagnosis of laboratory exam will be denied for a more specific diagnosis.
- Physical therapy, occupational therapy and speech therapy claims need to be itemized and filed by individual dates of service. One copayment applies per day when two types of therapies are billed by one physician. Two separate copayments apply per day when two types of therapies are billed by two different physicians.
- When a treatment plan is being submitted to New Directions for mental health services, the number of days of authorization being requested must be indicated for each visit the member will have.
- If a patient is Medicare age 65 or older, please verify Medicare eligibility prior to submitting the claim to Blue KC.
- Home nursing claims must be billed on a HCFA 1500 claim form using a professional physician number.
- Facility and/or provider numbers on prior authorizations must match the facility and/or provider number on the claims being submitted for the services. If the facility and/or provider numbers do not match, the claim will deny for no prior authorization.

- assignment of benefits agree to accept the amount approved by Medicare for covered service as payment in full. FEP benefits are provided for the applicable Medicare deductible and coinsurance amounts. Members are not responsible for any difference between the physician's charge and the combined Medicare and FEP payment. Under Basic option, only services rendered by in-network physicians are payable.
- When billing for late charges or corrected/replacement charges, please use the appropriate bill type.
- Physicians cannot update other insurance information for a member.
   Physicians can retrieve a Coordination of Benefits survey via the web. The member must update this information by responding to a coordination of benefits survey or by calling the Federal Customer Service Department. To update Medicare eligibility, the member must provide a copy of his/her Medicare card.
- CRNA and Anesthesiologists must submit a claim using valid anesthesia procedure codes and modifiers.
- Claims must be submitted with valid charge amounts. Zero charge claims will not be accepted or processed.

FEP claims should be submitted on a CMS claim form using the appropriate CPT or HCPCS codes and must be submitted within 180 days from the date of service.



Fax claims inquiries to the FEP member number indicated on the Claim Inquiry form. The Claim Inquiry form is available on the provider website (see Contact | Resource Directory).

# Reconsiderations and Appeals of Medical Necessity/ Appropriateness

Under the Federal Employee Program (FEP), reconsideration and appeal rights are available to the member as outlined in Section 8 of the Service Benefit Plan Brochure, under the Disputed Claims Process.

## Fraud, Waste, and Abuse

Fraud, Waste, and Abuse (FWA) encompasses a wide range of improper billing practices. Blue KC is committed to identifying, investigating and referring to law enforcement officials cases of suspected fraud and abuse by either providers or members.

For detailed information, please refer to the Fraud, Waste, and Abuse section of the Contact | Resource Directory. Providers may also use these contact options to report suspicions or allegations of Fraud or Abuse anonymously.



## Blue KC Provider Office Guide

Health Services Module

### **Provider Office Guide**

The Blue KC Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue Cross and Blue Shield of Kansas City (Blue KC). The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)

- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, please contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.

## **Health Services**



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## What is Care Management?

Care Management is defined as an integrated system that promotes cost-effective and appropriate interventions to improve the quality of health care services that are delivered to members, thus enabling Blue KC to achieve and monitor optimal outcomes in an equitable manner for all members across the network while managing care and cost.

The sections which follow describe Blue KC's care management programs and services.

## **Medical Necessity**

For Blue KC benefit plans, medical necessity denotes services and supplies that are essential to the health of the member for the diagnosis or care and treatment of a medical or surgical condition. Failure to meet medical necessity will be determined by Blue KC physician reviewers or their authorized physician designee (at their discretion) and under the terms of the applicable Benefit Plan, or as may be required by law.

Please note the following points regarding denials:

- Services or supplies that are determined not medically necessary are not a covered benefit. By provider contract you cannot bill the member for these services.
- A service or supply may meet the medical necessity criteria, but may also be specifically excluded from coverage by the terms of the Benefit Plan, and therefore is not a covered benefit (that is, medical necessity does not determine coverage). Services that are not covered under the member's contract are member responsibility.
- Medical necessity is subject to the appeals process.

Blue KC's Integrated Health Services (IHS) Division makes utilization of services decisions about our member's healthcare needs based on the medical appropriateness of the care and service. Blue KC does not reward its IHS staff for issuing denial of coverage decisions and there is no financial incentive offered to IHS staff to make decisions that would encourage inappropriate utilization of services. Our goal is to identify and promote appropriate usage and cost-effective healthcare resources to ensure quality healthcare services are delivered to our members.

#### **Health Services**



#### To be medically necessary, services or supplies must be:

- Appropriate and necessary for the symptoms, diagnosis and treatment of a medical or surgical condition
- Consistent with national Blue Cross and Blue Shield Association's uniform medical policy, as amended from time to time
- Not primarily for the convenience of the member, or the member's family, physician, or other provider
- Consistent with the attainment of reasonably achievable outcomes
- Reasonably calculated to result in the improvement of the member's level of physiological or psychological functioning

Medically necessary and/or medical necessity for third party payor benefit plans will be determined in accordance with the terms of a member's benefit plan, if different from above.

#### Health Services



#### **Utilization Review Criteria**

The Blue KC Utilization Review Department bases its medical necessity decisions on two criteria sets:

#### Set 1. MCG Guidelines ™

The guidelines are written by **MCG** clinicians and are a compilation of best practices for treating common conditions in a variety of settings. The basis for the guidelines are drawn from medical literature, practice observation, and the expert opinion of physicians, nurses, and other providers. They are founded on the use of evidence-based research methodology to support the development and understanding of medical care processes.

#### Set 2. Blue KC medical policy

This policy is a comprehensive set of criteria that helps determine medical appropriateness or necessity for procedures which do not have benefits or payment determinations clearly defined elsewhere. The Medical Policy Committee has oversight for development, review and revisions of the policy with approval from the medical director. The content includes inpatient procedures, outpatient procedures, and durable medical equipment.

All criteria sets are reviewed on an annual basis with local provider input and accepted for use by the Medical and Pharmacy Management Committee. In the event of a denial, a copy of the guideline, protocol, benefit provision or other similar criterion used to make the determination will be available upon request by calling the Integrated Health Services Department or writing to the attention of the medical director (see Contact | Resource Directory for details).

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# Reconsiderations and Appeals of Medical Necessity/Appropriateness

After a prior authorization, concurrent review or retrospective review for a service denied as not medically necessary, you have the opportunity to discuss the case with the Blue KC medical director who made the denial determination if your request is made by the end of the next business day after denial notification by calling Medical Management. Physicians may fax additional clinical information to Medical Management (see Contact | Resource Directory for details).

#### **Standard Appeal**

#### When to file

A standard appeal for a denial of medical necessity is available within 180 days after notification of the denial, or when waiting 30 days for a response does not jeopardize the member's health.

#### Initiation

To initiate a standard appeal the provider should submit additional information to Blue KC by calling, faxing or written correspondence (see Appeals in Contact | Resource Directory for details).

#### Review

The appeal review will be conducted by a medical director who has no previous involvement in the case, is in the same or similar specialty and is not a subordinate of the medical director who made the original decision. If the medical director is unable to reverse the decision then the case is sent to an independent peer review organization.

#### Response

Blue KC will make its best effort to issue a written decision to the provider and member within 30 days.

#### Health Services



### **Expedited Appeal**

#### When to file

An expedited appeal is available during care or pre-care, when the standard time frame for a response (30 days) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

#### Initiation

For expedited reconsideration of a denial, a provider may phone or fax additional clinical information to Blue KC to the attention of the medical director. A medical director will also be available within 24 hours to discuss the case with the provider. (see Appeals in Contact | Resource Directory for details)

#### Review

The Blue KC medical director will review any medical records and additional documentation submitted by the hospital or provider. The review will be performed by a medical director with no previous involvement in the case. If the medical director is unable to reverse the determination then the case is referred to an independent peer review organization.

#### Response

The Blue KC medical director will issue a decision promptly within 72 hours or two business days, whichever is less. Blue KC will notify the provider, member and hospital in writing of the Blue KC Medical Director's decision. Expedited appeals, on behalf of the member, which do not resolve a difference of opinion may be resubmitted through the standard appeals process.



#### **Prior Authorization**

Blue KC performs a pre-review of selected outpatient and inpatient procedures for all Blue KC programs, including lease and ASO business. A complete list of services requiring Prior Authorization may be found on the provider portal (see Contact | Resource Directory).

For local members contact the Prior Authorization/Clinical Operations Department.

See Contact | Resource Directory for FEP and Appeals contact details.

#### Overview of the process

The prior authorization process begins when a provider, facility, member, or the member's representative contacts Blue KC's Prior Authorization/Clinical Operations Department for authorization regarding a member's pending procedure, service or medication. Blue KC staff verifies the member's eligibility or, if after business hours will take the necessary information to verify eligibility the next business day. Answers to questions about specific benefits are available through the Blue KC Provider Portal or the Provider Hotline during business hours (see Contact | Resource Directory). At this time, specially trained registered nurses or pharmacists gather clinical information about the proposed service. Blue KC allows up to 45 business days to submit all necessary information for routine prior authorization cases. Prior authorizations are decided within 36 hours, to include one (1) business day, from the date of receipt of all necessary information. Based on medical review findings, the Prior Authorization/Clinical Operations Department confirms the need for the service. If the nurse or pharmacist is not able to approve the case, it will be referred to the medical director for review.

Predetermination is a voluntary pre-service review and is strongly recommended for those services indicated in Blue KC Medical Policy as "sometimes investigational" or "not medically necessary." To access the Blue KC Medical Policy, go to the provider portal. To determine if a predetermination is recommended, you may also call the Customer Service number listed on the member ID card.



## Radiology Prior Authorization (Outpatient, Elective Procedures and Lumbar Spinal Fusions)

Outpatient and elective MRI, MRA, CT, CTA, PET, echocardiogram and nuclear cardiology studies will require prior authorization from eviCore. Prior authorizations are decided within 36 hours, to include one (1) business day, from the date of receipt of all necessary information. Imaging performed in conjunction with an inpatient stay, 23 hour observation, or testing done in the emergency room is not subject to authorization requirements.

When imaging is required in less than 36 hours due to an urgent condition, call for authorization and tell eviCore that the imaging is urgent and ask for an expedited review.

eviCore is a radiology services organization specializing in the management of quality, cost-effective diagnostic services. To request an authorization, you may access their 24/7 web portal, call or fax (see Contact | Resource Directory for information about eviCore).

## **Blue KC Medical Policy**

Blue KC's Medical Policy is available on the provider portal. After acceptance of the disclaimer you may search using a keyword, procedure code, alphabetic search or topic search. Medical Policies are also available via the Blue KC website (Contact | FAQs | Medical Policy).

Please remember that State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage. Although a service may be medically necessary, it may be excluded under a member's benefit plan. If you have any questions please submit an inquiry to Medical Policy through the Contact tab on the provider portal.

In addition, please remember in accordance with Missouri law and your Blue KC provider contracts, you must clearly inform members in writing that the health plan may not cover a specific service prior to the service being rendered. The member must also agree in writing to be solely responsible for the specific non-covered service or you may not bill the member for the service.



## Notification for prenatal programs

In an effort to identify at-risk pregnancies and enroll them in the Blue KC Little Stars Prenatal Program, notification is essential. This program is available to all Blue KC members. Physicians should submit the notification either by phone or fax. (see Contact | Resource Directory for details.)

## **Out-of-network services**

For HMO and EPO members, prior authorization is required for any service provided at or by a non-network facility and/or provider. For HMO members who desire out-of-network services, if such a service or procedure is available in the network, the request would be typically denied, unless unusual circumstances warrant an approval. Preferred-Care and Preferred-Care Blue members may voluntarily elect to opt out of network. To those PPO members, out-of-network benefits would apply and an out of network prior authorization is not required or reviewed.

## Inpatient Authorizations

Blue KC registered nurses perform a review of all scheduled or acute medical and surgical inpatient admissions (except admissions for delivery and all scheduled Rehab or Skilled Nursing Facility admissions prior to the admission). To satisfy this requirement, the admitting provider must call or fax pertinent clinical information to Blue KC to obtain the admission authorization. All urgent/emergent admissions must be authorized within 48 hours after admission.

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# Inpatient and Outpatient Services Prior Authorizations

Services, Durable Medical Equipment (DME) and Prostheses currently requiring Prior Authorization are listed on the Provider Portal (Contact, FAQs). (Does not include FEP or JAA\*\* members.)

\*\*Please contact the customer service number on the back of the member's card for prior authorization requirements.

Information may be submitted by phone or fax. The Prior Authorization list and forms to use when making your request are located at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> (Contact, FAQs).

To request a prior authorization or predetermination, fax the request to the confidential fax number (816) 926-4253 with relevant clinical information, or contact Blue KC's Utilization Management Department (see Contact | Resource Directory for details):

Blue KC staff verifies the member's eligibility or, if after business hours, will take the necessary information to verify eligibility the next business day. Answers to questions about specific benefits are available through the Blue KC provider portal or the Provider Hotline during business hours.

- 1. Blue KC staff requests the following information at the time of the call:
  - a. Caller's name and telephone number
  - b. Admitting/Service provider
  - c. Member's name and birth date
  - d. Blue KC Identification number and Group number
  - e. Proposed treatment plan: tests, diagnostic procedures, surgical procedures, treatment, etc.
  - f. Date, place, and type of admission or service
  - g. Diagnosis primarily responsible for the admission or service
  - h. Provider number and group number
- 2. Blue KC staff verifies that the treatment plan meets the criteria based on MCG or Blue KC Medical Policy.

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- 3. If the admission or service is approved, the Blue KC nurse notifies the provider and requester within 36 hours, to include one (1) business day, from the date of receipt of all necessary information. A letter will be generated within one (1) business day following approval. For admissions, the nurse also assigns a length of stay.
- 4. If the nurse is unable to approve the services(s) or elective admission, the case is referred to the Medical Director for review.
- 5. The Blue KC Medical Director makes a determination based on the clinical information provided. If more information is necessary, the Medical Director or review nurse contacts the provider to request the additional information before a determination is made. A determination is made within 36 hours, to include (1) business day, from the date of receipt of all necessary information.
- 6. If the authorization is denied, the provider may file a standard appeal to the Appeals Department or an expedited appeal to the Medical Director by calling or in writing (see Contact | Resource Directory for details).

For questions about prior authorization, please contact the Utilization Management Department (see Contact | Resource Directory for details).

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## Medications: Prior Authorization, Step Therapy, Specialty Pharmacy, Dose Optimization/Quantity Limits

Blue KC's Prescription Drug Lists are available on the Blue KC website by scrolling to the bottom of the home page, clicking FAQS, then Prior Authorizations for Medications (see Contact | Resource Directory for details).

Please be aware that as new products are released and post-marketing information on existing therapies becomes available, changes in these lists may occur. Check online for a current list of drugs requiring Prior Authorization (see Pharmacy Services in our Contact | Resource Directory for website details).

All routine prior authorization requests are processed within 36 hours, to include one (1) business day, from the date of receipt of all necessary information. To check the status of a prior authorization call Pharmacy Services (see Contact | Resource Directory).

Prior authorization e-forms are available to help simplify and streamline the prior authorization process. The forms may be accessed on the website or the provider portal. These may be completed online and submitted to the Clinical Pharmacy Department for processing. Blue KC allows up to 45 business days to submit all necessary information for routine prior authorization cases. Prior authorizations are decided within 36 hours, to include one (1) business day, from the date of receipt of all necessary information (see Contact | Resource Directory for details).

All patient information is strictly confidential. Incomplete forms may result in a denial.

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#### Health Services



#### **Required Member Information**

When requesting prior authorization, the physician will need to provide the following member-specific information on the prior authorization form:

- Member name
- Blue KC member ID number
- Medication and the intended length of therapy
- Date of birth
- Relevant clinical information
- If necessary, medical office notes may be required to complete the review

Prior authorization e-forms are available to help simplify and streamline the prior authorization process. The forms may be accessed on the website or the provider portal. These may be completed online and submitted to the Clinical Pharmacy Department for processing. Please allow 36 hours, to include one (1) business day, from the date of receipt of all necessary information for processing (see Contact | Resource Directory for details).



### **Medical Review**

#### What is Medical Review?

Medical Review: The Blue KC claims management system contains clinical edits which identify services that require review by a registered nurse for pre-existing conditions, medical necessity, appropriate billing and coding practices. These clinical edits are comprised of edits set up specific to a member's benefits and contract exclusions, as well as, specific diagnosis and procedure codes used by providers upon claim submission.

Registered nurses review these procedures to verify the member's available benefit for the procedure prior to assessing the medical necessity based on Blue KC medical policies. In the event a procedure does not meet medical necessity criteria, the nurse will forward the case for review by a Medical Director, pursuant to Blue KC procedures. Additional information may be required to complete their review. Other reviews include but are not limited to subset, modifiers and other coding management.

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### **Concurrent Review**

#### What is concurrent review?

Concurrent review enables Blue KC to evaluate continued hospital, rehabilitation, or skilled nursing facility stays for medical necessity and appropriateness. Concurrent review takes place during an inpatient stay as a follow-up to prior authorization.

In this process, the Blue KC nurse reviewers actively monitor the member's progress to ensure that ongoing inpatient care is appropriate. These nurses assist in managing members and facilitate discharge planning. As a result of this management, a member's inpatient stay may be lengthened, shortened, or the member may even be moved to a more appropriate care setting.

#### Procedure for concurrent review

Upon authorization for admission, notification letters are sent to the provider, member and facility. The Blue KC nurse notifies the facility and provider of the number of days initially approved for the admission, and schedules the first concurrent review at the time of initial stay approval.

#### Step 1. Hospital's review nurse—responsibilities

The hospital's review nurse is responsible for initiating all concurrent review calls to Blue KC on the scheduled date at those facilities which do not have a Blue KC Utilization Review (UR) nurse with remote access to the electronic medical record. The hospital review nurse provides medical information that was collected no earlier than the morning of the concurrent review call. Blue KC must receive a call from the hospital by 2:00 p.m. to verify the member's need for continued stay.

#### Step 2. Approval of continued stay

When the continued stay request is appropriate, according to MCG Guidelines, the Blue KC nurse informs the hospital review nurse and provider of the number of additional days approved and the next date for concurrent review. Approval letters will be generated to the provider, facility and member.

#### Step 3. Referral to Medical Director

If the clinical information provided is not sufficient to approve a continued stay, the Blue KC nurse will inform the provider and facility UR staff that the stay will be referred to the Blue KC Medical Director for further review. The facility or provider is given the opportunity to give additional information if they have it and the guidelines are applied. If the additional information is enough to approve, then Step 2 is followed. If the information is not enough to approve by the guidelines, the case is sent to the Medical Director for review.

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#### Step 4. Denial of continued stay

When a continued stay is denied, the Blue KC review nurse will inform the attending provider that the service(s) or day(s) have been denied. The day the denial occurs, or the next business day, the Blue KC nurse will notify the facility UR nurse of the Blue KC Medical Director decision and their reconsideration and appeal rights. Blue KC will send a letter of denial to the hospital, provider and member within 24 hours of the verbal notification.

#### Step 5. Peer-to-peer conversation and appeal of denial

The organization provides, within one business day of request by the attending physician or ordering provider, the opportunity to discuss the denial decision with the Blue KC Medical Director making the initial determination; or with a different Medical Director, if the original Medical Director cannot be available within one business day.

If the peer-to-peer conversation or review does not result in an approval, the organization informs the provider of the right to initiate an appeal and the procedure to do so.

For continued stay denials, the provider or facility may initiate an expedited appeal by calling the Blue KC Medical Director (see Appeals on Contact | Resource Directory).

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## **Case Management**

#### What is the Case Management Program?

Members with chronic, catastrophic, high-risk, or high cost conditions are referred to the Case Management Program for assistance. This program goes beyond short term discharge planning. See the list below for case management referral criteria. For more information about case management services, or to make a referral, call Case Management (see Contact | Resource Directory for details).

#### Case manager

The proactive case manager serves as an ongoing member advocate, ensuring the coordination of care and resources required to maximize the member's medical outcome. There are specialty case managers for pediatrics, obstetrics and transplants.

#### **Little Stars Prenatal Program**

This program helps expectant mothers improve their outcomes if faced with a complex pre-term birth or other pregnancy related complications (see Contact | Resource Directory for details).

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#### Case Management Referral Criteria

Any individual utilizing healthcare resources may be assessed through the complex case management process (extensive assessment and care plan put into place) or coordination of care.

The following is a <u>guide</u> for referring cases that may benefit from complex case management services or coordination of care:

#### **Complex Case Management**

- Severe Trauma: Example: MVA with multi trauma
- Spinal Cord Injury: Example:
   Member became a paraplegic or quadriplegic
- Severe Brain Injury: Example: traumatic brain injury, stroke with multi factorial deficits, aneurysm with multi factorial deficits
- Children and adults sent home for the first time or new baseline with home ventilator
- Complex multi non healing wounds: Example: requires wound vac, long term acute care (LTAC) placement (> 21 days per guideline for admission) frequent IV antibiotic(s) and hyperbaric oxygen
- Pre- or post-transplant members with significant issues and/or complications or rejection (except cornea transplant)

- Neonates requiring multiple resources
- Member using out of area (OOA)facility for cancer treatment (in active treatment)
- Member with behavioral health and medical diagnosis requiring multiple services and nursing interventions
- Multiple resources being used by a member
- Nursing judgement finds a member falls outside the normal referral process. Communicate and problem solve with a case manager regarding the complex medical issue

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#### **Coordination of Care**

- Three or more urgent/emergent acute care admissions within a 6 month time period for any diagnosis or unexpected readmission within 30 days which may indicate member failing at home
- IV or po medication needed by a member: Example: Accredo used for specialty medications, discount coupon education
- Member requiring coordination of services received while away from their home: Example: high flow oxygen
- Member requiring coordination of care in the home health setting
- Member requiring coordination with durable medical equipment (DME) Example: wheelchair too small, suction machine not always providing needed suctioning

- Member on oral chemotherapy and in remission
- Member reaching out requesting assistance with a medical issue
- Members generating \$30,000 \$50,000 in designated time frame
- Nursing judgement finds a member falls outside the normal referral process. Communicate and problem solve with a case manager regarding the medical issue

If a member falls outside the normal referral process, communicate and problem solve with a Case Manager regarding the complex medical issue (see Contact | Resource Directory for additional details).



## **Disease Management**

Blue KC has a well-established population-based, disease management (DM) program, called Healthy Companion™: Working Together for Better Health. The Healthy Companion program is a comprehensive program designed to reinforce the care and treatment provided to Blue KC members with chronic conditions such as diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, asthma, metabolic syndrome and depression. Through education and care management support, this program helps members take a more active and responsible role in controlling their condition. This program is available to all Blue KC members.

#### Who Participates?

Medical and Pharmacy claims as well as other data; such as lab results and Health Risk Assessment information identify members who will be invited to participate in the program. The DM program is a value-added benefit that has no additional cost for the member. The program is based on an opt-out model which considers all identified members unless they choose to opt out.

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#### **Services for Members and Physicians**

Healthy Companion supplies members with education materials, including items such as standards of care for their condition, periodic newsletters, and reminders for needed services such as lab tests and exams.

The Healthy Companion program offers nursing support to Medical Home practices to increase the continuity of care for our members. These Nurse Coordinators assist Medical Home practices with care coordination by identifying and closing gaps in care, helping patients meeting their goals and overcome barriers. Nurse Coordinators also work toward Medical Home quality goal attainment as part of the Blue KC partnership and value-based care strategy.

The program supplies providers with physician support materials, including program description, copies of member materials, and best practice information. On request, Blue KC will also provide patient eligibility registries, outcomes reporting on aggregate population and individual panels, and clinical practice guidelines approved by Blue KC for the care of members with the aforementioned conditions. All of these materials are developed in conjunction with or by the nation's leading medical authorities and associations using evidence-based medicine and best practices.

For questions, comments or to refer a member directly to the Healthy Companion program, please call Healthy Companion (see Contact | Resource Directory for details).

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#### **Medical Records**

Well-documented medical records facilitate communication, coordination and continuity of care, and they promote the efficiency and effectiveness of treatment. The medical record communicates the member's past medical treatment, past and current health status and treatment for future healthcare. Medical records should be maintained in a manner that is current, detailed, organized and permits effective and confidential member care, along with quality review.

#### **Confidentiality of Medical Records**

Blue KC and the provider shall maintain the confidentiality of information contained in the medical records of members in accordance with federal and state laws and regulations as documented in the Physician Participation Agreement/Physician Network Agreement including any incorporated Amendments, Article 1.10. *Confidentiality of Medical Records*.

#### Maintenance, Audit and Access to Records

Documentation in the medical record must reflect the healthcare services rendered to the patient. The provider shall maintain medical, financial, accounting and other records and will:

- Provide records upon request in accordance with your Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments, including but not necessarily limited to
  - o Article 2.10 Maintenance of Records; BCBSKC Access to Records (records to be provided upon request).
  - o Article 2.11 Governmental Agency Access to Records

The provider may be considered in breach of our agreement which may result in termination of participation in accordance with the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments, Article 2.12 Effect of Refusal to Grant Access to Records.

Blue KC may conduct audits and/or reviews of services in accordance with your Physician Participation Agreement/Physician Network Agreement including any incorporated Amendments, Article 5.13 *Blue KC Right to Audit.* 



### **Sending Medical Records to Blue KC**

Medical records include but are not necessarily limited to the following: ER notes, office notes, operative reports, treatment records or any other clinical information maintained by a provider.

For all medical records requests, please attach the request letter to all medical records and fax or mail to the Medical Records address in the Contact | Resource Directory or FAX as indicated in the request letter.



#### **Documentation of Medical Services**

Medical records are expected to contain all elements required in order to file and substantiate a claim for services as well as the appropriate level of care, i.e. evaluation and management services. Each diagnosis submitted on the claim must be supported by the documentation in the patient's medical record. The contracting provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s).

Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be untestable to the reviewer.



Blue KC has the following standards for documentation of medical services. Each patient's health record shall meet these requirements:

- Be legible in both readability and content.
- Contain only those terms and abbreviations that are or should be comprehensible to similar provider/peers.
- Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
- Indicate the dates any professional service was provided and date of each entry.
- Contain pertinent information concerning the patient's condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
- Significant illnesses and medical conditions are indicated on the problem list.
- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, xray, etc.) performed, and the results of each.

- List start and stop times or total time for each CPT code/service performed on all timed codes per CPT nomenclature.
- Document the initial diagnosis and the patient's initial reason for seeking the provider's care.
- Document the patient's current status and progress during the course of treatment provided.
- Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each.
- Include all patient records received from other health care providers if those records formed the basis for treatment decision by the other provider.
- Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the provider's own handwriting.
- Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.



## **Quality Improvement**

#### Working Together to Improve Health Care Quality

Quality Improvement (QI) program information and accomplishments: Blue KC's mission statement declares that the company is committed to using its role as the area's leading health insurer to provide affordable access to healthcare and improve the health and wellness of our members. We pursue this mission by providing our members with comprehensive, affordable health insurance choices; access to quality health providers; knowledge necessary to make informed health care choices; guidance through the health care system; and superior service.

As part of our commitment to improving services to our members and other customers, we annually evaluate the effectiveness of our quality improvement program in order to improve the quality and safety of clinical care and the quality of Blue KC's service. Additionally, we review and update as needed our quality improvement program description and work plan. We also analyze data from complaints and the member and provider experience surveys, physician advisory groups and other feedback to improve our services. Practitioners and providers allow Blue Cross and Blue Shield of Kansas City to use their performance data for activities, such as quality improvement projects, or publicizing the practice's designation as a medical home, or NCQA-recognized patient-centered medical home (PCMH).

In addition to improved service quality, Blue KC continues to promote evidence-based clinical guidelines, wellness and preventive care services, early disease detection, and high-quality care for members with acute and chronic diseases by working in support of our network providers.



### **NCQA** Accreditation

#### Accreditation with distinction

The National Committee for Quality Assurance (NCQA) awarded Blue-Care HMO and Preferred-Care Blue PPO a "Commendable" accreditation status.

NCQA recognizes the commitment of our organization to offering quality healthcare to our community and demonstrates that we have incorporated quality improvements into our efforts to continually enhance the services we provide our members daily.

Our accreditation status was awarded after rigorous evaluation by NCQA of all aspects of our company, including preventive health services, member experience, physician credentialing and quality improvement.

Blue KC staff is extremely proud of this achievement and thanks practitioners for working with Blue KC to improve member health.





#### **Health Plan Accreditation**

Blue KC holds Commendable Accreditation for Blue-Care (HMO).



#### **Health Plan Accreditation**

Blue KC holds Commendable Accreditation for Preferred-Care Blue (PPO).



## Blue KC Provider Office Guide

Medicare for Other Blue Plans Module

#### **Provider Office Guide**

The Blue Cross and Blue Shield of Kansas City (Blue KC) Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue KC. The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

The Provider Office Guide consists of several stand-alone modules of related information.

- Away From Home Care (AFHC)
- Blue KC Basics
- Blue KC Networks Descriptions
- BlueCard
- Claims, Billing and Remittance
- Contact | Resource Directory
- Federal Employee Program (FEP)
- Health Services
- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

The Provider Office Guide modules are updated as needed and can be found at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> on the Resources page. Blue KC also communicates changes and updates periodically through our eNewsletter, BlueSpeak, or by mailing information.

If you are not able to access the internet, contact your Provider Relations Representative to request a printed or electronic copy be sent to you.

Note: In accordance with Article 2.8 Compliance with Policies and Procedures of the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments you agree to comply with all rules, regulations, procedures and administrative policies and programs outlined in the Provider Office Guide.



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### In this Document

This document provides information about serving members of **other Blue Plans** (not local Blue KC) with

- Traditional (Original) Medicare
- Medicare Advantage types: HMO, POS, PPO, PFFS and MSA

Note: Blue KC's Blue Medicare Advantage is an HMO plan with a Medicare contract. For information about the local Blue KC Blue Medicare Advantage plan, please visit <a href="Provider.BlueKCMA.com">Provider.BlueKCMA.com</a> where you will find that Provider Administrative Manual.



## Medicare Advantage (MA)

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage — by calling 1-800-676-BLUE (2583) or submitting an electronic inquiry via the Blue KC <a href="Provider Portal">Provider Portal</a> — for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.



#### **How do I Identify Medicare Advantage Members?**

Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

Member ID cards for	MEDICARE HMO	Health Maintenance Organization
Medicare Advantage	MEDICARE MSA	Medical Savings Account
products will display	MEDICARE PFFS	Private Fee-For-Service
one of the	MEDICARE POS	Point of Service
product logos shown here:	MA PPO MEDICARE ADVANTAGE	Network Sharing Preferred Provider Organization.

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Note: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.



#### **Types of Medicare Advantage Plans**

#### **Medicare Advantage HMO**

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

#### **Medicare Advantage POS**

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

#### **Medicare Advantage PPO**

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

#### Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.



#### **Medicare Advantage PFFS**

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Blue KC.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan and we advise that you review them before servicing MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- For your convenience, you will find MA PFFS Terms and Conditions for all Blue Plans at: <a href="Providers.BlueKC.com">Providers.BlueKC.com</a> by providing the member's three-letter alpha prefix.
- Submit your MA PFFS claims to Blue KC.



# Medicare Advantage PPO Network Sharing

## What is BCBS Medicare Advantage PPO Network Sharing?

All (other Blue) Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider.

Medicare Advantage PPO shared networks are available in the following states and territories:

Alabama	Arkansas	California	Colorado
Connecticut	Florida	Georgia	Hawaii
Idaho	Illinois*	Indiana	Kentucky
Maine	Massachusetts	Michigan	Missouri
Montana	North Carolina	Nevada	New Hampshire
New Jersey	New Mexico	New York	Ohio
Oklahoma	Oregon	Pennsylvania	Puerto Rico
South Carolina	Tennessee	Texas	Utah
Virginia	Washington	Wisconsin	West Virginia

<sup>\*</sup>participating

# What does the BCBS Medicare Advantage PPO Network Sharing mean to me?

If you provide services for any Blue plan's Medicare Advantage PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level.



## How do I recognize an out-of-area member from one of these Plans?

You can recognize a MA PPO member when their Blue Cross Blue Shield member ID card has the following logo.



The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

# Do I have to provide services to Medicare Advantage PPO members from other Blue Plans?

You may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to (other Blue) Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount.

### How do I verify benefits and eligibility?

You can check benefits and eligibility on the provider portal or by calling the BlueCard Eligibility Line at 1-800-676-BLUE (2583) and provide the member's three-digit alpha prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members.

- 1. Log in to provider's website.
- 2. Navigate to Eligibility Access.
- 3. Submit your request



# What is the member cost sharing level and copayments?

A MA PPO member cost-sharing level and co-payment is based on the member's health plan.

You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1-800-676-BLUE (2583).

## May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be balanced billed for any deductibles, coinsurance or copays.

## What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact BlueCard Eligibility (see Contact | Resource Directory).

# Who do I contact if I have a question about MA PPO network sharing?

If you have any questions regarding the MA program or products, contact BlueCard Eligibility (see Contact | Resource Directory).



# Medicare Advantage Eligibility Verification

- Verify BlueCard eligibility by contacting BlueCard Eligibility (see Contact | Resource Directory).
- Be sure to ask if Medicare Advantage benefits apply.

## **Medicare Advantage Claims Submission**

- Submit all Medicare Advantage claims to Blue KC.
- Payment is made directly by a Blue Plan.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.



# Medicare Advantage Reimbursement for PPO, HMO, POS

The reimbursement information in this section applies when a provider treats a Medicare Advantage member enrolled through another Blue plan to whom the provider's contract does not apply. For example:

- A provider contracted for Medicare Advantage PPO business treats a Medicare Advantage HMO member
- A provider contracted for commercial business only treats a MA PPO member
- A provider contracted for commercial business only treats a MA PPO member
- A provider contracted for Medicare Advantage HMO business treats any MA PPO member
- A provider contracted for local Medicare Advantage HMO business treats an out-of-area MA HMO member
- A provider not contracted with the local Plan treats a MA HMO member

Based on the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services. This is the amount you would collect if the beneficiary were enrolled in traditional Medicare.

Special payment rules apply to hospitals and certain other entities, such as skilled nursing facilities, that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Providers paid on a reasonable cost basis under original Medicare should send their CMS interim payment rate letter with their Medicare Advantage claim. The Plan needs this letter to calculate the Medicare allowed amount.

Other than the applicable member cost sharing amounts, a Blue Plan or its branded affiliate make reimbursements directly. In general, you may collect only the applicable cost-sharing (for example copayment) amounts from the member at the time of service, and may <u>not</u> otherwise charge or balance bill the member.

Note: Enrollee payment responsibilities can include more than copayments, for example deductibles.

Please review the remittance advice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.



## Medicare Advantage Reimbursement for Private-Fee-For-Service (PFFS)

If you have rendered services for Blue out-of-area Medicare Advantage PFFS members, but have no obligation to provide services to such members under a contract with a Blue plan, you are generally reimbursed the Medicare allowed amount for all covered services. This is the amount you would collect if the beneficiary were enrolled in traditional Medicare. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the terms and conditions under the member's Blue Plan. You can find the MA PFFS terms and conditions on the provider portal at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a>. Select the link to the Medicare Advantage Provider Portal, log in and then enter the member's three-letter alpha prefix.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (for example copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance advice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations

If you are a provider who accepts Medicare assignment and you render services to any Medicare Advantage member enrolled with another Blue plan for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual plan contractual arrangements.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance advice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.



# Medicare Advantage Claims Status Inquiries

You can make claim status inquiries through Claims Search on the provider home page at the Blue KC website, or by submitting an electronic inquiry to Blue KC.

### **Medicare Advantage Utilization Review**

Patients are responsible for obtaining precertification/authorization for their services from their Blue Plan.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

You can also contact members' Plans on their behalf:

For other Blue Plans members, do one of the following:

 Call BlueCard Eligibility then ask to be transferred to the utilization review area.

The member's Blue Plan may contact you directly about clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

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Providers.BlueKC.com
Provider Hotline: 816-395-3929

#### Medicare for Blue Plans



### **Traditional Medicare-Related Claims**

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is the primary payor, submit claims to your local Medicare intermediary.
- All Blue claims are set up automatically to cross-over to the member's Blue Plan after adjudication by the Medicare intermediary.

# How do I submit Medicare primary/Blue Plan secondary claims?

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification. In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- Include the alpha prefix as part of the member identification number. The
  member's ID includes the alpha prefix in the first three positions. The alpha
  prefix is critical for confirming membership and coverage, and key to
  facilitating prompt payments.

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Provider Hotline: 816-395-3929

#### Medicare for Blue Plans



#### When should I expect to receive payment?

Claims submitted to the Medicare intermediary are crossed over to the Blue Plan only after they have been processed, which may take up to 30 business days. This means that the Medicare intermediary releases the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 30 business day for you to receive payment from the Blue Plan. After receiving the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan.

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue KC with the Medicare remittance advice.

#### What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, do not submit another claim. Duplicate claims will result in processing and payment delays. Instead, you should:

- 1. Wait 30 days.
- 2. Check claims status before resubmitting.
- 3. Review the automated resubmission cycle on your claim system.

Note: Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

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Provider Hotline: 816-395-3929



# Blue KC Provider Office Guide

New Directions Behavioral Health (NDBH)
Module

### **Provider Office Guide**

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- Medicare for Other Blue Plans
- New Directions Behavioral Health (NDBH)
- Provider Credentialing and Contracting
- Specialty Services

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## New Directions Behavioral Health (NDBH)



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## New Directions Behavioral Health (NDBH)



## **Overview**

Blue KC contracts with New Directions Behavioral Health for coordination of all behavioral health, psychiatric and/or substance abuse services for members.

See the Contact | Resource Directory for information on reaching New Directions.

## New Directions Behavioral Health (NDBH)



## **Obtaining Appointments**

If a member requires behavioral health, psychiatric and/or substance abuse services, a PCP referral is not necessary. However, your staff can call the Physician Help Line for immediate assistance if your patient has an urgent need or you need to discuss a case with a clinician. The member may be instructed to call New Directions. An appointment will be scheduled at a convenient location with a provider who has expertise in the member's specific needs.

#### **Consultations**

If a physician treating a member on a medical/surgical unit requires a psychiatric consultation or evaluation, please contact New Directions staff. New Directions will provide a psychiatrist to evaluate the member.

#### **Additional Services**

- Telephone consultation 24 hours a day, seven days a week by a licensed behavioral health professional
- Consultation with a psychiatrist to consider treatment options for members with behavioral health concerns
- Referrals for urgent and emergency same day and next day appointments
- Prevention services for at-risk members including telephone support. In addition, educational materials are provided for members with depression, attention deficit hyperactivity disorder, and bipolar disorder.
- Physician HelpLine for immediate consultation and referrals when a physician's office calls
- Online educational resources at www.ndbh.com

## New Directions Behavioral Health (NDBH)



## **Prior Authorization**

To prior authorize mental health or substance abuse services, please call New Directions. See the Contact | Resource Directory for information on reaching New Directions.

For Mem	iber's Plan	Prior Authorization Requirement
	Ds: Blue-Care	<ul> <li>Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.</li> </ul>
		<ul> <li>No authorization required for outpatient services.</li> </ul>
		<ul> <li>Precertification is required for all inpatient, residential, partial hospitalization and intensive outpatient services.</li> </ul>
HMOs:		<ul> <li>Applied Behavior Analysis (ABA)         requires prior authorization from         first visit. A reference number will         then be assigned. (For         authorizations related to Autism         services, please refer to the Applied         Behavior Analysis for the Treatment         of Autism Spectrum Disorder         Medical Policy located under the         provider section of         www.ndbh.com.)</li> </ul>
		<ul> <li>Authorization is required for psychological testing after three (3) hours of testing.</li> </ul>
		<ul> <li>Authorization required for neuropsychological testing after eight (8) hours of testing</li> </ul>
PPOs:	Preferred-Care Preferred-Care Blue	<ul> <li>Failure to obtain prior authorization may result in denial of payment.</li> <li>Refer to the member's plan for</li> </ul>

## New Directions Behavioral Health (NDBH)



specific benefits and authorization
requirements.
<ul> <li>No authorization is required for outpatient services.</li> </ul>
<ul> <li>Precertification is required for all inpatient, residential, partial hospitalization and intensive outpatient services.</li> </ul>
ABA requires prior authorization from first visit. A reference number will then be assigned. (For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the provider section of <a href="https://www.ndbh.com">www.ndbh.com</a> .)
<ul> <li>Authorization is required for psychological testing after five (5) hours of testing.</li> </ul>
<ul> <li>Authorization is required for neuropsychological testing after five (5) hours of testing</li> </ul>

## **Medical Necessity Guidelines**

New Directions developed the Level of Care guidelines to determine medical necessity for behavioral healthcare. These guidelines are revised through the New Directions Quality Improvement Committee on an annual basis. This committee consists of New Directions network providers and senior clinical staff.

## **Claims**

Claims for behavioral health services should be sent electronically to Blue KC or sent by paper. See the Contact | Resource Directory for Claims address or the

## New Directions Behavioral Health (NDBH)



Contact | Resource Directory | New Directions Behavioral Health for correspondence address information.



## Blue KC Provider Office Guide

Provider Credentialing and Contracting Module

## **Provider Office Guide**

The Blue Cross and Blue Shield of Kansas City (Blue KC) Provider Office Guide has been developed to provide you and your staff with basic, important information about Blue KC. The office guide is intended to assist you in understanding the key policies and procedures applicable to your practice.

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## Provider Registration, Credentialing and Contracting

At a high level, a provider may become contracted with Blue KC following these steps:

- 1. Registering with CAQH.
- 2. Submitting the Blue KC Credentialing & Contracting Application Form.
- 3. Being successfully evaluated by the Blue KC Corporate Credentials Committee.
- 4. After committee approval, being offered a Contract for review and signature.

#### The following steps describe the process in greater detail.

- 1. The provider registers at the Council for Affordable Quality Healthcare (CAQH) website (see Contact | Resource Directory for website).
  - a. Please authorize Blue KC access to your online credential information.
- 2. After completing CAQH registration, the provider completes and submits the Blue KC Credentialing & Contracting Application Form.
  - a. The Credentialing Department will then download the necessary information from CAQH and begin the credentialing process.

Note: At this time in the process, any claims submitted by the provider to Blue KC will be processed as out-of-network, and any payment will be sent to the member. Alternatively, payment may be sent to a contracted supervising physician at an in-network level, if claims are submitted by the supervising physician who attests to the services being provided by the non-network provider.

- 3. If all the CAQH information is accurate and complete, the credentialing process will take approximately 45 to 60 days. Completed applications are presented to the Blue KC Corporate Credentials Committee for review and final approval. The Credentials Committee meets on a monthly basis. Please contact the appropriate Provider Relations Representative (see Contact | Resource Directory) for more information.
- 4. After Committee approval, the provider may be offered Blue KC contracts for



network participation.

5. If a provider is employed or contracted with a physician entity that previously signed a Blue KC Employed Physician Group Agreement, the provider is not required to sign individual Blue KC contracts. In this instance, the provider participates in the same networks selected by the physician entity. The effective date of the provider participation is normally the credentialing approval date.

Note: Even though the providers' effective date is the credentialing date, the provider will need to verify the provider setup is complete in the Blue KC system before filing claims.

Otherwise they will process as an out-of-network provider until the setup is completed.

- 6. If a provider is not employed by a physician entity, contracts may be emailed to the provider after the credentialing application has been approved by the Credentials Committee. Provider participation in Blue KC networks is effective based on one of the following scenarios:
  - a. If the provider is part of an employed group agreement, the network effective dates coincide with the provider's credentialing date.
  - b. If the provider is signing individual agreements, the effective date is the credentialing date as long as Blue KC receives e-signed contracts from the provider within 30 days.
- 7. Upon contract execution, the Provider Services staff loads the provider's applicable networks into the claims processing system.
- 8. The enrollment and contracting process is specific to the location and configuration of the provider entity at the time of contracting.

  Notwithstanding any corporate transaction involving two or more existing contracted entities, a provider will continue to be subject to the terms of the Network Agreement associated with that location and configuration unless Blue KC gives its prior written consent. For example, if one contracted entity acquires another contracted entity, the resulting entity may not elect to submit claims under a single Network Agreement without Blue KC consent, even though both previously contracted entities may share the same Federal Tax Identification Number, National Provider Identifier (NPI), or licensure.



Note: Provider will be notified when the final setup of Blue KC systems are complete and the provider may begin submitting claims.

## Credentialing

## What is Credentialing?

Blue KC performs credentialing on all providers to ensure that its members have their health care needs met by appropriately qualified providers. **Credentialing** is the initial verification that a provider's credentials meet the criteria established by Blue KC for education, training, licensure and experience. **Recredentialing** of providers occurs at a minimum of every three years following initial credentialing.

The Blue KC Corporate Credentials Committee is responsible for establishing the corporate credentialing policies and procedures, and for initial credentialing and recredentialing decisions. These policies and procedures govern provider participation in the Blue KC networks and all subsidiaries and affiliates, including (but not limited to) Good Health HMO, Inc. These policies and procedures are reviewed at least annually, and revised and approved as needed. Such reviews or revisions are reported to the appropriate governing bodies. The Blue KC Corporate Credentials Committee meets monthly or as often as necessary.

To obtain a copy of the meeting calendar, please contact the Blue KC Credentialing department at (see Contact | Resource Directory). Providers applying for initial credentialing will be notified by letter within 10 business days from the Credentials Committee decision that their application has been approved. This letter does not mean the setup is completed or that claims can be filed and processed as in network. The provider will need to verify the setup is completed before filing claims for in-network claims processing. A provider is considered to be recredentialed unless otherwise notified. Providers for initial credentialing and/or recredentialing will be notified within 10 business days by special notification letter of any adverse decision and which will include an explanation for the decision and the provider's applicable rights to appeal.



Note: For questions regarding the facility credentialing application please contact the Blue KC Credentialing Department (see Contact | Resource Directory).

As a part of the CAQH registration process, the applicant is required to sign and date an Attestation/Authorization verifying the correctness and completeness of the application and indicating authorization for primary source verification. You will also be required to submit copies of your license, certificate of insurance, DEA certificate, BNDD certificate (MO providers only) to CAQH.

Blue KC will not process credentialing applications older than 180 days. The standard practitioner application shall include a statement by the practitioner regarding the following:

- Any inability to perform the essential functions of the position
- Lack of impairment due to chemical dependency and/or substance abuse
- History of loss of license and /or felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage

#### Criteria

An applicant shall be evaluated in accordance with the process and criteria established by the Blue KC Corporate Credentials Committee. Credentials must be valid at the time of the Committee review and must be verified within the 180-day time limit. Minimum criteria for review include:



- Current valid license
- Clinical privileges in good standing at a Blue KC participating facility or arrangements with hospitalists. (Practitioner only)
- Valid DEA certificate (the DEA must reflect the current practice location address)
- Valid BNDD certificate (MO only) (the BNDD must reflect the current practice location address)
- Education, training and residency or special training of physician (Practitioner only)
- Board certification, as applicable (Practitioner only)

- Proof of current malpractice insurance
- History of professional liability claims history
- Medicare/Medicaid sanction activity
- Sanctions or limitations on licensure
- Past 10 years of work history with verification of gaps greater than 6 months (include month and year) (Practitioners Only)
- National Practitioner Data Bank query
- Accreditation Certificate (Facility Only)
- State Survey completed within the past 36 months (Facility Only)

#### **Provider Review of Application**

A provider has the right to review information obtained by Blue KC to evaluate his/her credentialing application. This review may include information from any outside primary source (for example, malpractice insurance carriers or statelicensing boards). The Blue KC Credentialing department will make a reasonable effort to complete primary source verification within 45 to 60 days of receiving a completed application from the provider. The provider has the right to correct erroneous information and, upon request, to be informed of the status of his/her credentialing or recredentialing application.

### Recredentialing

#### **Process**

All Blue KC providers are recredentialed at a minimum of every three years or more often as needed. The recredentialing process is initiated by Blue KC. Practitioners need to keep their CAQH Application up to date and re-attest that the information profile is correct.

Blue KC Facility applications must be completed and returned to Blue KC within 30 days of a Blue KC's request.



#### **Access to Information**

The recredentialing process assures that the Blue KC Corporate Credentials Committee has access to all pertinent information from quality improvement and risk management activities. Blue KC monitors performance of all providers on an ongoing basis. Information given to the Committee includes:

- Member complaints and grievances
- Performance in Blue KC quality programs
- State and Federal Sanctions
- Sanctions or limitations on licensure

#### **Results of Recredentialing**

Based on recredentialing results, a provider may be recredentialed, placed on a corrective action plan, or decredentialed. The provider is considered to be recredentialed unless otherwise notified in writing.



## **Decredentialing and Reasons for Termination**

The Blue KC Corporate Credentials Committee shall hear and review all information available to evaluate the applicant's:

- Current professional competence qualifications
- Standards and Quality of Care
- Adherence to the ethics of the applicant's profession
- Disciplinary actions

- Failure to maintain current, continuous, required malpractice insurance
- Malpractice claims
- Falsification of information or documentation supplied as part of the credentialing application

In reviewing the applicant, the Blue KC Corporate Credentials Committee may conduct such investigation as it deems necessary to make a decision, and to determine whether the applicant is qualified for network participation.

In the event of an adverse decision based on quality of care or service, the provider will be notified of the Corporate Credentials Committee decision in writing. The provider will be offered an appeal right and any such action taken by Blue KC shall be carried out in accordance with requirements of the Healthcare Quality Improvement Act of 1986 and state statutory requirements. The provider will be afforded all appeal rights under these requirements. The provider shall be notified within 10 business days of any decision of the Corporate Credentials Committee.

A provider with existing and current credentials can be immediately terminated from Blue KC and all subsidiaries. Reasons for termination include, but are not limited to, the following:

- Lack of a currently valid license in the States of Missouri or Kansas including probation,
- License suspension or revocation.
- Failure to maintain current malpractice coverage.

- Conviction of a felony.
- Lack of a currently valid DEA and/or BNDD certificate.
- Expulsion or suspension for sanctions from the Medicare/Medicaid program.



# Blue KC Provider's Office Guide

**Specialty Services Module** 

## **Provider Office Guide**

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## **Special Service Arrangements**

Blue KC may contract for Special Service Arrangements with Network Providers from whom a Covered Individual must obtain such services in order to receive



maximum benefits under his/her Benefit Plan. The Special Service Arrangements may be developed for any designated area of health benefits coverage. The physician agrees that when any such Special Service Arrangements are made, the physician will admit or direct Covered Individuals to those Network Providers that participate in the Special Service Arrangement. Notice will be provided to all Network Physicians in advance regarding all new Special Service Arrangements.

### What are Special Service Arrangements?

Blue KC may contract with a select network of physicians for designated areas of health benefits. These select networks must be used by members. To the extent you provide services subject to a Special Services Arrangement and you are not participating in such arrangement, Blue KC will not pay for such service and you must hold the member harmless.

### **Laboratory Services**

Currently, Quest Diagnostics is the exclusive, outpatient reference laboratory provider for these Blue KC products: Blue-Care, BlueSelect and BlueSelect Plus.

Streamlining Blue KC outpatient reference laboratory provider services to one vendor not only provides a more complete and organized system of ensuring quality care, but also simplifies data transfer to better meet NCQA and HEDIS reporting responsibilities.

Providers are required to direct members of these plans to Quest Diagnostics for their outpatient reference laboratory service needs. A list of Quest Diagnostics draw stations may be obtained on the Blue KC provider portal at <a href="Providers.BlueKC.com">Providers.BlueKC.com</a>.

### **Prescription Drugs**

Members are supplied with a listing of participating pharmacies. Members are responsible for notifying their physicians of the correct pharmacy to use.

## Home Health Agencies (HHA)

#### **HHA Policies**

The purpose of these descriptive policies and procedures is to provide specific explanations of provisions contained within a supplier's contract, and is intended to clarify contractual obligations and supplier's rights.

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Providers.BlueKC.com

Provider Hotline: 816-395-3929



#### **Claims Filing**

- FEP claims should be submitted on a CMS 1500 claim form using the appropriate CPT or HCPCS codes.
- For all other lines of business, the services should be reported using revenue codes on a UB04 claim form.
- All claims must be submitted within 180 days from the date of service.

#### Review/Appeals

The appeals process will be conducted by the Blue KC Medical Director and/or consultants qualified to make decisions as they relate to negotiated rates, medical necessity or general policy. All pertinent information should be forwarded to the Appeals Department.

## **Utilization Review and Medical Necessity**

Provider network contracts require physicians to cooperate in utilization review and medical necessity determinations. Utilization review is the process used to determine the appropriateness of services provided to members and payments made on behalf of members.

#### **Prior Authorization**

- For BlueCard members please check with the member's home Plan for authorization requirements.
- Prior authorization is not required for Blue KC members.

See Contact | Resource Directory | Prior Authorization/Pre-Determination | Notes or Contact | Resource Directory | Provider Portal for website details.



## **Home Infusion Therapy (HIT)**

Home infusion providers are licensed pharmacies who provide a wide range of services required to administer home infusion and nutritional therapies.

Drug therapies typically provided by a home infusion pharmacy include compounded solutions for parenteral, antibiotics, chemotherapy, pain medications, total parenteral nutrition (TPN), and other drug therapies. However, home infusion pharmacies may provide additional professional therapies, including enteral nutrition.

### Per Diem Payment

The term "per diem payment" is a payment for each day that a given patient is provided actual infusion therapy in the home as prescribed by his or her physician. The expected course and duration of the treatment shall be determined by the plan of care as prescribed by the ordering physician. When you perform a home infusion, you receive a per diem payment. The following services are included in the per diem reimbursement for the type of infusion therapy performed and are not to be billed separately.



## Products and Services Included in the Per Diem Payment

#### **Pharmacy Professional and Cognitive Services**

- Catheter care (except when provided as a stand-alone therapy)
- Comprehensive knowledge of vascular access systems
- Development and implementation of pharmaceutical care plans
- Drug utilization review
- Medication profile setup
- Other applicable professional and cognitive services
- Patient educational activities
- Recommendation of dosage or medication changes based upon clinical findings
- · Compounding of medications
- Coordination of care with physicians, nurses, patients, their families, other physicians, and other caregivers

- Diluents and flushes: Sterile water, sodium chloride, saline flush, heparin flush initial and ongoing patient assessment and clinical monitoring
- Monitoring of potential drug interactions
- Patient discharge services, including communication with other medical professionals and closing of the medical record
- · Pharmacokinetic dosing
- Review and interpretation of patient test results
- Sterile procedures, including intravenous admixtures, clean room upkeep, vertical and horizontal laminar flow hood certification, and all other biomedical procedures necessary for a safe environment

### **Infusion Therapy Related Supplies**

- Durable, reusable infusion pumps
- All other infusion therapy administration devices
- Other applicable supply expenses Elastomeric, disposable infusion pumps
- Short peripheral vascular access devices

- Infectious waste storage and removal
- Needles, gauze, sterile tubing, catheters, dressing kits, saline or heparin flushes and other supplies necessary for the safe and effective administration of infusion therapy



## Comprehensive 24 hours per day, 7 days per week delivery and pick-up services

Mileage and the constant availability of a dedicated infusion team consisting of pharmacist(s), nurse(s), delivery team, and all other medical professionals responsible for clinical response, problem solving, trouble shooting, question answering, and other professional duties during evenings, weekends, holidays, and all other times.

#### **Clinical Coordination**

- Development and monitoring of nursing care plans
- Development of patient assessment and patient education materials
- Case management services
- Coordination of benefits, care and services
- Coordination of non-infusion related services
- Measurement of field nursing competency with subsequent education and training
- Coordination, education, training and management of field nursing staff (or subcontracted agencies)

#### **Other**

- Overhead and operational expenses
- Inventories and accounts receivable
- · Costs associated with insurance requirements
- Costs associated with accreditation requirements
- Costs associated with administrative requirements

#### Products and Services not Included in the Per Diem

- Medications (drugs) and enteral formulae
- · PICC and midline insertion and associated supplies
- Blood products

- Field-based nursing services
- Surgically implanted central vascular access devices



## **Home Infusion Therapies**

### Antibiotics, Antifungals, and Antivirals

Bill per diem "S" codes for services associated with the provision of antibiotics, antifungals, and antivirals, using codes that specify frequency of administration (Q3H, Q4H, etc.). Use the general code S9494 if an "S" code is unavailable for the frequency. When using these codes, code all drugs and nursing visits separately.

## Chemotherapy

Use the per diem "S" codes that specify continuity of administration for the services associated with the provision of chemotherapy administered continuously or intermittently. Continuous administration is defined as that which occurs without interruption over a period of 24 hours or more; intermittent administration is chemotherapy administered for a period of less than 24 hours. When using these codes, code all drugs and nursing visits separately.

#### **Enteral Nutrition**

Bill the per diem "S" codes for services associated with the provision of home enteral nutrition, administered via gravity, pump, or bolus using codes that specify route of administration. Per diem includes all pump, feeding/supply kits, enteral buttons, and extension sets. Code all nursing visits and all enteral formulae separately.

When billing enteral formulae, please bill using the appropriate "B" code and the units specified. Please submit physicians order, NDC code, and from and to dates with each claim submitted. Please work with the physician's office to complete conversion from cans to calorie units prior to submission of claim if necessary.

## **Hydration Therapy**

Bill the per diem "S" codes for services associated with the provision of hydration therapy using the codes that specify volume of fluid. Use the general code S9373 if an "S" code is unavailable for the volume, and for fluid volume of less than one liter. Code all drugs and nursing visits separately.



## Pain Management

Use the per diem "S" codes for services associated with the provision of pain management administered continuously or intermittently. Continuous administration is defined as administration occurring without interruption over a period of 24 hours or more. Intermittent administration is for pain medications administered for a period of less than 24 hours. When using these codes, code all drugs and nursing visits separately.

### **Total Parenteral Nutrition (TPN)**

Bill the per diem "S" codes for services associated with the provision of TPN, using codes that specify volume of fluid. Use the general code S9364 if an "S" code is unavailable for the volume. Use S9365 for fluid volume of less than 1 liter. Code nursing visits separately. Some components of the TPN formula are included in the per diem, but all other drugs are coded separately. Specifically, products used in a standard TPN formula and included in the per diem are:

- Non-specialty amino acids (for example Aminosyn, FreAmine, Travasol)
- Sterile water
- Standard multi-trace element solutions (for example MTE4, MTE5, MTE7)
- Catheter care, when provided in conjunction with TPN is included in the TPN per diem

- Concentrated dextrose (for example D10, D20, D40, D50, D60, D70)
- Electrolytes (for example CaCl2, KCL, KP04, MgSo4, NaAc, NaCl, NaP04)
- Standard multivitamin solutions (for example MVI-13)



#### Not Included in the TPN Per Diem

The following items are to be coded separately.

- Specialty amino acids for renal failure (for example Aminess, Aminosyn-RF, NephrAmine, RenAmin)
- Specialty amino acids for high stress conditions (for example Aminosyn- HBC, BranchAmin, FreAmine HBC, Trophamine)
- Lipids (for example Intralipid, Liposyn)
- Added vitamins not from a standard multivitamin solution (e.g., folic acid, vitamin C, vitamin K)
- Please include appropriate NDC code for all billable medications.
- Specialty amino acids for hepatic failure (for example HepatAmine)

- Specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted patients (for example Aminosyn 15%, Novamine 15%, Clinisol 15%); if specialty amino acids are not medically necessary for the patient's condition but are standard protocol, they are not separately billable but part of the TPN per diem
- Added trace elements not from a standard multi-trace element solution (for example chromium, copper, iodine, manganese, selenium, zinc)
- Products serving non-nutritional purposes (for example heparin, insulin, iron dextran, Pepcid, Sandostatin, Zofran)

While extensive, the above lists cannot be all inclusive. Other products may appropriately be included in the categories of these lists. Trade names are used to provide a standard for communication. The use of trade names is neither a product recommendation nor comment on extent of use in practice.

### **Miscellaneous Infusion Therapies**

Bill per diem "S" codes for services associated with the provision of miscellaneous infusion therapies. Use the general code S9379 for miscellaneous infusion therapies not otherwise described by other per diem "S" codes. Code all drugs and nursing visits separately.

## Miscellaneous Non-Infusion Therapies

Bill per diem "S" codes for services associated with the provision of miscellaneous non-infusion therapies. Use general code S9542 for miscellaneous non-infusion therapies not otherwise described by other per diem "S" codes.

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#### **Catheter Care**

Use per diem "S" codes for services associated with the provision of catheter care, billable only when provided as a stand-alone therapy, or during days not covered under per diem by another therapy. The codes specify the maintenance for single or multiple lumens in the catheter or for an implanted access device (i.e., implanted port). As with most other per diem HCPCS, code all drugs and nursing visits separately for services associated with routine catheter care.

## **Nursing Services for Home Infusion**

The provision of home infusion sometimes requires home nursing visits. Since the per diem "S" codes exclude nursing visits, code each nursing visit lasting up to two hours using CPT code 99601. To report more than two hours, use CPT code 99602 with the appropriate number of units:

99601 - Home infusion/specialty drug administration, per visit (up to 2 hours).

99602 - Each additional hour (list separately in addition to primary procedure).

Use 99602 in conjunction with code 99601.



#### **Modifiers**

Two situationally used modifiers allow specifications of second, third, or more therapies provided in addition to primary therapy:

- SH Second concurrently administered therapy
- SJ Third or more concurrently administered therapy

#### Example

You provide a second anti-infective infusion drug therapy in a separately compounded IV bag during some of the same days as you provide a first anti-infective drug therapy. To bill the second, less expensive therapy for the overlapping per diem service days, append -SH to the "S" code.

Although Blue KC is prepared to accept these modifiers, our payment methodology will not change at this time. The company is currently investigating policies as they relate to the payment of second therapies.

The -SH and -SJ modifiers apply only to multiple therapies within the same category. For example, if a patient receives TPN and anti-infective therapy on the same day, do not use a modifier. The TPN and anti-infective per diem are allowed in full.

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### **Drugs**

A drug is a pharmacological agent which by federal law cannot be dispensed without a prescription.

Certain drugs do require prior authorization. Please consult the provider portal for a list of these drugs (see Contact | Resource Directory).

Blue KC has contracted a specialty pharmacy network to provide specific medications outside the home infusion contract. Included in these are drugs that may be billed by home infusion companies, are applied through the member's medical benefits, are priced at the specialty pharmacy rate, and for which no per diem will be paid.

There are also drugs that are not included under the home infusion contract, including growth hormones. These medications are included in the member's pharmacy benefit and must be obtained by the member through a contracted retail center, mail or specialty pharmacy. From time to time, certain specialty pharmacy medications, such as Hemophilia Factor may be restricted to a specified provider network.

All drugs should be billed using the appropriate and actual HCPCS J-Code. Only when no code is available, should you use code J3490. Please include the appropriate NDC code when billing J3490 or any other not otherwise classified medication.

We do not require a certificate for home infusion be included with your claim. However, all claims are still subject to a periodic audit where the certificate may be requested for review.

#### **Certification Process**

Infusion providers are no longer required to submit a Certificate of Medical Necessity (CMN) documents with claims. This applies to all Blue KC networks. To accommodate specific claims adjudication or retrospective review, you must keep the CMN documents in your patient files.

## **Home Setting**

Blue KC provides home infusion therapy benefits for services provided in the home. Services provided in a non-home (i.e. skilled nursing or hospital) setting should be billed as part of that physician's regular billing.



#### **HIT Provider Number**

All home infusion therapy is billed on a CMS 1500 with your assigned HIT provider number. Many HIT providers also provide other lines of business (i.e., home health services and home medical equipment). Blue KC requires a separate provider number and contract for each line of business.

When billing electronically please use your NPI number in place of the 8 digit provider number. When billing on paper for home infusion therapy please remember to include your 8 digit HIT provider number in both box 33B and in box 24J of the CMS 1500 for each billable line of service.

## **Billing Drugs**

All drugs having an assigned procedure code should be billed with that procedure code. Only drugs not having an assigned procedure code should be billed using J3490, J3590 or other NOC codes and require the NDC code(s).

## **Supplies**

The per diem methodology and fees are inclusive of supplies, as previously noted. Blue KC monitors supplies that are billed separately. The following are examples of supplies that are not separately billable:

- Syringes
- Needles
- Pump supplies
- Tape
- Enteral buttons and extension sets
- Gauze
- Transparent film
- IV poles
- Enteral feeding supply kits
- Saline or heparin flushes

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#### Certificate for Home Infusion

Although recommended, you are not required to use this form but you must have the following information available to accommodate specific claim adjudication or a retrospective review.

- Medication dispensed
- Initial certification/recertification from and to dates
- Frequency
- Method of administration

- NDC code for each medication
- Dosage
- Duration
- Therapy specific information noted in the document

## **Service Information Inquiries**

If you feel a claim has been processed incorrectly:

- 1. Contact the Provider Hotline (see Contact | Resource Directory).
- 2. If they are unable to adjust the claim or answer all or part of your questions, submit a Claim Inquiry form.
- 3. If after this review, you still feel a mistake has been made you may write a letter of formal inquiry to the attention of your home infusion Provider Relations Representative.

## When Submitting a Formal Inquiry, please include:

- A detailed description of your inquiry
- Additional documentation supporting your assertions.
- Remittance advice

- · Certificate of home infusion
- Nursing notes
- A copy of the original claim and corrected claim when applicable

You should receive a written response to both your claim inquiry and your formal inquiry, giving you the reason(s) for the allowed amounts on your claim.



## **Pharmacy Services**

## **Department Profile and Summary of Operations**

The Clinical Pharmacy Department is part of the Integrated Health Services (IHS) Division. All pharmacy benefit management operations are coordinated internally, with the exception of claims processing which is facilitated by Express Scripts, Inc. (ESI), St. Louis, Missouri. The Clinical Pharmacy Department handles the following functions and responsibilities:

- Drug utilization management
- Clinical support for the Medical and Pharmacy Management Committee (MPMC)
- Prescription Drug List management (formulary)
- Prior authorization for medications
- Physician and pharmacist education
- Department Profile and Summary of Operations
- Pharmacy Network

- Specialty Pharmacy Program
- Prescription Drug List (PDL)
- Utilization Management of Medication
- Pharmaceutical industry liaison
- Prescription claim oversight
- Pharmacy case management
- Cost management
- Support for Integrated Health Services staff
- Academic detailing

See the Contact | Resource Directory for information on reaching Pharmacy Services.



## **Pharmacy Network**

Blue KC has a pharmacy network available to its members through ESI. The member's Blue KC identification card reflects the pharmacy network a member may access.

## **Specialty Pharmacy Program**

A Specialty Pharmacy is one that provides specialized care for patients with complex chronic health conditions such as rheumatoid arthritis, multiple sclerosis, psoriasis, and others. These pharmacies do everything from dispense the specialty medication to help patients manage their health condition. The following is a list of other services provided by the Specialty Pharmacies:

- Assigns a Patient Care Coordinator who serves as a personal advocate and point of contact
- Provides the necessary supplies to administer the medications — at no additional cost
- Provides patients with refill reminder calls
- Works directly with patients to arrange a convenient shipment date
- Coordinates with Blue KC to take care of billing issues

- Offers access to a dedicated clinical staff of nurses and pharmacists who are knowledgeable about the medications and conditions
- Offers care management programs to help patients get the most from their medication
- Allows the medications to be delivered to either the physician's office or patients home
- Ships all medications overnight

These services are provided at no additional cost. Prescriptions for a specialty medication must be filled by a designated Specialty Pharmacy. See the Contact Resource Directory for information on reaching a Specialty Pharmacy. All new biotech medications (i.e., Xolair, Tysabri and Orencia) require prior authorization and must also be obtained from one of our specialty pharmacies. The specialty pharmacy will be able to provide the injectable medications to either the prescriber's office or the patient's home, and will bill Blue KC directly for the medication. Most specialty medications are covered under the pharmacy benefit. For a list of specialty medications including those covered under the medical benefit, please refer to the Prescription Drug List (PDL) (see Contact | Resource Directory | Prior Authorization/Pre-Determination | Notes or Contact | Resource Directory | Provider Portal for website details).



## **Prescription Drug List (PDL)**

The Medical and Pharmacy Management Committee (MPMC) of Blue KC develops and maintains the Prescription Drug List (PDL). The committee is composed of practicing providers and pharmacists within the Kansas City area. Quarterly meetings are held to evaluate new drug therapies and review drug utilization issues. Medications are evaluated on the basis of safety, effectiveness, adverse events, cost, and proven advantages over existing agents.

#### **Closed Formulary**

Some employer groups may have selected a closed formulary option to better control utilization and cost. In this situation, most drugs categorized in the top tier will not be covered. If a member has failed or is intolerant to a formulary medication (1st or 2nd tier), the prescribing provider can submit documentation to request coverage of a non-formulary medication.

#### **New Products**

Any new branded medication will automatically be assigned to the top cost-sharing tier until reviewed by the Committee. Please be aware that as new products are released and post-marketing information on existing therapies becomes available, changes in the PDL status may occur. Physicians will be notified of any such changes through newsletters and direct mailings.

#### **Online**

You can access the Prescription Drug Lists (PDL) on the provider portal (see Contact | Resource Directory).

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#### **Prior Authorization for Medication**

Blue KC may implement prior authorization processes as deemed necessary. Prior authorization is required in instances where there are safety concerns and significant risk of drug/drug interactions. Prior authorization is also required to ensure that the manufacturer's recommended dosing guidelines are followed.

#### **Member Information**

When requesting prior authorization, the physician will need to furnish the following member-specific information on the prior authorization form:

- Member name
- Blue KC member ID number
- Medication and the intended length of therapy
- Date of birth
- Relevant clinical information
- If necessary, medical office notes may be required to complete the review

#### **Medications Requiring Prior Authorization**

Please be aware that as new products are released and post-marketing information on existing therapies becomes available, changes in this list may occur. Physician and pharmacy providers will be notified of any such changes via newsletters and direct mailings. Check online for a current list of drugs requiring Prior Authorization (see Pharmacy Services in our Contact | Resource Directory for website details).

All prior authorization requests are processed within 36 business hours. To check the status of a prior authorization call Pharmacy Services (see Contact | Resource Directory). Prior authorization forms are available to help simplify and streamline the prior authorization process. The forms may be accessed on the provider portal. These may be completed and submitted online to the Clinical Pharmacy Department for processing. Please allow 36 hours - to include one (1) business day from date of receipt of all necessary information - for determination (see Contact | Resource Directory for details).

All patient information is strictly confidential. Incomplete forms may result in a denial.



#### **Utilization Management of Medication**

The Medical and Pharmacy Management Committee (MPMC) may implement utilization management processes as deemed necessary. Utilization management edits (such as quantity limits, length of therapy limits, prior drug therapy requirements or preclusive therapy) are used when the following exists: safety concerns, significant risk of drug/drug interactions, and potential deviation from the manufacturer's recommended dosing guidelines. For a complete listing of drug utilization management limits, please refer to the Prescription Drug List (see Contact | Resource Directory | Prior Authorization/Pre-Determination | Notes for website details.

If you have questions, please contact Pharmacy Services (see the Contact | Resource Directory for information on reaching Pharmacy Services).