Professional Provider
Report

A newsletter for professional providers and their staff members

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What's Inside

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

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Additional Instructions for Billing Code Ranges

Additional Instructions for Billing Code Ranges for Radiology Procedures (7XXXX), Laboratory Services (8XXXX), and Diagnostic/Vaccine/Immunization/Administration services (9XXXX), or HCPCs (excluding Ambulance):

The referring, ordering, or supervising provider qualifier, name, and NPI must be reported for any claim with a radiology procedure (7XXXX), laboratory service (8XXXX), diagnostic/vaccine/immunization/administration (9XXXX), or HCPC (excluding Ambulance) CPT codes. This requirement is a national standard for these code sets.

The appropriate qualifier code and referring, ordering, or supervising provider name is required in box 17 of the CMS-1500 Claim Form. The NPI of the referring, ordering, or supervising provider should be entered in field 17b.

The Qualifiers for use in box 17 are:

- DN, referring provider
- DK, ordering provider
- DQ, supervising provider

Failure to provide this information in the appropriate fields will result in claim denials. Denied claims will need to be submitted as new claims with the appropriate information.

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Updated Biosimilars Reminder

Over the last few years a number of biosimilars have hit the market for products like Rituxan, Herceptin, and Remicade. Biosimilars are FDA-approved drugs that are highly similar to the reference product. This means that they have no clinically meaningful differences from a reference product, and are expected to deliver the same outcome as the brand-name product.

Many of our providers have started switching to biosimilar products for many of our Blue Cross and Blue Shield of Kansas members. BCBSKS is implementing a preferred product medical policy strategy. Providers who use a preferred product will **NOT** need to pursue a prior authorization to use the preferred product, but providers who choose to use a non-preferred product will need to obtain a Prior Authorization to use the non-preferred product.

Effective April 1, 2022, BCBSKS will begin using preferred products for filgrastim and pegfilgrastim. Please reference the below table for a list of preferred and non-preferred products. Rituximab and trastuzumab preferred products became effective November 1, 2021. Infliximab preferred products became effective January 1, 2022.

Preferred products listed below will NOT require a Prior Authorization and may be prescribed for medically necessary services within the terms of your provider contracts.

Non-Preferred products listed below will require a Prior Authorization.

Reference Product	Preferred Products - do NOT require a Prior Authorization	Non-Preferred Products - DO require a Prior Authorization
Filgrastim	Nivestym Zarxio	Neupogen Granix
Pegfilgrastim	Fulphila Ziextenzo	Neulasta/Neulasta Onpro Nyvepria Udenyca
Infliximab	Inflectra Renflexis Remicade	Avsola
Rituximab	Ruxience Truxima	Rituxan Rituxan Hycela Riabni
Trastuzumab	Kanjinti Ogivri	Herceptin Herceptin Hylecta Herzuma Ontruzant Trazimera

Multiple Sclerosis Prior Authorization Updates

Blue Cross and Blue Shield of Kansas (BCBSKS) continually reviews Prior Authorization (PA) programs and looks for opportunities to improve provider experience.

Effective March 1, 2022, generic Copaxone (glatiramer) and generic Tecfidera (dimethyl fumarate) will no longer be subject to PA. These two generic products may be prescribed when medically necessary without needing to complete the PA process.

Please note, requests for brand-name Copaxone and brand-name Tecfidera will still be subject to PA. Requests for the generic products that exceed FDA labeled dosing will also require a prior authorization. The policy, Multiple Sclerosis Agents, posted on February 1, 2022 for review of the upcoming changes.

If you have any questions regarding this newsletter, please contact your BCBSKS provider representative.

Update for Colonoscopies as a Follow up to Positive Cologuard Test

It has been recommended by the United States Preventative Services Task Force (USPSTF) that when stool-based tests reveal abnormal or a positive result, a follow up screening colonoscopy is recommended. In order for claims to process for a follow up colonoscopy as screening, please bill with appropriate CPT and diagnosis codes according to the Preventive Services guidelines, which can be accessed here. Claims will process for a colonoscopy as a screening test after an abnormal Cologuard effective May 28, 2022 with a retroactive effective date of January 1, 2022. Claims will be adjusted accordingly.

Provider Message Board

Blue Cross and Blue Shield of Kansas (BCBSKS) is excited to kick off our new Provider Message Board! Registration begins April 1, 2022. The new process will replace the current letters BCBSKS sends to our providers requesting a new claim with records or additional information. The new message board will make it possible for offices to upload records through a secure portal. Additionally, providers who elect to participate are eligible for a QBRP incentive! For additional information regarding the QBRP incentive, please see page 11 in our 2022 Annual CAP Report. The program is optional, and you must sign up to participate due to a limited time-frame in turnaround time for the requested information. Contact your provider relations Representative with any questions you may have.

Understanding Provider Directory Requirements for the No Surprises Act

As Blue Cross and Blue Shield of Kansas (BCBSKS) has previously communicated with you, the Consolidated Appropriations Act (CAA) outlines new requirements for maintaining and validating information to include in provider directories (CAA Section 116). The intent of these requirements is to help individuals make informed choices when selecting a provider.

To comply with these new CAA provisions, insurers must develop a process to verify provider directory accuracy. Effective Jan. 1, 2022, CAA requires that BCBSKS provide and regularly maintain an online provider directory to members. Providers must validate their information at least every 90 days through the provider portal. The directories must be available to participants, beneficiaries, and enrollees.

BCBSKS would like to add that if your provider data can't be verified 180 days after the last attestation date, we will be required to suppress your information in our online provider directory. Once the data is verified, you'll be added back into the directory. All directory changes will occur within two business days of submittal.

If you have questions regarding this publication, please contact your BCBSKS provider representative.

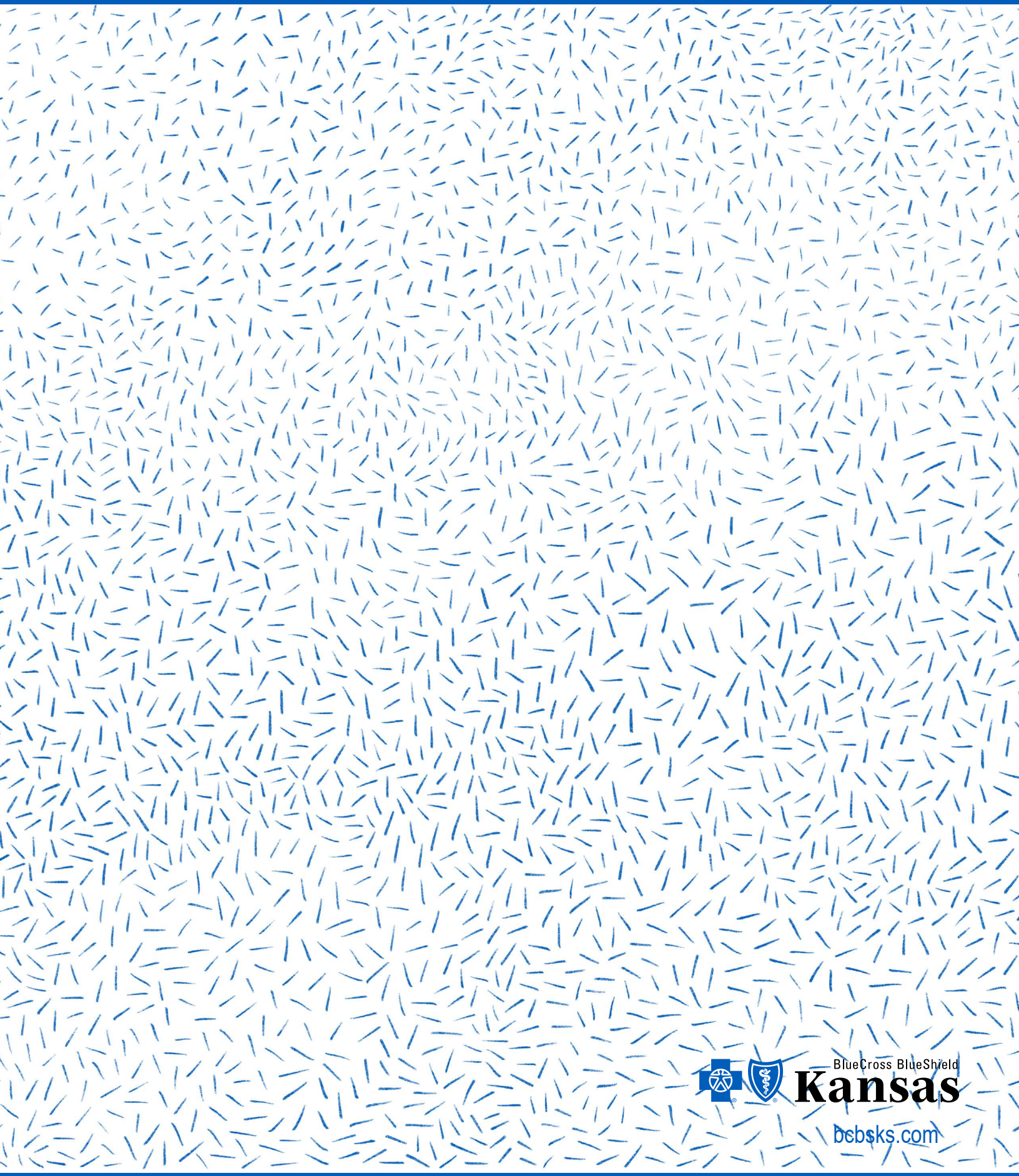
Update for Avastin Coding for Ophthalmic Use

For accurate billing and consistency for billing across payers, BCBSKS has updated the guidelines for Avastin coding for ophthalmic use.

When billing for ophthalmic Avastin, report the appropriate HCPC code (e.g. J3490: unclassified drug or J3590: unclassified biologic). Report the name of the drug, dosage, and NDC# in box 19 of the 1500 form or electronic narrative.

Please note this is a change to the previous instruction for vision providers. This change will be effective 03/21/2022.

If you have additional questions, please refer to page 10 of the Vision and Ocular Manual or contact your Professional Relations representative or Provider Network Services in Topeka at 785-291-4135 or 800-432-3587.



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