Professional Provider
Report

A newsletter for professional providers and their staff members

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What's Inside

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

Dustin Kimmel,
Communications Coordinator

Important screenings key to your patients' health

Quality matters, and Blue Cross and Blue Shield of Kansas (BCBSKS) is committed to working collaboratively with our providers to improve quality. We know better quality care means our members are healthier.

Dr. Michael Atwood

One way we work with our contracting providers is to give them incentives for completing recommended preventive screening tests for members. We see this as a win-win situation where providers are rewarded for providing high quality care and members get care consistent with national guidelines.

For example, cervical cancer screening for women is recommended by the National Committee for Quality Assurance (NCQA). The screening also is included in the Healthcare Effectiveness Data and Information Set (HEDIS) of quality measures. NCQA uses these measures to rate health plans on how well they are doing at keeping members healthy.

Cervical cancer is a type of cancer that can often be prevented through screening. Most cases of invasive cervical cancer in the United States today occur in women who have not had the recommended screening tests. The most

Please see **KEY**, *page* ***3***

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Clinical Care Coordinator seeks to close gaps in care

It is that time of year for the Clinical Care Coordinator (CCC) or other Blue Cross and Blue Shield of Kansas (BCBSKS) representative to begin contacting health care professionals (i.e. Primary Care Physician) regarding their attributed members identified as having a gap in care.

A gap in care for this provider outreach is considered to be where members previously diagnosed with a chronic condition have not had a clinic visit in 2019.

Effective care management practice suggests that members diagnosed with a chronic condition should be seen at least annually. Chronic conditions need to be evaluated, documented, coded, and submitted on a claim along with the appropriate evaluation and management (E/M) code in order to provide a complete and accurate risk assessment of the patient.

It is critical to capture and report diagnoses at their highest specificity level, and even more critical for the documentation to substantiate the diagnoses. The correct methodology for complete and accurate coding is to code for all current diagnoses, and it is with this provider outreach where BCBSKS is informing providers where the data indicates there is a gap in care for an attributed member.

For additional information, contact your Professional Relations representative.

Using modifier 52, RT, LT for coding fundus photography

When filing claims for fundus photography, providers should use the modifier 52 and then RT or LT in order to appropriately indicate fundus photography performed on only one eye. If performed on both eyes, the medical record documentation must support the medical necessity of bilateral photos and no modifier is needed. The use of modifier 50 is NOT appropriate as the code already includes both eyes.

Use member's name as is on ID card when submitting claims

Providers should use the member's name as it appears on their ID card when submitting claims to Blue Cross and Blue Shield of Kansas.

Using the name as it appears on the ID card will improve claims processing and ensure provider reimbursement in a timely manner.

KEY: BCBSKS offering financial incentive for cervical cancer screening

*Continued from page **1***

common and well-known test to prevent cervical cancer is the Pap test.

The Pap test is recommended for all women starting at age 21, and then every three years until age 29. After age 29, screening is recommended every 3-5 years, depending on your clinical circumstances.

Using the code Z90.710 (acquired absence of both cervix and uterus) helps BCBSKS find history on those members if a hysterectomy was performed more than 10 years ago.

For 2019, BCBSKS is offering a financial incentive to providers for ensuring all eligible women are screened for cervical cancer, as well as some other HEDIS-related conditions, according to the latest guidelines.

Preventing serious health problems makes our members healthier and saves money in the long term, helping to keep insurance premiums more affordable.

Do your part to keep your patients healthy by talking with them about the preventive tests that are appropriate.

Reminder: Refer to contracting providers when possible

Providers are reminded to refer members to providers and facilities contracted with Blue Cross and Blue Shield of Kansas, as stated in Policy Memo No. 1, Section IV. Utilization Review and Medical Necessity, which reads:

F. APPROPRIATE PLACE OF SERVICE — The provider agrees to use (to the extent possible) those inpatient, extended care, ancillary services and other health facilities and health professionals which have contracted with BCBSKS. Providers agree to render services to members in the most appropriate and economical setting consistent with the member's diagnosis, treatment needs, and medical condition. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation. In the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.

Workshops aim to educate on guidelines, programs

The Blue Cross and Blue Shield of Kansas (BCBSKS) Professional Relations department offers educational workshops that review BCBSKS programs, general benefits, current guidelines, proper billing, and coding requirements as they apply to BCBSKS.

These workshops offer Continuing Educaiton Units (CEUs) at no charge to contracting providers.

Insurance Biller's workshops

- April 11— Wichita
- April 12 — Topeka
- April 18 — Lawrence
- May 1 — Scott City
- May 2 — Norton
- May 3 — Hays
- May 8 — Wichita
- May 10 — Topeka
- June 5 — Great Bend
- June 6 — Garden City
- June 11 — Ottawa
- June 13 — Hutchinson
- June 13 — Wichita
- June 14 — Topeka

What's New in 2020

- Sept. 10 — Emporia
- Sept. 12 — Hutchinson
- Sept. 12 — Wichita
- Sept. 25 — Pittsburg
- Oct. 10 — Hutchinson
- Oct. 10 — Wichita
- Oct. 18 — Topeka
- Oct. 29 — Scott City
- Oct. 30 — Norton
- Oct. 31 — Hays
- Oct. 31 — Lawrence
- Nov. 5 — Garden City
- Nov. 7 — Great Bend
- Nov. 8 — Topeka
- Nov. 14 — Wichita
- Dec. 6 — Topeka
- Dec. 11 — Atchison
- Dec. 12 — Wichita

To register, click on the date and location or go to https://www.bcbsks.com/CustomerService/Providers/Training/workshops/pro_billing.shtml. For more information, contract your Professional Relations representative.

Behavioral health education workshops offering CEUs

Blue Cross and Blue Shield of Kansas (BCBSKS) and New Directions Behavioral Health are teaming to offer Behavioral Health Education workshops this May:

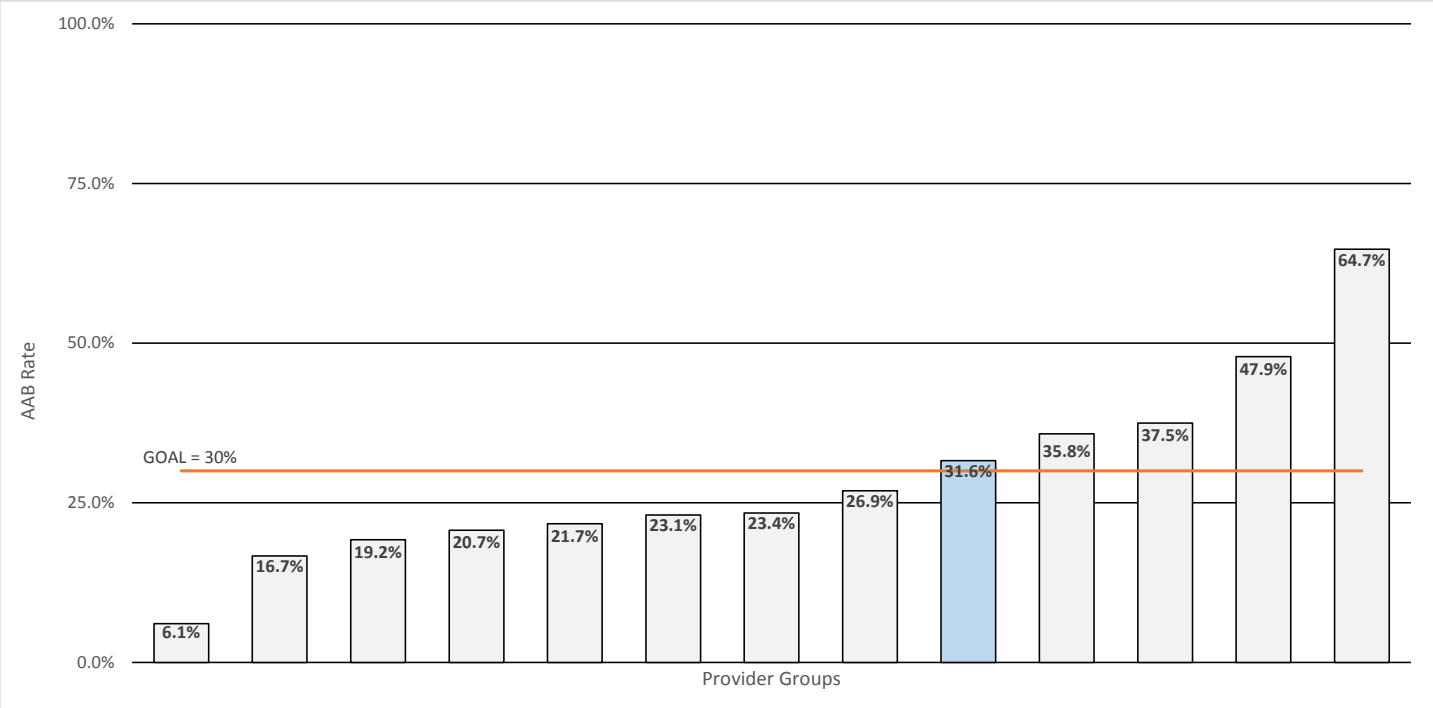
- May 6, Hays
- May 7, Topeka
- May 8, Derby

These workshops are free to all BCBSKS contracting behavioral health providers and staff members. Each participant will receive three Continuing Education Units (CEUs).

This three-hour course will focus on measuring outcomes within the therapeutic alliance. Also presented will be solution-oriented brief intervention tools and strategies that partner well with shared decision-making/feedback-informed treatment.

The featured speaker is Grey Endres, a full-time faculty member at Missouri Western and a founding partner of the Lifeworks Family Treatment group in Kansas City.

Register at https://www.bcbsks.com/CustomerService/Providers/Training/workshops/pro_billing.shtml and choose the date and location that works best for you. Seating is limited, so register as soon as possible.



Avoid overprescribing antibiotics

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) is a Healthcare Effectiveness Data and Information Set measure, and is incentivized through the Blue Cross and Blue Shield of Kansas (BCBSKS) Quality-Based Reimbursement Program (QBRP).

For this measure, the percentage recorded is the number of adult members 18 to 64 years of age that are not prescribed antibiotic treatment for a diagnosis of acute bronchitis on the first office encounter in an otherwise healthy adult. To meet the QBRP incentive, the percentage must be greater than or equal to 30 percent.

The Center for Disease Control and Prevention (CDC) recommendations state antibiotics will not help most cases of uncomplicated acute bronchitis. The usual cause of acute bronchitis is a respiratory virus that generally will improve in a week or two without antibiotic therapy. Appropriate use of antibiotics for patients with acute bronchitis can help avoid harmful side effects and possible antibiotic resistance over time.

While a higher percentage is better, the graph (above) shows many provider groups with more than 30 instances are below a conservative, target percentage of 30. The overall performance for BCBSKS providers for this measure was 31.6 percent for the reporting period of July 1, 2017 to June 30, 2018.

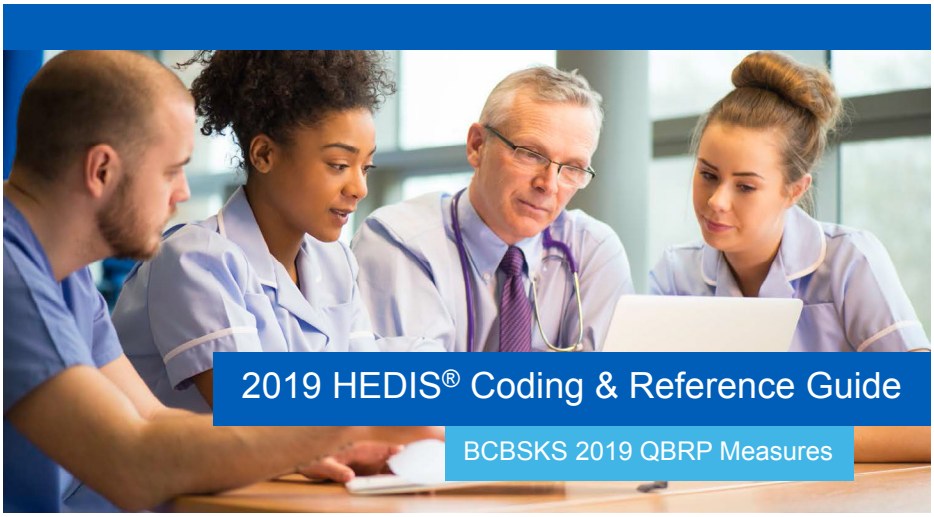
The CDC offers helpful information for both patients and providers related to appropriate antibiotic use, antibiotic resistance, when antibiotics are needed, and general advice for patients on how to feel better when experiencing symptoms of an upper respiratory infection. These helpful resources can be found at https://www.cdc.gov/antibiotic-use/community/materials-references/index.html.

2019 QBRP — HEDIS measures

The Blue Cross and Blue Shield of Kansas (BCBSKS) Quality-Based Reimbursement Program (QBRP) is designed to promote efficient administration, improved quality, and better patient care and outcomes for members.

BCBSKS recognizes the difficulty in receiving credit for certain aspects within QBRP. The targets set for the QBRP Healthcare Effectiveness Data and Information Set (HEDIS) measures were set based on National Committee for Quality Assurance's (NCQA) national PPO and EPO average, or near the 75th percentile for each measure. These may be stretch goals for some measures, as the data used to calculate the scores use claims (administrative) data only.

For some measures, this can produce incomplete results where data from the medical record could provide more complete and comprehensive results. However, setting the targets at the national average, or 75th percentile hopefully allows for some margin of error to hit the target without having to request medical records for all eligible members. For this reason, BCBSKS recognizes difficulties in identification of member inclusion/exclusion via claims data only and offers the following:



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BCBSKS offers a yearly HEDIS Coding and Reference Guide that gives an overview of each HEDIS-based QBRP measure, including details for identifying the eligible population and qualifying codes. The guide is available online at https://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/HEDIS-coding-reference-guide.pdf.

Preventive Cancer Screenings

Preventive cancer screenings are instrumental in early — and often symptomless — cancer detection. QBRP currently utilizes the HEDIS national standard for Breast, Cervical and Colorectal cancer screenings.

Since BCBSKS relies solely on claims data as indication of meeting these measures, there have been opportunities identified where certain instances of exclusions from these measures may apply that currently are not being identified via claims data.

For instance, a member who had a hysterectomy in the 1990s under a different payor will not be excluded unless identified on a claim via certain "history of" codes. By using the following ICD-10 codes for those members with a qualifying exclusion, providers will not be penalized as those members are excluded from the measure.

- Z90.13 (Acquired absence of bilateral breast and nipples)
- Z90.710 (Acquired absence of both cervix and uterus)
- Z90.712 (Acquired absence

Please see **HEDIS**, *page 7*

HEDIS: Measures aim at better outcomes

Continued from page ***6***
of cervix with remaining uterus)

Preventive Cancer QBRP measures are:

Breast Cancer Screening (BCS) — The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
QBRP goal: 75 percent

Cervical Cancer Screening (CCS) — The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: Women age 21-64 who had a cervical cytology performed every three years; or women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.
QBRP goal: 75 percent

Colorectal Cancer Screening (COL) — The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.
QBRP goal: 60 percent

Well-Child Visits

Well-child visits give providers an opportunity to influence an individual's health and development (both physical and mental), as well as critical opportunities for screening and counseling. These visits help ensure a child is developing healthy eating and exercise habits early in life, as well as creating strong relationships between providers, parents, and children.

BCBSKS relies solely on claims data as indication of meeting these measures. For that reason, please note that a well-care code must be utilized on the claim (qualifying codes can be found in 2019 HEDIS Coding and Reference Guide). Those BCBSKS QBRP HEDIS well-child measures are outlined below:

Adolescent Well-Care Visits (AWC) — The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
QBRP goal: 50 percent

Well-Child Visit in the First 15 Months of Life (W15) — The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during the first 15 months of life.
QBRP goal: 80 percent

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) — The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.
QBRP goal: 80 percent

Antibiotic Utilization

Although antibiotic prescription rates in adolescents have fallen, antibiotic overuse still remains high. Unnecessary antibiotic medications prescribed for viral upper respiratory infections (URIs) and illnesses (bronchitis, pharyngitis, sinusitis) can lead to antibiotic resistance and contribute to higher health care costs as well as the risk of adverse events.

It is important providers have consistent dialogue with and educate patients about the consequences of misusing antibiotics to prevent viral infections. Those current QBRP measures involving appropriate antibiotic utilization are:

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) — The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.
QBRP goal: 30 percent

Please see **QBRP**, *page* ***8***

QBRP: Measures designed using HEDIS

Continued from page 7

Appropriate testing for Children with Pharyngitis (CWP) — The percentage of children age 3-18 who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.
QBRP goal: 80 percent

Appropriate Treatment for Children with Upper Respiratory Infection (URI) — The percentage of children 3 months-18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.
QBRP goal: 85 percent

Comprehensive Diabetes Care

Mismanaged diabetes can lead to serious health effects including stroke, kidney disease, and premature death, to name a few.

One piece of proper diabetes management is Hemoglobin A1c (HbA1c) testing. HbA1c test results provide indication of diabetes as well as insight into how well a patient's diabetes is being managed. Those patients with well managed diabetes reduce their risk of adverse conditions. While there are multiple other HEDIS measures around diabetes (eye exams, BP control, Medical Attention for Nephropathy, HbA1c control groups of <7.0%, <8.0%, and >9.0%), BCBSKS has elected to include only the HbA1c test in QBRP, as it is the most comprehensive diabetes measure where claims data alone is used.

However, there are instances where HbA1c lab tests are not performed in the provider's office. For instance, HbA1c testing that occur outside of the provider's control (i.e. health fairs, health department, etc.) are not often captured in claims data. Providers can mitigate this gap when performing Evaluation and Management (E/M) visits for an eligible patient who provides them with lab results by including an appropriate code on the claim. The claim will then be accepted as a care-gap closure for the eligible patient receiving an HbA1c test. The qualifying codes are:

- 3044F (HbA1c Level Less Than 7.0)
- 3045F (HbA1c Level 7.0-9.0)
- 3046F (HbA1c Level Greater Than 9.0)

Comprehensive Diabetes Care: HbA1c Test (CDC) — The percentage of members 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) testing as of Dec. 31 of the measurement year.
QBRP goal: 90 percent

Lower-Back Pain

Back pain is one of the most common reasons why people visit the doctor. However, often times the pain goes away on its own or improves with alternative treatments like applying heat or ice, stretching, walking, physical therapy, massage therapy, or over-the-counter anti-inflammatory medicine.

Imaging tests (x-rays, CT scans, MRIs) can costs hundreds, even thousands of dollars depending on the test, and can deliver harmful radiation that can add up or reveal incidental findings that can divert attention and increase the risk of having unhelpful surgery. BCBSKS is committed to monitoring the use of imaging tests for lower-back pain as one of the QBRP HEDIS measures.

Use of Imaging Studies for Lower-Back Pain (LBP) — The percentage of members with a primary diagnosis of low-back pain who did not have an imaging study (x-ray, MRI, CT scan) within 28 days of diagnosis.
QBRP goal: 85 percent

Blue plans' programs require preauthorization

New offerings can be identified using member ID card

Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma, and Texas are offering members an enhanced Health Advocacy Solutions program and a new program, Wellbeing Management.

Both programs have new preauthorization requirements. Providers can check the back of the patients' ID cards to see which preauthorization requirements apply.

Blue Cross also encourages providers to check eligibility and benefits online using Availity.com. Additionally, providers can call the number on the member's ID card to check eligibility and benefits.

Health Advocacy Solutions

More than 717,000 members have health plans that include Health Advocacy Solutions. The following alpha prefixes identify these members. The prefix appears in front of the member's identification number:

BCS, BJG, EBY, EGM, FTD, FWA, FWB, FWG, GAM, GYK, HKR, HTC, HUR, IDX, JHU, JNW, JVH, JYT, KCG, KWE, KWR, NLW, NYW, PDB, PYH, TTF, UST, UTY, VRN, WAG, WTE, WWF, XOU, ZGA, ZGP

For a complete listing of services that require preauthorization for Health Advocacy Solutions, visit BCBSIL, BCBSMT, BCBSNM, BCBSOK, BCBSTX BEA, or BCBSTX PPO.

Wellbeing Management

As of Jan. 1, more than 8 million members have health plans that include Wellbeing Management. There are five Wellbeing Management packages:

- Wellness for IL HMO
- Enable
- Empower+
- Empower+ for Fully Insured
- Configurable Care management

For a complete listing of services that require preauthorization for patients with Wellbeing Management, visit BCBSIL, BCBSMT, BCBSNM, BCBSOK, BCBSTX BEA, or BCBSTX PPO.

Pharmaceutical Formulary Update

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

For commercial members, go to: https://www.myprime.com/content/dam/prime/memberportal/forms/2019/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSPREFDRUG/KS_Alpha_Drug_List.pdf

For BlueCare/EPO members, go to: https://www.myprime.com/content/dam/prime/memberportal/forms/2019/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSBLCREPO9/2019_KS_6T_BlueCare_Medication_List.pdf

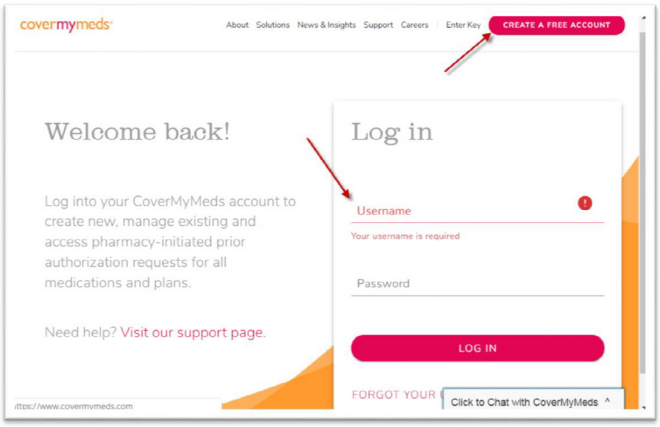
For BlueEdge/ResultsRx medication list, go to: https://www.myprime.com/content/dam/prime/memberportal/forms/2019/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSRXDRUG/KS_BlueEdge_MedicationList.pdf

Submitting prior authorization electronically

The following instructions walk through how to submit prior authorization for medications.

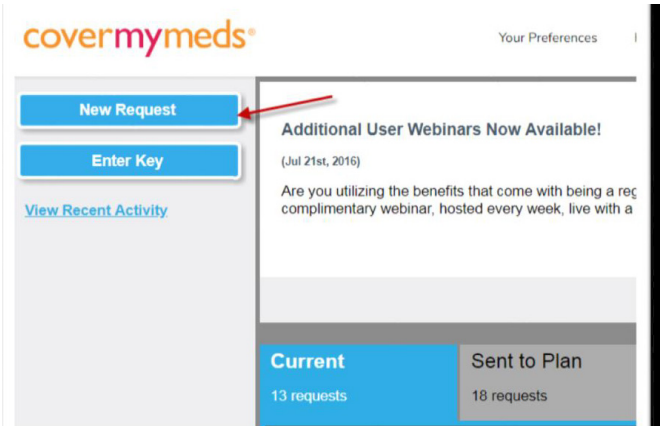
1. Log in/Create account

Go to covermymeds.com and log in or create a new account.



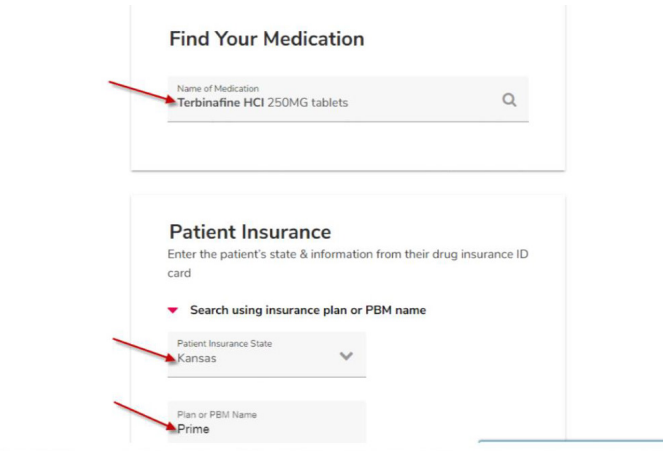
2. New Request

Click the “New Request” button on the landing page



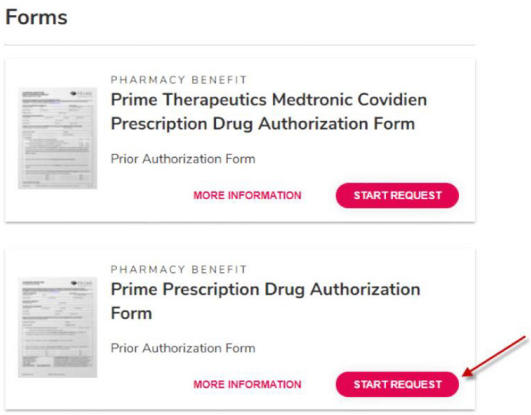
3. Find Medication, PBM

Find your medication, then include the patient’s state and Prime (Pharmacy Benefits Manager).



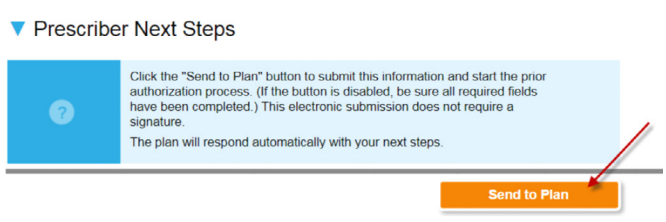
4. Pick Appropriate Form

Click the “Start Request” button of the form that fits your needs.



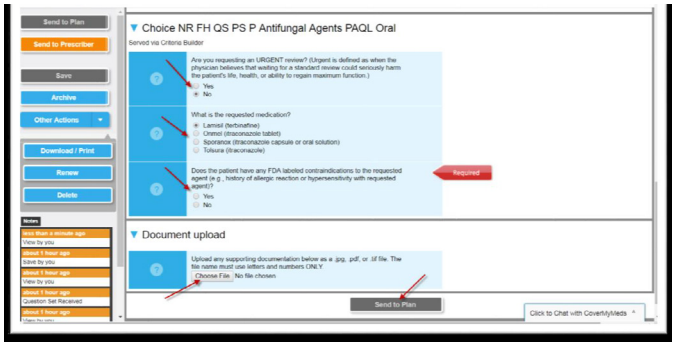
5. Send to Plan

Fill out all red “required” fields then click the “Send to Plan” button.



6. Send to Plan, again

Answer all red “required” questions, attach relevant documents and click the “Send to Plan” button.

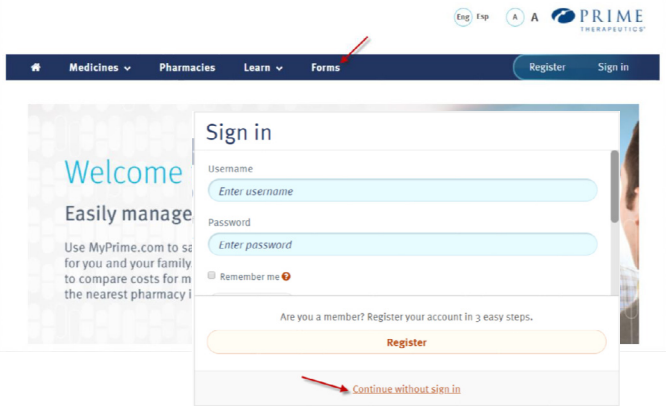


Submitting prior authorization by fax

While electronic submission of prior authorizations for medications is preferred, Blue Cross and Blue Shield of Kansas understands the need to submit forms by fax. The following instructions walk through how to download the form and submit it via fax.

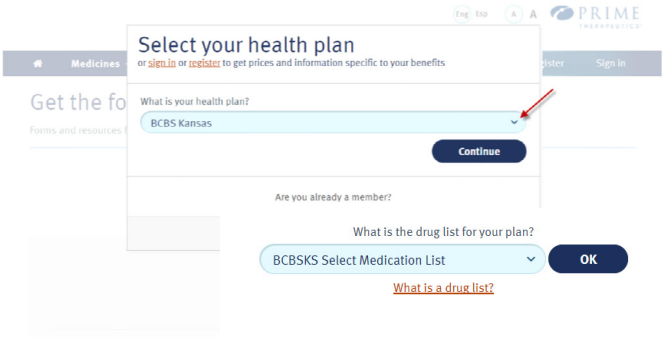
1. Go to MyPrime.com, bypass sign-in

Go to MyPrime.com and click “Forms” at the top of the page. If a sign-in window pops up, click “continue without sign in” to bypass.



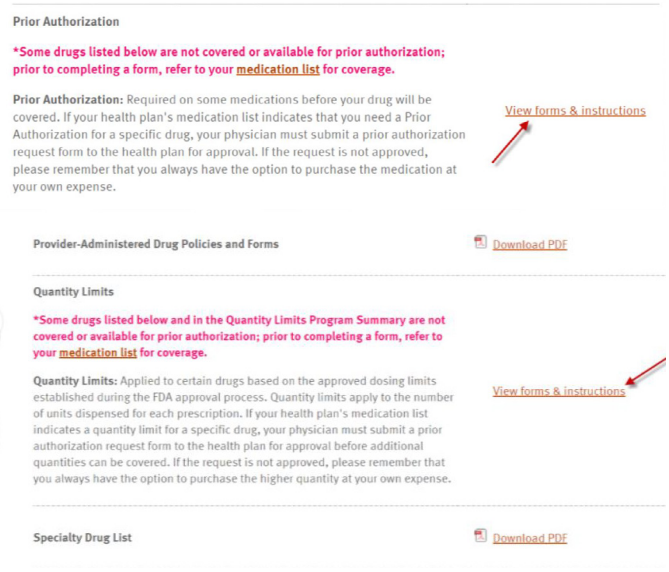
2. Pick health plan, drug list

Select “BCBS Kansas” from the drop-down menu and click “Continue.” On the next drop-down menu, select “BCBSKS Select Medication List” and click “OK.” (Most groups will use the Select list, while others will use Results Rx or BlueCare/EPO).



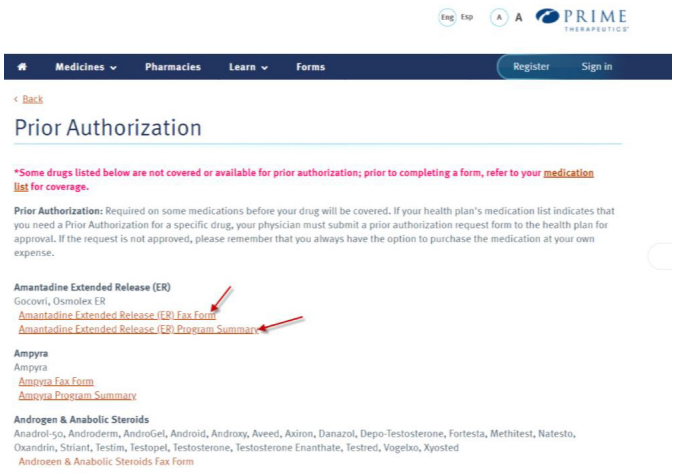
3. Find Prior Authorization form

Scoll to see all available forms. Note — Prior Authorization, Quantity Limits, and Step Therapy forms may also be found under the Utilzation Management link depending on formulary. Click the appropriate link to view available forms.



4. Pick Appropriate Form

Scroll to find the appropriate program, or use Ctrl+F function to search for the medication. Click the link for the Fax Form to download and print, or click on the link for the Program Summary to learn more about the program.



Pharmacy, Labs, DME, HIT filing Blue claims

Filing claims with proper Blue Plan reduces delays

Generally, as a health care provider, you should file claims for your Blue Cross and Blue Shield patients to the local Blue Plan. However, there are unique circumstances when claims filing directions will differ based on the type of provider and service.

Ancillary providers are Independent Clinical Laboratory, Durable/Home Medical Equipment (DME) and Supplies and Specialty Pharmacy providers. The local Blue Plan as defined for ancillary services is as follows:

Independent Clinical Laboratory (Lab) — The Plan in whose state* the specimen was drawn.

Durable/Home Medical Equipment and Supplies (DME) — The Plan in whose state* the equipment was shipped to or purchased at a retail store.

Home Infusion Therapy (HIT) — The Plan in whose state* the drug was shipped to or to the plan HIT was rendered.

Specialty Pharmacy — The Plan in whose state* the Ordering Physician is located.

*If you contract with more than one Plan in a state for the same product type, i.e. PPO or Traditional, you may file the claim with either Plan.

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 log on to Availity.com, before providing any ancillary service.

Providers that utilize 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 utilize in-network participating Ancillary Providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained at https://www.bcbsks.com/ProviderDirectory/index.htm

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 Customer Service, (800) 432-3990 or (785) 291-4180, or email csc@bcbsks.com at Blue Cross and Blue Shield of Kansas.

Labs, DME, HIT, Specialty Pharmacy Providers Filing Blue Claims

Provider Type	How to file (required fields)	Where to file	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 Submission or • Loop 2420F (line level) on the 837 Professional Electronic Submission	File the claim to the Plan in whose state the **specimen was drawn*** *Where the **specimen was drawn** will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in **Kansas**. Blood analysis is done in **Oklahoma**. File to: **Blue Cross and Blue Shield of Kansas**. *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.	**Patient's Address:** • Field 5 on CMS 1500 Health Insurance Claim Form or • Loop 2010CA on the 837 Professional Electronic Submission **Ordering Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form or • Loop 2420E (line level) on the 837 Professional Electronic Submission **Place of Service:** • Field 24B on the CMS 1500 Health Insurance Claim Form or • Loop 2300, CLM05-1 (claim level) on the 837 Professional Electronic Submissions or • Loop 2400 SV105 (line level) on the Professional Electronic Submission **Service Facility Location Information:** • Field 32 on CMS 1500 Health Insurance Form or • Loop 2310C (claim level) on the 837 Professional Electronic Submission	**D/HME:** File the claim to the Plan in whose state the equipment was **shipped to or purchased in a retail store**.	Wheelchair is purchased at a retail store in **Kansas**. *File to:* Blue Cross and Blue Shield of Kansas. Wheelchair is purchased on the internet from an online retail supplier in **Florida** and shipped to **Kansas**. *File to:* Blue Cross and Blue Shield of Kansas.
Home Infusion Therapy (HIT) Types of Service include but are not limited to: Administration of intravenous antibiotic, immune globulin fluid, etc., by a home health nurse in home or equivalent setting.		**HIT:** File the claim to the Plan in whose state the drug **was shipped to or where HIT was rendered**.	Wheelchair is purchased at a retail store in **Florida** and shipped to **Kansas**. *File to:* **Blue Cross and Blue Shield of Florida**. An HIT company in **Missouri** renders care at a patient's home in **Kansas**. *File to:* **Blue Cross and Blue Shield of Kansas**.
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include but are not limited to: injectable, infusion therapies, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form or • Loop 2310A (claim level) on the 837 Professional Electronic Submission	File the claim to the Plan whose state the **Ordering Physician is located**.	Patient is seen by a physician in **Kansas** who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in **Oklahoma** where the member lives for six months of the year. File to: **Blue Cross and Blue Shield of Kansas**.

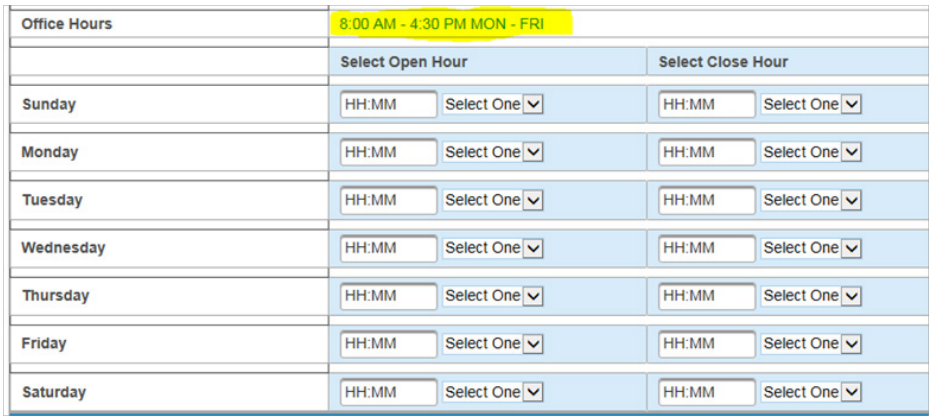
Qualifying for Provider Info Portal incentive by attesting to data

The qualifying period ends May 31 for the first of the biannual data attestations confirming accurate provider data on file at Blue Cross and Blue Shield of Kansas (BCBSKS) through the Provider Portal.

This information is used in provider directories, network adequacy reporting, and other down-line operations within the health plan, adding to the importance of the data remaining current.

Attesting to the accuracy of provider data is beneficial for several reasons:

1. Providers are contractually obligated by the contracting provider agreements to attest to data accuracy twice a year.
2. Reliable information for members, providers, and others.
3. Incentive is added to each eligible Current Procedural Terminology (CPT) code payments when the provider has satisfied the Quality-Based Reimbursement Program (QBRP) prerequisites. For more information on QBRP, go to https://bcbsks.com/CustomerService/Members/consumer-tools/blue-physician-recognition.shtml.



Office Hours	8:00 AM - 4:30 PM MON - FRI	
	Select Open Hour	Select Close Hour
Sunday	HH:MM Select One	HH:MM Select One
Monday	HH:MM Select One	HH:MM Select One
Tuesday	HH:MM Select One	HH:MM Select One
Wednesday	HH:MM Select One	HH:MM Select One
Thursday	HH:MM Select One	HH:MM Select One
Friday	HH:MM Select One	HH:MM Select One
Saturday	HH:MM Select One	HH:MM Select One

Providers who have not explored whether they qualify for QBRP by meeting the prerequisites are encouraged to contact their Professional Relations Representative or BCBSKS's Provider Data Quality Technician at (785) 291-7069 or (800) 432-3587 ext. 7069.

Important reminders when attesting to data on the Provider Portal:

1. Auto/Fill Complete — BCBSKS recommends not using your internet browser's auto fill/complete function at anytime on the Provider Portal. The auto fill/complete function sometimes accesses information from personal email accounts. The result is fields being populated with incorrect and personal information.
2. Contact Information required — The person responsible for attesting or submitting data changes need to use their own name. Submitting under another person's name may result in confusion and potential inaccuracies in provider data.
3. Office Hours — Current office hours are displayed at the top of the office hour grid (see screen shot above). It is not necessary to complete the office hour grid if the displayed data is correct. When office hour changes are needed, only complete the days and times on the grid that need updated.

Data updates can be sent anytime via Provider Portal

Making changes to information on file with BCBSKS can be done whenever the need arises throughout the year

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

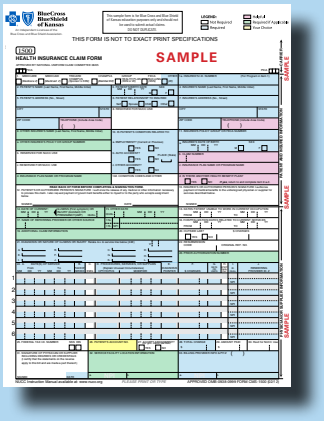
The section of the provider information display has three options to choose from when submitting a change and/or completing a PDA. Below is a brief explanation of the options to choose when reviewing or submitting and change.

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

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

Availity Registration reminder

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



Highmark adjusting Medicare Advantage claims

Highmark Blue Cross and Blue Shield is performing a high-volume Medicare Advantage claims adjustment because of a change in the Center for Medicare and Medicaid Services (CMS) fee schedule.

These adjustments will result in an increase in allowance and began April 5.

For more information, contact your Professional Relations representative or Provider Network Services in Topeka at 785-291-4135 or 800-432-0272.

Web Changes — Medical Policy

Since the publication of Professional Provider Report S-2-19, the following policies have been posted at: https://www.bcbsks.com/CustomerService/Providers/MedicalPolicies/policies.shtml

- Amniotic Membrane and Amniotic Fluid
- Automated Percutaneous and Percutaneous Endoscopic Discectomy
- Balloon Sinuplasty for Treatment of Chronic Sinusitis
- Bone Mineral Density Studies
- BRCA1 and BRCA2 Testing
- Breast Reconstructive Surgery After Mastectomy
- Chronic Intermittent Intravenous Insulin Therapy
- Cochlear Implant
- Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid
- Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors
- Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy for Select Intra-Abdominal and Pelvic Malignancies
- Diagnosis and Treatment of Sacroiliac Joint Pain
- Dynamic Posturography
- Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus
- Esophageal pH Monitoring
- Eteplirsen (Exondys 51) for Duchenne Muscular Dystrophy
- Gene Expression Profiling and Protein Biomarkers for Prostate Cancer Management
- Gene Expression Profiling for Cutaneous Melanoma
- Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
- Genetic Testing for Lynch Syndrome and Other Inherited Colon Cancer Syndromes
- Hyperbaric Oxygen Therapy (HBOT)
- Implantable Bone-Conduction and Bone-Anchored Hearing Aids
- Influenza Virus Diagnostic Testing and Treatment in the Outpatient Setting
- Insulin Pump
- Interspinous and Interlaminar Stabilization / Distraction Devices (Spacers)
- Lysis of Epidural Adhesions
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders
- Measurement of Lipoprotein-Associated Phospholipase A2 in the Assessment of Cardiovascular Risk
- Measurement of Serum Antibodies to Infliximab and Adalimumab
- Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease
- Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease
- Orthopedic Applications of Stem-Cell Therapy
- Pachymetry
- Panniculectomy and Abdominoplasty
- Periodontal Soft Tissue Grafting (Availity login required)
- Plugs for Anal Fistula Repair
- Positron Emission Tomography (PET) Scanning: Oncologic Applications
- Real-Time Intrafraction Motion Management During Radiotherapy
- Reduction Mammaplasty for Breast-Related Symptoms
- Scanning Computerized Ophthalmic Diagnostic Imaging Devices
- Screening for Lung Cancer Using CT Scanning
- Stereotactic Radiosurgery and Stereotactic Body Radiotherapy
- Surgical Deactivation of Headache Trigger Sites
- Surgical Treatment of Gynecomastia
- Surgical Treatment of Snoring and Obstructive Sleep Apnea (OSA) Syndrome
- Testing for Vitamin D Deficiency
- Transcatheter Aortic Valve Implantation for Aortic Stenosis
- Ultraviolet Light Therapy for Skin Conditions
- Vacuum Assisted Wound Closure (VAC)

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

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

BlueCross BlueShield of Kansas

bcbsks.com