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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All QBRP qualifying periods are now semi-annual

New for 2018, all metrics for the Quality-Based Reimbursement Program (QBRP) will be reviewed on a semi-annual basis, and any incentives earned will be effective either Jan. 1 or July 1, as applicable.

The qualifying periods for the 2018 incentives will differ depending on the metric (see page 9 for the metric review schedules).

Blue Cross and Blue Shield of Kansas (BCBSKS) will continue monthly reviews for 2018 to identify providers who did not qualify for incentive(s) beginning Jan. 1, 2018 because of not meeting prerequisites, or new providers after Jan. 1, 2018, but may subsequently qualify for incentive(s). If one of these two situations occur, the incentive(s) will be effective the first of the following month. A confirmation notice will be emailed to the provider to include the new incentive category and effective date.

QBRP is designed to promote efficient administration and improved quality with better patient care and outcomes, and contracting BCBSKS providers have an opportunity to earn additional revenue through add-ons to allowances for meeting the defined quality metrics.

For more information, please contact your professional relations representative or Provider Network Services in Topeka at (785) 291-4135 or (800) 432-3587.

BlueCross BlueShield of Kansas

bcbsks.com

Pharmacists to be able to bill MTM in office setting

In order to facilitate pharmacists working in collaboration with providers, effective Jan. 1, eligible pharmacists will be able to bill for medication therapy management (MTM) services in an office setting.

An eligible pharmacist is one who is performing the MTM service in an office setting. The office setting is defined as a group practice where the pharmacist is an employee of the office.

The American Medical Association Current Procedural Terminology (CPT) codes for the contracting pharmacist's MTM services are as follows:

- 99605 15 minutes medical therapy management initial; face-to-face time with patient
- 99606 First 15 minutes, established patient
- 99607 Each additional 15 minutes

Claims should indicate Place of Service 11 - Office. Appropriate documentation should be included in the patient's medical record.

To enroll a pharmacist into your group practice, please utilize the Provider Network Enrollment Request form available at bcbsks.com.

DME edits to change Oct. 15

Effective with date of service Oct. 15, Blue Cross Blue Shield of Kansas (BCBSKS) will implement new additional DME edits.

- Purchased DME will equal 10 months rental.
- For rented and purchased like DME equipment, BCBSKS will look at claims history.
- When replacement equipment and parts are billed for rented and purchased DME equipment, BCBSKS will look at claims history.

BCBSKS implemented new edits April 23 regarding CPAP/BiPAP supplies and diabetic supplies. These new edits set supply limits based on national standards and require the use of specific modifiers such as KS and KX with these supplies (see Professional Provider Report S-1-17 for modifier details).

Correctly coding for Prostate Specific Antigen (PSA)

When billing for a Prostate Specific Antigen (PSA), follow the guidelines below, which have been effective since Feb. 1, 2004.

1. Code 84153 should be used with Z80.42 diagnosis code for PSA annual screening individuals 40 through 49 years of age with a family history of prostate cancer.
2. Code 84153 should be used to bill PSA, annual screening, routine, individuals 50 to 80 years of age, need not be tied to a specific diagnosis code.
3. When billing PSA for diagnosis and management, any age, procedure code 84153 should be used with one of the following ICD-10 diagnosis codes (effective Oct. 1, 2015): N42.30, N42.31, N42.32, N42.39, R31.21, R31.29, R97.20, R97.21

For more information, contact your professional relations representative or Provider Network Services in Topeka at (785) 291-4135 or (800) 432-3587.

Guides for billing vision services appropriately

Recently, Blue Cross and Blue Shield of Kansas (BCBSKS) has seen inappropriate billing of vision services. The following guidelines should be followed for correct billing practices.

1. Intermediate Ophthalmological Services are treating an acute or known condition not requiring comprehensive services, while Comprehensive Ophthalmological Services are a complete evaluation of the full visual system to diagnose and treat the patient with symptoms indicating possible disease of the visual system or to rule out disease.
2. Mydriasis, or dilation of the pupil, is optional. Therefore, it doesn't drive intermediate vs. comprehensive code selection. Whether dilation is necessary depends on the reason for the exam, patient's age and overall health, and risks of eye diseases. If dilation is delayed (later same day or next day etc.), only a single service should be billed once testing is complete.
3. Refraction (92015) includes prescription of lenses, when required. Lens prescription is not considered "initiation of diagnostic & treatment program."
4. The primary diagnosis should be based on the chief reason patient sought care. If scheduled for routine/preventive or refractive care, then a routine diagnosis should be billed as primary regardless of any previously diagnosed conditions. If the medical condition is not actively being treated or managed as a result of the visit then it is a routine/preventive service. Billing a routine/preventive diagnosis on a refraction (92015) but a medical condition on the exam the same day is misrepresentation of the service, potentially to manipulate eligibility for benefits, and is inappropriate.
5. Compliance audits will take place on a post-payment basis, which may result in recoupment as outlined in Policy Memo No. 1.

Inovalon replaces Verscend for records requests

Effective Jan. 1, Inovalon will replace Verscend, collecting medical records on behalf of Blue Cross and Blue Shield of Kansas (BCBSKS).

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

As outlined in the contract, providers are required to respond to requests in support of Risk Adjustment and HEDIS, as well as other government-required activities within a requested time frame. This includes Inovalon's requests on behalf of BCBSKS.

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

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

Questions to ask when treating low-back pain

Do not obtain spinal imaging for patients with acute low-back pain during the six weeks after onset in the absence of red flags.

In the absence of red flags, evidence-based guidelines do not support the routine use of spinal imaging for patients with acute back pain of less than six weeks duration. Red flags include history of cancer, fracture or suspected fracture based on clinical history, progressive neurologic symptoms and infection, as well as conditions that potentially preclude a dynamic thrust to the spine, such as osteopenia, osteoporosis, axial spondyloarthritis and tumors. Unnecessary imaging incurs monetary cost, exposes the patient to ionizing radiation, and can result in labeling patients with conditions that are not clinically meaningful, creating a false sense of vulnerability and disability. Indeed, several studies have shown that the routine use of radiographs in the care of low-back pain may result in worse outcomes than without their use.

Avoid protracted use of passive or palliative physical therapeutic modalities for low-back pain disorders unless they support the goal(s) of an active treatment plan.

Choosing Wisely®

An initiative of the ABIM Foundation

Passive physical therapeutic modalities are defined as those interventions applied to a patient with no active participation on the part of the patient. These include heat, cold, electrical stimulation and ultrasound. These passive therapies can play an important role in facilitating patient participation in an active treatment program. However, the use of passive therapies untethered to the goal of increasing physical activity can be harmful, as it can lead to patient inactivity, prolonged recovery and increased costs. For any patient with a low-back pain disorder to achieve an optimal clinical outcome, an essential element is to restore, maintain or increase the level of physical activity. The evidence demonstrates that both general physical activity (e.g., walking, jogging, biking) and specific exercise regimens are effective in treating and preventing low-back pain and may lead to better outcomes when combined with spinal manipulation.

Do not perform repeat imaging to monitor patients' progress.

With few exceptions (e.g., the long-term management of idiopathic scoliosis) radiographic findings should not be used as outcome measures for low-back pain. There is currently no data available to support a relationship between changes in alignment or other structural characteristics and patient improvement. This practice increases costs, exposes patients unnecessarily to ionizing radiation and may distract from more meaningful outcomes. Furthermore, there is no known correlation between performing routine or repeat imaging studies to monitor a patient's condition and improved clinical outcomes or meaningful changes in patient management. Repeat imaging is appropriate only if strong clinical indications exist, such as a major change in diagnosis, documented worsening of symptoms or significant progression of disease. Failure to respond to treatment is not an indication for repeat imaging.

Do not provide long-term pain management without a psychosocial screening or assessment.

There is a high probability

Please see **PAIN**, *page* ***5***

Avoid antibiotics for upper respiratory infections

The majority of acute upper respiratory infections (URIs) are viral in etiology and the use of antibiotic treatment is ineffective, inappropriate and potentially harmful. However, proven infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotic therapy. Symptomatic treatment for URIs should be directed to maximize relief of the most prominent symptom(s). It is important that health care providers have a dialogue with their patients and provide education about the consequences of misusing antibiotics in viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

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As the nation increasingly focuses on ways to provide safer, higher-quality care, the overuse of health care resources is a concern. Many experts agree health care delivered in the U.S. is too wasteful, with some stating that as much as 30 percent of care is duplicative or unnecessary.

It is urgent that physicians and patients work together and have conversations about wise treatment decisions.

Choosing Wisely is part of a multi-year effort to help physicians be better stewards of finite health care resources. The Infectious Diseases Society of America (IDSA) contributed the above item.

For more information on the initiative, visit www.choosingwisely.org. For more information on the IDSA, visit www.idsociety.org. For more information on the ABIM Foundation, visit www.abimfoundation.org.

Pain: Prescribing supports, braces not recommended long term

*Continued from page **4***

that any person with a chronic pain syndrome has a concomitant psychological disorder, most notably depression and/or anxiety. The relationship between chronic pain and depression/anxiety is well established. The causal arrow between pain and these disorders can point in either direction and over time may form a positive feedback loop between these two elements. Screening tools are available that will aid in the detection of potential depression/anxiety, and, when indicated, a referral may be most appropriate for more extensive evaluation and treatment.

In addition, lesser psychological factors such as catastrophizing and fear avoidance behavior may interfere with a patient's recovery and should be recognized by the clinician. Recognizing indicators of patient psychosocial health behavioral factors can affect a patient's recovery and/or compliance with treatment and may decrease the risk of developing chronic illness/pain. Tools such as StarTBack 9 screening tool, PHQ-9 depression scale and the Fear Avoidance Belief Questionnaire are examples.

Do not prescribe lumbar supports or braces for the long-term treatment or prevention of low-back pain.

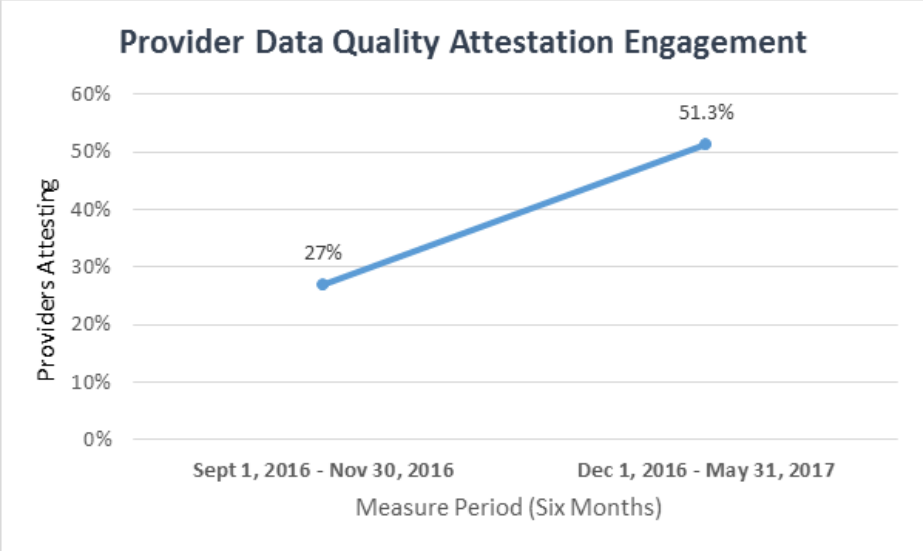
While there may be limited benefit in the short term, the prolonged use of lumbar supports is not supported by the literature for the treatment or prevention of low-back pain. Numerous systematic reviews have found limited to no value for their use in this context. The literature clearly demonstrates that such passive therapies are contrary to the currently accepted central principle of low-back pain care, which is that the patient must engage in an active rehabilitative regimen to achieve the best outcomes.

Earning incentive for data attestation

Blue Cross and Blue Shield of Kansas (BCBSKS) thanks providers who attested and continue to attest biannually through the Provider Portal to the accuracy of data on file.

Attestation jumped to 51.3 percent — up 24.3 percentage points — during the previous qualifying period that ended May 31.

For the second qualifying period — began June 1 and runs through Nov. 30 — BCBSKS is aiming for 80 percent provider attestation and is reaching out to providers to help achieve this goal.



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. Keep current and reliable information available 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.
4. Provides documentation to support data when records are audited.

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 new 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. If there are no changes, do not add any key strokes or characters in the blank data fields. Click the button labeled "Attesting as accurate with no changes," provide contact information, then submit.
2. 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.
3. 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.

Provider directory pilot program aims to eliminate penalties for inaccuracies

The Blue Cross and Blue Shield Association, along with several Blue Plans, have been participating in a directory-audit pilot program. The purpose of the program is to develop a best-in-class provider data-quality improvement and maintenance process that satisfies CMS directory-accuracy audits to minimize or eliminate plan penalties for inaccurate directory data.

The scoring methodology is based on key data elements that impact members access to care, including: Provider in directory and no longer at location; phone number; accepting-patients indicator; address; and suite number.

A large number of records did not have proper documentation for auditing (146 out of 710 total records unaudited). When providers attest to or submit data updates through the BCBSKS provider portal, proper documentation to support an audit is generated. Providers are encouraged to submit changes through the portal.

Most Common Data Errors

- Addresses
- Suite numbers missing or incorrect
- Phone number — Scheduling number incorrect
- Terminated providers — Provider no longer in-network and not removed from the directory. A result of the provider not notifying BCBSKS or the termination was not processed at time of audit.
- Print Directory Indicator — Records are displayed in the directory when they should be suppressed.

Coding prolonged direct (face-to-face) contact

CPT codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to the designated evaluation and management services at any level and any other physician services at the same session as evaluation and management services. These codes are used to report the total duration of face-to-face time spent by a physician on a given date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

The use of the time-based add-on codes requires that the primary evaluation and management service has a typical or specified time published in the CPT code book.

Providers must have the time documented within the record to show the total time spent with the patient during the evaluation and management as well as the specifics of what the additional code is being billed for. These codes should be used for unusual services but not for routine evaluation and management services.

Properly billing physicals

Physicals required as a condition of employment, school entry, work permit, insurance, or immigration are covered, including office calls, x-rays, and lab tests associated with the physical. The physical should be billed using CPT code 99455 (work related or medical disability evaluation services).

In loop 2400, NTE field for electronic submission or box 19 of the CMS 1500 claim form, note the type of physical (school, KDOT, etc.) being performed. If needed, medical records will be requested to determine if coding is for an appropriate physical service.

Code MA130 requires new claim

When Remark Code MA130 is indicated on the Remittance Advice, the claim has been rejected and cannot be processed or adjusted. A new claim must be submitted.

Providers should file the claim electronically as a new claim with the frequency code 1.

Providers should not file the claim electronically as a corrected claim with frequency codes 7 or 8.

Remittance Advice Remark Code MA130 states: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/ correct information.

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/2017/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSPREFDRUG/KS_Alpha_Drug_List.pdf

For BlueCare/BCBSKS Solutions members, go to: www.myprime.com/content/dam/prime/memberportal/forms/2017/FullyQualified/Other/ALL/BCBSKS/COMMERCIAL/KSBLCRDRUG/KS_BlueCare_complete_formulary_2017.pdf

New Anthem ID cards

Effective Jan. 1, some Anthem Blue Cross Blue Shield members will receive new ID cards, ID numbers, and prefixes.

Below are the old prefixes expiring Dec. 31 and the new prefix beginning Jan. 1. Remember to use the new prefix for all services beginning Jan. 1.

- FJJ will be KFM
- FFX will be QFM
- FJJ will be VFE
- FFX will be ZFE

For more information, contact Anthem Provider Inquiry Customer Service at (844) 594-0393.

Place of service 11 or 02 for telemedicine

Blue Cross and Blue Shield of Kansas will accept place of service 11 or 02 for telemedicine services for locations where the provider is located at the time of service.

A place of service 02 indicates a location where services are provided or received through a telecommunications system. A place of service 11 indicates a location, other than a hospital, skilled nursing facility, military treatment facility, community health center, State or local public health clinic, or intermediate care facility where the physician or practitioner routinely provides examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

BCBSKS will conduct refresh of QBRP schedule

Blue Cross and Blue Shield of Kansas will conduct a Quality-Based Reimbursement Program (QBRP) refresh in the first and second quarters (depending on the metric) of 2018 for an effective date of July 1, 2018 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective Jan. 1, 2018.

If the refreshed data indicates a provider is no longer meeting the performance standards for the metric(s), then the associated QBRP incentive(s) will cease beginning July 1, 2018 for the remainder of the year. If a provider no longer meets the performance standards for the metric(s), a new communication advising of the change in QBRP incentive(s) qualifications will be sent.

QBRP PREREQUISITES AND GROUPS FOR PROVIDERS	
QBRP Participation Prerequisites	Providers must conduct business with BCBSKS electronically (i.e. turn off paper). Providers must submit all eligible claims electronically, accept electronic remittance advice documents (ERAs: either through receiving the ANSI 835 transaction or by downloading the RA from the BCBSKS secured website (and turn off printed RAs), and receive all communications (newsletters, etc.) electronically.
Group A	Applies to all eligible contracting professional providers and to all eligible/covered CPT and HCPCS codes (excludes Clinical Lab [using codes on Medicare clinical lab fee schedule], Pharmacy and Pharmaceuticals, and Dental services).
Group B	Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and to all eligible/ covered CPT codes (excludes Clinical Lab [using codes on the Medicare clinical lab fee schedule], Pharmacy and Pharmaceuticals, and Dental services).
Group C	Applies to primary care professionals including supervised mid-levels (FP, GP, Peds, IM, PA, APRN) unless otherwise noted and only to covered E&M codes. Group C incentives are earned at the group level (for physicians with attributed members) with the exception of Level 3 PCMH Recognition, which is incentivized at the individual level. New providers joining a group or changing tax IDs will not be eligible for the HEDIS metrics under the new arrangement until the refresh period.
Group D	Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and only to covered E&M codes.

Incentive Qualifying Periods

The following lists are incentive effective dates for the corresponding qualifying periods.

- **Electronic Self-Service (ES3, ES2)**
- **KHIE Incentives (ADT, OPN, ABS, LAB, MED)**

Qualifying Period:	Incentive begins:
Aug. 1, 2017 - Oct. 31, 2017	Jan. 1, 2018
Feb. 1, 2018 - April 30, 2018	July 1, 2018

- **Provider Information Portal (PRT)**
- **Registry Data (REG)**

Qualifying Period:	Incentive begins:
June 1, 2017 - Nov. 30, 2017	Jan. 1, 2018
Dec. 1, 2017 - May 31, 2018	July 1, 2018

- **Access Formulary Electronically (EEX)**
- **Generic Utilization Rate (GUR)**

Qualifying Period:	Incentive begins:
Sept. 1, 2017 - Nov. 30, 2017	Jan. 1, 2018
March 1, 2018 - May 31, 2018	July 1, 2018

Metric	Percent	Group	Description
Electronic Self-Service (ES3, ES2)	2.5 (ES3) (96% or >) 1.5 (ES2) (86-95%)	A	Must use Availity portal or ANSI 270/271 & 276/277 transactions to electronically obtain BCBSKS patient eligibility, benefit, and claims status information. Electronic access must meet one of the percentages at left compared to the provider's total number of queries to BCBSKS, regardless of the mode of inquiry to receive the corresponding incentive. Providers billing under a single tax ID number will have their inquiries combined for determining the applicable percent.
Provider Information Portal (PRT)	2.0	A	Must verify provider information twice a year according to the qualifying schedule below. Each individual provider's information within a group must be verified. Verification must be completed within the BCBSKS provider information portal.
Registry Data (REG) (applies only to anesthesia, pathology, radiology, urology, and chiropractors)	1.5	B	Must send sufficient patient information to meet CMS quality measures to a CMS-approved registry. Electronic submission is preferred. Providers under a group qualify as a group. Must send report to BCBSKS demonstrating acceptance of submitting data and meeting registry requirements. **Note —** Although not prescribing providers, chiropractors will be eligible for this Group B measure only.
Well-Child visits (W15) (New) 6-plus visits in first 15 months	.25	B	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 their first 15 months of life. Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.
Well-Child visits (W34) (New) 1 or more visits for 3-6 year olds	.25	B	The percentage of members 3 to 6 years of age who had at least one well-child visit with a PCP during the measurement year. Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.
KHIE HL7 use — Each provider must have a user ID and real-time connectivity to qualify for:			
a-KHIE HL7 (ADT) Demographics, admissions, discharges, transfers	1.0	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.
b-KHIE HL7 (OPN) Progress notes	1.0	B	Must send progress notes on all patient encounters.
c-KHIE HL7 (ABS) Diagnosis, Procedure coding	1.0	B	Must send diagnosis and/or procedure coding on all patient encounters.
d-KHIE HL7 (LAB) Lab reporting	1.0	B	Must send all lab reports on all patient lab tests.
e-KHIE HL7 (MED) Medication records	1.0	B	Must send medication history on all patient encounters.

Metric	Percent	Group	Description
Access Formulary Electronically (EEX)	1.0	B	Must electronically access member benefit information for eligibility, formulary, and medication history a minimum of 120 times per quarter.
Generic Utilization Rate (GUR)	1.0	B	Minimum generic prescribing of 80 percent (for all BCBSKS members with a prescription drug benefit).
PCMH Recognition (BST) Level 3	2.0	C	Provider must achieve Level 3 NCQA and/or URAC Patient Centered Medical Home recognition.
Breast Cancer Screening (BCS)	1.0	C	The percentage of women 50 to 74 years of age (52 to 74 as of the end of the measurement period) who had a mammogram anytime in the past two years. Must be greater than or equal to 70 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients for breast cancer screening. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** OB-GYN and Geriatrician providers can qualify as well.
Appropriate Testing for Children with Pharyngitis (CWP)	1.0	C	The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e. appropriate testing). Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/ eligible patient to receive incentive.
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	1.0	C	The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. Must be greater than or equal to 85 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	1.0	D	The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. Must be greater than or equal to 30 percent to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.
Monitoring Patients on Persistent Medications (MPM)	1.0	D	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (ACE Inhibitors or ARB's, Digoxin, Diuretics) and also had at least one applicable lab test in the measurement period. Must be greater than or equal to 85 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.

Web changes — Medical policy

Since the publication of Professional Provider Report S-2-17, the following policies have been posted at: http://www.bcbsks.com/CustomerService/Providers/MedicalPolicies/policies.shtml

- Afrezza (human insulin)
- Alcohol Injection Therapy for Morton's Neuroma
- Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry
- Androgens and Anabolic Steroids
- Antidepressant Agents
- Aqueous Shunts and Stents for Glaucoma
- Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions
- Automated Ambulatory Blood Pressure Monitoring for the Diagnosis of Hypertension in Patients With Elevated Office Blood Pressure
- Automated Percutaneous and Percutaneous Endoscopic Discectomy
- Balloon Sinuplasty for Treatment of Chronic Sinusitis
- Biologic Immunomodulators Therapy (Pharmacy Benefit Only)
- Bronchial Thermoplasty
- Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
- Cardiac Rehabilitation in the Outpatient Setting
- Catheter Ablation as Treatment for Atrial Fibrillation
- Charged-Particle (Proton or Helium Ion) Radiotherapy for Neoplastic Conditions
- Circadian Rhythm Disorder
- Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid
- Coronary Computed Tomography Angiography with Selective Noninvasive Fractional Flow Reserve
- Cryosurgical Ablation of Primary or Metastatic Liver Tumors
- Cytoreductive Surgery and Perioperative Intraperitoneal Chemotherapy for Select Intra-Abdominal and Pelvic Malignancies
- Deep Brain Stimulation
- Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis
- Dry Needling of Myofascial Trigger Points
- Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures
- Electronic Brachytherapy for Nonmelanoma Skin Cancer
- Emflaza (deflazacort)
- Equipment for Cold Therapy
- Extracorporeal Shock Wave Therapy (ESWT) for Plantar Fasciitis and Other Musculoskeletal Conditions
- Genetic Testing for Tamoxifen Treatment
- Genetic Testing for Warfarin Dose
- H.P. Acthar Gel (repository corticotropin)
- Hepatitis C Second Generation Antivirals – Through Preferred Agent(s)
- Human Growth Hormone
- Idiopathic Pulmonary Fibrosis (Esbriet®/pirfenidone, Ofev®/nintedanib)
- Image-Guided Minimally Invasive Decompression for Spinal Stenosis
- Implantable Cardioverter Defibrillators
- Injectable Atopic Dermatitis Agent(s)
- Insulin Combination Agents (Soliqua, Xultophy)
- Intensity Modulated Radiotherapy (IMRT)
- Interspinous Fixation (Fusion) Devices
- Intra-Articular Hyaluronan Injections for Osteoarthritis
- Kalydeco (ivacaftor), Orkambi (lumacaftor/ivacaftor)
- KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy
- Lumbar Spinal Fusion
- Lysosomal Storage Disorders
- Meniscal Allografts and Other Meniscus Implants
- New to Market Drugs (Including: Ingrezza (valbenazine))
- Opioids, Extended Release (ER)
- Orthopedic Applications of Platelet-Rich Plasma
- Orthopedic Applications of Stem-Cell Therapy
- Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders
- PathFinderTG® Molecular Testing
- Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
- Photodynamic Therapy for Choroidal Neovascularization
- Progesterone Therapy as a Technique to Reduce Preterm Birth in High-Risk Pregnancies
- Proprotein Convertase Subtilisin/kexin type 9 (PCSK9) Inhibitors
- Radioembolization for Primary and Metastatic Tumors of the Liver
- Self-Administered Oncology Agents
- Spinal Cord and Dorsal Root Ganglion Stimulation
- Statin Therapy
- Substrate Reduction Therapy
- Surgical Treatment of Femoroacetabular Impingement
- Transcatheter Arterial Chemoembolization (TACE) to Treat Primary or Metastatic Liver Malignancies
- Transcranial Magnetic Stimulation (TMS)
- Tysabri® (natalizumab), Lemtrada™ (alemtuzumab), and Ocrevus® (ocrelizumab) (IV Multiple Sclerosis Agents)
- Ultrafiltration in Heart Failure
- Vacuum Assisted Wound Closure (VAC)
- Wearable Cardioverter Defibrillators

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

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

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