Blue KC Basics

General information that is of value to providers in the Blue KC networks.

Know the Networks

Very Important!

It is extremely important that contracted providers know what networks in which they participate. Please verify each participating Provider in the specific network prior to rendering services.

Please contact the **Provider Hotline** with any questions.

Kansas City

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

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- Credentialing and Contracting

Claims and Contacts

- BlueCard® Program
- Claims, Billing and Remittance
- Contact Resource Directory

Additional Services

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- Behavioral Health and Substance Use
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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 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. Providers can use this site to verify the accuracy of their own contact information.
- The organizational administrator who has the responsibility of adding and managing the users in a Provider's practice/facility will need access to the portal. Please do not share login information, HIPAA requires that each user have their own username and password. After login, access under the header titled Account Administration and the Manage Users area is on the right.
- You must sign in once every 30 days or the password will expire. With regular usage, passwords will expire every 120 days. Contact your Organizational Administrator or call 816-395-3700 for a password reset.

Providers must login to the Providers.BlueKC.com 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.

Contact the **Provider Hotline** with any questions

Request Access:

Follow these steps:

1. From Providers.BlueKC.com click REGISTER NOW.
2. Complete the form.
3. Click SUBMIT.

You will receive an email with login information.

LOGIN:

Follow these steps to login:

1. Go to Providers.BlueKC.com.
2. Type Username and Password, then click LOGIN.

All alphabetic characters in usernames and initial passwords are lower case.

Navigation

After LOGIN, the Home page will be displayed. From the Home page, use the navigation menu across the top or left side of the page:

- Claims/Eligibility
- Communications
- Resources
- Forms
- Medical Policies
- Account Administration

In the upper right see Find a Doctor, Contact and the LOG OFF links.

Plan Details

Member Identification and Verification of Eligibility

Before any services are rendered, Provider must conduct a member verification under each benefit plan. Once verification is in place, Provider shall provide timely accessibility to members.

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 at Providers.BlueKC.com
- By calling our Provider Hotline (see Contact Resource Directory)

Providers calling customer service must be able to verify their identity as well as the patient's identity:

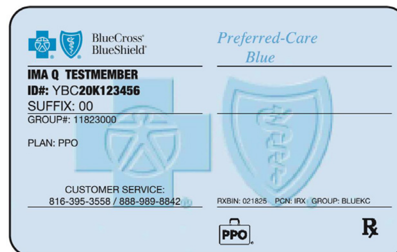
- Inquirer's name
- Inquirer's telephone number
- Provider Blue KC number or Tax ID number
- Provider name
- Member's Blue KC ID number or social security number

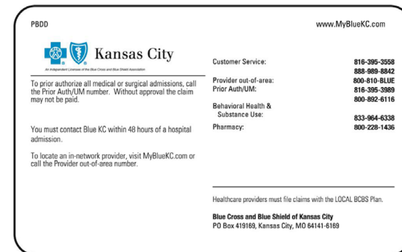
PPO, HMO and EPO Defined

Participating/Traditional Provider is a Participating Hospital, Participating Physician and any Ancillary Provider that has entered into agreements with Blue Cross Blue Shield of Kansas City (BlueKC), or with another organization that has an agreement with BlueKC to provide Covered Services to Covered Individuals at the negotiated payment rates.

Preferred Provider Organization (PPO) Emphasizes Choice	Health Maintenance Organization (HMO) Emphasizes Prevention and Predictability	Exclusive Provider Organization (EPO) Emphasizes Affordability Networks
Networks Preferred Care Preferred Care Blue Blue Access Blue Select Blue Select Plus Blue Medicare Advantage	**Networks** Blue Care Blue Medicare Advantage Networks	**Networks** Preferred Care Blue Blue Select Blue Select Plus Blue High Performance Network

Examples of Member Cards





PCP Required for the HMO Plan

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

Additional Plans

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. 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. 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.

BlueSaver HSA Plan

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 a certain amount every year. 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.

Provider Directory Updates

Blue KC shall have permission to include Provider's name and other information as needed. Providers authorize Blue KC to use names and other relevant, current information in the network Provider Directory and other marketing material. Providers must inform Blue KC of any changes 45 days prior to change taking effect. Provider must attest to accuracy of directory information every 90 days, consistent with Blue KC Policy and requirements under the Consolidated Appropriations Act. If Blue KC is fined or penalized for any Directory inaccuracies, Provider shall provide reimbursement to Blue KC.

Submitting Corrected or New Information

Keeping Provider data up-to-date is essential to appropriate claim payment and contractually required to maintain correct Member access to care. To update Provider data, please 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 other than rosters or change files:

1. Log into the provider portal at Providers.BlueKC.com.
2. Complete the **Provider Update Form** and submit online

Service Area Map for Blue KC Networks

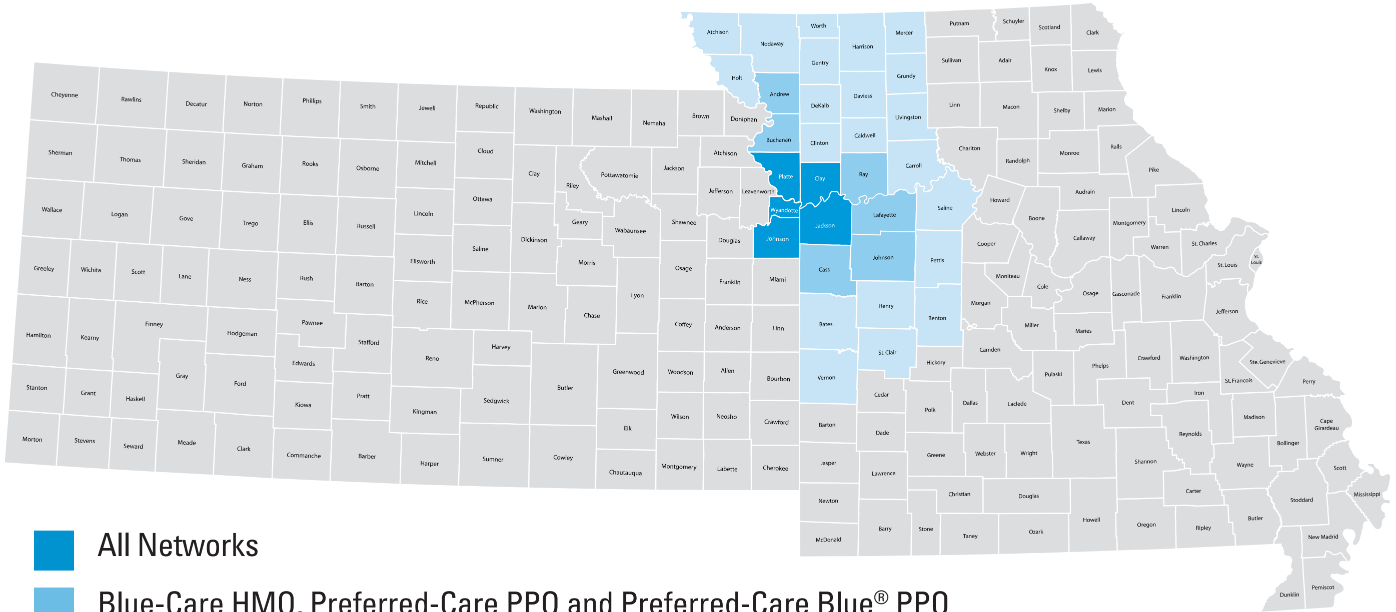
Kansas Counties

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 and Worth

See next page for exact network coverage for each county.



BlueAccess is a limited network that may or may not have any providers in the Blue KC counties. Network design is based on business and member needs.

Service Area Table for Blue KC Networks

State	County	Blue-Care HMO	BlueSelect PPO	BlueSelect Plus PPO	Preferred-Care PPO	Preferred-Care Blue PPO	Medicare Advantage HMO/PPO
Kansas	Johnson	●	●	●	●	●	●
	Wyandotte	●	●	●	●	●	●
Missouri	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				●	●	●

Member Rights and Responsibilities

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.

Member Rights

Blue KC members have certain rights and responsibilities, as outlined below.

- 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 member's condition from any participating Provider, regardless of cost or benefit.
- Receive medically necessary and appropriate care or services from any participating Provider or other participating healthcare Provider from those available as listed in a member's managed care plan Directory or from any nonparticipating Provider or other healthcare Provider.
- Receive information and diagnosis in clear and understandable terms and ask questions to ensure members understand what they are told by providers and other medical personnel.
- Participate with providers and practitioners in making healthcare decisions, 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 members cannot participate in decision making.
- Discuss medical records with providers and expect that health records are kept confidential, except when disclosure is permitted by law consistent with our Notice of Privacy Practices.
- Be provided with information about a member's managed healthcare plan, its services and the practitioners and providers providing care, as well as have the opportunity to make recommendations about the rights and responsibilities of members.
- Communicate any concerns with a member's managed healthcare plan, regarding care or services, receive an answer to those concerns within a reasonable time and initiate the complaint and grievance procedure if members are not satisfied.
- Respect the dignity of other members and those who provide care and services through their managed healthcare plan.
- Ask questions about a treatment Provider or until members fully understand the care they are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.

Member Responsibilities

- Follow the mutually agreed upon plans and instructions for care that members have discussed with a 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 their treatment Provider regarding a member's medical history, health conditions and care.
- Keep all scheduled healthcare appointments and provide advance notification to the appropriate Provider if it is necessary to cancel an appointment.

- Know how to properly use the services from managed healthcare.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

Privacy and Security

Protecting PHI is everyone's business. Blue KC and Provider each have independent obligations to protect member's protected health information (PHI) as covered entities under the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations found at 45 C.F.R. Parts 160 and 164 (HIPAA). Information regarding how Blue KC protects PHI can be found in its Notice of Privacy Practices.

If Provider has any questions or concerns regarding the privacy of PHI or the security of Blue KC's systems, please contact us. Please contact us immediately. See Contact Resource Directory, HIPAA Privacy and Security for details.

Risk Adjustment Process

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

Assessments

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 Provider-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®

HEDIS is administered by the National Committee for Quality Assurance (NCQA). NCQA has expanded the size and scope of HEDIS to include measures for providers, PPOs and other organizations.

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.

Member Medical Records

Providers must prepare, maintain and protect all medical health record in accordance to the Provider Agreement. These records shall be preserved for the longer of 6 years after termination of the Agreement or following the completion of any audit.

Failure to provide or release records, information or data as required under the Provider Agreement constitutes a material breach of the Agreement and, in Blue KC's sole discretion, may result in termination of this Agreement. Blue KC reserves the right to recoup payments made to the Provider. The Provider is not entitled to consequential damages if a termination is in result of failure to provide or release records. Provider is not entitled to remuneration for medical records unless specifically required according to the terms of the Provider Agreement.

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 a Provider office. You can be confident we will treat patients' PHI consistent with our Notice of Privacy Practices.

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

On-site Review

Prior to conducting an on-site review, our abstractors will contact providers' office to determine who will be coordinating the 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 Kiteworks system, fax-mail or U.S. mail. See HEDIS in Contact Resource Directory for details.

> As a reminder, Article 2.10 Maintenance of Records; Blue KC Access to Records of the Provider Network Agreement and the Provider 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 Provider at no cost to the requesting party. This includes records provided by a copy service.

Please make the data available consistent with the timeline in the request letter. 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.

Blue Distinction®

Blue Distinction Specialty Care Program

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 **expertise** in delivering specialty care.	1. Bariatric Surgery 2. Cardiac Care 3. Complex and Rare Cancers (Blue Distinction Center designation care only) 4. Knee and Hip Replacement 5. Maternity Care 6. Spine Surgery 7. Transplants
Blue Distinction Center+	Healthcare facilities recognized for their **expertise and efficiency** in delivering specialty care.	

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.

Total Care

Total Care (TC) s a delivery model designed to improve specific aspects of the healthcare delivery system. The Primary Care Providers (PCP) engaged in this delivery model will play a key role in the transformation of the delivery system.

The Advanced Primary Care (APC) Program is one of Blue KC's programs designed to align with the BDTC model. The APC Program is based on foundational medical home concepts as well as APC principles designed to improve aspects of the healthcare delivery system, such as:

- Person- and family-centered care.
- Care that meets population needs while ensuring it is continuous, comprehensive and equitable.
- Care that is team-based and collaborative.
- Care that is coordinated and integrated with the medical neighborhood and community-based services.
- Care that is accessible and of high value.
- A well-developed infrastructure that supports movement from fee-for-service to value-driven, population-based care and payment.
- Effective use of Health Information Technology (HIT) to include electronic records, data analytics and population health tools.
- Measurement and active improvement in quality, experience and cost/utilization outcomes.
- To find out more about the APC program and how to participate, please email _medical_home@bluekc.com and request more information.

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.

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.

If Provider suspects frauds, abuse or misconduct, Provider shall report this information immediately to Blue KC.

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.
- Offering, soliciting, paying or 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.
  - Filing claims for services or medications not received.
  - Forging or altering bills or receipts.
  - Using someone else's coverage or insurance card.
  - Allowing someone else to use a member's insurance card.

Applicable Laws

In providing covered services under the Provider Agreement, Provider must comply with all local, state or federal laws to conduct business and perform obligations.

The Provider shall not discriminate against a member on the basis of his or her source, method or rate of payment, his or her coverage under a Benefit Plan, age, sex or gender, sexual orientation or preference, marital status, race, color, ancestry, ethnicity, national origin, religion, veteran status, disability, handicap, health status or medical condition (including mental as well as physical), genetic condition, claims experience, evidence of insurability (including conditions arising from domestic violence), utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the member's filing of any complaint, grievance or legal action against the Provider. If Provider suspects frauds, abuse or misconduct, Provider shall report this information immediately to Blue KC.

The following information provides an overview of certain laws that apply to providers. This is not an exhaustive list.

The Federal Healthcare Fraud Statute:

Prohibits: Knowingly and willfully executing, or attempting to execute, a scheme or artifice

1. To defraud any health care benefit program; or
2. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

Penalties: In connection with the delivery of or payment for health care benefits, items, or services, shall by fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imposed not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

18 United States Code § 1347

The Civil False Claims Act

Prohibits:

- 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 $10,957 to $21,916 per claim submitted in violation of the False Claim Act.

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 healthcare program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Penalties: Shall be guilty of a felony and upon conviction, fines, jail terms and exclusion from participation in federal healthcare programs; $50,000 per kickback plus 3 times the amount of remuneration.

The Stark Statute (Provider Self-Referral Law)

Prohibits: A Provider from making a referral for certain designated health services to an entity in which the Provider (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.

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.

Revisor of Statutes State of Missouri

Fraudulent insurance act, committed, when – powers and duties of department – penalties –

1. As use in sections 375.991 to 375.994, the term "statement" means any communication, notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of damages, bills for services, diagnosis, prescription, hospital or doctor records, x-rays, test results or other evidence of loss, injury or expense.
2. For the purposes of sections 375.991 to 375.994, a person commits a "**fraudulent insurance act**" if such person knowingly presents, causes to be presented or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any oral or written statement including computer generated documents as part of or in support of, an application for the issuance of or the rating of, an insurance policy for commercial or personal insurance or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.
3. A "**fraudulent insurance act**" shall also include but not be limited to knowingly filing false insurance claims with an insurer, health services corporation or health maintenance organization by engaging in any one or more of the following false billing practices:
    i. "**Unbundling**", an insurance claim by claiming a number of medical procedures were performed instead of a single comprehensive procedure;
    ii. "**Upcoding**", an insurance claim by claiming that a more serious or extensive procedure was performed than was actually performed;

iii. "**Exploding**", an insurance claim by claiming a series of tests was performed on a single sample of blood, urine or other bodily fluid, when actually the series of tests was part of one battery of tests; or

iv. "**Duplicating**", a medical, hospital or rehabilitative insurance claim made by a healthcare Provider by resubmitting the claim through another healthcare Provider in which the original healthcare Provider has an ownership interest.

Missouri Statute 375.991 RSMo.

Kansas Office of Revisor of Statutes

40-2,118. Fraudulent insurance act defined; penalty; notification of commissioner, when; antifraud plan. For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic oral or telephonic communication or statement as part of or in support of, an application for the issuance of or the rating of an insurance policy for personal or commercial insurance or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

40-2, 118 – Revisor of Statutes

Blue KC Right to Audit

Blue KC is authorized to access, inspect, audit and review all claims and records obtained by participating providers.

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 or misrepresentation by the healthcare Provider 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 over-utilization 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.

Pre-Payment & Post-Payment Audits

Blue KC conducts pre-payment and post-payment audits of patient records and adjudicated claims to verify compliance with Blue KC medical and payment policies, American Medical Association (AMA) Guidelines, CMS regulations, including medical necessity, established standards of care, appropriate coding and member benefit certificates. Pre-payment and 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 Reference Guide.

If the records are not received within the timeline indicated in the request letter:

- 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.
- Blue KC may take additional actions as described in the Provider Agreement.

Medical Records for Pre-Payment & 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 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 unless otherwise specified in the Provider Agreement. 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.

Documentation of Medical Services for Pre-Payment and 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. Documentation must support the procedure code, diagnosis code and the appended modifier, as outlined by the American Medical Association (AMA) and ICD-10-CM Guidelines.

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.

Elements of a complete medical record include but are not limited to:

- Physician orders and/or certifications of medical necessity.
- Patient questionnaires associated with physician services.
- Progress notes of another Provider that are reference in your own note.
- Treatment logs.
- Related professional consultation reports.
- Procedure, lab, x-ray and diagnostic reports.
- Billing Provider notes for billed date of service.

The Special Investigations Unit (SIU) conducts pre-payment and post-payment Payment Integrity Reviews. Additional documentation that is not a part of the medical record and that was not provided at the time of the initial request for the Payment Integrity reviews may not be accepted. Only medical records that were created contemporaneously with treatment will be considered. Any services that were denied for failure to provide medical records are not eligible for provider dispute.

Blue KC will accept Amended Medical Records in the following instances:

Late Entry: A late entry supplies additional information that was omitted for the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical records and be signed by the person making the addendum.

Correction: When making a correction to a medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for the correction. Document the correct information on the next line or space with the current date and time, referring back to the original entry.

Providers are reminded that deliberate falsification of medical records and prior authorization requests is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

1. Creation of new records when records are requested
2. Back-dating entries
3. Post-dating entries
4. Pre-dating entries
5. Writing over, or
6. Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed.

Post-payment Audit Dispute Process

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. Submit the dispute as instructed in the findings letter containing the determination or outcome of the Post-Payment Audit.

Second-Level Dispute

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

Payments to Hospitals

The reimbursement in the Fee Schedule is the only payment required for services, subject to Coordination of Benefits and other sources of payment provisions. The member is responsible for any member cost share amount and Blue KC is responsible to pay other amounts. If Provider is a hospital, the Blue KC Policies and Procedures and following payment conditions shall apply: days of hospital service, changes in hospital charges, bundling of services, unbundling of services and Hospital Acquired Conditions (HACs).

Days of Hospital Service

The day of admission shall be counted, but not the day of discharge when calculating says of hospital service payments. No charge shall be made to payor or member for part of a day of hospital Service, except when an extended stay is elected by member after a Provider has recommended a hospital discharge. If member is absent from hospital at census-taking hour, daily service charge may be billed to member but not the payor. If member is required to leave for a short period of time, but is present during census-taking hour, no reduction in payment rate or normal daily service charge will be applied.

Changes in Hospital Charges

Hospitals shall notify Blue KC to all changes of Provider's Chargemaster at least 60 days in advance. Written notice should include the effective date and percentage increase of Chargemaster for inpatient charges, outpatient charges and all other charges (i.e., the aggregate percentage increase for inpatient and outpatient charges). The combined Chargemaster Increase for each consecutive 12-month period shall not exceed the three percent limit. When limited is exceeded, the following formula will instead be used to determine payment for services:

- Current Percentage of Billed Charges
- 1+ Chargemaster Increase Percentage

Blue KC will give notice to the hospital for any payment adjustments with supporting calculations. These adjustments will be effective as of the effective date of the Chargemaster Increase that exceeded the Chargemaster Limit.

The hospital shall provide Blue KC with a copy of the Contracted Provider's Chargemaster as of the effective date of the Agreement, within 60 days of the Chargemaster Increase notice and at any time upon Blue KC's request. If the hospital has failed to provided require notice or the corrected increase was not implemented, Blue KC may retroactively adjust payments recoup as overpayments. All relevant information shall be provided by the hospital at Blue KC's request.

If Blue KC is not notified 60 days in advanced to all changes, Blue KC may further adjust the discounts shown in each Benefit Plan Schedule to offset the increased charges. If the increase in charges exceeds the Consumer Price Index Formula, hospitals will increase discounts shown in each Benefit Plan Schedule to offset the amount of increase in excess of the CPI Formula.

Bundling of Services

Hospitals may be reimbursed for services under DRG, APC, per diem or other bundled rate as determined in the Provider Agreement. Hospitals shall follow all applicable bundling rules and BCBSKC Payment Policies when submitting claims for services. Improperly unbundled services are not reimbursable.

Hospital Acquired Conditions (HACs)

Provider shall comply with all Blue KC requirements relating to HACs including properly admission indicators or on claim forms for all diagnoses. Provider shall not receive reimbursement for inpatient services related solely to HACs and shall hold Blue KC and the Member harmless for charges for any inpatient services related solely to HACs.

HACs means any one or more of the following:

- Pressure ulcers stages III & IV
- Catheter-associated urinary tract infections
- Vascular catheter-associated infection
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)
- Air embolism
- Blood incompatibility
- Foreign object retained after surgery
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Surgical-site infections following:
  - Bariatric Surgery
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Manifestations of poor glycemic control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Deep vein thrombosis and pulmonary embolism following orthopedic procedures:
  - Total Knee Replacement
  - Hip Replacement
  - Other conditions subsequently identified as HACs by the Centers for Medicare and Medicaid. (Blue KC will use the CMS effective date as the effective date for any addition to this list.)

Negotiation of Agreements

Blue KC's practice is to engage directly with Providers in the contracting process; however, Providers may also elect to be represented by legal counsel. If Providers engage any other unaffiliated, third party consultants to assist Providers in contracting with Blue KC, then Blue KC requires the unaffiliated, third party consultants to first execute a non-disclosure agreement ("NDA") with Blue KC to ensure confidentiality of the contract terms, payment rates, and other confidential and proprietary business information.

Abbreviations

ABN	Advanced Benefit Notification
ACA	Affordable Care Act
AFHC	Away From Home Care
ASK	Administrative Services of Kansas
ASO	Administrative Services Only
Blue KC	Blue Cross and Blue Shield of Kansas City
BNDD	Bureau of Narcotics and Dangerous Drugs
BQCT	Blue Quality Center for Transplant
CAD	Coronary Artery Disease
CAQH	Council for Affordable Quality Healthcare
CDHC	Consumer Directed Health Care
CDHP	Consumer Directed Health Plan
CMN	Certification of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
COPD	Chronic Obstructive Pulmonary Diseases
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DEA	Drug Enforcement Administration
DM	Disease Management
DME	Durable Medical Equipment
EFT	Electronic Funds Transfer
EMS	Electronic Media Services
EOB	Explanation of Benefits
EPO	Exclusive Provider Organization
ESI	Express Scripts Inc.
ESRD	End Stage Renal Disease
FEHB	Federal Employee Health Benefits
FEP	Federal Employee Program
FSA	Flexible Spending Account
FWA	Fraud, Waste and Abuse
HCFA	Health Care Financing Administration (now CMS)
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set

HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
HIT	Home Infusion Therapy
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HSA	Health Savings Account
IVR	Interactive Voice Response
MA	Medicare Advantage
MM	Medical Management
MPMC	Medical and Pharmacy Management Committee
MSA	Medical Savings Account
MSN	Medicare Summary Notice
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NOC	Not Otherwise Classified
NPI	National Provider Identifier
OB/GYN	Obstetrics/Gynecology
OPL	Other Party Liability
OPM	Office of Personnel Management
PCP	Primary Care Provider
PDL	Prescription Drug List
PFFS	Private Fee For Service
POS	Point of Service
PPO	Preferred Provider Organization
QI	Quality Improvement
RA	Remittance Advice
RBRVS	Resource Based Relative Value System
RVU	Relative Value Units
SCHIP	State Children’s Health Insurance Plan
SNP	Special Needs Plan
TC	Total Care
TPN	Total Parenteral Nutrition
UM	Utilization Management
URAC	Utilization Review Accreditation Commission

Definitions

Accreditation - hospitals shall maintain full accreditation by JCHAO, AOA, Medicare or where applicable, any other accreditation body acceptable to Blue KC.

Acceptance of Members - If a hospital has available space, providers accept members at its facility on a first-come-first-served basis and shall not discriminate for any reason.

Affiliates - Means any Blue KC subsidiary or any company that controls or is under common control with Blue KC.

Affiliated Provider - Means any health care Provider or professional who is affiliated with another Provider, through employment, contract, ownership, staff privileges, or otherwise.

Agency or Agencies - Means federal, state and local government organizations or authorities (such as the Centers for Medicare and Medicaid Services, Department of Insurance, Department of Health, etc.) including without limitation, any of Blue KC's accreditation organizations (NCQA, URAC, etc.), and any of their authorized representatives.

Allowed Amount - Means the dollar amount that Provider has agreed to accept as full and final payment for services.

Ancillary Provider - Means a health care Provider or organization, other than a network hospital, Institution or network Physician, that has directly or indirectly entered into an Agreement with Blue KC, or another organization that has an Agreement with Blue KC, to provide services to members, including but not limited to providers of the following services or supplies: outpatient surgery, laboratory, durable medical equipment, or home health.

Applicable Laws - Any and all applicable local, state, or federal statutes, regulations, ordinances, or other requirements or judicial decisions having the force and effect of law, including without limitation, federal Medicare and Medicaid law, regulations, and other requirements; state Medicaid (with regard to dual eligible beneficiaries with coverage under Medicaid and Medicare) law, regulations, and other requirements; any willing Provider and prompt payment law, regulations and other requirements ;Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans With Disabilities Act, and all related implementing regulations ; the Violent Crimes Control Act, 18 U.S.C. §§ 1033 and 1034; the Controlled Substances Act, 21 USC§ 801, et seq.; the Anti-Kickback Act, 42 USC 1320a-7b and regulations ; and the False Claims Act, 31 USC§ 3729, et seq.; HIPAA and its implementing privacy, security transaction, and national Provider identifier regulations at 45 C.F.R. Parts 160, 162, and

164 ("HIPAA Privacy Rule ," "HIPAA Security Rule ," "HIPAA Transaction Rule," and "HIPAA NPI Standards"); the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") ; the Patient Protection and Affordable Care Act of 2010 (" PPACA") (including but not limited to Section 1557 and its implementing regulation at 45 C.F.R. Part 92, together the" 1557 Rules") and the Health Care and Education Reconciliation Act of 2010 ("HCE RA"); state privacy provisions (if not preempted by federal law); licensing law; workers ' compensation law; and minimum salary and wage statutes and regulations. With regard to services provided to members under a Blue KC Medicare Advantage Plan or providers' participation in any Blue KC network that includes a Medicare Advantage Plan, Applicable Laws shall also include the " CMS Requirements" as defined in the Medicare Advantage Addendum, attached to Agreement as Exhibit C and incorporated herein by reference.

Benefit Plan - Means the applicable government or commercial individual or group contract, plan or other document or Agreement, under which any Covered Individual is or becomes entitled to receive health care benefits underwritten or administered by Blue KC, a Blue KC Affiliate, or through BlueCard.

BlueCard - Means the program by which individuals receive health care benefits underwritten or administered by any Blue Cross and /or BlueShield Plans through the Blue Cross and Blue Shield Association .

Business Day - Means that in the calculation of the time period, Saturdays, Sundays, and federal holidays shall be excluded.

Case Management - Means the process through which Blue KC or payor provides coordination, assistance with and monitoring of the care needs of members.

Emergency Medical Condition - Means a sudden and unexpected onset of a health condition manifesting itself by acute conditions of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent layperson, possessing average knowledge of health and medicine, to result in:

1. Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions ; or
3. Serious dysfunction of any bodily organ or part;
4. Inadequately controlled pain; or
5. Serious harm to a member or others due to an alcohol or drug abuse emergency; or
6. Injury to self or bodily harm to others; or
7. With respect to a pregnant woman who is having contractions: (a) there is inadequate time to affect a safe transfer to another hospital before delivery or, (b) transfer may pose a threat to the health or safety of the woman or the unborn.

Emergency Medical Services - Means those health care items and services furnished or required to evaluate or stabilize an individual due to an emergency medical condition.

Emergency - Shall have the same meaning as used in the member's Benefit Plan and shall be defined consistently with Applicable Law.

Group Physician or Group Provider - Means two or more physicians or providers legally organized as a single legal entity (e.g. Partnership, professional corporation, foundation, not- for-profit, faculty practice, or similar association).

Inpatient - Means a Covered Individual who is admitted to a network hospital on the order of a physician with the expectation that the person will remain at least overnight and for at least twenty-four (24) hours and will occupy a bed even though the person may later be discharged or transferred to another facility and does not actually use a bed overnight.

Institution - Means an organization which provides health care services in an institutional setting such as, but not limited to, hospitals, skilled nursing facilities, nursing homes, and surgical centers.

Medically Necessary - Means those services and supplies which, in the judgment of Blue KC meet all of the following requirements:

- Are reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability and which could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered;
- In accordance with Blue KC medical policies and the medical policies of a payor or delegate and in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered and furnished in the most appropriate setting;
- Not primarily for the convenience of the Covered Individual, nor the Covered Individual's family, Provider or another Provider;
- Consistent with the attainment of reasonably achievable outcomes; and
- Reasonably calculated to result in the improvement of the Covered Individual's physiological and psychological functioning.
- If more than one service or supply would meet the requirements a through e above, such service or supply shall be furnished in the most cost- effective manner which may be provided safely and effectively to the Covered Individual. Services or supplies that are "not Medically Necessary" are not a covered benefit or services. Conversely, a service or supply may meet Medical Necessity criteria, but be specifically excluded from coverage by the terms of the Benefit Plan.

Network - Means those Blue KC networks shown in your Provider Agreement.

Network hospital or hospital - Means a general acute-care hospital, a specialty hospital such as a mental or behavioral health hospital, ambulatory surgery center, a skilled nursing facility, an acute long-term care facility, or an extended active rehabilitation facility that has an Agreement with Blue KC to participate in Blue KC network(s) in order to provide services to members.

Network Physician or Physician - Means any duly licensed physician who has an Agreement with Blue KC to participate in network(s) in order to provide services to members .

Network Provider or Provider - Means a hospital, physician, group physician, ancillary Provider, affiliated providers, employed, contracted or other individual or entity involved in the delivery of health care or ancillary services who or which have entered into agreements with Blue KC, or affiliates, to participate in network(s) in order to provide services to members.

Network Provider Directory - Means the document prepared and updated from time to time by Blue KC which contains a listing of network hospitals, network physicians and ancillary providers that have entered into agreements with Blue KC, or with another organization that has an Agreement with Blue KC, to participate in networks in order to provide services to members.

Payment Rate(s) - Means the rate at which Provider will be paid for services and is the lesser of the allowed amount for services rendered by Provider to members or Provider's Charges.

Payor - Means Blue KC or, alternatively, certain third parties (such as third-party administrators, insurance carriers or self-funded groups) with whom Blue KC has agreed to provide access to services, through BlueCard or otherwise.

Policies and Procedures - Means the Provider Reference Guide, all Blue KC, delegate, and payor guide(s), medical and Medical Necessity policies and policies related to billing (including, but not limited to, coding, mutually exclusive and incidental or included procedures), Utilization Review, Quality Improvement, peer review, credentialing, recredentialing, Covered Individual and Provider appeal and grievance procedures, other administrative guidelines, and any other similar Policies and Procedures as may be set forth in the Blue KC Provider Manual, Provider newsletters or bulletins, or otherwise communicated to Provider.

Prior Authorization - Means any requirement by Blue KC in the Policies and Procedures for prior review and approval of services covered under a Benefit Plan as a condition of payment for those services.

Provider Manual - Means the Provider Reference Guide made available to providers, as updated by Blue KC from time to time. If Blue KC renames the Provider Reference Guide, then the replacement manual will be the Provider manual.

Provider or Network Provider - Means a healthcare Provider under contract to provide services to members. Provider includes an individual who provides professional health care services and is licensed, certified, or registered by the state in which the services are performed, as well as an institution or institutional Provider, group Provider, affiliated Provider, and ancillary Provider.

Quality Improvement - Means the Blue KC program(s) that review the process and outcomes of services rendered to members to ensure that care provided is efficacious and consistent with generally accepted medical practices.

Retrospective Review - Means utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization Review - Means those activities conducted by Blue KC or payor in order to review the efficiency of the health care process, the Medical Necessity of the services provided or prescribed and/or the appropriateness of the site, frequency and duration of care. The utilization review includes, but is not limited to, prior authorization, quality improvement, concurrent review, case management, and retrospective review.

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

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