Health Services

Integrated system that promotes cost-effective and appropriate interventions to improve the quality of health care services for members.

Kansas City

BLUE KC NETWORK PROVIDER REFERENCE GUIDE

A reference manual for all Blue KC contracted network providers.

Additional Modules

Setup and Overview

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Health Services

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Care Management

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

Integrated Health Services Division

The goal of Integrated Health Services (IHS) is to identify and promote appropriate usage and cost-effective healthcare resources to ensure quality healthcare services are delivered to our members.

Blue KC's IHS division makes utilization of services decisions about member's healthcare needs based on the medical appropriateness of the care and service.

Blue KC does not reward its IHS staff for issuing denial of coverage decisions and there is no financial incentive offered to IHS staff to make decisions that would encourage inappropriate utilization of services.

Blue KC Medical Policy

The medical policy is available at Providers.BlueKC.com. After acceptance of the disclaimer, search using a keyword, procedure code, alphabetic search or topic search. Medical Policies are also available via the Blue KC website (Contact/FAQs/Medical Policy).

All applicable Blue KC Policies and Procedures must be followed by Provider and all affiliated providers. Affiliated providers must participate in the same network as identified by the Provider Agreement. Blue KC is only held responsible for cost of covered services outlined in the member's benefit plan. Provider shall not directly or indirectly advance funds to member.

Please remember that state and federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage. Although a service may be medically necessary, it may be excluded under a member's benefit plan. Please submit an inquiry to medical policy through the contact tab at Providers.BlueKC.com with any questions.

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

In providing covered services under the Provider Agreement, Provider must comply with all local, state or federal laws to conduct business and perform obligations. Any provision set forth in the BAA, MA Addendum and State Law Addendum takes priority over conflicts in the Provider Agreement.

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 Provider must comply with all HIPAA requirements for electronic transactions including transactions through a clearinghouse, intermediary, subcontractor or other agent.

Utilization Review and Appeals and Grievances

Milliman Care Guidelines (MCG) Guidelines™

The guidelines are written by **MCG** clinicians and are a compilation of best practices for treating common conditions in a variety of settings.

The basis for the guidelines are drawn from medical literature, practice observation and the expert opinion of physicians, nurses and other providers. They are founded on the use of evidence-based research methodology to support the development and understanding of medical care processes.

Blue KC Medical Policy

This policy is a comprehensive set of criteria that helps determine medical appropriateness or necessity for procedures which do not have benefits or payment determinations clearly defined elsewhere.

Providers need to understand all aspects of the Utilization Review and provide timely medical records as requested:

- Prior Authorization - prior review of services including all inpatient stays. services are medically necessary services and supplies covered under the Provider Agreement, the member's benefit plan
- Quality Improvement - process that oversees the process and outcomes of member services to ensure care is efficacious and consistent with generally accepted medical practices
- Concurrent Review - review of the medical necessity of healthcare services
- Case Management - coordination and healthcare assistance and monitoring
- Respective Review - review after the patient has received healthcare to assess reimbursement levels, consistency and adjudication

The medical policy committee has oversight for development, review and revisions of the policy with approval from the medical director. The content includes inpatient procedures, outpatient procedures and durable medical equipment. All criteria sets are reviewed on an annual basis with local Provider input and accepted for use by the Medical and Pharmacy Management Committee.

Failure to comply may result in denial of reimbursement for services. This includes the appeals and grievance procedures prescribed by Blue KC as well as state and federal law. This applies for any benefit plan, even ones that aren't administered by Blue KC.

In the event of a denial, a copy of the guideline, protocol, benefit provision or other similar criterion used to make

the determination will be available upon request by calling the Integrated Health Services (IHS) Division or writing to the attention of the medical director (see Contact Resource Directory for details).

Medically Necessary

Providers provide services to members in accordance with their Provider Agreement and applicable benefit plan. A benefit plan is the contract for members receiving health care benefits from Blue KC.

For Blue KC benefit plans, medical necessity denotes services and supplies that are essential to the health of the member for the diagnosis or care and treatment of a medical or surgical condition. Services and supplies that are essential to the health of the member 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;
- Consistent with national Blue Cross and Blue Shield Association's uniform medical policy, as amended from time to time;
- Not primarily for the convenience of the 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 above requirements, 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.

Failure to meet medical necessity will be determined by Blue KC Provider reviewers or their authorized Provider designee (at their discretion) and under the terms of the applicable benefit plan or as may be required by law. Medical necessity is subject to the appeals process.

- Services or supplies that are determined not medically necessary are not a covered benefit. In accordance with the Provider contract providers can't bill the member for these services.
- A service or supply may meet the medical necessity criteria, but may also be specifically excluded from coverage by the terms of the benefit plan and therefore is not a covered benefit (that is, medical necessity does not determine coverage). Services that are not covered under the member's contract are member responsibility.

Reconsiderations and Appeals

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

All overpayments or incorrect payment of either parties must be identified and recovered with no time limitation. However, Provider must send refunds to members within 30 days after receiving recovery payment from Blue KC.

Blue KC will recover any overpayments, payments related to billing code errors or incorrect payments by credit transactions on the remittance advice form either fee-for-service payments. Blue KC may offset the full amount of any incorrect payment and reissue payment for the correct amount.

Providers may request reconsideration of adjudicated claim. Blue KC may adjust an adjudicated claim if it is determined that the claim was incorrectly paid or denied.

Providers must give Blue KC written notice of a request for reconsideration within 90 days of the disallowance, payment, or other notice of adjudication. If the Provider fails to request reimbursement in a timely manner, the Provider can't bill or seek reimbursement from a member that was denied.

These adjustments are possible even after the 90 day period:

1. Claims for services rendered to a member under the Federal Employee Health Benefits Program (FEP).
2. Claims involving subrogation for self-funded groups not governed by state law.
3. Claims involving Coordination of Benefits with Medicare or another private payor.
4. Claims involving fraud, alleged fraud, and/or misrepresentation. Fraud means a claim which is based on a misstatement or omission of material fact by a member or Provider, resulting in incorrect adjudication of a claim.
5. Claims where a longer period of time is required by applicable state or federal law.
6. Claims where Blue KC or Provider is ordered to adjust a claim because of a decision in a health care appeal or other administrative/judicial proceeding.
7. Claims under a worker's compensation policy.

	Standard Appeal	Expedited Appeal
When to File	A standard appeal for a denial of medical necessity is available within 180 days after notification of the denial or when waiting 30 days for a response does not jeopardize the member's health.	An expedited appeal is available during care or pre-care, when the standard time frame for a response (30 days) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
Initiation	To initiate a standard appeal the Provider should submit additional information to Blue KC by calling, faxing or written correspondence (see Appeals in Contact Resource Directory for details).	For expedited reconsideration of a denial, a Provider may phone or fax additional clinical information to Blue KC to the attention of the medical director. A medical director will also be available within 24 hours to discuss the case with the Provider. (see Appeals in Contact Resource Directory for details).
Review	The appeal review will be conducted by a medical director who has no previous involvement in the case, is in the same or similar specialty and is not a subordinate of the medical director who made the original decision. If the medical director is unable to reverse the decision, then the case is sent to an independent peer review organization.	The Blue KC medical director will review any medical records and additional documentation submitted by the hospital or Provider. The review will be performed by a medical director with no previous involvement in the case. If the medical director is unable to reverse the determination, then the case is referred to an independent peer review organization.
Response	Blue KC will make its best effort to issue a written decision to the Provider and member within 30 days.	The Blue KC medical director will issue a decision promptly within 72 hours or two business days, whichever is less. Blue KC will notify the Provider, member and hospital in writing of the Blue KC medical director's decision. Expedited appeals, on behalf of the member, which do not resolve a difference of opinion may be resubmitted through the standard appeals process.

Prior Authorization

A complete list of services requiring prior authorization may be found at Providers.BlueKC.com. Blue KC performs a pre-review of selected outpatient and inpatient procedures for all Blue KC programs, including lease and ASO business.

- The prior authorization process begins when a Provider, facility, member or the member's representative contacts Blue KC's Prior Authorization/Clinical Operations Department for authorization regarding a member's pending procedure, service or medication.
- Blue KC staff verifies the member's eligibility or, if after business hours will take the necessary information to verify eligibility the next business day. Specially trained registered nurses or pharmacists gather clinical information about the proposed service. Based on medical review findings, the Prior Authorization/Clinical Operations Department confirms the need for the service.
- If the nurse or pharmacist is not able to approve the case, it will be referred to the medical director for review.
- As of February 1, 2020, Blue KC is no longer accepting medical pre-determination requests from providers for commercial plans.

To access the Blue KC medical policy, go to Providers.BlueKC.com. If members have questions, they should contact the Prior Authorization/Clinical Operations Department. Contact resources are located in the Contact Resource Directory. Also, for providers answers to questions about specific benefits are available through the Providers.BlueKC.com or the **Provider Hotline** during business hours.

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

1. Blue KC staff requests the following information at the time of the call:
    i. Caller's name and telephone number.
    ii. Admitting/Service Provider.
    iii. Member's name and birth date.
    iv. Blue KC Identification number and Group number.
    v. Proposed treatment plan: tests, diagnostic procedures, surgical procedures, treatment, etc.
    vi. Date, place and type of admission or service.
    vii. Diagnosis primarily responsible for the admission or service.
    viii. Provider number and Group number.
2. Blue KC staff verifies that the treatment plan meets the criteria based on MCG or Blue KC medical policy.
3. If the admission or service is approved, the Blue KC nurse notifies the Provider and requester within 36 hours (to include one business day) upon receipt of all necessary information. A letter will be generated within 1 business day following approval. For admissions, the nurse also assigns a length of stay.
4. If the nurse is unable to approve the services(s) or elective admission, the case is referred to the medical director for review.

5. The Blue KC Medical Director makes a determination based on the clinical information provided. If more information is necessary, the medical director or review nurse contacts the Provider to request the additional information before a determination is made.
6. If the authorization is denied, the Provider may file a standard appeal to the appeals department or an expedited appeal to the Medical Director by calling or in writing (see Contact Resource Directory for details).

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

Required Member Information

Before any services are rendered, providers must conduct a member verification under each benefit plan. The Blue KC staff verifies the member's eligibility or, if after business hours, will take the necessary information to verify eligibility the next business day. Answers to questions about specific benefits are available through Providers.BlueKC.com or the **Provider Hotline** during business hours. Once verification is in place, Provider shall provide timely accessibility to members. If Provider operates hospital, Provider must supply access to 24/7 urgent and emergency care services. Provider shall provide covered services to members as related to each benefit plan. This does not cover immediate family members. All services provided, billed or report shall be provided directly through Provider or employees of Provider.

Provider participation in all Blue KC coordinated care programs is mandatory. If external care is needed, providers must first send member to another participating network Provider. If not available, send to a qualified non-network Provider.

Electronic Submission

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

Prior authorization e-forms are available to help simplify and streamline the prior authorization process. The forms may be accessed on the website at Providers.BlueKC.com. These may be completed online and submitted to the Clinical Pharmacy Department for processing. Please allow 36 business hours for processing (see Contact Resource Directory for details).

The Provider must comply with all HIPAA requirements for electronic transactions including transactions through a clearinghouse, intermediary, subcontractor or other agent.

Inpatient and Outpatient

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

Information may be submitted by phone or fax. The prior authorization list and forms are located at Providers.BlueKC.com (Find a Form).

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

Out-of-Network Services

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

In certain situations where emergency care is received from an out-of-network Provider or facility or where an out-of-network Provider renders services at an in-network Facility, the federal No Surprises Act may require the out-of-network Provider to submit claims to Blue KC and require Blue KC to process the claims at the member's in-network cost share.

Radiology

Outpatient and elective MRI, MRA, CT, CTA, PET, spinal fusions, echocardiogram and nuclear cardiology studies will require prior authorization from eviCore. Imaging performed in conjunction with an inpatient stay, 23 hour observation or testing done in the emergency room is not subject to authorization requirements.

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

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

Prenatal Programs

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

Durable Medical Equipment

Services, durable medical equipment (DME) and prostheses that require prior authorization are listed at Providers.BlueKC.com in the forms section. The portal does not include FEP or JAA members. Please contact the customer service number on the back of the member's card for prior authorization requirements.

Medications

All prior authorization requests, including step therapy, specialty pharmacy, dose optimization/quantity limits are processed within 36 business hours. To check the status of a prior authorization call pharmacy services.

Prescription drug lists are available on the Blue KC website by scrolling to the bottom of the home page, clicking FAQs, then Prior Authorizations for Medications (see Contact Resource Directory for details). Also, check online under pharmacy services for a current list of drugs requiring prior authorization. Please be aware that as new products are released and post-marketing information on existing therapies becomes available, changes in these lists may occur.

Reviews

Medical Review

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

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

Concurrent Review

Concurrent Review is part of the Utilization Review process that enables Blue KC to evaluate continued hospital, rehabilitation or skilled nursing facility stays for medical necessity and appropriateness. Concurrent review takes place during an inpatient stay as a follow-up to prior authorization. In this process, the Blue KC nurse reviewers actively monitor the member's progress to ensure that ongoing inpatient care is appropriate. These nurses assist in managing members and facilitate discharge planning. As a result of this management, a member's inpatient stay may be lengthened, shortened or the member may even be moved to a more appropriate care setting.

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

Step 1. Hospital's Review Nurse—Responsibilities

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

Step 2. Approval of Continued Stay

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

Step 3. Referral to Medical Director

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

Step 4. Denial of Continued Stay

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

Step 5. Peer-to-peer Conversation and Appeal of Denial

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

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

For continued stay denials, the Provider or facility may initiate an expedited appeal by calling the Blue KC medical director (see Appeals on Contact Resource Directory).

Case Management

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

Case Manager

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

Little Stars Prenatal Program

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

Case Management Referral Criteria

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

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

Complex Case Management

- Severe Trauma - MVA with multi trauma.
- Spinal Cord Injury - member became a paraplegic or quadriplegic.
- Severe Brain Injury - traumatic brain injury, stroke with multi factorial deficits, aneurysm with multi factorial deficits.
- Children and adults sent home for the first time or new baseline with home ventilator.
- Complex multi non-healing wounds - requires wound vac, long term acute care (LTAC) placement (> 21 days per guideline for admission) frequent IV antibiotic(s) and hyperbaric oxygen.
- Pre- or post-transplant members with significant issues and/or complications or rejection (except cornea transplant).
- Neonates requiring multiple resources.
- Member using out of area (OOA)facility for cancer treatment (in active treatment).
- Member with behavioral health and medical diagnosis requiring multiple services and nursing interventions.
- Multiple resources being used by a member.
- Nursing judgement finds a member falls outside the normal referral process. Communicate and problem solve with a case manager regarding the complex medical issue.

Coordination of Care

- Three or more urgent/emergent acute care admissions within a 6-month time period for any diagnosis or unexpected readmission within 30 days which may indicate member failing at home.
- IV or PO medication needed by a member (for example, Kiteworks used for specialty medications, discount coupon education).
- Member requiring coordination of services received while away from their home (for example, high flow oxygen).
- Member requiring coordination of care in the home health setting.
- Member requiring coordination with durable medical equipment (DME) (for example, wheelchair too small, suction machine not always providing needed suctioning).
- Member on oral chemotherapy and in remission.
- Member reaching out requesting assistance with a medical issue.
- Members generating $30,000 - $50,000 in designated time frame.
- Nursing judgement finds a member falls outside the normal referral process. Communicate and problem solve with a case manager regarding the medical issue.

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

Disease Management

Healthy Companion

Blue KC has a well-established population-based, disease management (DM) program, called Healthy Companion™: Working Together for Better Health, that is available to all Blue KC members.

The Healthy Companion program is a comprehensive program designed to reinforce the care and treatment provided to Blue KC members with chronic conditions such as diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, asthma, metabolic syndrome and depression. Through education and care management support, this program helps members take a more active and responsible role in controlling their condition.

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

Members

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

Medical Home

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

Physicians

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

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

Medical Records

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

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.

Confidentiality Proprietary Rights

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

Through the Provider Agreement, each party may receive or become aware of confidential information. Each party must agree to hold such information confidential and shall not reveal information to any third party expect as otherwise permitted. Both parties reserve the right to control the use of their respective names, symbols, trademarks and service makes. Parties cannot use each other's marks without prior written consent, which can be ceased if a withdrawal from consent or termination of Agreement occurs.

- Provider shall limit the exposure of confidential information to necessary employees, while also educating staff on protocol and importance of maintain confidentiality. Do not disclose information to any person outside of organization except as needed to comply with the Provider Agreement.
- Providers shall ensure that any payment rate or other confidential information disclosed to billing company, attorneys, etc. is not disclosed to any other Provider or organization.
- Providers must promptly return or destroy all Blue KC's confidential information upon termination or request of Blue KC unless otherwise allowed by the Provider Agreement.
- Blue KC may disclose Provider information but shall take reasonable measures to ensure no violations are broken. The Agreement shall not restrict any disclosure required by law. If responding to a formal disclosure request by law, party must give advance notice to other party involved and take all action to not disclose unnecessary confidential information.

Notwithstanding the above confidentiality rights, Blue KC and Provider may disclose confidential information, including, but not limited to payment rates, quality metrics, and cost of care information, to members, referring providers, payors, plan sponsors, or any other individual or entity as required by law to provide transparency regarding the potential or actual cost or quality of health care services.

Maintenance, Audit and Access

Blue KC is authorized to access, inspect, audit and review all claims and records obtained by participating providers. For detailed information on these Blue KC Policies and Procedures, please refer to the Provider Agreement.

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. Provider is entitled to remuneration according to the terms of the Provider Agreement.

The Provider shall maintain medical, financial, accounting and other records and will:

- Reflect the healthcare services rendered to the patient in the medical record documentation.
- Provide records upon request in accordance with the Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments, including but not necessarily limited to:
  - Article/Agreement/Contract 2.10 Maintenance of Records; Blue KC Access to Records (records to be provided upon request).
  - Article/Agreement/Contract 2.11 Governmental Agency Access to Records.

Sending Medical Records to Blue KC

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

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

Medical Records containing more than 50 pages, for multiple dates of services, require a table of contents or index to identify the page number for each date of service. Payment may be denied or recouped when the facility or professional provider fails to submit medical records in an unorganized or illegible manner. It is the responsibility of the provider to ensure accurate and appropriate documentation consistent with industry standards.

Documentation Standards

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

Each diagnosis submitted on the claim must be supported by the documentation in the patient's medical record.

The contracting Provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s). Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted and clearly translated to be untestable to the reviewer.

Providers must submit a complete and accurate claim or encounter form in accordance with Blue KC's Policies and Procedures after providing services to a member.

Claims should be submitted electronically in a HIPAA standard or otherwise on a UB-04 or CMS 1500 standard form. Providers should follow National Correct Coding Initiatives (NCCI) while assigning the appropriate CPT®, HCPCS, ICD-10, and revenue codes, and avoid sending duplicate bills to Blue KC sooner than 30 days after original submission. If the bill is duplicated, the Provider may be required to repay amounts or it may be deducted from subsequent amounts due.

Patient Records:

- Be legible in both readability and content.
- Contain only those terms and abbreviations that are or should be comprehensible to similar Provider/peers.
- Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
- Include all patient records received from other health care providers if those records formed the basis for treatment decision by the other Provider.
- Indicate the dates any professional service was provided and date of each entry.

Document:

- Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the Provider's own handwriting.
- Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes other writings or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.

Medication Details:

- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Indicate the medications prescribed, dispensed or administered and the quantity and strength of each.

Treatment and Diagnosis Details:

- Contain pertinent information concerning the patient's condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
- Indicate significant illnesses and medical conditions on the problem list.
- Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed and the results of each.
- List start and stop times or total time for each CPT code/service performed on all timed codes per CPT nomenclature.
- Document the initial diagnosis and the patient's initial reason for seeking the Provider's care.
- Document the patient's current status and progress during the course of treatment provided.

Quality Improvement

Blue KC's mission statement declares that the company is committed to using its role as the area's leading health insurer to provide affordable access to healthcare and improve the health and wellness of our members.

To support this mission, Blue KC emphasizes the quality and safety of clinical care and services provided to our members.

Key to success to the quality improvement program is our commitment to continually improve services to our members and providers. On an annual basis, we conduct an extensive assessment of the quality provided by Blue KC, including outcomes, and identifying barriers and opportunities for improvement. Based on these findings, we update the Quality Improvement Description and Work Plan. We assure that policies, procedures, and outcomes related to utilization management, member services, care management services, network management, quality, and credentialing are updated and incorporate nationally recognized best practices and/or benchmarks. We continually analyze data from complaints, appeals, member surveys, and network operations functions. There is oversight of companies that provide clinical services on our behalf.

Providers play a large role in the success of the quality program.

Physician advisory groups, focus groups, provider/provider office participation in surveys, and feedback to network operations staff provide valuable feedback used to improve our services. Provider input into clinical guidelines, formulary, utilization management, and appeal processes help to identify opportunities and best practice. Practitioners and providers allow Blue KC access to their performance data for many activities, including quality improvement projects or publicizing the practice's designation as a medical home. Provider collaboration with Blue KC case management, disease management, and community health staff continues to promote evidence-based clinical guidelines, wellness and preventive care services, early disease detection, and high-quality care for members with acute and chronic diseases.

Working Together to Improve Health Care Quality

- Comprehensive, affordable health insurance choices
- Access to quality health providers
- Knowledge necessary to make informed health care choices
- Guidance through the health care system
- Superior service

NCQA Accreditation

Blue KC is accredited by the National Committee to Quality Healthcare (NCQA), a nationally recognized accrediting agency known for the

emphasis on highest quality of health plan services and clinical care. NCQA provides systems of standards, validated clinical and preventive service measures, and requirements to evaluate the member experiences with Blue KC and provider network services .

The National Committee for Quality Assurance (NCQA) awarded Blue-Care HMO and Preferred Care Blue PPO "Accredited" status in September 2020. NCQA recognizes the commitment of our organization to offering quality healthcare to our community and demonstrates that we have incorporated quality improvements into our efforts to continually enhance the services we provide our members daily. Our accreditation status was awarded after rigorous evaluation by NCQA of all aspects of our company, including preventive health services, member experience, credentialing, and quality improvement. Blue KC staff is extremely proud of this achievement and thanks providers for working with Blue KC to improve member health and Blue KC services.

Kansas City

BLUE KC NETWORK PROVIDER REFERENCE GUIDE

A reference manual for all Blue KC contracted network providers.

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