BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2021

Following is a summary of the changes to Blue Shield Policies and Procedures for 2021. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2020.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2020 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Policy Memo No. 1
SECTION V. Post-Payment Audits

- **Page 9:** Updated verbiage to reflect current practices.

V. Post-Payment Audits

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity and established standards of care. 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. Post-payment audits are performed after the service(s) is billed to BCBSKS and payments have been received by the provider. BCBSKS will not initiate audits more than 15 months following the date of claim adjudication. Post-payment audits being performed to resolve an allegation of fraud or abuse are not subject to the 15-month limitation. Due to additional time allowed for provider appeals, as outlined in this policy memo, refunds would be applicable after the provider appeals have been exhausted, regardless of the time frame involved. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, peer consultant medical opinion, and on-site visits.

If medical necessity is not supported by the medical record, BCBSKS will deny as not medically necessary. When BCBSKS requests medical records for an audit and no documentation is received within the 30-day time limit, BCBSKS will deny for no documentation. Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off. Please see Sections XVI. Refund Policy and XVII. Right of Offset for questions on notifications of overpayments.

Post-payment Audit Appeals:

A. First-Level Appeal – Services denied not medically necessary as a part of the post-pay audit process may be appealed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided

with the appeal. The BCBSKS determination will be made within 30 days of receipt of the appeal. Submit the appeal as instructed in the determination letter.

B. Second-Level Appeal – A provider may request a second and final appeal in writing within 30 days of notification of the first-level appeal determination. The second and final appeal determination will be made by a physician or clinical peer within 30 days of receipt of the appeal. Submit the appeal as instructed in the determination letter.

A contracting provider agrees to accept the determination made at each level or to appeal the determination through the appeals process. If through the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. However, a refund will be requested if the decision reverses a previous determination (either partially or totally).

~~When findings reveal issues, which are presently specified in~~ No appeals are available for post-pay audit findings and associated re-adjudications based on BCBSKS ~~policy memos, billing guidelines or newsletters relating~~ payment policies, including but not limited to content of service, multiple surgery guidelines, ~~and~~ or other billing ~~and/or reimbursement~~ guidelines.~~, the terms of this appeal are not available.~~

Policy Memo No. 1
SECTION XV. Claims Filing

- **Page 17:** Removed verbiage to reflect current practices.

XV. Claims Filing

The contracting provider agrees to submit claims to BCBSKS for covered services (excluding "self-pay" requests made by the patient as defined within the Health Information Technology for Economic and Clinical Health (HITECH) Act, Section 13405(a)) rendered to members at the usual charge (normal retail charge for HME suppliers) in the BCBSKS designated format, and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, indemnified payment balances and non-covered amounts. The contracting provider agrees to accept payment allowances in all cases once notified of payment determination. Claims must be filed within 15 months of the service date or discharge from the hospital. Failure to do so will result in claims being rejected with members held harmless. When BCBSKS becomes aware, BCBSKS will notify contracting providers when employee groups impose alternate timely filing requirements.

All contracting providers who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own billing National Provider Identifier (NPI) or specific rendering provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific rendering provider number, except when exempt by law) must appear on every claim. The contracting provider agrees to conduct claim transactions with BCBSKS as

standard transactions in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

BCBSKS may encounter a claim that has been submitted using one procedure code which, in the opinion of BCBSKS, is not an appropriate description of the service provided under the circumstances. In such a case, BCBSKS will assign a procedure code which, in its opinion, is appropriate for the service under the circumstance, and will adjudicate the claim based upon such alternative procedure code. BCBSKS may either report payment of the claim under the revised procedure code or under the originally submitted procedure code; in either case, the maximum allowable payment applicable to the revised procedure code shall be the one that applies.

BCBSKS requires providers to report procedures according to American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) guidelines. However, the proper submission of codes and/or modifiers according to these guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modified or add-on codes for additional reimbursement.

For primary procedures, providers should submit the code that most accurately describes the service provided. Add-on codes (as defined by CPT) should not be reported as stand-alone procedures and must be submitted with the primary service in order to be considered for reimbursement. ~~A list of additive codes BCBSKS recognizes for reimbursement is available from your provider representative or the BCBSKS website~~.

All services performed on the same date by the same provider should be billed as one claim. In cases where multiple paper claim forms are required, a total for all procedures should be reported only on the last claim form to prevent the claim from being split during processing.

With implementation of ICD-10-CM, coding to the highest level of specificity will be required for proper adjudication of benefits. Therefore, non-specific diagnosis codes will not be accepted when a more specific code is available.

If after BCBSKS makes its payment to the provider and a credit balance results from having collected payment from the member, then the provider must refund the credit balance to the member within sixty (60) days from the date the overpayment is identified, unless directed by the member to apply the credit balance to their account for future services.

Policy Memo No. 1
SECTION XVIII. Services Provided by Non-Physicians and Resident Physicians

- **Page 18:** Added verbiage to state current incident-to policy.

XVIII. Services Provided by Non-Physicians and Resident Physicians

A. All non-physicians, who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific rendering provider number, if applicable. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim. BCBSKS does not recognize incident-to billing.

B. A physician may bill for the services of a licensed nurse, other than an APRN, if there is an employer/employee relationship and the services are supervised by the physician (supervision means the patient recognizes the supervising physician as his/her physician and there is a periodic review of the records by the physician). These services must be an integral part of the physician's professional service, included in the physician's bill, and be of the type that are commonly furnished in the physician's office or clinic.

C. Independently practicing Advanced Practice Registered Nurses (APRNs) who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own NPI or specific rendering provider number. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim.

D. Services of a Resident Physician are billed under the attending Faculty Physician's NPI or specific rendering provider number if done in connection with the Residency Program.

E. If the Resident Physician is providing services outside of the Residency Program, all Blue Shield Policy Memos apply and services shall be billed under his/her own NPI or specific rendering provider number.

F. BCBSKS will not pay for any services performed and billed by an independent provider who does not meet applicable state or national licensure registration or certification requirements to perform that service or who is not defined as an eligible provider in the member's contract.

G. BCBSKS will not pay for outpatient services connected with a nervous and mental diagnosis when provided by an unlicensed provider, or a licensed provider with a licensure other than designated in the member's contract as eligible to provide nervous and mental benefits. Supervision of an unlicensed provider, a licensed counselor, or one not designated as eligible in the member's contract does not constitute a service being rendered by an eligible provider. The exception to this would be if the service was rendered through a state licensed alcohol or drug abuse treatment facility, a hospital,

psychiatric hospital, or a community mental health center. Eligible non-physician psychiatric providers include APRNs, certified psychologists, licensed specialist clinical social workers, licensed clinical marriage and family therapists, licensed clinical professional counselors, and licensed clinical psychotherapists.

Policy Memo No. 1
SECTION XXVI. Reimbursement for New Procedure Codes

- **Page 22:** Added verbiage to reflect current practices.

XXVI. Reimbursement for New Procedure Codes

Periodically new American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes are published and finalized, usually each December with a January 1 effective date; however, new codes can be added at any time. For those new codes that replace existing codes, BCBSKS will crosswalk the existing maximum allowable payment (MAP) to the new code. In the event a new code is established which combines two or more existing codes, a new ~~maximum allowable payment~~ MAP will be established for such new code. For those brand new codes or codes without a Relative Value Unit (RVU), BCBSKS will consider a number of sources, for example: the RVU when applicable, consultants, and input from providers to establish the MAP.

Policy Memo No. 2
SECTION I. Definitions

- **Page 3:** Added verbiage to reflect current practices.

I. Definitions

Patient Status

A. New Patient: A patient who is new to the practice/physician or a patient who has not been seen for three or more years.

B. Established Patient: A patient who has been previously treated by the practice/physician and for whom records have been established within the past three years.

NOTE – Within a group practice, a consulting physician of a different specialty can bill a new or established patient office visit when the new or established patient definition above for the consulting physician has been met. This does not apply to covering arrangements.

Evaluation and Management Levels of Service

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) follows CPT guidelines for Evaluation and Management service levels.

Policy Memo No. 2
SECTION VI. Telemedicine

- **Page 5:** Updated verbiage for clarity.

VI. Telemedicine

Telemedicine, including telehealth, is a covered service as per Kansas Telemedicine Act.

Telemedicine, including telehealth, means the delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine shall be provided by means of real-time, two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telemedicine does not include communication between:

A. Health care providers that consist solely of a telephone voice-only conversation, email/eVisits, text, or facsimile transmission; or

B. A physician and a patient that consists solely of an email/eVisit, text, or facsimile transmission.

Physical therapy, speech therapy, occupational therapy, and audiology services are not covered as telehealth services.

~~"Distant site" means a site at which a health care provider is located while providing health care services by means of telemedicine.~~

"Health care provider" means a physician, licensed physician assistant, licensed advanced practice registered nurse, or person licensed, registered, certified, or otherwise authorized to practice by the behavioral sciences regulatory board (BSRB).

"Licensed mental health care professional" means an individual licensed by the BSRB who is acting within the scope of the individual's professional licensure act and held to the standards of professional conduct as set forth by the BSRB.

"Physician" means a person licensed to practice medicine and surgery by the state board of healing arts.

"Distant site" means a site at which a health care provider is located while providing health care services by means of telemedicine.

"Originating site" means a site at which a patient is located at the time health care services are provided by means of telemedicine.

The rendering provider, located at the distant site, cannot bill for both the telemedicine service and the originating site facility fee. The telemedicine originating site facility fee is appropriate to bill when there is an eligible provider coordinating care at the originating site.

~~"Physician" means a person licensed to practice medicine and surgery by the state board of healing arts.~~

Policy Memo No. 3
SECTION I. Definitions

- **Page 3:** Removed verbiage for clarity.

I. Definitions

A. MEDICAL EMERGENCY

~~1.~~ Medical emergency means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

~~2. In addition to the conditions listed above, the following conditions will be considered medical emergencies even though they may not directly be life threatening:~~

~~a. Suspected heart attack~~

~~b. Unconsciousness~~

B. ACCIDENTAL INJURY

Accidental injury means an injury to the body caused solely through external, violent and accidental means.

Policy Memo No. 4
SECTION I. Quality Improvement Process

- **Page 3:** Remove verbiage to correct redundancy.

I. Quality Improvement Process

~~An integral component of the quality improvement process is the evaluation of the health care rendered to BCBSKS members by contracting providers through medical record peer review.~~ The initial step in improving health care is identification of areas needing improvement. Once identified, medical records are requested and reviewed to evaluate the appropriateness and effectiveness of health care.

Pertinent data collected from the medical record is analyzed according to established criteria and current standards of care by quality improvement staff and peer reviewers. Providers are encouraged to take an active role in the review process, providing additional information and clarification when appropriate. Failure by a contracting provider to respond to a request from BCBSKS for additional information during a quality of care review process constitutes grounds for further actions by BCBSKS, up to and including termination of the provider's participation agreement for cause.

The second step is to work cooperatively with providers in the development of solutions to the identified problems.

The third step requires solutions be evaluated to ensure the provider's future performance meets established standards.

The final step in quality improvement through medical record review is to revise or enhance solutions which are not improving or maintaining the quality of care as planned.

Emerging patterns of confirmed inappropriate or substandard care provided by contracting providers are monitored within the quality improvement department. Once a problem or pattern of problems is identified, a corrective action plan may be requested as an educational effort to correct a specific problem relating to the care rendered by contracting providers. All cases in which the quality of care is either questionable or may be substandard are referred for external review by a contracted quality improvement and peer review organization for a final determination. BCBSKS may report providers to the appropriate licensing authority based on peer review organization's final determination. BCBSKS may also take further action up to and including termination of the provider's participation agreement.

Corrective action plans are requested when an individual case or pattern of cases is identified with quality concerns. Corrective action plans may be requested for facility, physician, or ancillary providers depending upon the problem focus. If the provider or other entity submits a corrective action plan that is accepted by BCBSKS, the ongoing evaluation of the corrective action plan process is performed by the provider or other entity. The BCBSKS peer review process is complete.

When there is not a corrective action plan submitted and implemented by the provider or another entity, a Quality Improvement Plan (QIP) may be developed by BCBSKS for implementation. Evaluation of the effectiveness of a BCBSKS-developed QIP will be performed at intervals appropriate to the identified problem or deficiencies, but not to exceed one (1) year. BCBSKS will notify the provider when a BCBSKS-developed QIP and peer review process is complete

Policy Memo No. 4
SECTION III. Disease Management/Wellness

- **Page 4:** Added verbiage to reflect current practices.

III. Disease Management/Wellness

BCBSKS has telephone-based Disease Management and Wellness programs designed to help members improve quality of life and overall health by understanding health risks and possible complications, making healthy lifestyle choices, improving gaps in care/preventive care, and communicating with the health care team to make informed decisions in care. Disease Management programs offered may include but are not limited to diabetes, coronary artery disease, asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and hyperlipidemia. Wellness programs offered may include but are not limited to maternity,

weight loss, tobacco cessation, and stress management. Through these programs, registered nurses provide one-on-one support, coaching, and educational tools to assist members in self-management skills to improve overall health.

The Disease Management Program is URAC accredited. Both the Disease Management and Wellness programs are HIPAA compliant.

Members are identified for participation in one or more of the Disease Management programs by diagnoses codes on claims and will be invited to participate by letter or telephone. Additionally, members can self-enroll for any Disease Management or Wellness program, and providers may refer members for participation. Participation in the programs is voluntary. Members may choose to discontinue participation in the programs at any time. Participation in the programs will not affect any health insurance benefits. For additional information, go to bcbsks.com/BeHealthy/DiseaseMgmt or bcbsks.com/BeHealthy/Wellness-Management.

Policy Memo No. 5

SECTION I. Daily Hospital Medical Services (New or Established Patient)

- **Page 3:** Updated verbiage for clarity.

I. Daily Hospital Medical Services (New or Established Patient)

A. INITIAL AND SUBSEQUENT HOSPITAL CARE

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will follow the American Medical Association Current Procedural Terminology (CPT) guidelines.

B. INTENSIVE CARE UNIT AND CORONARY CARE UNIT (ICU/CCU) DAYS

If it is a provider's customary practice to make a different charge, regardless of the method of payment, for patients confined in ICU/CCU, the fee will be acknowledged. However, such fees are subject to substantiation by the hospital medical records and charge records in the provider's office. Individual consideration should be requested for any period of more than five (5) consecutive days of ICU or CCU care by submitting the CPT code with modifier 22 and attaching medical records.

Billing for ICU/CCU care is based upon the level of subsequent care days as indicated in CPT.

C. CRITICAL CARE SERVICES

Critical care includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician. Critical care is usually, but not always, given in a critical care area such as the emergency room. Critical care billings beyond the initial care are to be submitted for individual consideration with records. Such reports include the specific nature of the patient’s condition, details regarding the services rendered and documentation of the amount of time the physician was in direct patient attendance.

D. ~~PLACE OF SERVICE~~ DENIED ADMISSIONS AND LEVEL OF CARE

If patient's admission, continued stay, or level of care is determined to be not medically necessary by pre-certification or claim review, the physician's services will be denied or adjusted.

E. PLACE OF SERVICE

The Place of Service must match the institutional billing for claims processing.

Policy Memo No. 6
SECTION Intro & I. Instances When Concurrent Care Policy Applies

- **Page 3:** Removed verbiage for clarity.

Concurrent care takes place when two or more providers render medical and/or surgical services to the same patient during the same period of hospital confinement. Concurrent professional care may be covered if a Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) consultant concurs that supplementary skills by separate providers were medically necessary on the case. BCBSKS reserves the right to review claims as necessary. Contracting providers will write off charges in cases where review consultants determine that concurrent care was not medically necessary (see Policy Memo No. 1 and No. 5). There is one exception: If the patient has been notified by the physician that BCBSKS may deny the service but continues to insist the service be rendered anyway, the physician can bill the patient for these services if the patient was informed in advance and a signed waiver form is kept on file at the provider's place of business. (The waiver form is no longer required with claims submission. Use the GA modifier for all electronic and paper claims.) For further information, see Policy Memo No. 1, Section IX.

The medical necessity for concurrent care services must be substantiated by the ~~hospital~~ medical records.

I. Instances When Concurrent Care Policy Applies

Two or more providers rendering medical (non-surgical) services to the same patient on the same day ~~during a common hospitalization period~~.

Two or more providers rendering any combination of surgical and medical services to the same patient on the same day ~~during a common hospitalization period~~.

Any case where consultation is followed by daily care by the consulting provider in addition to continuing care by the attending provider.

Policy Memo No. 10
SECTION IV. Non-Physician Assistants

- **Pages 3:** Updated to reflect online presence.

IV. Non-Physician Assistants

BCBSKS will make payments for assistants only for those persons (Physician Assistants and Advanced Practice Registered Nurses/Advanced Registered Nurse Practitioners) licensed and authorized by Kansas law. BCBSKS will not make payments for services of a registered nurse or other non-physicians (including Certified Surgical First Assistants) assisting at surgery.

IMPORTANT NOTE REGARDING DENIAL OF BENEFITS: Denial of benefits for the services of an assistant surgeon is the result of the BCBSKS review process determination. In the event benefits are denied, contracting providers agree to forgive charges to BCBSKS members. Exception: If the patient has been informed such services may not be covered but requests the services be furnished, the patient may be charged for the service even though it was not considered medically necessary. A waiver must be signed by the member to support such requests (see Policy Memo No. 1, Section X. WAIVER FORM).

A list of those procedures for which an assistant surgeon is not ~~normally~~ reimbursed is found ~~in your BCBSKS Professional Provider Manual~~ online at https://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/assistant_surgery.pdf**.**