2021 Blue's Tour

August 2021

BlueCross BlueShield Kansas

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Billing Updates

Experimental/Investigational Denials

- Only Submit a corrected claim if the charges are changing
- Do an appeal
  - Written request with cover letter
  - Within 180 days of the RA date with the denial

FEP Newborn Claims

- Submit separate claims at the same time
- Mother must be covered for the baby to be covered

Interim Billing

- Every 30 days
- Inpatient
  - Second claim
    - Submit as paper claim with a copy of itemization
  - Final claim
    - Submit as paper claim for the full claim (admit thru discharge).
    - Submit an itemization for the entire stay.

Observation Stay (OBS)

- Be physician ordered
- Be medically necessary
- Billed with Revenue Code 0762 and valid HCPCS/CPT code
- Report on one line and number of hours in unit field
- No hourly limit
  - Reimbursed at 1 semi-private room rate or charges, whichever are less.
    - Important to keep your room rates up to date!!

Multiple Encounters Same Day

- 2 Emergency Room visits
  - Make notation in FL 80
    - Remarks field on UB-04

Multiple Services Same Day

- 2 chest x-rays
  - 1 line item with units of 2 and notation in FL 80
- 2 inhalation therapy treatments
  - 1 line item with units of 2 and notation in FL 80 with times of day patient received treatment.

Non-Contracting Provider Billing Procedures

- A contracting provider must bill for services ordered and performed by a non-contracting provider
- The contracting provider must hold the member harmless
- If a member request a referral to a non-contracting provider, a signed statement of financial obligation should be on file.

- Exclusive Provider Organization (EPO) Prefixes
  - XSN
  - XSZ
  - KSA

02

Pharmacy Updates

New Specialty Pharmacy

Effective July 1, 2021, Accredo will be the designated specialty pharmacy for BCBSKS members.

New Mail Order Pharmacy

Effective July 1, 2021, Express Scripts® will be the designated home delivery pharmacy for BCBSKS members maintenance medication needs.

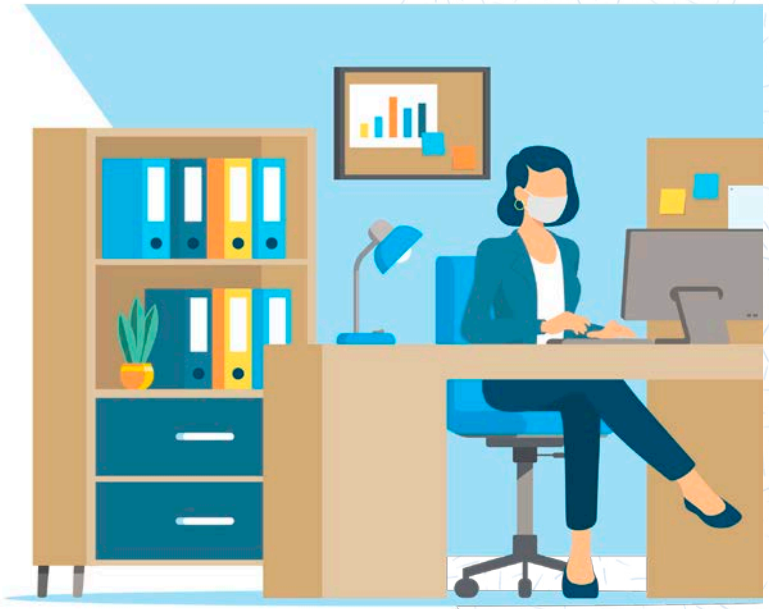
03

New Hospital Model

New Hospital Model

Rural Emergency Hospital (REH) Model

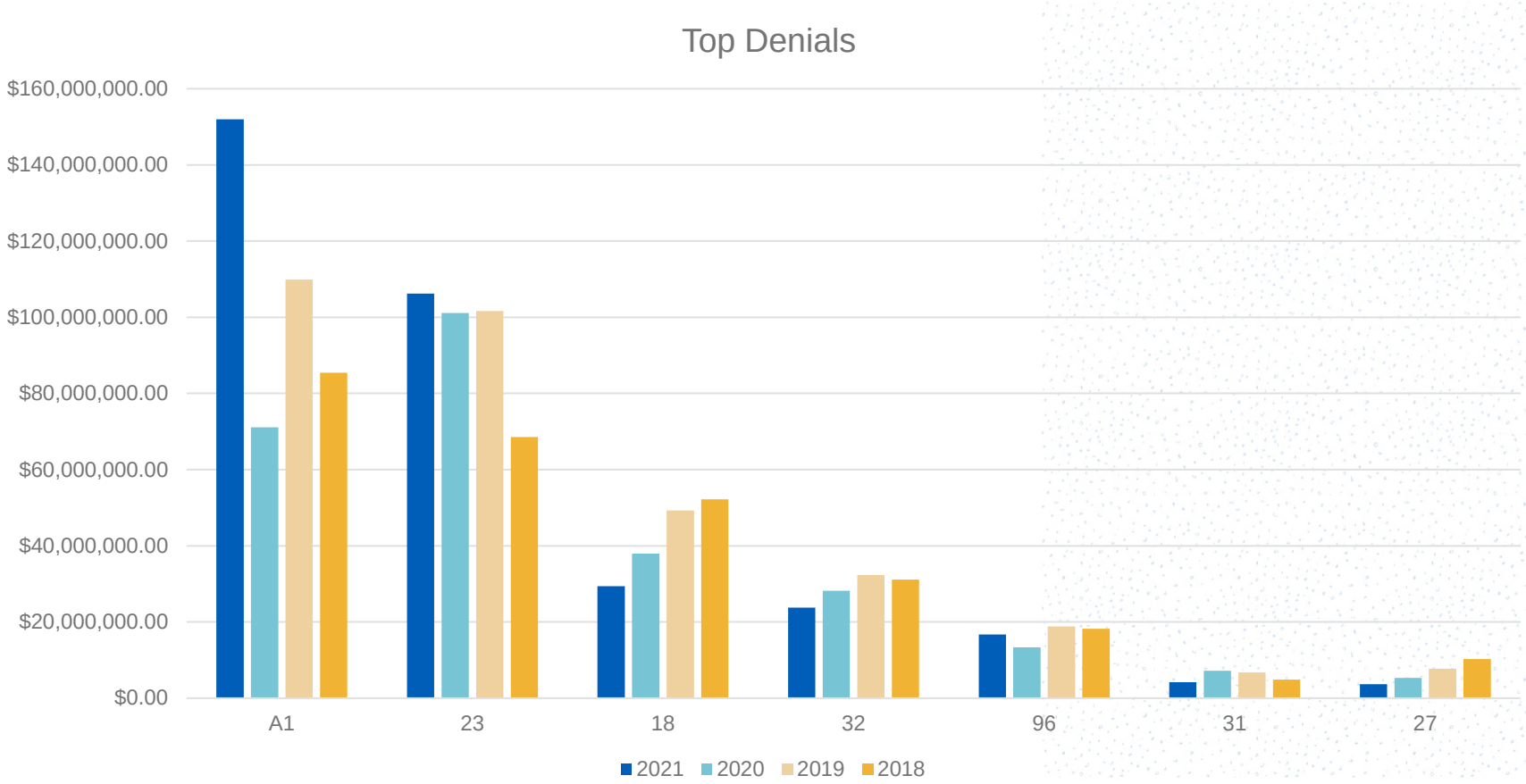
- Designation is effective Jan 1, 2023
- For CAH and PPS with fewer than 50 beds
- Designed to keep rural hospitals open in their communities
- Some considerations for the REH
  - No acute care inpatient services
  - Average LOS less than 24 hours
  - Transfer agreement with Level I or Level II trauma center
  - Maintain a staffed ED
  - Meet CAH-equivalent Conditions of Participation for emergency services
  - May convert back to a CAH or PPS



04

Top Denials

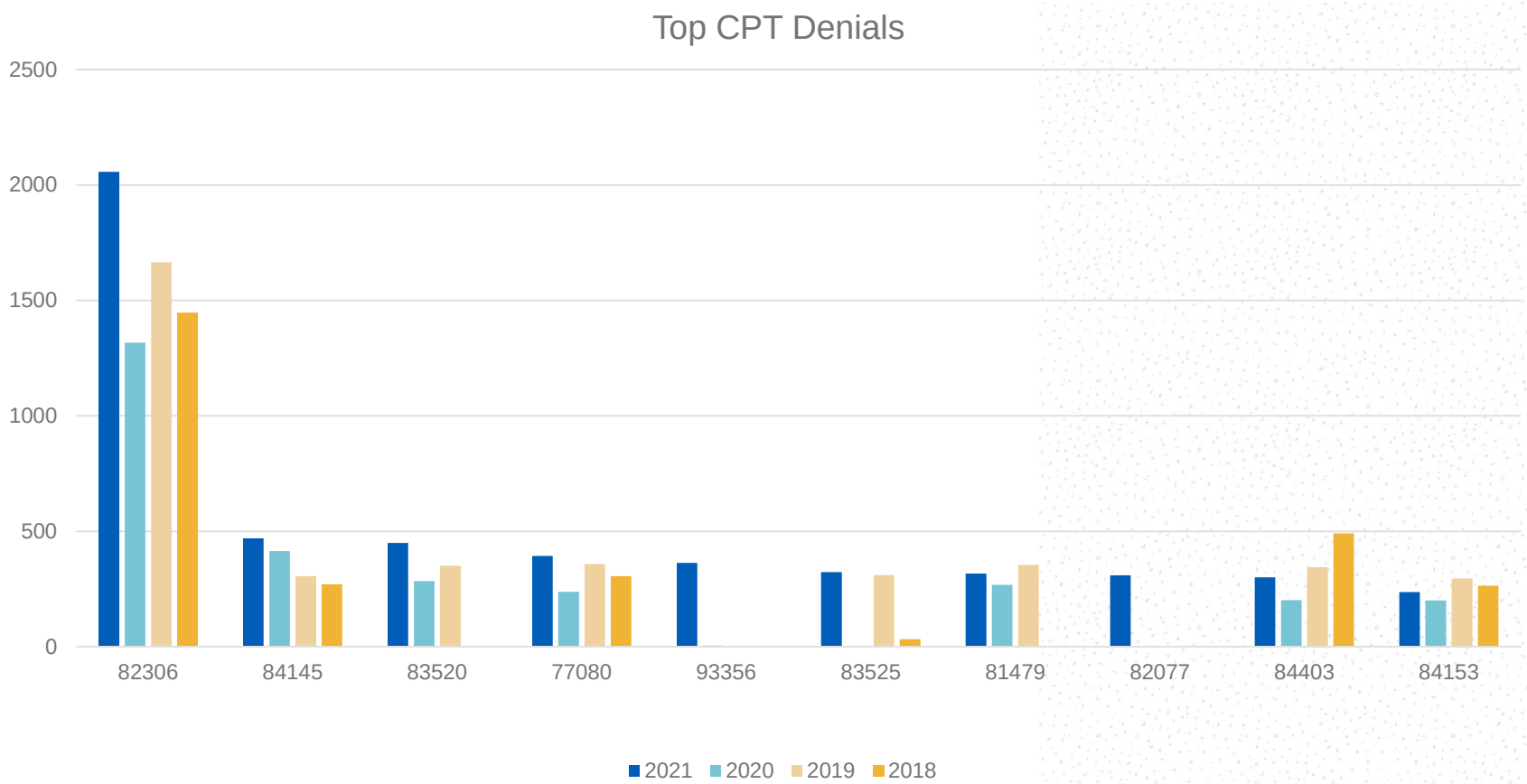
Top Denials


Top Denials
$160,000,000.00
$140,000,000.00
$120,000,000.00
$100,000,000.00
$80,000,000.00
$60,000,000.00
$40,000,000.00
$20,000,000.00
$0.00
A1
23
18
32
96
31
27
2021
2020
2019
2018

05

Top CPT Denials

Top CPT Denials



Top CPT Denials

82306: Vitamin D Testing

- Has a medical policy
- 2021 denied 2057 claims totaling $491,417.13

84145: Procalcitonin

- Does not have a medical policy
- 2021 denied 470 claims totaling $111,157.15

83520: Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified

- Has a medical policy
- 2021 denied 450 claims totaling $96,047.66

77080: DXA

- Has a medical policy
- 2021 denied 393 claims totaling $100,367.53

Top CPT Denials

93356: Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)

- Has a medical policy
- 2021 denied 363 claims totaling $65,011.01

83525: Insulin Total

- Does not have a medical policy
- 2021 denied 323 claims totaling $29,414.47

81479: Unlisted molecular pathology procedure

- Has a medical policy
- 2021 denied 317 claims totaling $385,029.43

82077: Alcohol (new code 01/01/21)

- Does not have a medical policy
- 2021 denied 309 claims totaling $85,003.61

Top CPT Denials

84403: Testosterone total

- Does not have a medical policy
- 2021 denied 300 claims totaling $29,466.85

84153: Prostate -PSA

- Does not have a medical policy
- 2021 denied 237 claims totaling $18,381.74

06

Medical Policy: RSV and Influenza

Medical Policy: RSV and Influenza

Influenza Virus Diagnostic Testing

- CPT: 87501, 8752, 87503, 87804
- Medically necessary for anyone who is symptomatic of influenza or undergoing evaluation for COVID-19.

Identification of Microorganisms Using Nucleic Acid Testing

- CPT: 87631, 87632, 87633, U0001, U0002, U0004, 0098U, 0099U, 0100U, 0115U, 0202U, 0223U
- CPT 87799: This code will always require records to determine what test was performed.

Using a diagnosis noted within the medical policy does not guarantee that the service will be allowed.
All servicers are subject to review to determine if the service is medically necessary

Not Medically Necessary Denials

- Can be appealed
  - Written request with a cover letter
  - Submit within 180 days of the RA denial date.

07

Medicare Advantage (MA) Updates

Expansion

Effective January 1, 2022

- New counties:
  - Chase
  - Coffey
  - Dickinson
  - Franklin
  - Geary
  - Linn
  - Lyon
  - Marion
  - McPherson
  - Miami
  - Morris
  - Riley

Current counties: Butler, Sedgwick, Kingman, Reno, Harvey, Sumner Cowley, Shawnee, Pottawatomie, Jackson, Jefferson, Douglas, Osage, Wabaunsee

CMS Rate Letters

- Send to marateletters@bcbsks.com
- Takes 30 days to update

Claims Submission

- Submit to BCBSKS
- Paper claims
  - Prefix M3A:
    - Mail to BCBSKS
  - All other prefixes
    - Mail to PO Box 261323 Plano, TX 75026-1323
- EFT required in 2022

Provider Information

- Update quarterly

Resources

- BCBSKS Webpage
  - MA Provider Manual
  - Benefit Summaries
  - Admission Guidelines

"Almost everything will work again if you unplug it for a few minutes.... including you."

–Anne Lamott

08

2022 Policies and Procedures

09

2022 QBRP

QBRP Changes for PPS Hospitals

- QM 1: Attestation language changed from data submission from KHC to QHi
- QM 2: Adverse drug event change from reporting hypoglycemic management to reporting Clostridium Difficile
- QM 9: Language changed in the measure from Hospitals Readmissions within 30 days (all causes) to Unplanned All-Cause 30-day Readmissions, Same Hospital
- QM 11-14: Added Discharge Checklist to the patient family and engagement metrics and removed Patient and Family Governing and Leadership Board
- QM 15: Removed Emergency Department Transfer Communication measure; replaced with Antimicrobial Stewardship
- QM 16: Changed description of measure from surviving Sepsis Campaign 3-hour bundle to Severe Sepsis and Septic Shock 3 Hour Management Bundle

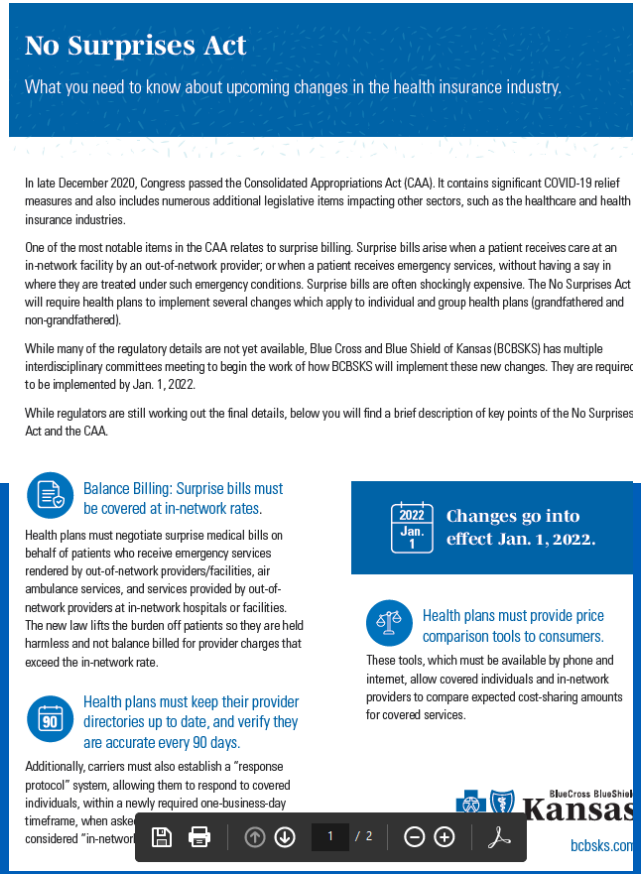
QBRP Changes for CAH Hospitals

- QM 1: Attestation language changed from data submission from KHC to QHi
- QM 2: Adverse drug event change from reporting hypoglycemic management to reporting Clostridium Difficile
- QM 6: Removed the Early Elective Delivery measure and replaced with Antimicrobial Stewardship
- QM 7: Simplified language regarding Hand Hygiene Compliance and moved from attestation to compliance percentage at or above 95%
- QM 8: Language changed in the measure from Hospitals Readmissions within 30 days (all causes) to Unplanned All-Cause 30-day Readmissions, Same Hospital
- QM 10-14: Added Discharge Checklist to the patient family and engagement metrics and removed Patient and Family Governing and Leadership Board
- QM 16: changed description of measure from surviving Sepsis Campaign 3-hour bundle to Severe Sepsis and Septic Shock 3 Hour Management Bundle

Cost Transparency

Cost Transparency

In late December 2020, Congress passed the Consolidated Appropriations Act (CAA).



No Surprises Act

What you need to know about upcoming changes in the health insurance industry.

In late December 2020, Congress passed the Consolidated Appropriations Act (CAA). It contains significant COVID-19 relief measures and also includes numerous additional legislative items impacting other sectors, such as the healthcare and health insurance industries.

One of the most notable items in the CAA relates to surprise billing. Surprise bills arise when a patient receives care at an in-network facility by an out-of-network provider; or when a patient receives emergency services, without having a say in where they are treated under such emergency conditions. Surprise bills are often shockingly expensive. The No Surprises Act will require health plans to implement several changes which apply to individual and group health plans (grandfathered and non-grandfathered).

While many of the regulatory details are not yet available, Blue Cross and Blue Shield of Kansas (BCBSKS) has multiple interdisciplinary committees meeting to begin the work of how BCBSKS will implement these new changes. They are required to be implemented by Jan. 1, 2022.

While regulators are still working out the final details, below you will find a brief description of key points of the No Surprises Act and the CAA.

Balance Billing: Surprise bills must be covered at in-network rates.

Health plans must negotiate surprise medical bills on behalf of patients who receive emergency services rendered by out-of-network providers/facilities, air ambulance services, and services provided by out-of-network providers at in-network hospitals or facilities. The new law lifts the burden off patients so they are held harmless and not balance billed for provider charges that exceed the in-network rate.

Health plans must keep their provider directories up to date, and verify they are accurate every 90 days.

Additionally, carriers must also establish a "response protocol" system, allowing them to respond to covered individuals, within a newly required one-business-day timeframe, when aske
considered "in-networ

2022 Jan. 1 — Changes go into effect Jan. 1, 2022.

Health plans must provide price comparison tools to consumers.

These tools, which must be available by phone and internet, allow covered individuals and in-network providers to compare expected cost-sharing amounts for covered services.

BlueCross BlueShield Kansas

bcbsks.com

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No Surprises Act Fact Sheet

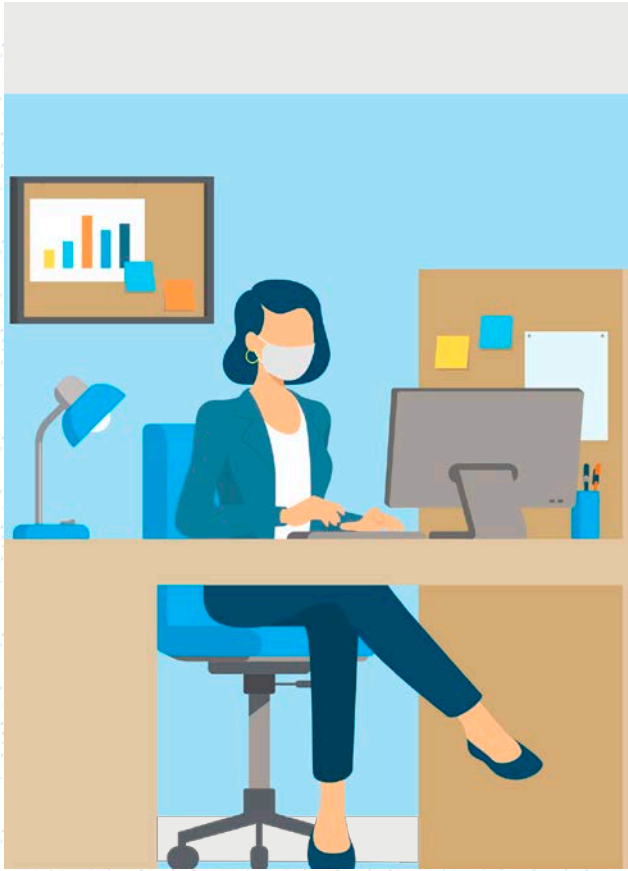
- BCBSKS Website
  - https://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/MC-320-no-surprises-act.pdf

PDI

PDI

Beginning January 1, 2022

- Your facility must attest to your provider information every 90 days.
  - Failure to attest will result in removal from BCBSKS Provider Directory.
- How to attest:
  - Availity
    - Payer Spaces
    - BCBSKS
    - BCBSKS Secure Section (Blue Access)
    - Provider Information
    - Provider Information Forms



NDC Numbers

NDC Numbers

BCBSKS continues to follow billing guidelines set by NUBC.

FL 43 should be used when reporting an NDC number on Medicaid involved claims.

N4 qualifier is reported in the first 2 positions

Following immediately by the 11-character NDC number in the 5-4-2 format with no hyphens

Following the last digit of the NDC number, the Unit of Measurement Qualifier.

Following the Unit of Measure Qualifier, the unit quantity with a floating decimal for fractional units limited to 3 digits. Any spaces unused for quantity are left blank.

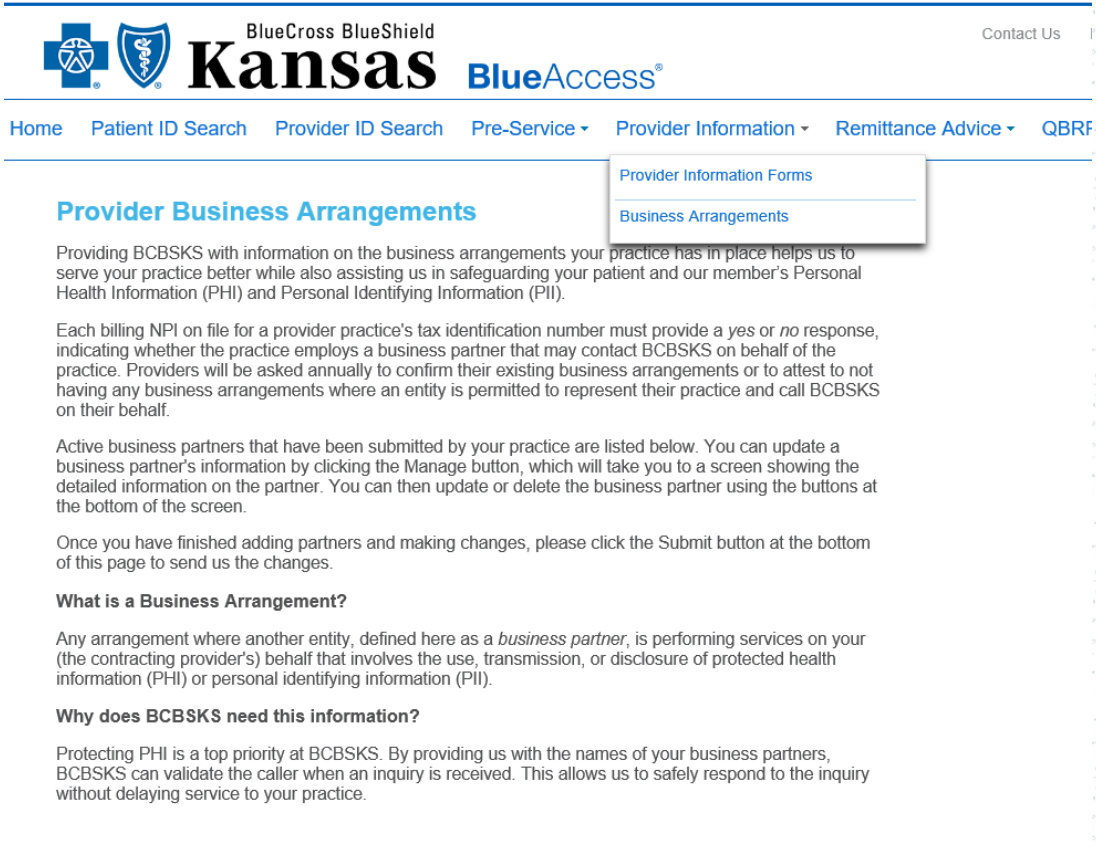
BAA

BAA

Any arrangement where another entity, defined here as a *business partner*, is performing services on your (the contracting provider's) behalf that involves the use, transmission, or disclosure of protected health information (PHI) or personal identifying information (PII). Protecting PHI is a top priority at BCBSKS. By providing us with the names of your business partners, BCBSKS can validate the caller when an inquiry is received. This allows us to safely respond to the inquiry without delaying service to your practice.

Availity.com>Payer Spaces>BCBSKS>BCBSKS Provider Secure Section (Blue Access)>Select NPI number for practice/facility you wish to attest on> Provider Information>Business Arrangements

BAA


BlueCross BlueShield
Kansas
BlueAccess®
Contact Us
Home
Patient ID Search
Provider ID Search
Pre-Service
Provider Information
Remittance Advice
QBRF
Provider Information Forms
Business Arrangements
Provider Business Arrangements
Providing BCBSKS with information on the business arrangements your practice has in place helps us to serve your practice better while also assisting us in safeguarding your patient and our member's Personal Health Information (PHI) and Personal Identifying Information (PII).
Each billing NPI on file for a provider practice's tax identification number must provide a yes or no response, indicating whether the practice employs a business partner that may contact BCBSKS on behalf of the practice. Providers will be asked annually to confirm their existing business arrangements or to attest to not having any business arrangements where an entity is permitted to represent their practice and call BCBSKS on their behalf.
Active business partners that have been submitted by your practice are listed below. You can update a business partner's information by clicking the Manage button, which will take you to a screen showing the detailed information on the partner. You can then update or delete the business partner using the buttons at the bottom of the screen.
Once you have finished adding partners and making changes, please click the Submit button at the bottom of this page to send us the changes.
What is a Business Arrangement?
Any arrangement where another entity, defined here as a business partner, is performing services on your (the contracting provider's) behalf that involves the use, transmission, or disclosure of protected health information (PHI) or personal identifying information (PII).
Why does BCBSKS need this information?
Protecting PHI is a top priority at BCBSKS. By providing us with the names of your business partners, BCBSKS can validate the caller when an inquiry is received. This allows us to safely respond to the inquiry without delaying service to your practice.

BlueCross BlueShield Kansas

bcbsks.com

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Blue's Tour 2021 Q&A

Q - What if one of the codes is a service found in a medical policy, how will the Advance EOB respond?

A- The Advanced EOB is providing a good faith estimate of costs based on billing information from the provider. Medical policy is not considered for the Advanced EOB.

Q – What if a predetermination is done that advises that the service is not medically necessary and then an Advance EOB is requested, how will the Advanced EOB respond?

A- The Advanced EOB is providing a good faith estimate of costs based on billing information from the provider. Medical policy is not considered for the Advanced EOB.

Q – Can a provider request an Advanced EOB or it just for members?

A- The Advanced EOB request will be provider submitted, but BCBSKS will reply directly to the member with the completed Advanced EOB.

Q – Will there be a confirmation/reference number given on an Advanced EOB?

A- The answer to this question is still pending. Please see follow up communication regarding Advanced EOB soon.

Q – Who is responsible for getting the codes for an Advanced EOB, member, hospital, physician?

A- The Advanced EOB request will be provider (provider or hospital) submitted and said person(s) will be responsible for submitting the appropriate billing information.

Q – Does our Limited Patient Waiver work for BlueCard members or do providers have to use the waiver for that Plan?

A- Unless communicated otherwise by the Home Plan, BCBSKS Limited Patient Waiver will be honored for BlueCard member services. We will notify our providers when a Home Plan requires their own Limited Patient Waiver.

Q – What outpatient services can be done by a Rural Emergency Hospital (REH)?
A – Here are few outpatient services a REH can provide. This is not a complete list.

- Primary healthcare including prenatal care
- Urgent care
- ED care
- Minor outpatient procedures
- Management of chronic conditions
- Telemedicine

IF unavailable locally

- Skilled care
- Rehabilitative services
- Behavioral health

You can visit this website for more detailed information rural-emergency-medical-ctr-act-2018.pdf (aha.org)