BLUE CROSS AND BLUE SHIELD OF KANSAS
HOME MEDICAL EQUIPMENT SUPPLIER
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2022

Following is a summary of the changes to Blue Shield Home Medical Equipment Policies and Procedures for 2022. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2021.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2021 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Home Medical Supplier Policy Memo
SECTION VI. Used Equipment

- **Page 4:** Removed section to reflect current practices.

  ~~Used equipment can be distributed when the supplier handles such equipment and it is available. Allowances will be less than the new equipment allowances and based on the life of the equipment.~~

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Policy Memo No. 1
SECTION II. Retrospective Claim Reviews/Corrected Claim

- **Page 4:** Updated broken link.

A. All requests for retrospective review must be submitted (in writing or by phone) to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice. To submit review online, go to: https://secure.bcbsks.com/bcbsks-provider/facelets/allUsers/form/ProviderClaimEnrollmentInquiry.faces. ~~https://clyde.bcbsks.com/WebCom/Secure/forms/bcbsks_provider_claiminquiry.htm~~

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

- **Page 8:** Updated verbiage for clarity of who reviews the post payment audit appeals.

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 first level appeal determination will be made by a physician or clinical peer who was not involved with the audit determination. 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 who was not involved with the audit determination. The BCBSKS determination will be made within 30 days of receipt of the appeal. ~~Submit the appeal as instructed in the determination letter~~.

Policy Memo No. 1
SECTION X. Waiver Form

- **Page 12:** Added link directly to our waiver form.

  C. WAIVER FORM (see last page of Policy Memo No. 1)

Policy Memo No. 1
SECTION XII. Uniform Provider Charging Practices

- **Page 16:** Updated verbiage to add clarity for no charge services.

  B. If a provider gives a lower charge to every patient who does not have health insurance, we consider that lower charge to be the "usual charge." Professional provider services where the provider would normally make no charge, a claim should not be submitted.

Policy Memo No. 1
SECTION XIV. Professional Services Coordinated with a Non-Contracting Provider

- **Page 16:** Updated verbiage to add clarity regarding new providers within a group.

  When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform ~~a portion of a~~ one or more professional services (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider who ordered the service(s) must bill BCBSKS for all services rendered by the non-contracting provider. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to ~~hold~~ ensure the member is held harmless.

  In the same manner, if a contracting group allows providers who have not yet received credentialing approval from BCBSKS to see members, the contracting group and non-contracting provider must hold the member harmless.

  ~~However,~~ In the event members request referrals to non-contracting providers, referring providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.

Policy Memo No. 1
SECTION XX. Contracting Status Determination

- **Page 20:** Added verbiage regarding assignment in the event of sale, consolidation, or merger of a contracting provider.

  E. In the event of sale, consolidation or merger of a contracting provider, the contracting provider must notify BCBSKS within 30 days of the sale, consolidation or merger being finalized. All rights, duties, obligations, and responsibilities of any provider contracts in place before the sale, consolidation or merger will be assigned to the new entity.

Policy Memo No. 1
SECTION XXVII. Reimbursement for Pharmaceuticals

- **Page 23:** Updated verbiage to reflect all published and publicly available pricing that is used.

  Covered pharmaceuticals are reimbursed based on a formula as determined by BCBSKS that utilizes the published average sales price (ASP), wholesale acquisition cost (WAC), or the average wholesale price (AWP). Reimbursement for pharmaceuticals will be reviewed periodically and may be adjusted during the year to reflect changes in the ASP, WAC or AWP. Individual drug pricing is available upon request.

Policy Memo No. 2
SECTION VI. Telemedicine

- **Page 5:** Added note to clarify billing ineligible telehealth services.

  Note: Telehealth services should be billed with place of service 02 and with a GT modifier. Telehealth should not be billed when services are inappropriate as telehealth, e.g. laboratory services, vaccine administration, injections, radiology services, etc.

Policy Memo No. 3
SECTION V. Additional Policy Clarification

- **Page 4:** Updated to reflect online presence.

  C. It is necessary to show the date of injury, the nature of accident, and ICD-10 diagnosis on all accident-related services. Please see our CMS 1500 Tutorial for specific information.

Policy Memo No. 7
SECTION I. Diagnostic Radiology Policy

- **Page 4:** Updated verbiage to include ordering providers.

D. DOCUMENTATION FOR INTERPRETATIONS OF DIAGNOSTIC IMAGING PROCEDURES

Interpretations of diagnostic imaging procedures reported separately for payment must include the following minimum information, either as a separate document or within the main body of the patient's record:

- Patient's name and other appropriate identifier (date of birth, Social Security number, record number, etc.)
- Referring/Ordering physician name
- Name or type of procedure performed