BLUE CROSS AND BLUE SHIELD OF KANSAS
HOME MEDICAL EQUIPMENT SUPPLIER
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2024

Following is a summary of the changes to Blue Shield Home Medical Equipment Policies and Procedures for 2024. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com by December 2023.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2023 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Home Medical Supplier Policy Memo
No changes

- No changes were made for 2024.

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Policy Memo No. 1
Introduction paragraph

- **Page 4:** Added verbiage to cover any changes in laws and regulations that we must abide by.

  In the event provisions of such BCBSKS publications, policy memos, and/or the provider agreement conflict, the most recently published provision controls. All provisions within policy memos are subject to changes in State or Federal laws and regulations. In the event any changes in laws or regulations preclude or prevent compliance with any portion of the policy memos, such portion of the policy memo shall be severable. Any changes in laws or regulations not addressed in policy memo at the time, will be automatically updated to comply.

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

- **Page 4:** Updated verbiage to add clarity and consistency on number of retrospective reviews allowed.

  The contracting provider shall have the right to one~~a~~ retrospective review of any claim denied in whole or in part.

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

- **Page 5:** Added part D. to add clarity that a corrected claim is part of their retrospective review.

  D. Corrected claims, regardless of reason for the correction, must be submitted to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice and include the original claim number. A corrected claim for services initially denied in whole or in part counts as the provider's retrospective review.

Policy Memo No. 1
SECTION IV. Utilization Review and Medical Necessity

- **Page 7:** Updated verbiage to add clarity on where pre-admission precertification is done.

  For the most accurate and complete information, all pre-admission certification should be validated through the BCBSKS provider portal (via Availity®).

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

- **Page 8:** Updated verbiage for clarity regarding timeframe we are following.

  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 business day time limit, BCBSKS will deny for no documentation.

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 9:** Updated verbiage to reflect current place of service codes.

  Telephone calls and web-based correspondence are content of service when billed with another service on the same day. Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 or 10 and the GT modifier.

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 10:** Added verbiage for consistency with policy memo 2.

  NOTE – All-inclusive procedure codes must be used when available.

  A handling fee may be allowed under certain conditions. See Policy Memo No. 7, Radiology and Pathology.

Policy Memo No. 1
SECTION VII. Experimental or Investigational Procedures

- **Page 10:** Updated verbiage for clarity of non-covered services and what that means for the provider.

  Any drug, device or medical treatment or procedure and related services that are experimental or investigational as defined by BCBSKS are ~~non-covered services~~ considered a provider write-off unless a Limited Patient Waiver is obtained prior to services being rendered.

Policy Memo No. 1
SECTION VII. Experimental or Investigational Procedures

- **Page 11:** Updated verbiage to reflect gender neutral pronouns for more sensitivity to DEI.

  Any patient being billed for services considered experimental or investigational must have a signed waiver in ~~his/her~~their file.

Note – we have updated this reference throughout all policy memo documents but have not redlined them in this document.

Policy Memo No. 1
SECTION VIII. Non-Covered Services

- **Page 11:** Updated order of verbiage for clarity and better flow.

  ~~Providers~~ There are several categories of services and procedures that may be considered non-covered services for various reasons. These denials are billable to the member. (See Section XV. CLAIMS FILING.)

  Providers are not reimbursed for professional services they provide to an immediate family member ("immediate family member" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service) or themselves as specified in the member contract.

  ~~There are several categories of services and procedures that may be considered non-covered services for various reasons. These denials are billable to the member. (See Section XV. CLAIMS FILING.)~~

Policy Memo No. 1
SECTION XI. Medical Records

- **Page 15:** Updated verbiage to clarify providers providing medical records.

  1. Contracting providers must provide ~~or make available~~ complete medical records at no charge in a format that can be utilized by BCBSKS or an entity acting on behalf of BCBSKS

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

- **Page 19:** Added verbiage to reflect current provider types applied.

  A. Independently practicing Advanced Practice Registered Nurses (APRNs) or Physician Assistants (PAs) 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.

Policy Memo No. 1
SECTION XIX. Locum Tenens Provider

- **Page 19:** Updated verbiage for clarity and better flow.

  In billing for services provided by a locum tenens, the claim must be filed using the NPI or specific rendering provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used. In addition, the medical record must indicate the services were provided by a locum tenens. ~~Locum tenens can be utilized in certain situations. However, covering for a deceased provider and billing under that deceased provider's NPI does not meet the criteria for locum tenens and is not permissible.~~ Situations when Locum Tenens is not permitted:

  A. Deceased provider

  B. Replace a provider who has permanently left the practice/group

  C. Locum tenens provider has a temporary license

  D. Provider is pending completion of credentialing

Policy Memo No. 1
SECTION XXIII. Amendments to Policies and Procedures; Right to Terminate Contract

- **Page 21:** Updated verbiage to follow current practices of notifications sent to providers.

  A. Annual Contract Renewal – As part of its annual provider contract renewal process, BCBSKS notifies providers via ~~U.S Mail~~, hand delivery or electronically of all changes to its Policies and Procedures and Maximum Allowable Payment schedules at least 150 days before the amendments' effective date, which shall be January 1 of the following year.

Policy Memo No. 1
SECTION XXV. Tiered Reimbursement and Provider Number Requirements

- **Page 22:** Updated verbiage to reflect all provider specialties.

  BCBSKS has established different MAPs for the same service for the following specialties: Advanced Practice Registered Nurses/Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, Outpatient Substance Abuse Facilities, Autism Specialists, Individual Intensive Support providers, Registered Behavioral Technician, Chiropractors, Physical Therapists, Certified Physical Therapist Assistants, Licensed Athletic Trainers, Licensed Dieticians, Occupational Therapists, Certified Occupational Therapist Assistants, Speech Language Pathologists, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, ~~and~~ Licensed Clinical Psychotherapists, Licensed Marriage and Family Therapist, Licensed Master level Psychologist, Licensed Master Level Social Worker, Licensed Master Addiction Counselor, and Licensed Professional Counselor. Please review your charge comparison (refer to Section XXXVI. CHARGE COMPARISON REPORTS) to determine any write-off amounts.

Policy Memo No. 2
SECTION II. Content of Service

- **Page 3:** Updated verbiage to reflect current place of service codes.

  Telephone calls and web-based correspondence are content of service when billed with another service on the same day. Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 or 10 and the GT modifier.

Policy Memo No. 2
SECTION VI. Telemedicine

- **Page 5:** Updated verbiage to reflect current practices of allowing e-visits and consistency of use of health care provider.

  A. Health care providers that consist solely of a telephone voice-only conversation, email~~/eVisits~~, text, or facsimile transmission; or
  B. ~~A physician~~ Health care providers and a patient that consists solely of an email~~/eVisits~~, text, or facsimile transmission.

Policy Memo No. 2
SECTION VI. Telemedicine

- **Page 5:** Updated verbiage to reflect current place of service codes.

  Telephone calls and web-based correspondence are content of service when billed with another service on the same day. Telephone calls may be covered if it meets the telemedicine/telehealth definition and is billed with place of service 02 or 10 and the GT modifier.

Policy Memo No. 2
SECTION VII. Additional Policy Clarification

- **Page 5:** Removed verbiage regarding observation care as observation codes were deleted for 2023.

  ~~D. Observation care (23-hour observation) is allowed for unscheduled medical care. It is not intended for pre and postoperative care of the surgical patient. Only one observation service is allowed unless the 23-hour observation extends into the next calendar day. In this case, a discharge observation would also be allowed. An observation care service is content of service of a hospital admission.~~

Policy Memo No. 4
SECTION I. Quality Improvement Process

- **Page 3:** Integrated introduction paragraph into section I. while updated verbiage of the entire section, including the title of the section, to more accurately reflect current AQC process *(does not reflect the removed information, only what we are replacing it with).*

I. Review of Reported Quality-of-Care Concerns

Reported quality-of-care concerns will be reviewed to determine if health services rendered were professionally indicated or were performed in compliance with the applicable standard of care. A quality-of-care concern may be reported by a member, a member's family/representative, a provider or provider's support staff, Blue Cross and Blue Shield of Kansas (BCBSKS) internal staff or business partners. Potential quality-of-care concerns, including adverse events, are referred to the Nurse Coordinator of Quality Improvement, who serves as a designated peer review officer for BCBSKS as defined in K.S.A. 65-4915.

In order to make a determination regarding the quality-of-care concern, records will be requested and reviewed by clinical staff and peer reviewers. Providers are encouraged to take an active role in the 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 constitutes grounds for further actions by BCBSKS, up to and including termination of the provider's participation agreement for cause. Additionally, as a provider must be in good standing with BCBSKS to qualify for and receive Quality-Based Reimbursement Program (QBRP) incentives, QBRP incentives may be removed for failure to respond to a request from BCBSKS for additional information.

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. If a reported quality of concern case is determined to not be within the acceptable standard of care, the finding is communicated in writing to the provider(s) with a request for response. A finding that health care services were not within the applicable standard of care will trigger an action plan.

An action plan will consider the standard of care, likelihood that not being within the standard of care contributed to injury or harm and the extent of the injury or harm. Action plans ideally will be mutually agreed upon by provider and plan. An action plan may include but may not be limited to:

- Tracking and trending
- Corrective action plans detailing specific actions and monitoring
- Disciplinary action by plan
- Reporting to appropriate external oversight entity for consideration of disciplinary action

BCBSKS will notify the provider of the determination of all quality-of-care concern reviews.

Policy Memo No. 7
SECTION I. Diagnostic Radiology Policy

- **Page 4:** Updated verbiage for clarity on signature requirements.

  Legible signature. Refer to Policy Memo 1, XI, 4 for specific signature requirements. ~~(holographic or electronic)~~

Policy Memo No. 9
SECTION I. Global Fee Concept

- **Page 4:** Updated verbiage to reflect current coding.

  New patient office or outpatient services (codes ~~99201~~99202-99205) will be allowed on the day of the procedures.

Policy Memo No. 12
SECTION V. Method of Determining the Maximum Allowable Payment (MAP)

- **Page 4:** Updated verbiage for consistency throughout policy.

  B. ANESTHESIA FOR MULTIPLE SURGICAL PROCEDURES
  Allowance determined by:
  1. Using the CPT code with the highest base value allowed.
  2. Payment of one unit of time per 15 minutes administration.
  3. Anesthesia units are rounded up to the next whole number for payment purposes.
  NOTE – The above are multiplied by the BCBSKS anesthesia conversion factor.