2024 Insurance Biller's Seminar

BlueCross BlueShield Kansas

What can your Rep do for you

- Insurance billing education
- CAP mailing
- Policy Memos
- Medical Policies
- Documentation
- Coding
- Provider Visits

Important Contact Information

BlueCross BlueShield Kansas

Customer Service Center (CSC)

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Questions regarding:
- Claim status
- Appeals
- Pre-determinations
- Benefits
- Eligibility

Contacts:
Email: csc@bcbsks.com
Phone: 800-432-3990 or 785-291-4180
Fax (written inquiries and predets): 785-290-0711
Fax (all others): 785-290-0783

CSC Providers Only Benefits Line

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Questions regarding:
- Benefits
- Eligibility

Contacts:
Email: csc@bcbsks.com
Phone: 800-432-0272 or 785-291-4183

Provider Network Services

Hotline Hours: Monday-Wednesday, and Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Contracting
- Credentialing
- Network enrollment

Contacts:
Email: prof.relations@bcbsks.com
Phone: 800-432-3587 or 785-291-4135
Fax: 785-290-0734

Availity® Essentials

Office Hours: Monday - Friday 7:00 a.m. - 6:00 p.m.

Contact Availity Client Services toll free at 800-Availity (800-282-4548) or log in to Availity Essentials to submit a support ticket.

Availity Client Services is available during the hours listed above.

BlueCard®

Eligibility for out-of-state members:
- Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.
- Phone: 800-676-BLUE (800-676-2583)

Claim info for out-of-state members:
- Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.
- Phone: 800-432-3990, ext. 4058

Case Management

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Assistance with coordination of care for patients with complicated health issues.

Contacts:
Phone: 800-432-0216, ext. 6628 or 785-291-6628
For FEP members: 800-782-4437, ext. 6611

MiResource

Contacts: Email: support@miresource.com

Lucet

Office Hours: 24/7/365

Questions for behavioral health care:
- Preauthorizations
- Outreach services for high-risk patients
- Coordination with behavioral health care

Contacts:
Phone: 800-952-5906
Fax: 816-237-2364

Medicare Advantage

Office Hours: Monday - Friday 8:00 a.m. - 6:00 p.m.

KS members or M3A prefix
- Provider Services: 800-240-0577 Fax: 800-976-2794
- Prior Authorization/Utilization Management/Care Transition: 800-325-6201 Fax: 877-218-9089
- After Hours Utilization Management/Care Transition: 800-331-0192 Fax: 877-218-9089
- Behavioral Health Services (Lucet): 877-589-1635
- Hearing Services: 800-334-1807
- Vision Services: 877-226-1115

Federal Employee Program (FEP) - All FEP inquiries except OPL

Office Hours: Monday - Friday 7:00 a.m. - 4:30 p.m.

Contacts:
Phone: 800-432-0379 or 785-291-4181
Fax: 785-290-0764

FEP Blue Dental Contacts:
Phone: 855-504-2583
www.bcbsfepdental.com

Electronic Data Interchange (ASK-EDI) - Payor ID: 47163

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Electronic claims transmission
- Electronic RA
- Billing software
- Clearinghouse services
- Internet file transfer and passwords
- Real-time vendors

Contacts:
Email: askedi@ask-edi.com
Website: ask-edi.com
Phone: 800-472-6481 or 785-291-4178
Fax: 785-290-0720

Fraud Hotline

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Reporting of any illegal activity involving BCBSKS. Callers may remain anonymous.

Contacts:
Phone: 800-432-0216, ext. 6400 or 785-291-7000, ext 6400.

Other Party Liability (OPL) & Pre-Existing

Office Hours: Monday - Friday 8:00 a.m. - 4:30 p.m.

Questions regarding:
- Duplicate coverage
- No-fault auto exclusion
- Subrogation
- Workers' compensation
- Pre-existing

Contacts:
Phone: 800-430-1274 or 785-291-4013
Fax: 785-290-0771

Pre-certification, Concurrent Review and Alternate Care

Office Hours: Monday - Friday 8:00 a.m. - 5:00 p.m.

Questions regarding:
- All hospital inpatient admissions

Contacts:
Phone: 800-782-4437

Teleorder

Office Hours: 24/7/365

Contacts:
Phone: 800-346-2227 or 785-291-8130

Location Address:

1133 SW Topeka Blvd
Topeka, KS 66629-0001

Billing Address:

P.O. Box 239
Topeka, KS 66601-0239

Competitive Allowance Program- CAP

- Annual Contract Update
- Provider contract is Perpetual
- Approved by Board of Directors at BCBSKS
- Emailed towards the end of July
- Where BCBSKS Ranks in Member Satisfaction
- Network Strength and Size
- Reimbursement Changes
- Provider Types / Specialties / Tiers
- Quality Based Reimbursement Program (QBRP)
- Changes / Updates

Quality Based Reimbursement Program

- Details are in the CAP report
- Allows the Provider the opportunity for increased revenue
- Four Prerequisites (Claims, Remits, Newsletters, and be in good standing with BCBSKS)
- Groups A, B & C
- Qualifying Periods for Each Measure – Quarterly/Semi Annual
- HEDIS Measures

Policy Memos

1. Policies and Procedures
2. Office/Outpatient
3. Outpatient Treatment of Accidental Injuries
4. Quality of Care
5. In-Hospital Medical
6. Concurrent Professional Care
7. Radiology and Pathology
8. Obstetrical Services
9. Surgery
10. Assistant Surgery
11. Multiple Surgical Procedures
12. Anesthesia

Policy Memo #1

Retrospective Claim Review

- 120 days from date of Remittance Advice
  - Written inquiry

    https://secure.bcbsks.com/bcbsks-provider/facelets/allUsers/form/ProviderClaimEnrollmentInquiry.faces
- Void Claim
  - CMS 1500: Box 22 use #8 claim frequency code indicator and ICN #
- Corrected Claim
  - CMS 1500: Box 22 use #7 claim frequency code indicator and ICN#

Appeals – only "Not Medically Necessary" denials

- 1st Level: Written notification within 60 days from Retrospective Review Determination
- 2nd Level: Written request within 60 days from 1st Level Appeal

Audits

- Post Pay Audits
- Fraud and Abuse
- Utilization
- Risk Assessment

Content of Service

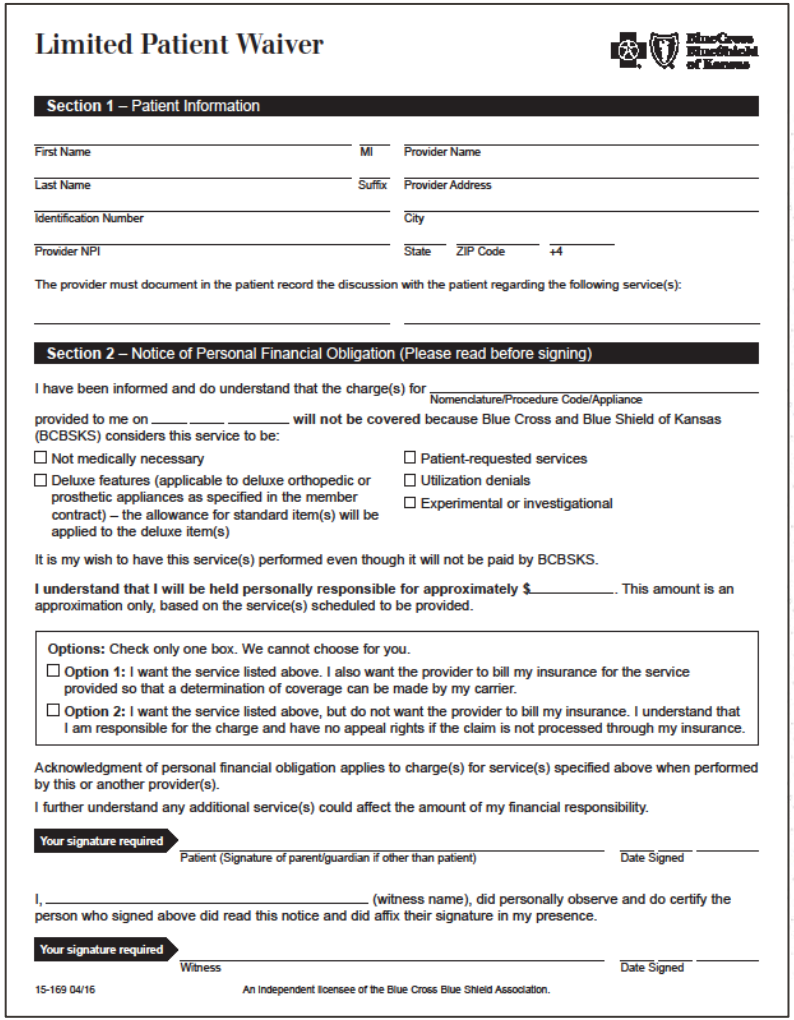
- Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office, home, or nursing home visit.
- Telephone calls & web-based correspondence.
- Additional charges beyond the regular charge. Ex – after office hours, holidays, or emergency
- A list is in Policy Memos 1 and 2. (not all-inclusive)

Non-Covered Services

Professional services are not reimbursed when provided to an immediate family member – spouse, children, parents, siblings, or legal guardian of the person who received the service (or themselves).

Member's contract may determine categories of services, procedures, equipment and/or pharmaceuticals. These denials are billable to the member.

Limited Patient Waiver



Limited Patient Waiver

Blue Cross Blue Shield of Kansas

Section 1 – Patient Information

First Name | MI | Provider Name

Last Name | Suffix | Provider Address

Identification Number | City

Provider NPI | State | ZIP Code | +4

The provider must document in the patient record the discussion with the patient regarding the following service(s):

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance

provided to me on ____ ____ _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- ☐ Not medically necessary
- ☐ Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s)
- ☐ Patient-requested services
- ☐ Utilization denials
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I understand that I will be held personally responsible for approximately $_____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Options: Check only one box. We cannot choose for you.

- ☐ **Option 1:** I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier.
- ☐ **Option 2:** I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Your signature required _____ Date Signed _____
Patient (Signature of parent/guardian if other than patient)

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Your signature required _____ Date Signed _____
Witness

15-169 04/16 An Independent licensee of the Blue Cross Blue Shield Association.

Documentation

- Chief Complaint
- Complete S.O.A.P. or M.E.A.T
- Abbreviations – Have a Legend
- Diagnosis and Dx Code
- Electronic vs Handwritten Signature
- Time-Based Coding – Time In & Time Out or Total Time

Uniform Charging

What constitutes a provider's usual charge?

- A discount to every patient without health insurance would be considered the "usual charge," and you must bill BCBSKS the same amount.

Concierge/Club Services are not to be offered to BCBSKS members

Are discounts acceptable?

- Based upon an individual patient's situation
- Community mental health centers and county health departments are allowed to use a sliding scale due to agency regulations
- Only collect deductible, co-payment, co-insurance, or non-covered services at the time of service

Non-Contracting Provider

- A contracting provider must bill for any services ordered and performed by a non-contracting provider
- The contracting provider must hold the member harmless
- If a member requests referral to a non-contracting provider, a signed statement of financial obligation should be on file
- Contracting/ordering provider must bill BCBSKS for all services rendered by the non-contracting provider
- Contracting/ordering provider will be required to ensure the member is held harmless if billed by the noncontracting provider

Claims Filing

- Contracting provider agrees to file claims for all covered services.
- Timely Filing
  - BCBSKS - 15 months from date of service or discharge from hospital
  - FEP - by Dec. 31 of the year after the year the service was received
  - ASO's - may have different timely filing requirements
- Eligible contracting providers must file services under their own billing NPI.
- BCBSKS does not recognize “incident to”.
- Use current Diagnosis and procedure codes.

Claims Filing

- Corrected claims are considered the retrospective review
  - Resubmission code 7 and original claim number
  - Do not write "corrected claim" on the claim form
- Void claim
  - Resubmission code 8 and original claim number
  - Wait for verification of voided claim on remittance advice
- New claim

Modifiers

- Modifier 59
  - Lesion Removal (10000's) and Radiology Codes (70000's) only
  - BCBSKS doesn't recognize it like Medicare
- Modifier 22
  - Drop claim to paper and attach records (unless lab/path handling fee)
- Modifier 25
  - Established patient E/M code (not new patient E/M)
  - Reduces the E/M by 25 percent MAP.
  - Do not use when billing 96372 (therapeutic injection)

Refund & Right of Offset Policy

- BCBSKS must request refunds within 15 months from the date of adjudication.
- Refund requests for fraudulent claim payments and duplicate claim payment, including other party liability claims, are not subject to the 15-month limitation.
- BCBSKS uses auto deduction processes for Right of Offset for claims previously paid.

Locum Tenens Provider

- BCBSKS allows use of a Locum Tenens
  - Provider must be same type of a provider for whom the locum is substituting for.
  - Locum Tenens must be licensed in the state of KS
  - No longer than 60 days
  - Billing: use NPI of the provider for whom the locum tenens is substituting. Add Q6 modifier.
  - Medical record must indicate the services were provided by a locum tenens
  - Can not use Locum Tenens for a provider who has passed away.

Tiered Reimbursement

85 percent*	70 percent*	50 percent*
Advanced Practice Registered Nurses (APRNs) [not including Certified Registered Nurse Anesthetists (CRNAs)]	Community Mental Health Centers	Certified Occupational Therapy Assistants (COTAs)
Chiropractors	Licensed Clinical Marriage and Family Therapists	Certified Physical Therapist Assistants (CPTAs)
Clinical Psychologists	Licensed Clinical Professional Counselors	Licensed Athletic Trainers (LATs)
Occupational Therapists	Licensed Clinical Psychotherapists	Individual Intensive Support (IIS) providers Registered Behavior Technician (RBT)
Physical Therapists	Licensed Specialist Clinical Social Workers (LSCSWs)	
Physician Assistants	Outpatient Substance Abuse Facilities	
Speech Language Pathologists	Autism Specialists (AS)	
Licensed Dieticians/Certified Diabetic Educators	Master's Level Social Workers Licensed Marriage and Family Therapist Licensed Master Level Psychologist Licensed Master Level Social Worker Licensed Master Addiction Counselor Licensed Professional Counselor	

Policy Memo #2

- Office/Outpatient Visits
- New vs Established Patient
- Content of Service
- Outpatient Consultations
- Telemedicine
  - POS 02 or 10 / GT Modifier
  - Provider must be licensed in the state the patient is located at time of service
  - Telemedicine is service with audio, visual or audio/visual – Does not include emails, faxes or texts.

Policy Memo #3

- Outpatient Treatment of Accidental Injuries and Medical Emergencies
- Accident Claims
  - Accident Indicator
  - Accident Date / Qualifier
  - Accident Dx - Primary

Policy Memo #4

- Quality of Care
- Quality Improvement Program
- Disease Management
  - bcbsks.com/BeHealthy/DiseaseMgmt
  - or bcbsks.com/Behealthy/Wellness-Management
- HIPAA
- Credentialing
  - CAQH – Standardized Credentialing Application for KS

Policy Memo #5

- In-Hospital Medical (Non-Surgical) Care
- Daily Hospital Services (New or Established Patient)
- In-Hospital Consultations

Policy Memo #6

- Concurrent Professional Care
- No Modifiers Needed
- Doesn't Apply To:
  - Radiology
  - Pathology
  - Dx Endoscopies
  - Asst Surgeries
  - Admin of Anesthesia
  - Single Consultations

Policy Memo #7

- Radiology and Pathology
- Diagnostic Radiology
- Therapeutic Radiology
- Pathology – Not Subject to Ancillary Guidelines
- Clinical Lab – Follow Ancillary Guides
    - Claim filed to the Blue Plan in the state where the referring/ordering provider resides

Handling Fee (CPT 99000)

Policy Memo #8

- Obstetrical Services
- OB Services Non-Surgical
  - Total OB Care
  - Antepartum Care
  - Delivery
  - Postpartum Care
- OB Services Surgical
- Services Qualifying for Additional Fees
  - Usual fee for Antepartum Care doesn't include lab services except for the UA.

Policy Memo #9

- Surgery
- Global Fee Concept

- Major – one day before, day of the procedure and six weeks (42 days) following
- Minor – day of the procedure and ten days following
- Zero – day of the procedure
  - Modifiers
  - Physicians in Group Practice
  - Adverse Events

Policy Memo #10

- Assistant Surgery
- Medical Necessity
- Reimbursement
- Non-Physician Assistants

Policy Memo #11

- Multiple Surgical Procedures
- Performed by One Provider
  - Allow procedure with higher RVU at 100%, other procedures at 50%
- Surgical Scope Procedures
  - Two or more scope procedures involving multiple compartments of the same anatomic area – only the procedure with higher/highest RVU will be allowed, the others are content of service.

Policy Memo #12

- Anesthesia
- Time of Administration
- Content of Service
- Nerve Blocks
- Maximum Allowable Payment (MAP)
- OB Epidural
- Monitored Anesthesia
- Moderate (Conscious) Sedation

Availity

Contact Availity for:

- Registration (www.Availity.com)
- Password issues
- Changes/updates to Availity provider profile
  - TIN / NPI changes
  - Name / address changes
- Questions regarding other Payers
- 800-282-4548

Availity/Blue Access - BCBSKS

On Availity site:

•Eligibility and Benefits

•Claim Status

On Blue Access:

•Patient ID Search: for BCBSKS members

•Provider Information

•Provider Information Forms: Attestation, Business Associate Agreements (BAA), Electronic Message Portal

•Remittance Advice: View / Print Remits

•QBRP: QBRP Earned Report

•Resources (i.e. EFT enrollment)

Prior Authorization

Prior Authorization - The process of obtaining prior approval from a health plan for services that require such approval based on the provider and/or member contract.

Example: Authorization required such as Rx

Predetermination

Predetermination - a documented response to an electronic/written request for review of available benefits and the medical necessity of service(s) requested prior to the service being rendered. This is a courtesy review and is NOT required by the member or provider contract.

Example: Confirming Medical Policy is met

Precertification

Precertification - The process of obtaining prior approval from a health plan for services that require such approval based on the provider and/or member contract.

Example: In-patient Hospital Stay

Electronic Precertification

Electronic Precertification- Is a requirement to earn QBRP incentives for institutional providers. You can only electronically precert inpatient admissions at this time. Call in precerts are still necessary for inpatient rehab services, home health and hospice.

Example: In-patient Admission

Pre-Service Reviews

- Roughly 75% of all pre-service review requests BCBSKS received last year were submitted by providers voluntarily. BCBSKS offers pre-determinations as a courtesy to providers – it is not required.

- BCBSKS Requires Pre-Service Review For The Following Services:
  - In-patient medical stays
  - In-patient mental health stays
  - Home health and hospice services
  - Transplants except for cornea and kidney
  - Human Growth Hormone
  - Germline genetic testing
  - Certain prescription drugs

Note: Some self-funded employer groups may have specific items that require prior authorization. These services are at the discretion of the employer -- not BCBSKS.

BCBSKS Provider Portal Attestation

- QBRP
- Consolidated Appropriations Act (CAA)
- 90-day attestation requirement
- Separate from Availity portal
- Group and Individual provider attestation

Business Associate Agreement (BAA)

- Required if you have a 3rd party entity representing your practice or to attest to not having any current business arrangements
- Protects Personal Health Information (PHI) and/or Personal Identifying Information (PII)
- Located in BlueAccess via Availity, BCBSKS Provider Secure Section (Blue Access), Provider Information, Business Arrangements.

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Electronic Provider Message Portal

- Upload records as requested
- Replaces receiving a more information request letter
- 1% QBRP Incentive
- Located in Blue Access
- Response required within 15 days of request
- Email notifications are sent every Monday

Remittance Advice

- Located in Blue Access via Availity
- QBRP Prerequisite
- Includes details on finalized claim
- Claim Adjustment Reason Codes (CARC)
- Remittance Advice Remark Codes (RARC)
- https://x12.org/codes

Claim Control Number Examples

252412300001

- 25 – Electronic claim
  - * 20 – Paper Claim
  - * 57 – Blue Card Claim
- 24 – It was received in 2024.
- 123 – It was received on May 3rd (Julian date).
- 00001 – It was the first claim in the sequence.

Electronic Funds Transfer (EFT)

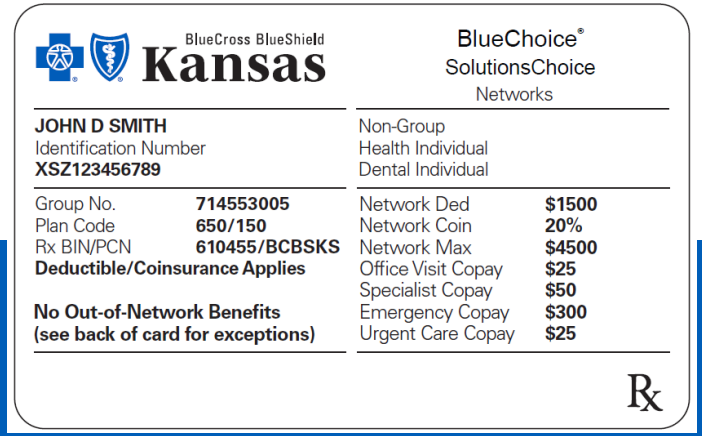
- Quicker Payment
- Less Paperwork
- Located in BlueAccess via Availity, BCBSKS Provider Secure Section (Blue Access), Resources, Forms, Professional, Electronic Fund Transfer (EFT) form.
- Upon enrollment with BCBSKS network providers will be required to sign up for EFT payment.

BCBSKS ID Cards

- Majority have a three-digit prefix (i.e.. XSB, KSE)
- Suitcase (PPO, PPOB, Empty, MA PPO, No Logo)
- No Suitcase (EPO) – No BlueCard benefits – can't travel
- Co-pays and deductibles listed
- Medical and Dental (if applicable)
- Group number
- CSC phone number on the back

BlueCare EPO

- Non-emergent, out-of-area care requires a prior authorization
- Covered benefits are for the BCBSKS service area
  - Request to receive service outside of Solutions Network form
- Zero coverage if the member is referred to a non-contracting entity for any service, including lab and radiology.
- Special contract with The University of KS Health System (KU Med in KC) and Children's Mercy



Prefixes for EPO members

- XSN – Individual on Exchange
- XSZ – Individual off Exchange
- KSA – Small Group off SHOP

BlueCard

- BlueCard program serves BCBS members worldwide.
- "BlueCard" is the term used for out-of-state plans.
- One source (Host Plan) for providers for claims submission.
- Claim Filing – All medical claims for out-of-state Blue Plans file to BCBSKS
- Terminology
  - HOME Plan: The BCBS plan where the patient's policy was issued.
  - HOST Plan: The BCBS plan where the services are rendered.

Medicare Advantage

- 27 Counties, including Sedgwick and Shawnee
- Medicare rates and policies apply
- No additional premiums for added services
- Not included in the QBRP
- Prefix – M3AK
- MA Provider Representative – Patrick Artzer
  - Patrick.Artzer@bcbsks.com
  - 785-291-6289

TRICARE

- The start of health care delivery for the next generation of TRICARE is to begin in the West Region on January 1, 2025.
- TriWest is contracting 26-states in the West Region of the United Stated.
- As of 2022 KS has 117,904 covered beneficiaries
- TRICARE covers:
    - » Active-Duty Service Members and their family members
    - » National Guard and Reservists and their family members
    - » Retirees and their family members
    - » Survivors
    - » Certain former souses

- Holli Dieckmann, Professional Relations TRICARE Representative; holli.dieckmann@bcbsks.com

Claim / Enrollment Inquiry Form

- Inquiry may be submitted for either claim or enrollment questions instead of calling customer service.
- Form is located on the bcbsks.com/providers/forms
- Located in BlueAccess via Availity under Resources, Forms, Professional, Claim/Enrollment Inquiry Form

Risk Adjustment

- Diagnosis (dx) coding is the primary indicator for risk adjustment calculation and auditing.
- When a claim record does not equal the clinical reality of patient's overall health, this creates a gap in the risk score.
- Dx specificity is critical for an accurate risk adjustment score.
- Current dx code vs. history dx code.
- Validate dx codes to medical record documentation.
- Risk Adjustment Data Validation Audit

Ancillary Billing Guidelines

- Independent (Clinical) Lab
- Durable Medical Equipment (DME)
- Home Infusion Therapy (HIT)
- Specialty Pharmacy

Specialty Guidelines

Heather Schultz, Specialty Provider Representative

- Heather.Schultz@bcbsks.com

Specialty Guidelines found on the BCBSKS.com website

- Ambulance
- Autism Guidelines
- Durable Medical Equipment/Home Medical Equipment
- Home Infusion Therapy

Reimbursement Reminders

- BCBSKS Accepts AMA-CPT, HCPCS and ICD-10
- Major/Minor/Zero Day Surgery Codes (42/10/0 Days)
- Unit Limitations
- Medical Policies
- Preventive Service Guide
- Limited Patient Waiver
- QBRP

Other Party Liability (OPL)

- Determines if services are eligible for coverage under another provider.
  - Verified annually for members and/or dependents.
  - Verifies if injuries/certain conditions are eligible under Work Comp or auto insurance.
- Helps contain costs that affect rates paid by members.
- Checks for:
  - Duplicate coverage
  - Workman's Compensation
  - No-fault Auto
- Does not coordinate with Medicare or Medicaid.

Lucky Strikes

- Department of Transportation (DOT) physicals
  - Use code 99455 (DOT Physical)
  - Note KDOT in box 19 of CMS form (Loop 2400 NTE)
  - Use E/M for ALL other school or work-related exams
- MiResource
- Healthy Blue pending…

Thank you for being a BCBSKS contracting provider

AAPC CEU's

CEU's are only valid for attendees who were present during the entire presentation.

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