Policy Memo - Policies and Procedures

2024 Policy Memos

Nos. 1 - 12

BlueCross BlueShield Kansas

bcbsks.com

2024 Policy Memo 1

Policies and Procedures

BlueCross BlueShield Kansas

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Please note: any timeframe listed in days, refers to calendar days unless otherwise specified.

The purpose of Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) Policies and Procedures is to provide specific explanations for provisions contained within the contracting provider agreements. This information is intended to supplement and further clarify the reciprocal rights and contractual obligations contained within the contract and the policies established by BCBSKS when services are provided in our service area (the state of Kansas not including Johnson and Wyandotte counties). All existing and future policies and procedures published within BCBSKS publications that are available via the BCBSKS website are considered part of the applicable Policy Memo. These publications include newsletters, provider manuals, and periodic update communications. 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.

I. Confidentiality

The effective delivery of health care requires communication and collaboration among providers, patients and payers. BCBSKS requires that all proprietary information be kept confidential. BCBSKS agrees to hold any and all information released to it in confidence unless otherwise instructed by the Contracting Provider or as otherwise required or permitted by law. The Contracting Provider may not disclose any terms of the Agreement to the third party except upon written consent of BCBSKS and as required by state or federal law, financial audits or quality of care investigations allowed by business arrangements and those additions are bound by confidentiality agreements. Failure to comply may result in penalties up to and including termination of the provider agreement.

Use of Confidential Information by Provider must be strictly for the purpose for which it was disclosed and may not be sold to any third party. Confidential Information, including claims data, obtained by provider may neither be de-aggregated in any manner to identify BCBSKS, other BCBS entities, and/or Member information, nor may it be comingled in any manner. Any disclosure of Confidential Information shall be limited to the minimum necessary to fulfill the purpose for which it was disclosed. Confidential Information must be returned or securely destroyed by the Provider upon conclusion of the purposes for which it was disclosed. In the event Provider cannot immediately return or destroy Confidential Information due to legal, license, or other requirements, Provider agrees to maintain the confidentiality of such information until the expiration of said requirements. BCBSKS maintains the right to audit Provider to ensure compliance with these provisions.

These requirements shall survive any termination or expiration of the Agreement and BCBSKS may seek injunctive relief or specific performance in order to enforce its terms.

II. Retrospective Claim Reviews/Corrected Claim

The contracting provider shall have the right to one retrospective review of any claim denied in whole or in part. The purpose of a retrospective review is to allow the provider to contact customer service to determine whether the original adjudication was correct.

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

B. The provider will be given a response to the request for a retrospective review as soon as possible, but no later than 60 days from receipt date. In cases where claims are adjusted, the remittance advice will serve as the response.

C. When a claim denial or adjustment is made as a result of a BCBSKS audit, the provider may not submit a corrected claim to reverse the decision. The provider's next course of action is to enter into the appeal process.

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.

III. Denied Claims Appeals Procedure

After completion of the retrospective review process (see Section II. Retrospective Claim Reviews), contracting providers may appeal certain pre and post-service claim denials. Only claims denied as not medically necessary may be appealed on the provider's own behalf as set forth in the policies and procedures. When BCBSKS requests records to support a claim denial, but does not receive them within the 45-day time limit, the service will be denied not medically necessary and will be a provider write-off. The provider may be designated as the member's authorized representative for appeal purposes according to the terms of the member's contract.

NOTE – Medical policies including Content of Service (COS) as described in BCBSKS Policy Memos 1-12 or provider's obligations specified in their provider contracts are not considered eligible claims appeals as outlined in Section III. DENIED CLAIMS APPEALS PROCEDURE. Annually, BCBSKS outlines any changes to the Policy Memos and forwards them to providers for their review. Once providers accept these changes, they are part of the provider's contract and therefore not considered for claims appeals. Providers disagreeing with any policies should submit their position and supportive documentation to BCBSKS staff for future consideration.

Appeals as the Member's Authorized Representative – Appeals that you can make as the member's authorized representative according to the terms of the member's contract are claims for which the member is financially responsible. When you act as the member's authorized representative, you are not separately entitled to any appeals pursuant to this Contracting Provider Agreement.

Appeals Pursuant to Contracting Provider's Agreement

First Level – Written notification of disagreement highlighting specific points for reconsideration of a claim denied not medically necessary shall be provided to BCBSKS within 60 days from the date of the retrospective review determination. This notice shall be considered an initial appeal and be forwarded with all pertinent medical records to BCBSKS Customer Service. Medical records submitted with the request for initial appeal will be referred to the appropriate consultant and a

determination will be rendered. This decision will be binding unless the provider files a second-level appeal within 60 days of notification of such decision.

Second Level – Forward a written request for the second-level appeal to BCBSKS customer service within 60 days following the first-level appeal denial notification. The second and final appeal determination shall be made by a physician or clinical peer. The contracting provider agrees to abide by the second-level appeal determination.

All appeal decisions under this agreement must be provided within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider and claim payments will be adjusted accordingly.

A contracting provider agrees to accept the determination made at each level or to appeal the determination at the next step of the appeals process. If throughout 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).

The result of the appeals process shall be binding on the provider and BCBSKS subject only to the provision for binding arbitration previously stated herein.

IV. Utilization Review and Medical Necessity

The contracting provider agreement requires providers to cooperate in utilization review and medical necessity determinations. Utilization review is the process of determining the appropriateness of services rendered to and payments made on behalf of members. Appropriateness of service and payment determinations consist of the following activities:

A. MEDICAL NEED FOR SERVICES RENDERED – Medical necessity policy applies to all services rendered to BCBSKS members and includes any services or supplies used to diagnose and/or treat illness or injury. Health care professionals should discuss all appropriate treatment alternatives available to patients regardless of benefit coverage limitations. To be determined medically necessary, the service must be performed, referred, and/or prescribed by a duly licensed provider; provided in the most appropriate setting and consistent with the diagnosis and treatment of the condition; be in accordance with current generally accepted standards of medical practice in the United States based on credible scientific evidence; not primarily for the convenience of the patient, physician, or other health care provider; and not more costly than an alternative service or supply or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the illness, injury, or disease. The following procedures/equipment would be subject to medical necessity and utilization review:
   1. Established procedures/equipment of questionable current usefulness in the treatment of a specific condition(s).
   2. Procedures/equipment which tend to be redundant when performed/supplied in combination with other procedures/equipment; or procedures/equipment which are unlikely to provide additional medical benefits, or are contradicting to one another.
   3. Specific procedures/equipment or patterns of care which vary significantly from a peer group.

B. PRE-ADMISSION CERTIFICATION & CONCURRENT REVIEW – Before admitting a member to a hospital for elective (non-obstetrical, non-life threatening) inpatient care, medical information will need to be supplied to BCBSKS in order to certify medical necessity. A length of stay will be assigned at the time of pre-certification and will be subject to concurrent review. Concurrent review is the process of obtaining current medical information to review for the medical necessity of a requested extension to the length of stay or course of treatment. For the most accurate and complete information, all pre-admission certification should be validated through the BCBSKS provider portal (via Availity®).

   BCBSKS pre-admission certification and concurrent review activity are conducted in compliance with URAC guidelines. This includes the availability of either the expedited or standard appeal to services denied for medical necessity during the pre-admission certification and concurrent review processes. To initiate an appeal (phone or fax), you must have complete information since the time frame begins with the appeal request. These appeal options are only available prior to claim submission and are subject to time frames as established by BCBSKS, Department of Labor, and URAC. All pre-admission certification appeals for professional and hospital services will be reviewed concomitantly.

C. OUTPATIENT PRE-CERTIFICATION/PRIOR AUTHORIZATION – Under certain circumstances, pre-certification/prior authorization may be required for outpatient services/procedures. BCBSKS will notify contracting providers at least 30 days in advance of such requirement.

   Pre-certification/prior authorization may also be required for other outpatient services such as home medical equipment and case management, including those services specified by employers, and outpatient procedures which necessitate a greater level of facility care than is usually needed.

   Following provider notification, continued failure to complete pre-certification/prior authorization activities will result in a 50 percent Maximum Allowable Payment (MAP) reduction up to $200 with the member held harmless. Compliance audits will take place on a post-payment basis, which may result in refunds.

D. CASE MANAGEMENT – Case management is a process that identifies and coordinates alternative treatment plans to enhance care through effective administration of available health care resources in the most cost-efficient manner. The process is accomplished through the development of a treatment plan by the patient or legal representative, the physician, other health care providers, and the BCBSKS case manager.

E. PREPAYMENT AND DATA ANALYSIS – BCBSKS will identify any trends or patterns of patient care, i.e., through data analysis, which appear inconsistent with overall patterns or trends. Prepayment review will be implemented if attempts to work with the provider have failed to resolve the issue. Specific utilization guidelines may be applied to individual prepay members. Prepayment review means all claims will be reviewed before payment and records will be required.

F. APPROPRIATE PLACE OF SERVICE – The provider agrees to use (to the extent possible) those inpatient, extended care, ancillary services and other health facilities and health

professionals which have contracted with BCBSKS. Providers agree to render services to members in the most appropriate and economical setting consistent with the member's diagnosis, treatment needs, and medical condition. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation. In the event members request referrals to non-contracting providers, 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.

G. RESOLUTION OF PROBLEMS – Providers agree to work with BCBSKS and other providers of care in the resolution of any utilization or medical review problems that may be identified. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally contract cancellation.

H. MEDICAL NECESSITY/UTILIZATION REVIEW DENIALS – Occasionally BCBSKS does not consider an item or service to be medically necessary. In such situations the item or service becomes a provider write-off. In the few situations where services are known to be denied as not medically necessary (including deluxe items) and the patient insists on the services, the provider must obtain a patient waiver in advance of the services being rendered. (See Section X. WAIVER FORM)

Failure to discuss the above with the patient in advance, document this in the medical record, and obtain the waiver will result in a provider write-off.

NOTE – BCBSKS members are not to be billed for services determined to be unnecessary through the medical and utilization review process, per the Contracting Provider Agreements.

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 business 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 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.

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).

No appeals are available for post-pay audit findings and associated re-adjudications based on published BCBSKS payment policies, including but not limited to content of service, multiple surgery guidelines, or other billing guidelines.

VI. Content of Service

Content of service refers to specific services and/or procedures that are considered to be an integral part of previous or concomitant services or procedures to the extent that separate reimbursement is not recognized. Not all content-of-service issues are identified in the policies and procedures. BCBSKS staff may identify and classify specific coding and nomenclature issues as they arise. Examples of services that can be considered content of service are:

- Examination of the patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Hearing and vision screenings.
- Any entries into the patient's records.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.

- Items of office overhead such as malpractice insurance, telephones, computer equipment, software, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- 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.
- Anesthesia provided in an office setting is considered content of service and not reimbursed separately. The provider cannot require the patient to sign a waiver or bill the patient for this service.
- For services that include assessment and evaluation of that assessment, the date of the assessment shall be the date of service.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

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.

VII. Experimental or Investigational Procedures

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

Experimental or investigational refers to the status of a drug, device or medical treatment or procedure:

A. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

B. If Credible Evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

C. If Credible Evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

D. If there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Credible evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Research-Urgent shall mean a drug, device, medical treatment or procedure that may be covered (even though otherwise excluded by the contract as experimental or investigational) providing the specified criteria outlined in the contract is met.

Contracting providers shall notify the patient when services to be rendered are considered experimental or investigational and may not be covered under the member's contract. Any patient being billed for services considered experimental or investigational must have a signed waiver in their file. The provider must discuss this with the patient in advance, document this in the medical record, and include the GA modifier (waiver on file) on the claim form (electronic or paper). (See Section X. WAIVER FORM) Failure to discuss and obtain a signed waiver in advance of the service will result in provider write-off.

VIII. Non-Covered Services

There are several categories of services, procedures, equipment and/or pharmaceuticals that may be considered non-covered services when designated by the member's contract. 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.

IX. Patient-Requested Services

A. If a provider prescribes services that he knows will not be covered because of a lack of medical necessity or the procedure being considered is experimental or investigational and he alerts the patient of the non-coverage, yet the patient still insists on the services, the provider may bill the patient if the request is properly documented and signed by the member. (See Section X. WAIVER FORM)

B. Providers must obtain a waiver on any mental health consultation, testing, or evaluation that is performed by agreement or at the direction of a court for the purpose of assessing custody, visitation, parental rights, or to determine damages of any kind of personal injury action and if the service is not otherwise medically necessary. To enable the provider to bill a patient for such services, BCBSKS will deny benefits for such services as lacking medical necessity.

X. Waiver Form

NOTE – The waiver cannot be utilized for services considered to be content of another service provided, nor can it be used to bill the patient the difference between the provider charge and the allowed amount.

A. SITUATIONS REQUIRING A WAIVER
   1. Medical necessity denials
   2. Utilization denials
   3. Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract)
   4. Patient-requested services
   5. Experimental/investigational procedures

B. THE WAIVER FORM MUST BE
   1. Signed before receipt of service.
   2. Patient, service, and reason specific.
   3. Date of service and dollar amount specific.
   4. Retained in the patient's 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.)
   5. Presented on an individual basis to the patients. It may not be a blanket statement signed by all patients.
   6. Acknowledged by patient that he or she will be personally responsible for the amount of the charge, to include an approximate amount of the charge at issue.
      NOTE – If the waiver is not signed before the service being rendered, the service is considered a contracting provider write-off, unless there are extenuating circumstances.

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

XI. Medical Records

A. Form of documentation in medical records – Documentation in the medical record must accurately reflect the health care services rendered to the patient and is an integral part of the reimbursement, audit, and review processes.

   1. Documentation of Medical Services – Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Each diagnosis submitted on the claim must be supported by the documentation in the patient's medical record. The contracting provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s) which shall be made available for audit and review at no charge.
      Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

2. Cloned Medical Record Documentation – BCBSKS expects providers to submit documentation specific to the patient and specific to the individual encounter. Documentation should support the individualized care each BCBSKS member received. Documentation identified as cloned, copied and pasted, pulled forward, or inserted via template without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining services provided for that visit.
3. BCBSKS has adopted the following standards for documentation of medical services. Each patient's health record shall meet these requirements:
    a. Be legible in both readability and content.
    b. Contain only those terms and abbreviations that are or should be comprehensible to similar providers/peers.
    c. Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
    d. Indicate the dates any professional service was provided and date of each entry.
    e. Contain pertinent information concerning the patient's condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
    f. Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed, and the results of each.
    g. List start and stop times or total time for each CPT code/service performed on all timed codes per CPT nomenclature.
    h. Document the initial diagnosis and the patient's initial reason for seeking the provider's care.
    i. Document the patient's current status and progress during the course of treatment provided.
    j. Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each.
    k. Include all patient records received from other health care providers if those records formed the basis for treatment decision by the provider.
    l. Each entry shall be authenticated by the person making the entry (see Signature Requirements) unless the entire patient record is maintained in the provider's own handwriting.
    m. Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.
4. Signature Requirements – In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.

a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date.
b. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
c. An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author's first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: "Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M."
d. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.
e. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

5. Corrections in the Medical Record – If the original entry in the medical record is incomplete, contracting providers shall follow the guidelines below for making a correction, addendum, or amendment. Signature requirements as defined above apply to all corrections in the medical record.
   a. Errors in paper-based records – To add an addendum or amendment to paper-based records, draw a single line in ink through the incorrect entry, print the word "error" at the top of the entry, the reason for the change, the correct information, and authenticate the error by signing (including credentials) the notation with the date and time. Entries should not be antedated (assigned a date earlier than the current date). Errors must never be blocked out or erased.
   b. Electronic medical records/Electronic health records:
      i. Addendum – An addendum is new documentation used to add information to an original entry that has already been signed. Addenda should be timely with date and time of the addendum. Write "addendum" and state the reason for the addendum referring back to the original entry.
      Complete the addendum as soon after the original note as possible. Identify any sources of information used to support the addendum. Entries should not be antedated (assigned a date earlier than the current date).
      ii. Amendment – An amendment is documentation meant to clarify or provide additional information within the medical record in conjunction with a previous entry. An amendment is made after the original documentation has been completed and signed by the provider. All amendments should be timely with the date and time of the amended documentation. Write "amendment" and document the clarifying information referring back to the original entry. Complete the amendment as soon after the original note as possible. Entries should not be antedated (assigned a date earlier than the current date).

6. Use of Medical Scribes – Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. BCBSKS expects the signing and dating of all entries made by a scribe to be identifiable and distinguishable from that of a physician or licensed independent practitioner. All entries made by a scribe are ultimately the practitioner's responsibility; therefore, review of the documentation and verification of its accuracy, including authentication by the practitioner, is required.

B. BCBSKS requests for medical records

1. Contracting providers must provide complete medical records at no charge in a format that can be utilized by BCBSKS or an entity acting on behalf of BCBSKS.
2. BCBSKS staff members conduct medical review of claims and seek the advice of qualified and, typically, practicing professionals when necessary. Contracting providers agree to accept the decisions made as a result of those reviews and to follow the appeals procedures established by this Policy Memo.
3. The entire review process itself includes the development of guidelines that relate to specific provisions of members' contracts; the processing of claims based on guidelines and medical records when indicated; the retrospective review of claim determinations; and the appeal process. BCBSKS seeks the advice of clinical professionals at appropriate points throughout the entire review process.
4. **Contracting providers must submit** all pertinent and complete medical records to BCBSKS within the time frame specified by BCBSKS when records are needed for the initial review of a claim or when records are requested for an audit. Medical records shall include all versions, whether handwritten or EMR/EHR-generated. Any applicable audit log documentation must be provided. In most instances, BCBSKS will allow 30 days for the production of the requested records. Failure to send the requested documentation or providing insufficient documentation to determine medical necessity may result in a claim denial and accordingly a provider write-off. In certain unusual circumstances as determined solely by BCBSKS, BCBSKS will require providers to submit medical records without advance notice. In such cases, a BCBSKS representative will visit the provider's office during business hours and secure the requested records immediately. The provider agrees to provide the requested records immediately. Members' contracts permit BCBSKS to obtain medical records without a signed patient release.
5. The ordering/referring provider shall also provide medical records to the rendering provider when requested for the purpose of medical necessity review. Additional documentation that is not a part of the medical record and that was not provided at the time of the initial request will not be accepted. Only records created contemporaneous with treatment will be considered pertinent.
6. If BCBSKS determines that the patient services provided by the contracting provider are not medically necessary, the claim is denied and is a write-off to the provider. If the services are requested by the patient after being advised by the provider of the lack of medical necessity and the daily record or patient chart has been documented to that effect and a written waiver is obtained by the provider before the service being rendered, charges for the services will be the patient's responsibility.

XII. Uniform Provider Charging Practices

Occasionally BCBSKS receives questions about what constitutes a provider's usual charge when a provider offers cash customers a discount and what amount to bill BCBSKS. The term "usual charge" is defined in our Contracting Provider Agreements, but to specifically address this question, our policy is as follows:

A. Provider discounts or charging practices based upon individual patients' situations (for example: patient hardship or professional courtesy) are acceptable and are not considered the provider's usual charge. If a provider gives a patient a discount for cash, they must bill BCBSKS the same amount.

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.

   Because a contracting provider agrees to not bill a BCBSKS member at the time of service, there should never be a circumstance in which a BCBSKS member pays anything other than a deductible, copayment, coinsurance, or non-covered procedure at the time of service. As an additional matter in regard to this point, our payments are timely enough that they are essentially cash for all practical purposes. If we are in fact late with payments, then the remedy is stated under the Prompt Payment law.

C. Agencies such as community mental health centers and county health departments would be allowed to use a sliding scale for charging practices due to agency regulations.

D. Provider may not charge a Blue Cross and Blue Shield (BCBS) member or employer policy holder any enrollment and/or maintenance fees associated with membership into a concierge, direct primary care, or any other similar model practice.

XIII. Purchased Services

When providers bill for PET, CT, or MRI services that were purchased from another provider, they must bill BCBSKS the amount for which the service was purchased.

XIV. Professional Services Coordinated with a Non-Contracting Provider

When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform 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 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.

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.

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.

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.

XVI. Refund Policy

BCBSKS must request refunds from providers within 15 months from the date of adjudication. Failure to do so will result in the provider being held harmless. Refund requests for fraudulent claim payments and duplicate claim payments, including other party liability claims, are not subject to the 15-month limitation. Providers shall promptly notify BCBSKS upon becoming aware of an overpayment to initiate the refund process. Initiation of the arbitration process described in Section XLVI will not delay or otherwise impact BCBSKS' determination of refunds for overpayments owed from the provider to BCBSKS through the offset process.

XVII. Right of Offset

BCBSKS will, through auto deduction processes, exercise the right of offset for claims previously paid. This right includes offset against any subsequent claim(s) submitted by the provider, including those involving other members. To accomplish this, BCBSKS will supply providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently. Initiation of the arbitration process described in Section XLVI will not delay or otherwise impact BCBSKS' right to collect refunds of overpayments owed from the provider to BCBSKS through the offset process.

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 their 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) 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.

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 their 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.

XIX. Locum Tenens Provider

In situations in which the regular provider is unavailable, a locum tenens can be used to provide a visit/service. The locum tenens must be the same type of provider as for whom the locum is substituting (for example, a physician can only authorize another physician as a locum tenens, an APRN/PA can only authorize another APRN/PA, etc.) and the locum tenens must be licensed in Kansas and only perform within their scope of license. The locum tenens must not provide services during a continuous period of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.

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. 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

XX. Contracting Status Determination

A. Any entity which provides and/or bills members and/or BCBSKS for health care services which advertises or represents itself to the general public as being owned/owning, controlled/controlling, managed/managing, affiliated with, or operated by a contracting provider must also be contracting with BCBSKS unless otherwise permitted by BCBSKS. Failure of such providers to contract with BCBSKS shall be considered cause for termination of the Contracting Provider Agreement in accordance with the Contracting Provider Agreement. This provision is applicable to entities serving members in the BCBSKS operating area. Contracting providers shall not subcontract other providers using their BCBSKS contracting agreement without the written consent of BCBSKS.

B. A provider who practices in multiple locations in the BCBSKS operating area must be contracting or non-contracting in all locations.

C. If the name of the provider set forth in the first paragraph of the contracting provider agreement is a professional association or other legal entity, rather than that of an individual, then the contracting provider agreement applies to all persons within the professional association. Any new providers who join the professional association will be understood to be bound by the contracting provider agreement. The party signing the contracting provider agreement on behalf of the professional association warrants to BCBSKS that such party: (1) has the authority to sign such agreement on behalf of the professional association; (2) shall make the terms of the agreement known to members of the professional association; and (3) shall inform new members of the professional association of the terms of the agreement upon entry into the professional association. The foregoing warranties apply to any person defined as an eligible provider in BCBSKS contracts employed by the individual, professional association or other entity signing the contracting provider agreement. If such eligible provider is among those identified in Section XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS hereof, the MAPs applicable to such eligible providers will apply to any services provided by them. If such persons are contracting separately with BCBSKS, until such contract is terminated, then it shall apply rather than these provisions, but if such separate contract terminates, then nonetheless these provisions shall apply with regard to the contracting status of such person.

   NOTE – In the event a provider has been terminated by BCBSKS from the network and subsequently joins a participating provider's practice, such participating provider will place their BCBSKS participating agreement in jeopardy (subject to termination for cause). Certain contracts offered by BCBSKS may offer individual physician options on contract status. Such options are specified by contract language and are offered solely at the discretion of BCBSKS.

D. It is the responsibility of the contracting provider or a representative to notify BCBSKS of any changes in practice information, e.g., license status, address, tax ID number, NPI, ownership, individual provider leaving/joining group practice, death of provider, closure of office, etc.

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.

XXI. New Techniques and Technology

Maximum allowable payments (MAPs) for new techniques, technology, home medical equipment and/or supplies will be based, when possible, on existing procedures/services and comparable value and result. Additional allowances for new techniques, technology, home medical equipment and/or supplies will be considered if there is documented significant improvement in safety or efficacy of patient care.

XXII. Reimbursement and Policy Changes

The BCBSKS Board of Directors authorized the following resolution regarding reimbursement changes and staff's authority.

> BE IT RESOLVED, that the Board of Directors of BCBSKS, hereby adopts as a policy the delegation of the authority to establish MAPs and to create or change policies and procedures under its contracts with providers of health care services to the executive staff of BCBSKS.
>
> BE IT FURTHER RESOLVED, that the Board of Directors of BCBSKS, hereby adopts as a policy of the corporation the understanding that any requirements for notifying annually each contracting provider at least 150 days in advance of the end of the calendar year of adjustments to the MAP shall not be construed to: (1) require adjustments on the first day of a year; (2) to limit the ability of the corporation, through the authority delegated to staff above, to change MAPs with less notice than 150 days; or (3) to prevent the corporation from changing MAPs, through the authority delegated to staff, more frequently than annually.
>
> BE IT FURTHER RESOLVED, that in making changes in MAP or in creating or changing policies and procedures staff shall provide notice to providers affected thereby at least 30 days in advance of the proposed effective date of such change in MAP or policies and procedures, and such affected providers shall have the ability to terminate their contracts with BCBSKS effective on the proposed effective date of such change rather than abide by such changes in MAP or such policies and procedures.
>
> BE IT FURTHER RESOLVED, that staff shall report to BCBSKS Board of Directors at the same time providers receive notification of changes in MAPs or policies and procedures which staff makes and the nature of such changes. The failure of staff to notify the Board of Directors shall not invalidate such changes to MAPs or policies and procedures.
>
> BE IT FURTHER RESOLVED, that this resolution shall be published as a policy and procedure of the corporation to all contracting providers.

XXIII. Amendments to Policies and Procedures; Right to Terminate Contract

This provision is intended to supersede and nullify Sections III.A.2. and V.A. of the contracting provider agreement to the extent this provision conflicts with those sections.

A. Annual Contract Renewal – As part of its annual provider contract renewal process, BCBSKS notifies providers via 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. Such amendments must be accepted or rejected in their entirety; acceptance requires no affirmative act by the provider. If the provider finds the amendments unacceptable, the provider agreement may be

terminated only by providing BCBSKS written notice of nonrenewal postmarked on or before September 3 of that same year. Such termination shall be effective January 1 of the following year.

B. Mid-year Amendments – Occasionally, BCBSKS will amend its Policies and Procedures or Maximum Allowable Payment schedules with mid-year effective dates. When this is necessary, notice of such amendment(s) shall be provided via mail or electronic mail to affected providers at least 30 days prior to the effective date of the amendment(s). If the provider finds the amendment(s) unacceptable, the provider may subsequently terminate their contracting provider agreement by providing BCBSKS with written notification of termination postmarked on or before the effective date of the amendment(s). Termination shall be effective on the effective date of the amendment(s).

XXIV. Establishing and Amending Medical Policy

The BCBSKS Board of Directors authorized the following resolution regarding establishing and amending medical policy changes and staff's authority.

WHEREAS, the Provider Relations and Medical Affairs Division has identified a need for the ability to establish and amend corporate medical policy in a more expeditious and efficient manner, and

WHEREAS, this division has developed new procedures to establish and amend medical policies more efficiently to better serve BCBSKS members and providers,

BE IT RESOLVED, that the BCBSKS Board of Directors hereby affirms as policy, that when a proposed medical policy does not originate in a Liaison Committee or does not rise to a level of concern requiring review by Liaison, Medical or Dental Advisory Committees, the Provider Relations and Medical Affairs Division is authorized to establish or amend corporate medical policy; and

BE IT FURTHER RESOLVED, that except for non-substantive operational changes, BCBSKS staff shall report all such new policies or amendments to the Board of Directors in a timely fashion. However, failure to do so shall not invalidate any new or amended medical policy.

XXV. Tiered Reimbursement and Provider Number Requirements

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, 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.

Eligible providers listed above must obtain an NPI and assure it is included as the rendering provider number on all claims submitted before any payment for such claims will be made by BCBSKS. Members may not be billed for services when a claim has not been paid because of the lack of the rendering provider NPI. Clinical laboratory, radiology, and drug MAPS are excluded from tiered reimbursement and will apply base MAP.

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 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.

XXVII. Reimbursement for Pharmaceuticals

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.

XXVIII. Reimbursement for Lesser Services

When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

XXIX. Reimbursement for Quality

In addition to, or in lieu of, the maximum allowable payment (MAP) as referenced elsewhere in any BCBSKS Policy Memo, BCBSKS may establish reimbursement criteria based on quality components to reward providers for meeting specified performance levels. Such criteria and corresponding reimbursement changes will be communicated in advance of the effective date.

XXX. Reimbursement for Site of Service

BCBSKS may apply a site of service differential when services which could be performed in an office are performed outside of the office setting. Reimbursement for overhead/supplies is included in the MAP for such services. When performed outside the office setting, the rendering provider should not incur overhead expense. That expense is incurred and billed by the facility where the procedure is performed. Therefore, reimbursement up to the MAP, or the provider’s charge (whichever is less) is made for those procedures performed in the office setting. The reimbursement is less when services are performed elsewhere.

XXXI. Adverse Events

The BCBSKS list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBSKS shall pay for the medical errors.

Adverse events A, B, and C are not billable to BCBSKS.

A. SURGERY PERFORMED ON THE WRONG BODY PART

B. SURGERY PERFORMED ON THE WRONG PATIENT

C. WRONG SURGICAL PROCEDURE ON A PATIENT

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT – In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object, then no payment for the correcting surgery will be made and the patient will be held harmless.
2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.

XXXII. Application of Contract

A. The conditions of these policies and procedures and the contracting provider agreement apply to all benefit programs, indemnity and to self-insured plans administered by BCBSKS or its subsidiaries, including those with deductibles, coinsurance and shared payments. For indemnity plans the difference between payment and the MAP allowance can be billed to the patient.

The conditions of these policies and procedures and the contracting provider agreement also apply to other entities when services (including services covered by workers compensation) are received within the company service area and BCBSKS, or its subsidiaries, is involved in the pricing and/or processing of the claim and payment is issued either by BCBSKS, its subsidiaries, other BCBS companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers compensation plans. In the event there is need for substantive differences between the terms and conditions of these Policies and Procedures and those applicable to a subsidiary of BCBSKS, a separate contract would govern the subsidiary network.

The conditions of these policies and procedures and the contracting provider agreement DO NOT apply to the programs insured and/or administered by BCBS companies/plans when such

programs rely upon providers who contract with an entity other than BCBSKS for the purpose of establishing reimbursement levels in the company service area. And, in the event the provider is required to submit claims direct to a BCBS company/plan outside the company service area that is adjudicating the claim, the provisions of these policies and procedures do not apply.

B. When BCBSKS receives and prices a claim which is paid by another entity, such other entity may make payments at variances with those which would be made by BCBSKS if it were adjudicating and paying the claim. In such a case, the provider must bring any such difference to the attention of BCBSKS within 15 months of payment to have such payment corrected.

C. BCBSKS may review charge/payment records of non-BCBSKS patients to determine contract compliance. The patients' anonymity can be protected by providing information specific to the contract compliance review.

D. Obligations under the contract with respect to services rendered while contract was in force survive termination of the contract.

E. When BCBSKS is the secondary insurance payer and the contracting provider has entered into an agreement with the insurance carrier who is the primary payer to accept an allowance which is less than the allowable charge under this contract, then the allowance of the primary insurer shall be considered the allowable charge under this contract for the purpose of that claim. When the allowance of the primary payer is greater than the allowable charge under this contract, the provisions of this contract are applicable.

F. In circumstances in which a party other than BCBSKS is entitled to the benefits of the Contracting Provider Agreement and these Policies and Procedures, such party may, at its discretion, honor assignments of benefits to providers not contracting with BCBSKS.

XXXIII. Acknowledgment of Independent Status of Plan

The provider hereby expressly acknowledges its understanding that the agreement to which these policies and procedures apply constitutes a contract between the provider and BCBSKS that the Plan is an independent corporation operating under a license with the Blue Cross Blue Shield Association (Association), an association of independent BCBS Plans, the Association permitting the Plan to use the BCBS Service Mark, and that the Plan is not contracting as the agent of the Association.

The provider further acknowledges and agrees that he/she has not entered into such agreement based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the provider for any of the Plan's obligations to the provider created under such agreement. This section shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of such agreement.

XXXIV. Acknowledgement of Balanced Budget Act of 1997

This contract will terminate if the provider is excluded from participation in any federal health care program, as defined under 42 U.S.C. 1320a-7b(f). Provider agrees to inform BCBSKS of the commencement of any proposed exclusion within seven (7) business days of first learning of it, and

to inform BCBSKS immediately upon any such exclusion becoming effective with respect to provider.

XXXV. Contract Scope of Services

When a provider contracts with BCBSKS, all covered services provided by that provider will be subject to the contract. This means that for covered services, the BCBSKS allowance for that service must be accepted as payment in full, e.g., medical equipment or supplies furnished by the provider.

XXXVI. Charge Comparison Reports

The provider may request one annual charge comparison report for procedures billed to BCBSKS on behalf of our members. Information included in the annual charge comparison will include services billed and allowed from January 1 to May 31 each year.

XXXVII. Pathology or Laboratory Services

Anatomical lab must be billed by the provider who renders the service. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

XXXVIII. Special Provision Pertaining to Pended Claims

The provider contract considers a person a member until such time as there is an indication they are no longer a member. This means that while a member's coverage is in a pending status for lack of payment of premium or notice of change of status, the provider contract continues to apply.

XXXIX. Limited Provider Networks

The overall business climate or some large employer groups may require a reimbursement level lower than that available under the ordinary MAP from BCBSKS. To meet these market needs, BCBSKS may offer an amendment to the Contracting Provider Agreement, or an additional agreement, providing for such lower level of reimbursement. While nothing in these policies will require a provider to accept this additional discount, if a contracting provider fails to accept such addendum or agreement, a contracting provider shall nevertheless accept as payment in full from a member covered under such a program the amounts established as the MAP under the contracting provider agreement. Such provider may collect from such member the deductible, co-insurance, and additional copayments which apply when such person obtains services from providers who have not signed such amendment or additional agreement.

XL. CAP Provider Directories

BCBSKS makes CAP provider information, including contracting providers' names, available to members on the BCBSKS website, www.bcbsks.com, and to the Association for national doctor locator directories. BCBSKS reserves the right to suppress a provider from the directory when current information is not provided upon request.

Providers must notify BCBSKS of changes to provider data (including, but not limited to, change in ownership, EIN, TIN, NPI, legal name, address, adding or removing a provider) within 10 business days.

XLI. Acknowledgment of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations

Although BCBSKS does not guarantee the availability of a website, if and when a website may be made available to contracting providers, the contracting provider shall access such website and the information available through it only for the purpose of payment, treatment, and operations as these terms are defined in HIPAA at 42CFR, part 164.

The Contracting Provider shall not, in connection with any functions, activities, or services directly or indirectly contract with any person or entity that undertakes any functions, activities, or services, including without limitation storage of member information outside of the United States of America or its territories without prior written consent from BCBSKS.

XLII. Acknowledgment of Non-Discrimination Laws

As a provider of services to the State of Kansas and to counties, municipalities and other state governmental units, BCBSKS is required by K.S.A. 44-1030 to observe the provisions of the Kansas Act Against Discrimination, not to discriminate against any person in the performance of work because of race, religion, color, sex, disability, national origin or ancestry, to include the phrase "equal opportunity employer" or a similar phrase in advertisements for employees, and to require in any contracts BCBSKS has with others that such others shall also abide by such provisions, and that if such contractors are found guilty of a violation of the Kansas Act Against Discrimination, such contractors shall be deemed to have breached their contracts with BCBSKS and the contract may be canceled, terminated or suspended in whole or in part. The contracting provider agrees that it shall abide by the foregoing provisions.

As a provider of services for qualified health plans, any entity that operates a health program or activity, any part that receives Federal financial assistance is required by Section 1557 of the Patient Protection and Affordable Care Act, and its implementing regulations published by the Office of Civil Rights, to not discriminate against any person on the basis of race, color, national origin, sex, gender identity, age, or disability, to accommodate individuals with limited English proficiency. Any entities that are found to have discriminated in violation of section 1557, and its implementing regulations, can be subject to a private right of action. The contracting provider agrees that it shall abide by the foregoing provisions.

XLIII. Medicare Advantage Claims

Medicare Advantage (MA) claims should be submitted directly to BCBSKS, which will report the status of such claims on its remittance advices. MA claims will be processed pursuant to BCBSKS policies and procedures specific to MA and are subject to applicable MA appeal rights. For MA claims occurring under a form of coverage offered by a BCBS Plan other than BCBSKS, the provider in the BCBSKS MA provider network will be reimbursed for covered services at the BCBSKS MA reimbursement rate. The other BCBS Plan is solely responsible for determining medical policy. BCBSKS providers not participating in the BCBSKS MA provider network who provide services to an MA member of either BCBSKS or another BCBS Plan will be reimbursed at the amount applicable in Original Medicare (as required by the Centers for Medicare & Medicaid Services (CMS)). BCBSKS contracting MA providers, see the Medicare Advantage Manual for MA-specific policies, procedures, and guidelines.

XLIV. Collection of Payment

The provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement, or have any recourse against Member, enrollee or persons other than BCBSKS acting on their behalf for services provided pursuant to the contracting provider agreement, including but not limited to, nonpayment by BCBSKS, BCBSKS insolvency, inability to continue operations or breach of this Agreement. This provision shall not prohibit collection of supplemental charges or copayments or reasonable deductibles, or charges for non-covered services where applicable made in accordance with the terms of the member's contract.

XLV. Provider Dispute Resolution

A. Providers may dispute issues of concern through their Professional or Institutional Relations Representative. A provider representative will respond to the provider in writing within 30 days of the request to advise of the status of the dispute or the outcome. The representative will work with the provider to address the dispute. If the provider remains dissatisfied the dispute may be escalated to BCBSKS management. Disputes referred to BCBSKS management must be in writing and include the supporting documentation used to initially resolve the dispute and any additional information submitted by the provider that supports the issue. BCBSKS will provide a written response to the provider within 60 days of BCBSKS management receiving the written request.

B. Any dispute relating to or arising out of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement, and that is not or cannot be resolved according to the appeal procedures of this Policy Memo, shall be resolved by binding arbitration. Arbitration is the process of resolving disputes between BCBSKS and a contracting provider separate and distinct from any appeal procedures described in this Policy Memo No. 1. Once such appeal procedures are completed, BCBSKS may begin recoupment measures of any refunds due from the audited provider as described in Sections XVI and XVII, and initiation of the arbitration process will not delay or otherwise impact the recoupment process set out therein. Such arbitration shall be conducted in accordance with the Healthcare Payor Provider Arbitration Rules of the American Arbitration Association. Arbitration shall be initiated by either party filing a written demand for arbitration with the American Arbitration Association and payment of all requisite fees.

   The arbitrator shall have the right to determine his or her own jurisdiction. The arbitration proceeding shall be conducted in Topeka, Kansas, unless both parties agree otherwise. The arbitrator may construe and interpret, but shall not delete from, add to, or modify the terms of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement. The arbitrator shall have no authority to award extra-contractual damages of any kind, including but not limited to consequential, punitive or exemplary damages, and shall be bound by controlling law. The arbitrator shall apply the substantive law of Kansas, without giving effect to any conflict-of-laws principles.

   The parties acknowledge that because the contracting provider agreement affects interstate commerce, the Federal Arbitration Act also applies. The parties agree that the decision of the arbitrator shall be final, binding and non-appealable, and that judgment on the arbitration award may be entered by any court of competent jurisdiction. The parties shall share all expenses of

the arbitration equally. However, each party shall bear the costs and expense of its own counsel, experts, witnesses, and preparation and submission of its claims and defenses to the arbitrator.

The arbitration process described above shall be available to providers only after exhaustion of all applicable review and/or appeal processes described within these policies and procedures. This exhaustion requirement shall apply to each claim or service in dispute. Providers who choose to initiate arbitration must do so within 90 days of the date of the second-level appeal determination. If a provider fails to initiate arbitration within this timeframe, the provider will be deemed to have waived his or her right to arbitration for all claims and services addressed in that second-level appeal determination.

XLVI. Right of Delegation

BCBSKS has the right to delegate any and all aspects of the audit and appeal processes to any qualified entity.

XLVII. Contract Amendment

The Contracting Provider Agreement is hereby amended to delete Section IV.B, paragraphs 1 through 5 (see below), which references certain circumstances under which BCBSKS could make adjustments to the maximum allowable payment (MAP) for services.

SECTION IV. MAXIMUM ALLOWABLE PAYMENT SYSTEM

B. B. The physician agrees to fully and promptly inform BCBSKS of the existence of agreements under which such physician agrees to accept an amount for any and or all services as payment in full which is less than the amount such physician accepts from BCBSKS as payment in full for such services. BCBSKS staff is authorized to adjust MAP for the physician in light of such agreements, under the following terms:

1. The BCBSKS staff may adjust the MAP only in circumstances in which the staff becomes aware through independent investigation or as a result of information provided by a contracting provider, that a contracting provider has a payment agreement with another payer or offers a discount or other financial arrangement, the effect of which is that such contracting provider accepts from another payer as payment in full an amount less than such contracting provider would accept from this corporation as payment in full;
2. Such adjustment shall be approved in writing by the executive vice president or by the president of this corporation.
3. Such adjustment shall be communicated in writing to the contracting provider. Such communication shall be considered a change in policy adopted by the board of directors, and the contracting provider shall have such advance notice of the change and such rights to cancel the Contracting Provider Agreement rather than abide by the change as are afforded for other amendments to policies and procedures under Section III.A.2. of this agreement.
4. The board of directors or executive committee of BCBSKS shall be informed by the staff of any such adjustments to MAPs so made, at the next meeting of the board of directors or executive committee immediately following such adjustment.

5. The board of directors or executive committee of this corporation shall have the ability to make subsequent changes in adjustments to MAPs so made, which changes shall be prospective only and shall be effective as any other amendment to policies and procedures after communication. If a change in such adjustments would have the effect of inducing a party which terminated its Contracting Provider Agreement as a result of the staff adjustment to MAPs to wish to contract anew with BCBSKS, a contract shall be tendered to such party and shall become effective on the date of execution by such party.

XLVIII. Glossary

A list of definitions for some of the language used in these Policy Memos can be found at the BCBSKS website.

https://www.bcbsks.com/help/glossary.shtml

Limited Patient Waiver

BlueCross BlueShield 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 _____ _____ _____ _____
Patient (Signature of parent/guardian if other than patient) Date Signed

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 _____ _____ _____ _____
Witness Date Signed

An independent licensee of the Blue Cross Blue Shield Association.

2024 Policy Memo 2

Office/Outpatient Visit

BlueCross BlueShield Kansas

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For additional information on medical emergency or accident related visits, see Policy Memo No. 3, Outpatient Treatment of Accidental Injuries and Medical Emergencies. Home services may be billed as defined in the American Medical Association Current Procedural Terminology (CPT).

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.

II. Content of Service (See also Policy Memo No. 1)

Usual fees for the professional services for new and established patients are considered to include the following:

- Examination of patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Hearing and/or vision screenings.
- Any entries into the patient's record.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- Examination and/or treatment room.
- Items of office overhead such as malpractice insurance, telephones, computer equipment, software, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- 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.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

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

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

III. Service Qualifying for a Separate Professional Fee in Addition to an Office/Outpatient Visit

- Charges for injectables may be listed separately from office visit fees and will be considered for payment separately. A separate administration fee will be allowed if no office visit is billed for therapeutic injections. Office visit services provided on the same day as an immunization or vaccine, may be billed in addition to the vaccine as long as medical need is justified.
- Laboratory examinations and/or diagnostic x-rays.
- Administration of chemotherapy when a separate and identifiable E&M is justified.
- In the case of a combination of office/home visits with physical therapy (modalities and/or procedures), services may be billed separately. The medical necessity of any physical therapy modality and/or procedure in excess of four on the same day must be supported with office records. See CPT for specific reporting of codes.

IV. Qualifications for Individual Consideration of Unusual Office/Outpatient Visit Charges

As with any unusual professional service, atypical office/outpatient visit fees are eligible for individual consideration when supportive medical records accompany the claim.

V. Outpatient Consultations

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient's condition and/or management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, three guidelines apply:

- The request for the consultation must be documented in the patient's medical record.
- The service must be for advice or opinion. While diagnostic work-up or therapy may be ordered and initiated by the consultant, this information must be documented in the record and included in the report to the referring physician.
- A report of the findings and advice must be sent to the referring physician.

When a consultant assumes responsibility for patient care (begins treating the patient, schedules follow-up care, etc.) the additional services are coded as office visits using the appropriate level of Evaluation and Management service for an established patient.

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, text, or facsimile transmission; or
B. Health care providers and a patient that consists solely of an email, text, or facsimile transmission.

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

"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.

Benefit coverage for health care services that are medically necessary – subject to the terms and conditions of the covered individual's health benefits plan – provided through telemedicine, rather than in-person contact or based upon the lack of a commercial office for the practice of medicine, will be the same when such services are delivered by a health care provider.

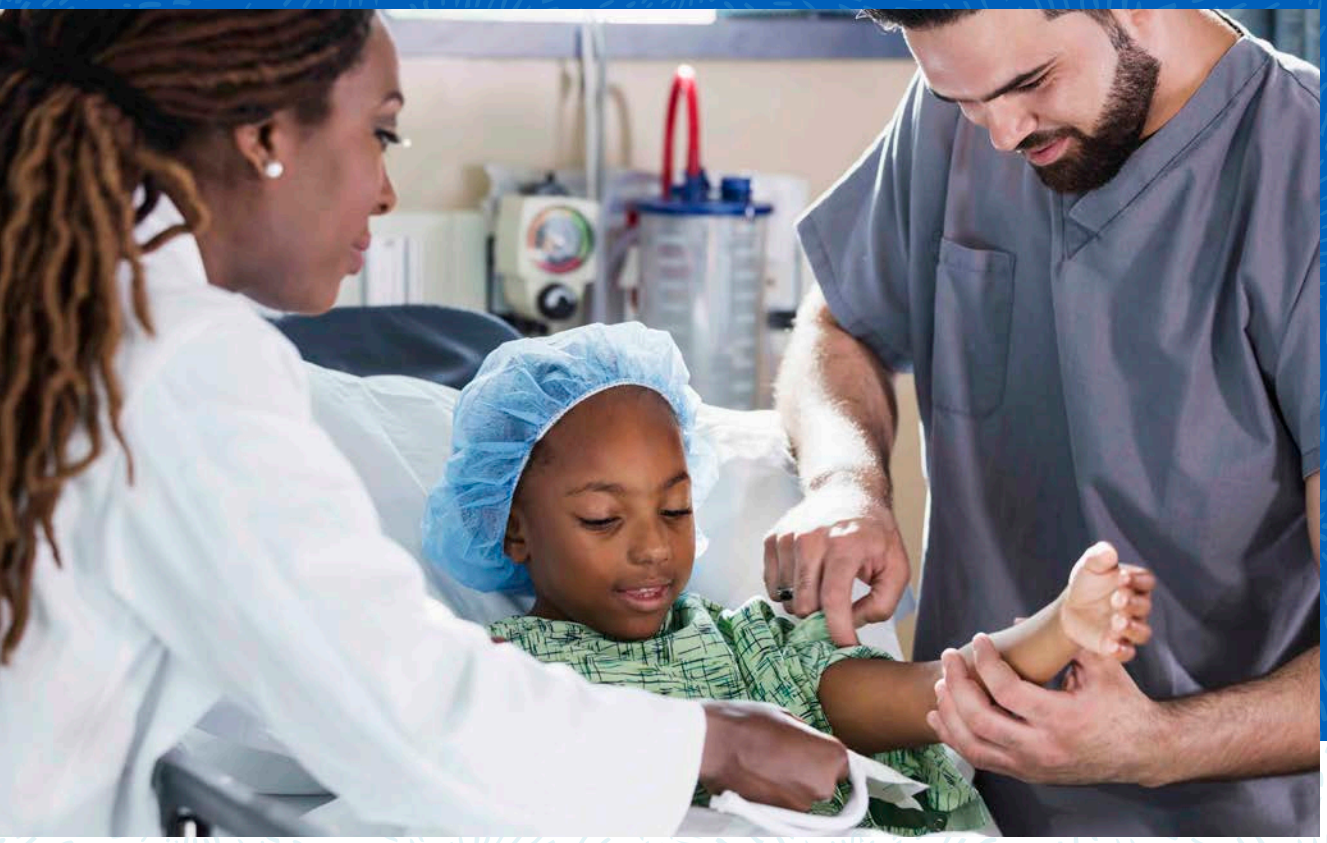
Note: Telehealth services should be billed with place of service 02 or 10 and with a GT modifier. Telehealth should not be billed when services are inappropriate as telehealth, e.g. laboratory services, vaccine administration, injections, radiology services, etc.

VII. Additional Policy Clarification

A. Office/outpatient visits provided on the same day as a hospital admission are considered content of the admission. (See In-Hospital Medical [Non-Surgical] Care Policy Memo No. 5.)
B. BCBSKS allows only one Evaluation and Management service per day per member by the same provider.
C. Contracting providers agree to assume the responsibility for filing covered office calls when there is payment for a portion of the service.
D. For new surgical patient visits, see Policy Memo No. 9, Section I., Paragraph C-2.
E. If a physician service is routinely provided to hospice patients, it is not separately billable.

2024 Policy Memo 3

Outpatient Treatment of Accidental Injuries and Medical Emergencies



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The contracting provider agrees to submit claims for treatment related to accidental injuries and medical emergencies as covered under the member's contract (see Business Procedure Manual for coverage information).

I. Definitions

A. MEDICAL EMERGENCY

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.

B. ACCIDENTAL INJURY

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

II. Content of Service (See also Policy Memo No. 1)

Usual fees are considered to include both professional fees and the following:

A. All materials, dressings and medicinals (other than immunizations or injections) furnished by the provider.

B. Topical or local infiltration anesthesia furnished by the provider.

C. Evaluation of reports of tests or studies earlier referred to another provider for radiological or pathological opinion.

III. 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.

IV. How to Bill for Treatment of Accidental Injuries and Medical Emergencies in a Hospital Emergency Department

When the physician is billing for services other than surgery in the treatment of accidental/medical emergency services, reference should be made to the Emergency Department Services section of the CPT for proper code use.

V. Additional Policy Clarification

A. Services in excess of specific payment limitations are subject to individual consideration if requested and supported by medical records.

B. When made by the same provider, charges for initial non-surgical treatment followed by in-hospital medical care on the same date will not be eligible for payment. In such cases, the

hospital medical care charges are considered to include initial temporary palliative or stabilization services. The provider should select the admission code that best represents this combination of services. Contracting providers agree to accept the review process determination in questions of medical necessity.

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.

D. It is necessary to show the date of onset on all services related to medical emergency care.

2024 Policy Memo 4

Quality of Care

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Please note: any timeframe listed in days, refers to calendar days unless otherwise specified.

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.

II. Member Satisfaction Survey

Members' perceptions are an essential source of information for BCBSKS. A satisfaction survey is not only a good management tool, but also a key indicator of the quality of care being provided. Surveys may be conducted to comply with performance standards and/or to gain insight into specific issues. BCBSKS is committed to continuous quality improvement and survey results are analyzed to determine areas of strength and areas of concern. Root causes are identified and action plans implemented so improvements can be achieved.

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.

IV. Health Insurance Portability and Accountability Act (HIPAA)

According to the HIPAA Privacy Rule, health care providers can disclose protected health information (PHI) to health plans pertaining to credentialing, retrospective review, office record reviews, and HEDIS (Healthcare Effectiveness Data and Information Set) data collection for the following types of health care operations:

A. Quality assurance and quality improvement activities
B. Accreditation activities (e.g., HEDIS data collection)
C. Case management, care coordination, and related functions
D. Disease management
E. Protocol development
F. Credentialing provider or health plan performance evaluation
G. Training
H. Certification
I. Licensing

Providers are permitted by HIPAA to disclose PHI to health plans for the above purposes without authorization from the patient when both the provider and health plan have or had a relationship with the patient and the information relates to that relationship.

V. Health Information Exchange (HIE)

BCBSKS believes in the value of health information exchange to support delivery of high-quality and cost-effective health care. BCBSKS is committed to supporting electronic sharing of clinical information that is HIPAA compliant and designed to achieve the goals of improving member experience, quality of care, and the health of our member population. BCBSKS may require electronic submission when requesting clinical information.

VI. Quality Reporting and Transparency

BCBSKS may establish quality initiatives and programs to monitor and report performance results of participating providers, and make available such results in web based and/or written form to the general public, enrolled employer groups, and members.

VII. Credentialing

A. Overview

1. Before a health care provider is eligible to become a contracting provider in the BCBSKS network, he/she must apply for and be granted credentialing status through the BCBSKS credentialing process as more fully described in the Credentialing Program Plan Description and BCBSKS policies and procedures (collectively, Program).
2. For providers who are not currently credentialed, he/she must submit application and undergo a full review as described in the Program. For providers who are currently credentialed, they must undergo the recredentialing process described in the Program at least every 36 months.
3. BCBSKS will monitor all network providers for continual compliance with established criteria as needed but at least monthly. If any derogatory information is identified during monthly monitoring, credentialing staff will report such findings to the Committee that will follow the process outlined below.

B. Initial Consideration by BCBSKS Credentialing Committee

1. In order for an applicant to be considered for credentialing by the Committee, he/she must meet all applicable criteria as set out in the Program and that are available on the BCBSKS website*. An applicant who does not meet all applicable criteria may not be considered by the Committee. The reconsideration and appeal process described below is not available to applicants who do not meet all applicable criteria.
   *Credentialing criteria are available on the BCBSKS website at https://www.bcbsks.com/providers/professional/publications/credentialing-information

2. The Committee reviews each provider's credentialing file in accordance with BCBSKS criteria and URAC standards. If a provider does not meet these standards or there is evidence that he/she does not adhere to BCBSKS policies and procedures, the Committee may deny or restrict participation in a BCBSKS network. If the provider disagrees with the denial or restriction and has additional information, he/she may request reconsideration by the Committee. In the absence of additional information, the provider may submit a written request for a first-level appeal within 30 days of the date BCBSKS sends notice of the denial or restriction to the provider.

C. Suspension for Member Safety – BCBSKS will review any action taken against a contracting provider where the provider has engaged in conduct or is practicing in a manner that raises competency concerns or appears to pose a significant risk to the safety of BCBSKS members. The contracting provider will be offered appeal rights if their contracting status is suspended.

D. Circumstances When Reconsideration/Appeal is not Available

1. If the Committee denies or cancels credentialed status for a provider because of one or more of the following reasons, the reconsideration and appeal process described below in Subsections E through G will not be available to such provider.
   a. Provider's professional license is not at full clinical scope of practice;
   b. Adverse action against the provider's DEA registration;
   c. Provider is unable to supply credentialing staff with documentation of successful completion of at least three years post-graduate training or equivalent work experience; or
   d. Provider is currently subject to any sanctions imposed by any CMS program or by the Federal Employee Health Benefit Program, including but not limited to being excluded, suspended, or otherwise ineligible to participate in any state or federal health care program.
2. If a provider's regulatory board suspends or revokes their license, that provider's BCBSKS network contract is canceled by operation of the terms of the contract. When credentialing staff members become aware of such suspension or revocation, they shall notify the Committee, but the Committee is not required to take any specific action since the provider's contract will terminate of its own accord. Credentialing staff shall also notify the appropriate internal departments of such suspension or revocation to ensure that appropriate administrative action is taken.

E. Reconsideration – If the Committee denies or restricts a provider’s participation status, the Committee will allow the provider to submit additional supporting documentation for reconsideration. If the denial or restriction is upheld by the Committee, the provider may submit a written request for a first-level appeal within 30 days of the date BCBSKS sends notice of the denial or restriction to the provider.

F. First-Level Appeal Panel – All appealed disputes are referred to a first-level appeal panel consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the provider that filed the dispute. BCBSKS will have 60 days from receipt of the first-level appeal request to convene a first-level appeal panel.

G. Second-Level Appeal Panel – If the first-level appeal panel upholds the denial or restriction, the provider may submit a written request for a second-level appeal. BCBSKS will convene a second-level three-member appeal panel consisting of at least one member who must be a contracting provider not otherwise involved in network management and who is a clinical peer of the provider who filed the dispute. None of the second-level panel may have been members of the first-level appeal panel. BCBSKS will have 60 days from receipt of the second-level appeal request to convene a second-level appeal panel.

H. Second-Level Appeal Panel Decision – The result of the appeals process shall be binding on both the provider and BCBSKS subject only to the provision for binding arbitration previously stated in Policy Memo No. 1.

   For every provider whose denial or cancelation of credentialing status is upheld, credentialing staff will report the decision to the provider's regulatory board and the National Practitioner Data Bank.

2024 Policy Memo 5

In-Hospital Medical (Non-Surgical) Care

BlueCross BlueShield Kansas

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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. 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.

II. In-Hospital Consultations

Consultations are services rendered to give advice or an opinion to a requesting physician about a patient’s condition and management. Medical records must contain documentation of the actual request, the evaluation, and include a copy of the report that is sent to the physician who requested the consultation. Consultations by the same specialty or within the same group are subject to the medical review process. To use the consultation codes, two guidelines apply:

The written or verbal request for a consultation may be made by a physician or other appropriate source and documented in the patient’s medical record. This must include the specific reason for the consultation.

The consultation service must be advice or opinion and the consultant’s findings must be documented in the patient’s medical record. While diagnostic work-up or therapy may be ordered by the consultant, it must be documented in the record and included in the reports to the attending physician.

Documentation is the key component because beginning treatment is considered assuming responsibility for care of the patient. When a consultant assumes responsibility for the patient care (begins treating the patient, schedules follow-up care, etc.) the subsequent services are not consults and must be coded as subsequent hospital visits. Any additional consultation visits must be requested by the attending physician and correctly documented to be coded as additional consults.

A. BCBSKS will follow CPT guidelines for initial consultations.

B. BCBSKS will follow CPT guidelines for follow-up consultations.

C. ADDITIONAL CONSULTATION POLICIES

1. One inpatient consultation may be allowed subject to medical necessity concurrence.
2. Additional consultations for multiple diagnoses may be allowed subject to medical necessity concurrence if the physicians are consulting within their defined specialties.
3. Any follow-up visits by a consultant while the attending physician still serves the patient are considered to be concurrent care and should be billed as such (see Concurrent Professional Care, Policy Memo No. 6).
4. A consultation preceding surgery within the usual preoperative timing would be considered within the surgeon's subsequent fee for the surgery, except in the case of a major classified procedure. Providers agree to accept the review process determination in such cases, subject to the rights to appeal and arbitration.

D. If a physician service is routinely provided to hospice patients, it is not separately billable.

2024 Policy Memo 6

Concurrent Professional Care

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Concurrent care takes place when two or more providers render medical and/or surgical services to the same patient on the same day. 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 not 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 medical records, upon request.

I. Instances When Concurrent Care Policy Applies

Two or more providers rendering medical (non-surgical) services to the same patient on the same day.

Two or more providers rendering any combination of surgical and/or medical services to the same patient on the same day.

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

II. Instances Where Concurrent Care Policy Does Not Apply

(The services below may be separately charged in all cases, whether surgical or non-surgical.)

A. Radiology services

B. Pathology services

C. Diagnostic endoscopies

D. Single consultation (one per hospital confinement)

E. Assistant surgery (when medically necessary)

F. Administration of anesthesia, other than topical anesthesia

G. Same provider specialties, different diagnosis

H. Same diagnosis, different provider specialties

III. Reporting of Concurrent Care on Claims

Diagnoses or conditions requiring concurrent care should be specified and explained to include documentation of medical necessity.

2024 Policy Memo 7

Radiology and Pathology/Laboratory Services

BlueCross BlueShield Kansas

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Please note: any timeframe listed in days, refers to calendar days unless otherwise specified.

I. Diagnostic Radiology Policy

A. WHEN BOTH PROFESSIONAL (PC) AND TECHNICAL (TC) COMPONENTS ARE INCLUDED IN THE CHARGE

The provider's usual fee is considered to include cost of materials and technical operating costs associated with securing the x-ray as well as the fee for interpreting and providing a professional opinion based upon an examination of films which constitute an x-ray study.

1. Definition of "Study"
   An x-ray is considered to be the examination of an area of the body as defined by codes and nomenclature. The number of individual x-ray films examined is not considered to affect the fee except as defined in codes and nomenclature.
2. Additional Studies
   Additional studies provided on different dates are considered to be eligible for additional usual fees. Coverage of services may vary in programs, but non-covered x-rays are the obligation of the patient. The only exception would be where a review consultant did not concur with the medical necessity for the x-ray study.
3. Multiple CT, CTA, MRI, MRA and PET Procedures
   a. When multiple CT, CTA, MRI, MRA or PET procedures are performed on the same day and billed as a total component, payment will be made at 100 percent of the primary procedure and 50 percent for each subsequent procedure(s).
   Providers may bill PC and TC components separately for CT, CTA, MRI, MRA or PET services performed on the same day. Payment will be made at 100 percent of the primary and 50 percent for each subsequent procedure(s) for TC services and 100 percent for all PC services. PC and TC services must be billed on separate lines with the appropriate modifier(s).
   b. NOTE: When radiology procedures are performed on a hospital inpatient, the technical component must be billed by the hospital. The physician may charge for the professional component only. When radiology procedures are performed on a hospital outpatient, the rendering provider may charge both professional and technical components only in such cases where the facility makes no charge to BCBSKS, related to the technical component. In those cases where the institution makes a charge, the provider may bill professional component only, and bill using modifier 26.
   c. If performed by different providers in an office setting, the services (PC/TC) may be billed separately as two lines of service as long as all providers are contracting with BCBSKS. If one provider is not contracting, you are required to bill both PC and TC.

B. WHEN THE PROFESSIONAL COMPONENT ONLY IS CHARGED

The provider's usual professional fee is expected to represent the charge for professional examination and opinion of x-ray films taken at the expense of a facility or institution when the patient is hospitalized as an inpatient/outpatient. The content of professional services within the fee for the study would be subject to the same definition and nomenclature qualifications as explained under “Definition of Study.” (above)

C. THE USUAL FEE FOR INTERPRETATION OF AN X-RAY DOES NOT INCLUDE

1. Fees for surgical injection or introduction procedures performed before or during the x-ray examination unless specifically defined by codes and nomenclature as included in the

overall service.
When interventional radiology procedures are involved, the professional component may also include injection of contrast media or other surgical intervention.

2. Fees for the administration of anesthesia (other than local infiltration) necessary for performance of special diagnostic x-ray procedures.
3. Fees for an office call which might include treatment of patient either immediately before or following the interpretation of a diagnostic x-ray.

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
- Date and time procedure was performed
- Name of interpreting physician
- Date and time interpretation was performed
- Body of the report, including
  - Procedures and materials
  - Findings
  - Limitations
  - Complications
  - Clinical issues
  - Comparisons, when indicated and available
  - Clinical impression and diagnosis, including differential diagnosis when appropriate
- Legible signature. Refer to Policy Memo 1, XI, 4 for specific signature requirements.

Records containing only documentation of diagnostic impressions, such as "Chest x-ray normal," "Chest x-ray shows CHF," and even more cryptic notations such as "CXR reviewed," are insufficient to support payment and must not be billed as a separately reported diagnostic imaging or interpretation.

II. Therapeutic Radiology Policy

A. WHEN BOTH PROFESSIONAL AND TECHNICAL COMPONENTS ARE INCLUDED IN THE CHARGE
The provider's usual fee is considered to include the cost of materials and technical operation costs as well as the professional fee for the administration of x-ray and other high energy modalities to include the concomitant office visits and follow-up treatment for 90 days for malignant conditions or 45 days for non-malignant conditions.

B. WHEN THE PROFESSIONAL COMPONENT ONLY IS CHARGED
The provider's usual fee is considered to represent the charge for the administration of radiotherapy provided at the expense of a facility or institution, and follow-up care as outlined

under "When Both Professional and Technical Components Are Included in the Charge." (See II. A. above.)

C. USUAL FEE FOR THERAPEUTIC RADIOLOGY DOES NOT INCLUDE
1. Consultations on need for radiotherapy.
2. Treatment planning.
3. Concomitant surgical, diagnostic radiological or laboratory services.

III. Pathology

A. PATHOLOGY

All anatomic laboratory and cytopathology examinations including gynecological specimens (i.e., Pap tests) must be billed by the entity that performs the entire exam, or a portion of the exam, with the following exception:

> When pathology procedures are performed on a hospital outpatient, the provider may charge both professional and technical components only in such cases where the facility makes no charge to BCBSKS related to the technical component. In those cases where the institution makes a charge to BCBSKS for the technical component, the provider should bill the professional component only, using modifier 26.

B. CLINICAL LABORATORY PANEL CODING

When automatable tests are performed on the same day, they may be billed using the appropriate panel or individually. BCBSKS will lump some automatable procedures specified in CPT panels and reimbursement will be limited to the appropriate panel MAP. When an all-inclusive code exists for commonly available clinical tests, the all-inclusive code must be used. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

NOTE: See Obstetrical Services, Policy Memo No. 8, regarding OB laboratory services.

C. THE ANATOMIC OR CLINICAL LABORATORY PROVIDER'S USUAL GLOBAL FEE IS GENERALLY CONSIDERED TO INCLUDE THE FOLLOWING

Cost of equipment and supplies used in performing a test or examination, as well as the performance of the test and the professional evaluation and report. A contracting BCBSKS provider may bill for a venipuncture when the specimen(s) is drawn.

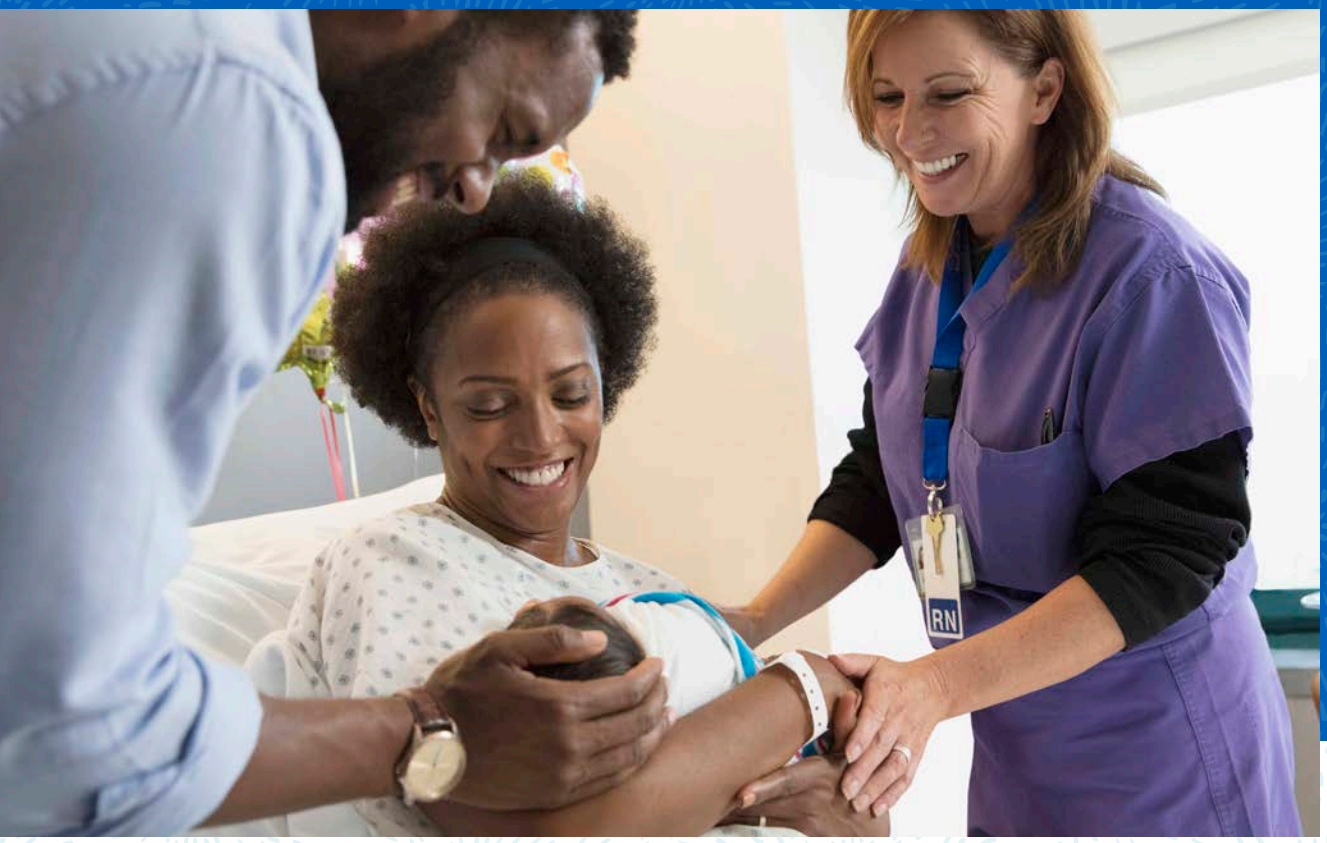
The usual fee is not considered to include an office call on the same date of the pathology or clinical laboratory service.

D. HANDLING FEE

To compensate for the cost of materials and services provided when specimens are sent to an outside laboratory, the provider may charge one handling fee per patient per date of service in those cases where he/she does not charge for the test itself. The handling fee must be billed with modifier 22. If the provider bills for the laboratory test, the handling fee is considered content of service of the laboratory charge.

2024 Policy Memo 8

Obstetrical Services



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Please note: any timeframe listed in days, refers to calendar days unless otherwise specified.

The Obstetrical (OB) Services policy is essentially broken into two sections, normal (non-surgical) OB delivery and surgical OB delivery. Policies governing the content of services for which usual fees are made and qualifications for individual consideration are broken into these two broad categories as follows:

I. OB Services — Non-Surgical Content of Service

A. **Total OB care** includes normal antepartum care, delivery (with or without low forceps and/or episiotomy), local anesthesia, and normal postpartum care.

B. **Antepartum care** includes office visits, routine urinalyses, fetal heart tone monitoring, non-stress testing, stress testing and internal fetal monitoring. (See Section IV. A.)

C. **Delivery only** includes delivery (with or without low forceps and/or episiotomy) and normal postpartum care.

D. **Postpartum care** includes hospital care and office visits following delivery.
In cases where the delivering physician provides antepartum care and postpartum care in addition to the delivery, total OB care is to be billed as an all-inclusive charge under the appropriate code.

II. OB Services — Surgical Content of Service

A. **Surgical delivery care** includes preoperative care from the admission of the patient to the time of surgical delivery, the surgical delivery itself, and postoperative and postpartum care from the time of surgical delivery through the period of usual hospitalization and customary post-hospitalization ending with the final postpartum examination.

B. In cases where the delivering physician provides antepartum care and postpartum care in addition to the surgical delivery, total OB care is to be billed as an all-inclusive charge under the appropriate code. However, if a patient has been insured by Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) for less than 240 days, you must bill (using appropriate codes) for those services provided after their effective date of coverage with BCBSKS. The previous insurance carrier (or the patient, if no coverage) would be responsible for services received before the BCBSKS effective date.

C. In cases where different physicians provide the antepartum care and surgical delivery, it will be assumed that the physician performing the delivery provided the post-delivery care. If this is not the case, this should be indicated by using the correct obstetrical CPT code(s).

III. Services Qualifying for Additional Fees

A. OB LABORATORY SERVICES
The usual fee for antepartum care does not include laboratory tests other than urinalyses. Please see Policy Memo No. 7, Radiology and Pathology, Section III. B., Clinical Laboratory Panel Coding.
Specific tests for complicated or unusual prenatal problems may be allowed on the basis of individual consideration and must be documented as to medical necessity.

B. OB ANESTHESIA
See Anesthesia Policy Memo No. 12 for more specific information. Local anesthesia is included in the delivery charge.

C. IN-HOSPITAL TREATMENT OF COMPLICATIONS
When hospitalization is required for severe complications during either the antepartum or

postpartum period, in-hospital medical care fees may be made for the management of the condition. Payment will be subject to medical necessity review of medical records provided to support the additional care and direct attendance.

D. UNUSUAL FULL-TERM FEES
Higher than usual professional charges will be considered by consultant review if unusual complications, including threatened miscarriage, occur during the prenatal period, the delivery itself, or during the postnatal period. Approval of such unusual charges is subject to substantiation of medical necessity and the concurrence of the consultant. The contracting provider agrees to accept the consultant's determination in any unusual fee case.

E. MULTIPLE DELIVERIES
When multiple births are involved, an additional 25 percent of the maximum allowable payment for the delivery performed will be allowed for each additional child.

IV. Additional Policy Clarification

A. Non-stress testing and internal fetal monitoring are considered content of service for the regular attending provider, unless for medically necessary conditions subject to concurrence of the review process determination (unusual conditions must be supported by medical records).

B. Stress testing is subject to substantiation of medical necessity and the concurrence of the review process determination.

C. When outpatient emergency or observation obstetrical care is provided by the patient's regular attending obstetrician, such care is considered to be within the usual and customary fee for total obstetrical care or for antepartum care. However, when emergency care is provided by a physician other than the regular attending obstetrician, the service is eligible for a separate fee.

V. Additional Obstetrical Procedures

A. MISCARRIAGE OR SPONTANEOUS ABORTION
If a D & C is involved, surgical policy governs. If only medical care is involved, in-hospital medical care policy governs.

B. THERAPEUTIC ABORTION AUTHORIZED BY LAW
Surgical policy governs. The usual fee is considered to include the initial examination, office visits up to hospital admission, all standard tests and evaluations, the surgical procedure and final checkup after hospital dismissal.

C. D & C FOR POSTPARTUM BLEEDING
Subject to individual consideration with the surgical policy governing.

D. LABOR MANAGEMENT FEE
Physicians are eligible for a separate labor management fee when the outcome of a pregnancy results in an emergency cesarean section that is performed by another physician. The physician who provided the antepartum and labor care may bill a separate labor management fee.

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Surgery

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Please note: any timeframe listed in days, refers to calendar days unless otherwise specified.

I. Global Fee Concept

The concept of a global fee for a surgical procedure is a concept under which a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during and after the procedure. Payment may be affected when someone other than the surgeon provides follow-up care as outlined in this policy memo.

To determine the global period for major procedures, count one day immediately before the day of the procedure, the day of the procedure and 42 days immediately following the day of the procedure.

To determine the global period for minor procedures, count the day of the procedure and ten days immediately following the day of the procedure.

To determine the global period for zero day procedures, count the day of the procedure only.

Complete Major and Minor and Zero Day Procedure listings can be found under Medicare listings: http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx.

The global maximum allowable payment (MAP) for a surgical procedure includes all services listed in Section A below related to that procedure. These services will not be separately reimbursed. The services included in the global surgical package may be furnished in any setting (e.g., hospitals, ASCs, physicians' offices). Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon.

A. COMPONENTS OF A GLOBAL SURGICAL PACKAGE

1. Preoperative Visits
   Preoperative visits begin one day before the day of the procedure for major procedures and the day of the procedure for minor and zero day procedures.
2. Intraoperative Services
   Intraoperative services (including intraoperative monitoring) are all usual and necessary aspects of a procedure.
3. Moderate (Conscious) Sedation
   CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
   Costs associated with the medically necessary moderate sedation performed in a separately billing facility are part of the all-inclusive facility MAP and are not reimbursed separately to the surgeon.
   Documentation must support the necessity of the anesthesia service and care provided. Blue Cross and Blue Shield of Kansas (BCBSKS) will monitor the appropriate use of the guidelines.
4. Local Infiltration or Topical Application of Anesthesia
   No additional fee is acknowledged for these services or supplies. The procedures are considered content of service of the surgical or anesthetic procedure.
5. Complications Following Surgery
   All additional medical or surgical services required of the surgeon during the postoperative

period of the procedure because of complications which do not require additional trips to the operating room.

6. Postoperative Visits
   Follow-up visits during the postoperative period of the procedure that are related to recovery are 42 days for major and ten days for minor procedures. Postoperative visits may be billed for zero day procedures.
7. Post-surgical Pain Management
   By the surgeon.
8. Supplies
   Initial casting, splints, and materials used
9. Miscellaneous Services
   Items such as dressing changes, local anesthesia, incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, routine peripheral intravenous lines, and postoperative pain control are considered content of service of the global fee.
   Blue Cross and Blue Shield of Kansas, Inc., (BCBSKS) through its Place of Service Differential Program will recognize the additional cost of supplies, personnel and time for selected procedures done in the office setting. Such additional charges are to be included in the surgery fee and are not eligible for reimbursement if itemized separately. It is understood that the fee for these designated outpatient procedures may be higher than those for the same procedure performed on an inpatient basis.

B. MODERATE (CONSCIOUS) SEDATION
When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider, other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the rendering provider and will be denied as a provider write-off. (Dental providers please refer to Dental Policy Memo, Section XXXVI.)

C. SERVICES NOT INCLUDED IN THE GLOBAL SURGICAL PACKAGE
These services may be paid for separately. In some instances, the procedure code will need to be billed with the appropriate modifier.

1. For major surgeries, the initial consultation or evaluation of the problem by the surgeon to determine the need for the procedure, is allowed as separate from the global. To report, add modifier 57 to the evaluation and management (E/M) code.
2. New patient office or outpatient services (codes 99202-99205) will be allowed on the day of the procedures.
3. Visits unrelated to the diagnosis for which the procedure is performed, unless the visits occur because of complications of the procedure. To report, add modifier 24 or 25 for E/M, or modifier 79 for unrelated procedure or service and include additional supportive diagnoses.
4. Treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the procedure. To report, add modifier 24 or 25 for E/M, modifier

79 for surgery procedures and additional supportive diagnoses or modifier 22 for individual consideration (see Section VII).

5. Diagnostic tests and procedures, including diagnostic radiological procedures.
6. Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Payment for laser eye surgery; e.g., code 67141 states that the code represents one or more sessions of a procedure. BCBSKS will pay for that service only once during the established period.
7. Modifier 78 is used to identify a separate but related procedure being rendered during a postoperative period of another procedure. When appending modifier "78", the original postoperative period ends and a new postoperative period begins, (e.g., major surgery is performed, on day 35 a second related procedure is performed).
8. BCBSKS will deny payment if one of the modifiers (22, 24, 25, 78) is not billed with a service furnished during a global period. These modifiers were established to facilitate physician billing and processing of services that are not included in the global package.
9. When a service performed is considered a lesser service and billed with a modifier 52, reimbursement may be reduced to an allowance reflective of the service performed.

II. Physicians Who Furnish Entire Global Package

Physicians who perform the procedure and furnish all of the usual pre and postoperative work bill for the global package by entering the appropriate American Medical Association Current Procedural Terminology (CPT) code for the procedure only.

III. Physicians in Group Practice

The following requirements are necessary to permit the BCBSKS payment policy to support the group practice's accounting arrangements.

A. PHYSICIANS RE-ASSIGNING BENEFITS TO THE GROUP
When different physicians in a group practice participate in the care of the patient, the group must bill for the entire global package. The physician who performed the procedure is shown as the performing physician.

B. PHYSICIANS NOT RE-ASSIGNING BENEFITS TO THE GROUP
When different physicians furnish the entire postoperative care, the group must bill for the surgical care and the postoperative care as separate line items with the appropriate modifiers.

IV. Providers Furnishing Less Than the Full Global Package

A. Except for physicians in group practice, there may be occasions when more than one physician provides services included in the global package. The physician who performs the procedure may not furnish the follow-up care. Payment for the postoperative, post-discharge care shall be split evenly between two or more physicians in those instances in which those physicians agree on transfer of care.
When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have

been paid if a single physician provides all services. Where physicians agree on the transfer of care during the global period, the appropriate modifier should be reported with the corresponding surgical code.

1. 54 for surgery only
2. 55 for postoperative management only
3. 56 for preoperative management only

B. EXCEPTIONS

1. When a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate E/M code. The services of a physician other than the surgeon may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.
2. In some instances, the itinerant surgeon and the physician providing pre and/or postoperative care may make different arrangements than indicated in Section IV. A. above. In such cases, only the itinerant surgeon would submit one global fee for the services to BCBSKS. The other physician would look to the itinerant surgeon for payment of the pre and/or postoperative services. This would allow them to divide the global fee differently than the Medicare percentages, which will normally be used by BCBSKS.

V. Date(s) of Service

A. Physicians who bill for the entire global package must enter the date on which the procedure was performed in the "from date of service" field. This will enable us to relate all appropriate billings to the correct surgery.

B. Physicians who share the out-of-hospital postoperative management with another physician are to submit the date on which the procedure was performed in the “from date of service” field. The date assumed/relinquished care along with the actual number of postoperative days being managed should be in box 19 or the equivalent electronic field.

C. If the physician who performed the procedure relinquishes care during the post-operative period, he or she need only report the date of the procedure in the “from” field on the claim.

VI. Reimbursement

BCBSKS will pay each physician direct for the portion of the global surgery services furnished to the insured. Generally the surgeon furnishes the usual and necessary pre and intraoperative services, and also, with a few exceptions, in-hospital postoperative services. In most cases, the surgeon also furnishes the postoperative office services necessary to assure normal recovery from the procedure. Recognizing that there are cases when the surgeon turns over the out-of-hospital recovery care to another physician, percentages have been determined for families of procedures for paying usual out-of-hospital postoperative care if furnished by someone other than the surgeon.

VII. Unusual Circumstances

Surgeries for which the services performed are significantly greater than usually required may be billed with the modifier 22 added to the CPT code for the procedure. Please provide:

A. A concise statement about how the service differs from the usual, and

B. An operative report or any other medical record documentation necessary to explain or describe the patient's condition with the claim.

VIII. Discharge Procedures by Someone Other Than the Surgeon

When a physician other than the surgeon performs discharge procedures at the request of the surgeon, these services are considered content to the global fee, and no additional payment will be made. BCBSKS will assume that discharge services are related to the procedure.

IX. Additional Policy Clarification

Up to 20 percent of the initial surgeon's fee may be allowed for postoperative bleeding for cardiac pulmonary bypasses and after use of the heart/lung machine. Other surgical postoperative complications may be eligible subject to individual consideration.

IMPORTANT NOTE: Other policies exist with respect to specific surgical situations. Providers specializing in surgery should check with the BCBSKS professional field representative whenever detailed questions arise.

X. Adverse Events

The BCBSKS list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBSKS shall pay for the medical errors.

Adverse events A, B, and C are not billable to BCBSKS.

A. SURGERY PERFORMED ON THE WRONG BODY PART

B. SURGERY PERFORMED ON THE WRONG PATIENT

C. WRONG SURGICAL PROCEDURE ON A PATIENT

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT
In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object, then no payment for the correcting surgery will be made and the patient will be held harmless.
2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.

2024 Policy Memo 10

Assistant Surgery

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Assistant surgery is considered to be only those services provided at the operating table by the surgical assistant. Being available to assist does not constitute assistant surgery (see important note below regarding non-physician assistant surgeons).

I. Medical Necessity Guidelines

A. Assistant surgery is covered by Blue Cross and Blue Shield of Kansas, Inc., (BCBSKS) if it is customarily required in conjunction with the surgical procedure because of medical necessity, and if it would customarily be billed to the patient regardless of their method of payment.

B. The use of more than one assistant surgeon is subject to individual consideration and covered only upon substantiation of medical necessity. Contracting providers agree to accept the review process determination in such cases.

II. Reimbursement

Assistant surgery reimbursement is based on a percentage of the surgical maximum.

III. Preoperative and Postoperative Care

With respect to assistant surgeons who provide pre- and postoperative care when the operating surgeon is in the "traveling" (itinerant) category, preoperative and postoperative care may be allowed in addition to assistant surgery if this is explained in the submission of claims. In these instances, preoperative and postoperative services should be itemized separately from the assistant surgery fee. In some cases, the itinerant surgeon will make their own arrangements for pre and postoperative care. In those cases, the physician should look to the surgeon for payment.

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 reimbursed is found online at https://www.bcbsks.com/CustomerService/Providers/Publications/professional/manuals/pdf/assistant_surgery.pdf.

2024 Policy Memo 11

Multiple Surgical Procedures

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This policy applies when more than one surgical (open, scope, or other) procedure is performed by one or more providers on the same patient on the same date. Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) requires providers to report procedures according to American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS) guidelines. However, the proper submission of codes and/or modifiers according to CPT and/or HCPCS 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.

I. Multiple Surgical Procedures when Performed by One Provider

The policy, in respect to multiple surgical procedures performed by the same provider, is based upon the premise that usual charges for multiple procedures will normally not equal the sum of the charges for each procedure, if these were done independently. This is because there would be a common episode of preparation and follow-up. BCBSKS follows the Relative Value Units (RVU) as published in the Federal Register for multiple surgical reductions (MSR) rules. BCBSKS will allow the lesser of (a) the provider's billed charge or (b) 100 percent of the usual maximum allowable payment (MAP) for the surgical procedure with the highest RVU. For other procedures performed at the same setting, BCBSKS will allow the lesser of (a) the provider's billed charge or (b) 50 percent of the usual MAP except as otherwise specified in this policy.

Services or procedures that BCBSKS considers to be an integral part of previous or concomitant services or procedures are not recognized for separate reimbursement. Examples would include two or more surgical procedures that involve multiple compartments or sections of the same anatomic area (including but not limited to joints, sinuses, and abdominal, chest, pelvic, and cranial cavities). Exceptions to this policy are limited to those unusual circumstances involving significant additional time or other physician resources and shall be granted solely at the discretion of BCBSKS. Procedures that accomplish the same result are also considered content of service. If two procedures accomplish the same result, but it is unlikely that it would be clinically appropriate for both to be performed at the same time, the more intense procedure will be reimbursed.

II. Endoscopies, Arthroscopies, and Other Scope Procedures

For two or more surgical scope procedures that involve multiple compartments or sections of the same anatomic area (including but not limited to joints, sinuses, and abdominal, chest, pelvic, and cranial cavities), only the procedure with the highest RVU will be reimbursed; other procedures shall be considered content of service. Exceptions based on unusual clinical intensity and/or use of physician resources are also available on a claim-by-claim basis; such claims will only be considered for additional reimbursement if modifier 22 and appropriate supporting records are submitted with the original claim.

- A diagnostic scope is incidental to another diagnostic scope or a surgical scope (including biopsy).
- A diagnostic scope “with” or “without” biopsy is incidental to an open surgical procedure in the same anatomical area.

- A diagnostic scope is incidental to a diagnostic scope with biopsy unless the verbiage distinguishes the procedure as “with biopsy” versus “without biopsy.”
- Incidental relationships are applied to endoscopic, arthroscopic, and other scope procedures based on the following:
    - complete versus partial
    - with versus without
    - extensive versus limited
- An endoscopic, arthroscopic, or other scope procedure and open surgical procedure in the same anatomic area will not both be reimbursed.
- If an open surgical procedure and an endoscopic, arthroscopic, or other scope procedure accomplish the same result, the clinically more intense procedure is recommended for reimbursement. The comparable procedure is found incidental.
- For some endoscopic, arthroscopic, or other scope procedure assisted, open surgical procedures performed on the same anatomic area during the same operative session, separate reimbursement will be allowed based on additional time, skill and physician resources.

III. Other Policy Provisions

A. A provider shall not charge for procedures to correct iatrogenic events resulting from medical or surgical treatment by that provider.

B. Certain procedures have individually established payment guidelines that do not follow this policy. Those procedures include the codes in which the code itself inherently describes multiple services or those recognized by BCBSKS as additive codes.

C. When multiple procedures are performed by more than one provider, see Policy Memo No. 6, Concurrent Professional Care.

2024 Policy Memo 12

Anesthesia

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I. Description

Anesthesia services consist of the administration of an agent in one of the following types of anesthesia:

A. General anesthesia – loss of ability to perceive pain associated with loss of consciousness produced by intravenous infusion of drugs or inhalation of anesthetic agents.
B. Deep sedation/analgesia – drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation.
C. Moderate sedation (conscious sedation) – drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.
D. Regional anesthesia – use of local anesthetic solutions to produce circumscribed areas of loss of sensation. This includes nerve blocks, spinal, epidural, and field blocks. Epidural anesthesia is produced by injection of local anesthetic solution into the peridural space.

NOTE – Anesthesia provided in an office setting is considered content of service and not reimbursed separately. The provider cannot require the patient to sign a waiver or bill the patient for this service.

II. Time of Administration

Anesthesia time begins with the initial administration of anesthetic agents by the anesthetist/anesthesiologist and ends when the anesthetist/anesthesiologist is no longer in personal attendance. The time of anesthesia administration and the CPT anesthesia codes are required on all claims to ensure proper payment.

III. Content of Services within Usual Anesthesia Fee

The usual professional charge for anesthesia includes the following services:

A. Preoperative or postoperative administration and monitoring of anesthetic or analgesia administration.
B. Administration of drugs, fluids, or blood incidental to the anesthesia.
C. Preoperative and postoperative monitoring and/or visits to the patient (including consultations).
D. Monitoring of sedation for cardiac catheterizations and PTCAs is done by the cardiologist and facility personnel. Therefore, separate reimbursement is not provided. If intraoperative monitoring is required and performed during a surgery, Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will content the service into the all-inclusive surgical MAP.
E. Local Infiltration or Topical Application of Anesthesia.

No additional fee is acknowledged for these services or supplies. The procedures are considered content of service of the surgical or anesthetic procedure.

IV. Surgical Procedures and Nerve Blocks Performed by the Same Anesthesia Provider

Surgical procedure(s) (e.g., arterial & CVP lines) billed with nerve blocks will be paid according to multiple procedure guidelines at full for the procedure with the greatest value and all others are paid at one half.

V. Method of Determining the Maximum Allowable Payment (MAP)

A. PROFESSIONAL ALLOWANCES

Professional allowances for general anesthesia are determined as follows:

1. Anesthesia base points of the CPT/American Society of Anesthesiologists (ASA) codes, plus
2. One point per each 15 minutes of 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.

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.

VI. Related Policies

A. UNUSUAL CASES

When the condition of the patient relative to the surgical procedure to be performed is such as to imply an unusual risk, consideration of an unusual fee may be provided. In such cases, it is necessary to use modifier 22 and send medical information that will substantiate the case and document direct attendance. It is acknowledged that unusual detention with the patient is eligible for additional time charges. Contracting providers agree to accept the review process determination in such cases.

B. REGIONAL ANESTHESIA

1. When administered by the surgeon or assistant surgeon, payment may be allowed. However, if an anesthesia provider monitors the patient following the regional block, the surgeon or assistant surgeon relinquishes the right to bill for the regional block.
2. A claim for epidural infusion for pain management will be subject to the review process before payment.
    a. If the epidural catheter is placed for the purpose of anesthesia and remains in place for postoperative pain management or local anesthetics, placement of the catheter will be considered content of service of the anesthesia.
    b. If the epidural catheter is placed solely for postoperative purposes (i.e., postoperative anesthetic or pain control), even if general anesthesia or other than epidural is performed, the catheter placement will be paid.
    c. Daily hospital management of epidural drug administration by an anesthesia provider may be paid when either options a. or b. apply. However, if the pain management is accomplished by the surgeon, the pain management is considered content of the service for the surgeon.
3. OB Epidural Guidelines
    a. Epidural placement should be billed separately and reimbursed under the appropriate placement CPT code. The time for the placement of the epidural should NOT be included in total time of the monitoring/delivery anesthesia.

b. Monitoring and delivery anesthesia will be reimbursed under the appropriate CPT neuraxial labor analgesia/anesthesia codes for vaginal and cesarean deliveries. BCBSKS will reimburse one unit for every hour of monitoring for vaginal deliveries and one unit for every 15 minutes for cesarean deliveries.
c. Anesthesia time should be reported as total minutes.
d. Anesthesia monitoring concludes at time of delivery for vaginal deliveries.
e. For cesarean deliveries, anesthesia monitoring concludes when patient is transferred to the post-anesthesia care unit/recovery room.

4. Nerve blocks administered on the same day as an anesthesia service will be paid at 50 percent and the anesthesia service paid in full.

C. MONITORED ANESTHESIA SERVICES

Monitoring of sedation by an anesthesia provider for CT scans, MRIs, cardiac catheterizations, and PTCAs is generally considered not medically necessary. BCBSKS will allow payment for inpatient or outpatient facility services when provided for other procedures when billed by an anesthesia provider capable of initiating general anesthesia should it be needed.

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.

D. MODERATE (CONSCIOUS) SEDATION

CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider**,** other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the rendering provider and will be denied as a provider write-off.

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.

E. MEDICAL DIRECTION

The medical direction or supervision of CRNAs is not a separately reimbursable service. BCBSKS will only reimburse one provider for an anesthesia procedure.

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