BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2025

Following is a summary of the changes to Blue Shield Policies and Procedures for 2025. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com by December 2024.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2024 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Policy Memo No. 1
SECTION I. Confidentiality

- **Page 4:** Added verbiage to cover complying with the gag clause prohibition.

  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.

  Nothing in this section shall be construed to limit the disclosure of confidential information to the extent required by law.

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

- **Page 9:** Updated verbiage for clarity regarding timeframe related to post-payment audits.

  If medical necessity is not supported by the medical record, BCBSKS will deny as not medically necessary. When BCBSKS requests medical records for an audit and no documentation is received within the 30 ~~business~~ day time limit, BCBSKS will deny for no documentation.

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 10:** Updated verbiage to reflect accurate examples of content of service.
    - 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.~~
    - 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.
    - Mileage (except for ambulance)

Policy Memo No. 1
SECTION XV. Claims Filing

- **Page 17:** Updated verbiage to add clarity on what information is needed to file a claim.

    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~~ the claim.

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

- **Page 19:** Updated verbiage to reflect current eligible providers.

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, or a 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.

Policy Memo No. 1
SECTION XXXIII. Acknowledgment of Independent Status of Plan

- **Page 25:** Updated verbiage to clarify BCBSKS jurisdiction.

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 Marks, and that the Plan is not contracting as the agent of the Association. BCBSKS serves an operating are of 103 counties in Kansas (all counties except Johnson and Wyandotte).

Policy Memo No. 1
SECTION XLII. Acknowledgment of Non-Discrimination Laws

- **Page 27:** Updated verbiage and section title to include equitable access along with non-discrimination laws.

Acknowledgement of Non-Discrimination Laws and Equitable Access Requirements

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.

Providers agree to ensure that all services are provided in a culturally competent manner to all enrollees and to promote equitable access to all enrollees, including but not limited to the following:

- People with limited English proficiency or reading skills.
- People of ethnic, cultural, racial, or religious minorities.
- People with disabilities.
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
- People living in rural areas and other areas with high levels of deprivation.
- People otherwise adversely affected by persistent poverty or inequality.

Policy Memo No. 2
SECTION II. Content of Service (See also Policy Memo No. 1)

- **Page 3:** Updated verbiage to reflect accurate examples of content of service and to match Policy Memo No. 1.
  - 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.
  - 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.~~
  - 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.
  - Mileage (except for ambulance)

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

Policy Memo No. 2
SECTION VII. Additional Policy Clarification

- **Page 5:** Removed inaccurate reference to Policy Memo No. 5.

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.)~~

Policy Memo No. 8
SECTION V. Additional Obstetrical Procedures

- **Page 4:** Removing reference of a labor management fee to reflect current billing practices.

~~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.~~

Policy Memo No. 12
SECTION II. Time of Administration

- **Page 3:** Updated verbiage to clarify on how anesthesia units should be billed.

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. Anesthesia units should reflect total minutes.