



Benefits and Exclusions

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INTRODUCTION

This section describes the common exclusions and benefits for many Blue Cross and Blue Shield of Kansas, Inc. contracts.

Groups purchasing medical coverage may tailor their coverage by adding or deleting benefits to meet the needs of their employees.

For specific information regarding a particular contract, contact the designated customer service center.

I. General Exclusions

General exclusions found in many Blue Cross and Blue Shield of Kansas contracts are (this list is not all inclusive):

- Benefits for which the insured would be eligible for payment under Workers' Compensation or other public laws.
- Services for plastic operations for cosmetic or beautifying purposes (limited coverage is available for cosmetic/reconstructive surgery for accidents, congenital abnormalities)
- Any charges for blood or donors.
- Charges for personal items such as television, radio, telephone, materials used in occupational therapy, or air conditioning provided on an optional basis by the hospital.
- Charges for admission of comfort kits for which a separate charge is made.
- Convalescent or custodial care or rest cures.
- The benefits of this contract are not available to the extent that the service has been covered under another Blue Cross and Blue Shield of Kansas contract or rider.
- Services not listed as benefits in the contract.
- Special appliances, such as hearing aids, dentures, eyeglasses, contact lenses, artificial eyes, artificial limbs, canes, crutches, wheelchairs, braces, and items of wearing apparel such as shoes or corsets.
- Benefits will not duplicate when provided under Federal, State or local laws, regulations or programs such as Medicare, TRICARE, services in any veterans facility when the service is covered by the government, etc.
- Services not medically necessary.
- Services determined not to be medically necessary through the hospitals utilization review (UR) process or in the absence of a UR process, by BCBSKS.
- Any drug, device or medical treatment or procedure and related services that is experimental or investigational.
- Drugs for take home use.
- Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.
- Services related to the reversal of sterilization.

- Health services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy.
- Services for disease or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion or aggression.
- Hospital, doctor or other health services when the patient is unnecessarily admitted to and/or retained in the hospital for services and evaluations that could satisfactorily be made on an outpatient basis. The services that would be covered as an outpatient will be covered.
- All services related to transplant procedures except those specifically set out as benefits in the member's contract.
- Charges for autopsies.
- Services and supplies related to sex changes, sexual misfunctions or inadequacies. All related complications are also excluded.
- Hospital admissions for the primary purpose of performing acupuncture and acupuncture services provided to bed-patients and outpatients.
- Refractive procedures including: radial keratotomies, corneal relaxation, keratophakia, keratomileusis or other procedure used to reshape the corneal curvature.
- Mass screening types of physicals or health examinations.
- Procedures and diagnostic test that are considered obsolete. Admissions and services primarily related to such procedures and diagnostic test are also excluded.
- Private duty nursing.
- In vitro fertilization, in vivo fertilization or any other medically aided insemination procedure.
- Any medical service, hospitalization, laboratory or X-ray service associated with dietary control, weight management, or weight reduction.
- Charges for services that are not listed as covered services.
- Charges for completion of insurance claim forms.
- Prescription drugs utilized primarily for stimulation of hair growth.
- Laboratory services performed by an independent laboratory that is not approved by Medicare.
- All services related to temporomandibular joint dysfunction syndrome, unless otherwise stated by the member's contract.
- Any service associated with or involving dental implants.
- Benefits for any service that Federal or State laws require be made available through a child's school district pursuant to an Individual Education Plan (IEP).

- Services not prescribed by a doctor or continued after the doctor has advised that further care is not necessary.
- Transportation other than covered ambulance.
- Automatic external defibrillators.
- Educational services unless otherwise specified in the contract (i.e. diabetic education).
- Any food item including breast milk and other nutritional products.
- Appetite suppressants.
- Room and board charges in a swingbed once the patient is no longer receiving acute care.
- Human growth hormone therapy except those situations specifically set out as eligible for benefits.
- Diagnostic tests and evaluations that are performed solely for the purpose of issues at dispute in the context of legal proceedings such as an issue of custody, visitation, severance of parental rights, or damages in any kind of personal injury action.
- Drugs used primarily for the treatment of obesity.
- Individual, custom fabricated shoe insert orthotic devices, appliances and those available over-the-counter foot devices.
- Services for disorders specified in the diagnostic and statistical manual of mental disorders which are not attributable to a mental disorder that are a focus of attention, e.g. marriage counseling.
- Any service or supply provided or obtained relative to an excluded service.
- Genetic Molecular Testing except when there are signs and/or symptoms of an inherited disease in the affected individual and other pre-testing requirements are met.
- Augmentative Communication Devices designed and used for enhancing or enabling communications, except for an artificial larynx.
- Medical care delivered via email or any other electronic means.

Exclusions also include:

- Consultations required by hospital rules and regulations are excluded from coverage
- Chelation therapy except for patients with certain types of heavy metal poisoning
- Laetrile and related services
- Immuno-therapy

- Charges for nursing baby while mother is hospitalized for other than maternity care
- Autologous/autogenous blood charges if not provided in connection with a scheduled covered surgical procedure.
- Garren gastric bubble and all related charges
- Electromagnetic treatment for bone repair if considered ineligible by Blue Shield (there are very specific guidelines to determine eligibility by Blue Shield).
- Codependency or charges made to family members of a substance abuser are ineligible unless they are admitted with their own substance abuse diagnosis (subject to medical necessity)

II. Inpatient Services

The following ancillary services are contractually covered by most contracts during an eligible hospital stay (this list is not all-inclusive):

- Room accommodation, dietary, and general nursing services
- Intensive care service (medically necessary)
- Operating room service
- Delivery room service (unless excluded by the contract)
- Surgical preparatory room service and anesthesia recovery room service
- Clinical laboratory and pathological examinations (Autopsies are excluded)
- Surgical dressing, splints, and casts. Excluded are special appliances
- Setups and intravenous solutions
- Setups for blood transfusions, including blood plasma but excluding blood and payments to donors of blood
- Oxygen and use of equipment for its administration
- Electrocardiograms (EKG's), electroencephalograms (EEG's)
- Hemodialysis, excluding kidney transplants and hemodialysis care covered by Medicare
- Diagnostic radiology and radiation therapy
- Anesthesia
- Radioactive isotopes
- Inhalation therapy
- Physical or Occupational therapy

Note: Rehabilitation services are covered only if they are expected to result in significant improvement in the member's

condition. There is no coverage for vocational rehabilitation or therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or re-injury.

- Cardiac or Pulmonary Rehabilitation (by BCBSKS approved program – a global program charge is not separately billable on an inpatient claim. Individual covered services such as physical therapy or diagnostic testing could be billed.)
- Drugs approved for use in the United States by the Federal Food and Drug Administration, except drugs approved for experimental use and drugs for take-home use.
- Chemotherapy, other than high-dose chemotherapy, for malignant conditions. NOTE: High-dose chemotherapy with hemotopietic support may be covered if determined through precertificaiton.
- Prostheses that require surgical insertion into the body and furnished by a hospital. This does not include artificial eyes, ears and limbs.

Charges (with revenue codes) for all services provided to an inpatient of your facility must be included on your inpatient institutional claim with the exception of ambulance charges. Examples of such charges are CT scans at another hospital, surgically inserted prosthetic devices and charges for the technical components of all services performed outside the hospital. This limitation does not include the professional component of diagnostic services such as pathology, radiology or cardiology. The professional component would be billed on the CMS-1500 claim form.

ADMISSION OR COMFORT KITS

Benefits provided for the room charge are intended to cover the room accommodation, general dietary services, general nursing services, and patient room supplies routinely furnished to all inpatients including admission or comfort kits. Admission or comfort kits for which a separate charge is made **are not** covered.

OUTPATIENT BUNDLING RULE

The information in this section **does not** apply to psychiatric, rehabilitation or specialty hospitals.

Charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the following day are considered to be

included in the DRG and CAH allowance for the inpatient stay and must be billed to BCBSKS as part of the inpatient claim. This applies only to outpatient services performed at the same facility where the patient is subsequently admitted.

To prevent claim overpayments, BCBSKS implemented the following claim processing guidelines:

Claims From Contracting Providers

When an outpatient claim is paid and BCBSKS receives an inpatient claim with service dates that indicate the outpatient bundling rule applies, we will return the inpatient claim to the provider indicating that the outpatient charges need to be added to the inpatient claim and to resubmit the inpatient claim. At the same time we will adjust the outpatient claim and either do an automatic deduct or refund request (depending on the hospital) to recoup the payment on the outpatient claim.

When an inpatient claim is paid and BCBSKS receives an outpatient claim with service dates that indicate the outpatient bundling rule applies, we will return the outpatient claim indicating that the charges should be added to the inpatient claim and a "corrected" inpatient claim should be submitted.

III. Inpatient Days

The number of inpatient days available depends on the contract the individual member has with BCBSKS.

A. Medical Days

The group may select to limit inpatient medical days to a specific number such as 120 days per benefit period or may offer unlimited medical days up to the lifetime dollar contract maximum (i.e., \$1,000,000).

B. Mental Health Days (including chemical dependency)

Due to mental health parity laws, inpatient admissions for the treatment of psychiatric conditions (including alcohol and drug addiction) are covered the same as any medical admission

Court ordered admissions/services are considered eligible subject to the member's contract limitations, including medical necessity. The court order does not negate the prior authorization requirement or the need to coordinate the care through our mental health vendor.

C. Room Coverage

Most Blue Cross and Blue Shield of Kansas contracts provide for full semi-private room coverage. If the member is confined in a semi-private room, he is entitled to the full charge for room accommodations, general dietary services, and general nursing services.

Type of Room

Semi-Private

Benefits

Most contracts provide for full coverage in semi-private room (two or more beds).

Private

Most contracts provide for a daily allowance equal to the hospital's average semi-private rate (average charge for rooms with two or more beds).

Note: Some groups may cover private room charges in full.

Intensive Care or Cardiac Care

Most contracts provide for full coverage if the unit is an approved ICU/CCU and it is medically necessary that the patient be in this type of room

Isolation Room

Most contracts provide for a daily allowance equal to the hospital's average semi-private room rate.

Nursery

Most contracts provide for full coverage for the nursery room charges under a family contract

- No payment will be made for room charges for patients on leave from the facility and not occupying the bed overnight unless approved by the Utilization Review Committee for therapeutic value.
- Room rates will be reimbursed according to the rates in effect at the time of the patient's discharge.
- In computing the number of inpatient days, BCBSKS counts the date of admission but not the day of discharge. The date of discharge is the calendar date on which the patient leaves the facility
- When patients are transferred from one unit of the hospital to another, BCBSKS will not reimburse for multiple room and board charges for the same date of service.
- BCBSKS provides for the payment of charges for a late discharge when the physician is late in dismissing the patient or when some other circumstance beyond the control of the patient exists. No benefits will be provided if charges are the result of a convenience factor for the patient.
- Room rates must be registered when there is a change in the number of beds or the rates change. Providers should use the online Room Rate Registration form available at the BCBSKS Web site http://www.bcbsks.com/providers/ps_forms.htm
- If the facility has only private beds, this becomes the average semi-private room rate and no patient responsibility will be applied.

D. ICU/CCU Requirements

In order to qualify for payment of intensive/critical care or coronary care units a hospital must meet the minimum essential requirements as outlined in the following requirements document:

BLUE CROSS AND BLUE SHIELD OF KANSAS
MINIMUM ESSENTIAL REQUIREMENTS FOR
APPROVED INTENSIVE/CRITICAL OR CORONARY CARE UNITS

The following criteria represents the minimum essential requirements of an intensive/critical and/or coronary care unit enabling a hospital to receive full payments for the Blue Cross patients requiring such care.

I. PHYSICAL ARRANGEMENT

The unit must be a multi-bed unit and must be distinctly identifiable as a separate unit. This does not preclude individual rooms within the defined unit.

II. STAFFING

The ICU/CCU must have its own separate nursing staff headed by a qualified R.N. The unit must be staffed by qualified personnel on a 24-hour basis while the unit is occupied. "Qualified" is defined to mean those personnel who have received specialized training in intensive or coronary care nursing.

III. EQUIPMENT

It is expected that the unit will be fully equipped to carry out all necessary intensive or coronary care functions. Specific equipment will be that deemed necessary and appropriate by the hospital's Intensive/Coronary Care Committee.

IV. LIST OF PERSONNEL AND EQUIPMENT RECOMMENDED FOR INTENSIVE CARE UNITS

A. NURSING

Number of clerks per 24 hours
Number of L.P.N.s per 24 hours
Number of Nurse Assistants per 24 hours
Number of R.N.s per 24 hours

B. EQUIPMENT AND SUPPLIES

Alternating Pressure Mattress
At least one of each sterile trays found in Central Supply plus
"clean" trays for certain types of nursing procedures
Cardiac Arrest Tray

- Cardiac Monitor
- Cardiac Pacemaker
- EKG Machine
- Emergency Drugs
- Endo-tracheal Tray
- External Cardiac Defibrillator
- Intermittent Positive Pressure Breathing Apparatus
- IV Cut-Down Tray
- IV Solutions
- Lumbar Puncture Tray
- Piped Oxygen
- Piped Suction
- Tracheotomy Trays
- Ventilation Monitors

C. MISCELLANEOUS

- Cardiac Rooms
- Cubicle Curtains
- Emergency Call System and Telephone
- Multi-Bed Unit

I HEREBY CERTIFY THAT OUR FACILITY IS IN COMPLIANCE WITH THE MINIMUM ESSENTIAL REQUIREMENTS FOR APPROVED INTENSIVE/CRITICAL OR CORONARY CARE UNITS. BLUE CROSS AND BLUE SHIELD OF KANSAS WILL BE NOTIFIED OF ANY CHANGES WHICH COULD AFFECT THE ELIGIBILITY.

Name of Hospital

Signature

Date

Provider has an intensive/critical care unit.

Current Rate: _____

Provider has a coronary care unit.

Current Rate: _____

E. Member In the Hospital or Medical Care Facility on Benefit Date
BCBSKS becomes liable in fully-insured and ASO cases as of the effective date of the member's coverage even though a hospitalization is in progress on the effective date of the new coverage.

Providers should bill for all services related to that admission and submit the claim hardcopy with an itemization of services.

IV. Transplants

Most contracts provide benefits for the following transplants:

- Heart
- Heart-Lung
- Lung (whole or lobar, single or double)
- Liver
- Kidney
- Cornea
- Pancreas
- Small Intestine
- Multivisceral (i.e. kidney/pacreas)
- Bone marrow

Bone marrow (high-dose chemotherapy with hematopoietic support) will only be considered when the condition for which the treatment is being proposed is not considered experimental or investigational. Costs associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available may be covered but limited to \$35,000 per member, per transplant.

The recipient and/or his doctor **MUST ALWAYS** receive advance authorization before benefits are available for a transplant. Cornea and kidney transplants are covered without pre-authorization.

There are very definite guidelines that **must** be adhered to regarding pre-authorization transplant procedures.

All questions regarding this pre-authorization procedure should be directed to the BCBSKS customer service center.

There is no coverage for any transplant not specifically listed as covered in the member contract or for the supplies or services provided directly for or relative to human organ transplants not specifically listed as covered.

No benefits will be provided for multiple organ transplant combinations that are not listed as eligible even when one or more of the organs involved is listed as a covered transplant.

As stipulated in the member's contract, BCBSKS has the right to require, request and obtain any information necessary to make a coverage determination. BCBSKS also reserves the right to limit its allowance to the lowest allowable amount, including organ or tissue acquisition cost, which would be accepted by a contracting facility.

V. Outpatient Services

Under most BCBSKS member contracts, if a service is listed as covered for inpatient care, it's considered covered for outpatient as well.

Coverage criteria or reimbursement guidelines for some outpatient services are:

A. OUTPATIENT SURGERY – HOSPITALS ONLY

- When a single surgical service has a maximum allowable payment (MAP), the services will be paid based upon the MAP of the applicable CPT-4 code.
- When multiple or bilateral surgical procedures are performed and a MAP has been set, payment will be based upon the CPT-4 code with highest MAP.
- When a surgical service that has been assigned a MAP is performed at the same time as another surgical service that has not been assigned a MAP, payment will be based upon the MAP'd service.
- All services provided during a surgical encounter must be billed on the same claim.

B. REFERENCE SERVICES – Hospitals only

Outpatient laboratory services are reimbursed at the laboratory fee schedule when the services are NOT provided as a result of an emergency room encounter or outpatient observation. If the claim includes either revenue code 045X or 0762, then the laboratory service is not paid according to the laboratory fee schedule.

C. OBSERVATION – Hospitals only

Reimbursement is available for outpatient observation when a patient's condition is such that it might be dangerous to send him/her home, although the need for admission is not yet clear.

Outpatient observation is reimbursable only under the following conditions:

- a. Observation must be physician ordered;
- b. Medical necessity for the observation must exist;
- c. The observation must be on an unscheduled basis;
- d. There is no hourly limitation for outpatient observation; however, payment will be limited to 24 hours by allowing the hospital's average semi-private room rate or charges, whichever is less. Any amount over the average semi-private (AVSP) room rate will be a write-off to contracting hospitals;
- e. When an outpatient claim has multiple lines of observation (revenue code 0762) that span two different pricing periods, the MAP for the earliest date of service will be used.
- f. All outpatient services (including observation) provided to a patient who is admitted as an inpatient before midnight of the following day are considered to be included in the DRG for the inpatient stay and must be billed to BCBSKS as part of the inpatient claim. This applies only to outpatient services performed at the same facility where to patient is subsequently admitted;
- g. If the patient is not admitted as an inpatient following observation, the observation charge will be paid according to the member's contractual outpatient benefit.

Use revenue code 0762 with an observation CPT.

D. ACCIDENTAL INJURY

Services and supplies furnished in conjunction with the treatment of an accidental injury are covered subject to the benefits available under the individual member's contract. Some BCBSKS member contracts include a specific benefit that allows payment at 100% of the claim allowance for services related to an accidental injury.

DEFINITION:

An accidental injury is defined as bodily injury effected solely through external, violent and accidental means, including the accidental inhalation of smoke or carbon monoxide.

Accidental injury does NOT include:

- Disease or infection (unless it is a pus-producing infection that occurred from an accidental cut or wound;
- Hernia
- Injuries cause by biting or chewing.

BILLING:

Hospitals

When billing treatment for accidents, our claims processing system will look at four form locators on the claim to explain the date and nature of the accidental injury. In order for your claim to be processed quickly and efficiently, preferably all four form locators, listed below, will reflect accident information. **If the information provided does not meet the definition of an accidental injury or is insufficient**, the claim could be returned to you for additional information or medical benefits will be applied rather than the accidental injury benefits.

Form Locators **NECESSARY** for accidental injury claims:

1. Occurrence code and accident date on the UB-04/371 claim (form locator 31-34). [Click here](#) for list of accident occurrence codes.
2. E-code (form locator 72). [Click here](#) for more information regarding E-diagnosis codes.
3. Remarks field (form locator 80). [Click here](#) for more information regarding remarks.

4. An accident diagnosis code in the primary diagnosis field (form locator 66). *If the accident diagnosis is not in the primary position and you have the preceding three indicators, the claim will process under the member's accident benefit. [Click here](#) for a list of diagnosis codes BCBSKS considers accident.

NOTE: If the reason for treatment does not meet the BCBSKS definition for an accidental injury, the presence of some or all of these four fields will still not allow accident benefits to be applied.

1) Occurrence Codes:
The following occurrence codes with dates should be used to report accident information:

01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage.
02	No-Fault Insurance Involved-Including Auto Accident/Other	Code indicating the date of an accident including auto or other where state has applicable no fault liability laws (i.e.: legal basis for settlement without admission of proof of guilt).
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by third party, other than no fault liability.
04	Accident/ Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05*	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

There is also an occurrence code 11 that is used to report the date the patient first became aware of symptoms/illness. Some providers have interpreted that occurrence code 11 can also be used to report an accident date. **THIS IS INCORRECT. Occurrence code 11 does not represent accident information.**

2) E-DIAGNOSIS CODES:

Include the E-diagnosis code in form locator 72 if it provides information regarding the nature of the accidental injury.

3) REMARKS:

*Remarks required and must specifically indicate the details of the accident:

Unacceptable - patient tripped
- patient tripped over garden hose

Acceptable - patient tripped over garden hose at own home.

4) ACCIDENT DIAGNOSIS CODES:

Accident Diagnosis Codes – Local and Blue Card

V54.01 – V54.9

V71.3 – V71.6

370.24*

692.76, 692.77

710 – 739.9 *(Excludes Diagnosis Codes 733.00, 733.01 and 719.98)

800 – 989.9

992.3, 992.4, 992.5

994.0 – 994.8

995.81

996.9 – 996.99

*Diagnosis 370.24, 710 – 739.9 processed as accident only when there is other accident info on the claim (i.e. accident occurrence code).

FEP Accident Diagnosis Ranges

V71.5

692.76, 692.77

800 – 897.7

900 – 999.9

*The FEP diagnosis listing is very limited and we MUST process claims according to their guidelines.

AMBULATORY SURGICAL CENTER (ASC)

When an ASC is billing treatment for accidents, our claims processing system will look in two boxes on the CMS-1500 claim form to explain the date and nature of the accidental injury. In order for your claim to be processed quickly and efficiently, preferably boxes will reflect accident information. **If the information provided does not meet the definition of an accidental injury or is insufficient**, the claim could be returned to you for additional information or medical benefits will be applied rather than the accidental injury benefits.

Boxes necessary for accidental injury claims:

Box 10: When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Box 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked

Box 21: Enter the patient's diagnosis/condition. List no more than four ICD-9-CM diagnosis codes. Relate lines 1, 2, 3, 4 to the lines of service in 24E by line number. Use the highest level of specificity. An accident diagnosis from the list above must be present on the claim.

PRICING OF OUTPATIENT ACCIDENT CLAIMS

Payment for most accident related services is not subject to the maximum allowable payments if done on the same date as the accidental injury. Instead, the allowance is based on billed charges less the applicable outpatient discount amount.

AUTO INSURANCE DOCUMENTATION:

On claims involving an auto insurance carrier, BCBSKS must have a complete itemization of ALL payments made by the auto insurance before we can process any related claims. A statement from the auto insurance indicating that the maximum has been met or showing the amount of payment made on claims is not sufficient. Usually, this itemization is sent to us by the member.

BCBSKS encourages providers to file a claim directly to us at the same time you file to the auto carrier. This will help reduce the risk of the claim being denied for timely filing in the event the auto carrier processes the claim past our timely filing limitation.

E. MEDICAL EMERGENCIES

DEFINITION:

A medical emergency is defined as a sudden and, at the time, unexpected onset of a health condition that requires 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.

The following conditions would qualify, assuming data indicates it is life threatening:

- Severe allergic reaction (anaphylactic shock)
- Blood clots
- Coma
- Complications of pregnancy and/or fetal distress, excluding false labor
- Continuous ongoing seizures (status epilepticus)
- Heart conditions
 - This includes only: coronary artery occlusion, coronary thrombosis; heart attack; myocardial infarction (MI); paroxysmal atrial tachycardia (PAT); ventricular fibrillation; or ventricular tachycardia.
- Severe hemorrhage
- Poisoning
- Severe respiratory distress, spontaneous pneumothorax
- Shock, including diabetic shock

- Sickle cell crisis
- Stroke

BILLING:

When billing the claim for a medical emergency, report the onset date with the occurrence code 11.

Medical emergencies are subject to deductible/coinsurance/copayment.

Note: These medical emergency guidelines are not necessarily applicable to other BCBSKS programs such as the Federal Employee Program, or other special programs.

- F. **OUTPATIENT PHARMACY – Hospitals and Dialysis Facilities**
Outpatient oncology drugs, outpatient chemotherapy and other designated outpatient pharmacy must be billed with HCPCS codes (usually begins with a “J”). Reimbursement for the drug is based on the codes billed and is subject to a payment limit. During the year if new HCPCS codes are created, the same reimbursement methodology will be applied.

The maximum allowable payment (MAP) for each code will be established annually, but adjusted during the year only if the packaging or volumes that make-up the code changes significantly.

Refer to the Policies and Procedures Payment Attachment for complete details relating to average wholesale price and maximum allowable costs for outpatient pharmacy reimbursement.

- G. **PARTIAL-DAY TREATMENT PROGRAM**
In order to be eligible to participate in the “Partial-Day Treatment Program”, providers must be approved by BCBSKS.

Due to Mental Health Parity, benefits for partial-day treatment programs are the same medical benefits based on an inpatient or outpatient setting.

Partial-day treatment programs require prior authorization by our mental health and substance abuse vendor. Providers should call New Directions at 1-800-952-5906 to precertify services.

Partial-day treatment programs are defined as:

1. SUBSTANCE ABUSE PARTIAL-DAY TREATMENT DEFINITION

A substance abuse partial-day treatment program must adhere to the standards outlined by the State of Kansas relating to the development and execution of an individual's treatment plan. The program must include a minimum of fifteen (15) hours per five (5) day week of structured activities geared to meet the individual client's need. Of the minimum fifteen (15) hours required per week, no less than ten (10) hours per week will be structured group, individual and/or family counseling for each client. (Group and family counseling requires the participation of the primary client.)

A substance abuse partial-day program must also meet and adhere to Substance Abuse Prevention, Treatment and Recovery (SAPTR) requirements relating to the development and execution of an individual's treatment plan.

2. PSYCHIATRIC PARTIAL-DAY TREATMENT DEFINITION

A psychiatric partial-day treatment program is a planned program of mental health treatment services provided at least twice per week in four (4) or more hours at a single visit for persons who need broader programs than are possible through outpatient care, but who do not require 24-hour hospitalization. For each day of client participation, a minimum of two hours of structured group, individual and/or family counseling is required. (Group and family counseling requires the participation of the primary client.)

A psychiatric partial-day program must also meet and adhere to the requirements of KDHE.

The following guidelines are applicable:

1. The program must be an approved program by BCBSKS. Submit your program information to your provider consultant for approval.

2. Pre-certification is required for partial-day programs. Our mental health vendor is responsible for the pre-certification review process. Providers should call New Directions at 1-800-952-5906.
3. Benefits paid on partial-day charges are limited to those services that would be eligible under the member's medical BCBSKS contract.
4. Payment will be made to providers using special BCBSKS provider numbers assigned for partial-day programs.

BILLING:

Outpatient Partial Day

Type of Bill

131 – Admit through Discharge

132 – Interim – First Claim

133 – Interim – Continuing Claim

134 – Interim – Last Claim

**FREE STANDING FACILITIES, AND
LOCAL & BLUECARD MEMBER CONTRACTS**

Revenue code 0912.

CPT 90899 or HCPCS code S0201

Units equal the number of days the patient participated in partial-day during the billing period.

FEDERAL EMPLOYEE PROGRAM (FEP):

Revenue code 0914, 0915, 0916

CPT 90801-09899, whichever is appropriate

Intensive Outpatient Program (IOP) – hospital setting

Revenue code 0905, 0906

HCPCS code S9480

Inpatient Partial Day Program – hospital and free standing

Revenue code 0100 (All-inclusive Room and Board, Plus Ancillary)

MUST bill the individual services the patient receives under the applicable revenue code and HCPCS/CPT (e.g., revenue code 0914 with HCPCS/CPT for individual therapy, etc.)

REFERENCE: Blue Cross newsletter [BC-10-2 \(Jan. 19, 2010\)](#)

H. SLEEP STUDY/POLYSOMNOGRAPHY SERVICES – Hospitals only

BCBSKS has established a medical policy that outlines coverage, documentation, utilization and billing requirements for sleep study/polysomnography services. To review the current policy, refer to the provider publication, medical review section of our Web site <http://www.bcbsks.com>

BCBSKS allowances include a tiered reimbursement for sleep study and polysomnography services.

The highest MAP reimbursement for these services is made to providers who have obtained accreditation by the American Academy of Sleep Medicine (AASM) or the Accreditation Commission for Health Care, Inc (ACHC).

Those who are not accredited will receive the lower MAP allowance.

Providers who are accredited need to submit to BCBSKS a copy of the certificate letter issued to them by the accreditation vendor. Send the information to:

Institutional Relations
cc 442D2
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Fax number: 785-290-0734

Note: If other services (i.e. laboratory, x-ray) are provided during the same outpatient encounter, please submit two separate claims. One for the sleep study/polysomnography services and another claim for all other services provided during the encounter.

I. CHEMOTHERAPY – Hospitals only

All services that are provided when surgery is performed in the outpatient department of a hospital (i.e.: OR, Anesthesia, X-ray, Lab, etc.) will be provided when cancer chemotherapy is performed in the outpatient department of a hospital.

The cost of administration, room and set-up should be billed:

<u>DESCRIPTION</u>	<u>REVENUE CODE</u>	<u>CPT</u>
RAD-CHEMO-INJECT	0331	Required*
RAD-CHEMO-ORAL	0332	Required*
RAD-CHEMO-IV	0335	Required*

* report the appropriate chemotherapy administration CPT.

In addition to the administration, the chemotherapeutic drug would be billed with revenue code 0636 accompanied by the appropriate drug HCPCS code. The primary diagnosis indicated on your claim should reflect the specific malignant diagnosis, which the patient is being treated for.

J. Diabetic Education

Outpatient diabetic education programs deemed appropriate for the educational requirements necessary to promote self-education toward a safe-and-healthy lifestyle for diabetic members may be eligible for coverage. Availability of benefits for individual Blue Cross members who have been referred for such education by a licensed physician would be determined by the specific contract covering the individual.

BCBSKS reimburses the following providers for diabetic education:

- Organizations which have programs certified by the American Diabetes Association;
- Persons who are certified by the National Certification Board for Diabetic Educators (NCBDE) (includes hospital and other institutional providers that employ certified educators);
- Medical doctors and doctors of osteopathy

This information specifically addresses services provided by hospitals and other institutional providers who bill using the UB-04/837I billing

format. Medical personnel who are not employees of a hospital/institutional provider should contact BCBSKS professional relations department at 1-800-432-3587 for applicable eligibility guidelines.

Institutional providers can be reimbursed by BCBSKS for diabetic education if they have either:

- a program certified by the American Diabetes Association (ADA);
or
- employ a certified diabetic educator (CDE). When the provider employs a CDE, BCBSKS will reimburse for the services of the educator as well as the services of their dietitian. The dietitian does not need to be a certified diabetic educator themselves but must be part of a program offered by an institutional provider that employees a CDE.

Providers who are certified need to submit to BCBSKS a copy of the certification issued to them by the accreditation vendor. Send the information to:

Institutional Relations
cc 442D2
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Fax number: 785-290-0734

BILLING

Revenue Code
0942 education/training

HCPCS
G0108: diabetes outpatient self-management training services,
individual session, per 30 minutes

G0109 diabetes outpatient self-management training services, group session, per individual, per 30 minutes
UNITS: report 1 unit for each 30-minute session of participation. If a diabetic education session is greater than 30 minutes but less than 60 minutes, BCBSKS suggests that providers round the units as follows:

Less than 40 minutes	= 1 unit
40 minutes or more	= 2 units

Claims for BCBSKS members who participate in diabetic education for greater than 15 hours will be subject to post payment review.

Diagnosis Code: The BCBSKS processing system looks for the presence of a diabetes diagnosis code in the primary diagnosis code field on the claim. If the primary diagnosis is not for diabetes, benefits will not be allowed.

REIMBURSEMENT

Diabetic education services provided by eligible providers will be reimbursed a maximum allowable payment (MAP) for each unit of service.

Other applicable discounts (Blue Choice, etc.) apply to these MAPs.

K. DIETARY AND NUTRITIONAL PATIENT EDUCATION

Diet instruction/patient education is not a covered service except for the State of Kansas member(s). All other patients should be given a [Notice of Personal Financial Obligation \(NOPFO\)](#) form when a non-covered service is provided. If you obtain a signed NOPFO, you do not need to actually submit the NOPFO with the claim. You can append modifier GA to the applicable CPT/HCPSC code(s) and submit the claim electronically. Modifiers should immediately follow the procedure code, with no space between. The waiver is retained in the patient's file. By obtaining a signed NOPFO, the non-covered services are denied as the patient's responsibility.

STATE OF KANSAS – Does allow for nutritional education. Please call customer service for benefit information prior to rendering services.

Providers should use:

- S9452 – Nutrition classes, nonphysician provider, per session
- S9470 – Nutritional counseling
- Revenue code 0942

L. MEDICAL NUTRITIONAL THERAPY (MNT)

Most traditional BCBSKS member contracts do not include a benefit for medical nutritional therapy. This includes MNT CPT/HCPCS 97802, 97803, 97804, G0270 or G0271 (or any other assigned code).

NOTE: Some administrative services only (ASO) or national groups may provide benefits for MNT. Providers should verify the member's benefits prior to rendering services.

REFERENCE: [BC Newsletter BC-03-08 \(April 10, 2003\)](#)

M. PULMONARY REHABILITATION – Hospitals only

Blue Cross and Blue Shield of Kansas offers coverage for pulmonary rehabilitation programs. Actual coverage is determined by the individual member's contract, referral by their attending physician, and our [medical policy](#).

A pulmonary rehabilitation program must be approved by BCBSKS before benefits are available. To request approval, submit a detailed program description which supports program criteria compliance. The description must include:

- A program schedule that includes date/times
- A description of the services and equipment available
- A description of the staff providing the services
- A notation of physician availability
- What criteria is used for patient assessment
- A charge structure

We must also receive a signed attestation certifying the facility's understanding and compliance with the criteria. While the initial program approval will be based upon the program description and

attestation, follow-up review will be conducted during routine visits to your facility by our provider consultants or as the result of review activity conducted by our medical review department.

- Programs will normally be considered approved the first of the month following receipt of the attestation and supporting documents. If deficiencies are noted, the effective date will be the first of the month after BCBSKS receives documentation that the deficiencies no longer exist.
- Members will receive eligible benefits for pulmonary rehabilitation programs that **BEGIN ON OR AFTER THE PROGRAM APPROVAL DATE**

BILLING:

Revenue code:	0419 0948	Other respiratory services, OR Pulmonary rehab.
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HCPCS:	S9473	Pulmonary rehab program, nonphysician provider, per diem
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When billing using S9473, the units' field should indicate the number of days the client participated during the billing period.

	G0424	Pulmonary rehab, including exercise (includes monitoring), one hour, per session, up to sessions per day
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When billing G0424, you need to bill each day on a separate line to receive reimbursement for each day.

- ★ These billing instructions are only applicable to hospitals that have 'approved' programs.

REIMBURSEMENT:

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BCBSKS reimbursement is based on a maximum amount (MAP) for each day of client participation. It will be necessary to submit your charge structure to us for review. Your daily charge should be inclusive of all services except as outlined in “III. Other Diagnostic Services” as indicated in the criteria on the following pages.

The actual requirements document is as follows:

BLUE CROSS AND BLUE SHIELD COVERAGE REQUIREMENTS FOR APPROVED OUTPATIENT PULMONARY REHABILITATION PROGRAMS

I. DEFINITION

For purposes of this coverage, a Pulmonary Rehabilitation Program is a multi-disciplinary therapy regime provided in a hospital outpatient setting or an approved professional free-standing pulmonary rehabilitation clinic by a team of physicians, respiratory therapists, occupational therapists, nurses, dietitians, and social workers to restore an individual with chronic pulmonary disease to the highest possible functional capacity allowed by his pulmonary condition and overall life situation.

II. REQUIREMENTS FOR COVERAGE

A. Pulmonary rehabilitation programs will be considered reasonable and necessary only for patients with a clear medical need who are referred by their attending physician or primary care physician, if in a managed care program. These patients should not be limited physically by the severity of the respiratory condition or other disabling diseases. Patients should also demonstrate the personal commitment required to successfully complete the program. At the end of the program, they should show a 'substantial increase' in their exercise tolerance.

In addition to meeting the criteria above, patients eligible for coverage for outpatient pulmonary rehabilitation should have a documented diagnosis of the following chronic obstructive pulmonary diseases: asthma, chronic bronchitis, and/or emphysema or a diagnosis of cystic fibrosis or pulmonary fibrosis with restriction. Coverage is also available for ventilator dependent patients, or patient's pre and post lung transplantation or lung volume reduction surgery, as long as all other requirements for coverage are met.

B. Pulmonary rehabilitation programs are subject to the following conditions:

1. The facility meets the definition of a hospital outpatient department or a free-standing pulmonary rehabilitation clinic, (i.e. a physician is on the premises available to perform medical

duties at all times, and each patient is under the care of a physician).

2. The facility has available for immediate use all the necessary cardiopulmonary emergency diagnostic and therapeutic life saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, defibrillator, etc.
3. The program is staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced cardiac life support techniques and in exercise therapy for pulmonary disease. Services of non-physician personnel must be furnished under the general supervision of a physician. General supervision means that a physician must be in charge of the program and be responsible for ensuring that individual patient assessments are performed on at least a weekly basis by the physician or whomever the physician designated as medically competent to perform this duty.
4. The non-physician personnel are employees of the hospital or the physician directed clinic conducting the program.

C. Diagnostic Testing

The patient must be evaluated for suitability to participate. A 6 to 12 minute walk test and a pulmonary function test must be performed by either the rehabilitation program or the patient's attending physician. Any stress testing performed in the outpatient department or in a physician-directed clinic may be covered when reasonable and necessary for the development of an exercise program for patients with known pulmonary disease.

III. OTHER DIAGNOSTIC SERVICES

Medically necessary diagnostic services may be performed and charged for separately from the rehabilitation program charges.

IV. THERAPEUTIC SERVICES

A. Respiratory Therapy, Occupational Therapy and Patient Education Services:

Health education lectures or counseling providing information regarding diet, nutrition, respiratory therapy, physical therapy, and occupational therapy, etc. are considered to be a part of the rehabilitation program and a separate charge cannot be made. Room and board for the patient and/or family members is 'non-covered'.

V. DOCUMENTATION

The following data should be documented in the medical record:

- A. Description of the patient's deficits that require the rehabilitation program.
- B. Stated goals that are measurable to include the patient's status related to those goals.
- C. Physiological status information to include blood pressure, heart rate, respiratory rate and oxygen saturation levels, if applicable.

VI. DURATION OF THE PROGRAM

When the patient has progressed to a maintenance program (not to exceed 18 sessions or 6 weeks), coverage will be discontinued. All services provided by the pulmonary rehabilitation program in excess of six weeks will be reviewed on a case-by-case basis if the claim is accompanied by acceptable medical documentation supporting the need for the patient to remain in the program longer than six weeks. Otherwise, the claim will be denied on a "not medically necessary" basis.

I HEREBY CERTIFY THAT OUR FACILITY IS IN COMPLIANCE WITH THE ABOVE CRITERIA AND WILL NOTIFY BLUE CROSS AND BLUE SHIELD OF KANSAS OF ANY CHANGES WHICH COULD AFFECT OUR ELIGIBILITY.

Name of Pulmonary Rehabilitation Facility

Signature

Date

N. CARDIAC REHABILITATION – Hospitals only

Blue Cross and Blue Shield of Kansas offers coverage for cardiac rehabilitation programs. Actual coverage is determined by the individual member’s contract and our [medical policy](#).

A cardiac rehabilitation program must be approved by BCBSKS before benefits are available. To request approval, submit a detailed program description which supports program criteria compliance. The description must include:

- A program schedule that includes date/times
- A description of the services and equipment available
- A description of the staff providing the services
- A notation of physician availability
- What criteria is used for patient assessment
- A charge structure

We must also receive a signed attestation certifying the facility’s understanding and compliance with the criteria. While the initial program approval will be based upon the program description and attestation, a follow-up review will be conducted during routine visits to your facility by our provider consultant or as the result of review activity conducted by our medical review department.

- Programs will normally be considered approved the first of the month following receipt of the attestation and supporting documents unless deficiencies are noted. If deficiencies are noted, the effective date will be the first of the month after BCBSKS receives documentation that the deficiencies no longer exist.
- Members will receive eligible benefits for cardiac rehabilitation programs that begin on or after the program approval date.

BILLING:

Revenue Code: 0943 – Cardiac Rehab

CPT Code: 93797 – Physician services for outpatient cardiac rehab; without

continuous ECG monitoring (per session). OR
93798 – Physician services for outpatient cardiac rehab; with continuous ECG monitoring (per session).

Units: report one (1) unit for each day the patient participated during this billing period.

The actual requirements document is as follows:

BLUE CROSS – BLUE SHIELD
COVERAGE REQUIREMENT FOR APPROVED CARDIAC
REHABILITATION PROGRAMS

- I. **DEFINITION:** Cardiac rehabilitation programs are for cardiac patients and are provided in specialized, freestanding cardiac rehabilitation clinics or in outpatient departments of acute care hospitals.

- II. **REQUIREMENTS FOR COVERAGE**
 - A. Cardiac rehabilitation programs will be considered reasonable and necessary for only patients with a clear medical need, who are referred by their attending physician and:
 - 1. have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
 - 2. have had coronary artery bypass surgery; and/or
 - 3. have stable angina pectoris; or
 - 4. have had either a percutaneous transluminal coronary angioplasty (PTCA) or percutaneous coronary angioplasty (PCA) or coronary stenting; or
 - 5. Have had heart transplantation, heart lung transplant or cardiac valve surgery (by individual consideration only).

 - B. Cardiac rehabilitation programs are subject to the following conditions.
 - 1. the facility meets the definition of a hospital outpatient department or a physician-directed clinic (ie: a physician is on the premises available to perform medical duties at all times the facility is open); the program may be conducted at a location other than the provider's if the program otherwise meets the

coverage criteria and the services are billed by the responsible provider;

2. the facility has available for immediate use all the necessary cardiopulmonary emergency diagnostic and therapeutic life-saving equipment accepted by the medical community as medically necessary (e.g.: oxygen, cardiopulmonary resuscitation equipment, defibrillator, etc.);
3. the program is conducted in an area set aside for the exclusive use of the program while it is in session;
4. the program is staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life-support techniques and in exercise therapy for coronary artery disease. Services of non-physician personnel must be furnished under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise program area and immediately available for an emergency at all times when the exercise program is conducted.

It does not require that a physician be physically present in the exercise room itself but must be at a location to be considered immediately available and accessible to the patient exercise area. A physician located in an office across the hall from the exercise room who is available at all times for an emergency would meet this requirement. A physician located in a building other than that containing the exercise room does not meet this requirement.

5. the non-physician personnel are employees of either the physician, hospital, or clinic conducting the programs and their services are “incident to a physician’s professional services.”

C. **Diagnostic Testing – Stress Testing**

The patient must be evaluated for suitability to participate. A valuable diagnostic test for this purpose is the stress test. The program need not necessarily include a stress test, but may accept one performed by the patient's attending physician. Stress testing performed in the outpatient department of a hospital or in a physician directed clinic may be covered when reasonable and necessary for one or more of the following:

1. Evaluation of chest pain, especially atypical chest pain;
2. Development of exercise prescriptions for patients with known cardiac disease;
3. Pre- and post-operative evaluation of patients undergoing coronary artery bypass procedures.

D. **ECG Rhythm Strips**

ECG rhythm strips and other ECG monitoring constitute an important and necessary procedure which should be performed periodically while a cardiac patient is engaged in a physician-controlled exercise program (refer to Section III.E. for utilization screens).

III. **OTHER DIAGNOSTIC AND THERAPEUTIC SERVICES:** Diagnostic and therapeutic services **other** than stress testing and ECG monitoring may be provided if the usual coverage requirements are met as outlined in Section I and II. Other such services may include:

- A. **Psychotherapy and Psychological Testing** – Although not all cardiac rehabilitation patients would require this type testing, where a patient has a diagnosed mental, psychoneurotic, or personality disorder, psychotherapy provided by a psychiatrist or psychologist incident to a physician's professional service may be covered if the patient shows appropriate symptoms of excessive anxiety or fear associated with the cardiac disease (for Blue Shield, the patient must have the psychiatric rider).
- B. **Physical and Occupational Therapy** – Physical and occupational therapy would not be covered unless there is a diagnosed noncardiac condition requiring such services (i.e.: patient is recuperating from acute phase of heart disease,

such as a stroke, and would require this type of physical/occupational therapy).

- C. Patient Education Services – Programs providing health education lectures or counseling, in which patients and/or family members are given information regarding diet, nutrition and sexual activity, are not considered reasonable and necessary as **separately** identifiable services when provided as a part of a cardiac rehabilitation exercise program. These services are considered included in the overall scope of the program. In addition, room and board for the patient and/or family member is also non-covered.
- D. Duration of the Program –For BCBSKS members, services provided in connection with a cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 18 sessions, usually 3 sessions a week in a single 6-week period. Coverage for continued participation would be allowed only on a case-by-case basis with exit criteria taken into consideration.

Although firm exit criteria for terminating the therapeutic outpatient exercise treatment and rehabilitation program have not been established, the following guidelines have been identified as acceptable:

- The patient has achieved a stable level of exercise tolerance without ischemia or dysrhythmia;
- Symptoms of angina or dyspnea are stable at the patient's maximum exercise level;
- Patient's **resting** blood pressure and heart rate are within normal limits; or
- The stress test is not **positive** during exercise. (A **positive test** in this context implies an ECG with a junctional depression of 2mm or more associated with slowly rising, horizontal, or down sloping ST segment.)

- E. Utilization Screens –
Group 1 Services

At least one Group 1 service must be performed during each cardiac rehabilitation visit. Group 1 services include:

- Continuous ECG telemetric monitoring during exercise;
- ECG rhythm strip with interpretation and physician's revision of exercise prescription; and
- Limited examination for physician follow-up to adjust medication or other treatment change.

Group 2 Services

- New patient comprehensive evaluation, including history, physical and preparation of initial exercise prescription.

Allow one at the beginning of the program if not already performed by the patient's attending physician, or if that performed by the patient's attending physician is not acceptable to the program's director.

- ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report.

Medicare allows one at the beginning of the program and one after three months (usually the completion of the program). BCBSKS would allow one at the program start and completion.

I HEREBY CERTIFY THAT OUR FACILITY IS IN COMPLIANCE WITH THE ABOVE CRITERIA AND WILL NOTIFY BLUE CROSS AND BLUE SHIELD OF KANSAS OF ANY CHANGES WHICH COULD AFFECT YOUR ELIGIBILITY.

Cardiac Rehabilitation Center

Signature

Date

O. POSITRON EMISSION TOMOGRAPHY (PET) SCANS

BCBSKS allowances include a tiered reimbursement for PET scans.

The two levels of reimbursement for PET scans are based on whether or not the provider has a fixed unit or uses a mobile unit. Providers with a fixed unit receive the highest allowance.

If you have a fixed unit, notify BCBSKS Institutional Relations. Be sure to include:

- Provider name and address
- Provider number
- Type and model of fixed PET unit
- Date fixed unit was installed

P. HEALTH FAIR SERVICES

Will BCBSKS pay for services provided at a health fair?

Coverage for any service, including those provided at a health fair, is determined by the member's contract with BCBSKS. If the member has benefits for a service they received at a health fair, the provider is required to submit a claim and payment would be allowed. See the examples below.

If you offer services at a health fair (or any type of promotion) at a discounted rate, BCBSKS expects to be billed that discounted rate for all services provided to its members during that same time frame. This requirement can be found in the BCBSKS Policies and Procedures for most contracting hospital types and reads as follows:

"If the Contracting Provider, through a short-term promotion such as a health fair, offers services for a reduced price, BCBSKS must also be billed the lower rate during that time frame."

SCENARIO #1 – health fair is offering lab services

1. Done on hospital grounds.
2. Done with hospital equipment.
3. Done by hospital personnel.

4. The patient is not registered as an outpatient and there is no direct physician care (no physician orders).

Most BCBSKS member contracts do not cover lab services without a physician order.

SCENARIO #2 – health fair is offering lab services

1. Done off hospital grounds.
2. Specimens are brought back to the hospital and ran on hospital equipment.
3. Hospital personnel volunteers at the health fair, but lab personnel is used to run the specimens.
4. The patient is not registered as an outpatient and there is no direct physician care (no physician orders).

Most BCBSKS member contracts do not cover lab services without a physician order.

SCENARIO #3 – health fair is offering screening mammogram services

1. Done off hospital grounds.
2. Done with hospital equipment.
3. Done by hospital personnel.

SCENARIO #4 – health fair is offering screening mammogram services

1. Done on hospital grounds.
2. Done with hospital equipment.
3. Done by hospital personnel.

Most BCBSKS member contracts cover screening mammogram services without a physician order. Therefore, the screening mammogram **MUST** be billed to BCBSKS.

REMINDER: Any time a provider offers services through a health fair (or similar promotion) at a discounted rate, BCBSKS must be billed the lower rate for all services provided to BCBSKS members during the same time frame.