



Hospitals

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I. General Guidelines

- A. Hospitals will include on all inpatient billings, charges for hospital services that are obtained from another organization (related or unrelated) while the BCBSKS member is an inpatient. There is an exception for anatomical laboratory. If the hospital does not have their own anatomical laboratory, they are not required to include the technical component on their inpatient claim.
- B. Charges for professional services provided to inpatients or outpatients by physicians, physician assistants, nurse practitioners, and certified registered nurse anesthetists must be billed on a CMS-1500 claim form. Durable medical equipment provided to outpatients and ambulance services must also be billed on a CMS-1500 claim form. Payment for services billed on the CMS-1500 claim form will be made according to Blue Shield reimbursement guidelines.

Because hospitals manage inpatient care and coordinate outpatient services, charges for services provided in a hospital setting by practitioners whose licensure scope does not include admitting patients or signing orders for outpatient hospital care are included as part of the hospitals charges on a UB-04/837I claim form. Reimbursement for these services will be included in the payment made to the hospital and will not be separately reimbursed to those practitioners.

- C. Generally, hospital and ancillary services must be ordered by a physician to be allowable for reimbursement. Services that are ordered by Advanced Registered Nurse Practitioner (ARNP), Nurse Practitioners (NP), Physician Assistants (PA) and other non-physician practitioners, who have admitting privileges and which are ordered, within the scope of their licensure may also be considered for reimbursement.
- D. Hospitals will not bill the member for services that are medically unnecessary or experimental/investigational unless the member was notified prior to the services being provided. Refer to section titled PRIOR AUTHORIZATION/PRECERTIFICATION of ADMISSIONS/SERVICES for complete details about the Notice of Personal Financial Obligation (link).
- E. Hospitals will not charge the member for services prior to them being provided except for deductible, coinsurance, and share payment amounts or non-covered services.

- Up front collection of these amounts is the provider's decision. BCBSKS does not have a policy that requires providers to collect up front.
 - If the member has already satisfied part of their deductible, coinsurance or share payment, providers can only bill up front for the balance.
 - Member responsibility must be calculated based on the BCBSKS MAP or allowance and not on the total charge.
 - If the up front collection results in an overpayment that is due the patient, a timely refund must be made to the patient.
- F. Claims will be submitted within 15 months from the date of discharge or the date of outpatient service. Some groups may impose alternate timely filing and claim assessment requirements. Failure to meet those requirements will result in claim denial.

If BCBSKS requests additional information or clarification about a claim before it can be processed, complete medical record information will need to be provided in a format that can be utilized by BCBSKS.

The member's contract allows BCBSKS to request and receive medical record information without the need for additional authorization.

Corrected claims or adjustment requests must also be filed within 15 months of the date of service or discharge. Some groups may impose alternate guidelines.

- G. In computing the number of inpatient days, the date of admission will be counted but not the date of discharge.

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.

- H. Interim billing for acute inpatient admissions may be submitted 60 days after admission and at 60-day intervals providing the proper pre-admission/concurrent review notices were given to BCBSKS. Interim payments will be estimated with final payment based on the appropriate MS-DRG for the entire admission.

- I. Acute care hospitals that have obtained separate NPIs for their Medicare certified rehabilitation or psychiatric units will submit separate claims for these inpatient admissions. Reimbursement will be a per diem for each covered day.

Hospitals that have not obtained separate NPIs for their Medicare certified rehabilitation or psychiatric units or when this type of care is provided in the acute hospital area instead of the certified unit, will submit claims for inpatient admissions using the acute hospital NPI. For inpatient claims reflecting charges for both medical and rehabilitation admissions, a daily allowance will apply for each day that a patient resides in that rehabilitation unit. This allowance applies when the initial MS-DRG is other than #462.

Details relating to this change are outlined in a BCBSKS newsletter dated June 15, 2007 include:

1. This change is effective for claims received by BCBSKS starting May 23, 2007, that have a 2007 service date or later. (NOTE: This does not apply to claims processed to final adjudication prior to May 23, 2007 or to claims with a 2006 service date. For those claims, please continue to report your acute hospital provider number and/or NPI).
2. The hospital determines the residency of the patient, acute versus excluded unit and will pre-certify the admission and bill the claim with the applicable NPI.
3. Hospitals will bill a separate inpatient claim for each different NPI.
4. When hospitals pre-certify an inpatient admission, they must identify if the patient is acute or if they reside in the excluded unit. The billed claim should match the pre-certification.
5. If the patient is admitted to acute care and later transferred to the excluded psychiatric or rehabilitation unit (or vice versa), split the inpatient claim and bill multiple claims using the separate NPIs.
6. If you have a patient that is admitted acute and later transferred to the excluded unit or vice versa, you must pre-certify the care in each unit. Providers use the online system to pre-certify acute care but the pre-certification of psychiatric or rehabilitation services must be done by telephone. Call New Directions at 1-800-952-5906.
7. If a patient is treated at your hospital as an outpatient and is admitted as an inpatient before midnight of the following day, the outpatient services must be included on the inpatient claim. This rule applies to inpatient acute, rehabilitation or psychiatric unit admissions. This applies even if the

- diagnosis for the outpatient service is different from the admitting diagnosis.
8. The payment allowance for care in an excluded psychiatric or rehabilitation unit will be a per diem per day.
 9. The payment allowance for psychiatric or rehabilitation care billed with the acute hospital NPI will continue to be based on the MS-DRG.
 10. If you are a hospital that has a unique contractual arrangement with BCBSKS, your allowance will continue to be based on that contract.
 11. PIP – periodic interim payments apply only to the acute hospital number/NPI. Rehabilitation and psychiatric checks will be based on actual claims paid.
- J. Separate billings must be submitted for mother and newborn charges. FEP may be different. See the FEP chapter for complete details ([link](#)).
- K. Hospitals that provide for and schedule patient clinic visits for physicians whose specialty is not otherwise available in the community and where services are not considered primary care, can make a facility technical component charge for the use of the hospital space. These charges will be reimbursed up to the assigned Maximum Allowable Payment for the visit (revenue code 0510).
- L. The professional component charges are not covered under this agreement and require that an agreement be executed with Blue Shield for these services.
- M. Services provided off site of the physical presence of the main hospital campus must be billed on the CMS-1500 claim form, except in those cases where the off-site location is the sole place of service for an outpatient ancillary service or as determined by BCBSKS.
- N. Charges for all hospital services, procedures, supplies, and pharmacies provided during an outpatient encounter are to be billed on one claim. Claims for a series of outpatient encounters occurring on different days may be interim billed.
- O. If the hospital offers services for a reduced price (i.e. a short-term promotion such as a health fair or a discount for a cash payment), BCBSKS must also be billed the lower rate during that time frame. (See Health Fair Services in the Section VIII Benefits/Exclusions)

- P. Whereas the inpatient admission and discharge of a patient is determined by a medical doctor, if a patient is discharged but readmitted to the same facility on or before the next calendar day and the reason for this readmission is because the patient had been prematurely discharged, the readmission stay will be considered a continuation of the original MS-DRG and as such will be submitted on the same claim as the prior admission.

Reimbursement will be based on the MS-DRG assigned to the complete stay including the room and board charges for medically necessary inpatient days, all ancillary charges that occurred during the admission and prior to physician discharge, as well as any outpatient services provided the day before the inpatient admission.

Room and board charges for medically unnecessary or patient requested inpatient days will be charged to the patient only if a *NOPFO* is obtained prior to services being provided.

- Q. When a patient is discharged by the physician from inpatient acute care and admitted to inpatient skilled care, the reimbursement information listed below will apply if the patient has coverage for inpatient skilled admission.

ALL MEMBER CONTRACTS

Hospitals with a skilled nursing unit or swing-bed will be reimbursed at the lesser of charge or MAP* based on the MS-DRG assigned to the inpatient skilled stay.

When a non-MAP'd MS-DRG applies, reimbursement will be the provider's charge less the appropriate discount as specified by the member's network.*

* Blue Choice discounts apply.

If the patient does not have an inpatient skilled-level-of-care benefit, the Contracting Provider may bill the patient for the non-covered room and board charges if the patient was given a written [Notice of Personal Financial Obligation \(NOPFO\)](#) prior to the services being rendered.

- R. When necessary, the Contracting Provider agrees to refer and/or transfer BCBSKS members to BCBSKS contracting providers.
- S. When outpatient psychiatric or substance abuse services are provided, all charges for services of the professional psychiatrist,

psychologist, licensed clinical social worker (LSCSW) or advanced registered nurse practitioner (ARNP) who have a professional provider contract with BCBSKS are billed on a CMS-1500 claim form. No charges will be submitted on a UB-04/837I claim form when a CMS-1500 is submitted.

Facility charges for covered services provided in an institutional setting by professionals who are not permitted to submit charges on a CMS-1500 claim form may be billed on a UB-04/837I claim form in lieu of the CMS-1500 if the facility charge is allowable.

- T. Outpatient laboratory services are reimbursed at the lab fee schedule established by BCBSKS when the services are NOT provided as a result of an emergency room encounter or outpatient observation. If the laboratory charges are billed with one or more of these outpatient services designated by revenue code 045X or 0762, then the lab reimbursement will not be subject to the lab fee schedule.

U. OUTPATIENT PHARMACY – Hospitals

Outpatient oncology drugs, outpatient chemotherapy and other designated outpatient pharmacy must be billed with HCPCS/CPT codes. 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.

Reimbursement for pharmaceuticals will be reviewed periodically and may be adjusted during the year to reflect changes in the ASP or AWP.

Covered pharmaceuticals are reimbursed based on a formula as determined by BCBSKS that utilizes the published average sales price (ASP) or the average wholesale price (AWP). Refer to the Policies and Procedures Payment Attachment for hospitals for complete details

- V. Outpatient observation services (revenue code 0762) will be reimbursed the lesser of charge or one day's average semi-private room rate of the hospital, per stay, regardless of the number of hours in observation. (See Observation in Section VIII Benefits/Exclusion).

- W. Payment for outpatient surgeries will be reimbursed at an all-inclusive rate based on the MAP for the surgery billed. When

multiple surgeries are performed during the same encounter, the all-inclusive rate is based on the highest MAP'd surgery code. All services provided during a surgical encounter will be reimbursed at the designated all-inclusive rate and must be billed on the same claim.

- X. Outpatient therapy services will be reimbursed at the fee schedule amount established by BCBSKS.

II. 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 efficient manner.

The process is accomplished through the development of a treatment plan by the patient or legal representative, the physicians, other health care providers, and a BCBSKS case manager.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the member would otherwise be entitled under the terms of their contract.

Participation in case management is voluntary. The member may withdraw at any time and return to the stated benefits of their contract.

If a member's care is being handled through the case management process, our medical staff may negotiate reimbursement rates different than the established maximum allowable payments.

III. Extension of Benefits – Change of Insurance Carriers During an Inpatient Stay

Most BCBSKS member contracts state that the benefits under the contract end on the date the coverage terminates except for a member who is receiving inpatient hospital services on the termination date. In these cases, benefits may be extended for that member for a period of 31 days following the termination date or until discharge whichever occurs first.

If the extension of benefits is applicable and if the patient has a replacement policy with another insurance carrier, the replacement insurance carrier immediately assumes the status of primary payer. BCBSKS will be the secondary payer for the period of up to 31 days or when the hospital confinement ends whichever happens first. If there is no replacement policy

with another insurance carrier, BCBSKS will continue as the primary payer during the extension of benefits period.

HOW WILL PROVIDERS KNOW IF THIS APPLIES

In these situations, the hospital may not know that there's been a change in insurance. Anytime one of our member's contracts terminates, BCBSKS will closely monitor any inpatient claims that extends past our termination date.

- If we know there is no replacement insurance, BCBSKS will process the inpatient claim for the entire stay based on the extension of benefit requirements of the members contract.
- If we know there is replacement insurance, BCBSKS will send the claim back to the provider asking for the bill to be split.
- If we don't know if there is replacement insurance, BCBSKS will contact the member to find out.

BILLING GUIDELINES

If the extension of benefits applies and if there is a replacement policy with another insurance carrier that immediately becomes the primary payer, hospitals will be asked to split bill the inpatient hospital claim to BCBSKS.

When splitting the hospital claim, the first part should reflect a statement covers period up to and including the contract termination date. This claim would show a patient status code of 30 (still patient). The second part of the claim would begin with the following day. These claims should be submitted electronically.

Billing Example:

BCBSKS contract terminated January 31, 2010. A replacement policy with XYZ Insurance became effective February 1, 2010.

The patient was a hospital inpatient from January 27, 2010 thru February 3, 2010.

When asked, you would split the claim and bill to BCBSKS as follows:

Claim 1:

Primary Payer	BCBSKS
Type of Bill	112
Statement Covers Period	January 27 thru January 31, 2010
Patient Status Code	30 (still patient)
Covered Days	5 (last day counts as patient wasn't discharged)

Claim 2:

Primary Payer	XYZ Insurance
Secondary Payer	BCBSKS
Type of Bill	114
Statement Covers Period	February 1 thru February 3, 2010
Patient Status Code	As appropriate for discharge
Covered Days	2
Other Party Liability Information	Report the amount paid by XYZ Insurance. BCBSKS cannot pay as secondary without this information.

The BCBSKS allowance on these claims will not exceed the MS-DRG allowance for the entire stay.

HOW TO BILL IF BCBSKS IS THE REPLACEMENT POLICY?

If the situation was reversed and XYZ Insurance terminated January 31, 2010 with BCBSKS being the replacement policy, you would file a claim to BCBSKS for services beginning with the BCBSKS effective date. This claim would reflect a 111 type of bill. No claim would be submitted to BCBSKS for services prior to our effective date.

IV. Intraoperative Monitoring

Inpatient: When an inpatient receives intraoperative monitoring, the facility should include the technical charge for the service on the inpatient claim.

Outpatient: Facilities who own the equipment will bill BCBSKS for the technical component. If the facility does not own the equipment, then the physician ordering the service bills a global charge. The facility **does not** bill for the technical component.

V. Inpatient Ancillaries for Noncovered Days

See Section VI Prior Authorization/Precertification of Admissions/Services, page 8.

VI. Preventable Adverse Events

As outline in the Policies and Procedures Agreement document, adverse events #1, #2, #3 and #5 listed below are not billable to BCBSKS.

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure on a patient

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

4. Retention of foreign object in surgical patient

In cases where a foreign object is mistakenly left during a surgical procedure the following applies:

- a) If the object is removed in the same facility, then no payment for the correcting surgery will be made and the patient will be held harmless.
- b) If the object is removed in a different facility, that facility shall receive payment.

5. Blood Incompatibility

- a) BCBSKS shall not reimburse and the patient shall be held harmless when incompatible blood is administered. The provider shall refund any payment when becoming aware of this event.

- b) When compatible blood is administered, but the patient suffers an unforeseeable reaction to either the administration of the blood or to the blood itself, this is not considered to be an error.

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.

The Blue Cross and Blue Shield list of "Preventable Adverse Events" shall automatically include all future CMS adopted "Never Events". The update shall be immediate upon adoption even if the addition occurs mid year. The CMS additions do not constitute a policy change and neither the patient nor BCBSKS shall pay for the medical errors.

VII. Patient's Reason For Visit – Outpatient Claims

As outlined by the UB-04 guidelines for Form Locator 70 (Patient's Reason For Visit), BCBSKS requires the presence of a diagnosis code describing the patient's reason for visit on claims for unscheduled outpatient visits.

A claim is considered an unscheduled visit when the following conditions are met:

- Type of Bill (Form Locator 4) is either 013X or 085X,
- Priority (Type) of Visit (Form Locator 14) is 1, 2 or 5. (1=emergency, 2=urgent, 5=trauma)
- Revenue code is 04X, 0516, 0526, or 0762.
 - 045X = emergency room,
 - 0516 = urgent care clinic,
 - 0526 = free-standing urgent care clinic,
 - 0762 = observation room

Outpatient claims that meet these conditions but don't include a patient reason for visit diagnosis code will be returned to the provider.

VIII. ICU/CCU Requirements

See section VIII Benefits/Exclusion of the Institutional Provider Manual.

IX. Partial-Day Treatment Programs

See section VIII Benefits/Exclusion of the Institutional Provider Manual.

X. PULMONARY REHABILITATION PROGRAM

See section VIII Benefits/Exclusion of the Institutional Provider Manual.

XI. CARDIAC REHABILITATION PROGRAM

See section VIII Benefits/Exclusion of the Institutional Provider Manual.