



## Federal Employee Program

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## I. FEP Customer Service Center

Federal employees, who choose coverage through Blue Cross and Blue Shield of Kansas, select one of the following benefit plans:

- Standard Option
- Basic Option

Our BCBSKS Customer Service Center includes a unit devoted strictly to the Federal Employee Program. Inquiries can be directed to them by calling:

(785) 291-4181 or toll free: 1-800-432-0379

You can visit the Web for complete benefit information at [Blue Cross and Blue Shield's Federal Employee Plan](#)

## II. New Directions – Mental Health/Substance Abuse Vendor

New Directions is involved in the approval of mental health/substance abuse services for FEP enrollees. This includes:

- Precertification of inpatient admissions
- Prior authorization of partial hospitalization services
- Approval of outpatient services/treatment plans

To contact New Directions:

(785) 233-1165  
Toll Free 1-800-952-5906

### III. Standard Option Benefit Recap

The Standard Option program uses the basic CAP\* Blue Cross contracting provider contract as their preferred provider network.

\* Competitive Allowance Program

Standard Option identification cards will reflect an enrollment code of:

104 = Standard Option/Single

105 = Standard Option/Family

**\*Prior approval is required for all inpatient admissions. Failure to do so will result in penalties or denial of services.**

**\*Prior approval is required for all inpatient and outpatient mental health and substance abuse services. Contact New Directions.**

**\*Prior approval must be obtained** for both the procedure and the facility, for the following transplant procedures:

- Blood or marrow stem cell transplant procedures
- Autologous pancreas islet cell transplant
- Heart
- Heart-lung
- Intestinal transplants (small intestine with or without other organs)
- Liver
- Lung (single, double, or lobar)
- Pancreas
- Simultaneous liver-kidney
- Simultaneous pancreas-kidney

**\*Prior approval is required** for the surgical services listed below when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services.

- Outpatient surgery for morbid obesity;
- Outpatient surgical correction of congenital anomalies; and
- Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

**\*Prior Authorization is required for all Hospice Services**

## IV. Basic Option Benefit Recap

The Basic Option program utilizes the Blue Choice provider network. Except for emergency care, NO BENEFITS are available for services provided by institutional providers who are not part of the Blue Choice provider network. Hospital providers would've had to sign the Blue Choice provider contract. Non-hospital institutional providers (home health agencies, hospice agencies, end stage renal disease facilities, birthing centers, and freestanding substance abuse facilities) who are in the CAP\* provider network are considered to be Blue Choice providers.

\*Competitive Allowance Program

Basic Option identification cards will reflect the word BASIC within an outline of the United States and an enrollment code of:

111 = Basic Option/Single

112 = Basic Option/Family

**\*Prior approval is required for all inpatient admissions. Failure to do so will result in penalties or denial of services.**

**\*Prior approval is required for all inpatient and outpatient mental health and substance abuse services. Contact New Directions.**

**\*Prior approval must be obtained** for both the procedure and the facility, for the following transplant procedures:

- Blood or marrow stem cell transplant procedures
- Autologous pancreas islet cell transplant
- Heart
- Heart-lung
- Intestinal transplants (small intestine with or without other organs)
- Liver
- Lung (single, double, or lobar)
- Pancreas
- Simultaneous liver-kidney
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**\*Prior approval is required** for the surgical services listed below when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services.

- Outpatient surgery for morbid obesity;
- Outpatient surgical correction of congenital anomalies; and
- Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

**\*Prior Authorization is required for all Hospice Services**

## V. Basic Consumer Option

In 2008, FEP began offering a new benefit option called Basic Consumer Option (a sub-option of Basic Option). This sub-option is a high-deductible health plan (HDHP) that encourages its members to act as consumers when spending their benefit dollars, much as they do when making any purchase decision. For 2009, Basic Consumer Option is offered to federal employees who live in the following areas: Ohio, Minnesota, Tennessee and Missouri-Kansas City. While FEP members living in the Kansas company plan area are not offered this option; some members from the Missouri-Kansas City area may seek services from Kansas providers.

### Basic Consumer Option Key Features

- Network of Providers: Except for certain circumstances such as emergencies, Basic Consumer Option members must obtain services from Blue Choice providers.
  - The Blue Choice provider network includes hospitals who have signed the Blue Choice provider agreement. It also includes non-hospital institutional providers (home health agencies, hospice agencies, end stage renal disease facilities, birthing centers, and freestanding substance abuse facilities) who are CAP providers.
- Deductible: Contact FEP Customer Service or visit the Web at [www.fepblue.org](http://www.fepblue.org)

## VI. Inpatient Admissions for Member Age 65 or Older and Does Not have Medicare

The information in this section applies only to hospitals paid based on the MS-DRG payment system.

When a Federal Employee Program (FEP) member is age 65 or over and does NOT have Medicare coverage, federal law limits the allowance for inpatient hospital care to an amount equivalent to the inpatient prospective payment amount. These regulations, which have been in effect since January 1992, require that the difference between the total charge and the Medicare equivalent amount be a provider write-off to Medicare participating facilities.

Claims will be handled as follows:

If the FEP member is not enrolled in Medicare at all, providers will submit the entire claim (room and board plus ancillary charges) to BCBSKS.

If the FEP member is enrolled in Medicare Part B but not in Medicare Part A:

- The provider will (must) file the Part B ancillary claim to Medicare. When the payment information crosses over to FEP, if our records indicate the patient does not have Part A, we will cancel that claim or payment record.
- The provider needs to file an inpatient claim to BCBSKS reflecting the TOTAL charges for the admission.
- On the claim filed to BCBSKS, the provider needs to indicate:
  1. their Medicare provider number
  2. the dollar amount and date that Medicare paid on the Part B ancillary claim
- BCBSKS will obtain the Medicare equivalent amount from the FEP center in Washington D.C. The claim allowance will be the Medicare equivalent amount less the payment made by Medicare on the Part B ancillary claim.

### I. Maternity Admissions

Hospitals are never to combine the mother's charges with the baby's charges. Instead, hospitals should bill the mother's claim with all charges for the mother from the admission to discharge.

However, when the baby remains in the hospital after the mother is discharge, claims for the baby should be submitted as follows:

- When the newborn remains in the hospital after the mother is discharged and revenue codes 173 (Level III sick neonates who do not require intensive care, but require 6-12 hours of nursing each day – Intermediate Care) or 174 (Level IV constant nursing and continuous cardiopulmonary and other support for severely ill infants – Intensive Care) are billed, we only need one claim for the newborn's stay showing charges from the date of birth to discharge.
- When the newborn remains in the hospital after the mother is discharged and revenue codes 173 or 174 are **not** included on the claim, then two claims need to be submitted for the newborn. One claim showing the baby's charges up until the time the mother's discharge and the other showing charges after the mother's discharge.

You do not need to precertify a maternity admission for a routine delivery. However, if a medical condition requires the mother to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then you must contact us for precertification of additional days. Further, if the baby stays after the mother is discharged, then you must contact us for precertification of additional days for the baby.

**Note:** When a newborn requires definitive treatment including incubation charges by reason of premature birth or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits.

Standard Option – No inpatient facility copay for maternity admissions for either the mother or the baby. If the baby remains after the mother is discharged, a deductible/copayment will be applied to the baby's days following the mother's discharge.

Basic Option – Only one inpatient copayment is applied to both the mother's and the baby's charges. If the baby remains in the hospital after the mother's discharge, a separate deductible/copayment will be applied to the baby's days following the mother's discharge.