



Ambulatory Surgical Center (ASC)

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I. General Guidelines

Effective January 1, 2009, ASC's no longer:

- Refer to the Blue Shield Policy Memo's
- Refer to the Blue Shield Business Procedure Manual
- Receive Charge Comparisons for services in 2009

Rather they will:

- Refer to their Policies and Procedures, Payment Attachment and Maximum Allowable Payment (MAP) listing for claims with services beginning January 1, 2009
- Continue to bill claims using the CMS-1500 claim format
- Continue to refer to the ASC Approved Procedure listing on the Web in addition to the MAP listing, and
- Continue to follow the Blue Shield Medical Policies

A. PAYMENT IN FULL PROVISION

The Contracting Provider shall accept the BCBSKS payment allowance as described below for any program set forth in the Introduction of the Policies and Procedures as payment in full, except for appropriate charges for non-covered services, deductible, coinsurance and shared payment amounts.

The Contracting Provider shall not require of any member, payment prior to or following a service for covered amounts in excess of any deductible, coinsurance, and shared payment amounts up to the Maximum Allowable Payment (MAP). The Contracting Provider shall look only to BCBSKS for payment of approved benefits with the exception of the coinsurance, deductible and shared payment amounts.

The term "party" in the Contracting Provider Agreement is not intended to apply to arrangements for Contracting Provider services billed to physicians, Contracting Provider services billed to government programs, or the Contracting Provider's acceptance of credit card payments.

B. MAXIMUM ALLOWABLE PAYMENT

Notification will be provided when MAPs are established for procedures/services. As national codes change, MAPs will be transferred to the appropriate new CPT-4/HCPCS codes.

In all reimbursement methods, the Contracting Provider is required to write off all charges in excess of MAPs for covered services and members will be responsible for any coinsurance, shared payment and deductible amounts up to the MAP. All payments shall be made on the basis of the allowance in effect on

the date the services were provided, not on the basis of when the Contracting Provider billed for the services.

C. CONTENT OF SERVICE

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

- Use of the ASC's facilities
- Patient preparation areas, operating and recovery rooms, waiting rooms, and other areas used by the patient or offered for the use by the patient's relatives in connection with surgical services
- Nursing services, services of technical personnel and other related services
- Services in connection with covered procedures furnished by nurses, technical personnel and others who are employees of the ASC involved in patient care.
- Drugs, biologicals, surgical dressings, supplies, splints, casts, orthopedic hardware, appliances and equipment
- All supplies and equipment commonly furnished by the ASC in connection with surgical procedures
- Exceptions: Tissue (i.e., allografts, eye tissue) will be allowed at invoice cost when determined to be medically necessary by BCBSKS. Certain drugs (i.e. Baclofen, Botox) may be allowed at average wholesale price.
- Radiology procedures and laboratory tests
- Administrative, record keeping and housekeeping items and services
- General administration functions necessary to run the facility, e.g., scheduling, cleaning, utilities and rent
- Blood, blood plasma, platelets, etc.
- Anesthesia equipment and supplies
- Video equipment

NOTE: The waiver/*Notice of Personal Financial Obligation (NOPFO)* cannot be utilized for services considered to be content of another service provided. Medical policies including Content of Service (COS) as described in the BCBSKS Ambulatory Surgery Center Payment Attachment or provider's obligations specified in their provider contracts are not considered eligible claim appeals as outlined in Section V. Appeals.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents. Appropriate all-inclusive procedure codes must be used when available.

D. MULTIPLE SURGICAL PROCEDURES

The premise of the multiple surgery policy is to allow additional reimbursement when additional supplies or equipment are utilized in addition to those required for the primary procedure. This policy applies when more than one surgical (open, scope, or other) procedure is performed by one or more providers on the same patient on the same date.

1. The procedure with the greater BCBSKS maximum allowable payment (MAP) will be allowed at 100 percent of the usual provider charge up to the MAP. For other procedures performed at the same setting, the usual provider charge, up to 50 percent of the MAP, will be allowed, except as otherwise specified in this policy.

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

2. For two or more surgical scope procedures that involve multiple compartments or sections of the same anatomic area (including but not limited to joints, sinuses and abdominal, chest, pelvic and cranial cavities), only the procedure with the highest BCBSKS MAP will be reimbursed; other procedures shall be considered content of service. Exceptions based on unusual clinical intensity are also available on a claim-by-claim basis; such claims will only be considered for additional reimbursement if Modifier 22 and appropriate supporting records are submitted with the original claim.
 - A diagnostic scope is incidental to another diagnostic scope or a surgical scope (including biopsy).
 - A diagnostic scope "with" or "without" biopsy is incidental to an open surgical procedure in the same anatomical area.
 - A diagnostic scope is incidental to a diagnostic scope with biopsy unless the verbiage distinguishes the procedure as "with biopsy" versus "without biopsy."
 - Incidental relationships are applied to endoscopic, arthroscopic and other scope procedures based on the following:

- complete versus partial
 - with versus without
 - extensive versus limited
- An endoscopic, arthroscopic, or other scope procedure and open surgical procedure in the same anatomic area will not both be reimbursed.
 - If an open surgical procedure and an endoscopic, arthroscopic, or other scope procedure accomplish the same result, the clinically more intense procedure is recommended for reimbursement. The comparable procedure is found incidental.
3. Dilations are content of service of the primary procedure.
 4. Content of service guidelines will apply when appropriate.
 5. Secondary procedures that are not on the ASC approved procedures list will be reviewed on an individual consideration basis. The ASC should provide documentation of the additional supplies, equipment and time involved in performing the secondary procedure for review.
 6. If two procedures are performed on the same day and only one procedure is on the approved ASC listing, the approved one will be allowed at the provider's charge up to the full MAP. The procedure not on the approved listing will be denied as a provider write-off.

E. MEDICAL NECESSITY/EXPERIMENTAL/INVESTIGATIONAL

Contracting providers shall not bill BCBSKS members for medically unnecessary services unless the members have been notified in advance that specific services, which they are going to receive, will be their responsibility. Providers should use the *Notice of Personal Financial Obligation* form (or approved equivalent) to notify members in advance that payment will be patient responsibility.

Medical Necessity Definition

Medically necessary means a service required to diagnose or to treat an illness or injury. To be medically necessary, the service must:

- Be performed or prescribed by a doctor,
- Be consistent with the diagnosis and treatment of the condition.
- Be in accordance with standards of good medical practice.
- Not be for the convenience of the patient or the doctor, and
- Is provided in the most appropriate setting.

BCBSKS has developed medical policies to promote knowledge and understanding of these guidelines. Providers are encouraged to share these medical policies and medical review articles with other health care

providers and professionals. The medical policies listed below reflect medical criteria used/developed by Blue Cross and Blue Shield of Kansas. These medical policies do not guarantee benefits under BCBSKS member contracts. The most current list of medical policies is available on the BCBSKS Web site:

<http://www.bcbsks.com/CustomService/Providers/MedicalPolicies/index.htm>

REMEMBER to sign-up for e-News to receive e-mail notification of changes to the BCBSKS medical policies:

http://www.bcbsks.com/CustomService/Providers/enews_institutional.htm

Experimental/Investigational Definition

Experimental or Investigational (E/I) refers to the status of a drug, device, medical treatment or procedure:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not research-urgent as defined by the BCBSKS member contract; or
- If Credible Evidence show that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not research-urgent as defined by the BCBSKS member contract; or
- If Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not research-urgent as defined by the BCBSKS member contract; or
- If there is no credible evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis.

Credible Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating eligible provider or the protocol of another eligible provider

providing or studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating eligible provider or by another eligible provider providing or studying substantially the same drug, device, medical treatment or procedure.

As services are reviewed by the medical review area, the experimental / investigational list may change. Therefore, it is important for providers to sign-up for the e-News to receive e-mail notification of changes to the E/I list.

The current list of E/I services can be found on the BCBSKS Web site at: <http://www.bcbsks.com/CustomerService/Providers/MedicalPolicies/institutional/experimental.htm>

F. APPEALS

Right of Appeal - The contracting provider shall have the right to appeal a claim, which has been denied based on:

- lack of medical necessity;
- a service being experimental/investigational

During any level of the contracting provider appeals process, only documents contained in the provider or physician medical records for the inpatient stay or outpatient encounter in question will be considered. All record information must be provided at the initial appeal.

Any health care practitioner's (including physician's) patient case recollection, case summary, case study or case analysis of any kind, not part of the initial medical record, will not be considered during the appeals process.

The Contracting Provider shall not bill BCBSKS members for medically unnecessary services or services deemed to be experimental/investigational unless the members have been notified in advance that specific services, which they are going to receive, will be their responsibility.

Claim Denial When Notice of Personal Financial Obligation Is Not Given

The guidelines in this section apply when claims have been denied and a *Notice of Personal Financial Obligation (NOPFO)* has not been signed by the patient. When this occurs, the contracting provider may not bill the member for the denied charges. This would be true if the service is determined to be not medically necessary or if the service is experimental/investigational.

Before entering into the appeals process, the contracting provider may verify the original payment determination through established inquiry procedures. The inquiry to verify the original payment determination should be made within **180 days of the date of the remittance advice.**

In cases where claims are adjusted, the remittance advice will serve as the written response.

Initial Appeal: Written notification of a disagreement with a medical necessity determination shall be provided to BCBSKS **within 180 days of the date of the remittance advice**. This notice shall be considered an initial appeal and should be forwarded with all pertinent information to BCBSKS customer service center. Information submitted with the request for initial appeal will be referred to the appropriate consultant and a determination will be provided. This decision will be binding unless the provider appeals the decision within 60 days of notification.

Final Appeal: A final appeal may be initiated by forwarding a written request to the BCBSKS Customer Service Center, with a letter addressed to the Chief Medical Officer. The final appeal determination shall be made by the Chief Medical Officer. The contracting provider contractually agrees to abide by the final determination in the appeals process.

All appeal decisions for medical necessity (including experimental/investigational) made by BCBSKS must be conveyed within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider, and claim payments will be adjusted accordingly.

Cases may only be appealed once at each level. The contracting provider agrees to accept the determination made at each level or to appeal the claim at the next step of the appeals process. If throughout the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. A refund will be requested if the decision reverses a previous determination (either partially or totally).

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

G. Post-Payment Audit Appeals

BCBSKS conducts periodic post-payment audits of patient records to substantiate the medical necessity of services billed on the provider claim. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, and onsite visits. In audits where audit findings conclude that education did not occur, BCBSKS will then provide education. If education does not resolve subsequent medical necessity findings, BCBSKS will seek refunds for those paid claims. If claims include billing for services not documented, then BCBSKS will request refunds and may refer the case for further investigation.

Post pay refund requests based on medical necessity must have an appeal filed in writing **within 30 days of the refund request**. The provider must include all relevant documentation with the appeal. The BCBSKS determination will be made within 30 days of receipt of the appeal.

A provider may request a second and final appeal in writing within 30 days of notification of the appeal determination. The second and final appeal determination will be made by the BCBSKS Chief Medical Officer within 30 days. When findings reveal issues, which are presently specified in the BCBSKS policies, billing guidelines or newsletters relating to content of service, multiple surgery guidelines, and other billing and/or reimbursement guidelines, the terms of this appeal are not available.

H. MEMBER APPEALS - Claims Denial After Notice of Personal Financial Obligation is Given

In situations where services are denied as non-covered and where the member is determined to be financially responsible for the claim and acknowledges responsibility, which includes an approximate amount of the charge, the member shall have appeal rights, which are governed by plan documents applicable to the member. In such circumstances, the contracting provider may appeal as the member authorized representative if the member so requests in writing, and must follow the guidelines governed by Employee Retirement Income Security Act of 1974 (ERISA) and/or the benefit plan documents applicable to the member.

I. PRE-DETERMINATIONS

Members have the opportunity to obtain pre-determination of coverage for services not on the ASC Approved listing. If you choose as a provider to submit a request on behalf of a member, we will review the service for coverage and at your request review the service to be performed in the ASC setting. Keep in mind that pre-determinations are worked as received and the timeline for response varies based on how many are in house at a given time. Therefore it is suggested that these are done prior to scheduling a patient for services. If you have not received a response from BCBSKS prior to the surgery date, the patient should be given a Notice of Personal Financial Obligation indicating they may be responsible for the cost of these services as they are not currently on the ASC Approved list and in addition coverage has not been determined at that time.

J. PREVENTABLE ADVERSE EVENTS

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 BCBS shall pay for the medical errors.

K. PURCHASED SERVICES

Charges for all Ambulatory Surgery Center (ASC) services, procedures, supplies and implants (to include those obtained from another organization) provided during an outpatient encounter are billed on one claim using the ASC National Provider Identifier (NPI) billing number.

L. PROFESSIONAL SERVICES

Payment for professional services will be in accordance with the reimbursement guidelines for BCBSKS contracting professional providers of service that are not included in the ASC Agreement.

M. SLEEP STUDY TESTING

Reimbursement for sleep study testing is based on a tiered payment system. Providers who have obtained accreditation through the American Academy for Sleep Medicine (AASM) or the Accreditation Commission for Health Care, Inc (ACHC) will receive a higher reimbursement rate.

II. CLAIMS

Typically, claims are submitted to BCBSKS electronically. Electronic claims must be submitted using the most current HIPAA compliant 837i format (i.e. ANSI ASC X12N v4010A1).

There are times when it may be necessary to submit a hard copy paper claim. An example could be when the provider needs to submit an attachment, like the NOPFO, to the claim. When necessary, Ambulatory Surgery Center providers should submit hard copy paper claims using the CMS-1500.

BCBSKS recognizes all claim codes as defined by the National Uniform Claim Committee (NUCC). A complete 1500 Instruction Manual is available at the NUCC Web site: www.nucc.org.

Although not all NUCC approved codes are required for claims processing, BCBSKS does support data accuracy and feels that all claims submitted should be accurate and complete. Submitting a claim using all the pertinent billing codes ensures prompt and accurate payment.

NATIONAL PROVIDER IDENTIFIER (NPI)

The administrative simplification provisions of HIPAA require the Secretary of Health and Human Services (HHS) to adopt a national standard identifier for covered health care providers. The [National Provider Identifier \(NPI\)](#) is the standard identifier. The Centers for Medicare and Medicaid Services (CMS) is responsible for the development of the [National Plan and Provider Enumeration System \(NPPES\)](#) to identify providers and assign NPIs.

The NPI is a ten-digit number and will be used to submit claim transactions to all government and non-government payers. It replaced existing provider legacy numbers assigned by these entities. CMS also discontinued the UPIN enumeration process.

Providers who are required to obtain an NPI include physicians, non-physician healthcare practitioners, other suppliers and certified providers such as institutions, home health agencies and skilled nursing facilities. Each individual practitioner will receive one NPI. However, an organizational provider may obtain an NPI for each of its subparts. A subpart can be considered a separate physical location of an organization health care provider, member of a chain, or an organization health care provider separately licensed or certified.

III. BILLING

A. AMBULATORY SURGERY CENTER ALLOWED CODES

A list of codes that can be performed in the Ambulatory Surgery Center (ASC) is located on the Web at www.bcbsks.com in the Institutional Publications section. This list is updated annually. Requests to have procedures added to this list should be submitted to your provider consultant in the first six months of the year to be considered for addition to the list for the following year. Send your request to:

Attn: Teresa Van Becelaere
Blue Cross and Blue Shield of Kansas
1133 Topeka Blvd
Topeka, KS 66629-0001
OR
Fax – 785-290-0734

The list of approved codes has grown considerably in the past few years. However, as new technology is developed and codes are deleted and revised this list will need to adjust to those changes. This list will remain consistent with the Maximum Allowable Payment (MAP) listing and as such will report codes that are also reported on the MAP listing.

B. PROSTHESIS AND IMPLANTS

The Ambulatory Surgery Center Allowed Code list includes implants that can be billed separately on the ASC claim. Those include for example:

1. Implantable Access Catheters
2. Implantable Breast Prosthesis
3. Joint Implants
4. Intraocular Lens

All costs of the surgery performed to include staffing, room, drugs, dressings, splints, casts, and orthopedic hardware, etc are recognized in the charge submitted by the provider for that surgical code.

Some services will require review to determine what service was performed. For example, the V2788 and V2787 are codes that can be used when a lens needs to be replaced due to cataract or can be used to correct vision. When used for vision correction only, the service falls under the vision benefits in the member's contract so coverage would need to be determined.

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	66984	SG	\$1000	1	\$700	17XXXXXXXXXX
07/01/10	24	F	V2632	SG	\$200	1	\$150	
				TOTAL	\$1,200		\$850	

The above claim was for a cataract removal with insertion of intraocular lens prosthesis. The lens codes were added to the allowed listing with a pure code. As such, even though these prosthesis implants are under \$500, they are allowed in addition to the surgical procedure when deemed medically necessary.

At times an implant or supply that is not a typical component of that procedure needs to be used. If the codes for those implants are not already on the approved listing and the invoice cost for the individual implant or supply exceeds \$500, it may be billed in addition to the surgery to receive consideration for additional payment.

These cases tend to be the exception and not the norm and may include, for example, silastic finger implants, joint prosthesis, external fixation frames or the polaris humeral component for fractures.

NOTE: *If the description on the invoice is abbreviated or truncated, please hand-write the complete description to avoid having the claim returned for more information.*

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	29877	SG	\$3000	1	\$1500	17XXXXXXXXXX
07/01/10	24	F	99199	SG/22	\$2500	1	\$1000	
07/01/10	24	F	99199	SG/22	\$1600	1	\$850	
				TOTAL	\$7,100		\$3,350	

The above claim example is for an arthroscopy, knee, surgical; debridement / shaving of articular cartilage. Two osteotomy wedges were billed with this surgery to correct bow leg. Because these supplies aren't always required when performing an arthroscopy and because they were over \$500 individually, they

were allowed in addition to the reimbursement for the surgery. These claims must contain modifier 22 with CPT 99199 to be considered for additional reimbursement.

C. MODIFIERS

Modifier SG, which states, "ambulatory surgical center (ASC) facility service" must be appended to all procedure codes submitted on BCBSKS primary claims. The SG modifier is not required when BCBSKS is secondary to Medicare.

Modifier GA may be used when submitting claims for both in-state and out of state members when the service is not on the ASC Approved List. The modifier GA states, "waiver of liability statement on file". The provider must advise the patient of the provider contract limits prior to the services being performed. Either the [Limited Patient Waiver](#) or the [Notice of Personal Financial Obligation](#) must be signed by the patient prior to services being rendered. This alerts the patient to possible additional out of pocket costs associated with this service.

Modifier 22 is used to indicate the service needs to be reviewed. It is defined as, "Unusual Procedural Services: when the service(s) provided is greater than that usually required for the listed procedure".

Any other modifiers billed on the claim must be valid.

D. COSMETIC PROCEDURES

The member contract has specific provisions of coverage for cosmetic procedures. As such, when procedures that could be considered cosmetic are performed, records will need to be submitted. Those procedures include but are not limited to;

1. Dermabrasion
2. Blepharoplasty
3. Mammoplasty
4. Rhinoplasty
5. Otoplasty

Below is an example of a reduction mammoplasty.

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	19318	SG/RT	\$2000	1	\$1000	17xxxxxxxxx
07/01/10	24	F	19318	SG/LT	\$1000	1	\$500	
				TOTAL	\$2100		\$1500	

E. SERVICES NOT ON THE ALLOWED LISTING

When services are provided to a member, both in-state and out of state, that are not on the ASC approved listing, a [Notice of Personal Financial Obligation](#) (NOPFO) must be signed by the patient prior to services being rendered. If you obtain a NOPFO, you do not need to actually submit the NOPFO with the claim. You can append modifier GA to the applicable CPT/HCPCS 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 charges will be denied as the patient's responsibility. If there is not a signed NOPFO, the charges will be processed as a provider write-off.

F. BILLING FOR DENIAL

At times, providers will bill implants/supplies in which they know reimbursement is already being made in the payment for the surgery. This allows the patient to see that all services provided during the surgery are billed to the insurance company. In these situations, providers may use the 99070 to report these services.

In the claim example below, a hysterectomy is being performed laparoscopically. Two supplies are being used; harmonic ace and laparoscopic tissue morcellator. These supplies are already included in the reimbursement for the surgery and each supply does not cost more than \$500 individually.

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	58543	SG	\$4000	1	\$2500	17xxxxxxxx
07/01/10	24	F	99070	SG	\$200	1	\$0	
07/01/10	24	F	99070	SG	\$200		\$0	
				TOTAL	\$4,200		\$2,500	

Therefore, these services can be billed with the 99070 to prevent the claim from being held up in medical review. In addition, do not use the modifier 22 with CPT 99070 as this will cause the claim to be reviewed which will slow down the processing of the claim. The CPT 99070 will content to the surgical procedure

In the claim example below, six (6) harmonic shears were shipped for a total cost of \$2100 and five (5) morcellators were shipped with an invoice of \$2000. Only one shear and one morcellator were used during the procedure for individual costs of \$350 and \$400.

Dates of Service	Place of Service	EMG	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	58543	SG	\$4000	1	\$2500	17XXXXXXXX
07/01/10	24	F	99070	SG	\$2100 (\$350)	1	\$0	
07/01/10	24	F	99070	SG	\$2000 (\$400)		\$0	
				TOTAL	\$8100 (\$4750)		\$2500	

Additional items that are reimbursed as part of the surgery payment include mesh for hernia repair, gastric banders, novasure, etc.

G. CPT 99199 AND 99070

There has been a lot of confusion when billing for services using the 99199 and the 99070. Here is an explanation as to when each is appropriate:

When billing for consideration of individual supplies or implants over \$500 and also when billing for individual supplies or implants you know are content that are under \$500, you will **always use CPT 99070 for FEP.**

All others – For memberships that are not FEP, you will bill 99199 with modifier 22 to describe an individual supply or implant that is over \$500 in which you are asking for consideration of payment in addition to the surgery payment.

CPT 99070 is billed when you are indicating that the individual supply or implant is under \$500 and you know it is not separately reimbursable but you need a denial for other insurance or so the member will know the service was billed to their insurance.

Regardless of which membership the patient has, it is requested that you provide a description of the service you are billing on the claim when 'not otherwise classified' (NOC) codes are used ie. 99199 and 99070. Your vendor should be able to assist you in providing this information on an electronic claim to print directly above the CPT code on the CMS-1500 claim form. Another option is to list this information in Box 19 which indicates 'for local use'.

If the description of the NOC is included and it's a service that does not require review, no records will be requested. However, if there is no description to identify the NOC, records and/or a description of the code will always be requested.

H. OBSERVATION / 23 HOUR AFTERCARE

On some surgeries, observation services are always allowed when medically necessary. Those cases do not need to go through the extensive review process to be approved for payment.

When the claim is billed with a surgery where observation is always allowed, bill 99234 and it will bypass the review process and be sent directly for processing.

Procedures where observation is always considered medically necessary are:

- **Hysterectomies, Reconstructive Gynecological Procedures and Bladder Suspension Procedures:** 51840, 51841, 51845, 51990, 51992, 57240, 57250, 57260, 57288, 58150, 58152, 58260, 58262, 58263, 58267, 58275, 58290, 58291, 58293, 58294, 58541, 58542, 58545, 58546, 58550, 58552, 58553, 58554, 58571
- **UPPP --** 42145
- **Thyroidectomies and subtotal Thyroidectomies:** 60210, 60220, 60225, 60500, 60240, 60252, 60254, 60260, 60270

When you file an observation with a surgical procedure that is not the above list, use CPT 99199 with modifier 22 and include medical records to the support the medical necessity for the observation.

There may be times when an overnight stay is deemed medically necessary due to a particular patient's outcome to include excessive post-op bleeding, surgical complications, intractable nausea and vomiting, etc. In these situations, medical records will be required with the claim.

Do not automatically send records when billing for observation. Only send records if requested by BCBSKS.

I. CANCELLED PROCEDURES

There may be unforeseen circumstances that present which cause a scheduled surgery to be canceled i.e. abnormal lab results, unexpected temperature, abnormal vital sign, etc.

The facility should bill for the costs incurred to that point. If the patient has already been prepped and moved to the O.R. when the cancellation occurs, the facility will need to bill a reduced charge. Charges for the opening of the O.R., any supplies that were unwrapped and ready to be used, or other costs should be included on the claim. The full provider charge for the surgery should not be billed.

J. UNSCHEDULED PROCEDURES

When a procedure which is on the approved list is scheduled but during surgery a procedure which is not on the approved list is actually done, the claim will need to be submitted with medical records. Include all documentation as to why the procedure was changed and the medical necessity of the procedure.

To have these services that are not on the approved listing considered, bill the service with CPT 99199 and modifier 22 and include medical records.

K. CLAIM EXAMPLES

Multiple Surgery Claim Example #1

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	45385	SG	\$500	1	\$425	17XXXXXXXXXX
07/01/10	24	F	45380	SG51	\$500	1	\$0	17XXXXXXXXXX
				TOTAL	\$1000		\$425	

The above claim shows a colonoscopy with biopsy, single or multiple with removal of tumor(s), or polyp(s) or other lesions by snare technique. In this example the 45385 which describes the snare technique is not only the highest clinical procedure but also the procedure with the highest MAP. Therefore the 45380 which only describes the biopsy is contented to the higher level snare procedure.

Multiple Surgery Claim Example #2

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	31020	SG50	\$2000	1	\$1000	17XXXXXXXXXX
07/01/10	24	F	30115	SG50	\$2500	1	\$500	17XXXXXXXXXX
07/01/10	24	F	31020	SG50	\$2000	1	0	17XXXXXXXXXX
07/01/10	24	F	30115	SG50	\$2500	1	0	17XXXXXXXXXX
				TOTAL	\$9,000		\$1,500	

The above claim reports a sinusotomy with excision of nasal polyps bilaterally. In looking at the ASC approved listing, both procedures allow one unit. Therefore, the multiple surgery rule applies. The highest MAP'd procedure receives payment at 100% with the second procedure at 50%.

Scope Surgery Claim Example

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	58563	SG	\$2000	1	\$1000	17xxxxxxxxx
07/01/10	24	F	58670	SG	\$2000	1	\$500	17xxxxxxxxx
07/01/10	24	F	58662	SG	\$2000	1	\$0	17xxxxxxxxx
TOTAL					\$6,000		\$1,500	

In the above example, a hysteroscopy, laparoscopic destruction of the oviduct and a laparoscopy to remove lesions was performed on the same day. In this example the procedure with the highest MAP is allowed at 100% of the MAP. The 58670 indicating fulguration of oviducts is allowed at 50% of the MAP with 58662 which is fulguration or excision of lesions of the ovary, pelvic, viscera, or peritoneal surface by any method is contented to the 58670.

Observation Claim Example

Dates of Service	Place of Service	Type of Service	CPT / HCPCS	Modifier	Charges	Days or Units	Allowed	Rendering Provider ID#
07/01/10	24	F	58150	SG	\$1500	1	\$990	17xxxxxxxxx
07/01/1	24	F	99234	SG	\$400	1	\$300	17xxxxxxxxx
TOTAL					\$1,900		\$1,290	

Beginning in 2009, you may start billing observation using CPT 99234. This code is more descriptive of the service being performed. A hysterectomy is performed and 23 hour observation is also billed. Because medically necessary observation will always be allowed when billed with the hysterectomy, this claim allowed both services.

L. ASC's BILLING ON UB-04

Today, ASC's bill using the CMS-1500 claim form. This is also the claim form used by both Medicare and Medicaid, as well as the claim form used by professional providers. Many of the other commercial payors only accept ASC claims billed on the UB-04 claim form which is the facility claim form. In addition, we are starting to see government programs transition ASC's to UB-04 billing to include TRICARE.

BCBSKS is exploring the possibility of allowing ASC's to bill on the UB-04 in lieu of the CMS-1500. Some of the reasons that this move would be beneficial to both BCBSKS and the ASC's are listed below.

1. Currently the Federal Employee Program (FEP) which is administered by BCBSKS uses a system out of Washington which can not accept the CMS-1500 claim form. BCBSKS currently changes the CMS-1500 to the UB-04 format before sending the claim for processing. In addition, when the claim is received back from Washington, BCBSKS then again converts it back to CMS-1500 form for reporting on the remittance advice to providers. This process causes delays in payment to the providers. This timeframe could be shortened if this conversion was eliminated.

In addition, we see challenges in the coding of the claim that also has to be changed. In the past, you were able to submit a CPT 99199 for FEP patients. In 2009, we are asking that you begin using the 99070 exclusively for FEP claims to eliminate this extra step which again delays claim processing.

2. Payment guidelines are complicated using the CMS-1500 to make a facility payment.
3. UB-04 would bring ASC's in line with how other facility claims are edited.
4. ASC's would follow facility medical policies which allow for a 30 day notification to update systems. Comment periods for draft policies would remain in tact.
5. The maximum allowable payment (MAP) listing was developed for facility providers and can be confusing when using it with respect to professional billing guidelines and rules as it doesn't address content of service, multiple billing guidelines, etc.

As BCBSKS prepares for a possible transition to UB-04 billing, ASC's should also evaluate their systems and procedures in place within the facility.

1. Identify key people within your organization that would need to be involved in this transition.
2. What systems are affected at the ASC? Vendor systems? Accounting systems?
3. If not initially, we may allow for line item billing of services. What changes would need to be made to implement this within your facility? Again, what systems are affected?
4. Determine what kind of timeline is needed to convert from 1500 to UB-04 billing at your facility.

IV. PAYMENT

A. MAXIMUM ALLOWABLE PAYMENT (MAP)

This listing was developed for publication in 2009. It replaces the Charge Comparison from prior years. The maximum allowable payment (MAP) was created for Ambulatory Surgery Centers (ASC) in 2009. The focus of ASC reimbursement is the use of facility resources and as such the payment structures will reflect that of a facility. For that reason, reimbursement may not necessarily be tied to each procedure code individually but rather to the overall facility costs involved when a surgical service(s) is performed.

Some procedures on the MAP listing will content to other higher level procedures when performed in the same setting. Keep this in mind when you are trying to determine reimbursement for a service ahead of time.

In the fourth quarter of each year, new, deleted and revised HCPC / CPT codes are published. Those changes will be considered and updates will be made to the ASC Allowed Code listing and the MAP listing. The MAP listing will then be mailed to providers so they have the most updated list. Some enhancements you will see on the new list include:

1. Long descriptions of the CPT/HCPCS codes.
2. Removal of deleted codes, addition of replacement codes and addition of new codes being added, which are approved to be performed in the ASC setting.

By Report codes are identified on the MAP listing with a BR. These codes may require medical records prior to payment to determine the medical necessity of the service. Some of these codes have a medical policy that applies. This designation is also used to determine if services are cosmetic in nature and payable under the member's contract.

B. ONLINE REMITTANCE ADVICES

Providers can access their remittance advices via the BCBSKS Web site.

In fact, we encourage providers to discontinue receiving RAs by mail and rely on the online RA for their payment information.

A few of the many advantages are:

- Gets to you faster. At least a day earlier, sometimes more.

- Multiple people can access the online RA at the same time. No longer do you have to copy the RA so each person has his or her own copy to work from.
- The information is stored securely protecting PHI.
- The online RA looks exactly like the paper copies.
- If you need a copy of the RA, you can print it off or if you only need one or two pages, you can print only those.
- You can search the online RA by any field including patient name, ID number, patient account number, etc.
- If you need to see it better, the online screen image can be made bigger. The paper copy only comes in one size.

RA information is confidential and requires the user to establish a provider profile. Information about using secured services including how to establish a provider profile is available at our Web site at <https://clyde.bcbsks.com/bcbsks/allUsers/ProviderGettingStarted>

Also, many providers have more than one NPI. For example, you may have an ASC NPI and separate physician NPI's. If you have multiple numbers, please be sure to shut off the paper RA for all of them.

A Remittance Advice (RA) Guide appears on the BCBSKS Web site at: http://www.bcbsks.com/CustomerService/Providers/Publications/institutional/manuals/pdf/RA_guide0609.pdf

C. OVERPAYMENTS

Refund/Deduct Authorization Form (29-202 6/01)

When providers discover an overpayment they need to notify BCBSKS by using the Refund/Deduct Authorization form. The provider can:

- ❖ Enclose a refund check
- ❖ Request that the money be deducted
- ❖ Request that a refund letter be sent

This form can be accessed, completed and emailed at our Web site www.bcbsks.com (located in the forms section under provider services.)

BCBSKS Refund Request

BCBSKS uses an automated accounts receivable system for handling refunds. When we discover overpayments, the provider will not receive a refund request letter instead, the overpayment will be deducted from the provider's RA.

V. Credit Balance Audits

Many circumstances can create an overpayment or a credit balance on a patient's account. When a credit balance occurs providers should follow the voluntary refund process to clear the account or if necessary, work with our customer service center to resolve outstanding issues leading up to clearing the account.

Blue Cross will request credit balances annually. These requests will only be for accounts that are outstanding at the time of the request. The main goal of credit balance audits is to ensure that member accounts are kept up to date which increases the value of the service you provide to your patients and our members.

Goal of Credit Balance Audits

- Ensure member accounts are correct and resolved timely
- Certify that provider payments are correct
- Resolve outstanding claims issues timely to reduce administrative burdens for providers and BCBSKS

Tracking Credit Balances

Providers need to develop a system for reporting and handling credit balances. This could include:

- Excel spreadsheet
- Communications log used to show follow-up activity
- Timely follow up

Credit Balance Audit Documentation

Credit balances that have not been resolved through normal channels within **six months** can be submitted to institutional provider relations for resolution assistance. You can either give them to your provider consultant when they're visiting your facility or mail them to:

Institutional Relations cc442D2
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629

Providers need to include:

- Claim specific detail
 - ✓ Patient name
 - ✓ Date of service
 - ✓ Total charge
 - ✓ Amount in question
 - ✓ Primary/secondary ID numbers
 - ✓ Reason for credit balance
- Excel spreadsheet/communications log reflecting follow-up activity

- Contact person

A sample of a credit balance spreadsheet appears below.

Institutional provider relations will:

- Research the account
- Initiate adjustments
- Report the results to the provider

Credit Balance Audits

Sample Credit Balance Spreadsheet

Patient Name/ Acct #	ID # Primary/ Secondary	Date of Service	Total Charge	Credit Balance on Account	Reason for Credit Balance	Follow-up Tracking
A. Smith	555555555	2/01/10-2/29/10	\$1,200.00	\$1,200.00	Duplicate Payment	3/10-Called BC to verify payment
B. Jones	666666666	2/12/10-2/13/10	\$525.00	\$420.00	Paid Primary instead of Secondary	3/28- Requested Primary RA
C. Myers	777777777	4/28/10-5/01/10	\$800.00	\$800.00		6/1- Researching reason for overpayment
D. Adams	888888888	5/12/10-5/15/10	\$1,500.00	\$426.82	Both plans reporting primary	6/3-Called BC-they are contacting other plan