



**BlueCross  
BlueShield  
of Kansas**

# **Ambulatory Surgery Center's (ASC) 2011 Workshop**

**Converting to UB-04/837I Claim Format Billing**

**FALL 2011**

# BLUE CROSS AND BLUE SHIELD OF KANSAS

## INSTITUTIONAL PROVIDER RELATIONS

### CONTACT INFORMATION

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## **FUNCTIONS OF THE INSTITUTIONAL RELATIONS DEPARTMENT**

The institutional relations department functions as a liaison between the providers and Blue Cross and Blue Shield of Kansas (BCBSKS). The staff in this department manages the contracts, provides training and communication to the following facility types:

- Birthing Centers
- Dialysis Centers (aka - ESRDs)
- Home Health Agencies
- Hospice Facilities
- Hospitals (including acute care, rehabilitation, psychiatric, military & VA)
- Substance Abuse Facilities
- Ambulatory Surgery Centers (ASCs)

We also handle inquiries related to services provided in hospital swing beds and/or skilled nursing facilities (SNFs). Since most BCBSKS plans do not have member benefits for skilled nursing, we generally do not contract with SNFs. However, we do handle issues related to Plan 65 (Medigap).

## **PROVIDER CONTRACTS**

Institutional provider contracts are automatically renewed each year, meaning unless either party states otherwise, the contract agreement continues. There are times when BCBSKS may offer a new product or make changes to the contracts. If contract changes are made, the providers are notified and may be asked to re-sign the contract. Although this doesn't happen very often, it is important that the facilities review the contract or contract changes and respond within the designated time frame.

In addition to the contracts, there are policies and procedures, which are generally updated annually as are the payment rates (maximum allowable payments (MAPs)). These updates are generally a year-long process and do not become effective until the following calendar year.

The Policies and Procedures are mailed to providers (generally CEO/Administrator) in late July. Along with the policies and procedures, the BCBSKS reimbursement department also sends out their proposed payment changes. Providers have until September 1<sup>st</sup> to submit comments and or notify BCBSKS (in writing) if they don't intend to contract for the following year.

A final version and/or any updates of the BCBSKS MAPs are always sent to contracting providers. These are usually sent to the CEO/Administrators.

From September 1<sup>st</sup> to the end of the year, Institutional Relations staff works to make the necessary changes to the BCBSKS claims system in order to be ready by January 1<sup>st</sup> so that claims are processed according to the policies and procedures and payment allowances.

## TRAINING

Throughout the year, institutional relations staff conducts a variety of training opportunities including:

- Workshops
- E-learning Courses
- Teleconferences
- Provider Visits
- Podcasts



## COMMUNICATION

The Institutional Relations Department has always believed that when changes occur, providers need to know as soon as possible. This enables providers to make system changes, educate internal staff and be prepared prior to the actual implementation.

When there are billing, coding or other changes that could affect provider claims, a newsletter is published to the [www.bcbsks.com](http://www.bcbsks.com) Website. Those individuals, who have signed up to receive e-mail notifications, will receive an e-mail notification whenever a newsletter is published.

Another source of information is the Institutional Provider Update (IPU). This is a quarterly publication that is also found on our website used to communicate information that is not necessarily in the form of policy, billing or contract change. The information is more general and informal.

## WWW.BCBSKS.COM

The next section gives information on where to access Provider information and educational tools on the Blue Cross and Blue Shield of Kansas website.

### BlueAccess -

BCBSKS's *Current* Secure Web site Access for Eligibility and Claim Status.

## BCBSKS WEBSITE [www.bcbsks.com](http://www.bcbsks.com)

The screenshot shows the BCBSKS website homepage. At the top left is the Blue Cross Blue Shield of Kansas logo. Navigation links include Contact Us, About Us, News, and Provider Directory. A search bar is located at the top right. The main content area features a 'BlueAccess' login box on the left, which includes fields for User Name and Password, a Log In button, and links for Forgot ID/Password, Sign-up, and BlueAccess Tour. Two red arrows point to this box. Below the login box is a 'Find a Doctor or Hospital' search box with fields for Facility or Dr. Last Name, State (KS), City, and State, and a Find button. The central part of the page has a 'Customer Service' menu with links for Members, Providers, Employers, Forms, Prescription Drugs, and Contact Us. To the right of this menu is a large image of a family. Below the family image are sections for 'What to do when...' and 'I have a...', each with a list of common user needs and a 'more...' link. At the bottom of the page, there is a footer with various links and a disclaimer.

The BCBSKS Web site [www.bcbsks.com](http://www.bcbsks.com) offers providers fast, easy access to a wide range of information including:

- ❖ Claim Status information\*
- ❖ Eligibility Information\*
- ❖ Remittance Advices\*
- ❖ Newsletters
- ❖ Manuals
- ❖ Workshop Information
- ❖ Education Material
- ❖ Medical Policies
- ❖ ASK/EDI
- ❖ And More

\* Secured Access Required

As noted above, some of the information on our Web site is confidential and therefore, accessing it is a secure process. The **secured** section of the Web site is referred to as BlueAccess

BlueAccess requires the user to create a “profile” during their first visit. Then on subsequent visits, the information established during the first visit is used to validate that the person has authorization to access the information.

When you’re visiting [www.bcbsks.com](http://www.bcbsks.com) for the first time, our user-friendly instructions will assist you in establishing a secure profile.

Non-confidential information such as provider publications can be accessed without establishing a provider profile. Claim status and eligibility information is also available for out-of-area (BlueCard) members.

## **CREATING A USER PROFILE FOR BlueAccess**

Creating a user profile to access BlueAccess is easy to do.

From the home page, click on 'For Providers' under the Customer Service tab.

Click on the **BlueAccess** Sign-up.

The screenshot displays the BlueCross BlueShield of Kansas website. At the top left is the logo, and navigation links include Home, Contact Us, About Us, News, and Provider Directory. A search bar is located at the top right. Below the navigation, there are tabs for Customer Service, Be Healthy, and Health Plans. A sidebar on the left lists various resources like Forms, Contact Us, and Latest News. The main content area features a 'BlueAccess' section with a list of services: Claim Status, Eligibility, Remittance Advice, Referrals, and Precertification. A 'Sign-up' button is visible in this section. To the right, a 'BlueAccess' login box contains fields for User Name and Password, a Log In button, and links for Forgot ID/Password, Sign-up (highlighted with a red arrow), and BlueAccess Tour. At the bottom, there are links for Forms, Publications, and e-News, along with text for 'Resize Text' and 'Printer Friendly'.

The initial page will be the step-by-step instructions for establishing a user profile. In the BlueAccess box (as you see above) click on to Sign-Up. You will be signing up as a Provider. As you scroll to the bottom of the next page, you will see "Create your Secure Access". Click on that link to proceed.

To initiate your user profile, you will be required to enter your facility's billing provider number (NPI) and tax identification number (EIN/TIN).

Once you enter your facility's provider number, the screen will update to require you to select whether you are an **institutional provider** or a **professional provider**. Click the appropriate button.

## Provider Identification

Please enter your **Billing Provider Number**, select your **Provider Type**, if applicable, and enter one of the following numbers: **Billing Provider Tax ID** or **Billing Provider Social Security Number (SSN)**.

**Billing Provider Number:**

**Institutional**     **Professional**

Please enter one of the following numbers:

**Billing Provider Tax ID:**

or

**Billing Provider SSN:**

[Return Home](#)

For security purposes, each individual should create their own user access. To do this, each individual should create their own user name, key in their first/last name, department within your facility and select and answer two challenge questions. The challenge questions will be used when you have forgotten your password and need to reset your password or when you need assistance in establishing access. For assistance in establishing access call 1-800-472-6481.

It is important when establishing the answers to your challenge questions, that the answer will be constant and not change over time.

## Welcome

Now that your identity has been verified, you may create a provider profile. This will make it quicker and easier for you to navigate through the secure area of this site on future visits.

To create a profile, please fill in the following blanks. Required fields feature an asterisk\*.

**Billing Provider  
Number:  
Provider Name:**

**Desired Provider User  
Name:**  \*  
(must have between 5 and 11  
characters)

**Your Name:**  \*  \*  
(Password will be sent to the person whose name is entered here)

**Your Department:**

**Challenge Questions**

**Challenge Responses**

Question One  \*  
 Question Two  \*

**E-mail Address:**

required fields \*

After the individual has created and submitted their user information, the system will generate a random password that will be mailed to the provider's address via the U.S. Postal Service.

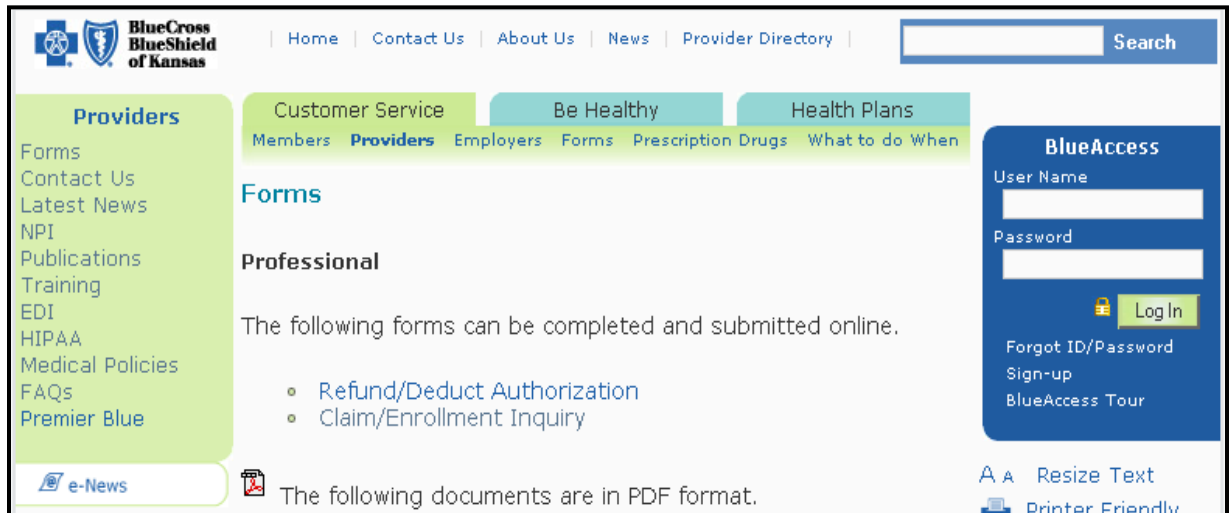
**YOU WILL NOT BE ABLE TO ENTER THE SECURED AREA UNTIL YOU HAVE RECEIVED AND ENTERED THE ORIGINAL PASSWORD SENT BY BLUE CROSS AND BLUE SHIELD OF KANSAS.**

This process takes generally 3-4 days. Once the password is received you will then be able to sign in to BlueAccess (Secured area) with this password. After you initially have logged into BlueAccess with the password you received from BCBSKS, it is recommended that you change the password.

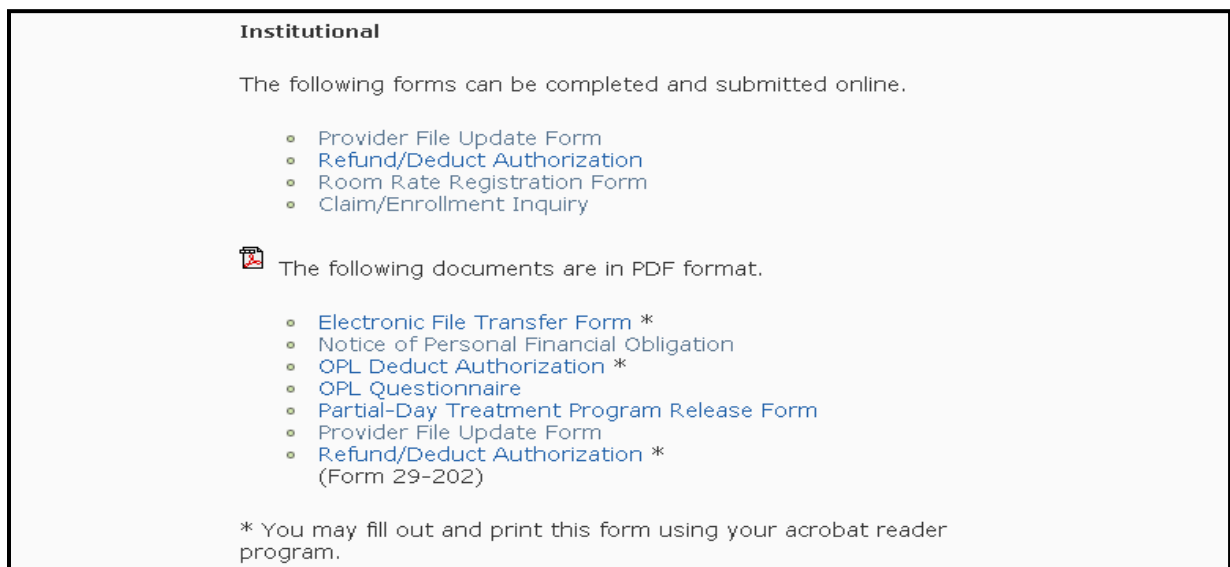
Each facility is responsible for monitoring who has access to BlueAccess and to notify BCBSKS when someone from your facility leaves. You can notify the Webmaster by clicking on Webmaster on the bottom of any bcbsks.com page who can remove any invalid user profiles.

## OTHER WEB RESOURCES

- There are many [forms](#) available for providers to use. Some forms can be completed and submitted online, such as provider file updates, refund/deduct authorizations and claim enrollment inquiries.
- Other forms, like the [Limited Patient Waiver](#) require a signature so providers must either print a blank form and fill it out by hand or fill out the form online and print off to send to BCBSKS with the signature.



The screenshot shows the BlueCross BlueShield of Kansas website. A red arrow points to the 'Providers' menu item in the left sidebar. The main content area is titled 'Forms' and lists 'Professional' forms that can be completed online: Refund/Deduct Authorization and Claim/Enrollment Inquiry. Below this, it states 'The following documents are in PDF format.' A 'BlueAccess' login box is visible on the right side of the page.



The screenshot shows the 'Institutional' forms section. It lists forms that can be completed online: Provider File Update Form, Refund/Deduct Authorization, Room Rate Registration Form, and Claim/Enrollment Inquiry. Below this, it states 'The following documents are in PDF format.' and lists: Electronic File Transfer Form \*, Notice of Personal Financial Obligation, OPL Deduct Authorization \*, OPL Questionnaire, Partial-Day Treatment Program Release Form, Provider File Update Form, and Refund/Deduct Authorization \* (Form 29-202). A note at the bottom states: '\* You may fill out and print this form using your acrobat reader program.'

## KEEPING CURRENT

It is important for providers to keep up on the latest information and updates to the Web. To help keep informed, providers can sign-up for e-News, which is an e-mail notification system.



## **Availity:**

BCBSKS's *Future* Secure Web site Access for Eligibility and Claim Status.

## **What is Availity?**

Availity offers a multi-payer portal at [www.availity.com](http://www.availity.com) that gives physicians, hospitals and other health care providers secure access to multiple payers' information through a single sign-on. Availity offers a variety of business and clinical solutions to help providers reduce administrative costs by eliminating paperwork and phone calls. Availity is one of the nation's largest electronic health information networks, processing more than a billion transactions each year.

## **Why is Blue Cross Blue Shield of Kansas teaming with Availity?**

Our relationship with Availity will help remove costs from the system by streamlining transactions and processes. This will help reduce the amount of paperwork for medical practices, allowing physicians to spend more time with patients.

## **What are the advantages of using Availity?**

- **No Charge** – Health plan transactions are available at no charge to providers.
- **Accessibility** – Availity functions are available 24 hours a day from any computer with Internet access.
- **Standard responses** – Availity returns responses from multiple payers in the same format and screen layout, providing users with a consistent look and feel.
- **Commercial and Government Payers** – Access to data from BCBSKS, Medicare, Medicaid and other commercial insurers. A full list of participating payers for each state by participation type is available at [www.availity.com](http://www.availity.com) > Info for Providers > View Availity Health Plan Partners. The link to 'View Availity Health Plan Partners' can be found on the right hand side of the 'Info for Providers' page.
- **Compliance** – Availity is compliant with the Health Insurance Portability and Accountability Act (HIPAA) regulations. Availity's statement of compliance is available at [www.availity.com](http://www.availity.com). Select Info for Providers and then click on the Regulatory Compliance link.

The link to Regulatory Compliance can be found on the right hand side of the Info for Providers page.

- **Training** - Availity offers free live and pre-recorded Web-based training seminars (webinars). Providers simply log into the Availity portal and register to attend the webinars of their choice. Demonstrations, frequently asked questions and comprehensive help topics are available online as well.

### **What services are available through Availity?**

Providers can use the portal for the following BCBSKS member transactions:

- Eligibility and Benefits
- Claim Status

Additional services and functions may be available from other payers.

### **Who should providers call if they have questions about Availity?**

Contact Availity Client Services toll free at 800.Availity (800.282.4548) or e-mail questions to [support@availity.com](mailto:support@availity.com). Availity Client Services is available Monday through Friday 8 a.m. to 7 p.m. ET (excludes holidays).

### **For other assistance:**

- **Availity Help**  
In Availity, click Help at the top of the page. Browse the books and topics as necessary
- **Show Me Demos**  
On the Availity website ([www.Availity.com](http://www.Availity.com)), click on the Demos tab, Explore Demonstrations, Log In (no Log in required to view the demos). Click any of the categories to expand them. Click a blue triangle to launch a demo.
- **Live and Pre-recorded Webinar Training**  
Availity offers live training conducted by phone and teleconferencing tools. To see the schedule and enroll: In Availity, click Free Training on any page. Click Live Webinar Schedule. To enroll, click a webinar title and follow the instructions on the page that displays.

## What are the technical requirements?

All a provider needs to access Availity.com is:

- A computer with internet access. High speed is recommended for best results
- Microsoft Internet Explorer 6.0 or greater, which supports 128-bit encryption.
- A 1024 x 768 or greater pixel display for best results.

Check with your facilities Information Systems Department to identify any issues you may encounter with accessing and utilizing Availity for BCBSKS member's eligibility, benefits and claim status.

# CONVERTING TO A UB-04/837I CLAIM FORM

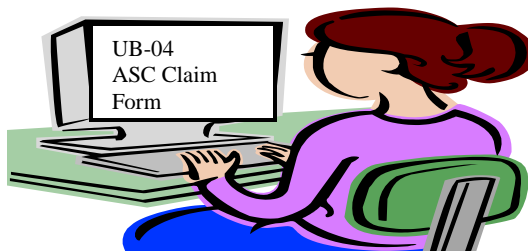
## GOALS:

Recently Blue Cross and Blue Shield of Kansas (BCBSKS) moved Ambulatory Surgery Centers (ASC's) from a professional provider to an institutional provider. All professional providers submit claims to BCBSKS on the CMS-1500 format. ASC services most closely follow the hospital methodology as opposed to the individual professional provider methodology. Moving to the UB-04 format will apply the facility edits to the ASCs.

Effective 1/1/2012, ASCs will submit claims to BCBSKS on the UB-04. This change will be effective for all claim submissions as of 1/1/2012. This change will be based on **effective date, not the date of service**. Claims with services dates prior to 1/1/2012 which are submitted on 1/1/2012 or later must be submitted in the UB-04 format.

## BENEFITS

- UB-04 submission will apply facility claims edits to ASCs.
- ASC will follow facility medical policies which allow for a 30-day notification to update systems.
- The maximum allowable payment (MAP) listing was developed for facility providers and is confusing when applying professional billing guidelines.
- All allowed codes will be MAP'd.
- ASCs will no longer be required to submit an invoice to receive reimbursement for implants.
- Claims will no longer require submission of the SG modifier.



## OUTCOME

The anticipated outcome is simply to move from the CMS-1500 format to the UB-04. ASC's will continue to do business as usual.

- All previous dollars paid for a surgical procedure will be applied to the new surgical level MAP.
- Surgical Level MAP: Reimbursement will be based on the highest MAP'd surgical code. The total MAP for this surgery will be allocated along all allowed lines of the claim. All services associated with that surgery will be included in the surgical MAP.

### UB-04 TRANSITION TIMELINE

|         |      |  |
|---------|------|--|
| MAY     | 2011 | Spring Workshops                         |
| June    | 2011 | ASC Podcast published to the Web         |
| JULY    | 2011 | 2012 Surgery level MAPS will be released |
| SEPT    | 2011 | Fall Workshops                           |
| OCT     | 2011 | ASC Newsletter published to the Web      |
| OCT/NOV | 2011 | Provider Claim Submission Testing        |
| JAN     | 2012 | Submit all claims on UB-04 Claim Form    |



# UB-04 COMPLETION GUIDELINES FOR AMBULATORY SURGERY CENTERS

## **FIELD 1 - REQUIRED**

### **BILLING PROVIDER NAME, ADDRESS, & TELEPHONE NUMBER**

Enter the billing name, street address, city, state, zip code, and telephone of the billing provider submitting the claim. Note: this should be the facilities address.

## **FIELD 02 - SITUATIONAL - PAY TO NAME AND ADDRESS**

Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent. Note: This is **required** when information is different from the billing provider's information in FIELD 01.

## **FIELD 03 -**

### **3a - REQUIRED - PATIENT CONTROL NUMBER**

Enter the patient's unique alphanumeric accounts control number assigned to the patient by the provider.

### **3b - REQUIRED - MEDICAL RECORD NUMBER**

Enter the number assigned to the patient's medical health care record by the provider

## **FIELD 04 - REQUIRED - TYPE OF BILL (TOB)**

Enter the appropriate code that indicates the specific type of bill such as inpatient, outpatient, late charges, etc. For more information on TOB, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual - [www.nubc.org](http://www.nubc.org).

## **FIELD 05 - REQUIRED - FEDERAL TAX NUMBER**

Enter the provider's Federal Tax Identification number.

## **FIELD 06 - REQUIRED - STATEMENT COVERS PERIOD (FROM/THROUGH)**

Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 080210. The FROM date should not be confused with the Admission Date (FIELD 12).

## **FIELD 07 - NOT USED - RESERVED FOR ASSIGNMENT BY THE NUBC**

## **FIELD 08 -**

### **8a - REQUIRED - PATIENT NAME**

Enter the patient's last name, first name, and middle initial

### **8b - SITUATIONAL - PATIENT ID**

Enter the patient's identifier. Note: The patient's identifier is situational if it is different than what is reported in Insured's Identifier (FIELD 60).

## **FIELD 09 - REQUIRED - PATIENT ADDRESS**

Enter patient's complete mailing address (field's 9a-9e), including street address (9a), city (9b), state (9c), zip code (9d), and county code (9e) if applicable to the claim.

**FIELD 10 - REQUIRED - PATIENT BIRTH DATE**

Enter the patient's date of birth using an eight-digit format (MMDDYYYY). For example: 04231966

**FIELD 11 - REQUIRED - PATIENT'S GENDER**

Enter the patient's gender using an "F" for female, "M" for male, or "U" for unknown.

**FIELD 12 - SITUATIONAL - ADMISSION/START OF CARE DATE**

Enter the start date of this episode of care using a six-digit format (MMDDYY). For inpatient services, this is the date of admission. For other (Home Health) services, it is the date the episode of care began. **Note: this is required on all inpatient claims.**

**FIELD 13 - SITUATIONAL - ADMISSION HOUR**

Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. For more information on Admission Hour, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 14 - REQUIRED - PRIORITY (TYPE) OF ADMISSION OR VISIT**

Enter the appropriate code indicating the priority of this admission/visit. For more information on POA, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 15 - SITUATIONAL - POINT OF ORIGIN FOR ADMISSION/VISIT**

Enter the appropriate code indicating the point of patient origin for this admission/visit. The PoO is where the patient came from **before** presenting to the health care facility. Based on this definition, the emergency room code (7) has been eliminated effective for discharges on or after July 1, 2010. See Blue Cross newsletter [BC-10-06](#). For more information on PoO, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 16 - SITUATIONAL - DISCHARGE HOUR**

Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. Note: This is required on all final inpatient claims. For more information on Discharge Hour, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 17 - REQUIRED - PATIENT DISCHARGE STATUS**

Enter the appropriate two-digit code indicating the patient's discharge status. Note: This is required on all inpatient, observation, or emergency room care claims. For more information on Patient Discharge Status, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 18 - 28 - SITUATIONAL - CONDITION CODES**

Enter the appropriate two-digit condition code or codes if applicable to the patient's condition. For more information on Condition Codes, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 29 - SITUATIONAL - ACCIDENT STATE**

Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.

**FIELD 30 - NOT USED - RESERVED FOR ASSIGNMENT BY THE NUBC**

**FIELD 31-34 - SITUATIONAL - OCCURRENCE CODES AND DATES**

Enter the appropriate two-digit occurrence codes and associated date using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition. For more information on Occurrence Codes and Dates, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org). BCBSKS encourages that this field be completed when submitting an accident claim.

**FIELD 35-36 - SITUATIONAL - OCCURRENCE SPAN CODES AND DATES**

Enter the appropriate two-digit occurrence span codes and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time. For more information on Occurrence Span Codes and Dates, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 37 - NOT USED - RESERVED FOR ASSIGNMENT BY THE NUBC**

**FIELD 38 - SITUATIONAL-  
RESPONSIBLE PARTY NAME AND ADDRESS (CLAIM ADDRESSEE)**

Enter the name, address, city, state, and zip code of the party responsible for the bill.

**FIELD 39-41 - SITUATIONAL - VALUE CODES AND AMOUNTS**

Enter the appropriate two-digit value code and value if there is a value code and value appropriate for this claim. For more information on Value Codes and Amounts, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

**FIELD 42 - REQUIRED - REVENUE CODE**

Enter the appropriate Revenue Code for the service(s) rendered. The only Revenue Code that should be used by an ASC is 049X. For more information on Revenue Codes, refer to the Revenue Code manual located in BlueAccess, the BCBSKS secure provider section at [www.bcbsks.com](http://www.bcbsks.com).

**FIELD 43 - SITUATIONAL - REVENUE DESCRIPTION**

Enter the standard abbreviation description of the related revenue code categories included on this bill. For more information on Revenue Codes, refer to the Revenue Code manual located on the BCBSKS secure provider section at [www.bcbsks.com](http://www.bcbsks.com).

**FIELD 44 - REQUIRED - HCPCS/CPT ACCOMMODATION RATES**

Enter the appropriate HCPCS/CPT/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report the appropriate modifier when it clarifies the code or improves reporting accuracy. Reimbursement will only be provided for codes on the [ASC Allowed Code List](#).

**FIELD 45 - REQUIRED - SERVICE DATE**

Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services. Not required for inpatient claim except for line item of the room & board revenue code.

**FIELD 46 - REQUIRED - SERVICE UNITS**

Enter the number of units provided for the service line item. The service units for ASC claims are always 1.

**FIELD 47 - REQUIRED - TOTAL CHARGES**

Enter the total charges related to the line item revenue code for the current billing period as entered in the statement covers period.

**FIELD 48 - SITUATIONAL - NON-COVERED CHARGES**

Enter any non-covered charges as it pertains to the related revenue code for the current billing period as entered in the statement covers period.

**FIELD 49 - DO NOT USE - RESERVED FOR ASSIGNMENT BY THE NUBC**

**FIELD 50 - a. REQUIRED - PAYER NAME**

Enter the health plan that the provider might expect payment for the bill. Line b and c are required when other payers are known to potentially be involved in paying this claim.

**FIELD 51 - NOT REQUIRED FOR BCBSKS - HEALTH PLAN IDENTIFICATION #**

Enter the number used by the health plan to identify itself.

**FIELD 52 - NOT REQUIRED FOR BCBSKS - RELEASE OF INFORMATION**

Enter a "Y" or "I" to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier. The member's BCBSKS agreement allows us to obtain this information from providers without the signed statement.

**FIELD 53 - NOT REQUIRED FOR BCBSKS - ASSIGNMENT OF BENEFITS**

Enter a "Y", "N", or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider.

**FIELD 54 - SITUATIONAL - PRIOR PAYMENTS - PAYER**

Enter the amount of payment the provider has received (to date) from the payer toward payment of the claim.

**FIELD 55 - SITUATIONAL - ESTIMATED AMOUNT DUE - PAYER**

Enter the amount estimated by the provider to be due from the payer.

**FIELD 56 - REQUIRED - NATIONAL PROVIDER IDENTIFIER - BILLING PROVIDER**

Enter the provider's 10-digit NPI number.

**FIELD 57 - SITUATIONAL - NOT USED BY BCBSKS OTHER (BILLING) PROVIDER IDENTIFIER**

**FIELD 58 - REQUIRED - INSURED'S NAME**

Enter the name of the individual (primary 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b & 58c).

**FIELD 59 - REQUIRED - PATIENT'S RELATIONSHIP TO INSURED**

Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b & 59c).

**FIELD 60 - REQUIRED - INSURED'S UNIQUE IDENTIFIER**

Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b & 60c).

**FIELD 61 - SITUATIONAL - INSURED'S GROUP NAME**

Enter insured's employer group name (61a). If applicable, enter other insured's employer group name when other payers are known to be involved (61b & 61c).

**FIELD 62 - REQUIRED FOR BCBSKS - INSURED'S GROUP NUMBER**

Enter the insured's employer group number (62a). If applicable, enter the other insured's employer group numbers when other payers are known to be involved (62b & 62c).

**FIELD 63 - SITUATIONAL - TREATMENT AUTHORIZATION CODE**

Enter the prior authorization for treatment number assigned by the primary payer (63a). If applicable, enter the prior authorization for treatment number assigned by the secondary and tertiary payer (63b & 63c).

**FIELD 64 - SITUATIONAL - DOCUMENT CONTROL NUMBER (DCN)**

Enter the control number assigned to the original bill by the health plan if this is a void or replacement bill to a previously adjudicated claim.

**FIELD 65 - SITUATIONAL - EMPLOYER NAME (OF THE INSURED)**

Enter when the employer of the insured is known to potentially be involved in paying claims.

**FIELD 66 - NOT REQUIRED BY BCBSKS**

**DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION INDICATOR)**

Enter the value of "9" for the Ninth Revision or a "0" for the Tenth Revision.

**FIELD 67 - SITUATIONAL - PRINCIPAL DIAGNOSIS CODE AND PRESENT ON ADMISSION (POA) INDICATOR REQUIRED ON INPATIENT CLAIMS**

Enter the principal diagnosis code for the patient's condition. For information on POAs, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org) or the BCBSKS provider manual section [www.bcbsks.com](http://www.bcbsks.com) - [Providers](#).

**FIELD 67a - 67q - SITUATIONAL - OTHER DIAGNOSIS CODES**

Enter additional diagnosis codes if more than one applies.

**FIELD 68 - NOT USED - RESERVED FOR ASSIGNMENT BY THE NUBC**

**FIELD 69 - REQUIRED FOR INPATIENT ADMISSION - ADMITTING DIAGNOSIS CODE**

Enter the admitting diagnosis code describing the patient's diagnosis at the time of admission.

**FIELD 70 - N/A FOR ASC's - REASON FOR VISIT.** Enter the appropriate diagnosis code describing the patient's reason for the visit at the time of the outpatient encounter only for bill types 013X, 085X, 045X, 0516, 0526, or 0762.

**FIELD 71 - N/A FOR ASC's - PROSPECTIVE PAYMENT SYSTEM (PPS) CODE**

Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

**FIELD 72 - N/A FOR ASC's - EXTERNAL CAUSE OF INJURY (ECI) AND PRESENT ON ADMISSION INDICATOR.** Enter the cause of injury code or codes when injury, poisoning, or adverse affect is the cause for seeking medical care. For information on POAs, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org) or the BCBSKS provider manual section [www.bcbsks.com](http://www.bcbsks.com) - [Providers](#).

**FIELD 73 - DO NOT USE - RESERVED FOR ASSIGNMENT BY THE NUBC**

**FIELD 74 - N/A FOR ASC's - (REQUIRED WHEN PROCEDURE WAS DONE INPATIENT PRINCIPAL PROCEDURE CODE AND DATE)**

Enter the principle procedure code and date using a six-digit format (MMDDYY) if the patient has under gone an inpatient procedure.

**FIELD 75 - DO NOT USE - RESERVED FOR ASSIGNMENT BY THE NUBC**

**FIELD 76 - REQUIRED - ATTENDING PROVIDER NAME AND IDENTIFIER**

Enter the attending provider's NPI number, last name, and first name.

**FIELD 77 - REQUIRED - OPERATING PHYSICIAN NAME AND IDENTIFIER**

Enter the operating provider's NPI number, last name, and first name.

**FIELD 78 & 79 - SITUATIONAL - OTHER PROVIDER (INDIVIDUAL) NAMES AND IDENTIFIERS.** Enter any other provider's NPI number, last name, and first name.

**FIELD 80 - SITUATIONAL - REMARKS FIELD**

Enter any information that the provider deems appropriate to adjudicate the claims that is not supported elsewhere on the claim. BCBSKS **requires** this field be completed when submitting an accident claim.

**FIELD 81a - 81d - SITUATIONAL - CODE FIELD**

Report additional codes related to a Form Locator or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. For information on Code-Code Field, refer to the National Uniform Billing Committee's official UB-04 Data Specifications Manual at [www.nubc.org](http://www.nubc.org).

# 2012 BCBSKS INSTITUTIONAL PROVIDERS POLICIES & PROCEDURES

- [Limited Patient Waiver](#) -  
[www.bcbsks.com/providers/forms/limited patient waiver](http://www.bcbsks.com/providers/forms/limited%20patient%20waiver)
  - This replaces the Notice of Financial Personal Obligation (NOPFO)
- In the event that the provisions of BCBSKS publications, policies and procedures, and/or the provider agreement conflict, the most recently published provision controls.
- Defined expectation of specificity in coding submissions
  - NOC and NOS codes will not be accepted upon implementation of ICD-10 coding.
- Health Information Exchange (HIE) Participation
  - If the HIE is approved, the contracting provider will be required to provide data.

## PAYMENT ATTACHMENT CHANGES FOR 2012

- 2012 Payment Attachment document has replaced professional language with facility language.
- Outpatient Surgical MAP
- Language regarding reimbursement for quality, transparency and quality reporting.



## *Ambulatory Surgical Center (ASC)*

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### TABLE OF CONTENTS

- **General Guidelines**
  - A) Payment in full provision
  - B) Maximum allowable payment
  - C) Outpatient Surgical Reimbursement
  - D) Medical necessity/experimental/investigational
  - E) Appeals
  - F) Post-payment audit appeals
  - G) Member Appeals
  - H) Predeterminations
  - I) Preventable adverse events
  - J) Outpatient Encounter
  - K) Professional Services
  - L) Sleep study testing

- **Claims**
  - A) Allowed codes
  - B) Claim level Payment
  - C) Revenue Codes
  - D) Type of Bill
  - E) Accident
  - F) Modifiers
  - G) Cosmetic Procedures
  - H) Services not on the Allowed Listing
  - I) Billing for Denial
  - J) NOC Codes
  - K) Cancelled Procedures
  - L) Unscheduled Procedures
  - M) Claims Examples
  - N) ASC's Billing on UB-04
  
- **Billing**
  - A) Maximum allowable payment (MAP)
  - B) Online remittance advice
  - C) Overpayments
  
- **Credit Balance Audits**

## General Guidelines

Effective January 1, 2012; ASC's will:

- Refer to their Policies and Procedures, Payment Attachment and Maximum Allowable Payment (MAP) listing for claims.
- Begin submitting claims on the UB-04 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 Institutional Blue Cross and 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.

BCBSKS requires providers to report procedures according to CPT and HCPCS guidelines. However, the proper submission of codes and/or modifiers according to CPT and/or HCPCS guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modifiers or add-on codes for additional reimbursement.

For primary procedures, providers should submit the code that most accurately describes the service provided. Add-on codes (as defined by CPT) should not be reported as stand-alone procedures and must be submitted with the primary service in order to be considered for reimbursement.

### **C. OUTPATIENT SURGICAL REIMBURSEMENT**

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 aforementioned all-inclusive rate and must be billed on the same claim. Below is a list of services that fall under this provision. This is not an all inclusive list.

- 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
- 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

#### **D. 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 *Limited Patient Waiver* 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](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 shows 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/CustomService/Providers/MedicalPolicies/institutional/experimental.htm>

## **E. 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 Limited Patient Waiver Is Not Given**

The guidelines in this section apply when claims have been denied and a *Limited Patient Waiver (LPW)* 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 made by BCBSKS for medical necessity (including experimental/investigational) 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.

#### **F. 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.

#### **G. MEMBER APPEALS - Claims Denial After Limited Patient Waiver 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.

#### **H. 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 Limited Patient Waiver 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.

#### **I. 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**

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.

- a) 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.

#### **J. OUTPATIENT ENCOUNTER**

Charges for all Ambulatory Surgery Center (ASC) services, procedures, supplies, equipment and implants (to include those obtained from another third party organization) provided during an outpatient encounter are billed on one claim using the ASC National Provider Identifier (NPI) billing number. Neither the ASC or third party organization are able to bill the member separately for the above stated services, procedures, supplies, equipment and implants which are considered part of the outpatient encounter.

#### **K. 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.

#### **L. 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.

## **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 LPW, to the claim. When necessary, Ambulatory Surgery Center providers should submit hard copy paper claims using the UB-04.

BCBSKS recognizes all claim codes as defined by the National Uniform Claim Committee (NUCC). A complete UB-04 Instruction Manual is available at the NUCC Web site: [www.nucc.org](http://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.

#### **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](http://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: Christie Blenden  
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. CLAIM LEVEL PAYMENT**

Claims will be reimbursed at the lesser of total charges or the highest MAP'd procedure on the claim. Reimbursement will be allocated proportionately among all lines of the claim.

| Dates of Service | Procedure Code | Charges | Percent of Total Charge | MAP     | Allowed | Claim Level Payment |
|------------------|----------------|---------|-------------------------|---------|---------|---------------------|
| 07/01/10         | XXXX1          | \$1,000 | 1/3                     | \$1,000 | \$825   |                     |
| 07/01/10         | XXXX2          | \$2,000 | 2/3                     | \$2,500 | \$1,625 | X                   |
|                  | TOTAL          | \$3,000 |                         |         | \$2,500 |                     |

## **C. REVENUE CODES**

The revenue code field is required when submitting claims in the UB-04 format and located in form indicator field 42. All ASC procedures should be submitted with the 0490 revenue code.

0490 = Ambulatory Surgical Care, General Classification.

We understand other payers use the UB-04 billing format and require correct revenue coding. We will be able to accept correct revenue coding for these claims. An example would be using 027X for supplies or implants.

## **D. TYPE OF BILL**

The Type of Bill field is another required field when submitting claims on the UB-04 format and is located in form indicator field 04. All ASC claims should be submitted with an 83X type of bill.

The first value of 8 = Special Facility or Hospital ASC Surgery

The second value of 3 = Outpatient Ambulatory Surgery

The third value may be subject to change as it should be submitted according to the correct description. Examples are listed below:

Value of 1 = Admission through Discharge  
Value of 7 = Replacement of Prior Claim  
Value of 8 = Cancel Prior Claim

## **E. ACCIDENT**

### Definition of an Accident:

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 caused by biting or chewing.

### Coding for Accidents:

Some BCBSKS member contract include a specific benefit which allows payment at 100% of the claim allowance for services related to an accidental injury.

When billing treatment for accidents on the UB-04 form, 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

- Form Locator 31-34: Occurrence code – Use 01-06 and Date
  - 01: Accident / Medical Coverage
  - 02: No-Fault Insurance Involved-Including Auto Accident/Other
  - 03: Accident (non-auto)/ Tort Liability
  - 04: Accident Employment Related

- 05: Accident / No Medical or Liability Coverage
- 06: Crime Victim
- Form Locator 66: Accident Diagnosis Code - If the accident diagnosis is not in the primary position and you have the other three indicators, the accident diagnosis must be in the second or third position for the claim to process under the member's accident benefit. Not all ICD-9 diagnosis codes (800-900 range) are considered to be 'accident codes'. Below is a list of diagnosis codes BCBSKS may consider as accident related.

○ Accident Diagnosis Codes - Local and Blue Card

- V540-1 - V54.9
- V71.3 - V71.6
- 692.76, 692.77
- 37024, 710 - 7399 excludes 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 and 710 -739.9 process as an accident only when there is other accident information on the claim.

- FEP Accident Diagnosis Ranges
  - V715
  - 692.76, 692.77
  - 800 - 897.7
  - 900 - 999.99
- Form Locator 72: Accidental External Cause (E) Code - Not all E-codes are considered to be 'accident' codes. Look at the code description to determine if the E-code describes an injury or accident. Always make sure the "accident" E-code is coded before any other E-codes.
- Form Locator 80: Remarks - Remarks/comments that indicate the nature of the accident. Be sure the remarks specifically indicate the details of the accident.

## **F. MODIFIERS**

**Modifier SG** states "Ambulatory Surgical Center (ASC) facility service" The SG modifier is not required when submitting claims to BCBSKS.

**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 indicates, "waiver of liability statement on file". The provider must advise the patient of the provider contract limits prior to the services being performed. The [Limited Patient Waiver](#) 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.

Any other modifiers billed on the claim must be valid. Modifiers should immediately follow the procedure code, with no space in between.

## **G. 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

## **H. SERVICES NOT ON THE ALLOWED LISTING**

When services are provided to Kansas members that are not on the ASC approved listing, a Limited Patient Waiver (LPW) must be signed by the patient prior to services being rendered. If you obtain a LPW, you do not need to actually submit the LPW 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 LPW, the charges will be denied as the patient's responsibility. If there is not a signed LPW, the charges will be process as a provider write-off.

#### **I. NOT OTHERWISE CLASSIFIED (NOC) CODES**

NOC codes should not be used. Please use the most appropriate code when billing for services.

#### **J. 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.

#### **K. 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. Contact your provider representative for assistance regarding how to submit this type of claim.

#### **L. ASC's BILLING ON UB-04**

**Effective 1/1/2012, all ASC claims** must be submitted to Blue Cross and Blue Shield on the UB-04 claims format. Please note this is the effective date of the change, which is not based on the date of service of the claim. Providers may continue to submit claims to Medicare in the Medicare required format. If these claims cross over to Blue Cross and Blue Shield of Kansas, we will convert to the UB-04 format. If these Medicare primary claims do not crossover, for what ever reason, they must be submitted to Blue Cross and Blue Shield in the UB-04 format.

#### **M. CLAIM EXAMPLES:**

## Multiple Surgery Claim Example #1

| Dates of Service | Place of Service | Type of Service | CPT / HCPCS | Charges | Days or Units | Claim Level MAP | Allowed |       |
|------------------|------------------|-----------------|-------------|---------|---------------|-----------------|---------|-------|
| 07/01/10         | 24               | F               | 45385       | \$500   | 1             | \$600           | \$275   |       |
| 07/01/10         | 24               | F               | 45380       | \$500   | 1             | \$600           | \$275   |       |
| <b>TOTAL</b>     |                  |                 |             |         |               |                 | \$1000  | \$600 |

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, both the 45385 and the 45380 have the same MAP. Therefore, the allowed charge of \$600 will be allocated proportionately among all lines of the claim.

## Multiple Surgery Claim Example #2

| Dates of Service | Place of Service | Type of Service | CPT / HCPCS | Charges | Days or Units | Claim Level MAP | Allowed |         |
|------------------|------------------|-----------------|-------------|---------|---------------|-----------------|---------|---------|
| 07/01/10         | 24               | F               | 31020       | \$2000  | 1             | \$1000          | \$220   |         |
| 07/01/10         | 24               | F               | 30115       | \$2500  | 1             | \$1000          | \$280   |         |
| 07/01/10         | 24               | F               | 31020       | \$2000  | 1             | \$1000          | \$220   |         |
| 07/01/10         | 24               | F               | 30115       | \$2500  | 1             | \$1000          | \$280   |         |
| <b>TOTAL</b>     |                  |                 |             |         |               |                 | \$9,000 | \$1,000 |

The above claim reports a sinusotomy with excision of nasal polyps bilaterally. In looking at the ASC approved listing, both procedures are on the allowed list with the same MAP. One claim level MAP will be allocated proportionately among all lines of the claim.

## Observation Claim Example

| Dates of Service | Place of Service | Type of Service | CPT / HCPCS | Charges | Days or Units | Claim Level MAP | Allowed |         |
|------------------|------------------|-----------------|-------------|---------|---------------|-----------------|---------|---------|
| 07/01/10         | 24               | F               | 58150       | \$1700  | 1             | \$2,000         | \$1,620 |         |
| 07/01/1          | 24               | F               | 99234       | \$400   | 1             | \$350           | \$380   |         |
| <b>TOTAL</b>     |                  |                 |             |         |               |                 | \$2,100 | \$2,000 |

Observation is included in the surgical MAP. The charge will be submitted as part of your total charge. Reimbursement will be provided at the surgical level MAP and allocated among all lines of this claim

## **BILLING**

### **A. MAXIMUM ALLOWABLE PAYMENT (MAP)**

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

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 surgical code. All services provided during a surgical encounter will be reimbursed at the highest level surgical MAP.

Annually, BCBSKS will provide ASC's with the updated MAP listing. This list will include the follow data fields:

- The CPT/HCPCS code
- The long description of the CPT/HCPCS code
- MAP amount
- By Report. 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.
- Newly Added field

### **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/CustomService/Providers/Publications/institutional/manuals/pdf/RA\\_guide0609.pdf](http://www.bcbsks.com/CustomService/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](http://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.

## **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 may 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/<br>Acct # | ID #<br>Primary/<br>Secondary | Date of Service | Total Charge | Credit Balance on Account | Reason for Credit Balance | Follow-up Tracking |
|-------------------------|-------------------------------|-----------------|--------------|---------------------------|---------------------------|--------------------|
|-------------------------|-------------------------------|-----------------|--------------|---------------------------|---------------------------|--------------------|

|             |           |                     |            |            |  |   |
|-------------|-----------|---------------------|------------|------------|--|---|
| A. Smith    | 555555555 | 2/01/10-<br>2/29/10 | \$1,200.00 | \$1,200.00 | Duplicate<br>Payment                       | 3/10-Called<br>BC to verify<br>payment                |
| B. Jones    | 666666666 | 2/12/10-<br>2/13/10 | \$525.00   | \$420.00   | Paid<br>Primary<br>instead of<br>Secondary | 3/28-<br>Requested<br>Primary RA                      |
| C. Myers    | 777777777 | 4/28/10-<br>5/01/10 | \$800.00   | \$800.00   |  | 6/1-<br>Researching<br>reason for<br>overpayment      |
| D.<br>Adams | 888888888 | 5/12/10-<br>5/15/10 | \$1,500.00 | \$426.82   | Both plans<br>reporting<br>primary         | 6/3-Called<br>BC-they are<br>contacting<br>other plan |

## SUMMARY

The UB-04 claim form will have minimal new fields.

- Revenue Code: Form Locator 42.  
Revenue Code will always be 0490 for ASC's.
- Type of Bill: Form Locator 04.  
Type of Bill will be 831 for ASC's.
- Coding for Accidents: The following fields will be necessary for accidental injury claims.
  - Occurrence Code: Form Locator 31-34. Claims must include the appropriate occurrence code and the date of the accident.
  - Accident Diagnosis Code: Form Locator 66. Claims must include an accident diagnosis code.
  - Accidental External Cause Code: Form Locator 72.
  - Remarks: Form Locator 80.

## CLAIM LEVEL PAYMENT

- Reimbursement on the CMS-1500 was paid on a line by line basis.
- Moving to the institutional reimbursement methodology, reimbursement will be applied at a claim level payment. BCBSKS will take the total dollars previously allocated to all medically necessary and covered services billed on the claim and apply a claim level MAP effective 1/1/2012.
- The surgical MAP will include all services provided during the same encounter.
- If multiple surgeries are performed, reimbursement will be based off of the highest MAP'd surgical procedure.
- The total MAP will be allocated proportionally over all approved lines of the claim.

## BUNDLED PAYMENT

The institutional world does not recognize the term, Content of Service, but the same principles apply. The all-inclusive MAP includes specific services and/or procedures that are considered to be an integral part of the previous or concomitant services or procedures.

Examples of such services 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 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
- 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

## **JANUARY 1, 2012**

### Effective Date of Change:

- All ASC claims submitted January 1, 2012 and later must be submitted on the UB-04 form. **This is based off of effective date, not service date.**
- Claims with service dates prior to January 1, 2012; must be submitted on a UB-04 form if submitted January 1, 2012 or later.
- Claims submitted on a 1500 on or after January 1, 2012 will be returned. These claims must be resubmitted on the UB-04 form in order to be processed. (Medicare primary cross over claims are excluded.)
- Medicare Primary cross over claims are the only ASC claims that will continue to be submitted on the CMS-1500 claim form.
- The existing BCBSKS business rules will still apply.
- This should not change or impact the manner in which providers care for members.