

BLUE CROSS AND BLUE SHIELD OF KANSAS

AUGUST 2007 QUADRANT MEETING HANDOUTS



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Table of Contents

Specialty Network Groups	2-11
2007 BlueCard® Program Satisfaction Survey	12-13
BlueCard® Inquiries	14-15
Medical Policy – Computed Tomography Angiography (CTA)	16
Experimental/Investigational Services	17
Blue Cross and Blue Shield Medical Policy Updates	18
National Provider Identifier (NPI)	19-33
Present on Admission (POA) /MS-DRGs	34-35
Accident Services/Codes	36
Revenue Code Updates and Clarifications	37-39
List of Drugs Classified as biological response Modifiers, chemotherapy, or monoclonal Antibodies	40-43
HCPCS Changes Effective July 1, 2007	44-47
Accumulated Questions and Answers	48-52

SPECIALTY NETWORK GROUPS

Specialty network groups that utilize the Blue Cross and Blue Shield of Kansas competitive allowance program (CAP) network are:

- Hallmark (dental)
- International Brotherhood of Electrical Workers (IBEW) Local 226 (effective 1/1/05)
- Kansas Building Trades Health And Welfare Trust Fund (KBTHWTF) (effective 4/1/05)

The identification card for a member enrolled in one of these specialty network groups will reflect the CAP logo.

All claims should be submitted to Blue Cross and Blue Shield of Kansas electronically. BCBSKS will price the claim according to the CAP contracting provider agreement and forward it on to the specialty network group for finalization. The specialty network group, NOT BCBSKS, will finalize the claim and report the claim processing information directly to the CAP provider.

The specialty network group, NOT BCBSKS should be contacted with all requests for benefit/eligibility information, customer service assistance, or pre-admission certification. The back side of the identification card indicates the telephone numbers that providers should use.

FISERV

Providers are having trouble filing claims specifically for groups that carry a card that indicates Fiserv Health. The particular example following is for an insured through Farmers Alliance.

The card has a group number on it but no identification number. When submitted with the SS#, it isn't accepted because there's no alpha prefix. The providers call Fiserv and are told to put CAP as the alpha prefix and it should go through the system. This is something that we have never heard.

An eligibility file in our system can indicate an entirely different number. SO NOW WHAT DO YOU DO?

1) Ask the insured to contact their group and get a new ID card. The cards were originally issued with no ID number and then re-issued with the NON-SSN number, which is the ID number in the membership system.

2) A new alpha prefix of CAP IS NOT APPROPRIATE. If that happens, the mailroom, claims processors, customer service and the claims system will

assume this is a BCBS of Texas insured. The claim would then be routed through ITS and the Texas plan would deny the claim as member not found.

3) Do not submit the SSN on these claims. That isn't the ID number in the membership system or on the valid ID cards.

3) Network pricing groups do not require an alpha prefix and do not have one on their ID cards.

BLUE CARD[®] REFRESHER

What is the BlueCard[®] Program?

A. Definition

BlueCard[®] is a national program that enables members of one Blue Plan to obtain healthcare services while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program allows you to submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan. Your local Blue Plan is your sole contact for claims payment, problem resolution and adjustments.

B. BlueCard[®] Program Advantages to Providers

The BlueCard[®] Program allows you to conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BCBSKS. BCBSKS is your one point of contact for all of your claims-related questions.

C. Accounts Exempt from the BlueCard[®] Program

The following claims are excluded from the BlueCard[®] Program

- Stand-alone dental
- Prescription drugs and
- The Federal Employee Program (FEP).

How Does the BlueCard[®] Program Work?

A. How to Identify BlueCard[®] Members

Member ID Cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out of area members is the alpha prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

Important facts concerning member IDs:

- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total.
- The alpha prefix on a member's ID must be three characters.
- Some member ID numbers may include alphabetic characters in other positions following the alpha prefix. Others may be fewer than 17 positions.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID number.

Alpha Prefix

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage. To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff. Do not make up alpha prefixes. Do not assume that the member's ID number is the social security number. Use of the social security number on ID cards was "generally" phased out by January 1, 2006.

Blank Suitcase Logo

A blank suitcase logo on a member's ID card means that the patient has Blue Cross Blue Shield traditional, POS, or HMO benefits delivered through the BlueCard[®] Program.

"PPO in a Suitcase" Logo

You'll immediately recognize BlueCard[®] PPO members by the special "PPO in a suitcase" logo on their membership card. BlueCard[®] PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard[®] Program. *It is important to remember that not all PPO members are BlueCard[®] PPO members, only those whose membership cards carry this logo.* BlueCard[®] PPO members traveling or living outside of their Blue Plan's area receive the PPO level of benefits when they obtain services from designated BlueCard[®] PPO providers.

To be considered a BlueCard[®] PPO hospital, the provider must be a Blue Choice hospital. Non-hospital **facility** providers (home health, hospice, end stage renal disease facility, medical care facility, birthing center) are considered a PPO provider just as long as they are a CAP contracting provider.

CAP = competitive allowance program.

The easy-to-find alpha prefix identifies the member's Blue Cross and Blue Shield Plan. The blank suitcase logo may appear anywhere on the front of the ID card. The "PPO in a suitcase" logo may appear anywhere on the front of the card.

How to Identify BlueCard[®] Point of Service (POS) Members

The BlueCard[®] POS program is for members who reside outside their Blue Plan's service area. If a group is enrolled in BlueCard[®] POS, then the employees are part of the POS program in the state in which they reside. If the member resides in Kansas, their ID card will reflect Blue Select. BlueCard[®] POS members residing in **the BCBSKS service area** should select a Blue Select primary care physician and utilize the services of the Blue Select hospital provider network. For non-hospital facility providers there is no special Blue Select provider network. Just as long as they're CAP they are considered a BlueCard[®] POS provider. Services must be authorized by the Blue Select primary care physician.

CAP = competitive allowance program.

How to Identify International Members

Occasionally, you may see identification cards from foreign Blue members. These ID cards will also contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.

NOTE: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the U.S.

B. Consumer Directed Health Care and Health Care Debit Cards

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives. Members, who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Accounts (HSA) or Flexible Spending Account (FSA).

Some cards are "stand-alone" debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

The card will have the nationally recognized Blue logos, along with the logo from a major debit card logo such as MasterCard® or Visa®. There is a sample stand-alone Health Care Debit Card and sample combined Health Care Debit Card and Member ID Card included in the Institutional Provider Manual on our website. The cards include a magnetic strip so providers can swipe the card at the point of service to collect the member cost sharing amount (i.e. copayment). With the health debit cards members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HAS or FSA account. Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments.

In addition, members are more likely to carry their current ID cards, because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card. Helpful tips:

- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at www.bcbsks.com (access provider services) or by calling 1-800-676-BLUE (2583) and providing the alpha prefix.
- If the member presents a debit card (stand-alone or combined), be sure to verify the member's cost sharing amount before processing payment.
- Please do not use the card to process full payment upfront. If you have any questions about the member's benefits, please contact 1-800-676-BLUE (2583), or for questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

C. Coverage and Eligibility Verification

Coverage and eligibility for out-of-area members can be verified through the BCBSKS Web site.

- Access for both local and out-of-area information is through the same "secured" services section of the BCBSKS Web site.
- For the most part, the same online screens will be used for BCBSKS members and out-of-area members.
- Inquiries about out-of-area members will require some additional information such as member name, date of birth, gender, relationship to insured, etc.
- The system will use the alpha prefix to determine if the inquiry is for a Kansas member or an out-of-area member. After using the online inquiry process, if you need additional information for out-of-area members, contact:

BlueCard *Eligibility*[®] 1-800-676-BLUE (2583)

1. English and Spanish speaking phone operators are available to assist you.
2. Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule. You may be transferred to a voice response system linked to customer enrollment and benefits.
3. The BlueCard[®] *Eligibility* line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. See the Claim Filing section for claim filing information. For BCBSKS members, contact Provider benefit line: 1-800-432-0272

D. Utilization Review

You should remind patients that they are responsible for obtaining precertification/preauthorization for their services from their Blue Plan. When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials. You may also contact the member's Plan on the member's behalf. You can do so by:

For BCBSKS members, contact 1-800-782-4437

For other Blue Plans members: Phone Call BlueCard *Eligibility*[®] 1-800-676-BLUE (2583) – ask to be transferred to the utilization review area.

Claim Filing

1. You should always submit claims to BCBSKS. Be sure to include the member's complete identification number when you submit the claim including the three character alpha prefix-do not make up alpha prefixes.
2. In cases where there is more than one payer and Blue Cross and/or Blue Shield is a primary payer, submit Other Party Liability (OPL) information with the BCBS claim. Upon receipt, BCBSKS will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment; BCBSKS will reimburse you for services.
3. Do not send duplicate claims. To check the status of the claim, visit our Web site at www.bcbsks.com (provider services section).

A. Medicare-Related Claims

For members with Medicare primary and Blue Plan secondary coverage,

- Submit claims to your Medicare intermediary or carrier
- On the Medicare claim, be sure to enter the correct Blue Plan name as the secondary payer. This may not be BCBSKS and you can verify the plan name by checking the member's ID card.
- Report the member's BCBS identification number including the alpha prefix. The alpha prefix appears in the first three positions of the ID number and is critical in confirming the member's coverage.

When you receive the Medicare remittance advice, look to see if the claim was automatically crossed over.

- If the Medicare RA indicates the claim was crossed over, the provider does not need to resubmit the claim.
- If the Medicare RA indicates the claim did not cross over, submit the claim to BCBSKS with the Medicare remittance advice. (All claims for any Blue Plan member should be sent to BCBSKS.) NOTE: There may be times when the Medicare RA shows the claim crossed over but actually didn't. When this happens, Medicare will send a separate notice showing the internal/document control number, HIC umber, medical record number, patient control number, beneficiary name, date of service, the date the claim was process and will state: "The above claims(s) was/were not crossed over to the patient's supplemental insurer due to a claim data errors". If this occurs, submit the claim to BCBSKS with the Medicare remittance advice.

How soon will the Blue Plan pay crossover claims?

The Medicare Coordination of Benefits Contractor (COBC) will cross over claim information to secondary payers AFTER Medicare pays the claim. (This includes satisfying the Medicare claim payment floor.) It may then take an additional 14-30 business days for providers to receive payment from the Blue Plan.

What should I do in the meantime? If you submitted a Medicare claim and haven't received a response,

- Don't automatically submit another claim.
- Check the online Medicare claim system to determine when Medicare paid.
- Use the BCBSKS Web site to check the status of the crossover claim.

International Claims The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to BCBSKS.

B. Coding

Code claims as you would for BCBSKS claims.

C. Medical Records

There are times when the member's BCBS Plan will require medical records to review the claim. When this occurs, here's what will happen:

- The request for records will be sent to contracting providers by their local BCBS plan.
- Noncontracting providers could receive record requests from either the local BCBS plan or the plan where the member is enrolled.
- The request will include a cover sheet that will clearly indicate what records are needed.
- The cover sheet will also indicate where the records should be sent.
- The cover sheet that BCBSKS uses indicates both a fax number and a mailing address that can be used to return records. Our preference is that you fax the records to us if possible.
- Providers are encouraged to respond to the record requests within 10 days.
- Once the records are received by the local plan, they will be forwarded to the member's home plan for review and claim finalization.

This process for BlueCard® record requests is intended to reduce the number of requests, provide clearer instructions, keep better track of requests and improve claim processing time.

D. Adjustments

Contact BCBSKS if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

E. Appeals

Appeals for all claims are handled through BCBSKS. We will coordinate the appeal process with the member's Blue Plan, if needed.

F. Coordination of Benefits (COB) Claims (Other Party Liability)

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment. If you discover the member is covered by more than one health plan, and:

- a) BCBSKS or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to BCBSKS. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- b) Other non-Blue health plan is primary and BCBSKS or any other Blue Plan is secondary, submit the claim to BCBSKS only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

Note: Timely filing guidelines apply to all BlueCard claims even those that are secondary to another health plan.

G. Accounts Exempt from the BlueCard Program

When a member belongs to an account that is exempt from the BlueCard Program, BCBSKS will electronically forward your claims to the member's Blue Plan. That means you will not send paper claims directly to the member's Blue Plan. Instead, you will submit them to BCBSKS.

How the Electronic Process Works

- Submit claims directly to BCBSKS who will forward the claims to the member's home Plan for you. It is important for you to correctly capture on the claim the member's complete identification number, including the three-character alpha prefix at the beginning. If you don't include this information, the claim will be

returned to you. You can call BlueCard *Eligibility*[®] at 1-800-676-BLUE to verify the member's eligibility and coverage.

- If the member's claim is exempt from the BlueCard[®] Program, BCBSKS will inform you that the claim is being forwarded to the member's Plan. Electronically forwarded claims will be reported to providers on the PENDED/SUSPENDED CLAIMS remittance advice. A printed message will appear on this RA and will tell providers what Plan we forwarded the claim to: Example:

THIS CLAIM HAS BEEN FORWARDED FOR PROCESSING TO BCBS NEBRASKA.

H. Claim Payment

1. If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs). BCBSKS' standard time for claims processing is an annualized average of 14 working days. However, claim processing times at various Blue Plans vary.

2. If you do not receive your payment or a response regarding your payment, please call BCBSKS at 1-800-432-3990 ext 4058 or visit our Web site at www.bcbsks.com, (provider services section) to check the status of your claim.

3. In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BCBSKS will ask you for the information.

I. Claim Status Inquiry

BCBSKS is your single point of contact for all claim inquiries. Claim Status Information for out-of-area members can be verified through the BCBSKS Web site.

- Access for both local and out-of-area information is through the same "secured" services section of the BCBSKS Web site.
- For the most part, the same online screens will be used for BCBSKS members and out-of-area members.
- Inquiries about out-of-area members will require some additional information such as member name, date of birth, gender, relationship to insured, etc.
- The system will use the alpha prefix to determine if the inquiry is for a Kansas member or an out-of-area member. After using the online inquiry process, if you need additional information for out-of-area members, contact: Toll free 1-800-432-3990 ext 4058 Topeka Local (785) 291-4058

J. Calls from Members and Others with Claim Questions

1. If members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

2. The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to BCBSKS.

IV. What Products Are Included in the BlueCard® Program?

BlueCard® Traditional

A national program that offers members traveling or living outside of their Blue Plan's area the traditional, or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

BlueCard® PPO

A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard® Managed Care/POS

Similar to BlueCard Traditional and BlueCard PPO, the BlueCard Managed Care/POS program is for members who reside outside their Blue Cross Blue Shield Plan's service area. However, unlike other BlueCard programs, BlueCard Managed Care/POS members are actually enrolled in the Blue Select network and primary care physician (PCP) panels. Therefore, you should treat these members as you treat any other BCBSKS POS member, applying the same referral practices and network protocols.

HMO Patients Serviced

Through the BlueCard® Program Blue Cross Blue Shield (BCBS) HMO members affiliated with other BCBS Plans may seek care at your office or facility. You should handle claims for these members the same way as you do BCBSKS members and BCBS traditional, PPO and POS patients from other Blue Plans by submitting them through the BlueCard® Program.

BlueCard® Program Quick Tips

The BlueCard® Program provides a valuable service that lets you file all claims for members from other Blue Cross Blue Shield Plans to your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character alpha prefix that precedes the member's ID number on the ID card.

BlueCard® eligibility and claim status information is available on the BCBSKS Web site www.bcbsks.com (provider services section).

BlueCard Program - benefits and eligibility for out-of-area members

1-800-676-BLUE (2583)

BlueCard® Program - claim inquiries for out-of-area members

1-800-432-3990 ext 4058

Provider Benefit Line - benefits and eligibility for Kansas members

1-800-432-0272

2007 BlueCard® Program Satisfaction Survey

2007 BlueCard® Program Satisfaction Survey will be conducted in two "waves".

- WAVE 1 – conducted between April 2 & May 18, 2007.
- WAVE 2 – will be conducted starting in early August through mid-September 2007.

If your office is contacted, we encourage you to participate. **YOUR FEEDBACK IS IMPORTANT TO US!**

Key survey elements areas are:

- Overall Satisfaction
- Claims Handling
- Eligibility
- Claims Resolution
- Provider Education
- Claims Status
- Customer Service
- Medical Policy
- Consumer-Directed Health Products

Blue Cross and Blue Shield of Kansas and the Blue Cross and Blue Shield Association are working to enhance the BlueCard® service levels. Targeted areas include but are not limited to:

- Consistent claims processing and claim accuracy
- Standardization of electronic eligibility responses
- Promote and educate providers on the enhanced electronic claim status and eligibility services available.
- Customer Service - first contact resolution

WAVE 1 RESULTS

300 telephone interviews were conducted in the Kansas company service area and 16,228 interviews were conducted nationwide.

Respondents from the Kansas service plan area include:

- 63.3% - doctor office
- 16.0% - hospital (including hospital clinic)

- 20.7% - other (billing company, lab, clinic)

ELEMENT	Kansas Provider Satisfaction with BlueCard Program	Kansas Provider Satisfaction with the Local Plan
Overall Satisfaction	78.7%	98.0%
Claims Processing Accuracy	83.9%	98.7%
Claim Processing Timeliness	85.9%	98.3%
Eligibility Inquiry Accuracy <ul style="list-style-type: none"> • Electronic • Telephone 	93.4% 86.3%	95.0% 99.0%
Eligibility Inquiry Timeliness	90.1%	97.2%
Claim Status Inquiry Accuracy <ul style="list-style-type: none"> • Electronic • Telephone 	89.7% 90.8%	Not include in survey
Claim Status Inquiry Timeliness (electronic)	89.7%	Not include in survey
Customer Service Overall Satisfaction	96.0% Frequency of Problems Encountered with Claims Requiring Follow-Up <ul style="list-style-type: none"> • Unclear denial • Question about the payment • Coordination of Benefits • Medicare-related claims • Claim not on file 	Not include in survey
Provider Education <ul style="list-style-type: none"> • Respondent reported receiving info in the last 12 months • Usefulness of information received 	64% 91.1%	Not include in survey

BlueCard® INQUIRIES

When submitting a Blue Exchange (a member of another plan) Eligibility, Claim Status or Referral transaction, we require the member's date of birth when we receive an inquiry for a patient who is the spouse or dependent. Providers don't always get that information so you are having difficulty completing the inquiry. **Be aware that you will be required to include this information beginning August 5th.**

This Sunday, August 5th, a change will be implemented that will change the requirement. Please see examples of the screens following.

INQUIRY FOR SPOUSE:



Patient Eligibility Inquiry

Please complete all of the required information to find eligibility information. Click on the Submit button when you are finished.

Member Identification Number: R1123456789

Patient Relationship: *

Member First Name: *

Member Last Name: *

Patient First Name: *

Patient Last Name: *

Patient Date of Birth: *

Patient Gender: *

Service Type:

Date of Service: *

* - required field

Please note: The response time for inquiries on BCBS members outside of Kansas may take up to 50 seconds. In addition, you may not receive any response if inquiring between midnight and 6 a.m., Monday through Saturday or anytime on Sunday, as information from other Blue Cross and Blue Shield Plans may not be available during these times.

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Blue Cross and Blue Shield of Kansas serves all counties in Kansas except Johnson and Wyandotte.
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INQUIRY FOR MEMBER



[Main Menu](#) | [Contact Us](#) | [Find a Doctor](#) | [Forms](#) | [Log Out](#)

Secured Services

Patient Eligibility Inquiry

Please complete all of the required information to find eligibility information. Click on the Submit button when you are finished.

Member Identification Number: R1123456789

Patient Relationship: *

Member First Name: *

Member Last Name: *

Member Date of Birth:
(mm) (dd) (yyyy) *

Member Gender: *

Service Type:

Date of Service:
(mm) (dd) (yyyy)
 *

* - required field

Please note: The response time for inquiries on BCBS members outside of Kansas may take up to 50 seconds. In addition, you may not receive any response if inquiring between midnight and 6 a.m., Monday through Saturday or anytime on Sunday, as information from other Blue Cross and Blue Shield Plans may not be available during these times.

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Medical Policy
Computed Tomographic Angiography (CTA)

Current Effective Date: April 1, 2007 Current Effective Date: April 1, 2007

DESCRIPTION

Computed tomographic angiography (CTA) is a procedure used for the imaging of vessels to detect aneurysms, blood clots, and other vascular irregularities. Contrast medium is rapidly infused intravenously at intervals, usually with an automatic injector, and the patient is scanned with thin section axial or spiral mode x-ray beams. Three-dimensional images are generated and post processing reconstruction is done at a workstation on the scanner.

POLICY

Computed tomographic angiography (CTA) is considered experimental/investigational for the evaluation of coronary arteries including but not limited to the following:

1. Screening for coronary artery disease (CAD), either in asymptomatic subjects or as part of a preoperative evaluation
2. Diagnosis of CAD, in patients with acute or non-acute symptoms, or after a coronary intervention
3. Delineation of a coronary artery anatomy or anomaly

Computed tomographic angiography (CTA) of other arteries may be indicated when medical necessity is properly documented. Note: As of June 14, 2006, per updated review by consultant, coronary CT angiography remains experimental/investigational because of lack of adequate repeated studies. Further investigation is needed.

In the last update of this policy, HCPC codes 0145T, 0150T, and 0151T were eliminated. These codes were reported as non-covered earlier however, Medical Review has confirmed these codes represent scans of the heart and they are covered by Blue Cross and Blue Shield of Kansas.

0145T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology
0150T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology in congenital heart disease
0151T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing, function evaluation (left and right ventricular function, ejection-fraction and segmental wall motion) (List separately in addition to code for primary procedure)

Experimental/Investigational Services

Coronary Computerized Tomographic Angiography as a component of Cardiac Tomography (CT) and Computerized Tomography (CT) Coronary Artery Scans

DESCRIPTION

This imaging study is a combination of two scans: a CT cardiac calcium scoring test analogous to the electron beam CT and CT with contrast of the coronary arteries.

Neither the American Heart Association nor the American College of Cardiology has come out with a statement or a position paper on this procedure.

POLICY

Coronary artery scans are considered experimental/investigational due to the lack of long-term studies.

CPT/HCPCS Codes

0144T

0146T

0147T


0148T

0149T

Determined by the Radiology (February 8, 2005) Liaison and Cardiology (April 27, 2005) Liaison committees and approved by the Medical Advisory Committee in April 2005 and August 2005. *January 1, 2006, added CPT codes 0144T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T, and 0151T.* April 5, 2006, deleted code S8093 per HCPCS (March 31, 2006). *August 2, 2006 deleted CPT codes 0145T, 0150T, and 0151T as directed by the Medical Director.* Name modified to be consistent with medical policy.

(Web Update 6/2007)

BLUE CROSS AND BLUE SHIELD MEDICAL POLICY UPDATES

Policy Title 	Date Posted	Effective Date
Ambulatory Event Monitors and Mobile Outpatient Cardiac Telemetry	05/01/07	05/01/07
Bone Mineral Density Studies	05/01/07	06/01/07
Computed Tomographic Angiography (CTA)	03/01/07	04/01/07
Deep Brain Stimulation of the Thalamus	03/01/07	04/01/07
Extracranial Carotid Angioplasty/Stenting (CAS)	06/01/07	07/01/07
Fetal Fibronectin	05/01/07	05/01/07
Gene Expression Assay for Breast Cancer Treatment	06/01/07	07/01/07
High Dose Rate (HDR) Breast Brachytherapy with HDR Radioactive Source via MammoSite Catheter	06/01/07	07/01/07
Home Phototherapy	03/01/07	04/01/07
Immune Globulin Therapy (IVIG)	03/01/07	04/01/07
Intra-articular Hyaluronan Injections for Osteoarthritis of the Knee	06/01/07	07/01/07
Positron Emission Tomography (PET)	05/01/07	05/01/07
Respiratory Syncytial Virus (RSV)	05/01/07	06/01/07
Stereotactic Radiosurgery	03/30/07	05/01/07
Vacuum Assisted Wound Closure (VAC)	05/15/07	06/15/07
Vagal Nerve Stimulator	03/01/07	04/01/07
Virtual Colonoscopy	06/01/07	07/01/07
Wireless Capsule Endoscopy	03/01/07	01/01/07

National Provider Identifier (NPI)

July 10, 2007

CMS Announces Availability of NPPES Database

The Centers for Medicare & Medicaid Services (CMS) has been authorized to make publicly available national provider identifiers (NPI) and certain other health care provider data. The information that will be made available has been determined to be disclosable under the Freedom of Information Act (FOIA) and is part of the National Plan and Provider Enumeration System (NPPES).

Provider specific details were published by CMS in their document dated June 20, 2007 and titled NPPES Data Elements Data Dissemination. It can be reviewed at:

http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf

It is anticipated that the online and downloadable databases will be available August 1, 2007.

If you have not already done so, we strongly encourage you to:

- Become familiar with the data elements that will be publicly displayed.
- Review and update as necessary your provider information on file with the NPPES. It is extremely important to keep all NPPES data current and complete. Providers must submit updates, changes, and deletions to NPPES no later than July 16, 2007 to ensure that these corrections are reflected in the initial downloadable file.
- When available, use the new database to obtain information that you might need such as information about referring providers.

IMPORTANT: Even though this new database is public information, providers must still notify BCBSKS and other payers when changes occur.

NOTE: The database includes fields for the provider's Social Security Number and Tax Identification Number. These data elements are not publicly available through the database however, please understand that this data could be viewable if the provider reports a legacy provider identifier that is or includes either the SSN or TIN.

Complete information about national provider identifiers including data dissemination is available at the CMS Web site

<http://www.cms.hhs.gov/NationalProvIdentStand/>

July 30, 2007

National Provider Identifier (NPI)

Data Dissemination, New Educational Products Available Through CMS, Group Practice Enumeration

The following information was provided by the Centers for Medicare & Medicaid Services (CMS)

The NPI is here. The NPI is now. Are you using it?

During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf.

National Plan and Provider Enumeration System (NPPES) FOIA-Disclosable Data to be Available on August 1, 2007

The NPI Registry, a query-only database, will be operational on August 1, 2007. The NPI Registry will operate in a real-time environment. This means that FOIA-disclosable data for newly enumerated providers, as well as updates and changes to enumerated providers' FOIA-disclosable data, will be available in the NPI Registry as that information is applied to NPPES. The NPI Registry will enable a user to query by, for example, NPI or provider name, and will return a list of all NPPES records that meet the query specifications. The user selects from that list the NPPES records he/she wants to see. The NPI Registry will then display the FOIA-disclosable data for those records. About a week later, CMS will make available a file for downloading that will contain the FOIA-disclosable NPPES data of enumerated health care providers. Technical expertise will be required to download that file and to import that data into a relational database or to otherwise manipulate the data. CMS will be furnishing more information about data dissemination, including a "Read Me" file, Header File, and Code Value document for the downloadable file, and will make that information available on the CMS NPI web page at

http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp.

Two New Educational Products Available Through CMS

NPI fact sheets:

[For Providers who are Organizations](#)

[For Providers who are Sole Proprietors](#)

Group Practices that Conduct Any HIPAA Standard Transactions MUST Have an NPI!

A group practice that conducts any of the HIPAA standard transactions is a covered health care provider (a covered entity under HIPAA) and, as such, must obtain and use an NPI. The providers employed by the group practice, on the other hand, are only furnishing services at the group practice; they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and obtaining claim status electronically). Therefore, these employed providers are not covered health care providers and are not required by the NPI Final Rule to obtain NPIs. However, as a condition of employment, the group practice could require these providers to obtain NPIs so that the group practice can use them to identify the employed providers as the Rendering Providers in the claims that the group submits to health plans. If these physicians prescribe medications, the pharmacies may require their NPIs because the pharmacies may be required by health plans to include the NPIs of prescribers in their claims. Additionally, health plans may require enrolled physicians or any other enrolled providers, to obtain NPIs in order to participate in those plans.

NPI UPDATE AND INFORMATION

Changes were made to BC newsletter, BC 07-13 originally published May 16, 2007. The section titled *ACUTE CARE HOSPITALS WITH MEDICARE EXCLUDED PSYCHIATRIC OR REHABILITATION UNITS* was updated but all other information remained the same.

This newsletter details BCBSKS' implementation of the national provider identifier. *IF YOU HAVE NOT READ THIS NEWSLETTER MAKE SURE YOU DO AS SOON AS POSSIBLE.* You will find everything you ever wanted to know about NPIs!!!!!! Such as...

CONTINGENCY PLAN

Blue Cross and Blue Shield of Kansas, a leader in the healthcare industry in the state of Kansas, is prepared to meet by the May 23, 2007 mandated deadline, all the HIPAA requirements for the implementation of national provider identifiers.

In early April 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for NPI implementation. This guidance allows covered entities (including health plans and covered health providers) who are actively working towards NPI compliance to establish contingency plans in order to facilitate compliance with their trading partners.

In recognizing the needs of healthcare providers, trading partners and other affected entities and to ensure a smooth transition to NPI, Blue Cross and Blue Shield of Kansas announces the following three stage NPI implementation contingency plan:

STAGE 1: Began May 23, 2007, with BCBSKS accepting claims (electronic and paper) showing the billing and performing provider numbers with:

- Legacy provider number only;
- Legacy provider number with NPI;
- NPI only*.

During Stage 1, BCBSKS encourages providers to begin or continue sending both legacy and NPI numbers.

*Providers should not submit NPI "only" claims until after they have contacted BCBSKS and verified their NPI readiness. More information about this appears below. **NOTE: MAKE SURE YOU CONTACT US**

PRIOR TO SUBMITTING CLAIMS WITH NPI ONLY. WE WILL RESEARCH THE SYSTEM AND INFORMATION REGARDING YOUR PROVIDER NUMBERS AND LET YOU KNOW IF CLAIMS WILL BE ACCEPTED OR KICKED OUT BECAUSE OF DISCREPANCIES FOUND IN THE NUMBERS.

STAGE 2: BCBSKS is monitoring the number of claims received that report the billing and performing providers with either (1) NPI with legacy provider number; or (2) NPI only*. Once we determine that this number is sufficient, BCBSKS will begin rejecting claims (electronic and paper) that do not include an NPI. We are monitoring claims that currently are not being submitted with an NPI on the claim. Due to the fact that we previously indicated to providers that we expected these numbers by July 1st...we are now calling you to determine why claims do not include NPI. If further assistance is needed in that area we can attempt to help you out.

STAGE 3: Implementation date to be announced.

The day WILL come when for billing and performing providers, an NPI number will be the ***only identifier*** accepted on electronic or paper transactions. Legacy numbers will not be accepted.

NOTE: Until May 23, 2008, BCBSKS will continue to accept UPINs for the secondary provider numbers.

NPI ONLY - During Stage 1 and Stage 2, if you are ready to submit claims and transact **all** other business by NPI "only", you must notify BCBSKS. When notified, we will work with you to determine the actual effective date for NPI "only" transactions and from that point on **all transactions will reflect only the national provider identifier**. So...as you can see...it is IMPERATIVE that you are totally ready to submit NPI only.

What does this mean? What business transactions will be affected?

1. Claim submission – billing and performing providers. Claims received after the NPI "only" start date that include a legacy provider number will be rejected. (Does not apply to secondary provider numbers.)
2. Remittance advices – paper and electronic
3. Eligibility and benefit inquiries (270/271) - web or batch
4. Claims status inquiries (276/277) – web or batch

Eventually during Stage 3 only NPI will be submitted. So if you are

ready to conduct business with NPI "only" contact:

Donna Bartee, institutional provider relations (785) 291-8692
or 1-800-432-0216 ext. 8692
or 1-800-432-0216 ext. 8692

ONE-TO-ONE MATCH vs. ONE NPI/MULTIPLE LEGACY NUMBERS

One-to-One Match

The term one-to-one match is used to identify providers who obtained a separate NPI for each existing BCBSKS provider number. When a one-to-one match exists, providers will see very few differences in how BCBSKS reports information or how you access information via our Web site.

One NPI/Multiple Legacy Numbers

This term is used to identify providers who have chosen to use the same NPI for more than one BCBSKS provider number. When this occurs, there will be differences in how information is reported or viewed.

WEB SECURITY – BCBSKS Web Provider Profile

One of the most frequent questions we receive is: "When NPI is implemented, will I need to set up a new provider profile using my NPI?" The answer is "no". BCBSKS will still be able to use your existing user name and password to validate your security and determine what Web features you can access.

When you established your provider profile, you included the following information:

- provider number
- indicated if it was "institutional" or "professional"
- included either the billing provider tax ID number or billing provider social security number.

Using this profile, you were then able to access the secure HIPAA transactions relating to that provider number. This includes claim status, eligibility, precertification and referral.

When NPI is implemented, BCBSKS will be able to use the same provider profile to determine the information that you can have

access to.

In the BCBSKS system, if the provider number you used to set up the provider profile:

has an NPI loaded, it is considered HIPAA compliant and you will be allowed access to all secure HIPAA transactions for that NPI.

does NOT have an NPI loaded, it will not be considered HIPAA compliant and no access will be allowed to the HIPAA transactions. These users will only be able to view the public information appearing on the BCBSKS Web site.

After you notify BCBSKS that you're ready to conduct NPI "only" transactions, starting on the agreed upon effective date all transactions (including Web transactions and inquiries) will be conducted and reported with the national provider identifier.

PROVIDER NAME

One-to-one match – no change. The name that is associated with your existing BCBSKS provider number is the same name that we have for your NPI.

One NPI/Multiple legacy numbers – An NPI can have only one name in the BCBSKS system. As necessary, BCBSKS has synchronized the names on our provider file.

EXAMPLE: XYZ Hospital is using the same NPI for two existing BCBSKS provider numbers. The names we currently have on file for these numbers are:

XYZ Hospital
XYZ Hospital ER Doctors

In this example the NPI name will be XYZ Hospital and anytime that BCBSKS reports a provider name, this is the name that will show. This includes Web, remittance advice, provider directory, checks, etc.

PROVIDER ADDRESS (including correspondence, remittance advice and payment addresses)

BCBSKS currently has and will continue to keep three separate mailing addresses. This includes correspondence, remittance advice and payment.

One-to-one match – no change. The correspondence, RA and payment address that we currently have on file for your existing BCBSKS provider number is the same addresses that we'll use for your NPI.

One NPI/Multiple legacy numbers – An NPI can only have one address for correspondence, a separate one for RA and also a separate address for payment. As necessary, BCBSKS has synchronized the addresses in our provider file.

EXAMPLE: XYZ Hospital is using the same NPI for two existing BCBSKS provider numbers. The addresses we currently show for these numbers are: (C=correspondence, R=remittance, P=payment)

XYZ Hospital

C=123 Avenue, Rural City, KS

R=123 Avenue, Rural City, KS

P=P.O. Box 67, Rural City, KS

XYZ Hospital ER Doctors

C=456 Avenue, Rural City, KS

R=456 Avenue, Rural City, KS

P=P.O. Box 67, Rural City, KS

For this example the NPI addresses will be:

C=123 Avenue, Rural City, KS

R=123 Avenue, Rural City, KS

P=P.O. Box 67, Rural City, KS

WEB VERSUS PAPER REMITTANCE ADVICE

Providers choose to either receive their remittance advice in the mail or to access it from the BCBSKS Web site.

One-to-one match – no change. You'll get the RA the same way you're getting it today.

One NPI/Multiple legacy numbers –

If all of the existing BCBSKS numbers that are tied to this one NPI are all getting the RA the same way (all off the Web or all through the mail), there's no change and that will continue.

If, however, part of the existing numbers are set up to get it off the Web and part is still getting it through the mail, the NPI will be set up to show that the provider will obtain the RA off

the Web.

PAYMENT AND REMITTANCE ADVICES (RA)

BCBSKS will continue to issue separate payments and remittance advices for:

BCBSKS Premier Blue and FEP

After you notify us that you are ready to go NPI only, BCBSKS will take the appropriate steps to establish all transactions (including Web transactions and inquiries, payments, remittance advice, etc.) with the national provider identifier.

One-to-one match – Now the RA shows the legacy provider number. Once you notify BCBSKS that you are NPI "only" ready, the RA will show the NPI number.

One NPI/Multiple legacy numbers – Now the RAs will show the legacy provider numbers. Once you notify BCBSKS that you are NPI "only" ready, the RA will show the NPI number.

For providers who are NPI "only" ready and who are using one NPI for multiple legacy provider numbers, transitioning the remittance advices to NPIs will occur in two phases.

PHASE 1 – which started on May 23, 2007 for NPI "only" providers with one NPI/multiple legacy numbers:

Level 1 – RAs will show the NPI

Level 2 – there will be separate RAs and checks issued for each line of business (LOB).

LOB 1 - Facility/institutional provider payments (billed using the UB-92/UB-04 claim format {837I}), or

LOB 3 - Professional payments (billed using the CMS 1500 claim format {837P})

Level 3 – under each LOB, we will then generate separate RAs and checks based on each of the different local provider numbers that are assigned to this NPI. (If searching a RA for information about a specific patient or account, be sure to search through the complete document.)

PHASE 2 – Applies to NPI "only" providers – one NPI/multiple legacy numbers. We are currently working on this phase.

In this Phase, we will:

Level 1 – pay at the NPI level.

Level 2 – there will be one RA and check issued for line of business 1 claims (Blue Cross) and one RA and check for line of business 3 claims (Blue Shield).

Level 3 – no longer applies.

ACUTE CARE HOSPITALS WITH MEDICARE EXCLUDED PSYCHIATRIC OR REHABILITATION UNITS

BCBSKS had originally understood that all inpatient claims grouping to a psychiatric or rehabilitation DRG would be billed with the NPI for the excluded unit. However, this is not the case and care provided in and billed with the hospital acute NPI could in fact, group to a psychiatric or rehabilitation DRG. We had to update our procedures to reflect this change. See # 2, 4 and 9 listed below.

If you're an acute care hospital with a Medicare excluded psychiatric and/or rehabilitation unit, you have separate Medicare provider numbers and are required to bill separate inpatient claims to Medicare for care provided in these units. You also obtained separate NPIs for these excluded units.

With the implementation of NPI, BCBSKS is changing our billing instructions and reimbursement for **inpatient** care provided in excluded units.

1. This change is effective for claims received by BCBSKS starting May 23, 2007, having a 2007 service date. (NOTE: This does not apply to claims processed to final adjudication prior to May 23, 2007 or claims with a 2006 service date. If you are still submitting services for 2006, please continue to report your acute hospital provider number and/or NPI.)
2. The hospital determines the residency of the patient, acute versus excluded unit and will pre-certify the admission and bill the claim with the applicable NPI.
3. Hospitals will bill a separate inpatient claim for each different NPI.
4. When hospitals pre-certify an inpatient admission, they must identify if the patient is acute or if they reside in the excluded unit. The billed claim should match the pre-certification.
5. If the patient is admitted to acute care and later transferred to the excluded psychiatric or rehabilitation unit (or vice versa), *split the inpatient claim and bill multiple claims using the separate NPIs.*

6. If you have a patient that is admitted acute and later transferred to the excluded unit or vice versa, **you must pre-certify the care in each unit.** Just like today, you use the online system to pre-certify acute care but the pre-certification of psychiatric or rehabilitation services must be done by telephone.
7. If a patient is treated at your hospital as an outpatient and is admitted as an inpatient before midnight of the following day, the outpatient services must be included on the inpatient claim. This rule applies to inpatient acute, rehabilitation or psychiatric admissions.
8. The payment allowance for care in an excluded psychiatric or rehabilitation unit will be a per diem per day. Those providers involved have already been notified by letter of these rates.
9. The payment allowance for psychiatric or rehabilitation care billed with the acute hospital NPI will continue to be based on the DRG.
10. If you are a hospital that has a unique contractual arrangement with BCBSKS, your allowance will continue to be based on that contract.
11. If you allow us to do auto deducts under your acute hospital provider number, we'll also do auto deducts under your excluded unit number.
12. PIP – periodic interim payments will be handled as follows:
 1. PIP will apply only to the acute hospital number. The weekly payment amount may need to be adjusted after the rehabilitation and/or psychiatric payments are removed.
 2. Rehabilitation and psychiatric checks will be based on actual claims paid.
 3. PIP payments do not apply to swing bed numbers.

THINGS TO REMEMBER:

- **If you recognize a new psych or rehab area in your facility in the future, you will need to establish a provider profile for the web using this new number.**
- **If you are an EFT provider, you must send in a new completed form to add this new number for EFT transfer activity. That form is available on our web site.**
- **If you receive electronic RA, we will add the new NPI and a legacy number to your file for BC processing purposes.**
- **If you add a new provider psych or rehab number or any other kind of number for that matter, we will set up the auto deduct activity to coincide with the base hospital activity.**

Reporting Secondary Provider Information - Includes Attending Provider, Operating Physician and Other Provider Information (UB-92/UB-04, 837I)

BCBSKS will continue to accept UPINs (including the generic UPINs i.e. SLF000, OTH000) in the secondary provider number fields. Secondary provider fields include attending provider, operating physician and other provider.

*If you are ready to start reporting NPIs in these fields, you may do so any time.

*On May 23, 2008, BCBSKS will no longer allow UPINs in these secondary fields. At that time, you must report NPIs.

Once you convert to using NPIs in these fields:

You may on rare occasions need to bill for services that can be performed without a physician's orders or for services ordered by a provider who does not have an NPI. In these cases and only these cases, you may report your NPI in the attending physician NPI field.

If you do not know the NPI for the attending provider or operating physician, do not use YOUR NPI. You must contact the provider/physician for this information. ☺

SHARE YOUR NPI OR REPORT CHANGES

Most institutional providers have furnished their NPI and taxonomy code information to BCBSKS. If you haven't, please do so immediately. Likewise, if you have any changes....you also need to notify us. FAX this information to 785-290-0734, ATTN: Nicole Dodds.

NPI ONLY MEANS NPI ONLY

If you are an NPI only provider you might have been told erroneously your claims MUST include the BCBSKS legacy number. ***THIS IS INCORRECT!!!!*** Quite the opposite actually...if you have converted to NPI ONLY we do not want the legacy number on the claim and if you do include it...your claims will reject from the system.

NPI BILLING CLARIFICATIONS

Implementing NPI instructions has brought to light some issues when hospitals have chosen to modify their claims submission with respect to their Medicare primary claims and this modification was not specifically reported to BCBSKS. The examples below illustrate the type of situations we're referring to. If these or similar situations apply to your hospital, please notify BCBSKS immediately. Failure to do so could mean a delay in claims processing.

Medicare *does not require* that these services be billed under a separate NPI. If your business decision is to continue to bill these services under the hospital NPI, that's acceptable. These examples are only intended to show how some providers have chosen to conduct their business.

NOTE: IF BCBSKS IS THE PRIMARY PAYER THESE SERVICES MUST CONTINUE TO BE BILLED IN THE 837P OR CMS 1500 BILLING FORMAT.

EXAMPLE 1: Hospital Based Ambulance

Before NPI, a hospital with an ambulance service billed the ambulance charges using the Medicare Part A hospital provider number and BCBSKS paid as secondary under the hospitals BCBSKS provider number.

With NPI, the hospital decides not to bill ambulance services with the hospitals NPI. Instead, they plan to bill the ambulance charges to Medicare in the 837I electronic format with an NPI specifically obtained for ambulance services.

NOTE: If BCBSKS is the primary payer, ambulance charges must continue to be billed in the 837P or CMS 1500 billing format.

Donna Bartee has worked extensively with providers on their NPI concerns and below is an example of the email she sent to those providers who would be having issues with their ambulance claims. I don't know anyone who has worked harder and more proactively than our staff to assure your claims are handled properly at the time you decide to go NPI only. (She deserves a big 'ole hug and thank you when you see her!!!!)

Our records show that your provider has a hospital based ambulance and we need some clarification from you.

Before NPI, you billed ambulance services to Medicare using your hospital provider number and BCBSKS paid balances secondary to Medicare under your BCBSKS hospital provider number.

When NPI is implemented, will you be billing ambulance services to Medicare with the hospital NPI? Or will you bill using the ambulance NPI?

BCBSKS needs to know this to ensure that payment on crossover claims is not interrupted when we go to NPI ONLY billing.

EXAMPLE 2: Hospital Based Clinic TC/PC Split

Before NPI, when a hospital bills Medicare for charges incurred in their hospital based clinic, they do a TC/PC split and bill the technical component (TC) charges under their hospital's provider number. BCBSKS pays as secondary to Medicare using the hospital's BCBSKS provider number.

With NPI, the hospital decides not to bill the TC of the hospital based clinic with the hospital's NPI. Instead, they plan to bill the TC of the hospital based clinic in the 837I electronic format with the clinic NPI.

NOTE: If BCBSKS is the primary payer, all clinic charges must continue to be billed in the 837P or CMS 1500 billing format.

EXAMPLE 3: CRNA

Before NPI, if you are either an OPPS hospital that is eligible for cost based reimbursement of CRNA charges or a CAH Method II hospital; you have been billing CRNA expenses using the Medicare Part A hospital provider number and BCBSKS paid as secondary under the hospital's BCBSKS provider number.

With NPI, the hospital decides not to bill CRNA services with the hospital's NPI. Instead, they plan to bill the CRNA charges in the 837I electronic format with an NPI specifically obtained for CRNA services.

NOTE: If BCBSKS is the primary payer, all CRNA charges must continue to be billed in the 837P or CMS 1500 billing format.

WE WILL DO WHAT WE CAN TO HELP YOU AVOID DELAYS IN THE PROCESSING OF YOUR CLAIMS. IF THESE OR SIMILAR SITUATIONS APPLY TO YOUR PROVIDER, IT IS EXTREMELY IMPORTANT THAT YOU NOTIFY BCBSKS AS SOON AS POSSIBLE.

Please send information to:

Donna Bartee
Institutional Relations, CC 442E1
FAX: (785) 290 - 0734
Telephone number: (785) 291-8692
Email: donna.bartee@bcbsks.com

Present on Admission (POA)/ Medicare-Severity DRGs

CMS (Centers for Medicare and Medicaid Services) is proposing to adopt a severity diagnosis related group (DRG) system for FY 2008, called the Medicare-Severity DRGs (or MS-DRGs).

On August 1, 2007 the final rule was posted on the CMS web site
<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>

CMS updated an analysis of a severity DRG system, that it considered adopting in the mid-1990s, and is proposing to create 745 new DRGs to replace the current 538.

The new DRG system presents opportunities to improve documentation and coding to receive higher payments without a real increase in patient severity of illness.

For Medicare, most Hospitals are required to begin reporting diagnosis present on admission (POA) for all patients effective for discharges on or after October 1, 2007.

For Medicare: critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement.

Effective October 1, 2007, Medicare will begin to accept a (POA) Indicator for every diagnosis on your inpatient acute care hospital claims. **Medicare will require POA on hospital claims beginning with discharges on or after January 1, 2008.** Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement.

Effective for acute care inpatient PPS discharges on or after October 1, 2008, the Secretary cannot assign cases with these conditions to a higher paying DRG unless they were present on admission. This instruction will require hospitals to begin reporting the POA code on claims with discharges beginning on or after October 1, 2007. Although hospitals must report the POA code on the claim, the information will not be used by claims processing systems until January 1, 2008. Beginning with claims with discharges on or after January 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will continue to process. However, hospitals will be provided with a remark code on their remittance advice advising them that they did not correctly submit the POA code on the claim. Beginning April 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will be returned to the hospital for correct submission of POA information. Direct data entry (DDE) screens cannot

be updated to include a space for entering POA information until January 1, 2008. Therefore, hospitals that submit claims via DDE will be unable to submit the POA indicator on October 1, 2007. These hospitals must begin submitting the POA indicator on January 1, 2008.

HOW DOES THIS IMPACT BLUE CROSS?

Blue Cross uses the CMS grouper to process most inpatient hospital claims. Most facilities are paid a Maximum Allowable Payment (MAP) according to the DRG assigned to an inpatient claim. There are some facilities that are not paid based on an inpatient MAP.

Blue Cross will adopt the 745 new DRG's and assign a MAP. New MAP's will be sent to hospitals reimbursed under the DRG system. Check with your CFO to see how your facility is reimbursed.

BCBSKS will accept the POA indicator, but it is not required. If this changes, you will be notified.

For further guidance, refer to the Medicare handouts regarding MS-DRG.

Accident Services

<http://www.bcbsks.com/providers/publications/institutional/newsletters/1998/9807299818AccidentRelatedServices.htm>

The above newsletter has been discussed at previous quadrant meetings.

Refresher- Some Blue Cross and Blue Shield of Kansas insured contracts include a specific benefit which allows payment at 100% (of the claim allowance) for services related to an accidental injury.

When a claim is received for outpatient services and the member contract has this accident benefit, our system looks at the PRIMARY diagnosis code to determine if the services are accident related. If the PRIMARY diagnosis code reflects an accident code, we pay 100% of the claim allowance. If it doesn't, we pay according to the other contractual benefits of the member contract (i.e. deductible, coinsurance, etc.).

The accident benefit (in most cases), applies to the initial accident care as well as follow up care. **Outpatient claims** must have the accident diagnosis in the PRIMARY diagnosis field in the billing process that must be followed to insure payment at the correct benefit level. This billing instruction may not represent established coding guidelines.

Also, if a claim indicates an accident diagnosis, it must indicate how the accident occurred and an occurrence code and date (see the newsletter). If it doesn't, it will be returned to the provider.

UPDATE - The following codes are aftercare fracture codes and are now also considered accident codes:

**V54.10, V54.11, V54.12, V54.13, V54.14, V54.15, V54.16, V54.17
and V54.19**

Revenue Codes and Updates

The information below highlights some of the changes to the revenue codes. Most of the changes occurred with the descriptions or standard abbreviations.

EFFECTIVE 10/1/07

REVENUE CODE – new code effective 10/1/07

CODE	DESCRIPTION	ABBREVIATION
0948	Pulmonary Rehabilitation	PULMONARY REHAB

Blue Cross will accept this revenue code. Facilities that have approved Blue Cross Pulmonary Rehab programs, can use this revenue code along with HCPCS S9473. Currently revenue code 0419 is billed with S9473.

EFFECTIVE 3/1/07

Revenue code 0392 was added to UB-04 to distinguish "Processing and Storage" from "other" (RC 0399).

Effective immediately NUBC states the revenue code listed below will be allowed as valid HIPPA compliant revenue codes until October 1, 2007

There were some revenue codes that were removed in the revisions, but are now allowed until 100107. These include:

- 0599 Home Health other units
- 0709 Other cast room
- 0719* Other recovery room
- 0749 Other EEG
- 0759 Other Gastrointestinal
- 0779 Other Preventive Care Services
- 0789 Other Telemedicine
- 0799 Other ESWT (Extra-Corporeal Shock Wave Therapy)

* REVENUE CODE 0719 – REMOVAL ON HOLD

Revenue code 0719 is widely used by Kansas hospitals for both Medicare and BCBSKS business. The removal of this revenue code is slated for 100107. Institutional relations will continue to monitor this code.

Revenue Code 0229 Clarification regarding Cancelled surgery

Blue Cross

Inpatient claims: Attempted surgery is identified with 229 revenue code on inpatient claims only with ICD9 diagnosis code V64.1, V64.2, or V64.3.

Hospitals must convert revenue code 0360 (operating room) to revenue code 0229 to avoid edits requiring ICD.9 procedure. (When revenue code 0360 is on an inpatient claim, an ICD9 procedure code is required).

The inpatient claim will be reimbursed at the MAP for the DRG assigned to the claim, or the rate applicable to your hospitals Blue Cross contract.

Outpatient claims: If the surgery was cancelled prior to the administration of anesthesia, services provided up to that point would be billed using the appropriate revenue /HCPCS codes. If the surgery is cancelled after the administration of anesthesia, the revenue/HCPCS code describing the procedure would be billed. Blue Cross accepts modifiers, but they do not change the reimbursement on the claim.

OBSERVATION

Blue Cross Observation Revenue code 0762

Revenue code 0762 should only be billed with observation E&M codes (99217-99220, G0378). Revenue code 0762 has an allowance equal to the provider registered average semi-private (AVSP) room rate. Therefore, regardless of the number of units or number of lines submitted with 0762, the cumulative allowance will be a one day AVSP room rate. Other services provided in the observation room MUST be billed under revenue code 0760 or 0769. If the other services are billed with revenue code 0762, no additional allowance will apply.

For Example:

The provider registered a 2007 room rate of 400.00 and only has Med/Surg private rooms. Therefore the AVSP rate will be 400.00.

The provider submitted a claim:

Rev code	HCPCS	Units	Charge
0250	drugs	026	507.25
0270	supplies	007	60.00
0636	J7070 D5W 1000cc	002	40.00
0762	99217 Obs. Room	036	600.00

0762	90760	IV adm Hydr.	001	80.00
0762	90761	*****	001	40.00

The provider will be allowed 400.00 for all charges billed with 0762 revenue code. The charges of 720.00 will receive an allowed amount of 400.00. However, if the provider had billed 90760 and 90761 with revenue code 0760, an additional allowance would apply to 90760 and 90761.

The other line items are reimbursed according to the Maximum Allowable Payment (MAP) for the service. Rev code 0250 and 0270 in this case would be allowed the hospital outpatient rate and J7070 is subject to a line item MAP.

Also, remember to register room rates. The observation allowance is subject to the room rate on file.

DRUGS BILLED USING CHEMOTHERAPY ADMINISTRATION CODES

The following list contains drugs that are identified as biological response modifiers, chemotherapy, hormonal antineoplastics or monoclonal antibodies. Chemotherapy administration codes should use billed when these drugs are provided to patients.

<u>Biologic Response Modifiers</u>	
J0128	Aberelix 10 mg
J0215	Alefacept 0.5 mg
J1440	Filgrastim 300 mcg
J1441	Filgrastim 480 mcg
*J1567	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), 500 mg
J2355	Oprelvekin 5 mg
J2425	Palifermin 50 mcg
J2505	Pegfilgrastim 6 mg
J2820	Sargramostim 50 mcg
J7511	Antithymocyte globulin rabbit 25 mg
J7516	Cyclosporin parenteral 250 mg
J7525	Tacrolimus 5 mg
J9015	Aldesleukin/single use vial
J9031	Bcg live intravesical per instillation
J9213	Interferon alfa-2a 3 million units
J9214	Interferon alfa-2b 1 million units
J9215	Interferon alfa-n3 250,000 IU
Q3025	Interferon beta 1-a 11 mcg IM
*Q4087	Injection, immune globulin (octagam), intravenous, non-lyophilized (E.G. liquid), 500 MG
*Q4088	Injection, immune globulin (gammagard), intravenous, non-lyophilized (E.G. liquid), 500 MG
*Q4089	Injection, RHO(D) immune globulin (human) (Rhophylac), intramuscular or intravenous, 100IU
*Q4090	Injection, Hepatitis B immune globulin (hepagam B) intramuscular, 0.5ML
*Q4091	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG
*Q4092	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG
* Clarification was received from AHA regarding the classification of IVIG. AHA determined IVIG to be a biological response modifier.	

Hormonal Antineoplastics	
J0970	Estradiol valerate, up to 40 mg
J1000	Depo-estradiol cypionate up to 5 mg
J1380	Estradiol valerate 10 mg
J1390	Estradiol valerate 20 mg
J1410	Estrogen conjugate 25 mg
J1435	Estrone 1 mg
J3315	Triptorelin pamoate 3.75 mg
J9165	Diethylstilbestrol 250 mg
J9202	Goserelin acetate implant per 3.6 mg
J9217	Leuprolide acetate suspension 7.5 mg
J9219	Leuprolide acetate implant 65 mg
J9225	Histrelin implant, 50 mg
J9395	Fulvestrant 25 mg
Monoclonal Antibodies	
J0130	Abciximab 10 mg
J0480	Basiliximab 20 mg
J1162	Digoxin immune fab (ovine) per vial
J1745	Infliximab 10 mg
J2357	Omalizumab 5 mg
J2503	Pegaptanib sodium 0.3 mg
J7513	Dacililzumab, parenteral 25 mg
J9010	Alemtuzumab 10 mg
J9035	Bevacizumab 10 mg
J9041	Bortezomib 0.1 mg
J9055	Cetuximab 10 mg
J9310	Rituximab 100 mg
Chemotherapy Drugs	
J9000	Doxorubicin HCl 10 mg
J9001	Doxorubicin HCl liposome 10 mg
J9017	Arsenic trioxide 1 mg
J9020	Asparaginase 10,000 units
J9025	Azacitidine 1 mg
J9027	Clofarabine 1 mg
J9040	Bleomycin sulfate 15 units
J9045	Carboplatin 50 mg
J9050	Carmustine 100 mg
J9060	Cisplatin 10 mg
J9062	Cisplatin 50 mg
J9065	Cladribine 1 mg
J9070	Cyclophosphamide 100 mg

J9080	Cyclophosphamide 200 mg
J9090	Cyclophosphamide 500 mg
J9091	Cyclophosphamide 1 g
J9092	Cyclophosphamide 2 g
J9093	Cyclophosphamide lyophilized 100 mg
J9094	Cyclophosphamide lyophilized 200 mg
J9095	Cyclophosphamide lyophilized 500 mg
J9096	Cyclophosphamide lyophilized 1 g
J9097	Cyclophosphamide lyophilized 2 g
J9098	Cytarabine liposome 10 mg
J9100	Cytarabine 100 mg
J9110	Cytarabine 500 mg
J9120	Dactinomycin 0.5 mg
J9130	Dacarbazine 100 mg
J9140	Dacarbazine 200 mg
J9150	Daunorubicin HCl 10 mg
J9151	Daunorubicin citrate, liposomal 10 mg
J9160	Denileukin diftitox 300 mcg
J9170	Docetaxel 20 mg
J9178	Epirubicin HCl 2 mg
J9181	Etoposide 10 mg
J9182	Etoposide 100 mg
J9185	Fludarabine phosphate 50 mg
J9190	Fluorouracil 500 mg
J9200	Floxuridine 500 mg
J9201	Gemcitabine HCl 200 mg
J9206	Irinotecan 20 mg
J9208	Ifosamide 1 g
J9211	Idarubicin HCl 5 mg
J9230	Mechlorethamine HCl 10 mg
J9245	Melphalan HCl 50 mg
J9250	Methotrexate 5 mg
J9260	Methotrexate 50 mg
J9263	Oxaliplatin 0.5 mg
J9265	Paclitaxel 30 mg
J9266	Pegaspargase single dose vial
J9268	Pentostatin 10 mg
J9270	Plicamycin 2.5 mg
J9280	Mitomycin 5 mg
J9290	Mitomycin 20 mg
J9291	Mitomycin 40 mg
J9293	Mitoxantrone HCl 5 mg
J9300	Gemtuzumab ozogamicin 5 mg

J9305	Pemetrexed 10 mg
J9320	Streptozocin 1 g
J9340	Thiotepa 15 mg
J9350	Topotecan 4 mg
J9357	Valrubicin 200 mg
J9360	Vinblastine sulfate 1 mg
J9370	Vincristine sulfate 1 mg
J9375	Vincristine sulfate 2 mg
J9380	Vincristine sulfate 5 mg
J9390	Vinorelbine tartrate 10 mg
J9600	Porfimir sodium 75 mg

The following is a list of some HCPCS changes effective July 1, 2007. Information in the notes section applies to Blue Cross and Medicare Part A, but may contain specific instructions when applicable.

HCPCS	Description	DOS effective date	Code Added date	Code Term date	Notes
C1716	BRACHYTHERAPY SOURCE, NON-STRANDED , GOLD-198, PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C1717	BRACHYTHERAPY SOURCE, NON-STRANDED , HIGH DOSE RATE IRIDIUM-192, PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C1718	BRACHYTHERAPY SOURCE, IODINE 125, PER SOURCE	04/01/01	07/01/07	06/30/2007	Code deleted June 30, 2006 and replaced with C2639 effective July 1, 2007.
C1719	BRACHYTHERAPY SOURCE, NON-STRANDED , NON-HIGH DOSE RATE IRIDIUM-192, PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C1720	BRACHYTHERAPY SOURCE, PALLADIUM 103, PER SOURCE	04/01/01	07/01/07	06/30/2007	Code deleted June 30, 2006 and replaced with C2641 effective July 1, 2007.
C2616	BRACHYTHERAPY SOURCE, NON-STRANDED , YTTRIUM-90, PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C2633	BRACHYTHERAPY SOURCE, CESIUM-131, PER SOURCE	04/01/01	07/01/07	06/30/2007	Code deleted June 30, 2006 and replaced with C2643 effective July 1, 2007.
C2634	BRACHYTHERAPY SOURCE, NON-STRANDED , HIGH ACTIVITY, IODINE-125, GREATER THAN 1.01 MCI (NIST), PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.

HCPCS	Description	DOS effective date	Code Added date	Code Term date	Notes
C2635	BRACHYTHERAPY SOURCE, NON-STRANDED , HIGH ACTIVITY, PALADIUM-103, GREATER THAN 2.2 MCI (NIST), PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C2636	BRACHYTHERAPY LINEAR SOURCE, NON-STRANDED , PALADIUM-103, PER 1 MM	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C2637	BRACHYTHERAPY SOURCE, NON-STRANDED , YTTERBIUM-169, PER SOURCE	04/01/01	07/01/07		Code created April 1, 2001. Short and long descriptors revised effective July 1, 2007.
C2638	BRACHYTHERAPY SOURCE, STRANDED , IODINE-125, PER SOURCE	07/01/07	07/01/07		
C2639	BRACHYTHERAPY SOURCE, NON-STRANDED , IODINE-125, PER SOURCE	07/01/07	07/01/07		
C2640	BRACHYTHERAPY SOURCE, STRANDED , PALLADIUM-103, PER SOURCE	07/01/07	07/01/07		
C2641	BRACHYTHERAPY SOURCE, NON-STRANDED , PALLADIUM-103, PER SOURCE	07/01/07	07/01/07		
C2642	BRACHYTHERAPY SOURCE, STRANDED , CESIUM-131, PER SOURCE	07/01/07	07/01/07		
C2643	BRACHYTHERAPY SOURCE, NON-STRANDED , CESIUM-131, PER SOURCE	07/01/07	07/01/07		
C2698	BRACHYTHERAPY SOURCE, STRANDED , NOT OTHERWISE SPECIFIED, PER SOURCE	07/01/07	07/01/07		
C2699	BRACHYTHERAPY SOURCE, NON-STRANDED , NOT OTHERWISE SPECIFIED, PER SOURCE	07/01/07	07/01/07		

HCPCS	Description	DOS effective date	Code Added date	Code Term date	Notes
C9728	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY/SURGERY GUIDANCE (EG, FIDUCIAL MARKERS, DOSIMETER), OTHER THAN PROSTATE (ANY APPROACH), SINGLE OR MULTIPLE	07/01/07	07/01/07		
J1567	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), 500 mg	01/01/06			Effective 070107 this code is no longer payable for Medicare- Use Q4087, Q4088, Q4091, or Q4092 Blue Cross will continue to accept J1567
Q4087	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	07/01/07	07/01/07		Q4087, Q4088, Q4091, or Q4092 replaces J1567
Q4088	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	07/01/07	07/01/07		Q4087, Q4088, Q4091, or Q4092 replaces J1567
Q4089	INJECTION, RHO(D) IMMUNE GLOBULIN (HUMAN), (RHOPHYLAC), INTRAMUSCULAR OR INTRAVENOUS, 100 IU	07/01/07	07/01/07		Rhophylac is the only product that should be billed using Q4089
Q4090	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAMUSCULAR, 0.5 ML	07/01/07	07/01/07		HepaGam B, when given intramuscularly, is the only product that should be billed using code Q4090
Q4091	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	07/01/07	07/01/07		Q4087, Q4088, Q4091, or Q4092 replaces J1567
Q4092	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	07/01/07	07/01/07		Q4087, Q4088, Q4091, or Q4092 replaces J1567

HCPCS	Description	DOS effective date	Code Added date	Code Term date	Notes
Q4093	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)	07/01/07	07/01/07		
Q4094	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)	07/01/07	07/01/07		
Q4095	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG	07/01/07	07/01/07		Q4095 is used when administering Reclast, J3487 is used when administering the drug Zometa
0178T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report	07/01/07	07/01/07		Hospitals should not use this code
0179T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, withOUT interpretation and report	07/01/07	07/01/07		
0180T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only	07/01/07	07/01/07		Hospitals should not use this code
0181T	corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report	07/01/07	07/01/07		
*0182T	High dose rate electronic brachytherapy, per fraction	07/01/07	07/01/07		
<p>* As indicated by CPT, do not report CPT code 0182T in conjunction with CPT codes 77761-77763, 77776-77778, 77781-77784, 77789. Additionally, when a high dose rate electronic brachytherapy service described by 0182T is provided, along with a procedure to place and remove (if performed) an applicator into the breast for radiation therapy described by HCPCS code C9726, both services are separately reportable.</p>					

Questions and Answers

Below are several questions compiled from past Quadrant meetings and e-mails.

Q.1. Why is P65 processing A9270 (Medicare non covered drugs) as covered and showing a paid amount on the RA? Patients are upset when we tell them they still owe the amount for A9270.

Answer- This is a problem. We are only processing the coinsurance amount, but this amount is prorated on every line. The patient does owe the A9270 amount as this is not covered by P65.

Q.2. When we call Blue Cross Customer Service about the A9270 showing as covered on the remittance advice, Customer Service representatives tell us that P65 did pay this service. We are concerned they will tell the patient they do not owe this amount.

Answer – We will remind CSC that this is a system problem and the patient is responsible for the amount.

Q.3. For BCBS since Medical Nutritional Therapy is not covered why can't BCBS deny 97802, 97803, 97804, G0270, G0271 as non-covered R64?

Answer-These services can be submitted and we will deny the service as non-covered. For groups that cover this service, these codes will be reimbursed.

Q.4. Blue Cross does not hold many billing workshops. Is there information somewhere to help new billers?

Answer – Generally we do not have many requests for BC new billing workshops. However, you should contact Institutional Relations if you have a training need.

There are also online courses available on our web site:

<http://www.bcbsks.com/providers/>

Click online training, on the left hand side of the screen:


The following information will appear

Online Training

Online training involves using multimedia technologies and the Internet to improve the quality of learning and deliver educational materials in a different way.

Online training allows BCBSKS to cost-effectively deliver important instructions and information to providers who can then go through the training at their own time and pace.

Institutional

[NPI - The Next Step](#) 
[Provider Remittance Advice](#)
[BlueCard - Understanding the Process Institutional](#)
[National Provider Identifier \(NPI\)](#)
[Hospital Pre-certification](#)

In addition our manuals are on the web site and are available to view or print. Click publications on the left side of the screen:

Manuals

Remittance Advice:

[HIPAA Codes](#) - (offsite link)
[Institutional Provider Manual](#) - 04/2006
[Pre-certification Manual](#) (large size PDF, **2.8mb** - updated 5/31/05)
[Crosswalk](#)
[Revenue Code Manual](#) - (December 2006 update)
(large size PDF, **1.7MB**, 413 pages)
[Items Not separately Chargeable](#) 02/2007
[2005 Remittance Advice Guide](#) - 06/2005

Workshop Handouts

[All Programs](#)
[Quadrant Meetings](#)
[NPI Webcast](#) (PowerPoint) - 10/2006
[ESRD Manual](#) - 06/2007
[Home Health/Hospice General Session](#) 08/2006
[Home Health Workshop Handouts](#) 08/2006
[Hospice Workshop Handouts](#) 08/2006
[Skilled Nursing Facility Statewide](#) - 04/2005

Q.5. Why is processing changing the order of diagnosis code on **inpatient** claims and putting the accident code first?

Answer – This should not occur. If you get an inpatient claim returned requesting the accident coding to be changed, return the claim and state coding is not to be changed on inpatient claims. If you find that we have changed the order of diagnosis codes on inpatient claims, please contact Institutional Relations.

Q.6. Why are claims being returned to us stating that occurrence code 11 requires an accident diagnosis code?

Answer – This should no longer occur. If it should occur return the claim stating this in not an accident occurrence code.

Q.7. How long should we continue to file our legacy number on the claims?

Answer – The following information was published in BCBS newsletter BC07-13 http://www.bcbsks.com/providers/publications/institutional/newsletters/2007/061407_NPIupdate.htm

PROVIDERS MUST REPORT NPI "ONLY" READINESS

During Stage 1 and Stage 2, if a provider is ready to submit claims and transact all other business by NPI "only", they must notify BCBSKS. When notified, BCBSKS and the provider will determine the actual effective date for NPI "only" transactions and from that point on all transactions will reflect only the national provider identifier.

This includes but is not limited to:

- Claim submission – billing and performing providers. Claims received after the NPI "only" start date that include a legacy provider number will be rejected. (Does not apply to secondary provider numbers.)
- Remittance advices – paper and electronic
- Eligibility and benefit inquiries (270/271) - web or batch
- Claims status inquiries (276/277) – web or batch

This notification is required during Stages 1 and 2. When Stage 3 is implemented, all transactions by all providers will be conducted with NPI only.

Institutional providers who are ready to conduct business with NPI "only" should contact:

Donna Barte, institutional provider relations (785) 291-8692 or 1-800-432-0216 ext. 8692.

Q.8. There are services that do not require a physician order- like screening mammograms and flu shots. What NPI # are we to use?

Answer – See BC Newsletter

http://www.bcbsks.com/providers/publications/institutional/newsletters/2007/061407_NPIupdate.htm

You may on rare occasions need to bill for services that can be performed without a physicians orders or for services ordered by a provider who does not have an NPI. In these cases and only these cases, you may report your NPI in the attending physician NPI field. If you do not know the NPI

for the attending provider or operating physician, **do not** use your NPI. You must contact the provider/physician for this information.

Q.9. If duplicate coverage is involved, is there any way BCBS can indicate if we're primary or secondary?

Answer – Blue plans are currently working on phase 4 of enhanced eligibility inquiry which is slotted for December 2008. One of the "optional" items in this project was to provide standard other payer information. As a plan, BCBSKS will not be including this optional item, but may include it in a future enhancement. Therefore providers will need to continue to call for verification regarding coordination of benefits.

Q.10. Why does BCBS Customer service tell us that we can look up why a claim was returned for more information? The web only shows us that it was returned, but not the reason it was returned.

Answer – The Blue Cross remittance advice lists reason code 16 when a claim is returned for more information. A remark code is also listed. Sometimes will reflect the reason why the claim was returned for more information. Providers receive a letter stating the specific information needed. However, if you are unable to locate the letter, or the remark code is not clear, you can ask CSC to fax a copy of the letter to you. We are still working the letters being available through our web site.

Q.11. Why are BCBS out of state plans requesting our NPI numbers?

Answer – They may request this information because they have legacy numbers set up in their systems and need to update with the NPI. BCBSKS chose not to solicit information from out-of-area providers. We will be updating on a claim by claim basis.

Q.12. Fiserv claims to be sent to BCBS of Kansas for pricing. However, the ID#'s do not have alpha prefixes. How can we get these through electronically?

Answer – This needs to be set up with your vendor. The claims need to indicate financial class, group and ID as BCBSKS- CAP etc. You must use your BCBS provider number. We will price the claim and then send it to Fiserve to pay the claim.

Q.13. Can we call to see if BCBS received the Fiserv claim?

Answer – Yes.

Q.14. When we have a problem with how a service was priced from Fiserv, Fiserv told us to call BCBS KS. BCBSKS said they could not help us. What now?

Answer – We should be able to tell you how a line was priced, for any network pricing group. Call provider relations if you have pricing questions.

Q.15. We hve separate NPI numbers for our Acute, Rehab and Psych all on one PIP, or will they each have a separate PIP payment?

Answer – The following information was published in BC newsletter BC 07-13 http://www.bcbsks.com/providers/publications/institutional/newsletters/2007/061407_NPIupdate.htm

PIP – periodic interim payments will be handled as follows:

1. PIP will apply only to the acute hospital number. The weekly payment amount may need to be adjusted after the rehabilitation and/or psychiatric payments are removed.
2. Rehabilitation and psychiatric checks will be based on actual claims paid.
3. PIP payments do not apply to swing bed numbers

Q.16. If an out of state plan requires precert, can they list the phone number to call through the web inquiry?

Answer – We have forwarded this suggestion.

Q.17. Does the essential blue ID card say it's Essential Blue?

Answer – No, the alpha prefix is XSB just like all other Blue Choice contracts.

Q.18. ENHANCED ELIGIBILITY: Can you find other individuals on the same policy without having to go back out and start all over?

Answer – Yes, at the end of the benefit detail, there's a couple of boxes. The user can choose another patient or service date or choose another ID.

Q.19. Can patients can go in and look at their own eligibility?

Answer – Yes, they have always had this ability. However, the new enhanced eligibility and service type drop down box doesn't apply to them. They should use their contract for details.

Q.20. Can providers check eligibility through batch transactions?

Answer – Yes, this is available through batch.