

# **SKILLED NURSING FACILITY Blue Cross**



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## **Member Contracts**

Blue Cross Blue Shield of Kansas Premier Blue member contracts offer an inpatient skilled benefit. Some administrative services only (ASO) or self-funded groups also have inpatient skilled benefits. However, no other Blue Cross Blue Shield of Kansas contracts offers a primary skilled benefit, which includes Blue Choice, Blue Select, and CAP contracts.

The Federal Employee Program (FEP) offers a skilled benefit only when services are secondary to Medicare. There is not a benefit if FEP is the primary coverage.

The State of Kansas (SOK) offers an inpatient skilled benefit under their Premier Blue contract and also when secondary to Medicare under their Senior Plan C contract.

## **Contracting Status**

Blue Cross Blue Shield of Kansas offers contracts to skilled nursing facilities for the limited number of member contracts offering the Premier Blue benefit. This network, established in 1998 is currently sufficient to support our member needs.

Under this contract, the skilled nursing facility (SNF) will not require from the member, payment in excess of any deductibles, coinsurance, non-covered or share-payment amounts up to the Maximum Allowable Payment (MAP).

Some of the benefits to being a contracting provider with Blue Cross Blue Shield of Kansas include:

- Electronic Claims Filing
- Prompt payment of claims
- Payment is made to the contracting provider and not the member
- Publication in our Blue Cross Blue Shield of Kansas Provider Directories each year and on the Web
- Claim status, member eligibility and electronic remittances advices via the Web

Each July providers are mailed the Policies and Procedures, which update the provider agreement.

These policies will advise your facility of any changes including reimbursement updates for the upcoming year. Providers are asked to respond to Blue Cross Blue Shield of Kansas no later than the first of September of the same year with any questions or concerns. The provider contract will automatically renew January 1 of the following year and the new Policies and Procedures, along with any changes to the per diem rate, will become effective.

Freestanding Premier Blue SNF - These SNF's will receive a set of Policies and Procedures for their facility as outlined above. The per diem rate will be updated as reflected in the Policies and Procedures each year.

SNF's shall submit claims for inpatient services provided to Premier Blue members using the UB-92 format. Outpatient services such as, physical therapy shall be submitted under the therapist professional provider number and billed using the CMS-1500 claim format.

*Denial Codes on the Detail Page of the Claim on the Web*

FF – “This policy does not provide benefits for skilled nursing care. Some ancillary charges (therapy, etc) may be eligible for benefits if the provider submits a CMS-1500. Room charges and ancillary services not billable on the CMS-1500 format, are the member's responsibility.”

FJ – “Outpatient and ancillary services should be submitted by the provider using a HCFA 1500 claim form.”

Hospital Based Premier Blue SNF or Swing-bed – The Policies and Procedures for these facilities are contained in the hospital Policy and Procedure mailing each year. The hospital based SNF's and Swing-beds will not receive a separate policy mailing. Reimbursement for these facilities will be contained in the hospital policy and procedure document.

*Denial Codes on the Detail Page of the Claim on the Web*

EF – “The patient does not have skilled nursing facility benefits. Covered ancillaries should be billed using the hospital provider number rather than the skilled nursing provider number. See the allowable charge section and the general exclusions of the contract.”

EG – “Outpatient services should be billed using the hospital provider number rather than the skilled nursing provider number. See the allowable charge section of the contract.”

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

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

When a non-MAP'd DRG applies, reimbursement will be the provider's charge less the appropriate discount as specified by the member's network (i.e. Blue Select or Blue Choice).

Premier Blue – Hospitals that have a Premier Blue skilled nursing unit or swing-bed will be reimbursed at the lesser of charge of contracted Premier Blue per diem rate.

When the patient does not have coverage for inpatient skilled care, the Contracting Provider will issue a written notice of non-coverage prior to the admission advising the patient that the room and board charges will be the member's responsibility.

## Letter Mailed to Hospital-Based SNF's and Swing-beds

December 29, 2004

*RE: Billing Inpatient Skilled Services*

*Beginning January 1, 2005, new guidelines will be in effect for billing claims for inpatient admissions to a hospital based skilled nursing facility (SNF) or swing bed unit. These guidelines are outlined below and require that these admissions be billed under a skilled provider number and not an acute care hospital number.*

*Some providers already have a BCBSKS provider number specifically assigned for billing skilled services. Others did not and if you didn't, BCBSKS has now assigned a skilled number to you. Also, some providers have both a hospital based SNF and swing bed unit. If you have both, you'll have two skilled numbers; one for SNF and one for swing bed.*

*The BCBSKS skilled provider number(s) for your facility is:*

*SWING BED:*

*HOSPITAL BASED SNF:*

*Very few BCBSKS member contracts include coverage for inpatient skilled services and the guidelines below include information when they do or don't.*

- When a patient is being discharged from acute to skilled care, this must be clearly reflected in the medical record. If it's a direct admission to skilled care, this too must be reflected in the record.*
- (If the medical record does not reflect a discharge from acute to skilled care and the patient remains in the hospital you need to follow the guidelines as outlined in our BCBSKS newsletter dated April 6, 2004 and titled Inpatient Claims – Not Medically Necessary Days.)*
- Skilled admissions must be prior approved by the BCBSKS medical review staff. When the patient is being transferred from acute to skilled care, this is usually handled through the concurrent review process.*
- If the patient has skilled benefits and the skilled admission is prior approved, you will submit the charges for the entire stay (room and board plus all ancillaries) using your **skilled provider number**.*

- *If the patient does not have skilled benefits (or the stay is not approved), you must give them a Notice of Personal Financial Obligation (NOPFO) prior to the service in order to bill them for the non-covered room and board charges. When you submit a claim, the non-covered room and board charges will be billed using your **skilled provider number** (be sure to include a copy of the NOPFO) and the ancillary charges will be billed as an outpatient claim using your acute hospital number.*
- *If you're a Premier Blue hospital the allowance for covered skilled admissions for Premier Blue members will be the lesser of your charge or the contracted Premier Blue per diem rate.*
- *For Competitive Allowance Program (CAP) the allowance for covered skilled admissions will be the lesser of charges or CAP MAP based on the DRG assigned to the inpatient skilled stay. For non-MAP'd DRGs, the allowance is the providers charge less the applicable discount (i.e. Blue Select, Blue Choice). For critical access hospitals that selected the CAH inpatient payment method, the allowance for covered skilled admissions will be the lesser of charges or the CAH inpatient allowance.*

*Attached are two billing examples showing how claims should be filed.*

*Also, if a Medicare claim pays under your Medicare swing bed number, BCBSKS is currently processing the balances under your acute hospital provider number. This is changing and as soon as we get the system updated, the Medicare swing bed balances will be processed under your BCBSKS swing bed number and not your acute hospital number. If you have a hospital based SNF, the Medicare balances for these claims are already being processed under the BCBSKS SNF provider number so you won't see a change.*

*Billing Examples Inpatient Skilled Services  
Effective January 1, 2005*

**EXAMPLE 1: ACUTE PATIENT DISCHARGED TO SWING BED/SNF - HAS SKILLED BENEFITS**

*Admitted acute: 1/1/05  
Discharged to Skilled: 1/8/05  
Discharged to Home: 1/16/05*

*The medical record reflects discharge to skilled care on 1/8/05. The skilled care is prior authorized.*

*You will submit two separate claims:*

**Claim 1:**

<b>Provider Number:</b>	<b>Acute Number</b>
-------------------------	---------------------

Type of Bill:	111
Date of Service:	1/1/05 thru 1/8/05
# of Days:	7 covered
Include Charges For:	R&B plus ancillaries

Claim 2:

Provider Number:	Skilled Number
Type of Bill:	18X for swing bed 21X for SNF
Date of Service:	1/8/05 thru 1/16/05
# of Days:	8 covered
Include Charges for:	R&B plus ancillaries

### Medically Unnecessary Services

The Contracting Provider shall not bill members for services which have been determined medically unnecessary, experimental/investigational, have been denied due to Utilization Review, and/or are patient demanded services unless the member has been given written notification in advance that specific services will be the member's responsibility. This notification is referred to as the *Notice of Personal Financial Obligation (NOPFO)*. Generic or all-encompassing notifications without advanced written authorization by BCBSKS shall not be deemed to meet the specific notification requirement mentioned above. In instances where medical necessity is questionable, the Contracting Provider may contact BCBSKS medical review department for a predetermination of coverage.

All claims for services for which the member has been given a *NOPFO* shall be submitted on a paper UB-92 claim form with the *NOPFO* form attached. Charges shall be billed as noncovered. If the member does not want the claim to be filed, obtain this instruction in writing from the member and keep it on file with the *NOPFO*.

## ***NOTICE OF PERSONAL FINANCIAL OBLIGATION (NOPFO)***

*Beginning with services July 1, 2002, all claims for services that are medically unnecessary or experimental/investigational must be submitted to Blue Cross and Blue Cross Blue Shield of Kansas (BCBSKS) with a copy of the Notice of Personal Financial Obligation. This process ensures that members receive notice of their appeal rights. This represents a change in that prior to July 1, 2002, providers were required to submit inpatient and partial-day claims with the NOPFO but were not required to submit outpatient claims unless the patient/member requested. For more details, refer to the BCBSKS institutional newsletter dated June 2002.*

*"The Contracting Provider shall not bill members for services which have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance that SPECIFIC medically unnecessary or experimental/investigational services will be the member's responsibility. This notification is referred to as the Notice of Personal Financial Obligation. Generic or all-encompassing notifications without advanced written authorization by BCBSKS shall not be deemed to meet the specific notification requirement mentioned above. In instances where medical necessity is questionable, the Contracting Provider may contact BCBSKS medical review department for a predetermination of coverage. This provision applies to inpatient, outpatient and partial-day services.*

*All claims for services that are medically unnecessary or experimental/ investigational and for which the member has been given a Notice of Personal Financial Obligation shall be submitted on a paper UB-92 claim form with the Notice of Personal Financial Obligation form attached. Charges shall be billed as noncovered."*

*BCBSKS staff developed a NOTICE OF PERSONAL FINANCIAL OBLIGATION that can be used by providers to meet this requirement. Providers are not obligated to use this exact form however if developing their own, it must be specific and we suggest that it be sent to the provider consultant for review prior to its use. The use of non-specific or incomplete forms places the provider at financial risk.*

Patient's Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Identification Number: \_\_\_\_\_ Provider Address: \_\_\_\_\_

**NOTICE OF PERSONAL FINANCIAL OBLIGATION**  
**Read Before Signing**

I have been informed and do understand the charges for \_\_\_\_\_  
services provided to me beginning on \_\_\_\_\_ (date)  
through the date of discharge **will not be covered by Blue Cross and Blue Shield of Kansas, Inc. or Premier Blue** because these services are considered medically unnecessary or because it is not necessary to be hospitalized to have these services performed or because the services are experimental/investigational.

I request that these services be performed even though they will not be paid by Blue Cross and Blue Shield of Kansas, Inc. or Premier Blue. I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR THE FULL FEE OF APPROXIMATELY \$ \_\_\_\_\_. This amount is an approximation only, based on the procedure/services scheduled to be performed and may be more if additional services become necessary.

Acknowledgment of personal financial obligation applies to charges for services specified above when performed by this provider **AND** any other provider whose services are related to or associated with the services I have requested on this form.

\_\_\_\_\_  
Patient or Member Signature

\_\_\_\_\_  
Date

Note to Patient: If you disagree with our determination you have appeal rights with your insurance company. You may contact the Blue Cross and Blue Shield of Kansas Customer Service Department for further information on your appeal rights.

Check one of the following:

I, \_\_\_\_\_ (witness name), did personally observe the patient/member whose signature appears above and do certify that he/she did read this notice, was given an opportunity to ask questions and did affix his/her signature in my presence.

Neither the patient nor member was available to sign the Notice of Personal Financial Obligation prior to \_\_\_\_\_ (scheduled start of care date). I, \_\_\_\_\_ (provider representative), did personally inform \_\_\_\_\_ (name of person informed) of the complete details of this notice by telephone on \_\_\_\_\_ (date) and advised him/her that other arrangements would have to be made prior to that date unless he/she agreed to accept personal financial responsibility. They have agreed to sign the notice at the earliest possible time.

I, \_\_\_\_\_ (witness Name), did personally observe that this Notice of Personal Financial Obligation was presented to and verbally explained to \_\_\_\_\_ (name of person informed) by \_\_\_\_\_ (provider representative) on \_\_\_\_\_ (date). This individual refused to sign the notice even though he/she was informed that Blue Cross and Blue Shield would not pay for charges on and after date shown above and that the facility would look to him/her for payment on and after that date if the patient remained in this facility. The stated reason for not signing was \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

Provider Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

This form needs to accompany the paper claim as non-covered.

## Refunds to Blue Cross

There could be situations where you will discover an overpayment on a claim in situations such as a late credit to a patient's account or because duplicate coverage is involved. When an overpayment situation occurs, use the Provider Refund/Deduct Authorization form (29-202) to notify our office. Copies of this form are located on the Blue Cross website at [www.bcbsks.com](http://www.bcbsks.com).

The inquiry should be directed to:

Blue Cross and Blue Shield of Kansas  
Customer Service Department  
PO Box 239  
Topeka, Ks. 66629-0001

Complete the form with as much information as possible to help us expedite the refund.

The minimum information required is:

- provider name
- provider number
- patient's name
- patient's identification number
- date of service
- reason for refund

You may use any of the following methods to accomplish the refund:

1. Return your check with either the Claim Inquiry Form or the Provider Refund/Deduct Authorization Form.

OR

2. Request that a refund letter be written to your hospital.


Blue Cross or Blue Shield overpayments should be returned to our Collection/Claims Overpayment Department, Cost Center 830. If it is determined that the refund is due to the patient, Blue Cross will then return the overpaid amount direct to the patient.

## **Timely Filing Requirements**

Initial billings must be submitted to BCBSKS within one year, three months (15 months) from the date of discharge or the date of outpatient services. In the event initial billings are not submitted timely, deductibles, coinsurance, non-covered and shared payments may be recovered from the member. All other balances as it relates to these initial billings will be a write-off to the Contracting Provider. Notification will be provided when employee groups impose alternate timely filing and claim assessment requirements. Failure to meet those requirements will result in claim denial.

## PAPER REMITTANCE ADVICE

We have been talking for months now about turning off the paper remittance advice. Some providers have taken the step to do this but there are still a number of you who have not. Eventually, there will be no choice.....you will only receive electronic RA...so we would like to move you in that direction as soon as possible. If you are not the person who has the authority to make that decision, please speak to whoever does and let them know that this information is accessible on line. Those that have converted have not suffered any pains (that we know of!!!). Go to the BCBSKS.com website under **Providers** and click on **Remittance Advice**, sign in, and follow the instructions. It is SO simple!!!! We want to thank those of you who have turned off the paper remittance. We appreciate your cooperation! Now, look how simple it is to do this.....



### Secured Services

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#### Remittance Advice Options

View the Remittance Advice documents or search for an archived document using a specific Pay Date.

Please note: Remittance Advice documents containing information on our Plan 65 members with supplemental Medicare coverage are not available at this time.

- [Stop receiving mailed Remittance Advice documents](#)
- [View Remittance Advice documents](#)  
(Displays 20 recent pay days in reverse chronological order.)
- [Remittance Advice documents Search by Pay Date](#)
- [View Pend/Suspend Notices](#)

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### Stop receiving mailed Remittance Advice documents

Save time and money when you choose to receive your Remittance Advice documents online.

The online documents are available sooner because you don't have to wait on the mail, and you can view this information at your convenience. You also may use the archived documents as a fast accounts receivable research tool.

**Please note:** You also may participate in electronic fund transfer (EFT) with BCBSKS. If you'd like to sign up for this service, [please complete and fax the form.](#)

Click here to:

[Stop receiving mailed Remittance Advice documents](#)

Return to [Remittance Advice Options](#)

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***THANK YOU FOR TURNING OFF  
YOUR PAPER REMITTANCE  
ADVICE...YOU ARE A WINNER!!!!***

# NATIONAL PROVIDER IDENTIFICATION

## **NPI Fact Sheet**

Prepared by Blue Cross and Blue Shield of Kansas

- NPI (National Provider Identifier) is a requirement of HIPAA.
- NPI is a ten-digit number that will be used to submit claims and transmit any electronic health information to all payers.
- NPI applies to physicians, non-physician health care practitioners, other suppliers and certified providers such as institutions, home health agencies and skilled nursing facilities.
- Each individual practitioner will receive one NPI.
- Organization providers (i.e., hospitals, group health care providers) 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.
- Providers can apply for NPIs beginning May 23, 2005.
- Starting May 23, 2007, providers will be required to use their NPI.
- Even after you receive your NPI, between May 23, 2005 and May 23, 2007 providers will continue to submit claims with their BCBSKS provider number.
- During this same time period (May 2005 through May 2007), providers can submit their NPI in addition to their BCBSKS provider number on electronic claims, eligibility and referral transactions. You should contact your vendor for the specific details regarding in what loop/segment the NPI should be reported.
- BCBSKS will continue to report the BCBSKS provider number on all remittance advices and correspondence until after the May 23, 2007 final implementation.
- After a provider receives their NPI, BCBSKS asks to be notified. Once notified, BCBSKS will add the NPI to our records for use in this transition process.
- The Centers for Medicare & Medicaid Services (CMS) has developed a National Plan and Provider Enumeration System (NPPES) to process applications and issue NPIs.
- A single entity referred to as an enumerator will operate the NPPES.
- CMS has chosen FOX Systems, Scottsdale, Arizona as the enumerator.
- **All dates are subject to change based on CMS direction.**

For current information about NPIs, visit the following Web sites:

Complete regulation

<http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf>

Summary of regulation <http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/NPI-FR-GeneralOverview-REV-2-18-04.pdf>

# **NPI Glossary of Terms**

**Prepared by Blue Cross and Blue Shield of Kansas**

**Bulk Enumeration** – (also referred to as mass enumeration) Mass enumeration of a large number of health care providers, all at one time.

**Covered Health Care Provider** – A person who is trained and licensed to give health care or a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

**Employer Identification Number** (EIN) – The number assigned by the Internal Revenue Service (IRS), or the provider being identified.

**Entity Type Code** – The type of health care provider that is being assigned an NPI. Codes are:

- 1 = (Person): individual human being who furnishes health care;
- 2 = (Non person): entity other than an individual human being that furnishes health care (for example, hospital, skilled nursing facility, hospital subunit, pharmacy, or health maintenance organization)

**Entity Type Code 1** – The type of NPI issued to health care providers who are human beings. Examples are physicians, dentists, nurses, chiropractors, pharmacists and physical therapists.

**Entity Type Code 2** – The type of NPI issued to health care providers other than individual human beings, that is, organizations. Examples are hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations (HMO), suppliers of durable medical equipment, supplies related to health care, prosthetics and orthotics, and pharmacies.

**Enumerator** – An organization under contract with the Department of Health and Human Services to assign NPIs. The enumerator will:

- receive and process National Provider Identifier (NPI) applications;
- notify health care providers of their NPIs;
- use the National Plan and Provider System (NPPES) to ensure the unique identification of a health care provider;
- answer questions about the processes of applying for and obtaining NPIs and furnishing updates;
- collect information, via the applications and updates, and maintain the NPPES database containing NPIs and information about the health care providers to which they are assigned; and
- furnish information upon request and in accordance with established guidelines.

**Individual Health Care Provider** – Health care providers who are human beings. The providers are considered entity type code 1. Examples are physicians, dentists, nurses, chiropractors, pharmacists and physical therapists

**IRS Individual Taxpayer Identification Number** (IRS ITIN) – The number assigned by the Internal Revenue Service (to individuals who are not eligible to be assigned SSNs) to the individual being identified.

**Legal Entity** – The covered entity ultimately responsible for complying with the HIPAA rules and for ensuring that its subparts and/or health care components are in compliance.

**National Provider Identifier** (NPI) – A system for uniquely identifying all providers of health care services, supplies, and equipment. NPIs are assigned by the NPPES and are 10-position, all-numeric identification numbers that will identify a health care provider in standard transactions, such as health care claims.

**National Provider System** (NPS) – Now known as National Plan and Provider Enumeration System.

**National Plan and Provider Enumeration System** (NPPES) - The administrative system for supporting a national plan and provider registry. This is a comprehensive uniform system for identifying and uniquely enumerating health care providers and plans at the national level.

**Nonhealth Care Services** – Atypical or nontraditional services that are indirectly related to health care but do not fall within the definition of health care services. These could include taxi, home and vehicle modifications or insect control.

**Organization Health Care Provider** – Health care providers who are not individuals, that is, human beings. These providers are classified as entity type code 2 providers. Examples are hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations (HMO), suppliers of durable medical equipment, supplies related to health care, prosthetics and orthotics, and pharmacies.

**Social Security Number** (SSN)– A number assigned by the Social Security Administration (SSA) to the individual being identified.

**Subpart** – A component or separate physical location of an organization health care provider. Examples:

- subpart of a hospital could include outpatient departments, surgical centers, psychiatric units and laboratories;
- provider chains that generally have a corporate headquarters and a number of separate physical locations. The separate physical locations are generally separately licensed or certified, i.e. DME supplier chain.

**Taxonomy Code** - An administrative code set that classifies health care providers by type, classification and specialization.