

August 2006

Blue Cross  
Hospital Quadrant  
Meeting

Handouts



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Blue Cross and Blue Shield of Kansas has been advised that certain private entities are continuing to conduct educational seminars, conferences, and workshops and using misleading wording and advertising in their marketing practices. We have also been advised that some of you have received telephone calls soliciting and urging you to attend certain seminars.

Although their marketing, advertisement, and phone calls imply that these seminars, conferences, and workshops are being conducted in partnership with the Medicare contractor, neither Blue Cross and Blue Shield of Kansas or the Centers for Medicare & Medicaid Services (CMS) is associated with these entities, nor are these seminars endorsed by Medicare.

The Provider Education and Training seminars and workshops that are offered by Blue Cross and Blue Shield of Kansas are those that are offered via our bulletins, Internet ([www.kansasmedicare.com](http://www.kansasmedicare.com)), or any other documentation that specifically identifies Blue Cross and Blue Shield of Kansas or the Centers for Medicare & Medicaid Services (CMS) (logo identification).

As a Medicare provider, you need to carefully evaluate information received at seminars, conferences or workshops to ensure it is accurate and that proper information has been received.

If you utilize information received at a seminar, conference or workshop conducted by someone other than Medicare and then are found to be in noncompliance with Medicare law, regulations, and guidelines; you are liable for any information you submit to the Medicare program. If you have any questions regarding the authenticity of any seminars, please feel free to contact us at: (785) 291-7236.

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## NATIONAL PROVIDER IDENTIFIER (NPI)

Blue Cross and Blue Shield of Kansas published a newsletter on May 23, 2006, which contained details and resources regarding NPI's.

[http://www.bcbsks.com/providers/publications/institutional/newsletters/2006/052306\\_NPI.htm](http://www.bcbsks.com/providers/publications/institutional/newsletters/2006/052306_NPI.htm)

This newsletter included information about NPIs that we **hope** most providers already knew. If you didn't..... there's still time to:

- find out about NPIs,
- decide what individual numbers should be obtained,
- apply for and obtain your NPI(s),
- determine your taxonomy codes, and
- **notify BCBSKS**

***PROVIDERS NEED TO NOTIFY BCBSKS ABOUT THEIR NEW NPI(s) NO LATER THAN OCTOBER 1, 2006. You also need to include the taxonomy code.***

***If you don't tell us what your NPI number is, we won't be able to process claims or issue checks.***

Donna Bartee has been calling providers requesting their NPI's. If you have already given her all of your NPI #'s, you will not need to complete the form on page 3. ***If you have not notified us, complete the information on the page 3 and bring it to the quadrant meeting.***

You may also notify us by:

Submitting the information online via the BCBSKS Web site [www.bcbsks.com](http://www.bcbsks.com) - secured services section, select "Provider Information". Because NPI information can vary so greatly, the online screens may not accommodate every provider and those NPI situations that require greater detail will need to be reported in writing.

- Writing the information on the list we send you and returning it to us. Please write legibly and include the name and telephone number of the person submitting the information.
- Preparing your own list that shows:
  - Existing BCBSKS provider number/provider name (be sure to include all your numbers);
  - NPI number and effective date for each BCBSKS provider number;
  - Verification that the employer ID number is correct;
  - Taxonomy code(s). If more than one taxonomy code applies, report all codes;
  - Type of NPI (individual, organizational, subpart)
  - Name and telephone number of person submitting the information.

When we receive your NPI information we'll share it with other areas at BCBSKS including EDI Blue Cross and Blue Shield of Kansas and Blue Shield professional relations.

**IF YOU HAVE NOT NOTIFIED BCBSKS PROVIDING YOUR NPI AND TAXONOMY CODES, PLEASE DO SO NO LATER THAN OCTOBER 1, 2006.**

**Mail information to:**

**Institutional Provider Relations CC442E1  
Blue Cross and Blue Shield of Kansas  
1133 SW Topeka Blvd.  
Topeka, KS 66629-0001**

**Fax information to:**

**Institutional Provider Relations  
785-290-0734**

**Excel spreadsheets can be emailed to:**

**[Nicole.Dodds@bcbsks.com](mailto:Nicole.Dodds@bcbsks.com)**

# Please include all Blue Cross and Blue Shield Provider Numbers

Blue Cross  
Of Kansas  
Provider #

Provider Name

NPI #

NPI  
Effective Date

Taxonomy  
Code

NPI Type  
(Ind., Subpart, Organization)

Name and telephone number of person submitting the information: \_\_\_\_\_

\_\_\_\_\_

## **CROSSOVER PROBLEMS**

### **Blue Cross and Blue Shield secondary to Medicare**

#### **When Medicare is primary and ANOTHER Blue Cross Plan is secondary**

- These claims do not crossover to Blue Cross and Blue Shield of Kansas. In the future, they will crossover electronically to the out of state Blue Cross Plan. Until then, providers must submit a paper claim to BCBSKS with the Medicare remittance advice.
- **YOU MUST INCLUDE YOUR BLUE CROSS PROVIDER NUMBER AND ASSURE THE PAPER CLAIM HAS THE SAME INFORMATION SUBMITTED TO MEDICARE.**
- Also, it is helpful to include your Medicare Provider number, it is not on your remittance advice.
- BCBS of Kansas sends the Medicare information to the Home Plan for pricing. At times, the Home Plan may not understand the Medicare information sent and they process “guessing” at how to handle their portion. There are also instances when the information we receive from the Home Plan is not completely clear. If the provider wants more information, they should call our Blue Card Customer Service Center and query the other plan to find out more specific information.

*Again, in the future these claims will crossover directly to the Home Plan which will resolve these problems.*

#### **ADJUSTMENTS:**

Currently we are unable to process crossover claims that have been filed to Medicare as an adjustment. There are several problems related to this issue. We ask that providers file a paper claim to BCBSKS with the Medicare remittance advice, when the Medicare adjustment will change the Blue Cross payment. **MAKE SURE TO INCLUDE YOUR BLUE CROSS PROVIDER NUMBER and YOUR MEDICARE PROVIDER NUMBER.**

#### **Medicare Allowance Greater than Charge**

When the above occurs, we are not able to accept these electronically. These types of claims are not crossing over from Medicare because they will not price correctly. This occurs frequently on Rural Health Clinic claims. Until this problem is resolved, we ask that providers file a paper claim to BCBSKS with the Medicare remittance advice. **MAKE SURE TO INCLUDE YOUR BLUE CROSS PROVIDER NUMBER and YOUR MEDICARE PROVIDER NUMBER.**

Please follow directions outlined in the March 16, 2006 when submitting paper claims to obtain secondary payments:

**PLEASE FOLLOW DIRECTIONS IN THE FOLLOWING NEWSLETTER WHEN SUBMITTING PAPER CLAIMS TO OBTAIN SECONDARY PAYMENTS...**

[http://www.bcbsks.com/providers/publications/institutional/newsletters/2006/031606\\_MedicareClaims.htm](http://www.bcbsks.com/providers/publications/institutional/newsletters/2006/031606_MedicareClaims.htm)

## OUT OF STATE INQUIRIES

This is available on the Blue Cross and Blue Shield of Kansas web site. It is available for all Blue Cross and Blue Shield members. However, not all Blue Cross plans offer online inquiry capabilities from 12 midnight to 6 a.m. If someone tries to use the online system and the other plan isn't up, they'll get the same message: cannot process. entity not real time, resubmit batch.

### **FREQUENT ERROR MADE BY PROVIDERS**

A frequent error made by providers is they're entering the patient/member last name in the first name field and vice versa.

Eligibility and claim status information for Kansas' members and out-of-area members is available through the BCBSKS web site [www.bcbsks.com](http://www.bcbsks.com) (provider services section). If after using the online inquiry process, additional information is needed, call:

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
BCBSKS customer service center -claim inquiries for Kansas members	1-800-432-3990

More information about the BlueCard program is available in the [BCBSKS Institutional Provider Manual](#).

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## ELIGIBILITY ENHANCEMENTS

By March of 2007, enhancements will be made to eligibility for all BCBS members (in and out of state). Providers will be able to get detailed information regarding specific benefits. Another enhancement will include coverage information based on HCPCS.

**WON'T THIS BE GREAT!!!!!!**

# MEDICAL REVIEW REQUESTS

[http://www.bcbsks.com/providers/publications/institutional/newsletters/2006/062106\\_MedicalRecordRequests.htm](http://www.bcbsks.com/providers/publications/institutional/newsletters/2006/062106_MedicalRecordRequests.htm)

Most claims that providers send to BCBS can be processed based on the codes that are included on the claim. There is however times when medical records are needed before a claim can be finalized. Medical records might be needed when:

- the medical necessity for a service is not clear;
- high cost/utilization services are provided; or
- an agreement with a specific group requires certain services be reviewed.

Providers located in the Kansas company service area submit all of their claims to BCBSKS. This includes claims for local members (enrolled in BCBSKS) as well as out-of-area members (enrolled in BCBS in another state). If a claim for either a local or out-of-area member requires medical records, you'll receive that request from BCBSKS. Providers will also return those records to BCBSKS.

The procedures for requesting and submitting medical records are different depending on whether the claim is for a local member or an out-of-area member. Here's how the processes work:

## **Medical record procedures for claims involving LOCAL MEMBERS**

When a claim for a local member requires medical records:

- BCBSKS temporarily denies the claim for more information.

BCBSKS sends a letter to the provider outlining the specific records needed.

The provider resubmits the claim to BCBSKS with the records attached.

BCBSKS finalize the claim.

BCBSKS expects that medical records for local members be submitted timely.

## **Medical record procedures for claims involving OUT-OF-AREA MEMBERS**

National BlueCard handling procedures requires that BCBSKS track medical record requests.

**BCBSKS is graded on the timeliness of the provider's response and the return of the records to the member's home plan.**

### **When a claim for an out-of-area member requires medical records**

The member's home plan tells BCBSKS what records they need,

BCBSKS faxes a letter to the provider clearly stating what records are needed.

The letter asks that the records be faxed to BCBSKS within 10 days of the date of the letter. A mailing address is also provided.

BCBSKS tracks the medical records request awaiting the provider's response.

- Providers submit the medical records to BCBSKS within 10 days of the date of the request. Fax submission is preferred.
- BCBSKS forwards the records to the member's home plan for review and claim finalization. (When records are faxed to BCBSKS we can redirect the fax onto the member's home plan without converting the information to paper.)

Because BCBSKS is graded on how timely records are provided to the member's home plan, we strongly encourage that all records for out-of-area claims be faxed to us within 10 days of the date of the request. We believe that the ability to request and submit medical records via a fax process is HIPAA compliant.

We also believe that the timely turnaround of all medical records (for both local and out-of-area members) not only enhances the overall claim processing cycle but also allows providers to satisfy State requirements that apply to record requests made by patients or their designee.

We appreciate your commitment to not only providing quality healthcare services but to making claim and medical information available in the requested timely manner that will enhance the claims process.

If you have questions about BCBS claims, contact:

Local Members:	Topeka Local	785/291-4180
	Toll Free	1-800-432-3990

Out of Area Members:	Topeka Local	785/291-4058
	Toll Free	1-800-432-3990 (4058)

## ICD9 DIAGNOSIS CODING

There is a change in how BCBSKS processes claims and validates the ICD-9 diagnosis and procedure codes reported on inpatient claims.

**Previously**, BCBSKS validated ICD-9 diagnosis and procedures codes based on the codes that were valid **at the time of admission**. This is different from some other insurance companies (including Medicare) that expect inpatient claims to reflect codes that are valid as of the date of discharge. BCBSKS has been told that this difference creates issues for providers including coding hardships for hospital staff. The difference was more pronounced this past year because of the significant number of code changes that went into effect October 1, 2005.

After evaluating this situation BCBSKS has agreed that inpatient claims should be billed and will be processed based on the ICD-9 diagnosis and procedure codes in effect **at the time of discharge or through service date reflected on the claim**. Claims processing includes DRG assignment as well as MAP, per diem or discounts calculations.

This change has been made to the BCBSKS processing system.

## NEW SERVICES AND EXPERIMENTAL/INVESTIGATIONAL SERVICES

There is so much new technology being approved today and vendors are anxiously waiting at the physicians offices to talk to them about the newest procedures and the newest equipment to provide these services. Typically, the physicians will attempt to talk the hospital into providing some of these services rather than invest in the equipment themselves. And, there are procedures that should not be done in a physician's office so this would be appropriate. Remember to let Angie Martin or Vicki Haverkamp know your facility is CONSIDERING doing a new procedure BEFORE it is actually done so that we can determine whether or not Medicare or Blue Cross and Blue Shield will allow coverage for such a service. Too often, the service is already being done in your facility and you are rushing around to determine coverage and billing instructions. One clue.....if the vendor is telling you to use a NOC code for the service, that should tip you off that this is a new service that might not have enough data (credible evidence) to support the efficacy of the service and you could possibly be left holding the bill on this service. Below is a list of the Experimental/Investigational services we have found. If you click on the specific service, you will find a description of the service, codes to accompany the service and the position of Blue Cross and Blue Shield. Several of these have been updated recently and should be viewed with the information being referred to the appropriate staff within your facility.

**Keep in mind that just because something has been approved by the FDA and EVERY OTHER STATE IN THE NATION IS PAYING FOR A PROCEDURE doesn't mean that Blue Cross and Blue Shield of Kansas will allow benefits for the procedure. Please notify us and let us check it out for you before doing anything.**

### Experimental/Investigational Services

- [Anodyne ® Therapy](#)
- [Artificial Disc \(i.e. CHARITÉ \)](#)
- [Carotid Angioplasty/Stenting \(CAS\)](#)
- [Computerized Tomography \(CT\)](#)
- [Coronary Artery Scans](#)
- [Coronary Magnetic Resonance Angiography](#)
- [Cryogenic Neuroablation of Lower Extremity Neuromas](#)
- [Diagnostic Spinal Ultrasound for trauma or back pain](#)
- [Ductal Lavage \(Breast\)](#)
- [Electron Beam Computerized Tomography \(EBCT\) Screening for Cardiovascular Calcium Deposits also](#)

known as Ultrafast CT, CT angiography and CINE CT

- Endoscopic gastroplasty for gastroesophageal reflux disease (GERD) and weight reduction
- Extracorporeal Magnetic Innervation (ExMI)
- Extracorporeal Shock Wave Therapy (ESWT) for Tennis Elbow and Musculoskeletal Conditions
- Genetic Breast Cancer Assay (i.e. Oncotype DX -21 gene assay)
- High Dose Rate (HDR) Breast Brachytherapy with HDR Radioactive Source via Mammosite Catheter
- Low-Level Laser Infrared Therapy (also known as soft laser therapy, Microlight 830, and cold laser therapy)
- Phototherapy Light for the Treatment of Seasonal Affective and Other Depressive Disorders
- Platelet Derived Wound Healing Formula, e.g. Gravitational Platelet Separation the GPS® System
- Radioimmunotherapy for Non-Hodgkin's Lymphoma with Tositumomab (Bexxar®)
- Repair of Foramen ovale with septal occluder device
- Sleep Apnea and Post Operative Sleep Studies
- Speculoscopy
- Sural Nerve Graft
- TheraTogs ® (trunk and hip orthotic)
- Thoracic bioimpedance
- Virtual Colonoscopy

## **Introduction**

Locally underwritten Blue Cross and Blue Shield of Kansas (BCBSKS) member contracts include a general exclusion for any drug, device or medical treatment or procedure and related services that are experimental or investigational. (The definition of experimental or investigational as defined in the member contract appears below - [view definition.](#))

The BCBSKS provider contract prohibits the provider from billing a member for experimental or investigational services unless the provider issued a written notice in advance stating that a specific service was not covered and why.

Providers are responsible to know if services offered at their facility are experimental or investigational. While it is not the responsibility of BCBSKS to keep providers informed of medical protocols and approvals, we may become aware of information about services through communications with providers and other medical resources.

This notice includes a list of experimental or investigational services. The list:

- Is not all-inclusive.
- Includes information that's valid as of the update date.
- Is subject to change without notice.
- Does not relieve the provider of their responsibility to monitor medical protocols and approvals.
- Is intended only as a method to share information with providers.

### **Experimental/Investigational Defined**

The following definition appears in the locally underwritten BCBSKS member contract.

**Experimental or Investigational** refers to the status of a drug, device, medical treatment or procedure:

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

**Credible Evidence** means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating eligible provider or the protocol of another eligible provider providing or studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating eligible provider or by another eligible provider providing or studying substantially the same drug, device, medical treatment or procedure.

(updated 2/2005)

## Computerized Tomography (CT) Coronary Artery Scans

One service we have received many questions about is the CTA. Following is the information published on our website stating the Blue Cross and Blue Shield position on this test. Please note this is listed under

### *Experimental/Investigational Services*

#### **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**  
**0145T**  
**0146T**  
**0147T**  
**0148T**  
**0149T**  
**0150T**  
**0151T**

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.

On January 1, 2006, the following CPT codes were added CPT codes 0144T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T, and 0151T.

On April 5, 2006, CPT code S8093 was deleted per HCPCS (March 31, 2006).

#### **(Web updated 7/2006)**

CPT	Description
70496	Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing

- 70498 Computed tomographic angiography, neck, without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing
- 71275 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing
- 72191 Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing
- 73206 Computed tomographic angiography, upper extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
- 73706 Computed tomographic angiography, lower extremity, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing
- 74175 Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

## MEDICAL POLICIES

There have been several updates made to Medical Policies this quarter. Below is the list of medical policies and the effective date of the latest update. If you have specific edits in your system concerning the policies you will want to review these updates and make any changes that may be pertinent. BCBSKS only displays the most current version of a medical policy. When updated policies become effective, prior versions are removed from this Web site.

Policy Title 	Date Posted	Effective Date
<a href="#">Ambulatory Blood Pressure Monitoring</a>	07/01/05	08/01/05
<a href="#">Ambulatory Event Monitors (AEM)</a>	12/30/05	02/01/06
<a href="#">Ambulatory Event Monitors (AEM)</a>	06/30/06	<b>08/01/06</b>
<a href="#">Bone Anchored Hearing Aids (BAHA)</a>	06/01/06	<b>07/01/06</b>
<a href="#">Botulinum Toxin (BT) (i.e. Botox ®)</a>	06/30/06	<b>07/01/06</b>
<a href="#">BRCA I and BRCA II Testing</a>	12/30/05	02/01/06
<a href="#">Cardiovascular Magnetic Resonance (CMR)</a>	06/01/06	<b>07/01/06</b>
<a href="#">Cochlear Implant</a>	06/01/06	<b>07/01/06</b>
<a href="#">Computed Tomographic Angiography (CTA)</a>	03/31/06	<b>05/01/06</b>
<a href="#">Continuous Glucose Monitoring System</a>	06/01/05	07/01/05
<a href="#">Deflux Injection for Vesicoureteral Reflux (VUR)</a>	12/30/05	02/01/06
<a href="#">Electrodiagnostic (EDX) Medicine and Related Services</a>	06/01/06	<b>07/01/06</b>
<a href="#">Esophageal pH Monitoring</a>	06/30/06	<b>05/01/06</b>
<a href="#">Extended Fundus Photography</a>	08/01/05	08/01/05
<a href="#">Equipment for Cold Therapy</a>	08/01/05	08/01/05
<a href="#">Extracorporeal Shock Wave Therapy (ESWT) for Plantar Fasciitis</a>	12/30/05	01/01/06
<a href="#">Fetal Fibronectin</a>	03/01/06	<b>04/01/06</b>
<a href="#">Home Phototherapy</a>	03/31/06	<b>05/01/06</b>
<a href="#">Homocysteine Testing</a>	08/01/05	08/01/05
<a href="#">Hyperbaric Oxygen (HBO) Therapy</a>	05/03/04	06/03/04
<a href="#">Immune Globulin Therapy (IVIG)</a>	03/31/06	<b>05/01/06</b>
<a href="#">Laser Assisted Uvulopalatopharyngoplasty (LAUP)</a>	12/30/05	02/01/06
<a href="#">Liver Tumors, Treatment of</a>	06/30/06	<b>08/01/06</b>
<a href="#">Magnetic Resonance Angiography (MRA)</a>	03/31/06	<b>05/01/06</b>
<a href="#">Magnetic Resonance Imaging (MRI) Breast</a>	12/30/05	02/01/06
<a href="#">Minimally Invasive Procedures For Spine Pain</a>	03/31/06	<b>05/01/06</b>

<a href="#"><u>Minimally Invasive Procedures For Spine Pain</u></a>	06/30/06	<b>08/01/06</b>
<a href="#"><u>Nuchal Translucency</u></a>	03/01/06	<b>04/01/06</b>
<a href="#"><u>Osteochondral Knee Allograft and Autograft</u></a>	07/01/05	08/01/05
<a href="#"><u>Panniculectomy and Abdominoplasty</u></a>	03/31/06	<b>05/01/06</b>
<a href="#"><u>Polysomnography and Sleep Studies</u></a>	03/31/06	<b>05/01/06</b>
<a href="#"><u>Positron Emission Tomography (PET)</u></a>	03/31/06	<b>05/01/06</b>
<a href="#"><u>Regional Nerve Blocks and General Anesthesia</u></a>	09/30/05	11/01/05
<a href="#"><u>Tumor Markers CA-15-3 and CA-27.29</u></a>	07/01/05	08/01/05
<a href="#"><u>Uvulopalatopharyngoplasty (UPPP) and Tongue Base Reduction Surgery</u></a>	12/30/05	02/01/06
<a href="#"><u>Vacuum Assisted Wound Closure (VAC)</u></a>	12/30/05	02/01/06
<a href="#"><u>Water-Induced Thermotherapy for Benign Prostate Hypertrophy (BPH)</u></a>	12/30/05	02/01/06

## 2007 POLICIES AND PROCEDURES

PAGE and SECTION	DESCRIPTION
	Clarified the use of the terms 'Plan' and 'Company' throughout the document.
Page 1, Introduction, Programs	Clarified that the service benefit programs covered by the Policies and Procedures include the Value Blue product.
Page 1 & 2, Introduction, Medicare Advantage Claims	<p>Added the following paragraph:</p> <p><i>“Medicare Advantage (MA) claims occurring under a form of coverage offered by a Blue Cross and Blue Shield Plan other than BCBSKS should be submitted directly to BCBSKS, who will report the status of such claims on its remittance advices. However, MA claims cannot and will not be processed or appealed pursuant to BCBSKS Policies and Procedures. Such other Blue Plan is solely responsible for determining pricing and medical policy (as required by the Centers for Medicare &amp; Medicaid Services). A provider’s contracting status with the Centers for Medicare &amp; Medicaid Services (CMS) determines MA payment allowances. The provider may appeal Medicare Advantage claims only to the Blue Plan providing the MA coverage regardless of whether BCBSKS or another Blue Cross and Blue Shield Plan issued payment. The provider agrees to abide by the final determination resulting from the MA appeals process, which is established by CMS. The appeals policies and procedures of such other Blue Plans should be obtained from those Blue Plans directly.”</i></p>
Page 5, Section I. Definitions, Company	<p>Added the definition for Company as a term used to describe BCBSKS.</p> <p><i>“The term <b>Company</b> is used throughout this and other documents to describe BCBSKS.”</i></p>
Page 7, Section I. Definitions, Partial-day Treatment	<p>Removed the reference to the Substance Abuse Prevention, Treatment and Recovery (SAPTR) program requirements.</p> <p>Added the American Society of Addiction Medicine Patient Placement Criteria second edition revised (ASAM PPC-2R) as the criteria used in partial-day substance abuse medical necessity review.</p> <p>Added the source used to review partial-day programs for the treatment of psychiatric conditions, which is ValueOptions</p>

	mental health criteria.
Page 8, Section I. Definitions, Peer Group	Added the following definition:  <i>“Peer groups categorize hospitals based upon the number of beds with zero to 49 beds being Peer Group 1, 50 – 99 beds being Peer Group 2 and 100 or more beds representing Peer Group 3. Additional peer groups exist for the Topeka and Wichita communities, for specialty hospitals and Critical Access Hospitals (CAH).”</i>
Page 8, Section I. Definitions, Plan	Clarified the definition for Plan as follows:  <i>“The term Plan is used throughout this document to describe a Blue Cross and Blue Shield Plan other than BCBSKS.”</i>
Page 8 & 9, Section I. Definitions, UB-92	Added the following definition:  <i>“The terms ‘UB-92’ and ‘UB-04’ (when effective) are interchangeable and may be used throughout the Policies to describe the claim form used by providers to submit institutional charges.”</i>
Page 10, Section II. General Conditions, Other Party Liability	Added the following paragraph:  <i>“BCBSKS will process the balances of the primary carrier’s allowable charge not paid by the primary carrier and will apply any applicable maximum payments.”</i>
Page 21, Section IV. Requests for Information, Quality of Care Reviews	Clarified that quality of care reviews are not limited to Blue Select and Premier Blue members and BCBSKS or their designee will investigate quality concerns.  Removed the reference to prior notification.
Page 22 & 23, Section V. Appeals, Provider Appeals For Experimental/ Investigational or Not Medically Necessary Services	Minimized the length of time the provider must spend in the appeals process in an effort to provide a quicker resolution on appealed cases.
Page 23 & 24, Section V. Appeals, Post-Payment Audit Appeals	Reworded this section to clarify that while appeals are available, they are not required.  <i>“BCBSKS conducts periodic post-payment audits of patient</i>

	<p><i>records to substantiate the medical necessity of services billed on the provider claim. BCBSKS provides education through Policy memos, Medical policy, newsletters, workshops, direct correspondence, and onsite visits. In audits where audit findings conclude that education did not occur, BCBSKS will then provide education. If education does not resolve subsequent Medical Necessity findings, BCBSKS will seek refunds for those paid claims.</i></p> <p><i>If claims include billing for services not documented, then BCBSKS will request refunds and may refer the case for further investigation.</i></p> <p><i><b>If post-pay refund requests based on medical necessity <del>must have an</del> are appealed, the appeal will be</b> filed in writing within 30 days of the refund request. The provider must include all relevant documentation with the appeal. The BCBSKS determination will be made within 30 days of receipt of the appeal.</i></p> <p><i>A provider may request a second and final appeal in writing within 30 days of notification of the appeal determination. The second and final appeal determination will be made by the BCBSKS Vice President of Medical Affairs within 30 days. When findings reveal issues, which are presently specified in the BCBSKS policies, billing guidelines or newsletters relating to content of service, multiple surgery guidelines, and other billing and/or reimbursement guidelines, the terms of this appeal are not available.”</i></p>
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ACUTE HOSPITAL PAYMENT ATTACHMENT

PAGE and SECTION	DESCRIPTION
	Removed outdated references to Choice Care and HCFA 1500 throughout the document.
Page 2 & 3, Maximum Allowable Payment	<p>Added references to how Premier Blue allowances are determined. Replaced the word ‘Reimbursement’ with ‘Payment’.</p> <p>Removed the following:</p> <p><i>“Allowable charges will be determined by applying the Blue Choice/Blue Select discount percentage agreed upon by the Contracting provider to the lesser of the charge or MAP previously established for the DRG....”</i></p>

	<p>Added the following wording in italics:</p> <p><i>“Charges will be allowed up to the discounted DRG MAP.”</i></p>
Page 3 & 4, Incentive Payments	<p>Removed the reference of payment based on the allowance in effect on the admission date to be in compliance with industry standard of using the allowance in effect on the date of discharge.</p>
Page 5 & 6, Skilled Nursing Unit And Swing-Bed Claims	<p>Added the following paragraph:</p> <p><i>“<u>Blue Choice/Blue Select</u> – Hospitals with a skilled nursing unit or swing-bed will be reimbursed at the lesser of charge or discounted CAP MAP based on the DRG assigned to the inpatient skilled stay.”</i></p> <p>Reworded the ‘Premier Blue’ section for clarity.</p>
Page 7 & 8, Outpatient Psychiatric and Substance Abuse Services	<p>Reworded for clarity.</p> <p><i>“When outpatient psychiatric or substance abuse services are provided, all charges for services of the professional psychiatrist, psychologist, licensed clinical social worker (LSCSW) or advanced registered nurse practitioner (ARNP) who have a professional provider contract with BCBSKS are billed on a CMS-1500 claim form. No charges will be submitted on a UB-92 claim form when a CMS-1500 is submitted.</i></p> <p><i>Facility charges for covered services provided in an institutional setting by professionals who are not permitted to submit charges on a CMS-1500 claim form may be billed on a UB-92 claim form in lieu of the CMS-1500 if the facility charge is allowable.’</i></p>
Page 10, Outpatient Reimbursement	<p>Reworded for clarity.</p> <p><i>“The charges for the list of specified outpatient services, drugs and items that have MAPs will be allowed up to the MAP. The Contracting Provider will be required to write off amounts above the allowance, and members will be responsible for any coinsurance, shared payment, deductible or non-covered amounts up to the MAP.</i></p> <p><i>All other procedures and outpatient services not subject to a MAP will be reimbursed according to a payment</i></p>

*calculated by reducing the total charge by the hospital's overall percentage of discount.*

*The discount percents for Blue Choice and Blue Select are documented in the Blue Choice/Blue Select Agreement.*

*For the CAP Contracting Provider Agreement, the overall discount percent will be computed by dividing the total inpatient and outpatient write-off amount by the total inpatient and outpatient charges. The percentage will be rounded to the nearest tenth (0.10) of a percent. No percentage less than one (1.0) will be applied with a maximum of ten (10) percent. The Contracting Provider will be required to write off the discounted amounts. The discount percentage will be evaluated and any necessary adjustments will be made effective the first day of each calendar quarter. The Contracting Provider will be notified by the 15<sup>th</sup> day of the third month of the calendar quarter as to their outpatient discount for the ensuing calendar quarter.*

*In all reimbursement methods, the Contracting Provider is required to write off all charges in excess of MAPs.”*